The Clinton Health Reform Plan: A Resort To Place

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ABSTRACT

Geographers have given little attention to the attempts by the Clinton administration to reform the US health care “system”. This paper considers the use of spatialized language in key documents and debates associated with the reform process. It considers the ways in which the administration exercised a Foucauldian form of governmentality appealing to interest groups and individuals on the basis of notions of place-in-society, place-in-life cycle, place-in-health care system and geographical place. These tactics are set in the context of the identified key principles underpinning the need for reform. The paper concludes by suggesting that whilst Clinton, in his attempts to achieve health care reform, may have appeared politically naive, his strategic use of sense of place was, on the contrary, very perceptive.

Key Words: Health care reform, United States, Place, Governmentality, Social Theory

Introduction

The attempt by the Clinton administration to enact a health care reform plan for the USA has received little attention in geography to date. One exception, McLafferty (1996), argues that the demise in Clinton's health plan was the signal, not for an end to health care reform, but for rapid and tumultuous change in the structure of health care delivery. The particular focus of McLafferty's paper was on the impact of state-level differences (political, institutional and ideological) on the form and formation of managed care organizations. In this paper we wish to move away from this functionalist approach and assess the Clinton health plan in the context of recent discussions in medical geography concerning developments in social theory, the so-called "post-medical turn" (Kearns 1993, 1995; Dorn and Laws 1994). In particular, we argue, through Foucault's (1979) notion of governmentality, that the Clinton administration sought to employ notions of place as a tactic to build support for their health reform plan.

We begin the paper by highlighting the central debates surrounding health care reform in the United States. We then move to an area of concern that remains as yet undeveloped: the spatialized language adopted by the administration, and President Clinton in particular, in the attempt to 'sell' the idea of reform to the majority of the American population. In this examination, we follow the argument of Marmor and Goldberg (1994) who view the language of the reform debate as a major force in both establishing the initial 'will to reform' and in its subsequent decline. As they state: 'How the President reaches out to the public, what counts in the evening news and the morning newspapers as the central reform themes, and whether the congress faces a determined grass-roots movement - all shape the legislative outcome and, even more important, whether the result is sufficiently coherent and implementable to satisfy the expectations for reform' (1994: 10).

It is to the first aspect of this complex reform debate, how the President reaches the public, that most attention will be paid in the present paper. We argue that, in their attempt to enact reform, the Clinton administration sought to localize debate. In addition, and in keeping with similar developments in many Western democracies, this movement towards a localized agenda has been embedded within a parallel language of anti-bureaucracy. Thus, as we shall argue, the Clinton administration adopted a narrative approach to elucidate the health care crisis. This effectively placed the newly-elected administration in partnership with the population and in opposition to those bodies that controlled the financing and practice of health care in the US. Clinton and his colleagues sought to promote this partnership both as a reason for adopting universal coverage and as a means by which the excesses of a market-led health care system could be controlled. The importance of geography both as a discipline and as a way of placing ones' self in the world is central to this political strategy, for ideas of place were used to establish the link between the nation as a whole and the health care experiences of individuals within it.

A Need For Reform

It is not the place of this paper to detail the complex history of health care development in the US as this has been comprehensively carried out elsewhere (see, for example, Starr 1982; Fuchs 1986; Marmor 1994; Navarro 1994). However, to place the Clinton health reform plan and this paper into context we must be aware both of the necessity behind proposals for health care reform in the US and, also, of previous attempts that have been made to enact reform.

Following the launch of the health reform task force, headed by the first Lady, in the spring of 1993, the presidential campaign commanded 71 per cent support of Americans (US News and World Report 1993) for the general principles on which the programme was based:

universal health coverage and a need to curb expenditure on health (Blendon et al. 1995: 8). This support appeared to be founded on a collectively-held recognition of three interlinked and fundamental problems increasingly associated with the US system of health care, namely its rising costs, the increasing numbers of people without insurance or under-insured, and the marked inequalities in access to good quality health care (OECD 1992; Wolfe 1993).

Although the figures given are rarely the same, the rate of increase in spending on health care and in the numbers either uninsured or underinsured highlights the depths of the crisis facing the Clinton administration. According to the OECD the United States' total expenditure on health care has been increasing at an annual rate of 5.5 per cent since 1970. This translates into an ever increasing share of the GDP being devoted to health care spending: 7.4 per cent in 1970, 12.1 per cent in 1990 (OECD 1992: 9). These percentage figures, when converted into hard currency, show that the US spent an extraordinary \$666 billion on health care in 1990, the next highest country being Japan with \$144 billion (OECD 1992: 80). Yet, despite this vast level of expenditure, the United States health care system has a large number of holes through which a high proportion of the population appears to be falling. This was a point noted within medical geography over 25 years ago by de Vise (1971:11) when he contrasted (Congressional) expenditure levels with '...our failure to match medical capacity to consumer need'.

One particular aspect of the health care problem for the United States concerns access. This too has long been recognised (Aday, Anderson and Fleming 1980). More recently, the OECD has commented, 'The issue of access can be thought of in two ways. The first is the availability of physical access to the physicians, nursing staff, hospitals, equipment, drugs and so forth needed to deliver care...The second, more pertinent, dimension of access is the affordability

of health care' (OECD 1992: 35). On this second issue, affordability, the Congressional Budget Office figures of 1991 reveal that there were a total of 33.4 million US citizens uninsured of which, 8.5 million were children and 9.6 million lived below the poverty line; 80 per cent of the adult uninsured were employed. The description of the US as 'the land of the free, the home of the uninsured' (Cohodes 1986) can be upheld - and, in addition, the evidence suggests that the problem grew through the 1980s and early 1990s.

Despite these obvious problems regarding the equity of the US health care system, Marmor and Goldberg (1994:1) note that: 'Precisely how and why [health care reform] came to be [top of the political agenda] is not self-evident. After all, Americans had been told for more than two decades that our medical system was in crisis'. Attempts to enact reform have an even longer history. The first of these came with Roosevelt's appointment of a Committee on Economic Security in June 1934. This committee was to report to Congress on the whole issue of Social Security by January of the following year. As Starr (1982) points out, whilst there was general support at this time for compulsory health insurance, the overwhelming view of the committee was that it would have to wait given the opposition it would arouse. This tentative approach appears well founded given that even the discussion of some general principles for health insurance in the committee's report to Congress raised a great deal of protest from the American Medical Association (AMA). Thus, Roosevelt did not even consider universal health insurance, fearing that the whole reform package embodied within the Social Security Bill would fail to pass through Congress.

This positioning of compulsory health insurance on the periphery of American politics under Roosevelt changed under Truman who, in 1945, pressed Congress to pass a national

programme ensuring adequate medical care and protection from the “economic fears” of sickness (Starr 1982: 281). Truman’s plans for a ‘Fair Deal’ were defeated by a combination of interest-group resistance and ideological conflict. On the former point Starr notes that the AMA suggested that Truman’s proposals would make doctors “slaves”, a claim not too dissimilar from that made contemporaneously by the British Medical Association’s when resisting nationalization in the UK (Klein 1983). With regard to ideological matters, Truman’s reforms were crippled by their being labelled a form of “socialized medicine” during the height of the Cold War. With the question of national health insurance temporarily removed from US political thought the ensuing “liberal” years saw the introduction of more limited and focused insurance schemes in the forms of the Medicare and Medicaid programs under the presidency of Lyndon Johnson in 1965.

The question of national health insurance once again took centre stage under the Nixon administration. As Marmor and Goldberg (1994) recount, the period between 1970 and 1974 was striking for its debate over the different forms of national health insurance that should be adopted. This era in American politics remained remarkably liberal in its attitude towards social welfare with the medical establishment apparently caught between the concerns of business and of protest movements and liberals seeking greater equality and participation in medical care (Starr 1982: 393). However, as Starr goes on to suggest, while the Vietnam and Watergate crises may provide partial underlying proximate reasons for the ultimate rejection of national health insurance, the real causes of failure lie in the fractured response of labour organisations, the continuing importance of medical power and the innate conservatism of US politics (see also Wier, Orloff and Skocpol 1988). Additionally, the struggle to find an acceptable national health insurance plan appeared to fail because of the shifting impact of non-health factors on alliances

between Republicans and Democrats as well as the more direct failure of the administration's Comprehensive Health Insurance Plan to appease the wishes of Democrats who sought more universal coverage (Marmor and Goldberg 1994: 7-8).

Fragmentation thus emerges as a key issue in the determination of US health policy. For Marmor and Goldberg (1994:5) an awareness of this issue is a central and longstanding requirement for understanding US policy debates. This is a point that Starr (1982: 240) also alludes to when he notes that, in the US, the political conditions and pre-existing institutions are altogether different from other Western democracies. The relations between society and the state have been fashioned most thoroughly by classical liberalism and hence government is highly decentralized and historically engaged in little direct regulation of the economy of social welfare. Interest groups are relatively free to exercise power and it is largely as a result of power group dynamics that moves towards universal health coverage have floundered, and continue to do so.

Importantly, we can extend this point to include a geographical dimension. Blendon et al. (1995) show, following an analysis of 28 national surveys carried out between 1990 and 1993, that perceptions regarding the extent of the health care crisis differ greatly between those defined as being 'experts' and the general public. The experts are seen to take an aggregate national view of the problems and solutions, whereas, the general public adopt a localized view that draws upon personal experiences of the health care system (1993: 2573). This geographically fragmented policy environment clearly militates against central imposition of policy, as Blendon et al. (1995) suggest: 'Policy makers should be aware that addressing the experts' concerns without due consideration of the public's perceptions of the issues may affect American's willingness to support proposed solutions to our difficult problems' (1995: 2753). As we will see

later in this paper the Clinton administration appeared well aware of the need to articulate a common perception of the health care problems, however, their ability to translate this into Congressional support remained in question.

Navarro (1989) is less certain of the importance of the central-local power nexus in the understanding of US health politics. He notes that, 'By focusing on the visible actors or interest groups whose interplay is assumed to shape the nature of national health policies (finally approved by the American people), they [power group theorists] do not seem to be aware of the nonvisible actors, who may in fact be more important than the visible actors in explaining those policies' (1989: 387). For Navarro these 'nonvisible actors' are specific class groups. Although we would reject any suggestion that 'nonvisible actors' are *only* class groups, we wish to follow Navarro in suggesting that "power group" explanations offer only a limited view of the health reform debate. As we shall demonstrate the Clinton administration sought to address issues directly to the American public, before it made firm proposals in Congress, and it was during this period that the support for the *idea* of reform was at its strongest. However, by the time the health reform plan was finally placed before Congress, in October 1993, general support for the idea of reform had dropped from 71 per cent to 59 per cent; by June 1994 this had been reduced further to 33 per cent (Blendon et al. 1995: 8). We shall argue that the Clinton administration, in the attempt to promote its health reform plan, employed a distinctly geographical language as a tactic for overcoming the difficulties previous regimes had encountered; it sought to marry class, interest and many other factors in creating place-based popular coalitions for reform drawing on locality-specific articulations of the need for change. As, however, with previous attempts at reform, the plan was to flounder in the formal political system, a space where popular, representative, medical and business interests clash and contest for power; the space where ideas

encounter the fractured reality of the formal political system.

The Clinton Health Reform Proposals

The central elements of the Clinton health reform proposals are to be found in *The Health Reform Plan* (White House Domestic Policy Council 1993). For the Clinton health care team there were six reasons why change was required (rising insecurity, growing complexity, rising costs, decreasing quality, and growing irresponsibility) and six ‘principles’ upon which reform would be based (security, simplicity, savings, quality, choice, and responsibility). We shall briefly outline what each of the six principles proposed in relation to health care reform:

- *Security* - this was to guarantee comprehensive benefits to *all* Americans including the provision of preventive care and prescription drugs. It was to restrict health insurance companies’ ability to deny coverage to the seriously ill or charge old people more than young people, set limits to health coverage costs to consumers, enhance Medicare and improve access to quality care;
- *Simplicity* - this proposed to simplify the health care finance systems by cutting ‘red tape’. It would have introduced a Health Security card for everyone, required all health plans to adopt a standard claim form and introduced a uniform, comprehensive claims package that would apply standardized billing and coding;
- *Savings* - this aimed to control health care costs through increasing competition between health plans. It was intended to strengthen the buying clout of consumers and businesses by creating “health alliances”, through setting limits on premium

rises, and through reduction in administration costs;

- *Quality* - in order to make the ‘world’s best care better’ the Health Security Act aimed to ‘arm’ doctors and hospitals with the best information and technology. It was hoped to empower consumers and force health plans to compete on quality. In addition it proposed to enhance preventive care by training more primary care doctors, nurses and health professionals;
- *Choice* - the preservation and enhancement of health care options were to be achieved by ensuring that consumers were able to follow the doctor of their choice into any health care plan, providing at least three kinds of health plans from which the consumer, and not their employer, could choose and, by enabling more elderly and disabled Americans to remain in their homes;
- *Responsibility* - this proposed to make everyone responsible for health care by 'requesting' that drug companies keep prices down, discouraging ‘frivolous’ medical malpractice lawsuits and, by asking all Americans to pay at least some contribution to their health care.

As this outline of the basic principles underlying *The Health Reform Plan* indicates, what was being proposed would have represented a radical movement away from the, then present, health care system. The impact that such changes would have on the US health care crisis were much debated within expert circles with a great deal of attention being focused on the proposed modifications to the existing health insurance system and on what were termed “healthy

alliances” (see for example Marmor 1994; Navarro 1995a). By far the greatest causes of concern for the American public, however, were the proposals for cost containment and universal health coverage. Whilst the recognition of these matters as desirable policy goals maintained a certain degree of general support (60 to 80 per cent according to public opinion polls (Rockman 1995: 401)) Clinton’s specific proposals had only 40 per cent support by the end of the health reform debate.

Running through the proposals was an attempt to transplant some of the central tenets of the individualist US ideology into a ‘softer’ position reflecting ideas of citizenship and social responsibility. Thus, key words were taken from the ‘New Right’s’ ideological dictionary (‘choice’ and ‘responsibility’ for example) and placed alongside welfarist notions such as ‘universal coverage’. In addition the Clinton administration sought to establish a bond between themselves and the individual citizen by positioning their plan in contradistinction to the existing practices of the agencies and institutions involved in the delivery and finance of health care in the United States. This locating of the health reform campaign alongside the plight of American citizens is clearly in evidence throughout the President’s health reform plan. A quite distinctive emphasis was placed upon the health care experiences of the American people, rather, than organizational perspectives of particular agencies or financial institutions,

Bring together any group of citizens and the dimensions of the health care crisis emerge from their stories. Stories about insurance coverage lost, policies cancelled, fear of financial ruin, better jobs not taken, endless forms filled out. They are stories of frustration and insecurity — and, too often, pain and fear (White House Domestic Policy Council 1993: 2).

The six reasons for reform, then, were not presented solely in terms of the financial cost to the US state but, rather, were expressed as obstacles to the accessing of affordable and good quality health care by all American citizens. In 'selling' health policy reform to the people, the Clinton administration sought to use a discourse of corporate greed and individual suffering. While this had popular appeal, it was perhaps inevitable that it would offend powerful interest groups in the fractured formal political space.

Health Reform, Belonging and Place

My fellow Americans, tonight we come together to write a chapter in the American story. Our forebears enshrined the American Dream — life, liberty, the pursuit of happiness. Every generation of Americans has worked to strengthen that legacy, to make our country a place of freedom and opportunity, a place where people who work hard can rise to their full potential, a place where children can have a better future...If Americans are to have the courage to change in a difficult time, we must first be secure in our most basic needs. Tonight I want to talk about the most critical thing we can do to build that security. This health care system of ours is badly broken and it is time to fix it (White House Domestic Policy Council 1993: 103)

We now wish to focus on an explicitly geographical aspect of the debate over the Clinton health care reform proposals. In their attempt to 'sell' the proposals, the Clinton administration not only employed a popularist discourse contrasting corporate greed and individual suffering, they also

sought to localize debate, to make universal coverage and the whole health care crisis a question pertinent to the understanding of the individual, spatially located 'American Dream'.

Notwithstanding the rhetoric that is an inherent part of political discourse, this strategy exemplifies the notion of 'tactics of government' (Miller and Rose 1990); the Clinton administration sought to configure notions of belonging and place as a means by which support for the health care reform proposals could be attained.

In using the notion of 'tactics of government', we are adopting a view of government that is embodied within Foucault's explorations of the 'rationality of government' (Gordon 1991; Donzelot 1984; Ewald 1986; Hacking 1990). This perspective sees government as an 'art' for acting upon the actions of individuals, singly or collectively, so as to 'shape, guide, correct and modify the ways in which they conduct themselves' (Burchell 1993:297). This idea of 'governmentality' has been used by a number of authors (Miller and Rose 1990; Rose 1993; Burchell 1991, 1993; Gordon 1987, 1991) for the analysis of government policy in advanced liberal democracies. A particularly useful aspect of the concept is that it identifies a space in which 'techniques of domination' and 'techniques of the self' are unified. Thus, following Miller and Rose (1990:1), we are not able to reduce notions of power to the singular idea of the State but, rather, must view it as that which is exercised, tactically, through a multitude of agencies and techniques some, but not all, of which are related to executives and bureaucracies of the formalized organs of state.

It is in the spatialized language of the health reform debates that these 'tactics of government' appear most clearly. Clinton's plan employed notions of belonging and place as a technique for removing the 'distance' between the idea of the State and the individual. The

fundamental purpose behind such a tactic was to establish the right to universal coverage and also to rein in the perceived excesses of some the main players in US health care, for example insurance companies and the AMA, by placing the plight of ordinary Americans in the spotlight. The reduction of the health care debate to individual experiences was central to Clinton's campaign. As he remarked when announcing the launch of the health care reform Task Force:

As I travelled across our country this past year, no stories moved me more than the stories of those families struggling to pay for health care. I listened to Marie Kostos, a working mother in Columbus, Ohio who had to quit work in order to get Medicaid coverage for her infant, who is stricken with spina bifida...To Mary Annie and Edward Davis, a New Hampshire couple who faced the terrible choice of having only enough money to buy the food they needed or the prescription drugs they had to have...And I listened to a group of coal miners in Beckley, West Virginia - some of whom had worked the mines for more than 30 years but were at risk of losing their health benefits

(REFERENCE)

What we observe in this address is the beginnings of a discourse which places the individual health care experiences of Americans in contradistinction to the agencies and institutions that control health care. We are presented with personalized case histories that highlight the 'place and 'identity' as well as the 'mode of suffering' which individuals have experienced under the current health care system. This narrative approach helps to position the administration outside of the existing health care system. The audience, particularly the general public, is asked to view health care both through their own experiences of the institutions concerned and through the experiences of others. The strategy seeks to embed notions belonging and place into the health

care debate by encouraging Americans to review not only their place-in-society but also their place-in-age, their place-in-class and ultimately their sense of geographical place.

The appointment of the First Lady as the head of the health care task force was a key element behind this strategy, providing a mouthpiece for the demonstration of empathy and involvement:

Over the past months, I have had the extraordinary opportunity of listening to thousands of Americans talk about health care. I've sat in living rooms talking to farm families. I've stood on loading docks talking to people who have worked for 10, 15, and even 20 years without insurance. I've visited hospitals, talking to doctors and nurses...I have read letter after letter of the more than 800,000 we have received at the White House from people all over the nation...I have carried their stories in my mind as we worked long and hard to devise solid answers to tough questions. The President's Health Security Act is a product of all of the people who took the time to share their ideas, their research, and their personal experiences with us (White House Domestic Policy Council 1993: xvi).

Hilary Clinton, was able to present herself as distinct from the health care crisis. She did not present the problematic elements behind the crisis as identified in the Clinton plan, she presented the 'normal' individuals whose experiences of health care were similar to all Americans. This emphasis on the experiences of ordinary Americans, whether farmers, dock workers or health professionals, was absorbed and encompassed into her own experiences as a mother, sister, daughter and woman:

As a mother, I can understand the feeling of helplessness that must come when a parent cannot afford a vaccination or well-child exam. As a wife, I can imagine the fear that grips a couple whose health insurance vanishes because of a lost job, a layoff or an unexpected illness. As a sister, I can see the inequities and inconsistencies of a health care system that offers a widely varying coverage, depending on where a family member lives or works. As a daughter, I can appreciate the suffering that comes when a parent's treatment is determined as much by bureaucratic rules and regulations as by doctors' expertise. And as a woman who has spent many years in the workforce, I can empathize with those who labor for a lifetime and still cannot be assured they will always have health coverage (White House Domestic Policy Council 1993: xvii-xviii).

By embodying this narrative approach within the rhetoric of *The Health Reform Plan*, the Clinton administration placed itself in the position of being able to present quite radical reforms as being necessary elements of the 'American Dream'. The six principles of 'security', 'simplicity', 'savings', 'quality', and particularly of 'choice' and 'responsibility' deliberately resonated with the established rhetoric of that dream and, in consequence, the Clinton administration was able to present itself as the protector of some highly evocative imagery.

As we move through *The Health Reform Plan* and its presentation to the public, we find that, whilst the central figures of the task force disappear from the debate, the experiences of individual 'ordinary' Americans are retained as a tactic, a technique, for establishing the link between problem and solution. The problems are presented as being universal to all Americans

whatever their social class, profession, gender, marital status; the solutions are to be found by promoting universalism through a contract between the State and the citizen which will defend the individual against the vagaries of a market-led health care system. Individual experiences are used to construct representative identities to which significant fractions of the population can relate; the call is made to Americans to view health care reform as necessary and overdue through the implicit positioning of references to geographical place and other shared symbols (job type, age group, ethnicity).

With regard to the six principles that guided *The Health Reform Plan* we find, prior to an expression of the policies associated with each principle, a presentation and exemplification of the problem which the principle aims to address. Whether discussing insecurity, complexity, rising cost, decreasing quality, declining choice or growing irresponsibility, the message is one that seeks to promote a common identity through the tactical deployment of Americans' own health care experiences. With regard to the problems of insecurity it is argued that,

At the root of the problem lies our health insurance system, which gives insurance companies the right to pick and choose whom to cover. Risk selection and underwriting - the practice of identifying the healthiest people, who pose the least risk - divide consumers into rigid categories used to deny coverage to sick or old people, or set high premium rates...The result is a system that is stacked against individuals, families and small businesses. Millions of Americans have lost their insurance when they got sick and needed insurance most (White House Domestic Policy Council 1993: 3).

We are informed here that the current system relies too heavily on market orientated insurance companies whose system of risk evaluation denies many Americans adequate or affordable coverage. The argument is well documented (Boyum 1994; Bodenheimer 1990), however the Clinton administration sought to direct it at all Americans by incorporating individual experiences into the reform plan,

“The way the system works now, even employed, insured people are just one major illness away from financial disaster” K.P. West Lafayette, Indiana (White House Domestic Policy Council 1993: 3).

“My husband and I own and operate a small business. This year we will make our employees pay for any increase in premiums and may drop [some benefits] altogether. Our company cannot shop around for lower cost health insurance because I am uninsurable” B.M. Phoenix, Arizona (White House Domestic Policy Council 1993: 5).

“Six months ago, my sister-in-law, Pam, had a disabling stroke. Pam is only 39 years old, and she’s a severe diabetic. Six months have passed, her short-term memory has deteriorated, her vision is leaving, and it looks as if my brother will either have to hire someone to come into their home full time to care for her, or put her in a nursing home, which his medical plan does not cover. My brother’s attorney has advised him to divorce Pam so that her medical bills don’t pull him into financial ruin...”A.P. Toledo, OH (White House Domestic Policy Council 1993: 39).

In this way, policy discourse not only reduced the health care crisis to its perceived parts but also localized the perceived bases for reform through the articulation of personal experiences and their location in place. While the problem of insecurity through poor insurance coverage is clearly articulated, it is also demonstrated that this is a problem for 'real' people, for small business owners, and for people in places like West Lafayette, Phoenix and Toledo.

This tactic for positioning health care at the forefront of the American psyche was used to link other causes to the general problems underpinning the need for reform. For example, *The Health Reform Plan* claimed that bureaucratic paper-work was seen as a major obstacle to the provision of efficient and cost effective health care. The tactic of individualization, paralleled by a language of anti-bureaucracy, was used to remove the 'distance' between government and consumer:

American health is choked by paperwork and strangled by bureaucracy. Administrative costs are higher in the American health care system than in any other country, and rising rapidly. Confusion, complexity and increasing costs stem from the peculiarities of our health insurance system. Consumers experience it around the office or the kitchen table, when they are faced with piles of incomprehensible forms or when an insurance company refers them to the fine print in a policy to answer a question. A change in jobs or a move to another state can mean deciphering a whole new set of documents and learning a whole new set of rules (White House Domestic Policy Council 1993: 7).

This glut of bureaucracy, which is distanced from the government through the emphasis on commercial health insurance companies, is expressed as being the enemy not just of health service users but also of providers. By drawing on the position of the doctor as expert, the claims being made, here with reference to bureaucracy, are legitimized. Thus, in relation to how the mass of paperwork affects a doctor's ability to provide a reasonable service, the reform plan again refers to the specific experiences of the individual:

“While we go about our business caring for our patients, we are being buried in paperwork. Everyday, my mailbox is filled with directives, new regulations and papers to sign. The truth is, if I read all my mail, there would be no time left to see my patients” Dr. Jules Zysman (White House Domestic Policy Council 1993: 7).

What we find, then, in *The Health Reform Plan*, is a recourse to ideas of ‘place’, ‘identity’ and ‘belonging’ as a means of building support for what was a controversial programme of reforms. Whilst these notions are not expressed in explicit language, the reference to the geographical origins of a letter's author and the expression of concern for particular groups (the elderly, small businesses, young families) helps to reinforce the idea that health care reform will affect all Americans. The audience is asked to view the debate by locating themselves within it and by identifying with the problems that others like them have experienced. In the next section we will show how the 'selling' of the plan also evoked these central ideas in different places and among different interest groups both prior to and, following, its presentation to Congress.

Constructing Alliances

Thus far, we have concentrated on *The Health Reform Plan* and the ideas of health, identity and place that are to be found within it. However, this document represents only a fraction of the discourse that surrounded the health reform debates. We wish now to turn to a further aspect of the strategy for reform, that is the communication of the health reform debate to specific interest groups through a series of meetings held both in Washington and throughout the United States. What can be seen through these meetings is the process by which the health reform team sought to construct alliances with particular interest groups, it is also apparent that ideas of identity and place remain firmly embedded in discourse.

The Health Reform Plan was produced following a long period of consultation, however, as Jacks and Jacks (1995) argue, the administration failed, despite initial success, in their attempts to persuade health providers, small business organizations and Congress to adopt the specific policies (1995: 60). It is suggested by Martin (1995) that this failure was based on Clinton's adoption of a 'politics of exclusion and a language of conflict' (1995: 434). In particular Martin argues that the administration suffered from confusion about the distinction between campaigning and governing. There is, no doubt, a degree of validity in this claim; the uses of place and identity discussed in the previous section may have alienated as many people as they impressed. It is this distinction that we wish to focus on here for, despite Clinton's ability to generate support, or even euphoria as Jacks and Jacks (1995:60) suggest, there seemed to be a clear shortfall in the young administration's ability to transform popular support to a Congressional majority.

In speeches made during the initial period of the health reform debate, the administration began by focusing on specific issues and targeting these at particular groups. For example, at a

meeting of the Association of American Retired People (AARP), President Clinton was keen to relate the problem of bureaucracy to the specific needs of the elderly:

We received a letter and then I had a chance to meet a man named Jim Hefferman from Venice, Florida, who came to Rose Garden a couple of weeks ago. He volunteers at a local hospice trying to help people understand the tangle of forms they have to fill out just in order to get the health care they are entitled to. And he wrote to me. "I can recall one patient who was in tears and shaking because the hospital in her hometown had placed the balance of her medical charges in the hands of a collection agency and wrote that she might be sent to jail for failure to pay her hospital bill. This kind of senseless action on an elderly, terminal widow is unforgivable". Stories like this need to be told in the nation's capital until, finally, we get action (Clinton 1993: May 10).

Personal identity and geographical location were central to his narrative. He also sought to demonstrate how this key aspect of the health care reform debate affected not only patients but also health care professionals:

I think the people in the press and maybe some others might have wondered why in the wide world we would come to a children's hospital, with all its gripping, wonderful, personal stories, to have an event about bureaucracy and paperwork. After you listen to a nurse say why she couldn't care for a sick child, and a doctor plead for more time to be a doctor, maybe you know. There is an intensely human element behind the need to reform the system we have (Clinton 1993: September

17).

Clinton went on further to relate a story that highlighted, through his own (second-hand) personal experience, how bureaucracy is affecting the health care system:

I've got a friend who is a doctor that I grew up with who happens to live in the area, who calls me about once every three months to tell me another horror story. And the other day, he called me and he said, "You had better hurry up and get this done." He said, "You know, I'm in practice with this other guy. We've got all of these people doing paperwork. Now we've hired somebody who doesn't even fill out any forms. She spends all day on the telephone beating up on the insurance companies to pay for the forms we've already sent in. We actually had to hire somebody to do nothing but call on the phone." He said, "I'm lost in a funhouse here." He said, "I went to medical school to try to practice medicine. Now I've got to hire somebody who does nothing but call people on the phone to pay bills they're supposed to pay, after I've spent all this time filling out forms?"
(Clinton 1993: September 17)

These experiences, first of an elderly person and, second, of health professionals, were articulated in a way that sought to promote a 'human-interest' awareness of the problems facing the health care system. More specifically this strategy sought to relate the personal experiences of those mentioned to the individual experiences of those in the audience. This strategy becomes even clearer when we move beyond speeches to general audiences and examine presentations made to specific interest groups. Thus, at the Annual Conference for Business for Social

Responsibility, references were made to the detrimental impact of health care on families and small businesses (Clinton 1993: October 21) and, at a meeting of the American Hospital Association (AHA), the problems of the giant bureaucracy related to the growth of the insurance industry were discussed and related to the subsequent impact upon hospitals. As this quote taken from President Clinton's address at the AHA meeting highlights,

We have created in this country, through the systems of hundreds of different insurance companies writing thousands of different policies, a giant bureaucracy which, on the insurance side, sorts the healthy from the sick, the old from the young, the geographically desirable from the undesirable. ...And what about the hospitals? You have had to create your own bureaucracy to deal with the insurance bureaucracy, and the government's as well. (Clinton 1994: February 1).

When discussing health care reform, with the American Society of Association Executives, President Clinton adopted a more universal tone. An attempt was made to relate the health care experiences of the American people to this audience through references to international health care policy and the negative impact poor health care has had on the overall American economy. As President Clinton stated at the beginning of his speech, 'I think my job is to do everything I can to help every American reach his or her God-given potential, and to try and bring the American people together to make our country stronger'. He went on to suggest that the health care crisis must be addressed if the federal government is to be able to confront successfully the challenges faced by the approaching *fin de siècle* (Clinton 1994: March 8).

In a series of regional meetings the Clinton administration sought to promote the six principles of health care reform as universal solutions to the problems facing all Americans. In so

doing, notions of geographic place were employed as a mechanism for removing the space that was perceived to exist between government and local health care experiences. In regional ‘question and answer’ sessions and conferences members of the audience were invited to recount their health care experiences to the President who took the opportunity to place these experiences within the rhetoric of the health care reform plan. In one such encounter the questioner stated:

I’m from Philadelphia Eye Care Program and I was wondering, does your health care reform plan have any...does it have anything to subsidize the kind of door-to-door service needed for these immunization programs, or any of the preventive medicine that really is needed in our communities? (Clinton 1993: August 31)

To this Clinton replied:

Yes, the health care plan that will be announced in the next few weeks will have a big component of preventative care in it and will also provide the resources necessary to support the community-based clinics...we’re going to try to invest more in preventive and primary care and in those neighbourhood clinics both in rural and urban areas...The Philadelphia program is very, very impressive (Clinton 1993: August 31).

These sessions saw experiences fixed in geographic place, here Philadelphia, being employed to present the universal benefits of the Clinton reform plan. This strategy for promoting the reform plan was employed throughout the campaign. At a meeting in the Rose Garden of the White House just two weeks later Clinton read out a series of letters sent to him outlining individual health care experiences:

In the weeks and months ahead, health care will often be topic number one at dinner tables, at offices, at medical clinics, and in the halls of Congress. But before we launch into the debate I wanted to invite you here to remind everyone that, as Hillary says, there are 250 million health care experts in our nation and everyone has a different story to tell (Clinton 1993: September 16).

One by one the letters were read out with the individuals concerned locating their experiences in place: Michigan, Mississippi, New York, Miami, California, Illinois, Savannah, Pennsylvania, Kansas, Maine and so on. The letters were grouped together according to the specific health care problems that they addressed: quality, security, increasing costs, bureaucracy. As we have noted, Clinton employed this same tactic throughout the health reform campaign. Local health care problems or successes were employed to highlight the advantages of the Clinton plan and, as he indicated at the end of the Rose Garden meeting, individual experiences, located by place demonstrated 'the voices of real people who know it has to be better and different (Clinton 1993: September 16).

Discussion

It is evident that the Clinton administration resorted to ideas of place and belonging as a central strategy for the promotion of their health care reforms. Referring back to the work of Blendon et al. (1995) and of Martin (1995) it could be argued that, in the early throes of the health care reform debate, the administration, through this strategy, was able to establish a considerable level of support. However, as the attempt was made to translate this support into policy the

administration's hopes foundered on the multiplicity of power relations that exist both within and outside the halls of Congress.

The reasons for the failure to pass health care reform through Congress have been the subject of much debate amongst political and policy analysts (Morone 1995; Navarro 1995; Steinmo and Watts 1995; Wood 1995). According to Blendon et al. (1995) Clinton's failure resulted from a combination of factors: the strong opposition of interest groups, the ideological composition of Congress, opposition by important segments of the media, the timing of the proposal, and the nature of public opinion (1995: 8). Other analysts (Brady and Buckley 1995; Baumgartner and Talbert 1995) pinpoint Congress as being the key to the failure to advance a single health reform plan. In particular, Brady and Buckley (1995:448) argue that 'Health care legislation did not pass because the proposals made by Clinton and members of Congress were too far from the preferences of critical voters in the House and Senate', while Baumgartner and Talbert (1995) distinguish between the setting of national agendas and the making of national decisions. Certainly the increasing attention paid to health care in congressional committees helped to fragment the debate along the lines of interest group support. This fragmentation was too difficult for Clinton to overcome and hence consensus over a health care plan became impossible.

What emerges from our particular analysis of the health care reform debate is the array of linguistic devices and, specifically, spatial metaphors used in the attempt to promote popular agreement with the Clinton administration's prescription for health care reform. We have suggested that, in the articulation of their health reform plan, the Clinton administration employed a variety of spatially loaded terms in the attempt to pass their plans through an

historically obstructive Congress. In so doing the administration invoked an image of the US that was firmly embedded in the idea of America as a nation of individuals unified under the banner of the American Dream. We have isolated, within the discourse of the health reform plan and in some of the many meetings that took place, this unifying language as it emerged as a series of statements locating individual experiences in a place or offering individual experiences as being universally held. A number of issues emerge from this examination that need discussion: in particular the representation of place and identity, and the analytical importance of the notion of governmentality.

The importance of space and time to our understanding of contemporary social relations has become a cause célèbre for many geographers in recent years (Soja 1989). In their examination of place and identity, Keith and Pile (1993), seek to determine whether geographical and historical circumstances can be understood merely as specific expressions of social relations. Having briefly reviewed the central tenets of the concept of spatiality, they turn to bell hooks (1991) for an explanation of how place, identity and politics need to be understood through an array of spatialized concepts. In so doing they note, 'A different sense of place is being theorized, no longer passive, no longer fixed, no longer undialectical...but, still, in a very real sense about location and locatedness' (1993: 5). What they take from the work of bell hooks is the idea that, through postmodern culture, a space emerges enabling traditional ties to be severed or, alternatively, for new and invigorating bonds to be formed (1991: 31). We suggest here that the Clinton administrations's implicit use of place and identity in the health care reform debate sought to draw on an experiential articulation of place and identity in order to fracture the traditional nexus of US health policy. They sought to link the popular support thus generated to a particular historical moment - the election of new president.

The use of place and identity as policy devices provides an exemplification of Foucault's notion of governmentality. Thus, we suggest that the health reform debate should be viewed not simply as a linguistic strategy for the practice of government but as evidence of the 'art of government' as it is practised in contemporary liberal economies. Spatially loaded linguistic devices were deployed throughout the health reform debate in the attempt to re-configure the relationship between citizen and state. The language adopted necessarily allowed for the individual agency of all American citizens yet invoked ideas of place and belonging as a technique for promoting the idea of more comprehensive health care. Key to such a strategy, and what differentiates our analysis from others, is a recognition that the strategy embodied the Foucauldian techniques of both domination and the self. Thus, although the strategy undoubtedly sought to manipulate the population through the appropriation of certain symbolically loaded signifiers, it also sought to use spatially loaded terms as a means to identify concerns central to individual's own subjective positions. By turning the health reform debate into a question of the responsibility, choice, security and in relating these ideas to that of the American Dream the administration sought to overcome the opposition it would inevitably receive from insurance companies, the AMA, Congress and other such interest groups.

That the attempt failed is evidence of the deeply entrenched fear of federal government and championing of individual choice and responsibility to be found in both historical and contemporary American politics. The Clinton campaign had sought to enlist these fears and transform them, using notions of place and identity; the health care reform proposals were presented in terms of the interests of individuals, in places, remote from government. As a campaigning tactic this appeared to work, yet support for reform ebbed when the presidency was

won and the proposals moved from a world in which individuals articulated their experiences to one in which interest groups held sway.

References

- Baumgartner, F. R. and Talbert, J. C. 1995 From Setting a National Agenda on Health Care to Making Decisions in Congress. Journal of Health Politics, Policy and Law 20: 2 pp 437-445
- Blendon, R. J. et al. 1995 What Happened to American's Support for the Clinton Health Plan? Health Affairs Summer pp 7-23
- Bodenheimer, T. 1990 Should We Abolish the Private Health Insurance Industry? International Journal of Health Services 20: 2 pp 199-220
- Boyum, D. 1994 American Medical Care Reform: Are We Doomed to Fail? In Marmor, T. R. 1994 Understanding Health Care Reform
- Brady, D. W. and Buckley, K. M. 1995 Health Care Reform in the 103d Congress: A Predictable Failure. Journal of Health Politics, Policy and Law 20: 2 pp 447-454
- Burchell, G. 1991 Peculiar Interests: Governing "The System of Natural Liberty", in Burchell, Gordon and Miller (eds) The Foucault Effect: Studies in Governmental Rationality
- 1993 Liberal Government and Techniques of the Self. Economy and Society 22: 3 pp 267-282
- Burchell, G., Gordon, C. and Miller, P. (eds) 1991 The Foucault Effect: Studies in Governmental Rationality, Brighton: Harvester

de Vise, P. 1971 Cook County Hospital: bulwark of Chicago's Apartheid Health System and Prototype of the Nation's Public Hospitals. Antipode 3: 1 pp. 9-20

Donzelot, J. 1984 L'Invention du Social. Paris

Dorn, M. and Laws, G. 1994 Social Theory, Body Politics and Medical Geography. The Professional Geographer 46 pp. 106-110

Ewald, F. 1986 L'Etat Providence. Paris

Foucault, M. 1979 On Governmentality. Ideology and Consciousness autumn: 6 pp. 5-21

Fuchs, V. R. 1986 The Health Economy. Cambridge, Massachusetts: Harvard University Press

Gordon, C. 1987 The Soul of the Citizen: Max Weber and Michel Foucault on Rationality and Government in Lash, S. and Whimster, S. (eds) Max Weber, Rationality and Modernity pp. 293-316

— 1991 Governmental Rationality: An Introduction in Burchell, G., Gordon, C. and Miller, P. (eds) 1991 The Foucault Effect: Studies in Governmental Rationality pp 1-51

Hacking, I. 1990 The Taming of Chance. Cambridge

hooks, b. 1991 Yearning: Race, Gender, and Cultural politics. Boston, Massachusetts: Turnaround

Jacks, J. C. and Jacks, L. 1995 Chronology of the Birth and Death of a Health Bill. Journal of Health Care Finance 21: 3 pp. 59-67

Jameson, F. 1984 Postmodernism, or the Cultural Logic of Late Capitalism. New Left Review 146 pp. 53-92

— 1991 Postmodernism, or the Cultural Logic of Late Capitalism. London: Verso

Kearns, R. 1993 Place and Health: Toward a Reformed Medical Geography. The Professional Geographer 45 pp. 139-147

— 1995 Medical Geography: Making Space for Difference. Progress in Human Geography 19 (2) pp. 251-259

Keith, M. and Pile, S. (eds) 1993 Place and the Politics of Identity. London and New York: Routledge

Marmor, T. R. 1994 Understanding Health Care Reform. New Haven and London: Yale University Press

Marmor, T. R. and Goldberg, M. 1994 American Health Care Reform: Separating Sense From Nonsense in Marmor, T. R. (ed) Understanding Health Care Reform

Martin, C. J. 1995 Stuck in Neutral: Big Business and the Politics of National Health Reform. Journal of Health Politics, Policy and Law 20: 2 pp. 431-436

McLafferty, S. 1996 Managing Health in the United States: Place, Politics, and the Geography of Health Care "Reform". Unpublished paper presented at the VIIth International Symposium in Medical Geography, University of Portsmouth, July 30th - August 2nd.

Miller, P. and Rose, N. 1990 Governing Economic Life. Economy and Society 19: 1 pp. 1-31

Morone, J. A. 1995 Nativism, Hollow Corporations, and Managed Competition: Why the Clinton Health Care Reform Failed. Journal of Health Politics, Policy and Law 20: 2 pp 392-398

Navarro, V. 1989 Why Some Countries Have National Health Insurance, Others Have National Health Services, and the United States Has Neither. International Journal of Health Services 19: 3 pp. 383-404

— 1994 The Politics of Health Policy. Oxford: Blackwell Publishers

— 1995 Why Congress Did Not Enact Health Care Reform. Journal of Health Politics, Policy and Law 20: 2 pp 455-462

Rockman, B. A. 1995 The Clinton Presidency and Health Care Reform. Journal of Health Politics, Policy and Law 20: 2 pp. 399-402

Rose, N. 1993 Government, Authority and Expertise in Advanced Liberalism. Economy and Society 22: 3 pp. 283-299

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

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 pp 329-372

US News and World Report (Storrs, Conn.: Roper Center for Public Opinion Research, 21 April 1993