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Author(s): David A. Danielson and Arthur Mazer
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The Massachusetts Referendum for a National Health Program

DAVID A. DANIELSON and ARTHUR MAZER

INTRODUCTION

FIVE times in this century the nation has intensely debated legislation to grant Americans the right to obtain basic health, medical and related social services. Each attempt has foundered and failed, usually generating a series of legislated half-way measures as consolation prizes for the legislators who fought so hard to ultimately achieve so little. The consistent winners have been directors of medical enterprises whose profits have grown each year as more money is channeled into a sickness-care system that underfunds prevention, chronic illness, and occupational health. Our record for access to care is also unimpressive. Approximately thirty-five million people now lack medical insurance during all or part of the year; their number had grown by some 50% over the last decade. An even greater number are inadequately covered, making it impossible for many to obtain even minimum care and for others to obtain needed health services. Access to health care is affected by race, age, socioeconomic status, geographical location, and employment.

There is remarkably broad agreement on the diagnosis of American medical care's systemic failures which we will not repeat here (1). Our concern instead is with finding a practical political treatment that may contribute to curing the resistant strain of greed and privatization that afflicts American medicine.

It is possible that local and state-level actions can be taken to build a grassroots political constituency for national health care reform that can undertake the sustained effort to obtain final enactment of a national law by the U.S. Congress. Perhaps statewide health demonstrations can be carried out that will prove the efficiency and wisdom of caring for everyone as needed. This is the lesson we learn by facing North for historic

guidance from our socioculturally similar neighbor—Canada. It is possible that state-by-state developments which are already emerging in Hawaii, Minnesota, and now in Massachusetts may lead, upon this fifth attempt, to an integrated, comprehensive system for all Americans. These observations upon what is truly work-in-progress are advanced to permit these questions to be explored more fully.

U.S. HISTORICAL CONTEXT

Major restructuring of the provision of hospital and medical services has received legislative consideration during five periods in this century: 1913–17, 1937–39, 1943–46, 1964–65, and 1969–75 (2). The reasons for failure differed in each case, but all involved a mix of competing national priorities, economic uncertainties, and well-organized and well-funded opposition. Political scientists (3) have cited our general difficulty as a nation in dealing with complex issues because of our short political electoral cycles, regional differences, and the frequent periods when Congress and the executive branch are at loggerheads, controlled by competing parties or competing factions within the Democratic Party. Useful analyses of these health reform failures have been published (4,5), and much can be learned by reviewing them.

If the past is prologue, are we not fighting the inevitable? Should we accept the exclusion of 35,000,000 people from medical insurance, the rationing of medical care, the imposition of DRGs, the sale of public hospitals to corporations, and the conversion of our pool of physicians and nurses to skilled hands on a production line run by CPAs as simply inevitable? Recent history suggests that the answer is no. Many providers and recipients of medical care, many corporations footing the bills, and many large municipalities that must try to pick up the fractured unfortunates who have fallen through the cracks which widen as "privatization" advances, are not in support of a profit-driven system (6). There may also be a dawning awareness of the futility of half-way measures. Medicare, twenty years after its creation, has left elders as bad off financially as they were in 1964. Medicaid, similarly, has not provided the promised access for the poor to mainstream medical care, and over half of the poor in over half the states are not covered by the Medicaid program (7). For health advocates, resistance to program cuts has dominated all other efforts during the past five years of Reaganism. But the advocacy efforts to conserve the elements of progress made in the Kennedy and Johnson years, the fights to save particular hospitals, to protect the victims of particular diseases, or to

conserve particular programs, have created constituencies and informed leaders at the local level, who are experts on each issue and see the relationships among all the issues.

ORIGINS OF THE HEALTH SERVICE MOVEMENT

During the last period of attempted reform of U.S. medical and health care (1969–75), a group of health care providers, many of whom were members of the Medical Committee for Human Rights, saw the need to present the policy option of a health service organization in America for Congressional consideration. Following negotiations with Congressman Dellums (Dem-CA) in 1974, he announced his intention to introduce such legislation, and in 1975 the Committee for a National Health Service (CNHS, which later became the Coalition for a National Health Service) was formed to draft a bill and promote its passage. Two years of intense discussion followed before obtaining agreement on an NHS bill which Dellums introduced in 1977 as the Health Service Act. There were no fewer than 18 bills for national health reform before Congress that year, ranging in scope from the fairly comprehensive Corman-Kennedy Bill to the so-called and well-named "Catastrophic Plans" of Long-Ribicoff and others.

In introducing the bill, Representative Dellums said:

> The solution to the crisis in health care in this country must go much further than financing; it must speak to the maldistribution of health manpower, the unequal access to services, the unreliable quality of care and lack of public control over health care. No matter how much we guarantee the payment of services to the people, it is of little comfort to them if there is no one around to provide the service.
>
> I introduced this bill not because I think the country is prepared to enact it today or tomorrow or even next year, but because it opens up a critically important debate in this country. Hopefully it will force everyone to discuss all the various alternatives. For I believe that when the people realize that this is an option, they will demand its enactment.
>
> Growing numbers of Americans realize that the present health care system, based on the private delivery of health care and financed on a fee-for-service basis, is unable to meet the health care needs of this country. One response has been to propose some form of national health insurance. However, no insurance plan will guarantee that

health care services are available to everyone, improve the quality of current services, or hold down costs (8).

Rather abruptly that year Congressional interest in health reform waned as President Jimmie Carter and the Democratic Party split over the issue, but CNHS activity continued. New groups, including the American Public Health Association, the National Association of Social Workers, the American Student Medical Association, the National Women's Health Network, and the national Gray Panthers, joined the coalition. The Boston Women's Health Book Collective (authors of *Our Bodies, Our Selves*) added a new section to the bill on women's rights as patients and health care workers. The bill was carefully revised by a CNHS committee working with Congressional staff members. But deprived of any realistic chance for legislative action in Congress, the CNHS became relatively inactive, with the exception of sessions at the Annual Meetings of the American Public Health Association which contributed to the breadth of support around the country among public health workers.

There was a resurgence when local activists in Pennsylvania organized the 1979 Pittsburgh CNHS Conference, held under the banner "Health Care is a Right—Not a Privilege." The conference attracted 450 participants, and, later that year, over 500 people came to each of two similar conferences in Chicago and Newark, but Congressional attention was moving further away from progressive health care reform. Congressman Dellums, overwhelmingly re-elected and with increasing seniority, took a seat on the House Armed Services Committee and began to focus more of his energies on national defense issues than on health care reform.

The strategy of conducting local referendum campaigns for a national health service was discussed by Dellums and elder activists in California in the mid-1970s (9), but it was decided that no action should be taken. The idea first came to our attention in February 1979 at the CNHS Conference in Pittsburgh. Dellums was the keynote speaker, and he urged that local ballot referendums should be organized to capture public attention and bring pressure upon members of Congress to hold hearings on the health service issue. He cited the example of his home state where binding and non-binding ballot questions had mobilized support behind a variety of issues.

CAMBRIDGE: STEP ONE

Energized by the Conference, the Massachusetts campaign was begun immediately. The Gray Panthers held meetings with elder groups, labor

organizers, progressive legislators, health reformers, and community organizations such as Fair Share and the Public Interest Research Group. Because 1979 was a year with no statewide election, the group decided that efforts should be made to place an NHS proposal on the ballot in several cities. Fortunately, in Cambridge, the required combination of an interested local politician (David Sullivan, now a Cambridge City Councillor), and an effective, dedicated organizer (Gerald Bergman, now Coordinator of the Gray Panthers of Greater Boston), was present. Sullivan, an expert on the state's election laws, advised the coalition (which was functioning then as the Massachusetts chapter of CNHS), to seek to have the City Council vote to put a referendum question on the ballot in Cambridge rather than gather thousands of signatures on petitions. Agreement formed around a statement that was drafted by Arthur Mazer, drawing upon other "statements of principle" from the American Public Health Association, Dellums' National Health Service Act, and elements of Senator Edward Kennedy's proposals. The language was identical to that of the later statewide question (Figure 1), except for a) references to a health *service* instead of a health program, b) a listing of the underserved groups in our population to whom "particular attention" would be paid, and c) less detail on cost control (10). The inclusion of occupational health reflected the emphasis Dellums had placed on that aspect of health care reorganization in the NHS bill, and the broad public awareness in Massachusetts of the importance of toxic chemicals. The language of the referendum was presented to the City Council and approved unanimously as written in June 1979, to be placed upon the ballot in the fall.

FIGURE 1

Massachusetts 1986 Ballot Question

Shall the Commonwealth of Massachusetts urge the United States Congress to enact a national health program which:

provides high quality comprehensive personal health care including preventive, curative and occupational health services; is universal in coverage, community controlled, rationally organized, equitably financed, with no out-of-pocket charges, is sensitive to the particular health needs of all, and is efficient in containing its cost; and whose yearly expenditure does not exceed the proportion of the Gross National Product spent on health care in the immediately preceding fiscal year?

CAMBRIDGE: STEP TWO

The campaign before the November election in Cambridge was run by the Cambridge Committee of Elders and involved a) organizational presentations and endorsements, b) support by candidates for local political office, c) posters, and d) leaflets on election day at a few major polling places. The leaflets listed the Cambridge Committee of Elders (CCE), twenty co-sponsoring organizations, the Mayor, and fifteen candidates for City Council, including all the incumbents, as endorsing the non-binding ballot question supporting a National Health Service for the United States.

The campaign effort can be characterized as "minimal," although we were helped to an unmeasured extent by having the first position on the ballot and the resultant desirable slogan "Yes on #1." There was no media attention prior to the election, and very little afterwards.

The election results were astounding to most of the handful of people who learned about them. Eighty percent of those in Cambridge who voted on this question voted yes. Almost everyone voted on this issue. And a National Health Service even outpolled the ever-popular Senator Kennedy who was urged to "run for President" on the same ballot; he only received a 60/40 majority. The detailed results are shown in Table 1 (11).

The press statements issued by the coalition after the election emphasized the health service aspects of the victory. A spokesman for the Gray Panthers, Nate Smith, said "Elder Americans, especially, are fed up with the insurance approach to medical care." The release continued: "Support for restructuring U.S. health care is emphatically on the rise. . . . Only 22% of Americans approved of a national health service in 1975, according to a national poll. The Harris Poll, two years later, reported that 39% of the American public favored a national health service. And now, in 1979, the voting public has approved by a margin of four to one."

MASSACHUSETTS: STEP ONE

Although the Cambridge results did not reach the national media and remained an isolated occurrence, the local endorsers were encouraged to attempt a statewide ballot referendum. Upon inquiry we learned that the requirements for placing questions on the ballot vary from state to state. Commonly, and in Massachusetts, there is provision for initiatives both by citizens' petitions and by direct legislative action. The excellent showing at the polls in Cambridge encouraged the Massachusetts coalition to attempt to obtain passage by the State Legislature. It appeared to be much less

TABLE 1

Election Results: National Health Service Referendum, Cambridge, Mass. Municipal Elections, November 6, 1979

Ward #	*Total votes cast*	*Per capita income*	*Percent of YES votes*[1]
1	2837	$5706	83.0
2	1686	$5724	83.6
6	2272	$6704	84.2
5	2398	$6808	84.3
11	2871	$6890	77.7
3	2039	$7380	85.9
10	2479	$9634	78.5
4	2368	$9657	82.3
9	2837	$10,818	77.4
7	2565	$11,180	73.0
8	2542	$15,441	70.7
ALL	26,894	$7,957	79.8+

[1] YES votes are expressed as a percent of votes cast on the question; 2609 voters (9.7%) left the question blank. A similar relationship with per capita income was found when the 55 precincts of Cambridge were analyzed. Residents in the 11 precincts with lowest incomes ($5174) favored a national health service by 82.3%; voters in the 11 precincts in the highest income quintile ($13,014) produced a 72.7% favorable vote on the question.

work and potentially faster than garnering the requisite 65,000 signatures of registered voters in statewide districts. Since the Cambridge delegation was fully convinced on the issue by the voters' action at the polls, we had a strong nucleus of support in the Legislature. On a statewide basis there were but a few hundred Gray Panthers, and gathering signatures appeared infeasible. (Details of the ballot requirements and deadlines in each state are available from the authors.)

Strategies for signature campaigns and legislative campaigns differ. We shall briefly describe the six-year-long legislative campaign leading to the Massachusetts Health Referendum Act. Possibly it could have been done more quickly if we had recognized the need for selected actions earlier. In retrospect, getting signatures might have required less net effort. On the other hand it was a learning process, which was perhaps inevitable for neophytes in the political arena.

MASSACHUSETTS: STEP TWO

In 1980, at the request of the Gray Panthers, a bill identical to the Cambridge Resolution was introduced into the Legislature by Senator Michael LoPresti. He is a politically moderate Senator who represents several wards in Cambridge where the referendum did best, as well as a much larger working-class area east of Boston. The few legislative co-sponsors who added their names to the bill were drawn from the liberal and progressive ranks of the legislature. No companion measure was introduced into the lower chamber. In the normal course of the legislative process a public hearing was held, and many articulate proponents were able to appear before the Health Care Committee on behalf of the bill.

In 1981–3 the bill was routinely refiled, but most health activists' efforts were fixed on damage control, as the "safety net" of programs for elders and the poor was swiftly unravelled from Washington. But amidst the struggles each year at the Legislature, a few different groups came to testify on behalf of the bill and broader support developed. The Gray Panthers slowly built a coalition as they participated in and organized street demonstrations, introduced conference resolutions, and conducted workshops, panels and symposia to call for health care reform. Nursing home residents became an important element in the coalition, regularly appearing at the legislature to testify for the Referendum proposal.

In 1984, Senator LoPresti announced that he would make an all-out effort on behalf of the bill. In a press release he said: "Health care costs have gone out of sight since the Cambridge vote five years ago. For example, Medigap insurance increases have doubled the cost of supplemental insurance for Medicare recipients in the last 4 years. A lot of us want to see what a statewide vote would be today on sending a message to Congress on national health service."

By 1984, the ballot question bill had 24 legislative co-sponsors who had been arranged by Gray Panther contacts and attention from an energetic aide to Senator LoPresti, Pat Matsumiya. The state AFL–CIO and Massachusetts Association of Older Americans were supporting it for the first time, and the Greater Boston Elderly Legal Services Coalition had made it a top priority. The bill by then also had a widening base of support among medical and public health professionals, social workers, unions and the elderly. Working with the Progressive Caucus of the Democratic Party, members of the coalition also succeeded in adding the language in Figure 1 to the party platform at the State Convention in the Spring of 1984.

As a media access strategy, the Gray Panthers also sought and received endorsements of a National Health Service by Presidential candidates Jesse Jackson, George McGovern, and Citizen's Party candidate Sonia Johnson. We arranged press conferences for these three candidates to speak on health care issues and gain momentum. Again, the media response was negligible.

Largely because of a personal appeal by elder activist Nellie Sullivan, a friend of the Senate President, the Senate issued a Resolution in December 1984 calling for a National Health Service. This was conveyed to Congress and to the President of the United States. Although it had no perceptible effect on U.S. policy, it was a tangible interim success for the coalition members in the Commonwealth, and encouraged their determination to push the bill through both houses in 1985 and onto the ballot in 1986.

The sessions of hearings and negotiations at the State House were probing and thought-provoking, and occasionally the questions had brought out the political detriments of two features of the Cambridge bill, 1) the uneasiness about a health "service" among people more accustomed to speaking of health "insurance," and 2) the attention, almost fixation, on cost-control among legislators on the health-related committees. So, in 1984, compromises were made reluctantly. The language was changed to a health "program," and a proposal was accepted that originated with Senator Edward Burke, Chairperson of the Health Care Committee, which would cap total expenditures by the National Health Program at the level of the fiscal year preceding passage of the Act.

With these compromises, we obtained additional support from several large and more centrist elder advocacy groups, and co-sponsorship from 80 Senators and State Representatives including an absolute majority of the State Senate. The chief criticism that remained among legislative leaders was that the effectiveness of the measure was limited, given a general desire not to burden the ballot with extraneous issues. Senator Burke, for example, said that "It's an apple-pie statement that may win but will be wholly without any practical benefit."

This criticism was evaluated and effectively countered by writing letters over the signatures of the primary House and Senate sponsors to the Massachusetts Congressional delegation. The replies from Senators Kennedy and Kerry, and Representatives Frank, Early and Moakley, helped to allay the Senators' and our own doubts about the utility of a state referendum in returning health to the political agenda of the U.S. Congress.

Our success in recruiting the champion of elder issues, Rep. Joseph

DeNucci, to be the principal House co-sponsor was expected to help greatly with the mainstream members of the General Court. Organizational support for the campaign came from the Massachusetts Health Action Alliance, Massachusetts AFL–CIO, Massachussetts Association of Older Americans, Massachusetts Chapter of the National Association of Social Workers, Ladies Garment Workers, Action for Boston Community Development, the Boston Commission on Affairs of the Elderly, and the Massachusetts Human Services Coalition, in addition to over 25 other organizations.

The Bill, as expected, sailed through the Senate in 1985 and, aided by rules reform, it also was successfully conducted through the House. The signature of Governor Michael S. Dukakis was never in great doubt. The support of the Commissioner of Public Health, Dr. Bailus Walker, and of Dr. Victor Sidel, the President of the American Public Health Association, was extended most graciously. To be certain, pressure from many statewide organizations was brought to bear on the Governor, and on September 30, the bill was signed into law as Chapter 324, Acts of 1985. Within 24 hours elation faded into the awareness that we had to organize a statewide campaign. We had not won. We had just been offered the chance to take on a more formidable challenge.

MASSACHUSETTS: STEP THREE

The coalition is in the first stages of assessing organizational support for a model bill for a statewide health care system. This was drafted by the authors and introduced in 1985 by 15 co-sponsors as the Massachusetts Health Security Act. The bill is founded upon the principles in the Health Referendum Act, and provides participatory mechanisms to plan goals, structure and organizations for a transition from the current system at the state level. If the referendum gains voters' support, this bill—refined by a broader group of analysts to take account of the legislative testimony—may become a major focus for the coalition effort.

Work is in progress on the formation of a state-wide campaign coalition for *passage* of the ballot question, and over 50 groups have already enrolled in the effort (Table 2). In November 1986, we expect the referendum question to be voted upon by around 2,300,000 voters. In urging Congress to enact legislation for a national health program, it discusses an efficient, universal, comprehensive system in broad terms that have proven to be acceptable to a wide range of groups concerned about health reform. It is hoped that others might apply the Massachusetts experience and initiate a series of

TABLE 2

Organizations Supporting the National Health Program Referendum Campaign in Massachusetts as of April 22, 1986

Action for Boston Community Development
American Public Health Association
Boston Commission on the Affairs of the Elderly
Boston Mobilization for Survival
Boston Women's Health Book Collective
Cambridge Commission on the Status of Women
Cambridge Committee of Elders
Cambridge Council on Aging
Cambridge Economic Opportunity Committee
Cape Organization for the Rights of the Disabled
Citizens for Participation in Political Action
Committee on Political Education, Service Employees International Union, Local 509
Elderly Legal Coalition
Gerontology Institute, University of Mass., Boston
Gray Panthers of Greater Boston
Gray Panthers of Pioneer Valley
Health Employees Union, District 1199, AFL-CIO
Health Care Providers for a National Health Program
Highland Valley Elder Services
House Officers Association, Boston City Hospital
International Ladies Garment Workers Union, New England Region
Jewish Community Relations Council
League of Community Health Centers of Massachusetts
Legislative Council of Older Americans
Living is for the Elderly (LIFE)
Massachusetts AFL-CIO Central Labor Council
Massachusetts Association of Older Americans
Massachusetts Association of Retired Persons
Massachusetts Chapter, National Association of Social Workers
Massachusetts Coalition for Occupational Safety and Health
Massachusetts Coalition for the Homeless
Massachusetts Democratic State Committee
Massachusetts Health Action Alliance
Massachusetts Health Council
Massachusetts Human Services Coalition
Massachusetts Law Reform Institute
Massachusetts Nurses Association
Massachusetts Psychological Association
Massachusetts Public Health Association
Massachusetts Public Interest Research Group
Massachusetts Teachers Association
Metropolitan Boston Chapter, National Caucus and Center on Black Aged
Northampton Elder Americans
Older Women's League
Reproductive Rights National Network
Senior Action Council of Franklin County
Seniors in Community Service, Urban League of Eastern Massachusetts
Service Employees International Union, Local 1475
Somerville Council on Aging
Somerville Portuguese American League
Tri-City Community Action Program, Malden
Unitarian Universalist Service Association, Massachusetts
United Auto Workers of Massachusetts
United Food and Commercial Workers, Local 1445, AFL-CIO
United South End Settlements

state-level actions leading towards a National Health Program. Indeed, in some areas—Chicago, California and New Jersey—coalitions have already been formed to place similar referendum questions before the voters, and to use this approach to build a support structure for system-wide reform.

DISCUSSION

Can voters appreciate that only system-wide integrated approaches can save money by introducing efficiency and reducing red tape? Will voters be able to appreciate the value of health services they rarely experience—health services at the workplace, and absence of barriers to primary care—and will they vote in support of them? Does American isolationism and "Americanism" rule out the effective use of international experience in Canada, Italy, Sweden and the U.K., as we look for the best models and for evidence that integrated approaches can work efficiently? What if the question loses? These are some of the issues that now confront the coalition as the November election approaches.

Massachusetts will be the first state to ask its voters to express their will on a national health program. If other states and cities join in an outpouring of public opinion that will reawaken interest in this issue, we believe we can force Congress to seriously reconsider a national system for delivering health care. As the Boston Globe observed in an editorial, "the voter-endorsement tactic may regain the attention of elected officials who have turned their backs on the national-health issue, largely out of cost considerations. The coalition may have hit on something" (12).

A clearinghouse for information on efforts around the nation has been set up by the CNHS. It is urging consideration of what can be done to put health on the ballot, either by joining an activity that is now under way or by starting similar actions in other states.

The urgency of these steps towards coalition building has been underscored by public health analysts. As early as 1981, Dr. Steven Schroeder predicted that the Reagan Administration would "attempt to buy out the middle class, probably in the form of a limited catastrophic health insurance plan," to undercut support for fundamental reforms (13). This idea was indeed advanced by the President in the 1986 State of the Union Message.

State activities now will allow public support to be developed for a comprehensive national health program. As Dr. Schroeder observed, "The

choice between these two options may be the most important decision this country will ever make regarding national health. . . . "

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