

## Clinton health care reform: The Squandering of Public Support

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**ABSTRACT:** In the spring of 1993 when President Clinton's task force began its work on the health care reform plan, 71 percent of Americans indicated they approved of what they knew about the president's initial (U.S. *News and World Report* Poll). However, by June 1994 only 33 percent believed that the president's health care reform proposal would be good for the country (Gallup/CNN/*USA Today* Poll). This paper examines what caused the dramatic decline of Americans' support for the Clinton health care reform plan, examining Clinton's internal choices as well as uncontrollable external factors.

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## Introduction

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To achieve success in creating any major legislative change, leaders must have the support of the public. When former President Bill Clinton embarked upon his attempt to guarantee universal health care coverage for all Americans, he thought an overwhelming majority of the American public would support him. Poll data indicated “nine out of 10 Americans (91%) agree[d] there ‘is a crisis in health care in this country today’” (CHCPE 8) and that “seventy-nine percent [of Americans] believe that ‘because of rising health care costs we are headed toward a crisis in the health care system’” (CHCPE 9). Thus, Clinton believed he could rally the nation behind his plan.

Furthermore, he seemed to have the American public’s support for a total overhaul of the health care system. In November of 1991, 42 percent of Americans believed the health care system needed to be totally rebuilt versus the 6 percent who believed it needed minor changes (Thomas 10).

Health care reform has been on the national policy agenda since Theodore Roosevelt raised the issue in his 1912 presidential campaign (Heclo 95). However, no comprehensive reform has ever been successful; only limited changes have been accomplished. Before the 1930s, health care and insurance for health care was a personal choice and responsibility (VandenBos, Cummings, and DeLeon). During the 1940s, Harry S. Truman supported efforts to build a national network of hospitals, expand the supply and level of training of health practitioners, and increase federal funding of health research. In the 1960s Lyndon B. Johnson created Medicare and Medicaid programs. Presidents Nixon, Carter and Reagan also worked at enacting limited reforms (Frank and VandenBos 853).

Clinton would be the third president since WWII to fail to convince the Congress to enact major health care reform. In the spring of 1993 when President Clinton’s task force began its work on the health care reform plan, 71 percent of Americans said that they approved of what they had heard or read about the president’s initial proposal according to a U.S. *News and World Report* Poll. However, by June 1994 only 33 percent believed that the president’s health care reform proposal would be good for the country (Blendon, Brodie, and Benson 8).

Pivotal to the battle for health care reform, public opinion must be analyzed in terms of what caused the rapid decline of support and how and why these methods were enacted. The rapid decline in public support for Clinton’s health care reform plan resulted due to both internal and external obstacles surrounding the attempted reform. The combination of flawed internal strategic and substantive decisions provided opponents of health care reform the opportunity to effectively attack the legislation, allowing them to drastically reduce public confidence in health care reform. This paper seeks to illuminate the reasons for decline of public support, especially that of the middle-class. Clinton and the task force made flawed and imprudent choices regarding the reform. There were also external

obstacles to the reform, including that of the inconsistency of the American value system with reform and the media attack fueled by various groups.

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### **The Rapid Decline of Public Support**

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When President Clinton gave his September 1993 speech to a joint session of Congress revealing his plan for health care reform, nearly six out of ten Americans (59 percent) said they supported the Clinton health plan. This percentage included a majority of Democrats, adults of all age groups and educational levels, and middle-income Americans. The only two major groups opposed to health care reform at this stage were Republicans and individuals who earned more than \$50,000 per year (Blendon, Brodie, and Benson 9).

Support from the majority among most of the groups that had supported Clinton in 1993 was significantly lower in April of 1994. Especially important was the decline in support from those over the age of sixty-five. The support from this group decreased from 62 percent in September 1993 to 37 percent in April 1994. Support only remained strong from Democrats and the poor, and even the Democrats had begun to lose faith in the plan: According to Gallup/CNN/USA Today poll, support among this group dropped from 83 percent in September 1993 to 58 percent in April 1994 (Blendon, Brodie, and Benson 9).

From the beginning, upper-income Americans were not in favor of health care reform; therefore, Clinton had to rely on the middle-class voters for support. It is important to note here the main audience health care reform was targeted at—the middle-class. To push health care legislation through Congress, Clinton would need the support of the middle-class. Unfortunately, Americans analyzed health care reform in terms of personal benefit. The middle-class did not see such personal benefit in the reform. The “middle-class opposition dealt a crippling blow to Clinton’s campaign to establish national health insurance, since it deprived the president of the one potentially convincing argument he could have used to mobilize congressional support for the program: that it would benefit the middle class” (Laham 213). The loss of middle-class support is a theme that will reoccur throughout this paper.

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### **What went wrong: Clinton’s Internal Choices**

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Internal choices made by Clinton and the task force, headed by Hillary Rodham Clinton and Ira Magaziner, reveal one reason why public support rapidly declined. Internal choices refer to decisions made regarding how to structure health care reform as well as advertise it. The two facets of Clinton’s internal choices, strategic choices and substantive choices, created additional obstacles for health care reform to overcome when trying to garner public support. Opponents of health care reform were easily able to exploit the flaws in these decisions, thus making their goal of lowering public support easier.

The first aspect, strategic choices, represents the process by which health care reform was developed. Clinton's first error was the structure of the task force, and the second was the choice of Hillary Clinton and Ira Magaziner to co-direct this huge undertaking. "Within five days of having become president, [Clinton] appointed Hillary Clinton to head a task force that would recommend a program of action to reform the American health industry, which accounted for over 14 percent of the gross domestic product" (Berman 26). This legislation is a huge responsibility to delegate to another person, and in the eyes of the American people (especially with effective counter-campaigning by opponents), this choice was unfavorable. Hillary became an easy target for opponents of health care reform. "By using [her] as a target, cartoonists and talk radio hosts could ridicule the Clinton plan for its alleged governmental overweeningness—and in the process subliminally remind people how much they resent strong women. Hillary Clinton was the ideal demon" (Skocpol 153). Ira Magaziner was seen as a "politically inept health adviser" that "designed a legislative behemoth that scared most members of Congress—and the public" ("Health Reform" A24).

Another aspect of the taskforce's organization created public doubts. "The public heard that a task force consisting of 500 'experts,' none of whom could be publicly identified, would develop a proposal for the president to consider" (Blendon, Brodie, and Benson 14). The White House provided very little information about the staff members. The "process was criticized as unwieldy, secretive and protracted" (Hill 118). An article in the Washington Post observed that "although the administration issued a list of more than 500 names last week, it gave no hint of the experience and background of this diverse group of people" (Trafford 11). By not providing the American public with information regarding members of the task force, Clinton and the task force hurt their cause. Polls have clearly shown Americans' deep cynicism of government, which became an external obstacle for health care reform to combat. Remaining silent fed Americans' fears of big government and created concern that decisions being made were not in their best interest.

Furthermore, the sheer size of the task force and all associated with it created problems. Robert J. Blendon, a Harvard School of Public Health professor stated, "They managed to get the worst of both worlds. They tried to do it secretly to get the speed, but brought in so many people that word was bound to leak out" (Gosselin and Neuffer). Information did leak out; as a result, the newspapers ran stories, many with inaccurate information, which in turn raised public expectations. In this way, Clinton created an unnecessary obstacle to fight, giving opponents one more aspect of the reform to attack.

Secondly, there was lack of cooperative discussion from private-sector leaders who had worked on health care reform in the past. Of particular importance was a "lack of visibility by business leaders who, in an employment-based program, were to be implicit partners in the new Clinton health plan" (Blendon, Brodie, and Benson 14). For one, not including views of important partners in reform contributed to the public's view that the task force was attempting to be secretive. More importantly, "employers will be the financiers of the health care system, and their views, especially with regard to the design

of the health care system, will become increasingly important” (Frank and VandenBos 853).

Clinton’s health care reform called for managed care, which would require “creating approximately two hundred regional health care alliances. These alliances would cooperatively market insurance to large employers, who would be required to purchase insurance from the alliances and to pay 80 percent of the insurance costs of their employees” (Levy 176). Not consulting business leaders was a huge error because of the large role businesses would play in health care reform’s success. The business sector’s support of health care reform would have applied very impacting pressure on legislatures to pass the reform. By isolating business leaders, Clinton and the task force alienated one of their biggest potential supporters.

A third internal, strategic flaw was the lack of use of tangible illustrations of already implemented comprehensive reform plans, such as Hawaii’s employer mandate and near-universal access to health care, which provides 98% of Hawaiians with some kind of medical insurance (Eckholm 191). Other positive illustrations include Maryland’s hospital payment program, or the Federal Employees Health benefits Program (Blendon, Brodie, and Benson 14). In not advertising programs that worked, Clinton missed a great advertising opportunity to boost public confidence in reform and the potential of the government.

Clinton’s plan was too complex and ornate and lacked any “real-world” examples. “The plan was cluttered with ancillary details: In order to “prove” that the new system would not bust the budget, a ridiculously detailed proposal was written, which specified the sort of coverage employers would have to provide and also created a complicated bureaucracy to make sure that health care costs remained in control” (Klein 119).

The bill itself was a tremendous 1,364 pages (Levy 176). According to a Gallup poll, “Less than a month after the president’s September 1993 speech, 54 percent of Americans said that they thought the president’s plan was too complicated to work.” (Blendon, Brodie, and Benson 14). The use of a tangible example would have helped Americans see health care reform could and has worked.

The loss of public support cannot be attributed just to the timing and process of the plan. While the process of creating the plan and its presentation are very important in gaining public support, it is necessary the substance of a bill be thorough and strong. Clinton’s substantive choices, the design of the plan, also contributed to the decline of public support.

The issues of universal coverage and employer mandate played a large role in shaping the health care program. During the 1992 presidential campaign, health care became an election issue because middle-class voters began to rank health concerns among the top issues politicians must address (Frank and VandenBos 851). It was clear Clinton knew from where he would need to draw support for his plan—from the middle-class. He even

stated his top priorities were for “those who do the work, pay the taxes, raise the kids and play by the rules” (Clinton).

Initially it was necessary to determine which of two approaches to use in providing universal coverage. In the Hawaiian model, in which universal coverage is achieved over a longer period of time, those who work more than twenty hours a week are part of the first group to be guaranteed coverage.

There is also the approach to guarantee everyone coverage over the same period of time, giving no preference to those who work. Clinton’s choice of “everyone together” unnerved the middle class because this system seems to favor the unemployed, giving them more benefit. Based on poll data, it was clear the public supported giving benefits to middle-class Americans first. Public support was twice as high for requiring employers to contribute to health premiums for full-time workers (60 percent) as it was for a similar requirement on behalf of part-time or seasonal workers (31 percent) (Blendon, Brodie, and Benson 15).

The dissatisfaction of the middle class fits with the notion that Americans were motivated by self-interest and looked for the personal benefit within health care reform rather than the benefit to the whole society. “More than 1 in 7 Americans are uninsured, a figure that rises to 1 in 4 among the working poor” (The Lancet 791). Middle-class Americans did not like the idea that their hard-earned money would be going to support someone else.

To provide universal coverage, Clinton’s health care plan would rely on the system of employer mandate, which would require that employers offer and contribute to health insurance coverage for all of their employees (Blendon, Brodie, and Benson 19). As previously discussed, employers would be required to subsidize 80 percent of the insurance costs of their employees. While Americans favored the concept of employer mandate, “they were not sure that [it] was the best way to guarantee insurance coverage and protect their own health insurance security” (Blendon, Brodie, and Benson 19).

A second major issue of the plan surrounded how to finance it. Providing universal health coverage for the entire American population would not be a small fiscal commitment. The health care sector already accounted for one-seventh of the Gross Domestic Product (GDP). Clinton decided not to require a tax increase, but rather proposed having additional tobacco taxes to fund the projected \$100 billion needed to start the program (Berman 28). Raising taxes on cigarettes by 75 cents a pack (“Health Security” 83) did not seem to be a feasible way to raise the needed funds. “Americans could not understand how more people could be covered, more benefits added, and more bureaucracies established without costing them more money” (Blendon, Brodie, and Benson 16). To the public, it seemed as though too much was being given away for free. According to a Harris poll, “75 percent of Americans expected that the savings would not be enough and that some tax increase would be required” (Blendon, Brodie, and Benson 16). The plan lacked credibility because financing it seemed impossible.

Consumers even indicated a willingness to pay additional taxes to support universal coverage. A Consumer Union/Gallup survey of middle-/higher-income households indicated that three out of four are willing to pay higher taxes to support such reform. Of those earning \$25,000 to \$50,000 a year, 64 percent said they would pay at least \$240 more in taxes a year to provide such coverage. Even those earning more than \$50,000 a year said they are ready to contribute additional money to bring all Americans into a universal health-care system, with 67 percent saying they endorse such a move. (Consumers Union/Gallup 20 Apr. 1993).

A risky aspect of the financing of the plan was an assumption it made—that of future Medicare savings. “Sixty-nine percent [of Americans] said that they would be less likely to support health care reform if it involved a threat to Medicare” (Blendon, Brodie, and Benson 16). Making this assumption gave the impression that the elderly were being asked to subsidize disproportionately the needs of the uninsured. With Americans focusing on the benefits or costs to themselves, the idea of contributing to the “greater good” caused a decline in support from the elderly population. As previously mentioned, in just eight months, support from those over the age of 65 decreased 25 percentage points.

The decision on how the plan should manage health care costs became the third major substantive issue. Health care costs had begun to rapidly increase. “Between 1980 and 1992, American health care spending rose from 9 percent of the Gross Domestic Product (GDP) to 14 percent” (“Health Security” 7). Projections were that US healthcare expenditure would reach “\$1740 billion or 15.1% GDP at decade’s end” (*The Lancet* 791).

While Americans were cautious of government involvement, they clearly did support the government stepping in to control the rising costs of health care. “Six in 10 respondents believe government ‘should have the primary role in...controlling health costs.’ Only 34% believe the ‘private sector’ should lead the way” (CHCPE 20). But, when presented with the option of either placing a limit on the rates that could be charged for private health insurance or placing a yearly limit on total private and government spending on health care, the public favored the former over the latter 58% to 26% (Harvard School of Public Health, et al. 18 March 1993).

The task force rejected a single-payer model that had worked well in Canada, a model that provided universal coverage as well as freedom of choice and that was paid for out of general tax revenues (Berman 27). Instead, the task force was guided by an approach already taken by the Jackson Hole Group, which “emphasized the centrality of market forces, tied to the creation of health maintenance organizations (HMOs) as the proper modality for limiting corporate and business costs” (Berman 27).

However, the public’s distrust of the government overshadowed the public’s desire for contained costs. The public associated government-controlled prices with a decline in quality of care because they did not trust the government to look out for their best interests. Fifty-four percent of those surveyed in a USA Today/CNN/Gallup poll said that

they feared “being worse off” under health care reform” (Laham 213). A majority of middle-class voters believed health care reform would leave them worse off than they were under the voluntary, employment-based insurance system.

The decision to rely on competing managed care plans became the fourth substantive issue which created major obstacles. Managed care, also called managed competition, describes several types of health insurance plans which are designed to reduce health care costs. Health maintenance organizations (HMOs) are the most common type of managed care plan. The task force also chose managed care because it gave the appearance of minimal government involvement.

Unfortunately, the public perceived managed care as contributing to additional bureaucracy and government control. It was clear American’s didn’t want more big government involvement. “In 1990 nearly two-thirds (63 percent) of those who did not belong to a health maintenance organization (HMO) said that they were not interested in joining one, and in 1993 most Americans (74 percent) said that they preferred to arrange their own care rather than joining an organization that arranged their care for them” (WH #38).

Furthermore, Americans greatly valued the ability to choose their own doctor. A Gallup poll indicated “66 percent of Americans said that it was very important for them to be able to choose any doctor they wanted rather than choosing from a list provided by their health plan” (Blendon, Brodie, and Benson 18). Under managed care “most Americans would obtain health insurance through new regional insurance purchasing cooperatives that would contract with private health plans and monitor the competition among them” (Hacker). This system takes away the freedom of choice the American public so clearly valued.

The Hawaiian model could have been a useful guide in this situation. Following a plan that provided more affordable fee-for-service plans rather than forcing Americans into managed care arrangements would have given Americans more choice and probably helped maintain more public support.

Finally, the decision to establish obligatory health alliances caused a decline in public support. Creation of health alliances, or large new government agencies, confused the public. “Only 25 percent of Americans said that they knew what a health alliance was” (Blendon, Brodie, and Benson 18). Because the task force did not do an effective job of informing the public, opponents could easily provide Americans with information that created opposition toward reform.

In creating these new government agencies, the task force unwittingly played into Americans’ opposition to bureaucracy. “Two days after President Clinton’s September speech,” according to a Gallup/CNN/USA Today poll, “65 percent of Americans agreed that the president’s plan would increase government bureaucracy and government control.” (Blendon, Brodie, and Benson 18) The public reacted negatively to the notion of an enlarged government in a Fabrizio, McLaughlin poll: “When one survey question



described the president's plan as establishing '79 new government agencies and commissions,' 72 percent of Americans said that they would not support the plan" (Blendon, Brodie, and Benson 18). For any type of universal coverage to work additional government agencies are obviously necessary. The task force failed to advertise and educate the public about health alliances effectively.

Finally, the public did not see a need to change how they purchased health insurance. "Only one in six Americans (17 percent) preferred to purchase insurance from a health alliance" (Blendon, Brodie, and Benson 19). Americans were satisfied with their current providers, and preferred to stay with arrangements they knew.

The employer mandate aspect of the reform previously discussed would allow people to continue with their current health care arrangements and build upon the current employer-based system of health insurance (Blendon, Brodie, and Benson 19). However, the system of health alliances directly contradicted the benefit of employer mandate of maintaining current health care arrangements. The system of health alliances would require "the millions of firms, governments, families and individuals who currently buy voluntary plans independently to join no more than several dozen health alliances, which would serve as insurance purchasing agents for the entire population" (Laham 37). While in actuality Clinton's national health insurance program would give the public a wide range of choice, this aspect was contradictory, giving critics the perfect vehicle for which to use in attacking the plan and appealing to those who could defeat it—the public.

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### **What went wrong: External Opposition to Reform**

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The other main contributing factor to the rapid decline in public support stems from the intense external pressures on Clinton, the task force, and on the concept of health care reform itself. The two major external obstacles, the value system of the country and the aggressive counter-marketing campaign worked to magnify the internal problems Clinton and the task force created.

The first external aspect that resulted in the decline of public support was the value system of the country. In designing the plan, Clinton misjudged these values and did not appropriately address them.

The public was deeply cynical about the government. Any perception of unnecessary (or even in this case, necessary) increase in government bureaucracy would displease voters. At the time of the planning and announcement of Clinton's Health Care Reform Plan, 65 percent of Americans believed the federal government controlled too much of daily life (Princeton Survey Research Associates/Time Mirror Center Poll 26 May 1993). 60 percent indicated they favored smaller government with fewer services over 29 percent that supported larger government with many services (Los Angeles Times Poll, 12 June 1993). Americans didn't believe the government could get anything done.

In addition, Americans analyzed health care reform in terms of personal benefit. Highly decentralized health care system has resulted because of American's juxtaposing values. One is the "ideal of rugged individualism" (Frank and VandenBos 852), but the opposing view is that Americans are "generous and compassionate" (Frank and VandenBos 852). Historically Americans have not been supportive of a welfare state. Health care reform runs counter to ideals of individualism and laissez-faire.

"When given a list of goals for health care reform, Americans chose making health care affordable for themselves and their families (34 percent) by nearly a two-to-one margin over controlling the total cost of health care (19 percent) (Blendon, Brodie, and Benson 12). It is clear Americans, especially the middle-class, was primarily concerned about their own well-being and health security. Brodie and Blendon provide a nice summary of the middle-class anxiety over health care reform:

By the end of this debate [on national health insurance], the middle class became more worried about the possible negative effects of health care reform than they were about the [medical crisis] itself. By June 1994, more Americans were worried that a health care reform bill would jeopardize quality and cost more (57 percent) than were worried that universal coverage and cost control would not be achieved (29 percent)...At the same time most Americans believed that under the Clinton plan their costs would increase, that they would have fewer choices of physicians, and that the quality of health care they received would decrease rather than improve...The status quo seemed more desirable than any major reform. In fact almost one-half of the public said they were relieved that Congress did not enact any reform" (Laham 213).

The middle-class did not want to see a reform pass that would endanger their benefits. However, Clinton and the First Lady "misjudged probable public reaction (Drew 1994, 305). [They] not only underestimated the public's response to their health care plan but overestimated their ability to overcome it" (Renshon 136).

Second, the aggressive marketing campaign against reform lead by various interest groups provided the vehicle for the decreasing of public support. Even if Clinton had worked to promote and educate Americans about health care reform, the opposition had several advantages over supporters of the plan. First, they were able to exploit all the internal strategic and substantive problems. Second, they had an uneasy public that was wary of big government and motivated by self-interest. Finally, opponents were able to able to donate more time and money to the counter-campaign.

The rapid decline in public support is largely due to the adamant opposition and successful advertising campaign of various interest groups. "Interests groups steadfastly opposed to the Clinton plan...got the jump on the Clinton administration in the battle for public opinion and took away the definition of the issue from its initiators. Coordinating their efforts with Republican leaders in Congress, these interest groups turned Clinton's bid for grand accomplishment into a political boomerang" (Skocpol 178). Opponents of health care reform consistently and constantly bombarded the public with information and emotional appeals warning of the downfalls of health care reform. Because of

Clinton's "vague and evasive explanations of how the reformed health care system would work," Americans were "[left] open to alternative descriptions purveyed by [health care reform's] fiercest opponents" (Skocpol 132). In Clinton's failure to take the initiative to show the benefits of reform, opponents were able to take advantage of every opportunity to criticize of health-care and lower public confidence in the plan.

Republicans convincingly argued that the Clinton plan would require middle-class, privately insured individuals to pay more for their coverage, with the added revenues devoted to providing coverage for the uninsured. Middle-class, privately insured individuals would at the same time receive less coverage, since health care would have to be stringently rationed to assure the economic and fiscal viability of the national health insurance program Clinton would need to establish. (Laham 212). Republican members of Congress worked with various interest groups that opposed health care reform to lead an advertising campaign against reform. Their joint marketing skills, ample funds, and indifference to truth-telling regarding domestic policy allowed opponents to triumph in defeating public confidence in health care reform. "The success of the opponents of the Clinton health care plan in the battle for public opinion translated into success in the legislative arena. It was the altered views of their constituents that made it impossible for Democrats to put together majorities for any significant health care bill" (Campbell and Rockman 81).

Many businesses opposed health care reform. "The major interest groups representing the business community—the Business Roundtable, Chamber of Commerce, and NFIB [the National Federation of Independent Business]—announced their adamant opposition to the Clinton plan" (Laham 139). Clinton's health care reform and the aspect of an employer mandate would require businesses to assume more responsibility in providing health care insurance to their workers. This obligation would raise operating costs significantly. As a result, "most large corporations joined a united small business community in opposing the Clinton plan" (Laham 139). The only way to protect their personal interests was to derail health care reform.

For example, the "NFIB directed a constant flow of faxes to its small-business constituents to send them into action, staged public forums in states where swing members of Congress had been targeted, and contacted scores of talk-radio shows across the nation to pillory the Clinton plan" (Schier 115). Business leaders worked diligently to turn public opinion against health care reform.

In addition to the business sector, the health care industry provided a major source of strong external opposition. "Health care is a trillion-dollar industry, which consumes 14 percent of GDP [in 1993]. With so much money at stake in the current health care system, the medical industry stood to lose hundreds of billions of dollars from national health insurance..." (Laham 206). Clinton's plan, with its creation of health alliances and managed care, threatened every aspect of the health care industry. Clinton's plan called for universal coverage without a tax increase. "To assure that national health insurance was established on an economically and fiscally viable basis, the federal government would have had to impose stringent health care cost-containment measures. Hospital and

nursing-home rates, physician fees, and drug prices would have had to be reduced...National health insurance represented a financial threat to practically every segment of the health care industry” (Laham 206). The approval of health care reform would cost the industry billions, if not trillions of dollars.

“Medical PACs [political action committees] provided \$26.4 million in campaign contributions to congressional candidates, mostly incumbent lawmakers, during January 1, 1993 to May 31, 1994, guaranteeing medical interest groups substantial influence over the 103<sup>rd</sup> Congress, which considered Clinton’s national health insurance plan” (Laham 206). The Health Insurance Association of America (HIAA), the largest interest group representing the private insurance industry, spearheaded advertising efforts to create public opposition to Clinton’s health care reform. At the time the HIAA was “composed of 271 companies, which collectively control[led] 35 percent of the private health insurance market” (Laham 74). If health care reform had passed, many of the 271 companies would have been forced out of business (Laham 135). It was in their interest to join forces with Republican opposition to turn public opinion against health care reform.

The HIAA created the Coalition for Health Insurance Choices (CHIC), whose purpose was “to mobilize grassroots opposition to the Clinton plan. By December 1993, the CHIC had enrolled 20,000 members” (Laham 74). “Grassroots lobbying and television ads to raise doubts about the emerging Clinton plan started in May [of] 1993” (Laham 137). In late August, “the HIAA released the first installment of \$14 to \$15 million that would be spent on the infamous “Harry and Louise” television commercials. Between the “Harry and Louise” ads and grassroots campaigning, the HIAA spent approximately \$100 million (Campbell and Rockman 80).

The “Harry and Louise” campaign is possibly the most memorable propaganda campaign against health care reform. Harry and Louise were a white, middle-class couple who discussed health care reform with each other, different family members, and Louise’s business associate, Libby (Goldstein et al. 1331). The ads were broadcast in New York, Los Angeles, and Washington DC and in some southern and border states, “where HIAA hoped to influence conservative Democratic legislators” (Goldstein et al. 1328). The campaign began on September 9, 1993, just before Clinton’s September 22 address to a joint session of Congress about the health reform plan he would soon introduce. It continued for a year until September 11, 1994 (Goldstein et al. 1328).

At the end of each ad an 800 number for CHIC appeared, encouraging people to call in with questions. “The HIAA reported that 500,000 people called this number, and of those, 45,000 were persuaded to write letters or place calls to Congress or the media” (Goldstein, et al. 1326). Clearly, the public was ready to be swayed. Clinton and the task force had not done a sufficient job in supplying the public with information to withstand counter attacks.

Harry and Louise appealed to Americans concerns about the loss of control and the creation of big government. One segment of a broadcast went like this:

Louise: “This plan forces us to buy our insurance through those new mandatory government health alliances.”

Harry: “Run by tens of thousands of new bureaucrats.”

Louise: “Another billion-dollar bureaucracy.” (Laham 138)

Interestingly, “the Clinton plan would actually expand the range of choices consumers would have in selecting their own private insurance” (Laham 76). Under the current system, privately insured employees covered through their employers are given a limited number of plans (if more than one) from which to choose. While Clinton would require most Americans to join regional health alliances, in actuality the public would have the widest possible range of choices in selecting a private plan.

However, the public did not see the choice they were being provided. As previously discussed, the case of health alliances inherently contradicted the concept of employer mandate. Although under the reform the two would be able to work concurrently, the public was not well educated enough on the complexities of the plan. Opponents were able to point out there was a contradiction and successfully worry the public.

Throughout the campaign, Harry and Louise addressed different issues to appeal to the public’s values and exploit their concerns about health care. Harry and Louise made the point that “The government shouldn’t choose our health care plan. We should choose our own” (Gergen 301). The viewing public sympathized with the views of Harry and Louise; after all, like the viewing public, they were an average American couple.

Some critics argue the Harry and Louise ads did not directly affect public opinion and rather were “intended to influence legislators in key districts by persuading them that the public did not support the Clinton plan” (Goldstein et al, 1326). However, “as the most coherent and well-funded attempt to sway public opinion during the 1993-1994 health care reform debate, it can be argued that the campaign played a part” in decreasing public confidence in health care reform.

One long-term comprehensive study done in Oklahoma revealed that public support for health care reform was fairly stable during pre-broadcast periods, and then rose when the Harry and Louise campaign was first introduced. But during February of 1994, the tone of the ad campaign became “assured and assertive rather than tentative and gently persuasive” (Goldstein et al. 1329). During this period, public support sharply declined and remained low through the post-broadcast period.

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## Conclusion

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Clinton’s attempt to undertake health care reform proved no easy task. Leadership proved extremely difficult because the “trust in the president [had] declined; the White House [commanded] less authority in pursuing major initiatives; Congress [was] more fractious; the press [was] more interested in scandal than substance and interest groups [had] acquired greater power” (Gergen 303).

Many of these obstacles either directly or indirectly affected public opinion, one of the Executive's greatest resources. When a president can draw a nation together to support a common cause, he can use their support as a leverage tool in Congress. But, when Clinton came into office in 1992, he had not won an electoral majority. Clinton faced an American public, especially the middle-class, which was content with the status quo and wary of any major government initiatives that would increase the bureaucracy with which they were so frustrated.

Therefore, Clinton and the task force had very little leeway for political error. To pass health care reform, Clinton needed the support of the middle-class, and had to attempt to emphasize they would benefit from the reform; that it was not just benefiting the most disadvantaged members of the nation. He further needed to assure the public about the costs of reform. Americans were concerned about the growth of the budget deficit, but more so concerned about the personal cost to themselves.

Universal coverage is based on the value of "the greater good." Clinton faced a self-interested nation whose first concern was their own benefit. Because of the predisposition of many middle-class citizens, opponents had an easy time exploiting (and in some cases, twisting) any and every flaw of the health reform plan. Opponents played to the public's fear that if the government were to choose, they would lose.

In the face of all these obstacles, Clinton attempted to do too much. His excessive ambition in many ways deterred incremental improvements, that when combined, would make a large impact. Fortunately, many of the proposals put forth in the health care reform plan later found their way into legislation. If nothing else, Clinton brought the issue of health care reform back to the forefront of the national agenda, raising public awareness of the need for reform.

The next years of Clinton's presidency saw many incremental accomplishments surrounding health care. A bill was passed guaranteeing that workers wouldn't lose their insurance when they changed jobs. In 1997, the Children's Health Insurance Program (CHIP) was passed, providing health care to millions of children in the largest expansion of health insurance since Medicaid was enacted in 1965. Women were finally able to stay in the hospital for more than twenty-four hours after childbirth. Other benefits included increased coverage for mammograms and prostate screenings, a diabetes self-management program, a large increase in the research and care of HIV/AIDS, child immunization rates about 90 percent, and a patient's "bill of rights." (Clinton, 620-21)

Clinton's loss of public support, especially that of the middle-class, reinforces the need to know the audience and their willingness "to sacrifice and risk the uncertain consequences of major changes in their lives" (Blendon, Brodie, and Benson 21). The failure of health care reform serves as a reminder of the power public opinion can ultimately wield.

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