Politics matters! If we learned nothing else from the 1992–94 debates on national health care reform, surely we learned that. Yet scholars have not given the relationship between politics and health care policy the attention it requires to avoid similar miscalculations in the future. Political scientists who study American government know a lot about how policy gets made—the process of agenda setting, the importance of the iron triangle, and the role of interest groups, among other things. But even though their insights come from studies in particular substantive areas, they tend not to be experts in the intricacies of those policy fields that, like health policy, can be quite complex. Similarly, policy analysts tend to know a lot about the particular policy arena they study and the specific policies found there, but they are not trained to supply the political dimension fully.

Policy analysis without politics is like architecture without engineering: an elegant design is no more than a pretty picture unless the columns are strong enough to support the structure and the electrical, plumbing, and other systems are made functional. Similarly, an elegant analysis of a problem in the health care field and a technically sensible proposal to solve it are simply academic exercises without an understanding of the politics that will permit a feasible solution to be identified, adopted, and implemented.

The most obvious recent illustration from the health policy arena is the failure of President Clinton’s Health Security Act—or, indeed, any
other health care reform proposal—to pass Congress and become the law of the land in the first two years of the Clinton presidency. The analysis of the problems to be solved was sophisticated, and the president’s proposal, as well as those advanced by others, had many appealing attributes. But even though the analysis was based on a detailed understanding of how the health care system operates and what it produces, the people who assembled the pieces into a comprehensive plan failed to allow sufficiently for the complex interplay of forces—including the actions of interest groups, the state of the economy, the composition of Congress, and other factors—that determine whether an idea becomes a law.\(^1\) Of course, Congress may still have failed to act even if a cogent political strategy had been built on as complete an understanding of the political processes as the president’s health care experts prepared about the health care system they were trying to reform. But the outcome might have been in doubt for longer and the seeds of future action might have been sown.

**The Federal System**

Politics is critical in every democracy, but our federal system adds still another important dimension because it divides some responsibilities of government between the national level and the states. Moreover, the distribution of roles between the two levels of government is not always clear. In some cases, states are left to devise the programs intended to solve problems that confront the nation; in other cases, they implement laws adopted at the national level. Given the obvious inefficiencies, why do we do this? Does this federal system make it more or less likely that we will solve our problems than if the capacity and responsibility for doing so were lodged in a single site, at the national level? As long as we maintain this shared responsibility, what are the likely results of dividing the tasks of government in different ways? What are the effects of the states’ playing different roles? What are the effects when the roles sometimes taken by states are left to the national government? Under what constitutional, resource, and other limitations do the states labor, and how do they affect the result? Since, structurally, the states are organized like the federal government, in what ways, if at all, does the exercise of sim-

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\(^1\) I do not mean to suggest that the president’s advisors paid no attention to political matters, only that either their analysis was incomplete or the strategy that resulted from it was inadequate.
ilar governmental processes differ at the state level and at the national level? How does the political process itself affect whether the states succeed or fail?

These are some of the questions that students of public policy in the United States need to answer. In this issue of *JHPPL* are five articles that deal with aspects of this peculiarly American phenomenon: the large role of the states in the policy making process even when the problems affect all parts of the nation. Although the focus here is on health policy, similar questions could be asked about other substantive policy arenas, as well.

Before discussing the articles themselves, I need to ask two additional questions. What are the purposes of public policy in the health arena? And what should be the concerns of students of health policy or, indeed, of government in general? Answers to these questions will influence my comments about the selections in this volume.

**The Challenge of Public Policy**

As a general rule, public policies address public problems—sometimes to correct system deficiencies or assist groups harmed by the market or some other external force, sometimes to create opportunities for groups in order to achieve a public purpose. Examples in the health care arena include policies designed to get services to people in underserved areas through the Hill-Burton Act of the 1940s, community health centers in the 1960s, and the National Health Service Corps in the 1970s. When it appeared that we would not have enough physicians to serve the growing population, federal funds were made available in the 1960s to support medical education. Now, we may have too many—even though some communities are still underserved—and new proposals are being considered to reduce future additions to the supply of physicians. To ensure continued new scientific developments, the federal government has invested billions of dollars in the intramural and extramural research programs of the National Institutes of Health (NIH). To protect the public from the potentially harmful risks that often accompany innovations resulting from research like that funded or conducted by NIH, the Food and Drug Administration regulates the introduction of new drugs and health care technologies. All of these public policies were adopted at the federal level, and most have an impact on states. In some cases, the impact is limited to the fact that federal money is spent in the states; in other cases, state governments have a substantial public policy role.
The best known and, arguably, the most important public programs in the health care field are Medicare and Medicaid, which were passed in the 1960s to make third-party coverage available to members of groups that tend to lack the funds to buy it in the open market. In a system in which most Americans obtain insurance through employment, those who are unemployed, are retired, or work for companies that do not offer coverage as a fringe benefit typically do not have the disposable income with which to purchase coverage on the open market. Since health care is important to all and the failure to provide it has costs to the society as a whole (in addition to the obvious costs to those unable to buy insurance), these two large programs were created to use public funds to provide that coverage to people who qualify. To outsiders and, indeed, to many Americans, it must seem strange that although these two public programs have similar purposes, Medicare is a national program operated by the federal government, while responsibility for Medicaid is shared by the federal and state governments.

Many problems related to health and health care can be found throughout the nation, and sometimes national legislation is enacted to solve them. Sometimes the states have a large role in implementing that legislation and, thus, in determining not just how the public purpose is achieved but even the extent to which it is achieved. (In other cases, the national government fails to act, and the states are left on their own.) Why should the states have a large role in the solution of national problems? Part of the answer lies in the peculiarly American distrust of government, especially the national government—an attitude with origins in colonial days when the nation was formed by people escaping the tyranny of a corrupt, domineering national government in England. But, if we are distrustful of the national government, why do we need to involve it at all?

One reason is that real problems do exist, and the states cannot be counted on to act. States differ in the political will to address certain issues. Some may be willing to act while others are not because, in addition to being a single nation, we are also several regions, which vary to some degree in history and cultural attitudes (Davidson, Cromwell, and Schurman 1986). Sometimes, even though some of its citizens suffer from a problem, the unwillingness of a state government to act may be related to benefits from the status quo that are received by political or economic elites (Piven and Cloward 1971). Some states do not act because they lack the financial capacity and choose other priorities for their limited funds. (The nation’s fiscal capacity is inherently more stable
than that of any single state.) Whatever the reasons, in these situations, one American will benefit because of where he lives, while another citizen, similarly situated, will suffer because he happens to live in a different state. While some variation is tolerable, too much is not, because despite the differences, the fifty states comprise a single nation, and the unity and strength of that nation may be undermined if the accident of where they live determines whether Americans benefit from a public policy. Partly as a result of these factors, Washington acts.

Even when the national government acts to achieve public purposes, however, many believe that giving the states a voice encourages innovation and avoids the natural tendency toward rigidity or stagnation in policies or programs (Katz and Kahn 1966). To accomplish this additional purpose, national policies often set the goals and the criteria for success and create a general framework for action without prescribing the means. They also often encourage action by the states, sometimes by making federal funds available to supplement state funds according to a formula that smooths some of the interstate differences resulting from variations in wealth and the differential regional impact of economic cycles. Some argue that the national government should avoid detailed prescriptions for two other reasons: federal officials cannot possibly anticipate every eventuality, and state and local conditions vary in ways that affect the selection of an optimal strategy to achieve goals.

A final, more subtle reason for an important state role in public policy is to allow different parts of the society different amounts of time to adapt to change because some may be ready to accept it sooner than others. If the states retain major decisions, each can move at its own pace, and progress can be made in some while others act in more modest ways or wait. By using the states in this way, more reluctant citizens have a chance to become accustomed to new ideas or new arrangements (e.g., Medicaid managed care), and the nation as a whole does not need to wait until they are ready to move forward. If change is too fast, it may be adopted in one year and repealed the next. (Of course, that can happen even within states when change is controversial and majorities are unstable, as Oliver and Paul-Shaheen show in their essay.)

Thus, for a variety of reasons, the states have a substantial role in some policy arenas, which promotes variation among the states in outcome. In this context, one goal of federal policy is to keep that variation within acceptable bounds and avoid the negative consequences of widely differing conditions around the nation, which might undermine the common foundation on which the society and its government are based.
The Student of Public Policy

Whether one's professional role is as policy analyst or political scientist, what are our common goals, given both this view of public policy and the nature of our federal system? The most obvious answer is to describe and explain what is going on (in the health care system and the public policy system, respectively) so that, as a society, we can understand the dynamics of governmental processes, what they produce, why, and how. Moreover, although knowledge has value for its own sake, the fact that we practice our professions in a democracy gives our work practical value, as well. The health of a democracy depends to some degree on truly solving (or at least reducing) the society's problems. The viability of a democracy depends less on which policy is adopted than on the effort to solve—or conscientiously address—problems. It is less important whether solutions have a market or a regulatory orientation, or some combination of the two, than that citizens come to believe that progress is being made. Otherwise, citizens may tend to lose confidence in the society and its order; if that happens, they decline to participate, and government increasingly becomes susceptible to forces wanting to use it for their own ends. Thus, an important role of serious students of the policy process—academics or not—is to look for methods to solve or reduce problems that affect the society. In turn, for that effort to have practical value, it must include serious attention to the processes of making decisions at the federal and state levels of government. One can disagree about which solution is best (including the decision to do nothing), but a democrat (small d) must support the notion that a serious public debate about the issue is important for the health of the democracy. Part of the difficulty is that sometimes what masquerades as a serious policy debate is really ideological posturing clothed in the fabric of substance.

The Articles

The five articles in this issue discuss both political processes and substantive policy issues and, as a group, illustrate the point I made at the outset, that too many published articles discuss one without the other, or if they treat both, emphasize one without giving adequate attention to the other. Together, they reveal the cost of this failure and help us imagine the potential of treating them together. Among the five, Anton provides a useful orientation to the federal system and to the role of the states in policy making, and Oliver and Paul-Shaheen analyze the policy-making
processes that occur in the states, focusing on the role of policy leaders in recent legislative actions in six states. The last three essays take up specific health policy issues. Medicaid policy is the subject of the articles by Grogan and Kronebusch; Sparer discusses the state role in policies relating to health professions. In the pages that follow, I will discuss the articles in this order.

The Federal Context

In his fine essay, Thomas J. Anton does several useful things. First, he clears away some widely held myths about the national government, thus alleviating the concern some people have about trying to address policy problems at the national level. Then, having increased our willingness to consider solutions at the national level, he discusses the value of "shared responsibility" and state-level action. Drawing on the work of Paul Peterson (1995), Anton shows that the two levels of government tend to specialize substantively, at least with regard to spending programs, with the national government focusing on redistributive policies and the states focusing on developmental efforts. In their shared efforts, they also tend to specialize functionally, with the federal government making national policy and the states implementing and administering it.

Anton sums up this part of the argument by saying that "the American system of federal governance, then, is one in which several levels of government typically share responsibility for policy and administration—and often for funding as well. . . . [O]ne level of government often invades policy spaces already occupied by the other. And because such invasions occur with some frequency, the federal system as a whole appears both ambiguous and dynamic" (p. 701).

Finally, Anton cautions that although "pressure for devolving authority from the national to state governments is powerful enough, . . . it would be well to remember that there are philosophical, economic, and political limits to the current devolutionary thrust" (p. 706). At the end, we recognize the value of action at both the national and state levels and the limitations of relying on either or both. We also realize that it is politics that determines the level at which actions occur, the relative distribution of responsibilities between national and state governments, and, ultimately, whether any action will be taken at all.

With this useful context, we come upon Thomas R. Oliver and Pamela Paul-Shaheen's ambitious article about the processes by which ideas
become laws in the states, focusing on the role of the "policy entrepreneur." If am right that we need to give more attention to politics in our examination of health policy, then this is a useful essay primarily because it provides a framework for considering the political issues in the context of health policy. Its weakness is that, in this version, it is relatively light on the empirical side, although their insights derive from the study of health policy innovations adopted in six states in the late 1980s and early 1990s. Moreover, I believe the authors give too little attention to the fact that in most (if not all) of these cases, the states failed to follow through with the laws that were the subject of their investigations. In Massachusetts, for example, the pay or play plan was never implemented; in Vermont, the legislature failed to choose between a single-payer or other model of universal coverage as originally expected, and instead, enacted nothing; and the Washington State plan, too, never was implemented. As a result, instead of a story of legislative success, what we have in each case is really one chapter in a continuing saga, and we should be wary about drawing conclusions at this intermediate point. While the same can be said of any social process, of course, it is important in this case because what followed was not refinement of the legislation that passed, but reversal of the successes described by Oliver and Paul-Shaheen. So, perhaps, the tale is less about policy entrepreneurs building coalitions and making compromises in order that their states can progress toward the solution of difficult public problems than about the limitations of compromise in situations with competing goals and unstable majorities. Although the authors do not hide these facts, it appears to me that they need to go further with them. Nonetheless, the essay has value as it stands in its presentation of an organizing framework for considering political and substantive policy issues.

Among other things, Oliver and Paul-Shaheen give us a healthy respect for the complexities of the legislative processes in the states. They present a general "model" arranged under two large headings—contextual conditions and dynamic factors—with several subfactors of each, which helps us organize the analysis of issues related to the debate and adoption of legislation. In addition, they present a $2 \times 2$ table which,

2. One question which their article raises implicitly is the extent to which their observations would hold equally well at the national level.

3. I assume they know a lot more about events in the six states than they shared with us and will present it in other places.

4. They call it a model, but I believe it is more useful to think of it as an organizing framework for consideration of these complex issues.
by comparing the costs and benefits of the policy based on the extent to which each is diffused or concentrated, permits analysts to characterize the distinctive political processes associated with policies of different types. Finally, by centering their article on the role of policy entrepreneurs, they provide some feel for the dynamics of the processes.

Presumably, if we have information about each of these elements—factors and subfactors in the framework, the substantive nature of the policy, and the policy entrepreneur—then we can do several things of value: (1) predict the outcome of a legislative process that either is ongoing or is about to start; (2) as policy advocates, develop an effective strategy based on the information available to us; or (3) explain why events that have already occurred turned out the way they did. As we will see, authors of some of the other papers could have benefited from the Oliver and Paul-Shaheen effort.

The Medicaid Papers

Colleen M. Grogan and Karl Kronebusch both discuss Medicaid policy in the states. Grogan tries to explain the willingness, even eagerness, of states to embrace risk-based managed care for their Medicaid programs and argues that attitudes toward poor people play an important role in leading toward that strategy. Kronebusch is not focused on a single policy idea, like managed care, but tries to explain the Medicaid policy process generally, which he views as a competition among “groups of claimants for the resources of the program” (p. 840). How persuasive are Grogan and Kronebusch? How would the Oliver and Paul-Shaheen framework have helped them?

Grogan asks why this developing policy consensus in the states in favor of risk-based managed care for AFDC-Medicaid recipients is “taking hold” (p. 818)? The oft-repeated reasons for state convergence on the concept of risk-based managed care are “cost containment and improved access” (ibid.). Its “benefits . . . for AFDC recipients are perceived to be so self-evident to state governments that as long as an adequate managed care marketplace exists, and even sometimes when the infrastructure does not exist, states will pursue the risk-based approach. Why states

5. The Oliver and Paul-Shaheen framework builds on the work of Theodore J. Lowi (1966) and James Q. Wilson (1980), among others. My comments are less an endorsement of the particular formulation than an appreciation of their attempt to use it to understand the adoption of public policy.
favor the risk-based approach for AFDC recipients has a lot to do with state policy maker beliefs about what is fair and appropriate public policy for welfare recipients” (p. 829).

The argument Grogan makes is indeed plausible, but she has not made a compelling case for it. Part of the reason rests with the nature of her data, and part is due to her failure to put the debate into a three-dimensional policy context. Essentially, she says that “as long as Medicaid remains a means-tested program, it will continue to be perceived by state policy makers as a welfare program” (p. 833). She uses terms like “deservingness,” which recalls the days when governments distinguished among people in need, differentiating the worthy from the unworthy poor. But then, she notes that many privately insured people in Connecticut, the site of her study, “are being forced into managed care plans and often have no choice among plans” (ibid.). As a result, the argument is not about treating AFDC recipients differently (presumably worse) than others because they are not worthy of better treatment, but treating them the same (i.e., as badly) as others. In fact, one could make a case on either of two grounds that AFDC recipients require special treatment, not equal treatment. One is that AFDC recipients have handicaps that their middle-class, privately insured neighbors do not share. In turn, these handicaps inhibit their ability to use the health care system and other institutions of society as the middle class is able to do. Therefore, they need extra help. The other is that, in order to prevent AFDC children from perpetuating the conditions in which they find themselves, an investment needs to be made, not just with regard to health care but in other areas as well; only if they have that extra help will they be able to overcome the handicaps (low income, violence in their neighborhoods, poor schools, etc.) that may keep them from advancing.

Having said this, however, is not to say that Grogan is wrong in her argument; indeed, it is quite plausible. But the evidence she cites does not persuade. In fact, she stacks the cards against herself by focusing on Connecticut, a wealthy, New England state with a history of relatively generous policies toward the poor, especially in comparison with some southern states (Davidson, Cromwell, and Schurman 1986). The statement found earlier in her article that “even sometimes when the infrastructure does not exist, states will pursue the risk-based approach” suggests that in other states, if not in Connecticut, Medicaid eligibles are

6. They are handicapped in part because of the inadequacy of other institutions of society, like schools which failed to educate them for contemporary work.
being treated differently—and worse—than the middle class. If that turned out to be the case, then her argument would be more persuasive. Although I suspect her investigation would reveal considerable variation among the states, an interesting and important question would be the extent to which historic differences (Davidson, Cromwell, and Schurman 1986) are being narrowed by contemporary forces.

By implication, she raises other important points that relate to her argument. Even if risk-based managed care is a good concept in theory, to what extent has it proven itself even among the middle class? A growing groundswell of sentiment in the nation at large is asserting itself against privately funded managed care because many do not like the methods being used to contain costs. The new varieties of managed care keep costs under control by paying physicians less than in fee-for-service plans, negotiating discounts with hospitals, and imposing onerous prior authorization requirements on doctors and patients. It is not clear, however, that they have learned to truly manage care in the sense that succeeding segments of an episode are integrated with one another (Davidson, McCol- lom, and Heineke 1996), that primary care providers have information about the results of services provided to their patients by specialists, or that providers in a given network are able to enter data into or retrieve data from a common information system. Is it rational to think that in a state with a limited managed care infrastructure, Medicaid eligibles can be cared for appropriately, especially given the characteristics noted that differentiate them from the middle class? If that is the case, why would supposedly rational state officials embrace managed care in their Medi- caid programs?

Certainly, under risk-based managed care, states’ financial outlays are more predictable and can be contained since their financial exposure is limited to the sum of the capitation payments for Medicaid eligibles, regardless of the amounts or types of services actually used. And that is a benefit state officials can appreciate, even if its sustainability over time is in doubt. Perhaps Grogan can find support for her argument about the treatment of welfare recipients in states that are willing to introduce risk-based managed care under those conditions. But, as it stands, the report of her qualitative study in Connecticut does not provide persuasive evidence.

If Grogan had had access to the Oliver and Paul-Shaheen article, she might have recognized not only the significance of the issues she raises but also more importantly, the context in which they need to be raised. Since, as she and others point out, Medicaid policies vary by state, it is
not surprising to learn that elements of political culture and history also vary by state as well as by region (Davidson, Cromwell, and Schurman 1986). One question is why some states mandate risk-based managed care when it has not yet proven itself. Similarly, why do some states (even the same states) implement a (PCCM) version of managed care even though its theoretical, not to mention empirical, foundations are weak? The answers, I believe, lie in the political processes and the political benefit state officials gain—from taxpayers and other interest groups—by adopting it.

The Kronebusch article also suffers from a failure to consider the context fully; again, the Oliver and Paul-Shaheen essay undoubtedly would have alerted him to its weakness. In this case, however, I fear that his fundamental argument is not as plausible as Grogan's. As I understand it, Kronebusch has the novel view of the Medicaid program as a set of resources available for "competing groups of claimants" (p. 840). In the context of "the politics of group differences," he focuses on the several groups of recipients and providers, the two principal claimants for the program's resources. Without using the term, he appears to believe that Medicaid policy is best understood in terms of "interest group politics" and, in doing so, implicitly suggests the following questions to the reader. First, if the competition among interest groups is the most useful way to think about Medicaid policy, are these the only groups or even the most important groups? Second, is interest-group politics the most appropriate lens through which to view Medicaid policy making?

To answer the first question: certainly, Medicaid recipients have an interest in the program and so do health care providers. Are they the only groups with an interest in the outcome of policy debates regarding the program? The answer to this question is, clearly, no. Two others that come immediately to mind are taxpayers and the public officials who are making the policy decisions. Taxpayers have a stake because the states pay part of the Medicaid bill (as much as 50 percent of it); policy decisions about who is eligible, what services are covered, the conditions under which care is delivered and paid for, among other things, all have implications for the level of program expenditures. And, even though Medicaid is a financial bargain for the states that want to provide health care coverage, since the federal government pays at least half of the bill,\(^7\)

\(^7\) One way to think of it is that the federal government adds to the state economy the money it uses to pay its share of the Medicaid bill.
the state must come up with the rest, which varies from 17 percent to 50 percent of the total.

The policy makers, too, have an interest that is intimately tied up with the policy decisions they make, but which also is not identical to them. Elected government officials may harbor ambitions for higher office. Their performance in whatever position they now hold, whether as governors or legislators, certainly affects their future prospects. Some may like to be seen as holding the line on state spending and, thus, oppose Medicaid expansions. Or, if the timetable for their ambitions is a short one, they may propose managed care arrangements of the kind Grogan discussed, even if the evidence regarding the long-term benefits is not conclusive. The important goal for them will be to pass a bill soon. Or, finally, regardless of their convictions on the substance, they may take the role of policy entrepreneur that Oliver and Paul-Shaheen describe in order to be seen by their constituents as someone "who gets things done," the person who puts together the coalition and engineers the compromises that eventually result in a law.

But even if we can complete the list of interests beyond just recipients and providers, is this the most useful way to see the policy-making process? Again, I think the answer is no, it is not. One reason is that, as Kronebusch himself seems to be aware, the interests of recipients and providers overlap to a considerable degree. The money goes to providers, but only if they agree to treat eligible patients. Both groups have similar stakes in eligibility rules that make it possible for needy clients to receive services, in reimbursement rates that make it economically feasible for providers to serve those clients, and in other policies, too.

Moreover, in the 1960s, Lowi described the distinctively different politics associated with different types of public policies. He distinguished between distributive policies (classic "pork barrel" public works projects, among others), regulatory policies, and redistributive policies. He hypothesized that while the regulatory arena corresponds to the pluralist school (i.e., interest groups), "the redistributive arena most closely approximates, with some adaptation, an elitist view of the political process," noblesse oblige (Lowi 1966: 29). If he is right, interest group politics is not useful in trying to understand Medicaid decisions because, fundamentally, they are redistributive.  

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8. Medicaid policy contains an element of regulation since providers must meet certain conditions to be eligible to participate. It also has elements of distributive policy since it is the providers who get the money, even if the eligibles get medical services.
Oliver and Paul-Shaheen refer to Lowi and others who have built on his work in presenting their framework for analysis of policy design and political feasibility in Figure 1. Interest group politics, according to their formulation, is appropriate when both the costs and benefits of a policy are concentrated, as in regulation. Medicaid is characterized by diffused costs and both concentrated benefits (for certain groups of providers) and diffused benefits (for Medicaid eligibles). While they do not present enough detail in their article for us to be able to describe Medicaid politics definitively, it is clear that interest group politics is not the most useful framework.

Medical Workforce Policy

Michael Sparer discusses federal and state action to reduce the maldistribution of providers by geography and specialty. Many communities do not have enough providers, and it has been thought that the United States has too many specialists relative to generalist physicians. The federal government has adopted a number of programs to address these problems, but with limited success. State activity increased in the mid-1980s because cuts in federal funding for the National Health Services Corps program (NHSC), which placed physicians and other providers in underserved areas, threatened the availability of needed services for residents of these areas.

As Sparer notes, however, the two types of maldistribution present different issues for policy makers and generate different politics. Influential interest groups representing medical schools, teaching hospitals, and mainstream medical professionals benefit from educating, training, or hiring large numbers of specialists to support research and to take care of patients. They argued against changes which would increase the number of generalists trained at the expense of specialists, at least in part, because they benefit from the public funds available for these purposes. Thus, they would lose resources if new policies changed the balance between specialists and generalists, and as a result, they oppose them in what appears to be a classic instance of interest group politics at work. Sparer shows that, in several states, their superior resources and influence enabled them to win the battle against the imposition of legislative mandates to train larger numbers of generalist physicians, but they lost the war because the medical schools began to train more generalists, anyway.

One reason is that, although they could not muster the votes to pass
their bills, the groups arrayed against the mainstream medical organiza-
tions have a popular message: increasing the number of generalists can
contain spending and improve quality at the same time. As a result, even
though they were not able to pass legislation to increase the numbers of
generalists, in a context of market changes in the demand for specialists,
these groups were able to use the possibility of future legislative success
to accomplish their goals through nonlegislative means.

Solving the problem of geographic maldistribution raises different
issues and generates a different brand of politics. The two principal pos-
sibilities for increasing the availability of health care providers in under-
served areas are (1) to provide incentives for physicians and others to
practice there for example, by offering to pay the costs of their education
in exchange for a commitment to serve there or (2) to provide subsidies
for facilities, like community health centers, in which willing providers
can practice. They need subsidies because the area population is often
too small or too poor for them to survive economically. These are not
policies that draw opposition to the concept, but sometimes they do draw
opposition to the price. However, since the beneficiaries do not have the
kind of political influence that can get legislation passed, decision mak-
ers who support such programs decide to do so for other reasons. This is
redistributive policy, produced by Lowi's politics of the elite, noblesse
oblige.

Regrettably, Sparer did not extend his fine analysis of workforce issues
to pursue the implications of these different politics for the capacity of
the states to take on redistributive issues that Peterson (1995) and Anton
(this issue) say are best left to the federal government, but which appear
to be falling to the states because of the federal failure to act. To what
extent is the state a good locus for successful policies in this arena? To
the extent that these policies depend on the availability of public moneys,
it would appear that the states are not good sites to solve national prob-
lems. But if the state is not the best site for such action in general, this
may be an example of action taken by the jurisdiction that feels the
greater impact in the face of an impasse at the federal level. Yet if states
do feel compelled to act even though they have limited resources with
which to do so, one can also ask why they did not act as a group to
encourage the federal government, the more appropriate level, to act.
How do political self-interest and ideology about the role of government
and the relationship between government and the private sector interact
in this instance?
Relying on the States to Solve National Problems

Oliver and Paul-Shaheen write that "the pattern of state actions reflects the rise of health care reform onto the national political agenda and its prominent role in the 1992 elections . . . [but] major state reforms came to a halt after 1993" (p. 737; emphasis added). Earlier they argued that the states are "specialized political markets, or niches in the national political market, in which individuals and groups can develop and promote an array of policy innovations" (p. 724). The juxtaposition of these two ideas is the source of much of the confusion many have in trying to sort out the respective roles of the states and the federal government on a variety of policy fronts. On the one hand, we have fifty individual political markets which, implicitly, act or fail to act for their own reasons; on the other hand, we have the phenomenon of many, if not most, states taking up the same thorny topic in the same period.

Even though state action follows in-state imperatives, it is not mere coincidence that many states were considering health care reforms in the late 1980s and early 1990s. What are the common elements, how do they fit into the political decision-making process, and how do they help us understand the value (or the limitations) of divided government?

One common element was presidential politics—Michael Dukakis, governor of Massachusetts, was looking for issues on which to base a presidential campaign in 1988; and Bill Clinton made health care an important part of his 1992 campaign. Many Americans were worried about the erosion of private-sector health insurance that was occurring in this period. Companies were dropping their coverage or requiring that employees pay a larger share of the cost, and strikes were called in unionized industries over their plans to do so. That the issue had resonance with voters was demonstrated by the victorious 1991 Senate campaign of Harris Wofford in Pennsylvania over a much better-known opponent. Further, after Clinton won in 1992, he made health care system reform a centerpiece of his legislative agenda. Although his proposal ultimately went down to defeat, for many months the general assumption was that something would pass, and many states were trying to "get out ahead" of the federal government, and perhaps in the process, do some good for their political leaders.

Another reason that states took up health care reform in this period was the growing bill for Medicaid. Spending on that program had grown dramatically during this period (Holahan et al. 1993) partly in response
to actions of the federal government. The imposition of new mandates and the devolution of additional responsibilities onto the states increased the states' bill. A variety of strategies to tame that growth failed, and states were looking for relief.

Not only were states facing similar health system problems, but also they faced similar constraints in their search for solutions. These included resource constraints which, given the vicissitudes of the economic cycle, were more severe in some states at this time than in others; historical and cultural differences among the states that contributed to the development of Medicaid and other programs and helped to form the foundation on which particular actions were built; health care system variations among the states; and constitutional or federally legislated constraints (like ERISA) which limit the scope of potential state actions.

Under these conditions, what can political scientists or policy analysts say about the value of our federal system? Is it hopelessly inefficient? Does it perpetuate the rule of power elites in the states? Is it a way to avoid solving problems? Does it promote a "race to the bottom," or does interstate competition spur innovation as slower states learn from the good experience and mistakes of their more aggressive neighbors? Anton and Oliver and Paul-Shaheen help us understand both the issues and the politics, and along with the substantive essays by Grogan, Kroeber, and Sparer, raise additional questions about health policy in the United States.

To the extent that our focus is on solving vexing problems relating to the health care system nationally, the federal system is inefficient at best and stacks the cards against real solutions to certain types of problems. If state legislative policy making depends on policy entrepreneurs in the states, then relying on them to solve national problems requires at least fifty such entrepreneurs on health policy (and similar numbers in other active policy arenas). If we recognize how difficult it was to achieve reforms in the states Oliver and Paul-Shaheen studied, it appears that the need for so many talented and committed political leaders is a major limitation and a serious constraint to be overcome by those who would depend on the states in this regard.

Yet, since involving the states in policy matters has benefits, as the authors have shown, how can we both minimize the dampening effect of the need for so many policy entrepreneurs at the same time that the states retain a substantial policy-making role? One answer is to use the Medicaid model—a federal framework, federal money, and state action within that framework. But the usual view of the Medicaid model, espe-
cially by those whose primary orientation is to the efficient solution of public problems, is negative: it is expensive; many do not get the services they need; many providers will not even serve Medicaid eligibles. The negatives of the Medicaid model can be reduced in two ways—first, by increasing the federal share of the cost and reducing the state share, and second, by imposing greater federal constraints on permissible state action and allowing less latitude for state obstructionism.

As sensible as such a proposal might seem to some, in the present political climate, it is foolish. To change the foolish into the possible is the business of advocates practicing politics. The eventual policy decisions, whatever they are, similarly will be the result of politics. The conclusion is simple: those of us with a serious interest in health policy must also study politics.

References


