The War over America's Health Care:

An Application of the Advocacy Coalition Framework to the Affordable Care Act

By

Mofenyi Kgotso Mofulatsi

Thesis presented in fulfilment of the requirements for the degree of Master of Arts (Political Science) in the Faculty of Arts and Social Sciences at Stellenbosch University

Supervisor: Prof. P.P. Fourie

Co-supervisor: Dr U.L. Adams

March 2023

Declaration

By the submission of this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly stated otherwise), that reproduction and publication thereof by Stellenbosch University will not infringe any third-party rights, and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Mofenyi Kgotso Mofulatsi

ABSTRACT

Health care in the United States has been, and continues to be, a contentious issue since the beginning of the 20th century. European nations instituted their own social health insurance programmes in the late 19th and early 20th centuries; following suit, individuals and organisations in the US have sought to institute national health insurance that fits the American political and cultural contexts which are based on limited government and a free-market economy. However, powerful interest groups have stood in strong opposition to their efforts. Indeed, attempts to pass health reform and institute national health insurance were evident throughout the 20th century; but were often met with strong opposition and charged political rhetoric, labelling these efforts as fundamental betrayals of America's values and beliefs. Though the US has to date only instituted public health insurance programmes specifically for senior citizens and the indigent population, the US continues to spend more on health care than any other industrialised nation; yet it produces poorer health care outcomes than peer nations do. The US has attempted to correct flaws in the system, but each attempt has been met with charged political rhetoric, questions surrounding government's role in health care, and input from interest groups which have muddied the health reform waters. In view of this, the student attempted to understand who have played significant roles in the state of US health policy reform and how this has occurred. To answer this question, the study utilised the elements of the Advocacy Coalition Framework (ACF) to identify these actors and the resulting advocacy coalitions. The student followed a qualitative research approach and surveyed available literature on health reform to identify actors who have featured most prominently in the health reform debate during and after the implementation of the case study law: the Affordable Care Act (ACA); as well as to identify their beliefs. These actors coalesce around their beliefs to form advocacy coalitions, which compete with one another to translate these beliefs into policy. The research findings confirm the complexity and multi-faceted nature of the US health care policy-making arena. Identified actors and the resulting advocacy coalitions have actively competed to translate their beliefs into policy; however, their policy positions have been influenced by the political and societal contexts of the US. Actors either leveraged the political and societal contexts for their benefit or had to amend or limit their proposed policies to fit these contexts. Lobbying has continued to hold significant sway over health care policymaking, despite elected officials' mandates, leaving interest groups in a privileged position in the policy process.

OPSOMMING

Gesondheidsorg in die Verenigde State was, en is steeds, ’n omstrede kwessie sedert die begin van die 20ste eeu. Europese nasies het in die laat 19de en vroeë 20ste eeue hul eie sosiale gesondheidsversekeringsprogramme ingestel; individue en organisasies in die VSA het daarna gepoog om nasionale gesondheidsversekering in te stel wat pas by die Amerikaanse politieke en kulturele kontekste gebaseer op beperkte regering en ’n vryemarkekonomie. Magtige belangegroepe het egter sterk teen hul pogings gestaan. Alhoewel pogings tot gesondheidshervorming en nasionale gesondheidsversekering deur die 20ste eeu duidelik was, het die pogings dikwels opposisie een gelaaide politieke retoriek teëgekom. Hierdie retoriek beskou so 'n hervorming as verraad van Amerika se fundementele waardes. Die VSA het tot dusver net openbare gesondheidsversekeringsprogramme spesifiek vir senior burgers en die hulpbehoewende bevolking ingestel, maar bestee steeds meer aan gesondheidsorg in vergelyking met enige ander geïndustrialiseerde nasie; tog lewer hul swakker gesondheidsorguitkomste as eweknielande. Die nasie het probeer om foute in die stelsel reg te stel, maar elke poging is ontmoet met gelaaide politieke retoriek, vrae oor die regering se rol in gesondheidsorg, en insette van belangegroepe wat die waters vir gesondheidshervorming vertroebel het. In die lig hiervan het die student gepoog om te verstaan wie ’n belangrike rol gespeel het in die toestand van die Amerikaanse gesondheidsbeleidshervorming en hoe dit plaasgevind het. Om hierdie vraag te beantwoord, het die studie elemente van die ACF gebruik om hierdie akteurs en hul gevolglike voorspraakkoalisies te identifiseer. Die student het ’n kwalitatiewe navorsingsbenadering gevolg en beskikbare literatuur oor gesondheidshervorming ondersoek om akteurs te identifiseer wat die prominentste in die gesondheidshervormingsdebat tydens en na die implementering van die gevallestudiewet verskyn het: die Wet op Bekostigbare Sorg (ACA); asook om hul oortuigings te identifiseer. Die komplekse en veelsydige aard van die arena waarin Amerikanse gesondheidsorgbeleide bepaal word, word deur die navorsing bevestig. Die akteurs wat hier betrokke is vorm voorspraakkoalisies rondom hulle oortuigings, wat op hul beurt met mekaar kompeteer om politieke beleide te bepaal. Hulle standpunte is egter deur die sosio-politieke konteks van die VSA beïnvloed. Hulle het òf die konteks ten gunste van hul eie belange gebruik òf hulle moes hulle beleid voorstelle by hierdie konteks aanpas. Dus het lobbyiste steeds ’n beduidende invloed op gesondheidsorgbeleide, ten spyte van staatsamptenare se beloftes. Dit beteken dat belangegroepe steeds in ’n bevoorregte posisie is in terme van die beleidsproses.

ACKNOWLEDGEMENTS

Firstly, I would like to take this opportunity to express my greatest gratitude to my supervisors, Prof. Pieter Fourie and Dr Ubanesia Adams for enabling me to satisfy my childhood curiosity in US health reform and for providing a guiding hand in public policy analysis, an unchartered academic field for me. Thank you for your patience and belief in me throughout the last two years and particularly within this year as I balanced full-time work and masters.

Secondly, I would like to thank Cenfri for providing the financial support to pursue my masters. All of this would have not been possible without your support.

Thirdly, to my family, thank you for your love and relentless support. I am grateful for your belief in me, your encouragement, and the prayers you offered that helped see me through this journey.

To my friends in Potchefstroom and Stellenbosch. Thank you for your love towards me and for pushing me to get this thesis done. Thank you for listening to me in my lowest and highest moments during this thesis and holding me accountable in completing it.

Lastly, and *above all*, I would like to thank my Lord and God for his gracious hand in enabling me to complete this thesis. You have seen me through in my most trying times and you have given me your strength in my weakness. For from you and to you are all things (Romans 11:36).

TABLE OF CONTENTS

LIST OF ACRONYMS AND ABBREVIATIONS

AALL	American Association for Labor Legislation
ACA	Affordable Care Act
ACF	Advocacy Coalition Framework
AdvaMed	Advanced Medical Technology Association
AFL-CIO	American Federation of Labor and Congress of Industrial Organizations
AFSCME	American Federation of State, County, and Municipal Employees
AHA	American Hospital Association
AHIP	America's Health Insurance Plans
AMA	American Medical Association
CCS	Crippled Children Services
CEOs	Chief Operating Officers
CES	Committee on Economic Security
CHIP	Children's Health Insurance Programme
CHIP	Comprehensive Health Insurance Plan
EU	European Union
FDR	Franklin Delano Roosevelt
GDP	Gross Domestic Product
GOP	Grand Old Party
HCAN	Health Care for America Now
HCCU	Health Coverage Coalition for the Uninsured
HEART	Health Equity and Access Reform Today

HIAA	Health Insurance Association of America
HIE	Health Insurance Exchange
H.R.	House Resolution
ILO	International Labour Organization
IRS	Internal Revenue Service
MA	Medicare Advantage
MAA	Medical Assistance for the Aged
MMA	Medicare Prescription Drug, Improvement, and Modernization Act
NAACP	National Association for the Advancement of Colored People
NFIB	National Federation of Independent Business
NHE	National Health Expenditure
OECD	Organisation for Economic Cooperation and Development
OPEC	Organisation of the Petroleum Exporting Countries
PAC	Political Action Committee
PHCE	Personal Health Care Expenditure
PhRMA	Pharmaceutical Research and Manufacturers of America
RSPs	Relatively Stable Parameters
SEIU	Service Employees International Union
SSA	Social Security Act
US	United States
USSR	Union of Soviet Socialist Republics

LIST OF FIGURES

Chapter 1: Introduction

1.1 Introduction

Health care, in particular health insurance, is and has always been a contentious issue in the United States (US) dating back to the beginning of the Progressive Era in the US under Theodore Roosevelt's presidency (Ubokudom, 2012: 236). Since the mid-20th century, the US has adopted a myriad of policies that have approached a national health insurance but still fall short in providing coverage to all its citizens. In that process, health care costs have escalated to historic levels, inefficiencies have remained prevalent in the system, and access and coverage have remained inadequate for many Americans. With the above noted, further polarisation and partisanship have been observed as the nation seeks to reform its health care system, with various stakeholders and advocacy groups vying to effect change in it. By means of this thesis, the student will seek to determine which actors have had the most influence on the current state of American health care, focusing mainly on the Patient Protection and Affordable Care Act (ACA) by utilising the Advocacy Coalition Framework.

1.2 Background of study

Figure 1 below provides an oversimplified timeline of the key events and legislation in American health reform. These arose from efforts to institute national health insurance at the start of the 20th century.

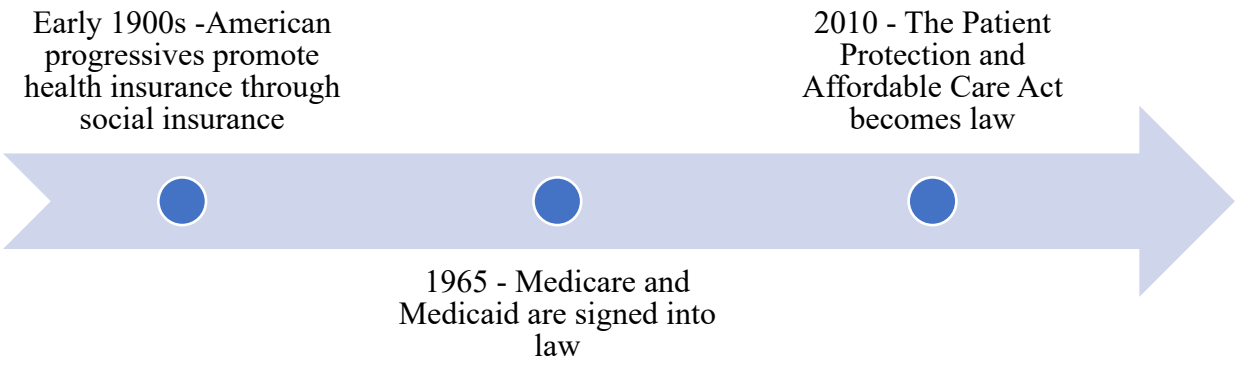


Figure 1: Oversimplified timeline of key events and legislation in US Health Reform.

Author's own adapted from (Kaiser, 2011)

During the late 19th and 20th centuries, several major European nations began to implement health insurance programmes aimed at assisting industrial workers. This occurred at a time when the region adopted several programmes which ensured unemployment compensation, senior citizen pensions, and industrial accidental insurance, in response to a decline in industrial activity and its fallout. However, in the US, any publicly financed health insurance programme which was promoted did not materialise. The interest group, American Medical Association (AMA), opposed any federally financed health insurance. The AMA had exploited the ideological tensions induced by the Cold War by coining the term "socialized medicine" for any proposed government health insurance program. With the 's failure to enact nationwide health insurance, the US moved to a primarily employment-based private health insurance which today follows a hybrid system of private and public health insurance (Starr, 2011: 2; Camillo, 2016:151).

Despite the resistance to national health insurance and the domination of employment-based health insurance, under the Johnson administration of the 1960s, the US adopted Medicare, a public health insurance programme specifically targeted at senior citizens, which built on the framework of Franklin Roosevelt's Social Security. Paul Starr states:

> No other country [had] created a separate health insurance system for the elderly: it is a peculiar American invention, established without a full appreciation of its political implications. (2011: 2).

Indeed, the creation of Medicare and Medicaid, a subsidised Federal-State partnership health insurance programme for the poor, had significant political implications and would give rise to a growing desire for nationalised health insurance amid the rise in health care costs and challenges in access to health care. Despite Medicare and Medicaid's implementation, many Americans remained uninsured, and the number continued to rise, further exacerbated by the rise in health care costs. Furthermore, small businesses struggled to provide their employees' health coverage. Self-employed workers and those who were not covered by their employers also found it difficult to obtain affordable health coverage from the individual insurance market (Antos and Rivlin, 2019: 4).

American health care expenditure ballooned from 6.9% to 17.7% of Gross Domestic Product (GDP) between 1970 and 2019, (Kamal et. al., 2020). This is in stark contrast to the average of only 8.8% of GDP in similarly wealthy democratic states (OECD, 2020). Median income growth stagnated while health care costs continued to rise. Consequently, more Americans fell out of

insurance due to its unaffordability. With more Americans falling out of private insurance, demand for publicly available programmes such as Medicare and Medicaid rose. Though these programmes are cheaper than private health insurance, the American people pay more for them in taxes than citizens of states providing universal insurance (Starr, 2011: 14).

The Commonwealth Fund, a think tank focused on the promotion of universal coverage, relegated the US health care system to the lowest position among all industrialised nations in terms of efficiency, equity, and health outcomes. Furthermore, US health care quality dropped to last place among 11 wealthy nations, despite having the most expensive health care system per capita (Manchikanti et. al., 2017: 113).

In response to the rise in uninsured Americans and the cost of health care, the Obama administration in 2009 stressed the importance of passing health care reform that sought to ensure that coverage would become more affordable and accessible. This period was marked by high levels of politicisation and polarisation of health care. Charged rhetoric was utilised in response, describing the ambition of the administration as "socialism", rationing", and a "government take-over of the health care system" (Ubokudom, 2012: 247). Despite the political rancour, health care reform passed successfully, albeit along partisan lines. This is in contrast to the greater bipartisanship witnessed when Medicare passed in 1965, further highlighting increased polarisation in the country (Hare and Poole, 2014: 422). The Patient Protection and Affordable Care Act (ACA), otherwise known as Obamacare, was signed into law in 2010 having the following goals: ensuring (1) a reduction in health care costs, (2) improved quality of health care, and (3) the increase in the number of Americans insured (Manchikanti, et. al., 2017: 111-112).

The ACA did manage to increase the number of individuals insured; however, it had mixed results in reducing health care spending, which was one of its stated goals (Branning & Vater, 2016: 1). At the same time, the ACA appears to have had little impact on easing the complexity of the health care system, which in turn has not improved care but has rather added to the regulatory burden health facilities have had to bear. According to the American Hospital Association (AHA), health systems, hospitals, and post-acute care providers have had to comply with 619 discrete regulatory requirements. To ensure compliance, they have collectively had to spend $39 billion per year which equates to an average cost of $1,200 per patient admitted or $47,000 per hospital bed per year. Lastly, the AHA has also noted that fraud and abuse requirements have not been updated to

support new models of care within the system (AHA, 2017: 3-5). Therefore, the ACA and updates to Medicare and Medicaid laws have had mixed results in addressing the significant complexities in the health care system, which in turn raises costs as well as inadvertently compromising on quality.

Brown (2010: 155) states that the public health profession has always seen itself as above politics. He further states that the public health profession rarely recognizes that its work is "pervasively political". Cooper et al. (2020: 2) expose the politics involved in health care spending by discussing how members of Congress obtained benefits from health interest groups in return for their votes on health legislation. They also illustrate how lobbying and political dynamics allow provisions which raise health spending to be included in laws and become entrenched in policy. Nevertheless Schechter (2017) notes that economists and other experts have not sufficiently investigated the link between politics and the US's health system. This study explores how politics has influenced the US health system by examining how political beliefs have influenced the most recent US Health Care legislation, the ACA.

1.3 The research problem and question

The United States in the contemporary era has been marked by increased polarisation and division not seen since the Civil War era. Increased partisanship and advocacy have been observed in every major policy area — health care has been no exception (Hare and Poole, 2014: 411). Health care has continually been a point of contention in the political arena, dating back to the start of the Progressive Era under Theodore Roosevelt (Ubokudom, 2012: 236). The US spends approximately 17% of its Gross Domestic Product on health care, the most of any industrialised nation. At the same time, it continues to offer inferior health care, in stark contrast to its peers (Kamal et. al. 2020; Manchikanti et. al., 2017: 113). Major health care programmes such as Medicare and Medicaid continue to contribute significantly to the national deficit and subsequently the US's public debt (McBride and Siripurapu, 2021). Indeed, on 9 September 2009, former President Obama, in his address to Congress on health care reform, stated that "our health care problem is our deficit problem" (Obama, 2009). The US has continually attempted to correct flaws in its health care system, whether they be cost, access, or quality for its citizens. However, each attempt at correction has been met by charged political rhetoric, questions on the role of government in health care, and input from interest groups which have muddied the waters on health reform.

Therefore, in the light of the above, the study addresses the following research question:

> Which actors have played a significant role in the current state of US Health reform – and how?

Considering the above research problem and question the study seeks to contribute to the discussion on understanding the extent to which US's democratic institutions and its policy decisions represent the beliefs and preferences of the electorate as well as contribute to the literature on US political polarisation[1].

1.4 Theoretical framework

Health policy analysis has been known to be useful "retrospectively and prospectively to understand past policy failures and successes and to plan for future policy implementation" (Walt et al., 2008: 308). Walt et al. (2008: 309) further state that the field of health policy analysis often seeks to answer the question of "what happened" rather than seeking to answer, "what explains what happened". The health care debate in the US has been marred by partisanship, zealous political rancour, and gridlock — all of which have reached fever pitch in contemporary times. As mentioned in the above rationale, lobbying carried out by various interest groups has had a significant impact on the nature of health care in the US. Despite the bitter polarisation, and vigorously debated successes and failures of the US's health care system, the system has remained relatively stable, with the only significant health care policy change found in the ACA which was passed in 2010. To help explain the relative stability in these policies, the division that has ensued taking cognizance of interest groups, and the beliefs promoted within the health policy arena, the student utilises the Advocacy Coalition Framework (ACF). The ACF is a framework conceptualised by Paul Sabatier and Henk Jenkins-Smith, which seeks to understand policy processes in a wide array of geographic and politically diverse areas. It conceptualises public policy as an arena where actors compete for power to turn their beliefs into policy (Pierce et. al, 2020: 65). The competition for influence in public policy affects institutional rules, policy outputs and impacts (Giordono, 2020: 1137).

[1] US political polarisation, in the study, refers to the increasing divergence in ideology and policy along partisan lines which have been driven by conflicts on social and cultural values (Hare and Poole, 2014: 412). Hare and Poole (2014: 422) show that a consequence of US political polarisation has been the increased incidence of policy outputs being determined along party lines.

Sabatier (1988: 130) conceptualised the ACF when he sought to address the complexity of the policy-making process mainly in the US. The ACF's genesis was additionally a response to the limitations which Sabatier and Jenkins-Smith believed had existed in the policy process literature at the time. The first limitation was the perceived inadequacy of the stages heuristic as a causal theory of the policy process (Weible et al., 2009: 122). The second limitation comprised the strengths and weaknesses which had existed in the top-down and bottom-up approaches to implementation research and the "need for system-based theories of policy-making" (Weible et al., 2009: 122). The third limitation was the lack of theory and research surrounding the role of "scientific and technical information in the policy process" (Weible et al., 2009: 122). Furthermore, Sabatier's main concern was the understanding and explanation of the causality within the "complex multi-level policy-making process" he had observed at the time (Wellstead, 2017: 550).

The ACF is grounded on three basic premises. The first premise states that a time span of at least a decade is imperative in understanding the policy-change process and the role of policy-oriented learning within the aforementioned. This stems from policy-implementation research which has shown the need for the best timespan to achieve relatively accurate portrayals of success and failure within public policy programmes (Sabatier, 1988: 131). The second premise introduces the need for 'policy subsystems' to best consider policy change over a timespan, as denoted in the first premise. Sabatier sought to broaden the conception of policy subsystems from what he calls 'traditional notions of iron triangles', which were limited to administrative agencies, legislative committees, and interest groups at one level of government — by also including actors who are active in policy formulation and implementation at multiple levels of government, journalists, and researchers (Sabatier, 1988: 131). The final premise introduces the idea that the conceptualisation of public policies can be achieved in the same manner as belief systems. This premise is predicated on the assumption that people participate in politics to shape public policy to conform to their own beliefs. The third premise "provides a vehicle for assessing the influence of various actors on public policy over time" (Sabatier, 1988: 131-132).

In expanding on one of the ACF's core assumptions, that beliefs play a role as propellants for political behaviour, the ACF prescribes a model for beliefs consisting of three tiers to articulate its position better. The three tiers consist of (i) deep core beliefs, (ii) policy core beliefs, (iii) and

secondary beliefs (Weible et. al., 2009: 122). The three tiers of the beliefs model will be discussed below.

(i) Deep core beliefs, the top tier of the model, consist of "very general normative and ontological assumptions about human nature", i.e., they are the foundational values and principles which individuals hold and through which they primarily interpret the world. Within the American context, this can easily be seen in the stark division between liberals and conservatives on key issues surrounding the US, such as the nature and role of government in the 21st century and its role in the provision of health care. Deep core beliefs are generally conceived in childhood and are therefore most resistant to change (Sabatier et al., 2007:194).

(ii) Policy core beliefs, the middle tier of the model, "span the substantive and geographic breadth of a policy subsystem" (Weible et al., 2009: 122). These beliefs are "subsystem or policy specific beliefs" which refer to problems, priorities, and values, either normative or empirical (Giordono, 2020: 1138). Eleven components of policy core beliefs were included, such as the establishing of the relative authority of government and the market, the priority of disparate policy-related values, and the appropriate role of the public, elected government officials, and experts in the policy subsystem and policy-making arena. It is assumed that those who participate in the policy-making arena are knowledgeable about relationships which exist within the policy subsystem and therefore may apply specific deep core beliefs in the subsystem to develop policy core beliefs (Sabatier et. al., 2007: 195). Policy core beliefs, like deep core beliefs, are difficult to change, however their ability to change is more feasible than the latter (Wellstead, 2017: 550).

(iii) Secondary beliefs, the last tier of the model, in contrast to the previously discussed tiers of beliefs in the model, are more likely to change due to their narrower scope substantively and geographically (Weible et al., 2009: 123). Secondary beliefs have more to do with instrumental beliefs and decisions which affect the policy core (Wellstead, 2017: 551; Giordono, 2020: 1138). Examples of items which secondary beliefs address are rules and budgetary applications in specific public programmes such as the yearly appropriations in specific areas within health insurance legislation, which will be further discussed within this thesis (Sabatier et al., 2007: 196).

A central aspect of the ACF comprises, as its name states, advocacy coalitions. Advocacy coalitions are found within the policy subsystem and are identified as subsets of policy subsystem actors. They form when actors with shared policy core beliefs strive to influence the policy subsystem through the coordination of their actions in a "nontrivial manner" (Giordono, 2020: 1138). Actors will find other actors with shared policy core beliefs in elected officials, interest groups, researchers, judges, and other individuals from various levels of government. To best observe and interpret the behaviour of all stakeholders from individuals to organisations in a policy subsystem over the timespan of a decade or more, the use of advocacy coalitions provides the best approach. Typically, two to five advocacy coalitions are found within a policy subsystem (Sabatier et. al. 2007: 196).

This theory provides an appropriate approach to understanding the influence of beliefs as well as the various stakeholders involved in US health care legislation and in the often hotly contested health care reform debate. The ACF helps to identify any coalition groups which have existed in the subsystem by operationalising deep core beliefs and policy core beliefs, to explain how policy change happens, as well as how it came about within the health care system. However, despite the ACF's ability to explain policy change, policy change is beyond the scope of this thesis and will *not* be a focus of the study. The ACF's inclusion of advocacy coalitions and a model of beliefs is used to answer the research question of this study. The ACF is thoroughly discussed and sub-divided into its hypotheses, assumptions, and tenets in detail in Chapter 3.

1.5 Research design and methodology

Burnham et al (2008: 39) defines research design as the logical structure of research inquiry which political scientists engage in. He further states that it is the plan, structure, and strategy of investigation conceived to answer research questions or problems. Baxter (2008: 545) states that the use of the case study approach should be considered when the focus of the study is answering *how* and *why* questions and when the behaviour of actors involved cannot be manipulated. This researcher seeks to understand who the actors are who have had the most significant impact on US health reform, particularly with regards to the most recent major law which is the ACA; but also wishes to understand *how* they were able to make that impact; which is in keeping with Baxter's previously mentioned point. Moreover, the student only identifies the actors involved and observes

their behaviour, therefore he has no ability to manipulate it. Therefore, the best research design in answering the stated research question and addressing the problem is the case study design.

Case study designs, according to Crowe et al. (2011: 1) allow for "in depth, multi-faceted explorations of complex issues" in their real-life context. Indeed, scholars and media confirm the US health care system as being "uniquely" and highly complex (Camillo, 2016; Mankiw, 2017). The focus policy area of the study is health financing legislation in the US, which contains several laws and regulations, which include Medicare, Medicaid, and the ACA, which have affected health care in the US throughout its history and have contributed to the complexity of the US health care system. However, the ACA and its development is the case study of this thesis for the following reasons: (1) the study would not be able to provide an in-depth analysis of the political dynamics behind each major legislation through the use of ACF and (2) though each piece of legislation have continue to affect US health policy, the study sought to conduct an analysis on the most *recent* piece of legislation considering its close proximity to the present day US political, social, and economic contexts in comparison to older pieces of legislation.

The study also follows a qualitative research approach. Neuman (2011: 176) states that qualitative researchers capture and discover meaning once they are well familiarised with the data in their research. He also states that the analysis extracts themes or generalisations from evidence and organises data to present a "coherent and consistent picture.". The increasing prominent of qualitative research in the social sciences and qualitative research's focus on determining the meaning behind collected evidence, makes it appropriate in answering the research question.

Lastly, the study is conducted through desktop research, in that the student used data from existing resources. These sources include the use of scholarly articles accessed via the Stellenbosch University library website as well as via Google Scholar. The student also obtained data from published books, policy briefs from think tanks, as well as articles on major news publications. Government documents available in the public domain which include speeches of members of government were also used. Therefore, the study is based on secondary sources and grey literature. Using these data sources, the student sought to identify actors who have featured most prominently in the health reform debate during and after the implementation of the ACA. Once identified, the student utilised the above-mentioned sources to identify the deep core and policy core beliefs the actors have held. Thereafter the student organised the actors into coalitions based on evidence of

similarly held beliefs and coordination of behaviour, so as to translate their beliefs into policy. Utilising secondary sources ensures that time is better utilised for the completion of the study within the present funding and time constraints. As such, no primary research was conducted.

1.6. Limitations of the study

Through the use of the ACF and its model of beliefs, the study identifies actors who had exerted significant influence on the current state of US health reform. Many other actors could have been included in the identified coalitions; however, an exhaustive list of actors would have required an in-depth of all literature on the topic and interviews with key informants to confirm the degree of their influence and their membership/s in the identified coalitions.

The study could have significantly benefited from semi-structured interviews with select stakeholders to confirm the memberships of actors in the identified coalitions. However, due to time constraints and limitations in funding, interviews were unfortunately not a possibility. Nevertheless, they would have assisted in verifying the beliefs of the actors and coalitions as well as strengthened the evidence of coordination of actors in the various coalitions.

The study primarily looks at major events primarily in the 20th century that set the trajectory of the state of US health care. However, a limitation, as noted in the following chapter, is that not every major event and/or period, such as the Reagan Administration era, could be discussed in the study. Moreover, other geopolitical events and global forces could have been considered to add further nuance to the study. Nevertheless, an in-depth review of each event and piece of legislation would have required a separate study on its own, therefore falling outside the scope of this thesis.

The study utilised the ACF premise that beliefs are the driving force behind the promotion of certain policies in the policy process. However, in the analysis, there is a possibility that some actors depended on their financial and economic interests rather than on pure values or beliefs to promote and reject certain elements of the ACA. Nevertheless, the influence of financial interests is beyond the scope of the ACF and therefore the scope of this study. Lastly, the study sought to conduct an in-depth analysis of one signature health care legislation. Conflicts surrounding other pieces of signature health care legislation could have also been conducted, nevertheless, considering the complexity of US health policy, it would have not been possible to analyse each health care legislation within one study due to time and funding constraints.

1.7 Ethical considerations

Resnik (2020) notes the need for research to avoid aspects such as the fabrication or misrepresentation of data in order to contribute knowledge. He also notes the need for ethics in research to help build trust in research as well as accountability for researchers. Moreover, the World Health Organisation stresses the importance of ethical research that protects research participants' dignity and rights (WHO, n.d.) Considering this, ethical considerations are paramount for the successful completion of a study in the discipline. This study, however, has no research participants and is only informed by secondary data. Nevertheless, the study follows the guidelines set out by the University of Stellenbosch's Research Ethics Committee for Humanities.

1.8 Conclusion

This chapter provided an overview of the history and current state of US health financing policy culminating in the ACA. The chapter stated the research problem as well as the research question that this study will seek to answer. The research problem calls attention to flaws present within US healthcare while noting the increased partisanship and conflict in advocacy by various groups over US health care policy. This analysis is conducted to understand the extent to which the US's democratic institutions and its policy decisions represent the beliefs and preferences of the electorate as well as contribute to the literature on US political polarisation. Chapter 1 introduced the ACF and its model of beliefs which will be the primary tool used to answer the research question. Lastly, the research design and methodology of the study were laid out and ethical considerations in research were acknowledged.

The following chapter provides the history of health reform in the US by engaging critically with the literature surrounding health reform. The student will seek to understand how the country arrived at its current position on health care delivery prior to the negotiations and ultimate enactment of the ACA. The latter forms the focus legislation of the study.

Chapter 2: Historical context of US health policy development

2.1 Introduction

The research problem of this thesis highlights the contentious nature of health reform in the US in the period stretching from the last century to the present era. Moreover, the continued presence of charged political rhetoric, interest groups, and clashes in government's role in health care have made substantive health reform cumbersome. To understand the contentious and polarised nature of US health care reform best, it is imperative that a review of the historical literature be undertaken. Therefore, in this chapter, the student will discuss several periods of US health care history that played a significant role in health care. Other events occurred that helped determine the direction of US health care; however, an in-depth review of every period of U.S. health care history ─ albeit a young history ─ and every piece of health care legislation, would require a separate study on its own. By providing a review of the historical literature, the chapter sets the historical context of the current state of US health reform and introduces the different sides of the health care debate.

The first section of the chapter will commence with an explanation of the start of the pursuit of health care reform which began during the Progressive Era at the turn of the 20th century. A brief overview of how the Progressive Era started will be provided, as well as an outline of the goals of this Era. Thereafter, the rise of state-subsidised health care in Europe and the debate that ensued in the US will be discussed. Finally, a discussion will be provided of the role of institutional structures in the journey towards health care reform and key actors who were involved in the national health reform debate during this period.

The second section will provide a discussion of the events that transpired during the Great Depression and the post-World War II era. It will begin with a discussion of the New Deal as a response to the Great Depression and the opportunity which arose for health reform. A discussion of health reform in the post-World War II era will follow, which will explore the exploitation of the ideological tensions of the Cold War to undermine health reform. This will be followed by a review of the outcomes of health care reform during this era.

In the third and fourth sections, the student will discuss the increased interest and the eventual passage of health care reform found in the Civil Rights era and the 1970s. These two decades saw

the greatest opportunities for the passage of universal health care legislation and had made significant strides towards obtaining it.

The fifth section will provide a discussion of the contemporary era of health care reform from the 1990s to the end of the first decade of the 20th century. Thereafter, a brief discussion will follow of the current state of health care reform in the US, starting from the Obama presidency and leading up to 2021. The section provides the context for understanding US health policy development during this period.

2.2 The Progressive Era

America, in the years following the Civil War and the Reconstruction era entered a period of significant economic growth driven by the Second Industrial Revolution (Klein, 2021). Heffner et. al. (2018: 189) describe the rapid expansion of America's industrialisation as "ruthless, audacious, and unrelenting". The amassing of wealth in the US ushered in the Gilded Age, a period marked by unbridled materialism, "coarseness, and vulgarity" (Heffner et. al., 2018: 189). In the process, the US experienced a marked increase in wealth inequality. By the last decade of the 19th century, 51% of the US's real and personal property was owned by the top 1% of American families, whereas the lowest 44% owned a meagre 1.2% (Klein, 2021).

An additional important feature that arose from the rapid expansion of America's economic might was the ever-increasing entanglement of corporations with the state, otherwise known as *crony capitalism*. Being cognizant of the laissez-faire nature of the American economy during the Gilded Age, Folsom Jr. (2019: 357) references Munger and Villarreal-Diaz's assertion that "It is at least possible that cronyism is intrinsic to and not separable from capitalism. Thus, capitalism may have a tendency (…) to devolve into crony capitalism." Though the US's Second Industrial Revolution unleashed an ingenuity not envisioned since pre-Civil War times and fundamentally altered human civilization with the inventions of the light bulb, and the typewriter, among others (Folsom Jr., 2019: 366), Klein (2021) notes that it was during this era that corporations colluded to form monopolies for the sole intention eliminating competition. It was also in this period that significant political corruption was observed, with many corporations bribing public officials to obtain favour within government policies. Though not equivalent to bribing, the extensive practice of lobbying has been to the advantage of certain industries including the health industry, with regard to

government policies and regulations and this has been described as giving rise to crony capitalism (Lachman, 2014).

Following the waves of immigration into the US and the local migration from rural to urban areas, many Americans worked in the cities which in turn formed the hub of the Industrial Revolution in the country. With it came dangerous working conditions and the expansion of slum areas for labourers. Individuals, seeking to improve these conditions, rose to prominence bringing in the Progressive Era (Library of Congress, n.d.) The objectives of *progressivism* were threefold: it sought to (1) remove corruption from public life; (2) allow for greater public participation in the US's governing affairs; and (3) expand the functions of government to eradicate "social and economic distress" (Kennedy, 1975: 454).

2.2.1 Rise of state-funded health care coverage in the West

Europe, like the US, was also undergoing the Second Industrial Revolution; however this region's position on insurance for workers was in stark contrast to America's more classical liberal position of limited government and unfettered free markets. The first social health insurance system ergo the introduction of health insurance as a concept, was established in Germany in 1883 by Chancellor Bismarck (Jost, 2004: 433). The intention behind the programme was to establish "sickness funds" which possessed defined benefits such as sick pay, free pharmaceuticals, death benefits, and limited in- and out-patient services. Through Bismarck's innovation, the state took on a broader role in securing social protection in health. It also fundamentally altered the debate on government involvement in private health by including provisions on how benefits would be defined, as well as how health financing would be guaranteed (Bump, 2015: 32).

Enrolment in the programme was mandatory for eligible German citizens, who at the time, were mainly industrial workers. Though it appeared solely altruistic, the introduction of the aforementioned system was also a response to the Socialist threat in Germany at the time by winning over those industrial workers who were being courted by Socialist parties (Ross, 2002: 129; Bump, 2015: 32). German society at the time had undergone rapid industrialisation due to the Second Industrial Revolution. Workers in the nation transitioned from typical agrarian work to work possessing a higher degree of risk: they were exposed to disease, accidents, and risks of retrenchment. Despite the Socialist threat to his chancellorship, Bismarck firmly believed that the state had a role to play in ensuring that members of the working class had social protection and he

stated that, "The social insecurity of the worker is the real cause of their being a peril to the state" (Bump 2015: 32). Indeed, Paul Starr (1982: 238) would add that the original function of sickness insurance such as that instituted by Bismarck, was primarily focused on income stabilisation as a response to the destitution that arose from industrial capitalism. Bismarck's model of social health insurance paved the way for several social health insurance programmes across Europe. Austria adopted the system in 1888, and Hungary adopted its own version in 1891. In the early 20th century, more European states adopted compulsory sickness insurance, thereby solidifying its place in western society (Starr, 1982.: 237).

2.2.2 Debate over state-subsidised health care in the United States

While establishing government-instituted health insurance was well underway in Europe, the US government had very little involvement in social welfare and health. By the turn of the 20th century, the federal government had been significantly decentralised with minimal involvement in the regulation of the economy. In addition, its bureaucratic system was kept at a small scale (Starr, 1982: 240). Nevertheless, several groups and individuals belonging to the socialist, unionist, and progressive movements sought to advocate a national health insurance similar to that which existed across the Atlantic in Europe (Ross, 2002: 129). Despite their efforts, much resistance was met, ranging from institutional structures to 4.4.2 among the population.

2.2.3 Institutions: Progressive reformers' greatest obstacle

As previously stated, the US followed a largely classical liberal style of government and a laissez faire economy. Emerging from the Civil War, Reconstruction, and the Second Industrial Revolution that had catapulted the US as a formidable economic power on to the world stage, the Small-government and free market of the US seemed to have brought it much success.

The Constitution of the United States lays down the duties of the Federal government and the States. Under Article 1 section 8 and 9, Congress, i.e. the Federal government, has its powers and limits clearly stated.[2] A few years after the ratification of the Constitution, the 10th Amendment,

[2] Congress's powers are listed under section 8. These are limited to general responsibilities of a national government such as providing defence, establishing rules for immigration, and creating and regulating the currency of the nation. Section 9 stipulates a few limits on Congress such as prohibiting Congress from giving preference to a particular state on commerce regulation. Refer to Sections 8 and 9 of the US Constitution to read more on the specific powers and limits of Congress.

the last of the 'Bill of Rights', made it clear that "the powers not delegated to [Congress] by the constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people" (U.S. Const, Amend. X). James Madison in the Federalist Papers No.45 made it clear that powers given to Congress are "few and defined" and those reserved for the States are "numerous and indefinite" (Hamilton et al., 2001: 241). The Constitution set the clear and limited nature and role of the Federal government; however, with the inclusion of the 10th Amendment, it doubled down on this distinction, with the intention of ensuring no ambiguity on what the Federal government can and cannot do. Nevertheless, since that time, the debate regarding the Federal government's powers and limits has continued.

Raskin (2011: 1) argues that the Commerce Clause[3] under Article 1, section 8, provided the impetus for the Federal government to intervene in the economy, however this was not the widely accepted rationality across the country in the early 20th century, particularly in the judicial system. For example: in Adair v. United States, 208 U.S. 161, the courts struck down a federal law that had prohibited the firing of workers who had joined trade unions, ruling that the Commerce Clause does not give Congress, i.e., the Federal government, the power to issue labour laws; defining *labour* as a *local commerce issue* (Raskin, 2011: 4).

Lastly it is also important to note the U.S. Constitution's strong separation of powers and its system of checks and balances. Each branch of government, the executive, legislative, and judicial, has mechanisms in place to prevent the overreach of each branch. The executive has the ability to veto legislation from the legislature. The legislative branch, with its two chambers, the House of Representatives, and the Senate, has the ability to stall legislation supported by the executive, particularly if the head of the executive's party is not in control of both houses of Congress. The judicial branch has the power to strike down laws issued by the executive and legislative through judicial review (Jost, 2004: 437-438). Starr (1982: 257) notes this difficulty by stating that a President of the United States who supports health insurance would "not have the leverage to force the opposition to compromise" due to the previously mentioned checks and balances. He further notes that for significant health reform to occur, only a serious threat to the stability of the political

[3] The Commerce Clause gives Congress the power to "regulate commerce with foreign Nations, and among the several States (U.S. Const. Article 1, Sect. 8 clause 3).

system, such as had been seen in Europe, would have to take place to bring interest groups together and debate the possibility of reform.

2.2.4 Health reformers and the advocacy for mandatory health insurance

America's industrial revolution brought to the forefront the political significance of industrial workers' concerns, which occurred particularly through trade unions. Progressive reformers - who laboured under the conviction that the US government's functions were too restricted and sought to expand them for the relief of social and economic distress (Kennedy, 1975: 454) - were able to lobby successfully for regulations that targeted industries and monopolies as well as establish health and safety standards that protected industrial workers (Bump, 2015: 35).

Within the Federal government, President Theodore Roosevelt, a distant cousin of future President, Franklin D. Roosevelt who would propose similar policies, advocated for some form of health insurance during his presidential bid in 1912. Theodore Roosevelt's new party, the Progressive Party called for the "protection of home life against the hazards of sickness, irregular employment and old age" by adopting a social insurance system modelled for the US context. In addition, earlier in 1910, Theodore Roosevelt had called for the nation's laws to protect the health and security of its working class by including progressive taxes such as an inheritance tax and a "graduated income tax keeping in line with progressivism's goals and his party platform" (Skidmore, 2011: 2). Roosevelt believed that "no nation could be strong whose people were sick and poor", reiterating his support for social and health insurance. However, in the general election bid of 1912, he lost to Democratic candidate, Woodrow Wilson. From this, the leadership that could promote such a programme would only emerge two decades later with Franklin Roosevelt's rise to the presidency (Starr, 1982: 243).

After the electoral defeat of Roosevelt, one group that played a significant role in the promotion of compulsory health insurance was the American Association for Labor Legislation (AALL). Socialism was a perceived threat to the US, but the threat was not as severe as it was in Europe. Despite that, members of the AALL consistently disavowed socialism as they utilised scientific methods to reform capitalism in the country by curtailing its abuses (Quadagno, 2005: 18) though founders of the AALL had once embraced socialism, albeit briefly. The AALL main focus was on the protection of wage earners, believing that creating a 'security state' where the state would play a largely regulatory role rather than a redistributive role, would best protect labourers from

exploitation by their employers. Therefore, the AALL sought a system consisting of labour legislation and regulation that would ensure that employers make rational choices that improve their employees' lives and which reduce their dependence on direct relief (Hoffman, 2001: 25).

Regarding health care, the AALL was a firm believer in mandated health insurance and was its most important advocate. Indeed, the AALL's initial success on health regulations in the working place, which were: (1) the elimination of poisonous materials in workplaces: (2) the compensation of workplace injuries, succeeding in 33 states at the time; gave them confidence that a mandatory health insurance policy might be possible in the US (Quadagno, 2005: 19). In keeping with the US's federalist system, the AALL proposed a Health Insurance Bill which was largely modelled on the German Bismarck model. Employers would contribute 40% to the programme, employees would contribute 40%, and the State would contribute 20% (Bump, 2015: 35). The bill proposed by the AALL not only applied to workers but also included their dependents. The bill consisted of four kinds of benefits: (1) employees would receive medical aid which consisted of physicians, nurses, and hospital services; (2) they would receive sick pay which consisted of two thirds of their wages up to 26 weeks and one third of their wages if they were hospitalised; (3) wives of insured men and insured female employees would be entitled to maternity benefits; and (4) they would be entitled to a benefit of $50 in the event of death to cover funeral expenses (Starr, 1982: 244).

The objectives of the AALL were two-fold: first, in order to reduce poverty, they sought to eliminate sickness as its cause by distributing individual wage losses and medical costs by using insurance; and second, they sought to reduce the social costs of sickness by ensuring that effective medical care was provided to workers and money incentives were created to prevent disease. The AALL had won the sympathies of middle-class Americans and seemed to gain momentum. It was introduced for debate in 12 States (Ross, 2002: 129). However, by 1921, with 15 State legislatures having considered the AALL's Health Insurance Bill, the bill was unsuccessful in every state with only New York passing it in one house of its state legislative branch. The bill lacked sufficient support by its target population: the workers. The workers' main interest was in sick pay and they were reluctant to pay for medical coverage. The American Federation of Labor President rejected the bill due to its compulsory enrolment component which, it was argued, would deny workers' their right to choose. Lastly, the preference of the workers was for a voluntary medical scheme which allowed workers not to pay for services they did not need or want (Bump, 2015: 35).

2.2.5 Opposition to health reform

The state of health care in the US, for the most part, has been largely determined by its opponents to reform. Any discussion on health care in the would be wholly incomplete without the special interest groups that have largely determined its course.

The first opponent to the health reform proposals put forward during this era was the American Medical Association (AMA). The AMA, a group representing US physicians, was founded in 1847 with its mission to "promote the art and science of medicine and the betterment of public health". Its goals were scientific advancement, setting standards for medical education, launching a medical ethics programme and improving public health (American Medical Association, n.d.) Regarding the need for health reform during the progressive era, the AMA was initially in favour of the AALL's Health Insurance Bill, hailing it as a "great movement" and "the next step in social legislation." At the same time, its constituents such as public health physicians and nurses' organisations also supported the bill, leading the AALL to proceed with the introduction of the bill in state legislatures around the country. However, a year after the AMA's endorsement of the plan, smaller medical societies were strongly opposed to the bill. This started in New York after the state legislature had debated the bill. Doctors in the state had pressured their medical society to reverse their position on the bill, with more physicians vocalising their opposition to it. The grassroots opposition from the state forced the AMA to rescind their support of the bill and become one of the strongest opponents to health insurance in the country (Hoffman, 2001: 85).

Physicians' opposition to the AALL bill was premised on three reasons: (1) they refused to fall under the management of any central state or federal public health authorities; (2) they disapproved of reorganisation of medicine through the use of specialised group practices that were designed to improve the proposed programme's efficiency; (3) and they issued a strong rejection of any form of contract or capitation payment practices that were introduced to control the costs of health care (Ross, 2002: 129).

Lastly physicians also had an ally in their opposition against the bill. In California, where the bill initially seemed to have good prospects of being passed, (but inevitably failed), physicians in the state formed a coalition called the League for the Conservation of Public Health. They partnered with the Insurance Economic Society, which was led by insurance groups, Prudential and Metropolitan. Insurance groups feared that the AALL bill would undermine the life insurance and

funeral benefits private market; that they would essentially price them out of business and lead to a government takeover of their industry. Indeed, the general fear of insurance companies was that the AALL bill "would mean the end of all Insurance Companies and Agents" (Quadagno, 2001: 20-21). Ultimately the opposition from physicians, as represented by the AMA and other smaller coalitions, as well as the opposition from the insurance companies, brought the downfall of the AALL's bill. With the U.S. entry into World War I, debate over health insurance was brought to a halt and would not be discussed until two decades later.

2.3 The Great Depression and the Post-World War II Era

With the stock market crash of 1929, the US entered a period of great economic depression, affecting important industries in the nation such as manufacturing. Crafts and Fearon (2010: 285) reference Keynes who stated that "when this crisis is looked back upon (…) it will be seen to mark one of the major turning points" in the world. Millions of Americans had lost their employment as a result of the economic downturn. Estimates reveal that unemployment rose from a low 2.9% prior to the economic bust in 1929 to 22.9% in 1932. With no formal national system to protect the unemployed in the US, newly-unemployed people relied on locally administered relief which was known to be inefficient and insufficient to adequately alleviate the effects of unemployment (Crafts and Fearon, 2010: 292).

Though access to health care was inevitably affected by the loss of income, the discussion surrounding health insurance was not at the forefront at this time. Nevertheless, it was still being discussed. A more pressing issue was brought to the forefront: alleviating the effect of unemployment and loss of income. This was carried out through the Social Security Act. Though it was not its focus, President Roosevelt did raise the potential inclusion of a national health insurance within the Act. This will be discussed below.

2.3.1 A New Deal on health care? Franklin Roosevelt's (FDR) thoughts on publicly funded health care

After winning the Democratic Party presidential nomination, FDR (1932) said in his acceptance speech, "I pledge you, I pledge myself, to a new deal for the American people." This was said to address the issues emanating from the Great Depression. After a landslide victory in the

presidential election, FDR obtained his mandate to institute a new deal for the US which would fundamentally alter the nature and role of the Federal Government in American society.

The main purpose of this new deal was to end the Great Depression and ensure structural reforms to bring security to Americans in order to avoid the "hazards and vicissitudes" of life. This was codified in several programmes mainly (i) The Federal Deposit Insurance Corporation, (ii) the Securities and Exchange Commission, (iii) the Federal Housing Administration, (iv) the National Labor Relations Board, (v) the Fair Labor Standards Act, (vi) and the Social Security Act (SSA), which formed the cornerstone of the new deal reform era (Kennedy, 2009: 254). The SSA did contain four provisions that referred to public health. These four were: (i) the Title V federal grants given to the states for Maternal and Child Health (MCH) (ii) Crippled Children Services (CCS), (iii) permanent federal grants to states for vocational rehabilitation, (iv) and federal grants given to states for Public Health under title VI of the SSA (Cohen, 1984: 381).

Health insurance was not a major policy priority. However, during the Economic Security Conference in 1934, FDR acknowledged the need to address the economic loss incurred by sickness, stating:

> Whether we come to this form of insurance soon or later on, I am confident that we can devise a system which will enhance and not hinder the remarkable progress which has been made and is being made in the practice of the professions of medicine and surgery in the United States. (Roosevelt, 1934).

Roosevelt was known to have a cautious approach to the issue of health insurance. Kooijman (1999: 336) issues a myriad of possibilities for this position, ranging from the direct opposition of the nation's medical profession represented by the AMA to general apathy surrounding the issue. Roosevelt mainly submitted the issue to mediators and advisors who consulted with stakeholders on the possibility of health insurance as part of the new deal reforms (Kooijman, 1999: 337). In June 1934, Roosevelt created the Committee on Economic Security (CES) with the main aim of studying old age and unemployment policies; however, it also researched medical care and health insurance. Despite their research and keen interest in this issue, the committee generally took the position that health insurance would have to be delayed particularly due to the potential opposition it would incur which could threaten the viability of any new deal reforms proposed by the administration, particularly Social Security (Starr, 1982: 267-268).

However, in a second opportunity for health reform two years after the passage of the SSA, the CES issued a report that proposed the following: (1) the expansion of public health and maternal and child services under the SSA; (2), the expansion of hospital facilities through federal aid to states for the construction of 3-year operating support; (3) increased medical care aid for individuals on relief and those who were unable to pay for their own care; (4) the consideration of a general medical care programme that was supported by taxes, insurance or both; and (5) a federal programme to compensate for wage loss due to temporary or permanent disability. After this proposal had been compiled, Roosevelt made the report public and in 1938 convened a conference in the nation's capital, bringing together representatives of various stakeholders, including the AMA (Starr, 1982: 276).

2.3.2 Opposition to potential health care provisions within the Social Security Act

After Roosevelt had created the CES and had considered the inclusion of national health insurance in the report, opposition emerged, coming first from the AMA. The AMA feared that expected legislation would be introduced soon after the CES's report. Acting on that fear, a House of Delegates meeting was called which adopted a resolution that called for all features of medical services to be under the control of its dispensers. The AMA stuck to the position it had held during the Progressive Era but also made a concession on their position on health insurance: they would concede to voluntary insurance only if it were under the control of county medical societies (Quadagno, 2005: 23). Starr (1982: 271-273) explains that the concessions the AMA made were an attempt to retain the political loyalty they had from physicians who had changed their positions on health insurance because of the effect the Depression had had on their livelihoods. Roosevelt's initiative would provide federal aid for maternal and child health care, hospital construction and the disabled. It also called for grants that provided medical care for the poor as well as health insurance for the public. In June 1938 the bill began to gain momentum. Immediately, opposition arose against the initiative: first, the AMA brought together opposition to fight the initiative; secondly, members of Congress indicated that they would not support the provisions of the bill (Starr, 2013: 39).

2.4 Socialized Medicine: The Cold War and resistance to compulsory health insurance

By the time World War II had come to an end, the US faced a new adversary on the global stage: the rise of the Communist regime found in the Soviet Union (USSR). Discussion surrounding

single payer health insurance was met with significant opposition and skepticism. Prior to the end of the war, in 1943 the first National Health Insurance bill was introduced in Congress by Senators Murray, Wagner and Dingell and became known as the Wagner-Murray-Dingell Bill (Derickson, 1997: 1837). One of the post-war era institutions, the International Labour Organization (ILO), became a target for opponents to health care reform, labelling it as an institution seeking global domination. With Social Security officials attending and Truman's call for insurance legislation in 1945, opponents to reform labelled the Wagner bill a "Product of the [ILO]" that was not "American Made" but was "written largely by ILO leaders." This was found under the Medical Economics' thesis: "Labor's Program to Socialize Medicine Internationally" (Derickson, 1997: 1837). Indeed, fear of communist influence in America was used to undermine the push for compulsory health insurance, with opponents to the measures using the term 'Socialized Medicine', thereby conflating health insurance's advocacy with the threat from the US's communist adversary (Starr, 1982: 280).

2.4.1 Harry Truman's Fair Deal and attempt at universal health care

Social Security became entrenched in government. The passage of the Social Security Act created new government agencies such as the Social Security Board which, in 1938, set up a conference that sought to discuss issues surrounding health in the nation. FDR was supportive of the bill but once again was reluctant to endorse it. The bill did not progress past the committee stage due to the focus on the war. By the end of the war, the Wagner-Murray-Dingell Bill may have been promoted once more after FDR's re-election; however, FDR had passed on before giving a formal endorsement (Schremmer and Knapp, 2011: 399).

After Truman took the reins of power, he continued to advocate universal health care more fervently than his predecessor had. Truman firmly believed that health care was a human right, evidenced by his posing the question and appealing to the morals of the AMA, "I put it to you, is it un-American to visit the sick, aid the afflicted or comfort the dying? I thought that was simple Christianity" (Harry S. Truman Library: n.d.; Schremmer and Knapp, 2020: 390). Then in a speech to Congress in 1949, Harry Truman announced his Fair Deal programme, thereby launching his attempt at passing health insurance. The Fair Deal contained a multitude of policy proposals ranging from controlling inflation to providing education aid and providing health insurance for all Americans (Truman, 1949).

2.4.2 Strong opposition to the Fair Deal

Following Truman's push for health care reform, the AMA launched a full-on attack against his agenda. The AMA began the National Education Campaign which was geared towards blocking the passage of Truman's health care plan, as well as encouraging members of the public to opt for private health insurance (Quadagno, 2005: 34). In the same breath, with US politics dominated by heightened fears and suspicion during the Cold War, as well as by raising McCarthyite witch hunts aimed at persecuting any and all individuals who were suspected of having communist sympathies, reform was significantly stifled (Birn et. al. 2003: 87). The AMA continued to push for the end of the Truman health care agenda, hiring Clem Whitaker and Leon Baxter to terminate his plan. In reference to the ideological tensions of the Cold War, Whitaker explained the AMA's tactic against universal health insurance:

> All you have to do is give it a bad name and have a Devil. America is opposed to socialism, so we are going to name national health insurance "socialized medicine." And we have got to have a devil (Quadagno, 2005: 35).

Republicans in Congress had also equated the drive to establish national health insurance to socialism, accusing the Truman administration of allegedly spending millions of dollars "on behalf of a nationwide program of socialized medicine". More members launched the allegation that "known communists (…) within Federal agencies" were using federal funds to further the "Moscow party line" (Starr, 1982: 284). The attacks on the President's proposal were bearing fruit, causing public approval for the plan to plummet from a high of 75% in 1945 to 21% in 1949 (Quadagno, 2005: 38). Once the Republican Party had regained the House, the chances for the Truman Health Care Bill's success were slim to non-existent and the bill was not given any further consideration (Harry S. Truman Library, n.d.). Truman called the failure of the plan his biggest disappointment as President, lamenting, that "[he had] never been able to understand all the fuss some people make about government wanting to do something to improve and protect the health of the people" (Yarrow, 2021).

2.4.3 Takeaway from the Truman Administration: The passage of the National Mental Health Act and the Hill-Burton Act

Despite the failure of universal health insurance under Truman's presidency, some laws that had a significant impact on health care were passed and were signed into law under his leadership. In

1946, President Truman signed into law the National Mental Health Act, which established the National Institute of Mental Health. The Institute has sought to transform "the understanding and treatment of mental illnesses through basic and clinical research" to prevent mental illness, promote recovery, and cure mental illness (National Institute of Mental Health, n.d.). In the same year, the President signed the Hospital Survey Construction Act, also known as the Hill-Burton Act. The effect of this Act on US health care has, according to Schumann (2016) been nothing short of monumental. The Act served to provide federal funds to hospitals, nursing homes, and other facilities to construct and modernise their facilities. The condition attached to the federal funds was that health care facilities were obliged to provide a "reasonable volume of services" to individuals who lacked the funds to pay for them. In addition, they were obliged to make health services available to all individuals who lived around the facilities. Though funding ceased in 1997, health care facilities receiving funds under this Act are still obliged to provide their services to individuals at reduced costs or free of charge (Health Resources and Services Administration, 2021).

2.4.4 The institutionalisation of third-party health insurance

In the process of universal health insurance advocacy, the private market saw a chance to offer a product to companies and individuals to meet the need for health insurance. Initially, following the Great Depression and discussions on possible public health insurance, the possibility for private universal coverage for hospitalisation existed through the Blue Cross. The Blue Cross, a non-profit organisation, offered plans which included prepaid coverage for hospitalisation. Plans were charged at uniform rates by community rating, which means every individual had the same rate based on his or her community, which helped to spread the risk for the insurance provider and ensure coverage for every individual at affordable fees (Skidmore, 2010: 187). However, for-profit insurance companies began to offer similar plans to individuals, but instead of using a community rating that benefitted every individual, benefits were targeted towards healthy members of the community. Less healthy individuals, however, using this model, were charged more owing to the risk involved and the higher chances of having to provide care more often. The practice outcompeted Blue Cross plans and the latter were left with high-risk individuals (Skidmore, 2010: 188).

In 1943, the Internal Revenue Services (IRS) started to exempt employment-based health insurance from taxation following Truman's predecessor's post-War executive order which prevented businesses from raising wages to attract workers. Businesses began to offer benefits to potential employees to circumvent the order. Through the IRS's tax exemption of work-based health insurance and being cognizant of the increased cost of private insurance offered by for-profit insurance companies, it became cheaper for individuals to obtain their health insurance through their jobs instead of through any other avenue that existed at the time (Carroll, 2017). Following the end of World War II, and the entry of the new Truman administration, government-provided insurance was promoted but the business lobbying group, the Chamber of Commerce, and the AMA opposed it. As discussed previously, Truman's health care plan failed to materialise due to the strong response from the opposition. By the 1960s, two thirds of Americans had some form of health insurance, mainly through their employment. Individuals were locked in their employment to keep their health insurance and avoid the increasingly costly individual health insurance offers (Carroll, 2017).

2.5 The Civil Rights Era

America during the Civil Rights Era was at a critical moment in its history. The US was at the height of the Cold War, with increased tensions rising between America and the USSR. At the same time, the era was marked by increased political awareness and involvement among its citizens due to injustices and racial segregation incurred by minorities. The Civil Rights Era brought instability not seen since the Civil War almost 100 years earlier. At the same time, it was during this era that the discussion surrounding health care access gained greater momentum. Public opinion surrounding health coverage was largely positive prior to the introduction of Truman's health insurance policy, with 82% of respondents believing that something had to be done to make payments of doctors and hospital care easier for Americans. Indeed, 68% of respondents also believed that Social Security would be a good way to pay for doctor and hospital bills (Blendon and Benson, 2001: 34).

Furthermore, after Truman had announced his insurance programme, 59% of respondents had approved of it, but as was stated in the previous section, the AMA was strongly opposed to the plan and this ultimately affected the prospects of its success. By 1953, a minority of respondents (30%) were in favour of Federal Government-controlled health insurance. With the continued

institutionalisation of employer-sponsored health insurance, more Americans were insured, whereas for those who were uninsured, the costs of health care continued to spiral out of control (Roper Center, 2017). This decade saw the doubling of the price of hospital care as well as an increase in National Health Expenditure (NHE) by the 1960s when the government began to track it (Griffin, 2020).

Indeed, more than 70% of Americans had some form of hospital insurance and 67% had surgical insurance. However, only a minority of citizens had primary, or out-of-hospital care insurance (Stevens, 1996:11). The increased cost of health insurance in particular affected the indigent population of the country, who were mainly retirees and generally lower-income Americans. The first step towards addressing this was the introduction of the Kerr-Mills Act of 1960. This Act created the Medical Assistance for the Aged programme (MAA). The Act was largely crafted by policy entrepreneur, Wilbur Cohen who was an important actor during negotiations over the New Deal as well as during reforms under the Johnson administration. Nevertheless, despite the successful passage of the Act, three years after its enactment, it had only managed to cover less than 1% of senior Americans and because of its dependence on state implementation, was inconsistent in terms of service and access across the country. (Gritter, 2019: 2210-2211). From this point, urgent reform was needed, after the assassination of President Kennedy, who had also advocated health reform for the elderly. His Vice President and successor, Lyndon B. Johnson became the new advocate for health reform embodied in his 'Great Society' plan.

2.5.1 The Johnson Administration's 'Great Society': an opportunity for health care reform

On May 22, 1964, during a commencement ceremony at the University of Michigan, President Johnson gave his speech that would launch the defining feature of his administration:

> … we have the opportunity to move not only toward the rich society and the powerful society, but upward to the Great Society. The great society rests on abundance and liberty for all. It demands an end to poverty and racial injustice (Johnson, 1964).

It was this speech which allowed him to gain the mandate from the American people when he won decisively in the presidential election of 1964. In the following year, Johnson in his State of the Union speech now sought to convince Congress of his ambitious domestic agenda in an era of American history that had immense prosperity but was still plagued by racial injustice and poverty. Johnson affirmed that "The Great Society asks not how much, but how good; not only how to

create wealth but how to use it; not only how fast we are going, but where we are headed." (Johnson, 1965a).

According to Johnson's pitch of his domestic agenda, the Great Society sought to achieve the following goals: to tackle inequality in education, to address issues in urban areas such as urban decay, and to tackle environmental degradation. Johnson also launched the War on Poverty which sought to tackle the increased rate of families in poverty (Germany, n.d.). The Great Society agenda produced a myriad of reforms in five areas mainly: income assistance, education and training, housing, civil rights, and health care legislation. Legislation that was passed within the first two years of the Johnson administration comprised: the Economic Opportunity Act, food stamp legislation, mass transportation programmes, the Elementary and Secondary Education Act, the Higher Education Act, the Public Works and Economic Development Act, the Civil Rights Act, and for the purposes of this thesis, Medicare, and Medicaid (Brown-Collier, 1998: 260-261).

2.5.2 The introduction of Medicare and Medicaid

Discussions surrounding the funding of health care for the elderly and the indigent population had long been prevalent in American society. A Gallup poll from 1961 showed that 67% of citizens were in favour of a higher social security tax to pay for the elderly population's medical insurance (Erskine, 1975: 131). Another poll in 1963 from the state of Minnesota asked respondents if they were in favour of a hospital-care federal programme for the elderly who resorted under social security. The poll showed that 75% were in favour of the idea. Regarding medical insurance for the poor, as far back as 1936 and 1937, 74% and 73% of respondents from the Roper for Fortune and Gallup polls respectively had been in favour of government providing free medical care for citizens who were unable to afford it. By 1961, when asked who should pay for the medical care of the poor, however, 12% selected the Federal government, whereas 33% and 39% selected the state and county government (Erskine, 1975: 130-131), confirming the skepticism and hesitancy that the American people had of the federal government's involvement in health care. Despite that, a significant proportion of Americans still supported some form of government role in the provision of health care for the poor and most certainly for the elderly.

Indeed, Johnson, in a special message to Congress in January 1965, called upon the US Congress to advance his agenda on health care. In it, Johnson called for hospital insurance for the elderly population of the country, motioning that Social Security be extended to cover the costs of basic

health services. In addition, he called for states to improve their medical assistance under the Kerr-Mills programme for the elderly who could not afford health care. Also, Johnson called for the improvement of health services for young Americans as well as community health services (Johnson, 1965b). Resulting from this message, the journey to pass Medicare and Medicaid was in full swing and the President had the support of the American people to do so.

2.5.3 Opposition from the AMA

While support from labour unions, civil rights organisations, and the hospital and insurance industry grew in favour of the passage of Medicare in particular, the AMA continued to condemn the measure as "socialized medicine" (KFF, 2009a). The AMA along with Republican members of Congress criticised the programme as a form of compulsory insurance (Starr, 2011: 4). However, the tide had turned in favour of the Federal Government. Insurance companies had attempted to insure the elderly in response to the government's attempt to pass reforms to do the same. However, after noting the high cost of insuring the elderly population and the inadequacies of their policies to cover all their medical needs, insurance companies conceded that privatised elderly health coverage would never be profitable. This concession pushed insurance companies to lobby in favour of Medicare rather than against it (Quadagno, 2004: 32). With the AMA backed solely by the minority Republican Party in opposition to Medicare, they drafted and promoted their own bill called 'Eldercare'. The bill was more expensive but had a means-test component to qualify for its benefits. However, their proposal failed to be considered with the numerous other proposals put forward by various stakeholders in Washington (Gordon, 2003: 28).

2.5.4 Johnson's Victory: The passage of Medicare and Medicaid

In 1965, the push for the passage of Medicare and Medicaid were in full swing. Republican ranking member of the House Ways and Means Committee, John Byrnes, proposed a programme called 'Bettercare' which offered to provide coverage for fees payable to physicians, hospitals, and nursing homes. The Democratic Party had proposed a compulsory hospital insurance programme for the elderly. Congressman Wilbur Mills then consolidated the proposals into one bill that would be brought forward to a vote. The Democratic Party's proposal would be known as Medicare Part A, whereas Republican Congressman, Byrnes's proposal would be known as Medicare Part B. In creating Medicaid, Congressman Mills then proceeded to expand the Kerr-Mills programme to

cover lower income individuals. The expansion of the Kerr-Mills programme would then serve to be Medicaid (Starr, 2011: 4).

Then on 30 July 1965, with the consolidated legislation passed in both houses of Congress, President Johnson journeyed to the Harry Truman library in Missouri to sign the Social Security Amendments Act of 1965, creating Medicare and Medicaid. His guests of honour, witnessing the signing of the unprecedented law, were former President Truman and former First Lady, Bess Truman. Now over 80 years old and retired, President Johnson offered the Trumans the first two Medicare cards. Later on, writing about the historic occasion, Johnson wrote, "I want him to know that America remembered" referring to Truman's efforts to advance the cause of health insurance (Beto, 2014: 7).

2.6 Rising Health care costs and growing calls for Universal Health Insurance

After the passage of Medicare and Medicaid and at the turn of the decade, health care costs rose to 6.9% of US GDP. Health care spending amounted to a total of $74.6 billion in 1970 and to the end of this decade, health care spending outpaced economic growth, growing at 12.2% in comparison to 9.2% economic growth (Rosenberg, 2018). The inclusion of the Federal Government as a third-party payer for health care, according to Steinmo and Watts (1995: 350), contributed to the inflation of health care costs. Indeed, Starr (2011: 1) confirms this, stating that Medicaid and particularly Medicare, contributed to the complexity and administrative burden of the US health care system, leading to inflated medical costs which cast doubt on the feasibility of a true universal health care system for the nation. Nevertheless, calls for a national health insurance system continued. Reformers remained optimistic that momentum from the Johnson administration would carry over, even though the next president, Richard Nixon, was a member of the opposing political party (Gordon, 2003: 31-32).

2.6.1 Proposals for universal health insurance from Congress

In April 1970, Senator Jacob K. Javits (R-New York) introduced a bill that would make every American citizen eligible for Medicare by 1973. To finance the extension, the bill proposed that employer-employee contribution reach 3.3% of annual wages with an additional Federal subsidy that would increase from $3.5 billion to $22.7 billion in the period between 1971 and 1974. The

bill would be a partnership between the states and existing private health insurances in the nation (New York Times, 1970).

The following year after the Javits 'Medicare-for-All' bill had failed, Senator Ted Kennedy (D-Massachusetts) drafted the Health Security Bill when he became Chairman of the Senate Sub-Committee (Quadagno, 2005: 113). The bill sought to implement universal coverage of hospitalisations, services delivered by physicians, a limited coverage for mental health, dental, and prescription drug benefits. The plan was to be financed using a combination of payroll taxes and general revenues. Supporters of the bill believed that the bill would be able to cover the whole U.S. population "for a cost no greater than that actually expended to provide fragmentary service for fewer". In addition, they believed it would help employers with their payment of work-based benefits and relieve states from the uneven burden of Medicaid (Gordon, 2001: 33).

Soon after the introduction of the Health Security Bill, President Nixon introduced a health care plan of his own, as a measure to compete against the increasingly popular Kennedy who had suffered the Chappaquiddick scandal in his home state but had soon became the Democratic Party's favoured presidential candidate in the 1972 election lead-up. Kennedy aggressively pushed the issue of health care, holding hearings in cities across the country. After the hearings tour and amassing press coverage, Kennedy issued a report titled "The Health Care Crisis in America" (Quadagno, 2005: 113). Nixon had no other option but to respond. Nixon announced the National Health Insurance Partnership in a speech to Congress on February 18, 1971. The bill would only cover employees through employer mandates, and it would also provide group plans for small employers, self-employed individuals, and low-income groups (Steinmo and Watts, 1995: 351).

In his speech to Congress, Nixon proposed a strategy that was based on the following four principles:

(1) Assure Equal Access: Nixon believed that the Federal government should play a role in ensuring that all citizens can obtain a "decent standard of medical care". He proclaimed that "without good health, no man can fully utilize his other opportunities."

(2) Balance Supply and Demand: Nixon pinpointed the imbalance that Medicare and Medicaid had created: an increase in demand for health services without the necessary supply to meet it; which led, in part, to the increase of health care costs. Nixon sought to correct this

through the power of the Federal government to respond to the issues that may arise when barriers to health care access are removed.

(3) Organising for Efficiency: Nixon called for a two-part process in improving health care efficiency. First, he emphasised the need for health maintenance which would focus on illness prevention rather than on illness treatment. Second, he called for Cost Consciousness preservation, which referred to the issue that may arise in the abuse of "free" health care services, otherwise known as the moral hazard problem. But this not only applied to the recipient of health care services but also to the provider who would be paid by the State. Therefore, he sought to eradicate the incentive to abuse Federal health care programmes.

(4) Building on Strengths: Nixon cautioned against the narrative that would lead to the complete eradication of the then current health care system to replace it with something new. (Nixon, 1971)

Nixon's plan generated approval from the Wall Street Journal, stating that it was superior to Ted Kennedy's health care plan. Nevertheless, Nixon failed to generate any support from members in his own party in Congress. The bill received no sponsor or introduction from any Republican in the House or the Senate. Rejection from business constituents, who were concerned about the costs that would affect them, had an impact on the bill's feasibility (Nathan, 1996: 162).

Notwithstanding the failure of Nixon's health strategy, the Social Security amendments of 1971 and 1972 passed through Congress and reached his desk to be signed into law. In 1971, Nixon signed House Resolution (H.R.) 10604 which extended Medicaid benefits to cover services provided by the Intermediate Care Facilities. The amendment provided a reduced cost option for medically indigent individuals who were not in need of institutional or intensive care provided by hospitals or skilled nursing homes (Social Security Administration, n.d.). Then, in 1972, Nixon signed H.R. 1 which he believed would end "many old inequities" as well as "provide a new uniform system of well-earned benefits for older Americans, the blind, and the disabled." The resolution extended Medicare to 1.5 million social security disability beneficiaries and limited monthly premiums under Medicare Part B. It also allowed for optional Medicare cover through

health maintenance organisations and extended coverage for kidney transplants and renal dialysis (Social Security Administration, n.d.).

In 1974, Nixon saw another opportunity for health reform and announced a further health insurance plan, more comprehensive than that of his 1971 plan. Nixon's voluntary Comprehensive Health Insurance Plan (CHIP) was his attempt at comprehensive health care reform that would take effect in 1976. CHIP proposed a model differing from previous health insurance proposals: instead of doctors working for the federal government or insurance companies, they would work for their patients (Kidd, 2015). The plan also differed from past proposals in excluding the provision of new federal taxes. CHIP included three "branches of health care", which were: Employee Health Insurance, which would be the dominant type of insurance for employed Americans; Assisted Health Insurance, which targeted low-income individuals; and an improved Medicare plan, which would provide additional benefits to Americans over the age of 65. The cost of CHIP was estimated to be slightly below $7 billion with the Federal government bearing most of the cost at $6 billion and state governments covering $1billion (Kidd, 2015).

2.6.2 Bipartisan negotiation and compromise under the Nixon Administration

Prior to the introduction of CHIP, key members of government were ready and willing to compromise. Senator Ted Kennedy began considering the scale-back of his proposal and showed a willingness to compromise. This willingness to compromise was not founded on a preference for less comprehensive insurance; rather it was grounded on political calculation, particularly after the introduction of a moderate health insurance bill introduced by Senator Russel Long (D-Louisiana). Senator Kennedy believed that the success of a universal coverage plan had reached its opportune time (Steinmo and Watts, 1995: 350).

Senator Kennedy also broke with his liberal caucus and worked with Congressman Wilbur Mills (D-Arkansas) to compile a bill that brought together components of single payer health care with an employer mandate, with insurers serving as fiscal intermediaries (Altman, 2009). On the other side of the political aisle, President Nixon's breakaway from his own party with his health insurance plan brought the two sides to the negotiation table. Kennedy began giving orders to staffers to reach out to members of the Nixon administration to reach a compromise. However, with pressure from the unions and Nixon's Watergate scandal which ultimately led to his resignation, a bipartisan compromise on health care between Kennedy and Nixon failed to come

to fruition (Stockman, 2012). The US was at its closest point to obtaining national health insurance. Starr, referenced by Wainess (1999: 307) states that national health insurance would probably have been enacted had it not been for the Watergate scandal that brought Nixon down. Following Nixon's resignation, and the bill only mustering a one-vote majority in the committee, Congressman Mills, Chairman of the powerful House Committee on Ways and Means, had pronounced the issue of national health insurance dead (Wainess, 1999: 305).

2.6.3 An ailing economy: Recession of 1973-1975

Following the Watergate scandal and the subsequent resignation of Nixon from the presidency, Nixon's Vice President, Gerald Ford, took the reins of power. Ford was determined to continue the push for universal health coverage; however, Chairman Mill's pronouncement on the death of health reform meant Nixon's bill would fail to materialise into law.

Following high government spending on the Vietnam War, the increase in oil prices by the Organisation of the Petroleum Exporting Countries (OPEC) and the embargo on US oil exports leading to increased gas prices in the country, the US entered a recession from 1973-1975 (Koba, 2011). The country faced accelerating rates of high inflation, referred to as the "worst of world's-high inflation and recession" (Sprinkel, 1975: 1). In 1976, Ford abandoned the promotion of health insurance following the recession, stating that the passage of health insurance legislation would increase inflation. Treasury Secretary William Simon concurred, stating that it would be "an unmitigated disaster that could bankrupt the country" (Starr, 1982: 406). Another opportunity for health reform as it had been seen in 1974 would not materialise until the last decade of the 20th century.

2.7 The Contemporary Era: The Clinton and Bush administration's opportunity at health care reform

2.7.1 The continued rise in health care costs of the 1990s

Following the 1970s and 1980s, health care costs continued to rise at an exponential rate. By the start of the 1990s, health care expenditure had reached a high of $666.2 billion. In the period between 1989 and 1990, NHE grew at 10.5%; which was equal to the approximate growth rate of the preceding two years. At the start of the decade, per capita expenditure stood at $2566 which was approximately 1.5 times larger than the preceding ten years. Personal health care expenditure

(PHCE) stood at 87.9% of NHE; this translated to $585.3 billion. Hospital services spending posted double-digit growth in 1990, increasing by 10.1% from 1989 to 1990 and accounting for 38.4% of total health expenditure. Bearing in mind the above increased costs of health care, a significant portion of Americans were still without health insurance, with 33.4 million individuals having been uninsured since 1989 (Levit et. al., 1991: 29-30). During the 1992 election campaign, health care became the centre of attention once more. Both candidates firmly believed that it was crucial that costs needed to be reined in (Pear, 1992).

2.7.2 The Clinton Administration's 1993 health care plan

During the 1992 Election, Democratic candidate, Bill Clinton, stated his opposition to "a nationalized or socialized plan" but favoured the imposition of national public and private health spending, stating that health care costs ought to not rise faster than the average national individual income. Candidate Clinton also favoured the addition of a federal law mandating employers to purchase insurance for employees, available on the private or public markets (Pear, 1992). When Clinton won the 1992 election, ending the 12 years of Republican leadership in the presidency, and was sworn in the following year with a Democrat majority in both houses of Congress, his administration introduced an ambitious health care plan not seen since the 1970s.

In September 1993, President Clinton delivered his speech to Congress calling for action on health care, stating that Congress "must make this [their] urgent priority, giving every American health security, health care that can never be taken away, health care that is always there" (Clinton, 1993). Following the delivery of the speech, polls showed that 56% of Americans approved of the President's plan on health care (White, 1993: 12).

The Health Security Act of 1993 proposed the following:

(1) It had a provision for universal coverage which would entitle every citizen and legal resident in the US to comprehensive health care benefits regardless of pre-existing conditions or change of employment.
(2) Insurance Reform: the bill would prohibit insurance companies from excluding individuals with pre-existing conditions. Coverage would be guaranteed and access to most health services would have no lifetime limits. The bill also included a community rating which meant

that insurance companies would be unable to limit coverage to certain segments of the market only.

(3) Regional Alliances: the bill would introduce alliances comprising affiliated groups of physicians, hospitals and providers organised by insurance companies which would be in competition for customers on the basis of price and quality. These regional alliances would obtain premiums from employers comprising contributions from employees and employers. Thereafter, they would receive subsidies from the Federal and States governments. Regional alliances are tasked with the responsibility of ensuring that the market encourages high quality delivery of health care with controlled costs.

(4) Medicaid amendments: The bill proposed that beneficiaries under Medicaid who did not have any Medicare cover would be enrolled under regional alliance health plans. States would be required to cover individual health insurance premiums of Medicaid beneficiaries who received no cash payments[4] (Plaut and Arons, 1994: 872-873).

2.7.3 Failure of Clinton's health reform

Despite the administration's confidence in their plan, public support of the bill began to wane. Clinton's Secretary of Health and Human Services stated, "the public clearly told us that the idea of taking on the whole-system, every aspect of it, was unacceptable" (Hamburg and Ballin, 1995: 8). Indeed, Gordon (2003: 41) makes it clear that the bill had tried "vainly to satisfy an array of often-contradictory goals and interests". Although the Clinton administration had a Democratic majority in both houses of Congress, division on the issue of health reform within the Democratic Party prior to the administration had also affected their ability to pass the 1993 bill. The Democrat left had advocated a Medicare for all programme, extending Medicare benefits to individuals below the age of 65. The Democrat right, however, advocated for a managed competition model which involved the private sector but with added regulations from the Federal government. The Clinton administration's plan had tried to reconcile the differences between the two factions in the party; however, their attempt failed to garner any support or understanding from the party (Starr, 2013: 104).

[4] The bill proposed other measures that are discussed in greater detail under Plaut and Aron's article on the health care proposal. Refer to 'President Clinton's Proposal for Health Care Reform: Key Provisions and Issues (Plaut and Arons, 1994: 87-874). To read the full act, refer to H.R. 3600- 103rd Congress: Health Security Act.

This division regarding the Clinton health care plan led party leaders in Congress to introduce various proposals and four of five committees succeeded in having proposals passed. Party leaders attempted to piece proposals together that could garner support from members of Congress, but with the 1994 mid-term Congressional elections approaching, and lack of any support from their Republican colleagues which was necessary to break any voting threshold, the Democrat Party entered the election with a significant campaign promise unfulfilled (Hamburg and Ballin, 1995: 9).

2.7.4 The 2000s: The Bush Administration's health care reform

The United States entered a new century and still had not instituted any form of health insurance for all its citizens. In the controversial 2000 Presidential election, Texas governor and the son of former president, George W Bush, had won the White House by a razor-thin margin given by the Supreme Court's 7-2 decision (CNN, 2000).

The Bush administration was still confronted by similar issues that the previous administration had had to contend with regarding health care: health care costs continued to spiral out of control. Health care spending had increased to $1.3 trillion at the start of century with an average of $4,637 per person. Nominal health care expenditures grew by 6.9%. Predictions suggested that health spending as a share of GDP was expected to increase in the 'near future' because of the deceleration of GDP growth and the increasing growth of health care employment, medical inflation, and premiums. Lastly, the administration noted with concern the increasing rate of growth of drug costs as a component of health spending (Levit et. al., 2002: 172).

At the same time, interest groups that had once been at loggerheads regarding universal health insurance had begun to build consensus on health care access. Kahn III, a member of the Health Insurance Association of America (HIAA), which represented the US Health Insurance industry, and Pollack, Executive Director of the pro-universal health insurance advocacy group, Families USA, argued:

> To win broad-based support from across the ideological and political spectra, a meaningful proposal should achieve a balance between public- and private-sector approaches, focus attention on those who are most in need of assistance and build on systems that work today (Kahn III and Pollack, 2001: 40).

This marked a shift in the general disagreement on universal health insurance that had been seen from the HIAA in the 20th century. Despite the slight decline of 0.3%, 14% of Americans were still without any health insurance coverage, a percentage which translated to 38.7 million citizens (Mills, 2001).

In response to the issues outlined above, the Bush administration proposed modest solutions, albeit cautiously. To address the issue of uninsured Americans, Bush proposed a spending of $70 billion over a ten-year period that would grant a $1000 tax credit to low-income individuals and $2000 to families, to cover health care if they had no employer-sponsored coverage. Regarding Medicare, Bush believed that the programme was heading for bankruptcy and was in urgent need of reform (Gregg, n.d.). Therefore, the administration sought to cover prescriptions of Medicare beneficiaries and proposed an increase of $48 billion in spending over 4 years. Furthermore, the administration proposed an increase in Medicare's 2002 Fiscal Year budget by $230 billion and to double Medicare's budget over a 10-year period to ensure that Medicare kept up with the increase in medical costs (Casscells, 2001).

2.7.5 Continued expansion of Medicare: Passage of the Medicare Prescription Drug, Improvement and Modernization Act

After the midterm Congressional election of 2002, Bush's Republican Party gained control of the Senate and now had control over both Houses of Congress and the White House, a situation which had last been seen in the Eisenhower era in the 50s. In addition, the new Senate Majority Leader and Committee of the House Ways and Means Committee (both Republicans), were able to prioritise the issue of Medicare reform with their powerful positions in relation to the control of the legislative agenda. The alignment of both the executive and legislative branches made it clear that Bush's objective to pass Medicare reform on prescription drug benefits would be possible (Oliver et. al., 2004: 309).

Then on 8 December 2003 President Bush signed Public Law 108-173, otherwise known as the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Social Security, n.d.). Upon signing the law, Bush proclaimed that this law would give senior Americans "better choices and more control over their health care [to] receive the modern medical care they deserve". The law was the largest expansion of the programme since its inception under the Johnson administration in 1965 (CNN, 2003). The MMA implemented an addition to Medicare by

creating Medicare Part D. Part D focused on covering retail prescription drugs for beneficiaries on Medicare through "unique stand-alone drug insurance plans." The stand-alone drug insurance feature is explained as follows: Medicare part D's coverage of prescription drugs can be an add-on to beneficiaries on Medicare Advantage (MA), which covers all medical spending, including physician visits, prescription drugs, and hospital visits, or a stand-alone benefit for beneficiaries without MA. Drug costs for beneficiaries without MA are set to the expected prescription drug spending in the population, therefore premiums and cost-sharing typically follow drug spending trends (McCaughan, 2017: 1-2).

2.7.6 Revival of universal health insurance: Proposals from Congress

Bush won his 2nd term and his party retained both houses of Congress in the 2004 general election. However, in the 2006 midterm elections, the Republican Party lost both houses of Congress to the Democratic Party (Pilkington, 2006). The victory for the Democratic Party gave it a new opportunity to present universal health care once more. Members from the Democratic Party presented two health insurance bills in their attempt to pass universal health care coverage. Congressman John Conyers introduced the United States National Health Care Act, also known as "Expanded and Improved Medicare for All". The Act would provide a publicly financed and privately delivered health care system to all residents in the US (H.R. 676, 2007: 1). The second bill, the Healthy Americans Act of 2007, introduced by Senator Ron Wyden, was estimated to cover virtually all Americans. Its aim was to lower national health spending, decrease the growth rate of health spending and save almost $1.5 trillion during the first decade of its enactment (Galston, 2009).

Both bills did not reach President Bush's desk for signature, nor did they pass through Congress. However, with costs still spiralling upwards, there was a growing desire for health care spending to be reined in and a push to provide health care coverage to all uninsured Americans.

2.8 The Obama administration's attempt at health reform and opposition

Health care spending during the last year of the Bush presidency stood at a worrying $2.4 trillion, which translated to an average of $7,868 per individual. In addition, national health spending as a percentage of GDP grew from 7.2% in 1970 to a staggering 16.6% in 2008, further affirming the US as the highest spender on health care among Organisation for Economic Cooperation and

Development (OECD) countries (KFF, 2008). The recession of 2007-09 further exacerbated the cost of health care for individual Americans. With almost nine million Americans losing their employment during this period (CBPP, 2019), and with the majority of insured Americans receiving their insurance from their employers, this entailed more Americans being without health care coverage, resulting in the further deepening of the health care crisis (Holahan, 2011: 145).

With the victory of the nation's first African American President, many were hopeful that a new political era would arise in the US. At the same time, coupled with the ever-growing power of the Federal government in response to the recession, the Republican party became increasingly reactionary towards the prospects of a significant overhaul by the incoming administration; calling the proposed changes by the Democratic Party a "government take-over" (Starr, 2013: 104).

The Obama administration's pursuit of health reform was no longer marked by opposition from major interest groups such as the AMA or HIAA, but was now faced with opposition from within the halls of Congress. Members of the Republican Party continued to use charged rhetoric to describe the administration's attempt at health care reform, calling it "socialism", "rationing", an example of "big government" (Skidmore, 2010: 190). Despite the political opposition and virulent rancour, President Obama addressed a joint session of Congress on September 9, 2009, calling for significant changes within health care, declaring that "the time for bickering" about health care had come to an end (CNN, 2009).

Days after the general election, a White Paper, written by Democrat Senator, Max Baucus, was issued which laid out a "nationwide insurance pool called the Health Insurance Exchange (HIE)". The HIE would ensure access to "affordable, guaranteed coverage" which would include every individual, regardless of pre-existing conditions. It would also extend Medicaid coverage to more individuals and provide tax credits to subsidise premiums for families and small businesses who met an unspecified criterion. Lastly, the White Paper contained a requirement for all individuals to obtain insurance once the HIE had been established (Starr, 2013: 197). Indeed, after Obama's address to Congress, the President's health care plan was revealed with similar proposals to those outlined in the White Paper. The objectives of the Act were to expand insurance access to uninsured Americans, increase consumer protection, improve quality and system performance, focus on prevention and wellness, control the rising costs of health care, and expand the health workforce (National Conference of State Legislatures, 2011).

Soon after the President's speech on health care reform, the President's bill had passed both houses of Congress. On March 23, 2010, the President signed the Patient Protection and Affordable Care Act (ACA) into law. However, despite its codification, opposition remained unabated and undeterred, with members of the Republican Party vowing to repeal and replace the ACA once they had obtained control of the federal government again (Stolberg and Pear, 2010). Indeed, following the signing of the ACA, the law became one of the signature issues the Republican Party utilised in its campaigns, helping them regain the House in 2010 and the Senate in 2014. After having gained the Senate in 2014, Republican Speaker of the House stated "The American people (…) are not for Obamacare. Ask all those Democrats who lost their elections (…) A lot of them voted for Obamacare" (Pramuk, 2019).

Once in control of both houses of Congress, the party attempted to repeal the ACA more than 50 times between 2010 and 2016. Members of the Republican Party state officials were resistant to expand Medicaid under the law. At the end of the Obama presidency and the start of the Trump presidency, the law had remained largely intact. However, a major campaign promise of the Trump administration was to repeal and replace the law. Now with both houses of Congress and the White House under the control of the GOP, the future of the ACA was more uncertain (Cohn, 2020).

Despite the rhetoric of repeal from the GOP, the Trump administration failed to repeal the whole law. However, the administration managed to implement one significant modification to the Act: the GOP managed to eliminate the individual mandate component of the law which required every U.S. resident to have health insurance or face a penalty. The GOP-controlled Congress managed to eliminate the mandate by setting the penalty to $0. According to the Kaiser Family Foundation, after the removal of the penalty fee, premiums on the ACA silver plans had gone up by an average of 32% (Simmons-Duffin, 2019).

Following the presidential election of Obama's Vice-President, Joseph Biden, the new administration now seeks to prioritise Medicaid and the Affordable Care Act (Jost, 2021). At the time of writing[5], the new administration, under President Joseph Biden, is only 5 months into its term. However, due to the incumbent's history of serving with Obama for 8 years, the expectation

[5] As of June 2021.

is that there will be an attempt to return the ACA to its condition prior to the start of the Trump administration.

2.9 Conclusion

Health care in the US has remained an incredibly complex subfield of US public policy, filled with charged rhetoric, vitriol, and political rancour as is reflected in the research problem and has been demonstrated in this chapter. Major advances in health care have only managed to provide for the nation's elderly population and the poor. However, for the nation to have reached the point of providing some form of health insurance for these subgroups in the population, several administrations had to propose reforms in order to move closer to the eventual enactment of Medicare and Medicaid. With each attempt at health care reform, America's pluralistic society, institutions, and interest groups have stood in the way. The Advocacy Coalition Framework, the theoretical framework of this study, will be utilised to answer this study's research question which is to identify the actors with significant influence in health reform as reflected in the contextual background discussed in this chapter. For a better understanding of the main theoretical framework of this study, as well as how it will be utilised to answer the research question, the ACF will be reviewed in the next chapter.

Chapter 3: The Advocacy Coalition Framework - An overview

3.1 Introduction

In the first chapter, it was mentioned that the attempt to reform health care in the US has been fraught with charged political rhetoric, debates on the appropriate role of the state in health care, and input from various actors and interest groups who have continued to make the process of enacting health care reform cumbersome. From this, the thesis is an attempt to draw attention to the identification of actors present with the most influence within US health policy development prior to and after the enactment of the ACA.

Research of any type can be further enhanced through the use of an appropriate theory or framework. By utilising an appropriate theory or framework, this research and its conclusions can be legitimated and thereby contribute to a greater understanding of society and in this context, health policy. Therefore, in addressing the problem identified and the ensuing question posed, which is, *which actors have played a significant role in the current state of US health care reform policy?* the Advocacy Coalition Framework (ACF) has been identified as an appropriate framework for addressing the research question.

This chapter serves to provide an overview of the framework by providing a brief background and rationale for the conceptualisation of the framework. Subsequently, a breakdown and discussion of the several components of the framework, which all work together to provide an understanding of the policy process, will be given. Thereafter, a review of previous applications of the ACF in health policy shall be conducted, where it is hoped that this study will contribute to the limited literature on US health reform that has utilized the ACF. The chapter will culminate in a conclusion that provides an overview of aspects which were discussed in the chapter and what the student hopes to achieve by the application of the framework.

3.2 Suitability of the ACF to the study

The focus of the ACF is to provide a holistic understanding of the policy process. Its central point is that actors in any policy sphere compete to translate their beliefs into actual policy which will ensure policy change (Luxon, 2019: 106; Henry et al.,2014: 300). In addition, by its inclusion of actors across all levels of government and society, it provides the opportunity for journalists, researchers, and judges - in addition to traditional actors such as elected officials, interest groups,

and bureaucrats - to coalesce into advocacy coalitions (Brooks, 2018:12). By making use of this framework, a thorough review of stakeholders involved in any policy area can be achieved. Lastly, the framework has been identified as useful in identifying coalitions in terms of the prescribed beliefs system (Henry et al, 2014: 304) and has also been seen as the most appropriate framework to utilise when studying "contentious politics" (Weible and Jenkins-Smith: 2016: 20). Therefore, one may deduce from these two reasons that the framework may help in accomplishing the aim of this study, which is to identify actors who have played a significant role in health reform, particularly within the context of the polarised and contentious nature of health reform.

3.3 Rationale behind the ACF

In the late 1980s, Jenkins-Smith and Sabatier developed the ACF to respond to "wicked problems", a term used to describe problems in the policy sphere which are highly complex, consist of various possible causes, and are known to have significant ramifications to society if not resolved accordingly (Sabatier and Weible, 2007: 189; Peters, 2017: 385). Examples of wicked problems can be found in health care such as the obesity pandemic or in environmental challenges such as the biodiversity loss (Walls, 2018: 1). In analysing federal air pollution policies from the 1950s to the 1970s, Sabatier (1988: 129-130) noted the elements which existed within the complex nature of U.S. policymaking, mainly: (1) the fundamental role of how problems are perceived; (2) shifts in opinion among members of the elite and the public regarding the importance of different problems identified; (3) periodic debate over the appropriate place of government's authority (4) failure to fully achieve policy goals; and (5) the issues present within the policy formulation process, implementation and reformulation. These listed complexities of the US policymaking environment were observed in his analysis of the federal air pollution policy, which Sabatier (1988:130) sought to understand in his policy analysis. For this reason, a new framework of analysis was required that would explore the above-listed problems.

In addition, Jenkins-Smith and Sabatier (1994: 177) noted the serious issues present within the dominant policy analysis model of the time: the stages heuristic. The stages heuristic, otherwise known as the stages model, is a policy model which consists of five stages, mainly "agenda setting, policy formulation, decision-making, implementation, and evaluation" (Benoit, 2013: 1). Jenkins-Smith and Sabatier (1994:177) posit that the stages heuristic had "suffer[ed] from a built-in legalistic, top-down focus," resulting in the model being too rigid in its analysis of policy and

focused too often on traditional actors in policy such as legislators. This focus had excluded other actors who may have played a significant role in the policy cycle of problem identification, decision-making, and implementation. Furthermore, these writers state that the stages heuristic evinced a myopic view of policy by focusing on one policy at a time. Therefore, including other actors from multiple levels of government and other areas of civil society was believed to be beneficial in providing an increasingly holistic review of policy analysis.

From the issues identified, Sabatier drew inspiration from Heclo's (1974) work on welfare policy in the United Kingdom and Sweden. A fundamental element that Heclo put forward was the inclusion of specialists and their role within specific policy areas. He argued that specialists interacted within policy areas and obtained greater knowledge and understanding of the aspects of the problem over a period, thereafter using a plethora of different methods to obtain their policy objectives (Heclo 1974, as cited in Sabatier, 1988: 130). Policy change was, therefore, a result of "large scale social, economic, and political changes and the strategic interaction of people within a policy community which involved both competition for power and efforts to develop more knowledgeable means of addressing the policy problem" (Heclo 1974, as cited in Sabatier, 1988: 130). Sabatier (1988: 130) then built on Heclo's work, by creating a framework that examined policy change over a period and continued the focus on observing the interaction of political elites within the policy community in their responses to changing socioeconomic conditions in the society.

3.4 The Advocacy Coalition Framework

The ACF provides a holistic review of the policy process by analysing policy change in a particular policy area over an extended period — usually a decade. This is typically carried out by multiple actors at various levels of government and society who coalesce into advocacy coalitions which will promote a specific policy position. The ACF achieves this through four premises set out by the developers of the framework. Firstly, policy change is understood over a period of a decade or more, as any policy change observed in a period less than a decade does not provide an accurate analysis of the success or failure of the policy, nor does it observe a full policy cycle of formulation, implementation, and reformulation (Sabatier, 1988: 131). Secondly, the policy subsystem, which consists of stakeholders from various institutions who interact with each other to influence decisions made by the state in any particular policy area, is the best unit of analysis when reviewing

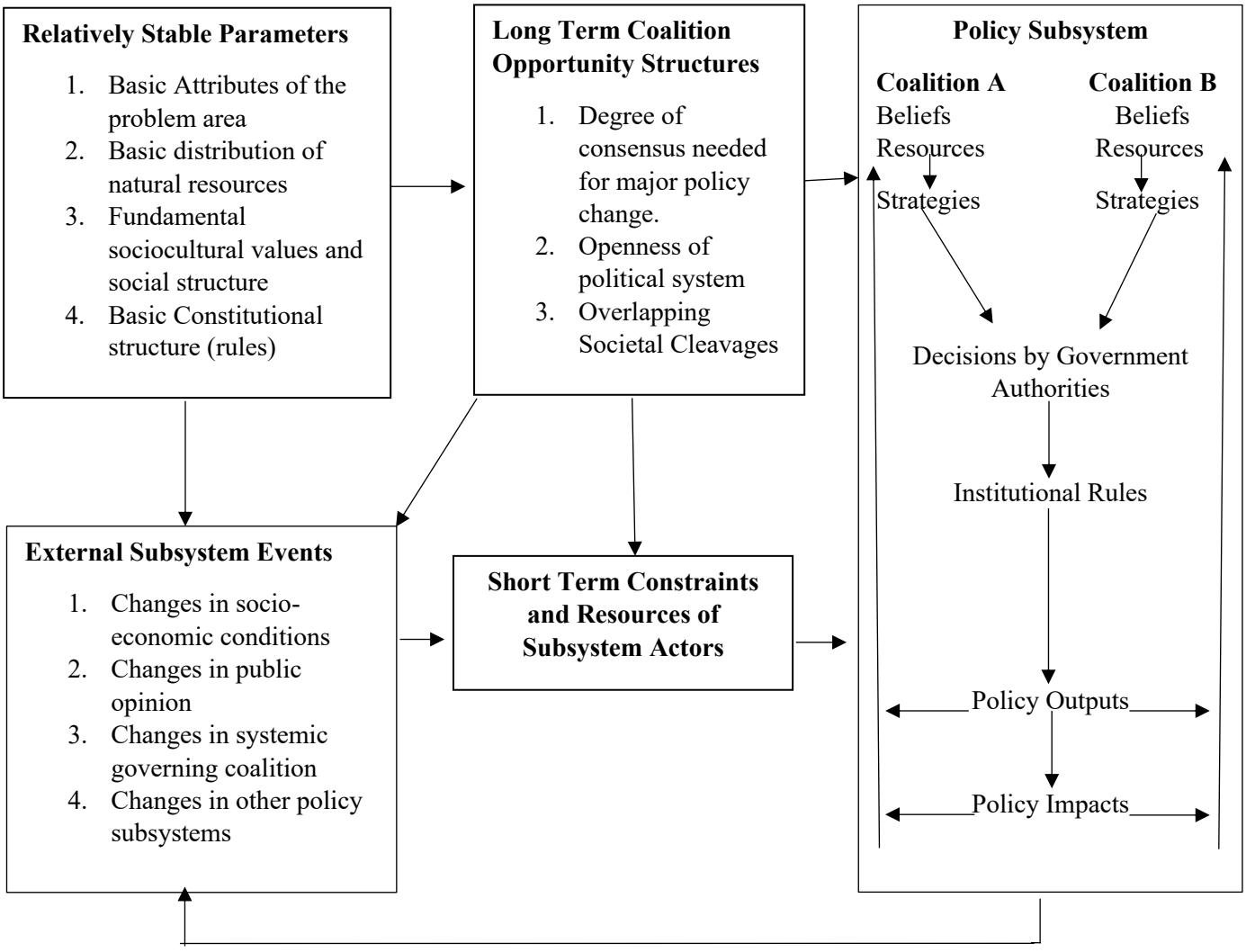
policy change (Jenkins-Smith and Sabatier, 1994: 178). Thirdly, policy subsystems must include all levels of government (Federal, state, local) in society to provide an holistic overview of all actors involved in the policy process; and fourthly, policies passed by the state can be understood as the manifestation of the beliefs of actors involved in formulating the policies, which is understood through the use of a belief system that will be explained in greater detail below (Jenkins-Smith and Sabatier, 1994: 178).

On the next page the flow diagram of the ACF is provided. Though seemingly convoluted, all elements of the flow diagram mainly affect the policy subsystem and the coalitions within it. Despite the focus of the present study on the subsystem, coalitions, and beliefs, the other elements of the flow diagram must also be discussed in order to provide a greater understanding of how actors conduct themselves within the subsystem in their attempt to pass their policy positions within US health policy. This would help in understanding how actors played their role in US health reform during the development and implementation of the ACA.

3.4.1 Relatively Stable Parameters and External Subsystem events

In providing an overview of the diagram, two elements, Relatively Stable Parameters (RSPs) and External Subsystem Events, are categorised as stable and dynamic respectively, and are seen as fundamental in guiding the actions and behaviours of actors within the policy subsystem (Sabatier, 1988: 132). Relatively Stable Parameters, defined as *structures that set the foundation of policy subsystems and the behaviour and actions of actors within the subsystem* (Alvarez-Rosete and Hawkins, 2018: 30), tend not to change often, and any change is only observed over approximately a decade or more, affecting the occurrence of behavioural or policy change in policy subsystems (Sabatier and Weible, 2007: 193). The difficulty in their modification also affects the strategies, resources, and beliefs of actors involved in any policy subsystem. Ergo, actors within the subsystem are forced to confine their actions to the parameters established. Four parameters are presented in the framework: (1) Basic attributes of the problem area; (2) Basic distribution of natural resources; (3) Fundamental cultural values and social structure; (4) and Basic constitutional or legal structure (Sabatier, 1988: 136).

Figure 2: 2005 Advocacy Coalition Framework Flow Diagram (Sabatier and Weible, 2007: 202)



Basic attributes of the problem area: According to Ostrom (1975: 846), public choice theorists have been particularly concerned about the nature of goods when measuring which goods are provided solely by the free market and which can be provided through the public sector. This concern refers to the excludability and jointness of use of goods and services. Excludability or exclusion refers to the ability of producers to deny the use of their product to consumers on condition that they pay for it, whereas jointness of use refers to the ability of individuals to enjoy the benefits derived from goods at the same time as others. An example of excludable goods would be access to private education, and an example of jointness-of-use goods would be the benefit

derived from streetlights, as all individuals have access to these, whether they have the ability to "pay" for it or not. In addition, an example that Sabatier (1988: 135) was concerned about was the inability of markets to deal with common pool problems[6] which occurred with ocean fisheries and underground aquifers. Government regulation would then be necessitated to enact a fair use policy to avoid the problem of the common pool.

Basic distribution of natural resources: Sabatier (1988: 135) notes that the use and distribution of natural resources has a significant impact on the nation's wealth and serves as a determining factor on the viability of various economic sectors, affects a multitude of aspects within the nation's culture, and whether options in a plethora of policy areas remain feasible to pass and implement. An example used by Sabatier (1988: 135) is the US's ability to transition to coal-based energy from oil in the 1970s due to its abundance of coal reserves, whereas France had transitioned to the use of nuclear energy due to the lack of coal reserves to meet energy demand. Both countries were limited by the natural resources they possessed in addressing their energy needs and therefore had to choose the most feasible option for their context.

Fundamental cultural values and social structures: Sabatier (1988: 136) notes that a "large scale nationalisation of the means of production" has been implemented in Europe but has proved to be difficult if not impossible in the context of the US. For example, the promotion of a single payer health insurance system has been largely adopted within Europe and other OECD countries, but the US continues to resist the idea, though a select few actors continue to advocate for it. Another example would be the US's strong individualistic culture and advocacy for small government, which would affect the viability of government programmes such as a single payer health insurance system; whereas EU Countries are more open to greater government involvement and would support programmes that may be deemed 'socialist' by their American counterparts. An additional point, however, is the change in various social groups' influence in policy. Sabatier (1988: 136) states that political power has largely been reserved for groups of high income, social class, and large organisations. However, noting the influence of various social groups and their possession or lack of political resources, is starting to add a different dimension to policy-making

[6] A common pool problem refers to the overconsumption of limited goods/resource by an individual which ultimately impacts on the ability of others to enjoy the same goods/resource (McLaughlin and Pathak, n.d.) and relates to the *jointness of use* principle.

within subsystems, and which actors within the subsystem are cautioned to take into consideration when creating strategies in the short- or medium-term for their advocated policies.

Basic constitutional and legal structure: The constitutional and legal structure of any state rarely changes and when any amendments are made, an amendment process that typically consists of a significant majority must be followed. Sabatier (1988: 136) confirms this by referencing the US constitution's last significant amendment which was passed in 1920. He further concludes that basic traditions such as "the role of the courts and… norms of administrative law" are stable and rigid in nature (Sabatier, 1988: 136). Because of the rigidity of the legal norms of the state, actors within the policy subsystem are confined to the prescriptions stipulated within the legal code of the nation, which ultimately affects the policy changes they ultimately seek to enact.

In other words, because of the unchanging nature of relatively stable parameters (RSPs) when it comes to effecting any change in policy in any subsystem, actors who seek to enact a particular policy may be restrained from doing so due to limitations that may be present. On the other hand, actors who may be in favour of a particular policy which appears compatible with the above-mentioned RSPs may view RSPs as an opportunity to promote and eventually succeed in having their policy position become actual policy. RSPs therefore affect the long-term opportunity structures, which are situated in the middle of policy subsystems and RSPs as shown in Figure 1. For example, the constitutional and legal structure of a country would affect the level of consensus needed for major policy change i.e., the number of votes needed to pass a law or overcome veto points (Sabatier and Weible, 2007: 200). Though not the focus of this thesis, RSPs have been seen as providing "long term constraints and opportunities" for actors within the subsystem, which can serve as advantages or disadvantages depending on the coalition within the subsystem (Alvarez-Rosete and Hawkins, 2018: 27). The inclusion of RSPs can serve to provide greater depth in answering the research question when discussing the actions and behaviour of identified actors within the health policy subsystem, as will be done in the subsequent chapter.

External subsystem events constitute another element that significantly impacts the actions and behaviour of actors within the subsystem, as well as the ability for policy change to occur. These events are seen as a "necessary but not sufficient" condition for major policy change to occur (Sabatier and Weible, 2007:198), i.e. though their occurrence can allow for major policy change, their occurrence does not provide certainty that policy change *will* indeed occur. What would lead

to change is the existence of a coalition (most likely a minority/opposition coalition) that exploits the external event for its own objective in the subsystem (Weible and Jenkins-Smith, 2016: 24). Nevertheless, external subsystem events in comparison with RSPs are dynamic in nature, meaning that a change in events is more likely to be observed and shock the policy subsystem than is the case with RSPs. Due to their susceptibility to change as well as their unpredictability, actors within the subsystem are challenged always to prepare for the possibility of an external event that may significantly affect the subsystem (Sabatier, 1988: 136). External subsystem events are classified into the following categories: (1) changes in socio-economic conditions and technology; (2) changes in systemic governing coalitions; (3) policy decisions and impacts from other subsystems; (4) and changes in public opinion (Sabatier, 1988: 136-138; Sabatier and Weible, 2007: 198-199).

Changes in socio-economic conditions and technology: Sabatier (1988:136) notes that this category can affect the overall objectives of enacted policies as well as change the political support of coalitions within the subsystem. An economic downturn can serve as an example of an external subsystem event which would force a governing coalition to respond through amending or enacting a different policy. An economic downturn would have a broad effect on multiple policy subsystems, but it does provide a general example of the effect this category may have on the subsystem. This category, along with the example, will be further discussed in the next chapter.

Changes in systemic governing coalitions: Sabatier (1988: 137) argues, through his air pollution policy example, that by a change in government or administrations through elections, support for a particular policy position can be promoted. In his example, the Reagan administration's victory in the 1980 election allowed a minority coalition, which had favored deregulation in federal environmental legislation, in order to have a say in air pollution policy through the Environmental Protection Agency. This category will be applied in the subsequent chapter when discussing the various administrations which have played a role in health care reform during the last decade.

Policy decisions and impacts from other subsystems: The founders of the ACF view subsystems as semi-autonomous i.e. though they may focus on a specific policy area and consist of specialists in that area, events and actions from other subsystems have the ability to impact other subsystems (Sabatier, 1988: 137). An example provided by Sabatier (1988:137) can be found in the US government's attempt, during the Nixon and Ford administrations, to transition to energy independence which would entail the increased use of fossil fuels, which in turn impacted the air

pollution control subsystem which sought to improve air quality (Sabatier, 1988:129). In summary, what occurred in the energy subsystem had an impact on the air pollution subsystem.

Changes in public opinion: A shift in public opinion on a policy has the ability to force a governing coalition to reassess its position on the policy. For example, by an increased interest in environmental issues by the public in the 1960s and early1970s, actors in the environmental subsystem promoted and passed policies that led to new "national and state environmental regulatory statutes and grants" (Weible and Sabatier, 2007: 129).

Though RSPs and external subsystem events can play a role in the actions and behaviours of coalitions as they vie for influence on policy-making, the focus of this study is to identify the actors involved in health care reform policy. The inclusion of RSPs and external subsystem events in the study serves to indicate the constraints and key events which identified actors in the health care reform debate have had to contend with as they vie to influence policy. Nevertheless, it is imperative that the discussion pertaining to the framework move to the main unit of analysis: the policy subsystem, and the two components that will be focused on are advocacy coalitions and beliefs.

3.4.2 The Policy Subsystem and its components

The policy subsystem is a unit of analysis used to understand the policy process which consists of actors found within the public and private sectors, who are concerned about policy problems and vie for influence in the policy-making arena of any field such as health, environmental, or welfare policy (Sabatier, 1998: 99). Based on the ACF's assumption of the significant complexity of modern policy-making, actors within the policy subsystem tend to specialise in the specific policy field they advocate, in order to become influential in passing new policy (Sabatier and Weible, 2007: 192). Sabatier and Weible's (2007: 127) use of the Lake Tahoe water quality subsystem serves as an example of policy participants who have specialised to effect change. In it they note the existence of several groups such as the Federal Environmental Protection Agency, environmental groups such as the "League to Save Lake Tahoe' and researchers at universities such as the University of California - Davis. They further note that the specialisation of policy participants tends to be long term within the subsystem, stating that some policy participants have spent more than 30 years advocating for certain positions pertaining to the Lake Tahoe water quality policy.

Furthermore, in discussing the role of crises (i.e. external events) in effecting policy change, Nohrstedt and Weible (2010: 14) list three types of policy subsystems which were conceptualised to measure the level of conflict that may exist between actors present in the subsystem as policy change is attempted. These subsystems are listed as unitary, collaborative, and adversarial subsystems. Unitary subsystems are described as consisting of one dominant coalition which effects largely unchallenged changes in policy as most actors in this type of subsystem share similar policy core beliefs. Collaborative subsystems tend to have two or more coalitions which tend to share secondary beliefs more than policy core beliefs. A degree of conflict and cooperation can exist within this subsystem (Heinmiller et al, 2021: 76). Adversarial subsystems, however, are characterised by the lack of shared beliefs and heightened competition between the two or more coalitions present within the subsystem (Heinmiller et al, 2021: 77). Indeed, Nohrstedt and Weible (2010: 15) view adversarial subsystems as "more prone to politicization" than the other types of subsystems. Therefore, being cognizant of the polarised nature of the US health reform debate, one can infer that the adversarial subsystem category is the most appropriate lens through which to view the health reform subsystem, and this will be done in the next chapter. However, depending on the number and types of coalitions identified, the subsystem may be categorised differently.

Within the policy subsystem, Sabatier and Weible (2007:127) list the key components which this study will utilise, which are: advocacy coalitions and the belief system. These can be found in Figure 1 under the policy subsystem, beginning with coalitions and followed by beliefs. These writers do mention other elements such as the existence of policy brokers, resources used by coalitions, and venues used to influence policy. 'Policy brokers' refers to actors who are seen as mediators within the subsystem, who attempt to de-escalate conflict between advocacy coalitions. They can include elected officials, bureaucrats, or courts (Weible and Sabatier, 2007: 128). 'Venues' refer to arenas where actors in the subsystem attempt to influence beliefs or policy. Actors engage in 'venue shopping' where they believe they would have a competitive advantage to have their policy position promoted eventually. Examples of venues are legislative bodies, the courts, or the media (Weible and Sabatier, 2007: 129). These elements do also show in the discourse on health reform in the US. However, in order to provide greater detail on how identified actors have conducted themselves in advancing their health policy position in the next chapter, the use of *resources*, immediately following *beliefs* in Figure 1, will also be included in the discussion.

The developers of the ACF formulated a highly complex system which maps out the various types of beliefs through which advocacy coalitions (which will be discussed in the next section) coalesce and compete against one another. This belief system, shown in Figure 1 under the policy subsystem, serves as coalitions' first point of departure in advocating policy change. Sabatier (1988: 144) states that the basic strategy of the framework to predict changes in beliefs among policy participants as well as changes attempted in policy over time, is to utilise the structure of belief systems. From this, the belief system utilised in the framework is laid out, which consists of the following categories: (1) Deep Core beliefs, (2) Policy Core beliefs, and (3) Secondary beliefs. These categories are structured from most resistant to least resistant to change (Sabatier, 1988: 144).

Deep core beliefs consist of "normative and ontological assumptions" regarding human nature and can be formed during childhood (Sabatier and Weible, 2007: 194). The category is further described as comprising the debate between fundamental societal values such as liberty and equality as well as the provision of a basic criterion of distributive justice such as deciding on the hierarchy of welfare in society. Particularly within pluralistic societies such as the US, the liberal left and conservative right spectrum also features prominently within deep core beliefs (Sabatier and Weible, 2007: 194; Sabatier, 1988: 145). Sabatier (1988: 145) expands further and describes deep core beliefs as "akin to religious conversion", thereby reiterating the resistance to change of these beliefs. Deep core beliefs also serve as the foundation from which all ideas on the policy front emanate, in that an individual's deep core beliefs will inform his/her position on all policy areas.

Policy core beliefs, positioned in the middle of the three-tier hierarchy, are deep core beliefs applied in policy (Alvarez-Rosete and Hawkins, 2018: 30); that is, they are "subsystem or specific policy beliefs about problems, priorities, and values, and can be either normative or empirical" (Giordono, 2020: 1138). Despite their somewhat rigidity in susceptibility to change, the possibility for change to be observed within this category of beliefs is still present. Jenkins-Smith and Sabatier (1994: 182) state that the change observed within the category is more evident in policy beliefs possessing an empirical rather than a normative element. The former tends to change over a period when more evidence is accumulated. Sabatier (1988: 145) categorises policy core beliefs as consisting of debates about the size and proper role of government intervention and the free market

in society; decisions on the appropriate level of power given to the various levels of government; or examining society's ability to solve issues in policy areas with examples consisting of "zero-sum competition vs potential for mutual accommodation, or technological optimism vs technological pessimism" (Sabatier, 1988: 145).

Generally, the operationalisation of at least two or three policy core beliefs is seen to be sufficient in identifying two advocacy coalitions. Nevertheless, a strong recommendation to operationalise as many policy core beliefs as possible is present, since disagreements found in the various policy core beliefs tend to be sufficient in explaining the subdivisions found within coalitions as well as assisting in possibly identifying a third coalition within the specific policy subsystem (Sabatier and Weible, 2007: 195). Also, additional components that are introduced within policy core beliefs, due to the varying disagreements present among coalitions in reference to subsystem-wide policy proposals, are *policy core preferences*. These are known to have a subsystem-wide scope, are viewed as highly important, and have been contentious among actors in the subsystem for extended periods of time. In addition, they assist in guiding the strategic behaviour of coalitions within the subsystem, as well as serve as a unifying element for allies and a polarising element for opponents within the subsystem (Sabatier and Weible, 2007: 195).

Lastly, secondary beliefs, the third and final layer of the three-tier hierarchy, is the most susceptible to change, since it is assumed as the "more readily adjusted" layer when new data, experience, or changing strategic considerations are introduced (Jenkins-Smith and Sabatier, 1994: 182). Secondary beliefs are known to be narrow in their scope within the subsystem and this further confirms their susceptibility to change due to the need for less evidence and agreement among actors within the subsystem (Sabatier and Weible, 2007: 196). Sabatier (1988: 145) defines secondary beliefs as "instrumental decisions and information searches" that are found to be necessary in implementing policy core beliefs and priorities. Typical components demonstrating secondary beliefs are found to be most decisions made concerning "administrative rules, budgetary allocations, disposition of case, statutory revisions, and information concerning program performance and severity of problems, among others" (Sabatier, 1988: 145).

The ACF's belief system hierarchy is derived from its conception of the Model of the Individual (Weible and Sabatier, 2007: 127). The Model of the Individual is based on the idea that actors are rationally motivated in their pursuit of policy change. However, due to their limited ability to

process new information, the complexity of the policy process, and problems within society, actors use heuristics or filters which allow them to understand easily and solve problems they observe. This is done through the belief system described above. Through these filters, actors can filter any information that contradicts their beliefs and embrace information that confirms their beliefs. When actors within the subsystem lose to their opponents in their policy advocacy, the losing actors tend to overemphasise the loss incurred rather than previous wins in the subsystem. Through this, the losing coalition tends to view their opponent as more evil and more influential than they are. This suspect view of opponents by losing actors can be explained by the concept of *the devil shift* which will be explained below (Weible and Sabatier, 2007: 127).

Although not the main objective of this study, the devil shift, within the context of US politics, may possibly be exhibited in the nation's political discourse. The ACF's inclusion of this element helps explain the charged political rhetoric in the country which has occurred in the heated debate on health reform, among other policy areas. Indeed, Sabatier et al (1987: 451) confirm that the devil shift tends to occur in "high conflict situations". In the previous chapter, the discussion about the history of health reform in the US has given indications of a high conflict characteristic and in the next chapter, certain elements of the characteristic continue in contemporary efforts for health reform. In addition, considering the belief system which includes deep core beliefs described as "akin to religious conversion", demonstrating the deep conviction one has for one's own beliefs, it is probable for elements of the devil shift concept to exist and be applicable in the polarised debate of health reform.

Sabatier et. al (1987:451) list four hypotheses supporting the argument of the devil shift. The hypotheses are listed as follows:

(1) Actors within a coalition will tend to cast doubt on the motives of the opposing coalition in their policy position, while maintaining the position that they care most about the public's welfare, as opposed to their opposition.
(2) Actors within a coalition will be more critical than other members of the policy community on their opposition's behaviour, while viewing their own behaviour in a positive light.
(3) Actors within a coalition will view themselves as possessing less influence than their opposition and overestimate the amount of influence the opposition possesses.

(4) The level of devil shift among the actors within the subsystem has a strong correlation with the level of differences in beliefs, particularly the ideological differences between coalitions.

The above-mentioned hypotheses contribute towards providing evidence of the devil shift in any policy conflict. Coalitions that have polar-opposite beliefs tend to view each other with heightened suspicion in the subsystem, as they continue to vie for influence in the policy subsystem. Bearing in mind the effect of ideological beliefs on the polarised nature of US politics, the belief system prescribed by the ACF helps to sort actors into groups or coalitions sharing similar beliefs. Therefore, this assists in achieving the objective of this study, which is to identify the actors who have played a role in health care policy development in the US.

Within the policy subsystem, actors who share similar beliefs such as core values and perceptions of problems in society tend to coalesce into advocacy coalitions. Advocacy coalitions have been seen as powerful forces capable of limiting participation within the policy-making process as well as: determining which issues are included on agendas, shaping policy participants' behaviours, manipulating evidence that reaches decision makers, as well as prioritising groups' interests in the subsystem (Buse, 2008: 353). Coalitions can typically range from one to four within the subsystem; however, there can be a dominant coalition in the subsystem with other coalitions occupying minority positions (Cairney, 2015: 486). Advocacy coalitions compete against one another in translating their beliefs into material policy (Sabatier and Weible, 2007: 196). Once more, when a fear of losing to opponents is present, coalitions typically employ the devil shift where the intentions and policy positions of the winning coalition are represented with heightened mistrust, and further division ensues between the coalitions involved (Weible et al, 2009: 132).

The ACF contains three hypotheses which focus on advocacy coalitions. According to Jenkins-Smith and Sabatier (1994: 183), these hypotheses are grounded on the premise that policy core beliefs serve to bind coalitions together. The hypotheses are as follows:

"Hypothesis 1: Regarding major controversies within a policy subsystem when policy core beliefs are in dispute, the lineup of allies and opponents tends to be rather stable over periods of a decade or so.

Hypothesis 2: Actors within an advocacy coalition will show substantial consensus on issues pertaining to the policy core but less so on secondary aspects.

Hypothesis 3: An actor or coalition will give up secondary aspects of a belief system before acknowledging weaknesses in the policy core" (Jenkins-Smith and Sabatier, 1994: 184).

These hypotheses assist in supporting how coalitions form and remain stable within the policy subsystem. Indeed, they allude to the point mentioned earlier suggesting that the identification of at least two advocacy coalitions is carried out through the operationalisation of at least two policy core beliefs. In addition, these hypotheses, according to Weible et al (2020: 1067) apply to the ideal type of coalition, known as an adversarial advocacy coalition[7]. This type of coalition contains policy actors who share policy core beliefs, coordinate their political behaviour, possess an opposing coalition, tend to have balanced resources with the opposing coalition over time, and tend not to coordinate with the opposing coalition (Weible et al, 2020: 1068). These criteria will be expanded on shortly. However, when it comes to policy learning, coalitions tend to modify their secondary beliefs when new information is presented. Policy learning occurs when coalitions potentially modify or adopt new elements to their beliefs which can affect their policy positions (Cairney, 2015: 488). However, learning regarding policy core beliefs is more rigid than secondary beliefs and is done "on their own terms" i.e., coalitions engage in selective learning, only accepting new information that does not compromise core policy beliefs which threaten to undermine the coordination within the coalition (Cairney, 2015: 488).

In providing an expanded conceptualisation of Advocacy coalitions, Weible et al (2020: 1060) expand the attributes that can be used to identify coalitions to include not only policy actors and shared beliefs but also three other attributes which are coordination, resources, and stability. Policy actors comprise individuals or groups present in the public or private sectors who seek to influence policy. The number of policy actors involved in the subsystem depends on how contentious the policy conflict is, the degree of attention given to the conflict and whether it is a recent or old

[7] Weible et al (2020: 1068) provide a flowchart detailing the subtypes of coalitions which exist based on the criteria they fulfil. The subtypes of coalitions that exist, provided they have policy actors and share policy core beliefs, are disconnected/potential coalition, ephemeral coalition/coalition of convenience, dominant coalition without opposition, dominant and minority coalitions, and cooperative coalitions.

policy problem (Weible et al, 2020: 1061). Lastly, shared beliefs refer to the three-tiered belief system discussed earlier.

The attribute of coordination shows how policy actors work with or against other actors in the policy subsystem through two categories: coordination among allies and coordination between opposing or rival coalitions (Weible et al, 2020: 1065). Allied actors within coalitions tend to coordinate resources and efforts to achieve a policy objective. However, coalitions sometimes work with opposing coalitions to achieve a win-win policy outcome; this is seen in a collaborative subsystem. But in adversarial subsystems, this type of coordination with opposing coalitions is not present; actors would rather attempt to achieve a win-lose policy outcome where the opposing coalition suffers a policy defeat (Weible et al, 2020: 1065). Certain elements of these two types of coordination have occurred in the health reform debate and will be explored in the subsequent chapter.

Stability serves as an additional attribute of advocacy coalitions. Weible et al (2020: 1067) posit that stability and change over time is a feature that every subsystem, coalition, and actor experiences at some point. The attribute of stability also assists in measuring any potential changes in resources, shift in the coordination of coalitions as well as the potential of learning occurring between coalitions. Typically, this is observed over an extended period which also reiterates the need for policy change to be observed over a period of no shorter than a decade (Weible et al, 2020: 1067). Though stability can aid in measuring changes in and between advocacy coalitions, this attribute falls outside the scope of this thesis and will not be explored.

Lastly, resources serve as an additional attribute of advocacy coalitions. The ACF, since its inception, has undergone a few modifications. The framework added coalition opportunity structures, which sought to address the context in which coalitions operate; a typology of coalition resources, which sought to address the prevalent lack of focus on coalition resources; and two additional paths to policy change (Sabatier and Weible, 2007: 199, 201). However, for the purposes of this study, the modification that will be discussed will be the typology of coalition resources, which will assist in showing how the identified actors translated their beliefs into policy in the health care reform debate.

The addition of a typology of Coalition Resources was to address the significant focus on belief systems when observing advocacy coalitions within subsystems. This has been done but studying

the resources that advocacy coalitions could utilise in advancing their objectives has been neglected) However, despite the inclusion of this typology, the authors still note that the operationalisation of these resources has been tedious in research. Nevertheless, they still do provide more insight into the theory and will assist in observing the influence exerted by identified actors in the health care reform debate. The typology consists of the following resources: (1) Formal legal authority to make policy decisions; (2) Public Opinion; (3) Information; (4) Mobilisable Troops; (5) Financial Resources; and (6) Skilful Leadership (Sabatier and Weible, 2007: 201, 203). These are described below:

(1) *Formal Legal authority to make policy decisions*: The ACF includes actors who are in a position of authority in the legal system as possible members of advocacy coalitions within the subsystem. By including actors such as legislators, judges, and agency officials, these serve as major assets for coalitions to use in advancing their policy goals. For a dominant coalition to exist, an important feature is that it has more of its members in positions of power than opposing minority coalitions do. To carry this out, coalitions utilise strategies such as appointing allies to these positions through political appointments or elections or by employing the use of lobbying campaigns to persuade actors with legal authority to side with their position (Sabatier and Weible, 2007: 203). These tactics have been used significantly in the US, irrespective of the policy subsystem. For example, during the Menu Labelling Policy Debate in the state of California, one of the identified coalitions, the Public Health Coalition, had a key ally within the California state legislature which promoted their bills. Eventually, the Public Health coalition's policy position was successful (Payan et al, 2017: 7).

(2) *Public Opinion:* As was discussed in the preceding chapter, public opinion has played some role in the health care reform debate throughout the 20th century and in recent history. Opinion polls supporting the policy positions of coalitions tend to be a significant resource for actors within the subsystem. By ensuring that a majority of the public is behind a policy position of a specific coalition, the likelihood that officials are elected who will promote and ensure the passage of the policy position in legislative and legal positions will be higher (Sabatier and Weible, 2007: 203). For example, the anti-fracking coalition in the Colorado hydraulic fracturing debate had more public support than the pro-fracking coalition and ultimately became the winning coalition in

the debate (Pierce, 2016: 1163). Another example is found in the use of public opinion polls by the Public Health coalition in California's menu labelling policy debate (Payan et al, 2017: 8).

(3) *Information:* Information can be used to convince members within strategic bodies as well as members of the public to support one coalition's policy position over the other. However, with this resource, distortion of information is possible in order to strengthen arguments presented and therefore the inclusion of researchers serves as a benefit for the framework (Sabatier and Weible, 2007: 203). An example of the use of information as a resource is found in the development of a policy on food service guidelines which sought to "improve the health and productivity" (Rice et al, 2019: 53) of a select population in the state of Washington in the US. The proponent coalition utilised research and evidence compiled by experts in the camp of the proponent coalition, which in turn influenced strategic members in the state government (Rice et al, 2019: 53).

(4) *Mobilisable troops:* Sabatier and Weible (2007: 203) posit that politically active members of the public who share the beliefs of policy elites are often used by coalitions to engage in activities such as public demonstrations and electoral and fund-raising campaigns. Through these actions, a coalition's policy position is promoted and possibly reaches key actors who may implement it. This is closely related to public opinion as advocacy coalitions attempt to gain the sympathies of the public on their policy positions. This resource is also seen as an inexpensive resource and therefore many coalitions, particularly those which do not have abundant financing, use it to further their policy positions (Sabatier and Weible, 2007: 203). An example of the use of this resource is found in Kubler's (2001) article on Swiss Drug Policy. In it, the Quality-of-Life coalition, consisting of landlords, shopkeepers, and residents among others, mobilised to protest the creation of harm reduction facilities, which were considered open drug-use areas. Their mobilisation, petitions, and litigation led to a delay in the further creation of more harm reduction sites (Kubler, 2001: 634-635).

(5) *Financial Resources:* Advocacy coalitions with sufficient financial resources can use their finances to purchase other resources in order to further their policy positions. This can be carried out through the funding of research and the organisation of think tanks

which are able to produce and promote information supporting a coalition's policy position. Lobbying can also be employed by providing financial contributions or incentives to key actors who are able to promote their policy positions. Lastly, coalitions with sufficient financial resources may be able to launch targeted marketing by using the media to garner support from the public (Sabatier and Weible, 2007: 203). However, despite the benefit of having financial resources, the use of this resource, according to Pierce (2016: 1163) seemed not to have had any benefit for the pro-fracking coalition in the Colorado Hydraulic Fracturing debate. Indeed, this is confirmed in California's Menu Labelling Policy Debate with the industry coalition, which used financial resources but lost to the public health coalition, although the latter did not have the same amount of financial resources (Payan et al, 2017: 8). Though little benefit is derived from the *sole* use of this resource in achieving policy objectives, it can still be applied when identifying actors and their roles in the US health care reform policy debate.

(6) *Skilful Leadership:* The inclusion of skilful leadership is an invaluable asset to coalitions. Skilful leaders can articulate the policy position of a coalition in a manner that can garner greater support in decision-making bodies. Skilful leaders are able to use resources in an efficient manner, as well as bring more resources to a coalition (Sabatier and Weible, 2007: 203). An example of skilful leadership is found in the California Menu Labelling Policy Debate. A key ally of the Public Health Coalition in the state legislature, Senator Padilla, with the addition of two other interest groups, was able to approach the media and advocate for the beliefs and arguments of the coalition. By his involvement, the framing of the issue was obtained to the advantage of the coalition. In addition, public opinion and lawmakers were moved closer to their policy position (Payan et al, 2017: 8).

Though the possession of all the resources listed above do not necessarily translate into success in the policy subsystem for any coalition involved, they can be of assistance in that regard. Nevertheless, for purposes of this study, the inclusion of the resources is not to determine how the winning coalition succeeded in passing its policy position but is solely to identify tools of influence used by the identified coalitions, regardless of the success/failure of their policy position.

3.5 Prior applications of the ACF in identifying coalitions in health policy

Since its inception, scholars have reviewed the ACF's application in policy analysis in almost 250 applications, with 80 applications having occurred between 1987 and 2006 and 161 applications between 2007 and 2014 (Weible et al, 2009: 122; Ma et al, 2020: 8). Between 2015 and 2018, an additional 46 applications were reviewed by Ma et al (2020: 12). Indeed, Wellstead (2017: 550) confirms that Sabatier's 1988 article, "*An advocacy coalition framework of policy change and the role of policy-oriented learning therein"* is the most cited paper in the Policy Sciences Journal as well as posting almost 3,000 google scholar citations as of 2017. Pierce et al (2020:80) note the application of the ACF in several policy areas such as public health, social welfare, education, immigration, and foreign policy and defence. However, despite the relatively wide application of the framework, Pierce et al (2020:80) further note the primary application of the framework within the fields of energy and environmental policy, largely due to its conceptual foundation by scholars within these fields. Nevertheless, they raise concerns about the apparent infrequent application of the framework in areas other than energy and the environment and urge scholars to rectify this.

Indeed, scholars have sought to apply the framework in other policy areas, not just in the US where it was conceptualised, but in other regions across the world, with 30 applications outside the US and 20 applications in policy areas outside environment and energy (Weible et al, 2011: 349; Ma et al, 2020: 15-16). Nevertheless, for the purposes of this study, which is to utilise the ACF in identifying actors who have played a significant role in the state of health reform policy in the US, it is imperative that a review of the literature pertaining to the application of the ACF in health policy be conducted.

Health Policy has been defined as "policy that aims to impact positively on population health" (De Leeuw et al, 2014: 2). Some of the focus areas in the health policy field include nutrition (Payan et al, 2017; Rice et al, 2019), vaccinations (Wilson, pharmaceutical policy (Larsen et al, 2006), and health care reform (Alvarez-Rosete and Hawkins, 2018). Indeed, policy in this field has been concerned with ensuring that citizens' lifestyles, nutrition, childcare, and community and personal social and health services are improved (De Leeuw et al, 2014: 2). Though most of the health policy articles reviewed in this study do not focus on health reform, their use of ACF as a theoretical framework assists in detailing how the ACF has been utilised in the field and which areas this study's use of the ACF will attempt to fill.

Firstly, what is observed from literature is that the belief system of the ACF can be used to sort actors into coalitions from which they promote their policy positions. Actors tended to coalesce around deep core beliefs and/or policy core beliefs (Larsen et al, 2006; Payan et al, 2017; Rice et al, 2019; Alvarez-Rosete and Hawkins, 2018; Wilson et al, 2008). For example, in their article on reforming pharmaceutical policy in Denmark, Larsen et al (2006: 216) used official documents that were cross-checked with interview data to identify coalitions. They found that coalitions were coalescing around two policy core beliefs which focused on public control and market mechanisms. The two camps' ideologies were strongly grounded in the ideological debate on the role of government and the free market in the provisions of goods. Elements of this ideological debate have been seen in US health reform in the past and present.

In addition, the literature observed tended to identify two coalitions. For example, in their articles, Payan et al (2017) and Rice et al (2019) identify two coalitions in their studies. Payan et al (2017:1) identified a public health coalition and an industry coalition regarding California's Food Menu Labelling Policy Debate and Rice et al (2019:51) identified a proponent and opponent coalition against Executive order 13-06 which encoded food service guidelines for the state of Washington. Payan et al (2017) hypothesised the two identified coalitions based on previous studies in the Menu Labelling Policy Debate. Moreover, they relied on legislative bills and newspaper articles to identify the policy positions and beliefs of the actors they would categorise in their coalitions. On the other hand, Rice et al (2019) used semi-structured interviews and compiled a pre-determined list of 25 potential interviewees who were involved in the focus policy of the study in determining the coalitions.

However, three coalitions were identified in the study on health care reform in Colombia by Alvarez-Rosete and Hawkins (2018: 29). Health insurance companies and private health care providers were observed as the dominant coalition in the subsystem, whereas two minority coalitions comprised the medical establishment and social movements which were left-leaning members of congress and public hospitals (Alvarez-Rosete and Hawkins, 2018: 29). Alvarez-Rosete and Hawkins (2018: 34) identified these coalitions by selecting four variables[8] which differentiated deep core beliefs that were health-systems-related and by using interviews to

[8] These four variables include: "(1) the extent of private versus public provision, (2) the extent of private versus public financing of health care, (3) the basis of eligibility for health care (i.e., who is entitled to receive care), and (4) the role (and autonomy) of the medical profession." (Rosete and Hawkins, 2018: 34).

determine where actors would lie in terms of coalition membership. Alvarez-Rosete and Hawkins (2018: 34-35) further reviewed legislative documents and publicly available sources to identify key legislators and advocacy coalitions who supported them. The possibility of identifying more than two coalitions in the US health reform debate does exist, particularly when taking note of the change in tone of certain prominent interest groups in US health reform. This was partially discussed in the previous chapter.

3.6 Usage of the ACF in the study

Similar to what previous scholars have done, which was described in the literature above (with the exception of interviews) the present student will utilise documents in the public domain as well as newspaper articles. In addition, he will make use of secondary sources which discuss the political dynamics behind the Affordable Care Act, to identify the actors that have played a significant role in health policy reform in the US. Once these actors have been identified, the study will apply the ACF by grouping the identified actors into coalitions based on statements and publications which reflect their beliefs. The ACF's model of beliefs is an important element that will be used to sort identified actors into coalitions, particularly when taking into consideration the ever-increasing polarised nature of US politics. Showing that actors in policy compete against each other through coalitions in translating their beliefs into material policy, will provide a theoretical understanding of the polarisation in the American political system; and for purposes of this study, in the health reform debate.

In addition, despite the difficulty in the operationalisation of coalition resources, some of the literature in health policy has been able to identify the use of resources by coalitions in influencing policy as was demonstrated earlier (Payan et al, 2017; Rice et al, 2019). For example, Payan et al (2017: 7) show how one coalition used public opinion polls and media to bring lawmakers over to their policy position regarding California's food menu labelling policies. Though not the central focus of the study, the student hopes that this could be expanded to show how identified coalitions have influenced the health reform debate. This will also help to provide a degree of nuance to the discussion of the actions taken in the subsystem.

Though RSPs do not form the focus of the study, identified coalitions can use them to their advantage to shape policy; and this study seeks in part to reflect an understanding of this aspect by asking which actors have played a significant role in US health care reform. Alvarez-Rosete and

Hawkins (2018: 29-30) attempted to contribute further to the development of RSP within the ACF. Furthermore, they sought to demonstrate how coalitions can utilise institutional structures such as the constitution and other legal structures which shape the policy process, these being RSPs. The study will include RSPs to provide some background to the constraints and opportunities which identified actors in the US health reform policy debate have faced and which have ultimately affected how they have influenced policy. The study will also include external events which provide the context of how and why certain policies have been promoted by some coalitions in the health reform policy subsystem.

3.7 Conclusion

In this chapter, the student sought to demonstrate how the ACF will be used as a tool in identifying the actors involved in influencing the US health reform policy debate. This has been done by discussing the key components of the framework and the elements which will be used; mainly the belief system and advocacy coalitions. The student also expanded on the resources utilised by coalitions in promoting their policy position. The chapter also included a discussion of the devil shift, a unique component of the ACF, which is particularly relevant for contentious areas of policy. The student hopes that the study can expand on this concept, particularly when one notes the polarised nature of US politics and particularly health reform.

Lastly, the student hopes that through the use of the ACF as an analytical tool in health reform policy, the ACF's wide use and applicability can be expanded. Moreover, now that the ACF and its tenets and assumptions have been explored, he hopes further that a greater understanding of who the actors in the US health reform policy debate are and how they have influenced the health policy, can be achieved in Chapter 4. Chapter 4 will serve to answer the research question of the study.

Chapter 4: Identifying the actors and coalitions in America's health reform: Utilisation of the ACF's model of beliefs

4.1 Introduction

The preceding two chapters served to give an overview of the history of health care in the US from the start of the 20th century, as well as an overview and conceptualisation of the ACF, which will form the theoretical groundwork of the analysis of the health reform debate with the aim of answering the research question. The research question seeks to identify who the actors are who have played a significant role in the state of US Health reform policy and how this has been done. In addition to the research question, the research problem highlights the increased partisanship and advocacy over every major area in American policy, include health care. Moreover, the US has had flaws in its health care system, which include cost, access, and quality, thereby making the country an anomaly among industrialised and advanced economies. However, each attempt at correction in the health care system has been met with clashes in the role of government in health care, accompanied by charged political rhetoric, and interest groups that have muddied the waters on health reform.

Considering the above, the ACF and its model of beliefs, particularly deep core and policy core beliefs, serve as tools which take into consideration the hyper-polarisation and charged political rhetoric present in American political discourse owing to the degree of resistance to change. For example, in Chapter 2, opponents to national health insurance under the Roosevelt and Truman administrations in the mid-20th century labelled national health insurance as "socialized medicine", as they held strong anti-socialist beliefs and were wary of anything that might involve greater government involvement. Most important, the ACF model of beliefs can be used to identify actors and the resulting advocacy coalitions which have attempted to translate their beliefs into policy in US health care reform.

In this chapter, the student will primarily utilise the ACF model of beliefs to answer the research question when the actors are to be identified. However, to add nuance to the discussion i.e., to position the context, to detail how identified actors modified, mobilised and promoted their beliefs to become policy and also to show how the actors played their roles in US Health care policy, the chapter will briefly include secondary aspects of the ACF. These include the use of external events, which are exogenous shocks which provide the impetus to policy change and relatively stable

parameters (RSPs) which, as stated in Chapter 3, set the foundation of policy subsystems and the behaviour and actions of actors within the subsystem. Additional secondary aspects of the ACF include the devil shift, which explains the demonisation of opposing coalitions which tend to occur in contentious policy areas such as health reform; and the use of resources, which provides an understanding of how the actors and the coalitions advanced their policy position.

In carrying out the above, the chapter will provide a brief overview of the state of health care prior to the enactment of the Affordable Care Act, to show which events provided an impetus to health reform. Thereafter, a brief breakdown of the ACA will be provided and will highlight the main points of contention in the legislation. The rest of the chapter will identify the actors and coalitions involved in the health reform by providing each actor and his/her respective coalition's overarching beliefs. It will show how they coordinated their behaviours and resources to translate their beliefs into policy and how they interacted with each other in the health policy subsystem prior to and after the enactment of the ACA.

4.2 The state of health care before the passage of the Affordable Care Act

Though in this chapter the student will attempt to identify the coalitions that have played a role in health reform prior to the passage of the ACA, it is still useful to provide a brief breakdown of the events that led to the adoption of the ACA and the subsequent clash around the law that continues today. Doing so provides the context to the policy positions that the identified actors and coalitions espoused and the manner in which some of the actors coordinated their behaviours.

In the preceding chapter, it was mentioned that external events can shock the subsystem, which compels actors to respond accordingly in policy (Sabatier, 1988:136). External event elements such as *changes in socio-economic conditions* as well as *changes in systemic governing coalitions* have featured in health reform. Though the issues surrounding cost and coverage of health insurance in the US have existed for a significant time in American contemporary history, external events such as the great recession of 2007-09, the 2008 presidential election of Obama, and the sweeping victories of the Democratic Party in the congressional elections set the groundwork for the first significant reform of health care since the passage of Medicare and Medicaid in 1965.

The great recession of 2007-2009, left in its wake a 10% unemployment rate, increasing from 5.3% at the start of the recession in 2007 (Cunningham, 2018). Bearing in mind the prevailing

employment-based health insurance model and the general cost of insurance in the US, the recession also affected the number of uninsured individuals in the nation. Between 2008 and 2009, the number of uninsured Americans rose from 46.3 million to 50.7 million, with an additional increase noted in people who had lost their private and employment-based health insurance in the same period (Kavilanz, 2010).

With the increase in unemployed individuals, more Americans saw their incomes fall below 200% of the federal poverty level[9], rising from 32.8% in 2007 to 38.5% in 2009 (Holahan, 2011: 146). It is important to highlight the federal poverty level (federal poverty guidelines) as this is used to determine eligibility for government programmes such as Medicaid and the Children's Health Insurance Program (CHIP) (Health Care, n.d.). With more Americans' incomes falling close to or at poverty levels during the recession, eligibility for Medicaid grew. In fact, between 2008 and 2009, Medicaid enrolment increased by 8.2% which translated to an additional 3.7 million people receiving Medicaid coverage (Sack, 2010).

Since Medicaid is a state/federal partnership health insurance programme, individual states set their own poverty levels to be eligible for the programme. Though more Americans were being covered by Medicaid and CHIP, prior to reform the rate of uptake of these programme benefits was not sustainable. States, unlike the federal government, had to ensure that their budgets were balanced. Since these programmes were state-managed with a degree of federal government subsidisation, the continued uptake of the benefits from the programmes forced states to adjust their budgets through spending cuts (Kaiser Family Foundation, 2008). For example, during the fiscal year of 2009, it was reported that 22 states planned to freeze provider rates while 5 states reduced Medicaid eligibility and 7 issued cuts to specific benefits (Kaiser Family Foundation, 2008).

In addition, the election of President Obama and the Democratic sweep in the 2008 presidential and congressional elections reflected a change in governing coalition. This change provided an impetus for reform in health care as the President and his political party had made health reform a

[9] The federal poverty level is a tool used by the federal government to measure poverty. The poverty level is adjusted yearly for inflation and is consistent across every state and Washington, D.C., with the exception of Alaska and Hawaii (Fass, 2009). The federal government specifies two different measures of poverty, mainly poverty thresholds and poverty guidelines. Poverty thresholds are used by the U.S. Census Bureau to ascertain the number of Americans in poverty. Whereas poverty guidelines are simplified federal poverty thresholds used to determine eligibility for select government programmes (Assistant Secretary for Planning and Evaluation, n.d.).

significant issue on the campaign trail. Indeed, according to Blendon et al (2008: 2051) at the time they wrote their article, health care had been consistently ranked a top six election issue since 1988, coming in as the third most important issue for voters during the 2008 election. Therefore, as a result of the external perturbations of the public calling for reform and the sweeping electoral wins of the pro-health reform Democratic Party, an opportunity for a change in health financing policy occured.

4.3 The Patient Protection and Affordable Care Act and its objectives

The ACA's foundation is largely built on the health insurance model employed by the state of Massachusetts. The Massachusetts model, passed under a Republican governor in 2006, sought to achieve universal health insurance coverage for its citizens. Under the reform, all state residents who had the means to afford health insurance were required to purchase health insurance; more individuals would be eligible for Medicaid; and a state-based subsidised health insurance programme would be created through the state health insurance exchange, which is a state-provided and state-operated insurance marketplace where individuals and small businesses can purchase state-approved insurance plans (Doonan and Tull, 2010:55-56; Garrow, 2022). Moreover, the reforms instituted in the insurance market were meant to improve affordability and availability to state residents, as well as to mandate all those employers who did not offer coverage to employees, to contribute to state-financed insurance subsidies (Doonan and Tull, 2010: 55)

The ACA is the response to the problem of the uninsured that had been exacerbated by the recession. Achieving near-universal and affordable health insurance coverage was its central goal (Rosenbaum, 2011: 130). By largely borrowing from the previously described Massachusetts model, the law sought to accomplish the following aims: (1) to ensure that every American had access to near-universal coverage through a partnership of the state, the individual, and the employer; (2) to ensure that health insurance offerings are fair, affordable and of high quality; (3) to improve quality, value, and efficiency of health care in the nation and also to control health care spending; (4) to "strengthen primary health-care access" as well as to ensure that primary and preventative health care is more readily available for citizens in the long term; and (5) to invest in public health through the "expansion of clinical preventative care and community investments" (Rosenbaum, 2011: 130).

To achieve its primary goal of coverage expansion, the ACA (1) includes a mandate for every individual to obtain health insurance; (2) subsidises health coverage costs for individuals with low to middle incomes; (3) mandates that small employers provide health insurance coverage to their employees; and (4) carry out a large expansion of Medicaid eligibility to more Americans (Harrington, 2010: 704). The first and third provision, otherwise known as the *individual and employer mandate* respectively, carried non-compliance penalties. Individuals from the start of 2014 would be required to pay "$95 or 1% of taxable income in 2014, increasing to the greater of $695 or 2.5% of taxable income in 2016, and indexed to inflation in later years" (Harrington, 2010: 704). Under the employer mandate, if employers failed to provide at least one health insurance plan that was deemed to offer "affordable and minimum value coverage" to employees, they would be subject to a penalty of $2570 for every full-time employee except the first 30 employees (Cigna, n.d.). The individual and employer mandate were significant points of contention in the policy subsystem as they directly challenged policy core beliefs of the coalitions identified. This contention will be discussed.

In ensuring health coverage affordability, the ACA contained two provisions: (1) the creation of State health insurance exchanges, and (2) the expansion of Medicaid eligibility (Kirsch, 2013: 1745). The ACA gave states the option of creating their health insurance exchange together with the assistance of the federal government or to cede full responsibility to the federal government to set it up for them (Kirsch, 2013: 1745). In expanding Medicaid eligibility, the law would raise the minimum federal poverty level standard by enabling all non-elderly and non-pregnant adult Americans with incomes up to 133% of the Federal Poverty Level to qualify for Medicaid (Kirsch, 2013: 1745). Though states were able to set their own Medicaid poverty level criteria, Medicaid expansion under the ACA was mandatory for all states until the 2012 Supreme Court ruling which allowed states to opt out of the mandate (Mitchell and Bencic, 2018). The Medicaid expansion was an additional point of contention among some of the identified coalitions as it too challenged the policy core beliefs of some identified actors, which will be discussed in the upcoming analysis.

4.4 Identification of advocacy coalitions

In the present study, the student will utilize the ACF's deep core and policy core beliefs to the literature on health reform in the period from 2007 to 2021. Through this, three coalitions were identified which played an important role in the state of U.S. health reform during the development

and implementation of the ACA. The study matched the policy positions and stated values and/or beliefs of the actors which would constitute the identified coalitions with the deep core and policy core beliefs related to the components listed by Sabatier and Weible (2007: 195). Deep core beliefs consisted of the debate over fundamental societal values such as liberty and equality and would include ideologies such as Liberalism and Conservatism, particularly in a pluralistic society such as the US (Sabatier and Weible, 2007:194). Policy core beliefs would be deep core beliefs applied to policy and would consist of components such as debating the relative authority government and the free market in addressing problems in society; deciding on "whose welfare counts"; and determining the appropriate roles of various actors in society, such as elected officials, experts, and the public (Alvarez-Rosete and Hawkins, 2018: 30; Sabatier and Weible, 2007: 195).

In addition, components of the ACF, such as relatively stable parameters, external events, and resources, have been used to provide the context for the coalitions identified and how they have become engaged in the policy subsystem. It must be noted that there is a plethora of actors, ranging from media personalities to special interest groups, who have played some role in the passage of the ACA as well as in the attempts of repeal throughout the previous decade. However, it is not possible to list every actor and therefore preference will be given to those who featured most prominently in the literature.

The ACF makes it clear that subsystem actors who coalesce around a particular set of beliefs include other actors such as academics and personalities in addition to the traditional iron triangle actors such as legislators, administrative agents, and interest groups (Sabatier and Weible, 2007: 192). However, these traditional actors, particularly legislators, play a fundamental role in policy-making. America's two major political parties, the Republican and Democratic parties, were included in the list of identified actors. Though it may be assumed that the two parties are highly homogenous in their political ideology and beliefs, it is important to highlight that this homogeneity is a recent phenomenon. According to Starr, both major political parties had often overlapped each other ideologically depending on the geographic areas where their members and party officials were located (Starr, 2013: 162). For example, liberal Republicans were concentrated in the Northeast and Pacific Northwest regions of the country whereas Democrats had conservative members concentrated mainly in the South (Starr, 2013:162). The ideological overlap between the two main political parties, though not large, assisted in enabling bipartisanship in law-making.

However, this overlap has gradually faded and Democratic and Republican voters and elected officials have further entrenched themselves in their respective ideological corners. This was made evident during the debate on health reform in 2009, thereby cementing the hyper-polarised environment that so dominates American political discourse (Starr, 2013: 162-163). In the following analysis, there may be elected officials on both sides of the political aisle that were found to have worked together and who differ from their parties' positions on health reform.

4.4.1 '*Health Care for All' Coalition*

As discussed in Chapter 2, since the start of the 20th century, the U.S. has had a segment of its society who have advocated for a form of universal health insurance, whether at state or at federal level. This position, found under the progressive wing of the American political spectrum, has continued to grow in the contemporary era of American society.

The '*Health Care for All coalition'* consists of a myriad of actors who are consistent with what the ACF posits in including a wide set of diverse actors outside the traditional policy iron triangle (Brooks, 2018:12). The coalition does indeed consist of actors from the traditional policy iron triangle but also includes academics and think tanks. Actors identified in this coalition consist of: (1) the Democratic Party; (2) Health Care for America Now (HCAN), the largest grassroots advocacy group on health reform; and (3) Yale Political Science Professor, Jacob Hacker. Members of the coalition change as time progresses, but the deep core and policy core beliefs have remained relatively unchanged. Members of this coalition typically subscribe to deep core beliefs such as those founded within liberalism and progressivism which can be deduced from their policy core beliefs. Policy core beliefs that members of this coalition hold are typically related to greater government authority over the market. In the instance of health care, it would mean that health care would be viewed as a right that government would have to provide or guarantee for all citizens (Democratic National Committee, n.d.; PNHP, 2008; Hacker, 2007). Regarding whose welfare counts, actors in this coalition advocate equitable access to health care which in turn would mean they are more likely to support government-provided health care for lower income individuals (Patrick et al, 2008; PNHP, 2008; Hacker, 2007).

a. The Democratic Party

With a few exceptions in the previous century, the Democratic Party and its members have been the main proponents of the right to health care and view it as a core policy value (Democratic National Committee, n.d.). Indeed, the party was successful in promoting and passing the ACA into law, which was the most significant piece of health care legislation since the passage of Medicare and Medicaid in 1965. The party's deep core and policy core beliefs are generally on the left side of the political spectrum. The party has generally subscribed to liberal and progressive values (Starr, 2012; Kurtzleben, 2021). However, as briefly mentioned earlier, the party has had three ideological camps that have affected its positioning on health reform. These ideological camps are liberal, moderate, and conservative. Though most Democrats described themselves as liberal (51%), the gap between moderate and liberal Democrats was minor between 2007 and 2012 with 39% describing themselves as liberal and 38% as moderate. Conservative Democrats represented 20% of the party in the same period (Saad et al, 2019). For example, in the same survey period stated above, liberal Democrats were more likely to support a universal health care system (72%), whereas 53% of moderates and 47% of conservative Democrats shared the same position as their liberal counterparts (Saad et al, 2019). This is important to note as no singular position on health care would have been successful without obtaining consensus across the three ideological camps in the party.

In terms of the party's health reform position, the 2008 Democratic Party platform recognised the different policy positions of three ideological camps on health reform. However, there was consensus that the party would promote the core policy belief that health care was a right for all Americans as reflected in the Party's 2008 general election manifesto (Patrick et al, 2008: 5, 12). Though seemingly appearing hesitant to disrupt the private health insurance model, the first policy proposal outlined by the party was the introduction of a public health insurance plan alongside private health insurance. This, they argued, would enable Americans to have a greater choice over their health needs along a wide array of affordable plans made possible by tax credits and other means (Patrick et al, 2008: 12). The public option proposal was a core policy proposal espoused by the progressives within the party that would prove most controversial in the deliberations over the ACA. Among other health policy proposals, the Democrats recognised the role that state and local governments have played in developing their own health care models; however, they stressed

that reform across the country should build on what had already been done at state and local levels. This represented a recognition of state and local rights but also the role of the federal government in health care delivery (Patrick et al, 2008: 13).

b. Health Care for America Now

Though liberals in the Democratic Party held a slim plurality over other ideological camps in the party, their activism on health reform was the most significant. This activism was mostly seen in the Health Care for America Now (HCAN) advocacy group. HCAN was conceptualised in 2007 after Richard Kirsch, the founder of the organisation, had brought together the Service Employees International Union (SEIU), of which more than 1.2 million health care workers were part, and the American Federation of State, County, and Municipal Employees (AFSCME), which represented approximately 1.6 million state and local government employees, including health workers, across 44 states (Kirsch, 2011: 47, 48). The organisation also brought together other prominent groups such as the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO), the largest union organisation in the country; the prominent civil rights organisation, the National Association for the Advancement of Colored People (NAACP); and the progressive think tank, the Center for American Progress, among many others (Kirsch, 2011: xiii; Pollack, 2014).

In terms of their health care policy position i.e. policy core beliefs, the organisation firmly stated in their statement of purpose that it was the federal government's responsibility to guarantee quality and affordable health coverage by "regulating, financing, and *providing* health coverage." (PNHP, 2008). The organisation laid out a set of principles that were incorporated in the manifestos of the presidential candidates of the Democratic Party, which included Obama, and were in part incorporated in the general Party manifesto. The list of core policy proposals the advocacy group espoused were as follows:

> "Guarantee of coverage; a choice of private or public plans; regulation of insurance; requirements that health coverage be comprehensive, and that cost would be based on a family's ability to pay; measures to address inequities in health care in communities of color; and cost controls that encouraged quality and lowered administrative costs." (Kirsch, 2011: 91).

Key to the founding and advocacy of the organisation was the guarantee of universal health coverage and the choice of a public option that was similar to Medicare. The organisation would achieve this through a grassroots effort which would be carried out by rallying progressives around their principles for health reform and leveraging the large bases of trade unions and other organisations which had joined the advocacy group. Moreover, they would target all Democrat members of Congress, who had members in all three ideological camps of the party, to demonstrate their support for the group's health reform principles (Kirsch, 2011: 50, 55).

c. Jacob Hacker

The ACF lists researchers, which included academics, as among key players in the policy process (Sabatier and Weible, 2007: 192). Professor Jacob Hacker exemplifies this role for his effort in conceptualising the public option that would eventually become a core policy proposal on the HCAN and Democratic Party platform for health reform (Hacker, 2001 as cited in Hacker, 2021: 536; Kirsch, 2011: 34).

Hacker is a professor at Yale University and is an expert on American health and social policy, having written or co-written six books on health care policy. Hacker's policy core beliefs, which link him to the Health Care for All coalition, include the belief in the right to health care and universal coverage which can be deduced from his conceptualisation of a public health insurance plan (Hacker, 2007; 1-2) In 2000, Hacker conceptualised a Medicare style plan that would run parallel to private plans on the health insurance market, which would be called the 'public plan'. Because a universal health insurance system has always been met with much resistance, Hacker understood the politics in health care policy and saw the need to create a policy plan that would satisfy his and the Left's core beliefs in the right to health care. This would be accomplished by offering the public a voluntary government-sponsored health plan, while not significantly disrupting the prevailing health insurance system which opponents vehemently support. The plan would preserve the employer-based health insurance model while "provid[ing] a safety net for the uninsured" (Yang, 2009).

4.4.1.1 Coordination of Health Care for All actors

The ACF posits that for policy actors to have success in translating their beliefs into policy, they must "seek allies, share resources, and develop complementary strategies" (Sabatier and Weible, 2007: 197). HCAN can be considered a coalition on its own, considering the number of actors, ranging from trade unions to think tanks and influential individuals, whom it had brought together under the agreed set of beliefs discussed above. This included the guarantee of equitable and affordable health care coverage. Indeed, the organisation was further able to obtain financial resources from other groups and individuals who resonated with their cause, which the ACF views as a vital resource for purchasing other resources such as starting up media campaigns to obtain public support (Sabatier and Weible, 2007: 203). For example, HCAN was able to obtain $5 million from Families USA, a non-profit health advocacy organisation as well as $10 million from the Atlantic Philanthropies, a private organisation which donates to causes that address left-leaning issues such as improving health care equity (Kirsch, 2011: 60-62; Atlantic Philanthropies, n.d). Furthermore, HCAN was in frequent contact with Hacker, who would also serve as the informal health policy advisor to Democratic presidential candidates, who would use his public option idea as the main policy item they would advocate (Kirsch, 2011: 34-37).

The ACF includes formal legal authority as a key resource in its typology for making policy decisions. This enables a coalition to have legislators and executive officials in its camp to directly promote and translate policy beliefs into materialised policy. Therefore, an important ally the coalition needed was support or allies in the political sphere to realise its policy goals. A major political party that best aligned with HCAN was the Democratic Party as demonstrated by the previously stated policy positions and values of the party which include the promotion of health care as a right. Though donors were concerned about the possibility of a Democrat not winning the presidency, HCAN had support from the Democratic Party. The Democratic Party had an extensive history of advocating for universal health care, as was demonstrated in Chapter 2 of this thesis and most important, both the Democratic Party and other members of HCAN agreed on the core belief of health care being a right. Moreover, candidates within the Party and members of the coalition such as the SEIU and Center for American Progress as well as Democrat presidential candidates engaged with each other on which health reform plans they would advocate (Kirsch, 2011: 83).

It was mentioned in the Chapter 3 that relatively stable parameters (RSPs) can affect the strategies, resources, and beliefs of actors in the policy subsystem. Prior to the creation of HCAN, Kirsch (2011: 39-42) noted a study conducted on the public's view on health reform. The study was consistent with the general values held by Americans on personal responsibility, individual choice and a general suspicion of government's role in providing and running services i.e., a single payer health insurance system; all of which the ACF would categorise as an RSP found under fundamental socio-cultural values and social structure. Although liberal members of the Democratic Party and HCAN strongly supported a single payer health insurance plan, they had to adapt their strategies and beliefs and focus solely on advancing the public option in their health reform proposal, to the disappointment of ardent single payer advocates. This was viewed as the most practical position in terms of ensuring a Democratic win at the polls as well as possibly standing up to intense scrutiny from opponents such as the health industry and the Republican Party who would argue and leverage core American values and claim it was a "government takeover of health care" (Kirsch, 2011: 78-80).

It is important to note that Democrats still had a moderate and conservative base in their congressional ranks who were sympathetic to the cause of universal health care, but were hesitant or outright opposed to the single payer proposal that their liberal counterparts had promoted. For example, Hacker (2010: 866) noted the differences in policy proposals among the different groups in the Democratic congressional caucus during the Clinton administration, which ultimately contributed to the failure of Clinton's health reform plan. Moderate Democrats suggested employers be mandated to either provide insurance for their employees or pay into a public insurance plan that would cover individuals without employment-based coverage; whereas conservative Democrats suggested cost containment and limited coverage expansion (Hacker, 2010: 866). Bearing this in mind, Democratic leadership along with Hacker sought to ensure that a repeat of what had occurred during the Clinton administration would not be repeated and attempted to bring consensus within the party regarding their policy position on health care (Hacker, 2010: 866). Moreover, as stated previously, Democrats and HCAN had agreed on a set of common principles for health reform as reflected in their 2008 election manifesto and would proceed to obtain landslide victories in the election, which gave them their mandate to pursue national health reform.

The party would hold strong majorities in congress, with 257 seats in the House of Representatives and 57 seats in Senate with an additional 2 seats held by Independents who caucused with the party (Federal Election Commission, 2009: 3). The party initially failed to obtain a super-majority in the Senate (60 seats) which would enable them to overcome the Senate's filibuster[10] procedure. Additionally, though, they had two Independents caucusing with them. One of them, Joseph Lieberman of Connecticut, had supported the Republican presidential candidate, John McCain (Starr, 2013: 201). This would mean that the party would need to ensure agreement within the party and potentially reach across the political aisle to find a bipartisan solution to health reform. However, by the start of the new Congress in 2009, the Party had reached the 60-vote threshold, as one Republican senator had switched to the Democratic Party and another Democrat from Minnesota would be added to the Senate after the completion of a recount and litigation of the Senate race (Starr, 2013: 201).

4.4.2 *'Health Industry' Coalition*

As detailed in Chapter 2, the US health industry was known to be generally opposed to significant reform in the sector. Bodaken (2008: 667) notes that the previous attempt at health reform during the Clinton administration had been met with significant opposition from the Health Insurance Association of America (HIAA). The HIAA issued a series of attack advertisements against the Clinton reform plan, emphasising that "change [was] coming, and not for the better" (Bodaken, 2008: 668). This ultimately led to the defeat of Clinton's health reform plan. However, in the lead-up to former President Obama's election and the ultimate call for reform, health industry players had softened their tone on health reform and were more open to the possibility of change to the system (Oberlander, 2010: 1115). Being cognizant of the growing number of uninsured Americans, in 2007 several key health industry players joined opposing stakeholders, with some found in the 'Health Care for All' coalition, to form the Health Coverage Coalition for the Uninsured (HCCU). The coalition sought to promote policy positions that would expand health

[10] The Senate filibuster is a traditional tactic of the Senate typically used by the minority party to carry out drawn out debates for the intention of delaying or preventing a vote on any "bill, resolution, amendment, or other debatable question" in the Senate. To overcome the filibuster, the majority party would need to have 60 votes to end debate and bring the bill to a vote; this is otherwise known as invoking cloture (U.S. Senate, n.d.). Use of the filibuster is nearly as old as the constitution itself, however, as of 2010, the invocation of cloture since its introduction in 1917 to end the filibuster reached 1200, with more than 80% of them occurring during the 1981-1982 Congress and 60% since the 1993-1994 congress (Hacker, 2010: 867).

coverage to uninsured Americans. This would be achieved through a "balance of private and public initiatives" (HCCU, 2007). The alliance signaled a departure by the Health Industry coalition from its general opposition to government's involvement in health financing and access. This shift which would ultimately play a role in the passage of the ACA and its continued existence to this day, will be discussed below.

The student identified four health industry actors in health reform, these being mainly: the American Medical Association (AMA), the American Hospital Association (AHA), the America's Health Insurance Plans (AHIP) (formerly HIAA), and the Pharmaceutical Research and Manufacturers of America (PhRMA). The Health Industry coalition has been typically characterised as possessing policy core beliefs which hold to free-market principles in health care provision, while supporting public-private solutions to health care coverage. This is seen under the HCCU and evidenced under each identified actor below (HCCU, 2007; AMA, 2019; AHA, 2017; AHIP, n.d; PhRMA, 2009). Their position has allowed them to be willing partners with government in terms of health care, yet at the same time, being opponents to any reform that may be seen as too 'radical', such as extending Medicare-type insurance to all Americans.

a. The American Medical Association (AMA)

The AMA's history of antagonism made it an unlikely advocate for expanding health insurance coverage to the uninsured, particularly through any potential state action. But in 2007, the AMA launched the 'Voice for the Uninsured' campaign that would last for three years and would attempt to highlight the problem of uninsured Americans in the lead-up to the general elections that would occur in following year (Leander, 2007). Nevertheless, the AMA held the position that "Consumer-driven health care [led] to greater coverage and improved access" (AMA, 2007). Furthermore, the AMA held deep core beliefs such as "pluralism, freedom of choice, freedom of practice, and universal access for patients" (Madara, 2017). These positions pointed to the central idea that the patient (individual) should have full say on how and which health care he or she can receive based on affordability. Moreover, in its support of freedom of practice, it also showed its support for the free market in health care provision. The AMA promoted three solutions to the problem of the uninsured:

1. That the U.S. health insurance system should transition to an individual rather than employment-based system. Health insurance offerings obtained by individuals would not

lapse if a job change would occur. This would typically occur with employment-based health insurance.

2. That income-tax credits be introduced to improve the health coverage affordability. These tax credits would be related to the size of an individual's income and would differ based on the size of families. Low income individuals would have access to them prior to purchasing insurance, in order to increase affordability
3. That reform in the health insurance market would be achieved by ensuring uniformity in health insurance regulations across state lines. In addition, the proposal would call for a modified community rating[11] and risk corridors[12] while also calling for benefit mandate limitations as well as deregulation in group purchasing arrangements (AHA, 2007).

From the above, it can be seen that the consumer, i.e. the individual, is central to the AMA's policy beliefs in health reform, as the group calls for greater freedom of choice and a transition to an individual health insurance system. The AMA further supported the free market in health care provision by advocating freedom of practice. However, in supporting income-tax credits as well as uniform insurance regulations, the AMA demonstrated its support for public-private solutions to health reform.

b. The American Hospital Association (AHA)

The second identified actor, the AHA, is an interest group comprising approximately 48 000 members, consisting of hospitals, other health care organisations, and individuals (AHA, n.d.). The AHA's mission statement is to "advance the health of individuals and communities" by promoting the interests of the previously-mentioned groups related to the health care industry (AHA, n.d.). Regarding health reform, the organisation's board of trustees created a framework used since 2008 for its advocacy which consists of the following five reform priorities: "(1) Coverage for all, paid for by all; (2) Focus on wellness; (3) Best Information; (4) Most Efficient Affordable Care; and

[11] A modified community rating refers to the degree of premium differences that may exist in health insurance policies. These differences would depend on each individual's factors of risk but the key would be that differences in premiums would be limited within "specified rate bands" (AMA, 2015). A modified community rating would allow for high-risk individuals to have coverage but also to ensure that the rest of the general populace is not significantly affected in terms of their premiums, resulting from the possible prevalence of high-risk individuals in the community. The opposite would be that every individual in the population would pay the same health insurance premium regardless of risk (AMA, 2015).

[12] Risk corridors serve to enable health insurers to set accurate premiums for individuals as well as to decrease any volatility in premiums by limiting any profits or losses to a specific range (AMA, 2018).

(5) Highest Quality Care" (AHA, 2017b). For the purposes of this study, priorities 1 and 4 of the framework will be discussed. In terms of priority 1, the AHA held a policy core belief that all actors in health care, from the individual to the state, ought to contribute towards expanding health care coverage to all citizens, stating that it would improve the health of citizens, lead to increased economic gains due to the improved health of citizens, and reduce costs for private insurers and businesses (AHA, 2017b). With priority 4, the AHA highlighted the need to reduce the cost and improve the efficiency of health care by stating the impact that they have on patients, physicians, and hospitals. The AHA also described the benefits of an affordable health care system which included savings of US$4-8 billion a year in the reduction of preventable hospitalisations. It stated further that affordable and efficient health care would improve business productivity through the reduced use of sick days by eliminating sub-optimal health care (AHA, 2017b). By highlighting the negative impacts of the status quo of health care at the time and the benefits of a reformed health care system on businesses and the economy, the AHA attempted to generate support from the business lobby and from the government.

c. America's Health Insurance Plans (AHIP)

The third actor, AHIP, represented the industry with the highest stake in health reform. The organisation represents around 1300 health insurance companies in the US and has a mission to advocate for "great access to high quality, cost-effective care for all Americans" at state and federal levels (AHA, 2007). Prior to the enactment of the ACA, AHIP had been a signatory to the HCCU which had advocated for expanding health coverage "incrementally" through the preservation of entitlement programmes, expanding eligibility for federal programmes, and providing tax incentives. AHIP also promoted policies that would advocate consumer choice, post a reduction in the cost of health care, as well as increase the quality of health care (AHA, 2007).

AHIP takes a hybrid approach regarding its view on the authority of the state and free market in addressing health policy problems. AHIP prefers market-based solutions to policy problems in health financing, but simultaneously also seeks public-private partnerships (AHIP, n.d.). This position is carried out through:

> "(1) Supporting and promoting the value of the private market; (2) promoting and protecting the value of employer-based coverage; (3) promoting and defending Medicare Advantage; (4) advancing health equity; (5) promoting the value of Medicaid-managed

> Care; (6) advancing positive [prescription drug] pricing and [Medicare] Part D reforms; and (7) expanding Affordable Care Act coverage and affordability" (AHIP, n.d.).

AHIP's policy positions are consistent with the stated policy core beliefs of the health industry coalition as it clearly states its support for free-market solutions while supporting public-private partnerships in health coverage.

d. Pharmaceutical Research and Manufacturers of America (PhRMA)

The fourth actor within this coalition, PhRMA, is the leading representative of pharmaceutical companies in the U.S., which include companies such as Pfizer, Johnson & Johnson, Bayer, and AstraZeneca (PhRMA, n.d.). In terms of its public policy advocacy approach, this interest group seeks to promote the discovery of ground-breaking medicines for patients across the United States and in other markets across the globe, which are produced by the companies it represents. In its advocacy, the group prioritises three positions: (1) that patients should have wide access to "safe and effective medicines through a free market, without price controls"; (2) all legislation/regulation should have "strong intellectual property incentives"; and (3) that regulation should be transparent and efficient, and patients should have access to a free flow of information (PhRMA, 2016: 72).

In 2009, PhRMA supported a public-private approach to improving access to health insurance coverage. The group rallied behind the prevailing employment-based health insurance system, preferring to build on, rather than create, an alternative system. Moreover, they supported expanding coverage through the already existing public programmes such as the State Children's Health Insurance Program (SCHIP) as well as Medicaid (PhRMA, 2009: 17). Therefore, rather than promoting an entirely new system, PhRMA advocated for the expansion of eligibility and enrolment in existing public programmes as well as the modification of the dominant mechanism for which employed Americans had obtained their health coverage.

From the above, it can be concluded that all four members of the health industry coalition held the belief that the free-market ought to play a role in health care provision and coverage; however, each member did leave room for the government to be involved in ensuring coverage, whether through additional regulations or expanding access to already existing government health coverage programmes.

4.4.2.1 Coordination of health industry actors

According to Open Secrets (2021), a think tank dedicated to monitoring lobbying in US politics, the Health Sector was the largest lobbying spender in 2021, spending approximately $690 million. This was almost $200 million dollars more than the second biggest spender, the miscellaneous business sector and the third biggest spender, the finance, insurance, and real estate sector, which also received a significant portion of its lobbying expenditure from health insurance companies (Open Secrets, 2021). No other industry stood more to gain or lose from health reform than the health care industry. Moreover, according to Stritch (2015: 448), American scholars have noted that interest groups typically work in coalitions rather than alone to advance their policy positions in government. Therefore, with health reform being a real possibility, industry players needed to ensure that their policy positions and interests were implemented in any health reform proposal from the federal government.

Though interest groups would work together to advance their policy positions, what should be noted is that health industry actors did not coordinate among themselves when advancing a policy agenda; rather they worked with a diverse range of actors who either opposed health reform measures as evidenced in Chapter 2; or in recent times, worked with actors who advocated certain health reform priorities of the 'Health Care for All' coalition. An example of this includes the earlier mentioned HCCU which involved the coordination of key members of the health industry who had joined up with health reform advocates to promote agreed-upon policy positions in the wake of the health insurance crisis. An additional example is pro-health reform Families USA's Health Reform Dialogue which brought together health industry groups including AHIP, AMA, AHA, PhRMA; business groups such as the National Federation of Independent Business (NFIB); and trade union organisations such as SEIU and AFL-CIO. The 7-month long dialogue led to the consensus on principles that would eventually be contained in the ACA. They include: (1) universal coverage; (2) effective and efficient health care; (3) prevention and wellness promotion; and (4) health costs reduction (McDonough, 2011: 57). From the literature identified, health industry actors have appeared not to purposefully act in concert with one another to push a particular policy in health reform. Indeed, all four actors represent different segments of the health care industry. They preferred working with other actors, including those who viewed them with suspicion, with a view to promoting a common goal of universal coverage.

4.4.3 *'Small-government' Coalition*

The last coalition identified is the 'Small-government' coalition which has served as the main antagonist to the ACA since its enactment and has been the most virulent in its opposition. Therefore, regarding the debate and enactment of the ACA, the small-government coalition can be classified as an adversarial coalition to the *Health Care for All* coalition which consisted of actors who promoted and enacted the ACA. The Small-government coalition consists of actors who held to conservative/libertarian views in terms of their deep core beliefs. Indeed, the libertarian ideological position has been a defining feature of American societal values and beliefs: that self-governance, individual freedom, and limited government, which are central tenets of libertarianism, and which have been held in high regard from the very founding of the nation, have consequently limited government's involvement in the health care system and can be considered an RSP, as stated earlier (Boaz, 2015, Goldfield, 1999: 1). As evidenced in Chapter 2, historical opponents of health reform such as the Republican Party, have leveraged the values of libertarianism espoused by the general American public to rail against efforts to expand the size and scope of government in domestic affairs. This has been to the detriment of the federal government's ability to enact substantial policy reform in health care.

Ergo, based on the above, the political ideology of this coalition has informed its policy core beliefs and therefore its position on health policy. The Small-government coalition, like the health care for all coalition, consists of actors as well as the traditional iron triangle of actors involved in policy-making. Key actors identified within this coalition are the Republican Party, which also include Republican state attorneys, and the Tea Party Patriots. Generally, in terms of their policy core beliefs, the actors within the coalition support the idea that free market solutions to domestic policy problems should be sought first before considering government solutions and that government has instead been an impediment and in certain instances, the cause of those problems.

a. The Republican Party

The Republican Party, the main political opposition to the Democratic Party that had enacted the ACA, was the most consistent and ardent opponent to the ACA before its passage into law and has been even to this present time. There is, however, a degree of irony, because as stated earlier, the ACA is largely built on a model passed by a Republican governor in Massachusetts. Moreover, in 1993, Senate members of the Party promoted the Health Equity and Access Reform Today Act

(HEART Act) as an alternative to the unsuccessful Clinton Health Reform Bill. The HEART Act contained similar provisions to those found in the ACA such as an individual mandate and a pre-existing condition non-exclusion clause (Quadagno, 2014: 41). However, as detailed in Chapter 2, since the Truman presidency, the Party has long associated significant government involvement in health care financing with Socialism.

Apart from the Nixon presidency, the party and its members have generally continued to maintain the same position. The Republican Party, otherwise known as the Grand Old Party (GOP), has supported political ideologies to the right of the Democratic Party. The Party has held deep core beliefs that are founded in conservatism and economic libertarianism and has been an ardent supporter of policy core beliefs such as belief in the free market, limited government, state and local rights (Starr, 2012; Cook, 2019). In terms of health care, the Party's deep core and policy core beliefs were strongly reflected in their health reform proposals. For example, in their 2008 election platform, the GOP's foundational belief on health reform was the belief in individuals' right to determine their own health care. The Party affirmed its support for private health care and unequivocally stated their opposition to government involvement by describing it as "socialized medicine"— the old trope that members of the party have used over the last century (Republican National Convention, 2008: 37). Moreover, to provide detail to their policy position, the party's first guiding principle, on health reform, "do no harm" contained in part the following objectives:

> "We *will* protect citizens against all risky restructuring efforts that would complicate or ration health care.
> We *will not* put government between patients and their health care providers.
> We *will not* put the system on a path that empowers Washington Bureaucrats at the expense of patients.
> We *will not* raise taxes instead of reducing health care costs.
> We *will not* replace the current system with the staggering inefficiency, maddening irrationality, and uncontrollable costs of a government monopoly" (Republican National Convention, 2008: 37-38).

These objectives were overwhelmingly in line with the Party's core belief of limited government, and it also inferred the support of the prevailing system in the United States by emphasising its

intention not to replace it. In reducing costs and increasing the quality of health care, one of the suggestions the Party made was the introduction of state-regulated national health insurance markets which would enable various groups across civil society to purchase insurance plans across state lines. This suggestion is similar to the state health insurance exchange implemented in Massachusetts, as well as the exchanges proposed under the ACA. Nevertheless, the proposal supported the Party's core belief of state rights as it called for states to create their own markets that would provide greater choice, competition, and reduce the cost for citizens (Republican National Convention, 2008: 40).

b. The Tea Party Patriots

The Tea Party Patriots, or Tea Party, has its origins in the conservative wing's anger at the profligate spending and growing size of the federal government, beginning with the George W. Bush Administration (Hawkins, 2019). However it was the moment that CNBC news anchor, Rick Santelli, expressed his frustration with President Obama's promotion of another bailout package and its subsequent passage, in addition to other packages passed under the Bush Administration during the recession, that the Tea Party began to organise itself. (Hawkins, 2019). Santelli's response to the signing of the $1 trillion American Recovery and Reinvestment Act was as follows:

> "The government is promoting bad behavior... This is America! How many of you people want to pay for your neighbor's mortgage that has an extra bathroom and can't pay their bills? Raise their hand." (Hawkins, 2019)

Santelli's statement echoed sentiments held by members that would form part of the Tea Party, which is the deeply held belief of individual responsibility (Haltinner and Sarathchandra, 2017: 564). In terms of whose welfare counts, it also played to the "producerist narrative", which is described by Haltinner and Sarathchandra (2017: 563) as "the perception that true Americans work hard and produce despite having to fend off the threats of parasites at the top and bottom of society". Members of the Tea Party viewed themselves as hard-working Americans whose tax dollars were being used to bail out other individuals and entities, which they viewed as rewarding bad behaviour, as Santelli stated.

The Tea Party holds to libertarian policy core beliefs which include fiscal responsibility and government debt reduction, limited government, which also includes reduced taxation, and free

market capitalism. The organisation also has a strong belief in constitutionalism, which they view as a key institution to enable a core tenet of libertarianism: individual freedom (Tea Party Patriots, n.d; Haltinner and Sarathchandra, 2017: 558). The organisation resulted from the coalescing of conservative interest groups such as FreedomWorks and Our Country Deserves Better Political Action Committee (PAC) (Haltinner and Sarathchandra, 2017: 558).

In terms of their health care policy position, the Tea Party has been aligned with right-wing views on health reform. Skinner (2012: 607) states that the right wing has viewed previous health reform efforts as being enacted for the purpose of undermining American liberty and this is evident in the Tea Party's position. The Tea Party describes the ACA as a threat to Americans' financial wellbeing which ultimately impacts their freedom to choose a health care programme that fits their needs (Tea Party Patriots, n.d.). The Tea Party outlines nine principles to health reform, which in their view will enable and protect health care freedom, of which seven will be described below:

1. The Tea Party seeks "real health care reform" that adheres to protection and will protect the individual right of Americans to make personal choices regarding their health care.
2. They advocate for "real health care reform" that will not further contribute to the US's debt levels or deficit.
3. They seek "real health care reform" that will strengthen the doctor patient-relationship which they described as the most "sacred" relationship in health care.
4. They believe that "real health care reform" will utilise the free market to encourage innovation and competition in the health industry
5. They advocate that "real health care reform" will reduce the involvement of the federal government in the health care sector and fiercely protect confidentiality between individuals and their doctors.
6. They posit that "real health care reform" will enable the private sector and private individuals such as citizens and doctors to provide charitable health care solutions to low-income citizens. They believe that "real health care reform" increases consumer choice for their health coverage and services which are inhibited by government regulations. (Tea Party Patriots, n.d.).

All the above principles are in line with the core ideological beliefs of the Party and clearly emphasise the importance of individual freedom, and limited government to the organisation.

4.4.3.1 Coordination of the Small-government Coalition

From the above description of the GOP and Tea Party, their ideological and political beliefs were similar if not the same as those which the ACF views as a prerequisite for the formation of a coalition. Both these actors supported limited government and the free market. Moreover, both were strongly opposed to the further involvement of government in health care. However, it was not necessarily their shared resistance to discussions on health reform by Democrats; rather it was the ballooning recession-era government-spending that led to the start of their coordination, which Skocpol and Williamson (2012: 6) describe as a "betrayal of small-government principles"; which had started under the Bush administration and continued under the newly-formed Democratic-led government.

The ACF states that actors seek allies and share resources in their coalition (Sabatier and Weible, 2007: 196). Following the GOP's severe electoral defeat in 2008 which had cast doubt on the party's future, the Tea Party, symbolically named after the revolutionary Boston Tea Party (in which colonial American rebels threw British tea into the Boston harbour to protest against British taxes), served as a rallying point to mobilise frustrated conservatives across the country to protest against the perceived threats to the "country they love[d]" and the very "nature of their country" (Skocpol and Williamson, 2012: 7). The Tea Party was a grassroots movement of conservative Americans which had a critical resource of mobilisable troops which the GOP could leverage to energise its base for future elections. However, they also shifted the Party to a greater hardline position on the right of the political spectrum by pressuring incumbent Republican officials to promote their policy core beliefs and refrain from compromising with Democrats, under threat of losing their political positions in subsequent elections (Skocpol and Williamson, 2012, 155).

4.5 Cooperative coalitions: collaboration between the 'Health Care for All' and 'Health Industry' coalitions

Cooperative coalitions are naturally found in collaborative policy subsystems just as adversarial coalitions (discussed as the next coalition) are typically found in adversarial policy subsystems (Weible, et al, 2020: 1065; Satoh et al, 2020: 4). However, as discussed in this section and in the following coalition, Satoh et al (2020:4) demonstrate in their analysis that both adversarial and cooperative coalitions, in addition to other types, can exist within one subsystem. Such has been the case in the US health policy subsystem.

Though the health industry has historically been opposed to health reforms proposed by actors within the Health Care for All coalition, as briefly discussed in Chapter 2, the turn of the century marked a change in position from general antagonism towards health reform by the health industry to a willingness to engage in health reform that would involve a partnership between the state and the industry. This was first seen in the joint article by representatives of the HIAA (now AHIP) and Families USA which promoted a public-private approach to health reform and the expansion of health insurance coverage (Kahn III and Pollack, 2001: 40). Their joint proposal sought to build on already existing structures such as Medicaid and employment-based coverage by expanding Medicaid eligibility and expanding tax credits to businesses, thereby making health insurance affordable to their low-income employees, as well as other proposals (Kahn III and Pollack, 2001: 42, 45). Additional instances of both coalitions cooperating with each other include the earlier discussed HCCU and the Health Reform Dialogue.

External events which included the socio-economic and political environment described earlier, in addition to the marked change in tone from the health industry, were a clear indication of the industry's willingness to work together with the Health Care for All coalition. Moreover, as seen by the Health Care for All coalition, there was a clear indication that a significant disruption to the status quo in health care delivery was not something that the American people had an appetite for, as evidenced by the rejection of the single payer health plan; nor was it something that the health care industry, which had vast amounts of monetary resources to terminate any reform, would tolerate. Therefore, for any reform to occur, members of the coalitions recognised the need to co-operate with each other and negotiate reforms that would satisfy both sides. Moreover, although Democrats had consensus on health reform, they only held a slim filibuster-proof majority in the more conservative Senate. They had two Senators, one Independent Democrat, who had supported John McCain as mentioned earlier, and one Democratic Senator, Max Baucus of Montana, who was a conservative member of the party who had voted against Clinton's health care plan and who often sided with Republicans (Starr, 2013: 197). Baucus was chair of the influential Senate Finance Committee and had penned the White Paper mentioned in Chapter 2, which would serve as the Democratic reform model. However, Democrats remained wary of him as a result of his past behaviour on health reform and other policy areas, as well as his having received campaign contributions from the health and insurance sector (Starr, 2013: 197; Blumenthal, 2009)

Bearing in mind the Democrats' slim filibuster-proof majority, and the pivotal position of chairman Baucus who had the ear of the health industry, the Health Care for All coalition under the leadership of the Obama administration conceded that they would need to have the support of the health industry, which in turn could influence other moderate Democrats in their favour (Hacker, 2010: 865). Additionally, the Democrats passed a budget resolution to enable them to pass health reform through budget-reconciliation[13] to protect themselves from a filibuster; however, they would be limited in what could be implemented (Starr, 2013: 202).

In March 2009, President Obama convened a meeting that brought together members of the Health Industry coalition, Health Care for All coalition, and both Democrat and Republican caucuses in Congress to discuss health reform. The President had stated that the goal of the health reform summit was to "determine how [they would] lower costs for everyone, improve quality for everyone, and expand coverage to all Americans" with the purpose of "enact[ing] comprehensive health care reform by the end of [2009]" (Obama, 2009). Two months later, the four members of the health industry coalition, in addition to the medical devices industry group, AdvaMed, and trade union, SEIU, sent the President a signed letter promising a saving of $2 trillion over 10 years in health care spending and stating their commitment to work with the administration to advance the policy core beliefs of universal coverage, affordability, and quality (AdvaMed et al, 2009; McDonough, 2011: 75).

The health industry had promised significant savings in health care costs, which was a core objective for many actors in the policy subsystem. However, this had come with trade-offs from the Obama administration which some members of his coalition would describe as a capitulation to special interests (Starr, 2013: 205). Hacker (2010: 865) describes the deals cut by the administration and health industry members as examples of *quid pro quos*, stating that health care industry actors would "accept greater public regulation and involvement in return for greater guaranteed financing" i.e. both coalitions would coordinate their resources to achieve their policy objectives and would make concessions on certain policies which they deemed not imperative to their overall objective. This is an example of the ceding of secondary beliefs which the ACF

[13] Budget reconciliation is a special procedure enabling the Senate to circumvent the filibuster rule and pass legislation with a simple majority. However, reconciliation only permits policies which change government spending or revenues, and which are found under the 'Byrd rule', which prevents legislators from passing legislation unrelated to taxes or spending (House Committee on the Budget, 2020). For further details on the budget reconciliation process and the Byrd rule, refer to the House Committee on the Budget article (2020).

describes as "narrow in scope" and easier to change (Sabatier and Weible, 2007: 196). Moreover, Hacker (2010: 865) makes an important assessment, which is that health industry actors sought to leverage on government's sole ability to compel people to obtain health insurance, which in turn would assist in raising revenues for the industry, by having individuals subscribed to their products and services.

The administration and key player, Senator Baucus, had brokered two deals which would set health reform on course for approval. The first deal was brokered with PhRMA and would serve as the most important, as PhRMA had played a significant role in blocking Clinton's health reform in a series of negative advertisement campaigns. Furthermore, they had sufficient resources to launch another series of negative ad-campaigns if health reform negotiations resulted in a direction they did not support (McDonough, 2011: 76; Starr, 2013: 204). The deal included a ceding of "$80 billion over ten years in rebates, assessments, and contributions" for a prohibition of imported medicine into the U.S. and the cancellation of negotiations on drug-pricing for Medicare, which would contribute a significant portion to health care spending[14] (Starr, 2013: 205; Spithoven, 2016: 633). In addition, PhRMA used their financial resources by investing $150 million in ad-campaigning to promote the administration's health reform objectives (McDonough, 2011: 76). This meant that the Obama administration had obtained a key ally in advancing health reform; however the failure of advancing price reduction of drugs went against the Democrat Party's and HCAN's (Health Care for All coalition) policy core belief of ensuring affordable health care; considering the extent to which drug-spending contributes to the national health expenditure. The second deal with the Health Industry coalition was achieved with AHA and other hospital associations. Hospitals agreed to reduce Medicare and Medicaid payments by $155 billion over 10 years and Medicaid eligibility would be expanded to include nearly all Americans under the age of 65 who had incomes at or below 100/133 percent of the federal poverty level. This meant that more Americans would be eligible for coverage (Starr, 2013: 205; Spithoven, 2016: 634; KFF, 2012: 3).

[14] In 2016, of the $3.3 trillion spent on national health expenditures, $329 billion was spent on prescription drugs. Moreover, the growth of prescription drug spending has been observed to exceed some categories of medical spending and is expected to be the fastest growing category of health spending within this decade (Hanna and Uccello, 2018: 1).

However, the public option, a key policy objective of the Health Care for All coalition, was rejected by the AHA and AMA, since the AMA argued it would "push private insurers out of the market and consequently restrict a patient's choice" (Spithoven, 2016: 634). AHIP and PhRMA were also opposed to the public option: AHIP believed the public option would fundamentally undermine the private health insurance industry, whereas PhRMA viewed it as the lead-up to state-controlled health care (Milani, 2010: 156; Frates, 2009). Progressive members of the Health Care for All coalition had viewed the exclusion of the public option from any health reform bill as not being "real reform" (Halpin and Harbage, 2010: 1121). Members of HCAN and the AFL-CIO had mobilised 400 000 members to petition members of Congress to promote the public option in the negotiations. However, although the Obama administration supported the public option, it did not actively push for the public option's inclusion in the final bill. Moreover, the administration purposefully put forward a vague position on the proposal, as it attempted to satisfy its core base while preserving moderate and conservative Democrat support in the Senate as well as support from the health industry (Halpin and Harbage, 2010: 1122)

AHIP had obtained several provisions that were in their favour, which were an individual and employer mandate, as well as the exclusion of the public option (Spithoven, 2016: 634). This was significant, since individual Americans and businesses would be compelled by law to purchase insurance or face a penalty which would in turn benefit many of AHIP's members who provided insurance plans. Although this meant increased health insurance coverage, which was a core policy objective of both members, the health industry was able to translate their beliefs into policy to a greater extent than the Health Care for All coalition, since the latter had lost the public option, a core policy objective they had hoped would be implemented in health reform.

4.6 Adversarial Coalitions: vehement opposition to the ACA

Weible et al. (2020: 1067) view adversarial coalitions as the "theoretical ideal type" of coalition which contains attributes such as shared beliefs, coordination, resources, and stability. From the above description of the Small-government coalition's shared beliefs and coordination, it becomes evident that a significant base of the coalition viewed their opposition, the Health Care for All coalition (particularly the Democrat Party) and their beliefs as a significant threat, and especially one that had dire consequences for what they viewed as the fundamental nature of America as they had known it. The ACF describes this degree of suspicion towards the true motives of opposing

coalitions as one of four hypotheses for the argument of the devil shift (Sabatier, 1987: 451). Moreover, the ACF states that prevalence of the devil shift is significant in high conflict situations, and this is supported by the increased degree of polarisation in the country from the 1970s up to the beginning of the 20th century (Sabatier, 1987: 451; Oberlander, 2020: 476)

4.6.1 Use of the devil shift

As stated in Chapter 3, losing coalitions tend to view their opponents as more evil and more influential than they are and view themselves as considering the public's welfare to a greater degree than do their opponents. During negotiations of the ACA, a conservative writer made the claim that a draft bill of the ACA in the house would require Medicare recipients, who are senior citizens, to "have a counselling session that [would] tell them how to end their life sooner" (Starr, 2013; 212). This allegation referred to Section 1233 of House Resolution 3200 which included a provision for Medicare to pay for voluntary "advance care planning consultation" where Medicare beneficiaries would have an added benefit to discuss "key questions and considerations, important steps, and suggested people to talk to". Beneficiaries would also receive an explanation of "advance directives, including living wills and durable powers of attorney, and their uses" by their physicians (Fleming, 2009). Republican officials such as House Republican Leader, John Boehner, doubled down and used strong language to describe the allegation as "government-encouraged euthanasia" (Starr, 2013: 212). However, the most incendiary comment came from the 2009 former Vice-Presidential Republican candidate, Sarah Palin, who described the allegation as Obama's "death panels" which would go on to serve as rallying point for the Tea Party (Gonyea, 2017). Palin stated:

> The America I know, and love is not one in which my parents or my baby with Down Syndrome will have to stand in front of Obama's 'death panel' so his bureaucrats can decide, based on a subjective judgment of their 'level of productivity in society (Stossel, 2009).

The Tea Party had also engaged in similar harsh rhetoric by organising its members to attend Democrat-led town hall meetings and voice their opposition to the ACA. One member said to a Democrat congressman that by supporting the ACA he would be "order[ing] the death sentence" of another member's son who had cerebral palsy. Another member labelled the ACA as "socialism" (Fried and Harris, 2015: 436). Dr. Frank Luntz, a Republican political consultant, had compiled a document titled "The Language of Healthcare 2009" which helped the GOP strategise on how best to shift public opinion to their position. Though the description of section 1233 as

"death panels" was not directly suggested by Luntz, his document did play a significant role in the use of charged rhetoric in the coalition. The document contained ten principles which included the utilisation of anti-Washington rhetoric such as "politicians" and "bureaucrats" to demonise the Democratic Party's reform agenda as a "government takeover of health care"; all of which are phrases that the GOP and Tea Party had used to influence public opinion (Luntz, 2009: 1). Indeed, the strategy was effective, as 57% of the public in 2010 believed the ACA contained provisions for a death panel and 54% were opposed to the law (Brodie, 2020: 467; Starr, 2013: 272). Though the ACA became law without a single Republican vote, the GOP managed to unseat 63 Democrats in the House of Representatives and gain a majority in the 2010 Midterm elections, with nearly half the voters stating their vote had been influenced by their opposition to Obamacare (Pramuk, 2019).

4.7 Use of venues to influence policy

Coalitions also attempt to influence policy by *venue shopping*, a phenomenon whereby actors seek venues such as courts, the media, or legislatures to promote their policy position (Weible and Sabatier, 2007: 159). In 2010, several Republican state Attorney Generals joined the state of Florida in filing a lawsuit at a district federal court to challenge the constitutionality of the ACA's individual mandate and Medicaid expansion. Another lawsuit on the same grounds was filed at the same district federal court by a small business interest group, the NFIB, and other individuals without health insurance (KFF, 2012: 1) The lawsuit was in line with the espoused values of the coalition as it argued that the individual mandate was an encroachment on individual liberty and that Medicaid expansion[15] was in violation of state rights under the Tenth Amendment which protects state rights (State of Florida, 2010: 4-6). The District Court ruled in favour of the state Attorney Generals and the other complainants by stating that Congress had no power to enforce an individual mandate but dismissed their arguments on Medicare expansion. The Eleventh Circuit U.S. Court of Appeals also ruled with the District Court (Oyez, 2012).

However, the Obama administration appealed the decision which led the case to escalate to the Supreme Court. In the NFIB v. Sebelius case the Supreme Court ruled in favour of the Obama administration to uphold the individual mandate as part of the Federal government's taxing power,

[15] Under the ACA's Medicaid expansion provisions, states had to expand eligibility for Medicaid or risk having federal funds for State Medicaid programmes withheld (Cornell Law School, 2012).

thereby overruling the decisions of the District and Eleventh Circuit court. But the Supreme Court ruled in favour of the NFIB and the attorney generals on Medicaid expansion. The decision stated that the Federal government's withholding of federal Medicaid funds for states that do not expand Medicaid eligibility is a form of coercion (Cornell Law School, 2012). Though the coalition was unable to reverse the individual mandate, states were able to decide whether they would proceed with expanding eligibility for Medicaid. As of July 2022, 12 states, which include the 2nd and 3rd most-populated states in the country, Texas and Florida, have not carried out any Medicaid expansion (KFF, 2022). The coalition has continued to use courts as a venue to reverse the ACA, the most recent of which was the lawsuit of Republican attorney generals and governors across 20 states who challenged the NFIB v. Sebelius decision on the constitutionality of the individual mandate once more, especially after the Republican-led Congress had passed the Tax Cuts and Jobs Act of 2017, thereby reducing the individual mandate penalty to zero (Keith, 2019). The lawsuit went beyond challenging the individual mandate but also called for the entire law to be invalidated, as they argued that the mandate could not be severed from the whole law if it had been found to be unconstitutional (Keith, 2019).

4.8 Endurance of the ACA

The ACF view is that policy change should occur over a period of a decade as any shorter period will not provide an accurate picture of the success or failure of the policy (Sabatier, 1988, 131). In the case of the ACA, the law has been in place for longer than a decade since its passage in 2010 and has remained relatively intact, despite it being known as "the most challenged statute in American history" and the subject of more than 2000 lawsuits since its enactment (Shen and Staman, 2021: 1). Moreover, as stated in Chapter 2, there were more than 50 attempts to repeal the law between 2010 and 2016 from members of the GOP. Indeed, the ACF states that the several necessary pathways such as external and internal events are not sufficient to cause a change in policy (Pierce et al, 2020: 70). For example, the policy subsystem experienced a change in systemic governing coalition after the passage of the ACA, as the GOP had managed to take control of the House of Representatives in 2010, which was largely attributed to disapproval of the law. Moreover, in 2014, the GOP took control of the U.S. Senate which meant that they had control of both houses of Congress, thereby having the ability to repeal the law —which they attempted to do several times as stated earlier (Weisman and Parker, 2014). With the election of Trump in 2016,

the Small-government coalition had full control over the federal government, a critical resource which the ACF categorises as a formal legal authority to make policy decisions and which would provide them an opportunity to effect policy change.

The Trump administration and GOP-led Congress had attempted to repeal and replace the ACA in 2017 with an alternative plan which ironically contained certain elements of the ACA, such as the health insurance exchanges and insurance subsidies. However, members of the Health Industry coalition had opposed the effort. The AMA and AHA's CEOs and Vice Presidents urged Senate leadership to reject the bills, warning that they would result in an increase of uninsured Americans, as well as significantly reduce Medicaid funding (Madara, 2017; Pollack, 2017). The AHA also launched advertising campaigns against the GOP's health reform efforts with the CEO stating (in reference to the ACA) that "we must protect affordable coverage for as many Americans as possible" (Minemyer, 2017). Indeed, it is reported that 35 million people were able to enrol in an insurance plan because of the ACA (HHS, 2022). Interestingly, three Senate Republicans opposed their Senate caucus by not voting for the repeal effort, thereby preserving the ACA (Oberlander, 2020: 477). Despite the repeal failure, the Trump administration used executive orders to undermine the law which included: allowing states to add work requirements to qualify for Medicaid, reducing funds that facilitated sign-ups on the healthcare.gov website, and ending cost-sharing reduction subsidies to insurers (Simmons-Duffin, 2019). However, though efforts to undermine or repeal the law formed part of the campaign promises made by the GOP and were strongly desired by the Tea Party, over time public opinion became more favourable towards the law. From June 2017 onwards, a majority of the public viewed the ACA favourably and this coincided with the attempts at repeal (Kirzinger et al, 2020). With more Americans viewing the law favourably, Democrats, who were part of the Health Care for All coalition, used the same tactic employed by the GOP in 2010 by using the GOP's repeal efforts of the law against them on the campaign trail. Democrats were found to have spent a significant amount of their House and Senate campaign budgets on television advertisements for health care, promoting the message that the GOP sought to "take away people's health care and end Obamacare's protections for people with pre-existing conditions", which is similar to the type of language Republicans had used against Obamacare before and immediately after its passage (Scott, 2018). This subsequently led to the GOP's loss of the House of Representatives in the 2018 mid-term elections (Oberlander,

2020: 477). In both uses of the ACA as a campaign issue, public opinion had dictated the campaign strategy used by the resulting winning coalition.

Moreover, in continuing the use of courts to influence policy, the District Court and Fifth Circuit of Appeals ruled in favour of the Small-government coalition in striking down the entire law; however Democrat state attorney generals and governors had appealed the ruling to the Supreme Court (Keith, 2020). In addition, AHIP filed an amicus brief in support of the Democrat coalition appeal, stating that the "invalidation of the ACA would wreak havoc on the entire health care system" (AHIP, 2020). In 2021, the Supreme Court ruled in a 7-2 decision that the lawsuit by the Small-government coalition be thrown out. This would once again preserve the ACA as law (Jost, 2021).

4.9 Conclusion

The ACF model of beliefs helped to identify actors that comprised of three coalitions which sought to translate their beliefs into policy in the American health policy subsystem thereby helping to answer the research question. The Health Care for All coalition sought to promote health care as a right for all Americans, whereas the Small-government coalition sought to prevent greater government involvement in health care and was diametrically opposed to the beliefs and policies proposed by the Health Care for All coalition. The Health Industry coalition was open to negotiating with the Health Care for All coalition as changes in the socio-economic conditions of the country as well as public opinion had pressured the industry to act in reforming health insurance. However, in passing the ACA, the coalition that was most successful in translating their beliefs into policy was the Health Industry, as their core policy objectives were achieved and the policy proposals they were most opposed to, such as the public option and limits on drug-pricing, were not incorporated into the final Bill. Though the Small-government coalition was able to take control of the federal government, they had failed to repeal the ACA whether through legislation or through the courts. Moreover, Democrats were able to take back control of the House of Representatives as a result of the shift in public opinion towards their position on the ACA; however the Health Industry coalition's policy interests in the ACA were preserved. Public opinion has shown to be an important resource for coalitions in promoting their policy position, but powerful interests as encapsulated in the Health Industry coalition may set the parameters for what type of reform can be implemented.

Now that the analysis of the study, which serves to answer the research question, has been conducted, the following chapter will conclude the study by discussing and reflecting on its main findings. It will provide an overview of the study as a whole, reflections on the study, as well as provide recommendations on future research.

Chapter 5: Conclusion

5.1 Introduction

In the preceding chapter, the ACF was utilised to help identify the actors and resulting advocacy coalitions involved in US health care reform policy. Other aspects of the framework were also utilised in order to demonstrate how they influenced health reform policy, as well as how they interacted with one another in the health policy subsystem. This chapter serves as the culmination of the findings from the study. It begins with an overview of the study by restating the research problem and question and providing the logical progression of the study through a summary of its previous chapters. The chapter then proceeds to answer explicitly the research question and concludes with exploring future areas for research.

5.2 Overview of the study

Health care has and continues to be a contentious issue in the United States (US) from the start of the 20th century to the present era. The passage of Medicare and Medicaid in the 1960s, coupled with the employment-based health insurance system would create a hybrid model of private and public health insurance. However, this hybrid model would still leave many Americans uninsured and would prove ineffective at curtailing the exponential rise in health care costs. Indeed, there have been continued attempts to correct the flaws in the system such as cost, access, and quality; the latest attempt at correction being the Affordable Care Act (ACA). However, each correction attempt in the health care system has been met with clashes regarding the role of government in health care, bringing along with it charged political rhetoric, and interest groups which have muddied the waters on health reform. Therefore, through this study, the student sought to identify the actors who had played a significant role in the current state of US Health reform and how they had played that role.

Therefore, in answering the above question, this section seeks to demonstrate the logical progression of the thesis by providing a synopsis of the discussion in Chapter 2 which provided the historical background of the study; Chapter 3, containing a discussion of the analytical framework; and Chapter 4, which provided an analysis of the case study.

To understand the complexity and highly polarised nature of US health care, Chapter 2 provided an historical overview of the US health care system and the several attempts at reform in the period

from the previous century to the contemporary era. American Progressives such as Theodore Roosevelt and organisations such as the American Association for Labour Legislation (AALL) had attempted to promote a social health insurance programme that fitted the American political context. The latter is based on a classical liberal style of government and a laissez faire economy i.e., a Small-government and free-market system. However, their efforts were met by strong opposition by groups such as the AMA, who labelled attempts to institute federal and state health insurance programmes as a government takeover of the health care industry and violation of the free market, a core institution of the nation.

Chapter 2 also provided a discussion of how efforts to institute a national health insurance programme resumed during the Great Depression and post-World War II era; an era which included the passage of the signature Social Security Act which in turn brought large-scale changes in America's welfare system. Health insurance legislation was still strongly opposed by special interest groups which lobbied members of Congress not to support any provisions related to health insurance. Moreover, due to the Soviet threat during the Cold War, health insurance legislation was further demonised by being labelled "socialized medicine" and plots to entrench Socialism and Communism in the nation. Ultimately the Internal Revenue Service (IRS) started to exempt employment-based health insurance from taxation which led to the adoption and resulting entrenchment of an employment-based health insurance system as more businesses began offering it to employees.

Moreover, Chapter 2 explored the adoption of Medicare and Medicaid under the second round of large-scale changes to the welfare system. Government programmes would provide health insurance to the elderly and indigent population. This constituted the rare occurrence of significant policy change in US health policy. However, costs remained high, and many Americans were still without insurance.

Chapter 2 further provided a discussion of the additional attempts at reform during the 1970s until the 1990s. It detailed the continued increase in health care spending and the rise in the number of uninsured Americans. Passage of a national health insurance programme had been highly possible during the 1970s when there was bipartisan negotiation and compromise between both Republican and Democratic politicians. Nevertheless, the Watergate scandal and the resulting resignation of

Republican President Nixon, a key player in its potential passage, terminated its possible passage and implementation.

The chapter concluded with a snapshot of the attempts at health reform in the 2000s in the period between the Bush Administration and the Trump Administration, until 2021. It provided a discussion of the expansion of Medicare and the revival of universal health insurance from its advocates. Moreover, it provided the context and summary of the events leading to the passage of the ACA. It also contained a brief discussion of the attempts at repeal and replacement of the ACA after its passage and during the Trump Administration.

In Chapter 3 the theoretical framework of the study, the ACF, was discussed in order to understand its appropriateness in answering the research question. The chapter provided the rationale behind the ACF which was to address the limitations of existing theories such as the stages heuristic. This was believed to have had a legalistic, top-down focus and had focused on traditional iron triangle actors (interest groups, legislators), and had excluded other actors from multiple levels of government and other areas of civil society in policy analysis.

The chapter provided the premises of the ACF which includes the policy subsystem as the best unit of analysis when looking at policy change, the need to include multiple actors from all levels of government (Federal, state, local) and civil society, so as to provide a holistic overview of the actors involved in the policy process, and so that implemented policies can be understood as the manifestation of the beliefs of the actors involved in the policy process. These beliefs are described under the ACF model of beliefs, which was the primary tool utilised to answer the research question.

The ACF model of beliefs consists of three tiers of beliefs which include deep core beliefs, policy core beliefs, and secondary beliefs. Of these, deep core beliefs and policy core beliefs were utilised to answer the research question. Deep core beliefs inform an individual's position in every policy area, thereby informing the next tier of the beliefs model (policy core beliefs). Both tiers of beliefs are difficult to change, but the latter tier is more susceptible to change than the former. The chapter also contained a discussion of advocacy coalitions, which can be identified through the operationalisation of at least two or three policy core beliefs. It expanded on the hypotheses and attributes of advocacy coalitions which also include coordination, to show how actors in advocacy coalitions coordinate their behaviour, and resources, which show the tools of influence used by the

coalitions in promoting their policy position. Moreover, considering the polarised political environment in US health reform and the two tiers of beliefs which are resistant to change, the chapter contained an introduction to the ACF's devil shift. This explains the vilification of an opposing advocacy coalition in the policy subsystem.

Chapter 3 provided an overview of the other components of the ACF, some of which have been used to help demonstrate how the identified actors and their resulting advocacy coalitions interacted with one another in the policy subsystem and attempted to translate their beliefs into policy. These components include relatively stable parameters (RSPs) which are the structures that set the foundation of policy subsystems and the behaviour and actions of actors in the subsystem; external events, which provide the impetus for policy change.

Lastly, Chapter 3 detailed prior applications of the ACF in identifying coalitions in health policy. It showed how scholars identified coalitions by utilising policy core and deep core beliefs which they confirmed through a combination of publicly available sources and interviews with actors involved in the policy process. It also clarified how the study would use the ACF model of beliefs to identify actors and their resulting advocacy coalitions.

Chapter 4 contained an application of the ACF model of beliefs to answer the research question in identifying the actors with the most significant role in US health reform. The chapter began by briefly discussing the state of health care prior to the passage of the ACA. It discussed the external events that provided the impetus for policy change in US health policy. These events include the 2008 recession and the change in governing coalition that would be a proponent of health reform. The chapter proceeded to provide a brief overview of the provisions and objectives of the ACA and highlighted the provisions that were points of contention between actors in the policy subsystem.

After discussing the provisions of the ACA, in Chapter 4 the student proceeded to identify the advocacy coalitions and actors who played a significant role in the passage of the ACA. Actors were identified from the literature on health reform in the period 2007-2021, and these identified actors' policy positions and stated beliefs were matched with the deep core and policy core beliefs related to components listed under the ACF to form which would form the advocacy coalitions. In Chapter 4 coalitions were identified. After identifying the coalitions, the student sought to demonstrate how actors within their respective coalitions coordinated their behaviours to translate

their beliefs into policy. To show how they interacted with one another, the chapter also provided the evidence of interaction between the coalitions to promote their respective policy positions, whether through collaboration or through opposition. Thereafter, a brief discussion was given of the endurance of the ACA, despite a change in governing coalition which opposed the law.

Chapters 2 through to 4 helped set the logical progression of the study. In Chapter 4, however, the application of theory to the case study, the ACA, helped show the findings that would assist in answering the research question and solving the research problem.

5.3 Discussion of the research findings

Now that the logical progression of the study has been outlined in detail, the analysis contained in Chapter 4 helped reveal the findings of the research which are vital for answering the research question and thereby solving the research problem. Before discussing these findings, however, it is important to restate the research question that it aims to solve. The research question of the study is:

> *Which actors have played a significant role in the current state of US Health reform – and how?*

By using the ACF and its model of beliefs in answering the research question above, the student identified three advocacy coalitions whose members played a significant role in the current state of US Health reform: (1) the *Health Care for All coalition*; (2) *Health Industry coalition*, and (3) the *Small-government coalition*. These coalitions and their members will be explained below.

The *Health Care for All coalition* consisted of the Democratic Party advocacy group, Health Care for America Now, and Yale Political Scientist, Jacob Hacker. These three actors were bound by their policy core belief in the right to health care and the right to guaranteed and equitable access to health care which would be guaranteed through government action. Indeed, the coalition reflected beliefs held by the Progressives that had attempted to institute national health insurance at the start of the 20th century. However, in considering the history of the repeated failures in instituting a national health insurance, the coalition sought to promote politically realistic policy in the context of the RSPs of the country. These RSPs included societal values of individual choice and legal structures such as the filibuster rule, which would make it difficult to pass a major law without 60 votes in a nearly evenly party split Senate. They would need to garner the support of

powerful interest groups who had a significant track record in preventing health reform, while still keeping to their core belief in the right to health care, by promoting the public option.

The *Health Industry coalition* included actors who were notorious for their significant opposition to national health insurance and significant involvement of government in the health industry. These actors were the AMA, the American Hospital Association (AHA), America's Health Insurance Plans (AHIP), and Pharmaceutical Research and Manufacturers of America (PhRMA). These four actors were bound by their policy core beliefs in the free market for the provision of health care goods and services; however they also supported public-private solutions to health care coverage which meant there would be *some* government involvement in health care. The rising number of uninsured Americans followed by the 2008 recession which further exacerbated the number of uninsured or underinsured Americans, helped shift their tone on health reform. However, in analysing their influence in the subsystem in Chapter 4, it was made evident that the industry played a significant role in what would eventually be contained in the ACA. The industry's role can be attributed to their lobbying ability through significant financial resources which could be leveraged to launch a large-scale media campaign that could influence public opinion as well as influence the votes of certain Members of Congress who depended on their funding for their electoral campaigns. Indeed, the coalition served as the gatekeeper to health reform. For example, the Health Care for All coalition ceded the public option and drug price controls to Medicare, for which high drug prices have been a significant contributor to health spending. These were ceded in exchange for the industry coalition's savings of $80 billion over a period of 10 years and their support of the ACA bill.

The final identified coalition, the *Small-government coalition*, also included actors that were strongly opposed to health reform. However, the difference between this coalition and the Health Industry coalition is their hard-line stance against health reform under the Obama administration which was part of the Health Care for All coalition. The actors of this coalition included the Republican Party (GOP) and their Republican state attorneys, and the Tea Party Movement. The actors in this coalition were bound by conservative/libertarian deep core beliefs and firmly believed in the free market and limited government involvement in health care provision. Despite its employment of the devil shift through vitriolic language against the ACA, which shifted public opinion in their favour and helped them regain full control of the federal government under the

Trump administration, and utilising the courts to overturn the law, the coalition did not succeed in implementing their policy core beliefs in health reform. However, where they may have succeeded is in the failed attempt to pass the public option which the coalition was diametrically opposed to as the public option went against their deep core and policy core beliefs of the coalition.

The actors who have had the most significant role in current US health reform have been mentioned above. The Health Care for All coalition helped conceptualise the most significant piece of health care legislation since the passage of Medicare and Medicaid, but it was an already compromised plan, since it did not advance national health insurance in the way that previous actors had attempted in the 20th century, because of the earlier mentioned RSPs. Indeed, such a bold plan would not be politically palatable, particularly with the hard-line opposition from the Small-government coalition, which meant they could not depend on bipartisanship to pass health reform legislation. Therefore, the Health Industry coalition held significant sway in the passage of the ACA, despite not having a single member of its coalition who was part of the US political and democratic system.

5.3.1 Reflections on the study

Through the use of the ACF and its model of beliefs, the student was able to identify actors who had exerted significant influence on the current state of US health reform. However, there are many actors who could have been included in the identified coalitions. For example, an exploration of the judges in the various courts involved in the litigation of the ACA could have been undertaken to determine the coalition they would have fitted into. Indeed, the ACF's premise of including non-traditional actors in the policy process allows for this possibility. However, an in-depth investigation of the judgements written by the various judges would have been needed to determine their deep core and policy core beliefs. Moreover, interviews would have been needed to confirm the assumptions of the investigation, had it been undertaken.

The study also highlighted the existence of conservative, liberal, and moderate elected officials in the Democratic and Republican Parties. Their existence meant that they did not neatly fit into the mainstream policy core beliefs of their party, which ultimately means they would not neatly fit in the advocacy coalition of their party.

In addition, though the study clarified the beliefs of the identified actors and sorted the actors into coalitions, it would have been of further value to the study if semi-structured interviews with select stakeholders could have been conducted to confirm the memberships of the identified actors in the identified coalitions. Due to time constraints and limitations in funding, interviews were unfortunately not a possibility. Nevertheless, they would have assisted in verifying the beliefs of the actors and coalitions as well as strengthened the evidence of coordination of actors in the various coalitions.

Lastly, the student utilised the ACF premise that beliefs are the driving force behind the promotion of certain policies in the policy process. However, when observing the malleability of the Health Industry coalition's policy position on health reform, there is a possibility that the coalition depended on their financial and economic interests rather than on pure values or beliefs to promote and reject certain elements of the ACA. For instance, the increase in uninsured Americans meant that members of the health industry had a reduced number of individuals who used their products. Indeed, it was stated in Chapter 4 that government had the sole power to mandate individuals to obtain health insurance which would be in the financial interest of the industry. However, the influence of financial interests is beyond the scope of the ACF and therefore the scope of this study.

5.4 Recommendations for future research

The US's current polarised political climate makes of the ACF an excellent tool to utilise to explore multiple policy areas including health care, as the ACF has been seen as the most appropriate framework to utilise when studying contentious areas of politics.

Though the role of beliefs in the promotion and implementation of policy is significant, particularly in the current hyper-polarised political environment, future research ought to and will benefit from considering the role of financial interests in the health policy process, particularly given the US's diverse, well-established, and multi-billion dollar lobbying industry. The ACF can still be used in such a research undertaking; however it ought to be utilised with an additional theoretical or analytical framework that may include the aspect of financial interest in the policy process.

In addition, the role of the Judicial branch of government has gained further prominence in the policy process in the contemporary era. Future areas of research ought to make an undertaking to

understand the beliefs of members of the judiciary in the policy process, particularly as they play a prominent role in landmark cases such as the NFIB v Sebelius case which has been included in this study.

5.5 Conclusion

US health care policy-making remains significantly complex and polarised, despite the passage of the ACA, which sought to address, among others, health care coverage and affordability. The study sought to contribute to the literature on US political polarisation as well as uncover the extent to which democratic institutions in the US and policy decisions made by elected officials represent the beliefs and preferences of the electorate. Through the study, the student sought to identify actors who played a significant role in the current state of US health reform and for this purpose, he utilised the ACF. By applying the ACF system of beliefs, he identified three advocacy coalitions who competed to translate their beliefs into policy. Moreover, the use of the ACF demonstrated how these coalitions sought to promote their policy beliefs by taking into consideration their political contexts, by leveraging their resources, which include public opinion and financial resources, and by utilising venues such as the courts.

Public opinion was an important resource for the coalitions in advancing their policy positions, with some coalitions possessing a political mandate from the electorate to institute their policy position. The ACA was passed along partisan lines in Congress in the midst of heated political rancour, particularly from the opposition party, the GOP, in the Small Government Coalition. This pointed towards the impact of political polarisation on policy outputs in Congress. However, despite high partisan and ideological tension, the contents of the law and the extent to which the policy positions of the Health Care for All Coalition and preferences of the electorate were instituted have depended on the support and buy-in of unelected powerful interests such as the Health Industry coalition. Political polarisation makes any meaningful reforms to the healthcare system difficult but not impossible as evidenced by the passage of the ACA. However, it would be important to take into consideration the gatekeeping effect that special interest groups may have on the passage of meaningful reforms in US healthcare and other policy areas that may be supported by the public.

Bibliography

AdvaMed, AHIP, AHA, AMA, PhRMA, and SEIU. 2009. *Health Group Letter* [Online]. Available: http://graphics8.nytimes.com/packages/pdf/politics/20090511_HealthGroups_Letter.pdf [2022, July 12].

Altman, S. 2009. *Legacy of practicality, compromise.* [Online]. Available: https://www.modernhealthcare.com/article/20090907/MAGAZINE/309079992/legacy-of-practicality-compromise [2021, June 06].

Alvarez-Rosete, A. and Hawkins, B. 2018. Advocacy Coalitions, Contestation, and Policy Stasis: The 20 Year Reform Process of the Colombian Health System. *Latin American Policy.* 9(1): 27-54.

American Health Insurance Plans. N.d. *About Us* [Online]. Available: https://www.ahip.org/about/#who_we_are [2021, October 09].

American Health Insurance Plans. 2020. *AHIP Files Amicus Brief in Texas v. United States.* [Online]. Available: https://www.ahip.org/news/press-releases/ahip-files-amicus-brief-in-texas-v-united-states [2022, July 25].

American Hospital Association. N.d. *About the AHA* [Online]. Available: https://www.aha.org/about [2022, October 07].

American Hospital Association. N.d. *Mission and Vision* [Online] Available: https://www.aha.org./about/mission-vision [2021, October 08].

American Hospital Association, 2007. *American Health Insurance Plans (AHIP)* [Online]. Available: https://www.aha.org/system/files/content/00-10/0704-uhp-ahip.pdf [2021, October 09].

American Hospital Association, 2007. *American Medical Association (AMA)* [Online]. Available: https://www.aha.org/system/files/content/00-10/0704-uhp-american-medical.pdf [2021, October 08].

American Hospital Association. 2017a. *Regulatory Overload: Assessing the Regulatory Burden on Health Systems, Hospitals, and Post-acute Care Providers*. American Hospital Association [Online]. Available: https://www.aha.org/sites/default/files/regulatory-overload-report.pdf. [2021, March 10].

American Hospital Association. 2017b. *Health Reform: Health For Life. Better Heatlh. Better Health Care* [Online]. Available: https://www.aha.org/2017-12-11-health-reform-health-life-better-heatlh-better-health-care [2022, June 12].

American Medical Association. N.d. *About*. [Online]. Available: https://www.ama-assn.org/about [2021, June 05].

American Medical Association, 2015. *Improving the Health Insurance Marketplace: Modified community rating* [Online]. Available: https://www.ama-assn.org/media/11166/download [2021, October 08].

American Medical Association, 2018. *Improving the Health Insurance Marketplace: Reinsurance* [Online]. Available: https://www.ama-assn.org/media/22586/download [2021, October 08].

Antos, J. and Rivlin, A. 2019. *A New Vision for Health Reform*. *Report.* [Washington, D.C.]: American Enterprise Institute [Online]. Available: https://www.aei.org/wp-content/uploads/2019/09/A-NEW-VISION-FOR-HEALTH-REFORM-AEI-BROOKINGS-1.pdf?x91208 [2021, March 10].

Assistant Secretary for Planning and Evaluation. nd. *Frequently Asked Questions Related to the Poverty Guidelines and Poverty* [Online]. Available: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/frequently-asked-questions-related-poverty-guidelines-poverty [2022, March 27].

Atlantic Philanthropies. N.d. *Our Story: Investing in a Better Future for All* [Online]. Available: https://www.atlanticphilanthropies.org/our-story [2022, July 04].

Baxter, P. and Jack, S. 2008. Qualitative Case Study Methodology: Study Design and Implementation for Novice Researchers. *The Qualitative Report.* 13(4):544-559.

Benoit, F. 2013. *Public Policy Models and Their Usefulness in Public Health: The Stages Model*. Montreal, Quebec: National Collaborating Center for Healthy Public Policy.

Beto, D.R. 2014. Leadership Qualities Examined. *Texas Probation.* 29(3): 1-21.

Birn, A., Brown, T.M., Fee, E., and Lear, W.J. 2003. Struggles for National Health Reform in the United States. *American Journal of Public Health.* 93(1): 86-91.

Blendon, R.J. and Benson J.M. 2001. Americans' Views on Health Policy: A Fifty-Year Historical Perspective. *Health Affairs.* 20(2): 33-46.

Blendon, R.J, Altman, D.E., Benson, J.M., Brodie, M., Buhr, T., Deane, C., and Buscho, S. 2008. Voters and Health Reform in the 2008 Presidential Election. *The New England Journal of Medicine.* 359(19): 2050-2061.

Blumenthal, P. 2009. *The Max Baucus Health Care Lobbyist Complex* [Online]. Available: https://sunlightfoundation.com/2009/06/22/the-max-baucus-health-care-lobbyist-complex/ [2022, July 09]

Boaz, D. 2015. *Nation's Libertarian Roots.* [Online]. Available: https://www.cato.org/commentary/nations-libertarian-roots [2022, June 18]

Bodaken, B.G. 2008. Where Does the Insurance Industry Stand on Health Reform Today? *Health Affairs.* 27(3): 667-674.

Branning, G. and Vater, M. 2016. Healthcare Spending: Plenty of Blame to go around. *American Health and Drug Benefits.* 9(8): 445-447.

Brodie, M., Hamel, E.C., Kirzinger, A., and Altman, D.E. 2020. The Past, Present, and Possible Future of Public Opinion on the ACA. *Health Affairs.* 39(3): 462-270.

Brooks, E. 2018. Using the Advocacy Coalition Framework to understand EU pharmaceutical policy. *European Journal of Public Health.* 28(3): 11-14.

Brown-Collier, E.K. 1998. Johnson's Great Society: Its Legacy in the 1990s. *Review of Social Economy.* 56(3): 259-276.

Brown, L.D. 2010. The Political Face of Public Health. *Public Health Reviews.* 32(1): 155-173.

Bump, J.B. 2015. The Long Road to Universal Health Coverage: Historical Analysis of Early Decisions in Germany, the United Kingdom, and the United States. *Health Systems & Reform.* 1(1): 28-38.

Burnham, P., Lutz, K.G., Grant, W. and Layton-Henry, Z. 2008. *Research Methods in Politics* New York: Palgrave MacMillan.

Buse, K. 2008. Addressing the theoretical, practical, and ethical challenges inherent in prospective health policy analysis. *Health Policy and Planning.* (23): 351-360.

Cable News Network. 2000. Victory restores Bush Dynasty to Washington. [Online]. Available: https://www.cnn.com/2000/ALLPOLITICS/stories/12/13/president.bush/index.html [2021, June 06].

Cable News Network. 2003. Bush signs landmark Medicare bill into law [Online]. Available: https://edition.cnn.com/2003/ALLPOLITICS/12/08/elec04.medicare/ [2021, June 06].

Cable News Network. 2009. Obama calls for Congress to face health care challenge [Online]. Available: https://edition.cnn.com/2009/POLITICS/09/09/obama.speech/index.html [2021, June 06].

Cairney, P. 2015. Paul A. Sabatier, "An Advocacy Coalition Framework of Policy Change and the Role of Policy-Oriented Learning Therein", in M. Lodge, E.C. Page, and S.J. Balla (eds). *The Oxford Handbook of Classics in Public Policy and Administration. United Kingdom: Oxford University Press*

Camillo, C.A. 2016. The US Healthcare System: Complex and Unequal. *Global Social Welfare.* (3): 151-160.

Carroll, A.E. 2017. *The Real Reason the U.S. Has Employer-Sponsored Health Insurance.* [Online]. Available: https://www.nytimes.com/2017/09/05/upshot/the-real-reason-the-us-has-employer-sponsored-health-insurance.html. [2021, June 08].

Casscells W. 2001. Bush Administration and the New Senate Converge on Health Care. *Circulation.* 103(24): 9051-9053.

Center on Budget and Policy Priorities. 2019. *Chart Book: The Legacy of the Great Recession* [Online]. Available: https://www.cbpp.org/research/economy/the-legacy-of-the-great-recession [2021, June 26].

Cigna. N.d. *Employer Mandate* [Online]. Available: https://www.cigna.com/employers-brokers/insights/informed-on-reform/employer-mandate#:~:text=Employer%20mandate%20penalty%20amounts%20and%20processes&text=The%20penalty%20is%20%242%2C570%20per,excluding%20the%20first%2030%20employees. [2022, June 18]

Cohen, W.J. 1984. The Development of the Social Security Act of 1935: Reflections Some Fifty Years Later. *Minnesota Law Review.* 68: 379-408.

Cohn, J. 2020. *The ACA, Repeal, And the Politics of Backlash.* [Online]. Available: https://www.healthaffairs.org/do/10.1377/hblog20200305.771008/full/ [2021, June 08].

Cook, B. 2019. *Traditional Republican values* [Online]. Available: https://www.nhbr.com/traditional-republican-values/ [2022, October 27].

Cooper, Z., Kowalski, A., Powell, E.N., and Wu, J. 2020. Politics and Health Care Spending in the United States. Paper No. 23748. NBER.

Cornell Law School. 2012. *National Federation of Independent Business v. Sebelius (2012)* [Online]. Available: https://www.law.cornell.edu/wex/national_federation_of_independent_business_v._sebelius_(2012) [2022, July 23].

Crafts, N. and Fearon, P. 2010. Lessons from the 1930s Great Depression. *Oxford Review of Economic Policy.* 26(3): 285-317.

Crowe, S., Cresswell, K., Robertson, A., Huby, G., Avery, A., and Sheikh, A. 2011. The case study approach. *BMC Medical Research Methodology.* 11(100): 1-9.

Cunningham, E. 2018. Great Recession, great recovery? Trends from the Current Population Survey. *Monthly Labor Review.* [Electronic], April 2018. Available: https://doi.org/10.21916/mlr.2018.10 [2021, October 01].

De Leeuw, E., Clavier, C., and Breton, E. 2014. Health policy- why research it and how: health political science. *Health Research Policy and Systems.* 12(55): 1-10.

Democratic National Committee. N.d. *Where we stand* [Online]. Available: https://democrats.org/where-we-stand/ [2022, June 26].

Derickson, A. 1997. The House of Falk: The Paranoid Style in American Health Politics. *American Journal of Public Health.* 87(11): 1836-1843.

Doonan, M.T. and Tull, K.R. 2010. Health Care Reform in Massachusetts: Implementation of Coverage Expansions and a Health Insurance Mandate. *The Milbank Quarterly.* 88(1): 54-80.

Erskine, H. 1975. The Polls: Health Insurance. *The Public Opinion Quarterly.* 39(1): 128-143.

Fass, S. 2009. *Measuring Poverty in the United States* [Online]. Available: https://academiccommons.columbia.edu/doi/10.7916/D81J9KGK/download. [2021, October 01].

Federal Election Commission. 2009. *Federal Elections 2008: Election Results for the U.S. President, the U.S. Senate, and the U.S. House of Representatives.* [Washington, D.C.]: Office of Communications.

Fleming, C. 2009. *Fact of Fiction: Advance Care Planning in Health Reform* [Online]. Available: https://www.healthaffairs.org/do/10.1377/forefront.20090907.002016/full/#:~:text=Section%201233%20of%20the%20House,nurse%20practitioner%2C%20or%20physician%20assistant [2022, July 19].

Folsom Jr., B.W. 2019. The Fall and Rise of Laissez-Faire in the United States, 1789-1900. *The Independent Review.* 23(3): 357-367.

Frates, C. 2009. *Adversaries team up on health care.* [Online]. Available: https://www.politico.com/story/2009/04/adversaries-team-up-on-health-care-021434. [2022, July 17].

Fried, A. and Harris, D.B. 2015. The Strategic Promotion of Distrust in Government in the Tea Party Age. *The Forum*. 13(3): 417-433.

Galston, W.A. 2009. *The Healthy Americans Act is No Laughing Matter* [Online]. Available: https://www.brookings.edu/opinions/the-healthy-americans-act-is-no-laughing-matter/ [2021, June 05].

Garrow, S. 2022. *What Is a State-Based Health Insurance Exchange?* [Online]. Available: https://www.ehealthinsurance.com/resources/individual-and-family/state-based-health-insurance-exchange [2022, June 17].

Germany, K. n.d. *Lyndon B. Johnson: Domestic Affairs* [Online]. Available: https://millercenter.org/president/lbjohnson/domestic-affairs. [2021, June 04]

Giordono, L.S. 2020. Advocacy Coalitions in Low Salience Policy Subsystems: Struggles Under a Smooth Surface. *Policy Studies Journal.* 48(4): 113-1167.

Goldfield, N. 1999. Why we cannot agree on the direction of health reform: an exploration of American values. *Physician Executive* 18(4): 1-5.

Gonyea, D. 2017. *From The Start, Obama Struggled With Fallout From A Kind of Fake News* [Online]. Available: https://www.wvpe.org/2017-01-10/from-the-start-obama-struggled-with-fallout-from-a-kind-of-fake-news. [2022, July 26]

Gordon, C. 2003. *Dead on Arrival: The Politics of Health Care in Twentieth-century America.* Princeton: Princeton University Press.

Gregg II, G.L. n.d. *George W. Bush: Domestic Affairs* [Online]. Available: https://millercenter.org/president/gwbush/domestic-affairs. [2021, June 05].

Griffin, J. 2020. *The History of Medicine and Organized Healthcare in America* [Online]. Available: https://www.griffinbenefits.com/blog/history-of-healthcare. [2020, June 30]

Gritter, M. 2019. The Kerr-Mills Act and the Puzzles of Health-Care Reform. *Social Science Quarterly.* 100(6): 2209-2222.

Hacker, J.S. [2007]. Health Care for America: A Proposal for guaranteed affordable health care for all Americans building on Medicare and employment-based insurance. *EPI Briefing Paper*, (180) [Online]. Available: http://www.sharedprosperity.org/bp180/bp180.pdf [2022, October 06].

Hacker, J.S. 2010. The Road to Somewhere: Why Health Reform Happened: Or Why Political Scients Who Write About Public Policy Shouldn't Assume They Know How to Shape It. *Perspectives on Politics. September 2010.* 8(3): 861-876.

Hacker, J.S. 2021. Between the Waves: Building Power for a Public Option. *Journal of Health Politics, Policy, and Law.* 46(4): 535-547.

Halpin, H. and Harbage, P. 2010. The Origins and Demise of the Public Option. *Health Affairs.* 29(6): 1117-1124.

Haltinner, K. and Sarathchandra, D. 2017. Tea Party Health Narratives and Belief Polarization: the Journey to Killing Grandma. *AIMS Public Health.* 4(6): 557-578.

Hamburg, R.S. and Ballin, S.D. 1995. Politics of the Demise of Healthcare Reform. *American Heart Association.* 91(1): 8-9.

Hamilton, A., Jay, J., and Madison, J. 2001. No. 45: A further discussion of the supposed danger from the powers of the union, to the state governments, in G.W. Carey and J. McClellan (eds.). *The Federalist.* Indianapolis: Liberty Fund. 237-242.

Hanna, C. and Uccello, C. 2018. *Prescription Drug Spending in the U.S. Health Care System.* [Washington, D.C.]: American Academy of Actuaries.

Hare, C., and Poole, K.T. 2014. The Polarization of Contemporary American politics. *Polity.* 46(3): 411-429.

Harrington, S.E. 2010. U.S. Health-Care Reform: The Patient Protection and Affordable Care Act. *The Journal of Risk and Insurance.* 77(3): 703-708.

Harry S. Truman Library. N.d. *The Challenge of National Healthcare* [Online]. Available: https://www.trumanlibrary.gov/education/presidential-inquiries/challenge-national-healthcare [2021, June 14].

Hawkins, M. 2019. *A History of the Tea Party Movement* [Online]. Available: https://www.thoughtco.com/a-history-of-the-tea-party-movement-3303278 [2022, June 26].

HealthCare. N.d. *Federal Poverty Level (FPL)* [Online]. Available: https://www.healthcare.gov/glossary/federal-poverty-level-fpl/ [2021, October 03].

Health Coverage Coalition for the Uninsured. 2007. *Unprecedented Alliance of Health Care Leaders Announces Historic Agreement to Help Reduce the Number of America's uninsured.* [Online]. Available: https://www.coalitionfortheuninsured.org/news/pressrelease_20070118.html [2021, October 04].

Health and Human Services. 2022. *New Reports Show Record 35 Million People Enrolled in Coverage Related to the Affordable Care Act, with Historic 21 Million People Enrolled in Medicaid Expansion Coverage* [Online]. Available: https://www.hhs.gov/about/news/2022/04/29/new-reports-show-record-35-million-people-enrolled-in-coverage-related-to-the-affordable-care-act.html#:~:text=media%40hhs.gov-,New%20Reports%20Show%20Record%2035%20Million%20People%20Enrolled%20in%20Coverage,Enrolled%20in%20Medicaid%20Expansion%20Coverage [2022, July 25].

Health Resources and Services Administration, 2021. *Hill-Burton Free and Reduced-Cost Health Care.* [Online]. Available: https://www.hrsa.gov/get-health-care/affordable/hill-burton [2021, June 19].

Heffner, R.D., and Heffner, A.B. 2018. *A Documentary History of the United States.* New York: Penguin Random House.

Heinmiller, B.T., Osei, E.M., and Danso, E. 2021. Investigating ACF Policy Change Theory in a Unitary Policy Subsystem: The Case of Ghanaian Public Sector Information Policy. *International Review of Public Policy.* 3(1): 72-99.

Henry, A.D., Ingold, K., Nohrstedt, D., Weible, C.M. 2014. Policy Change in Comparative Contexts: Applying the Advocacy Coalition Framework Outside of Western Europe and North America. *Journal of Comparative Policy Analysis: Research and Practice*. 16(4): 299-312.

Hoffman, B.R. 2001. *The Wages of Sickness: The Politics of Health Insurance in Progressive America.* Chapel Hill: The University of North Carolina Press.

Holahan, J. 2011. The 2007-09 Recession and Health Insurance Coverage. *Health Affairs.* 30(1): 145-152.

House Committee on the Budget. 2020. *Budget Reconciliation: The Basics* [Online]. Available: https://budget.house.gov/sites/democrats.budget.house.gov/files/documents/Budget%20Reconciliation%20The%20Basics%20-%20Final%202021.pdf. [2022, July 11]

Jenkins-Smith, H.C., and Sabatier, P.A. 1994. Evaluating the Advocacy Coalition Framework. *Journal of Public Policy.* 14(2): 175-203.

Johnson, L.B. 1964. *Remarks at the University of Michigan,* 22 May, Ann Arbor [Online] Available: https://www.presidency.ucsb.edu/documents/remarks-the-university-michigan [2021 June 20].

Johnson, L.B. 1965a. *State of the Union*, 04 January, Washington, D.C. [Online] Available: https://millercenter.org/the-presidency/presidential-speeches/january-4-1965-state-union [2021, June 20].

Johnson, L.B. 1965b. *Special Message to the Congress: "Advancing the Nation's Health*, 07 January, Washington, D.C. [Online] Available: https://www.presidency.ucsb.edu/documents/special-message-the-congress-advancing-the-nations-health [2021, June 21].

Jost, T.S. 2004. Why can't we do what they do? National health reform abroad. *Journal of Law, Medicine & Ethics.* 32(3): 433-441.

Jost, T.S. 2021. *The Supreme Court Throws Out the ACA Lawsuit, Not the ACA.* [Online]. Available: https://www.commonwealthfund.org/blog/2021/supreme-court-throws-out-aca-lawsuit-not-aca [2022, October 02].

Kahn III, C.N. and Pollack, R.F. 2001. Building a Consensus for Expanding Health Coverage. *Health Affairs.* 20(1): 40-48.

Kamal, R., McDermott, D., Ramirez, G., and Cox, C. 2020. *How has U.S. spending on healthcare changed over time?* [Online]. Available: https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-start. [2021, March 24].

Kavilanz, P. 2010. *Number of insured drops for first time* [Online]. Available: https://money.cnn.com/2010/09/16/news/economy/census_latest_uninsured_numbers/. [2021, October 10]

Keith, K. 2019. *Texas v. United States: Where We Are Now and What Could Happen Next* [Online]. Available: https://www.healthaffairs.org/do/10.1377/forefront.20190709.772192/full/. [2022, July 24]

Kennedy, D.M. 1975. The Progressive Era. *The Historian*. 37(3): 453-468.

Kennedy, D.M. 2009. What the New Deal Did. *Political Science Quarterly.* 124(2): 251-268.

Kaiser Family Foundation. 2008. *Health Care Costs and Election 2008* [Online]. Available: https://www.kff.org/health-costs/issue-brief/health-care-costs-and-election-2008/. [2021, June 07].

Kaiser Family Foundation. 2009a. *National Health Insurance—A Brief History of Reform Efforts in the U.S.* [Online]. Available: https://www.kff.org/wp-content/uploads/2013/01/7871.pdf [2021, June 27].

Kaiser Family Foundation. 2009b. *Americans' Satisfaction with Insurance Coverage* [Online]. Available: https://www.kff.org/wp-content/uploads/2013/01/7979.pdf [2022, June 30].

Kaiser Family Foundation. 2011. *Timeline: History of Health Reform in the U.S.* [Online]. Available: https://www.kff.org/wp-content/uploads/2011/03/5-02-13-history-of-health-reform.pdf [2022, August 29].

Kaiser Family Foundation. 2012. *A Guide to the Supreme Court's Affordable Care Act Decision.* Menlo Park: Kaiser Family Foundation.

Kaiser Family Foundation. 2022. *Status of State Medicaid Expansion Decisions: Interactive Map* [Online]. https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/ [2022, July 23]

Keith, K. 2020. *DOJ, Republican AGs Ask Supreme Court To Strike Down ACA* [Online]. Available: https://www.healthaffairs.org/do/10.1377/forefront.20200626.180922/ [2022, July 25].

Kidd, L. 2015. *The Nixon Comprehensive Insurance Plan* [Online]. Available: https://www.nixonfoundation.org/2015/11/the-nixon-comprehensive-health-insurance-plan/ [2020, June 05].

Kirsch, R. 2011. *Fighting for Our Health: The Epic Battle to Make Health Care a Right in the United States.* Albany: The Rockefeller Institute Press.

Kirsch, R. 2013. The Politics of Obamacare: Health Care, Money, and Ideology. *Fordham Law Review.* 81(4): 1737-1747.

Klein, C. 2021. *How Gilded Age Corruption Led to the Progressive Era* [Online]. Available: How the Gilded Age Led to the Progressive Era - HISTORY [2021, May 20].

Koba, M. 2011. Recession: CNBC Explains [Online]. Available: https://www.cnbc.com/id/43563081 [2021, June 06].

Kooijman, J. 1999. Soon or Later On: Franklin D. Roosevelt and National Health Insurance, 1933-1945. *Presidential Studies Quarterly.* 29(2): 336-350.

Kubler, D. 2001. Understanding policy change with the advocacy framework: an application to Swiss drug policy. *Journal of European Public Policy.* 8(4): 623-641.

Kurtzleben, D. 2021. *More And More Democrats Embrace The 'Progressive' Label. Here's Why* [Online]. Available: https://www.npr.org/2021/09/13/1035971261/more-and-more-democrats-embrace-the-progressive-label-heres-why [2022, October 28].

Lachman, D. 2014. *America's Crony Capitalism Challenge* [Online]. Available: https://www.aei.org/articles/americas-crony-capitalism-challenge/ [2022, October 18].

Larsen, J.B., Vrangbæk, K., and Traulsen, J.M. 2006. Advocacy Coalitions and Pharmacy Policy in Denmark—Solid cores with fuzzy edges. *Social Science and Medicine.* (63): 212-224.

Leander, D. 2007, AMA joins the battle with the campaign for the uninsured [Online]. Available: https://www.cunninghamgroupins.com/news/ama-joins-the-battle-with-a-campaign-for-the-uninsured/ [2021, October 08].

Leiberman, T. 2008. "*Socialized Medicine" RIP* [Online]. Available: https://archives.cjr.org/campaign_desk/socialized_medicine_rip.php [2021, June 07].

Levit, K.., Smith, C., Cowan, C, Lazenby, H., Martin, A. 2002. Inflation Spurs Health Spending in 2000. *Health Affairs.* 21(1): 172-181.

Levit, K.R., Lazenby, H.C., Cowan, C.A., and Letsch, S.W. 1991. National Health Expenditures, 1990. *Health Care Finance Review.* 13(1): 29-54.

Library of Congress. N.d. Progressive Era to New Era, 1900-1929: Overview [Online]. Available: https://www.loc.gov/classroom-materials/united-states-history-primary-source-timeline/progressive-era-to-new-era-1900-1929/overview/ [2021, June 06].

Luntz, F.I. 2009. *The Language of Healthcare 2009* [Online]. Available: https://www.politico.com/pdf/PPM116_luntz.pdf [2022, July 21].

Luxon, E.M. 2019. What do advocates know about policymaking? Revealing process in the Advocacy Coalition Framework. *Journal of European Public Policy.* 26(1): 106-125.

Ma, J., Lemos, M.A.C., and Vieira, D.M., 2020. How is the Advocacy Coalition Framework Doing? Somes Issues since the 2014 Agenda. *Revista Brasileira de Ciêcia Política.* (32): 7-42.

Madara, J.L. 2017. *AMA urges Senate to reject efforts to repeal or replace ACA* [Online]. Available: https://www.ama-assn.org/press-center/press-releases/ama-urges-senate-reject-efforts-repeal-or-replace-aca [2022, July 25].

Manchikanti, L., Helm II, S., Benjyamin, R.M., and Hirsch, J.A. 2017. A Critical Analysis of Obamacare: Affordable Care or Insurance for Many and Coverage for Few? *Pain Physician.* 2017(20): 111-138.

Mankiw, N.G. 2017. *Why Health Care Policy Is So Hard* [Online]. Available: https://www.nytimes.com/2017/07/28/upshot/why-health-care-policy-is-so-hard.html [2022, July 23].

McBride, J. and Siripurapu, A. 2021. *The National Debt Dilemma* [Online]. Available: https://www.cfr.org/backgrounder/national-debt-dilemma [2022, October 27].

McCaughan, M. [2017]. Prescription Drug Pricing: Medicare Part D. *Health Policy Brief Series,* (6) [Online]. Available: https://www.healthaffairs.org/do/10.1377/hpb20171008.000172/full/healthpolicybrief_172.pdf [2021, June 26].

McDonough, J.E. 2011. *Inside National Health Reform*. California: University of California Press.

McLaughlin, D and Pathak, P. n.d. *Improving Management of Common Pool Resources* [Online]. Available: https://environmentalsolutions.mit.edu/common-pool-resources/ [2021, September 07].

Milani, F. 2010. Public Option and Private Profits. *Applied Health Economics and Health Policy.* 8(3): 155-165.

Mills, R.J. 2001. Health Insurance Coverage: 2000 [Online]. Available: https://www.census.gov/library/publications/2001/demo/p60-215.html#:~:text=An%20estimated%2014.0%20percent%20of,million%20from%20the%20previous%20year [2021, June 07].

Minemyer, P. 2017. *AHA launches ad campaign against GOP healthcare bill* [Online]. Available: https://www.fiercehealthcare.com/regulatory/aha-launches-grassroots-campaign-against-gop-healthcare-bill [2022, July 25].

Mitchell, A. and Bencic, S. 2018. *Overview of the ACA Medicaid Expansion* [Online]. Available: https://sgp.fas.org/crs/misc/IF10399.pdf [2022, June 19].

Moseley, G.B. III. 2008. The U.S. Health Care Non-System, 1908-2008. *American Medical Association Journal of Ethics.* 10(5): 324-331.

Nathan, R.P. 1996. A Retrospective on Richard M. Nixon's Domestic Policies. *Presidential Studies Quarterly.* 26(1): 155-164.

National Conference of State Legislatures. 2011. *The Affordable Care Act: A Brief Summary* [Online]. Available: https://www.ncsl.org/portals/1/documents/health/HRACA.pdf [2021, June 06].

National Institute of Mental Health. N.d. *About the National Institute of Mental Health.* [Online]. Available: https://www.nimh.nih.gov/health/publications/about-the-national-institute-of-mental-health-nimh. [2021, May 31].

Neumen, W.L. 2011. *Social Research Methods: Qualitative and Quantitative Approaches.* United Kingdom: Pearson Education Limited.

New York Times. 1970. *Medicare for all is asked by Javits* [Online]. Available: https://www.nytimes.com/1970/04/15/archives/medicare-for-all-is-asked-by-javits.html. [2021, June 05].

Nixon, R. 1971. *Special Message to the Congress Proposing a National Health Strategy,* 18 February, Washington, D.C. [Online] Available: https://www.presidency.ucsb.edu/documents/special-message-the-congress-proposing-national-health-strategy [2021, June 24].

Nohrstedt, D. and Weible, C.M. 2010. The Logic of Policy Change after Crisis: Proximity and Subsystem Interaction. *Risk, Hazards & Crisis in Public Policy.* 1(2): 1-32.

Obama, B.H. 2009. *Remarks by the President at the Opening of the White House Forum on Health Reform* [Online]. Available: https://obamawhitehouse.archives.gov/realitycheck/video/White-House-Forum-on-Health-Reform#transcript [2022, July 12].

Obama, B.H. 2009. *Remarks by the President to a Joint Session of Congress on Health Care* [Online]. Available: https://obamawhitehouse.archives.gov/the-press-office/remarks-president-a-joint-session-congress-health-care [2021, March 26].

Oberlander, J. 2010. Long Time Coming: Why Health Reform Finally Passed. *Health Affairs.* 29(6): 1112-1116.

Oberlander, J. 2020. The Ten Years' War: Politics, Partisanship, and the ACA. *Health Affairs.* 39(3): 471-478.

OECD. 2020. *OECD Health Statistics 2020* [Online]. Available: https://www.oecd.org/health/health-data.htm.

Oliver, T.R., Lee, P.R, and Lipton, H.L. 2004. A political history of Medicare and Prescription Drug Coverage. *The Milbank Quarterly.* 82(2): 283-354.

Open Secrets. 2021. *Ranked Sectors* [Online]. Available: https://www.opensecrets.org/federal-lobbying/ranked-sectors [2021, October 09].

Ostrom, V. 1975. Public Choice Theory: A New Approach to Institutional Economics. *American Journal of Agricultural Economics.* 57(5): 844-850.

Oyez, 2012. *National Federation of Independent Business v. Sebelius: Facts of the Case* [Online]. Available: https://www.oyez.org/cases/2011/11-393 [2022, July 26].

Patrick, D., Madrid, P., and McHale, J. 2008. *Renewing America's Promise* [Online]. Available: https://www.presidency.ucsb.edu/sites/default/files/books/presidential-documents-archive-guidebook/national-political-party-platforms-of-parties-receiving-electoral-votes-1840-2016/78283.pdf [2022, July 01].

Payan, D.D., Lewis, L.B., Cousineau, M.R., and Nichol, M.B. 2017. Advocacy Coalitions involved in California's Menu Labeling Policy Debate: Exploring Coalition Structure, Policy Beliefs, Resources, and Strategies. *Social Sciences Medicine.* 177: 1-13.

Pierce, J.J., Peterson, H.L., and Hicks, K.C. 2020. Policy Change: An Advocacy Coalition Framework Perspective. *Policy Studies Journal.* 48(1): 64-86.

Pramuk, J. 2019. *A decade of Obamacare: How health care went from wrecking to boosting Democrats* [Online]. Available: https://www.cnbc.com/2019/12/26/how-obamacare-affected-democrats-in-presidential-elections.html. [2022, July 22]

PhRMA. n.d. *About* [Online]. Available: https://phrma.org/About [2022, June 13].

PhRMA. 2009. *Biopharmaceutical Research Industry Profile.* [Washington, D.C.]: Pharmaceutical Research and Manufactures of America [Online]. Available: http://www.phrma-jp.org/wordpress/wp-content/uploads/old/library/industryprofile/PhRMA2009ProfileFINAL.pdf [2022, June 13]

PhRMA. 2016. *Biopharmaceutical Research Industry Profile.* [Washington, D.C.]: Pharmaceutical Research and Manufactures of America [Online]. Available: http://phrma-docs.phrma.org/sites/default/files/pdf/biopharmaceutical-industry-profile.pdf [2022, June 13]

Pierce, J.J. 2016. Advocacy Coalition Resources and Strategies in Colorado Hydraulic Fracturing Politics, Society & Natural Resources. 29(10): 1154-1168.

Pierce, J.J., Peterson, H.L., and Hicks, K.C. 2020. Policy Change: An Advocacy Coalition Framework Perspective. *Policy Studies Journal.* 48(1): 64-86.

Pear, R. 1992. *The 1992 Campaign: Issues—Health Care; Health-Care Policy: How Bush and Clinton Differ* [Online]. Available: https://www.nytimes.com/1992/08/12/us/1992-campaign-issues-health-care-health-care-policy-bush-clinton-differ.html [2021, June 06].

Peters, B.G. 2017. What is so wicked about wicked problems? A conceptual analysis and a research program. *Policy and Society.* 36(3): 385-396.

Pilkington, E. 2006. *Democrats control both houses after Virginia win* [Online]. Available: https://www.theguardian.com/world/2006/nov/10/midterms2006.topstories3 [2021, June 10].

Plaut, T.F.A. and Arons, B.S. 1994. President Clinton's Proposal for Health Care Reform: Key Provisions and Issues. *Hospital and Community Psychiatry.* 45(9): 871-876.

Pollack, H. 2014. *The group that got health reform passed is declaring victory and going home* [Online]. Available: https://www.washingtonpost.com/news/wonk/wp/2014/01/05/the-group-that-got-health-reform-passed-is-declaring-victory-and-going-home/ [2022, July 02].

Pollack, R.J. 2017. *AHA to Senate Re: Deliberations to Repeal and Replace the Affordable Care Act* [Online]. Available: https://www.aha.org/system/files/advocacy-issues/letter/2017/170725-let-pollack-senate.pdf [2022, July 25].

PNHP, 2008. *What is "Health Care for America Now" doing?* [Online] Available: https://pnhp.org/news/what-is-health-care-for-america-now-doing/ [2022, July 02].

Pramuk, J. 2019. *A Decade of Obamacare: How Health care went from wrecking to boosting Democrats* [Online]. Available: https://www.cnbc.com/2019/12/26/how-obamacare-affected-democrats-in-presidential-elections.html [2021, June 08].

Quadagno, J. 2004. Why the United States Has No National Health Insurance: Stakeholder Mobilization against the Welfare State, 1945-1996. *American Sociological Association.* 45: 25-44.

Quadagno, J. 2005. *One Nation, Uninsured: Why the U.S. Has no National Health Insurance.* New York: Oxford University Press.

Quadagno, J. 2014. Right-Wing Conspiracy? Socialist Plot? The Origins of the Patient Protection and Affordable Care Act. *Journal of Health Politics, Policy, and Law.* 39(1): 35-56.

Republican National Convention. 2008. *2008 Republican Platform* [Online]. Available: https://www.presidency.ucsb.edu/sites/default/files/books/presidential-documents-archive-guidebook/national-political-party-platforms-of-parties-receiving-electoral-votes-1840-2016/78545.pdf [2022, June 30].

Resnik, D.B. 2020. *What Is Ethics in Research & Why Is It Important?* [Online]. Available: https://www.niehs.nih.gov/research/resources/bioethics/whatis/index.cfm [2022, October 27].

Rice, L., Benson, C., Podrabsky, M., Otten, J.J. 2019. The development and adoption of the first statewide comprehensive policy on food service guidelines (Washington State Executive Order 13-06) for improving the health and productivity of state employees and institutionalized populations. *Society of Behavioral Medicine.* 9(1): 48-57.

Roosevelt, F.D. 1932. *Address Accepting the Presidential Nomination at the Democratic National Convention in Chicago,* 02 July, Chicago [Online] Available*:* https://www.presidency.ucsb.edu/documents/address-accepting-the-presidential-nomination-the-democratic-national-convention-chicago-1. [2021, June 12].

Roosevelt, F.D. 1934. *Address to Advisory Council of the Committee on Economic Security on the Problems of Economic and Social Security.* 14 November, Washington, D.C. [Online] Available: https://www.presidency.ucsb.edu/documents/address-advisory-council-the-committee-economic-security. [2021, June 14].

Roper Center. 2017. *Public Opinion and the Passage of the Medicare Bill blog* [Online]. Available: https://ropercenter.cornell.edu/blog/public-opinion-and-passage-medicare-bill-blog/ [2021, June 03].

Rosenbaum, S. 2011. The Patient Protection and Affordable Care Act: Implications for public health policy and practice. *Public Health Reports.* 126: 130-135.

Rosenberg, J. 2018. *How US Spending on Healthcare Has Changed Over Time* [Online]. Available: https://www.ajmc.com/view/how-us-spending-on-healthcare-has-changed-over-time [2021, June 06].

Ross, J.S. 2002. The Committee on the Costs of Medical Care and the History of Health Insurance in the United States. *Einstein Quarterly Journal of Biology and Medicine.* 2002(19): 129-134.

Saad, L., Jones, J.M., and Brenan, M. 2019. *Understanding Shifts in Democratic Party Ideology* [Online]. Available: https://news.gallup.com/poll/246806/understanding-shifts-democratic-party-ideology.aspx [2022, July 01].

Sabatier, P.A. 1988. Policy Change and Policy-Oriented Learning: Exploring an Advocacy Coalition Framework. *Policy Sciences*. 21(2/3): 129-168.

Sabatier, P.A. 1998. The advocacy coalition framework: revisions and relevance for Europe. *Journal of European Public Policy.* 5(1): 98-130.

Sabatier, P.A., Hunter, S., and McLaughlin, S. 1987. The Devil Shift: Perceptions and Misperceptions of Opponents. *The Western Political Quarterly.* 40(3): 449-476.

Sabatier, P.A & Weible, C.M. 2007. The Advocacy Coalition Framework, in P.A Sabatier (ed.). *Theories of the Policy Process*. United States: Westview Press

Sack, K. 2010. *Recession Drove Many to Medicaid Last Year* [Online]. Available: https://www.nytimes.com/2010/10/01/health/policy/01medicaid.html [2021, October 03].

Satoh, K., Gronow, A., and Ylä-Anttila, T. 2020. The Advocacy Coalition Index: A new approach for identifying advocacy coalitions. *Policy Studies Journal.* 00: 1-21.

Schechter, A. 2017. *The Secret Driver of US Health Care Costs: Politicians Wanting to Get Re-elected.* [Online]. Available: https://promarket.org/2017/12/11/secret-driver-us-health-care-costs-politicians-wanting-get-reelected/ [2021, March 10].

Schremmer, R.D. and Knapp, J.F. 2011. Harry Truman and Health Care Reform: The Debate Started Here. *Pediatrics.* 127(3): 399-401.

Schumann, H.H. 2016. *A Bygone Era: When Bipartisanship Led To Health Care Transformation.* [Online]. Available: https://www.npr.org/sections/health-shots/2016/10/02/495775518/a-bygone-era-when-bipartisanship-led-to-health-care-transformation [2021, June 25].

Shen, W.W., and Staman, J.A. 2021. *Affordable Care Act Litigation Still on the Docket After California v. Texas.* [Washington, D.C.]: Congressional Research Service.

Scott, D. 2018. *Half of 2018's Democratic campaign ads are about health care* [Online]. Available: https://www.vox.com/policy-and-politics/2018/9/24/17897962/health-care-campaign-ads-democrats-2018-midterm-elections-voxcare [2022, October 07].

Simmons-Duffin, S. 2019. *Trump is Trying Hard to Thwart Obamacare. How's that going?* [Online]. Available: https://www.npr.org/sections/health-shots/2019/10/14/768731628/trump-is-trying-hard-to-thwart-obamacare-hows-that-going [2022, July 24].

Skidmore, M.J. 2010. Health Care in America, and Everywhere Else: A Review Essay. *Poverty & Public Policy.* 2(1): 185-194.

Skidmore, M.J. 2011. The History and Politics of Health Care in America: From the Progressive Era to the Patient Protection and Affordable Care Act. *Poverty & Public Policy.* 3(1): 1-9.

Skinner, D. 2012. "Keep Your Government Hands Off My Medicare!": An Analysis of Media Effects on Tea Party Health Care Politics. *New Political Science.* 34(4): 605-619.

Skocpol, T and Williamson, V. 2012. *The Tea Party and the Remaking of Republican Conservatism.* New York: Oxford University Press.

Social Security Administration. N.d. *Social Security History: President Richard M. Nixon*. [Online] Available: https://www.ssa.gov/history/nixstmts.html#amend [2021, June 05].

Social Security Administration, n.d. Medicare Modernization Act. [Online]. Available: https://www.ssa.gov/privacy/pia/Medicare%20Modernization%20Act%20(MMA)%20FY07.htm [2021, June 06].

Spithoven, A. 2016. The Influence of Vested Interests on Healthcare Legislation in the USA, 2009–2010. *Journal of Economic Issues.* 50(2): 630-638.

Sprinkel, B.W. 1975. 1975: A Year of Recession, Recovery and Decelerating Inflation. *The Journal of Business.* 48(1): 1-4.

Starr, P. 1982. *The Social Transformation of American Medicine.* New York: Basic Books.

Starr, P. 2011. The Health-Care Legacy of the Great Society, in N.J. Glickman, L.E. Lynn, and R.H. Wilson (eds.). *Reshaping the Federal Government: The Policy and Management Legacies of the Johnson Years.*

Starr, P. 2012. *Center-Left Liberalism* [Online]. Available: https://www.princeton.edu/~starr/articles/articles12/Starr_Center-left-liberalism.html [2022, October 28].

Starr, P. 2013. *Remedy and Action: The Peculiar American Struggle Over Health Care Reform.* New Haven: Yale University Press.

State of Florida. 2010. *Florida v. HHS – Original Complaint* [Online]. Available: https://digitalcommons.law.scu.edu/cgi/viewcontent.cgi?article=1037&context=aca [2022, July 23].

Statista. 2021. *Top lobbying spenders in the United States in 2020* [Online]. Available: https://www.statista.com/statistics/257344/top-lobbying-spenders-in-the-us/#:~:text=In%202020%2C%20the%20top%20lobbying,of%2084.11%20million%20U.S.%20dollars [2022, June 28]

Steinmo, S. and Watts, J. 1995. It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America. *Journal of Health Politics, Policy and Law.* 20(2): 329-368.

Stevens, R.A. 1996. Health Care in the Early 1960s. *Health Care Financing Review.* 18(2): 11-22.

Stockman, F. 2012. *Recalling the Nixon-Kennedy health plan.* [Online]. Available: https://www.bostonglobe.com/opinion/2012/06/22/stockman/bvg57mguQxOVpZMmB1Mg2N/story.html [2021, June 06].

Stolberg, S.G. and Pear, R. 2010. *Obama Signs Health Care Overhaul Bill, With a Flourish*. [Online]. Available: https://www.nytimes.com/2010/03/24/health/policy/24health.html [2021, June 07].

Stossel, J. 2009. *Obamacare's Inevitable Logic* [Online]. Available: https://abcnews.go.com/2020/Stossel/story?id=8358377 [2022, October 28].

Stritch, A. 2015. The Advocacy Coalition Framework and Nascent Subsystems: Trade Union Disclosure Policy ifn Canada. *Policy Studies Journal.* 43(4): 437:455.

Tea Party Patriots. N.d. *About: Our Mission* [Online]. Available: *https://www.teapartypatriots.org/about/* [2022, July 02].

Truman, H.S. 1949. *Annual Message to the Congress on the State of the Union,* 05 January, Washington, D.C. [Online] Available: https://www.trumanlibrary.gov/library/public-papers/2/annual-message-congress-state-union-0 [2021, June 16].

Ubokudom, S.E. 2012. *United States Health Care Policymaking: Ideological, Social and Cultural Differences and Major Influences.* New York: Springer.

U.S. Constitution. 1787. *CONSTITUTION OF THE UNITED STATES OF AMERICA* [Online]. Available: https://uscode.house.gov/static/constitution.pdf [2021, May 20].

U.S. Senate. N.d. *About Filibusters and Cloture* [Online] Available: https://www.senate.gov/about/powers-procedures/filibusters-cloture.htm#:~:text=The%20Senate%20tradition%20of%20unlimited,amendment%2C%20or%20other%20debatable%20question [2022, July 08].

Wainess, F.J. 1999. The Ways and Means of National Health Care Reform, 1974 and beyond. *Journal of Health Politics, Policy, and Law.* 24(2): 305-333.

Walls, H.L. 2018. Wicked Problems and a 'wicked' solution. *Globalization and Health.* 14(34): 1-3.

Walt, G., Shiffman, J. Schneider, H., Murray, S.F., Brugha, R. Gilson, L. 2008. 'Doing' health policy analysis: methodological and conceptual reflections and challenges. *Health Policy and Planning.* 2008(23): 308-317.

Weible, C.M., Ingold, K., Nohrstedt, D., Henry, A.D., and Jenkins-Smith, H.C. 2020. Sharpening Advocacy Coalitions. *Policy Studies Journal*. 48(4): 1054-1081.

Weible, C.M. and Jenkins-Smith, H. 2016. The Advocacy Coalition Framework: An Approach for the Comparative Analysis of Contentious Policy Issues, in B.G. Peters and P. Zittoun (eds.). *Contemporary Approaches to Public Policy*. United States: Palgrave Macmillan

Weible, C.M. and Sabatier, P.A. 2007. A Guide to the Advocacy Coalition Framework, in F. Fischer, G.J. Miller, and M.S. Sidney (eds.). *Handbook of Public Policy Analysis: Theory, Politics, and Methods.* Boca Raton: Taylor & Francis Group.

Weible, C.M., Sabatier, P.A., and McQueen, K. 2009. Themes and Variations: Taking Stock of the Advocacy Coalition Framework. *The Policy Studies Journal*. 37(1): 121-140.

Weible, C.M., Sabatier, P.A., Jenkins-Smith, H.C., Nohrstedt, D., Henry, A.D., and DeLeon, P. 2011. A Quarter Century of the Advocacy Coalition Framework: An Introduction to the Special Issue. *Policy Studies Journal.* 39(3): 349-360.

Weisman, J. and Parker, A. 2014. *Riding Wave of Discontent, G.O.P. Takes Senate* [Online]. Available: https://www.nytimes.com/2014/11/05/us/politics/midterm-elections.html [2022, July 23].

Wellstead, A. 2017. An Advocacy Coaliton Framework of Policy Change and the Role of Policy-oriented Learning therein. *Policy Sciences.* 50: 549-561.

White, J.H. 1993. Clinton's Health Plan: Politics and State Responsibility. *Health Progress.* *https://www.chausa.org/publications/health-progress/article/november-1993/health-policy---clinton%27s-health-plan-politics-and-state-responsibility* [2021, June 24].

Wilson, K., Barakat, M., Vohra, S., Ritvo, P., and Boon, H. P. 2008. Parental views on pediatric vaccination: the impact of competing advocacy coalitions. *Public Understanding of Science.* 17: 231-243.

World Health Organisation. N.d. *Ensuring ethical standards and procedures for research with human beings* [Online]. Available: https://www.who.int/activities/ensuring-ethical-standards-and-procedures-for-research-with-human-

beings#:~:text=It%20is%20important%20to%20adhere,ethical%20standards%20are%20being%20upheld [2022, October 27].

Yang, J.L. 2009. *The man who invented health care's public option* [Online]. Available: https://archive.fortune.com/2009/09/04/news/economy/public_option_hacker.fortune/index.htm [2022, July 07]

Yarrow, A.L. 2021. *Harry Truman's Radical Health Care Plan.* [Online]. Available: https://www.milkenreview.org/articles/harry-trumans-radical-health-care-plan [2021, June 07].