Policy Change as Political Strategy:

America's Health Reform Mosaics in Comparative Perspective

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By

Carolyn Hughes Tuohy, Ph.D.

School of Public Policy and Governance

University of Toronto
Introduction:

Understanding the dynamics of policy change – and in particular the conditions under which change is likely to be discontinuous or incremental – is one of the principal projects of the study of comparative public policy. Typically, discontinuous change is defined as comprehensive and almost immediate transformation of policy frameworks in contrast to the incremental norm. One of the central debates in this literature is about whether the dynamics of policy change are best understood as the periodic eruption of “big-bang” episodes of dramatic change during windows of opportunity that punctuate long periods of stability, or as a slow accretion along a path of incremental adjustments.

In a forthcoming book (Tuohy 2018 forthcoming) and a previous paper (Tuohy 2017), I present a framework that offers a more nuanced and less dichotomous understanding of the dynamics of policy change. The book analyses ten case of health policy changes across seven decades and four nations (the US, Britain, the Netherlands and Canada) within this framework, and offers commentary on several other related cases. In the present paper, I focus on three American cases that have been the subject of much scrutiny – the establishment of Medicare and Medicaid in 1965, the failed Clinton reform attempt of 1993-94, and the passage of the Affordable Care Act in 2009-2010 – as well as a precursor case (the establishment of Social Security in 1935) and an epilogue (the Republican attempt to repeal and replace the ACA in 2017). Examining these cases within the framework I offer, and against a comparative background, both raises and answers a new set of questions. Why, within the relatively propitious conditions for policy change in which they found themselves, did political actors made the particular strategic decisions they did about not only the scale but also the pace of change? Why these strategies and not others that were proposed at the same time? And why were the chosen strategies relatively successful in some cases but not in others?
A framework for understanding discontinuous policy change:

To understand episodes in which discontinuous policy change is attempted, we need to make two distinctions. First, the dependent variable of interest, policy change, can be discontinuous in two respects: the scale of change in prevailing policy frameworks and the pace at which those changes are pursued. The intersection of these two dimensions yields to two but four possible strategies of policy change: large-scale and fast-paced (big-bang), large-scale and slow-paced (“blueprint”), small-scale and fast-paced (mosaics) and small-scale and slow-paced (incremental). Big-bangs redefine the policy framework in a swift, encompassing sweep. Blueprint strategies secure broad-based agreement on a schematic for the design of a new framework, to be enacted gradually in stages that extend beyond the current mandate of the enacting government. Mosaics make multiple relatively small but simultaneous adjustments to various aspects of the prevailing framework. Incremental strategies take a series of relatively small disjointed steps over time. Determining when each of these patterns is likely to occur is the challenge for those who would understand the dynamics of policy change.

Second, in developing a theory of causal dynamics, we need to distinguish between the opening of windows of opportunity for change, on the one hand, and the decisions that are made within those windows on the other. Windows of opportunity are created when a set of political actors has both the institutional and electoral capacity and the partisan motivation to enact major change in a policy framework. But the occurrence of such windows does not determine the scale and pace of change that then occurs. The essential argument of this paper is that strategies of scale and pace change are products of strategic judgments made by political actors in distinctive types of political and institutional circumstances. Crucially, however, these strategies are determined, not by institutional and political conditions per se, but by the ways in which political actors, individually and collectively, assess their current and prospective future influence in these circumstances. These readings yield sets of assumptions that I term “strategic domains.”
Effectively, this is an argument that focuses on what in John Kingdon’s formulation would be the “political stream” of developments that form policy agendas (Kingdon 1995). Developments in Kingdon’s other two streams, relating to the perception of problems and the identification of policy solutions, affect what might be termed the “direction” of change. The embrace of “market-oriented” approaches to the delivery of public services in the millennial period spanning the turn of the twenty-first century is an example of such a policy direction. But the scale and pace at which such change is pursued is an inherently political decision. Major, discontinuous change in policy means disrupting established balances of power, sets of sanctions and legitimating principles, as discussed in the following section. Therefore deciding on the scale and pace at which to attempt such change requires political actors to assess their political capacity and prospects. And in areas such as health care, where the political stakes and risks of discontinuous change are especially large, these calculations tend to be matters of “high” politics at the political centre, in the context of an overarching agenda and/or a threatening competitive challenge.

Defining the scale and pace of change:

The scale of change can be defined in terms of a shared logic of collectively enforced expectations (Streeck and Thelen 2005: 9). Policy frameworks are a particular type of institution, in which the mechanism of collective enforcement is the ultimate coercive power of the state. As state-sanctioned settlements, policy frameworks govern and legitimate what Easton classically called “the authoritative allocation of values” (Easton 1953). They do so, first, by establishing a balance of influence among key interests – in the state, the market and civil society – and delineating the lines of accountability through which those who make day-to-day decisions ultimately report. Second, policy frameworks determine the ways in which those decision-makers interact, by establishing the mix of available instruments of governance – hierarchy, exchange or peer control. That mix sets the sanctions that govern interactions among decision-makers and the types and channels of information available. Third, policy frameworks embed certain organizing
principles regarding the basis of entitlement and obligation of citizens and the functional role of the state, and thereby legitimize the resulting distribution of costs and benefits so long as those principles are observed.

Together these elements create a distinctive logic— and it is the magnitude of change in this decision-making logic, traceable to change in one or more of its intersecting components, that constitutes the scale of change in policy frameworks that we seek to understand. These changes in scale involve not only the degree of change in policy logics but also the scope of change across the relevant policy arena: as I shall argue below, both degree and scope must be taken into account in distinguishing across cases. The scale of change can thus be defined as comprising changes of degree and scope in the logic established by the policy framework governing decision-making over the allocation of resources - that is, who controls the allocation of resources, the sanctions and the information available to those actors and how their decisions are legitimated. This is not a scale that lends itself to quantitative specification: rather, it is a matter for qualitative assessment, to be supported by evidence and argument.

The second dimension of interest, the pace of change, has received relatively less attention than has scale in the study of policy change. To be sure, much has been written about the role of time in the politics of public policy. Most of the focus, however, is on the importance of history and sequence in understanding the evolution of public policies (Baumgartner and Jones 2009; Pierson 2000, 2004; Howlett 2009). My principal focus here, however, is on timing as an element of the strategic judgments made by policy-makers in response to their reading of political circumstances. Just as policy-makers need to decide how large a change in the prevailing policy framework is desirable and feasible in given circumstances, so they need also to decide how quickly to enact the desired change. The emphasis here on enactment is deliberate: the fundamental parameters of a policy framework are set by legislative action, although they may take further shape in the implementation process. The degree to which changes are hard-wired up-front affects the extent to which those changes can be further shaped in the implementation process.
Using these definitions, Figure 1 arrays ten cross-national cases in according to the strategy of scale and pace adopted when a window of opportunity for major change in health policy frameworks was open in Britain, the US, the Netherlands and Canada from the end of World War II through the first fifteen years of the twenty-first century. (I discuss the factors opening these windows in the next section.) This period captures the founding of the modern health care state in each nation (except the Netherlands) through to the major reforms of the British, Dutch and American systems in the “millennial” period from 1987-2012. This millennial period also encompasses a period of dramatic fiscal constraint and recovery in Canada, which is of interest precisely because it did not yield major reform, despite the opening of a window of opportunity in 2004.

The only two American cases of the successful enactment of health care reform that departed in scale and/or pace from the incremental norm (Medicare/Medicaid and the Affordable Care Act) followed “mosaic” strategies, and the one attempt at big-bang change (the Clinton proposal) failed to be enacted. But lest this be taken as evidence of American exceptionalism resulting from its veto-ridden institutions, note that the US is not unique in adopting mosaic strategies, which also characterized the reforms to the English NHS adopted by the British Conservative/Liberal-Democrat coalition government in 2012.

The classification of these two American cases as “mosaics” – that is, as sets of multiple adjustments to the established policy framework – requires some explanation. Medicare and Medicaid essentially augmented but did not replace the existing American employer-based system, through an amalgam of proposals from several key politically-independent sets of actors. Although these changes were significant in the degree of change they represented (by establishing a new mandate for the state), they were limited in scope (in that this mandate affected only a segment of the health care arena representing about twenty percent of the US population at the time). Such a scope-constrained case contrasts with cases such as the establishment of the British National Health Service in 1948 (or even the sweeping reform of the organization of the NHS in
1990) that changed the logic of decision-making across most if not all of the health care arena. Nonetheless, I place the Medicare/Medicaid case close to the boundary with big-bang change, given its introduction of a new role for the federal government in the health care arena and the relative simplicity of the policy design.

The distinction between the Clinton’s proposed Health Security Act (HSA) (which I classify as big-bang) and the Affordable Care Act (classified as mosaic) also turns on the scope of the reforms. Although both sets of reforms established individual and employer mandates, the institutional changes wrought by the ACA were far less sweeping. The health insurance exchanges established by the ACA were targeted at only about 10 percent of potential insurees at any given time (those with neither employer-based or government coverage), in contrast to the HSA’s mandatory regional health alliances that would have covered all but the largest employers. Moreover, participation in the ACA exchanges was voluntary for employers as well as individuals. Congressional Budget Office scoring of insurance revenue under the two sets of reforms – deemed to be public under the HSA and private under the ACA – underscores this difference in institutional sweep.3

The ACA’s expansion of Medicaid also represented a marginal increase in the scale of government involvement in the health care arena. Newly-eligible beneficiaries amounted to 15 percent of Medicare coverage by March 2016 (Kaiser Family Foundation 2016a). Although the expansion was the largest since the establishment of the program, it was part of an ongoing evolution whereby Medicaid was becoming a more and more significant part of what Colleen Grogan has called “America’s hidden national health system” (Grogan in progress) and what John McDonough has described as a “policy afterthought” at the time of its enactment and an “unheralded stepchild of the US health care system” that had nonetheless surpassed Medicare as the largest program of public coverage even before the passage of the ACA (McDonough 2011: 141, 152).
Windows of opportunity and what happens in them: Four strategic domains

To understand the dynamics of the cases in Figure 1, we need to look at what created the opportunity for change and then at what political actors did with that opportunity. A window of opportunity for major change in health policy (or other policy arena) opens when a set of political actors is willing to take the political risks of such change: de-stabilizing established accommodations among the key structural interests in the arena, disrupting modes of interaction and challenging prevailing understandings of rights, obligations and the function of the state. Accordingly, those actors must have some confidence that they have the electoral mandate and the institutional resources to mobilize the authority necessary to overcome vetoes. Examples include landslide elections such as Labour’s 1945 victory preceding the establishment of the National Health Service in Britain, and the Democratic landslide of 1964 in the US preceding the establishment of Medicare and Medicaid, or successive electoral re-endorsements such as Margaret Thatcher’s third majority in 1987 preceding the “internal market” reforms of the NHS. Sometimes electoral strength compensated for the lack of a firm institutional base. In the Netherlands in the late 1980s, electoral outcomes (a second mandate for the Lubbers CDA-VVD coalition in 1986 and then a third endorsement of the CDA in 1988 that allowed Lubbers to consolidate his authority through coalition with Labour) allowed Lubbers to overcome the typically tempering effects of Dutch coalition governments and corporatist institutions to embark on a plan for a new framework of universal coverage. Conversely, propitious institutional conditions can compensated electoral weakness: even a minority Liberal government in Canada in the 1960s was able, in informal alliance with the social-democratic NDP, to seize the opportunity created by a rare institutional climate of “cooperative federalism” to embark upon on major social policy reforms.

Equally important, there must be some prospect of partisan advantage that spurs the political actors to take action of health care. Such conditions arise when health policy forms a central component of a politically-driven agenda of change. In some cases, such
as such as Labour’s social policy agenda in 1945 and Johnston’s Great Society in 1964, health care was central to what might be called the “meta-agenda” of change reflected in the election platform on which the government’s mandate had been won. In other cases, such as the UK in 1988 and the Netherlands in 1986, health care moved up the agenda as long-serving governments worked through the logic of their approach to welfare-state reform more broadly, and used the opportunity afforded by electoral re-endorsement to take action on health care. In the case of the Conservative/ Liberal-Democrat coalition government in the UK in 2010, comprehensive changes to the NHS emerged as central to the agenda only after the election, as part of the branding of the historic coalition as representing a radical break from the past rather than an alliance of electoral losers. In Canada, the imperative was internal to the governing Liberal party: in both the 1960s and the 2000s, health care provided a means for an insurgent faction to distinguish itself from co-partisan rivals (Coutts 2003).

The confluence of electoral and institutional strength and partisan impetus places the possibility of major policy change in a given area on the agenda, but it does not necessarily mean that such major change will occur. To assume otherwise risks making a tautology of a “window of opportunity” argument – we must be able to identify a window of opportunity regardless of whether major change actually occurs. But even given the capacity and the motivation to make major change, there is nothing inevitable about the key strategic decisions to be made about how big a change to make and how fast to do it. These decisions will be based on the judgements of political actors must about their own political capacity and institutional position, both at present and into the future. These assessments are fundamental to all others: the acquisition, exercise and maintenance of power are at the heart of the political enterprise, as preconditions for the achievement of other political objectives. Judgments about current and future political capacity therefore essentially set the context in which other assumptions are made. They permeate and condition the ways in which political actors think about the tractability of various policy problems and the efficacy of various technical modes of addressing them.
Judgments about the scale of change to be attempted depend on how political actors assess their current positions of influence – how well they are positioned to overcome vetoes at a point in time to build a winning coalition. That is, overcoming vetoes in the present requires navigating political space, defined by both governance and ideational configurations (Ferguson and Jones 2012): what is the array of actors with independent bases of power who must be brought on board, and how well aligned are their policy preferences? Judgments about pace, on the other hand, depend on what political actors project their likely influence to be in the future. That is, they need to assess whether they will be able to overcome vetoes through time: whether they would be able to re-invoke or re-assemble the coalition for change at the points in time at which vetoes are likely to re-emerge. Such considerations of vetoes through time drive the pace of enactment and implementation. In windows of opportunity for major change, then, members of a potential winning coalition will find themselves in one of four possible strategic domains, characterized by distinctive conditions as summarized in Figure 2.

**Big bangs:** Where the leadership of the coalition for change has the political and institutional resources to command support for a centrally-driven agenda, sweeping comprehensive change is possible. Such conditions of centralized control are rare, however. They are more likely (though not exclusively) to be found in institutional systems with relatively few independent veto points such as unitary states and Westminster parliamentary systems. Leaders in positions of centralized control can take swift and comprehensive action, but in democratic systems they typically do so against the spectre of a rapidly closing window of opportunity. Big-bang strategies can yield coherent policy frameworks, but in so doing they place high demands not only on the policy development capacity of the party in power and but also on its tactical ability to maintain focus and momentum. This approach is also likely to be marked by adversarial political conflict, which may or may not persist through the implementation phase.
depending on the extent to which the new framework maintains or removes platforms for subsequent opposition.

It is not surprising that each of the cases of big-bang change sketched in Figure 1 occurred in Westminster systems, in which leaders typically have to navigate relatively few independent bases of power but also confront competitive challenge. In the two British cases, majority governments had strong electoral mandates (resulting from a landslide win for Labour in 1945 and a third successive endorsement of the Conservatives in 1987) but faced uncertain prospects in the next election. In the United Kingdom in 1945, the size of Labour’s electoral landslide had been unanticipated, and the opposition Conservatives were still led by a popular war hero. The Labour government embarked on a sweeping agenda to establish the foundations of the modern British welfare state, including the NHS, by an “appointed date” only three years after the election. Thatcher’s “internal market” reforms of 1990, while not quite as “big” a “bang” as the initial establishment of the NHS, in that they did not alter the principles of universal eligibility and first-dollar coverage, nonetheless cut across the full sweep of the NHS to create new institutional forms based on “purchaser” and “provider” status, and instituted a transactional logic of contract to replace the prevailing logic of command. In the Canadian case, its minority position gave the federal Liberal government a strong incentive to seize the opportunity afforded by a rare alignment of the interests of federal and provincial governments and the neutralization or support of opposition parties in the federal parliament, and to enact a federal framework for universal physician services insurance in 1966.

Blueprints: Blueprint strategies of large-scale but slow-paced change entail reaching a broad-based agreement on an overall schematic for a new regime, the end-point of reform - not a detailed prescription of the design. Progress toward this endpoint is planned to occur in successive phases of enactment over a period of time which extends beyond the current period in office of the initiating government. Although policy development may not proceed precisely in the linear sequence or on the timeline initially anticipated, the
defining characteristic of a blueprint strategy is that the process builds in deliberate steps toward the realization of the principal elements of a framework set out at the beginning. Such strategies make sense where members of the winning coalition for reform have a reasonable expectation that they will continue to be in a position to enforce the balance of the overall compromise and to shape its interpretation. Hence each has an incentive to participate in designing a commonly-agreed framework in which each will make some gains. Such circumstances are most likely to occur in systems of inclusive governance such as those with an established tradition of coalition governments involving multiple parties with independent power bases. The principal strength of blueprints lies in their impact on collective expectations, and hence their success is likely to turn on the breadth of the initial coalition: the inaugural schematic, broadly endorsed, establishes a “shadow of the future” which shapes subsequent behavior (Groenewegen 1994).

All of these features are apparent in the one case of a blueprint strategy represented in Figure 1 – the Netherlands in the 1980s – characterized by a quasi-hegemonic Christian Democratic (CDA) party that had been part of every government since 1918, often as the lead party, and by norms and structures of consensual corporatist decision-making in a “social middle ground” of shared political space linking state and civil society (Crouch 1993: 50-63; Schut 1995: 622-3). Even in these relatively favourable circumstances, however, this strategy type proved its vulnerability to contextual shifts and to tactical challenges of maintaining political balance at each step. In the event, the Dutch time frame was much more protracted, as the originally-projected five-year process extended, with fits and starts, over a twenty-year period (van de Ven and Schut 1995; Helderman et al. 2005).

**Increments:** One of the novel insights to be gained from the framework I am presenting here is that, given a window of opportunity for major change, incrementalism can be a deliberate strategic choice, not just a default position in the absence of such a window. This sort of incrementalism is distinguished from the “normal” kind of incremental change in that it is neither driven by increasing returns to
the prevailing policy framework nor is it a by-product of what Howlett and Mukherjee (2014) term “non-design” processes such as log-rolling or electoral opportunism. Instead it occurs by design, when there is a coalition of support for change, all of whose members would prefer to reach an agreement rather than retain the status quo, but who differ in their expectations of future influence. In particular, if at least some members of the reform anticipate being in an improved position in the future, such that they may be in a better position to effect and claim credit for the change, they will have an incentive to seize their current position of advantage to make investments upon which they can capitalize in the future. Accordingly, they will seek an agreement that advances the agenda and keeps it alive for future action – a strategy that yields incremental outcomes. As in the case of blueprint change, an incremental change strategy allows for adaptation over time, but unlike a blueprint an incremental strategy establishes no shadow of the future to draw change toward a coherent end-point and ensure that the pieces of the framework are complementary. Incremental strategies also share with blueprints a vulnerability to unanticipated shifts in context, which in the case of incremental change may deny its designers the ability to build upon the platforms they create.

England and Canada in the early 2000s provide cases in point. In both cases a window of opportunity was open – created in the English case by a second consecutive landslide victory for Labour at the polls in 2001, together with the rise of health care to prominence within a governmental agenda of public service reform, and in Canada by the margin of electoral safety enjoyed by the federal Liberals as a result of the splintering of the political right, the rise of health care to the centre of the federal-provincial agenda with the fading of competing agenda items such as constitutional reform and with the potential for federal re-investment after a period of deep austerity, and with the transition in the prime ministership from Jean Chretien to Paul Martin in 2003. In England, however, one of the partners in the “duopoly” within the Labour government, Chancellor Gordon Brown, foresaw a future in which he would replace the other, Tony Blair, as prime minister: hence his interest as a member of the current government was to ensure the government’s success but also to preserve discretion for himself in the
future. Brown’s agreement to go so far but not farther in health care reform (particularly in the case of a “Foundation Trust” model giving greater independence to public hospitals) acted as a brake on the scale and pace of change, and the Blair government continued with a pattern of incremental adjustments to and augmentations of the internal market reforms of its Conservative predecessor (Mays et al. 2011). In Canada, Paul Martin sought to inaugurate his prime ministership by establishing a platform for future activity, beginning with the removal of the thorn of federal “underfunding” of provincial health care programs. So positioned, he would then embark on a broader reform agenda from an improved stance vis-à-vis the premiers. The expectation of continuity was radically upended, however, when voters in the 2004 federal election reduced the Martin government to minority status. This reversal of fortune dramatically foreshortened Martin’s time horizon, and securing an immediate agreement within the terms of its existing offer became the federal government’s key priority.

**Mosaics:** Finally, we turn to remaining set of possible combinations of scale and pace: a fast-paced cobbling together of multiple small-scale changes that I term a “mosaic.” Like blueprints, mosaic strategies are likely to arise where the winning coalition for change comprises multiple actors with independent power bases. But unlike the political stability that can yield a blueprint, mosaics arise in the more likely circumstance that political leaders judge their current power positions to be precarious. They may judge that they are well-enough positioned to form a minimum winning coalition within a relatively brief window of time, but because of the need to accommodate a variety of contending interests, they cannot enact sweeping institutional change within that brief time window. Nor, unlike the case of blueprint strategies, can they secure agreement to the outline of a comprehensive reform framework to be enacted over time, since the various actors in the coalition of support cannot be confident that they will retain positions of influence at subsequent stages.

Such circumstances are likely to favour a “mosaic” strategy, which can be thought of as a highly accelerated and thus more jolting version of the incremental and
disjointed “layering” phenomenon described by Thelen and colleagues (Streeck and Thelen 2005). The resulting mix is likely to include not only interconnected elements as a matter of policy design but also a variety of _ad hoc_ elements added as the price of securing political agreement. The multiple deals typical of mosaic strategies are also likely to include delays in the effective dates of various provisions to allow time for adjustment while still hard-wiring changes up-front. Hence the main vulnerability of mosaic strategies is that they result in highly complex and inchoate policy frameworks, presenting major challenges both of public communication and of implementation.

The US political system with its multiple veto points is especially prone to mosaic strategies in health care, and it is not surprising to find that two of our three mosaic cases are American, and that those cases represent the only incidences of successfully enacted major reform in American health care. These cases will be more fully discussed below. But mosaics are not unique to the US. Indeed, another case of mosaic reform occurred in a setting ordinarily not conducive to such strategies – the British Westminster system - albeit only after a historically unprecedented turn in British politics, namely the formation of a Conservative-Liberal/Democrat Coalition government after the 2010 election. Notwithstanding their desire to present themselves as offering a radical new departure in British politics, they were constrained by myriad differences of opinion not only between but within the parties. Moreover, action would need to be taken rapidly: the electoral horizon was even shorter for the two parties in the coalition than normal in a Westminster majority government. The parties had agreed to a fixed date for the next election five years hence, but they knew that they would have to distance themselves from each other increasingly as that deadline approached.

The result was a convoluted piece of legislation that seized upon a plan developed in opposition by the now Conservative health secretary, Andrew Lansley. As adapted over the rapid course of intra-Coalition bargaining, the reform maintained the logic of the purchaser-provider split in the English NHS while reconstituting the purchaser agencies to invert the relationship between purchasing authorities and their
advisory councils of general practitioners, accelerating the transition of NHS hospital providers to Foundation Trust status and reconfiguring central regulatory agencies. Moreover, what began as a centrally-driven amalgam of Conservative and Liberal-Democrat positions on NHS reform became even less coherent through a series of amendments and concessions in a tortuous legislative process almost as unusual in the Westminster context as was the historic coalition that had generated it (Timmins 2012; Waller and Yong 2012; Klein 2013, ch. 10).

**American health care reform in comparative perspective:**

The comparative background provided so far can cast our American cases – and in particular the relative success of mosaic strategies and the failure of a big-bang in the US context – into greater relief. Indeed, the founding of the modern American health-care state itself was brought about by such a rapidly-assembled package of modifications to existing institutions under President Lyndon Johnson in 1965, after health care had been omitted from the one big-bang episode of social policy change in American history – the establishment of Social Security as part of Roosevelt’s New Deal in 1935.

**Social Security: no window for health coverage**

The conditions under which Social Security was enacted in 1935 and expanded in 1939 were extraordinary in historical perspective. The economy was in the aftermath of the Great Depression. Progressive social policy reform was the definitive theme of the agenda of a popular Democratic president elected in 1932 with a majority of more than 57 percent of the popular vote, and again in 1936 with over 60 percent. The Democrats controlled the White House and held a nominal majority in the House and a nominal supermajority in the Senate. Only once again in the twentieth century would anything resembling such conditions coalesce – in the mid-1960s under President Lyndon Johnson (Figure 3).
These institutional and electoral circumstances created one of the conditions for a window of opportunity for major change in health-care policy. But the second condition – the centrality of health policy to a broader partisan agenda – failed to materialize. The linkage of health care to the broader economy was not as strong as it would become in subsequent eras. Health insurance had not yet become tied to employment, and health care costs had not emerged as a perceived drag on economic growth. Indeed moving on health policy might have threatened the broader social policy agenda. Southern Democrats, responding to fears in their constituencies that government-based social security would destabilize the paternalistic authority of landowners over their tenants in the sharecropper economy of cotton farming, constituted a major interest to be accommodated in the design of any income-security program (Quadagno 1988: 127-151). The Depression had created a sense of urgency – never to be matched in the realm of American social policy – that was barely sufficient to keep the Southern Democrats in the reform coalition despite their significant misgivings. Including health care in the package would have added an inchoate concern about what universal access to health insurance might imply for the segregation of health care facilities (Blumenthal and Morone 2010: 37). Perhaps even more potently, it would have added the powerful opposition of organized medicine to the coalition of opposition to social security (Orloff 1988: 75-6). For a mix of reasons, then, Roosevelt demurred and America’s only big-bang in social policy passed without bringing about a national health insurance program.

The banner was taken up again by Roosevelt’s successor, Harry Truman who, unlike Roosevelt was committed to achieving universal health insurance and made it central to his agenda. But in this case the institutional and electoral resources were lacking. Even the nominal representation of the Democrats was considerably less in both houses of Congress throughout Truman’s tenure than it had been under Roosevelt, and party unity continued to be weakened (Figure 3). Proposals for universal health insurance introduced by Truman in 1948 and 1949 died at the committee stage.
The Medicare/Medicaid mosaic:

The 1964 elections established Lyndon Johnson as President, put Democratic supermajorities in place in both houses of Congress and thus placed an extraordinary concentration of legislative and executive authority in the hands of Democratic leaders. Johnson’s victory over an arch-conservative opponent could be seen as a resounding endorsement of the Democrats’ progressive social policy agenda in which health care figured prominently (Jacobs 1993: 191). Johnson made the passage of Medicare his first legislative priority after the 1964 election (Sirgo 1985: 827; Marmor 2000: 46). He had a keen sense that the window of opportunity – the honeymoon enjoyed by a newly-elected president – would soon close (Blumenthal and Morone 2010: 166, 174), and was prepared to commit his substantial political capital to securing Medicare’s enactment. If ever a window of opportunity for health care reform were open, this was it. The issue was what the scale and pace of that reform would be.

The scale of the reform pursued by the Democrats has been the subject of much retrospective debate. Johnson’s electoral majority in the popular vote, at more than 61%, surpassed even Franklin Roosevelt’s (and indeed any president’s since 1820). But even with their large majorities of 68 seats in the Senate and 295 in the House, party unity was strained as it had been for the previous three decades by the presence of the southern conservative bloc. Even with his legendary legislative and persuasive skills, Johnson could count on levels of party unity of about 75 and 78 percent in the Senate and House respectively (Figure 3).

In similar circumstances Roosevelt had nonetheless attempted and accomplished a big-bang change with the establishment of Social Security. Why Johnson did not attempt another big bang, in this case to bring about universal health insurance, remains one of the enduring puzzles of American social policy development. Some have seen this as a leading example of the “blinders of incrementalism” that have hobbled social policy development in the US over time, that prevented reformers from recognizing and seizing the opportunity afforded them by the Johnson win (Jacobs 1993: 210-11). But the
answer may well be that the same dynamics that dissuaded Roosevelt from including universal health insurance within his own big-bang strategy – the combined opposition of southern Democrats and powerful interests within the health care arena – were at play for Johnson as well. The earlier inchoate concerns of the southerners about implications for segregation were given sharp focus by the intersection between a government program of health insurance and the other major initiative inherited from the Kennedy administration – civil rights legislation. For the southern Democrats, the passage of the Civil Rights Act in 1964 not only represented a major loss; it also “raised the stakes” of other reforms, by requiring that no program receiving federal funding could discriminate on grounds of race, colour or national origin (Blumenthal and Morone 2010: 195-196). The Johnsonian strategy is thus understandable at least in part as a strategic trade-off across agenda items: Johnson may have resiled from a big-bang approach in health care precisely because he was pressing forward with a big-bang on civil rights.

The scale of the reform was therefore to build on an established program – Social Security – and to do so by assembling various disparate proposals for physician services insurance for the elderly, hospital services insurance for the elderly and physician and hospital insurance for low-income families in a “three-layer cake” in order to attract a winning coalition within the nominally-dominant Democratic caucuses in the two houses of the US Congress (Marmor 2000: 46-56). Although a foundational moment for the American health care state, this legislation affected only a minority of health care recipients not in the workforce, and left the bulk of the arena premised on employer-based coverage largely intact.

The pace of the reform was established by Johnson’s strategic aversion to delay. His mode was to strike quickly, to press for quick passage through the legislative process before opposition could build. Blumenthal and Morone quote his salty admonition: “For God’s sake don’t let dead cats stand on your porch .... When you get one [of your bills] out of your committee, you call that son of a bitch up before they [the
opposition] can get their letters written” (Blumenthal and Morone 2010: 190, brackets in original). And indeed the process through which the legislative package and the coalition of support were assembled was breathtakingly swift. A bill was reported out of Mills’ Ways and Means Committee in the House in March 1965, only two months into the new legislative session, and passed by the House in early April. The Senate Finance Committee reported out its bill at the end of June; the Senate approved it in early July and the House and Senate bills were reconciled in conference to produce the final legislation passed by both houses at the end of July. Later reformers would look back in envy.

Medicare/Medicaid nonetheless faced implementation challenges. As Marmor notes, grafting an insurance program for an arena with a complex web of providers onto a Social Security program aimed at relatively straightforward income transfers presented a “historically unprecedented level of complexity for Social Security’s administrative elite” (Marmor 2000: 97), and meant dealing with hostility from the very intermediaries – hospitals and physicians – upon whom implementation would depend. Under different political circumstances, having to develop the infrastructure to deal with such complexity might have argued for a “blueprint” strategy in the first place. For example, agreement on the three layers of the Medicare/Medicaid cake could have been reached up front, with each layer to be added through sequential legislative action, beginning with Medicare Part A, hospital insurance. Such a strategy was followed in building the regulatory infrastructure necessary for the Dutch reforms noted above. But a blueprint strategy could not have succeeded in the adversarial US system. The various veto players who had agreed to the three-layer package needed to secure it by enacting it as a whole, lest they not be in a position to affect future legislative phases.

The Clinton big-bang fizzle:

The case of the Clinton health reform initiative of 1993-94 is one in which a window of opportunity was pried open by sheer force of political will even in the face of less-than-favourable institutional and electoral conditions. The Democrats held control
of both houses of Congress and the presidency but crucially lacked the institutional lock of a filibuster-proof super-majority in the Senate. Clinton himself lacked a majority popular electoral mandate, having won less than a majority of the popular vote in an election marked by a third-party contestant. Nonetheless, Clinton had campaigned on national health insurance as central to his “New Democrat” agenda. He and his advisers, emboldened by the apparent electoral success of the health care issue, believed that they could ride that momentum to seize “a little window of opportunity, a needle we could thread” (Johnson and Broder 1996: 622).

That sense of “threading the needle” bred a desire to act quickly. Clinton had pledged during the campaign that he would introduce a full health care reform plan to Congress within his first 100 days in office, and that it would yield universal coverage within five years (Johnson and Broder 1996: 192, 613; Blumenthal and Morone 2010: 359). In Clinton’s early days in office, there was a strong sense that “time was of the essence” in order to forestall the mobilization of opposition (Johnson and Broder 1996: 119). Even so, there were some voices of caution. For example, Robert Reischauer, the director of the Congressional Budget Office, was advocating for what in my terms would be a blueprint approach over a fifteen-year timeframe (Johnson and Broder 1996: 117-119). For Reischauer, the staged approach of a blueprint would not overly strain either the technical or the political capacity of the system at any point in time. But although and Clinton himself would later express regret about his “mistake in not going for a multi-year strategy” (ibid: 127), the political conditions for a blueprint strategy, bipartisan or not, were simply not present: neither Democrats nor Republicans could count on having sufficient influence at each stage of the process to enforce their interests. A rapid pace was the only realistic political option.

As for scale, the fundamental question was where to establish the centre of gravity for the proposed reform. There were essentially two strategic possibilities, each implying a rapid pace but differing in scale. A mosaic strategy would start from the centre, seeking bipartisan compromise through multiple adjustments to the existing
system. A big-bang strategy would start from the left, with a comprehensive Democratic plan and move only as far into the political centre as necessary to build a minimum winning coalition of support (Johnson and Broder 1996: 301). It is conceivable that Clinton could have been successful with such a strategy, had he been able to create a bandwagon “politics of legislative certainty” (analogous to the legislative context for Medicare and Medicaid in 1965 [Marmor 2000: 45-62]) to draw opponents to a table of compromise, around a model similar to that which would emerge sixteen years later under Obama. Moderates in the Senate such as Daniel Patrick Monihan among Democrats and John Chafee and, for a time, the pivotal Robert Dole among Republicans, were open to such a possibility. Clinton himself later regretted that he had not seized that opportunity to reach “a direct understanding with Dole” (Johnson and Broder 1996: 394).

Whether or not such a bipartisan mosaic could have succeeded in the polarized context of 1993-94, even with the moderating influence of Chafee, Dole, Monihan and a few others, must remain one of the imponderables of history. Instead, Clinton and his advisers misread the context for health care reform “as a change in the climate when it was only a change in the weather,” as a senior Clinton adviser was later to reflect (quoted in Blumenthal and Morone 2010: 381). Accordingly, while eschewing the left-most of the major options in play (a single-payer plan), the Clinton reforms attempted to restructure the broad sweep of the health care arena around new institutions – regional health alliances for the purchase of all private health insurance (other than that provided by the largest employers), and also incorporating Medicaid and Medicare recipients on a compulsory or voluntary basis respectively. This approach was consistent with what Quirk and Cunion have called the “principled” or “integrative” centrism that marked Clinton’s early presidency – attempting to find innovative policies that serve the goals of both the left and the right – through his “New Democrat” agenda. Only later would he adopt a more “opportunistic” centrism – tacking left and right to negotiate and seize agreement where it could be found (Quirk and Cunion 2000).
In Clinton’s case, however, scale was the enemy of pace. The task force process established to work out the many inter-related components of the plan went through various rounds and drafts while the President’s attention was drawn to the pressing issue of securing Congressional approval of his first budget. Indeed, the initial strategy had been to include the health care legislation in omnibus budget legislation, thus allowing for a truly rapid big-bang enacted through the budgetary reconciliation process requiring only a simple majority in the Senate, but that possibility was foreclosed by the Senate parliamentarian. But in the event, once the plan reached Congress it could not even be reported out of committee.

The Affordable Care Act mosaic:

In 2009, Democratic president Barack Obama enjoyed conditions that were arguably more favourable than those confronting any of his predecessors including Johnson (Peterson 2011). Obama had won a solid majority of the popular vote in the 2008 election. For a brief period, the Democratic Senate caucus (which included two independents) had a razor-thin nominal supermajority. The long Democratic quest to complete the “unfinished business” of the American welfare state by enacting universal health insurance had been awaiting just such a moment; and Obama as President placed health care reform as central to the overarching demands of economic recovery.

The very conditions that opened this window might be thought to have favoured a big-bang strategy. And indeed the groundwork for such a strategy was laid with the passage of budget reconciliation instructions in April 2009 that would allow the Democrats to enact the reform with only a simple majority in the Senate if need be. But the shadow of the failure of Clinton’s big-bang hung heavily over strategic decision-making in the Obama administration (Oberlander 2010; Washington Post 2010: 15-16; McDonough 2011: 73; Brown 2011: 420; Beaussier 2012: 742-3). (To a lesser extent, so did the beacon of Johnson’s Medicare and Medicaid success.) Many of Obama’s advisors, a number of whom had served in the Clinton administration, paid close attention to the history of that episode.
Furthermore, although the Democratic congressional caucuses were more united than they had been since the beginning of the twentieth century, the leadership could still not count on commanding its nominal supermajority in the Senate as necessary to overcome a united Republican front of opposition by invoking cloture. Opinion within the Democratic caucuses in each house ranged from “Blue Dog” fiscal conservatives on the right to advocates of a single-payer government-sponsored insurance plan on the left, and also included pro-life advocates leery of the implications of government insurance for access to abortion. Indeed, differences among congressional Democrats regarding specific policy elements were greater than those among Republicans (Rigby et al. 2014).

Negative lessons from the Clinton episode and intra-party divisions recommended a reform of relatively modest scale – drawing multiple interests together through a broadly consultative process to agree on a set of adjustments to the employer-based system without jeopardizing the broad institutional structure to which most Americans were accustomed. As for pace, the question was whether to get “points on the board” with immediate relatively small-scale initiatives and then proceed step-by-step over the course of the first term, or to launch at once into a larger-scale project. Obama was urged by his close advisors within the White House to adopt the first approach, proceeding cautiously on the health policy front (Alter 2010: 80; McDonough 2011: 74). Others, however, opposed this incremental reading of the strategic domain: there was no reason to believe that Democrats would be better positioned in the future to build on initial platforms. Key Senate Democrats, most notably the chairs of the two committees which would have carriage of any health care bill – Max Baucus of Finance and Ted Kennedy of Health, Education, Labour and Pensions (as well as Tom Daschle, Obama’s initial ill-fated choice for Secretary of Health and Human Services) – pressed Obama to move ahead quickly on health care as the highest priority after economic stabilization (Jacobs and Skocpol 2010: 43). They believed that the depth of the problem required tackling multiple dimensions simultaneously and that, even though the Senate Democratic caucus initially lacked the votes necessary to overcome a filibuster, sufficient
Republican votes could be found early on to push legislation over that threshold (McDonough 2011: 65-69). The same factors that led Obama to make a central priority of health care also led him to agree with his erstwhile Senate colleagues.

The resultant Affordable Care Act was a product of its time, but also the product of determined leadership. In a polarized context in which they enjoyed extraordinary but precarious electoral and institutional advantages, Democratic leaders judged they had a short time in which to fashion a package that would satisfy enough marginal supporters to create a winning coalition. Accordingly the legislation was crafted through a strategy of multiple mosaics – made, remade, assembled, disassembled, and reassembled in the space of a year. To drive the process the Democratic leadership created a bandwagon climate to persuade affected interests against “waging another scorched-earth campaign [at the risk of being left] without political leverage on the surviving legislation” and rather to adopt “a ‘constructive’ approach that would enable them to smooth the rough edges of the emerging reform and to amass political capital they could invest in further favorable legislative and regulatory adjustments as reform played out” (Brown 2011: 425). Or, as the president of the Chamber of Commerce put it more pithily in March 2009, “[i]f you don’t get in this game … you’re on the menu” (quoted in Washington Post Staff 2010: 17).

In addition to the multiple consultations held by the Democratic leadership in congress and the administration with affected interests, the legislation followed a tortuous legislative track as institutional conditions shifted and the 60-vote Senate threshold was gained and lost within a period of nine months. The process comprised 79 hearings involving 181 witnesses in the House, and “approximately 100 hearings, roundtables, walkthroughs and other meetings [as well as] after 25 consecutive days [of debate] in continuous session” in the Senate (Jost 2017), and a lengthy but ultimately futile quest to bring a few Republicans by offering opportunities to shape the final result. A bandwagon of a sort marked this phase of the process as well, with the result that miscellaneous provisions were added as the price of securing the support of
individual legislators. “The store is open,” Speaker Pelosi is reported to have told at least one recalcitrant Democrat. “Now is the time to get in your provisions” (Washington Post Staff 2010: 30). The end result was a complex and ultimately entirely Democratic amalgam formally comprising a Patient Protection and Affordable Care Act with more than four hundred sections and a budget reconciliation act with thirty-eight sections relating to health care reform (collectively known as the Affordable Care Act), as well as a four-section executive order reinforcing the prohibition on federal funding for abortions.

The reforms amounted to a modest increase in the influence of the state in the health care arena: they left the employer-based system in place as the modal form of health care coverage, although the regulation of private insurance was tightened, and large employers now faced a form of mandate to cover their workers. The most significant institutional change was the requirement for health insurance exchanges to be established in each state, but these exchanges were far from the muscular regional health alliances that had been proposed in the doomed Clinton plan sixteen years earlier. In contrast to the mandatory Clintonian alliances covering all but the largest employers, participation in the exchanges was voluntary for employers as well as individuals, and they were targeted at making private health insurance affordable, through a combination of regulation and subsidy, for those with neither employer-based nor government coverage (even after the expansion of Medicare also provided for in the ACA) - about 10 per cent of insurance coverage at any given time. A similar-scale material increase in the presence of the state related to the ACA’s expansion of Medicaid. Although the enrolment increase would be the largest since the establishment of the program, it was part of an ongoing evolution whereby Medicaid was becoming a more and more significant part of what Colleen Grogan has called “America’s hidden national health system” (Grogan in progress; see also McDonough 2011: 141, 152). As for the regulation of private insurance, the effect of the Act was to fill in existing gaps essentially by universalizing existing provisions in state-level regulation and employer-based insurance contracts.
With the important exception of the Medicaid expansion – itself dependent on state adoption – the thrust of the reforms was to work at the margins to channel private finance and harness the private market towards the public objectives of improving the security and extending the accessibility of private insurance. In this sense it exemplified the agenda of “reconstituting the submerged state” that Suzanne Mettler (2010) has described as characterizing the approach of the Obama administration to taxation and higher education policy, as well as to health care. Similarly the employer mandate continue a particular aspect of the submerged state: a pattern of “delegated governance” that has characterized much of US health care policy (Morgan and Campbell 2011).

It was on the ideational plane, however – in its impact on fundamental organizing principles – that the shift in logic brought about by the Act was greatest. The institution of individual and employer mandates implied a two-fold change in organizing principles: one relating to the rights and obligations of citizenship, the other to the legitimate functions of government. To some extent the enforcing of an employer mandate is consistent with government’s traditional role as delegator in the US shadow state. But an individual mandate was a more significant change: it altered fundamental premises about the responsibility of individuals to the collective and about the function of the state. The individual mandate made having health care coverage not only a right, but also an obligation of membership in the polity, exercised not through the payment of taxes in support of a universal program but through the purchase of private insurance. The function of the state was also altered: not only was the state a regulator of private insurance, a delegator of responsibilities to various private actors, and a funder of public programs (including public subsidies for the purchase of private insurance); it was now also an enforcer of mandatory coverage and a major participant a market segment to facilitate the fulfilment of that mandate.

The implementation timeline set out in the ACA was protracted, involving fixed stages over eight years. The very institutional hurdles that so complicated the adoption of the ACA would also, the Democrats believed, frustrate attempts to dismantle it, and
they therefore had some confidence that their implementation timeline would stick once inscribed in legislation. As multiple Republican attempts at repeal were blocked, first by a Democratic Senate and then by a Democratic president, that confidence appeared to be borne out. But that landscape changed dramatically in 2017.

The Republican repeal attempt:

When the 2016 election gave the Republicans control of both the House and the Senate as well as the White House, they were finally if unexpectedly in a position to carry out their long-avowed intention to repeal the legislation. That position satisfied the two conditions – capacity and motive – for creating an opportunity for major change of some sort. It also set the stage for strategic judgments as to the scale and pace of that change. Because this very recent episode has not yet received extensive scholarly treatment, I will deal with it in somewhat greater detail than those discussed above. Because the history of this case is still in progress, I have not mapped it onto Figure 1. Were I to do so, it would fall, as of the time of writing in August 2017, as a failed case below and to the right of the location for the ACA in the mosaic quadrant – smaller in scale and more rapid in pace.

The Republican leadership was motivated to act quickly. Moreover, the slim Senate majority of 52-48 put them within three votes of failing to pass legislation, and meant that the Senate could potentially be lost as early as the congressional elections of 2018. Although the 2018 Senate map was relatively favourable for Republicans, the presence of an erratic and divisive president made prospects uncertain. Having won the presidency with less than a majority (46.2 per cent) of the popular vote – indeed, less than his rival Hillary Clinton’s 48.1 per cent – Trump had a much weaker electoral mandate than Obama had enjoyed. Compounding the problem, Trump’s public approval ratings over the course of the six months between his inauguration and the August congressional recess were at historically low levels for an early presidency (Bycoffe, Mehta and Silver 2017).
Trump’s campaign promises added further urgency. He had pledged to move on “Day One” of his presidency to ask Congress to commence the process of repealing the Affordable Care Act. Even before his inauguration, the congressional Republicans took the first legislative steps toward repeal. Within hours of the inauguration Trump issued an executive order directing the various agencies charged with administering the Affordable Care Act to “take all actions consistent with law to minimize the unwarranted economic and regulatory burdens of the Act, and prepare to afford the States more flexibility and control to create a more free and open healthcare market” (United States 2017b.) Trump’s nomination for secretary of health and human services, Tom Price, brought into the administration the congressman with arguably the longest history of devising alternatives to the Affordable Care Act, dating from before its passage.

But the question of the pace of change intersected with that of scale. Would the Affordable Care Act simply be repealed in a single comprehensive sweep? Or would it be necessary to simultaneously put a replacement in place? And if the latter, what should the replacement(s) be? On these questions the Republicans were divided, especially in the Senate.

The twin needs for speed and for accommodating a variety of positions within their own ranks, let alone coming to terms with a sufficient number of Democrats to repeal and replace all of the provisions of the Affordable Care Act, augured for a fast-paced, cobbled-together mosaic strategy. With their unified control of government and their commitment to immediate action, the Republicans were to some extent in a strategic domain similar to that of the Democrats in 2009. But there were critical dissimilarities, which would drive differences in both tactics and outcome.

First and foremost, the fundamental agendas were different: whereas the Democrats had been establishing a new program structure, the Republicans were seeking to dismantle it – a type of project in which conservative parties have been more successful through stealth than through overt legislative action, given opposition from
beneficiaries among both providers and recipients (Pierson 1994, Pal and Weaver 2003). The Democrats had had to navigate internal divisions over the shape of the new program, but they did not have to confront internal opposition to any program at all. The Republicans in contrast had to bridge the gap that opened up once the shelter of a Democratic presidential veto no longer prevented a pure repeal agenda from being implemented. The effect of any and all of their proposals would be to reduce both the extent and the quality of coverage, and raised the risk (soon realized) that the Republicans would encounter grassroots protest as millions of individuals faced reduction or loss of coverage – a mirror image of the Tea Party protest against the Democrats’ proposals in the summer of 2009.

Although public opinion remained polarized on “Obamacare” as an overall construct, almost all of its major provisions – including not only the popular features banning most risk-related underwriting practices, but also the Medicaid expansion, the marketplaces, an even the increase in the Medicare payroll tax on upper-income individuals – attracted strong majority support among both Democratic and Republican identifiers. Only the most-loathed symbols of government overreach – the individual mandate – attracted less than a majority. The employer mandate was supported by only 45 per cent of Republicans, but by 60 per cent overall (Kaiser Family Foundation 2016b). Meanwhile insurers themselves, as well as hospitals, pointed to the intricate bargains that had underlain their acquiescence to the Act, and warned that time and care would be necessary to renegotiate those arrangements (Abelson 2016). Unlike the other cases reviewed in this paper, the Republican repeal agenda involved taking away benefits, and thus thrust them into a politics of blame-avoidance.

In addition to this fundamental difference in agendas, the Republicans were, as noted above, in an institutional position much weaker than that of the 2009-10 Democrats. With a filibuster-proof Senate majority for a crucial period in 2009-10, Democrats had been able to assemble most of the pieces of the Affordable Care Act under regular legislative order, and many of those provisions could therefore be undone
only through regular order a well. With fifty-two seats in the Senate, the Republicans in 2017 were nowhere close to the number required to overcome a Democratic filibuster. They would have to craft their repeal legislation in a way that would pass through the budget reconciliation process – to which the Democrats had to resort only to reconcile the House and Senate versions of the legislation. These requirements essentially limited the Republicans to dealing with those elements of the legislation with fiscal implications (including the tax penalties necessary to enforce the mandates), while leaving much of the regulatory infrastructure beyond their reach. Technically, however, the key features of the Affordable Care Act were so interrelated that dismantling them piecemeal would sow chaos in the individual and small-group insurance markets.

These fundamental differences in agenda and institutional resources yielded markedly different tactics. The Democrats in 2009 worked to create a bandwagon effect to galvanize their caucus and bring affected interests (and, they hoped, a few Republicans) on board. The Republican tactic can been better described, using Weaver’s (1986, 2013) concept, as a blame-avoidance exercise of “circling the wagons,” in which party leaders “negotiate behind closed doors to try to strike a grand deal … which they then sell jointly to the public and to rank-and-file legislators (‘circling the wagons’) as the best deal that is achievable—and better than no deal at all” (2013: 6) and which is both “necessary and inevitable” (Pal and Weaver 2003: 29). Bandwagon and circling-the-wagons tactics have in common the creation of a sense of inevitability and “security in numbers.” But bandwagons are essentially “offensive” tactics allowing supporters to claim credit for shaping an outcome, whereas circling the wagons is a defensive tactic, aimed at diffusing blame by providing group protection for taking an unpopular position.

Accordingly, the Republicans tried immediately to establish a sense of necessity and inevitability. In so doing they raised the stakes markedly, by adopting a legislative strategy in which repeal of the Affordable Care Act would have to be accomplished before the next major piece of the Republican agenda, tax reform, could be acted upon.
(Because Republican-style tax reform would very likely not attract support from Democrats, it would therefore have to pass through budget reconciliation as well. Technically, the deficit-control requirements of budget reconciliation meant that the savings from ACA repeal would have to be booked before the revenue losses from tax cuts could be adopted.) Therefore, as one of their first legislative acts in the 115th Congress and even before Trump’s inauguration, the Republican majorities in both chambers adopted – on a straight party-line vote in the Senate and with very few Republican defections and no Democrat support in the House12 – a budget resolution with reconciliation instructions establishing the parameters for a partial repeal of the ACA. The resolution set a tight deadline of 27 January 2017 for the development of draft budget legislation, expected to set effective repeal dates for various sections of the Act – the first of many deadlines that would come and go while the Republicans continued to argue internally.

Discussions at the closed annual policy retreat of the Republican House and Senate caucuses in Philadelphia at the end of January an audio recording of which was obtained by the Washington Post, revealed widespread unease about the implications of following through on their repeal promises. Some attendees expressed concerns about “pulling the rug out from under” those with coverage gained under the ACA, or pulling a “bait-and-switch” with the states who had expanded Medicaid with federal funding. Others warned about the destabilizing effects of a partial repeal on insurance markets. Yet others worried about proposals to use the repeal legislation as a vehicle for other pet objectives such as defunding Planned Parenthood clinics (which included abortion among their services, although federal finds could not be used for those purposes) (Pear and Kaplan 2017).

To craft the legislation the Republican House and Senate leadership adopted closed-door processes aimed a crafting take-it-or-leave-it packages, again in marked contrast to the process through which the Affordable Care Act had been developed. The course of developing the ACA included both open and closed elements, and was
brought to completion through processes closely held by the congressional and White House leadership, but at the outset it made full use of the committee structure in both houses and allowed for extensive debate both among Democrats and between Democrats and Republicans. It involved five different committees, three in the House and two in the Senate, as well as a Senate floor debate stretching over almost a month in November-December 2009. In contrast, the Republicans in 2017 adopted a closed process very tightly managed by the House and Senate leadership from the beginning.\textsuperscript{13} Such closed processes are more typical of big-bang processes aimed at developing a comprehensive architecture without having to incorporate piecemeal concerns Aneurin Bevan in 1948, Margaret Thatcher in 1989-90 and Bill Clinton in 1993 all confined the process of crafting the legislation for their new models to a tight group of close advisers (Tuohy 2018 forthcoming). Even the negotiation of the Canadian medicare model in 1965-66 was kept to the relevant federal and provincial cabinet ministers and their officials within the closed structures of “executive federalism.” The Republican leadership, however, attempted to build a minimum winning coalition by incorporating the disparate desires of their legislators through anticipation, not consultation, and to allow amendments only at the stage of floor debate. This sprinting pace and exclusive process was to prove counter-productive.

In the House, Speaker Paul Ryan worked through February with the administration and senate leadership to craft a bill drawing heavily on a white paper (the “Better Way”) which he had released eight months earlier, and held a series of closed-door meetings in which he offered to meet with any Republican member of the House of Representatives who wished to see the draft legislation and provide feedback.\textsuperscript{14} The American Health Care Act (AHCA) was introduced into the House Ways and Means, Energy and Commerce and Budget Committees in early March.

The AHCA was a less onerous and less generous, purely Republican mosaic to replace the purely Democratic mosaic of the Affordable Care Act, variously eliminating or modifying pieces of the ACA architecture while leaving the overall scaffolding in
place. It eliminated the ACA’s tax penalties enforcing the individual and employer mandates as well as the revenue-generating taxes on upper incomes, and shrank and simplified the subsidies while removing much of their redistributive progressivity. And like the Democrats before them who had built Medicare reform into the ACA, the Republicans could not resist the opportunity of the legislative repeal project to realize their own long-held goals for the reform of established “entitlement” programs – in this case Medicaid. Not only would federal funding for Medicaid expansion be phased out after 2020 but also, in a major shift, federal funding across the entire Medicaid program would take the form of a block grant based on a capped grant per-enrollee. The AHCA would retain most of the ACA’s insurance regulation provisions, but would dilute them in various ways unfavourable to high-risk insurees, while providing some federal funding for state-based high-risk pooling arrangements. Generally, the effective dates of these provisions were spread over the 2016-2020 period, front-loading the tax cuts (indeed making the elimination of the taxes enforcing the mandates retroactive to December 31, 2015) and back-loading the changes related to subsidies and Medicaid. Finally, the bill contained a number of provisions for Republican signature items such as anti-abortion measures and liberalizing constraints on the use of health savings accounts.

Even so, the AHCA as introduced failed to find an optimal mix that could span the conservative and moderate wings of the Republican caucus. For the most conservative members, the bill retained too much of “Obamacare,” while more moderate members were disquieted by its implications for removing benefits and reducing federal funding to their home states. These concerns were augmented by widely-publicized Congressional Budget Office estimates of the resulting losses of insurance coverage and by public opinion polling finding widespread opposition to the bill. When more than thirty Republican representatives spanning the ideological spectrum of the caucus indicated that they would vote no, Ryan pulled the bill from a scheduled March 24 floor vote and embarked on a month-long process of closed negotiations with individuals and small-groups within the Republican caucus to build support.
Ryan brought an amended bill back to the House on May 4 and scheduled a vote the same day. For the conservatives, provisions have been added allowing a state to waive various insurance regulations if the state could demonstrate that it had alternative ways of insuring high-risk insurees. For the moderates, funding for state pools for high-risk insures was increased by $8 billion. Replicating the Democrats’ tactic of geographically targeting certain miscellaneous measures in order to build the legislative coalition for the original Affordable Care, the amended AHCA included a provision aimed at winning the support of wavering Republican representatives from upper New York state, preventing the state government from requiring any localities other than New York City to contribute to Medicaid funding – a tactic quickly tagged the “Buffalo Bribe.” These amendments barely succeeded in overcoming the unease of enough Republicans to achieve passage on a vote of 217-213, with no Democrat support and twenty Republicans opposed.

The Senate process was even more streamlined than that in the House. Majority Leader Mitch McConnell by-passed the committee process entirely, instead writing the legislation in his own office advised by a working group of thirteen senators including himself as chair, the three other senior members of the Republican Senate leadership, the chairs of the health, finance and budget committees and six other members. The ideological centre of gravity of the group was similar to that of the Senate Republican caucus as a whole, but the inclusion of two of the most conservative senators (Ted Cruz and Mike Lee) and the exclusion of the most moderate (Susan Collins and Lisa Murkowski) suggested that McConnell was seeking to deal with the conservative and moderate wings of his caucus by co-opting the former and counting on the reluctance of the latter to oppose legislation presented as a “necessary and inevitable” step toward moving on with the rest of the Republican agenda. In response to criticisms of the closed process McConnell announced that any senator who wished to drop in to a meeting of the group was welcome (rather similar to Ryan’s open invitation to House Republicans in February).
On June 22, McConnell made public the text of his proposed legislation, the Better Care Reconciliation Act, aiming to have it passed by June 30, before the Senate recessed for ten days. The BCRA was broadly similar to the House bill, but would retain the structure of premium tax credits in the Affordable Care Act, basing the subsidies on income and local costs of plans, but also adding an age factor and reducing both the generosity of the subsidies and their span along the income scale. The Senate bill would also allow greater flexibility for the states in insurance regulation.

McConnell’s bill met with a response similar to that which had initially greeted Ryan’s bill in the House: conservatives opposed it as too close to the Affordable Care Act model, and moderates worried about its impact on coverage, their concerns again fuelled by Congressional Budget Office estimates of its impact on coverage which were similar to those for the AHCA. Within days of the unveiling of the bill, at least eleven Republican senators expressed concerns about the bill, and the Senate recessed without acting on it. After the recess, McConnell brought back a revised discussion draft of the bill with two significant amendments. To respond to the concerns of moderates about the politically toxic implications of simultaneously cutting taxes for the wealthy and removing benefits from those on low incomes, the amendment left the Affordable Care Act taxes on upper incomes in place. For conservatives, the draft included an amendment from Senator Ted Cruz that would allow insurers to operate outside the regulated and subsidized marketplaces to offer much slimmer plans. Even so, four senators – two moderates, one centrist and one conservative – rejected that draft.

These Senate defections illustrated a fundamental risk with circling-the-wagons tactics: as noted by Weaver (1986, 389) they will work “only if near-unanimity can be maintained.” Each defection erodes the sense of inevitability and therefore increases the risk that more deflections will follow. But even with the growth in power of congressional party leadership in the US, congress and especially the Senate lack the party discipline necessary to enforce sanctions against defectors, which is much more characteristic of Westminster systems. Thus McConnell was facing a Catch-22: he needed to create a sense of inevitability to maintain unanimity, but unanimity was
necessary in order to maintain a sense of inevitability. To break out of this dilemma, he had to rely on conveying the “necessity” of passing the legislation in order to move on to the rest of the Republican agenda. He strove to get to a floor vote that would yield enough support to pass some legislation that would serve as the basis for further negotiation with the House at the conference stage, which would then return to both houses for passage as – to recall Weaver’s terms (2013, 6) – “the best deal that [was] achievable – and better than no deal at all.” He therefore announced that he would seek a vote on a motion to proceed with health care legislation, but for days it was unclear what that legislation would be. Matters were further complicated when the Senate parliamentarian ruled, as might have been expected, that thirteen provisions of the BCRA, including those relating to state waivers for insurance regulation, fell outside the rules of the reconciliation process and would require sixty votes for passage.

In this context McConnell adopted one last desperate tactic resulting in a veritable caricature of a mosaic strategy of rapid pace and piecemeal cobbling. He would use the House-passed American Health Care Act as a legislative shell, its contents to be revised and replaced on the Senate floor over twenty hours of debate, with the express goal of creating a bill that could attract a bare minimum winning coalition of fifty Republican senators with the vice-president casting a tie-breaking vote. That bill would then go to a conference with the House to create a final compromise that would return to each house for final passage, and clear the way for the rest of the Republican agenda.

McConnell barely won the vote on the motion to proceed with this order of business, 51-50 with the vice-president’s tie breaking vote. But that was all. The Better Care Reconciliation Act failed 43-57 on a procedural vote, attracting not even a simple majority let alone the sixty votes it required to proceed. The Obamacare Repeal and Reconciliation Act (legislation that had been passed in December 2015 by a Republican congress but vetoed by Obama) failed 45-55. Finally, the night before the final day of voting, McConnell presented a last-ditch eight-page Health Care Freedom Act. Dubbed a “skinny repeal,” it would have repealed only the penalties enforcing the mandates and
would have requiring, rather than simply permitting, the relevant federal agencies to approve state waivers for experimentation under conditions specified in the ACA. It also included a few Republican standbys such as banning payments to Planned Parenthood clinics for a year and liberalizing health savings accounts. With the express purpose of getting to a conference negotiation with the House, the Republican leadership announced its willingness to include whatever other provisions it would take to get to fifty votes. Accordingly, as one Republican senator put it, they began to work “down the laundry list of things we can agree on.”

The fatal flaw with this tactic was that, in order to agree to pass the bill as a vehicle to get to conference but not to have it become law, senators had to trust that the House would cooperate, and would not seize the opportunity to simply pass the bill and declare victory with some version of “repeal.” The House leadership expressed its desire to go to conference, but could not offer a guarantee. The bill then failed in the senate in a dramatic 51-49 vote.

No account of this episode would be complete without attention to perhaps the most dramatic difference between the process leading to the passage of the Affordable Care Act and that leading to the failure of its repeal: the role of the president. This stark difference bears out the Blumenthal and Morone (2010, 410) observation that “the first key to success” in US health care reform is the full commitment of the president. The contrast between Obama and Trump in this regard cannot be over-stated. The problem was not that health care was not central to Trump’s agenda: even more than Obama, Trump made health care policy (in his case the repeal of the Affordable Care Act) a signature campaign plank and his first, not second, legislative priority. The problem was in constancy of purpose and engagement. Obama made only one significant shift over the course of his campaign and early presidency: from opposing to supporting an individual mandate. Trump continued to vacillate, often within days, in advocating at least four different strategies: repealing the ACA outright; repealing the ACA and replacing it with an alternative simultaneously; letting the operation of Obamacare
marketplaces “implode” to drive Democrats to the negotiating table; or simply agreeing to sign whatever legislation the Republican congress could agree upon. He was particularly ineffective at the Senate stage – alternately cajoling, criticizing and threatening – although his hosting of a White House lunch for all Republican senators in mid-July paved the way for the final legislative push.

When the final push to Senate passage failed at the end of July, Trump invoked again the high-stakes demand that congress should not move on to any other legislative priorities until the repeal of the Affordable Care Act was accomplished. This time, however, Republican senators simply indicated in words and actions that they intended to move on. In the following days, key Republican and Democratic senators began to express openness to finding a bipartisan solution. Promising avenues included those aimed at stabilizing the marketplaces and allowing greater flexibility for adaptations at the state level. Lamar Alexander, the chair of the Senate Health, Education, Labour and Pensions committee, announced that he would begin hearings to this effect immediately after the August recess. In the House, a bipartisan group of about forty styling itself the “problem solving caucus,” also began to propose solutions that could attract support from both parties.

It would be an exquisite irony if health care, having in 1994 provided one milestone along the road of increasing polarization in congress in 1994, should provide another marking a turn in the opposite direction if the experiences of 2017 were to serve as a catharsis opening the way to bipartisanship. At the time of writing in August 2017 it is far too soon to make such a projection. Much will depend on the fate of the turbulent Trump presidency.

The strengths and vulnerabilities of mosaic strategies:

Each strategy type – big-bang, blueprint, incremental and mosaic – can be seen as having a characteristic set of implications for policy coherence, policy durability and political conflict. The greater degree and scope of large-scale policy redesigns may allow
for a greater complementarity among the elements of the resultant framework, and hence a greater coherence of the overall design. More coherent designs should prove more durable than more piecemeal reforms which can be attacked and dismantled by opponents one by one. (On the other hand, some elements of piecemeal reforms might survive precisely because they are decoupled from more controversial elements.) Fast-based reforms may also prove more durable, by being hard-wired into legislation up-front and hence less vulnerable to subsequent shifts in the political context than are slower-paced reforms. But a fast pace yields other dangers: by collapsing in time the veto points to be navigated, it may make for a greater degree of conflict than does a process of narrowing the scope of conflict at any given time. In the larger work from which this paper is drawn, I explore these hypothesized effects for each type of strategy. Here the focus will be on the mosaic form that has characterized the only two successful episodes of major policy change in American health care – as well as the unlikely case of the 2012 reforms to the English NHS, which will be treated here as a point of comparison.

If blueprint strategies seem to offer the best of both worlds – relatively low levels of political conflict and high levels of policy coherence – mosaic strategies seem to present the worst in both respects. Such strategies, followed in the United States in 2009–10 and in the United Kingdom in 2010–12, yielded incoherent pieces of legislation. In both cases provisions inserted before and during passage through the legislature added features that had relatively little to do with the goals of the reforms. Although the “three-layer cake” generated by the Johnson Medicare/Medicaid mosaic was a relatively more elegant result, even it was “a model of unintended consequences [that] … incorporated features that no one had fully foreseen” (Marmor 2000: 58-9).

In their attempts to incorporate numerous partisan and/or interested-based actors into a set of multiple piecemeal agreements, mosaic processes typically involve the sort of sprawling consultations exemplified by the committee processes through which the Affordable Care Act was developed in the United States. The
Medicare/Medicaid mosaic, though largely negotiated within the Democratic leadership, had to run the full legislative gamut (Marmor 2000: 45-61). Even in a Westminster system, the UK Coalition government was forced into an extraordinarily extended and open legislative process, including a “pause” mid-way for further public consultation, in order to pursue its mosaic strategy, sacrificing some speed as a result. And in an exception that proves the rule, the US Republican leadership’s attempt to rapidly cobble together a consensus sufficient to repeal the Affordable Care Act through a closed and tightly managed process ended in failure.

Furthermore, even while trading off policy coherence mosaic strategies appear to yield high levels of political conflict, as quintessentially demonstrated by the ACA and the Coalition reforms in Britain. Johnson’s Medicare/Medicaid mosaic strategy, while yielding a relatively more orderly result, was nonetheless also highly conflictual. Unlike the Affordable Care Act mosaic, the Medicare/Medicaid process deeply divided the Democratic Party, even as it attracted some Republican support. And although congressional negotiators incorporated a version of a proposal from the American Medical Association into the final design – as the Medicare Part B program of voluntary coverage for physicians’ services – they treated the AMA itself as a “nuisance” to be excluded from behind-the-scenes negotiations (Jacobs 1993: 200).

Finally, the vulnerability of mosaic strategies might depend in part on the pace of implementation. The Affordable Care Act (like the 2012 Health and Social Care Act mosaic in the England) allowed for phased implementation – extending beyond the life of the enacting Congress and the president’s first term. In theory such an attenuated implementation timetable could allow for the development of technological and other capacity before reforms come on-stream. This is one of the attractions of blueprint strategies, in which detailed designs and dates are not specified up-front. But the implementers of the ACA were not in blueprint territory: because the implementation dates were specified in the legislation, they were tied to a fixed timeline whether or not capacity development proceeded as anticipated, thus providing opportunities for
opponents to seize upon and exacerbate administrative problems. The Obama administration had to resort on more than twenty occasions between January 2013 and March 2015 to providing “significant” delays, extensions, exemptions, provisions for retroactive payments and other deviations from the strict provisions of the ACA in order to smooth its implementation (Redhead and Kinzer 2015). Much controversy and debate surrounded the question of whether at least some of these measures should have been accomplished through legislative rather than executive action, although there were precedents for considering them within the scope of administrative discretion (Jost and Lazarus 2014). In contrast, Lyndon Johnson had a general strategic aversion to allowing time for opponents to mobilize. He insisted on rapid implementation of the 1965 Medicare and Medicaid legislation – especially Medicare, which, as a federal program, did not require action at the state level – while making other compromises to ensure rapid implementation, including a very generous settlement regarding physicians’ remuneration.

As for durability, the cases of mosaic strategies reviewed here present a study in contrasts. The Obama and Coalition reforms both encountered turbulence in the implementation phase and virulent opposition from opposition parties who vowed to repeal the legislation if elected. As of this writing (August 2017) the Coalition reforms had not been through a partisan change in government. In the case of the Obama reforms, the 2016 election put the Republican opponents of Obamacare in place to carry out their threat to repeal and replace the legislation, at least in part. As predicted, however, the very institutional structures that so complicated the passage of the Affordable Care Act and resulted in a dizzyingly complex package of both interrelated and extraneous elements also made it fiendishly difficult to undo. Attempting their own mosaic strategy of making multiple changes to the ACA framework within their first seven months of unified control of government, the Republicans nonetheless could not find an internal consensus sufficient to succeed. Nonetheless, some significant adjustments to the ACA model, possibly on a bipartisan basis, appeared likely. The Medicare and Medicaid mosaic, in contrast, has stood the test of time. These two
programs did not encounter the turbulence and policy adjustments in the immediate implementation period that characterized the Obama and coalition mosaics. And they have not only persisted but expanded over time, in part because of demographic change, but also as a matter of deliberate policy choices.

These observations suggest some nuances for hypotheses about the implications of different strategies of policy change for the level of political conflict and the durability of policy frameworks. First, it appears that the level of conflict over the legislative politics of reform is driven less by the scale of changes than by their pace. A shorter timeframe exacerbates conflict by compressing veto points in time, and this is the case whether the scale of change involves sweeping institutional replacement or multiple, smaller-scale adjustments. In each case the reform touches most aspects of the system and can trigger opposition at any point. A compressed timeframe also means that changes in organizing principles implied by reforms, whether initially explicit in the case of large-scale reforms or implicit in the case of multiple, small-scale reforms, become clear early on, raising the ideational stakes. The British experience provides a dramatic illustration. Throughout the various phases of the unfolding of the logic of the internal market, initiated by the big bang of the Thatcher reforms, incrementally extended under Labour, and then accelerated by the coalition mosaic, the principles underlying the functional role of the state moved progressively from those of an owner-operator to those of a single payer of independent providers. But these phases were marked by very different politics. The two fast-paced phases were highly conflictual, whereas the incremental Labour phase was a “gradual, step by step process … providing little opportunity for a confrontation on the principles underlying the model that finally emerged” (Klein 2013: lcn 7143).

Consider as well the different ways in which an “individual mandate” to have health insurance was instituted in the Netherlands and the United States. In the relatively non-conflictual Dutch case, the move was signalled well before it was made, and the ground was gradually prepared. In the highly conflictual US case, the mandate
became an immediate flashpoint and the focus of a high-profile legal challenge. It must be granted, however, that this latter comparison is confounded by profound differences in the starting points for these processes. Furthermore not all fast-paced change is highly conflictual: Canada’s Parliament unanimously adopted physician services insurance at a time when both jurisdictional and partisan vetoes were muted. And although implementation encountered some resistance at the provincial level, within five years all provinces were participating in the federal framework, which became a settled feature of the policy landscape.

A second nuance has to do with the relationship between the internal coherence of comprehensive change and the durability of the resulting policy framework. The contrast between the Johnson and Obama mosaics in this respect is telling. Both focused on a relatively small segment of the private insurance market as well as on the indigent. In the Johnson case the small market segment was the elderly (ages sixty-five and older), representing about 7 per cent of the private insurance market at the time. The indigent target population for the Medicaid program comprised social assistance recipients who either had no coverage or relied on widely variable state plans. By focusing on covering those not in the workforce the two programs left intact arrangements for employer-based coverage and the norms of the private insurance industry. They thus had little impact on two major interests in the arena: employers and private insurers. [add something on payroll taxes here – built on SocSec.] It is true that Medicare and Medicaid potentially affected all physicians and hospitals, but the two programs essentially added another (public) payer to the mix of private payers to which those providers were accustomed, and those relationships with other payers were left alone. No grand accommodation, such as that binding the medical profession and the state into exclusive or near-exclusive relationships as in Canada and the United Kingdom, was brought about.

In contrast to this segmented mosaic, the Obama reforms made small adjustments that touched almost all actors in the health arena. Those reforms, too, were
aimed at covering a relatively small population segment: those uninsured or underinsured under either public programs or private insurance. But in so doing the reformers made multiple changes in three streams, each with different implementation dynamics (Béland, Rocco and Waddan 2016). They sought to regulate and structure the individual and small-group insurance market, to expand Medicaid, and to regulate the underwriting practices and profit margins of private insurers more broadly – in addition to many other provisions added to the legislation as the price of passage. The changes thus affected, at the margins, not only all providers of covered services, but all insurers and many employers. In this respect the Obama reforms were more similar to the Coalition reforms in England. Although the latter effectively accelerated changes already under way under the previous Labour government, the organizational changes required affected all purchasers and providers of NHS services. In both the Obama and Coalition cases, the inevitable collisions of unanticipated consequences of these multiple changes – including implicit shifts in organizing principles that had not been recognized or acknowledged at the outset – fuelled opposition in both the health care arena and the broader political system. And in each case the complexity, incoherence, and pervasiveness of the changes made it difficult for proponents to build support by communicating the overall purpose and intended benefits of the reforms.

The contrasts among these cases suggest some further hypotheses about the relationship between the complementarity of the elements of a policy framework and its durability. It might be that reforms will prove more durable either if they are products of large-scale big bang or blueprint strategies resulting in internally coherent policy designs or if they result from smaller-scale mosaic or incremental processes that yield segmented designs whose effects are relatively insulated from the broader arena. Policy frameworks resulting from mosaic strategies that involve multiple small adjustments across the policy arena are more vulnerable to unanticipated collisions of these effects. Our few cases are not sufficient to explore these hypotheses further, but they raise questions for further research.
These observations also suggest the need to explore further the relationship between the enactment and the implementation phases of major reforms. The former typically involves the dynamics of the broad political arena in windows of opportunity; the latter involves the subsequent dynamics of the targeted policy arena itself. Nonetheless the enactment phase has important implications for implementation. First, as I have just argued, the design of the policy framework as determined in the enactment period has important implications for durability. Second, the broad politics of the enactment period can persist after enactment, especially if the process was marked by a high level of political conflict. In such circumstances opponents might continue the battle by forming venue-seeking blocking coalitions, as experience with judicial challenges and state resistance to the Affordable Care Act quintessentially demonstrated. Third, the different strategic types offer different opportunities for, and establish different constraints on, the emergence of new actors who might take the reforms in unanticipated directions.

Conclusion and envoie:

This paper has offered a way of understanding patterns of policy change as the product of strategic political judgment. No one depiction of a political calculus such as the one presented here can capture the full nuance of the assumptive worlds of strategic decision-makers, in which policy and politics are intermingled. But such a calculus strongly conditions those worlds and colours the judgments that are made. In the “fog” of policymaking (pace Clausewitz) at the pinnacles of government, policymakers themselves may be hard put to tease out the relative importance of their various assumptions. On the evidence of the cases reviewed in this paper and the underlying book, it appears that an appreciation of political actors’ strategic assessments of their current and future positions is the best single clue to understanding the choices of scale and pace that they make – a parsimonious and powerful way of understanding similarities and differences across cases of political decision-making.
In the particular case of the US, the framework offered here sheds further light on why big-bang change is so rare American social policy. It has long been recognized that American political institutions, with their multiple independent platforms, provide purchase for the dense and varied interests that populate social policy arenas, and raise high bars to mobilizing the necessary authority to overcome the resulting proliferation of institutional veto points. Windows of opportunity for major, discontinuous change in social policy are therefore exceedingly rare. But what the argument of this paper adds is the recognition that even when a rare confluence of factors provides a set of political actors with the authority necessary to overcome vetoes, and creates a strong partisan incentive to use that authority to effect major social policy change – that is, even when a window of opportunity is open – it may still not be possible to make sweeping, comprehensive institutional change. Such big-bang change is not impossible, as the New Deal attests (although the economic cataclysm and partisan landslide that paved the way for that legislation were so extraordinary as to suggest that the New Deal may be the exception that proves the rule). But big-bang strategies are especially vulnerable in the US context to tactical errors such as not moving quickly enough to maintain a bandwagon momentum, as the 1993-94 Clinton episode suggests. What is more likely, even within an episode of discontinuous change, is that the need to rapidly navigate institutional veto points within the winning coalition will drive a strategy of multiple small-scale simultaneous adjustments to the prevailing framework – yielding yet another American mosaic.
While Streeck and Thelen emphasize the “obligatory” character of institutions, “third-party” mechanisms of collective enforcement other than the state characterize different types of institutions.

In the Netherlands, the essential features of modern health care state were established under the German occupation. Hence this “founding moment” is anomalous and is not treated here as a case.

Because the regional alliances would collect premium revenue and distribute it to insurers on a risk-adjusted basis, the CBO scored the revenues of the alliances as government receipts. Conversely, the risk-adjustment mechanism under the ACA envisaged transfers between insurers with lower-risk pools to insurers with higher-risk pools, which would net to zero. Because insurers would collect their own premium revenue, while the federal government’s involvement was only at the margin to administer the risk-adjustment transfers among insurers, the CBO considered the premium revenue to be private (Congressional Budget Office 1994, 2010).

This mix of assumptions is what Vickers called ”appreciative judgment,” (Vickers 1965), what Jacobs, following Denzau and North, calls the “mental models” of political actors (Denzau and North 1994, Jacobs 2011), what Hall calls “instrumental beliefs” (Hall 2010: 207-08) and what Marmor and Klein call “assumptive worlds” (Marmor and Klein 2013: 2).

Rare systems of single-party dominance in democratic states allow for the expectation of continuing influence, but such systems are marked by intra-party competition requiring party leaders to negotiate among factions with relatively independent power bases.

This is a version of the strategy of “political investment” described by Teles (2009).

See Boothe (2015) on the importance of the lack of such a set of “principled ideas” about the end-point of reform in understanding the limits that incremental strategies place on the scope of change.

The phrase was a reference to advice from Sam Rayburn, a former Democratic Speaker of the House whom Johnson considered a mentor (Blumenthal and Morone 2009: 14).

Indeed Reischauer would continue to make this case, arguing in 2013 for a larger-scale, slower-paced approach to health-care reform: "What you want to do is to design a decade or two-long
plan towards a different kind of delivery system supported by a different kind of payment system” (quoted in Masters 2013).

Unlike Clinton, Obama was able to gain clearance for including health care in the reconciliation instructions in the 2009 budget. It is nonetheless arguable that the actual execution of those instructions a year later was politically possible only because the passage of legislation under normal rules in both houses of Congress had already been accomplished.


The resolution passed 52–48 in the Senate. The vote in the House was 227–198, with no Democrats in support and 9 Republicans against (most of them to the left of the median House Republican); 5 Democrats and 5 Republicans did not vote.


Ryan himself described this process in a March 8 2017 media interview posted on his website, justifying the closed and truncated process on the grounds that the “Better Way” white paper itself had been developed through a process open to all members of the House Republican caucus and had formed part of the Republican 2016 election platform.

http://www.speaker.gov/general/regular-order-speaker-ryan-hugh-hewitt


Senator Pat Roberts, quoted in Caldwell 2017.

For a simplified timeline of these vacillating positions, see Graham (2017).

The election of May 2015 returned the Conservatives to power without their erstwhile junior coalition partners the Liberal Democrats. An election in June 2017 reduced the Conservative
government to a minority, supported by a “confidence and supply” agreement with the Democratic Unionist Party of Northern Ireland.

19 As I described in Chapters 6 and 8, although the Dutch had achieved near-universality in the absence of a mandate, the rate of uninsured in the United States stood at about 15 per cent of the population prior to the reforms. Furthermore, although both systems were largely employer-based, the boundary between employer-based group membership and citizenship in the Netherlands was blurred in a political culture in which social partners and the state occupy a “shared political space” (Crouch 1993: 50-63).
Figure 1: Ten Cases of Policy Change, 1945-2012, By Strategy Type Chosen within Window of Opportunity
Figure 2: Characteristics of Four Strategy Types

**BLUEPRINT**
- Consensus re overall schematic for end-point; elements to be enacted over timeframe exceeding mandate of initiating government
- New institutions supplant previous institutions; new organizing principles
- Typical where members of winning coalition have independent power bases and expect the balance of power to remain fairly stable – e.g. systems with established traditions of coalition government

**BIG-BANG**
- Large-scale change in a single comprehensive sweep.
- New institutions supplant previous institutions; new organizing principles
- Typical where actors have consolidated authority but face potential loss of power – e.g. Westminster system with competitive parties

**INCREMENTAL**
- Gradual piecemeal adjustments to existing institutional arrangements
- New institutions may co-exist with established; no new organizing principles
- Typical where members of winning coalition have independent power bases and at least some anticipate improvement of their position of influence in future – e.g. federal states, intra-party factionalism

**MOSAIC**
- Multiple simultaneous adjustments to existing institutional arrangements
- New institutions may co-exist with established; may or may not introduce new organizing principles
- Typical where members of winning coalition have independent power bases and at least some anticipate deterioration of their position of influence in future - e.g. supermajorities in veto-ridden systems; unstable coalitions
Figure 3: Party Strength, * House and Senate, 1933-2011

* number of seats X likelihood of party members voting with the majority of their party on “party unity” votes (50%+ of Democrats vs 50%+ of Republicans
(from Poole, Keith. Party Unity Scores for Democrat and Republican Members of Congresses 35-113 (1857-2014) Accessed August 3, 2017.)
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