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

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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

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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 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 81^{st} 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 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). 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 Appendix Section E.4 for more information on Blue Cross hospital prepayment plans. 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 (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) (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 (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 (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); 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 two-fold: First, Blue Cross had started slightly earlier and thus built up administrative expertise in billing

[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] 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 Appendix Figure A5).

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 by the CMA and launched the California Campaign. Key strategies that would be replicated later on a

[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 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.

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 (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 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 and then send signed resolutions to their elected representatives. Appendix Figure B2 Panel A shows an

[16] For further details on the California Campaign see 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).

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). 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 outresourced: 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) (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.

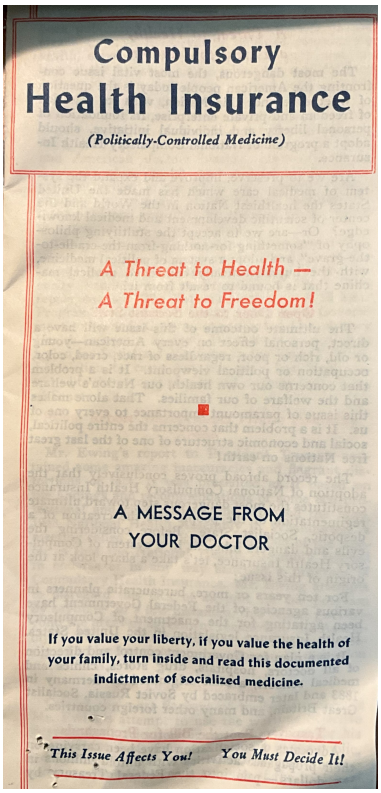
[22]In terms of cost of the national Campaign, the AMA paid Whitaker & Baxter 1.2 million dollars per year in current terms (Whitaker & Baxter *Campaigns, Inc.* 1946-1973). Regarding who was responsible for Campaign content, a 1949 article in *Medical Economics* profiling the duo wrote: "Clem Whitaker 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 Appendix Figure B3. Example taken from page 16 of *Athens Alabama Courier* (American Medical Association 1950*c*).

Figure 2: Campaign Tie-in Ads

(a) Walgreens



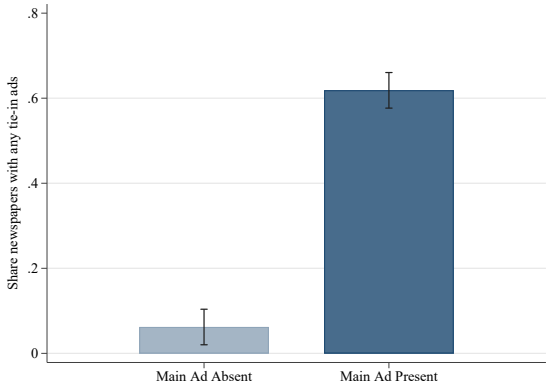
(b) Dillon Implement Co.



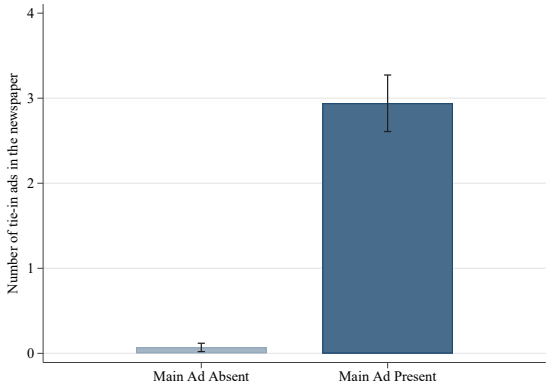
(c) Oklahoma State Bank



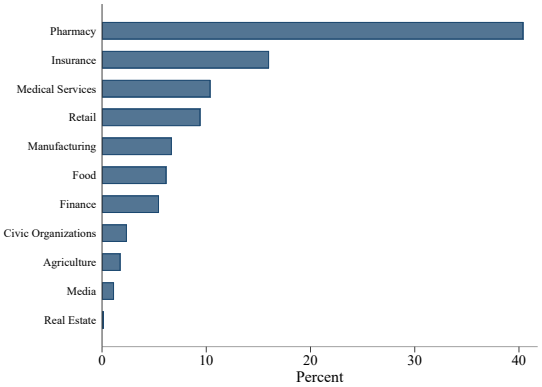
(d) Any Tie-in Ad



(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 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 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*). 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 Appendix Figure A9). The number of physicians by state from the digitized microdata is close to published aggregates (see 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 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 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 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 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 D shows

[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 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 Appendix Section F.3.

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. 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 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 Appendix Figure A13 Panels A and B). Gallup surveys were sponsored by local newspapers (see 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 favor of PHI (see

[30]The growth in enrollment in plans over time is shown in 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.

example in 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 80^{th}, 81^{st}, and first session of the 82^{nd} 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 81^{st} 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 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 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 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 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 (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 (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 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:

$$I_{ist}^{\text{Support NHI}} = \alpha + \sum_{k \neq -1} \beta_k \cdot \left(I_t^k \times \text{Campaign exposure}_{is} \right) + \sum_{k \neq -1} \delta_k \cdot I_t^k + X_i' \Gamma + X_{st}' \Omega + \mu_s + \epsilon_{ist} \tag{8}$$

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.

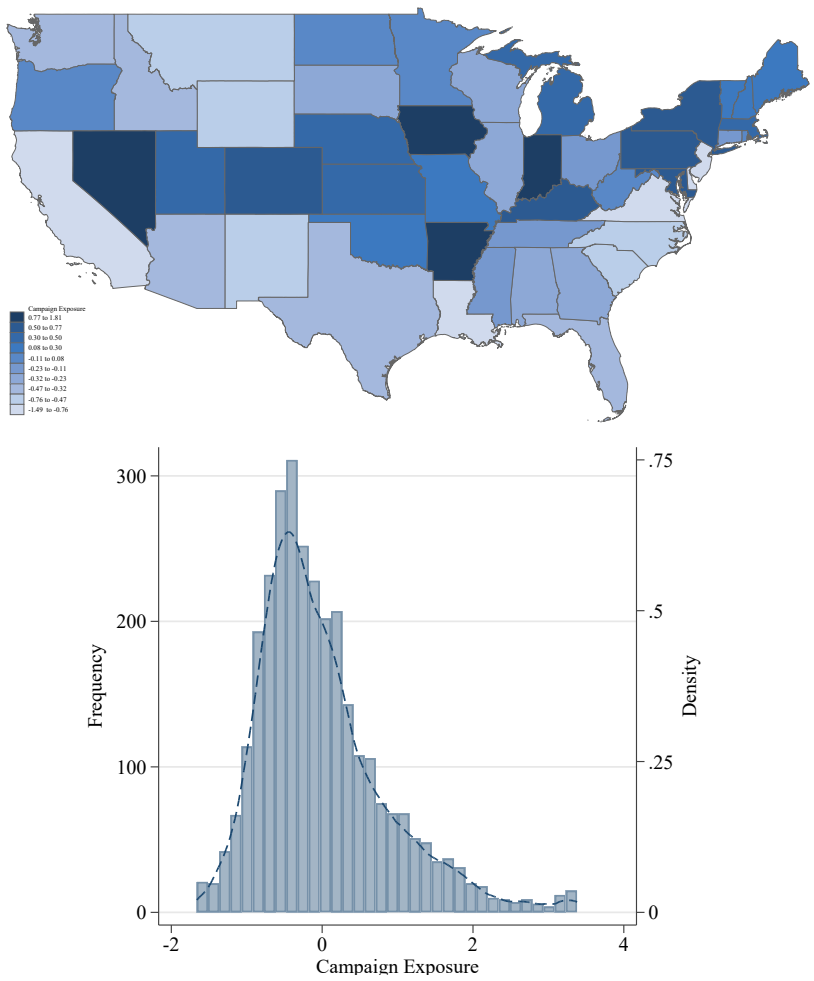
For the civic organization resolutions, our estimating equation is given by:

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

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



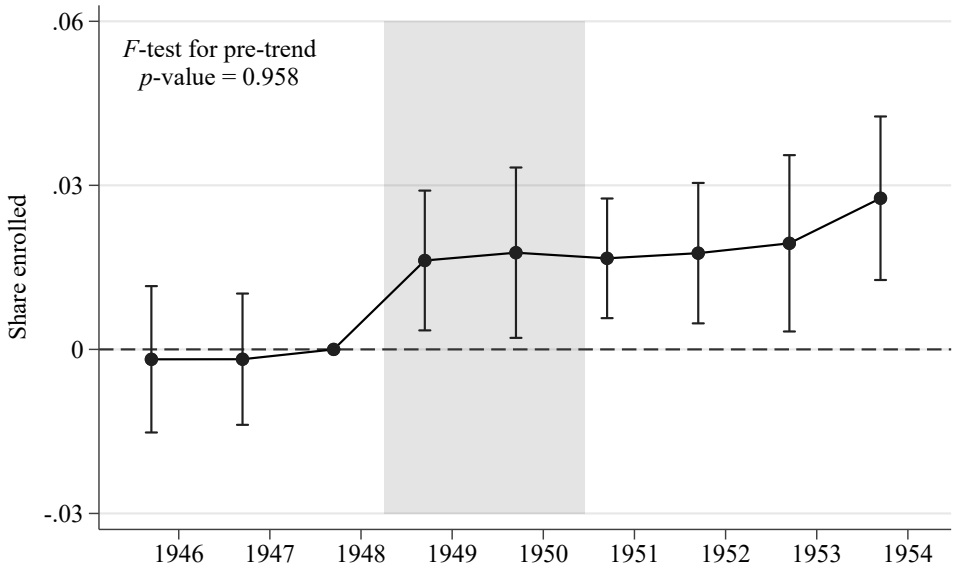
	(1)	(2)	(3)
	Overall Mean	Coefficient	SE
Panel A: State Level			
Mean PHI Share Enrolled 1946-1948	0.034	-0.014	(0.015)
Mean Share Republican Vote 1946-1948	0.426	0.053	(0.037)
Mean Voter Turnout 1946-1948	0.437	0.032	(0.023)
Share Female 1940	0.494	-0.001	(0.003)
Share Black 1940	0.094	-0.036**	(0.016)
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. 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

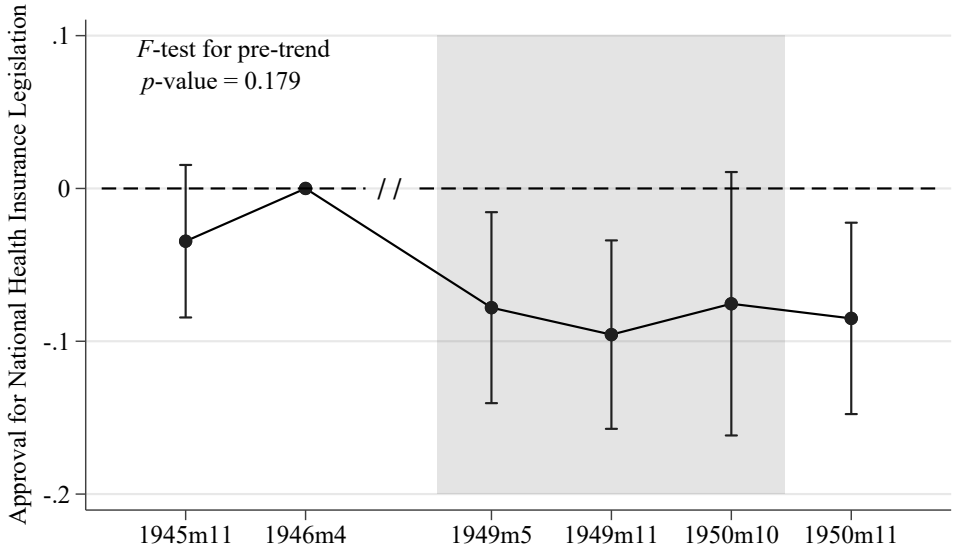
	(1)	(2)	(3)	(4)
Campaign Exposure $\times$ I^{Post}	0.025***	0.025***	0.020***	0.020***
	(0.008)	(0.008)	(0.007)	(0.007)
Campaign Exposure	0.004			
	(0.005)			
I^{Post}	0.102***	0.102***	0.025***	
	(0.008)	(0.008)	(0.006)	
Dependent Mean	0.034	0.034	0.034	0.034
Observations	423	423	423	423
State FE	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

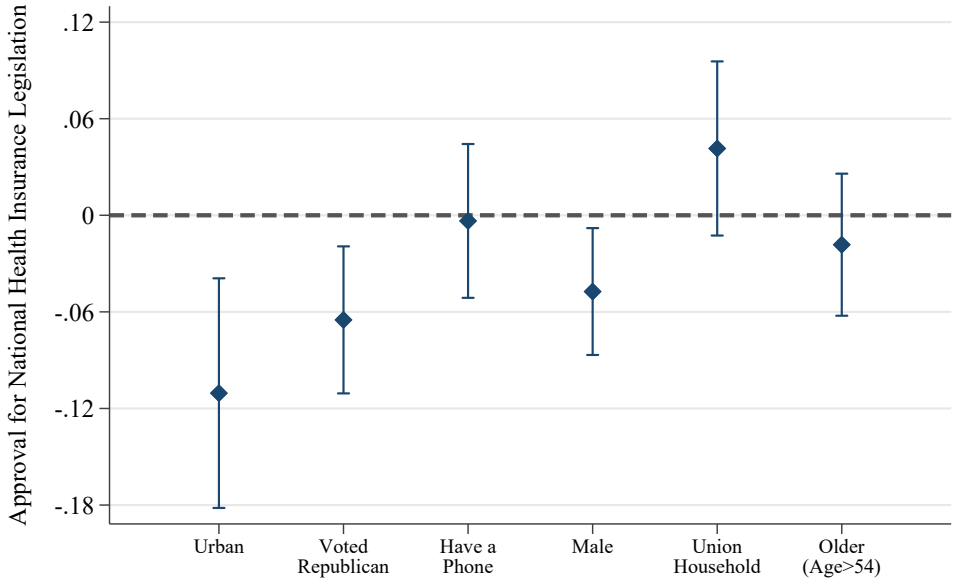
Table 2: Effect of Campaign on Approval for National Health Insurance Legislation

	(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 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.

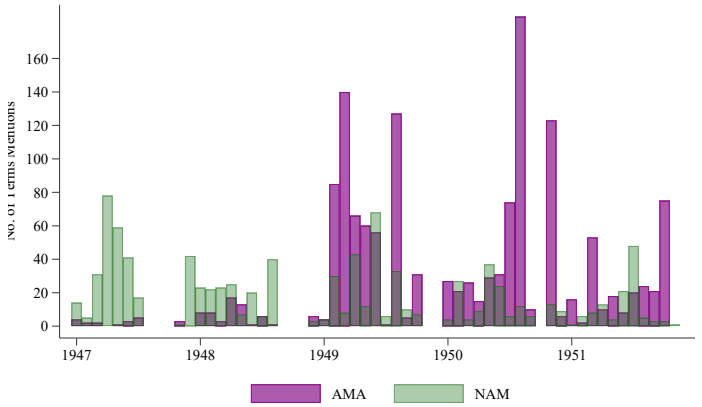
Figure 7 explores the relationship between the AMA-WB Campaign and Congress. Panels A and B aggregate terms from the Congressional Record covering years 1947 to 1951 to the monthly level. In Panel A, the frequency of the phrase "health insurance" peaks during the 81^{st} Congress, reaching nearly 200 mentions per month before tapering off by the first session of the 82^{nd} 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 80^{th} Congress, mentions of the NAM do not reach the same level as mentions of the AMA during the 81^{st} Congress.

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

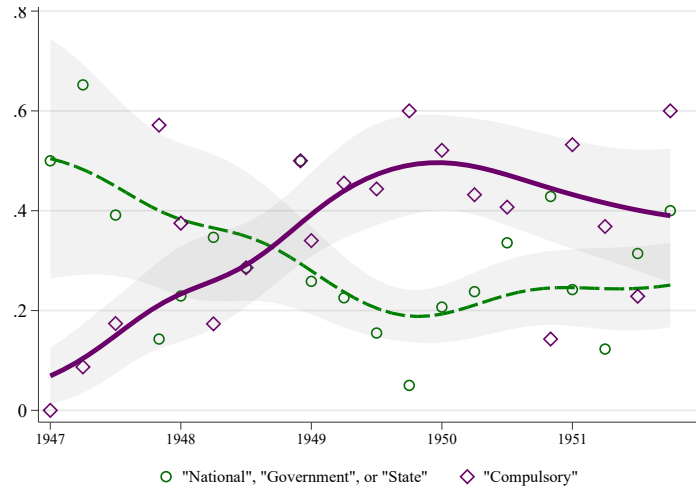
(a) Mentions of Health and Unemployment Insurance



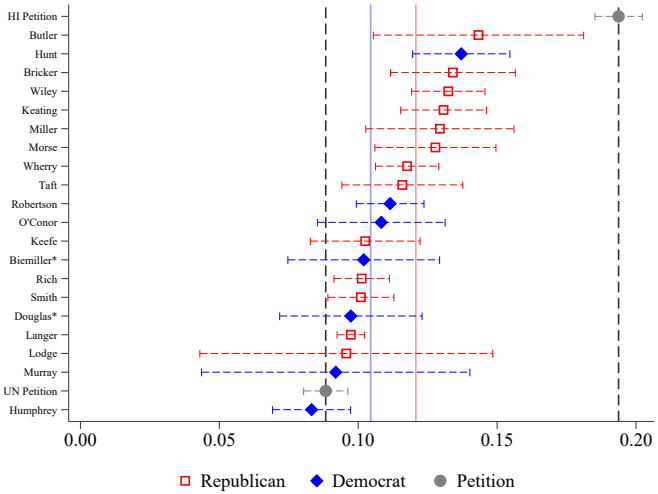
(b) Mentions of American Medical Association (AMA) and National Association of Manufacturers (NAM)



(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 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 81^{st} Congress. Panel D plots the average similarity for the top 25^{th} percentile of legislators mentioning "health insurance" (the full Congress is plotted in 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 81^{st} 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 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 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. 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 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 (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 Appendix Tables C1 and C2, and Column 8 of Appendix Table C3). Constructing the exposure with printed propaganda materials leads to comparable estimates for enrollment and civic organizations (Column 9 of Appendix Table C1 and Column 7 of Appendix Table C3) but is weaker for public opinion (Column 9 of 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 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 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 (Appendix Table C1 Column 10). Results are predictably larger but otherwise similar. We also assess robustness to different weights in the Gallup poll data (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 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 (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." 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 Appendix Tables C1 and C2 and Column 9 of Appendix Table C3).

[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 Appendix Tables C1 and C2.

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

Lastly, we return to the Gallup data, this time using questions on anti-Russian sentiment. 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.

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Appendix

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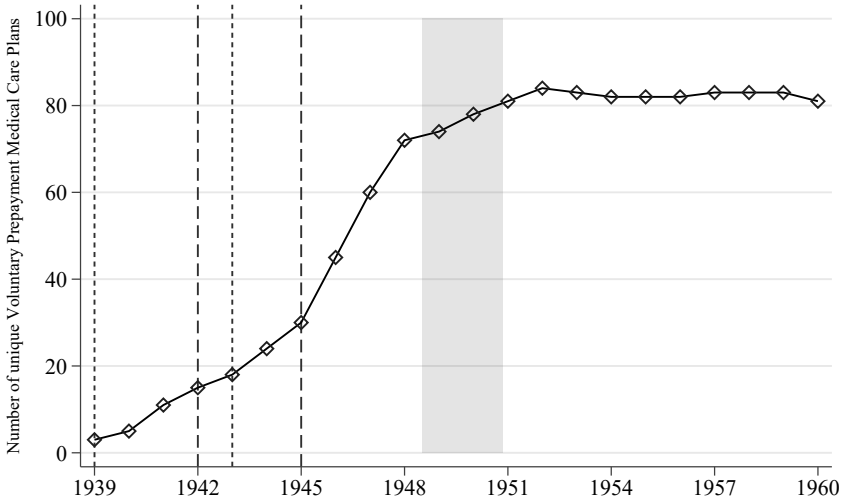
A Descriptive Data Exhibits

Appendix Table A1: Gallup Questions on National Health Insurance

Year	Question Text
Nov 1945	Have you heard or read about President Truman's proposal for having a compulsory health insurance plan in this country? If yes: Do you approve or disapprove of Truman's plan for health insurance in this country?
Apr 1946	Have you heard or read about the Wagner-Murray-Dingell health insurance bill which would require weekly pay deductions from every worker and employer for medical, dental and hospital insurance? If yes: What do you think of this bill?
May 1949	Should the U.S. Congress pass the government's compulsory health insurance program which would require wage or salary deductions from all employed persons to provide medical and hospital care for them and their families? *Or:* The Truman administration has proposed a compulsory medical and hospital insurance program to benefit all employed persons and their families. The cost would be paid by requiring every employed person to pay $15 on every thousand dollars earned UP TO the first $4,800, and the employer would match this by paying an equal amount. Would you favor or oppose such a bill?
Nov 1949	Have you heard or read about the Truman administration's plan for compulsory health insurance? If yes: What is your own opinion about it – are you for the Administration's plan, or not?
Oct 1950	Have you heard or read anything about the Truman Administration's Compulsory Health Insurance Plan? If yes: Do you approve or disapprove of this plan?
Nov 1950	Have you heard or read about the Truman administration's plan for compulsory health insurance? If yes: What is your own opinion about it – are you for the Administration's plan, or not?

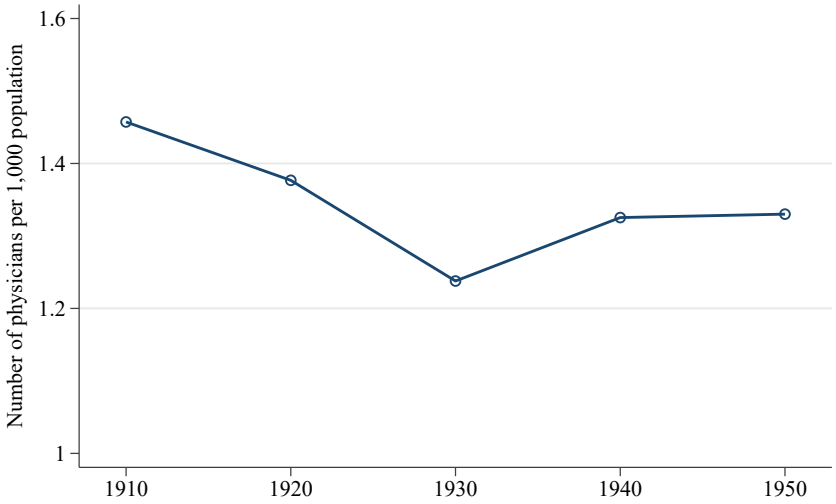
Notes: Table reports the questions Gallup Organization asked respondents over the time period of the analysis (Gallup Organization 1945, 1946, 1949, 1950). In the May 1949 Gallup wave, the question on approval for NHI was asked in two different ways, shown above, as part of a Gallup experiment.

Appendix Figure A1: Number of Voluntary Prepayment Medical Service Plans by Year



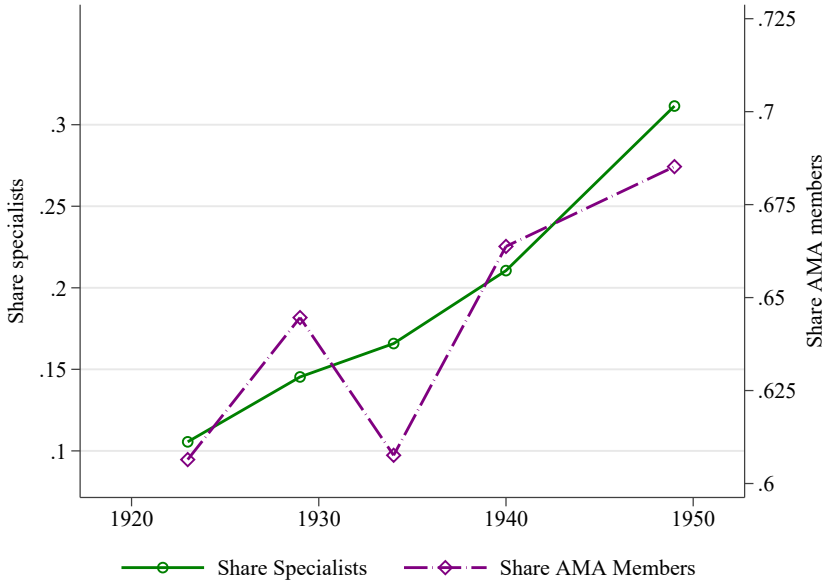
Notes: Figure shows the total number of unique voluntary prepayment medical care plans each year. 1939 marks the formation of the California Physicians Service, the first Blue Shield plan, and California Governor Olson's support of AB 2172 (Board of Trustees of Mississippi State Medical Association 1965; Dimmitt 2007; Morrisey 2013). 1942 marks the AMA House of Delegates' approval of medical service plans when sponsored by a state or county medical society (Board of Trustees of Mississippi State Medical Association 1965). 1943 marks the first introduction of the Wagner-Murray-Dingell bill for centralized medical services at the national level (Palmer 1999; Corning 1969). 1945 marks the death of President Roosevelt, President Truman's call for public health insurance, the introduction of Senate Bill 1606 by Senators Wagner and Murray to provide for a national health program, and the AMA House of Delegates' decision to promote and develop prepayment medical plans sponsored by medical societies.

Appendix Figure A2: Number of Physicians per 1,000 Population, 1910-1950



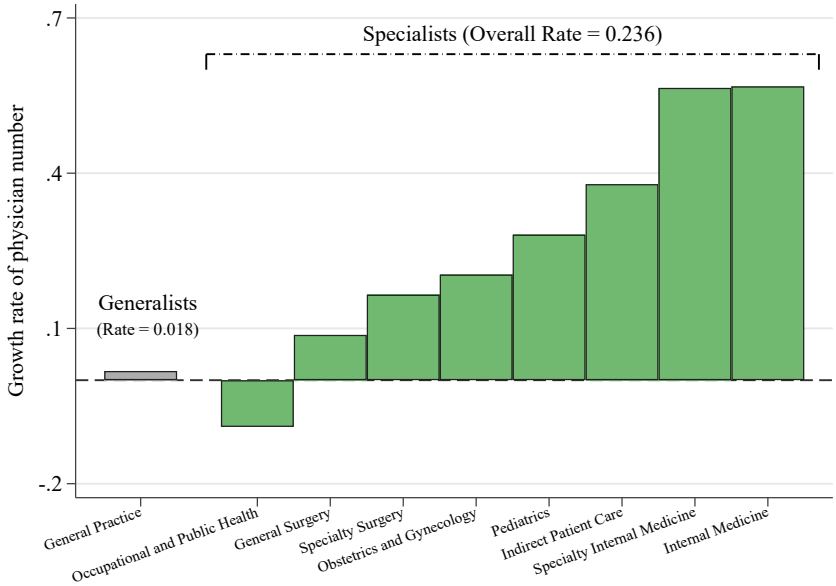
Notes: Figure plots the number of physicians per 1,000 population. Physician data are from the AMA House of Delegates Proceedings (American Medical Association 1910, 1920, 1923, 1929, 1930, 1934, 1940, 1950*b*). Population data are from the 1910, 1920, 1930, 1940, and 1950 Census (Haines 2010).

Appendix Figure A3: Shares of Specialists and AMA Members, 1923–1949



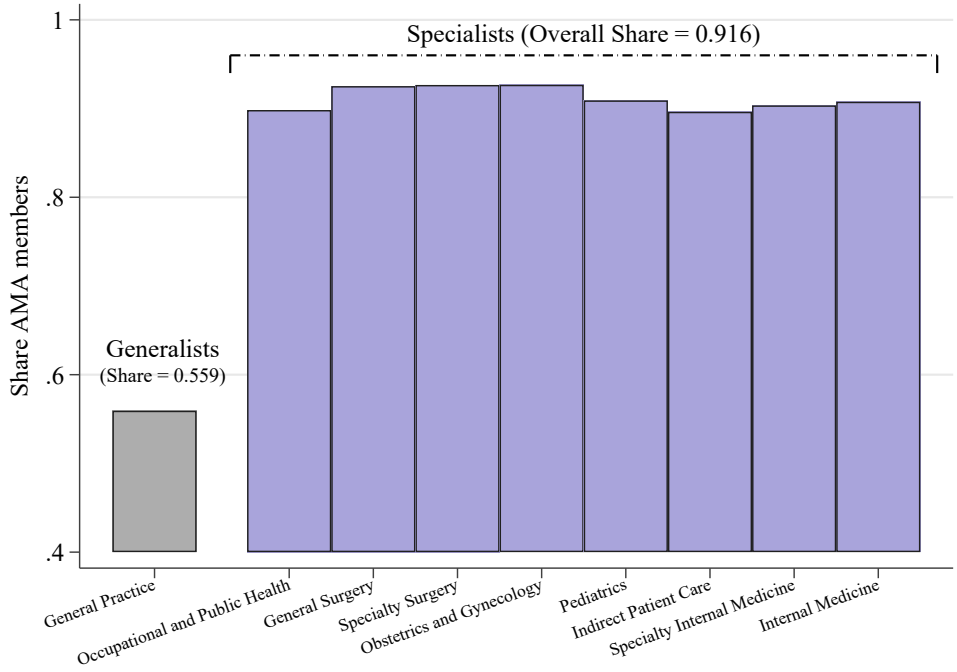
Notes: Figure plots the shares of specialists and AMA members over the total number of physicians in the years 1923, 1929, 1934, 1940, and 1949. Only years with available data on both specialists and AMA membership are included. Data on the number of specialists are from Perrott and Pennell (1957). Data on AMA members are from the AMA House of Delegates Proceedings as well as the *American Medical Directory* (American Medical Association 1910, 1920, 1923, 1929, 1930, 1934, 1940, 1950*b*, 1942, 1950*a*).

Appendix Figure A4: Growth Rate of Specialist and Generalist Physicians from 1942 to 1950



Notes: Figure plots the growth rates in the number of physicians by specialty from 1942 to 1950. The growth rate is computed as the difference between the number of physicians in 1950 and the number of physicians in 1942 divided by the number of physicians in 1942. Data are from the *American Medical Directory* (American Medical Association 1942, 1950*a*).

Appendix Figure A5: Share AMA Members among Specialist and Generalist Physicians in 1950



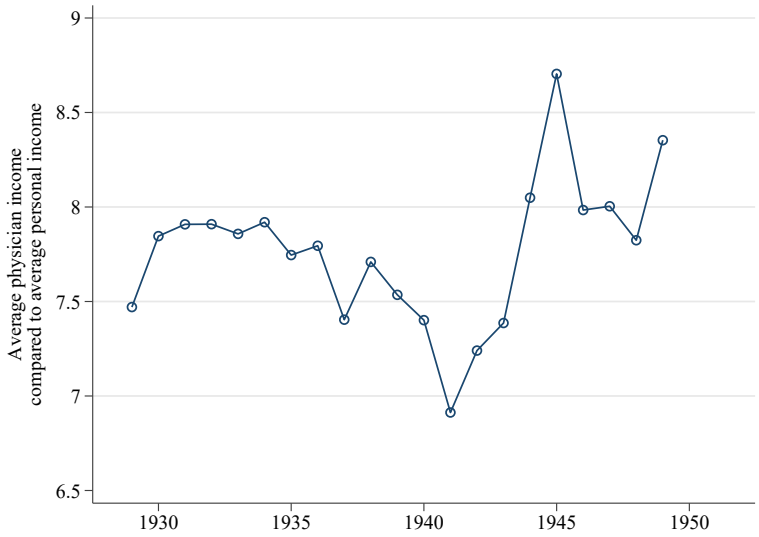
Notes: Figure plots the share of physicians who are AMA members by specialty. Data are from the 1950 *American Medical Directory* (American Medical Association 1950*a*).

Appendix Figure A6: Physician Income Growth, 1929–1949

(a) Average Annual Income

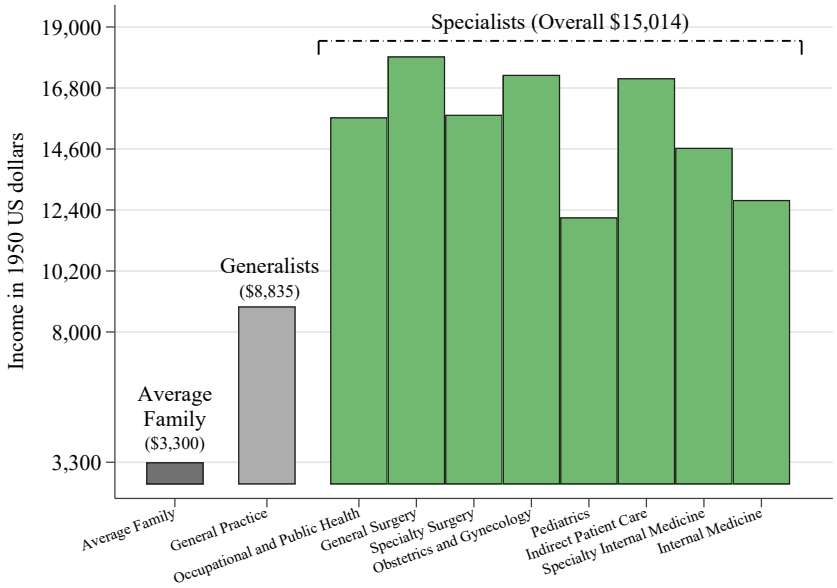


(b) Ratio of Physician to Individual Income



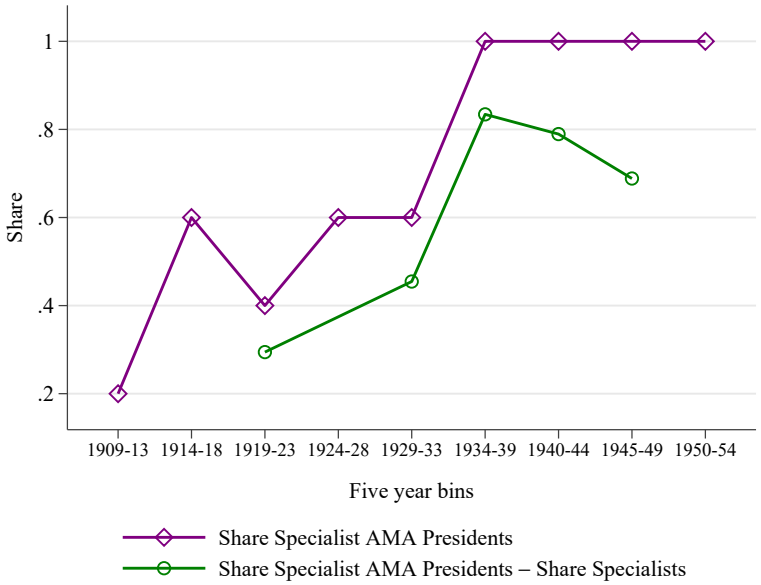
Notes: Figure plots time trends for the average income of physicians from 1929 to 1949. Panel A plots the average income for physicians and all Americans. Incomes are adjusted to 1950 U.S. dollars. Panel B plots the ratio of average physician income to average personal income in the same year. Physician income data are from the Survey of Current Business (Weinfeld 1951), and national income data are from Bureau of Economic Analysis (2023).

Appendix Figure A7: Average Annual Income of Specialist and Generalist Physicians in 1949



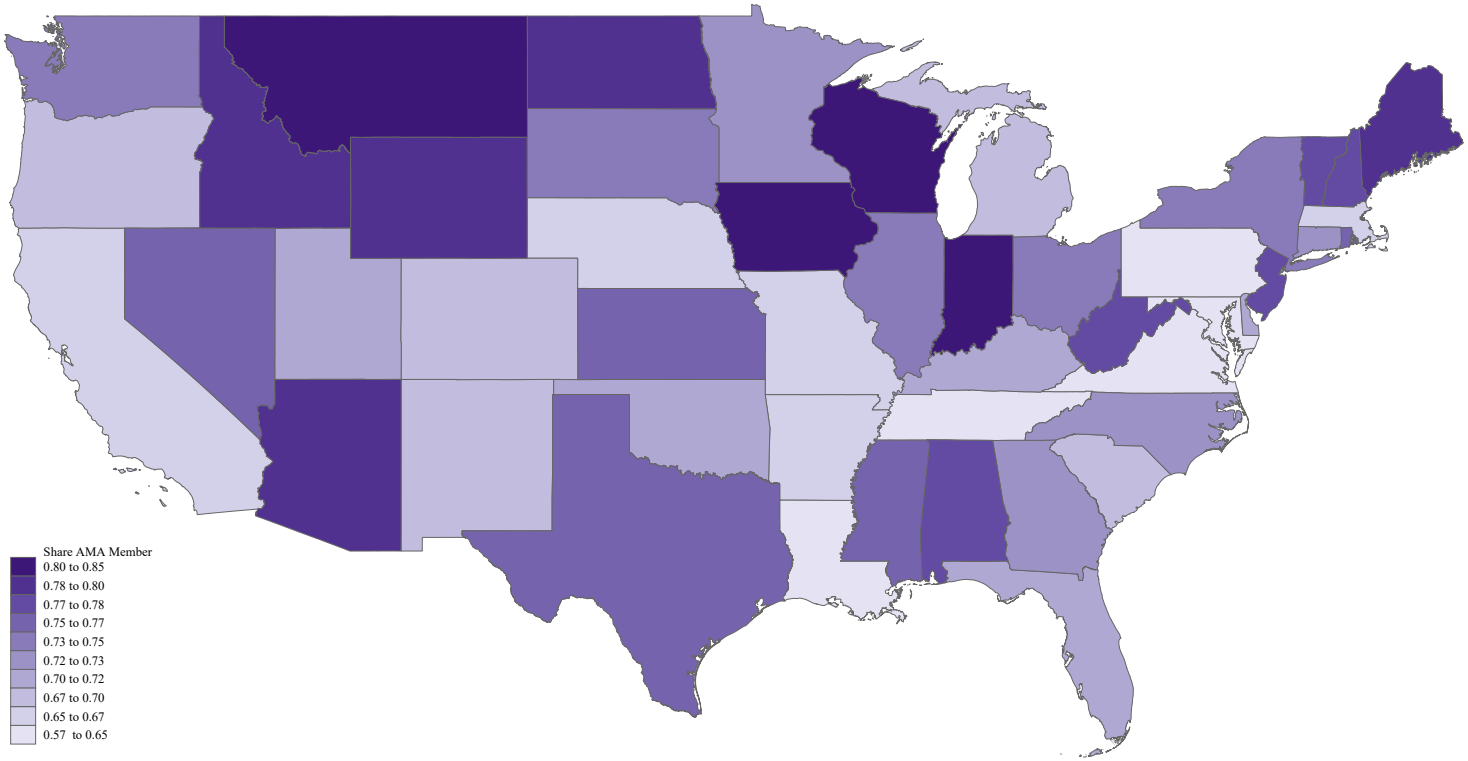
Notes: Figure plots the average annual income for physicians by specialty in 1949 and average annual family income in 1950. Incomes are adjusted to 1950 U.S. dollars. Physician income data are from the Survey of Current Business published by the Bureau of Economic Analysis (Weinfeld 1951). Family income data are from the Population Report published by the Census Bureau (Peel 1952).

Appendix Figure A8: Share of Specialist AMA Presidents, 1909-1954



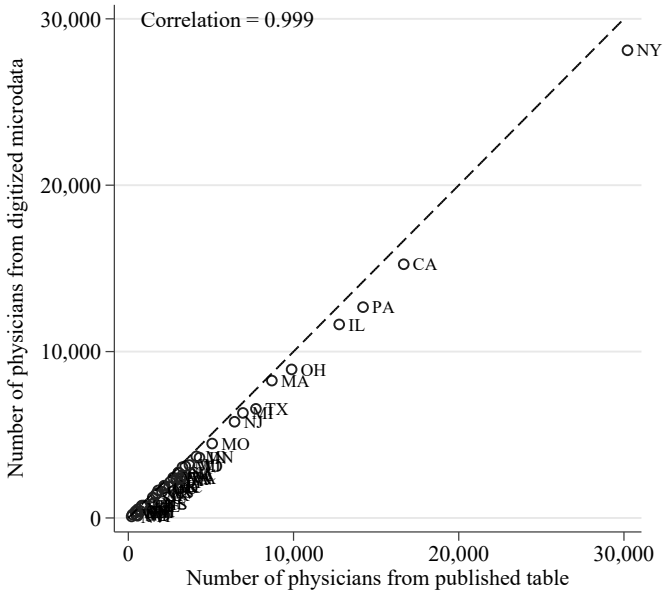
Notes: Figure plots the share of specialists among AMA presidents by decade from 1909 to 1954. The green line with circles plots the difference between share of specialist AMA presidents and the share of specialist physicians. AMA president data are from American Medical Association (1950*a*), and specialist data are from Perrott and Pennell (1957).

Appendix Figure A9: Share of AMA Members by State in 1950



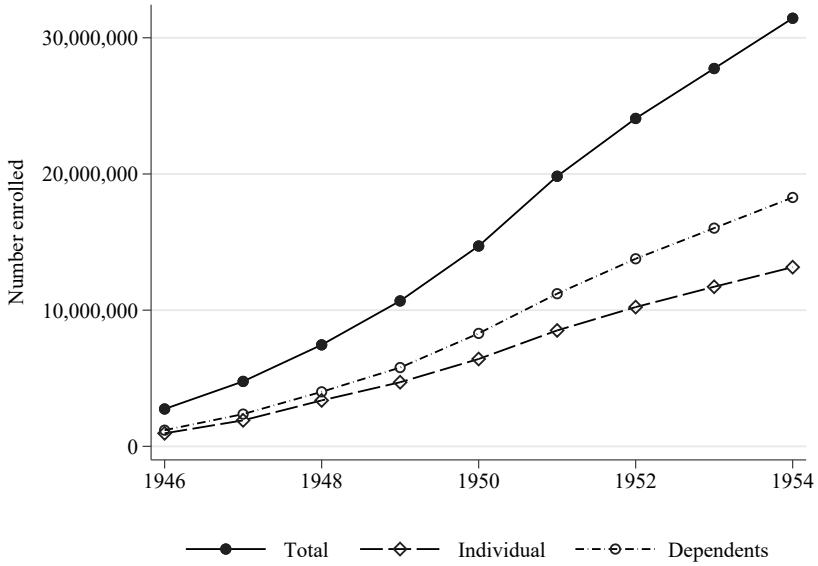
Notes: Map shows the share of total physicians that are members of the AMA as of 1950. Data are from American Medical Association (1950*a*).

Appendix Figure A10: Number of Physicians by State
from Published Table and Digitized Microdata



Notes: Figure plots the total number of physicians by state, where the x-axis represents data from tables published in the *American Medical Directory* (American Medical Association 1950*a*), and the y-axis represents counts aggregated from the microdata digitized from individual records in the 1950 *American Medical Directory* (American Medical Association 1950*a*). The dashed line is the 45-degree line.

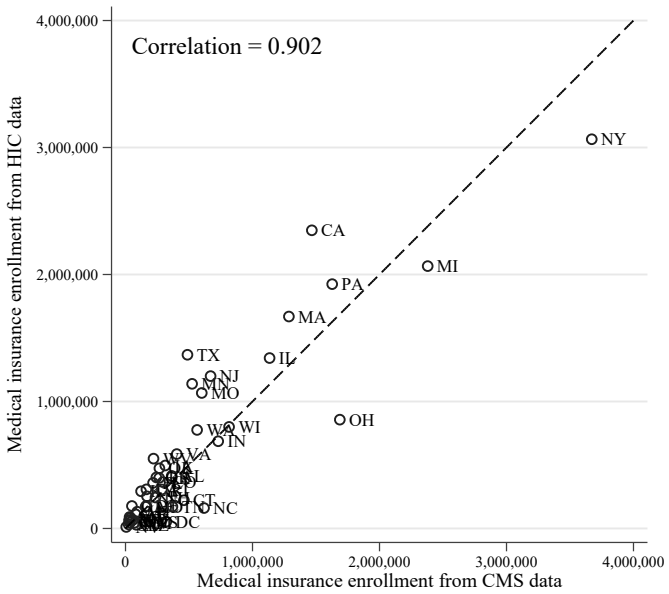
Appendix Figure A11: PHI Enrollment Over Time



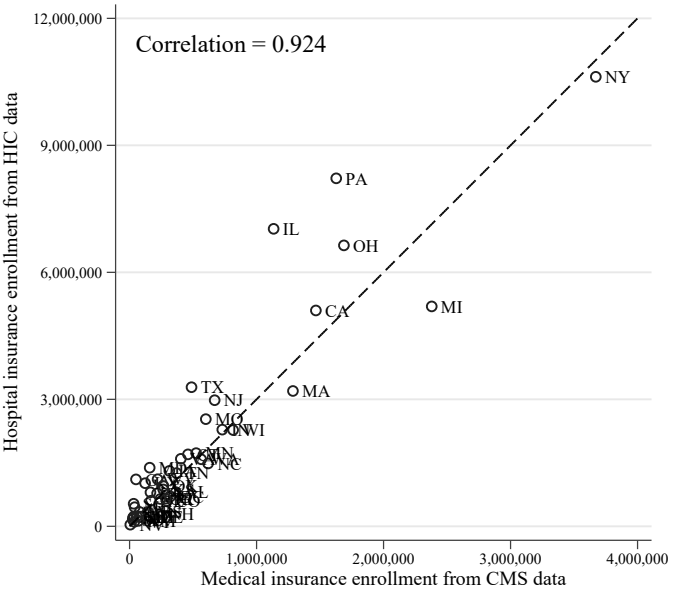
Notes: Exhibit plots voluntary (private) health insurance enrollment over time. Data are from Council on Medical Service (1946-1954).

Appendix Figure A12: Comparison of CMS and HIC Voluntary Health Insurance Data

(a) HIC Medical Insurance Enrollment



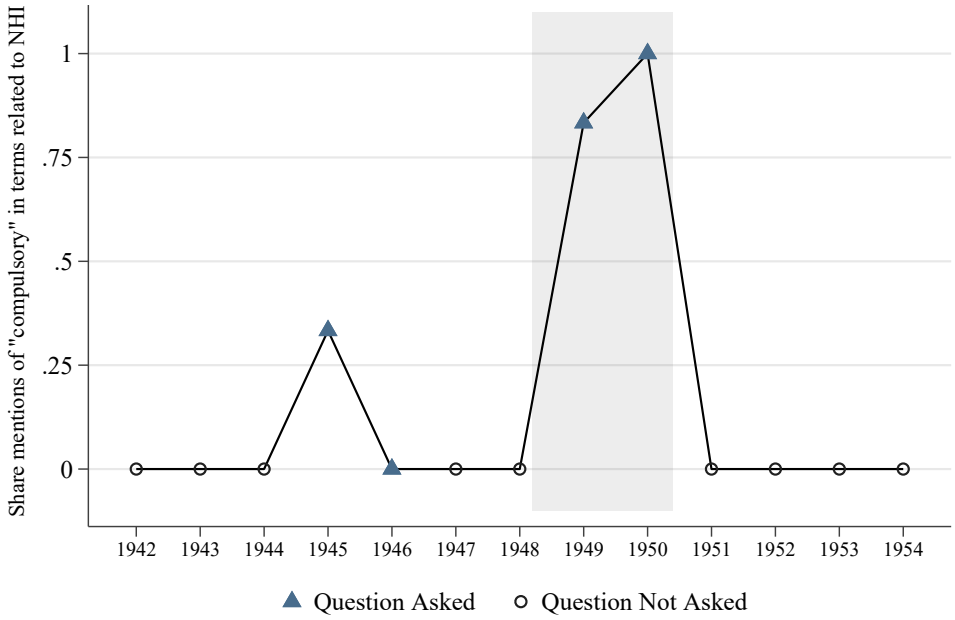
(b) HIC Hospital Insurance Enrollment



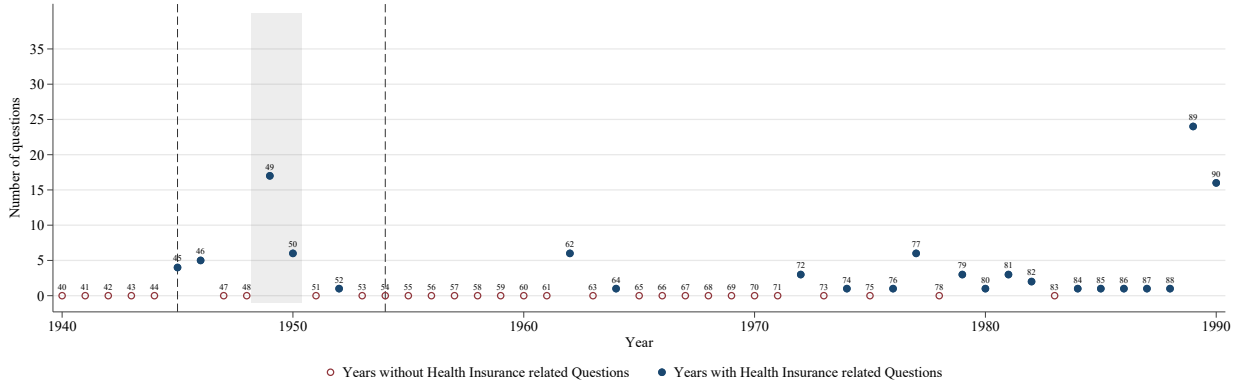
Notes: Figure plots the total number of enrollees. CMS indicates counts from the Council on Medical Service - American Medical Association (Council on Medical Service 1946-1954). HIC indicates counts from the Health Insurance Council (The Survey Committee of the Health Insurance Council 1949-1965). Panel A plots the correlation between HIC medical insurance enrollment and CMS medical enrollment in 1952, and Panel B plots the correlation between HIC hospital enrollment and CMS medical enrollment in 1952.

Appendix Figure A13: Descriptive Terms used and Frequency of Gallup Poll Questions about Health Insurance

(a) Terms Used in Gallup Polls about NHI

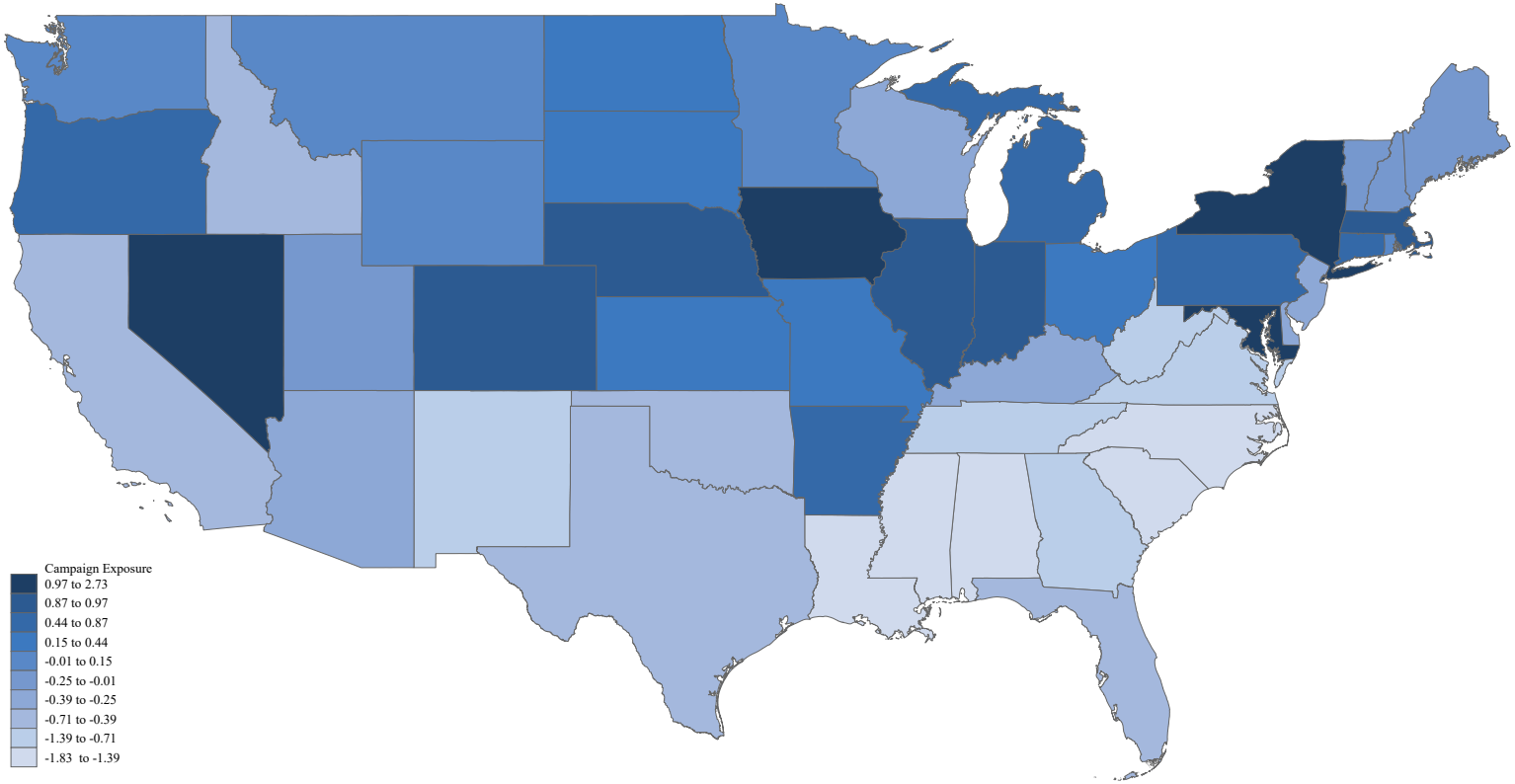


(b) Number of Health Insurance Questions Over 50 years



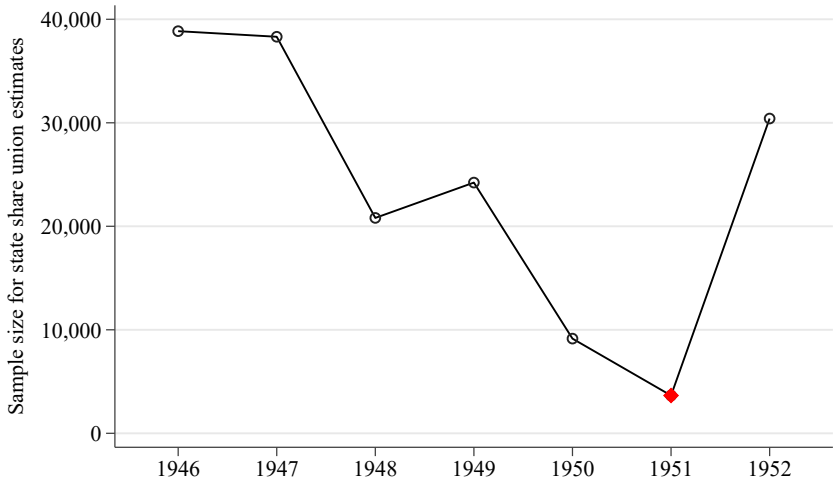
Notes: Figure demonstrates trends in Gallup questions on health insurance. Panel A focuses on the study period and plots the share of "compulsory" among terms referring to NHI in Gallup poll questions in Appendix Table A1. The numerator is total mentions of "compulsory" in the given questions, and the denominator is the sum of total mentions of "compulsory," "national," "government," "country", and "state." Triangles represent years where Gallup polls asked questions about NHI. The share is coded as 0 for April 1946 as both the numerator and the denominator are 0. Open circles represent years where Gallup polls did not ask questions about NHI. Panel B plots the frequency of health insurance questions in Gallup over five decades (1940-1990). The procedure for identifying questions involved limiting to the health and health policy sections of Gallup questions, then detecting if the questions contain a set of key words (*e.g.*, "Insurance" and "Health Care"). Within the set of questions selected, two research assistants independently validated whether the questions concerned the health insurance system or its reform and a third research assistant broke ties in rare cases of disagreement. Shaded area indicates the Campaign period. The vertical dashed lines indicate this study's period of analysis.

Appendix Figure A14: Campaign Exposure, State Level



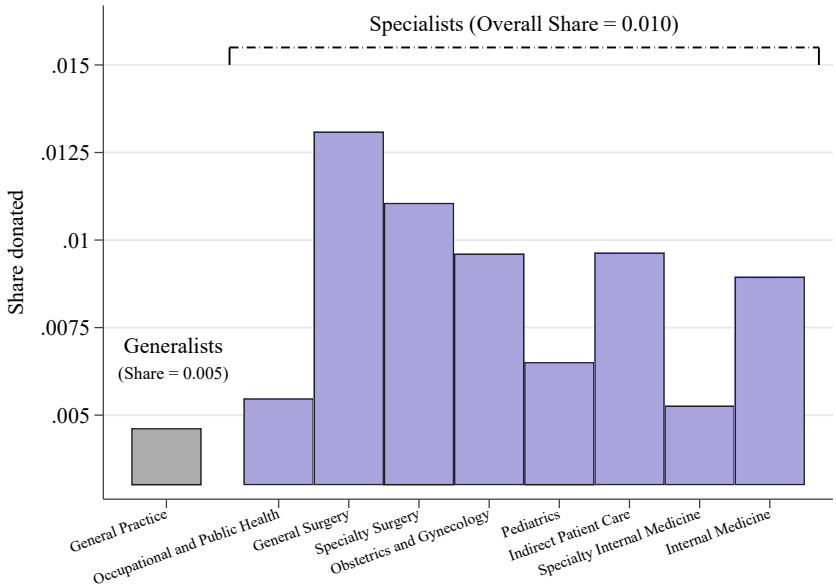
Notes: Map of the raw Campaign exposure variable.

Appendix Figure A15: Sample Size for Union Household Share Estimates



Notes: Figure plots the sample size used for state share union household estimates. Data are from Farber et al. (2021).

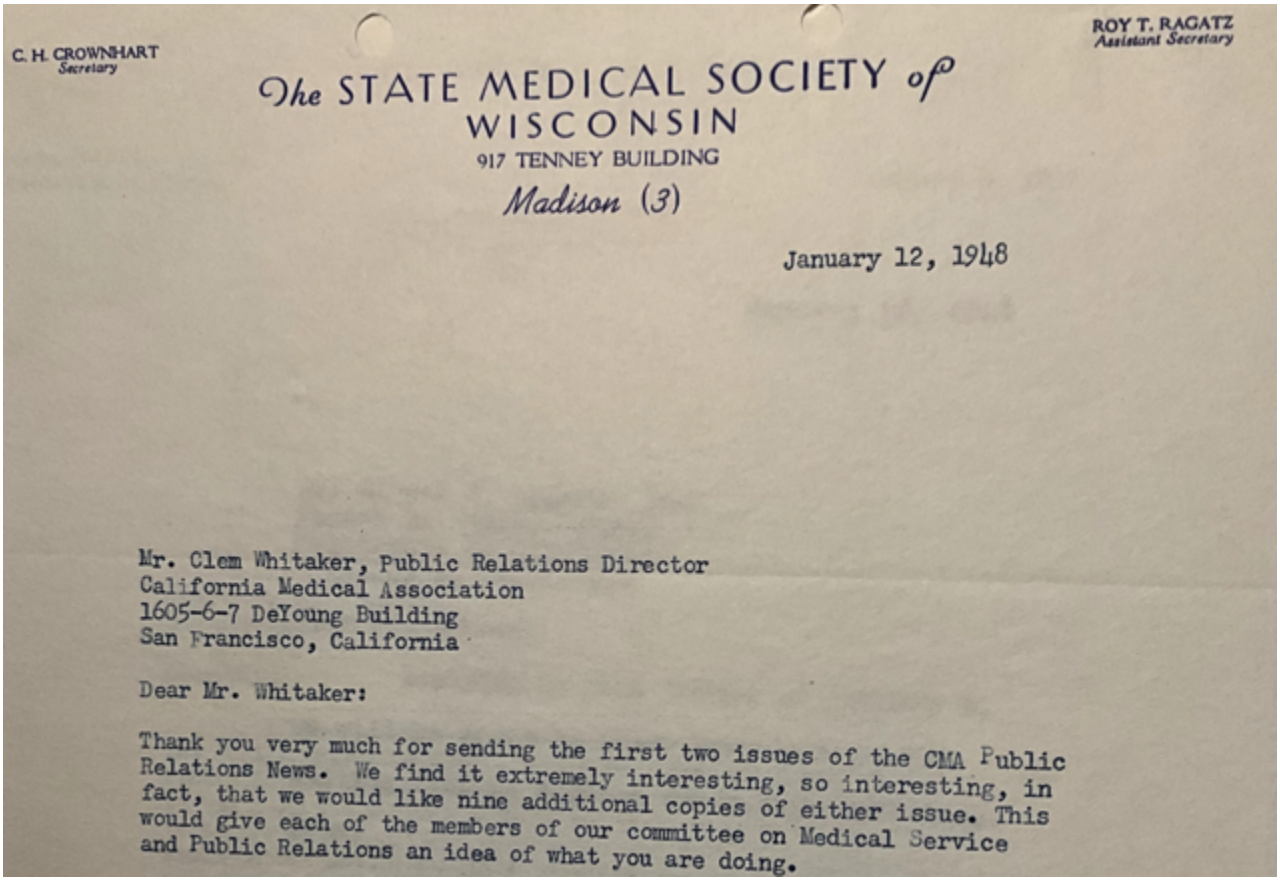
Appendix Figure A16: Share Donated to Eisenhower-Nixon Ticket among Specialist and Generalist Physicians



Notes: Figure plots the donation rate among specialist and generalist physicians. Each bar indicates the share of physicians who donated within each group. The overall share for specialists is computed using all specialists who donated divided by the total number of specialists. Specialty data are from the *American Medical Directory* (American Medical Association 1950*a*), and donation data are from the National Professional Committee for Eisenhower for President (Whitaker & Baxter *Campaigns, Inc.* 1946-1973).

B Primary Source Exhibits

Appendix Figure B1: *CMA Public Relations News*
Sent to the State Medical Society of Wisconsin



C. H. CROWNHART
Secretary

ROY T. RAGATZ
Assistant Secretary

The STATE MEDICAL SOCIETY of
WISCONSIN
917 TENNEY BUILDING
Madison (3)

January 12, 1948

Mr. Clem Whitaker, Public Relations Director
California Medical Association
1605-6-7 DeYoung Building
San Francisco, California

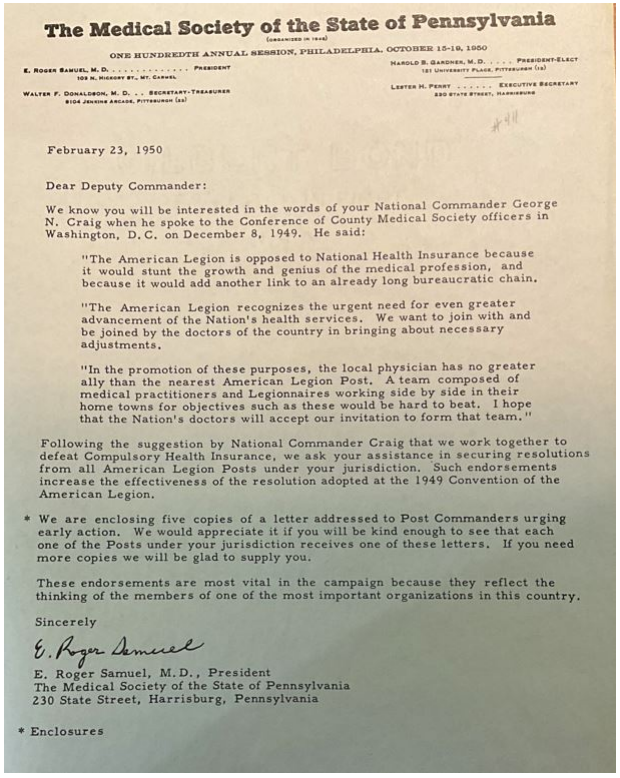
Dear Mr. Whitaker:

Thank you very much for sending the first two issues of the CMA Public Relations News. We find it extremely interesting, so interesting, in fact, that we would like nine additional copies of either issue. This would give each of the members of our committee on Medical Service and Public Relations an idea of what you are doing.

Notes: Evidence of outreach by Whitaker & Baxter to national, state, and local medical societies (Whitaker & Baxter *Campaigns, Inc.* 1945-1949).

Appendix Figure B2: Example Resolution Letter and Passed Resolution against National Health Insurance

(a) Resolution letter



The Medical Society of the State of Pennsylvania

ONE HUNDREDTH ANNUAL SESSION, PHILADELPHIA, OCTOBER 15-19, 1950

E. ROGER SAMUEL, M. D. . . . . PRESIDENT
109 N. HICKORY ST., MT. CARMEL

HAROLD B. GARDNER, M. D. . . . . PRESIDENT-ELECT
121 UNIVERSITY PLACE, PITTSBURGH (13)

WALTER F. DONALDSON, M. D. . . SECRETARY-TREASURER
8104 JENKINS ARCADE, PITTSBURGH (22)

LESTER H. PERRY . . . . . EXECUTIVE SECRETARY
230 STATE STREET, HARRISBURG

February 23, 1950

Dear Deputy Commander:

We know you will be interested in the words of your National Commander George N. Craig when he spoke to the Conference of County Medical Society officers in Washington, D.C. on December 8, 1949. He said:

"The American Legion is opposed to National Health Insurance because it would stunt the growth and genius of the medical profession, and because it would add another link to an already long bureaucratic chain.

"The American Legion recognizes the urgent need for even greater advancement of the Nation's health services. We want to join with and be joined by the doctors of the country in bringing about necessary adjustments.

"In the promotion of these purposes, the local physician has no greater ally than the nearest American Legion Post. A team composed of medical practitioners and Legionnaires working side by side in their home towns for objectives such as these would be hard to beat. I hope that the Nation's doctors will accept our invitation to form that team."

Following the suggestion by National Commander Craig that we work together to defeat Compulsory Health Insurance, we ask your assistance in securing resolutions from all American Legion Posts under your jurisdiction. Such endorsements increase the effectiveness of the resolution adopted at the 1949 Convention of the American Legion.

* We are enclosing five copies of a letter addressed to Post Commanders urging early action. We would appreciate it if you will be kind enough to see that each one of the Posts under your jurisdiction receives one of these letters. If you need more copies we will be glad to supply you.

These endorsements are most vital in the campaign because they reflect the thinking of the members of one of the most important organizations in this country.

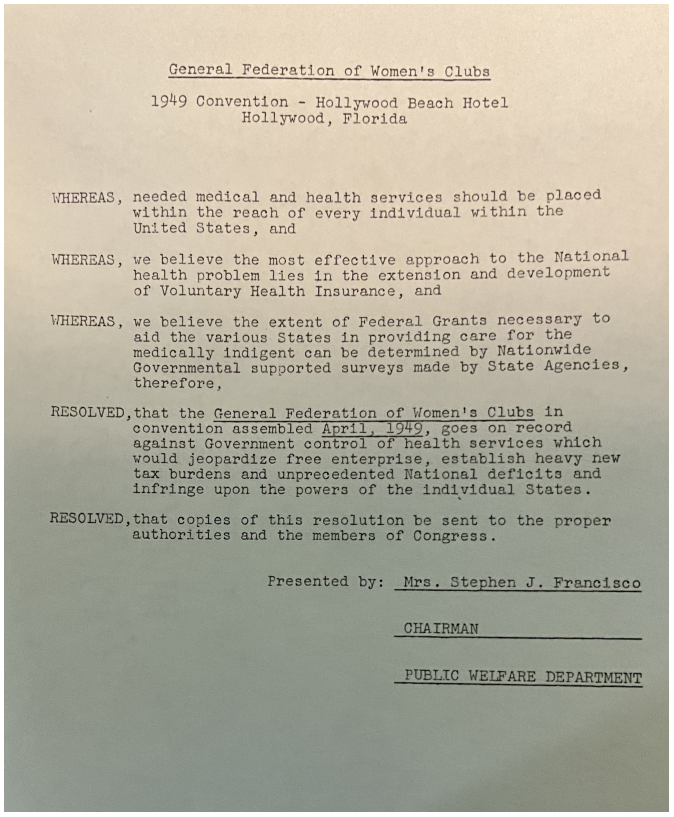
Sincerely

E. Roger Samuel

E. Roger Samuel, M.D., President
The Medical Society of the State of Pennsylvania
230 State Street, Harrisburg, Pennsylvania

* Enclosures

(b) Resolution text



General Federation of Women's Clubs

1949 Convention - Hollywood Beach Hotel
Hollywood, Florida

WHEREAS, needed medical and health services should be placed within the reach of every individual within the United States, and

WHEREAS, we believe the most effective approach to the National health problem lies in the extension and development of Voluntary Health Insurance, and

WHEREAS, we believe the extent of Federal Grants necessary to aid the various States in providing care for the medically indigent can be determined by Nationwide Governmental supported surveys made by State Agencies, therefore,

RESOLVED, that the General Federation of Women's Clubs in convention assembled April, 1949, goes on record against Government control of health services which would jeopardize free enterprise, establish heavy new tax burdens and unprecedented National deficits and infringe upon the powers of the individual States.

RESOLVED, that copies of this resolution be sent to the proper authorities and the members of Congress.

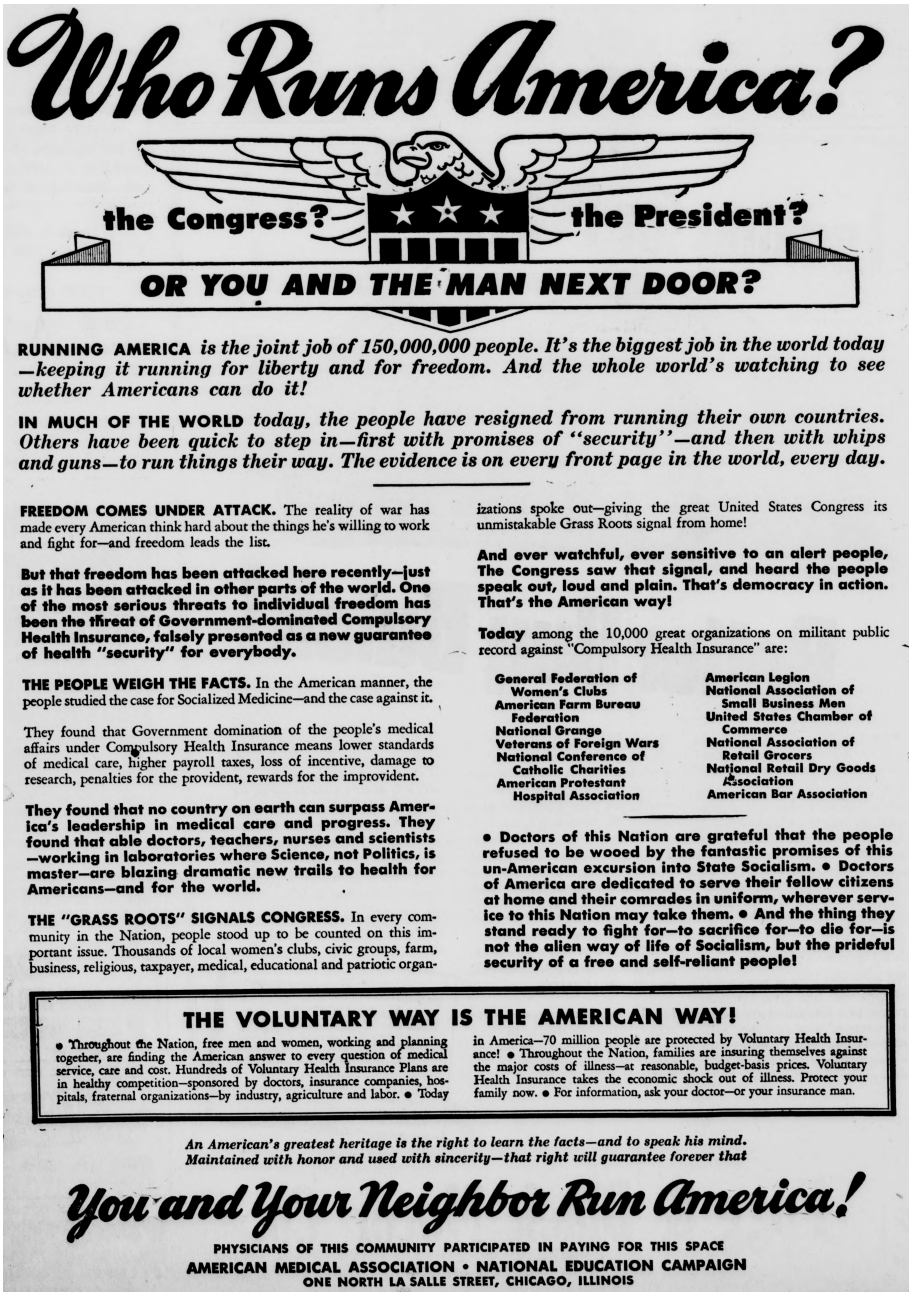
Presented by: Mrs. Stephen J. Francisco

CHAIRMAN

PUBLIC WELFARE DEPARTMENT

Notes: Panel A shows a request to pass local resolutions against NHI from the Medical Society of Pennsylvania. Panel B shows a local resolution against NHI passed by the General Federation of Women's Clubs (Whitaker & Baxter *Campaigns, Inc.* 1949-1952).

Appendix Figure B3: Main Campaign Newspaper Ad



Who Runs America?

the Congress? **the President?**

OR YOU AND THE MAN NEXT DOOR?

RUNNING AMERICA *is the joint job of 150,000,000 people. It's the biggest job in the world today —keeping it running for liberty and for freedom. And the whole world's watching to see whether Americans can do it!*

IN MUCH OF THE WORLD *today, the people have resigned from running their own countries. Others have been quick to step in—first with promises of "security"—and then with whips and guns—to run things their way. The evidence is on every front page in the world, every day.*

FREEDOM COMES UNDER ATTACK. The reality of war has made every American think hard about the things he's willing to work and fight for—and freedom leads the list.

But that freedom has been attacked here recently—just as it has been attacked in other parts of the world. One of the most serious threats to individual freedom has been the threat of Government-dominated Compulsory Health Insurance, falsely presented as a new guarantee of health "security" for everybody.

THE PEOPLE WEIGH THE FACTS. In the American manner, the people studied the case for Socialized Medicine—and the case against it.

They found that Government domination of the people's medical affairs under Compulsory Health Insurance means lower standards of medical care, higher payroll taxes, loss of incentive, damage to research, penalties for the provident, rewards for the improvident.

They found that no country on earth can surpass America's leadership in medical care and progress. They found that able doctors, teachers, nurses and scientists —working in laboratories where Science, not Politics, is master—are blazing dramatic new trails to health for Americans—and for the world.

THE "GRASS ROOTS" SIGNALS CONGRESS. In every community in the Nation, people stood up to be counted on this important issue. Thousands of local women's clubs, civic groups, farm, business, religious, taxpayer, medical, educational and patriotic organizations spoke out—giving the great United States Congress its unmistakable Grass Roots signal from home!

And ever watchful, ever sensitive to an alert people, The Congress saw that signal, and heard the people speak out, loud and plain. That's democracy in action. That's the American way!

Today among the 10,000 great organizations on militant public record against "Compulsory Health Insurance" are:

General Federation of Women's Clubs
American Farm Bureau Federation
National Grange
Veterans of Foreign Wars
National Conference of Catholic Charities
American Protestant Hospital Association
American Legion
National Association of Small Business Men
United States Chamber of Commerce
National Association of Retail Grocers
National Retail Dry Goods Association
American Bar Association

• Doctors of this Nation are grateful that the people refused to be wooed by the fantastic promises of this un-American excursion into State Socialism. • Doctors of America are dedicated to serve their fellow citizens at home and their comrades in uniform, wherever service to this Nation may take them. • And the thing they stand ready to fight for—to sacrifice for—to die for—is not the alien way of life of Socialism, but the prideful security of a free and self-reliant people!

THE VOLUNTARY WAY IS THE AMERICAN WAY!

• Throughout the Nation, free men and women, working and planning together, are finding the American answer to every question of medical service, care and cost. Hundreds of Voluntary Health Insurance Plans are in healthy competition—sponsored by doctors, insurance companies, hospitals, fraternal organizations—by industry, agriculture and labor. • Today in America—70 million people are protected by Voluntary Health Insurance! • Throughout the Nation, families are insuring themselves against the major costs of illness—at reasonable, budget-basis prices. Voluntary Health Insurance takes the economic shock out of illness. Protect your family now. • For information, ask your doctor—or your insurance man.

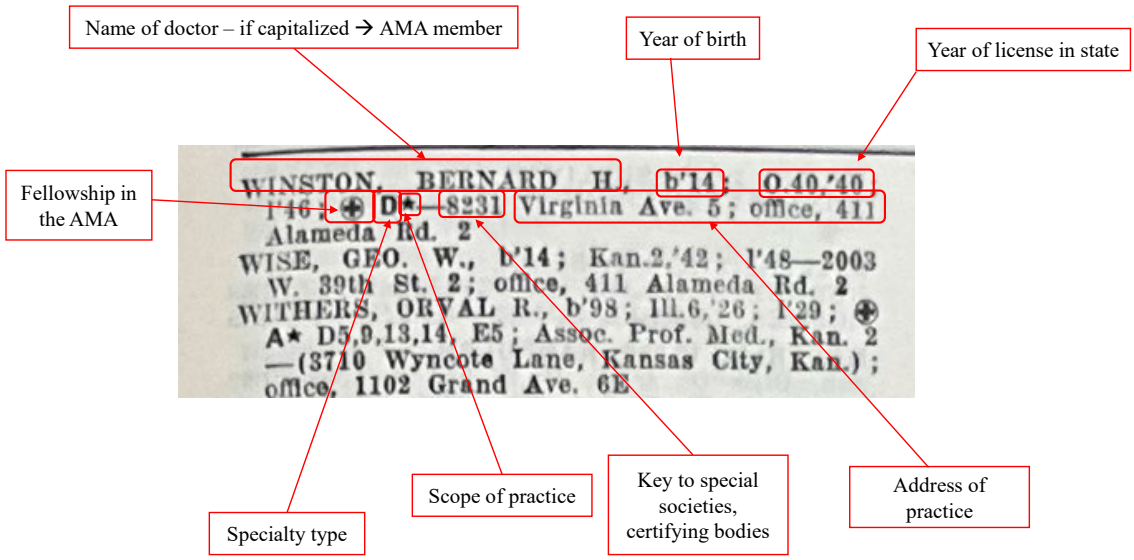
An American's greatest heritage is the right to learn the facts—and to speak his mind. Maintained with honor and used with sincerity—that right will guarantee forever that

You and Your Neighbor Run America!

PHYSICIANS OF THIS COMMUNITY PARTICIPATED IN PAYING FOR THIS SPACE
AMERICAN MEDICAL ASSOCIATION • NATIONAL EDUCATION CAMPAIGN
ONE NORTH LA SALLE STREET, CHICAGO, ILLINOIS

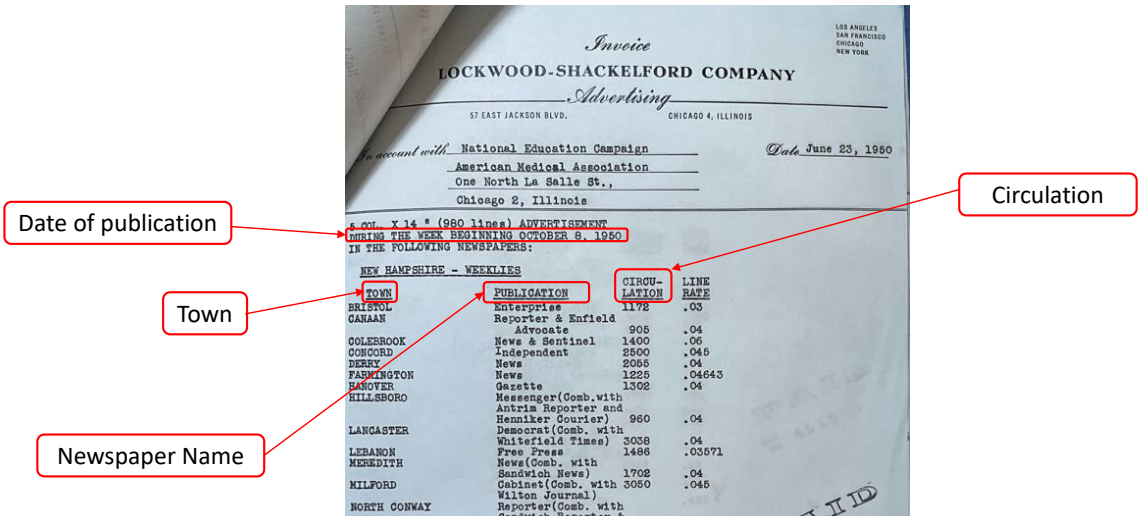
Notes: Exhibit shows the standard template for the main Campaign advertisement which circulated in October 1950. The size and content were constant across newspapers. Example taken from page 16 of the *Athens Alabama Courier* published on October 12, 1950 (American Medical Association 1950*c*).

Appendix Figure B4: Example Records from the American Medical Directory



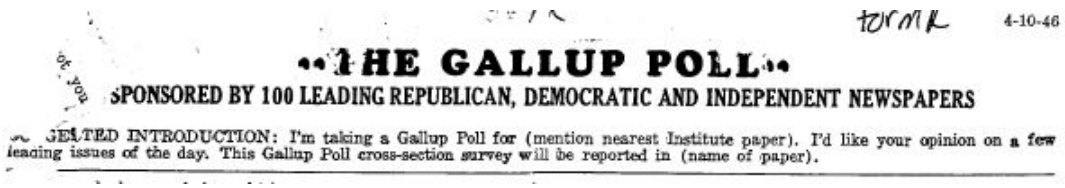
Notes: Exhibit shows example records from the *American Medical Directory* (American Medical Association 1950*a*, p.339).

Appendix Figure B5: Lockwood-Shackelford Advertising Agency Invoice



Notes: Exhibit shows an invoice from the Lockwood-Shackelford Advertising Company, outlining the data extracted in red (Whitaker & Baxter *Campaigns, Inc.* 1946-1973). The 980 line advertisement referenced is the main Campaign ad shown in Appendix Figure B3.

Appendix Figure B6: Gallup Sponsor and Recruitment Instructions



4-10-46

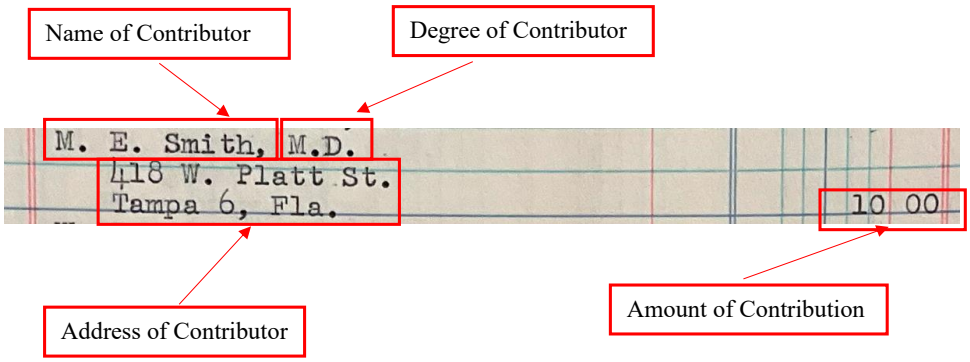
THE GALLUP POLL

SPONSORED BY 100 LEADING REPUBLICAN, DEMOCRATIC AND INDEPENDENT NEWSPAPERS

SELECTED INTRODUCTION: I'm taking a Gallup Poll for (mention nearest Institute paper). I'd like your opinion on a few leading issues of the day. This Gallup Poll cross-section survey will be reported in (name of paper).

Notes: Exhibit shows Gallup Poll instructions for recruitment and sponsorship. Example taken from page 16 of the study documentation for Gallup Poll # 1946-0369 (Gallup Organization 1946).

Appendix Figure B7: Example Record from National Professional Committee for Eisenhower for President



Notes: Exhibit shows an example record from the National Professional Committee for Eisenhower for President (Whitaker & Baxter *Campaigns, Inc.* 1946-1973).

C Appendix Tables

Appendix Table C1: Effect of Campaign on Private Health Insurance Enrollment
Robustness Tests

	Additional and Alternative Controls					
	(1)	(2)	(3)	(4)	(5)	(6)
Specification:	Unit-Specific Pre-Trend	War Bond Control	Blue Cross Control	Enabling Legislation	Specialist Control	New Deal Spending
Campaign Exposure $\times$ I^{Post}	0.028***	0.019***	0.019***	0.020***	0.018***	0.025***
	(0.005)	(0.004)	(0.004)	(0.005)	(0.004)	(0.005)
Dependent Mean	0.034	0.034	0.034	0.034	0.034	0.034
Observations	423	423	423	423	423	423
State FE	✓	✓	✓	✓	✓	✓
Design Controls	✓	✓		✓	✓	✓
Year FE	✓	✓	✓	✓	✓	✓

	Design and Inference		Alternative Sample, Weights, and Exposure		
	(7)	(8)	(9)	(10)	(11)
Specification:	Binary Treatment	Potential Trends Violations	Alternative Exposure	Alternative Denominator	Without California
Campaign Exposure $\times$ I^{Post}	0.035***	0.017**	0.018***	0.041**	0.020***
	(0.009)	[0.001, 0.032]	(0.004)	(0.017)	(0.004)
Dependent Mean	0.034	0.034	0.034	0.135	0.033
Observations	423	423	423	423	414
State FE	✓	✓	✓	✓	✓
Design Controls	✓	✓	✓	✓	✓
Year FE	✓	✓	✓	✓	✓

Notes: Table reports specification checks for the outcome of private health insurance enrollment. 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) (Council on Medical Service 1946-1954). Column 1 reports regression results controlling for unit-specific pre-trends following Miller (2023). Column 2 reports regression results controlling for war bonds (U.S. Census Bureau 2012). Column 3 reports results adding the share of Blue Cross hospitals to the controls (American Hospital Association 1948, 1950, 1952). Column 4 reports results controlling for an indicator for enabling legislation. Column 5 reports results controlling for share specialists interacted with a time trend. Column 6 reports results controlling for total New Deal grants spent per 1930 population (Fishback and Kantor 2018) interacted with a time trend. Column 7 reports results where treatment is dichotomized at the 50th percentile of Campaign exposure. Column 8 reports the Campaign effect in the first year after the Campaign completed (1951) and the associated 95% robust confidence interval computed following the procedure recommended by Rambachan and Roth (2023), which bounds the worst-case post-Campaign difference in trends by the equivalent maximum in the pre-Campaign periods. Column 9 reports results using only published propaganda materials (per capita Campaign pamphlets and per capita circulation of Campaign ads) as the exposure. Column 10 reports results using total enrollment denominated by the number of White employed males. Column 11 reports results excluding California. Design Controls include income per capita (Bureau of Economic Analysis 2023) and share unionized (Farber et al. 2021). Dependent Mean is the unconditional mean of the dependent variable in the pre-period. Robust standard errors clustered at the state level are in parentheses. *, **, *** refer to statistical significance at the 10, 5, and 1 percent level, respectively.

Appendix Table C2: Effect of Campaign on Approval for National Health Insurance Legislation Robustness Tests

	Additional and Alternative Controls					
	(1)	(2)	(3)	(4)	(5)	(6)
Specification:	Unit-Specific Pre-Trend	War Bond Control	Blue Cross Control	Enabling Legislation	Specialist Control	New Deal Spending
Campaign Exposure $\times$ I^{Post}	-0.052***	-0.067***	-0.059***	-0.059***	-0.062***	-0.059***
	(0.015)	(0.016)	(0.015)	(0.017)	(0.015)	(0.017)
Dependent Mean	0.687	0.684	0.684	0.684	0.684	0.684
Observations	4918	5112	5112	5112	5112	5112
State FE	✓	✓	✓	✓	✓	✓
Design Controls	✓	✓		✓	✓	✓
Individual Characteristics	✓	✓	✓	✓	✓	✓
Wave FE	✓	✓	✓	✓	✓	✓

	Design and Inference		Alternative Sample, Weights, and Exposure		
	(7)	(8)	(9)	(10)	(11)
Specification:	Binary Treatment	Potential Trends Violations	Alternative Exposure	Alternative Weights	Without California
Campaign Exposure $\times$ I^{Post}	-0.118**	-0.078**	-0.019	-0.055***	-0.056***
	(0.048)	[-0.204, -0.013]	(0.017)	(0.017)	(0.017)
Dependent Mean	0.684	0.684	0.684	0.684	0.698
Observations	5112	5112	5112	5112	4704
State FE	✓	✓	✓	✓	✓
Design Controls	✓	✓	✓	✓	✓
Individual Characteristics	✓	✓	✓	✓	✓
Wave FE	✓	✓	✓	✓	✓

Notes: Table reports specification checks for the outcome of 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. I^{Post} is an indicator for post-Campaign. The outcome is an indicator for approval (see Appendix Table A1). Column 1 reports regression results controlling for unit-specific pre-trends following Miller (2023). Column 2 reports the results of a regression controlling for war bond purchases (U.S. Census Bureau 2012). Column 3 reports results adding the share of Blue Cross hospitals to the controls (American Hospital Association 1948, 1950, 1952). Column 4 reports results controlling for an indicator for enabling legislation. Column 5 reports results controlling for share specialists interacted with a time trend. Column 6 reports results controlling for total New Deal grants spent per 1930 population (Fishback and Kantor 2018) interacted with a time trend. Column 7 reports results where treatment is dichotomized at the 50th percentile of Campaign exposure. Column 8 reports the Campaign effect in the first post Campaign survey wave and the associated 95% robust confidence interval computed following the procedure recommended by Rambachan and Roth (2023), which bounds the worst-case post-Campaign difference in trends by the equivalent maximum in the pre-Campaign periods. Column 9 reports results using only published propaganda materials (per capita Campaign pamphlets and per capita circulation of Campaign ads) as the exposure. Column 10 reports results with sampling weights based on voting eligibility (Gallup Organization 1945, 1946, 1949, 1950). The sample includes Gallup polls from November 1945, April 1946, May 1949, November 1949, October 1950, and November 1950 (Gallup Organization 1945, 1946, 1949, 1950). Column 11 reports results excluding California. 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, urbanicity, and education. Sample weights applied in all columns. 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-by-urbanicity level are in parentheses. *, **, *** refer to statistical significance at the 10, 5, and 1 percent level, respectively.

Appendix Table C3: Effect of Campaign on Resolutions Passed by Civic Organizations
Robustness Tests

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
	Additional and Alternative Controls						Alternative Sample and Exposure		
Specification:	War Bond Control	Blue Cross Control	Demographic Controls	Enabling Legislation	Specialist Control	New Deal Spending	Alternative Exposure	Binary Treatment	Without California
Campaign Exposure	0.034***	0.033***	0.033***	0.059***	0.037***	0.033***	0.031**	0.026**	0.035***
	(0.010)	(0.010)	(0.011)	(0.008)	(0.011)	(0.010)	(0.014)	(0.011)	(0.011)
Dependent Mean	0.138	0.138	0.138	0.138	0.138	0.140	0.138	0.138	0.140
Observations	3059	3059	3059	3059	3059	3031	3059	3059	3002
State FE	✓	✓	✓		✓	✓	✓	✓	✓
Division FE				✓					
Design Controls	✓		✓	✓	✓	✓	✓	✓	✓

Notes: Table reports results of Equation 9 for the outcome of civic organizations on record supporting voluntary (private) health insurance from Whitaker & Baxter *Campaigns, Inc.* (1933-1974). The outcome is normalized by county population and 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. Column 1 reports regression results controlling for 1944 per capita war bond purchases at the county level (U.S. Census Bureau 2012). Column 2 reports results adding the share of Blue Cross hospitals to the controls (American Hospital Association 1948, 1950, 1952). Column 3 reports results controlling for county shares of Black, female, employed, and urban populations (Haines 2010). Column 4 reports results controlling for an indicator for the passage of enabling legislation at the state level and including division instead of state fixed effects. Column 5 reports results controlling for share specialists. Column 6 reports results controlling for total New Deal grants spent per 1930 population (Fishback and Kantor 2018). Column 7 reports results using only published propaganda materials (per capita Campaign pamphlets and per capita circulation of Campaign ads) as the exposure. Design controls include income per capita (Bureau of Economic Analysis 2023) and share unionized (Farber et al. 2021). Column 8 reports results where treatment is dichotomized at the 50th percentile of Campaign exposure. Column 9 reports results excluding California. 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.

Appendix Table C4: Effect of the Campaign on Donating to Eisenhower-Nixon Ticket
Continuous Outcome

	(1)	(2)	(3)	(4)
Campaign Exposure $\times$ I^{AMA}	0.018***	0.018***	0.006***	0.018***
	(0.002)	(0.002)	(0.001)	(0.002)
Campaign Exposure	0.011***	0.011***	0.003***	0.011***
	(0.003)	(0.003)	(0.001)	(0.003)
I^{AMA}	0.017***	0.017***	0.005***	0.017***
	(0.001)	(0.001)	(0.000)	(0.002)
Dependent Mean	0.004	0.004	0.004	0.004
Observations	166,507	166,507	166,507	166,507
State FE	✓	✓	✓	✓
Design Controls		✓		✓
Individual Characteristics			✓	✓

Notes: Table reports the continuous outcome of the amount physicians donated on the interaction of Campaign exposure and I^{AMA}. The outcome is the inverse hyperbolic sine transformation of the dollar amount each physician donated to Eisenhower's presidential ticket (Whitaker & Baxter *Campaigns, Inc.* 1946-1973). 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 median county level 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.

Appendix Table C5: Effect of Campaign
Controlling for Share AMA and Share Educated

	(1)	(2)	(3)	(4)
Dependent Variable:	PHI Enrollment	NHI Approval	Civic Orgs.	Eisenhower Donation
	Panel A: Share AMA Control			
Effect of Campaign	0.020***	-0.057***	0.032***	0.007***
	(0.007)	(0.016)	(0.010)	(0.001)
	Panel B: Share Educated Control			
Effect of Campaign	0.021**	-0.060***	0.030***	0.006***
	(0.009)	(0.018)	(0.010)	(0.001)
Dependent Mean	0.034	0.684	0.138	0.006
Observations	423	5112	3059	166507
Design Controls	✓	✓	✓	✓
Additional Controls	✓	✓	✓	✓

Notes: Table reports effects of the Campaign for the outcomes of private health insurance (PHI) enrollment, approval for legislation establishing National Health Insurance, civic organizations on record supporting voluntary (private) health insurance from Whitaker & Baxter *Campaigns, Inc.* (1933-1974), and doctor donations to the Eisenhower Campaign Whitaker & Baxter *Campaigns, Inc.* (1933-1974). Column 4 reports the coefficient on the Campaign exposure interacted with an indicator for being an AMA member. Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. Regressions in Columns 1 and 2 control for trends in share AMA members (Panel A) and share educated (Panel B). Share educated is defined as the share of adults with more than five years of schooling. Trend in share AMA members is estimated using share AMA members interacted with a time trend. Trend in share educated is estimated using share educated linearly interpolated with 1940 and 1950 census data for each state. Regressions in Columns 3 and 4 control for the 1950 share AMA (Panel A) and share educated (Panel B). Design controls include state level income per capita in Columns 1 and 2 (Bureau of Economic Analysis 2023), county level median family income in Columns 3 and 4 (U.S. Census Bureau 2012), and state share unionized (Farber et al. 2021). Dependent Mean is the unconditional mean of the dependent variable in the pre-period. Robust standard errors (Column 3) and robust standard errors clustered at the state (Column 1), state-by-urbanicity (Column 2), and county level (Column 4) are in parentheses. *, **, *** refer to statistical significance at the 10, 5, and 1 percent level, respectively.

Appendix Table C6: Effect of Campaign
Controlling for Radio and Television Penetration

	(1)	(2)	(3)	(4)
Dependent Variable:	PHI Enrollment	NHI Approval	Civic Orgs.	Eisenhower Donation
	Panel A: Share HH. Owning a Radio Control			
Effect of Campaign	0.019***	-0.066***	0.059***	0.006***
	(0.007)	(0.016)	(0.009)	(0.001)
	Panel B: Share HH. Owning a TV Control			
Effect of Campaign	0.016*	-0.063***	0.073***	0.006***
	(0.008)	(0.016)	(0.009)	(0.001)
Dependent Mean	0.034	0.684	0.138	0.001
Observations	423	5112	3059	166507
Design Controls	✓	✓	✓	✓
Additional Controls	✓	✓	✓	✓

Notes: Table reports effects of the Campaign for the outcomes of private health insurance enrollment, approval for legislation establishing National Health Insurance, civic organizations on record supporting voluntary (private) health insurance from (Whitaker & Baxter *Campaigns, Inc.* 1933-1974), and doctor donations to the Eisenhower Campaign from (Whitaker & Baxter *Campaigns, Inc.* 1933-1974). Column 4 reports the coefficient on the Campaign exposure interacted with an indicator for being an AMA member. Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. Regressions in Columns 1 and 2 control for trends in share households owning a radio (Panel A) and share households owning a TV (Panel B) (U.S. Census Bureau 1953). Regressions in Columns 3 and 4 control for share households owning a radio (Panel A) and share households owning a TV (Panel B) (U.S. Census Bureau 1953). State fixed effects are not included since radio and TV penetration are at the state level. Design controls include state level income per capita in Columns 1 and 2 (Bureau of Economic Analysis 2023), county level median family income in Columns 3 and 4 (U.S. Census Bureau 2012), and state share unionized (Farber et al. 2021). Robust standard errors (Column 3) and robust standard errors clustered at the state (Column 1), state-by-urbanicity (Column 2), and county level (Column 4) are in parentheses. *, **, *** refer to statistical significance at the 10, 5, and 1 percent level, respectively.

Appendix Table C7: Individual Campaign Components and their Interaction

	PHI Enrollment		NHI Approval		Civic Orgs.		Eisenhower Donation	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Ad Effect	0.020***		-0.059**		0.025**		0.000	
	(0.006)		(0.022)		(0.010)		(0.000)	
MD Effect	0.005		-0.033***		0.010*		0.010***	
	(0.010)		(0.006)		(0.006)		(0.001)	
Std. Interaction		0.018**		-0.026**		0.030***		0.001
		(0.007)		(0.012)		(0.009)		(0.001)
p-value Ad Effect = MD Effect	0.315		0.193		0.210		0.000	
Dependent Mean	0.034	0.034	0.684	0.684	0.138	0.138	0.001	0.001
Observations	423	423	5112	5112	3059	3059	166507	166507
Design Controls	✓	✓	✓	✓	✓	✓	✓	✓
Additional Controls	✓	✓	✓	✓	✓	✓	✓	✓

Notes: Table reports results from regressions of private health insurance enrollment, approval for legislation establishing National Health Insurance, civic organizations on record supporting voluntary (private) health insurance from Whitaker & Baxter *Campaigns, Inc.* (1933-1974), and doctor donations to the Eisenhower Campaign from Whitaker & Baxter *Campaigns, Inc.* (1933-1974) on the interaction of Campaign exposure components. All controls in the last column of Table 1, Table 2, Table 3, and Table 5 are included. Ad and MD Effect in Columns 1, 3, 5, and 7 are standardized. Interaction in Columns 2, 4, 6, and 8 are the standardized product of non-standardized Ad and MD Effect. Robust standard errors (Column 5-6) and robust standard errors clustered at the state (Column 1-2), state-by-urbanicity (Column 3-4), and county level (Column 7-8) are in parentheses. *, **, *** denote statistical significance at the 10, 5, and 1 percent levels, respectively

Appendix Table C8: Effect of Campaign on Private Health Insurance Enrollment, Nonparametric ACR Estimates

	(1)	(2)	(3)	(4)
	Baseline	Nonparametric Estimator		
Method:	TWFE	Polynomial	B-Spline	Spline
Effect of Campaign	0.025***	0.023***	0.022***	0.022***
	(0.008)	(0.007)	(0.007)	(0.007)
Observations	423	423	423	423

Notes: Table reports effects of the Campaign for the outcome of private health insurance enrollment. Column 1 reports the baseline estimate from Table 1 Column 4. Columns 2-4 report results obtained by implementing the nonparametric estimation procedure proposed in Callaway, Goodman-Bacon and Sant'Anna (2024). Column 2 adopts a polynomial transformation of the Campaign exposure, and Columns 3 and 4 implement a b-spline and a natural spline, respectively. Robust standard errors are in parentheses. *, **, *** refer to statistical significance at the 10, 5, and 1 percent level, respectively.

Appendix Table C9: Socialism-Related Terms in Ads

	(1)	(2)	(3)	(4)
Dependent Variable:	Any Keyword		Number of Keywords	
$I^{\text{Campaign Ad}}$	0.887***	0.897***	3.878***	4.809***
	(0.010)	(0.010)	(0.143)	(0.168)
Dependent Mean	0.008	0.008	0.015	0.015
Observations	5108	5108	5108	5108
Newspaper FE		✓		✓

Notes: Table reports a regression of mentions of socialism-related terms in newspaper advertisements on an indicator for whether the advertisement is a Campaign ad. The outcome is either an indicator for containing any keyword (Columns 1 and 2) or the number of keywords (Columns 3 and 4). The list of keywords includes "socialism," "socialist," "communism," "communist," "American way," "freedom," and "tyranny." The Dependent Mean is the unconditional mean of the outcome for non-Campaign ads. Campaign ads include both the main ad (see Figure 1 Panel C) and tie-in ads (see Figure 2), which circulated in October-November 1950. Non-Campaign ads are randomly sampled from the same set of newspapers published one month before the introduction of the Campaign ads (September 1950). Data are from NewspaperArchive (2023). Robust standard errors clustered at the newspaper level are in parentheses. *, **, *** refer to statistical significance at the 10, 5, and 1 percent level, respectively.

D Appendix Figures

Appendix Figure D1: Word Cloud of Campaign Pamphlets and Ads

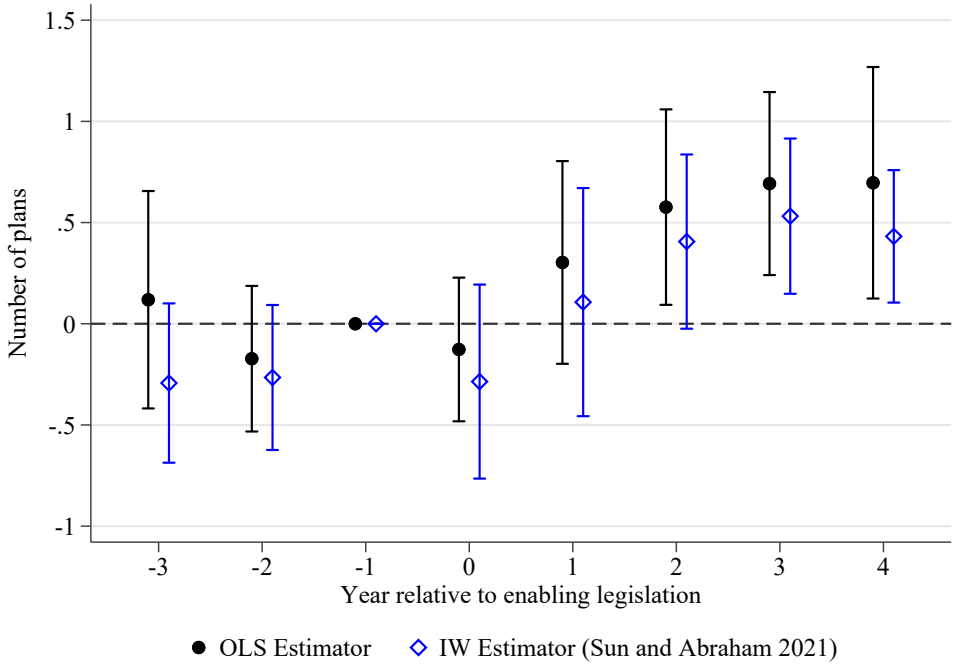
(a) Campaign Pamphlets

(b) Campaign Ads



Notes: Panel A shows a word cloud made from text in Campaign pamphlets. Panel B shows a word cloud of newspaper main ads and tie-in ads from *NewspaperArchive*. The top five most frequent words are shown in red bold font.

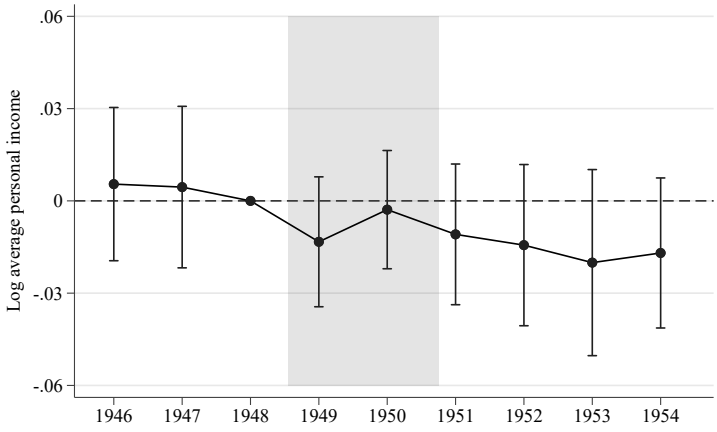
Appendix Figure D2: Effects of Enabling Legislation on Number of Prepayment Plans



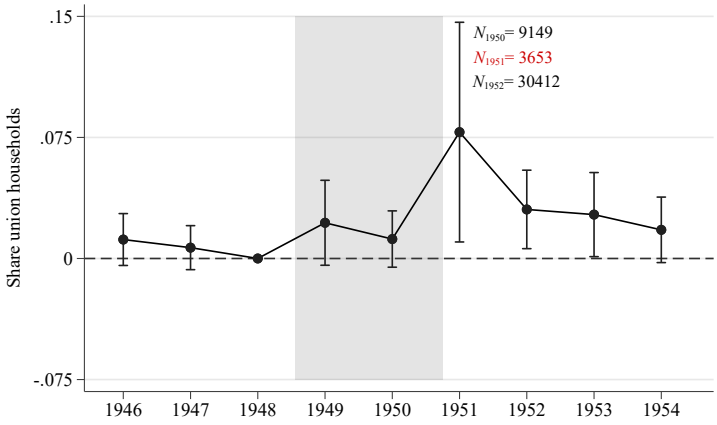
Notes: Figure plots the effect of enabling legislation on the number of prepayment plans (Council on Medical Service 1946-1954), and associated 95% confidence intervals. State and year fixed effects and income per capita (Bureau of Economic Analysis 2023) are included. IW estimates are computed according to Sun and Abraham (2021).

Appendix Figure D3: Effects of Campaign on Log Average Personal Income and Share Union Households

(a) Log Average Personal Income

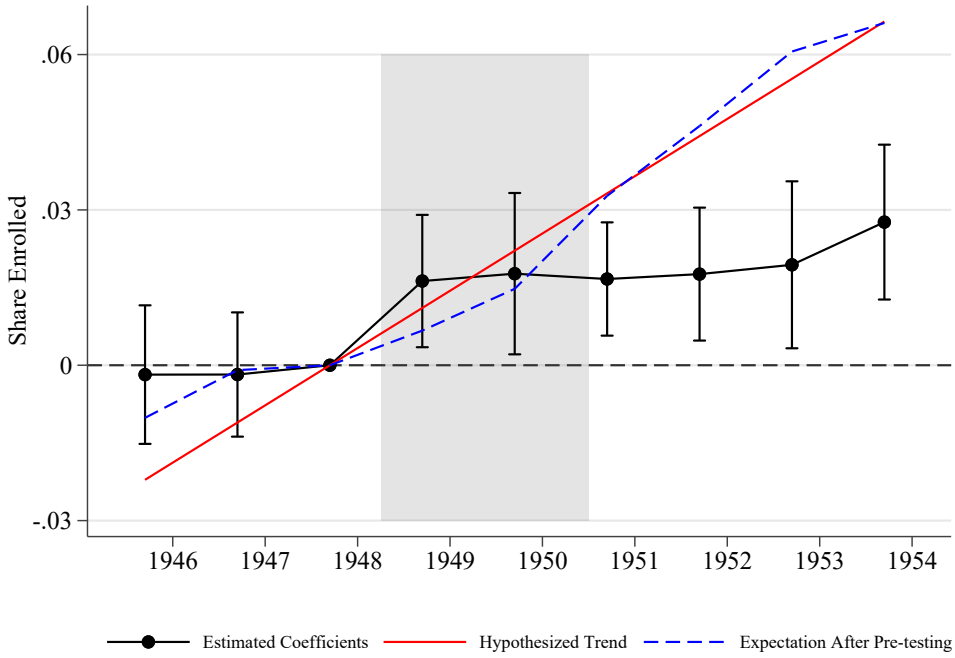


(b) Share Union Households



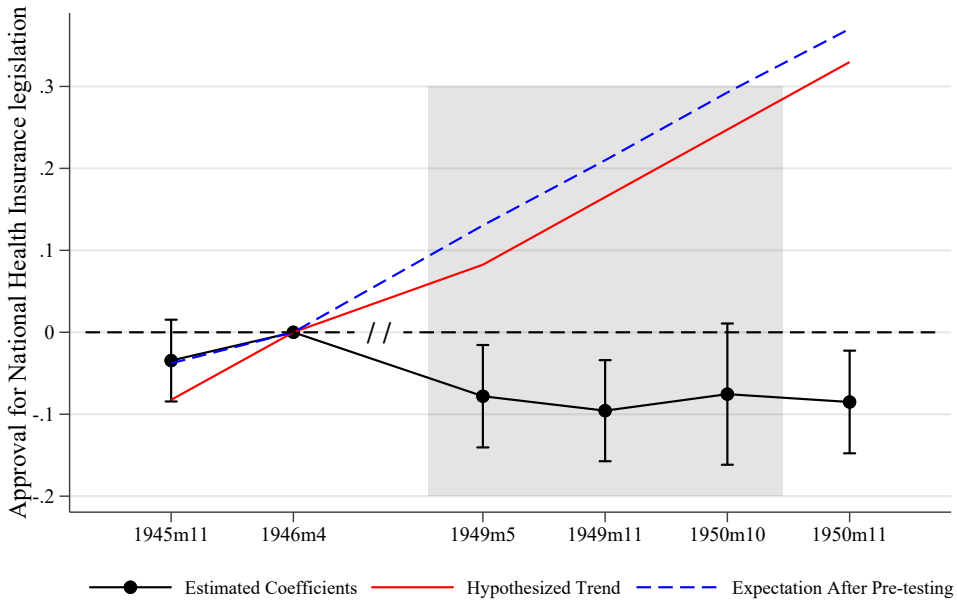
Notes: Figures plot the β coefficients from a regression similar to Equation 7, and associated 95% confidence intervals. The outcome in Panel A is log personal income per capita and the outcome in Panel B is share union households, both at the state level. Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. Union data are obtained from Farber et al. (2021), which are based on Gallup samples that differ over time. Income data are from Bureau of Economic Analysis (2023).

Appendix Figure D4: Effect of Campaign on
Private Health Insurance Enrollment, Pretrend Test



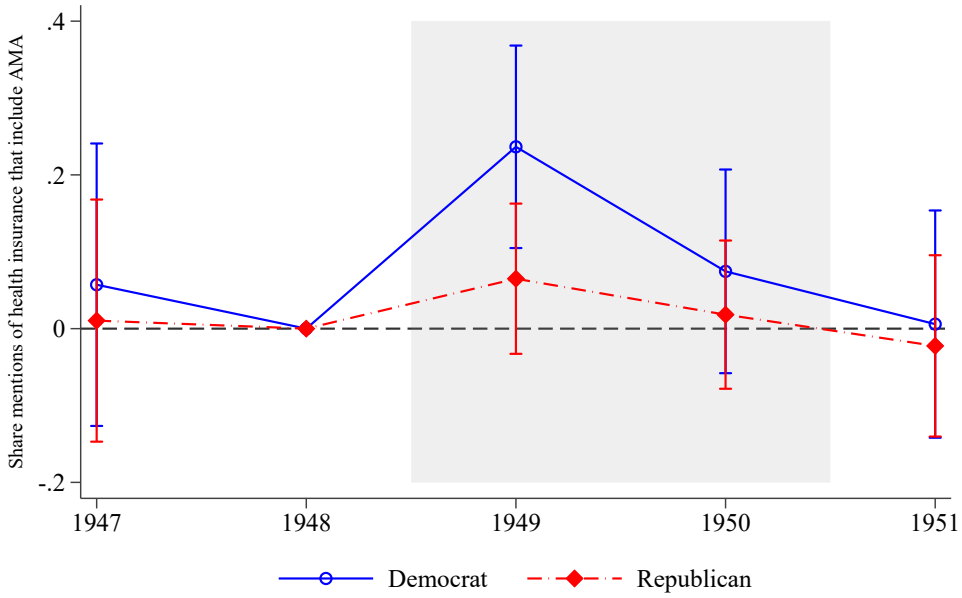
Notes: Figure plots potential violations of parallel trends based on methods proposed in Roth (2022). The coefficients on the interactions are estimated in an event study regression given by Equation 7, and the error bars represent the associated 95% confidence intervals. The red solid line represents the conjectured linear violation of parallel trends with 90% power. The blue dashed line represents the expected values of event study coefficients if the violation were present but undetectable using standard techniques. Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. Design controls include personal income per capita (Bureau of Economic Analysis 2023) and share unionized (Farber et al. 2021)

Appendix Figure D5: Effect of Campaign on
National Health Insurance Approval, Pretrend Test



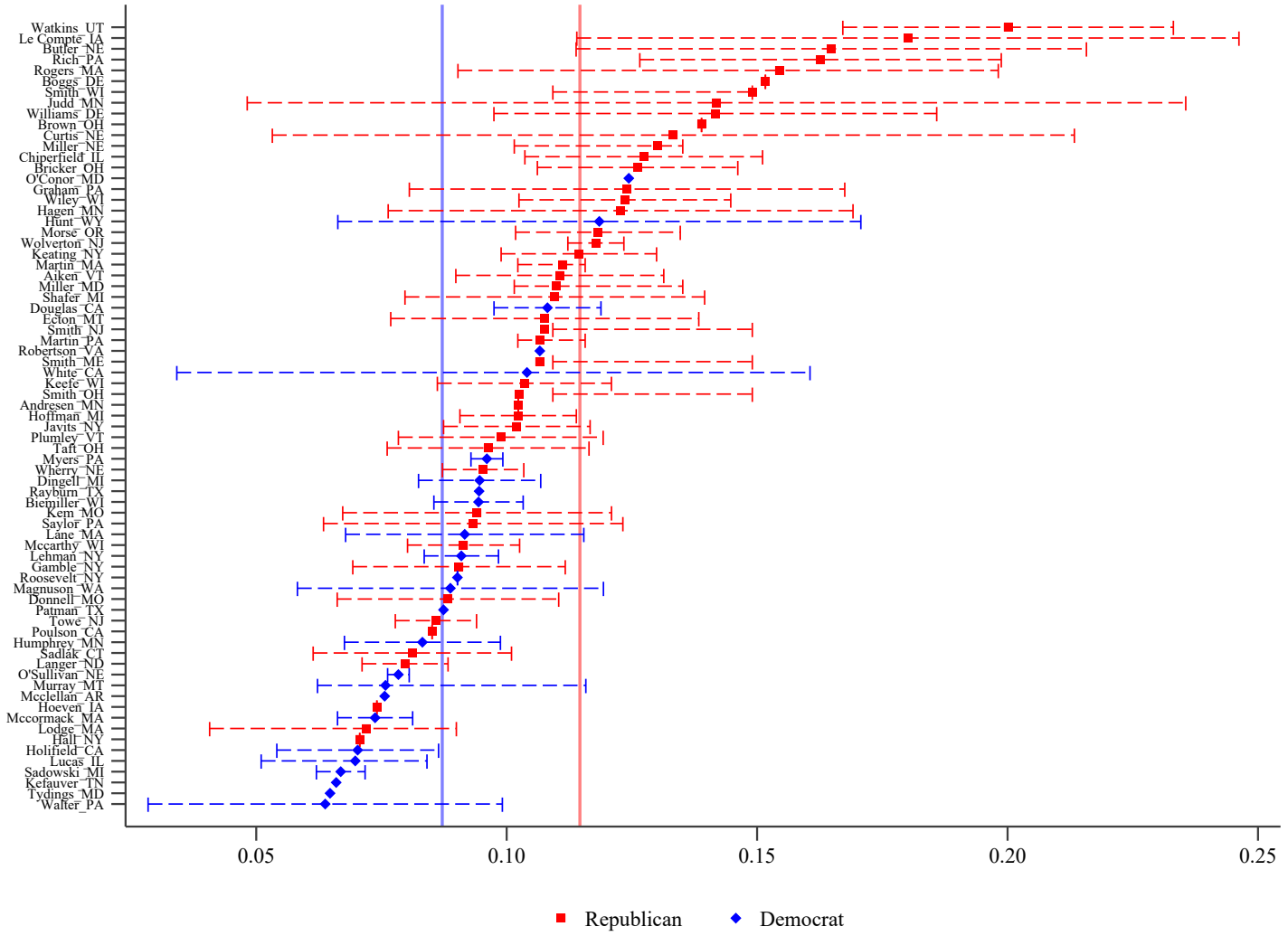
Notes: Figure plots potential violations of parallel trends based on methods proposed in Roth (2022). The coefficients on the interactions are estimated in an event study regression given by Equation 8, and the error bars represent the associated 95% confidence intervals. The red solid line represents the conjectured linear violation of parallel trends with 90% power. The blue dashed line represents the expected values of event study coefficients if the violation were present but undetectable using standard techniques. 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. The sample includes Gallup polls from November 1945, April 1946, May 1949, November 1949, October 1950, and November 1950. Individual level controls are also included. Design controls include personal income per capita (Bureau of Economic Analysis 2023) and share unionized (Farber et al. 2021). Sampling weights for the voting-eligible population are applied.

Appendix Figure D6: Mentions of AMA by Congressional Members, by Partisanship



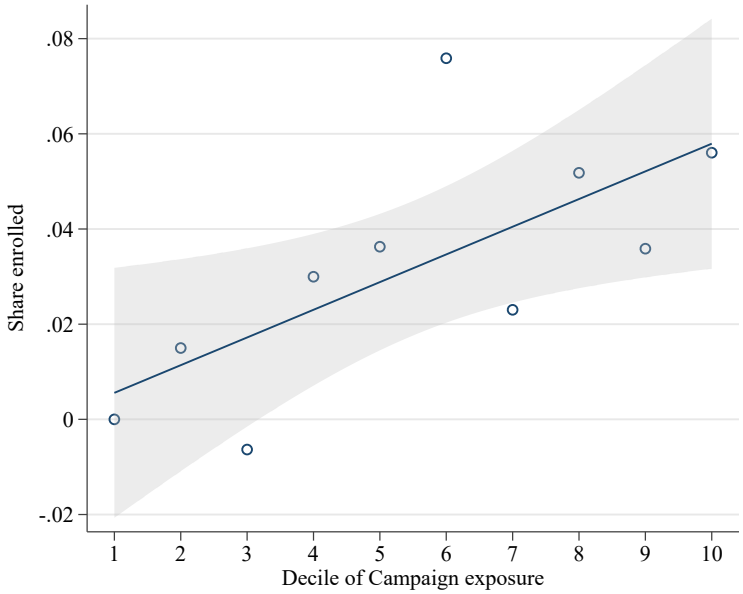
Notes: Figure plots coefficients and associated 95% confidence intervals of a regression of an indicator for AMA mention on party affiliation. Data are taken from the U.S. Congress (1947, 1948, 1949, 1950,1951). Shaded area indicates AMA-WB Campaign period.

Appendix Figure D7: Cosine Similarity of Legislator Quotes with AMA Propaganda



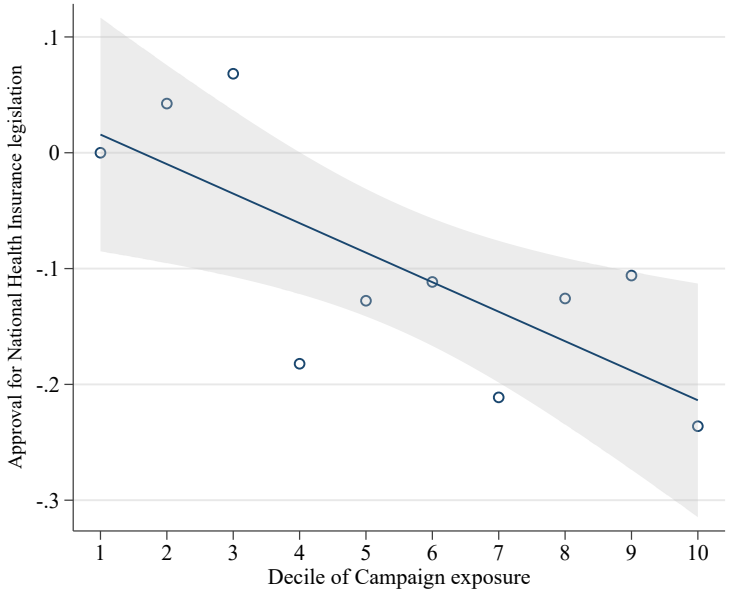
Notes: Figure plots the mean of cosine similarity for quotes in Column 7-8 of Table 4. Confidence intervals are obtained from a bootstrapping procedure with 100 repetitions. Red squares refer to Republicans, and blue diamonds refer to Democrats.The blue dotted and red solid vertical lines are the means across Democratic and Republican legislators respectively.

Appendix Figure D8: Private Health Insurance Enrollment by Campaign Exposure Decile



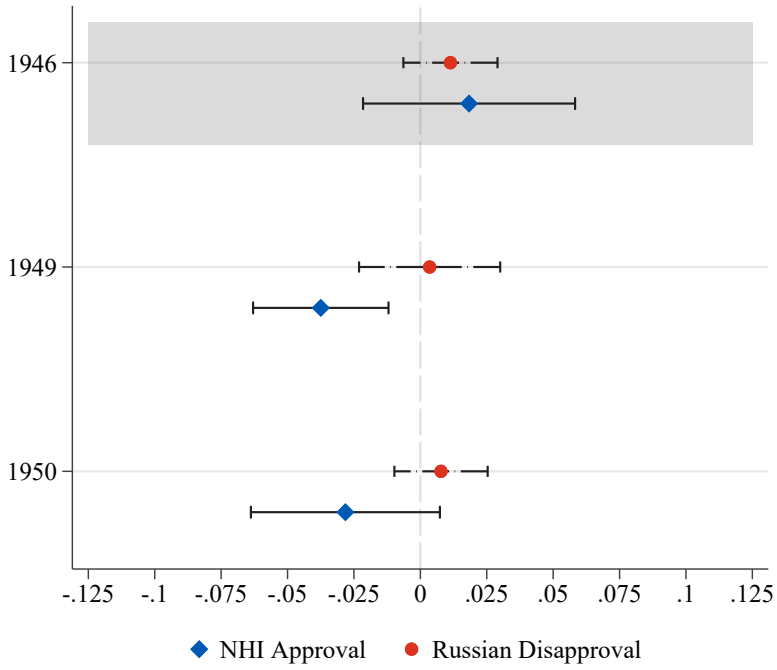
Notes: Figure plots the effect of the Campaign on share enrolled by exposure decile. Dots represent the point estimates of coefficients on the interaction of decile indicators and I^{Post}. The solid lines are fitted linear trends, and the shaded areas are associated 95% confidence intervals.

Appendix Figure D9: Approval for National Health Insurance by Exposure Deciles



Notes: Figure plots the effect of the Campaign on approval for NHI legislation by exposure decile with all controls included. Dots represent the point estimates of coefficients on the interaction of decile indicators and I^{Post}. The solid lines are fitted linear trends, and the shaded areas are associated 95% confidence intervals.

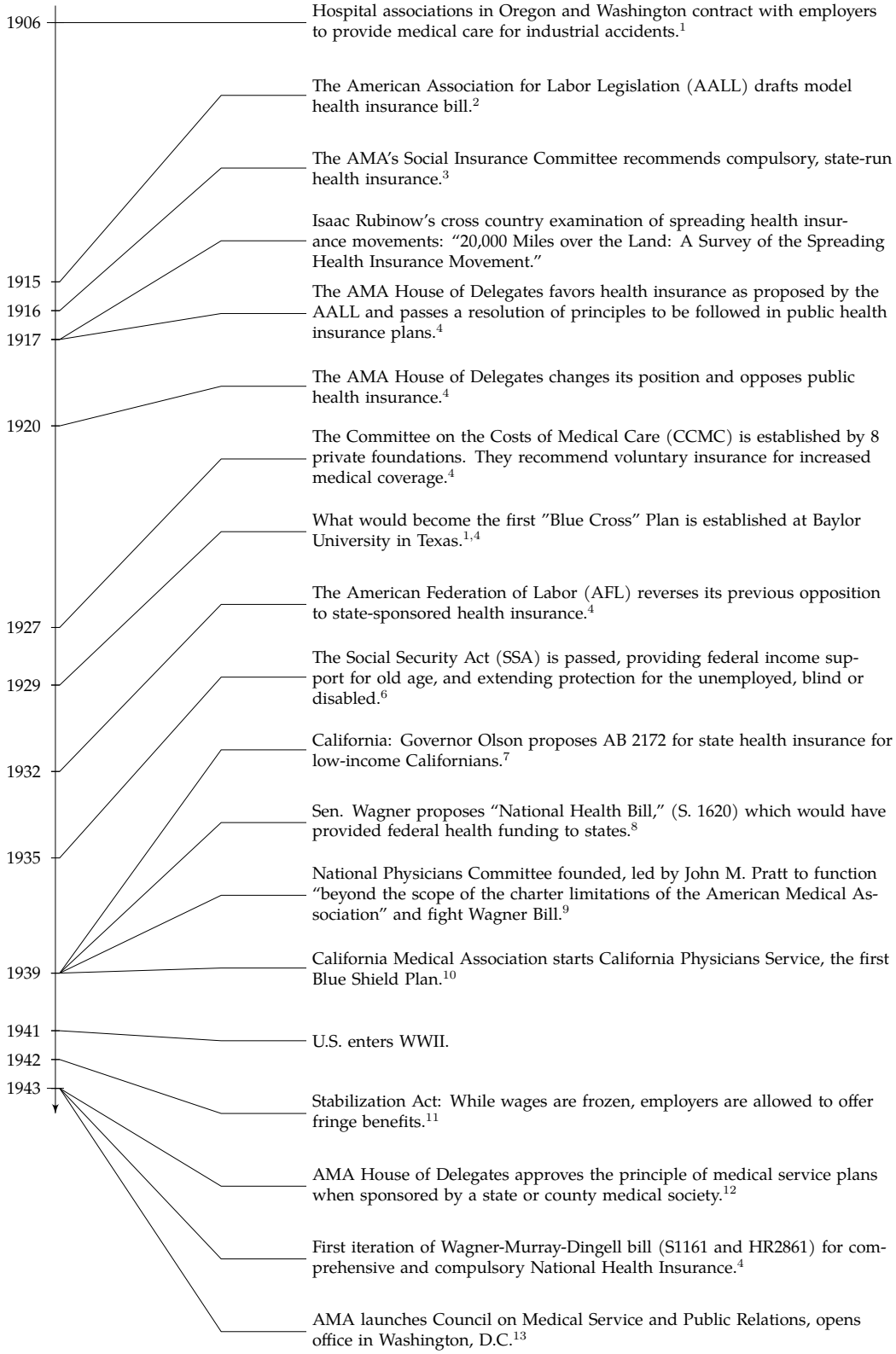
Appendix Figure D10: Campaign Exposure and anti-Russian Sentiment

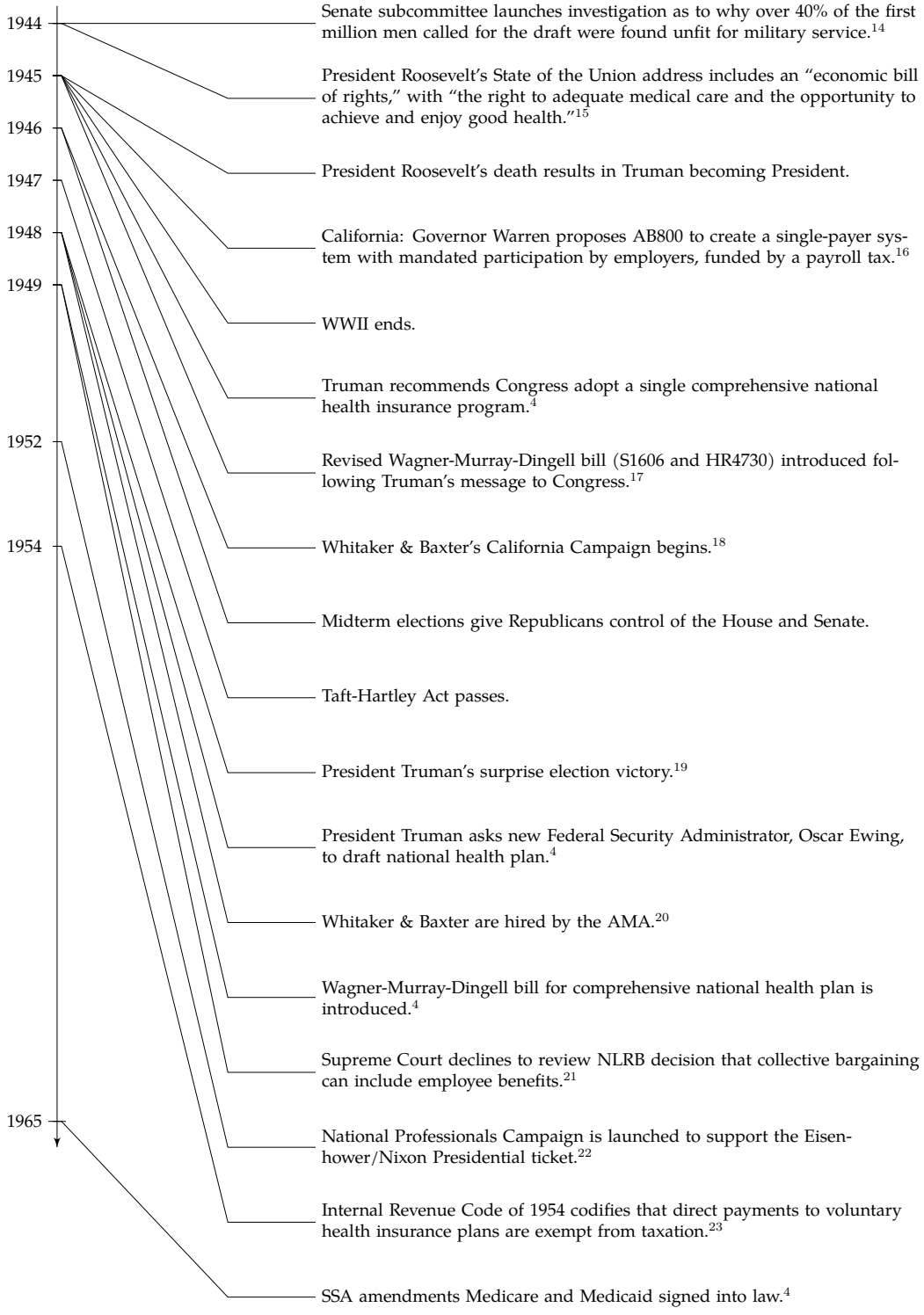


Notes: Figure plots coefficients relating Campaign exposure to Russian disapproval and NHI approval from Gallup polls (Gallup Organization 1945, 1946, 1949, 1950). The y-axis indicates the year of the survey wave, with the shaded area representing the pre-Campaign period. Questions related to Russian disapproval are as follows: "Do you think Russia will cooperate with us in world affairs?" (1946; coded as one if no; sample mean is 0.391) and "Do you believe Russia is trying to build herself up to be the ruling power of the world?" (1949 and 1950; coded as one if yes; sample mean is 0.775 for 1949 and 0.888 for 1950). Diamonds and solid error bars represent the estimates and the associated 95% confidence intervals for the outcome of NHI approval, whereas circles and dashed error bars represent the estimates and the associated 95% confidence intervals for the outcome of Russian disapproval.

E Institutional Appendix

E.1 Timeline: A Brief History of U.S. Health Insurance in the Early 20th Century




1944
1945
1946
1947
1948
1949
1952
1954
1965
Senate subcommittee launches investigation as to why over 40% of the first million men called for the draft were found unfit for military service.[14]
President Roosevelt's State of the Union address includes an "economic bill of rights," with "the right to adequate medical care and the opportunity to achieve and enjoy good health."[15]
President Roosevelt's death results in Truman becoming President.
California: Governor Warren proposes AB800 to create a single-payer system with mandated participation by employers, funded by a payroll tax.[16]
WWII ends.
Truman recommends Congress adopt a single comprehensive national health insurance program.[4]
Revised Wagner-Murray-Dingell bill (S1606 and HR4730) introduced following Truman's message to Congress.[17]
Whitaker & Baxter's California Campaign begins.[18]
Midterm elections give Republicans control of the House and Senate.
Taft-Hartley Act passes.
President Truman's surprise election victory.[19]
President Truman asks new Federal Security Administrator, Oscar Ewing, to draft national health plan.[4]
Whitaker & Baxter are hired by the AMA.[20]
Wagner-Murray-Dingell bill for comprehensive national health plan is introduced.[4]
Supreme Court declines to review NLRB decision that collective bargaining can include employee benefits.[21]
National Professionals Campaign is launched to support the Eisenhower/Nixon Presidential ticket.[22]
Internal Revenue Code of 1954 codifies that direct payments to voluntary health insurance plans are exempt from taxation.[23]
SSA amendments Medicare and Medicaid signed into law.[4]

Notes: [1]Reed (1947). [2]The draft legislation provided broad hospital and medical benefits to low-income workers and their dependents. The AMA supported the AALL's proposal, and by 1916 the AMA board established a committee to work with the AALL (Corning 1969; Palmer 1999). [3]Corning (1969). [4]Corning (1969); Palmer (1999). [5]A University official introduced the plan, which guaranteed teachers 21 days of hospital care for six dollars a year, and became popular among other employers in Dallas, garnering national attention (Blue Cross Blue Shield Association 1997). [6]Starr (1982).[7] AB 2172 would have established compulsory health insurance that was integrated into unemployment insurance for workers and their families below a given income (Dimmitt 2007, p.11-12). [8]The bill was "an omnibus five-point program, which would have amended the Social Security Act and provided federal funds for a litany of services – from basic hospital care and disability benefits to aid for child care – with states acting as the administrators" (Doherty and Jenkins 2009, p.3). [9]Corning (1969), (Poen 1996, p.47). [10]Board of Trustees of Mississippi State Medical Association (1965); Morrisey (2013). [11]Thomasson (2002). [12]The resolution approved "that principle of medical service plans on a service basis when sponsored by a constituent state medical association or a component county medical society in accordance with recommendations relating to medical service plans adopted by the House of Delegates"(Board of Trustees of Mississippi State Medical Association 1965, p.12). [13]Board of Trustees of Mississippi State Medical Association (1965); American Medical Association (2023). [14]Poen (1996); New York Times (1944, 1945). [15]Corning (1969). [16]Dimmitt (2007); Corning (1969). [17]The bill would have amended the Social Security Act of 1935. It proposed grants and loans for hospital and health center construction, grants to states for maternal, child, and public health services, grants to states for public assistance, and a national social insurance system (Smith 1945; Corning 1969). [18]Whitaker & Baxter *Campaigns, Inc.* (1945-1949). [19]Johnson (2016, p.33). [20]Whitaker & Baxter *Campaigns, Inc.* (1949-1952); Johnson (2016). [21]Inland Steel Co. v. NLRB, 170 F.2d 247 (7th Cir. 1948), *cert. denied*, 336 U.S. 960 (1949). [22]Whitaker & Baxter *Campaigns, Inc.* (1949-1952). [23]I.R.C. §106 (1954); Thomasson (2003).

E.2 Health Insurance Prior to World War II

This section heavily draws from the Federal Security Agency report: *Blue Cross and Medical Service Plans* (Reed 1947), the *Social Transformation of American Medicine* by Starr (1982), the *Wages of Sickness* by Hoffman (2001), and other sources cited herein.

Serious movements for state-sponsored health insurance began in the early 1900s with the American Association for Labor Legislation, founded by academic economists Richard Ely, Henry Farnam, and John R. Commons (Hoffman 2001). AALL leaders believed in a "security state" that was engaged in regulation and prevention more than direct relief, which it thought encouraged pauperism and dependency (Hoffman 2001, p.25). According to Hoffman, "Compulsory health insurance also opened another avenue for AALL's belief in the prevention of social ills. Just as workmen's compensation created a material incentive for employers to improve safety, health insurance, reformers thought, would place a monetary value on sickness prevention in the workplace" (Hoffman 2001, p.28).[45] However, several elements derailed any legislation from passing – most significantly, the First World War allowed those in opposition (including some elements of organized labor under Sam Gompers, some physicians, and the powerful life insurance industry) to defeat all such proposals .[46]

Coinciding with the demise of the Progressive movement and plans for state-sponsored health insurance, medical costs continued to rise as technology improved. Alongside the Great Depression of 1929, this inspired a handful of nonprofit hospitals to experiment with pre-payment schemes, which eventually became known as the Blue Cross system. The system started with community hospitals pulling together and offering services for employed individuals on a pre-paid basis, but community plans often then consolidated and operated on a state-wide basis. There were very few plans that crossed state boundaries, as the plans required state-specific enabling legislation to operate: They were typically not actually deemed insurance products, but rather service products that would operate as nonprofits.

FDR's New Deal afforded another opportunity for the potential incorporation of health insurance into the landmark Social Security Act of 1935. In 1934, Roosevelt appointed a Committee on Economic Security to study the issues of social insurance, including old-age, unemployment measures, and health insurance, chaired by Secretary of Labor Frances Perkins. Committee members, despite generally being in favor of health insurance, anticipated strong opposition to its inclusion in the Act, noting that it would "spell defeat for the entire bill" (Starr 1982, p.269). Agreeing with this sentiment, President Roosevelt commissioned a private report on health insurance and followed Secretary Perkins' recommendation that it not be made public until the Social Security Act was passed. The Committee's report supported a program that would be optional at the state level, but compulsory for residents in those states where adopted (Starr 1982). While politically contentious, a national health program may have also been personally problematic: President Roosevelt's son was married to Dr. Harvey Cushing's daughter, and Dr. Cushing's opposition to the policy is thought to have influenced Roosevelt's inaction on the proposal at the time (Blumenthal and Morone 2010; Rovit and Couldwell 2001).

While not included in the Social Security Act of 1935, support for health insurance legislation within the Roosevelt administration continued. In 1935, the Interdepartmental Committee to Coordinate Health and Welfare Activities was formed. In 1937, it established a Technical Committee on Medical Care, which was authorized to develop a national health program. The Technical Committee's proposal mirrored that of the Committee on Economic Security's, proposing state level health programs. President Roosevelt made

[45] The AALL's focus on industrial labor, and exclusion of agricultural and domestic workers from its proposals, reflected a broader historical trend of a neglect of the needs of non-White workers. Hoffman writes: "AALL leaders never spoke explicitly about excluding black workers from the health insurance plan. The reformers likely shared the racial assumptions of most whites of their era – they had no qualms about appointing scientific racist Frederick Hoffman to the Social Insurance Committee – but they rarely referred to the race question in their correspondence and publications" (Hoffman (2001, p.31); Hammonds (2003)).

[46] Isaac Rubinow, a physician and economist from Belarus and the leading authority on social insurance for the time, remarked that the inclusion of a funeral benefit in social insurance proposals was a "grave tactical error because of the implied threat to the gigantic structure of industrial life insurance" (Starr 1982, p.255). The life insurance industry was quite large as, according to Starr, "the fear of a pauper burial was so great that Americans bought $183 million of such insurance in 1911 – about as much as Germany spent on its entire social insurance system" (Starr 1982, p.242-3).

public part of the committee's report and convened a National Health Conference in 1938 to discuss the national health program, where delegates largely supported the Technical Committee's program. With this support, President Roosevelt first planned to make health insurance an issue in the 1938 midterm elections, later deciding to wait for the 1940 elections. However, with Democrats losing seats in Congress in 1938 and the advent of World War II, reform became less feasible. Before his abrupt death, President Roosevelt planned to push for health insurance when the war ended and asked Congress to affirm an "economic bill of rights," including medical care (Starr 1982, p.280). In January 1945, FDR included in his State of the Union address an expanded social security program that would include health. Later that year, the *Journal of the American Medical Association* would write: "No other year has seen such a demand for compulsory health insurance" (Poen 1996, p.50). Yet in April 1945, FDR died and was succeeded by Harry S. Truman.

On November 19, 1945 Truman made history by having the "first presidential message devoted exclusively to the subject of health" (Poen 1996, p.64). He first outlined unmet needs and the misallocation of healthcare resources before proposing solutions such as expanded research and training programs, federal funds for hospital construction, and a comprehensive pre-paid medical service plan financed through payroll taxes. This marked the beginning of making a National Health Insurance program a central component of the Truman Administration (Truman Library 2023).

E.3 California Campaign

The renewal of interest in state-sponsored health insurance led the CMA to hire Whitaker & Baxter in 1945 to direct an intensive public relations and ad campaign. The California Campaign was laid out in a *Campaigns, Inc.* document from April 1945 – the backbone was an "aggressive, affirmative campaign throughout this year and next, to develop and expand California Physicians Service" (Whitaker and Baxter 1945, p.7). The document went on to call out every potential constituency and how they could be persuaded to see their interests as aligned with those of the doctors – including those that could have potentially benefited from a steady stream of income linked to health care, like charitable hospitals run by religious organizations or rural medical professionals.

There were two key pieces of the California Campaign. The first was a series of "Voluntary Health Insurance weeks" designed to raise awareness of voluntary insurance. Mayors were encouraged to declare voluntary insurance weeks and to urge observance of the week, and public meetings were held with chambers of commerce and other civic groups (Whitaker & Baxter *Campaigns, Inc.* 1949-1952). Another component was a newspaper advertising campaign to promote the Voluntary Health Insurance weeks – newspaper advertising would also be used in the national Campaign.

E.4 Blue Cross Hospital Service Plans

This section heavily draws from the Federal Security Agency report: *Blue Cross and Medical Service Plans* (Reed 1947).

By 1947, several organizations were providing medical care on a "prepayment basis." First in importance were the Blue Cross hospital service plans sold in nonprofit hospitals.[47] During the Great Depression, hospitals experimented with approaches to improve their stream of income. A notable example is that of school teachers in Dallas, Texas approaching Baylor University hospital for coverage (possibly wanting maternity care, as "there [was] no mention in the pamphlet of any maternity waiting period"), which would become "the father of the hospital service plan movement" (Reed 1947, p.9-10). According to the FSA report, after teachers were found to be a "bad risk," fees were increased and insurance was extended to other groups. Many other hospitals followed suit, joining together to create community-based plans (so that the hospitals would not compete within a given catchment area for patients). "In this way the unethical and unsound features attending solicitation of patients by individual hospitals would be eliminated and subscribers would retain freedom of choice as to the hospital they desired" (Reed 1947, p.10).

As noted in Section II, the hospitals took the lead on starting these plans, per the FSA: "Generally the plans have been started by the voluntary hospitals of the area and it is these hospitals which have been

[47] By 1947, 28.18% of all hospitals were nonprofit, and 74.94% of Blue Cross hospitals were nonprofit (American Hospital Association 1948).

identified with and have supported the plans" (Reed 1947, p.28). These are typically places with a "high degree of urbanization and industrialization, and relatively high per capita income" (Reed 1947, p.28). We control for unionization and income in all preferred specifications, and for the share Blue Cross hospitals as a robustness check.

Enabling Legislation: Concerning the prepaid hospital and medical service plans, many required special enabling legislation in order to be exempt from typical insurance regulations. This was important, as "it meant that the plans would not need to make their subscribers liable for assessments, and could start without the sizable capital required of stock companies" (Reed 1947, p.11). Most states followed the legislative template provided by New York in 1934, which specified that "any corporation organized for the purpose of operating a non-profit hospital service plan" is considered a charitable institution (and therefore tax exempt) and must abide by certain rules in terms of structure (*e.g.*, trustees must include hospital administrators), including some oversight of the rates charged to subscribers by the insurance department (Reed 1947, p.11-12).

Enrollment in Blue Cross: According to the FSA, "the enrollment methods of Blue Cross plans are designed to secure the largest possible enrollment at the least possible expense and to assure actuarial soundness" (Reed 1947, p.59). This led to the main method of enrollment through employed groups, to address adverse selection.

Blue Cross Competition with Private Insurance Plans: Intense competition started between Blue Cross and commercial insurance plans by the mid-1940s – especially since the latter was not limited in geography and could offer uniform benefits across states for large employers. This only accelerated after the tax code change in 1954.

E.5 Blue Shield Medical Service Plans

Medical service plans started around the same time as hospital service plans, first in the Pacific Northwest, and were initially met with skepticism by physicians who eschewed the idea of contract work (Reed 1947). An inflection point came in 1939 when Governor Culbert Olson of California – the first Democratic governor elected in the state in four decades – introduced AB 2172 which provided for health insurance integrated into unemployment insurance for workers (and their families) below a given income (Dimmitt 2007). "These two factors" (the growing popularity of prepayment hospital service plans and the Governor's bill) "were primarily responsible for the establishment in 1939 of the California Physicians' Service by the California Medical Association" (Reed 1947, p.137).

As discussed in Section II.1, the AMA was undecided about insurance in the early 20th century. However, in late 1945 the AMA's policy towards prepayment medical service plans was made clear by passage of a resolution in the House of Delegates, which instructed the Board of Trustees and the Council on Medical Service and Public Relations "to proceed as promptly as possible with the development of a specific national health program with emphasis upon the nation-wide organization of locally administered prepayment plans sponsored by medical societies"(Reed 1947, p.147). Out of this, Associated Medical Care Plans Inc. was formed to perform the same duties of coordination as the Blue Cross Commission, and the Blue Shield Seal of Acceptance was established in 1946 to distinguish plans that were approve by the AMA's Council on Medical Service. Medical plans were more likely to be state-wide than the hospital plans, as they were not tied to a particular set of community hospitals.

E.6 Equity Considerations

How did advocates for private health insurance foresee care for the indigent and for non-White individuals? To gain some insight into this question we consider two sources. The Director of the Bureau of Medical Research for the AMA, Frank Dickinson, referred to an exhibit first published in 1939 when dismissing the notion of the medically indigent (*i.e.*, individuals who were poor because of their sickness). The figure divided the population by income and divided medical care into mutually exclusive categories: minor illness, major illness, chronic illness, institutional care, and prevention (Dickinson 1949). The chart is shown in Appendix Figure E11 and demonstrates that the indigent sick were designated as a "community responsibility." Institutional care (which would include mental health, convalescence or nursing home care) as well

Appendix Figure E11: Chart of Medical Services and Economic Status

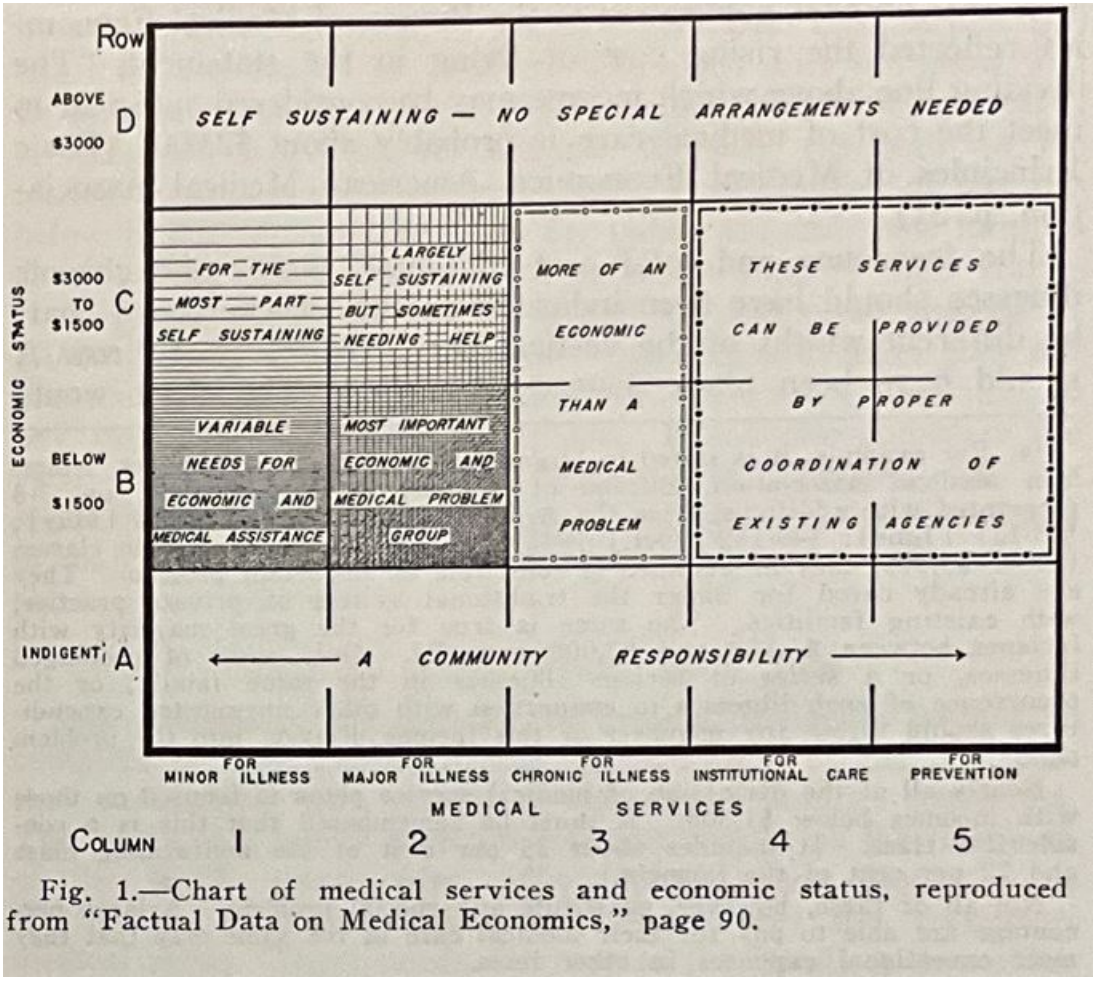


Fig. 1.—Chart of medical services and economic status, reproduced from "Factual Data on Medical Economics," page 90.

Notes: Exhibit shows a chart of medical services and economic status internally reproduced by Council on Medical Service (1946-1954).

as preventive care were designated to be provided by existing agencies. The conclusion of the figure is that there was no need for voluntary plans to cover these income groups or set of health issues.

The National Association for the Advancement of Colored Persons (NAACP) supported the notion of National Health Insurance as did the National Medical Association (NMA). The NMA consisted of Black physicians, as they were de facto barred from membership in the AMA. The NMA supported the initial Wagner-Murray-Dingell bill. Eventually, however, as the AMA invited the NMA to its meetings, NMA members began to flip their views in favor of PHI. The NAACP felt betrayed by this change. As noted by Poen (1996, p.161-162), "Beginning in April [1949], important lobbies fell into line against the president's proposal for national health insurance...In August, even the National Medical Association, composed of the nation's black physicians, balked on the issue. Despite their incoming president's warning that 'if you support the stand against Truman, you will receive a pat on the back from the AMA, but condemnation from ten million Negroes and the NAACP,' delegates to the association's 1949 convention refused to renew the NMA's earlier endorsement. This rising tide of opposition can be attributed mostly to the effectiveness of the AMA's Whitaker and Baxter campaign to associate the president's program with socialism."

E.7 Role of Organized Labor in National Health Insurance

Labor unions and other organized labor movements in the early 20th century did not fully embrace the idea of comprehensive social insurance for health care. Most prominently, Samuel Gompers, the first president of the American Federation of Labor (AFL) rejected the concept in the 1910s, citing the workers' capability to independently self-organize insurance plans that were paid by union dues (Derickson 1994, p.1337). His aversion to a government-run plan reflected his belief that workers' problems could be solved by bargaining between unions and businesses, without the government's intervention (Schlabach 1969; Yellowitz 1989, p.31). Gompers's death in 1924, the Great Depression, and the subsequent New Deal all laid the groundwork for unions to back government involvement in health insurance. In 1935, the AFL officially endorsed "the enactment of socially constructive health insurance legislation through Congress and the individual States" (Derickson 1994, p.1337).

During the 1948 presidential election, organized labor's support went to Democratic congressional candidates and President Truman out of a desire to repeal the Taft-Hartley Act (Leeds 1950). The Taft-Hartley Act, however, forbade contributions to federal political campaigns by unions, leading the AFL to legally bypass this restriction by creating a new body: Labor's League for Political Education (LLPE) (Leeds 1950, p.208-9). LLPE disseminated information on the voting records of candidates, held rallies, and hired a public relations firm to try and influence public opinion (Leeds 1950). The total amount spent by LLPE was $319,000 for these efforts (Leeds 1950, p.211). Labor's League for the Election of Truman and Barkley, another organization created to bypass the restrictions of the Taft-Hartley Act, spent an additional $32,535 (Chang 1953, p.566).

Despite its defeat in Congress in 1948-1950, organized labor continued to advocate for NHI. The Congress of Industrial Organizations (CIO, which would merge later to become AFL-CIO in 1955) held its 14th annual convention in 1952, where "even though various types of health plans had spread in collective bargaining, the 1952 convention of the CIO asserted: 'The CIO reaffirms its support for a national health program which will provide the people of our nation with needed medical services, facilities, and personnel...It must also include a system of national health insurance' " (Shister 1956, p.454). Simultaneously, unions negotiated for PHI through employers (Derickson 1994, p.1334). An example is the landmark "Reuther's Treaty of Detroit" negotiated between the United Automobile Workers (UAW) and General Motors (GM) in 1950, which included company-paid healthcare (Harbison 1950, p.398-99). Other large companies and union groups followed suit.

E.8 Relationship between the AMA and the Veterans Administration (VA)

The AMA was also opposed to the establishment of the Veterans Administration as an independent agency in 1930. The consolidation of the former Veterans Bureau into a federal Administration under President Hoover was threatening to the AMA, who feared veterans' care would extend to non-service-related sickness (the VA's care was initially restricted to service-related illnesses) and the construction of VA hospitals (Kendall 1995). In the early 1930s, AMA delegates lobbied against the provision of veterans' care in Congress and proposed that veterans be offered cash to seek a private, fee-for-service doctor. Unsuccessful, the AMA became more concerned with the growing sentiment in Washington in favor of extending the Social Security Act of 1935 (American Medical Association 1972).

How did veterans themselves perceive NHI? In the Gallup data, we observe whether male respondents are veterans of WWII in the November 1945 and April 1946 waves, or only before the Campaign begins. Although we are not able to observe Campaign treatment effect heterogeneity on this dimension due to this limitation, veterans of WWII are nine percentage points more likely to support NHI than non-veterans in the pre-Campaign period, though this relationship becomes weaker and not significant when conditioning on full demographic and design controls. In our lobbying data, we do not observe that veteran physicians differentially donated to the Eisenhower campaign.

F Methods Appendix

F.1 Enrollment Calculations

We calculate the approximate increase in the number of enrollees for both medical and hospital insurance, using a 2 percentage point estimate for each year after the Campaign on the number of medical and hospital enrollees. Hospital data are from The Survey Committee of the Health Insurance Council (1949-1965). This calculation suggests that a one standard deviation increase in Campaign exposure lead to an increase of about 3 million medical and 11 million hospital insurance enrollees. About 24 million people were newly enrolled in medical insurance and 46 million in hospital insurance between 1949 and 1954, (Council on Medical Service 1946-1954, The Survey Committee of the Health Insurance Council 1949-1965), reflecting 20% of the increase in enrollment: $\frac{3+11}{24+46} = 0.2$.

Thomasson (2003) examines the 1954 tax subsidy for employer-sponsored health insurance and its effect on demand for group health insurance, estimating that a ten percentage point increase in the marginal income tax rate corresponds to an increase in access to group health insurance by five percent in 1957. From this estimate, a back-of-the-envelope calculation indicates that a one standard deviation increase in the marginal tax rate corresponds with an increase in access to group health insurance coverage for approximately 650,000 - 1.1 million households or 2.2 - 3.7 million individuals. The insurance data in Thomasson (2003) comes from surveys asking whether anyone in the family has any medical, surgical, or hospital insurance; for this calculation we use the 1957 distribution of family incomes from U.S. Department of Commerce and Bureau of the Census (1958), the 1957 tax schedule from the Tax Foundation (2021), assume that every individual in the household is insured, and use the average 1957 household size of 3.4 reported by Thomasson.

F.2 Categorizing Tie-in Ads by Industry

We use key words or strings in company names, seen in Appendix Table F1 below, to categorize tie-in ads by industry. Among the 2114 companies with tie-in ads, 1778 were categorized into an industry.

Appendix Table F1: Keywords for Industry Categories

Industry	**Keywords**
Insurance	"Insur," "Casualty," "Mutual," "Accident," "Bounds," "Ins.," "Assurance," "Plan," "Agent," "Blue Cross"
Pharmacy	"Drug," "Pharm," "Rexall," "Pharmacy"
Medical Services	"M.D.," "Hospital," "Dentist," "Dr.," "Medical," "Physician," "Dental," "Optician," "Prescription," "O. D.," "D. D.," "Clinic," "Nursery," "Surgical," "Doctor," "D.D.S.," "O.D."
Finance	"Bank," "Saving," "Reserve," "Cash," "Trust," "Bonds"
Food	"Dair," "Food," "Cafe," "Milk," "Coffee," "Beverage," "Bakery," "Chicken," "Restaurant," "Creamery," "Package," "Ice Cream"
Manufacturing	"Motor," "Power," "Elec," "Machine," "Garage," "Factory," "Engineer," "Ford," "Metal," "Gas," "Manufacture," "Oil," "Glass," "Audi," "Buick," "Coal," "Auto," "Chevrolet," "Paint"
Retail	"Home," "Utilit," "Stores," "Appliance," "Hardware," "Shop," "Clean," "Repair," "Grocery," "Cloth," "Furn," "Dress," "Shoe," "Store," "Jewel," "Optical," "Super," "Market," "Sport," "Gulf," "Bicycle," "Beauty," "Laundr," "Radio," "Service," "Wear," "Plumb," "Mercantile," "Gold," "Auction," "Cemetery," "Towel," "J.C. Penney," "Floor Covering," "Refrigeration," "Wallpaper"
Real Estate	"Real Estate," "Construction," "Hotel"
Civic Orgs.	"Chamber of Commerce," "Association," "Veteran," "Public," "Society," "Federation," "Congress," "Representative," "Committee," "Auxiliary," "Implement"
Agriculture	"Lumber," "Forest," "Mill," "Farm," "Greenhouse," "Hatchery," "Animal Trap," "City," "Seed," "Cottage"
Media	"The Independent," "Doyle Post," "The Progress," "The Vogue," "Book," "Mail," "Tribune," "The Norwich Sun," "Herald," "Telegraph," "Journal," "News"

Notes: Table reports the keywords used to categorize tie-in ads into industries.

F.3 Identifying Campaign Ads and Characteristics of Newspapers with Ads

We draw on three archival sources of newspaper data: the Lockwood-Shackelford Advertising Company data from the *Campaigns, Inc.* archives (Whitaker & Baxter *Campaigns, Inc.* 1946-1973), *N.W. Ayer & Son's Directory of Newspapers and Periodicals* (Ayer 1949), and the NewspaperArchive (2023). We describe the process of locating the Campaign ads, linking newspaper level data, and creating Appendix Tables F2 and F3.

Identifying Campaign Ads. Appendix Figure B3 shows the main Campaign newspaper advertisement. We use direct template matching methods to locate the advertisement in each newspaper from the NewspaperArchive (2023), where the template we use is the heading of the ad containing an image of an eagle, and the matching tool is the match_template function in the skimage package in Python. To identify and classify tie-in advertisements, Harvard students were employed to search for key Campaign phrases in the full sample of newspapers available in October 1950.

Linking Newspapers. We matched two sets of newspapers to the *Ayer & Son's* newspaper directory: newspapers from the NewspaperArchive (2023) and newspapers from the Lockwood- Shackelford invoices.

Appendix Table F2: Comparison of Newspapers with and without Main Campaign Ad, Sample includes Newspapers available in 1950

	(1)	(2)	(3)
	Overall Mean	Difference	SE
Log(Circulation)	8.231	-0.223	(0.226)
Urban	0.708	-0.040	(0.063)
Weekly	0.550	-0.096	(0.069)
Established before 1940	0.985	0.029	(0.021)
Leans Republican	0.227	0.089	(0.063)
Railways Crossed	0.994	0.008	(0.014)
F-Stat		1.637	
F-Test *p*-Value		0.159	
Observations		616	

Notes: Newspaper sample is from the NewspaperArchive (2023) and includes all daily and weekly newspapers with issues in October 1950 merged to the *Ayer & Son's* data as described in Section IV. Column 1 reports the unconditional mean for the sample. Column 2 reports the coefficient on an indicator for having the ad in a regression with the newspaper characteristic. Column 3 reports the associated robust standard errors clustered at the state level. *F*-stat and *p*-value are for an *F*-test of the joint significance of the variables listed. *, **, *** refer to statistical significance at the 10, 5, and 1 percent level, respectively. Newspaper characteristics data are from Ayer (1949).

All newspapers from the NewspaperArchive (2023) with at least one issue available in October 1950 were matched to the *Ayer's & Son's* newspaper directory, including newspapers with and without the Campaign ad. We kept newspapers with non-missing attributes, used in Table F2.

We also linked newspapers from all Lockwood- Shackelford invoices to the *Ayer & Son's* directory. To do this linkage, we first exactly matched the two datasets using newspaper name, city, and state of publication. For unmatched entries, we computed the Levenshtein distance and considered it a match if the score was greater than or equal to 0.9 and the city and state were exact matches. These data are used in Appendix Table F3.

Appendix Table F3: Comparison of Newspapers with and without Main Campaign Ad, Lockwood-Shackelford and Ayer & Son's Directory

	(1)	(2)	(3)
	Overall Mean	Difference	SE
Log Circulation	7.737	-0.186**	(0.080)
Urban	0.563	-0.065*	(0.037)
Weekly	0.806	-0.024	(0.017)
Established before 1940	0.923	0.012	(0.012)
Lean Republican	0.202	0.014	(0.039)
Railways Crossed	0.993	-0.000	(0.002)
F-Stat		4.751	
F-Test *p*-Value		0.001	
Observations		11667	

Notes: Table reports differences between newspapers having the main Campaign ad shown in Appendix Figure B3 and those that did not. The sample includes Lockwood & Shackelford records and the Ayer & Son's data as described in Section IV. Newspapers are restricted to weeklies and dailies. Column 1 reports the unconditional mean for the sample. Column 2 reports the coefficient on an indicator for having the ad in a regression with the newspaper characteristic. Column 3 reports the associated robust standard errors clustered at the state level. *F*-stat and *p*-value are for an *F*-test of the joint significance of the variables listed. *, **, *** refer to statistical significance at the 10, 5, and 1 percent level, respectively. Newspaper characteristics data are from Ayer (1949), and Campaign ads data are from Whitaker & Baxter *Campaigns, Inc.* (1933-1974).

F.4 Linkage of the *American Medical Directory* to Lobbying Data

The data linkage procedure for the 1950 *American Medical Directory* (American Medical Association 1950*a*) and the list of donors who contributed to the National Professional Committee for Eisenhower for President (Whitaker & Baxter *Campaigns, Inc.* 1946-1973) is similar to Abramitzky et al. (2021) and can be summarized as follows:

1. Restrict to individuals with an M.D. degree in the donor list. Clean names in both datasets to remove any non-alphabetic characters and account for common abbreviations and nicknames (*e.g.*, so that Chas. and Charles would be considered the same name).
2. Split the AMD dataset into two, by whether the physician has a middle name.
   (a) For physicians with a middle name, look for individuals residing in the same state that match on last name, first initial, middle initial.
   (b) For physicians without a middle name, look for individuals residing in the same state that match on last name and first initial.

3. For the remaining records in the AMD dataset, we match on residing town and last name.

Among the donors with an M.D. degree, 81% of them were linked to at least one record in the AMD dataset, and 99% of matched pairs are unique. We dropped the observations that have multiple potential matches and only kept the unique matches.

F.5 Congressional Record OCR Process

This is a two-step process where PDFs of the *Congressional Record* are converted to images then to text using LayoutParser (Shen et al. 2021). In the first step, PDFs are processed to extract individual pages as images using the pdf2image library. In the second step, Optical Character Recognition (OCR) is performed on the pages using Google Cloud Vision integrated with LayoutParser, which facilitates the extraction of sequential and structured paragraphs from the pages. We then count mentions of keywords and extracted the date and last names of speakers from the text using regular expression from Judge-Lord (2022). The last names are then linked with legislator information from Inter-university Consortium for Political and Social Research (2010)

Most closely related to our procedure is Gentzkow, Shapiro and Taddy (2019) who obtain digital text from HeinOnline, and parse out speeches on the floor of Congress in the daily edition record to 550 individual speeches in the 81^{st} Congress. We used the speeches and petitions from 547 voting members of Congress.[48] We also included the Congressional Appendices in our work.

After the automated OCR process, we randomly selected 100 entries from the 294,745 speeches and petitions and manually checked with the original PDFs of the *Record* to confirm alignment.

G Model Appendix

G.1 Model Details

Recall that $\pi|m \sim \mathcal{B}(1+m_0, 1+m_1)$, the closed form expression of the updated payoff is then:

$$\begin{aligned} U_i(x_i, m) = &\left(\frac{1+m_0}{2+m_0+m_1}\right)[-(P-(x_i-\delta))^2] \\ &+\left(\frac{1+m_1}{2+m_0+m_1}\right)[-(P-(x_i+\delta))^2] \end{aligned} \tag{10}$$

We further assume that m_0 and m_1 are independent and $m_0, m_1 > 0$. Now the utility gain from adopting the policy $D_i \equiv U_i(x_i, m)_{|P=1} - U_i(x_i, m)_{|P=0}$ is given by:

$$D_i = 2x_i + 2\delta\left(1 - 2\mathbb{E}[\pi|m]\right) - 1 \tag{11}$$

Note that the FOC of U_i with respect to x_i is characterized by

$$\textbf{FOC: } x_i + \delta\left(1 - 2\mathbb{E}[\pi|m]\right) > \frac{1}{2} \iff D_i > 0 \tag{12}$$

[48] The three non-voting members who are not in our sample are: Bob Bartlett (Alaska Territory), Joseph Rider Farrington (Hawaii Territory), and Antonio Fernós-Isern (Puerto Rico).

G.2 Proofs

Proof of Proposition. Note that m_0, m_1 are independent and $m_0, m_1 > 0$, then

$$\begin{aligned}\frac{\partial}{\partial m_0}\mathbb{E}[\pi|m] &= \frac{\partial}{\partial m_0}\left(\frac{1+m_0}{2+m_0+m_1}\right) = \frac{1+m_1}{(2+m_0+m_1)^2} > 0\\ \frac{\partial}{\partial m_1}\mathbb{E}[\pi|m] &= \frac{\partial}{\partial m_1}\left(\frac{1+m_0}{2+m_0+m_1}\right) = \frac{-(1+m_0)}{(2+m_0+m_1)^2} < 0\end{aligned} \tag{13}$$

With $\frac{\partial x_v}{\partial m_0} < 0$, it follows that

$$\begin{aligned}\frac{\partial D_v}{\partial m_0} &= 2\frac{\partial x_v}{\partial m_0} - 4\delta\frac{\partial}{\partial m_0}\mathbb{E}[\pi|m] < 0\\ \frac{\partial D_v}{\partial m_1} &= -4\delta\frac{\partial}{\partial m_1}\mathbb{E}[\pi|m] > 0\end{aligned} \tag{14}$$

□