WHY DOESN'T THE UNITED STATES HAVE NATIONAL HEALTH INSURANCE? THE ROLE OF THE AMERICAN MEDICAL ASSOCIATION

Marcella Alsan
Harvard
NBER

Yousra Neberai
Harvard

Abstract

This study revisits a critical juncture in the development of national health insurance (NHI) in the United States in the post-World War II era. We investigate the role of the American Medical Association (AMA) which financed a campaign against NHI that was directed by the country's first political public relations firm, Whitaker & Baxter's *Campaigns, Inc.* The Campaign had two key components: (1) physician outreach to patients and civic organizations; and (2) mass advertising that tied private insurance to "freedom" and "the American way." We bring together archival data from several novel sources documenting Campaign strategy and intensity. We find a one standard deviation increase in Campaign exposure explains about 20% of the increase in private health insurance enrollment and a similar decline in public opinion support for legislation enacting NHI. We also find evidence that the Campaign influenced the narrative for how legislators described health insurance, leading Republicans to use speech similar to the Campaign. These findings suggest the rise of private health insurance in the U.S. was not solely due to wartime wage freezes, collective bargaining, or favorable tax treatment. Rather, it was also enabled by an interest group-financed Campaign that used ideology to influence the behavior and views of ordinary citizens.

Keywords: health insurance, interest groups, ideology, indirect lobbying, propaganda
JEL Codes: N32, N42, I14, I18, D72

The United States is almost alone among developed countries in lacking some governmentally mandated form of comprehensive health coverage for all or nearly all its population. Its divergent path became apparent primarily after World War II, when most other countries moved to adopt, restructure, or complete their schemes for protecting most of their population against expenses for medical care.

- **Institute of Medicine (1993, p.57)**

I   Introduction

America is exceptional on several margins, and one of the most prominent is in its financing and provision of health care. The U.S. relies heavily on the private sector for both functions and spends more on health care and its administration than any other country. Yet health outcomes are often worse on average with substantial variability (Chetty et al. 2016; Papanicolas, Woskie and Jha 2018). Americans also experience higher rates of uninsurance and higher medical debt than citizens of peer nations (Kluender et al. 2021; Himmelstein et al. 2022). This performance has heightened scrutiny of the current healthcare system, including by leading health economists (*e.g.*, Baicker, Chandra and Shepard 2023; Brown and Glied 2020; Case and Deaton 2020; Einav and Finkelstein 2023). Our project steps back from current debates and attempts to shed light on how the U.S. arrived at its present system.

Much of the economic literature concerning the rise of private health insurance in the U.S. focuses on inflationary pressure, collective bargaining, and preferential tax treatment.[1] In this paper we investigate an underappreciated potential factor: the role of the American Medical Association (AMA) – a lobbying group representing physicians – and their campaign against national health insurance (NHI) during the post-World War II period. In 1948, the AMA was facing a self-described "Armageddon moment" for several reasons: First, the National Health Service was launched in the United Kingdom that year, providing a road map to nationalizing medical services from a country sharing a common language and legal tradition; Second, the unexpected election of Harry Truman brought an ardent NHI supporter into power alongside a Democratic Congress; Last, a majority of informed voters in America favored the policy.

Facing what appeared to be imminent government intervention, the AMA hired Whitaker & Baxter (WB) to direct a nationwide marketing campaign. The husband-wife team of Clem Whitaker and Leone Baxter started the first political lobbying firm in the U.S., *Campaigns, Inc.*, in 1933. The firm was initially based out of California, the breeding ground for progressive ideas due to the state's referendum system, and according to Whitaker, also the "burial ground" due to their efforts (Whitaker and Baxter 1945, p.9). *Campaigns, Inc.* mastered *indirect lobbying* – the persuasion of ordinary citizens with simple, repetitive messages. The goals of the Campaign were laid out by Whitaker at an AMA meeting: "The immediate objective is the defeat of the Compulsory Health Insurance program in Congress...The long-term objective is to put a permanent stop to the agitation for Compulsory Health Insurance – and the most vital step in achieving that objective will be an all-out campaign to enroll the American people in Voluntary Health Insurance systems" (Whitaker and Baxter 1949, pp.3-4).

Political scientists, sociologists, and historians have theorized on the effects of the AMA-WB Campaign. Most notably, Jill Lepore's 2012 *New Yorker* article profiled the duo, asserting their AMA Campaign made

---

[1]There is an extensive literature on the relationship between U.S. tax policy and private health insurance. See Feldstein and Friedman (1977), Goda (2011), Gruber and Madrian (1997), Gruber and Poterba (1994), Gruber (2002), Gruber (2003), Gruber and Washington (2005), Gruber (2011), Holmer (1984), Madrian (1994), Selden (2009), Stavrunova and Yerokhin (2014), Thomasson (2003), and Thomasson (2002).

"sensible, popular, and urgently needed legislative reform into a bogeyman so scary that, even today, millions of Americans are still scared." To our knowledge, this paper provides the first in-depth description of key components of the AMA-WB Campaign and the first quantitative analysis of its effects.

The Campaign was comprised of two main components: Physician outreach and mass communications. Tens of thousands of AMA members were tasked with distributing pamphlets and endorsing private (*i.e.,* voluntary) health insurance, including medical plans run by physicians via local or state medical societies (*i.e.,* Blue Shield). Given their prominent role in society, AMA physicians were also asked to serve as liaisons to local civic organizations by urging them to pass resolutions against NHI and send them to their elected officials. Second, a massive newspaper ad buy was conducted in coordination with other industries to oppose NHI. Whitaker and Baxter marketing framed the push for NHI as ''un-American" and "socialized medicine" while associating the private option with "freedom" and the "American way." The Truman administration and its allies attempted a rebuttal, but faced charges of executive lobbying and were vastly outspent.

We investigate the Campaign's effects by compiling data new to this literature, including internal documents on Campaign strategy and operations recovered from the Whitaker & Baxter Archives in Sacramento, California, and resolutions against NHI found in the National Archives in Washington, D.C. (National Archives 1950*a*). These sources are combined with data we digitized from various years of the *American Medical Directory*, the *American Hospital Directory*, *N.W. Ayer & Son's Directory of Newspapers and Periodicals* and newly discovered Blue Cross insurance enrollment data from annual reports produced by the Council on Medical Service (American Medical Association 1942, 1950*a*; American Hospital Association 1948, 1950, 1952; Ayer 1949; Council on Medical Service 1946-1954). We use a combination of automated and manual techniques to analyze advertisements from historical newspapers and assess whether pollsters and policymakers adopted the language of the Campaign (Berinsky and Schickler 2020; Caughey et al. 2020; U.S. Congress 1947, 1948, 1949, 1950,1951; Shen et al. 2021).

Our primary estimation strategy compares enrollment in private health insurance (PHI) and individual citizens' views on NHI before and after the Campaign, across places that differed in its intensity. The Campaign occurred in a brief window relative to the frequency of most outcomes and pursued a common objective. Thus, to construct Campaign exposure, we combine mass advertising with physician outreach. The former is measured as per capita ads circulation scaled by local newspaper readership, and the latter is measured as per capita pamphlets scaled by local AMA membership. We sum these two components in our preferred specification, giving each equal weight as we cannot statistically reject equality between them, but test a variety of other combinations.[2] Rising incomes and unionization are other factors postulated to affect demand for private health insurance. Therefore, we include these factors as a core set of design controls and show that exposure is conditionally as-good-as-randomly assigned. We leverage spatial and temporal variation, allowing us to flexibly control for location and time fixed effects. The former accounts for static features such as frontier experience and the ethos of rugged individualism, while the latter captures secular trends such as advances in medical technology and knowledge.

Our identifying assumption is that, conditional on these historically motivated controls, there were no shocks to the evolution of potential outcomes correlated with our treatment nor selection into dosage groups. This aligns with the historical record – the Campaign was organized hastily in response to the shock of Truman's election leaving little time for planning. Further, the market for medical care insurance was far from saturated, creating broad scope for advertising and sales. Empirically, we show that Campaign

---

[2]For instance, we also estimate a multiplicative version and one without any scaling at all. See Section VI.1 and Online Appendix Table C7 for details.

exposure is not systematically correlated with observable features at the individual or state level nor do the dynamics of income or unionization change sharply with Campaign onset. We conduct various tests for pre-trends and adopt recent suggestions regarding continuous treatments.

We find that a one standard deviation increase in Campaign exposure explains about 20% of the increase in private health insurance enrollment in the post-Campaign period, or 14 million new enrollees, roughly the equivalent of increasing average income per capita at the time by about $100 (or seven percent).[3] Although public support for NHI was strong in the pre-Campaign period, this quickly eroded: A one standard deviation increase in AMA-WB Campaign exposure led to a six percentage point decline in popular support per survey wave. As a benchmark, this magnitude is approximately the same as the difference in NHI policy support between union and non-union households or one-third the racial gap. We also document a positive relationship between Campaign intensity and civic groups passing resolutions favoring PHI. These findings are robust to a battery of checks including controlling for additional covariates, adding trends in AMA or specialist physicians, using alternative samples or exposure variables, and adopting different types of estimators.

Three pieces of evidence suggest the Campaign also influenced the legislative process. First, we find resolutions passed by civic organizations indeed reached their policymaker target as they were listed in the *Congressional Record* and filed in the National Archives. Second, although NHI legislation was never brought to a vote, we detect Campaign influence on elected officials using text analysis. We find spikes in the frequency of the terms "health insurance" and the "American Medical Association" during the 81st Congress. We also find that Campaign intensity predicts similarity between Republican legislator speech and Campaign propaganda. Third, we examine physician donations to the Republican ticket of Eisenhower-Nixon. By 1952, the Republican platform had fully embraced the AMA's position. Our estimates suggest that AMA members were five times as likely to donate than non-AMA physicians, with a rate increasing in Campaign intensity.

A natural question is: Why did the U.S. fail to adopt NHI legislation in the subsequent decades? Although outside the scope of our empirical exercise, we offer several explanations for persistence. First, as formalized in the conceptual framework (Section III) policy support is shaped by voter beliefs regarding whether enactment will improve social welfare and whether the voter will personally benefit from the legislation. As middle-class Americans gained coverage for themselves and eventually their dependents through the private sector, a public option to defray medical costs became less of a priority. Second, and more generally, groups that benefit from the status quo seek to maintain it (Acemoglu, Egorov and Sonin 2021; Coate and Morris 1999; Freitas-Groff 2024). Today, Blue Cross Blue Shield, the American Medical Association, the American Hospital Association, and the pharmaceutical industry comprise four of the top ten direct federal lobbyists (Open Secrets 2023). Third, the Campaign tightly linked views on health insurance with ideology: Opposing a national system and enrolling in a privately-owned plan of your choice were hallmarks of a "free" and "self-reliant people" who eschewed socialism. In recent reform attempts under the Clinton and Obama administrations, ideological framing similar to the AMA-WB Campaign has been used.[4] These appeals to ideological identity have been linked to an increase in adverse selection and preventable deaths (Bursztyn et al. 2022; Galvani et al. 2022; Krugman 2012).

Our paper cuts across several literatures, but our largest contribution is to the economic history of the

---

[3]A one standard deviation increase in Campaign exposure corresponds to an increase in one pamphlet or ad in circulation per 10 people.

[4]For example, a *Wall Street Journal* editorial against Obamacare used the same quote attributed (apparently falsely) to Lenin: "Socialized medicine is the keystone to the arch of the socialist state" (Sommers 2013).

development of social insurance in the United States.[5] We offer the first causal evidence on the political role of the AMA in thwarting NHI at a pivotal moment in the country's history. We also contribute to the literature on advertising and lobbying. Regarding the former, causal estimates on the returns to advertising are difficult to obtain (see discussion in Lewis and Rao (2015)) and, according to a review by DellaVigna and Gentzkow (2010) results tend to be mixed. On the other hand, messaging on medical issues by physicians has been shown to be persuasive (Alsan, Garrick and Graziani 2019; Breza et al. 2021). We provide credible estimates of how a sustained national marketing Campaign combining trusted field agents with mass communications affected demand for a private good and policy views. Whitaker and Baxter coupled private insurance with ideas of free choice and individualism, tapping into deeply-rooted cultural values. In this sense, the tactics used relate to behavioral models of advertising such as Mullainathan, Schwartzstein and Shleifer (2008) whereby advertisers may create or tap into associations to impact people's beliefs about a product. Much of the empirical work on lobbying seeks to measure and identify the effects of relationships between policymakers and official lobbyists (Bertrand et al. 2020; Bombardini and Trebbi 2020; Snyder and Ting 2008). Our project builds on this important scholarship by highlighting indirect lobbying as an additional tool used by advocates to achieve policy aims. A large literature in health economics studies physician behavior in the context of clinical decision-making (*e.g.,* Chandra, Cutler and Song 2011; Ellis and McGuire 1986). We examine physician behavior outside the clinic and document how rents generated from supply-side constraints were used to shape the medical services market (Stigler 1971).

The paper proceeds as follows: Section II provides historical context and describes the Campaign in greater detail. Section III introduces a conceptual framework to formalize our hypotheses. Section IV describes the data. Section V outlines the empirical strategies. Section VI reports our findings, and the last section concludes.

II   Historical Background

This section describes the origins of private health care plans, the consolidation of medical power in the AMA, the operations of *Campaigns, Inc.*, and the AMA-WB Campaign against National Health Insurance.[6]

II.1   Origins of Private Health Insurance and Brief Legislative History

In the early 20th century, the major health-related insurance product available to Americans was life insurance. Groups such as the American Association for Labor Legislation (AALL) alongside members of the AMA began to design state-sponsored health insurance plans, but efforts were derailed by life insurance companies due to the inclusion of burial costs and the advent of World War I (Anderson 1968; Rubinow 1934). In the aftermath of the Great Depression, an opportunity to introduce NHI presented itself along with other forms of social insurance.[7] However, for reasons that may have ranged from the personal to the political, President Franklin Delano Roosevelt (FDR) declined to include health insurance in the Social Se-

---

[5]See also Bordo, Goldin and White (1998), Cutler and Johnson (2004), Fetter (2017), Fetter and Lockwood (2018), Lindert (1994), Rubinow (1934), and Thomasson (2003).

[6]We provide a more thorough treatment of the role of unions, the establishment of Blue Cross and Blue Shield, equity considerations, and the establishment of the Veteran's Administration alongside a timeline in Online Appendix Section E.

[7]The Great Depression presented an opportunity for and led to the establishment of various forms of social insurance, accelerating government spending. As Bordo, Goldin and White (1998, pp.18-19) write: "Without the depression, there would not have been a flood of New Deal-style legislation...lacking the catalyst that jarred public attitudes and demanded action, the new economic institutions would have been more modest and different in character."

curity Act of 1935, focusing instead on old age and disability insurance (Blumenthal and Morone 2010; Rovit and Couldwell 2001).

Nonprofit hospitals, also hit hard by the Great Depression, experimented with plans eventually known as Blue Cross. These plans allowed consumers to prepay for room and board at local hospitals, and required special enabling legislation to launch, making it difficult for plans to operate across state lines (Eilers 1963).[8] To counter potential government encroachment and hospital pressure, state medical societies began their own prepaid medical service plans (*i.e.*, Blue Shield). The first such plan, the California Physicians' Service, was created by the California Medical Association (CMA) in 1939 in response to an attempt to introduce tax-financed health coverage by Democratic Governor Culbert Olson. In the following decade, Republican Governor Earl Warren would attempt multiple times to introduce similar legislation, only to be rebuffed by a CMA-financed campaign led by Whitaker & Baxter (Johnson 2016).

Spurred on by the Beveridge Report in Great Britain and the high rate (more than one-third) of American registrants examined and deemed unfit to fight by the Selective Service, tax-financed health insurance legislation at the federal level gathered traction in the U.S. Congress (Bachman and Meriam 1948; U.S. Selective Service System 1947). The 1943 Wagner-Murray-Dingell (S.1161-HR.2861) bill broadened the Social Security Act to include NHI and enjoyed support from organized labor but events in Europe distracted FDR (Corning 1969). During his January 1944 State of the Union address, FDR appeared ready to embrace NHI and included a right to adequate medical care in his Second Bill of Rights. His death following a successful bid for a fourth term stunned the nation, and after only a few months as vice president, Harry Truman assumed the presidency. Truman quickly revealed himself to be a staunch supporter of NHI, giving the first-ever presidential address on health care in November of 1945 (Harry S. Truman 1956).[9] An attempt to re-introduce the legislation led the AMA House of Delegates to shift its position from merely endorsing medical insurance to encouraging all state and local medical societies to develop their own plans "as promptly as possible" (Board of Trustees of Mississippi State Medical Association 1965, p.12). Online Appendix Figure A1 demonstrates that there was a sharp increase in the number of plans immediately following the 1945 directive.[10]

In the 1946 midterm elections, Republicans gained control of the Congress, and Truman had little hope of getting legislation passed during his remaining term (Graf 1947). This changed with Truman's upset victory over Dewey in the 1948 presidential election.[11] As described by Doherty and Jenkins (2009, p.5), the election, "catapulted national health insurance from a longshot idea to a viable possibility almost overnight." Truman worked with members of Congress to craft a comprehensive national health plan, posing the most

---

[8]See Online Appendix Section E.4 for more information on Blue Cross hospital prepayment plans. Online Appendix Figure D2 demonstrates the number of prepayment hospital plans at the state level in relation to the timing of the passage of enabling legislation. The data cover 1935 to 1946.

[9]In his memoir [p.18](Harry S. Truman 1956), President Truman wrote: "This is a terrible indictment. I believed the United States should be the healthiest country in the world and lead in finding and developing new ways to improve the health of every citizen. As soon as I could direct my attention to the most pressing domestic matters, I proposed a national health program. President Roosevelt had set the stage for a health program in his "economic bill of rights," which included "the right to adequate medical care and the opportunity to achieve and enjoy good health."

[10]The 1943 and 1945 bills were referred to the fiscally conservative Ways and Means Committee in the House and Finance Committee in the Senate and died there. Later attempts went through the Senate Committee on Education and Labor and the House Committee on Interstate and Foreign Commerce (Linford 1946).

[11]Truman's victory in the presidential election, coupled with the Democrats' success in Congress, was unexpected. According to Johnson (2016, p.33), "Nearly every commentator, pollster, and editorial writer had written off the Harry Truman–Alben Barkley ticket, knowing that there was no way it could stop Thomas Dewey and his running mate, Earl Warren. But not only did Truman retain the presidency, but Democrats also won seventy-five additional seats to regain control of the House of Representatives."

serious attempt the country had made to having a universal, tax-financed health insurance system.

II.2   Medical Authority, Specialization, and the AMA

The AMA famously opposed the passage of Medicare, but its role in the earlier critical period of NHI is less widely known nor, to our knowledge, has it been evaluated empirically. Truman, however, alluded to the subject in his memoir: "I have had some bitter disappointments as President but one that has troubled me most, in a personal way, has been the failure to defeat organized opposition to a national compulsory health insurance program" (Corning 1969, p.69). The AMA was not always so firmly opposed to NHI. In 1916 the AMA established a Committee on Social Insurance to cooperate with the AALL regarding state-sponsored health insurance plans. Yet as the wealth and prestige of the profession grew, so too did its opposition to NHI (Institute of Medicine 1993; Markel 2015).[12]

Several factors accounted for the increasing specialization and growth of incomes among physicians over this time (see Starr (1982) for a review). The Flexner Report of 1910 highlighted massive problems in medical education and practice, leading to the closure of over half of all medical colleges in the U.S. by 1930 (Clay et al. 2023; Moehling et al. 2020). The result was a slight overall decline in per capita doctors (Online Appendix Figure A2). Simultaneously, state medical boards established or tightened license requirements as specialties emerged to master the post-War technologies (Moehling et al. 2020). Occupational licensing in turn might have further increased the incomes and stabilized the membership of the AMA (Stigler 1971).

Data we entered from the *American Medical Directories* demonstrate that, over the period 1920 to 1950, AMA membership grew by 7.9 percentage points (from 60.6 to 68.5 percent of all US physicians) while the share of physicians who were specialists grew by 20.6 percentage points (from 10.6 to 31.1 percent) (Online Appendix Figure A3).[13] Physician incomes also increased from about $7,400 to $12,000 in 1950 dollars with much of the growth occurring between 1940 and 1945 (Online Appendix Figure A6). Then, as now, specialists earned significantly more than generalists (about twice as much) and both earned much more than the average American household (Online Appendix Figure A7). The high status of specialists was reflected in the leadership of the AMA – presidents were increasingly drawn from a specialist pool of "grass root" practitioners as opposed to the more academically oriented individual or generalist ((Anderson 1968); Online Appendix Figure A8). The vertical structure used to enforce professional norms and raise incomes was peaking at the time of Truman's election. These resources were deployed by the AMA in the Campaign to defeat NHI.

II.3   Other Factors Hypothesized to Affect Enrollment in Private Health Insurance

To recap, America's modern private health insurance system was founded by nonprofit hospitals and state medical societies at different times and for different reasons. The former were financially strained and the latter were seeing their finances and power grow. Eventually, these two initiatives (Blue Cross and Blue Shield, respectively) would merge, but over much of the period of this analysis, their major connections were

---

[12]As summarized by Starr (1982, p. 232), "the advent of antibiotics and other advances gave physicians increased mastery of disease and confirmed confidence in their judgment and skill. The chief threat to the sovereignty of the profession was the result of this success. So valuable did medical care appear that to withhold it seemed deeply unjust. Yet as the felt need for medical care rose, so did its cost, beyond what families could afford. Some agency to spread cost was unavoidable. It would have to be a third party, and yet this was exactly what physicians feared."

[13]Online Appendix Figure A4 demonstrates that nearly all the growth between 1942 and 1950 among physicians was among the specialists. Specialists were much more likely to be AMA members than generalists (91.6% vs. 56.0%, see Online Appendix Figure A5).

two-fold: First, Blue Cross had started slightly earlier and thus built up administrative expertise in billing that some state physician groups leveraged. Second, the earliest medical services covered included surgical, obstetric, and anesthetic services that were typically delivered in hospitals (though the plans quickly expanded to include outpatient services as well).

A related question is what led to enrollment growth after plans were established? Several supply- and demand-side factors have been hypothesized to have played a role. First, there was a rise in incomes that increased demand for all normal goods, including medical care. On the supply-side, massive war-time public investment spurred technological advances in medicine that made doctors' services more valuable (Gross and Sampat 2023). The Stabilization Act of 1942 froze wages but did not prohibit offering benefits. In the late 1940s, it was clarified that unions could include benefits in collective bargaining agreements (Blue Cross Blue Shield Association 1997; Brown and Glied 2020; Thomasson 2002). Lastly, and perhaps most importantly according to Thomasson (2003) was a 1954 change to the Internal Revenue Service code that made payments to private health insurance companies tax exempt.

For these and other reasons related to data quality (commercial insurers garner an increasing market share after the tax change and granular data from these entities do not, to our knowledge, exist), we end our analysis in 1954. Yet by that time, many non-elderly middle-class Americans were already enrolled in some form of private health insurance.[14] We return to factors that shaped demand for insurance and Campaign intensity when discussing identification and our empirical approach (see Section V).

II.4 Origin of Political Public Relations: Whitaker & Baxter's *Campaigns, Inc.*

When faced with a credible legislative threat, the AMA turned to Clem Whitaker and Leone Baxter, the husband-wife founders of *Campaigns, Inc.* for assistance. The duo are credited with revolutionizing political campaigns through their "rules" (Cutlip 1994). First and foremost: Simplify. Whitaker & Baxter remarked, "a wall goes up when you try to make Mr. and Mrs. Average American Citizen *work or think*...The average American doesn't want to be educated; he doesn't want to improve his mind; he doesn't even want to work, consciously, at being a good citizen. But there are two ways you can interest him in a campaign that we have ever found successful. You can put on a fight...or you can put on a show" (Johnson 2016, p. 26).

The firm, founded in 1933, was initially based in California, a state that allows citizens to affect policy outcomes through direct democracy (*e.g.,* initiatives, referendums). In such a circumstance, indirect lobbying, or persuading the American citizen via campaigns, was particularly valuable. As Whitaker stated: "California has been the testing ground for a great many visionary schemes and phony movements – but it has also become the burial ground for most of them," taking credit for their demise (Whitaker and Baxter 1945, p.9).

In 1945, California Governor Warren endorsed AB 800, a health insurance bill designed for California workers, after Warren suffered a kidney infection and became concerned about the high cost of medical care (Mitchell 2002).[15] The bill mandated a payroll tax to fund a health plan that would extend to wage earners and cover a variety of medical and hospital services (Dimmitt 2007). In response, *Campaigns, Inc.* was hired

---

[14]According to Thomasson (2003), by 1952, 63% of households had some form of insurance for medical expenses (including medical, hospital, or surgical insurance). Note this is higher than our 3.4% number provided in Figure 3 Panel A since it is several years later, includes all forms of insurance for medical expenses and is a self-reported survey measured at the household level, whereas we use administrative data and denominate by total population from the Census. When we denominate our number of insured by white employed males individuals the baseline share insured is 13.5% (see Online Appendix Table C1 Column 10).

[15]AB 800 was similar to the 1939 proposal of Governor Olson that had initially spurred the CMA to start the CPS.

by the CMA and launched the California Campaign. Key strategies that would be replicated later on a national scale included labeling the effort an "educational" initiative and focusing on voluntary enrollment in the CMA Blue Shield plan.[16] The goal was to "secure public action informally through mass persuasion rather than through force of law" (Whitaker & Baxter *Campaigns, Inc.* 1945-1949).

In an April 1947 letter to the president of the CMA, Whitaker & Baxter reported on their progress to date: Governor Warren's latest proposal garnered much less support than his earlier proposal, and supporters of state health insurance went on the defensive (Whitaker & Baxter *Campaigns, Inc.* 1945-1949). The duo went on to found a magazine entitled *CMA Public Relations News* which publicized defeating Warren. The magazine was sent to the offices of state medical societies and to the headquarters of the AMA (Online Appendix Figure B1). Whitaker & Baxter's partnership became synonymous with success: They won 58 of 63 legislative battles in California by the time they were hired by the AMA (Evans 1949).

II.5   The National Campaign

While campaigning for the presidency in 1948, Truman embraced a national health plan crafted by his Federal Security Agency (FSA) Administrator, Oscar Ewing. Truman's surprise victory in November sparked an apocalyptic mentality at the AMA and a desire to amplify its anti-NHI efforts – launching two special assessments and hiring Whitaker & Baxter.[17] The firm's mandate was to once and for all end "agitation" for NHI by rebranding and expanding the AMA's earlier efforts as the National Education Campaign (NEC).[18] The Campaign consisted of two main components: Physician outreach and mass communications via newspaper advertising.[19]

The physician component involved sending pamphlets and other materials to doctors. Physicians were instructed to warn their patients about the dangers of "socialized medicine" and encourage their enrollment in private plans. Per Whitaker: "[W]e are going to ask the doctors, when they are talking to patients in their offices, who are in need of budget-basis medicine, to take time to encourage them to enroll in a good, sound Voluntary health system," (Whitaker and Baxter 1949, p.4). Figure 1 shows examples of pamphlets designed by the Campaign for distribution to patients by their physician, with the most popular pamphlet entitled *The Voluntary Way is the American Way*. Note that most of these brochures and ads provide little if any information on insurance – who can be covered, what is covered, its cost, and so on. As can be seen from the word cloud in Online Appendix Figure D1 Panel A, the messaging tied together health and medical care with America, freedom, and individual choice (*i.e.*, the voluntary way).

In addition, physicians served as liaisons to local civic organizations, pushing them to modify template resolutions against NHI and then send copies of these resolutions to elected officials. According to Whitaker & Baxter, support of such organizations would be "a vital step in broadening the campaign into a public crusade." Medical societies mailed template resolutions and encouraged local civic organizations to pass

---

[16]For further details on the California Campaign see Online Appendix Section E.3.

[17]This strong sense of urgency was reflected in a 1949 address by AMA president Elmer Henderson, who devised the term "Battle of Armageddon" and called it "the decisive struggle which may determine not only medicine's fate, but whether state socialism is to engulf all America" (Henderson 1949, p.36). As described by Poen (1996, p.141), "Stunned by the president's reelection, the AMA Board of Trustees vowed to exhaust the association's treasury if need be, to prevent passage of Truman's health insurance scheme."

[18]The AMA had tried to influence public perception in the past: Its in-house lobbying arm – the National Physicians' Committee for the Extension of Medical Service (NPC) – launched a newspaper cartoon contest attacking state-sponsored insurance as early as 1946 (Burrow 1963; Knoblauch 2014; National Physicians' Committee for the Extension of Medical Service 1947-1949; Wehrle 1993).

[19]We could not find consistent documentation of radio or TV programming: In robustness checks we control for trends in both (see Section VI.1).

and then send signed resolutions to their elected representatives. Online Appendix Figure B2 Panel A shows an example of an appeal made by the Medical Society of the State of Pennsylvania to the local American Legion Posts and Panel B shows a resolution passed by the Federation of Women's Clubs.[20]

The AMA also tapped allies in industry for tie-in advertising to be scheduled simultaneously with the main ad. Then AMA President Dr. Elmer Henderson reached out to approximately 23,000 corporations and 7,000 members of the National Retail Dry Goods Association to provide support. These firms, trade, and interest groups spent another $19 million in 1950 dollars, or approximately $240 million in current dollars (Begeman 1950).[21] Examples of these tie-in ads are shown in Figure 2 Panels A, B, and C. Approximately 60% of all newspapers with a main ad included tie-in ads, with an average of three per issue (Panels D and E). The ads represented a broad array of industries: The largest share (about 40%) were near in product space to the medical industry (*i.e.*, pharmaceutical interests, see Figure 2 Panel F) but some were much farther away (*e.g.*, clothing). Online Appendix Figure D1 Panel B shows the word cloud of Campaign ads which emphasized the terms "America" and "freedom." The use of such ads has implications for our conceptual framework as consumers may have been unaware of the coordination between the AMA and other business organizations (see Section III).

The Truman administration sought their own publicity campaign for NHI. Zilpha Franklin, the FSA Director of Information, outlined an unprecedented, ambitious program, advising a "state of emergency" for the FSA, and estimated that the plan would need a relatively large team and interagency cooperation (Poen 1996, p.81). However, in part due to concerns about executive lobbying and interagency politics, her plan was never realized. The Committee for the Nation's Health (CNH) also attempted to sway voters in favor of NHI and was less restricted as a non-governmental body. However, they were vastly out-resourced: CNH took in $104,000 in 1949 with nearly $100,000 spent on its working budget: "like the AMA, the CNH...published and distributed pamphlets, but not in nearly so large a number." Furthermore it lacked the appeal of the Whitaker and Baxter content. According to Poen (1996, p.152), "the CNH's pamphlets included *Are Blue Shield Plans Satisfactory?* In which it was argued that they were not; *Restrictions on Free Enterprise in Medicine,* in which the AMA stood accused of monopolizing health services through its control over insurance plans; and *Record of the American Medical Association*, which chronicled the AMA's shifting attitude on the legitimacy of government and private health insurance since the early part of the century." Unions too were limited in their financing of political campaigns following the passage of the Taft-Harley Act of 1947 (Kallenbach 1948) (Online Appendix Section E.7 provides a more detailed description of the historical relationship between organized labor and health insurance).[22]

---

[20]The Campaign explicitly called upon doctors' wives to be involved and noted they have important roles to play via such auxiliary clubs. "Women are reluctant to take direction from other women, but they love to do things for their menfolk...Women have ingenuity and can help you, if they are guided" (Craig 1950, p.13).

[21]Griffith (1983) argues that many business leaders were shaken by price controls and the popularity of New Deal programs following World War II. Though there was substantial disagreement on international trade and labor relations, preserving the autonomy of the corporate enterprise united these interests.

[22]In terms of cost of the national Campaign, the AMA paid Whitaker & Baxter 1.2 million dollars per year in current terms (Whitaker & Baxter *Campaigns, Inc.* 1946-1973). Regarding who was responsible for Campaign content, a 1949 article in *Medical Economics* profiling the duo wrote: "Clem Whitaker and Leone Baxter eat, sleep and breathe public relations. At breakfast, they check over the morning papers to decide how best to align their current publicity programs with the latest news developments. On their way to work, they map out the day's schedule. Stopping to chat with elevator operators, shoe-shine boys and a variety of other people is an important part of their routine. Many of their best ideas stem from these daily samplings of popular opinion" (Evans 1949, p.3). Clem Whitaker Jr. in an oral history interview for the State of California also noted: "Everybody likes to think they got their own two cents in [on the health insurance campaign] but that was my father and Leone. That was their thinking and their planning and their strategy" (Morris 1988, p.19).

Figure 1: Campaign Pamphlets Distributed by Physicians and Excerpt from the Main Campaign Ad

(a) Pamphlet Example 1

(b) Pamphlet Example 2
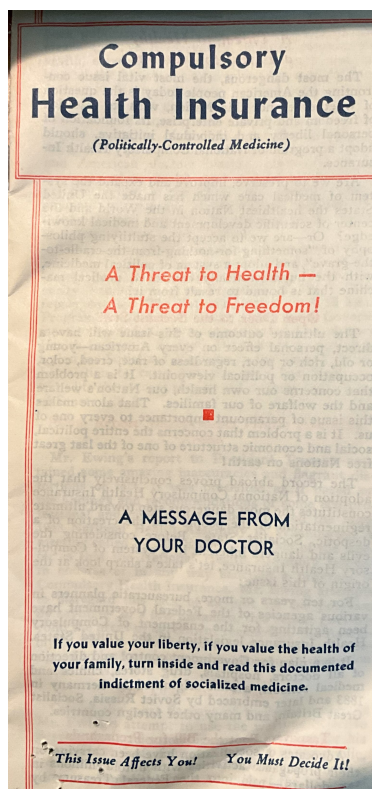
(c) Excerpt of Main Ad

Notes: Exhibit shows examples of materials distributed during the Campaign. Panels A and B show the covers of *The Voluntary Way is the American Way* and *A Threat to Health: A Threat to Freedom!*, respectively (Whitaker & Baxter *Campaigns, Inc.* 1949-1952). Panel C shows an excerpt of the standard template for the main Campaign advertisement. The size and content were constant across newspapers. For the full advertisement see Online Appendix Figure B3. Example taken from page 16 of *Athens Alabama Courier* (American Medical Association 1950c).

Figure 2: Campaign Tie-in Ads

(a) Walgreens
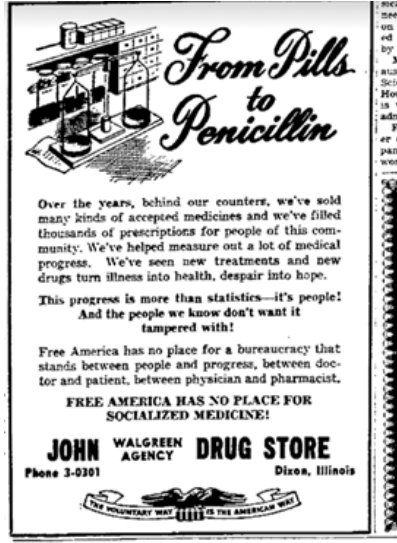
(b) Dillon Implement Co.

(c) Oklahoma State Bank
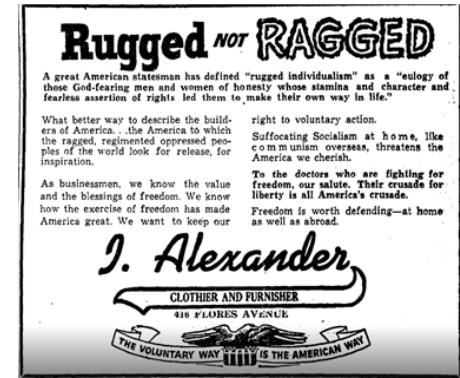
(d) Any Tie-in Ad
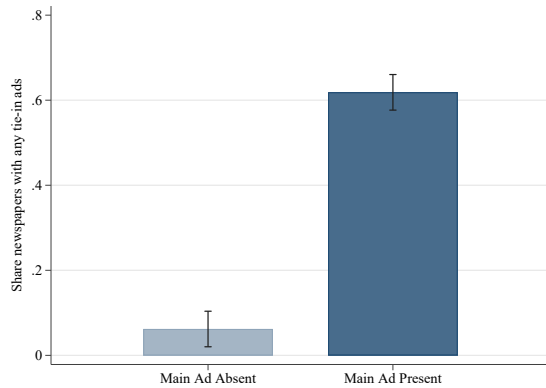
(e) Number of Tie-in Ads
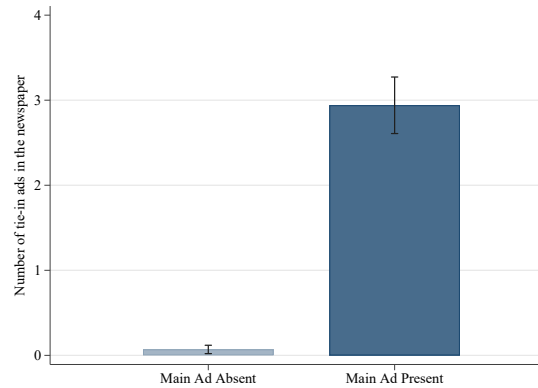
(f) Tie-in Ads by Industry
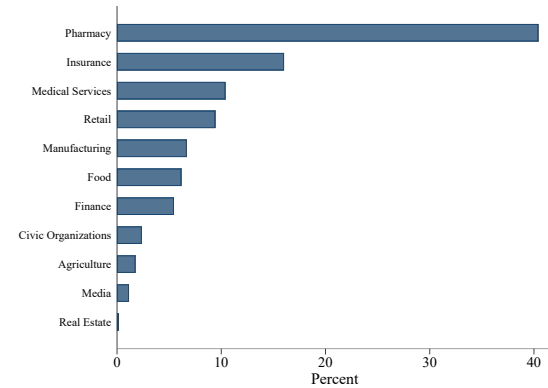
Notes: Panels A, B, and C show examples of tie-in advertisements sponsored by three different companies. While the size and content of tie-in advertisements vary across newspapers and sponsors, the slogan "The Voluntary Way is the American Way" appears in most ads. The examples in Panels A, B, and C are from issues of the *Dillon Daily Tribune*, the *Laredo Times*, and the *Ada Evening News*, respectively. Panels D and E plot the share of newspapers with any tie-in ads and the number of tie-in ads, separated by whether the newspaper has a main Campaign ad. Panel F plots the distribution of tie-in ads by industry (NewspaperArchive 2023). See Online Appendix Section F.2 for details of categorization of industries.

II.6 National Professional Committee for Eisenhower

During the presidential election year of 1952, the AMA pivoted to focus on direct lobbying. By that time, legislative threats had been weakened and the Republican party platform had officially adopted the AMA stance. The party plank read: "We are opposed to federal compulsory health insurance with its crushing cost, wasteful inefficiency, bureaucratic dead weight, and debased standards of medical care" (U.S. Senate Library 1952, p.78). A separate lobbying entity called the National Professional Committee for Eisenhower for President (NPCE) was created because, as noted by Clem Whitaker, "the American Medical Association cannot either legally or ethically, support or oppose candidates for public office" (Whitaker 1950, p.21). However, the NPCE could directly steer campaign contributions. Whitaker became the NPCE's Director, Baxter the General Manager, and former AMA President, Dr. Elmer Henderson, was named Chairman. The NPCE raised approximately \$1.5 million in current terms for the Eisenhower campaign (Whitaker & Baxter *Campaigns, Inc.* 1946-1973).

III Conceptual Framework

As discussed above, Whitaker & Baxter are credited with creating the field of political public relations and developing campaigns intended to sway the electorate. In this section, we formalize the notion of indirect lobbying, adapting the insights of Sobbrio (2011).

III.1 Setup

In our environment, legislators must decide whether to pass the NHI policy $P = 1$ or keep the status quo $P = 0$. Since this is a model of indirect lobbying, legislators care about the public's views and enact the policy preferred by the median voter. Voter utility is represented as a quadratic loss function between the legislative outcome and the voter's policy preference:

$$U_i(P, d_i) = -(P - d_i)^2 \tag{1}$$

The voter's policy preference (d_i) is a combination of his private valuation of the policy, $x_i \sim U[0,1]$ as well as his perceived state-dependent social benefit of the policy (I). Specifically, $d(x_i, I) = x_i + I(s)$, where $s = \{s_0, s_1\}$ denotes two mutually exclusive and exhaustive states of the world. s_1 represents a state whereby policy enactment (*i.e.*, $P = 1$) yields net positive social surplus $(+\delta)$ whereas s_0 represents a state where it yields net negative social surplus $(-\delta)$:

$$I(s) = \begin{cases} -\delta, & \text{if } s = s_0. \\ \delta, & \text{if } s = s_1. \end{cases} \tag{2}$$

with $\delta \in (0, 1/2]$.

III.2 Updating

Let π be the voter's prior probability on the state of the world. We assume the voter is uninformed about the policy and thus model priors as uniform over the unit interval.[23] A private sector advocate and a public

---

[23]This is equivalent to assuming $\pi \sim \text{Beta}(1, 1)$.

sector advocate each send signals regarding the state with the former sending $s = s_0$ and the latter sending $s = s_1$.[24] We posit a straightforward influence function whereby the level of resources (r) determines the number of messages (m) sent by an advocate: $m_j = r_j$ for $j \in \{0, 1\}$ (Becker 1985). After message receipt, the voter updates his belief on s_0 using Bayes' rule: $\pi|(M = m) \sim \text{Beta}(\alpha + m_0, \beta + m_1)$. Messaging by the private advocate also encourages enrollment in PHI, which we assume indirectly decreases the private benefit of the public option *i.e.*, $\frac{\partial x_i}{\partial m_0} < 0$. The payoff is therefore:

$$U_i(x_i, m|P, s) = \mathbb{E}[\pi|m] \times \left(-[P - (x_i - \delta)]^2\right) + (1 - \mathbb{E}[\pi|m]) \times \left(-[P - (x_i + \delta)]^2\right) \tag{3}$$

The difference in utility between adopting the policy and maintaining the status quo is given by: $D_i = U_i(x_i, m)_{|P=1} - U_i(x_i, m)_{|P=0}$.

III.3 Proposition

Substituting individual preferences with the preferences of the median voter and differentiating D_i yields the following predictions:[25]

   a. $\frac{\partial D_v}{\partial m_0} < 0$ messages by the private sector advocate reduce median voter support for NHI due to:

       i. a higher posterior probability $s = s_0$,

       ii. a lower private valuation of the policy, x_i.

   b. $\frac{\partial D_v}{\partial m_1} > 0$ messages by the public sector advocate increase median voter support for NHI via lowering the posterior probability $s = s_0$.

We can empirically verify or historically motivate many of the assumptions in the model. Given the tight legislative window of opportunity, there was very little scope for strategic responses by advocates. Turning to the assumption of flat priors, health insurance was relatively new and just being introduced and expanded throughout the world, so this seems natural in our setting. Regarding naivete of the voter, it would have been difficult for the average citizen to be aware of the coordination across industries or the motivation behind the messaging. Lastly, doctors were likely assumed to be a credible source of health-related information. Given the far greater resources the private advocate commanded in our historical context, we focus attention on the first part of the proposition in our empirical analysis.

IV   Data

This section summarizes the novel archival sources, directories, and administrative data we use in the project. We first discuss the data used to measure the Campaign components of physician outreach and mass advertising, and then we describe the data used to measure the outcomes of private health insurance enrollment as well as citizen and policymaker views.

---

[24]This bifurcation in signal sending could arise from different welfare weights on consumer vs. producer surplus, where the former is the sum of private valuations of the policy and the latter is profit from enrolling citizens in a private alternative to the policy. Another possibility is that nature moves and determines the true state, sending a signal to the advocates, which is interpreted through heterogeneous and strong perceptions with little scope for updating (Alesina, Miano and Stantcheva 2020).

[25]Proofs can be found in Online Appendix Section G.

IV.1 Campaign Data

Physician Outreach Component. Physicians were the "field workers" of the Campaign, serving as liaisons to other civic organizations and passing out pamphlets opposing NHI. Overall, nearly 50 million pieces were sent to physicians including mailing stickers, cartoons, posters, and pamphlets. Some were brochures targeting doctors themselves, such as information on antitrust activity against the AMA. Most pamphlets, however, were intended for patients, and we extract data from the firm's archives on the distribution of the four most popular: *The Voluntary Way is the American Way*, *Your Medical Program: Compulsory or Voluntary?*, *It's Your Crusade, too!*, and *A Threat to Health: A Threat to Freedom!* (examples in Figure 1). We combine data on the distribution of the pamphlets from the Whitaker & Baxter Archives at the state level (the finest level available) with detailed information on the location of AMA physicians that we obtain by digitizing the 1950 AMA Medical Directory.

The AMA directories were and still are the most comprehensive database of physicians in the United States.[26] During our period of interest, the directories were published in large multi-volume books in 1940, 1942, 1950, and 1956. We digitize and OCR the 1950 directory and extract several pieces of biographical information on each physician (American Medical Association 1950*a*). Online Appendix Figure B4 displays a typical entry – small symbols in the book indicate memberships and other important career milestones. We use this information to construct a dataset including physician name, year of birth, specialty, office and home address, and the status of AMA membership for the universe of physicians in the U.S. circa 1950. The final dataset contains about 160,000 observations from 48 states (see Online Appendix Figure A9). The number of physicians by state from the digitized microdata is close to published aggregates (see Online Appendix Figure A10). To construct exposure to pamphlets distributed by physicians, we use the 1950 share of doctors that belong to the AMA at the relevant geographic level (see Section V.1 below for further details).[27]

Mass Communications Component. The public relations firm's archives also contain invoices from the Lockwood-Shackelford Advertising Company (see Online Appendix Figure B5), which provide several pieces of information. First, they are invoiced to the AMA. Second, they confirm the same ad was used in every outlet. Third, they provide details on where and when the ad would appear – including the newspaper name, town, and circulation. We extracted information from the 1949 *Ayer & Son's* Newspaper Directory to obtain important characteristics on the newspapers Lockwood-Shackelford advertised in, as well as those it did not. These data include, for each weekly and daily newspaper, its total circulation, political leaning, frequency, railroad accessibility, and formatting information (number of columns, width, and depth).[28]

To detect tie-in ads, we use *NewspaperArchive*, an online database containing newspaper articles from 1607 to present. From the archive, we find 834 newspapers with at least one issue in the month and year the Campaign ad buy took place. After merging with the *Ayer & Son's* newspaper directory data, we are left with 616 newspapers of which 542 have the ad shown in Online Appendix Figure B3.[29] Political leaning and frequency of publication are not different on average across newspapers with and without Campaign ads (as seen in Online Appendix Table F2). Lockwood-Shackelford tended to advertise in less urban areas and with slightly lower circulation newspapers, at least compared to the universe of weeklies and dailies in *Ayer & Son's* (see Online Appendix Table F3). One concern might be that we are mis-specifying our exposure variable if tie-in ads were taken out in newspapers other than those with Campaign ads. Figure 2 Panel

---

[26]Today, commonly known as the AMA Masterfile and distributed electronically through third-party vendors.

[27]The geographic distribution of AMA doctors is shown in Online Appendix Figure A9.

[28]We include publications that are dailies or weeklies well as those with a circulation number less than 600,000 to avoid national publications.

[29]Details on detecting Campaign main and tie-in ads are in Online Appendix Section F.3.

D shows that the vast majority of tie-in ads were placed in newspapers that also had the main Campaign ad. Panel E shows there were on average three tie-in ads per paper, thereby magnifying the effect of the Campaign substantially.

IV.2 Outcome Data

Private Health Insurance Enrollment. We compile newly discovered data on PHI enrollment from annual reports entitled, "Voluntary Prepayment Medical Care Plans," published by the AMA's Council on Medical Service (CMS) (Council on Medical Service 1946-1954). The first edition was published in 1946 and thus is the first year of the analysis. We enter the number of enrollees from plans covering 48 states between 1946 and 1954.[30] We aggregate enrollment to the state level and divide by state population to construct shares (Haines 2010). In general across the plans, infants, older people, the indigent, women who were unmarried and pregnant, or women who were married but became pregnant within 10 months were not eligible for coverage. Most plans charged higher rates for women than men. Regarding catchment area, most plans operated statewide. One exception was New Hampshire and Vermont, which combined areas to provide a single plan. Over time, plans were extended to dependents of the policyholder and covered services were expanded.

Although Blue Shield does not capture the entire universe of voluntary health insurance options (for example, hospital insurance was separately sold as Blue Cross per Section II.1) industry data do not cover the main Campaign period. The Health Insurance Council (HIC), a network comprised of representatives from the commercial life and accident insurance companies, started reporting state level enrollment aggregates in 1952. Online Appendix Figure A12 shows HIC data are highly correlated with CMS hospital and CMS medical service enrollment in 1952 (Correlation of 0.902, and 0.924, respectively).[31]

Policy Views. To determine whether the Campaign was successful in changing views of individual citizens we use Gallup survey data (Gallup Organization 1945, 1946, 1949, 1950). The surveys included questions on policies related to NHI in various waves (see Online Appendix Table A1 for wording of questions).[32] After 1948, Gallup began using the term "compulsory" almost exclusively to describe the policy – shortly thereafter, the questions on health insurance disappeared until around the time of the Medicare and Medicaid debates (see Online Appendix Figure A13 Panels A and B). Gallup surveys were sponsored by local newspapers (see Online Appendix Figure B6). As found in Reuter and Zitzewitz (2006), advertisers might have influenced how questions were asked. This should be kept in mind when interpreting coefficients on wave fixed effects or the post indicator. Gallup data include information on sex, race, age, state of residence, phone ownership, political leaning, employment, and (for most waves) union status.[33] Public opinion at the group level is sourced from the firm's archives. *Campaigns, Inc.* recorded the name and location of all civic organizations "on record against compulsory health insurance" implying they had passed resolutions in

---

[30]The growth in enrollment in plans over time is shown in Online Appendix Figure A11. Since individuals could enroll in medical and surgical plans separately or combined, we use the maximum enrollment number across both, including dependents. In addition, we ascribe enrollment to the year of publication as enrollment windows were not uniformly adopted. Using the end of year date yields estimates similar to those reported in Table 1.

[31]The Blue Cross Commission enrollment numbers by state from 1936 to 1947 were collated and published by the FSA (Reed 1947), who took pains to deflate them due to concerns of double counting.

[32]Most of the questions are conditional on having heard of the bill, yet we find no effect of Campaign exposure on knowledge of specific legislation, which further suggests that the Campaign was not designed to be informative.

[33]We use phone ownership as a proxy for income and confirm that phone ownership is a strong predictor of income using the 1960 census 5% sample (the oldest sample we could locate with both variables) – having a phone is associated with $3,540 greater total family income (Ruggles et al. 2024). In April 1946, union status was not asked, so we include a missing indicator for employed persons union status in that wave.

favor of PHI (see example in Online Appendix Figure B2). The instructions given to the civic organizations were to send a copy of the signed resolution to Campaign headquarters in Chicago and another copy to their Congressional representatives. We exploit the firm's archives of passed resolutions in our regression analysis, but are able to trace resolutions to Congressional leaders in D.C. as described below.

Congressional Discourse, Petitions and Direct Lobbying. NHI legislation never came to a formal floor vote, for reasons described in Section II. In such a circumstance, how can researchers discern whether health insurance was an important topic or whether the AMA-WB Campaign was influential in policy circles? We make progress on these questions by extracting data from the Congressional Record and associated appendices from 1947 to 1951 (covering the 80th, 81st, and first session of the 82nd Congress).[34] We perform the OCR de novo since prior products did not capture the appendices. We use these data in two ways. First, we ascertain the importance of health insurance and the AMA by assessing their frequency relative to other social insurance and lobbying benchmarks. Second, we assess how legislators described health insurance. Specifically, we compare text similarity between quotes from legislators and the Campaign using latent semantic analysis (Schwarz 2019).[35]

The Campaign provided template resolutions, some of which were referred to in the text of the *Congressional Record* as per legislative procedure (Blackhawk et al. 2020). We also discovered folders of full-text petitions and resolutions sent to the 81st Congress in the Washington, D.C. National Archives. We digitized petitions and resolutions from two other topics garnering attention during this time: The strengthening of the United Nations (UN) and the conflict in Korea (National Archives 1950*b,c*). We compute the frequency of petitions on different topics and assess their semantic similarity to the AMA-WB Campaign.

Lastly, we digitize the list of individuals who contributed to the National Professional Committee for Eisenhower in 1952 (Whitaker & Baxter *Campaigns, Inc.* 1946-1973). These records include the name, address, medical degree (*e.g.*, M.D. and D.D.S.), and the amount contributed (see Online Appendix Figure B7 for an example). We exclude entries without an M.D. degree (representing about one-third of the overall sample, the majority of whom were dentists) before linking to the *American Medical Directory*.[36] Given the richness of these data, we are able to link approximately 80% of all physician donors. We create an indicator for whether a doctor donated as well as the amount he contributed.

IV.3 Additional Data

We bring in additional variables including union data from Farber et al. (2021), state income per capita from the Bureau of Economic Analysis (2023), war bonds purchases and county family median income from the U.S. Census Bureau (2012), television, radio and demographic information from the 1950 Census (U.S. Census Bureau 1953; Haines 2010), and New Deal spending data from Fishback and Kantor (2018). We also digitize hospital locations and attributes, including Blue Cross status, from the *American Hospital Directory* (American Hospital Association 1948, 1950, 1952) for use in robustness checks.

---

[34]For details of this digitizing process see Online Appendix Section F.5.

[35]Through this approach, we capture the semantic relationships of texts and calculate the cosine similarity, which ranges from -1 to 1. However, cosine similarity is rarely negative with latent semantic analysis, typically ranging from 0 to 1 (Schwarz 2019).

[36]Further details on the linkage are provided in Online Appendix Section F.4.

V Empirical Approach

Below we describe Campaign exposure, identification, and estimation.

V.1 Campaign exposure

Campaign exposure is defined at the geographic level j, where j varies by outcome (*i.e.*, for enrollment it is state s, for Gallup it is state-by-urbanicity, for civic organizations and doctors' donations it is county or town c, and for legislator text it is state for Senators and district for House Representatives). As noted above, the campaign had two key components: Physician outreach and mass communications. Each component can be further disaggregated into propaganda material and the propagating factor, where the former includes the persuasive content (*i.e.*, pamphlets and ads) and the latter is the manner of diffusion (*i.e.*, AMA doctors and newspaper readership). We combine the two components as follows:

$$\text{Campaign exposure}_j = \text{MD}_j + \text{Ad}_j \tag{4}$$

where MD_j represents per capita pamphlets distributed by the share of all doctors (D_j) that are AMA physicians (recalling that the pamphlet distribution is available only at the state level):

$$\text{MD}_j = \left(\frac{P_s^{\text{Camp.}}}{N_s}\right) \times \left(\frac{D_j^{\text{AMA}}}{D_j}\right), \tag{5}$$

and Ad_j reflects per capita advertising circulation (main and tie-in) consumed by local newspaper readers:

$$\text{Ad}_j = \left(\frac{C_j^{\text{Camp.}}}{N_j}\right) \times \left(\frac{N_j^{\text{Readership}}}{N_j^{\text{Adult}}}\right). \tag{6}$$

We proxy for readership using the share of adults with more than five years of schooling in the 1950 Census. For Gallup, legislative, and lobbying outcomes, we can assign or interact exposure at the individual level using sociodemographic characteristics (*e.g.*, instead of using the share educated to allocate treatment, we observe a particular Gallup respondent's educational status and assign treatment based on this). We find similar though sometimes noisier results using an exposure variable constructed exclusively with the printed propaganda material. We report these results as well as those using other functional forms or controlling for share AMA and share educated in robustness checks described in Section VI.1.

We standardize both summands in Equation 4, giving each equal weight, and standardize the resultant for ease of interpreting the coefficients. A map of the residualized Campaign exposure at the state level is shown in Figure 3. A map of raw state-level Campaign exposure variable can be found in Online Appendix Figure A14. The correlation between the Ad and MD components in the enrollment data is 0.266 (*p*-value = 0.071).[37]

---

[37] For county and town level exposure variables, we winsorize the top one percentile of exposure.

V.2 Identification

Identification requires that, conditional on a limited set of historically motivated controls, the intensity of the Campaign was uncorrelated with the evolution of potential outcomes. This rules out selection-on-gains into a particular dose group (Callaway, Goodman-Bacon and Sant'Anna 2024). Our main estimating equations (Equations 7 and 8 below) are event studies that leverage both spatial variation in the intensity of the Campaign as well as its timing. The Campaign strategy emphasized leveraging existing networks so it could quickly respond to the unanticipated legislative threat. These networks included AMA doctors and the third party advertising agency, Lockwood-Shackelford. We therefore include variables that could influence the distribution of AMA physicians, newspaper readers, and demand for health insurance: income per capita and union membership.

Tables in Figure 3 show balance tables between the Campaign exposure and our main outcome variables. The unit of analysis for the balance tables varies based on the data. Campaign exposure is not correlated with insurance enrollment or other observables in the pre-Campaign period (*e.g.,* share Republican) conditional on the design controls with the exception of share of the Black population in the 1940 Census. Campaign exposure does not predict views on health insurance prior to the Campaign and has few statistically or economically significant relationships with the sociodemographic characteristics of Gallup respondents prior to the Campaign (Panel B) or to physicians circa 1950 (Panel C). In particular, it is not correlated with Democratic leaning or union households. In addition, income per capita and unionization rates at the state level do not change discontinuously after Campaign onset in relationship to the exposure (Online Appendix Figure D3 Panels A and B).[38] In our analysis, we adopt procedures recommended by Roth et al. (2023) and Rambachan and Roth (2023) to diagnose pre-trends and use a non-parametric estimator recommended by Callaway, Goodman-Bacon and Sant'Anna (2024) for continuous difference-in-differences. These and additional robustness checks are discussed in Section VI.1.

V.3 Estimating Equations

Enrollment in Private Health Insurance. We estimate number enrolled E per total 1950 population N at the state level. These data are available annually, allowing us to estimate for state s and year t:

$$\frac{E_{st}}{N_s} = \alpha + \sum_{k \neq -1} \beta_k \cdot \left(I_t^k \times \text{Campaign exposure}_s\right) + \sum_{k \neq -1} \delta_k \cdot I_t^k + X'_{st}\Omega + \mu_s + \epsilon_{st} \tag{7}$$

where k denotes event time, and X_{st} includes the time-varying design controls noted above and μ_s represents state fixed effects.[39] Time indicators capture broad secular changes in technology or national sentiment and location fixed effects capture slowly evolving cultural attributes. Standard errors are clustered at the state level.

Public Opinion. We use two variables to capture public opinion: (1) an indicator variable for NHI legislation approval from Gallup, and (2) resolutions per capita passed by civic organizations in favor of PHI.[40]

---

[38]There appears to be an anomalous value in the raw state union data of Farber et al. (2021), which may be due to the much smaller survey sample that year and explains the peak in the event study circa 1951 (Online Appendix Figure A15). However, excluding this variable from the analysis does not change the conclusions.

[39]The number of plans was fairly constant over this time period, see Online Appendix Figure A1.

[40]We are not aware of a comprehensive historical census of civic organizations and therefore denominate total resolutions passed by civic organizations at the county level by its corresponding 1950 population (Haines 2010)

Using Gallup poll data we estimate the following equation for individual i in state s during wave t:

$$I_{ist}^{\text{Support NHI}} = \alpha + \sum_{k \neq -1} \beta_k \cdot \left(I_t^k \times \text{Campaign exposure}_{is} \right)$$

$$+ \sum_{k \neq -1} \delta_k \cdot I_t^k + X_i'\Gamma + X_{st}'\Omega + \mu_s + \epsilon_{ist} \qquad (8)$$

where k denotes event time, and X_i includes a set of indicators for female, Black, age, phone ownership as a proxy for income, employment status, union membership, job class, urbanicity, education, and the main effect of the Campaign. X_{st} represents the state level time-varying design controls, and μ_s represents state fixed effects. Campaign exposure is constructed at the state-by-urbanicity level and standard errors are clustered at that level. Survey weights are applied.

For the civic organization resolutions, our estimating equation is given by:

$$\frac{O_c}{N_c} = \alpha + \beta \cdot \text{Campaign exposure}_c + X_c'\Gamma + \mu_s + \epsilon_c \qquad (9)$$

where O_c is the number of civic organizations at the county level passing resolutions against NHI, and N_c is the county population. X_c indicates county-level median family income (U.S. Census Bureau 2012), and in some specifications county share employed since state union share is absorbed by μ_s, state fixed effects.

Congressional Discourse & Direct Lobbying. For outcomes of text mentions and donations, we use legislator-quote and doctor as the unit of analysis i, respectively. Estimation is on a cross-sectional sample and thus similar to Equation 9. Outcomes of interest are indicators for legislator mentions of a particular phrase (*e.g.*, the AMA, political medicine), cosine similarity between a given legislator and the AMA-WB Campaign propaganda, or an indicator for a doctor donating to the Eisenhower-Nixon Ticket in 1952. The finest geography j is used to assign the exposure to both legislators and physicians. We include the main effect of the exposure and examine whether the Campaign affected legislators and doctors differently depending on their party (*e.g.*, Republican vs. Democrat) or AMA membership status, respectively. Design controls are included in preferred specifications alongside physician characteristics (*e.g.*, specialist, age, clinically active).

Figure 3: Campaign Exposure Distribution and Balance
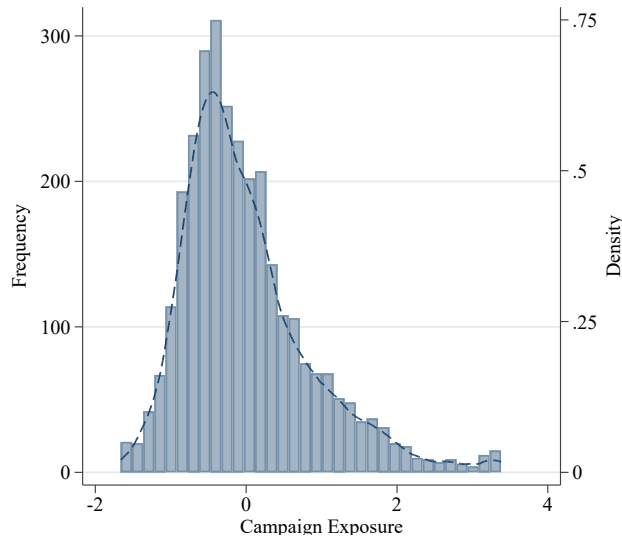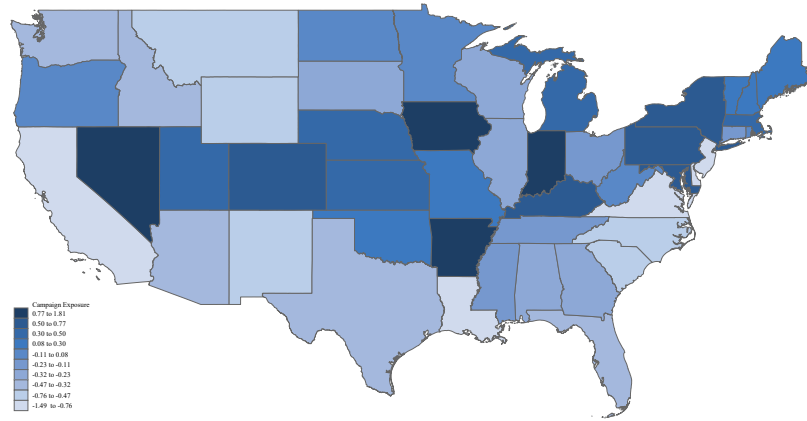
|	(1)	(2)	(3)
	Overall Mean	Coefficient	SE
Panel A: State Level			
Mean PHI Share Enrolled 1946-1948	0.034	-0.014	(0.015)
Mean Share Republican Vote 1946-1948	0.426	0.053	(0.037)
Mean Voter Turnout 1946-1948	0.437	0.032	(0.023)
Share Female 1940	0.494	-0.001	(0.003)
Share Black 1940	0.094	-0.036**	(0.016)
Share Employed 1940	0.336	-0.006	(0.004)
Share Urban 1940	0.474	-0.003	(0.025)
F-Stat		1.466	
F-Test *p*-value		0.210	
Observations		47	
Design Controls		✓	
Panel B: Individual Level - Gallup Data			
Approved Truman Health Plan, 1945-6	0.684	0.029	(0.018)
Female	0.440	-0.010	(0.012)
Age	43.250	0.433	(0.379)
Have a Phone	0.621	-0.012	(0.019)
Voted Democrat, 1944	0.408	-0.020	(0.027)
Unemployed	0.023	0.002	(0.004)
Union Household	0.144	-0.000	(0.008)
Black	0.032	-0.006*	(0.003)
F-Stat		1.191	
F-Test *p*-value		0.316	
Observations		1193	
Design Controls		✓	
Panel C: Individual Level - Lobbying Data			
In Practice	0.016	0.000	(0.001)
General Practitioner	0.636	0.014*	(0.008)
Years Experience	10.393	0.355*	(0.200)
Age	47.469	0.165	(0.179)
Faculty Indicator	0.054	-0.006	(0.005)
Urban Practice	0.964	-0.003	(0.006)
F-Stat		2.106	
F-Test *p*-value		0.050	
Observations		166507	
Design Controls		✓	

Notes: Map of the state level Campaign exposure variable, residualized by the 1948 design controls of income per capita (Bureau of Economic Analysis 2023) and unionization rates (Farber et al. 2021). The distribution of Campaign exposure across counties is shown below the map, residualized by the design controls of county family median income (U.S. Census Bureau 2012) and state unionization rates (Farber et al. 2021). Tables in Panels A and B report balance tests for Campaign exposure in the pre-period, and Panel C reports a cross-sectional balance test for the data on physician lobbying. Column 1 reports the sample mean, and Column 2 reports estimates from an OLS regression of variables listed as row headings on Campaign exposure. Column 3 reports the associated robust standard errors. *F*-stat and *p*-value are for an *F*-test of the joint significance of the variables listed. All panels include the design controls of income and state union share. Panel A reports balance for insurance enrollment. Panel B reports balance for Gallup poll data, where indicators for education and urbanicity are included as stratifying variables. Sample weights for the voting population are applied. Panel C reports balance for lobbying, where AMA membership is included as a stratifying variable. *, **, *** refer to statistical significance at the 10, 5, and 1 percent level, respectively. Demographic data are from 1940 Census (Haines 2010), turnout data are from U.S. Census Bureau (1948), insurance data are from Council on Medical Service (1946-1954), and individual data are from Gallup Organization (1945, 1946, 1949, 1950).

VI   Results

Figure 4 plots event study coefficients of Campaign exposure on PHI enrollment between 1946 and 1954. There is an increase in enrollment post-Campaign that appears markedly different from prior years (p-value for F-test on pre-trend $= 0.958$). PHI enrollment increases mildly over time, potentially reflecting expansion of dependent coverage available through plans and the collapse of a viable public option. Due to changes in the tax code and the increasing presence of corporate insurers, we stop our analysis in 1954 at which point there are further increases in enrollment. Online Appendix Figure D4 demonstrates the hypothesized trend for insurance enrollment in the absence of the Campaign is substantially different from what we observe.

Figure 4: Effect of Campaign on Private Health Insurance Enrollment
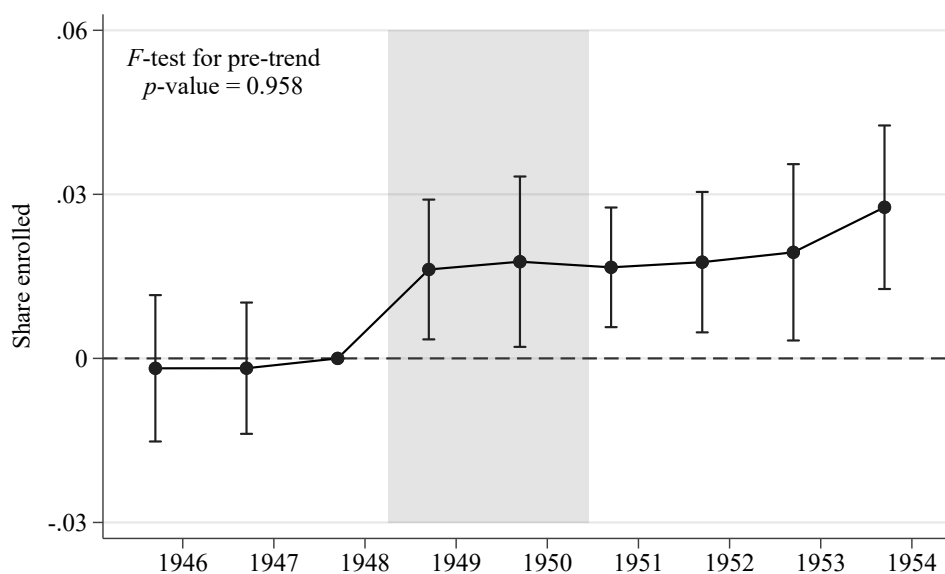
Notes: Figure plots β coefficients from Equation 7 and associated 95% confidence intervals using cluster-robust standard errors. The outcome is share enrolled in private health insurance. Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. Campaign period is shaded in gray. Sample includes the years 1946-1954. Design controls include income per capita (Bureau of Economic Analysis 2023) and share unionized (Farber et al. 2021). State and year fixed effects are included.

Summary measures of the effect of Campaign exposure on enrollment are provided in Table 1. The main effect of Campaign exposure in the pre-period is not statistically significant, and the causal estimates of interest appear relatively stable conditional on design controls. Column 4 is our preferred specification and includes income and unionization, as well as state and time fixed effects. A one standard deviation increase in Campaign exposure is associated with a two percentage point increase in share enrolled, on average accounting for approximately 20% of the overall post-Campaign increase in PHI.[41]

---

[41]This estimate is obtained by dividing the coefficient on the interaction of Campaign exposure and post by the coefficient on post in Table 1 Columns 1 or 2. A similar estimate is obtained by dividing the absolute number enrolled as a result of a one standard deviation increase in the Campaign with the overall number enrolled. For details on this

Table 1: Effect of Campaign on Private Health Insurance Enrollment

	(1)	(2)	(3)	(4)
Campaign Exposure $\times I^{\text{Post}}$	0.025***	0.025***	0.020***	0.020***
	(0.008)	(0.008)	(0.007)	(0.007)
Campaign Exposure	0.004			
	(0.005)			
I^{Post}	0.102***	0.102***	0.025***	
	(0.008)	(0.008)	(0.006)	
Dependent Mean	0.034	0.034	0.034	0.034
Observations	423	423	423	423
State FE		✓	✓	✓
Design Controls			✓	✓
Year FE				✓

Notes: Table reports results from a regression of share enrolled in private health insurance on the interaction of Campaign exposure and I^{Post}. Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. I^{Post} is an indicator for post-Campaign. The sample includes 48 states from the years 1946-1954, where we collapsed Vermont and New Hampshire (see Section IV). Dependent Mean is the unconditional mean of the dependent variable in the pre-period. Design controls include income per capita (Bureau of Economic Analysis 2023), and share unionized (Farber et al. 2021). Robust standard errors clustered at the state level are in parentheses. *, **, *** refer to statistical significance at the 10, 5, and 1 percent level, respectively.

---

calculation see Online Appendix Section F.1. The same section also offers comparisons of the effect of the Campaign to tax subsides for health insurance.

We next turn to how the Campaign affected views regarding NHI. Figure 5 presents the event study estimates from Gallup data using Equation 8. The pre-trend is not significant (p-value for F-test = 0.179) and, if anything, approval for NHI was high (69%) and trending upwards (see Online Appendix Figure D5). Although the survey waves are not evenly spaced, there appears an abrupt reversal in support for NHI of about six percentage points per wave post-Campaign.

Figure 5: Effect of Campaign on
Approval for National Health Insurance Legislation
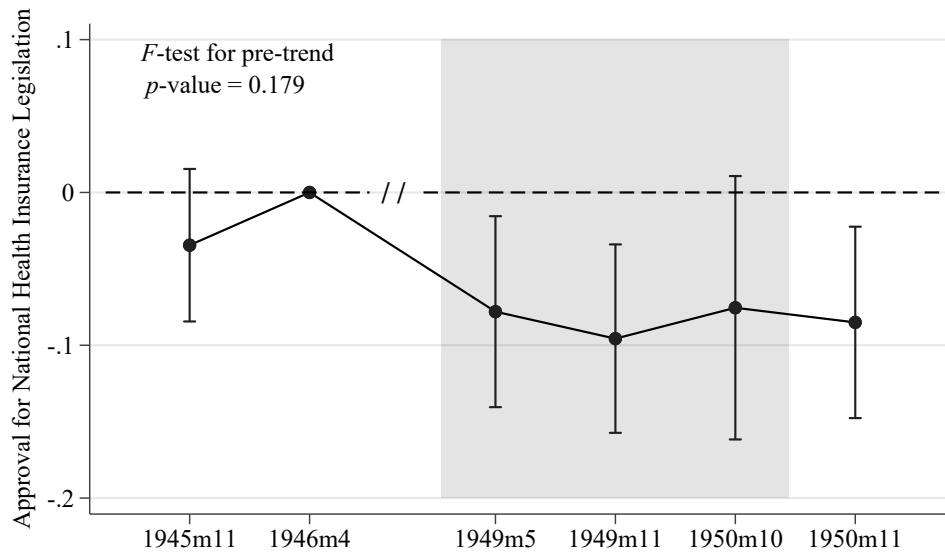
Notes: Figure plots β coefficients from Equation 8 and associated 95% confidence intervals using cluster-robust standard errors. The outcome is an indicator for approval for legislation establishing National Health Insurance. Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. Campaign period is shaded in gray. Individual characteristics described in Table 2 notes are also included (Gallup Organization 1945, 1946, 1949, 1950). Design controls include income per capita (Bureau of Economic Analysis 2023) and share unionized (Farber et al. 2021). Sample weights are applied.

Table 2 provides a summary measure of the Campaign's effect on public opinion. The main effect is again marginally or statistically insignificant in the pre-period across most specifications. The interaction of Campaign exposure and post is negative and significant and indicates that a one standard deviation increase in Campaign exposure reduced support by about six to eight percentage points. The post indicator is also negative, though this could reflect subtle changes in how the legislation was described in the question text. As we move across columns, we add additional controls. Our last column includes individual sociodemographic characteristics – which provide a useful benchmark for our effects and tend to align with the prior literature. For instance, respondents who were Black were 17 percentage points more likely to support NHI than white respondents and union household respondents were about six percentage points more likely to support the policy than respondents whose households were not union affiliated.

Table 2: Effect of Campaign on Approval for National Health Insurance Legislation

	(1)	(2)	(3)	(4)
Campaign Exposure $\times$ I^{Post}	-0.076***	-0.084***	-0.074***	-0.057***
	(0.020)	(0.015)	(0.018)	(0.017)
Campaign Exposure	-0.008	0.000	-0.009	0.019*
	(0.016)	(0.017)	(0.015)	(0.010)
I^{Post}	-0.268***	-0.134***		
	(0.026)	(0.043)		
Dependent Mean	0.684	0.684	0.684	0.684
Observations	5112	5112	5112	5112
State FE	✓	✓	✓	✓
Design Controls		✓	✓	✓
Wave FE			✓	✓
Individual Characteristics				✓

Notes: Table reports a regression of approval for legislation establishing National Health Insurance on the interaction of Campaign exposure and I^{Post}. Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. I^{Post} is an indicator for post-Campaign. The outcome is an indicator for approval using Gallup data (see Online Appendix Table A1) (Gallup Organization 1945, 1946, 1949, 1950). Dependent Mean is the unconditional mean of the dependent variable in the pre-period. Individual Characteristics include a set of indicators for female, Black, age, having a phone, employment status, union membership, job class, and urbanicity. Education (an indicator for high school completion or greater) is included in every specification. Design controls include income per capita (Bureau of Economic Analysis 2023) and share unionized (Farber et al. 2021). State fixed effects are included. Sample weights are applied. Robust standard errors clustered at the state-by-urbanicity level are in parentheses. *, **, *** refer to statistical significance at the 10, 5, and 1 percent level, respectively.

Figure 6 examines heterogeneous effects by individual characteristics. Treatment effects are similar across a range of socioeconomic and demographic variables, with the exception of partisan leaning and urban (as defined by Gallup) residency. Private insurance could have resonated more with urban dwellers given their higher incomes and easier access to hospitals compared to rural respondents. Republican voters also responded more to the Campaign than those who had previously voted Democratic, providing suggestive evidence that the ideological framing had differential appeal across party lines. Lastly, there is a slightly larger effect on male versus female respondents.

Figure 6: Effects of Campaign on Approval for
National Health Insurance Legislation by Individual Characteristics
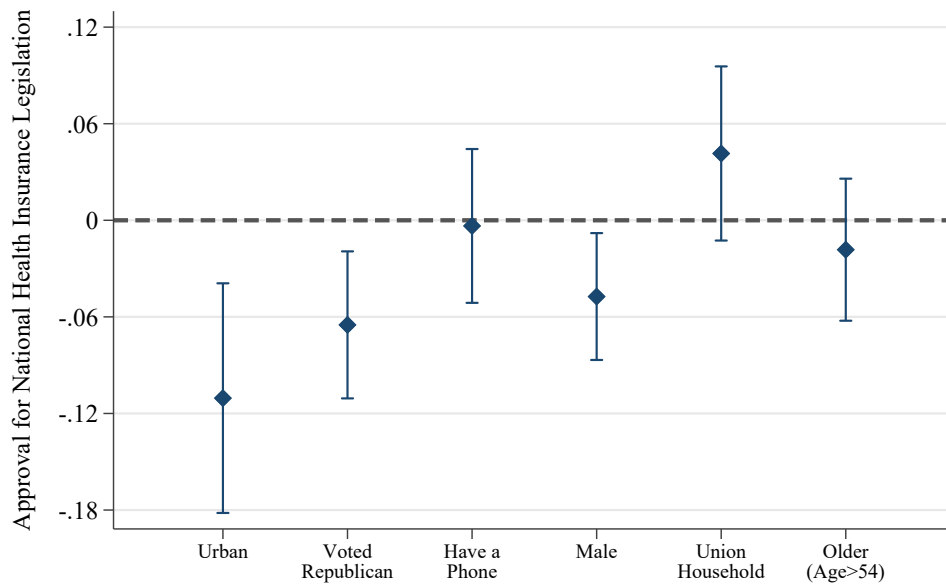
Notes: Figure plots the coefficient on the triple interaction of Campaign exposure, I^{Post}, and the variable on the outcome of approval for National Health Insurance legislation. 95% confidence intervals using cluster-robust standard errors are shown. Sample weights are applied.

Figure 7 explores the relationship between the AMA-WB Campaign and Congress. Panels A and B aggregate terms from the Congressional Record covering years 1947 to 1951 to the monthly level. In Panel A, the frequency of the phrase "health insurance" peaks during the 81st Congress, reaching nearly 200 mentions per month before tapering off by the first session of the 82nd Congress. For comparison, we also plot the frequency of unemployment insurance, another form of social insurance. Unemployment insurance mentions are less frequent and do not exhibit the same spike as health insurance. In Panel B we examine mentions of "American Medical Association" and related terms (*e.g.,* "AMA"). Alongside the AMA, we also include the frequency of mentions for the National Association of Manufacturers (NAM). The NAM had lobbied for the passage of the Taft-Hartley Act in 1947 and the frequency of NAM mentions are highest during that year (Fones-Wolf 1994; Lacey 1989). Yet even at the height of Taft-Hartley activity during the 80th Congress, mentions of the NAM do not reach the same level as mentions of the AMA during the 81st Congress.

Figure 7: Descriptive Analysis of Text from the Congressional Record, 1947-1951
and Petitions Submitted to the 81st Congress

(a) Mentions of Health and Unemployment Insurance
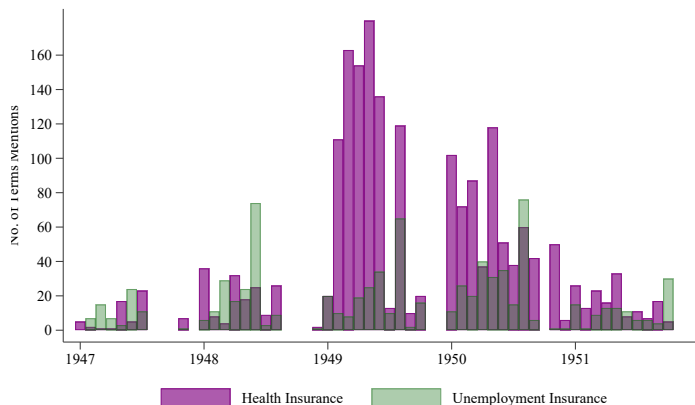
(b) Mentions of American Medical Association (AMA)
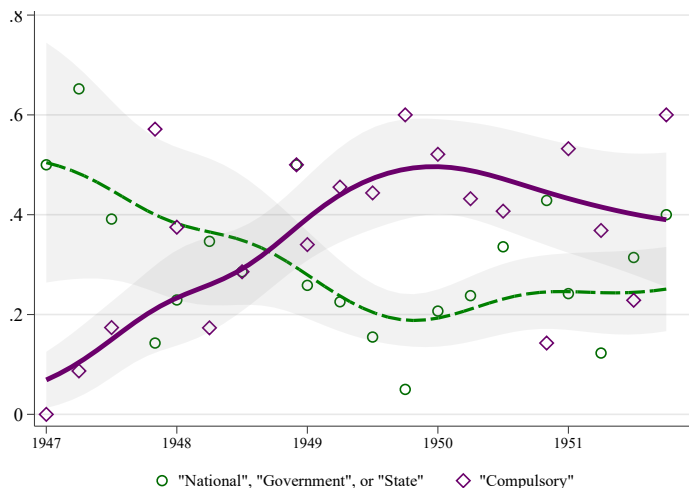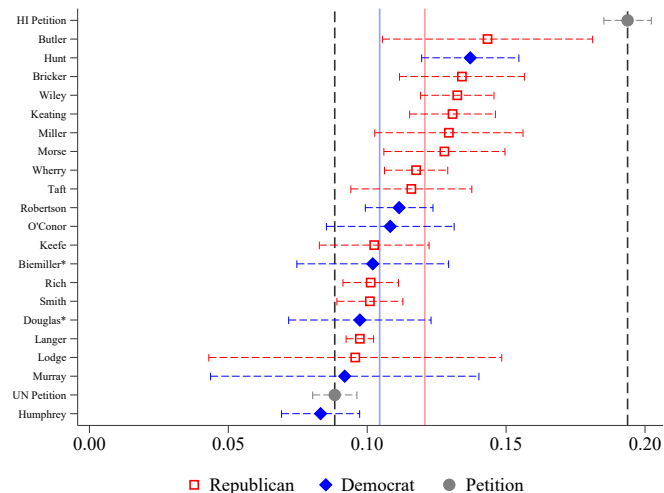and National Association of Manufacturers (NAM)
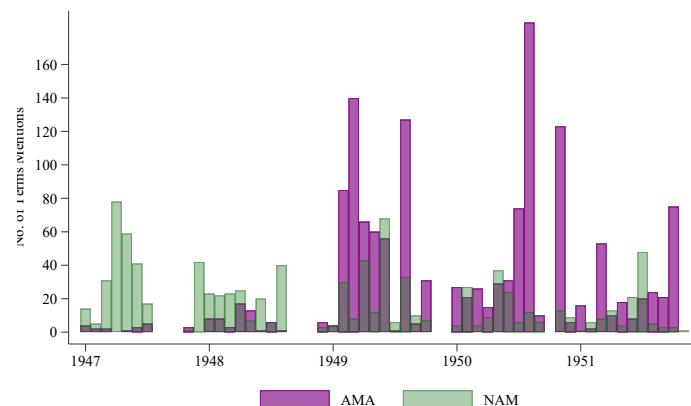
(c) Descriptors for Health Insurance

(d) Cosine Similarity with AMA Propaganda

Notes: Panel A plots the frequency of mentions of the terms Health Insurance (dark purple bars) and Unemployment Insurance (light green bars) from the digitized Congressional Records of the 80th, 81st, and the first session of the 82nd Congress. Panel B uses the same data as in Panel A but plots the frequency of the terms AMA (dark purple bars) and NAM (light green bars). Panel C plots the monthly share of terms used to describe health insurance in the Congressional Record (U.S. Congress 1947, 1948, 1949, 1950, 1951). Green circles are shares of the terms "national health insurance," "government health insurance," and "state health insurance" used over total mentions of "health insurance" in a given part of the record, whereas purple diamonds are shares of the term "compulsory health insurance" used over total mentions of "health insurance." Scatters are the means of each quarter. The curves are fitted using the raw data by local polynomial regressions with a six month bandwidth and 95% confidence intervals. Panel D uses text from petitions obtained from the National Archives in D.C., the text from legislators in the top 25th percentile for mentions of health insurance in the Congressional Record and Campaign propaganda from the *Whitaker & Baxter* Archives in Sacramento, California. The average cosine similarity to the Campaign text is plotted. Confidence intervals are obtained from a bootstrapping procedure with 100 repetitions. Red squares refer to Republicans, blue diamonds refer to Democrats, and gray circles refer to petitions. An asterisk by a legislator's name indicates they were not re-elected to a chamber in the subsequent election cycle.

To understand why the AMA's name was being invoked, we first observe that most of the AMA mentions were by Democratic legislators supportive of NHI (see Online Appendix Figure D6). Turning to our qualitative analysis, the text surrounding mentions of the AMA tends to either acknowledge the organization's influence on pending legislation and/or be critical of the AMA's position. For example, Representative Anthony Tauriello (D-NY) in May 1949, cited an article noting: ''Although most Americans are for this vital part of the Fair Deal, they are being bombarded with an abundance of American Medical Association propaganda against health insurance'' (Tauriello 1949). In October of 1951, Senator William Benton (D-CT) cited *Colliers Magazine*: ''For the AMA lobby is powerful indeed...[T]he real power behind the scenes is the California publicity firm of Whitaker & Baxter which, for the last 2 years, has been directing the American Medical Association's well-heeled national educational campaign aimed at preventing [the legislation's] passage'' (Pepper 1951).

Speaking on the floor of the Senate in June 1950, Senator Murray (D-MT) noted how the AMA framed the health insurance debate: "[t]hat horrible word 'compulsion' which the Republicans and the American Medical Association have used to try to crucify those of us who are in favor of social legislation..." Murray's remarks appear to be supported in Panel C of Figure 7 which plots the share of times health insurance is discussed with a given modifier, averaged over a three-month time span. Comparing pre-post Campaign means, we find an increase in the usage of the term "compulsory" and a corresponding decline in the words "national," "state," or "government" when describing health insurance.

A key part of the AMA-WB Campaign involved doctors asking civic organizations to pass resolutions in support of private health insurance. Table 3 shows this strategy was effective: greater exposure to Campaign material translated into a higher number of resolutions being passed. In our preferred specification (Column 4) a one standard deviation increase in Campaign exposure is associated with 3.4 more civic organizations signing resolutions in support of PHI per 100,000 population per county.

Table 3: Effect of Campaign
on Resolutions Passed by Civic Organizations

	(1)	(2)	(3)	(4)
Campaign Exposure	0.038***	0.038***	0.034***	0.034***
	(0.010)	(0.010)	(0.010)	(0.010)
Dependent Mean	0.138	0.138	0.138	0.138
Observations	3059	3059	3059	3059
State FE	✓	✓	✓	✓
Design Controls			✓	✓
Demographic Controls		✓	✓	

Notes: Table reports results of Equation 9. The outcome is multiplied by 1,000 for readability. Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. Design controls include county level median family income (U.S. Census Bureau 2012) and the demographic controls include the county level employment rate. Dependent Mean is the unconditional mean of the dependent variable. Robust standard errors are in parentheses. *, **, *** refer to statistical significance at the 10, 5, and 1 percent level, respectively.

We track these petitions and resolutions finding they were indeed sent to legislators – discovering several in the D.C. National Archives (National Archives 1950*a*). The number of petitions for health insurance was an order of magnitude higher than for other major topics (225 for NHI versus a dozen for the topic of strengthening the U.N. and the Korean conflict). The relatively high number and boilerplate text of these insurance resolutions provide prima facie evidence of a well-coordinated Campaign.[42]

To further assess Campaign influence on Congress, we compute cosine similarity across data from three sources: (1) Health insurance and U.N. petitions from the National Archives; (2) Legislator speech from the Congressional Record; and (3) AMA-WB Campaign propaganda from the Whitaker & Baxter Archives. We assess how similar speech is between the AMA-WB Campaign items and the legislators or petitioners in the 81st Congress. Panel D plots the average similarity for the top 25th percentile of legislators mentioning "health insurance" (the full Congress is plotted in Online Appendix Figure D7). We exclude quotations that specifically reference the AMA as they are mechanically related. Health insurance petitions have the highest similarity to AMA-WB Campaign text and UN petitions have a relatively low similarity. Most Republican legislators lie between the health insurance and UN petitions, but there are some exceptions: Langer, a Republican from North Dakota espoused many of the same arguments for supporting the legislation as Murray – the Democratic Senator and co-sponsor of the legislation from Montana. Both men argued the bill would relieve critical shortages of healthcare inputs and financing in rural areas. An asterisk by the name of the legislator indicates they were defeated in the next election. This includes prominent critics of the AMA: Andrew Biemiller of Wisconsin and Helen Gahagan Douglas of California.

Table 4 relates Campaign exposure to the speech of every member of the 81st Congress. Each observation is a legislator-quotation. The dependent mean is the average outcome across Republicans in the sample. In Columns 1 and 2, Campaign exposure does not appear to influence the extensive margin of discussing health insurance overall or by party. For subsequent columns, given that there is no evidence of an effect of the Campaign on the extensive margin, we limit to the sample of quotations that reference health insurance to assess whether the Campaign affected the way in which the topic was discussed. In Columns 3 and 4 we also note that Campaign exposure does not predict AMA mentions, but consistent with Online Appendix Figure D6, Democratic legislators were 30.8 percentage points more likely to mention the interest group than their Republican colleagues. When computing cosine similarity, we thus drop explicit reference to the AMA as it may contain direct quotations.

Columns 5 and 7 show positive small overall effects of the Campaign exposure on mentions of the phrase "political medicine" and cosine similarity between legislator text and AMA-WB Propaganda. Yet these small positive average effects mask substantial heterogeneity by party. Columns 6 and 8 fully saturate the exposure in partisanship: A one standard deviation increase in Campaign exposure leads to a nine percentage point (33%) increase in mentions of the phrase political medicine for Republicans and a four percentage point decline for Democrats. The partisan gap between Republican and Democratic reactions is statistically significant with a *p*-value of 0.002. A one standard deviation increase in Campaign exposure also leads to about a ten percent increase in similarity to AMA-WB messaging among Republicans, which again is oppositely signed and significantly different from the effect on Democratic legislators (*p*-value of 0.010).

---

[42]One of the resolutions from the Kiwanis Club had not fully scratched out the header, which read: "SUGGESTED GENERAL RESOLUTION (We suggest that you may desire to tailor this form resolution to the particular policies and objectives of your organization)" (National Archives 1950*a*).

Table 4: Effect of Campaign on Congressional Discourse

	Mentions of Health Insurance		Mentions of AMA		Mentions of Polit. Med		Cosine Sim. with AMA-WB Propaganda	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Campaign Exposure	0.00007		-0.00904		0.030		0.00538*	
	(0.00010)		(0.01993)		(0.021)		(0.00285)	
Campaign Exposure $\times I^{\text{Republican}}$		0.00021		-0.013		0.091**		0.011**
		(0.00019)		(0.022)		(0.036)		(0.004)
Campaign Exposure $\times I^{\text{Democrat}}$		-0.00001		-0.004		-0.044*		-0.003
		(0.00011)		(0.035)		(0.024)		(0.003)
I^{Democrat}		-0.00014		0.308***		-0.119***		-0.023***
		(0.00022)		(0.038)		(0.034)		(0.004)
I^{Democrat} + Campaign Exposure $\times I^{\text{Democrat}}$		-0.000		0.304***		-0.163***		-0.027***
		(0.000)		(0.054)		(0.040)		(0.005)
Rep. = Dem. [p-value]		0.339		0.826		0.002		0.010
Dependent Mean	0.003	0.003	0.146	0.146	0.272	0.272	0.117	0.117
Observations	233,268	233,268	545	545	545	545	385	385
Number of Legislators	536	536	185	185	185	185	163	163
Design Controls	✓	✓	✓	✓	✓	✓	✓	✓

Notes: Table reports results of a regression of indicator variables for mentions of specific phrases given by the column heading (Column 1-6) or the cosine similarity between legislator text and AMA-WB Campaign propaganda (Column 7-8) on Campaign exposure. The number of unique legislators sometimes exceeds 535 due to staggered terms in Congress. Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. I^{Democrat} is an indicator for Democrat party member. Mean is the unconditional mean of the dependent variable among Republicans. Health Insurance (Column 1-2) is defined as a binary variable indicating whether the speech mentioned "health insurance." Subsequent columns condition on mentioning "health insurance." Design controls include state level share unionized (Farber et al. 2021) and congressional district level income aggregated from county level median family income (U.S. Census Bureau 2012). *, **, *** denote statistical significance at the 10, 5, and 1 percent levels, respectively. Standard errors are clustered at the state level.

Given that Republican legislators adopted the language of the AMA-WB Campaign when discussing health insurance, it is perhaps not surprising that by 1952 their official party platform had endorsed private health insurance. Table 5 investigates whether physicians with greater exposure to the Campaign were more likely to donate to the 1952 Republican presidential ticket of Eisenhower and Nixon. The main effect of the Campaign is significant with donations occurring in the post-Campaign period. A one standard deviation increase in Campaign exposure is associated with a 0.3 percentage point increase in the probability of donating to the Eisenhower-Nixon ticket, which is three times larger than the sample mean of non-AMA physicians. The effect of the Campaign is doubled among AMA physicians who were donating at a rate five times higher than non-AMA members. These effects are relatively stable across different specifications, including adding individual characteristics and design controls (similar results are obtained using amount donated, see Online Appendix Table C4).

Table 5: Effect of Campaign on
Donating to Eisenhower-Nixon Ticket

	(1)	(2)	(3)	(4)
Campaign Exposure $\times$ I^{AMA}	0.006***	0.006***	0.006***	0.006***
	(0.001)	(0.001)	(0.001)	(0.001)
Campaign Exposure	0.003***	0.003***	0.003***	0.003***
	(0.001)	(0.001)	(0.001)	(0.001)
I^{AMA}	0.005***	0.005***	0.005***	0.005***
	(0.000)	(0.000)	(0.000)	(0.000)
Dependent Mean	0.001	0.001	0.001	0.001
Observations	166,507	166,507	166,507	166,507
State FE	✓	✓	✓	✓
Individual Characteristics			✓	✓
Design Controls		✓		✓

Notes: Table reports results of a regression for donations to the Eisenhower-Nixon Campaign in 1952. Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. I^{AMA} is an indicator for whether the physician was a member of the AMA. Individual physician characteristics include age, an indicator for faculty, an indicator for specialist, and an indicator for currently being in practice (American Medical Association 1950*a*). Design controls include county level median family income (U.S. Census Bureau 2012), and state level share unionized (Farber et al. 2021). Dependent Mean is the unconditional mean of the dependent variable for non-AMA physicians. Robust standard errors clustered at the county level are in parentheses. *, **, *** refer to statistical significance at the 10, 5, and 1 percent level, respectively.

VI.1 Robustness Checks

We perform several tests to address possible threats to identification. To address concerns regarding Campaign exposure exogeneity, we show robustness to potentially confounding variables. Online Appendix Tables C1, C2, and C3 include controls for war bond penetration, which has been linked to Republican electoral success in the 1950s (Brunet, Hilt and Jaremski 2023), unit-year pre-trends (Miller 2023), Blue Cross hospitals, the passage of enabling legislation, trends in the 1950 share of specialist physicians, and New Deal spending, which impacted local economic activity (Fishback, Horrace and Kantor (2005), Fishback (2017)).[43] We also control for linear trends in the share of AMA members and the share educated in Online Appendix Table C5. Our understanding is that the use of radio was limited relative to the other components in the Campaign, yet estimates are similar when including radio and television penetration controls (Online Appendix Table C6).

Second, we verify that our results are not sensitive to precisely how we define the exposure or outcome: Using a dichotomous treatment for above and below median produces similar conclusions (Column 7 of Online Appendix Tables C1 and C2, and Column 8 of Online Appendix Table C3). Constructing the exposure with printed propaganda materials leads to comparable estimates for enrollment and civic organizations (Column 9 of Online Appendix Table C1 and Column 7 of Online Appendix Table C3) but is weaker for public opinion (Column 9 of Online Appendix Table C2). Separately including Campaign components yields coefficients that are statistically indistinguishable from each other for PHI enrollment, NHI approval, and civic organization endorsement (Columns 1, 3, and 5 of Online Appendix Table C7). However, for the outcome of physician lobbying, the physician component is driving the overall effect, as might be expected. Estimates from the multiplicative form suggest complementarity of the two components (even-numbered Columns in Online Appendix Table C7) again for every outcome except direct lobbying. For PHI enrollment, we consider an alternate denominator: the total White working-age male population instead of the total population (Online Appendix Table C1 Column 10). Results are predictably larger but otherwise similar. We also assess robustness to different weights in the Gallup poll data (Online Appendix Table C2 Column 10).

Regarding our identifying assumption, we compute the F-test on pre-trends in all our main analyses.[44] We also perform sensitivity analyses as proposed by Rambachan and Roth (2023) allowing for potential parallel trends violations (Column 8 of Online Appendix Tables C1 and C2), and estimates remain stable. We produce non-parametric estimates of the average causal response, adjusting for the TWFE weighting schemes (Online Appendix Table C8) (Callaway, Goodman-Bacon and Sant'Anna 2024). Results are similar to our main estimates in Table 1.

Although McCarthyism grew to full strength on the heels of the AMA-WB Campaign, perhaps Whitaker & Baxter were mimicking a common marketing ruse which was to use fears of Communism to sell products. To investigate this, we first collect a random sample of ads from the same newspapers that ran AMA-WB Campaign ads a month prior to the dates indicated on Lockwood-Shackleford invoices. We searched for common AMA-WB Campaign phrases such as "American way," "freedom," "socialism," "socialist," "communism," "communist," and "tyranny." Online Appendix Table C9 shows negligible rates of these terms in random ads. In stark contrast, about 90% of AMA-WB related ads contained such terms (Columns 1 and 2) and on average each ad contained four to five of these words (Columns 3 and 4). We also drop California given that Hollywood was a target for Red Scare tactics (Humphries 2008). The results excluding the state are fairly similar to our baseline results (see Column 11 of Online Appendix Tables C1 and C2 and Column

---

[43]As noted by Lee and Solon (2011) and summarized by Goodman-Bacon (2021, p.2561), unit-specific linear time trends "cannot distinguish between time-varying treatment effects and preexisting trends." We follow Goodman-Bacon (2021) and omit these, given that time-varying treatment effects are demonstrated in Figure 4, and instead per Miller (2023), estimate unit-specific pre-trends in Column 1 of Online Appendix Tables C1 and C2.

[44]We estimate effects using deciles of Campaign exposure. Online Appendix Figures D8 and D9 demonstrate approximately linear dose responsive behavior for PHI enrollment and public opinion.

9 of Online Appendix Table C3).

Lastly, we return to the Gallup data, this time using questions on anti-Russian sentiment. Online Appendix Figure D10 demonstrates that Campaign exposure is not associated with Russian disapproval before or after the AMA-WB Campaign initiation. Thus it does not appear likely that our results can be ascribed to broader movements in anti-Communist sentiment.

VII   Conclusion

Our analyses demonstrate that the rise of private health insurance in the U.S. can in part be attributed to a coordinated campaign against universal, tax-financed health insurance. At this critical juncture, when support for NHI was strong – backed by the executive branch, a Democratic legislative branch, and was being implemented in peer nations worldwide – efforts to derail implementation succeeded by using the rhetoric of freedom and providing a private alternative that would persist. The Campaign increased enrollment in PHI, reduced support for NHI, and led to the use of language from the Campaign by Republican Congressional representatives when debating health insurance legislation.

The Campaign may have affected the current U.S. healthcare landscape in other ways not included in our analyses. For example, the growth of private health insurance, and particularly group enrollment through employment, left many retirees aged 65 and above without insurance previously obtained through their employer and may have contributed to the establishment of Medicare (McClellan and Skinner 2006). Future work may elucidate whether the Campaign had spillover effects on other countries or other forms of social insurance. A related and open question is how other countries overcame resistance from the medical lobby and achieved universal health coverage.

Bibliography

Abramitzky, Ran, Leah Boustan, Katherine Eriksson, James Feigenbaum, and Santiago Pérez. 2021. "Automated Linking of Historical Data." *Journal of Economic Literature*, 59(3): 865–918.

Acemoglu, Daron, Georgy Egorov, and Konstantin Sonin. 2021. "Institutional change and institutional persistence." In *The Handbook of Historical Economics*. 365–389. Elsevier.

Alesina, Alberto, Armando Miano, and Stefanie Stantcheva. 2020. "The Polarization of Reality." *AEA Papers and Proceedings*, 110: 324–328.

Alsan, Marcella, Owen Garrick, and Grant Graziani. 2019. "Does Diversity Matter for Health? Experimental Evidence from Oakland." *American Economic Review*, 109(12): 4071–4111.

American Hospital Association. 1948. *American Hospital Directory.* Chicago: American Hospital Association.

American Hospital Association. 1950. *American Hospital Directory.* Chicago: American Hospital Association.

American Hospital Association. 1952. *American Hospital Directory.* Chicago: American Hospital Association.

American Medical Association. 1910, 1920, 1923, 1929, 1930, 1934, 1940, 1950*b*. *House of Delegates Proceedings of the American Medical Association, Annual Session.* American Medical Association Archives. https://ama. nmtvault.com/jsp/PsBrowse.jsp.Accessed: 10/01/2023.

American Medical Association. 1942. *American Medical Directory.* Chicago: American Medical Association.

American Medical Association. 1950*a*. *American Medical Directory.* Chicago: American Medical Association.

American Medical Association. 1950*c*. "Who Runs America? the Congress? the President? OR YOU AND THE MAN NEXT DOOR?" *Athens Alabama Courier*, October 12.

American Medical Association. 1972. "Veterans Administration Medical Care, the Private Physician: Report of the Council of Medical Services." In *House of Delegates Proceedings, Annual Session*. American Medical Association Archives. https://ama.nmtvault.com/jsp/PsBrowse.jsp. Accessed: 10/01/2023.

American Medical Association. 2023. "AMA history." American Medical Association. https://www. ama-assn.org/about/ama-history/ama-history. Accessed: 07/11/2023.

Anderson, Odin Waldemar. 1968. *The Uneasy Equilibrium: Private and Public Financing of Health Services in the United States, 1875-1965.* New Haven: College & University Press.

Ayer, N. W. 1949. *N.W. Ayer & Son's Directory of Newspapers and Periodicals.* Philadelphia: N. W. Ayer.

Bachman, George W., and Lewis Meriam. 1948. *The Issue of Compulsory Health Insurance: A Study Prepared at the Request of Senator H. Alexander Smith, Chairman of the Subcommittee on Health of the Senate Committee on Labor and Public Welfare.* Washington, D.C.: Brookings Institution.

Baicker, Katherine, Amitabh Chandra, and Mark Shepard. 2023. "Achieving Universal Health Insurance Coverage in the United States: Addressing Market Failures or Providing a Social Floor?" *Journal of Economic Perspectives*, 37(2): 99–122.

Becker, Gary S. 1985. "Public Policies, Pressure Groups, and Dead Weight Costs." *Journal of Public Economics*, 28(3): 329–347.

Begeman, Jean. 1950. "The Crude Big Lie." *The New Republic*, October 2. https://newrepublic.com/article/ 122400/american-medical-association-vs-national-insuranceAccessed: 10/01/2023.

Berinsky, Adam, and Eric Schickler. 2020. "The American Mass Public in the 1930s and 1940s [Computer file]. Individual surveys conducted by the Gallup Organization [producers], 1936–1952." Roper Center for Public Opinion Research, University of Connecticut [distributor].

Bertrand, Marianne, Matilde Bombardini, Raymond Fisman, and Francesco Trebbi. 2020. "Tax-Exempt Lobbying: Corporate Philanthropy as a Tool for Political Influence." *American Economic Review*, 110(7): 2065–2102.

Blackhawk, Maggie, Daniel Carpenter, Tobias Resch, and Benjamin Schneer. 2020. "The Contours of American Congressional Petitioning, 1789-1949: A New Database." https://dcarpenter.scholar.harvard.edu/files/dcarpenter/files/contours.pdf.

Blue Cross Blue Shield Association. 1997. "BCBSA History Fact Sheet." Communications Division of the Blue Cross and Blue Shield Association. https://digitalcommons.unf.edu/cgi/viewcontent.cgi?article=3089&context=flablue_text. Accessed: 10/01/2023.

Blumenthal, David, and James Morone. 2010. *The Heart of Power: Health and Politics in the Oval Office.* Berkeley: University of California Press.

Board of Trustees of Mississippi State Medical Association. 1965. "Blue Shield in the United States." Mississippi State Medical Association.

Bombardini, Matilde, and Francesco Trebbi. 2020. "Empirical Models of Lobbying." *Annual Review of Economics*, 12: 391–413.

Bordo, Michael, Claudia Goldin, and Eugene White. 1998. "The Defining Moment Hypothesis: The Editors' Introduction." *The Defining Moment: The Great Depression and the American Economy in the Twentieth Century*, 1–20. Chicago: University of Chicago Press.

Breza, Emily, Fatima Cody Stanford, Marcella Alsan, Burak Alsan, Abhijit Banerjee, Arun G. Chandrasekhar, Sarah Eichmeyer, Traci Glushko, Paul Goldsmith-Pinkham, Kelly Holland, Emily Hoppe, Mohit Karnani, Sarah Liegl, Tristan Loisel, Lucy Ogbu-Nwobodo, Benjamin A. Olken, Carlos Torres, Pierre-Luc Vautrey, Erica T. Warner, Susan Wootton, and Esther Duflo. 2021. "Effects of a large-scale social media advertising campaign on holiday travel and COVID-19 infections: a cluster randomized controlled trial." *Nature Medicine*, 27(9): 1622–1628.

Brown, Lawrence D., and Sherry A. Glied. 2020. "Regression to the increasingly mean? Private health insurance in the United States of America." *Private Health Insurance: History, Politics and Performance*. of *European Observatory on Health Systems and Policies*, ed. Sarah Thomson, Anna Sagan and Elias Mossialos, Chapter 15, 494–524. Cambridge University Press.

Brunet, Gillian, Eric Hilt, and Matthew Jaremski. 2023. "Inflation, War Bonds, and the Rise of Republicans in the 1950s." *NBER Working Paper No. 31969*.

Bureau of Economic Analysis. 2023. "Personal Income by Major Component and Earnings by Industry (Historical)." https://apps.bea.gov/regional/histdata/releases/0922spi/index.cfm Accessed: 10/01/2023.

Burrow, James Gordon. 1963. *AMA: Voice of American Medicine.* Baltimore: Johns Hopkins Press.

Bursztyn, Leonardo, Jonathan T Kolstad, Aakaash Rao, Pietro Tebaldi, and Noam Yuchtman. 2022. "Political Adverse Selection." *NBER Working Paper No. 30214*.

Callaway, Brantly, Andrew Goodman-Bacon, and Pedro HC Sant'Anna. 2024. "Difference-in-Differences with a Continuous Treatment." *NBER Working Paper No. 32117*.

Case, Anne, and Angus Deaton. 2020. *Deaths of Despair and the Future of Capitalism.* Princeton: Princeton University Press.

Caughey, Devin, Adam J. Berinskey, Sara Chatfield, Erin Hartman, Eric Schickler, and Jasjeet S. Sekhon. 2020. *Target Estimation and Adjustment Weighting for Survey Nonresponse and Sampling Bias.* In *Elements in Quantitative and Computational Methods for the Social Sciences*. New York: Cambridge University Press.

Chandra, Amitabh, David Cutler, and Zirui Song. 2011. "Who Ordered That? The Economics of Treatment Choices in Medical Care." *Handbook of Health Economics*. Vol. 2, ed. Mark V. Pauly, Thomas G. Mcguire and Pedro P. Barros, Chapter 6, 397–432. Elsevier.

Chang, Don Mark. 1953. "Labor Political Action and the Taft-Hartley Act." *Nebraska Law Review*, 33: 554.

Chetty, Raj, Michael Stepner, Sarah Abraham, Shelby Lin, Benjamin Scuderi, Nicholas Turner, Augustin Bergeron, and David Cutler. 2016. "The Association Between Income and Life Expectancy in the United States, 2001-2014." *JAMA*, 315(16): 1750–1766.

Clay, Karen, Grant Miller, Margarita Portnykh, and Ethan Schmick. 2023. "Medical School Closures and Health Care Market Adjustment in the Flexner Report Era." NBER Summer Institute - Development of the American Economy.

Coate, Stephen, and Stephen Morris. 1999. "Policy persistence." *American Economic Review*, 89(5): 1327–1336.

Corning, Peter A. 1969. *The Evolution of Medicare: From Idea to Law.* Washington, D.C.: US Social Security Administration, Office of Research and Statistics.

Council on Medical Service. 1946-1954. *Voluntary Prepayment Medical Care Plans.* Chicago: American Medical Association.

Craig, Paul C. 1950. "Auxiliary Cooperation in the National Education Campaign." In *Inventory of the Whitaker & Baxter Campaigns, Inc. Records*. Sacramento: California State Archives. Collection Number C134.1.43, Box 9/31.

Cutler, David M, and Richard Johnson. 2004. "The Birth and Growth of the Social Insurance State: Explaining Old Age and Medical Insurance Across Countries." *Public Choice*, 120(1/2): 87–121.

Cutlip, Scott M. 1994. "Whitaker & Baxter: Architects of the New Politics." *The Unseen Power: Public Relations: A History*, Chapter 19, 611–655. Taylor & Francis.

DellaVigna, Stefano, and Matthew Gentzkow. 2010. "Persuasion: Empirical Evidence." *Annual Review of Economics*, 2(1): 643–669.

Derickson, Alan. 1994. "Health Security for All? Social Unionism and Universal Health Insurance, 1935-1958." *Journal of American History*, 80(4): 1333–1356.

Dickinson, Frank G. 1949. "Misuse of American Medical Association Data." *Journal of the American Medical Association*, 140(15): 1234–1237.

Dimmitt, Michael. 2007. *Ninety Years of Health Insurance Reform Efforts in California.* Sacramento: California State Library, California Research Bureau.

Doherty, Kathleen, and Jeffery A Jenkins. 2009. "Examining a Failed Moment: National Health Care, the AMA, and the US Congress, 1948–50." *Annual Meeting of the Southern Political Science Association*. New Orleans.

Eilers, Robert Dale. 1963. *Regulation of Blue Cross and Blue Shield Plans.* University of Pennsylvania.

Einav, Liran, and Amy Finkelstein. 2023. *We've Got You Covered: Rebooting American Health Care.* New York: Penguin Publishing Group.

Ellis, Randall P., and Thomas G. McGuire. 1986. "Provider Behavior Under Prospective Reimbursement: Cost Sharing and Supply." *Journal of Health Economics*, 5(2): 129–151.

Evans, M. G. 1949. "Meet Whitaker & Baxter." *Medical Economics*, 26: 62–64.

Farber, Henry S, Daniel Herbst, Ilyana Kuziemko, and Suresh Naidu. 2021. "Unions and Inequality over the Twentieth Century: New Evidence from Survey Data." *The Quarterly Journal of Economics*, 136(3): 1325–1385.

Feldstein, Martin, and Bernard Friedman. 1977. "Tax Subsidies, the Rational Demand for Insurance and the Health Care Crisis." *Journal of Public Economics*, 7: 155–178.

Fetter, Daniel. 2017. "Local government and old-age support in the New Deal." *Explorations in Economic History*, 66: 1–20.

Fetter, Daniel K., and Lee M. Lockwood. 2018. "Government Old-Age Support and Labor Supply: Evidence from the Old Age Assistance Program." *American Economic Review*, 108(8): 2174–2211.

Fishback, Price. 2017. "How Successful Was the New Deal? The Microeconomic Impact of New Deal Spending and Lending Policies in the 1930s." *Journal of Economic Literature*, 55(4): 1435–1485.

Fishback, Price, and Shawn Kantor. 2018. "New Deal Studies: New Deal Spending." Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor]. https://doi.org/10.3886/E101199V1-24102. Accessed: 10/01/2024.

Fishback, Price V., William C. Horrace, and Shawn Kantor. 2005. "Did New Deal Grant Programs Stimulate Local Economies? A Study of Federal Grants and Retail Sales during the Great Depression." *The Journal of Economic History*, 65(1): 36–71.

Fones-Wolf, Elizabeth A. 1994. *Selling Free Enterprise: The Business Assault on Labor and Liberalism, 1945-60.* Urbana: University of Illinois Press. Includes bibliographical references (pp. [291]-295) and index.

Freitas-Groff, Zach. 2024. "Persistence in Policy: Evidence from Close Votes." *Working Paper*.

Gallup Organization. 1945, 1946, 1949, 1950. "Gallup Public Opinion Polls."

Gallup Organization. 1946. "Gallup Poll 1946-0369: Atomic Bomb/Unified Armed Forces/Foreign Affairs/Health Insurance, 1946 [Dataset]." Roper #31087352, Version 3. Gallup Organization [producer]. Cornell University, Ithaca, NY: Roper Center for Public Opinion Research [distributor]. Accessed: 12/07/2023.

Galvani, Alison, Alyssa S. Parpia, Abhishek Pandey, Pratha Sah, Kenneth Colón, Gerald Friedman, Travis Campbell, James G. Kahn, Burton H. Singer, and Meagan C. Fitzpatrick. 2022. "Universal healthcare as pandemic preparedness: The lives and costs that could have been saved during the COVID-19 pandemic." *Proceedings of National Academy of Science*, e2200536119.

Gentzkow, Matthew, Jesse Shapiro, and Matt Taddy. 2019. "Measuring Group Differences in High-Dimensional Choices: Method and Application to Congressional Speech." *Econometrica*, 4: 1307–1340.

Goda, Gopi Shah. 2011. "The impact of state tax subsidies for private long-term care insurance on coverage and Medicaid expenditures." *Journal of Public Economics*, 95(7-8): 744–757.

Goodman-Bacon, Andrew. 2021. "The Long-Run Effects of Childhood Insurance Coverage: Medicaid Implementation, Adult Health, and Labor Market Outcomes." *American Economic Review*, 111(8): 2550–93.

Graf, William. 1947. "Statistics of the Congressional Election of November 5, 1946." *Clerk of the U.S. House of Representatives*.

Griffith, Robert. 1983. "The Selling of America: The Advertising Council and American Politics, 1942–1960." *Business History Review*, 57(3): 388–412.

Gross, Daniel P., and Bhaven N. Sampat. 2023. "America, jump-started: World War II R&D and the takeoff of the US innovation system." *American Economic Review*, 113(12): 3323–3356.

Gruber, Jonathan. 2002. "Taxes and Health Insurance." *Tax Policy and the Economy*. Vol. 16, ed. James Poterba, 37–66. MIT Press.

Gruber, Jonathan. 2003. "Evaluating Alternative Approaches to Incremental Health-Insurance Expansion." *American Economic Review*, 93: 271–276.

Gruber, Jonathan. 2011. "The Tax Exclusion for Employer-Sponsored Health Insurance." *National Tax Journal*, 64(2): 511–530.

Gruber, Jonathan, and Brigitte C. Madrian. 1997. "Employment Separation and Health Insurance Coverage." *Journal of Public Economics*, 66: 349–382.

Gruber, Jonathan, and Ebonya Washington. 2005. "Subsidies to employee health insurance premiums and the health insurance market." *Journal of Health Economics*, 24(2): 253–276.

Gruber, Jonathan, and James Poterba. 1994. "Tax Incentives and the Decision to Purchase Health Insurance: Evidence from the Self-Employed." *The Quarterly Journal of Economics*, 109: 701–733.

Haines, Michael R. 2010. "Historical, Demographic, Economic, and Social Data: The United States, 1790-2002." Inter-university Consortium for Political and Social Research. https://www.icpsr.umich.edu/web/ICPSR/studies/2896 Accessed: 10/01/2023.

Hammonds, Evelynn. 2003. "Interview with Evelynn Hammonds." *RACE – The Power of an Illusion. Background Readings*. PBS. https://www.pbs.org/race/000_About/002_04-background-01-05.htm Accessed: 09/29/2023.

Harbison, Frederick H. 1950. "The General Motors-United Auto Workers Agreement of 1950." *Journal of Political Economy*, 58(5): 397–411.

Harry S. Truman. 1956. *Memoirs by Harry S. Truman.* Garden City, N.Y.: Doubleday and Company Inc.

Henderson, Elmer L. 1949. "Report of Coordinating Committee." *House of Delegates Proceedings of the American Medical Association, Clinical Session*. American Medical Association Archives. http://ama.nmtvault.com/jsp/PsImageViewer.jsp?doc_id=1ee24daa-2768-4bff-b792-e4859988fe94%2Fama_arch%2FHOD00001%2F00000046&pg_seq=1. Accessed: 10/01/2023.

Himmelstein, David U, Samuel L Dickman, Danny McCormick, David H Bor, Adam Gaffney, and Steffie Woolhandler. 2022. "Prevalence and Risk Factors for Medical Debt and Subsequent Changes in Social Determinants of Health in the US." *JAMA*, 5(9): e2231898–e2231898.

Hoffman, Beatrix. 2001. *The Wages of Sickness: The Politics of Health Insurance in Progressive America. Studies in Social Medicine*, Chapel Hill: University of North Carolina Press.

Holmer, Martin. 1984. "Tax Policy and the Demand for Health Insurance." *Journal of Health Economics*, 3: 203–221.

Humphries, Reynold. 2008. *Hollywood's Blacklists: A Political and Cultural History.* Edinburgh: Edinburgh University Press.

Inland Steel Co. v. National Labor Rel. Board 170 F.2d 247 (7th Cir.). 1949.

Institute of Medicine. 1993. *Employment and Health Benefits: A Connection at Risk.* Washington, D.C.: The National Academies Press.

Inter-university Consortium for Political and Social Research. 2010. "United States Congressional Roll Call Voting Records, 1789-1998 (ICPSR 4)." Inter-university Consortium for Political and Social Research. https://www.icpsr.umich.edu/web/ICPSR/studies/4. Accessed: 10/01/2024.

Johnson, Dennis W. 2016. "In the Beginning, Whitaker and Baxter." *Democracy for Hire: A History of American Political Consulting*. Oxford University Press.

Judge-Lord, Devin. 2022. "congressionalrecord: Scrape, Parse, and Analyze the Congressional Record." https://judgelord.github.io/congressionalrecord/, https://github.com/judgelord/congressionalrecord.

Kallenbach, Joseph E. 1948. "The Taft-Hartley Act and Union Political Contributions and Expenditures." *Minnesota Law Review*, 33(1): 1–26.

Kendall, John W. 1995. "The evolution of American Medical Association policies concerning health care of veterans." *Military Medicine*, 160(10): 518–521.

Kluender, Raymond, Neale Mahoney, Francis Wong, and Wesley Yin. 2021. "Medical Debt in the US, 2009-2020." *JAMA*, 326(3): 250–256.

Knoblauch, Heidi. 2014. ""A Campaign Won as a Public Issue Will Stay Won": Using Cartoons and Comics to Fight National Health Care Reform, 1940s and Beyond." *American Journal of Public Health*, 104(2): 227–236.

Krugman, Paul. 2012. "Death by Ideology." *The New York Times Accessed: 10/01/2023.*

Lacey, Michael J. 1989. *The Truman Presidency.* Washington, D.C.; Cambridge [England]; New York: Woodrow Wilson International Center for Scholars; Cambridge University Press. Includes Congresses on Truman's political and foreign relations from 1945-1953.

Leeds, Morton. 1950. "The AFL in the 1948 Elections." *Social Research*, 17(2): 207–218.

Lee, Jin Young, and Gary Solon. 2011. "The Fragility of Estimated Effects of Unilateral Divorce Laws on Divorce Rates." *NBER Working Paper No. 16773.*

Lewis, Randall A., and Justin M. Rao. 2015. "The Unfavorable Economics OF Measuring The Returns TO Advertising." *The Quarterly Journal of Economics*, 130(4): 1941–1974.

Lindert, Peter H. 1994. "The Rise of Social Spending, 1880-1930." *Explorations in Economic History*, 31(1): 1–37.

Linford, Alton A. 1946. "Review of National Health Program: Hearings before the Committee on Education and Labor, United States Senate, 79th Congress, 2d Session, on S. 1606, a Bill to Provide for a National Health Program, April 2 to July 10, 1946." *Social Service Review*, 20(4): 595–597.

Madrian, Brigitte C. 1994. "Employment-Based Health Insurance and Job Mobility: Is there Evidence of Job-Lock?" *The Quarterly Journal of Economics*, 109: 27–54.

Markel, Howard. 2015. "Give'em Health, Harry." *The Milbank Quarterly*, 93(1): 1–7.

McClellan, Mark, and Jonathan Skinner. 2006. "The Incidence of Medicare." *Journal of Public Economics*, 90(1): 257–276.

Miller, Douglas L. 2023. "An Introductory Guide to Event Study Models." *Journal of Economic Perspectives*, 37(2): 203–30.

Mitchell, Daniel J.B. 2002. "Impeding Earl Warren: California's health insurance plan that wasn't and what might have been." *Journal of Health Politics, Policy and Law*, 27(6): 947–976.

Moehling, Carolyn M., Gregory T. Niemesh, Melissa A. Thomasson, and Jaret Treber. 2020. "Medical Education Reforms and the Origins of the Rural Physician Shortage." *Cliometrica*, 14: 181–225.

Morrisey, Michael. 2013. *Health Insurance, Second Edition.* Chicago: Health Administration Press.

Morris, Gabrielle. 1988. "Oral History Interview with Clement Sherman Whitaker, Jr." *California State Archives State Government Oral History Program.*

Mullainathan, Sendhil, Joshua Schwartzstein, and Andrei Shleifer. 2008. "Coarse Thinking and Persuasion." *The Quarterly Journal of Economics*, 123(2): 577–619.

National Archives. 1950*a*. "Compulsory Health Insurance and Socialized Medicine." Interstate and Foreign Commerce Committee; Records of the United States House of Representatives; 81st Congress; Record Group 233; HR81A - H7.2, National Archives Building, Washington, DC.

National Archives. 1950*b*. "Korea." Committee on Foreign Affairs; Records of the United States House of Representatives; 81st Congress; Record Group 233; HR81A - H5.5 to HR 81A-H5.8, National Archives Building, Washington, DC.

National Archives. 1950*c*. "Strengthening of the United Nations." Committee on Foreign Affairs; Records of the United States House of Representatives; 81st Congress; Record Group 233; HR81A - H5.5 to HR 81A-H5.8, National Archives Building, Washington, DC.

National Physicians' Committee for the Extension of Medical Service. 1947-1949. "National Physicians' Committee for the Extension of Medical Service Records." Hanna Holborn Gray Special Collections Research Center, University of Chicago Library.

NewspaperArchive. 2023. "NewspaperArchive." https://www.newspaperarchive.com Accessed: 12/20/2023.

New York Times. 1944. "Ask Why 5 Million Are Unfit for War: Senate Hearings Will Go Into Mental and Physical Defects Revealed in Draft." *New York Times*, July 9.

New York Times. 1945. "40% of Men of 28 Rejected by Army: Selective Service Survey Reveals Why Policy is Not to Draft Registrants Over 29." *New York Times*, January 26.

Open Secrets. 2023. "Top Lobbying Organizations." Open Secrets. https://opensecrets.org/orgs/all-profiles?topcontribcycle=2022&topoutspendcycle=A&toplobcycle=2023 . Accessed: 02/27/2024.

Palmer, Karen. 1999. "A Brief History: Universal Health Care Efforts in the US." Physicians for a National Health Program. https://pnhp.org/a-brief-history-universal-health-care-efforts-in-the-us/.Accessed: 10/01/2023.

Papanicolas, Irene, Liana R Woskie, and Ashish K Jha. 2018. "Health Care Spending in the United States and Other High-Income Countries." *JAMA*, 319(10): 1024–1039.

Peel, Roy V. 1952. "Income of Families and Persons in the United States: 1950." U.S. Census Bureau.

Pepper, Claude (FL). 1951. *Feared Tactics of Lobbyists.* Vol. 97, Congressional Record.

Perrott, George St. J., and Maryland Y. Pennell. 1957. *Health Manpower Chart Book. Public Health Service Publication*, Washington, D.C.: U.S. Government Printing Office.

Poen, Monte M. 1996. *Harry S. Truman versus the Medical Lobby: The Genesis of Medicare.* Vol. 1 of *Give 'Em Hell Harry.* 1 ed., Columbia: University of Missouri Press.

Rambachan, Ashesh, and Jonathan Roth. 2023. "A More Credible Approach to Parallel Trends." *The Review of Economic Studies*, 90(5): 2555–2591.

Reed, Louis S. 1947. *Blue Cross and Medical Service Plans.* Washington, D.C.: Federal Security Agency, U.S. Public Health Service.

Reuter, Jonathan, and Eric Zitzewitz. 2006. "Do Ads Influence Editors? Advertising and Bias in the Financial Media." *The Quarterly Journal of Economics*, 121(1): 197–227.

Roth, Jonathan. 2022. "Pretest with Caution: Event-Study Estimates After Testing for Parallel Trends." *American Economic Review: Insights*, 4(3): 305–322.

Roth, Jonathan, Pedro H. C. Sant'Anna, Alyssa Bilinski, and John Poe. 2023. "What's trending in difference-in-differences? A synthesis of the recent econometrics literature." *Journal of Econometrics*.

Rovit, Richard L., and William T. Couldwell. 2001. "No Ordinary Time, No Ordinary Men: The Relationship Between Harvey Cushing and Franklin D. Roosevelt, 1928–1939." *Journal of Neurosurgery*, 95(2): 354–368.

Rubinow, Isaac Max. 1934. *The Quest for Security.* New York: Henry Holt and Company.

Ruggles, Steven, Sarah Flood, Matthew Sobek, Daniel Backman, Annie Chen, Grace Cooper, Stephanie Richards, Renae Rogers, and Megan Schouweiler. 2024. "IPUMS USA: Version 15.0 [dataset]. Minneapolis, MN: IPUMS." https://doi.org/10.18128/D010.V15.0. Accessed: 9/15/2024.

Schlabach, Theron. 1969. *Rationality and Welfare: Public Discussion of Poverty and Social Insurance in the United States 1875-1935.* Washington, D.C.: US Social Security Administration, Office of Research and Statistics.

Schwarz, Carlo. 2019. "lsemantica: A command for text similarity based on latent semantic analysis." *The Stata Journal*, 19(1): 129–142.

Selden, Thomas M. 2009. "The Impact of Increased Tax Subsidies on the Insurance Coverage of Self-Employed Families: Evidence from the 1996–2004 Medical Expenditure Panel Survey." *Journal of Human Resources*, 44(1): 115–139.

Shen, Zejiang, Ruochen Zhang, Melissa Dell, Benjamin Lee, Jacob Carlson, and Weining Li. 2021. "LayoutParser: A Unified Toolkit for Deep Learning Based Document Image Analysis." *International Conference on Document Analysis and Recognition*, 131–146.

Shister, Joseph. 1956. "Unresolved Problems and New Paths for American Labor." *Industrial and Labor Relations Review*, 9(3): 447–457.

Smith, Donald W. 1945. "Social Security: The Wagner-Murray-Dingell Bill (1945) Senate Bill 1050, H. R. 3293." *The American Journal of Nursing*, 45(11): 933–936.

Snyder, Jr, James M., and Michael M. Ting. 2008. "Interest groups and the electoral control of politicians." *Journal of Public Economics*, 92(3-4): 482–500.

Sobbrio, Francesco. 2011. "Indirect Lobbying and Media Bias." *The Quarterly Journal of Political Science*, 6: 3–4.

Sommers, Suzanne. 2013. "The Affordable Care Act Is a Socialist Ponzi Scheme." *The Wall Street Journal*.

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

Stavrunova, Olena, and Oleg Yerokhin. 2014. "Tax incentives and the demand for private health insurance." *Journal of Health Economics*, 34: 121–130.

Stigler, George J. 1971. "The theory of economic regulation." *Bell Journal of Economics and Management Science*, 2(1): 3–21.

Sun, Liyang, and Sarah Abraham. 2021. "Estimating dynamic treatment effects in event studies with heterogeneous treatment effects." *Journal of Econometrics*, 225(2): 175–199. Themed Issue: Treatment Effect 1.

Tauriello, Anthony (NY). 1949. *United States Can Well Afford Health Plan.* Vol. 95, Congressional Record.

Tax Foundation. 2021. "Historical U.S. Federal Individual Income Tax Rates and Brackets."

The Survey Committee of the Health Insurance Council. 1949-1965. *A Survey of Accident and Health Coverage in the United States.* New York: Health Insurance Council.

Thomasson, Melissa A. 2002. "From Sickness to Health: The Twentieth-Century Development of U.S. Health Insurance." *Explorations in Economic History*, 39(3): 233–253.

Thomasson, Melissa A. 2003. "The Importance of Group Coverage: How Tax Policy Shaped US Health Insurance." *American Economic Review*, 93(4): 1373–1384.

Truman Library. 2023. "The Challenge of National Healthcare | Harry S. Truman." Truman Library. https://www.trumanlibrary.gov/education/presidential-inquiries/challenge-national-healthcare. Accessed: 10/03/2023.

U.S. Census Bureau. 1948. "Estimates of the Population of Voting Age, by States: 1948." *Current Population Reports*.

U.S. Census Bureau. 1953. *Census of Housing: Volume 1. General Characteristics.* Washington, D.C.: U.S. Government Printing Office.

U.S. Census Bureau. 2012. "County and City Data Book Consolidated File: County Data, 1947-1977." Inter-university Consortium for Political and Social Research. https://doi.org/10.3886/ICPSR07736.v2. Accessed: 10/01/2023.

U.S. Congress. 1947, 1948, 1949, 1950,1951. *Congressional Record, 1947-1951.* Washington, D.C.: U.S. Government Printing Office.

U.S. Department of Commerce and Bureau of the Census. 1958. "Current Population Report: Consumer Income."

U.S. Selective Service System. 1947. *Physical Examination of Selective Service Registrants. Special Monograph - Selective Service System*, Washington, D.C.: U.S. Government Printing Office.

U.S. Senate Library. 1952. *Factual Campaign Information.* Washington, D.C.: U.S. Government Printing Office.

Wehrle, Edmund F. 1993. "'For a Healthy America': Labor's Struggle for National Health Insurance, 1943-1949." *Faculty Research & Creative Activity*, 63.

Weinfeld, William. 1951. "Income of Physicians, 1929-49." *Survey of Current Business*.

Whitaker & Baxter *Campaigns, Inc.* 1933-1974. *Inventory of the Whitaker & Baxter Campaigns, Inc. Records.* Sacramento: California State Archives. Collection Number C134.

Whitaker & Baxter *Campaigns, Inc.* 1945-1949. "California Medical Association Files 1945-1949." In *Inventory of the Whitaker & Baxter Campaigns, Inc. Records*. Sacramento: California State Archives. Collection Number C134.1.34, Box 4/38-Box 6/8.

Whitaker & Baxter *Campaigns, Inc.* 1946-1973. "Accounting Files 1946-1973." In *Inventory of the Whitaker & Baxter Campaigns, Inc. Records*. Sacramento: California State Archives. Collection Number C134.4, Box 145-Box 149, Box 153, Box 153A-Box 183.

Whitaker & Baxter *Campaigns, Inc.* 1949-1952. "American Medical Association Files 1949-1952." In *Inventory of the Whitaker & Baxter Campaigns, Inc. Records*. Sacramento: California State Archives. Collection Number C134.1.43, Box 9/25-Box 11/4, Box 184.

Whitaker, Clem. 1950. "Medicine's Road Ahead: Part 2 – Campaign Strategy and Policies." In *Inventory of the Whitaker & Baxter Campaigns, Inc. Records*. Sacramento: California State Archives. Collection Number C134.1.43, Box 9/31.

Whitaker, Clem, and Leone Baxter. 1945. "Preliminary Outline of Campaign Against Compulsory Health Insurance and for the Extension of Voluntary Pre-paid Medical and Hospital Systems in California." In *Inventory of the Whitaker & Baxter Campaigns, Inc. Records*. Sacramento: California State Archives. Collection Number C134.1.34, Box 4/39.

Whitaker, Clem, and Leone Baxter. 1949. "AMA's Plan of Battle: An Outline of Strategy and Policies in the Campaign Against Compulsory Health Insurance." In *Inventory of the Whitaker & Baxter Campaigns, Inc. Records*. Sacramento: California State Archives. Collection Number C134.1.43, Box 9/27.

Yellowitz, Irwin. 1989. "Samuel Gompers: a Half Century in Labor's Front Rank." *Monthly Labor Review*, 112: 27.