

Health, Health Care, and Incompletely Theorized Agreements: A Normative Theory of Health Policy Decision Making

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Abstract The years 2003–2004 marked the tenth anniversary of the rapid rise and demise of the Clinton administration’s health reform efforts. Health reform may again be a political issue in the 2008 congressional and presidential elections. However, analysts still disagree over why large-scale health reform efforts continue to fail in the American political landscape. This article presents a *normative theory* for analyzing federal health policy decision making in the United States. This theory states that values and norms, particularly their level of generality, and the social agreement or lack thereof around them have a central role in understanding health policy reform. This theory does not attempt to arrive at a single unified framework for explaining health policy reform, and it recognizes the complementary roles of political science and economic explanations. Nonetheless, it argues that unarticulated values and norms have a critical role to play in health-policy making and reform; this role has been inadequately studied and has lacked a theoretical framework. Within this perspective, this article argues that policy goals, which require individuals to make financial commitments (e.g., tax contributions) in the form of redistributing resources for implementation (e.g., universal health insurance), should be analyzed within a normative framework that evaluates individuals’ ethical commitments to making such sacrifices that are beyond their self-interest. The distribution of *pub-*

I acknowledge the helpful comments of Amartya Sen, Cass Sunstein, Mark Schlesinger, Allan Brandt, Jerry Green, Jenny Mansbridge, Ted Marmor, Joe Newhouse, Theodore Ruger, three anonymous reviewers, participants in the Harvard Doctoral Seminar Series in Health Policy, and Nicole Kemper for research assistance. This paper is drawn in part from my mimeograph titled “Health, Health Care, and Incompletely Theorized Agreements,” Harvard University, 1995. For research support, I thank the Health Institute, the Henry J. Kaiser Family Foundation, the National Library of Medicine (NIH), the Mark DeWolfe Howe Fund, and the Brookings Institution.

Journal of Health Politics, Policy and Law, Vol. 32, No. 1, February 2007
DOI 10.1215/03616878-2006-028 © 2007 by Duke University Press

lic moral norms, their degree of *internalization*, and the *social consensus*, or lack thereof, that applies to them must be objects of study in the effort to better understand health policy reform. By emphasizing these factors, this approach offers findings distinct from those provided by existing analyses, and the article concludes with prescriptions for future health reform efforts.

Introduction

Although health care reform was attempted several times during the twentieth century, most large-scale efforts failed. One of the most well-known failures occurred in 1993–1994 under the presidency of William Jefferson Clinton. That period offered prospects for successful health policy reform, but most promises were unfulfilled, and 46 million Americans are still uninsured (Kaiser Commission on Medicaid and the Uninsured 2006). Health policy reform and the concerns that drive it—cost, quality, and access—may again be issues in the 2008 congressional and presidential elections.

Despite many valuable efforts to explain the fate of large-scale reforms, it is still unclear why Americans are unwilling to pass federal legislation that ensures equal access to health care for all. The United States remains the only industrialized country that does not guarantee universal health insurance coverage or access to health care. To address this question, this article presents a normative theory for analyzing federal health policy decisions in the United States. The goal of this article is to advance an approach to understanding health care reform that analyzes the role of values and norms, particularly their level of generality, in health policy decision making and the extent to which different policy actors (political and nonpolitical) internalize norms themselves and attempt to produce coalitions around them. This normative framework integrates public moral norm internalization and the social agreement model of incomplete theorization. Prior work on public values in health policy has overlooked the ways in which values of different levels of specificity connect to create a coherent rationale for health reform. This article aims to address this gap in the literature by advancing an approach based on a more accurate framework of social agreement, which reflects the fact that values and norms operate at multiple levels of generality and degrees of internalization and in so doing provides a better understanding of how norms and values work together to form a coherent (or incoherent) basis for reform.

An *internalized norm* is one that is so widely accepted as to have a “taken-for-granted” quality (Finnemore and Sikkink 1998). Individuals

intrinsically conform to internalized norms in the absence of external rewards or punishments (Bénabou and Tirole 2003). *Social internalization* occurs when the public legitimacy of a norm is such that there is widespread general adherence to it, whereas *political internalization* occurs when political elites accept the norm and promote its adoption as a matter of public policy (Koh 1998). What I call a *public moral norm* is a moral value that pertains to our individual and collective morality in the public sphere; an example of such a norm would be collective organization to achieve common goals. A public moral norm contrasts with an individual moral norm in that the moral value pertains not just to individual action but to individual and collective action regarding the public sphere (e.g., norms about procedural justice, rules of accuracy, trust, ethicality, and neutrality). In this article I analyze a particular type of public moral norm, a *distributive justice norm*, that determines the distribution of societal resources for health care.

An *incompletely theorized agreement* is one that is not uniformly theorized at all levels and across all dimensions of specificity and abstraction. Such agreements fail to produce *depth* (full accounts of foundations) or *width* (coherence with other dimensions). The approach offered here has roots in contemporary legal and political theory and builds on the social decision-making framework of incompletely theorized agreements (ITA). The concept of ITA can be attributed to Cass Sunstein (1995), but it also relates to John Rawls's notion of overlapping consensus (OC) (Rawls 1993). Both authors have tried to create frameworks for understanding how stability and social agreement might be established among elites (in law and the judiciary for ITA and in politics for OC) who disagree on fundamental matters. But neither Sunstein nor Rawls has applied these frameworks to public discourse about policy reform and the understanding of how public values are effectively internalized by citizens. Moreover, neither framework has been applied to specific policy domains such as health care.

I argue that the reason health care reform efforts have consistently failed in the United States can be understood by first analyzing the extent of individual, societal, and political internalization of the public moral norm that one has an ethical commitment to make financial sacrifices to support the expansion of health insurance, and then determining the extent to which social agreement about this ethical commitment has occurred. This agreement may come at the expense of a lack of consensus on abstract higher-level principles and on principles in other domains of social life (e.g., welfare). It will be difficult for the United States to adopt universal

health insurance coverage until this more concrete ethical norm of willingness to pay for others' health care coverage is internalized and agreed upon at the social and political level. In turn, social and political internalization will cause this norm to be enshrined in domestic legislation. Efforts to achieve public consensus on abstract principles (e.g., equality or egalitarianism) or on the vagaries of "universal coverage" will continue to fail because they create more disagreement than agreement. This is because Americans, especially liberal Americans, experience considerable ambivalence and conflict among the abstract higher-level principles invoked in debates about universal coverage. I use the framework of ITA to illustrate how these cleavages and uncertainties work and how they allow opponents of reform to launch value-based arguments that disrupt reform-supporting coalitions.

The first section presents an overview of previous academic discussion of the role of values in motivating citizens' support for public policies. To frame my discussion, I then explore the differences between social agreement frameworks (such as ITA and OC) and the more traditional political science models of political decision making that focus on political bargaining. I pay particular attention to how the more traditional models concentrate on what Rawls calls a *modus vivendi* as opposed to the formation of real and stable coalitions. This section also highlights theoretical differences between frameworks for decision making among elites in the law and judiciary and in politics.

Building on the theory of the second section, I present the three types of ITA, briefly outlining why the ITA framework is useful in drawing attention to the different levels of generality in value-based arguments and to the potential for building stable reform coalitions in public discourse among citizens. By studying how public values are internalized and agreed upon by citizens and their elite representatives, I extend these frameworks to include public discourse about policy reform.

I then survey the literature that attempts to discover why the health reform efforts of the Clinton administration failed. This section demonstrates that, while virtually all of the major scholarship in political science refers to the importance of underlying public values in understanding the fate of health care reform, none of it provides a theoretical framework for analyzing these values.

In light of my earlier discussion of social agreement models, I analyze why American health care reform during the 1993–1994 Clinton administration generally fits into the norm- and value-based framework of ITA. The main argument here is that deliberations about health care in the

United States represented agreement on the midlevel concept of universal coverage, concurrent with disagreement both on higher-level abstract principles and on low-level principles for particular outcomes. Further, while social internalization of and social agreement on some broadly defined health policy metaphors (such as universal coverage or a right to health care) may have occurred during the debate, both social and political internalization and agreement were lacking on the more concrete public moral norm of willingness to pay for universal health insurance measuring the public's and political elites' strength of commitment to that norm.

Juxtaposing this second model with ITA's other two models, the second model is found to be particularly susceptible to the destabilizing influence of competing values and is therefore less successful at producing social stability and social agreement. Social and political internalization of concrete norms works to *reduce* rather than to increase variation by stabilizing expectations and limiting options for policy choice. Without a shared and internalized norm of willingness to pay for universal coverage, the variation created by numerous floating policy metaphors and ideas failed to stabilize expectations and ultimately limit rather than expand policy options.

Applying the ITA methodology to decision making about reforms to universalize health insurance coverage in the United States, the last section explores the notion that agreement on a high-level principle (such as health for all) or on a low-level principle for a substantive outcome (such as willingness to pay for others' health insurance) might lead to more stable and broadly endorsed support for reform that universalizes insurance coverage in the United States.

Norms and Values in the Public's Assessment of Policy

Norms and values have always played a role in the study of public policy and political science, although they have typically been consigned to the categories of political culture or political ideology. Cultural and ideological explanations of political attitudes and behavior typically focus on deeply ingrained social patterns, path dependency of historical events (e.g., the libertarian essence of the western frontier in American expansion, an aversion to state control in various social and economic activities, the legacy of slaves brought to the United States from Africa, or women's traditional societal roles), and key ideologies (e.g., liberal or conservative ideologies). Although ideological and cultural explanations have at times

been the focus as an explanatory category for policy outcomes, they have received less attention than the more widely studied economic and political factors (Lipset 1963; Feldman and Zaller 1992; Free and Cantril 1968; Hochschild 1981; Verba and Orren 1985).

For nearly half a century, scholars studying political culture and political ideology in the realm of social policy have focused on the degree to which the American public is contradictory—oscillating between ideological convictions—or ideologically innocent—not coherently organizing policy preferences in accordance with liberal or conservative ideology (Converse 1976; Lane 1962). Some have focused on organized ideological conventions, which might serve to categorize Americans' values into distinct "value sets" (e.g., conservative ideology favoring capitalism and liberal ideology stressing democratic values; McClosky and Zaller 1984). Even this conception highlights individuals' inconsistencies, which preclude their full participation in mutually exclusive liberal or conservative ideologies, and temporal instability and inconsistency in individuals' issue preferences (Feldman 1988). Others have focused on the value conflict that underlies Americans' political behavior and the difficulty, inconsistency, or even lack of interest in resolving differences (Hochschild 1981; Reinerman 1987) between libertarian and socialist principles, for example. This work highlights the fact that individuals rarely completely resolve this conflict in a consistent or coherent manner. Some have argued that for many social welfare policy issues, supporters (liberals) are more conflicted in policy preferences and underlying values (e.g., compassionate toward disadvantaged groups but opposed to higher taxes, expansion of budgets, and government) than are opponents (conservatives). Conservatives are generally more consistent in their ideological justification against expanded services (e.g., individuals should get ahead on their own and without more taxes and bigger government) (Feldman and Zaller 1992). In brief, American political culture is full of unresolved value conflicts, especially between freedom and equality, particularly when applied to social policy (Lipset 1963; McClosky and Zaller 1984). Indeed, it may be the case that those who generally support social welfare policies are more conflicted about the abstract values they invoke to justify their support than are social welfare opponents.

Another major finding from the literature on political ideology and political culture is that individual use of abstract principles and beliefs may vary by issue domain. This phenomenon is relevant for health policy because of the unique nature of health and health care in political decision making. Health differs from other social policy domains because the same

feelings of individualism do not seem to apply to health as to welfare, job guarantees, guaranteed living standards, or spending on education. Health departs from welfare in a number of respects, mostly related to people's views of individualism, responsibility, dependency, and just deserts. Individuals do not always have full control over their health—people get cancer for unknown reasons—and health problems can arise even when individuals are doing everything they can to be healthy. In addition, welfare “dependency” does not appear to have a health care equivalent (Cook and Barrett 1992). Although more recent work has shown some dependency stigma associated with means-tested health programs like Medicaid, these biases are much less pronounced than cash assistance programs (Stuber and Schlesinger 2006). Not including hypochondriacs or individuals with Munchausen's disorder, and with the exception of market failures such as moral hazard or supplier-induced demand, individuals do not have the same dependency incentives in health as in welfare, because health care should be provided on an as-needed basis. Also, the principle of just deserts does not always apply to health. With some exceptions, people do not necessarily think that individuals should be denied health care because they are to blame for their health condition. This is different from attitudes about social welfare and poverty, where some individuals do believe that poor people deserve to be poor because America provides every opportunity to lift oneself out of poverty. Health disadvantage is not typically the result of lack of hard work or failure to take advantage of equal opportunity. Schlesinger and Lee (1993) found, for example, differences between people's views of health programs and their views of general redistributive policies. By comparison, federal health initiatives were viewed by the public as: (1) “less identified with racial minorities or economically disadvantaged groups”; (2) “less constrained by notions of individual responsibility”; (3) “more closely associated with concerns about equal opportunity in American society”; and (4) “somewhat more constrained by choices between federal and local government” (Schlesinger and Lee 1993: 551).

When individuals experience ambivalence about abstract values and principles, they must draw on lower-level principles and concrete considerations that appeal to them (Kahan and Braman 2006) to justify policy choices, otherwise conflict will prevent such choices. However, while past research on public values has examined how individuals endorse particular values and policies on an ad hoc basis, these studies have overlooked the ways in which values of different levels of generality connect to form a coherent basis for policy reform. They have also overlooked the com-

plex way in which individuals may incompletely theorize policy choice. Because of this, the theoretical framework for analyzing values and norms should do so in terms of multiple levels of specificity and recognize the value of conflict and ambiguity that underlies policy choice.

Alternative Frameworks: Political Conceptions and Political Processes

Standard political science models of decision making among policy makers generally focus on political and institutional factors. In the context of health reform in the United States, many explanatory models focus on the American political process and the relationship between the U.S. legislative and executive branches of government. The roadblocks to health reform that scholars cite include:

1. A fragmented and decentralized system of national policy making
2. Weak political parties
3. Personal politics
4. Congressional policy-making strategies
5. Strong interest group opposition
6. Reelection incentives
7. Financial contributions
8. Presidential tactics and strategy
9. Powerful congressional personalities
10. Character and judgment flaws of key actors

John Kingdon (2002) also notes other factors that make it difficult to reform policy, even during “open” windows of opportunity. These factors include rules of procedure, the U.S. Constitution, statutes, prescribed jurisdictions and other legal requirements, the budget, and political culture. While the goal of this article is not to state whether the political and institutional factors were or were not adequate to explain the defeat of health reform during the Clinton administration, these other factors may have themselves been the result of a public insufficiently mobilized by values and norms. Drawing attention to coalitions around and internalization of different levels of values and norms offers insights and prescriptions distinctive from those offered by prevailing analyses.

I advance an alternative framework that builds on political philosophy and legal theory, which I refer to as social agreement theory. From this perspective, pluralistic constitutional regimes, such as the United States, are composed of individuals and their representatives, whose diverse com-

prehensive doctrines create social tension and make social agreement difficult to achieve. Therefore, attempts to make collective decisions—for example, through the legislature—must emphasize shared values to achieve stability and social unity. Rawls calls this outcome an “overlapping consensus,” while Sunstein calls it an “incompletely theorized agreement.” Both frameworks emphasize the need to determine shared values—even values that are shared for different reasons—and to achieve social agreement for political and legal decision making. Although these conceptions were originally intended to facilitate elite deliberation in law and politics, I argue that social agreement theory can help us understand how public values are effectively internalized by citizens and their representatives and connected through stable coalitions.

Rawls, in particular, draws a sharp distinction between political bargaining models and conceptual models rooted in political philosophy and legal doctrine. He suggests that political process models based on political bargaining are akin to a *modus vivendi*—a “social consensus founded on self- or group interests, or on the outcome of political bargaining: social unity is only apparent” (Rawls 1993: 147). A *modus vivendi* is thus a consensus on “accepting certain authorities, or on complying with certain institutional arrangements, founded on a convergence of self- or group interests” (147). For example, acceptance of the principle of universal coverage by both Orrin Hatch and Ted Kennedy due to log rolling (the process by which politicians trade political favors to support personal legislative interests) would be unstable because the bargain would be “contingent on circumstances remaining such as not to upset the fortunate convergence of interests” (147). Thus, if the senators’ personal relationships dissolved or if the position of either person changed in Congress or within their respective parties, and they were no longer in a position to strike the bargain and hold their committee or party to it, the principle of universal coverage would no longer be followed. Agreements based on *modus vivendi* are also less stable than agreements based on a true overlapping consensus because the former depend more on “happenstance and a balance of relative forces” (148).

Sunstein’s ITA typology also contrasts with a political bargaining framework. The ITA framework, rooted in legal theory, was originally developed for legal, particularly judicial, decision making to address the need to achieve social agreement amid pluralism in law. This framework is usefully applied to legislation and to citizens’ and their representatives’ support for policies, and it augments the OC framework by describing the process of producing agreement on low-level principles when peo-

ple are unable to agree on higher-level abstractions. Like the OC model, actors within the ITA model are motivated by a good faith effort to do the right thing. Thus the decision or conception that is the object of a social agreement is supported on its own merits. A social consensus based on an OC/ITA framework differs from a political bargaining approach because it will not change if the distribution of power among decision makers changes.

There are additional reasons for a distinction between social agreements based on an overlapping consensus or an incompletely theorized agreement and those that result from political bargaining. First, as Rawls notes, the object of an overlapping consensus is itself a *moral* conception, such that it is valued in itself. Second, the OC is affirmed on moral grounds and includes “conceptions of society and of citizens as persons, as well as principles of justice, and an account of the political virtues through which those principles are embodied in human character and expressed in public life” (Rawls 1993: 147). In other words, it represents a consensus among elites—and in this case, citizens as well—on the public good, which may rise above the intersection of group or self-interests. Third, the OC is more stable because it is not simply a balance of power but is instead a *reasonable* consensus (148). A *modus vivendi*, by contrast, reflects a *temporary* agreement among different and opposing peoples and parties. Thus, the OC/ITA framework increases stability because those who affirm a decision “will not withdraw their support of it should the relative strength of their view in society increase and eventually become dominant” (148). Fourth, a social agreement framework attempts to draw out “certain fundamental ideas viewed as latent in the public political culture of a democratic society” (175). As such, it attempts to tap into individuals’ true values, even if individuals and their representatives have difficulty articulating those values in a completely theorized way. Fifth, this type of framework contrasts legitimate political authority with political power. For example, it differentiates “an account of the legitimacy of political authority” from “an account of how those who hold political power can satisfy themselves, and not citizens generally” (143–144). Stability is not promoted by “bringing others who reject a conception to share it, or to act in accordance with it, by workable sanctions” (143). Instead, it is promoted by a reasonable consensus on a conception that is politically legitimate. Political legitimacy, in turn, involves a “public basis of justification and appeals to public reason, and hence to free and equal citizens viewed as reasonable and rational” (144).

From this social agreement perspective, legitimate political authority is not just a matter of political philosophy; it has pragmatic advantages in forging consensus and coalitions amid pluralism. In this way, a social agreement framework helps further traditional political process and bargaining arguments because it illuminates how political actors can undermine the conditions for reasoned agreement on common interests. It challenges the current scope of public opinion research in that it calls for research on public opinion that considers aspects not addressed in most prior studies connecting values to support for policies. Furthermore, it calls for research to examine whether the conditions of public communication help produce an informed, reasoning, and deliberative public that may come to agreement on norms and values for policy. Jacobs and Shapiro's (2000) work, for example, complements a social agreement model by shedding light on the barriers to social consensus posed by the efforts of political leaders and the mass media to distort and manipulate public opinion. A social agreement model of policy decision making is thus linked to traditional political science models through an emphasis on public deliberation, responsible leadership, and mass communication. Moreover, a social agreement model relies on popular sovereignty and political leadership to enhance deliberative public debate and public reasoning in order to agree on the common good. In the United States, common ground for reaching agreement on the ethical principles that govern health and health care has yet to be achieved, or if it has been achieved implicitly, the agreement is on the libertarian principle that espouses the market as the default way to allocate health care resources.

Incompletely Theorized Agreements

The incompletely theorized agreements framework has the potential to enlarge our understanding of social decision making in democratic societies. In his work on the framework, Sunstein (1995) argues that, in well-functioning democracies, incomplete theorization helps produce agreement in the midst of social pluralism and population heterogeneity. I created diagrams to capture three types of ITAs: *incompletely specified agreements* (figure 1), *incompletely specified and generalized agreements* (figure 2), and *incompletely theorized agreements on particular outcomes* (figure 3). Sunstein places the most emphasis on the third type of ITA, using it as a framework to describe existing practices in Anglo-American law and to make claims about the virtues of ITA. He argues that this model is especially useful and perhaps necessary when a diverse

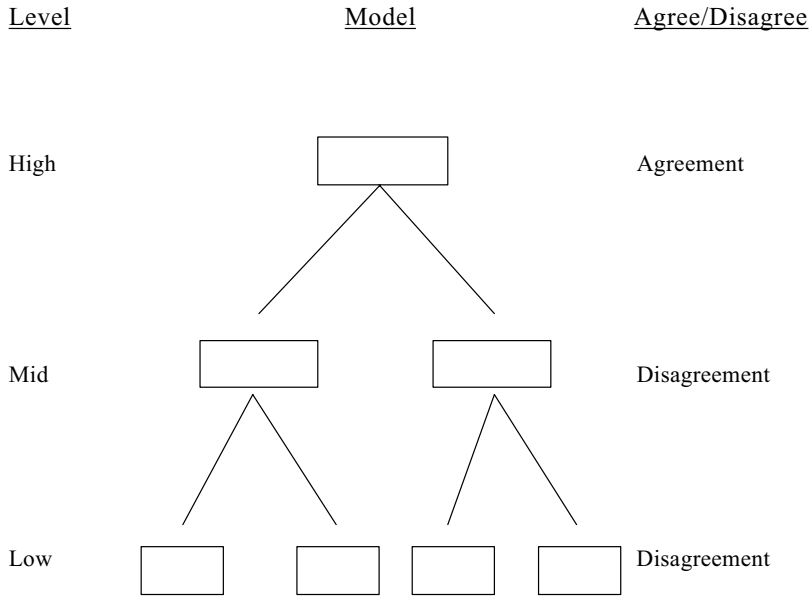


Figure 1 Model One: Incompletely Specified Agreements (High-Level Agreement). *Source:* Ruger 1998: 105.

group of decision makers must work together and express mutual respect. The ITA model is especially appropriate for ordinary legal and political discussions because political participants, lawyers, and judges are primarily concerned with seeking agreement on practical matters rather than with political philosophy. The ITA model is particularly useful when such practitioners have difficulty understanding abstract general theories or completely grasping complex, high-level principles.

Incompletely Specified Agreements

The first type of ITA occurs when there is agreement on a general principle but disagreement about particular cases or controversies (figure 1). For example, people can accept that murder is wrong but disagree on the interpretation of that statement, as happens in the controversy over abortion. Similarly, I argue, people who define health as an appropriate level of physical and mental functioning might disagree about how society should provide medical care and other social services in order to improve health.

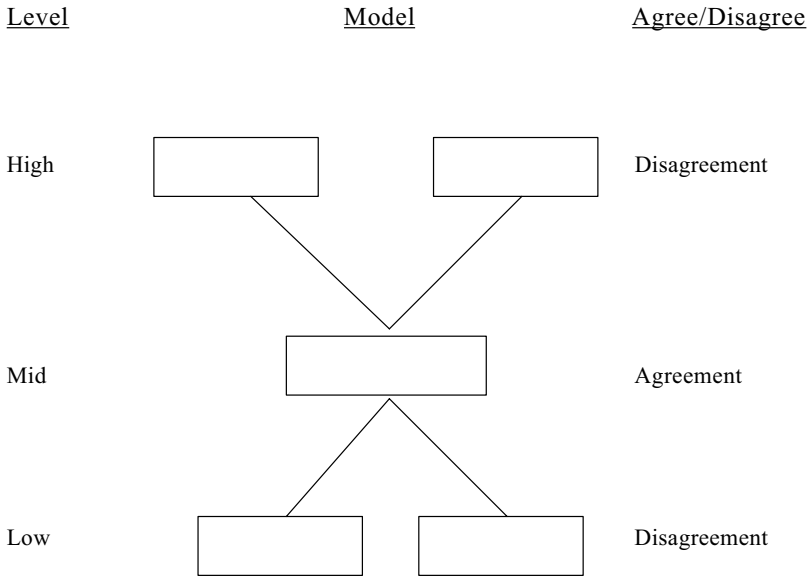


Figure 2 Model Two: Incompletely Specified and Generalized Agreements (Midlevel Agreement). *Source:* Ruger 1998: 106.

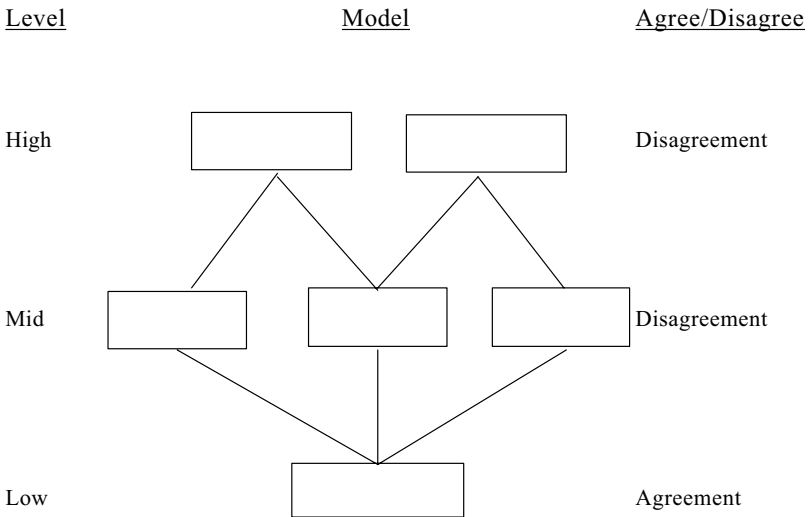


Figure 3 Model Three: Incompletely Theorized Agreements on Particular Outcomes (Low-Level Agreement). *Source:* Ruger 1998: 107.

Incompletely Specified and Generalized Agreements

The second type of ITA occurs when people agree on a midlevel principle but disagree on overarching theory or particular outcomes (figure 2). Here, the connections are unclear *both* between the general theory and midlevel principles and between specific cases and midlevel principles. For example, people might agree on the midlevel principle of universal coverage without agreeing on a high-level principle to justify universal coverage, or on low-level principles or strategies to achieve universal care. The ambiguity inherent in this model tends to promote more divergence than convergence.

Incompletely Theorized Agreements on Particular Outcomes

This third type of ITA involves agreement on low-level principles that are not necessarily explicitly derived from any particular high-level theory of the right or good (figure 3). For example, legislators might agree to expand coverage for children (e.g., through the State Children's Health Insurance Program [S-CHIP]) without agreeing on universal coverage and without justifying this outcome on the basis of any one overarching political philosophy (e.g., utilitarianism or communitarianism) (Dougherty 1988). Because low-level principles may be compatible with more than one high-level theory, people who disagree on a high-level abstraction can reach agreement on a low-level outcome or policy decision through this model. Sunstein (1995) explains this process of convergence by pointing out that people can know that something is true without entirely knowing why it is true. In fact, they may offer very different reasons for reaching the same conclusion. For example, some legislators may have wanted to enact the S-CHIP program on the basis of equality among children, regardless of income, while others agree on S-CHIP because they might prioritize children's health over that of adults. This type of incomplete agreement is useful, Sunstein purports, in a pluralistic society because it aims "to make it possible to obtain agreement where agreement is necessary, and to make it unnecessary to obtain agreement where agreement is impossible" (ibid.: 1743). An ITA framework thus recognizes that ethical discussion and principle clarification may potentially highlight incompatibility and may in some cases make coalition building more difficult (Kingdon 2002). However, it rests on an ideal of democracy that entails collective

reasoning and compromise for public decision making *even when people have divergent views*. In the case of S-CHIP, it is important to note that Congress was able to find common ground and coalesced to approve legislation on S-CHIP despite the rationale being incompletely theorized. But with equally incomplete arguments, the Clinton reform was defeated a few years earlier. One goal of my argument is to help explain why ITAs can in some cases lead to successful policy outcomes and in other cases not. This can help us better understand how health reform debates can be made more effective in the future.

Why the Clinton Administration Failed to Achieve Health Reform

There are many explanations of why accord on policy never developed during the Clinton administration and why the Health Security Act (HSA) was defeated. Among analyses of the Clinton debacle are those offered by Skocpol (1996), Johnson and Broder (1996), Jacobs and Shapiro (2000), Mashaw and Marmor (1996), Tuohy (1999), and Hacker (1997). For example, Skocpol (1996) argues that, despite its popularity during the 1992 campaign, by 1994 health reform and the HSA in particular became “ideal targets” for their political enemies (conservatives) to distort, while its promoters failed to gain the support necessary to pass Congress. Even though the HSA was actually a compromise between market-oriented and government-centered reform, she argues, it was portrayed as a liberal, big-government proposal. She rejects explanations that point to the failures of key participants and divided public opinion. Tuohy (1999) argues that, while factors such as institutional barriers, interest-group mobilization, public opinion, and strategic miscalculations all played a role, the failure of the Clinton proposal was primarily due to the inability of political actors to mobilize authority on an “extraordinary scale” in order to enact a program of universal health insurance. Hacker (1997) argues that there was an inadequate constituency for Clinton’s proposed compromise. Clinton failed to obtain sufficient support from either liberals or conservatives.

Johnson and Broder (1996) argue that private interests triumphed over public interests and that a small but powerful minority manipulated public opinion to dismantle the proposal. They reject explanations that point to the decentralized structure of the American political process, although they do not discount this as one factor that makes comprehensive reform more difficult than incremental reform. They highlight three major political mistakes made by the Clinton administration. The administration’s

first mistake was to “mismatch” Clinton’s political capital (having been elected by only 43 percent of the popular vote) with the scale of the reform (comprehensive instead of incremental). The administration erred twice more by choosing to make a secretive task force the center of policy making and by failing to distinguish between strategies suited to the House (where the Democratic left was predominant) and the Senate (where Democrats forwarded legislation through consensus and strong support by moderates in both parties). A fourth problem, which was beyond the Clinton administration’s control, included institutional barriers and “historical forces” that have “weakened the presidency as a vehicle for change” and have led to a “perpetual campaign” whereby the “politics of governing have been all but overwhelmed by the demands of seeking and retaining office” (ibid.: 613). All this is exacerbated by a “credibility gap” that makes it increasingly difficult for presidents to communicate with the American public on complex issues and a set of public and private institutions (including the media) that attempts to manufacture and control public opinion rather than inform, clarify alternatives, and help search for consensus. Johnson and Broder’s work has been criticized, however, for being primarily descriptive and not analytical (Jacobs 1997).

Jacobs and Shapiro (2000) use this point about political manipulation and the loss of democratic responsiveness as their main thesis about contemporary politics in America. They argue that during the health reform efforts of the Clinton administration, policy makers were driven by ideology and personal preferences and focused on political calculations of allies and opponents. Rather than follow public opinion as their guide, they instead used “crafted talk” to shape their policy options in efforts to gain public support. Opponents of the Clinton plan achieved their goals of reducing public support for the plan (a 20 percentage point decline in a year) by polarizing public debates and the press’s coverage of them so as to create uncertainty and fears among the public about their personal interest in the policies being proposed (221). Jacobs and Shapiro (2000) have also argued that the increases in partisan conflict and public opinion manipulation have actually reduced the effectiveness of the governing process and public confidence in American politics.

Finally, Mashaw and Marmor (1996) critique policy development explanations, stating that they tend to focus on solutions that respond to circumstantial failures and attempt to “fix” the process of American policy development. Instead, they argue that the “same structural conditions that defeated universal health insurance in the 1930s, the 1950s, the 1960s, and the 1970s” (63) were responsible for the stalemate in 1994. Their main

argument is that the United States faces structural institutional and fiscal problems that limit its ability to function as the “guarantor of the population’s health security.” The structural impediments relate to the mismatch between political legitimacy—and thus governmental authority—and the level of government. For example, state governments may have the political legitimacy to ensure universal health insurance, but they lack the fiscal and legal authority to do so. Conversely, the federal government has the fiscal and legal abilities but lacks the political legitimacy needed to enact comprehensive health reforms. Thus, the United States has not enacted comprehensive health reform because of both political culture and institutional structures.

Each of the major explanations of the Clinton debacle provides insights into what went wrong in 1993–1994, and together they offer a partial explanation for the failure to achieve comprehensive reform. However, although political scientists have different factors that they emphasize as their particular favorites in explaining health reform failure, virtually all of them agree that public values are an important but neglected aspect of these policy episodes. Some of the major scholarship in political science alludes to the importance of underlying values, but no major scholarship provides a framework for analyzing these values. Skocpol (1996: 187), for example, discusses the need for “a renewed social vision . . . with frank statements about social justice and moral values” in an effort to promote comprehensive health reform. Johnson and Broder (1996: 638) state that health reform is centrally about “American values, raising the question of whether our handling of public programs reflects those values of charity and compassion or suggests a sharp change in attitudes. . . . It sets the stage for the most fundamental debate about national values America has had in decades.” In addition, they argue the need for a “great public debate about what kind of health care Americans want” (629). Jacobs and Shapiro contend that individuals’ values and fundamental preferences differ from the public’s perceptions, evaluations, and choices regarding specific policy proposals and that, during the health reform debate of 1993–1994, policy makers were focused on personal preferences and ideology and political calculations about their opponents and allies rather than responding to public opinion. As a result, polarized policy debates and the press’s coverage of them reduced support for the Clinton plan by creating uncertainty and fear about people’s self-interest. Public opinion is much more than the addition of discrete individual preferences, they argue; instead, it requires a community-oriented process that deals with complex motivations, multiple and competing tendencies, and more thought and public reasoning

than the contemporary concept of public opinion suggests (Jacobs and Shapiro 2000). They also highlight the destabilizing and delegitimizing force of deceptive and manipulative crafted talk. Thus, more work must be done to better understand the values and norms necessary to create agreement on the political conception underlying policy reform.

A Model of American Health Care Reform and Incomplete Theorization

The Clinton administration's plan for health care reform was an example of the second type of ITA, an *incompletely specified and generalized agreement*. The nation had formed a consensus on the midlevel principle of universal health care coverage, but no single high-level principle was invoked to explain why such coverage was justified. Moreover, the connection between this agreed-upon midlevel principle and the particulars of how society should achieve and pay for universal coverage were equally unclear.

Agreement on Universal Health Care Coverage

In the early 1990s, most Americans and their representatives supported the view that universal health insurance should be a priority for policy makers. Jacobs and Shapiro (2000: 96) found, for example, that through September 1993 “clear majorities (close to two-thirds in some cases)” favored universal coverage. In 1992, support for national health insurance was at 66 percent—the highest it had been in forty years (CBS News/*New York Times* Poll 1992). Moreover, public opinion surveys in September and November 1993 and July 1994 found that Americans were willing to increase government spending for health insurance coverage (Jacobs and Shapiro 2000: 228). Several public opinion studies (Blendon and Donelan 1989, 1990; Blendon et al. 1990, 1994; Schlesinger and Lee 1993; Shapiro and Young 1989) revealed that:

1. Relative to other social policies, consensus about health policy had grown among groups that previously had been separated by traditional social cleavages such as race, socioeconomic status, gender, age, and education level.
2. There was long-standing and near-universal support for equal access to health care regardless of ability to pay.
3. Though an overwhelming majority of Americans thought that health care was too costly, they ranked universal access high on opinion polls.

Thus, the debate about comprehensive health reform during the 1990s was characterized by agreement that universal coverage was a major objective. Universal coverage became the key issue in the 1993–1994 health care debate, and President Clinton made it the centerpiece of his presidential campaign, his presidency, and his health care reform package.

Multiple High-Level Theories for Universal Coverage

Many high-level principles could justify the midlevel principle of universal coverage (Kymlicka 2002). Among them are: (1) communitarian theories of justice that require the expression of accepted community values and collective responsibility; (2) utilitarian or welfare economic theories of justice that require maximization of utility or social welfare; (3) liberal egalitarian theories of justice that require equality of opportunity (Daniels 1985; Dworkin 1993; Rawls 1971); (4) a Rawlsian theory of justice that requires fair distribution of resources (primary goods; Rawls 1971); (5) a Kantian theory of justice that requires others to be respected as moral agents; (6) ethical theories (virtue ethics) that emphasize compassion, charity, and altruism, such as moral concern for others; (7) a right to health care; and (8) the principle that society should provide social conditions to maintain and improve individuals' capability for health functioning (Ruger 1998, 2003, 2004a, 2004b; Sen 1985, 1992). Additional higher-level justifications for universal coverage include human capital concerns about workforce productivity and global competitiveness; financial risks associated with lack of insurance or underinsurance (Ruger, forthcoming); and the notion that citizens have political, legal, and social rights (Marshall 1950).

The problem with having multiple high-level justifications for one midlevel principle is that it restricts policy options to those that fit with certain high-level schemes. It also reveals significant conceptual vagueness about the underlying values that could guide health policy. For instance, a communitarian theory would allow the justification for health care to vary by community (Walzer 1990), arguing that each society constructs its own principles as it evolves politically and that morality is therefore cultural rather than abstract. Taken to the extreme, this viewpoint could undermine political and social cooperation in societies that respect individual liberties and diversity (Buchanan et al. 2000). Similarly, a strict, liberal, egalitarian approach that offers a more literal interpretation of equal health care access might restrict free-market principles by not allowing wealthy citi-

zens to buy health care that was unavailable to the poor (Gutmann 1981). A single-payer system such as the Canadian health system would come close to satisfying these philosophical requirements because participating physicians, hospitals, and clinics have not been allowed to offer services outside the provincial system until recently. In contrast, a focus on human capital would favor health reform that improved worker productivity and therefore global competitiveness, whereas a focus on charity or compassion would emphasize the importance of voluntary charitable acts toward others by nongovernmental organizations and individuals.

The 1993–1994 debate surrounding universal health care coverage never settled on one general theory or ethical conception. For example, Americans' support for a collective responsibility for medical care was deeply divided. When surveyed about a collective or individual commitment for medical care in 1993 and 1994, a slight majority of the American public in 1993 (51.7 percent) favored collective responsibility, whereas 15.9 percent favored individual responsibility, and 32.5 percent favored split responsibility between collective and individual (Schlesinger 2004: 977). In 1994, the American public remained divided (47.5 percent favored collective, 33.6 percent favored split responsibility, 20.7 percent favored individual responsibility). When asked, Americans were also divided on whether or not they supported a "right to health care": in 1993, while 59 percent favored a right to health care, 36 percent thought of health care as merely a privilege (*ibid.*: 978). In another survey of American values at the time, Robert Blendon and colleagues (1994: 282–284) found that Americans held conflicting core values, which included (1) "a moral commitment to the uninsured," (2) a desire to achieve "personal peace of mind," (3) "a lack of self-blame," (4) "a limited willingness to sacrifice," (5) "reasoned self-interest" in what changes are enacted, (6) "a distrust of government," and (7) a healthy cynicism of the behavior of our major institutions. While moral concern for the uninsured was a strong core value among the American public, this value alone was not enough to generate strong support for national health insurance. In these and other surveys, researchers found Americans to have competing core values, to express ambivalence about health and health care, and to exhibit a conflict among core beliefs (Blendon, Brodie, and Benson 1995).

These results are consistent with findings from Schlesinger and Lau (2000), who speculate that health reform failure resulted from efforts to combine two policy metaphors—societal rights and marketable commodity—that individuals perceived as incompatible, and with findings from Frohlich and Oppenheimer (1992) and Mitchell et al. (1993), who find

that individuals contemplate multiple principles (e.g., equality, merit, efficiency, need) and make trade-offs among them, but that conflict among such principles leads to contradictory results. Nearly all political science research on higher-level norms of distributive justice has shown that individuals have conflicting views on justice (Hochschild 1981; Kluegel, Mason, and Wegener 1995; Verba and Orren 1985). More recent work on values and democratic decision making adds more evidence to a lack of coherence among the public (and political elites) regarding deep values for health reform. At the same time that Americans strongly supported health reform that would help them personally, they also supported the notion that health care should be provided based on medical need, not ability to pay, and that the medical care system should treat everyone equally (Schlesinger 2002), but conflict among these principles failed to lead to a widespread value that could support health reform.

Thus, although these studies rely primarily on public opinion surveys and more extensive studies of value-based reasoning in political science are needed, this evidence suggests significant higher-level value differences underlying Americans' views about health care reform.

Strategies for Attaining Universal Coverage

Two types of strategies for attaining universal coverage dominated the debate of the early 1990s: an employer mandate (plus an individual mandate) and a single-payer option.

The employer mandate would have required all employers to make health insurance available to all employees—part-time, seasonal, and temporary in the strictest model—and to pay a defined proportion of the cost. The advantages of this mandate were its ability to supplement the existing American employer-based system and its potential to increase the financial risk pool. A disadvantage was the perceived harmful effect on businesses, such as restaurants and stores, that were small or employed mostly low-wage or part-time workers, even though small businesses would likely have received government subsidies. There was also speculation that employers would lay off workers and that small-group insurance reform would be required. The insurance industry was concerned about and forcefully opposed to the employer mandate. In order to achieve universal coverage, however, an employer mandate would need to be supplemented with an individual mandate or other mechanism for covering those not in the workforce.

The single-payer option involves one public payer for health care ser-

vices and health-related products. Thus, the government would provide health insurance, using funds collected from individuals and employers (Marmor and Goldberg 1994). Because the single-payer system largely eliminates private health insurance, it is opposed by the insurance and related industries. In some single-payer systems, medical services are organized and delivered by a central body, simplifying administration and reducing costs. The Canadian universal health insurance program is an example of a single-payer system, as is the U.S. Medicare program (though the latter was not presented as such during the debate). Canada and many other countries have single-payer programs, but opponents (especially the Health Insurance Association of America) argue that introducing such a system into the United States would require social transformation of American medical care.

Numerous other characteristics of health care proposals emerged in 1993–1994, including, but not limited to, managed competition, price controls and co-payments, health purchasing cooperatives, quality controls, standardized benefits, payroll taxes, medical savings accounts, electronic billing, freedom of choice, and global budgets. Some of the competing proposals fused elements of different “categories” of reform described above (Marmor and Goldberg 1994). One such proposal was the “pay or play” plan, which gave companies the option of covering health insurance for their employees or opting out by paying a portion of the employee’s premium (Hacker 1997).

Despite all these options, Americans disagreed on how best to achieve universal coverage and on specific strategies for reform. The public was deeply divided in its support for alternative approaches, in particular the single-payer and employer mandate option. In a survey of Americans’ views on health policy, researchers found that most Americans do not favor a single-payer type of national health plan (Blendon and Benson 2001). These researchers found that, generally speaking, in January 1993 (63 percent) and March 1993 (59 percent) the majority of Americans favored *some type* of national health insurance; however, they just were unsure about *what type* of health plan they wanted. As Blendon and Benson note, “Among the confounding factors is the lack of an underlying consensus among the American public over the preferred type of national health plan. Polls that offer only one plan as a possible solution often show majority support for that proposal. But when other major alternative proposals are offered, . . . public support splinters” (ibid.: 36). Among the employer mandate, single-payer, and tax credit strategies, Americans were nearly equally divided with 28 percent, 32 percent, and 33 percent public

support, respectively, in 1992 (Blendon et al. 1992: 3373). As Jacobs and Shapiro (2000: 220) note, for example, the public “tortured” itself but ultimately failed “to reach a verdict that would give a ‘full endorsement’ to one of the leading proposals.”

The Clinton plan, the Health Security Act, was an employer mandate model, based on a managed competition framework. It relied on government regulation rather than market forces alone to control costs. It created a system of regional purchasing monopolies and placed price controls on health-plan premiums. It also set up a National Health Board to oversee health care quality. Opponents quickly pointed to inefficiencies and bureaucratic problems they surmised the plan would create.

Divergence on policy particulars was one factor in the plan’s failure. Central to the standard explanations for the public’s and their representatives’ failure to deliver a clear choice on health reform, which I reviewed earlier, is the thought that although most lawmakers supported universal coverage, they did not want to take political risks by raising taxes or upsetting small businesses. They perceived that the voting public, while generally supportive of universal coverage, was *unwilling to pay higher taxes* or to have *its* health care rationed.

Americans not only disagreed on how to achieve universal coverage, but they gave weak responses on their preferences for universal coverage when higher taxes were envisioned. The conflict and lack of strong support for willingness to pay is illustrated by responses to public opinion surveys. While one survey, for example, found that only 22 percent of Americans were willing to pay an additional \$200 a year in new taxes to support national health care (Blendon and Donelan 1990), another survey, which did not ask about an amount of willingness to pay, found that 61–64 percent of Americans indicated *some* willingness to pay higher taxes to cover the cost of universal health insurance (Jacobs and Shapiro 2000: 228). Indeed, the majority of Americans at the time (55 percent in 1993 and 66 percent in 1994) indicated that the amount of federal taxes they had to pay *in general* was already too high (Blendon and Benson 2001: 42).

This pattern of differentiated responses at different levels of generality emphasizes the need for further clarity about the balance of underlying values and consensus on Americans’ political conceptions of the health care system. This lack of cohesion provides evidence of a lack of social and political internalization of and agreement on the public moral norm of willingness to pay extra taxes to support universal health care. Furthermore, Americans shifted toward self-interest over the course of

the health reform debate: fierce opposition to the specific objective of expanding health insurance coverage undercut the public's support, which dropped from 64 percent in 1993 to roughly 55 percent in 1994 (Jacobs and Shapiro 2000: 228). This is supported by the belief that Americans were interested in reform based on whether or not they personally would be better off as a result. As political analysts note, "Americans' strong support could be quickly tempered by messages implying that personal sacrifices might be required to deal with the broader problems," especially if reform would "require more than a modest tax increase" (Blendon, Brodie, and Benson 1995: 12). Americans' focus on limiting the harm to them personally "created a serious constraint to maintaining public support for comprehensive reform" (ibid. 1995: 12). Americans' unwillingness to pay sufficient taxes to support universal health insurance coverage reflects an ITA; indeed, supporting values were never effectively marshaled to provide a rationale for internalizing this collective commitment.

A Wedge Theory of the Failure of Health Care Reform

This article offers an additional way of analyzing the failure of the Clinton plan: the consensus on the need for universal coverage at that time was an *incompletely specified and generalized agreement* and therefore lacked both high-level and low-level agreements. A second type of ITA can be particularly problematic in achieving stability and permanence because, without a consensus on a higher-level political conception *and* without agreement on lower-level principles for particulars, the idea of universal coverage was vulnerable to value-based attacks from opponents. A failure to more clearly articulate and agree on these values left the Clinton proposal vulnerable to Republican attacks. As such, opponents used value- and norm-based assaults to insert a wedge between competing models of health care reform, preventing agreement on particular outcomes. These attacks generally took the form of libertarian and individualistic sentiments and emphasized the value conflict between freedom and equality. In what follows, I further develop this wedge theory and illustrate how reformers' failure to address the incomplete nature of the public's value-based support left reforms vulnerable to counterattack.

This wedge theory is reinforced by Jacobs and Shapiro's (2000) work on crafted talk and the loss of democratic responsiveness and by Marmor and Oberlander (1994), which I suggest demonstrate how opponents of

reform exploited the fragility of the agreement on universal coverage and enhanced the appeal of competing values. These adversaries prevented major changes in the health care system by convincing the public that reform threatened core values in America's liberal tradition. These values included individualism, distrust of government, and the idea that the private sector is more efficient than government (capitalism). For example, Republican strategists created confusion about reform because their party did not want to concede too much political ground to the Democrats. Entrenched Republican interests blocked reform by manipulating people's fears and misunderstandings (*ibid.*). Several themes contributed to this confusion: (1) questions about whether a health care crisis actually existed and thus whether a moral concern for others or even reasoned self-interest justified legislative efforts, (2) false dichotomies between regulation and competition and thus confusion about the role of the private sector and the role of government in American liberal society, and (3) false dichotomies between radical and conservative plans and efforts to polarize citizens into ideological camps with which they may not entirely identify.

As noted in my first section, efforts to categorize Americans' values into "value sets" reveal that supporters of health reform (liberals) are more conflicted in policy preferences and underlying values than are opponents (conservatives). Thus efforts to force American ideals as such—for example, contrasting freedom and equality—leaves liberals even more fragmented and divided than conservatives on underlying values. Furthermore, the *style* of opponents' attacks, as adversarial and based on ideological cant, name calling, exaggeration, and distortion, is in itself value based, taking the focus off collective efforts to achieve the common good and toward an us-versus-them way of thinking. Jacobs and Shapiro (2000) similarly argue that the media's focus on political conflict and strategy heightened public cynicism and the risk of altering the status quo, causing concern about government effectiveness and the personal risk of health reform to individuals. For example, opponents of reform distorted the choice issue in health care, marshaling a threat to individualism, all the while failing to note that the private sector's quest for cost containment was restricting choice more than any reform might do. They also exaggerated the role of government in the Clinton plan and other reform packages, causing the public to question whether loss of freedom through regulation was worth the potential benefits of comprehensive reform. Senator Bob Dole, with his organizational charts, was particularly skilled at this type of dialogue. He and others used competing values to drive a *wedge* between the parties, destabilizing the midlevel agreement on uni-

versal coverage. By 1994, “as the media conveyed the genuinely fractious nature of policy debates, the public became increasingly fearful . . . of the personal costs of higher taxes and lower quality care, and many people switched from supporters . . . to opponents of the Clinton plan or any reform” (ibid.: 237).

While value articulation does not inoculate the public against disruptive arguments, lack of agreement on the ethical commitment to redistribute wealth to expand coverage left the scenario vulnerable to dissolution by opposing forces. For large-scale reform, individuals must be willing to pay for health insurance for fellow citizens, otherwise universal coverage cannot be achieved. This is because any policy enacted to achieve universal health insurance coverage will require individuals to make a financial commitment to fulfill claims by others. Because universal coverage requires social organization in the form of a redistribution of resources and related legislation and regulation, it requires an ethical commitment on the part of a majority of individuals. Without this ethical commitment, it will not be possible to redistribute resources from the wealthy to those less fortunate, because the effort to do so is—and must be—essentially voluntary, not coercive (Ruger 2006).

The view presented here is that health care reform would not have been as susceptible to the wedge strategy if social agreement on either a high-level conception (such as equality of opportunity) or low-level principles (such as the ethical commitment of willingness to pay an agreed amount for others' health insurance) had occurred. One reason is that agreement on a high-level political conception or lower-level agreement on particular principles provides a focal point around which agreements can coalesce and provide guidance for policy. Such a framework can facilitate the possibility for political action by enabling deep social compromise upon which to build new policy proposals. Such compromise takes as given the numerous disagreements that divide citizens and policy makers. By accepting disagreement (and its plurality), promoting social compromise, and putting forward conceptual tools for coming to agreement on policy proposals (legislation), social agreement theory has prescriptive advantages in facilitating political agreement on health reform through deliberation in a pluralistic constitutional democracy such as the United States. Such a consensus potentially would have promoted further agreement at lower levels of policy by putting the focus on discrete trade-offs in willingness to pay (e.g., paying \$200 more in taxes for universal coverage). It also might have forced Americans to define their priorities, obliging them to decide

collectively how much they valued health as compared, for example, to national security (at a higher level) *or* how to trade off public and private sector or federal and state initiatives as was done in the S-CHIP program (at a lower level). Such decision making would ultimately require more objective and explicit information on how society's money is spent and whether such expenditures match up with Americans' own values. The result would be clarity—not uncertainty—about Americans' core values and social consensus on the principles that should guide health care decisions. Americans should be given the opportunity to weigh the costs and trade-offs between public policy to improve the health and financial security of all Americans and policies that achieve other social ends.

Although many high-level principles could justify universal coverage, certain principles—equality of opportunity, health equity, human rights, altruism, health need, equal treatment—might have improved the health policy debates of the early 1990s, especially if policy elites or grassroots organizations had focused on mobilizing and seeking a consensus among the American public—and representing that consensus—on norms of equity and fairness related to health care. The American public has expressed strong support for equal health care treatment (65–93 percent) and for health care needs (38–84 percent) (Schlesinger 2002). Alternatively, they could have argued that health care is important for ensuring equal opportunity since it gives every American the opportunity to get ahead meritoriously. These sentiments have deep roots in American political thought and philosophy about the human condition, yet reformers failed to address the incomplete nature of the public's value-based support. From this perspective reformers may need to address value conflict among *potential supporters* as much if not more than among *potential opponents*.

One important idea that was incorporated into the debates was that America was experiencing a multidimensional health care crisis: costs were too high, people were uninsured or underinsured, and quality was too variable. Thus, Americans were willing to address these problems, but as social agreement theory demonstrates, they shifted toward self-interest over the course of the reform debate. Because of this shift, consensus on individuals' willingness to sacrifice or pay for others' health insurance never solidified. Indeed, as Jacobs and Shapiro (2000: 236) note, during the period 1990–1993, “Americans consistently looked beyond their own personal situation to focus on national and collective benefits such as easing the burden of health expenditures . . . and making altruistic efforts to pro-

vide others with quality care.” During “this period of public-spiritedness, the influence of personal costs on the public’s preferences for reform were relatively weak, while expectations toward the potentially positive consequences of national reform were comparatively strong” (ibid.). This climate led to the beginnings of health care reform. But as the year(s) progressed, Americans judged reform based on its effect on them personally (Blendon, Brodie, and Benson 1995). Indeed, when the American public was asked about willingness to pay higher taxes so that the uninsured could have the same benefits available to the average person (or pay lower taxes and provide the uninsured with a scaled-down plan), only 40 percent of middle-class Americans said they would support higher taxes (ibid.).

In the absence of sufficient public support for paying taxes, the Clinton administration had to focus on delivering a plan that promised not to increase costs. As a result, the HSA was held to a high financial standard and was expected to generate economic efficiencies from the health care system to pay for expanded health insurance coverage. This need to fiddle with the health care system left the proposal vulnerable to attacks such as those noted above, which evoked public fears that government was tinkering with health care and that individuals were going to lose more than they gained as a result of reform. This is where the absence of internalized values of sacrifice is especially relevant for the fate of the Clinton reforms. If reformers had engaged the public’s values enough to create a willingness to pay more taxes, then the Clinton plan would have never needed to tinker with the health care system as a whole and thus would not have been vulnerable to opponents’ (Republicans’) attacks that it used “big government” or “government control” to do so. In the counterfactual, the Clinton plan could potentially have been a reform primarily, even solely, about financing health care, where the public is comfortable with a government role. Conversely, reformers might have been able to engage the public with a values-based argument about the need to sacrifice a bit financially and perhaps even a bit in terms of health care convenience, in order to help others deprived of health care. This could have helped to inoculate the Clinton plan against opponents’ attacks.

Conclusion: Internalization and Agreement on Moral Values

Despite the features of American public policy discussed herein, some reform efforts have succeeded. They include large-scale social movements such as the New Deal, the civil rights movement, and the women's movement and smaller-scale efforts like the S-CHIP program. A number of factors underlie the success of reforms, including changes in collective policy preferences resulting from gradual social and economic trends, social movements, organized interests, and mass-media reports. Page and Shapiro (1992: 77), for example, argue that support for civil rights was energized by a series of events that were "manifestations of a powerful social movement that ultimately raised white as well as black Americans' consciousness of the mistreatment suffered by black people." There is little doubt, they add, that the civil rights movement had a "major impact on public opinion" (*ibid.*). Indeed, the impact of the movement was so great that it connected to fundamental American values through the use of norms-based arguments to forge a consensus on the need to take legislative and judicial action to ensure equal treatment for all persons, regardless of race. In this case, both the public (through grassroots organizers; Lee 2002) and elites worked to address the incomplete nature of the public's value-based support by making value-based arguments. Ultimately, Americans changed and solidified their values. Through a struggle over moral principles, norms became internalized and equal protection and antidiscrimination were enshrined in legislation and judicial doctrine.

With respect to equal rights for women, Page and Shapiro (1992: 101) argue that the "shift in favor of equal employment opportunities for women seems, like the similar movement with respect to blacks, to have followed naturally from basic American values of individualism and equal opportunity." Public opinion on domestic aspects of the economy has been fairly stable over time. It demonstrates a "coherent view of public policy" and a "substantial, though bounded, welfare state" that "reflects a sense of societal obligation, a strong commitment to government action . . . to protect the helpless, and to provide a substantial degree of equal opportunity for all" (118). Rawls might say that this "coherent" view reflects a political conception of justice that centers on the principle of equal opportunity. Indeed, social welfare programs that have been successfully implemented typically have reflected Americans' enduring commitments to social insurance and equal opportunity while also appealing to commitments to the market, individualism, and limited government (Marmor,

Mashaw, and Harvey 1990). In terms of the Social Security program, Page and Shapiro note that the system of aiding broad categories of the “truly needy,” under a logic of self-insurance, seems to fit the American conception of fairness. This agreement on policy particulars through lower-level reasoning on person categories and type of insurance fits within the ITA framework of social agreement as well. It also fits with the notion of norm internalization—that these norms have a “taken for granted” quality (Finnemore and Sikkink 1998).

To truly address the nation’s public health problems would likely require norms and values to be restructured, as has happened during other social movements, such as the civil rights movement. That movement generated strong opposition from interest groups, but its focus on racial justice and equality was informed and energized by the high moral vision and rhetoric of leaders such as Martin Luther King Jr. and other clergy. At the same time, grassroots organizations and local protests by individual citizens pressed for social change in the moral consciousness of the American public (Lee 2002). Indeed, the strong support of clergy and grassroots organizations around the nation and the corresponding moral rhetoric that these leaders and citizens offered in support of the bill were influential factors leading to enactment of the Civil Rights Act of 1964. No such coalition of moral thinkers or grassroots organizers took center stage in the health reform debates of the early 1990s. Although agreement on particulars, such as affirmative action, is still incomplete, this high-level moral theory has established racial equality as a defining principle—an internalized norm—of American political thought. In contrast, though Americans have expressed concern for others and have indicated general support for a right to health care, they have yet to clarify and internalize the underlying values that relate to health reform and the health system. Because high-level theory was important to major American reforms in other policy areas, it seems that abstract arguments about higher-level principles can be important to democratic politics generally and to health reform specifically. Agreements on low-level principles have also been important and can be the product of reforms that narrowly escape the political impasse between opposing parties.

Thus one way to achieve comprehensive health care reform might be to make a higher-level theory of the right or the good central to a public deliberation about comprehensive health reform. This proposal is consistent with Bruce Ackerman’s (1991) discussion of “constitutional moments” in which citizens become excited and mobilize around a “big idea.” This

would suggest we need what I would call “a constitutional moment for health” to mobilize the support needed to move this sentiment forward toward social internalization and then political internalization such that political elites will accept the norm and promote its adoption for health policy. It also fits with Jon Elster’s argument that deontological claims can help produce large-scale social change (Elster and Slagstad 1988). Such a consensus might better withstand attack by opposing theoretical camps than did the health care reform efforts of the early 1990s. This argument is consistent with social agreement theory that high-level principles can play a defining role in American social reform. It is also consistent with public opinion polls suggesting that high-level principles about health care exist or are latent in American political culture. Page and Shapiro (1992: 129) found that “large majorities of the public have seen medical care as a ‘right’ to which all citizens are entitled: NORC [National Opinion Research Center] found 87 percent so responding in 1968, and CBS News/*New York Times* Poll, asking a slightly different question, found 78 percent in 1975 and 81 percent in 1979.” The issue here is that support for health care rights has since dissipated to the point that it is not, in itself, sufficient as a high-level principle to support reform. Indeed, Clinton did not take this tack in his health reform efforts and explicitly did not evoke rights in his speeches introducing the Health Security Act. Indeed, as a Rawlsian OC framework might suggest, the common high-level values for reform need to represent an overlapping consensus among higher-level principles, perhaps including rights *with* other justifications. Indeed, from a Rawlsian perspective, it may be necessary through an OC to draw out certain fundamental ideas that are latent in the public political culture by recognizing the incomplete nature of the American public’s value-based support for health reform.

Jacobs and Shapiro’s work during the 1993–1994 health reform debate suggests that public opinion during that period was in part motivated by concern for others, although self-interest still played a role. For example, “the public receptiveness to rebuilding the country’s health system was . . . a persuasive indicator of the public’s concern for others who are most vulnerable” (Jacobs and Shapiro 2000: 241). A social agreement model demonstrates that, while complete theorization may not be necessary or possible, some degree of agreement—even if incompletely theorized—is important for stable governance and policy selection. According to Rawls, as long as a strong social consensus is achieved around a political conception that is agreed to for its own sake, such agreements can provide

guidance for specific policy proposals. Agreement at lower levels may then be achieved as a separate step, after public debate about principles and priorities for specific policy alternatives. Some innovative methods of democratic deliberation, such as national issues forums, citizen juries, and deliberative polling, may be instructive here in efforts to define a model of respectful public exchange in creating consensus (Kahan and Braman 2006; Fishkin 1991). A report from the Institute of Medicine (2004), for example, identified several principles (universality, continuity, affordability, and enhanced health and well-being) around which social agreement could be achieved. Collectively, such principles might form a framework for designing and evaluating new approaches to universal health insurance coverage.

Social consensus for health reform may occur at different levels, but it will require conditions that permit truth telling and rational debate. Collective reasoning about public policy requires a truthful deliberative process as an essential component of democracy and a sincere and dedicated effort to achieve consensus on both the ends (values) and means (acceptable policy solutions) of public policy. These efforts are critical to citizens' ability to "rule themselves" (Richardson 2002). Moreover, while public opinion can be manipulated and distorted, the challenge in a constitutional democracy is to create the conditions under which Americans can agree on a political conception that governs health and health care. Such a conception is likely latent in the political culture and may emerge through public deliberation and social consensus of the type described above. Public opinion research suggests that the American public is capable of rational collective policy preferences that reflect underlying social values (Page and Shapiro 1992). It is therefore important to invoke principles such as equal opportunity, health equity, altruism or moral concern for others, or public spiritedness in order to clarify what Americans value in a political conception to guide policy makers. Efforts to involve the government in improving the health of the nation and to ensure access to quality health care for all *require more than fragile agreement on midlevel principles*. These efforts require invoking principles, values and norms, and honest discussion about the consequences on people's health and security of denying necessary and appropriate care. One argument in favor of universal coverage is that denying people health care infringes upon their opportunities, while another is that unequal access reduces individuals' abilities to function as full-fledged members of society; another is that it leaves families vulnerable to financial ruin. There are numerous ethical values

that can be invoked to mobilize support for health reform, but an objective in invoking higher-level theory is to gain greater clarity of thought and to achieve social consensus. This agreement must then be translated into implementable public policies (such as Medicare and Medicaid) that prioritize public investments in health and health care over social ends that are perceived as less important. In a world of scarce resources, such trade-offs must and should be made through informed choice by the people who are ultimately affected by those decisions: the citizenry. The Medicare program, though not universal, represents a successful partial reform that has achieved agreement about both ends (values) and means (Marmor and Barer 1997).

Even if clarity of thought is achieved at a higher level, reform must take place at the level of policy. It is thus more likely that agreement on lower-level principles will occur on the path to achieving health care reform. The passage of the S-CHIP program is an example of lower-order consensus to achieve health reform. In this case legislators agreed to expand coverage for children (e.g., through S-CHIP) without agreeing on universal coverage and without justifying this outcome on the basis of any one overarching political philosophy (e.g., utilitarianism or communitarianism). In fact, they may have offered very different reasons for reaching the same conclusion: some legislators may have wanted to enact S-CHIP on the basis of equality among children, regardless of income, while some agreed on S-CHIP because they prioritized children's health over that of adults, and still others may have viewed children as the most vulnerable members of society. Furthermore, the S-CHIP program was designed to allow states to implement it using different models (e.g., public insurance, Medicaid extension, or private insurance), in such a way that Congress could get agreement on reform without forcing agreement on lower-order strategies. Congress was able to find common ground and coalesced to approve legislation on S-CHIP despite the rationale being incompletely theorized. In conclusion, the remarkably quick collapse and fragmentation of the seemingly potent movement for universal health coverage in the United States during 1993–1994 may be viewed as evidence for the inherent fragility of values that have not been internalized or agreed upon at a higher or lower level of generality.

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