

POLITICAL ACCOUNTABILITY

THE BIAS OF AMERICAN POLITICS: RATIONING HEALTH CARE IN A WEAK STATE

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Americans, we are often assured, do not like their government.¹ The assertion is partially truth and partially myth. This Article offers a more detailed map of the American political processes, and applies it to the debate over rationing health care.

Three forces shape our public policies: the first is a distinctive tendency to bash the state. The scope and intensity of anti-governmental ideology are exaggerated by a second feature of the American political landscape, the organization of our government. Fragmented, overlapping, often incoherent institutions blunt political action—more or less as the Founders intended.² Thirdly, Americans are swift to mobilize politically. Interest groups, organized lobbies, and ad hoc “action” committees all find this government comparatively easy to influence. Taken together, ideology, institutions, and interests systematically bias our public policies and public debates toward the status quo.

This bias of American politics shapes the paradoxical debate over health care rationing. The very notion of rationing alarms

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¹ See JAMES A. MORONE, *THE DEMOCRATIC WISH: POPULAR PARTICIPATION AND THE LIMITS OF AMERICAN GOVERNMENT* 2-5 (1990) (analyzing the American “dread” of government).

² The point is often exaggerated, although *The Federalist* did call for ambition to counteract ambition. *THE FEDERALIST* NO. 51, at 265 (Alexander Hamilton or James Madison) (Max Beloff ed., 2d ed. 1987). The Federalists tirelessly repeated a new kind of administrative catechism: their government would operate with energy, vigor, firmness, steadiness, and decision. See *THE FEDERALIST* NOS. 17, 27, 68 (Alexander Hamilton), NO. 46 (James Madison). For a discussion of the subsequent development of the administrative state from this perspective, see JOHN A. ROHR, *TO RUN A CONSTITUTION: THE LEGITIMACY OF THE ADMINISTRATIVE STATE* (1986) (attempting to reconcile discourse of Constitution with contemporary administrative apparatus). See also MORONE, *supra* note 1, at 66-72 (discussing the Federalist’s pursuit of an ambitious and energetic executive, both at the Constitutional Convention and during Washington’s administration).

people on all sides, yet few health care systems anywhere are as heavily rationed as the American.³ The first procedure in any health care setting is the inevitable "wallet biopsy," a stringent rationing tool.⁴ I contend that the American political system fosters contradictions in the ways we ration health care and in the ways we frame potential alternatives. Ultimately, our health care debate proceeds backwards. My purpose here is to show how and explain why this is so.

I. PATTERNS OF AMERICAN POLITICS

A. *Ideology: The Distrust of Government*

Americans do not like government.⁵ The state occupies an unusually ambiguous place in our society. Public power has long been viewed as a threat to liberty—James Madison contrasted the American Constitution with the European legacy of Magna Carta as a charter of power granted to liberty rather than a charter of liberty granted by power.⁶ The preoccupation with limiting government has remained a vivid feature of American political life. Tocqueville reported, "the society acts by and for itself. . . . so feeble and restricted is the part left to [government] administration."⁷

Even as the American administrative state began to take its contemporary form, somewhere between the two Roosevelt administrations, the anti-governmental impulse remained. For example, Americans developed their social insurance programs far more reluctantly than did most Western democracies. In Europe, benefits were generally proffered from the political center by statesmen bidding for the allegiance of workers. Bismarck, Lloyd

³ See Leonard M. Fleck, *Just Health Care Rationing: A Democratic Decisionmaking Approach*, 140 U. PA. L. REV. 1597, 1602 (1992); David Mechanic, *Professional Judgment and the Rationing of Medical Care*, 140 U. PA. L. REV. 1713, 1745-46 (1992).

⁴ See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 436 (1982) (discussing how physician's economic power has replaced their former cultural authority).

⁵ See MORONE, *supra* note 1, at 4 (arguing that a pervasive American "dread" of government has been repeatedly overcome by broad reform movements seeking to restore power to the people).

⁶ See GORDON S. WOOD, *THE CREATION OF THE AMERICAN REPUBLIC 1776-1787*, at 601 (1969); *id.* at 593-615 (noting that the Revolutionary period was marked by a pervasive civic republicanism that gave way to incipient liberalism by the time of the Constitution's drafting).

⁷ ALEXIS DE TOCQUEVILLE, *DEMOCRACY IN AMERICA* 53 (J.P. Mayer & Max Lerner eds., George B. Lawrence trans., Harper & Row 1966) (12th ed. 1848).

George, and Napoleon III each sought to coopt the working classes with social insurance programs.⁸ In the United States, the political payoffs from such programs are not often noted and new social-welfare programs not often won. The American social-welfare debate focuses more on the dangers from prompting laziness than the opportunities of promoting loyalty.⁹ When new programs are proposed, they provoke the same anti-governmental reflex that shackled the government's early development. Throughout most of the twentieth century, great cries about looming socialism accompanied the government bashing.

Louis Hartz described the result as "American exceptionalism," a distinctive opposition to the state that weakens every move toward government programs, let alone toward class-based politics or socialism.¹⁰ Granting old age benefits, financing health care publicly, legitimating labor unions, legislating civil rights, fluoridating water, regulating industry, and a multitude of other policies all elicit a similar response. New forms of state authority, even those that extend narrow benefits to broad constituencies, evoke the charge that an overreaching state threatens the people's liberty.¹¹

⁸ See GASTON V. RIMLINGER, WELFARE POLICY AND INDUSTRIALIZATION IN EUROPE, AMERICA AND RUSSIA 60-61, 112-22 (describing the formation and political uses of welfare state programs); STARR, *supra* note 4, at 237-40 (same).

⁹ See MICHAEL B. KATZ, THE UNDESERVING POOR: FROM THE WAR ON POVERTY TO THE WAR ON WELFARE (1989) (demonstrating how images of poverty shaped social welfare programs); ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA (1974) (showing how views of deserving and undeserving poor shaped Medicaid).

¹⁰ See LOUIS HARTZ, THE LIBERAL TRADITION IN AMERICA 3-23 (1955) (arguing that the absence of a feudal tradition results in the absence of class politics and, consequently, a truncated political spectrum defined by a fundamentally Lockean view of politics). An extensive literature follows, attacks, and defends this influential analysis. Perhaps the best single statement of the Hartz thesis and its critics is by J. David Greenstone, *Political Culture and American Political Development: Liberty, Union, and the Liberal Bipolarity*, in 1 STUDIES IN AMERICAN POLITICAL DEVELOPMENT 1 (1986).

¹¹ The rhetoric goes back to the American colonists' cry against George III's "multitude of New Offices" and "swarms of Officers." THE DECLARATION OF INDEPENDENCE para. 12 (U.S. 1776). The anti-Federalists greeted the proposed Constitution with the same rhetoric. See James Madison, *The Federal Convention: Madison's Notes of Debates, in THE FEDERAL CONVENTION AND THE FORMATION OF THE UNION OF THE AMERICAN STATES* 71, 107-08, 335-38 (Winton U. Solberg ed., 1958). See generally THE AMERICAN CONSTITUTION: FOR AND AGAINST (J.R. Pole ed., 1987) (collecting anti-Federalist writings). For an effort to trace this anti-governmental theme through American political development, see MORONE, *supra* note 1. See also Theodore J. Lowi, *American Business, Public Policy, Case Studies, and Political Theory*, 16 WORLD POL. 677, 690-707 (1964) (book review) (distinguishing the passionate broad-

At times, the ideology is articulated with great gusts of hyperbole. For example, school desegregation left Southern editorialists speculating how “[t]he communist masses of Russia and Red China must have howled with glee.”¹² The Kennedy administration’s scaled back Medicare program would lead us to “awake to find that we have socialism. . . . [O]ne of these days you and I are going to spend our sunset years telling our children and our children’s children what it once was like in America when men were free.”¹³ Recently, the dread of government has been articulated in more sober, but equally passionate terms: “no new taxes.”¹⁴

Observers of American health care are familiar with this theme of government distrust. It is, we are frequently told, the reason Americans have no national health insurance; it is the reason a national health scheme such as Canada’s remains “off the radar screen of American possibility.”¹⁵ Although this ideology runs long and deep in America politics, it is also overstated. There are other legacies in American political history. Hamilton’s “energy” in government,¹⁶ Lincoln’s “political religion of the nation,”¹⁷ and Franklin Roosevelt’s “four essential human freedoms”¹⁸ are all familiar visions of a radically different nature—visions of a strong and active state.

Indeed, anti-statist rhetoric failed to bury any of the examples noted above—social security, Medicare, protecting voting rights, business regulation, and water fluoridation are all unexceptional

based response to “redistributive politics” from the easy incremental politics of “distributive” and “regulatory” policies).

¹² Tom Brady, *Communist Masses Howled With Glee on Black Monday*, in *THE STRUGGLE FOR RACIAL EQUALITY* 71, 73 (Henry S. Commager ed., 1967).

¹³ MAX J. SKIDMORE, *MEDICARE AND THE AMERICAN RHETORIC OF RECONCILIATION* 127-28 (1970) (quoting Ronald Reagan).

¹⁴ JAMES MACGREGOR BURNS ET AL., *GOVERNMENT BY THE PEOPLE* 212 (14th ed. 1990) (quoting George Bush in the 1988 Presidential campaign).

¹⁵ Theodore R. Marmor & Jerry L. Mashaw, *Canada’s Health Insurance and Ours: The Real Lessons, The Big Choices*, *AM. PROSPECT*, Fall 1990, at 18, 25 (quoting Alain Enthoven).

¹⁶ For a discussion of Alexander Hamilton’s administrative vision, see MORONE, *supra* note 1, at 66-68.

¹⁷ Abraham Lincoln, Address Before The Young Men’s Lyceum of Springfield, Illinois (Jan. 27, 1837), in 6 *THE WRITINGS OF ABRAHAM LINCOLN* 148, 155 (Arthur Brooks Lapsley ed., 1905) (discussing the necessity of respect for the laws and institutions of government).

¹⁸ Franklin D. Roosevelt, The Annual Message to the Congress (Jan. 6, 1941), in *THE PUBLIC PAPERS AND ADDRESSES OF FRANKLIN D ROOSEVELT: 1940 VOLUME 672* (Samuel I. Rosenman ed., 1941) (articulating four essential human freedoms, including freedom from want).

duties of the American state today. The American fear of government matters, but it is only part of the political story.

B. *Institutions: Fragmented Government*

Anti-statist ideology is built into the chaotic fragmentation of American political institutions—and commonly celebrated as checks and balances. “No other nation,” report Peter Marris and Martin Rein, “organizes its government as incoherently as the United States.”¹⁹ The political chaos “leaves most reforms sprawling helplessly in a scrum of competing interests.”²⁰ The President and both houses of Congress pursue their own agendas; in the past century and a half, the three bodies have been divided by party forty percent of the time, by region and institutional loyalty constantly.²¹ Together, they compete to oversee a federal bureaucracy that is in many ways beyond their control. The President, for example, names little more than one-tenth of one percent of federal office holders.²²

Political programs must pass through the presidency, Congress, the federal bureaucracy, and then negotiate the layers of American federalism—regional governments, state government, sub-state regional bodies, counties, and local governments, each of which is divided by function.²³ The courts intervene at every stage. To pass this gauntlet, proposed programs are typically oversold (promising all kinds of benefits to all sorts of constituencies) and, at the same time, heavily compromised.²⁴ The combination creates an often-sampled recipe for disappointment.

¹⁹ PETER MARRIS & MARTIN REIN, *DILEMMAS OF SOCIAL REFORM: POVERTY AND COMMUNITY ACTION IN THE UNITED STATES* 7 (1967); *see id.* at 113-19 (attempting to explain the formation and fate of President Johnson’s war on poverty).

²⁰ *Id.* at 7.

²¹ *See* MORONE, *supra* note 1, at 10.

²² *See* James A. Morone, *Representation Without Elections: The American Bureaucracy and Its Publics*, in *REPRESENTATION AND RESPONSIBILITY* 283, 294 (Bruce Jennings & Daniel Callahan eds., 1985) (reviewing models of representation as they apply to American federal bureaucracy).

²³ *See* THOMAS J. ANTON, *AMERICAN FEDERALISM AND PUBLIC POLICY* (1989) (describing American federalism); Morton Grodzins, *The Federal System*, in *AMERICAN FEDERALISM IN PERSPECTIVE* 256, 257 (Aaron Wildavsky ed., 1967) (describing the overlap of agencies and functions in the U.S. government).

²⁴ *See, e.g.*, JEFFREY H. BIRNBAUM, *SHOWDOWN AT GUCCI GULCH* (1987) (describing the special interests that were catered to during negotiations leading to the Tax Reform Act of 1986).

The chaos of checks and balances is rooted in the Constitution and was exacerbated by succeeding reform generations. In the vain hope of getting beyond politics, wave after wave of American reformers have organized new agencies designed to be independent, expert, and apolitical. For example, reformers organized the civil service in 1883 to meet these specifications, promising that the result would be honest and efficient government.²⁵ Additional examples range from independent regulatory agencies (beginning with the Interstate Commerce Commission in 1887)²⁶ to the Health Care Finance Administration (formed in 1977).²⁷ The new agencies swiftly added to the uncoordinated, fragmented character of the American regime; they quickly found themselves bogged down in the politics they were designed to avoid.²⁸

The result is a political framework geared towards narrow incremental changes best negotiated by individual, independent agencies with narrow jurisdictions. The system is especially maladroit at securing broad policy changes that require coordination from the political center. For instance, when the Supreme Court took a leftward turn and championed desegregation, it was frustrated for more than a decade by Congress, executive agencies, state governments, county and municipal officials, and local school boards.²⁹ By contrast, our government is well-designed for granting agricultural subsidies or damming rivers.

The bias of our political institutions can easily be misread as an American bias against government action. National health insurance offers a familiar example. Americans may be skeptical of their state, but Harry Truman was elected, in 1948, touting universal government health insurance as his major domestic issue.³⁰ While his promise to "remove the financial barrier to health care" played

²⁵ See generally STEPHEN SKOWRONEK, *BUILDING A NEW AMERICAN STATE: THE EXPANSION OF NATIONAL ADMINISTRATIVE CAPACITIES, 1877-1920*, at 47 (1982) (tracing the structural reform of the American civil service and the military).

²⁶ See GRANT MCCONNELL, *PRIVATE POWER AND AMERICAN DEMOCRACY* 281 (1966) (describing the institutional fragmentation that resulted from the Progressive ideal).

²⁷ See FRANK J. THOMPSON, *HEALTH POLICY AND THE BUREAUCRACY* (1981) (tracing the design of the federal health bureaucracy).

²⁸ On the impossibility of apolitical government, see James Morone, *Hidden Complications: The Ironic Flaw of Health Care Competition*, in *AM. PROSPECT* (forthcoming Summer 1992). For an historical account, see MORONE, *supra* note 1, at 119-23.

²⁹ See RICHARD KLUGER, *SIMPLE JUSTICE: THE HISTORY OF BROWN v. BOARD OF EDUCATION AND BLACK AMERICA'S STRUGGLE FOR EQUALITY* (1977); *WITH ALL DELIBERATE SPEED* (John H. McCord ed., 1969).

³⁰ See STARR, *supra* note 4, at 284-86.

well on the campaign hustings, it was repeatedly rejected in Congress.³¹ In a parliamentary system free of checks and balances, one party (or coalition) would control the legislature, the executive office, and the bureaucracy. In such a setting, the Truman administration would have had the opportunity—indeed, it would have been expected—to legislate its major campaign promise. An America that operated under English (or Canadian or German) institutional rules would likely have legislated national health insurance several times over. This elusive reform has been wrecked as much by the organization of our government as by public skepticism about government health policies. Of course, a consistently stymied state exacerbates public contempt, fostering the ideology described in the preceding section.

C. *Interests: The Politics of Conflict*

An entirely different line of inquiry focuses on the politics of clashing interests. Proponents of this perspective note that the United States has had plenty of reformers, socialists, and class-based movements. Their successes and, more often, their failures were forged in political conflicts. Power has always been the crux of the matter. One traditional reading of American political development interprets it as a long series of clashes between entrenched haves and aspiring have-nots.³² National health insurance, in this view, was repeatedly defeated by powerful, self-interested opponents—the American Medical Association in 1935 and 1948,³³ or the health insurance industry today.³⁴ Ideology and institutions are important as mechanisms employed by self-interested groups resisting reform.

³¹ See MORONE, *supra* note 1, at 258.

³² This view is associated with the Progressive tradition of American historiography. See, e.g., CHARLES A. BEARD, *AN ECONOMIC INTERPRETATION OF THE CONSTITUTION OF THE UNITED STATES* (1913) (arguing that the Founders were motivated by class interests); VERNON L. PARRINGTON, *MAIN CURRENTS IN AMERICAN THOUGHT* (1930) (claiming that American intellectual history is cast in the Progressive rubric of class conflict). For a lengthier discussion, see MORONE, *supra* note 1, at 19-23.

³³ See STARR, *supra* note 4, at 266-89. Theodore R. Marmor traces the conflict between reformers and medical opponents in the fight for Medicare and emphasizes mobilization of interests and institutional settings. See THEODORE R. MARMOR, *THE POLITICS OF MEDICARE* (1970). For an especially potent critique of medical interests, see Comment, *The American Medical Association: Power, Purpose, and Politics in Organized Medicine*, 63 *YALE L.J.* 938 (1954).

³⁴ See Ronald Pollack & Phyllis Torda, *The Pragmatic Road Toward National Health Insurance*, *AM. PROSPECT*, Summer 1991, at 92, 99 (describing the opposition of insurance companies to national health insurance).

The emphasis on interests highlights a third distinctive feature of the American political scene: broad and persistent participation at every point in the political process. This theme, too, has a long legacy. William Penn crystallized the "noisy" politics of his colony with an oft-quoted plea: "For the love of God, me and the poor country, be not so governmentish."³⁵ The settlers ignored him, he later complained, and remained "open and noisy in their dissatisfactions."³⁶ A century-and-a-half later, Tocqueville reported: "It must be seen to be believed Almost the only pleasure an American knows is to take part in the government and discuss its measures."³⁷ Americans help themselves, concluded Lord Bryce in 1888, and they "did not care whether [their functionaries] were skillful or not."³⁸ Americans (or rather white males) won voting rights early in the nation's history and rapidly developed an ethos of civic participation and interest group formation.³⁹ Although two radically different interpretations of America's participatory political culture exist,⁴⁰ most political scientists focus on the proliferation and influence of interest groups as "perhaps the feature of political power most characteristic of American democracy."⁴¹

The proliferation of groups continues. Political scientists once celebrated the resulting interest group pluralism as a bulwark for

³⁵ BERNARD BAILYN, *THE ORIGINS OF AMERICAN POLITICS* 64-65 (1967).

³⁶ *Id.*

³⁷ 1 ALEXIS DE TOCQUEVILLE, *DEMOCRACY IN AMERICA* 318-19 (Henry Reeve trans. & ed., Cambridge, Sever & Francis 2d ed. 1863); see also *supra* text accompanying note 7.

³⁸ 2 JAMES BRYCE, *THE AMERICAN COMMONWEALTH* 485 (AMS Press 1973) (1888).

³⁹ See Ronald P. Formisano, *Deferential-Participant Politics: The Early Republic's Political Culture, 1789-1840*, 68 AM. POL. SCI. REV. 473 (1974) (discussing voting changes and their implications); see also EDWARD PESSEN, *JACKSONIAN AMERICA* (Illini Books 1985) (1969) (describing the ethos of Jacksonian America); ROBERT V. RIMINI, *THE REVOLUTIONARY AGE OF ANDREW JACKSON* (1976) (same); ROBERT H. WIEBE, *THE OPENING OF AMERICAN SOCIETY* (1984) (same); SEAN WILENTZ, *CHANTS DEMOCRATIC* (1984) (same).

⁴⁰ Roughly speaking, one is a class-based view that can be identified most clearly with the Progressive and New Left historians, see *supra* note 32, and the other is a group-theory view that replaces broad, relatively fixed socioeconomic classes with far more fluid interest-group formation. See MORONE, *supra* note 1, at 19-23 (contending that these apparent alternatives are, ultimately, different levels of analysis). For a thoughtful historical perspective on this subject, see Edmund Morgan, *Conflict and Consensus in the American Revolution*, in *ESSAYS ON THE AMERICAN REVOLUTION* 290 (Steven G. Kurtz & James K. Hutson eds., 1973). Samuel Huntington provides the view from a "consensus political scientist." See SAMUEL P. HUNTINGTON, *AMERICAN POLITICS: THE PROMISE OF DISHARMONY* 5-10 (1981).

⁴¹ MCCONNELL, *supra* note 26, at 3.

democratic participation. Today, they call it "hyperpluralism" and generally lament the resulting stalemate.⁴² In sum, an activist interest group culture operates within a sprawling, fragmented state that is always vulnerable to challenges of illegitimacy. One result is that organized interests can influence policies at multiple points in the political process.

The broader consequence is that ideology, institutional design, and the politics of both interests and groups all cast the same biases into American politics. Change is difficult to introduce, and the broader the change, the more difficult the task. Large scale innovations require the construction of broad coalitions among both private groups and public agencies; opponents can successfully resist in any of the political arenas through which all reform must pass. On the other hand, organized interests can far more easily win discrete benefits from legislative committees or bureaucratic agencies. The overwhelming bias is toward incremental adjustments to the status quo.

The very idea of systematically rationing a scarce good such as health care runs directly counter to all the patterns I have described. Rationing requires hard, visible decisions with identifiable winners and losers in a well-defined political setting. The preceding sections each present obstacles to doing so. First, American rationers would have to meet challenges to the legitimacy of a public effort. Second, any effort is apt to involve a multiplicity of agencies; a recent effort to ration health care in Oregon is now debated, not just in that state, but in the federal bureaucracy, in the Health Care Finance Administration and the Office of the Secretary of HHS, in Congress (on and off relevant committees), and in studies by the Office of Technology Assessment. This bureaucratic fragmentation, in turn, offers multiple venues for rationing losers who organize, join coalitions, and struggle for their benefits—what rationer would relish the prospect of facing an aroused American Association of Retired People (with politicians inevitably in tow)? Or, for that matter, the Children's Defense Fund? Or ACT UP? Rationing requires precisely the attribute that is in shortest supply

⁴² On pluralism, see ROBERT A. DAHL, *WHO GOVERNS?* (1961); DAVID B. TRUMAN, *THE GOVERNMENTAL PROCESS* (1951). For a discussion of the strengths and weaknesses of the pluralist tradition, see J. David Greenstone, *Group Theories*, in 2 *THE HANDBOOK OF POLITICAL SCIENCE* 243 (Fred I. Greenstein & Nelson W. Polsby eds., 1975). On "hyperpluralism," see BRYAN JONES, *GOVERNING URBAN AMERICA* 190-92 (1983).

in American government: centralized political strength. The next section unpacks the consequences for rationing health care.

II. RATIONING HEALTH CARE

The American health care enterprise is now in its third decade of a cost crisis. Richard Nixon first sounded the alarm in 1969.⁴³ By any measure, the health care industry's expansion has been phenomenal. The United States devoted an extra percentage of GNP to health care every forty months through the 1980s.⁴⁴ While our rate of health care spending accelerates in the 1990s, most other nations of the Organization of Economic and Development (OECD) have kept their health spending stable relative to their economies.⁴⁵

Soaring costs have stimulated earnest talk of rationing health care. After all, advocates reason, unlimited demand for a scarce good can only be controlled by making tough decisions about who is to get how much of what. In theory, an extremely wide array of rationing devices is possible; however, the American political context as I have sketched it sharply limits the possibilities. This section will first examine the current state of health care rationing in the United States and then discuss some strategies proposed for the future.

A. Rationing Health Care in the United States

Many Americans bridle at the idea of "rationing" health care.⁴⁶ They oppose centralized, public sector choices about who gets what. Just invoking the prospect of government rationing, the "dreaded R word," is a rhetorical strategy to discredit national health proposals.⁴⁷ It is a predictable political tack. A nation suspicious

⁴³ See STARR, *supra* note 4, at 381.

⁴⁴ See James A. Morone, *American Political Culture and the Search for Lessons from Abroad*, 15 J. HEALTH POL. POL'Y & L. 129, 130 (1990). The literature documenting health inflation is enormous. See, e.g., Uwe E. Reinhardt, *Could Health Care Swallow Us All?*, BUS. & HEALTH, Jan.-Feb. 1990, at 47 (a satiric account forecasting 100% of GNP going to medicine by the year 2072).

⁴⁵ See Martin Pfaff, *Differences in Health Care Spending Across Countries: Statistical Evidence*, 15 J. HEALTH POL. POL'Y & L. 1, 2 (1990).

⁴⁶ See, e.g., Joseph A. Califano, Jr., *Rationing Health Care: The Unnecessary Solution*, 140 U. PA. L. REV. 1525 (1992).

⁴⁷ Lawrence D. Brown, Remarks before the UNY*CARE Commission (Universal Health Care for all New Yorkers) (Dec. 12, 1990); see also Lawrence D. Brown, *The National Politics of Oregon's Rationing Plan*, HEALTH AFF., Summer 1991, at 28, 31

of its government regularly shapes its public policies in a way to avoid explicit, visible decisionmaking by public officials. There are numerous ways to do so.

The most direct way to avoid conscious political choices is to hide them or shift them to the private sector. Thus, a roundabout government policy that induces or even coerces employers to offer insurance is widely touted as more politically practical than direct government insurance.⁴⁸ The preference for invisible choices explains the fundamental paradox of the American discussion about rationing: the industrialized nation in which medical care is least accessible to a large number of citizens—and in that sense, the nation that most tightly rations medicine—is the one in which attempts to ration health care explicitly are political dynamite.

That Americans ration medicine is, by now, a familiar claim to even the most casual observer of health care. Some thirty-seven million Americans have no health insurance and, as a result, are likely to encounter serious obstacles to getting care.⁴⁹ One study found that as many as sixty million people spent some time without insurance in a recent eighteen month period.⁵⁰ Another survey reported that the fear of losing health insurance dissuaded individuals from switching jobs in three out of ten American households.⁵¹

The American way of rationing is to decentralize (in political terms, hide) the choices; the result is rationing through an accumulation of narrow public policies, private decisions, and luck. Access to health care depends, most importantly, on where a citizen falls in the extraordinarily complex pastiche of health insurance programs. In New York, Medicaid covers citizens eligible for Aid to Families

[hereinafter Brown, *Rationing Plan*] (noting business leaders' ambivalence to rationing).

⁴⁸ See Lawrence D. Brown, *The Merits of Mandates*, 15 J. HEALTH POL. POL'Y & L. 793, 794 (1990).

⁴⁹ The actual numbers are subject to political redefinition. The Bureau of the Census set the number of uninsured at 37 million nonelderly Americans in March 1987. See Katherine Swartz, *Why Requiring Employers to Provide Health Insurance is a Bad Idea*, 15 J. HEALTH POL. POL'Y & L. 779, 780 (1990). In 1988, the census changed the questions on health insurance surveys and got a number of 31 to 33.5 million. *Id.* For a detailed accounting of the numbers, see KATHERINE SWARTZ, *THE URBAN INST., THE MEDICALLY UNINSURED: A SPECIAL FOCUS ON WORKERS* (1989).

⁵⁰ See Katherine Swartz & Timothy D. McBride, *Spells without Health Insurance: Distributions of Durations and Their Link to Point in Time Estimates of the Uninsured*, 27 INQUIRY 281, 281-85 (1990).

⁵¹ See Erik Eckholm, *Health Benefits Found to Deter Switches in Job*, N.Y. TIMES, Sept. 26, 1991, at A1.

with Dependent Children (AFDC) with income during the first four months of employment of up to 113% of the poverty line; in Texas, those whose incomes reach only twenty-three percent of the poverty line are not eligible.⁵² For other citizens, employers made the crucial access decision when they chose to offer (or not offer, or limit) health benefits. Insurers, in turn, influence the prospects for coverage by deciding how aggressively to manage their risk pool; the consequences range from higher premiums, to no coverage for pre-existing medical conditions, to no coverage at all. Of course, the entire insurance issue is beside the point in poor neighborhoods where providers have left or gone bankrupt.⁵³

In short, our rationing choices are scattered throughout the public and private sectors. American health care rationers include: employers; insurers; providers, who decide where to open offices and how to deal with those who cannot pay; citizens who can decide to seek new jobs, buy private insurance, or risk going bare; fifty state Medicaid programs; and a host of other national, state, and local programs that range from Medicare to local hospital subsidies. The same uncoordinated array of actors makes the decisions that keep medical inflation soaring.

The issue is not whether to ration health care. Rather, the debate is about replacing a typical American policy pattern of fragmented, hidden, and private decisions with the kind of choice our system is especially ill-gearred to make—conscious, collective decisions made at the political center.

In practice, we face two different kinds of decisions about who is to get which medical resources. One kind are the macro allocational choices about the nature of the health care system—how should the health system as a whole operate? These decisions grapple with the broad questions of financing and access; they are brought to the political surface by reformers advocating national health insurance or systematic market competition. A second kind

⁵² See CONGRESSIONAL RESEARCH SERV., HOUSE COMM. ON ENERGY & COMMERCE, 100TH CONG., 2D SESS., MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS app. A at 285 tbl. A-3 (Comm. Print 1988).

⁵³ See, e.g., ALEX KOTLOWITZ, THERE ARE NO CHILDREN HERE 12 (1991) (noting that the two clinics that remained near the Henry Horner Homes in Chicago both shut down in 1989); see also James Fosset et al., *Medicaid and Access to Child Health Care in Chicago*, 17 J. HEALTH POL. POL'Y & L. (forthcoming Summer 1992) (providing a more systematic account of the absence of providers in poor neighborhoods in Chicago).

is micro questions about selecting among claims for scarce medical resources.

The micro questions are not sensibly divorced from the macro ones. It makes no analytic sense to talk about tough allocational choices at the individual level before we decide about financing, funding, and cost control. Indeed, this is precisely the lesson from comparative health policy. Other nations construct their national health programs by first designing and debating the macro issues and then using rationing as one, often minor, way to strike the balance between cost control and equity.⁵⁴ Rationing debates that begin by asking who is to get what are posing the questions backwards.

What fails to add up analytically, however, can be understood in political terms—the policy debate over rationing unwittingly reflects the nation's institutional bias against broad policy shifts. Reformers who despair of wresting larger changes from the American political apparatus turn to the smaller, micro rationing choices as a means of rationalizing American health policy. Indeed, it is precisely that frustration that is said to have moved the Oregon reformers to their experiment with ranking procedures for Medicaid funding.⁵⁵ The effort to reorganize American medicine by examining the merits of individual claims is shaped by the powerful political dynamics described earlier. Health care markets have long offered Americans the promise that individualized choices can, if organized properly, inject policy coherence into the entire system.⁵⁶ The debate over rationing care, though it often comes from a distinctly different point on the political spectrum, rests upon the same belief that fiddling with the standing of individual claimants might result in a sensible ethical policy.

B. *Future Rations*

The political framework that sets the rationing question also shapes many of the answers. Typically, rationing proposals face a paradox: How to make explicit rationing decisions without vesting the power of explicit decisionmaking with the government.

⁵⁴ See Brown, *Rationing Plan*, *supra* note 47, at 28; President's Letter: Simple, Elegant and Wrong 2, from Bruce C. Vladeck, President, United Hospital Fund (Sept. 1990).

⁵⁵ See OREGON HEALTH SERVICES COMMISSION, *PRIORITIZATION OF HEALTH SERVICES: A REPORT TO THE GOVERNOR AND THE LEGISLATURE*, at xiii-xix (1991).

⁵⁶ For a broad critique of the market approach, see Morone, *supra* note 28.

American public policy offers a rich menu of alternative strategies, each designed to sidestep the state.

Perhaps the most common way to avoid conscious choices at the political center is to seek mechanistic, self-enforcing, automatic solutions designed to operate without politics or politicians. The benign invisible hand of a properly functioning free market is the paradigmatic case. The appeal to science holds a similar attraction—simply applying the correct technique will, it is hoped, yield the correct result. Precision vanquishes politics and the concomitant deals, special favors, or lobbying groups. A great many recent health policy nostrums reflect this faith. For example, rather than explicitly negotiating prices with providers, most American programs hide the price negotiations in arcane, ostensibly objective, formulae. Diagnosis Related Groups and Relative Value Scales, which fix Medicare payments to hospitals and physicians, are good examples.⁵⁷

The lure of science has been especially strong in the health rationing debate. Cost-benefit analyses, professional planning techniques, and the search for appropriate formulae all appear to offer “objective” justifications for hard choices. A polity that distrusts its politicians looks for firm ground upon which to ration. Unfortunately, the numbers are willy-nilly political, resting on assumptions and choices that benefit some and harm others.⁵⁸ The real political advantage is that the methodologies bury political decisions so that fewer citizens can challenge them.

By obscuring choices, the scientific reflex can be used to negotiate the political problem of legitimacy. Public officials may extend their discretion under the cover of precise calculations. Ironically, the more arcane the rationing process, the better its political prospects. Eventually, however, the losers are likely to mobilize, regardless of scientific methods. The larger conceptual flaw is that this method of rationing repeats the hidden rationing that characterizes the present American health regime. The political advantages are philosophic liabilities.

⁵⁷ See Morone, *supra* note 44, at 133; see also James A. Morone & Andrew B. Dunham, *Slouching Towards National Health Insurance: The New Health Care Politics*, 2 YALE J. ON REG. 263, 291 (1985) (tracing the political evolution of Diagnosis Related Groups and speculating that this change will lead to powerful demands for national health insurance).

⁵⁸ See, e.g., DEBORAH A. STONE, POLICY PARADOX AND POLITICAL REASON 127-46 (1988) (arguing that in politics, numbers are political constructions).

An alternate strategy is to take rationing to the people. Open meetings, citizen committees, and consumer advocates would hammer out the hard choices. The impulse to return power to the people is as old as American politics.⁵⁹ The citizenry will resolve the dilemmas that the politicians duck. The trouble with the democratic ideal is that a heavily biased selection of "the people" show up at town meetings—the upper middle class (with leisure time and good government scruples), the most self-interested parties (often the medical providers and their lawyers), and an occasional interest group.⁶⁰ As a result, citizen participation programs tend to lurch between apathy and self-interested conflict. In the end, such efforts tend to be less representative than government itself.⁶¹ The rhetoric of broad participation often obscures the lack of formal mechanisms of accountability. Offering the public an opportunity to speak up at a meeting is no substitute for making decisions and standing for reelection. In addition, finding ways to systematically represent the citizenry on a special board poses daunting obstacles, such as who selects them and how?⁶² In short, participatory programs generally prove weak duplicates for what formal government structures are designed to do, represent the public. Rather than reinventing the government, and diffusing accountability for public policy as a result, real democrats would do better by addressing, attacking, or reforming the state directly. The call to the people should be seen for what it usually is—the oil of legitimation.⁶³

There is an exception. Citizen participation programs enable previously ignored or repressed groups to come forward. Again and again, participatory programs have shaken up the political establishment with new voices, new concerns, and new forms of politics. For example, the Community Action Agencies from the War on Poverty proved a way to inject African American voices into urban govern-

⁵⁹ This point and the following argument are drawn from MORONE, *supra* note 1.

⁶⁰ Precisely this criticism is raised about the town meetings in OREGON's rationing experiment. See Brown, *Rationing Plan*, *supra* note 47, at 40.

⁶¹ See Harvey M. Sapolsky, *Bottoms Up is Upside Down*, in COMMITTEE ON HEALTH PLANNING GOALS & STANDARDS, INSTITUTE OF MEDICINE, 2 HEALTH PLANNING IN THE UNITED STATES: SELECTED POLICY ISSUES 143 (1981).

⁶² See James A. Morone & Theodore R. Marmor, *Representing Consumer Interests: The Case of American Health Planning* 91 ETHICS 431 (1981) (describing the many representative dilemmas posed by participatory boards in health care).

⁶³ See Rudolf Klein, *Control, Participation, and the British National Health Service*, 57 MILBANK MEMORIAL FUND Q. 70 (1979).

ments that had long resisted them.⁶⁴ Citizen participation introduces new and often unexpected perspectives; but this is a way to reform our politics, not fashion public policy over time.

CONCLUSION

Few medical systems ration care as tightly as the American. A broad array of public policies, private choices, and random circumstances combine to determine who gets what kind of medicine. What is most peculiar about the American way of rationing is its hidden, often haphazard, character. I have argued that these patterns of health policy reflect the broad features of American politics—a skeptical view of government, institutional fragmentation, and hyperpluralism. All undermine the prospects of more careful, more rational, rationing.

More important, questions about reforming the rationing of health care cannot be answered sensibly without tackling a prior question: What kind of health care system do we want? This Article has suggested why that prior question is hard to answer. Even so, American political history is full of great reforming battles that resulted in effective and popular programs. Those who care about American health care can draw some comfort, and many cautions, from the patterns of American politics described in the preceding pages.

⁶⁴ See MORONE, *supra* note 1, at 223-52.