

A Citizen's Guide to the Healthcare Reform Debate

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Introduction

Universal health insurance has been a source of both promise and peril for the Clinton Administration. The promise was most evident in the early months of 1993, following candidate Clinton's effective use of the problems of American healthcare in the 1992 presidential campaign. A healthcare reform plan, the nation was told, would be unveiled in April, 1993; the unveiling was then postponed, in turn, to May, June, August, and September. Despite the predictable grouching of interest groups left out of the initial design phase, anticipation of the plan was great.

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The President's presentation of his reform plan to the Congress on September 22, 1993 and his 1994 State of the Union message prompted moments of hope for healthcare reformers. Before the Whitewater scandal broke, Hillary Rodham Clinton had become a star speaker on what is wrong with American medicine and a clear articulator of what the Administration hoped to achieve by changing the rules of the healthcare game. Mrs. Clinton delivered her message to the Congress and the public without notes and with admirable grace, leaving her most severe critics on the defensive. The public's regard for the First Lady soared, as did the Administration's standing in the polls for a while.

Neither the timing nor the substance of the healthcare task force's report fulfilled the promise. Delays eroded public confidence. The task force's report, and the resulting Clinton bill, failed to demonstrate how the Clinton Administration would bridge the gap between admirable aims and workable, acceptable means. Instead, the Clinton plan proved a Rube Goldberg contraption, a remarkably complex proposal shaped as much by hidden political constraints as by sensible, understandable techniques for achieving agreed-upon objectives.

In addition, by the spring of 1994, the Whitewater affair preempted healthcare reform's place on the nation's public agenda. Yet the most stunning disappointment has been the quality of the national debate over reform itself. After more than a year of anticipation, concentrated press attention, and innumerable explanations, the public is more confused about the Clinton plan and less supportive of reform than it was before all the debate began in earnest. Why this turned out to be the case is the subject of this Essay. Our focus, however, will be narrow: we will selectively identify themes that have contributed to the public's mystification about what is perhaps the most important reform issue of the 1990s. In so doing, we cannot hope for comprehensive treatment; the range of confusions is too great for any brief essay. But our hope is that some clarification will contribute to a more sensible discussion of what is both possible and desirable in healthcare reform.

Sources of Confusion: Cant, Hyperbole, and Misrepresentation

No one should be surprised that the debate over comprehensive reform of American healthcare should prompt ideological cant, name-calling, exaggeration, and distortion. The healthcare system represents nearly one-seventh of the national economy. It consumes over fourteen cents of every dollar of national income, affecting a huge workforce of doctors, nurses, and other personnel, and supports thousands of firms, hospitals, and clinics. American politics is never tidy, and the style of political discussion, now determined so much by television, inclines towards a war of words. Even so, one hoped for more clarity this time from a President gifted in communication.

One hoped that Clinton could lead the equivalent of a national teach-in. He did not do so, and the debate surrounding seven critical areas shows it.

A. *The Need for Reform: What Kind of Healthcare Problems Does the Nation Face, Anyway?*

A particularly unhelpful form of revisionism emerged in the healthcare reform debate during late 1993 and early 1994. The revisionists began to claim loudly that America did not face a healthcare crisis. Americans, they contended, have the finest medical system in the world: the private sector is bringing medical inflation under control, and the problem of the uninsured is exaggerated. “Our country has healthcare problems,” Senator Robert Dole conceded, “but no healthcare crisis.”¹ The healthcare system does not, the revisionists claim, require major reform, since in most respects it is working well. Senator Dole’s comment makes a semantic distinction—“problems” versus a “crisis”—but one that for weeks in early 1994 dominated what passes as a national debate over healthcare reform.

No one seriously doubts that there are significant problems in American healthcare. Rising costs, increasing numbers of uninsured, and substantial insecurity about the future are all well-documented. The United States spends more resources on medical services than any other nation in the world. Yet the nation has thirty-seven million citizens without health insurance at any one time, over fifty million without insurance at some time within a two year period, and millions more who fear losing their health insurance coverage. What, then, is one to make of the claim that “we don’t,” in Senator Moynihan’s words, “have a healthcare crisis in this country.”² Have we misunderstood the significance of the problems? Is the current system basically sound? Is major reform really necessary?

The “discovery” on the part of some politicians that America faces no healthcare crisis has little to do with the real condition of the healthcare system. Instead, conditions in the political system triggered this revisionism. A fundamental law of politics is that whoever controls how an issue is defined will control how it is resolved. In other words, by seeking to influence how a problem is perceived, political actors hope to influence which alternatives will be selected for its resolution. This is the politics of agenda-setting.³

Not surprisingly, then, the revisionism challenging the existence of a healthcare crisis originated with a Republican strategist who was concerned that

1. Gwen Ifill, *State of the Union: The Overview; Clinton Vows to Fight for His Health Plan*, N.Y. TIMES, Jan. 26, 1994, at A1.

2. Richard Knox, *‘What Crisis?’—GOP to Tackle Views on Health*, BOSTON GLOBE, Jan. 27, 1994, at 1, 17.

3. See ELMER E. SCHATTSCHNEIDER, SEMISOVEREIGN PEOPLE: A REALIST’S VIEW OF DEMOCRACY IN AMERICA 68 (1960).

the Republican party had ceded too much ground to the Democrats on healthcare.⁴ If Republicans could convince the public that the healthcare crisis was an exaggeration, support for reform would diminish and the Clinton Administration's proposal might be defeated. This strategy was adopted by many Republicans—Robert Dole and Phil Gramm were but the most prominent—and the associated claims were even repeated, albeit briefly, by Democratic lawmakers such as Senator Moynihan. As a result, the press ran many stories asking if the nation indeed had a healthcare crisis. What was not widely acknowledged, however, is that the “no crisis” claim hardly represented a new understanding of the American healthcare system. Put more bluntly, there was little attention to the politics of this tactic: it was a move by opponents of healthcare reform to redefine the public debate so as to protect the status quo.

The dispute over whether or not the American healthcare system is in crisis is misguided. What ultimately matters is not what labels we attach to the nation's healthcare problems, but what these problems are and what remedies should be considered to address them. To stop calling our problems a “crisis” is not to make them disappear.

B. *False Dichotomies: Regulation vs. Competition*

Americans are repeatedly told that the choice in healthcare reform is between regulation and competition: we must choose either a healthcare system that relies on the free market or one run by government. This dichotomy is false and grossly misleading. Healthcare reforms associated with competition require regulation, but the regulation required does not amount to a government takeover of the healthcare system. Moreover, no system of regulated medical provision—even a Canadian-style single-payer plan—would abolish competition. (Canadian doctors and hospitals compete for patients, prestige, honor, and so on.) The regulation/competition dichotomy contributes to the confusion in the healthcare reform debate. It obscures important questions that need to be asked about all healthcare reforms: What is to be regulated? Who should have the authority to regulate? What is required for regulation to succeed?

The juxtaposition of “regulation” and “competition” is particularly misleading in connection with managed competition reforms. “Managed competition” is a contemporary euphemism for what should be termed “regulated competition.” Managed competition plans like that proposed by President Clinton do not seek to create a free market in healthcare. They instead prescribe an extensive regulatory framework to assure that competing health

4. Republican strategist William Kristol was the moving force behind the new revisionism. For an account of the origins of the “there's no health care crisis” strategy, see Ruth Shalit, *The Wimp-Out: Republicans and Health Care*, THE NEW REPUBLIC, Feb. 14, 1994, at 19.

plans do not engage in discriminatory insurance practices. The regulatory regime of the Clinton bill is so complicated that the Administration took over 1,330 pages to “explain” it. While justified with the rhetoric of the market, managed competition is an admission that market forces cannot be permitted to work in healthcare without elaborate restraints.

Moreover, healthcare plans broader than the Clinton plan rely on regulatory and budget devices to achieve cost savings. They constrain medical care practices through means such as utilization review, physician gatekeepers, and prior authorization requirements. The fact that the Clinton plan differs from plans that emphasize government insurance, in that it locates regulation in “private” healthcare plans, does not change the fact that managed competition requires regulation.

Even more misleading than the assumption that managed competition eliminates the need for regulation is the belief that public regulation, according to the exaggerated language of Texas Republican Senator Phil Gramm (R., Tex), amounts to “having the Government take over and run the healthcare system.”⁵ In particular, the proposal of fee schedules for provider charges and limits on price increases in insurance premiums is interpreted as evidence that the government is going to run the healthcare system and that patients will lose their freedom to make healthcare choices.

This stereotype of regulation has little basis in the reality of proposed reforms. Healthcare reform plans that emphasize the regulation of provider charges—most obviously the McDermott-Wellstone bills modeled on Canadian national health insurance⁶—would leave the delivery of medical services predominantly in private hands. Physicians would not be government employees, patients would choose their own physicians, and physicians would be largely free to prescribe treatments, although not to charge whatever they desire. Physician fees and hospital budgets would be negotiated between providers and government actors. An underappreciated truth is that Canadian-style health insurance plans, which supposedly advocate a government takeover of the healthcare system, would leave patients and physicians more choice than would competitive proposals that rely on extensive intervention in the delivery of medical care. The choice is not between regulation and competition. The choice is between regulating medical care finance and regulating both medical care finance and delivery.

Managed competition proposals ironically require more sophisticated regulation than so-called “regulatory plans.” Because they advocate a system of competing health plans, managed competition proposals must provide for

5. Adam Clymer, *Hype About Health*, N.Y. TIMES, Feb. 5, 1994, at A8.

6. See Theodore R. Marmor & Michael S. Barr, *Making Sense of the Health Care Debate*, 10 YALE L. & POL’Y REV. 228, 253-54 (1992). This confusion is highlighted as well in CONSUMER REPORTS, HOW TO RESOLVE THE HEALTH CARE CRISIS: AFFORDABLE PROTECTION FOR ALL AMERICANS 197-99 (1992).

regulatory regimes to guard against the market incentives that insurers would have under these plans to seek out healthier patients and shift costs. The problem is that health insurers are remarkably resourceful in finding new methods to achieve the "risk selection" of healthier clients. Any regulatory regime would be hard pressed to keep up with the efforts of health insurers to adapt their plans to discourage enrollment of high cost patients.⁷

Regulation versus competition is thus an enormously misleading dichotomy. But it is just one of the many sources of distortion in the healthcare reform debate. Simple-minded history is another.

C. *Misreading History*

The reform movement of the 1990s hardly represents the first effort in American history to enact universal health insurance. Comprehensive healthcare reform was considered in the Progressive Era, during the New Deal, under President Truman, and most recently during the early 1970s. In each era reformers believed universal health insurance was imminent, only to be disappointed when it did not come to pass.⁸

Interpretations of past healthcare reform efforts are crucial because they shape the present reform campaign. There are a number of similarities between the healthcare reform movement of the 1990s and previous reform movements. Now, as earlier, entrenched interests try to block reform by manipulating our deepest fears to protect their interests. Now, as in the 1970s, there is a consensus that reform is needed but widespread disagreement among reformers about what precisely should be done. These divisions once again threaten to deadlock the legislative process.

The similarities between contemporary reform efforts and past reform efforts can be overdrawn. The politics of healthcare reform have changed. First, problems in the American medical system have reached the middle class. The spiral of rising costs, employer cutbacks of health benefits, and the exclusion of individuals with pre-existing medical conditions have caused concern in the middle class about health security. Universal health insurance is no longer regarded primarily as an egalitarian goal; many see it as essential to protecting Americans who have insurance coverage but feel threatened by current trends.

Second, while the healthcare industry hardly qualifies as an avid supporter of reform, its opposition to universal health insurance is not as united as it was in past reform debates. Many organizations representing physicians and health

7. See James Morone, *The Ironic Flaw in Health Care Competition: The Politics of Markets*, in *COMPETITIVE APPROACHES TO HEALTH CARE REFORM* 217 (Richard J. Amould et al. eds., 1993).

8. For accounts of the history of American health reform efforts, see RASHI FEIN, *MEDICAL CARE, MEDICAL COSTS: THE SEARCH FOR A HEALTH INSURANCE POLICY* (1986); THEODORE R. MARMOR, *THE POLITICS OF MEDICARE* (1973); RONALD L. NUMBERS, *ALMOST PERSUADED: AMERICAN PHYSICIANS AND COMPULSORY HEALTH INSURANCE, 1912-1920* (1978); PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982).

insurance firms have endorsed the goal of universal health insurance. To be sure, many of these groups continue to resist proposals that impinge on their financial or professional interests. But it is nonetheless noteworthy that the current debate is less about whether universal coverage is a legitimate policy goal than about what kind of universal coverage should be enacted.

Finally, in previous reform debates, opponents employed symbolism that has since lost its effect. Past opponents of universal insurance successfully played on anticommunist sentiment by warning that universal health insurance would be tantamount to “socialized medicine.” The end of the Cold War, however, has dissipated the national concern with communism and diminished the stigma of associating national health insurance with socialism. George Bush’s 1992 campaign remarks forecasting that the federal government would act in healthcare “with the compassion of the KGB” seemed out of place and worn.⁹ If the lessons of past healthcare reform efforts are to be properly applied, and the possibilities for contemporary reform correctly understood, the changed character of American healthcare politics must be recognized.

D. Another Dichotomy That Misleads: Radical vs. Conservative Reform Plans

According to the conventional wisdom, a single-payer plan for national health insurance proposes changes that are too radical to be politically feasible, while managed competition is sufficiently conservative in its alteration of the current system to be a leading option for reform. This presumption distorts the reform debate.

In fact, the conventional wisdom may be exactly backward. Proposals that would adapt Canada’s model of universal health insurance to the United States could just as legitimately be considered conservative; the Canadian model, after all, requires little change in how physicians and hospitals deliver medical care, and how patients receive it. Moreover, managed competition plans are rightly regarded as radical for the extent of delivery adjustments they require.

Proposed reforms modeled on the Canadian experience—including most so-called single-payer plans—do not propose to change the nation’s system of delivering medical services. Patients would choose physicians as they do now; physician practice patterns would not be disturbed; existing institutions would be retained. What would change under such systems is the source of insurance funds and the system of payment. Single-payer plans would transform insurance provision but not current patterns of medical care.

Managed competition plans, on the other hand, aim to alter the delivery and organization of care in radical ways. Patients would face strong incentives

9. For a pessimistic assessment of how little has changed in American health politics and the troubled prospects for successful reform, see Robert B. Hackey, *The Illogic of Health Care Reform: Policy Dilemmas for the 1990s*, 26 *POLITY* 233 (1993).

to join prepaid health plans, doctors would be pressured to join competing plans, and new institutions to deliver care would be energetically created. Thus, in terms of the delivery of medical care, Canadian-style health insurance is more conservative than managed competition.

If the issue is how much a plan would change the delivery of healthcare in the United States, we have mistakenly applied a label of "too radical" to a plan that does not seek to alter significantly medical practice. Whether conservatism about delivery reform is wise is quite a different issue from which type of reform is conservative.

E. *The Failure to Learn from Others*

The United States is the only industrial democracy that fails to guarantee universal health insurance coverage to its citizens. There is no shortage of other nations—Australia, Canada, Germany, and Japan, to name a few—that have achieved universal coverage and, comparatively speaking, the control of costs. When other nations achieve what the United States would like to achieve, it makes good sense to look beyond our borders.

Despite the widespread availability of foreign models, the American reform debate has largely distorted international experience. That debate has consisted mainly of unreflective repetition of myths about the alleged shortcomings of other models, rather than thoughtful analysis of what lessons should be drawn from the performance of these models in other nations.

The American failure to learn from others is illustrated most graphically by the treatment of proposals that favor the adaptation of the Canadian model of national health insurance to the United States. The Canadian program provides universal coverage of comprehensive medical services. It combines reasonably high quality medical care with low administrative costs and enjoys substantial popularity with Canadians. It does so while keeping total costs at lower levels than the United States has experienced over the past two decades. Not surprisingly, then, the Canadian model has intermittently emerged as a popular alternative with healthcare reformers in the United States. Canadian-style national health insurance, or single-payer reform as it is frequently called, has been endorsed by physicians, consumer groups, and academic specialists in healthcare. By 1994, nearly 100 members of the United States Congress had endorsed single-payer proposals, and the supporters included prominent lawmakers on committees with jurisdiction over healthcare reform. Moreover, opinion surveys have consistently demonstrated public receptivity to reform proposals modeled on the Canadian system.¹⁰

10. For a more extensive treatment of the place of the Canadian model in the American health care debate, see Theodore R. Marmor, *Health Care Reform in the United States: Patterns of Fact and Fiction in the Use of Canadian Experience*, 23 AM. REV. CAN. STUD. 47 (1993). For a discussion of how the

Nevertheless, Americans have been showered with commentary, arguing that Canada is “too different” from the United States to provide useable lessons for healthcare reform. This misguided notion has narrowed the American debate and foreclosed, for many, an important opportunity for international learning.

Arguments that Canada is too different from the United States to serve as a useful model generally assume two different forms: cultural and institutional. Cultural arguments emphasize differences in beliefs and values between the United States and Canada.¹¹ Canadians, it is claimed, respect government more than Americans, and are committed to peace, order, and good government. Americans, on the other hand, are alleged to prefer the individualistic pursuit of happiness.

This account neglects the obvious cultural similarities shared by Canada and the United States: the English language, similar political roots, diverse populations, increasingly integrated economies, and constitutional federalism. Moreover, until Canada consolidated its national health insurance system in 1971, the American and Canadian medical systems were nearly identical. If there is any country in the world from which the United States can learn, it is Canada.

A second common objection to drawing lessons from Canada is based upon institutional differences between Canada and the United States. Canada’s national health insurance system operates within the institutional framework of parliamentary government; the American political system, by contrast, is a separation of powers regime. The implication is that even if the Canadian model is worth emulating, the distinctiveness of Canada’s political institutions prevent the adoption of a similar model in the United States.

It is clear that American political institutions are different from those of Canada. Less clear is what this difference has to do with healthcare policy. There is simply no compelling logic to the claim that American political institutions cannot sustain national health insurance.¹²

The argument that the United States is too different from Canada to learn from its northern neighbor rests on weak assumptions and faulty stereotypes. It is simply wrong to extrapolate from the presence of differences between the two countries the conclusion that Canada and the United States are not

Canadian model was distorted and largely discarded, see Thomas Hamburger & Theodore R. Marmor, *Dead on Arrival: Why Washington's Power Elites Won't Consider Single Payer Health Reform*, WASH. MONTHLY, Sept. 1993, at 27. For Canadian dismay about the characterization of their system, see R.G. Evans, *The Canadian Health-Care Financing and Delivery System: Its Experience and Lessons for Other Nations*, 10 YALE L. & POL'Y REV. 362 (1992).

11. SEYMOUR M. LIPSET, *CONTINENTAL DIVIDE: THE VALUES AND INSTITUTIONS OF THE UNITED STATES AND CANADA* (1990).

12. For a discussion of how the American debate has distorted the character and significance of institutional differences between Canada and the United States, see R. Kent Weaver, *The Governance Agenda in the United States*, in POLICY CHOICES: POLITICAL AGENDAS IN CANADA AND THE UNITED STATES 133 (Keith Banting et al. eds., 1991).

comparable or that lessons cannot be drawn from the Canadian experience. National provincialism, then, is another source of difficulty in the American debate.

F. *Failing to Learn from Our Own Experience*

It is a remarkable feature of the current struggle over healthcare reform that interpretations of the Medicare experience have been almost completely absent from the debate. Medicare, the broadest example we have of government health insurance in the United States, has received scant attention despite the fact that it provides health insurance to over 30 million elderly and disabled Americans and is overwhelmingly popular with beneficiaries.

Congressman Stark's proposed expansion of Medicare to the uninsured focused attention on the program for a brief time in early 1994. Yet the most prominent lessons drawn have been misleading. A prominent editorial diatribe against Congressman Stark's healthcare reform proposal, reflected ideological preconceptions, not reasoned analysis and evidence.¹³ The editorial's central claim was that because Medicare "has demonstrably failed to control costs and provide first-rate care" to elderly Americans, the program does not deserve an expanded role in healthcare reform.

The factual premises of this argument are simply mistaken. Medicare's costs, as recent scholarship has shown, have increased less rapidly over the past decade than average medical costs.¹⁴ This is true whether one measures Medicare's total expenditures per year or its per capita expenditures. And since the elderly population is growing—and on average uses more services than other age groups—this comparative performance is noteworthy. It is true that Medicare's expenditures grew quickly in the late 1960s and in the 1970s, but that was before government officials made cost control in Medicare a priority. The ratio of per capita Medicare benefits to average per capita spending on health in the United States increased from .95 in 1975 to 1.58 in 1985. But from 1985 through 1991, that ratio fell steadily to 1.38.¹⁵

Second, the contention that Medicare has produced poor quality care is groundless. While Medicare does have its share of difficulties, the program has not caused whatever quality problems plague American medicine. There is considerable variation in the quality of care the elderly receive, as is the case with American medical care generally. Medicare pays for good care and bad, because Congress has determined that it could not tell the difference at a price worth paying. Medicare does not micromanage the care it finances. Its

13. *Mr. Stark's Race Backward*, N.Y. TIMES, Mar. 10, 1994, at A24.

14. MARILYN MOON, *MEDICARE: NOW AND IN THE FUTURE* (1993).

15. *Id.* at 19.

administrative costs are far below those of managed care plans (only 3% of outlays compared to 10-15% for private insurers). This is one of the bases for Congressman Stark's embrace of Medicare as a reform model. No reputable analysis of American medical services would support the contention that Medicare has produced poor quality care, although it may have paid for some of it.

Medicare is represented as a "dismayingly backward looking" model of reform. Some commentators are sure that "a better way to achieve high-quality, affordable healthcare is the creation of integrated networks of doctors and hospitals that are paid a fixed annual fee for taking care of enrollees."¹⁶ This argument is raw assertion and wishful thinking combined. The claim that the Medicare experience demonstrates the unworkability of reform based on public health insurance is not supportable. Indeed, by most measures, the Medicare story is one of success.

Why has Medicare received short shrift in the current debate and, when discussed, been the subject of such misleading criticism? The same conventional wisdom that ruled out Canadian-style health insurance as an option relegated Medicare to obscurity in the healthcare reform debate. The irony is that the anti-government stereotypes which pushed Medicare to the periphery of the reform debate prevented serious examination of a program that would have demonstrated the distortions of these stereotypes. The failure to learn from Medicare represents elements of both national amnesia and antigovernment propaganda.

G. *Imbalanced Choices*

Confusing theoretical versions of reform with operational models—or confusing an idealized past with the present—constitutes an additional source of distortion. For example, one commentator has charged the Clinton plan with pushing American healthcare towards a brave new world of bureaucratic medicine, administrative intrusion on physicians, and restriction on patient choice.¹⁷ Americans should reject the Clinton plan, according to this argument, if they want to avoid the dismantling of what is valued in American medicine.

The problem with this grim vision is that the brave new world feared already largely exists. Quite apart from the Clinton plan, administrative review of physician decisionmaking by insurers has grown enormously in the last decade. Some seventy percent of Americans with health insurance are in plans loosely termed "managed care." Employers are rapidly moving to restrict their employees' choice of physicians. The Clinton plan did not create these

16. *Mr. Stark's Race Backward*, *supra* note 13, at A24.

17. Elizabeth McCaughey, *No Exit: What the Clinton Plan Will Do For You*, NEW REPUBLIC, Feb. 7, 1994, at 21.

phenomena; by removing the choice of insurance coverage from employers and allowing patients to select plans through a health alliance, the Clinton goal is to enhance choice.¹⁸ Commentators have a tendency to mislead by misrepresenting the current medical system as unobtrusive fee for service care, a system that has largely vanished from America.¹⁹

Conclusion

This Essay hardly exhausts the misleading and confusing features of the American health reform debate.²⁰ The persistent search for panaceas turns attention away from options that are both feasible and desirable.²¹ Marketing labels—such as “managed competition,” “single-payer,” “health security”—delude more than they clarify.²²

This Essay has emphasized three patterns of linguistic distortion: language that confuses (e.g., opaque marketing labels), language that misleads (e.g., false dichotomies), and language that evokes fear (e.g., antigovernment diatribes). As the debate over health reform continues, we can expect the language of fear to be even more prominent than the language of confusion and distortion. The danger posed by linguistic distortion is not simply muddled public debate. Forging a workable and acceptable reform of American medical care will require public support. Yet that support will not arise if the problems are ill-defined, the options misdescribed, and the issues surrounding implementation ignored or distorted.

18. For an excellent analysis of issues surrounding the Clinton plan's health alliances and patient choice, see Paul Starr, *Alliances for Progress*, N.Y. TIMES, Mar. 6, 1994, at D15.

19. For a rebuttal to the assertion that the current medical system consists of unobtrusive fee for service care, see Theodore R. Marmor & Jerry L. Mashaw, *Cassandra's Law*, NEW REPUBLIC, Feb. 14, 1994, at 20.

20. The effort to estimate the costs of reform into the twenty-first century represents a quixotic yearning for specificity and a fantasy that confuses forecasts (feasible but of limited usefulness) with longterm predictions (which are impossible). See THEODORE R. MARMOR ET AL., AMERICA'S MISUNDERSTOOD WELFARE STATE 216-19 (1990). The fear of rationing has twisted the discussion of sensible and senseless limits on the resources available for medical care. *But see* Symposium, *The Law and Policy of Health Care Rationing: Models and Accountability*, 140 U. PA. L. REV. 1505 (1992).

21. For a discussion of panaceas, see Marmor & Barr, *supra* note 6.

22. See Mark Goldberg & Theodore Marmor, *And What the Experts Expect*, WASH. POST, Feb. 14, 1993, at C3.