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Race and the Politics of Health Reform: Antigovernment Opposition to National Health Insurance from the New Deal to the Affordable Care Act

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ABSTRACT

Intense opposition was mounted against the Affordable Care Act (ACA) before and after the law's passage. Antigovernment protests and rhetoric by a segment of conservative activists prompted debate in popular media and social psychological research on the role of race in shaping opposition to President Obama's health reform effort. Missing from these studies and media discourses is a socio-historical examination of the ways in which the politics of race shaped health reform debates and limited the involvement of the federal government in health care. This study relies upon historical case studies, legislative histories, and government and media reports to examine how race informed health reform debates and policy across three political economic periods: the New Deal Era, Postwar Years and Retrenchment Years. The analysis is guided by concepts of *interest convergence, institutional racism* and *colorblind* and *symbolic racism* derived from Critical Race Theory (CRT). CRT offered an alternative framework for examining the evolution of health care policy and antigovernment mobilization in response to efforts to achieve universal coverage.

Findings reveal that from the New Deal to the current era of social policy retrenchment, race has been a constant explicit or implicit consideration in health reform debates and the structure of health policy. During the New Deal and Postwar years, health and other social policies were specifically structured to maximize power at the local and state levels of government so as to maintain the race and class-based structures of the South. Major health care legislation such as the Hill-Burton Hospital Construction Act and Medicare/Medicaid were ushered through Congress by pro-segregation southern Democrats. Their passage can be described as a convergence of interests among elite stakeholders and southern legislators.

These and other key health policy legislation were intended to thwart efforts at achieving a universal national health insurance program. As a result of this convergence, however, African Americans experienced improved access to health care even though some of these policies inevitably reproduced racial inequities in access to health care.

Results also show that anti-communist and anti-socialist rhetoric served as a vehicle for expressing opposition to the expansion of federal authority in health care during all three political economic periods. This rhetoric often carried a subtext of race. In the post-civil rights context of the Retrenchment Years, notions of symbolic and colorblind racism were embedded in the antigovernment rhetoric expressed by prominent conservative leaders in their opposition to the health reform efforts of Presidents Clinton and Obama. During the Obama administration, antigovernment opposition was sustained by new media and mobilization of conservative activists through organizations (e.g., Tea Party, FreedomWorks) funded by wealthy donors.

This study also highlights the involvement of African American organizations in an effort to link the quest for national health insurance to the continuous civil rights struggle against systemic racism in health care access and services. The findings from this research demonstrate that the interaction of race the politics of health reform has deep historical linkages that continue to shape current debates about the role of federal government in health care. The historical patterns identified in this work suggest that racialized strains of antigovernment opposition will continue to constrain health policy and limit efforts to create a more inclusive and just health care system.

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INTRODUCTION

As early as the turn of the 20th century, social reformers argued for a system of health insurance that provided protection against the economic costs of illness (Starr 1984; Beatrix 2003). Ensuring equitable access to health care for racial and ethnic minorities would later become a central concern for health care advocates who saw universal coverage as a pathway to reducing racial health disparities (Thomas 2011). Despite periods of intense activism, presidential leadership and passage of the landmark Patient Protection and Affordable Care Act (ACA) in 2010, the U.S. remains the only industrialized nation without a universal health care program.

Several factors have been offered to explain the lack of universal health care in the U.S. These include a relatively weak labor or class-based movement (Navarro 2003), interest group politics (Quadagno 2005), public opinion (Jacobs 1993), antistatism (Skocpol 1997; Quadagno and Street 2005) and past policy choices/path dependencies (Mayes 2005). Given the subtle but substantial and persistent interface of racial inequality with all of these explanations, one might expect that race may, at least partially, explain the structuring of health services in the U.S. While a strong body of literature has demonstrated that race influences the development and administration of social welfare programs (Piven and Cloward 1992; Quadagno 1994; Lieberman 1998; Keiser et al. 2004), the interplay of racial politics and health policy remains a largely unstudied area of research on race and the welfare state. Few scholars have explored how racial politics contributed to the nation's inability to achieve government-sponsored universal health coverage.

The ACA marks a major breakthrough in the long history of attempts, usually led by Democratic presidents, to pass large-scale health reform. Franklin D. Roosevelt first sought to implement national health insurance as part of Social Security legislation in the 1930s. After several failed attempts to pass national health insurance legislation in the 1940s, Democrats embraced an incremental approach to expanding access to health care. Incrementalism secured Medicare, a universal program for seniors, and Medicaid for certain segments of the low-income population. The last major attempt to achieve large-scale reform occurred under Bill Clinton and was handily defeated by Republicans, leaving many reformers once again disillusioned by the inability to achieve some form of universal health care (Starr 1995).

Based on the existing system of private and employer-based coverage, the ACA instituted new market reforms that expand health insurance coverage to more individuals and families. As of January 2014, individuals who are not covered through employer-based plans or public programs must obtain coverage through state-based health insurance exchanges created as result of the law. The law prohibits insurers from discriminating on the basis of pre-existing conditions and eliminates lifetime caps on coverage. The ACA also includes an individual mandate which requires citizens (and some legal residents) who can afford health insurance to purchase coverage or pay a financial penalty. Individuals and families with incomes between 133-400% of the federal poverty level are eligible for subsidies that reduce out-of-pocket costs for plans purchased on the exchanges (Kaiser Family Foundation 2011).

The ACA includes a number of provisions to address racial disparities, including funding to support community health clinics, workforce diversity and improvements in the collection and monitoring of data on race and ethnicity. An important part of this effort includes

expansion of the Medicaid program. Jointly funded by the federal government and states, Medicaid was initially designed to cover medical expenses as an extension of public assistance for vulnerable populations including the aged, blind, and dependent children (Rowland 2006). Since then, Medicaid has been expanded to include low-income pregnant women, parents with dependent children, and people with disabilities (Families USA 2011). States set the income level required for eligibility; however, the ACA as it was originally written expanded eligibility to all Americans under age 65 with individual or family incomes below 133% of the federal poverty level. The federal government is responsible for the cost of the expansion at 100 percent the first three years and a minimum of 90 percent thereafter. The ACA included a provision that required states to implement the expansion as a condition for receiving existing federal Medicaid funds. Republican state attorneys general and the National Federation for Independent Businesses challenged the constitutionality of the individual mandate and Medicaid expansion in the Supreme Court in 2012. While the Court upheld the mandate, it ruled that the ACA's Medicaid expansion provision was coercive. As a result of the Court's decision, states can now voluntary choose to implement the Medicaid expansion. Despite the financial incentives and benefits to their residents, Republican-led state legislatures and governors have largely rejected the Medicaid expansion and have chosen to allow the federal government to create their states' exchanges. Most of these states are concentrated in the South and have among the highest proportions of uninsured individuals and African Americans who would qualify for Medicaid (Kaiser Family Foundation 2013). The contretemps between the Democratic government and Republican state leadership, along with continued national

debate, suggest that several years after becoming the law of the land the ACA remains highly contested.

The political battle over the ACA, like previous health insurance debates, was sharply drawn along ideological lines; however, the racially-tinged protests and rhetoric led by some opponents, including the antigovernment and fiscally conservative Tea Party movement (NAACP 2010; Beck 2010; Washington 2010), emerged in a unique moment in American political history. The ACA was championed and enacted by Barack Obama, the nation's first black president. The framing of Obama and his policies as "socialist" has been a constant theme throughout his presidency and candidacy for the office. With scant evidence to support their claims, opponents constructed a narrative of President Obama as a radical Muslim driven by an agenda to redistribute wealth to African Americans. Given this broader narrative, it is not surprising that the health care law would be referred to as "reparations" and a "big government," "socialist" takeover of health care (Beck 2010; Limbaugh 2010). The ACA and the effort to pass it provided a tangible symbol of the economic and racial anxieties inherent in these claims. The sense that the country is in the midst of a racial backlash in response to an African American president, the changing demographic makeup of the country due to immigration, and persistent economic insecurity well after the 2007-2009 Great Recession has been widely discussed by the media and political observers. A small number of studies have examined this issue in the context of the debate on the ACA. Findings suggest that racial resentment (Hetherington and Weiler 2009) and the harboring of anti-black stereotypes account for some of the public's opposition to President Obama's health care plan and policies overall (Tesler 2012).

Missing from these studies and media discourses is a historical examination of the ways in which health reform efforts interacted with the politics of the South and antigovernment sentiment fueled by racial hostility. As Lieberman (1998), Williams (2003) and Katznelson and colleagues (1993) have shown, American welfare policy, beginning with the New Deal, was strongly influenced by efforts to limit federal government involvement in social provision in order to maintain the supply of cheap labor and the racial status quo in the South. Southern Democrats exercised their power in Congress to uphold the racial and class-based structures in the region through policy arrangements that excluded and marginalized blacks. These arrangements continue to underlie social policymaking today. Despite frequent commentary and reporting on some elements of the movement's use of racially offensive rhetoric and signs, the Tea Party's rise to national prominence in August of 2009, during the health reform debate, has not been fully examined in the context of long-standing conservative opposition to federal involvement in health care—which has also had a clear racial component (Thomas 2011; Beardsley 1989). Together, these issues present a set of questions worthy of sociological analysis. More broadly, they suggest that the racial structure of American society may have limited the possibilities of national health insurance.

Addressing these questions through a historical-sociological lens may shed light on how and why government programs such as the Affordable Care Act evoke oppositional responses that constrain social policy and limit efforts to create a more inclusive and just social safety net. Examining the overt and subtle ways that race underpins the struggle for universal health care may help fully explain the social and political processes that shape policymaking and public opinion during critical junctures in American health care policy. By analyzing the influence of

race on national health care debates, this study seeks to contribute to the literature in this area by presenting an alternative narrative on why universal health coverage remains elusive. Through the analysis of historical processes, this study may provide reformers and policymakers a greater understanding of how and why race remains a salient factor in social policy debates.

Statement of the Problem

The purpose of this study is to explore the role of race in shaping health reform debates and policy. Guided by critical race theory (CRT), this study examines the relationships among shifts in the political economy (with a focus on the racial characteristics of society) and efforts to expand federal government involvement in health care. The interaction of these dynamics is examined across three political economic periods. For the purposes of this study, political economy is broadly defined as the economic, social and political context in which health care debates and policymaking occur. This delineation is a modified version of Minkler and colleagues' (1994) definition of the political economy of health. As an analytical tool, the political economy framework pays "special attention to the expanding and contracting of the economy, and the conflicts and tensions among groups and classes in the larger society."

The first political economic period examined in this study spans the years between 1929 and 1944. This span of time was marked by economic decline because of the Great Depression, the expansion of the welfare state through New Deal social insurance policies, and the racial subjugation of blacks through Jim Crow segregation. The second period, 1945-1965, is marked by the Post-World War II economic expansion that made the civil rights movement and Great Society health programs possible. The third political economic period, 1993-2013, is

characterized by economic decline, a retrenchment of the welfare state, and an evolving post-civil rights politics. The policy debates and programs that will be the focus of this study are outlined below.

1. **Period I: 1929-1944 - The Great Depression & New Deal Era**
    a. New Deal Policies and Health Programs
    b. Wagner National Health Bill
    c. Wagner-Dingell-Murray National Health Insurance Bill (1943)
2. **Period II: 1945-1965 - Post World War II Economic Boom**
    a. Wagner-Dingell-Murray National Health Insurance Bills (1945-9)
    b. Medicare and Medicaid
3. **Period III: 1993 to 2013 – General Economic Decline**
    a. Health Security Act
    b. Patient Protection and Affordable Care Act

The political economic periods and corresponding polices under investigation were selected based on their significance in the literature and the increased possibility for achieving some form of universal health coverage with a Democratic president and liberal majorities in Congress. Health systems, as Mayes (2004:2) has noted, "reflect the political and social circumstances of historical periods." Therefore, examining health policy in the manner proposed promises to yield important insights about the context in which social welfare policies are debated and developed. Analyzing debates and policies can also reveal much about a society and its power arrangements. While the periods outlined for this study are part of a historical line of struggle and change, they are not mutually exclusive; they provide an analytical

framework for examining established as well as evolving economic, social, and political characteristics of American society, and their relationship to health policy development.

For this study, the economic factors under examination include employment and the affordability and costs of health care. Political factors of interest are presidential leadership, Congressional action to block or limit the scope of national health insurance proposals, advocacy efforts among civil rights, labor and pro-reform coalitions and organizations, and oppositional strategies (e.g., antigovernment rhetoric and protests) employed by interest groups and political elites (e.g., Members of Congress, think tanks, media commentators). Social characteristics include the public's opinions with regard to welfare and government health insurance, as well as the nature of race relations. The study's research questions are presented below.

Research Questions and Definitions

1. What role, if any, did racial politics play in shaping health reform debates and policy during the period of economic contraction, racial segregation and New Deal social reforms (1929-1944)?

2. What role, if any, did racial politics play in shaping health reform debates and policy during the post-World War II period of economic prosperity and expansion of the welfare state and civil rights era (1945-1965)?

3. What role, if any, did racial politics play in shaping health reform debates and policy during the period of economic decline, retrenchment of the welfare state and post-civil rights politics (1993-2013)?

Racial politics in this study is defined according to Lieberman's (1998:7) discussion of the role of race in American politics. Racial politics is therefore defined in this study as "racially structured power arrangements—class conflicts, party coalitions, political institutions, and the

like whose characters are shaped by racial distinction—that produce public policy" and other political phenomena (e.g., discourse, protests).

This study primarily focuses on national health insurance, which was debated during the New Deal and Postwar years. *National health insurance* is a form of universal insurance program in which the government is the single payer. Financing for the program is based on a payroll tax. Under this system, health care is provided by the government (e.g., U.K. system) or private entities (Canadian system) (Reid 2010). The national health insurance bills debated in the U.S. were based on the later. The Clinton and Obama health reform debates are discussed as examples of the evolution of the larger debate over the role of the federal government in health care.

Scope of Study

No single factor is wholly responsible for shaping the formation of U.S. welfare policy. Therefore, it is important to set the parameters of this study to avoid the misinterpretation of its findings. Scholars argue that different factors should be considered in explaining and understanding the unique character of health care organization and financing in the U.S. Several previously outlined explanations ranging from the individualistic nature of American society to the power of interest groups have provided important insight on the processes that shape health care policy. Race, class, gender and regional differences also play significant roles in shaping the terms of debate and policy preferences. These distinctions of difference are linked to power relations that arise from economic, political and social processes that evolve across time. In the current study, attention is given to the ways that many of these variables

interact and influence health care policy; however, the nature of research requires the setting of parameters for practical and analytical purposes. Thus, the present study focuses on the ways in which race influenced key health reform efforts from 1929 to 2013 and contributed to the inequitable structure of health care in the U.S.

Significance of the Study

This study holds theoretical and practical significance. Its theoretical significance lies in its use of critical race theory to examine the politics of universal health coverage in the U.S. To date, the influence of racial politics in this domain remains understudied. Scholars have sought to explain the inability to secure national health insurance or other forms of universal coverage by focusing on the role of interest groups including health care, labor and business organizations (Skocpol 1997; Gottschalk 1999; Gordon 2003; Quadagno 2005; Quadagno 2011) and path dependencies that limit options primarily to private, tax-subsidized employer-based coverage (Mayes 2004). Others have examined the influence of political ideology (Farrow 2007) and institutional arrangements including federalism and the two-party system (Maioni 1997). Still, others have chosen to focus on public opinion (Jacobs 1993) and antistatism or antigovernment mobilization (Skocpol 1997). Only a limited number of studies mention race as a possible factor that has limited the prospects of national health insurance (Boychuk 2008; Gordon 2003). In sum, however, race is not given sufficient attention in the health policy literature despite indications that racial politics, in addition to the other factors listed above, separately and collectively, shape debates about federal involvement in health care.

Although exploratory, this study fills a gap in the theoretical approaches used to understand national health insurance policymaking in the U.S. The use of CRT as a guiding theoretical framework promises to increase our understanding of the historical and ongoing significance of race in policymaking, especially as it relates to social welfare programs such as the ACA. By locating the analysis of racial politics within periods of economic decline and expansion, this study seeks to add to the understanding of the ways in which social policy discourse and policymaking have paralleled shifts in the political economy and hindered the establishment of a government-funded national health insurance program. In the current period of economic decline, retrenchment of the welfare state and increased racial hostility, this study may contribute to the theoretical conceptualization of processes (e.g., racialization of universal programs, antigovernment mobilization) and discourses (e.g., arguments in support of individualism, meritocracy and market-based justice) that are likely to emerge in response to new government programs.

The *Practical Significance* of this study is in its potential to provide insight on how racial politics constrain health policy and policymaking in the U.S. The present research is useful and unique in that it examines the social, political and economic contexts of health reform debates, especially as they relate to the state of race relations over time. This study may illustrate how social policies become racialized. Findings may help scholars, policymakers and activists better understand the root causes of resistance to an expanded role for the federal government in health care administration and provide insight on how to frame future programs in light of this historical information. This study also introduces and analyzes historical data in an effort to link the struggle for national health insurance to civil rights. Finally, the study may help illuminate

how antigovernment mobilization can hinder efforts to address disparities in health, income, education, and other important areas. Understanding the factors that underlie hostility and resistance to large-scale government initiatives may inform advocacy and policy efforts that seek to dismantle structural barriers to equity and improve conditions for all Americans.