Health Policy and White Nationalism: Historical Lessons, Disruptive Populism, and Two Parties at a Crossroads

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Abstract The Trump administration's effort to repeal and replace the Affordable Care Act (ACA) broke with Republican health care policies that stretch back more than six decades to the early Eisenhower administration. While Republicans have always opposed Democratic plans, once in office they generally found creative, market-oriented ways to try to extend access to health care. This article summarizes the health policy legacy of past Republican administrations, contrasts it to the Trump administration's repeal and replace effort, and locates that effort in a larger political context: the rise of white nationalism. White nationalism erodes the social capital that fosters social welfare policies; it challenges the basic idea of a right to health care. White nationalism is an old urge that rises with a new twist in the Trump era: the political parties, which historically diffused conflicts about American identity, have for the first time become divided by ideology, by race, and by immigration status. As a result, racialism and nativism may be more difficult to contain, for the parties now amplify questions of national identity. Health policy debate has become connected to something more powerful and fundamental: the definition of America and Americans.

Keywords Affordable Care Act, white nationalism, political parties, repeal and replace, access to care

The Trump administration's efforts to repeal and replace the Affordable Health Act (ACA) broke with Republican health care policies that stretch back more than six decades to the early Eisenhower administration. While Republicans fiercely opposed Democratic plans, their behavior in power has been very different. Pressed by public opinion, they generally found creative, market-oriented ways to try to extend access to health care. In

Journal of Health Politics, Policy and Law, Vol. 43, No. 4, August 2018
DOI 10.1215/03616878-6527983

contrast, the Trump administration's proposals—though not its rhetoric—aimed to roll back the health care coverage of between 20 million and 32 million people and, in the process, raised the fundamental question of whether there is any right to health care that the government ought to guarantee. This article summarizes the health policy legacy of past Republican administrations, contrasts it to the repeal and replace effort, and locates that effort in a larger political context: the rise of white nationalism.

White nationalism is often overlooked in the rich history of American ideas and movements, but it has a long provenance and rests on the claim that white people rightly own a special social and economic status in the American regime (Morone, forthcoming). White nationalism tends to rise up during periods of social upheaval, such as the debate over slavery in the 1850s or the civil rights debate a century later. Today, the recrudescence of white nationalism—and hostility to people of color, immigrants, and internationalism—is exacerbated by two unprecedented factors.

First, the political parties traditionally deflected politics away from issues of national identity because each embraced very broad coalitions. Beginning in the Richard Nixon years (1969–74), the Republican Party became predominantly a white person's party; people of color increasingly gravitated (or were pushed) toward the Democrats, where they were joined by a minority of the white population. There is no precedent, in American history, for parties divided by both race and immigration in this way (Morone, forthcoming). The nation's deepest historical anxieties are, for the first time, projected onto party politics. As a result, parties now amplify rather than muffle the explosive questions of national identity and Americanism.

Second, the Census Bureau estimates that the United States is hurtling toward becoming majority minority. While that may oversimplify matters (because the Census Bureau uses a "one drop of blood rule" to tag someone a "minority"; Alba 2016), there is no denying that the face of the nation is changing. Nothing symbolized that change like President Obama. Nothing gives voice to the fretful backlash like President Trump.

The idea of whites in the minority, perhaps exacerbated by declining social mobility, has generated deep political anxieties. The national debate—about health care coverage, about the nature of political parties, about the future of the nation itself—touches the powerful question: who are we? Raising the issue of identity has important implications for health care policy. Debates about the communal boundaries, about us versus them, erode the social capital that fosters social welfare policies. Today they challenge ideas that long seemed settled, such as whether or not there is a right to basic health care.

Each party confronts basic decisions about its health policy. Republicans, who face the brunt of the white nationalist pressure from elements in their own party base, must choose between continued efforts to underwrite health care coverage in Republican ways (the moderates' position) or a "hell no" rejection of the entire idea that government has a role in promoting access to health care (as some conservatives insist). At the same time, the Trump ascension highlights the choice facing the Democratic Party, pulled between its own populist base, focused on economic inequality and a universal right to health care, and the remnants of a more centrist, soft neoliberalism that seeks more practical, incremental change.

Repeal and Replace in Context

The Donald Trump administration opened with a seven-month legislative campaign to repeal and replace the Affordable Care Act of 2010 (ACA). The legislation, which fell just two Senate votes short, reveals the Republican Party at a major crossroads in health care policy. Republicans have always been nimble and ferocious in opposing Democratic health plans. However, once in office, every modern Republican administration has tried to extend health care coverage while bending it toward market principles. Republicans in power have constructed a series of creative proposals—many of them later refurbished by Democrats and in turn fiercely denounced by the next generation of Republicans (Blumenthal and Morone 2009).

The Trump administration, along with congressional leaders, introduced something almost unprecedented: a major rollback of health insurance coverage. On May 4, 2017, the White House managed to goad the House Republicans into approving legislation that slashed the ACA and turned Medicaid from an entitlement program into a block grant. The plan would shrink Medicaid by $880 billion (roughly 25 percent of its budget) and an estimated 14 million beneficiaries over ten years (though that Congressional Budget Office [CBO] estimate was for a more moderate version of the House plan). It would eliminate the ACA individual mandate, likely subverting the ACA insurance exchanges; permit states to opt out of insurance regulations, such as those that restrict policies with preexisting conditions; and stop federal funding for Planned Parenthood. The legislation squeaked through by two votes, 217 to 213. Every Democrat and twenty mostly moderate Republicans voted against. The May 4, 2017, *New York Times* editorial page summarized the reaction from the political left and center: "The Trumpcare Disaster."

In the Senate, the Republican leadership bypassed the committee process and released a bill that, according to the CBO, would reduce health insurance coverage by 22 million people by 2026 (CBO 2017d). When that proposal failed to secure enough ayes, the Republicans tried three different approaches: a repeal only bill (32 million lose health insurance; CBO 2017b), a "skinny" repeal bill (16 million fewer insured; CBO 2017c, table 3), and in September the Graham-Cassidy-Heller-Johnson bill (the CBO did not have time to construct an estimate and noted only that "the number of people with comprehensive health insurance . . . would be reduced by millions"; CBO, 2017d). The last two tries each fell one vote short (51–49, with Vice President Mike Pence in the chamber to break a tie).

In muscling the legislation through the House and almost winning the Senate, the Republicans tore up the normal political playbook. They pushed aside almost all the health care stakeholders—physicians, hospitals, AARP, consumer groups, Republican governors, and the list goes on. Polls consistently registered roughly two-thirds disapproval. Meanwhile, late-night talk show host Jimmy Kimmel described his baby's dangerous heart condition and tearfully begged Congress not to gut protections from preexisting conditions; his moving monologue went viral—to no visible effect in Congress. The traditional political vectors appeared to be offset by two groups who were "furious" for repeal: strong Trump supporters, especially in the South, and major donors (Hulse 2017). A new normal appears to have emerged: the risk of being "primaried"—losing a seat to a more ardent party member in a very-low-turnout primary election—has replaced the old politics of tacking to the center. Unlimited campaign money from highly politicized donors reinforces the trend (Mayer 2016).

Conventional wisdom holds that it is extremely difficult to take away health benefits once they are in place. Even Ronald Reagan, who burst onto the national political scene with a powerful denunciation of the Kennedy administration's Medicare proposals, ended up sponsoring what was then the largest expansion of the program in its twenty-five-year history. President Reagan, who was responding to a tough midterm in which Democrats recaptured the Senate (in 1986), reflected the rule. From Dwight Eisenhower (1953–61) to George W. Bush (2001–09), every modern Republican president felt the heat of public opinion and sponsored ideas to expand coverage while, at the same time, turning health care policy toward Republican principles: limit large government programs, introduce markets and competition, rely on private insurers, and reduce or eliminate cross-subsidies between rich and poor, young and old, tax payers and program beneficiaries. Now, the Trump administration and all but a handful

of Republicans appeared to be breaking with the precedents. Their efforts raised the fundamental questions that lie under most government health care programs: what do Americans owe one another?—Should we guarantee Americans a right to at least basic, emergency care?

During the ACA debate, a rarely expressed argument arose: the idea that there is no right to even basic health care. Arguing before the Supreme Court in *National Federation of Independent Business v. Sebelius* (567 U.S. 519 [2012]), Solicitor General Donald Verrilli defended the ACA mandate to buy health insurance "because of the social norms to which we've obligated ourselves so that people get health care" even if they cannot pay. Note the wording: Verrilli was not referring to laws that forbid dumping but the basic "social norm" that everyone gets at least the basics, which the rest of us will pay for. Scalia objected: "Well, don't obligate yourself to that. You could do it." Paul Starr (2013: 282–83) explicates Scalia's thinking: "Leave the sick and injured without treatment if they couldn't pay for it." Scalia was expressing something few policy makers had said out loud: there is no right—government has no business providing coverage or meddling with private health care markets regardless of need; even more, we're not obligated by social norms to cross-subsidize those in need. In the Trump era, this no-government perspective appears to be gaining traction. In both the House and Senate, some conservatives argued that the leadership bills had left too much government intervention intact. What has fueled the spread of this no-government, no-social-norm health policy?

A historical and comparative perspective reveals how every administration and its plans are influenced by the broader political environment. Health policy today, with its intense animosity to government and what might be termed health coverage nihilism, reflects two formidable social forces that have in the past often been quietly interlinked: conservative, antigovernment views and the resurgence of white nationalism—finally given its voice and a certain measure of legitimacy by President Trump.

"Few democracies," wrote political scientists Robert Mickey, Steven Levitsky, and Lucan Ahmad Way (2017: 29), "have survived transitions in which historically dominant ethnic groups lose their majority status." Of course, few rich democracies have ever faced such a change. But the United States has experienced one sobering precedent. After the Civil War, Republicans tried to build a new southern society with a place in it for the former slaves. Local authorities fought even hints of racial change by constructing a bluntly authoritarian regime that stripped both blacks and poor whites of the right to vote. When caught in the glare of international

publicity during the civil rights movement, segregationists took a page from the proslavery argument of antebellum America: transmute racial hostility (unacceptable) into a fierce resistance to federal government in the name of state's rights and individual freedom (perfectly respectable and a good way to win allies). Today's health care policy debate may be reflecting something ominous: as Mickey, Levitsky, and Way (2017: 26) put it, "The South's racial politics has gone national."

Republican Health Policy: Expanding Coverage Their Own Way

Republicans have always been ferocious in opposition. The Truman administration and its Democratic allies in Congress were stunned by the fury (and the verve) of the mobilization against their national health insurance, and this in an era when the proposal did not have a ghost of a chance. The Southern Democrats, who dominated the key committees, would not even sanction hearings. The Democrats stripped the plan of any financing provisions to get around Walter George (D-GA), the implacable chair of the Senate Finance Committee. The same (always unexpected, always ferocious) outcry rose up to greet each new Democratic idea—national health insurance, Medicare, the ACA (Blumenthal and Morone 2009; Morone 2016).

The Republicans in power, however, took an entirely different approach. Some presidents eagerly grappled with health care policy (e.g., Richard Nixon). Others wanted nothing to do with it (George H. W. Bush). Regardless, the pressures to solve the problems of health care pushed every administration to compose a plan, and each did so on Republican terrain: maximize markets, minimize government. Of course, the larger political setting always shaped Republican thinking about health reform. That larger setting can be divided in three very different eras, each with their own assumptions, coalitions, prospects, snares, and limits: The New Deal era, the Reagan era, and, now, perhaps, something quite different from health policy in the past—we might provisionally call it the Trump era.

The New Deal Era

The Republicans—a minority party between 1930 and the 1970s—found creative ways to limit the New Deal's big government influence on American health care policy. In the process, they were often more inventive and successful than many of the Democratic administrations.

President Dwight Eisenhower came to office after five consecutive Democratic terms (1933–53) by defeating a more conservative Republican faction, led by the dour Robert Taft (R-OH), intent on rolling back the New Deal. Instead, Eisenhower struggled to bend the formidable welfare state in a Republican direction. For health care, that meant using government carrots to move the nation away from public health care programs and toward private insurance coverage.

Eisenhower's second State of the Union message signaled the unexpected Republican health agenda. "The federal government can do many helpful things," he said, "and still carefully avoid the socialization of medicine" (Blumenthal and Morone 2009: 111). His administration proposed government-sponsored reinsurance designed to encourage health insurance companies to accept new risks. And, most important by far, the administration formalized and expanded the tax deduction for health insurance premiums paid by employers or employees. That tax break had been put into place during World War II, when employee health insurance was a relatively new and untested idea and the revenue service was uncertain how to treat it. The Revenue Act of 1954, passed over the discomfort of congressional deficit hawks, locked the employer-based health coverage into place—and was explicitly designed to counter Democratic calls for government-sponsored health insurance (Blumenthal and Morone 2009: chap 3).

Eisenhower set the Republican pattern. He was always wary of government power and spending. However, he consistently looked for ways to "do helpful things" to expand private insurance. He balanced the tension between resisting government and promoting coverage. In this balancing act, perhaps he reflected the larger American political economy: an era of big government and a powerful welfare state intermittently racked by Senator Joe McCarthy and the echoes of the anticommunist red scares of the early 1950s.

The next Republican president, Richard Nixon (1969–74), was the first to take office after Medicare and Medicaid had been implemented. The Nixon administration did not challenge the programs but instead transformed the debates about next steps. Democrats, led by Senator Ted Kennedy (D-MA), continued to press for a public national health insurance system—they had always seen Medicare as the first installment. Nixon rewrote the idea. "Zero in on what is wrong," said Nixon. But successful reformers in every nation were always "very careful not to destroy more than they constructed" (White House Domestic Council 1970). There should be no tearing down private health insurance. National health care

policy, thought Nixon, ought to simply fill in the gaps. For the Nixon administration, this meant three overarching innovations. First, rather than replace the employment-based system, work around it; Nixon was the first to mandate employer health insurance. Second, construct a new national program (Assisted Health Insurance) to replace Medicaid and fill in the gaps in coverage; people without employment-based coverage would have their own program. And, finally, render the system more efficient through competition between prepaid group practices.

Democrats might still pledge fealty to single-payer plans out on the hustings—Ted Kennedy famously, and reluctantly, rejected the Nixon proposal at the time (under strong pressure from union leaders). But every Democratic administration health care plan, Carter's, Clinton's, and Obama's—followed the Nixon formula and simply aimed to fill in the gaps around the existing private insurance system (Blumenthal and Morone 2009). Moreover, health maintenance organizations would also become a standard of future health policies, inspiring the Clinton health plan in 1993–94, the managed care revolution of the mid-1990s, and George W. Bush's Medicare Modernization Act. For the next forty years, Democratic and Republican administrations would propose variations of the Nixon administration proposal.

Below the surface, the old tension between Eisenhower and Taft was growing within the Republican Party. President Nixon himself was inspired by Benjamin Disraeli, the Tory prime minister who had been a major social reformer in late nineteenth-century Britain. "You know," said adviser Daniel Patrick Moynihan to President Nixon, "it is the Tory men with liberal policies who have enlarged Democracy." Nixon warmed to that comparison—and his health policy reflects the model (Lammers and Genovese 2000: 225; Blumenthal and Morone 2009). At the same time, another spirit was stirring in the party. "We have a serious problem developing on the Right," wrote presidential speechwriter Pat Buchanan. "The president [according to his critics] is adopting a liberal Democratic program . . . his proposals make him a more effective 'Presidential Liberal' than any Democrat could possibly be" (Blumenthal and Morone 2009: 218). When the administration's national health plan came before the Ways and Means Committee in 1974, it was the Republicans who supplied most of the nays and stopped the plan, which squeaked by with only a 16 to 15 vote—too small a margin to take to the House floor. The Republican coalition was already splitting between Nixon's Disraelis, pushing to reform health care along less liberal (or big government) lines than the Democrats, and the conservative base growing restive over what they were calling "President Liberal."

The Reagan Era

Looking backward, historians speculate that a distinct era in presidential politics coalesced at the start of the Reagan administration (1981–89) and appears to have run to the election of President Trump (Skowronek 1993, 2016). President Reagan tirelessly articulated the emerging political framework. First, as he flatly put it in his inaugural address, "government is the problem." The solution, he continued, lay in the private sector: chop taxes, cut spending, roll back regulations, shrink the federal government, let the entrepreneurs loose. Second, expose and end the vast network of cross-subsidies that the New Deal and Great Society had put into place across American society. Each individual and group should be responsible for itself. And, finally, what Reagan repeated more often than anything else was a soaring patriotism. As he wrote again and again in his diary, "You have to feel good about our country" (Reagan 2007: 11). This light vision, however, was one half of a Manichean perspective that turned everything into us versus them, patriots versus cynics, we win–they lose (Blumenthal and Morone 2009: chap. 8). A new coalition rose out of the South and Southwest and reorganized national politics around the ideas that Reagan effectively articulated; the new coalition drew together business interests, libertarians, and cultural and religious conservatives.

Despite the tectonic political shifts, Republican presidents continued to pursue health reform and tried to expand access to care. Of course, they pursued these goals in Republican ways, emphasizing competition and markets. Democratic administrations continued to borrow freely from the Republican playbook (though by the time Democrats adapted their ideas, Republicans had moved on and vigorously denounced Democratic efforts as socialism).

Reagan himself had first made a national reputation by eviscerating the Democrat's Medicare proposal as the path to socialism and "the end of freedom as we have known it in this country" (Blumenthal and Morone 2009: 288). However, from early in his administration he began calling for an expansion of Medicare to cover catastrophic costs and scribbled in his diary that he also wished he could get some additional health coverage "for the working stiff" (Blumenthal and Morone 2009: 310). When the Republicans lost control of the Senate in the 1986 midterms, Health and Human Services Secretary Otis Bowen proposed a Medicare Catastrophic Cost proposal that Reagan took to the Democratic Congress—over the opposition of every other member of the cabinet and most White House advisers. The internal Reagan administration memos are full of schemes to

try to talk the president out of his plan. Instead, the ensuing negotiations with congressional Democrats produced the largest expansion of Medicare to that date. Of course, the expansion came on Republican terms: there would be no cross-subsidy from young to old or from taxpayers to beneficiaries; the beneficiaries themselves would have to pay for their expanded coverage. Democrats reluctantly acquiesced to a budget-neutral entitlement—an oxymoron in the old liberal lexicon (Blumenthal and Morone 2009).

While Democrats and Republicans clashed almost continuously over health care, they shared considerable common ground that can roughly be described as neoliberalism. Republicans like Reagan, facing electoral pressures, continued to try to expand health care coverage. Democrats in office—both Bill Clinton and Barack Obama—proposed more ambitious efforts that generally drew on two different ideas: expanding the Great Society programs, especially Medicaid; and drawing on old Republican proposals that rested not just on government programs and regulations but also on competition, markets, and private health insurance.

George H. W. Bush (1989–93), who followed Reagan into the Oval Office, could not care less about health care—he practically filibustered his way through White House meetings on the subject, free associating about football and other irrelevant subjects. He stood by as a Congress led by Democrats quickly repealed the Reagan's Catastrophic program—subverted by the protests from seniors who had already purchased coverage in private markets and did not want to pay for it through their Medicare premiums. The conventional wisdom was clear: health care had burned the Republicans and was off their agenda for the foreseeable future. Then, in 1991, Democrat Harris Wofford made up a forty-point polling deficit and won an off-year Senate election in Pennsylvania by waving a copy of the Constitution and repeating the same rhetorical question: "If the Constitution guarantees criminals the right to a lawyer, shouldn't it guarantee working Americans their right to a doctor as well?" Wofford artfully avoided committing to any details, but the surprising result (he won by ten points) threw health care right back onto the agenda.

The Bush administration, reluctantly, turned to health care reform. The rightward motion in American national politics had turned Nixon's approach—mandating employer insurance—into a Democratic strategy that was no longer acceptable to Republicans. The Bush administration team, scrambling for a health care strategy, came up with many features that would eventually become mainstays of health care policy in both parties: applying industrial-quality management approaches to health care

delivery, relying on health information technology to empower health care consumers and to transform health care systems (very much part of the Obama-era approach), and finding ways to reform individual and small-group insurance markets (an idea that would eventually lead Governor Romney to his insurance mandate in Massachusetts, and from there to the ACA).

George W. Bush (2001–9) was more ambitious than his father about health care. His administration eagerly tried to deploy the promise of prescription drug coverage, Medicare Part D, as a hook to move Medicare from an old-style big government program into a market in which consumers could choose among competing private plans for their Medicare coverage. Although the Bush administration could not manage to get his ambitious modernization plan through the Republican Congress (only the prescription drug benefit would be sold by private companies), it introduced a creative way to think about markets and government programs.

In short, for the thirty years that followed Reagan's election, Republican administrations and their allies in Congress looked for market solutions to expand health care coverage—often overcoming skeptics from within the Republican ranks. Their enthusiasm for health reform never matched that of the Democrats—nowhere close. But, when they were in control, they did not disparage the Democratic goals: solve the problems of health care costs and coverage. Instead, they worked to do so by transforming (as well as extending) the old entitlement programs, by maximizing markets, and by minimizing the government's direct role. Each effort aimed to reduce the ranks of the uninsured and the gaps in coverage.

Republicans with a sharp political eye might have noticed something disconcerting running across all their efforts. The electorate never gave them credit for their health care achievements. George W. Bush, for example, sponsored the single largest benefits expansions in Medicare's history—and a limited but serious experiment in bringing markets into the program. And yet, by the next midterm, the Democrats enjoyed their largest polling advantage, thirty points, on the question, "Which party do you trust most on health care issues?" (Blumenthal and Morone 2009: chap. 11).

The Great Republican "Hell No": Health Policy after Trump's Election

The first nine months of the Trump administration marked a dramatic break with every modern Republican presidency. In the past, each administration

won a more expansive health policy over the objection of an antigovernmental minority within the party. Now the majority shifted to the nays. The change may be related to the larger political environment. The Trump campaign fostered the rise of a populist, white nationalism that has grown into a potentially formidable independent force exerting pressure, in different ways, on both political parties.

Repeal and Replace

Republicans took control of the national government in 2017 and immediately challenged a standing health care program that had extended coverage to over 22 million Americans. In addition to rolling back the ACA, the congressional majority could not resist the opportunity to reach for a long-standing conservative goal and transform Medicaid from an entitlement program into a block grant.

As the repeal and replace proposal wended its way through the congressional gauntlet, leadership in each chamber was forced to negotiate with conservatives who were eager to further limit the government's health policy role. The House bill, as originally scored by the CBO, would push 24 million Americans out of health care coverage over its first ten years. That bill was rejected by the Freedom Caucus, which won a later iteration without any CBO estimates—though most neutral analysts predicted that the number would be higher. "Reducing insurance access," wrote Theresa Brown (2017) in the *New York Times*, "is not a bug in the plan. It's a feature." Or, to return to Justice Scalia: "Well don't obligate yourself to that"—forget the social obligation to care for those who can't pay. Moderates balked at the idea, won some face-saving concessions, and then acquiesced before enormous pressure.

The House had put something dramatic on the table. Jennifer Rubin, a conservative blogger for the *Washington Post*, put the question that the Freedom Caucus had raised in the House: "Are we as a society willing to say the federal government should not be guaranteeing coverage for just about everyone?" (Rubin 2017). The House answered loud and clear within the week: hell yes. The Senate came within a vote of matching them. As the final Senate effort—Graham-Cassidy-Heller-Johnson—fell just short, the authors pledged to continue the fight. Republican moderates in both chambers resisted the majority of their party and stuck to the party's traditional position: protect health care coverage and, where necessary, accept existing regulations (especially those protecting people with preexisting conditions) and government programs (especially Medicaid).

Some even spoke of insuring that the ACA marketplaces would continue to operate. But the traditional view came up against a powerful majority perspective: walk the national government away from responsibility over health care. President Trump belittled members who expressed concerns and some, such as Senator Dean Heller (R-NV), faced terrific pressure to side with the administration and the rising majority to their right.

Is "hell no" a viable long-term position for health care coverage? In the past, even the most recalcitrant administration (that would be the first President Bush) eventually felt the gravity of voter demands to extend coverage. That era may now be over, replaced with an opposition to government intervention into health care; the party's most intense base voters and its billionaire donors appear to be locked onto this attitude (Hulse 2017). On the other hand, time will tell if the effort to repeal and replace was an aberration. Perhaps a party that had not expected to win had not yet toggled from opposition mode. And they were hamstrung by a White House with little policy experience. In any case, the Republican coalition is at a crossroads, and health care policy, which the party chose as its first legislative test, will continue to be a key indicator of its future direction. Of course, no health policy is forged in a vacuum—it will have to account for, among other things, the rising white nationalism that confounds many Republican leaders in Congress.

White Nationalism and America First

Health policy always reflects the larger political context. Eisenhower, for example, operated in the shadow of the New Deal, an era of expansive government programs inflected by a red scare that both unified and divided American communities. The Reagan era introduced neoliberal premises that, in different ways, shaped both Republican and Democratic plans. It was Democratic President Bill Clinton who announced that the era of big government was over. Now, the election of Donald Trump appears to signal a new force (or, more accurately, a resurgent force) in American politics: an intensely populist reaction against immigration, people of color, and internationalism. A historical perspective can offer some hints about how the new setting may influence governance in general and the future of health policy in particular.

Throughout American history, racial issues checked government programs.[1] Former President John Quincy Adams (1842: 23), an irascible

1. The next five paragraphs are drawn from a book I am now writing. See Morone, forthcoming.

antislavery congressman from Massachusetts, put it this way: "Slavery stands aghast at the prospective promotion of general welfare," it "palsied" the arm of the nation. A coalition, ranging across both the North and the South, defended slavery and later Jim Crow by questioning the legitimacy of federal government action. Every policy proposal had to be negotiated against anxiety about the national government and its potential to upset racial relations (Katznelson 2013; Morone, forthcoming).

The clashing attitudes toward federal power were vividly illuminated when the North and South split in 1861. With the slave states gone, the Union Congress released a cascade of previously blocked national programs—land grant colleges, railroad bills, a homestead act, banking bills, a progressive income tax, and the first national currency. The Confederate Constitution, in contrast, carefully forbade its central government from engaging in any "internal improvements." Vice President Alexander Stephens, in a famous speech, explained the twin cornerstones of the fledgling Dixie: slavery for Africans, and no national projects under the guise of interstate commerce. Guarding racial hierarchy meant binding the central government (Morone, forthcoming).

The pattern persisted long after slavery ended. Men and women fighting to preserve segregation in the mid-twentieth century eventually learned that that raw racism provoked national backlash. In contrast, calling for liberty and bashing the government yielded allies. The segregationists who resisted integration in the southern cities like Atlanta began to find, as early as the 1940s, that the language of racism and segregation was far less effective and legitimate than the language of rights, freedom, and individualism, alongside attacks on active government. The battle for segregation in Atlanta turned the white majority there from segregationist Democrats to antigovernmental Republicans (Kruse 2005).

Immigration creates a similar racialized dynamic. "Large scale immigration," wrote Abrajano and Hajnal (2015: 4) "creates a sense of threat to white populations which flee to anti governmental policies—and move solidly into the Republican party—as the number of immigrants (and especially Latino immigrants) grow." Today's populist backlash, like the movement of the original populists more than a century ago, is especially powerful in rural areas. A fierce consciousness arises, summarizes Katherine Cramer (2016), that resents cities, resents the kind of people who live in them, and resents the kinds of programs and policies that those people get from the federal and state governments (see also Hochschild 2016).

The arguments have become especially salient as Donald Trump won the presidency amid a full-throated attack on immigrants and an embrace (or at least a refusal to criticize) ardent white nationalists and even neofascists. "Donald Trump heard something," mused House Speaker Paul Ryan after the election of 2016, "that no one else heard" (Reilly 2016). That something was as old as the republic: racial threat and status anxiety. Frederick Douglass (1994 [1845]: 80–81) captured it in his autobiography. While he was a slave he worked in a shipyard and got along fine with the white workers whom he assisted; however, when black freemen were hired on, the white workers threw down their tools, walked off the job, and forced the managers to turn out the newcomers. As Tocqueville (1969 [1835]: 343) reported, a kind of status anxiety made racial prejudice "stronger in the states that have abolished slavery than those where it still exists."

Now the status anxiety turns against government programs—and against the Democrats who sponsor them. Social scientists have long debated the centrality of the often implicit role that racialism played in building the Republican coalition. The twin passions of race and dread of government were independent yet historically linked (Klinker and Smith 1999; Smith 1997). Barry Goldwater eloquently preached free market liberty but did not say a word as segregationists clambered aboard. The powerful libertarian streak running through American politics from Goldwater through Reagan down to the present always seemed, somehow, to wink at the bigots. Of course, proper conservative demurred; after all, every coalition has its lunatic fringe.

Over time the racialist strain grew in intensity and then with the election of 2016 became explicit and unabashed. What had appeared to be fringe burst onto center stage, trumpeting racial animosity to a roaring base (Morone 2018). Its partisans blast the federal government not on libertarian grounds but for coddling a set of unworthy clients—black Americans, immigrants, the lazy, the other—who enjoy preferential treatment and lush government programs (Hochschild 2016; Gawande 2017). In health care, middle-class workers with shaky, high-premium, high-deductible health plans resent Medicaid recipients who are perceived to enjoy fuller, less expensive coverage; that resentment erodes any sense of shared community (Gawande 2017). Candidate Trump gave full voice to the white nationalist fears and hopes. His rallies and his rhetoric picture a rising tide of others, enjoying government privilege and usurping the place of real Americans.

There is, to be sure, a debate about the boundary between economic nationalism and white nationalism. The former emphasizes antiglobalism, anti-immigration, trade protection, and a truculent unilateralism, in contrast to an insistence on the primacy of white, native-born people. To what extent were Trump voters and the Trump movement motivated by declining economic mobility, rising inequality, and the other pressures on people with low educational attainment? Scholars will be parsing the coalition for years to come, but the evidence suggests that both white nationalism and economic nationalism are at play, overlapping on the issues of immigration and that anxieties about race, immigration, and white status play a very large part (Fowler, Medenica and Cohen 2017; Tesler 2016).

The Party Difference

Two changes make rising white nationalism especially sharp-edged today. First, the political parties have sorted themselves in an unprecedented way. It is often observed that conservatives and liberals once populated both political parties; in the past four decades, they have sorted themselves by party—few Democrats are now more conservative than the most liberal Republicans, and visa versa. However, there is another powerful sorting that has become intertwined with ideology: the parties are increasingly distinguished by perceived race. The Republicans garner a large majority of the white vote year after year, averaging roughly 60 percent in presidential elections since 1980; the Democrats gather most immigrants and people of color. To be sure, a white minority still turns out for Democrats, but the party derives much of its strength, growing every year, from people of color.

In contrast, politically liminal groups in the past always split between parties or party factions. In the very first contested election of 1800, for example, Federalists fiercely opposed immigrants (they passed three different Alien Acts to suppress their influence) but were far more generous to Africans; the Jeffersonians took just the opposite view (Morone 2016, forthcoming). During the New Deal, the Democratic Party always had to balance the southern segregationists and civil rights activists within its ranks; the Republicans covered a similar range, from urban liberals fighting corruption to the John Birch Society. Starting in the Nixon years, however, and accelerating over the last half century, the two parties became, for the first time, cleanly divided by race and immigration. Parties traditionally muffled battles over identity; now they amplify them.

Second, there is a widespread perception that the majority ethnic group—people who describe themselves as white natives—are becoming a minority. The US Census Bureau projects that by 2060 the white population will make up just 43 percent of the population—what might be called the Californication of the United States (Frey 2012). Many social scientists criticize these projections. Still, there is no question about the rising number of Americans born abroad and the changing demographics of America and Americans. We have been here before, many times. High immigration fosters anxiety for traditional values and ethnicities (Tichenor 2002; Zolberg 2008). As Representative Steve King (R-IA) put it, channeling many generations of anxious natives, we cannot restore "our civilization, with someone else's babies" (Polakow-Suransky 2017: 4). Precisely that fear fuels the rise of right-wing parties across Europe. Ironically, America First policies strengthen the links among immigrants, African Americans, and the Democratic Party (Prasad 2006). Indeed, with young people routinely marrying between races (Wang 2012), the very idea of whiteness may be under stress, aggravating the racial backlash that is disrupting American politics.

What has emerged is two very different coalitions evenly matched, at least for the present. A cosmopolitan, diverse, internationalist, urban-leaning coalition elected (and celebrated) Barack Obama. A whiter, older, anti-international, rural-leaning population resented Obama, was open to the fantasy that he was not an American, and rallied to an alternative coalition that includes white nationalists.

Of course, there is no way to know whether this spasm of white nationalism will pass swiftly from the political scene (the great nativist eruption of the 1850s lasted just one election cycle) or whether a populist Right, empowered by race-based parties, will grow into a fixture of American politics. Whatever its future, racial fears may well help explain the ferocity of the antigovernment, anti-Obamacare, anti-social-policy backlash. Racial tensions in the past repeatedly turned angrily against government policies, especially those perceived to aid marginal groups aligned with the other party. That racialist force, stirring again, may help explain the break with past Republican administrations. It is hard enough to get legislation through the political process when it is designed to help "us"; when the clients are painted as "them," the difficulties (and the passions) only grow more intense. Even a relatively small, but highly mobilized, highly motivated part of the base—with a sympathetic president—may lock "hell no" into the new administration's policy toward insuring Americans. And that, in turn, places new pressure on the Democrats.

The Democratic Crossroads: Populism, Inequality, and Health Care

The Democratic party faces its own health policy reckoning. Back when the Clinton administration prepared its health plan, in 1993, William Kristol wrote a now famous strategy memo. "The Clinton proposal," he wrote, is "a serious political threat to the Republican party. If it passes, it will revive the reputation of the . . . Democrats as the generous protector of middle class interests" (Kristol 1993). It took almost two decades, but the Democrats finally achieved a significant expansion like the one that Kristol warned about. Why did President Obama's ACA fail to live up to the Republican worries? On the contrary, the policy changed the politics in precisely the opposite way: the program mobilized opponents more than beneficiaries. Why?

One Democratic congressman with an Ivy League degree in public policy put his ACA problem this way: "When I saw the write up on that bill, I said how the hell am I going to message this thing?"[2] The intricate, economistic plan worked through multiple intermediaries: private health insurance plans operating through federal- and or state-designed exchanges. It was, in short, typical of an American social welfare policy in the neoliberal age that followed the Great Society. In many ways, it had more in common with the thinking of the Bush administration than with the Johnson or Nixon administrations. Different eras brought different assumptions, different politics, and different policies.

In the Reagan era, Democrats struggled to win their health and social welfare programs. Their strategy was to operate through what Mettler (2011) has called the submerged state: government benefits that, in contrast to programs like Medicare and Social Security, run barely visible below the political surface. Though they are easier to win, they are less likely to alter the political calculus by building a powerful constituency—precisely what Kristol had been worried about. Other social scientists offer nuanced variations of the same theme: "the hidden welfare state" (Howard 1997), "the shadow welfare state" (Gottschalk 2000), the "misunderstood welfare state" (Marmor, Mashaw, and Harvey 1990), "the welfare state nobody knows" (Howard 2006), and "the divided welfare state" (Hacker 2002). Few programs illustrated the political science wisdom quite like the ACA. Beneficiaries had no clear idea of what they would be getting. The administration itself did not help. Poll after poll revealed the same thing: the vast

2. Congressman Dan Maffei, private conversation, April 11, 2017.

majority of the beneficiaries expressed strong, often negative, views on the ACA without any idea that it might help them or their neighbors. For example, one Kaiser poll reported that 78 percent of the uninsured had no idea that the law might assist them in attaining health coverage (DiJulio, Firth, and Brodie 2015).

To be sure, the submerged or shadow welfare state goes far back, but the ACA experience offers a powerful political caution. The era of submerging complicated benefits in intricate market arrangements may be drawing to a close. The political dynamics have changed if the Republican party—in office and out—sticks to its no-coverage policy, inflected with racial and immigrant resentment. Soft neoliberalism will not build a lasting coalition, much less a political movement. It may be that only clear, visible policies, built around clear, visible political coalitions, are likely to bend politics toward social justice in the new era.

Rising, left-leaning populism challenges Democrats to do just that: squarely address inequalities and social injustice, dare to name the beneficiaries, and place the benefits themselves in the sunlight. Their progress within the Democratic Party can be gauged by the rise of Medicare for All. Last time Senator Bernie Sanders proposed the plan alone; in September 2017, fifteen Democratic senators stood by his side. That number, of course, reflects the Sanders revolution (as he called it) in the Democratic primaries. The number of Democrats sponsoring such progressive populism will rise (or fall) as the politicians continue to take Medicare for All to the voters (Morone 2017). Moderate plans will soon challenge the Sanders idea for control of the Democratic policy agenda. Their plans may need to break with the old centrist pattern—the era of borrowing creative ideas from the other party appears to be over.

Two additional features in the Democratic Party's health policy debate bear watching. First, repeal and replace raised that fundamental ethical question: is there a right to health care? If so, should Americans aspire to a generous minimum or an equal right for all? And, in either case, how should that right be guaranteed? This controversy, which had been central to health policy in the 1960s and then slipped from view, is back at the center of the debate. It has the potential to inject moralism into health care policy—a powerful theme running under many reform movements and much public health debate right back through American history (Morone 2003).

Second, American inequality has risen higher and steeper than most rich and many developing nations: the bottom 90 percent of American households control just 59 percent as much of the nation's wealth as the top 1 percent does, the median white family is ten times wealthier than the

median black family, and intergenerational economic mobility has stagnated (Bricker et al. 2017: 11, 13, 10; Morone and Fauquert 2015). Populism rising on the left challenged past American gilded ages, and it may eventually mount a sustained challenge to the current one. If it does, national health insurance is one of the few programs already on the agenda that directly addresses the issue. It lifts a significant financial burden from low- and middle-income families—their health insurance premiums—and shifts the weight to wealthier Americans by raising their taxes (Morone 2017).

Conclusion: Two Parties at Their Crossroads

The first nine months of the Trump administration featured a long and concerted effort to repeal and replace the ACA. A series of proposals would have pushed an estimated 20 million to 32 million Americans out of their health insurance coverage within a decade. The Republicans followed that up with a successful tax bill that ended the ACA mandate—a move with the potential to destabilize the health insurance marketplaces. The efforts represent a sharp break with the long, often creative Republican tradition of expanding coverage through private markets and competition. The larger political frame may help explain the difference: from early in the nineteenth century, white nationalism has been fiercely antigovernmental.

The Republican Party faces a formidable choice: walk away from insuring any right to health care, as Antonin Scalia proposed during oral arguments when the court first considered the ACA, or revert to the long tradition established by Dwight Eisenhower. Republican moderates can argue, at least as of this writing, that they successfully protected Medicaid from radical surgery. In any case, Republican health policy debates will take place in the context of a party divided and confronting a white nationalist backlash to immigration, internationalism, people of color, and social welfare programs.

The Democrats face their own fundamental choices. A long history of repurposing features of Republican health care now appears to have run its course. The party faces the challenge of rising from minority status in both national and state governments. The Democratic base—now the most racially and ethnically diverse political party in American history—is likely to demand visible solutions to the issues of inequality, social mobility, and social justice; moderates respond that the American system is geared for slower, more incremental change. For both Democrats and Republicans, health care reform lies in the eye of the political storm.

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Acknowledgments

Special thanks to Joe White for his commentary on the manuscript; to the participants in an outstanding workshop at Brown University who made wonderful comments; to David Blumenthal, who shared the primary research on which this article is partially based; and to an especially thoughtful anonymous reviewer.

References

Abrajano, Marisa, and Zoltan Hajnal. 2015. *White Backlash: Immigration, Race, and American Politics.* Princeton, NJ: Princeton University Press.

Adams, John Quincy. 1842. *Address of John Quincy Adams to His Constituents, of the Twelfth Congressional District at Braintree, September 17.* Boston: J. H. Eastburn.

Alba, Richard. 2016. "The Likely Persistence of a White Majority: How Census Bureau Statistics Have Misled Thinking about the American Future." *American Prospect.* prospect.org/article/likely-persistence-white-majority-0.

Blumenthal, David, and James Morone. 2009. *The Heart of Power: Health and Politics in the Oval Office.* Berkeley: University of California Press.

Bricker, Jesse, Lisa Dettling, Alice Henriques, Joanne Hsu, Lindsay Jacobs, Kevin Moore, Sarah Pack, John Sabelhaus, Jefferey Thompson, and Richard Windle. 2017. "Changes in U.S. Family Finances from 2013 to 2016: Evidence from the Survey of Consumer Finances." *Federal Reserve Bulletin* 103, no. 3. www.federalreserve.gov/publications/files/scf17.pdf.

Brown, Theresa. 2017. "The Real Problem with the A.H.C.A." *New York Times*, A31.

CBO (Congressional Budget Office). 2017a. H.R. 1628, Obamacare Repeal Reconciliation Act of 2017. July 19. Washington, DC: CBO.

CBO (Congressional Budget Office). 2017b. H.R. 1628, the Better Care Reconciliation Act of 2017: An Amendment in the Nature of a Substitute. July 20. Washington, DC: CBO. www.cbo.gov/publication/52941.

CBO (Congresional Budget Office). 2017c. Estimate of Direct Spending and Revenue Effects of H.R. 1628, the Healthcare Freedom Act of 2017, an Amendment in the

Nature of a Substitute [S.A. 667]. July 27. Washington, DC: CBO. www.cbo.gov/publication/52979.

CBO (Congressional Budget Office). 2017d. "Preliminary Analysis of Legislation That Would Replace Subsidies for Health Care with Block Grants." September 25. Washington, DC: CBO. www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/s.a.667.pdf.

Cramer, Katherine J. 2016. *The Politics of Resentment: Rural Consciousness in Chicago and the Rise of Scott Walker.* Chicago: University of Chicago.

DiJulio, Bianca, Jamie Firth, and Mollyann Brodie. 2015. *Kaiser Health Tracking Poll: March 2015.* Kaiser Family Foundation. www.kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-march-2015/.

Douglass, Frederick. 1994 [1845]. *Narrative of the Life of Frederick Douglass, an American Slave.* New York: Library of America.

Fowler, Mathew, Vladimer Medenica, and Cathy Cohen. 2017. "Why 41% of White Millennials Voted for Trump." *Washington Post*, December 15. www.washingtonpost.com/news/monkey-cage/wp/2017/12/15/racial-resentment-is-why-41-percent-of-white-millennials-voted-for-trump-in-2016/?utm_term=.41a1754799f2.

Frey, Willliam. 2012. "Census Projects New 'Majority Minority' Tipping Points." *Brookings.* December 13. www.brookings.edu/opinions/census-projects-new-majority-minority-tipping-points/.

Gawande, Atul. 2017. "Is Health Care a Right?" *New Yorker*, October 2. www.newyorker.com/magazine/2017/10/02/is-health-care-a-right.

Gottschalk, Marie. 2000. *The Shadow Welfare State: Labor, Business, and the Politics of Health Care in the United States.* Ithaca, NY: Cornell University Press.

Hacker, Jacob. 2002. *The Divided Welfare State: The Battle over Public and Private.* New York: Cambridge University Press.

Hochschild, Arlie Russell. 2016. *Strangers in Their Own Land: Anger and Mourning on the American Right.* New York: New Press.

Howard, Christopher. 1997. *The Hidden Welfare State: Tax Expenditure and Social Policy in the United States.* Princeton, NJ: Princeton University Press.

Howard, Christopher. 2006. *The Welfare State Nobody Knows: Debunking Myths about U.S. Social Policy.* Princeton, NJ: Princeton University Press.

Hulse, Carl. 2017. "Behind New Obama Care Repeal Vote: 'Furious GOP Donors.' " *New York Times*, September 23, A12.

Katznelson, Ira. 2013. *Fear Itself: The New Deal and the Origins of Our Time.* New York: Liverwright.

Klinker, Philip, and Rogers Smith. 1999. *The Unsteady March: The Rise and Decline of Racial Equality in America.* Chicago: University of Chicago Press.

Kristol, William. 1993. "Defeating President Clinton's Health Care Proposal." talkingpointsmemo.com/edblog/the-1993-kristol-memo-on-defeating-health-care-reform.

Kruse, Kevin. 2005. *White Flight: Atlanta and the Making of Modern Conservatism.* Princeton, NJ: Princeton University Press.

Lammers, William, and Michael Genovese. 2000. "The Presidency and the Domestic Policy: Comparing Presidential Styles from FDR to Clinton." Washington, DC: CQ Press.

Marmor, Theodore, Jerry Mashaw, and Phillip Harvey. 1990. *America's Misunderstood Welfare State.* New York: Basic Books.

Mayer, Jane. 2016. *Dark Money: The Hidden History of the Billionaires behind the Rise of the Radical Right.* New York: Doubleday.

Mettler, Suzanne. 2011. *The Submerged State: How Invisible Government Policies Undermine American Democracy*. Chicago: University of Chicago Press.

Mickey, Robert, Steven Levitsky, and Lucan Ahmad Way. 2017. "Is America Still Safe for Democracy? Why the US Is in Danger of Backsliding." *Foreign Affairs*, May/June, 20–29.

Morone, James A. 2003. *Hellfire Nation: The Politics of Sin in American History.* New Haven, CT: Yale University Press.

Morone, James A. 2016. "Partisan, Dysfunction, and Racial Fear: The New Normal in Health Care Policy?" *Journal of Health, Politics, Policy and Law* 41: 827–46.

Morone, James A. 2017. "How To Think about Medicare for All." *New England Journal of Medicine* 377: 2209–11.

Morone, James A. 2018. "How America Went Haywire." *Foreign Affairs*, March/April 2018. 47: 156–61.

Morone, James A. Forthcoming. *George Washington's Revenge: Two Hundred Years of Parties, Politics, and Race.* New York. Basic Books.

Morone, James A., and Elizabeth Fauquert. 2015. "The Medicare in American Political History: The Rise and Fall of Social Insurance." In *Medicare and Medicaid at Fifty*: *America's Entitlement Programs in the Age of Affordable Health Care*, edited by Keith Wailoo, Alan Cohen, Julian Zelizer, and David Colby, chap. 15. New York: Oxford University Press.

New York Times. 2017. "The Trumpcare Disaster." May 4, A30.

Polakow-Suransky, Sasha. 2017. "White Nationalism Is the Real Existential Threat to the West, Not Jihad." *New York Times Weekend Review*, October 15, 3–4.

Prasad, Shankar. 2006. *Red, Brown, and Blue: The Political Behavior of Asian Indian Americans.* PhD diss., Brown University.

Reagan, Ronald. 2007. *The Reagan Diaries.* New York: Harper.

Reilly, Katie. 2016. "Paul Ryan's Speech Calling Donald Trump's Victory 'the Most Incredible Political Feat'" *Time Magazine*, November 9. time.com/4564832/paul-ryan-speech-donald-trump-election/.

Rubin, Jennifer. 2017. "We're Finally Having the Health Care Debate We Need." *Washington Post*, May 3.

Skowronek, Stephen. 1993. *The Politics Presidents Make.* Cambridge, MA: Harvard University Press.

Skowronek, Stephen. 2016. "Barack Obama and the Promise of Transformational Leadership." Paper presented at the conference "L'heritage Obama: Tension et reconfigurations après la presidentielle," December 14, Paris, France.

Smith, Rogers. 1997. *Civic Ideals.* New Haven, CT: Yale University Press.

Starr, Paul. 2013. *Remedy and Reaction: The Peculiar American Struggle over Health Care Reform.* Rev. ed. New Haven, CT: Yale University Press.

Tesler, Michael. 2016. *Post Racial or Most Racial? Race and Politics in the Obama Era.* Chicago: University of Chicago Press.

Tichenor, Daniel. 2002. *Dividing Lines: The Politics of Immigration Control in America.* Princeton, NJ: Princeton University Press.

Tocqueville, Alexis de. 1969 [1835]. *Democracy in America*. New York: Harper.

Wang, Wendy. 2012. "The Rise of Intermarriage." Pew Research Center, February 6. www.pewsocialtrends.org/2012/02/16/the-rise-of-intermarriage/.

Zolberg, Aristede. 2008. *A Nation by Design: Immigration Policy in the Fashioning of America.* Cambridge, MA: Harvard University Press.