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

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Abstract

This study examines a critical juncture in the development of health insurance in the United States. We examine how the American Medical Association (AMA) reduced support for National Health Insurance (NHI) in the immediate post-World War II period and contributed to the entrenchment of private insurance coverage. The AMA's national campaign against NHI - directed by the country's first political public relations firm, Whitaker & Baxter's *Campaigns, Inc* - implemented a two-pronged strategy: (1) persuade the American voter that supporting NHI was equivalent to supporting socialism; and, (2) enroll working-age adults (and eventually their dependents) in private health insurance plans to reduce demand for a public scheme. We bring together archival data from several novel sources documenting Campaign operations, which involved leveraging mass communications and the professional network of physicians. We find a one standard deviation increase in Campaign exposure explains approximately 20% of the increase in private medical insurance enrollment and a similar decline in public opinion support for legislation enacting NHI. We further show that Republican legislators from jurisdictions with greater Campaign exposure were more likely to oppose the Truman plan, and adopted rhetoric closely aligned with the Campaign's messaging.

Keywords: health insurance, interest groups, indirect lobbying, public opinion
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I Introduction

America is exceptional 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, though key population health metrics often lag behind peer nations. This paradox has heightened scrutiny of the health care system by leading health economists and has renewed interest in what led the U.S. to its current institutional arrangement.[1]

This article advances understanding of the evolution of health insurance in the U.S. by quantitatively examining a potentially important factor: the mobilization of the American Medical Association (AMA) against national health insurance (NHI) in the post-World War II period. Specifically, we study the AMA's campaign to defeat President Truman's universal health insurance proposal, a policy modeled on old age security that would have reimbursed care at private hospitals and compensated physicians through public funds. This was a pivotal period for the development of health insurance for several reasons. First, a majority of Americans lacked formal insurance coverage, and those with coverage were typically insured only for hospital room and board. Second, improved medical technology increased demand for a product to defray the increased costs of care. Third, strong Presidential and (for a time) popular support existed for the idea. Fourth, countries around the world were also expanding or completing statutory insurance coverage.

The AMA, representing two-thirds of physicians at the time, opposed NHI and hired the country's first political public relations firm, Whitaker and Baxter (WB) to direct a Campaign to defeat it. The Campaign's strategy focused on associating the plan with socialism and promoting private ("voluntary") health insurance. Several historians have emphasized the fundamental role of the AMA–WB Campaign in shaping the expansion of private health insurance (PHI), while political scientists have identified it as one of the earliest instances of industry and interest group influence on American public opinion (Lepore 2012; Johnson 2016; Cutlip 1994; McWilliams 1951). Yet empirical evidence is lacking, with many attributing the dominance of private health insurance in the U.S. today to collective bargaining, inflationary pressure, tax policy, or historical accident.[2]

We revisit this critical juncture with new data and empirical methods to evaluate the Campaign's effects. We investigate whether the rise of PHI in the U.S. was not solely an unintended consequence of economic policy, but instead partially driven by an unprecedented, large-scale, and professionally orchestrated public relations effort on behalf of the AMA. This question has enduring relevance: since the defeat of Truman's plan, all major U.S. health reforms have accepted the primacy of private insurance and focused on expanding coverage incrementally, rather than replacing it. Our analysis centers on whether Whitaker and Baxter accomplished their stated goals to defeat compulsory insurance in Congress and "put a permanent stop" to further agitation through the "vital step" of enrolling the American people in private health insurance (Whitaker and Baxter 1949, pp.3-4).

Archival documents reveal two main components of the Campaign's operations: physician outreach and mass communications. Tens of thousands of AMA members were tasked with distributing pamphlets to patients and endorsing voluntary health insurance, including medical plans run by physicians. Given their

[1] See for example, Baicker, Chandra and Shepard 2023; Brown and Glied 2020; Case and Deaton 2020; Einav and Finkelstein 2023.

[2] For instance, Case and Deaton (2020, p.211) write: "The historical accident by which most Americans are covered through their employers is a huge source of difficulty and a barrier to reform." Aaron Carroll (2017) of the *New York Times* in an article entitled, "The Real Reason the U.S. has Employer-Sponsored Health Insurance" explains the system is mostly due to, "wage freezes and tax policy that emerged because of [the war]." A fact sheet from Blue Cross and Blue Shield of America points to the bargaining strength of unions (Blue Cross Blue Shield Association 1997).

prominent role in society, AMA members were also asked to serve as liaisons to local civic organizations – urging them to pass and forward anti-NHI resolutions to their congressional representatives. Second, a massive newspaper ad buy was conducted in coordination with other industries to oppose NHI. The push for NHI was framed as "un-American" and "socialized medicine," while private insurance was associated with "freedom" and the "American way." The Truman administration and its allies attempted a rebuttal, but were unprepared and vastly outspent.

We investigate the Campaign's effects by compiling data new to this literature, including internal documents recovered from the *Campaigns, Inc.* 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 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 Congressional speech (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 PHI and individual citizens' views on the Truman administration plan 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 both components: mass advertising and 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 AMA membership. We motivate the functional form of our exposure variable via "zero-stage" regressions, showing that pamphlets and ads were indeed more effective in areas with a higher share of AMA physicians or informed readership, respectively.[3] Rising incomes and unionization are other factors postulated to affect demand for PHI. Accordingly, we include these variables as part of a core set of design controls and show that, conditional on these controls, exposure approximates random assignment. 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 insurance was far from saturated, creating broad scope for advertising and sales. Empirically, we show that Campaign exposure is not systematically correlated with observable features at the state or individual level, including pre-period changes in medical insurance enrollment or anti-Russian sentiment, 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 accounts for roughly 20% of the growth in private health insurance enrollment between 1949 and 1954 – equivalent to 13 million new enrollees. This effect is quantitatively large, comparable to the effect of a seven percent increase in per capita

[3]We add the components in our primary specification, but estimate a multiplicative version and one without any scaling in robustness checks.

income.[4] Although public support for NHI was strong in the pre-Campaign period, this quickly eroded: a one standard deviation increase in Campaign exposure led to about a six percentage point decline in popular support per survey wave. These persuasive effects appear stronger among men, urban-dwellers, and Republican voters. As a benchmark, this magnitude is approximately two-thirds the difference between union and non-union households or one-third the size of the racial difference in NHI policy support. 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.

Whitaker and Baxter mastered the strategy of indirect lobbying, aiming to influence legislation by shaping public opinion and catalyzing citizen engagement, arguing this was much more durable than conventional lobbying. We provide three pieces of evidence indicating that their efforts were effective. First, we find Campaign exposure increased passage of resolutions supportive of PHI. Furthermore, we find these resolutions reached policymakers, as evidenced by their preservation in the National Archives. Second, using sentiment and text analysis, we show that representatives – particularly Republicans – whose constituencies experienced greater Campaign exposure were more likely to oppose the Truman plan and to adopt rhetoric closely aligned with the Campaign's messaging. Third, representatives from high-exposure jurisdictions were more likely to vote against a Cabinet reorganization that would have advanced NHI.

When the AMA's preferred policy – PHI for most with subsidies for the poor – was formally integrated into the national Republican Party platform in 1952, the AMA launched a political action committee (PAC) with Whitaker and Baxter at the helm to support the Eisenhower-Nixon ticket. We find that AMA physicians were five times more likely to make PAC contributions than non-AMA physicians, with donation rates increasing in Campaign exposure. In contrast, we find no compelling evidence the Campaign influenced county-level Republican vote shares over time.

Our main contribution is to scholarship on the development of social and private insurance in the United States.[5] We offer the first detailed, quantitative account of the strategy and operations of the AMA-WB national Campaign, along with the first causal estimates of its effects. A second contribution is to the literature on lobbying. Building on empirical work that quantifies the impact of direct relationships between interest groups and legislators (Bertrand et al. 2020; Bombardini and Trebbi 2020; Snyder and Ting 2008), we assess the role of indirect influence through voter persuasion. In doing so, we highlight how interest groups can shape economic institutions and policy outcomes through channels beyond direct legislative access. A third contribution relates to the literature estimating the returns to advertising. These returns are difficult to measure (see discussion in Lewis and Rao (2015)), and, as noted in the review by DellaVigna and Gentzkow (2010), empirical results are often mixed. Whitaker and Baxter coupled the purchasing of 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 that of Mullainathan, Schwartzstein and Shleifer (2008) whereby advertisers may create or tap into associations to impact people's beliefs about a product. However, advertising constituted only *one* component of this sweeping public relations campaign, which leveraged the professional network and social standing of physicians. Thus, we also contribute to the large literature in health economics concerned with physician behavior. We note that most of the liter-

[4] See Appendix Section F.1 for calculation comparing the increase to changes in the marginal tax rate. 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).

[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).

ature assesses the impact of the profession in the context of clinical decision-making (*e.g.,* Chandra, Cutler and Song 2011; Ellis and McGuire 1986), and we extend this to physician behavior outside the clinic. In so doing, we bring together novel evidence of how rents generated from barriers to entry (Stigler 1971) and labor-augmenting technology (Acemoglu and Johnson 2023) can be used to fund a broad political Campaign that shapes policy debates for decades.

The paper proceeds as follows: Section II provides historical context and describes the Campaign in greater detail. Section III provides a framework for interpreting the results. Section IV describes the data and the construction of key variables. Section V outlines the empirical approach. Section VI reports our findings. Section VII discusses the persistence of the Campaign effect, and the last section concludes.

II Background

Our empirical results will show that the AMA-WB Campaign accelerated the growth of private health insurance that became entrenched in the U.S. health care system, and reduced support for national health insurance. Below, we provide evidence of the importance of these developments in the broader health reform context, then review the market for PHI, the growth of the AMA, and the advent of political public relations. We end this section with a description of the AMA-WB Campaign.

II.1 The Truman National Health Plan in Broader Context

The Truman National Health Plan represents both the first and last serious legislative attempt for NHI to receive strong support from the executive branch in U.S. history. Yet legislative activity on health care exhibits some cyclicity. Figure 1 places the Truman plan in broader historical perspective. Panel A plots all questions about health insurance in Gallup surveys as a fraction of all questions asked in a given wave from 1935 to present day. Panel B shows an even longer series from the *Congressional Record* where mentions of health insurance are normalized by the number of pages to proxy for the word count. Light bars represent the share of health insurance-related questions (Panel A) or health insurance mentions (Panel B). Four periods of time are shaded darker and correspond to points of major activity on health care in the U.S. – the Truman administration proposal for NHI (our period of study), the time period leading up the passage of the Act establishing Medicare and Medicaid (1965), the failed reform attempts under the Clinton administration (1993) and the debate around the Affordable Care Act (starting in 2009). We refer to the latter two as Hillarycare and Obamacare, respectively.

In the Gallup data, we see a spike in questions about health insurance in the 81st Congress (1949-1951) during the hearings for Truman's National Health Program. This is mirrored in a similar spike in mentions in the *Congressional Record*. Both data sets show little discussion of health insurance before the 1940s. The timing of onset of health insurance activity in the two series is likely three-fold; first, medical science advanced dramatically over the course of the two World Wars, rendering its value much higher. Concomitant with this advancement was demand for a means to defray the increasing cost. Second, the surprise election of Harry Truman brought a staunch NHI supporter into the White House with a Democratic majority in Congress. Third, policy debates in Europe on the subject heated up, especially given the launch of the National Health Service in the United Kingdom. Relative to other periods of health care reform, the Truman administration discussion is on par with all the other periods measured by Gallup questions. In the Congressional text, the era is less pronounced. Following the failed Clinton reform, measures to extend coverage for needy children and medications for seniors became of increasing importance before discussion became dominated by expanding health insurance options for working age, low-income adults (*i.e.*, Obamacare).

Although not appearing prominently before World War II in either Figure 1 series, it would be inaccurate to conclude that statutory health insurance had never been debated prior to Truman. During the Progressive Era and the New Deal, a federally sponsored system of health insurance was discussed, though there were questions about its constitutionality and strategic importance (Blumenthal and Morone 2010; Rovit and Couldwell 2001).[6] As medical technology improved and costs increased, several states introduced legislation to expand access to health insurance. In the wake of the Great Depression and a decline in philanthropic funding, some hospitals implemented prepaid service plans covering room and board, marking the distress-related origins of Blue Cross. These plans were set up relatively quickly through the use of enabling legislation which did not require the plans to hold large capital reserves. Physicians in local medical associations responded to the creation of Blue Cross and state legislative activity by starting their own medical pre-payment service (*i.e.*, Blue Shield).[7]

Government reports surveyed the PHI landscape in the late 1940s and found a fragmented market, with substantial variation in eligibility, benefits, and generosity across plans. There were some regularities; however, plans typically excluded the elderly, infants, and pregnant women, and were unavailable to those who were indigent (Murray 2007). The best estimates suggested that approximately 17% of the population (24 million) had hospital service coverage through Blue Cross, a potentially overlapping 3-4 million had medical or surgical coverage through Blue Shield, and several million more had some form of indemnity payment for hospital stays or lost wages associated with sickness or accidents (Reed 1947).[8] According to Federal Security Agency (FSA) Administrator Oscar Ewing (1948)[p. 80], "only about 3,500,000 – less than 3% of the population – have anything approximating comprehensive insurance protection that includes hospitalization and also doctors' care in office, home and hospital."

In the context of a private system that excluded the majority of Americans and left gaps among those with coverage, the Truman administration saw an opportunity to introduce legislation for universal, federally-sponsored health insurance. The debate on how to provide medical care for all Americans took center stage with the surprise election of Truman over Dewey in 1948. Although there were many proposals in the 81st Congress, the two which garnered the most attention were the Administration's plan for a tax-financed plan which covered hospital, medical and dental services for all and the AMA-backed plan introduced by Republican Senator, Robert Taft which encouraged private insurance expansion and federal grants-in-aid to states to subsidize low-income families (Corning 1969).

II.2 The AMA and *Campaigns, Inc.*

In addition to having a staunch supporter of NHI in Truman, the period was also unique in the strength of the medical lobby. Although the AMA strongly supported the expansion of PHI and opposed NHI during the Truman Administration, this represented a shift from prior views and coincided with the height of the association's membership (Appendix Figure A2). During the Progressive era, the AMA established a Committee on Social Insurance to cooperate with the American Association for Labor Legislation (AALL) regarding the formation of state-sponsored health insurance plans. In the 1930s, the AMA did not officially

[6] See Appendix Sections E.1 and E.2 for a timeline and additional information on federal health insurance prior to the Truman plan as well as Anderson (1968); Rubinow (1934) and Hammonds (2003).

[7] See Appendix Figure A1 for the growth in voluntary prepayment medical plans.

[8] The fact that some Americans held overlapping plans, and most Americans that had plans were covered for hospital room and board only, leads to many different estimates for coverage over our time period. For instance, the ad in Appendix Figure B1 states that, "70 million people are protected by Voluntary Health Insurance" in 1950. See Appendix Sections E.4 and E.5 for more information.

endorse any form of financing: as physicians preferred to operate independently, using first-degree price discrimination (Drum 2016).

Yet medical innovation spurred by war coupled with supply-side regulation increased physician incomes and strengthened the AMA. Doctors began to specialize in particular branches of the rapidly expanding corpus of medical knowledge (Markel 2015; Starr 1982). Data we entered from the *American Medical Directories* demonstrate that, over the period of 1920 to 1950, AMA membership grew to nearly 70% percent of all U.S. physicians, while the share of physicians who were specialists grew by 20.6 percentage points (Appendix Figure A3). Specialists earned more and were much more likely to be AMA members than generalists (91.6% vs. 56.0%) and the president of the AMA was increasingly drawn from the specialist pool (Appendix Figure A4). Physician incomes also increased from about $7,400 to $12,000 in 1950 dollars, with much of the growth occurring between 1940 and 1945, and widening the income gap between physicians and average Americans (Appendix Figure A5).

The Truman plan posed a threat to the clinical and financial autonomy of physicians. The AMA president elect's address warned of "Armageddon" and labeled the moment "a decisive struggle" (Henderson 1949, p.36). The AMA Board of Trustees took action by levying special assessments on its members to raise $3.5 million in 1948 dollars (Poen 1996; The New York Times 1948). The resulting funds were used to hire the public relations firm, *Campaigns Inc.*, which supplanted the AMA's in-house attempts at public relations (Burrow 1963; Knoblauch 2014; National Physicians' Committee for the Extension of Medical Service 1947-1949; Wehrle 1993).

Campaigns, Inc., was the country's first political public relations firm, and was co-founded by the husband-wife team of Clem Whitaker and Leone Baxter. Their firm specialized in defeating progressive measures by crafting campaigns around simple, emotionally resonant messages, and disseminating those messages through mass media (Khullar 2019). Historians of American political campaigning have underscored their significance with titles such as, "In the Beginning: Whitaker and Baxter," (Johnson 2016) and, "Whitaker & Baxter: Architects of the New Politics" (Cutlip 1994).

Initially based out of California, *Campaigns, Inc.* capitalized on the state's leadership in direct democracy to focus their business on indirect lobbying. Their view was that direct lobbying of policymakers provided only temporary policy wins, since politicians' wavering loyalty and limited tenure required constant investment. A more surefire way to successful and persistent policy change was by changing peoples' views. As Leone Baxter explained in 1951: "Our conception of practical politics is that if you have a sound enough case to convince the folks back home, you don't have to buttonhole the senator. He will hear from home, and he is prone to respect very highly the opinions he gets from that quarter" (Cutlip 1994, p.609).

The firm was formidable: winning 58 out of 63 state legislative contests (Evans 1949). Notably, the firm was retained by the California Medical Association (CMA) to oppose Governor Earl Warren's repeated attempts to introduce publicly funded health insurance. The initial legislative proposal was narrowly defeated in the state assembly by a vote of 39 to 38 (McWilliams 1951). Whitaker and Baxter amplified their success over Warren through a public relations magazine circulated to medical societies nationwide, including the national headquarters of the AMA. Thus, the firm was well-positioned to lead the AMA's national campaign against federal health legislation. Upon accepting the role, they relocated operations to the AMA headquarters in Chicago, Illinois.

II.3 The AMA-WB Campaign's Objectives and Strategy

The Campaign to defeat NHI developed by Whitaker and Baxter included two main objectives: associate the Truman plan with socialism and rapidly increase enrollment in private health insurance. These objectives were clearly outlined in archival documents. The oral history of Oscar Ewing recalls a confident Whitaker, who, despite being cognizant of the Truman's plan's high favorability, was convinced the firm could defeat any legislative threat: "We've been through this fight with Governor Warren's proposal for a state health insurance program and it's a cinch to beat it...First you have to give the program a bad name and we're going to call it 'socialized medicine' because the idea of socialism is very unpopular in the United States." Whitaker further explained the "long-term objective" was "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). Thus, enrollment in PHI was crucial for reducing demand for NHI among Americans over the long-term.

The Campaign strategy to achieve these objectives consisted of two main components: physician outreach and mass communications via newspaper advertising.[9] 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 2 Panels A and B show examples of pamphlets for distribution, with titles such as: *The Voluntary Way is the American Way*, and, *Compulsory Health Insurance* (*Politically Controlled Medicine*)*: A Threat to Health – A Threat to Freedom*.

Physicians also functioned as intermediaries between organized medicine and local civic institutions. Leveraging their prestige and social networks, they encouraged civic groups to adopt pre-drafted resolutions opposing NHI, which were then transmitted to elected officials as signals of constituent opposition. Appendix Figure B2 Panel A shows an example of an appeal made by the Medical Society of the State of Pennsylvania to local American Legion Posts. Panel B shows a resolution passed by the Federation of Women's Clubs. The resolution is in support of the extension of "voluntary health insurance" with grants-in-aid to states for the medically indigent, and stands "against government control of health services" which would "jeopardize free enterprise" and increase the deficit.

Figure 2 Panel C presents the main ad circulated during the lead-up to the 1950 midterm elections. This full-page ad, occupying approximately 980 lines of print space, featured a prominent image of a bald eagle accompanied by the question: *"Who Runs America? The Congress? The President? OR YOU AND THE MAN NEXT DOOR?"* The accompanying text framed NHI as an "un-American excursion into state socialism." and instructed the reader to ask their doctor about signing up for health insurance.[10] The tagline in the doctors' pamphlets was repeated: "THE VOLUNTARY WAY IS THE AMERICAN WAY!" Appendix Figure D1 Panels A and B show the word cloud of Campaign pamphlets and ads with the top ten most frequent words in bold, red font. These top words are about evenly split between medical (*i.e.*, health, medical, insurance, care, and doctor) and ideological terms (*i.e.*, America, voluntary, compulsory, freedom, business, government, people, politics, and socialism). The Campaign contracted out distribution to Lockwood-Shackelford Advertising Agency, which placed ads in local newspapers.

[9] We could not find consistent documentation of TV programming. In Cutlip (1994) there is mention of some radio ads that were timed with those in the newspaper, but no details were found elsewhere. In robustness checks we control for trends in TV and radio (see Section VI.3).

[10] Appendix Figure B1 shows the full-page ad.

The AMA also tapped allies in industry for tie-in advertising to be scheduled simultaneously with the main ad, reaching 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). *Campaigns, Inc.* also sent an ad kit with several pitches for local manufacturers to use in support of the AMA (Cutlip 1994). Examples of these tie-in ads are shown in Figure 3 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 3 Panel F) but some were much farther away (*e.g.*, clothing).

The Truman administration sought their own publicity campaign for NHI. However, in part due to concerns about executive lobbying and interagency politics, the plan was never realized. The Committee for the Nation's Health (CNH) also attempted to sway voters and was less restricted as a non-governmental organization. However, it lacked the resources and public relations expertise of *Campaigns, Inc.*[11] Labor unions were also constrained from directly financing political campaigns following the passage of the Taft-Harley Act of 1947 (Kallenbach 1948).[12]

In 1952, after four years serving as the head of AMA's Campaign, Whitaker and Baxter resigned from their posts (New England Journal of Medicine 1952). By that time, legislative threats had been weakened and the Republican 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 so that it could directly steer campaign contributions to that ticket. Whitaker became the NPCE's Director, Baxter the General Manager, and a former AMA President, its Chairman. The NPCE raised approximately $1.5 million in current terms for the Eisenhower campaign (Whitaker & Baxter *Campaigns, Inc.* 1946-1973).

III Conceptual Framework

Whitaker and Baxter are credited with creating the field of political public relations and using indirect lobbying to influence legislative outcomes. We formalize this tactic by adapting the insights of Sobbrio (2011) with model details in Appendix Section G.

Consider two agent-advocates, one from the private sector and one from the public sector, who send signals to voters regarding the state of the world. The state signaled is in relation to a proposed policy (*i.e.*, NHI), and the number of messages sent is an increasing function of sector-specific resources. The industry advocate messages that adoption of the policy would yield lower net social benefit, while also selling a private substitute service (*i.e.*, PHI). The public advocate provides the opposite message, but is prohibited from offering the public option until after legislation has passed.

[11] 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." 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).

[12] Appendix Section E.6 provides a more detailed description of the historical relationship between organized labor and health insurance.

After receiving signals, the voter updates his flat priors on the state of the world using Bayes' rule, and communicates his policy preferences to his representative. With this setup, we predict the better endowed advocate will have his preferred outcome realized (*i.e.*, status quo vs. enactment). In our setting, this corresponds to the private sector advocate (*i.e.*, the AMA and other industrial allies).

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. Flat priors seems natural given that medical insurance was a relatively new product. Regarding naivete of the voter, it would have been difficult for the average American to understand they were in the midst of a large-scale Campaign. Lastly, doctors were likely assumed to be a credible source of health-related information.

IV Data Sources and Description

We draw on several data sources new to the literature to construct Campaign exposure and explore its effects. These sources include a combination of archival materials, historical directories, and institutional records. This section provides a detailed description of each data source and the construction of key variables. Additional documentation and variable definitions are available in Appendix Section A.

***Campaigns, Inc.* Firm Archives.** The archives are housed in Sacramento, California, and consist of 178 cubic feet of materials, including strategic documents from Whitaker and Baxter's Campaign on behalf of the AMA, opposition research on Oscar Ewing, and a range of financial records such as invoices, audits, ledgers, and correspondence. These materials enable us to reconstruct key dimensions of the Campaign's design and implementation for both descriptive and inferential purposes.

The firm disseminated approximately 50 million printed items to physicians, including mailing labels, cartoons, posters, and pamphlets. While some materials were aimed directly at physicians – for instance, brochures discussing antitrust proceedings against the AMA – the majority were designed for patient outreach. From the archives, we extract data on the distribution of the four most widely circulated pamphlets, including those in Figure 2. We also digitized a series of invoices from the Lockwood-Shackelford Advertising Agency to the AMA's National Education Campaign (see Appendix Figure B3). These invoices document uniform advertisement sizing across newspapers, scheduled publication dates, publication town and state, cost per line, total cost, and estimated circulation. We verify these circulation figures using audited figures. We use the pamphlet and ad data to construct our main Campaign exposure variable as described in Section V.1.

Also from the firm's archives, we obtained a ledger documenting individual contributions to the NPCE PAC. Each entry includes the contributor's name, street address, professional degree, and donation amount (see Appendix Figure B4 for an exemplary entry). We merge these records with the *American Medical Directory* to identify licensed physicians and construct an indicator variable for whether a physician made a financial contribution to the PAC. The firm also maintained a list of civic organizations that submitted signed resolutions opposing NHI, as part of their grassroots outreach. We use these data to construct a county-level measure of organized civic opposition to NHI.

AMA Archives. The AMA archives, located in Chicago, Illinois, do not contain documentation related to Whitaker and Baxter or the associated Campaign. However, we identified a complementary set of documents produced by the AMA's Council on Medical Service and Public Relations (CMS), including annual reports titled *Voluntary Prepayment Medical Care Plans* (Council on Medical Service 1946-1954). Since the

long-term objective of the Campaign was to enroll Americans in private plans to quell agitation for a public one, these data form one of our primary outcomes. We obtained a complete series of the CMS reports from 1946, the first year of publication, through 1954 using library sources. Each annual volume lists individual plan characteristics, including the plan name, state medical society approval, Blue Cross affiliation, covered services, eligibility criteria, cost, and enrollment. Catchment areas were typically defined at the state level, which we adopt as the unit of analysis.[13]

Because individuals could enroll in medical and surgical plans separately, we define total enrollment as the maximum reported enrollment across plan types, inclusive of dependents. Appendix Figure A6, Panel A, documents the expansion in aggregate private plan enrollment from 1942 to 1954. The 1942 figure is derived from a one-time publication by the Hospital Service Plan Commission of the American Hospital Association (1942) and is therefore excluded from our core empirical analysis due to concerns about consistency. From the onset of the Campaign to the end of the series, private medical insurance enrollment tripled, increasing from approximately 10 million to 30 million individuals. Panel B disaggregates states by above- and below-median levels of Campaign exposure (description of Campaign construction forthcoming), revealing a steeper upward trajectory in states with higher exposure.

The primary outcome variable of private health insurance enrollment sums plan-level enrollment to the state-year level and divides by total state population from the 1950 Census (Haines 2010). While the CMS data do not capture the full universe of private insurance offerings due to market fragmentation, we validate their numbers with data published by the Health Insurance Council (HIC)(The Survey Committee of the Health Insurance Council 1949-1965). CMS enrollment figures exhibit high correlations with HIC data for medical service coverage ($\rho = 0.902$) and hospital coverage ($\rho = 0.924$) in 1952 (Appendix Figure A7).

National Archives. From the National Archives in Washington, D.C., we obtained information on petitions to the Records of the United States House of Representatives, Committee on Foreign and Interstate Commerce for the 81st Congress. 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). From these archives, we discovered folders of full-text resolutions and petitions. We extracted information on the number of different petitions submitted and the language used. The three most common petitions were those on health insurance, the conflict in Korea, and on membership in the United Nations (National Archives 1950*b*,*c*). We compute the frequency of petitions on different topics and assess their semantic similarity to legislator speech.

Directories. We digitize and apply optical character recognition (OCR) to three historical reference sources: the *American Medical Directory*, the *American Hospital Directory*, and *N.W. Ayer & Son's Directory of Newspapers and Periodicals*. During the period of interest, the medical directories were published as large multi-volume editions 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 B5 displays a typical entry – small symbols in the book indicate memberships and other important career milestones, summarized in Appendix Table C1. 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 166,000 observations from 48

[13]New Hampshire and Vermont are combined into a single service area. We assign enrollment based on the beginning of the calendar year of the publication. Results in Table 1 are robust to assigning enrollment at the end of the last calendar year instead.

states. The geographic distribution of AMA doctors is shown in Appendix Figure A8 Panel A. The number of physicians by state from the digitized microdata is close to published aggregates (see Appendix Figure A9). We compute the share of physicians in each state who were AMA members in 1950 and use this measure as a proxy for local alignment with the AMA's campaign activities. We link the directory data to the PAC ledger to obtain personal characteristics on physicians who donated to the NPCE.[14] We also digitize the *American Hospital Directory* for the years 1948, 1950 and 1952. These directories include comprehensive information on the location, establishment, ownership, capacity, and Blue Cross status of American hospitals. We aggregate the total number of hospitals and the share of hospitals that are Blue Cross to the county or state level for use in robustness checks.

The third directory we digitized and extracted information from was the 1949 *N.W. Ayer & Son's Directory of Newspapers and Periodicals*. We used this directory to compare newspapers in which Lockwood-Shackelford placed advertisements to those in which it did not. The dataset includes, for each weekly and daily newspaper, information on total circulation, stated political orientation, publication frequency, railroad accessibility, and physical formatting characteristics (*e.g.*, number of columns, page width, and depth). To focus on regional rather than national outlets, we restrict the sample to dailies and weeklies with circulation below 600,000. We link advertising records from Lockwood-Shackelford invoice data with the *Ayer & Son* directory to verify circulation.[15] Appendix Table F2 shows that newspapers with and without main Campaign ads do not differ systematically in terms of political leaning or publication frequency. However, Lockwood-Shackelford disproportionately targeted outlets in less urban areas and with somewhat lower circulation levels (Appendix Table F3), relative to the full universe of publications.

To quantify the ad component of the Campaign, we compute the aggregate circulation of newspapers that carried the main Campaign ad, inclusive of accompanying tie-in ads and divide by population.

NewspaperArchive. To capture the use of tie-in ads, advertising by other industries in support of the AMA-WB Campaign, we used *NewspaperArchive*, an online database containing newspaper articles. From the archive, we extracted information on newspapers with at least one issue in the month and year the Campaign ad buy took place. We searched for the main ad in these issues using image detection techniques (described in Appendix Section F.3) and then hired two Harvard students to independently classify all ads in the newspapers as a Campaign tie-in or not, using key Campaign phrases (for example, "*The Voluntary Way is the American Way*"). Figure 3 shows examples of how such a strategy magnified the messaging of the Campaign. We obtain the tie-in ad circulation from the merge with *Ayer & Son's* and incorporate this into our main ad measure.

Congressional Voting Behavior and Speech. We use OCR tools and digitize the *Congressional Record* and associated appendices from 1947 to 1951 (covering the 80th, 81st and first session of the 82nd Congress). Information on the digitizing process is in Appendix F.5. Although proprietary products are available, they typically exclude the Appendices which have extended remarks and submitted materials. We include all legislators affiliated with the Republican or Democratic party. We use these data in three ways. First, we ascertain the importance of health insurance and the AMA by assessing their frequency relative to other social insurance and lobbying benchmarks, respectively. Second, we assess how legislators described health insurance. Specifically, we compare legislator quotes on health insurance to Campaign materials by applying

[14] Details on linkage between the ledger of NPCE contributions and the Medical Directory are in Appendix Section F.4.

[15] Details on linkage for newspapers in Appendix Section F.3.

latent semantic analysis and then computing the cosine similarity between the two sources (Schwarz 2019).[16] Third, we classify the sentiment of the legislators when discussing NHI into oppose, support, or neutral via generative AI. We use GPT-4o, a frontier large language model (LLM) developed by OpenAI, as it has been shown in prior studies to achieve high reliability and consistency in such tasks (Lagakos, Michalopoulos and Voth 2025). We construct a dichotomous variable from this analysis with oppositional sentiment coded as one and zero otherwise. In addition, we extract the top-ranked keywords identified as being most influential in determining sentiment classification.

A vote on the Truman administration plan never came to the Congressional floor. However, the AMA also opposed a plan to reorganize the FSA into a Department of of Health, Education and Security, elevating NHI proponent Oscar Ewing into a Cabinet-level position. In Ewing's oral history, he pointed to the AMA as being the key factor precluding this development, stating the group "did not want me to be given a higher platform from which to argue for national health insurance" (Ewing 1969). We enter roll call votes from two resolutions aimed at blocking the reorganization: *Senate Resolution 147: Resolution Disapproving Reorganization Plan No. 1* (1949) and *House resolution 647: Resolution Disapproving Reorganization Plan No. 27* (1950). A vote in favor of the resolution indirectly reflects opposition to NHI (Doherty and Jenkins 2009). We use two versions of the outcome: first, we use a simple measure of whether a legislator voted "yea" versus "nay" on the floor. However, since legislators often used the procedural practice of not voting but rather "pairing" their votes to others who would vote on the opposite side of the issue, we create a dichotomous measure of support that equals one for all those who voted or would have voted "yea" on the resolution and zero otherwise.

Congressional Election Outcomes. We also investigate whether and to what extent Congressional legislators were punished or rewarded at the ballot box for their views in support or opposition to NHI. We use data from the Inter-university Consortium for Political and Social Research (1999) on county-level House of Representatives Republican vote share over the period 1944 to 1954.

Gallup Opinion Data. The Campaign's immediate objective was to shift public opinion against NHI, which we assess using public opinion data from Gallup Organization (1937, 1938, 1945, 1946, 1949, 1950, 1952). Gallup data are generally considered reliable indicators of voter sentiment, particularly when assessing changes over time. However, there are several features of the data collection process that are important to highlight. First, polls over this time period were partially sponsored by local newspaper organizations as shown in Appendix Figure B6, which may have subtly shaped questions. Second, Gallup relied on quota-controlled sampling, a method that allows for interviewer discretion on respondent selection and thus introduces bias (Berinsky 2006). We reweight the sample using weights from Berinsky et al. (2011), but note there are still differences between Gallup respondents and the general population.[17] Third, most waves had two different forms to test different styles of questions. Following the failure to predict Truman's 1948 victory, pollsters, including Gallup, switched to area sampling and made other methodological improvements to improve accuracy.

Appendix Table A1 details the wording and timing of all survey questions within our study period. We highlight in bold the survey waves included in our main analysis, while lighter shading denotes those incorporated into an extended event study which we use to further probe pre-trends, improve power and test

[16] Cosine similarity, ranges from -1 to 1, though in practice typically falls in the range 0 to 1.

[17] As noted by Gallup, respondents tended to be "upscale" (Moore 1997).

for persistence. The latter set includes items that propose federal sponsorship of health insurance for specific demographic groups (*e.g.*, the indigent or elderly) or those not directly referencing the Administration's proposal. Questions in bold were selected for our main analysis based on two criteria: 1) Whether the question text explicitly mentioned Truman's plan or its Congressional corollary over this time period, the Wagner-Murray-Dingell bill; and, 2) Whether the question explicitly asked the respondent if they were for or against the policy. Appendix Figure A10 also shows that the framing of Gallup questions changes over time in a manner consistent with the Campaign's preferred terminology (*i.e.*, compulsory) which we discuss further in Section V. Many of the questions on whether a respondent supports the plan are conditional on having heard of it, thus we investigate but find no effect of Campaign exposure on whether the respondent is aware of specific legislation. This provides suggestive evidence the Campaign was not designed to be informative about policy details. Our primary outcome of interest is whether the respondent supports the Administration's plan, which we code as a one, and zero otherwise.

Demographic characteristics such as age, sex, race, political leaning, union status, phone ownership, and employment are also found in Gallup. We use these covariates as controls in our preferred specification and to assess for heterogeneity in the persuasive effect of the Campaign. Although we lack respondent income in most waves, phone ownership serves as a proxy and is strongly predictive of total family income in the 1960 Census 5% sample (Ruggles et al. 2024).

From the universe of all Gallup questions on "Health" or "Health Issues/ Policies, and Nutrition" topics from the Roper Center between 1935 and 2020, we searched for waves which had a question on policy support for a major expansion of federal authority in health care and the respondent's own health insurance coverage status. We use these waves to assess the relationship between private health insurance enrollment and support for federally sponsored health insurance reforms over subsequent decades.

Historical Controls. Our analyses control for historical variables that are often cited as being alternative theories for the rise of PHI in the U.S., such as unionization or rising income (Farber et al. 2021; Bureau of Economic Analysis 2023). In some specifications we include war bonds purchases and county family median income (U.S. Census Bureau 2012). Television, radio and demographic information from the 1950 Census (U.S. Census Bureau 1953; Haines 2010) are also included in robustness checks as are New Deal spending data from Fishback and Kantor (2018) and hospital locations and attributes from newly digitized American Hospital Association directories (American Hospital Association 1948, 1950, 1952).

V Campaign Construction and Estimation

This section describes Campaign exposure, identification and estimation. There are several components to the Campaign and it occurred over two years – so the precise way to aggregate is *a priori* unclear. Our preferred strategy is to follow the historical description which included a field component comprised of AMA physicians distributing pamphlets and an ad component published in local newspapers. We provide empirical motivation for the functional form and weighting used and, in Section VI.3, show results using alternative formulations.

V.1 Campaign Exposure

Campaign exposure is constructed at the geographic level j, where j differs by outcome (*i.e.*, for enrollment it is state, for Gallup it is state-by-urbanicity, for civic organizations and doctors' donations it is county, and for

legislator text or roll-call vote 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 the persuasive content developed by Whitaker and Baxter, (*i.e.*, pamphlets and ads) and the intended recipients or nodes of diffusion (*i.e.*, AMA doctors and newspaper readership). We sum the two components as per below:

$$\text{Campaign exposure}_j = \text{MD}_j + \text{Ad}_j, \tag{1}$$

where MD_j represents per capita pamphlets (P) distributed by doctors (D) who were members of the AMA:

$$\text{MD}_j = (\frac{P_j^{\text{Camp.}}}{N_j}) \times (\frac{D_j^{\text{AMA}}}{D_j}), \tag{2}$$

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

$$\text{Ad}_j = (\frac{C_j^{\text{Camp.}}}{N_j}) \times (\frac{N_j^{\text{Educ.>5 yr}}}{N_j^{\text{Adult}}}). \tag{3}$$

Newspaper readership is proxied using the share of adults with more than five years of schooling in the 1950 Census (Haines 2010). For Gallup, we assign exposure at the individual level for greater precision using respondent's own characteristics. Specifically, instead of using the share educated to allocate advertising receipt, we observe a particular Gallup respondent's educational level (whether they completed high school or not) and allocate the Ad component using this attribute while controlling for the main effect of their education level.

We standardize both summands giving each equal weight, and standardize the resultant for ease of interpreting the coefficients.[18] A map of the raw and residualized Campaign exposure at the state level is shown in Appendix Figure A8 Panels B and D, and the distribution at the county level is shown in Panel C.[19] The correlation between the Ad and MD components in the enrollment data is weakly positive: 0.266 (p-value = 0.071).

V.2 Motivation for the Functional Form

To motivate our main estimating equation, we present zero-stage regressions on enrollment. Specifically, we assess whether the effect of per capita pamphlets on enrollment is indeed larger in locations with a greater share of physicians affiliated with the AMA. Similarly, we assess whether the effect of per capita advertising is stronger in locations with a higher share adult population educated. Figure 4 displays event study plots split by the mean of high and low share AMA physicians and share adults educated, respectively.[20] Panel A shows pamphlets per capita increases enrollment most in places with a higher share of AMA physicians. The increase starts about the time of Campaign onset and is sustained until 1951. Panel B shows ads per capita increases enrollment most in places with a higher share of educated adults and this starts around 1950, consistent with when the advertising program was launched.

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

[19] For county and Congressional district level exposure variables, we winsorize the top one percentile of exposure.

[20] These figures suppress confidence intervals for readability. We use the mean instead of median to split given the distribution of the education data. In other Gallup waves from this time, there is a strong correlation between higher education and subscribing to a newspaper.

These findings lend support to considering both components in Campaign exposure, but do not settle the issue of how to weight them. To address this issue, we iterate over a range of weights that sum to one. Findings shown in Appendix Figure D2 demonstrate that an equally weighted convex combination of the two components provides a balance between the MD component and the Ad component. We find similar, though sometimes noisier, results using an exposure variable constructed exclusively with the printed Campaign material. We report these results as well as those using other functional forms, such as a multiplicative specification, in robustness checks described in Section VI.3.

V.3 Estimation and Identification

Our main estimating equations 4 and 5 test whether the Campaign's key objectives of increasing private health insurance enrollment and reducing the popularity of the Truman administration's proposal were achieved. For the former, we estimate:

$$\frac{E_{st}}{N_s} = \alpha + \sum_{k \neq -1} \beta_k \cdot \left(I_t^k \times \text{Campaign exposure}_s \right) + \sum_{k \neq -1} \delta_k \cdot I_t^k + X_{st}' \Omega + \mu_s + \epsilon_{st}, \tag{4}$$

where $\frac{E}{N}$ reflects enrollment per population, s denotes state, t denotes year and k denotes event time relative to the year before the Campaign onset. X_{st} includes design controls, and μ_s represents state fixed effects. We start our analysis at the beginning of the series' publication (1946) and stop when the IRS changes the tax code to make payments to private insurance exempt from taxation. Using Gallup poll data we assess the Campaign effects on an indicator variable ($I^{\text{Support Truman Plan}}$) equal to one if respondent i in state s during wave t approves the Administration-backed health care reform and zero otherwise:

$$\begin{aligned} I_{ist}^{\text{Support Truman Plan}} = \alpha + \sum_{k \neq -1} \beta_k \cdot \left(I_t^k \times \text{Campaign exposure}_{is} \right) \\ + \sum_{k \neq -1} \delta_k \cdot I_t^k + X_i' \Gamma + X_{st}' \Omega + \mu_s + \epsilon_{ist}, \end{aligned} \tag{5}$$

where k denotes event time relative to the wave before Campaign onset, and X_{st} and μ_s are defined as above. 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. There are only two waves we identified that ask specifically about administration backed proposals prior to the Campaign, thus in robustness checks we expand our outcome variable definition to include support for any public insurance scheme, including those limited to the indigent.

Equations 4 and 5 leverage both spatial variation in the intensity of the Campaign as well as its timing for causal inference. Identification requires that the exposure 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). We do not argue that the Campaign was unconditionally random, rather, given the "Armageddon" AMA mentality, it exploited existing professional networks and business ties to deploy quickly in response to the unanticipated legislative threat. These networks included AMA members and newspapers affiliated with the advertiser, Lockwood-Shackelford. We therefore include variables that could broadly influence the pre-Campaign distribution and trajectory of these factors: income per capita and the share unionized. Appendix Figure D3 Panels A and B show event studies in log income per capita and unionization rates using Campaign exposure, and both outcomes fail to evince sharp, sustained changes.[21]

[21] There appears to be an anomalous value in the raw state union data of Farber et al. (2021), which may be due to

Tables in Appendix Table C2 Panels A and B show that, conditional on design and stratifying controls, Campaign exposure is not correlated with changes in our main outcome variables of private medical insurance enrollment or support for Truman's health plan in the pre-Campaign period.[22] Panel A also shows that private medical insurance penetration was very low in the pre-Campaign period (only 3.4% of the population) and support for the Truman plan was very high (nearly 70%). There does not appear to be targeting of the Campaign towards places based on medical insurance enrollment.

Campaign exposure across both panels also does not appear to correlate strongly with Republican leaning, employed or union households. A notable exception is that Black individuals were less likely to be exposed as measured by 1940 Census shares (Panel A) or individual respondent racial characteristics in Gallup (Panel B).[23] Our empirical approach follows the procedures recommended by Roth et al. (2023) and Rambachan and Roth (2023) to assess pre-trends and estimate treatment effects flexibly over time. For continuous treatment variation, we employ the non-parametric estimator developed by Callaway, Goodman-Bacon and Sant'Anna (2024). These strategies, along with additional robustness checks, are detailed in Section VI.3.

V.4 Cross-Sectional Patterns

There are several outcomes that are specific to our analysis period and/or were curated from various archives and cannot be examined over time. These include Campaign drafted resolutions sent by civic organizations to policymakers, the roll-call vote on Truman's proposed Cabinet reorganization, physician donations to the 1952 Eisenhower-Nixon ticket, and an analysis of Congressional speech for opposition to the administration's plan or similarity to the Campaign's messaging. Although these estimates are necessarily more suggestive than those which include temporal variation, they provide important insights into the Campaign's effectiveness. We estimate the cross-sectional relationship between Campaign exposure and these outcomes at the individual (*i.e.*, physician, legislator) or county (*i.e.*, civic organization) level controlling for income and unionization or employment rates depending on the set of included fixed effects. In some specifications, 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.

VI Results

We first present results on the primary objectives of the Campaign – enrollment in private health insurance and public opinion – which serve as a check on the direct effects of the Campaign among ordinary Americans. We then measure the extent to which the Campaign indirectly affected policymakers, via Congressional speech, voting behavior, electoral outcomes and donations.

VI.1 Direct Effects on Ordinary Americans

Figure 5 plots event study coefficients of Campaign exposure on PHI enrollment. There is an increase in enrollment post-Campaign that appears markedly different from prior years (p-value for F-test on pre-trend

the much smaller survey sample that year and explains the peak in the event study circa 1951.

[22] Stratifying controls include urbanicity and education for Gallup as they are used to assign Campaign exposure at the individual level.

[23] Lockwood-Shackelford invoices did not include the Black Press and Black physicians were excluded from the AMA at this time.

= 0.952). PHI enrollment increases are sustained over time, potentially reflecting expansion of dependent coverage available through plans and the collapse of a viable public option. Notably, there is a sharper uptick in the final year of our sample, which may be attributable to changes in the tax code that rendered private insurance premiums tax-exempt. Given this tax change, we stop our analysis in that year as our data source becomes less comprehensive due to the growing market share of commercial insurance.

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, 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. This estimate is obtained by dividing the coefficient on the interaction of Campaign exposure and post by the total post effect in Table 1 Column 1. 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 in either medical, surgical and/or hospital insurance over this period.[24] In Figure 6, we fail to find evidence of differential effects of the Campaign across states that differed in median Republican vote share, hospital prevalence, physician density, share Black population, or income per capita. However, the Campaign does appear to have more resonance in states in the upper 50th percentile of population living in urban areas (U.S. Census Bureau 1952).

Figure 7 plots event study estimates for approval of Truman's national health plan using Gallup data. The pre-trend is not significant (p-value for F-test = 0.112) and the projected trajectory is upward sloping.[25] Following the onset of the Campaign, we observe a sharp and persistent decline in support. Table 2 provides a summary measure of the Campaign's effect. The main effect is statistically insignificant in the pre-period across specifications. The interaction of Campaign exposure and post is negative and significant indicating that a one standard deviation increase in Campaign exposure reduced support by about five to seven percentage points. The coefficient on the post indicator is also negative, which may partially reflect changes in question wording. Across specifications, we sequentially introduce additional controls, with the final column incorporating additional individual-level covariates.

As described in Section IV, the Gallup survey questions used in our analysis often conditioned respondents' opinions on whether they were previously aware of the proposal. To evaluate whether the Campaign influenced knowledge of the legislation, we estimate a difference-in-differences model using awareness as the outcome. The estimated effect is near zero, suggesting that the Campaign did not measurably inform the electorate about the legislation.

Figure 8 explores heterogeneous effects by individual characteristics. Treatment effects are similar across older age and phone ownership, but the Campaign appeared to be more effective at shaping opinion among urban-dwellers, men, and those who previously voted for the Republican party. Private insurance could have appealed more to those living in urban areas given their easier access to hospitals compared to rural respondents. The ideological framing of individualism and freedom may have resonated more with Republican voters.

[24] Details on these calculations and comparison to tax code changes are in Appendix Section F.1.

[25] Predicted trends for insurance enrollment and Gallup responses are substantially different from the observed – results available on request (Roth et al. 2023).

VI.2 Indirect Effects on the Legislative Process

The Campaign sought to exert indirect influence on policymakers by engineering a "grassroots revolt" against NHI (Robertson 1949). To evaluate this mechanism, we examine whether civic organizations in counties more exposed to the Campaign were more likely to adopt and transmit template resolutions drafted by *Campaigns, Inc.* to their elected representatives. As shown in Table 3, greater exposure is associated with increased civic mobilization. In our preferred specification (Column 4), a one standard deviation increase in Campaign exposure is associated with 4.6 additional civic organizations per 100,000 county residents passing resolutions against NHI.

To assess whether these efforts translated into federal-level pressure, we analyze archival records of petitions (resolutions) submitted to Congress. The number of petitions advocating for PHI was an order of magnitude greater than for other contemporaneous issues: 225 compared to approximately a dozen each on strengthening the United Nations or addressing the Korean conflict. The language in these petitions closely mirrors the Campaign's template text, with some resolutions appearing to have been adopted verbatim. For example, one submission from a Kiwanis Club chapter included the unedited instruction: "We suggest that you may desire to tailor this form resolution to the particular policies and objectives of your organization."

Although we trace Campaign resolutions directly to Congress, it is still possible that policymakers were either unaware of or unresponsive to them. As an initial step in assessing Congressional awareness, we analyze the relative salience of health-related issues by examining the frequency of relevant terms in the *Congressional Record* between 1947 and 1951. Figure 9 Panel A plots the frequency of the phrase "health insurance" and, for comparison, "unemployment insurance." Mentions of the former peak in 1949, at the time of the Campaign (darker blue bars), reaching over 200 mentions per month before tapering off by the first session of the 82^{nd} Congress. These frequencies substantially exceed those for unemployment insurance (shown in light gray bars).

Figure 9 Panel B examines references to the AMA relative to mentions of the National Association of Manufacturers (NAM), another leading interest group at the time. NAM had actively lobbied for the passage of the Taft-Hartley Act in 1947, and consistent with this activity, NAM mentions peak in that year (Fones-Wolf 1994; Lacey 1989). Despite the NAM's central role in the Taft-Hartley debate during the 80^{th} Congress, references to the interest group never reach the frequency of the AMA during the 81^{st} Congress.

To better understand how the AMA was being referenced in the legislative discourse, we first examine the partisan distribution of these mentions. As shown in Appendix Figure D4, references to the AMA came predominantly from Democratic members of Congress. Qualitatively, the text surrounding mentions of the AMA often acknowledged the group's influence on the legislative process: 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 the manner in which 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..." Senator Murray's observation appears to be supported empirically. Figure 9 Panel C plots the relative frequency of modifiers used in conjunction with the phrase "health insurance," averaged over three-month intervals. Following Campaign onset, we observe an increase in usage of the term "compulsory" and a corresponding decline in the words "national," "state," or "government" as modifiers for health insurance. Another term Whitaker and Baxter purposively associated with the Truman plan

was "socialized medicine" – returning to Figure 1 Panel B, we plot frequency of the phrase on the right-hand axis – finding the first notably high occurrence of the phrase was in 1949.

Next we compute cosine similarity across three data sources: (1) Resolutions sent by civic organizations to Congress, found in the National Archives; (2) Legislator speech from the *Congressional Record*; and (3) Campaign pamphlets and the main Campaign ad. Figure 9 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 D5). As anticipated, health insurance petitions have the highest similarity to Campaign messaging while, for comparison, petitions regarding the U.N. have a relatively low similarity. Most Republican legislators lie between the health insurance and U.N. petitions, but there are some exceptions: Langer, a Republican from North Dakota, argued NHI would relieve critical shortages of health care inputs in rural areas.

To further investigate whether the Campaign indirectly affected policymakers, we created a dataset of over 200,000 legislator-quotes from the 81^{st} Congress. We assess the relationship between the electorate's Campaign exposure and their legislator's speech. Findings are reported in Table 4. Odd columns report average effects of the Campaign and even columns are saturated by party affiliation. In Columns 1 and 2, Campaign exposure is not associated with the extensive margin of mentioning health insurance on average or across party lines. Given this null result, subsequent columns are limited to quotations mentioning health insurance. Columns 3 and 4 demonstrate Campaign exposure does not significantly predict whether the legislator references the AMA. However, consistent with Appendix Figure D4, Democratic legislators were approximately 31 percentage points more likely than Republicans to mention the group.

Columns 5 and 6 assess the relationship between Campaign exposure in a legislator's jurisdiction (district or state) and the similarity of their speech to the language used in Campaign materials. There is a weak positive relationship between exposure and speech driven by Republican legislators. The final two columns of Table 4 report results from an LLM and sentiment analysis. A similar pattern emerges, where there is a positive response to the Campaign attributable to Republican legislators. As shown in Column 8, a one standard deviation increase in Campaign exposure is associated with a 3.7 percentage point increase in the likelihood that a Republican legislator expresses opposition to the plan. The most influential keywords used by the language model to classify quotes are shown in Appendix Figure D6. The words "political medicine," "compulsory," and "socialized medicine" feature prominently in oppositional statements, whereas "national," "social security," and "welfare" are common in supportive statements.

Appendix Table C3 reports results on Senate Resolution 147 and House Resolution 647 disapproving Truman's reorganization plan. When restricting to the official votes on the floor, there is no clear association between voting patterns and Campaign exposure (Columns 1 and 2). However, once we include paired votes, by which absent legislators could record their vote in the *Congressional Record*, and combine these with those who voted in person, we find results similar to those in the text analysis above – a one standard deviation increase in Campaign exposure among the constituency of a Republican legislator is associated with a 5.3 percentage point increase in the probability they voted for the resolution. No such pattern is demonstrated among Democratic legislators.

As a final empirical exercise, we assess whether the Campaign affected Republican vote shares in the House of Representatives. We fail to find strong evidence the Campaign had electoral consequences when analyzed in this manner (Appendix Figure D7). The lack of electoral consequences could be ascribed to several factors. First, the content of the Campaign did not impugn specific elected officials but rather Administrator Oscar Ewing; second, NHI never received an on-the-record floor vote so Congressional members avoided potential electoral consequences; third, PHI growth continued, and – as anticipated by Whitaker

and Baxter – may have reduced demand for government involvement in health insurance. Lastly, there were other tools the AMA could have used to influence specific election outcomes, not captured by our data.[26]

One of those additional tools was the creation of a PAC, the aforementioned NPCE, to support Eisenhower in the 1952 election. In Table 5 we test whether physicians with greater exposure to the Campaign were more likely to donate to the NPCE. The main effect of the Campaign is significant, as all donations occurred in the post-Campaign period. A one standard deviation increase in Campaign exposure is associated with a 0.3 percentage point increase in the likelihood of donating to the Eisenhower–Nixon ticket – three times the donation rate among non-AMA physicians. Among AMA members, who contributed at five times the rate of non-members, the estimated Campaign effect is approximately twice as large. These effects remain robust across model specifications that include individual covariates and design controls. Similar patterns are obtained when using donation amounts as the outcome (see Appendix Table C4).

VI.3 Robustness Checks

We perform a comprehensive set of robustness checks to assess the sensitivity of our estimates. To address concerns related to endogenous targeting by the Campaign, we include a broad array of potential confounders. Additionally, we explore alternative specifications of both the exposure and outcome variables. Finally, we provide supporting evidence that distinguishes our findings from broader political dynamics associated with the Cold War and McCarthyism.

To address concerns that our findings are driven by a backlash to the New Deal or wartime policies, we include controls for war bond penetration (Brunet, Hilt and Jaremski 2023) and New Deal spending (Fishback, Horrace and Kantor (2005), Fishback (2017)). We include other factors that might have encouraged insurance enrollment such as Blue Cross affiliated hospitals or specialist physicians. We do not find significant differences in our estimates for the effects of the Campaign on enrollment, public opinion or civic organization engagement, as reported in Appendix Tables C5, C6, and C7. Since our Campaign exposure includes share educated and share AMA, we also report estimates dropping state fixed effects and instead including these variables. Our findings are broadly robust to these changes.

We next assess the robustness of our estimates to the inclusion of time trends and the extension of the event-study window. Specifically, we incorporate both general and targeted trends in key covariates, finding little change in our results. These include unit-time pre-trends following Miller (2023) and linear trends in the share of households owning a radio and the share of households owning a television (Appendix Table C8).[27] In Appendix Figure D8 we extend the time period of the Gallup event study by including questions that do not reference NHI, but are still broadly concerned with federal involvement in health insurance and find little targeting of places by pre-existing support for these related policies.[28].

We verify that our results are not sensitive to precisely how we define the exposure or outcome: using a binary treatment for above and below median produces similar conclusions (Column 7 of Appendix Tables C5 and C6, and Column 9 of Appendix Table C7). Constructing the exposure with Campaign materials leads to comparable estimates for enrollment and civic organizations (Column 10 of Appendix Table C5

[26] In Figure 9 Panel D, 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.

[27] We do not include unit-specific linear time trends, as these can conflate time-varying treatment effects with pre-existing secular trends. Following the guidance of Goodman-Bacon (2021), we exclude such trends and instead implement the approach of Miller (2023), estimating unit-specific pre-trends as reported in Column 1 of Appendix Tables C5 and C6.

[28] Note that education is not available in earlier waves of Gallup

and Column 8 of Appendix Table C7) but is weaker for public opinion (Column 10 of Appendix Table C6). Separately including Campaign components yields coefficients that are statistically indistinguishable from each other for PHI enrollment, NHI approval, and civic organization endorsement (Appendix Figure D9). 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 and produce an effect size comparable to that of the baseline specification, with no statistically significant difference. For PHI enrollment, we consider an alternate denominator: the total White employed male population instead of the total population (Appendix Table C5 Column 11). Results are predictably larger but otherwise similar. We also assess robustness to different weights in the Gallup poll data (Appendix Table C6 Column 11).

Regarding our identifying assumption, we compute the *F*-test on pre-trends in all our main analyses.[29] We also perform sensitivity analyses as proposed by Rambachan and Roth (2023) allowing for potential parallel trends violations (Column 8 of Appendix Tables C5 and C6), and estimates remain stable. We produce non-parametric estimates of the average causal response, adjusting for the TWFE weighting schemes (Appendix Table C9) (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 Campaign, perhaps fears of Communism were commonly used to influence consumers. To investigate this, we first collect a random sample of ads from the same newspapers that ran Campaign ads a month prior to the dates indicated on Lockwood-Shackleford invoices. We searched for common Campaign phrases such as ''American way", ''freedom", ''socialism", ''socialist", ''communism", ''communist", and ''tyranny". Appendix Table C10 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 drop California given that Hollywood was a target for Red Scare tactics (Humphries 2008) and it had been previously treated by *Campaigns, Inc.* Results excluding California are fairly similar to our baseline results (see Column 12 of Appendix Tables C5 and C6 and Column 10 of Appendix Table C7). Lastly, we return to the Gallup data but this time focus on questions regarding Russia. Appendix Figure D12 demonstrates that Campaign exposure is not associated with Russian disapproval before or after Campaign onset. Thus it does not appear likely that our results can be largely ascribed to anti-Communist sentiment.

VII Discussion of Persistence

A natural question arising from our analysis is: Why did the United States fail to adopt NHI legislation in the decades following World War II? Prominent legislators, including Senator Ted Kennedy, Representative John Conyers and Senator Bernie Sanders have introduced NHI or "Medicare for All" proposals over the last several decades (U.S. Congress 2023). Yet none of these proposals have gained substantial traction, and all have lacked strong support from the executive branch. In contrast, U.S. health care reforms that have advanced – as evidenced by Gallup surveys in Figure 1 – tended to be those that were careful to preserve the private market for health insurance.

While a causal empirical test is beyond the scope of this section, we offer three complementary explanations for the persistence of the United States' predominantly voluntary approach to insurance. First, as

[29] We estimate effects using deciles of Campaign exposure. Appendix Figures D10 and D11 demonstrate approximately linear dose responsive behavior for PHI enrollment and public opinion.

formalized in the conceptual framework (Section III), voter support depends on two beliefs: (1) whether the policy will improve aggregate social welfare; and, (2) whether it will provide individual-level benefits. With respect to the first dimension, *Campaigns, Inc.* was instrumental in framing NHI as synonymous with "socialized medicine." This rhetorical linkage has persisted. During every major U.S. health care reform debate since the 1940s, the frequency of the phrase "socialized medicine" increases sharply (Figure 1, Panel B, right axis).[30]

Regarding individual-level benefits, the Campaign was built around the idea that if more people obtained coverage through the private sector, support for a public option would erode. Gallup data spanning multiple reform periods support this view. As shown in Appendix Table C11, private health insurance coverage, or a close proxy, is consistently associated with lower support for federal health care involvement.[31]

Third, and more generally, persistence is reinforced by groups that benefit from the status quo (Acemoglu, Egorov and Sonin 2021; Coate and Morris 1999; Freitas-Groff 2024). For example, the commercial health insurance industry spent almost the same amount (in current terms) on television advertising during the Clinton administration's attempt at reform as the AMA did during Truman's, and employed many of the same messaging techniques as *Campaigns, Inc.*[32] An October 1993 Gallup poll found that 70% of all adult respondents had heard of ads regarding President Clinton's health care plan – and those that did were about six percentage points less likely to support the reform (Appendix Table C12). Today, Blue Cross Blue Shield of America, the American Medical Association, the American Hospital Association, and the pharmaceutical industry comprise four of the top ten direct federal lobbyists (Open Secrets 2023).

VIII Conclusion

Our analyses demonstrate that an unprecedented Campaign, sponsored by the AMA and orchestrated by the pioneering political public relations firm of Clem Whitaker and Leone Baxter – contributed to the post–World War II defeat of a universal, tax-financed health insurance system in the U.S. The Campaign unfolded during a critical period when public support for NHI was substantial, reinforced by alignment between the executive branch and a Democratic-controlled Congress, and amid similar reforms being implemented in peer nations worldwide. At the same time, most Americans lacked comprehensive health coverage and expressed growing interest in a mechanism to manage rising health care costs. Despite these favorable conditions, the Campaign framed NHI as a form of socialism, altered the discourse in Congress, and accelerated the expansion of a private insurance alternative that persists as a defining feature of the American system.

The long-term implications of the Campaign may extend beyond the scope of our current analysis. For example, the expansion of private group-based insurance through employers left many older adults – particularly retirees aged 65 and above – without coverage once they exited the workforce. This gap may have contributed to the eventual creation of Medicare (Patashnik, Gerber and Dowling 2017; McClellan and Skinner 2006). Future research could explore whether the Campaign had broader spillover effects, such as influencing health policy trajectories in other countries, shaping the debate about other merit goods, or

[30] For example, a 2013 editorial opposing the Affordable Care Act in the *Wall Street Journal* cited the oft-misattributed Lenin quote, "Socialized medicine is the keystone to the arch of the socialist state" (Sommers 2013).

[31] The 1960s wave lacks insurance coverage data so we use age and employment as a proxy.

[32] As described by Bok (1993), "Interest groups spent large sums communicating with the public, but most of these efforts seemed designed less to inform than to arouse latent fears and anxieties. 'This plan forces us to buy our insurance through those new mandatory government health alliances,' complained a prototypical wife, Louise, in a celebrated series of TV ads paid for by the Health Insurance Association of America."

influencing the pace or trajectory of medical innovation. A related question concerns how, despite facing strong opposition from their own medical lobbies, other nations implemented national health insurance.

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Main Tables

Table 1: Campaign Exposure and Private Health Insurance Enrollment

	(1)	(2)	(3)	(4)
Campaign Exposure $\times$ I^{Post}	0.026***	0.026***	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 1 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.

Table 2: Campaign Exposure and
Approval for National Health Insurance Legislation

	(1)	(2)	(3)	(4)
Campaign Exposure $\times$ I^{Post}	-0.070***	-0.075***	-0.068***	-0.050***
	(0.018)	(0.015)	(0.016)	(0.015)
Campaign Exposure	-0.010	-0.005	-0.011	0.016
	(0.016)	(0.019)	(0.015)	(0.011)
I^{Post}	-0.248***	-0.123***		
	(0.029)	(0.045)		
Dependent Mean	0.684	0.684	0.684	0.684
Observations	6465	6465	6465	6465
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 1 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 1937, 1938, 1945, 1946, 1949, 1950, 1952). 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.

Table 3: Campaign Exposure and Resolutions Passed by Civic Organizations

	(1)	(2)	(3)	(4)
Campaign Exposure	0.052***	0.050***	0.047***	0.046***
	(0.017)	(0.017)	(0.016)	(0.016)
Dependent Mean	0.138	0.138	0.138	0.138
Observations	3101	3101	3101	3101
State FE	✓	✓	✓	✓
Design Controls			✓	✓
Demographic Controls		✓		✓

Notes: Table reports results of a regression of resolutions passed by civic organizations on campaign exposure per 1,000 population. Campaign exposure is constructed as in Equation 1 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 county level employment rate. Demographic controls include share female, share Black and share urbanized. 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.

Table 4: Campaign Exposure and Congressional Discourse

	Mentions of Health Insurance		**Mentions of AMA**		**Cosine Sim. with Campaign Materials**		**Oppose Sentiment towards NHI**	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Campaign Exposure	0.00012		0.00506		0.003		0.010	
	(0.00009)		(0.01927)		(0.003)		(0.017)	
Campaign Exposure $\times I^{\text{Republican}}$		0.00010		-0.005		0.007*		0.037**
		(0.00019)		(0.023)		(0.004)		(0.016)
Campaign Exposure $\times I^{\text{Democrat}}$		0.00013		0.015		-0.002		-0.018
		(0.00010)		(0.031)		(0.003)		(0.028)
I^{Democrat}		0.00014		0.310***		-0.022***		-0.415***
		(0.00024)		(0.039)		(0.005)		(0.041)
I^{Democrat} + Campaign Exposure $\times$ I^{Democrat}		0.000		0.325***		-0.432***		-0.024***
		(0.000)		(0.049)		(0.006)		(0.048)
Rep. = Dem. [p-value]		0.900		0.604		0.091		0.088
Dependent Mean	0.002	0.002	0.141	0.141	0.145	0.145	0.863	0.863
Observations	234,655	234,655	533	533	533	533	533	533
Number of Legislators	550	550	189	189	189	189	189	189
Design Controls	✓	✓	✓	✓	✓	✓	✓	✓
Year	✓	✓	✓	✓	✓	✓	✓	✓

Notes: Table reports results of a regression of indicator variables for mentions of specific phrases given by the column heading (Column 1-4), cosine similarity between legislator discourse and AMA-WB Campaign materials (Column 5-6) or oppositional sentiment towards NHI (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 1 and standardized to a mean of 0 and a standard deviation of 1. I^{Democrat} is an indicator for Democratic 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 text mentioned "health insurance." Subsequent columns condition on mentioning "health insurance." Design controls include state level share unionized (Farber et al. 2021) and income (U.S. Census Bureau 2012). All regressions include year fixed effects. *, **, *** denote statistical significance at the 10, 5, and 1 percent levels, respectively. Standard errors are clustered at the state level.

Table 5: Campaign Exposure and Contributions to the Eisenhower-Nixon Ticket

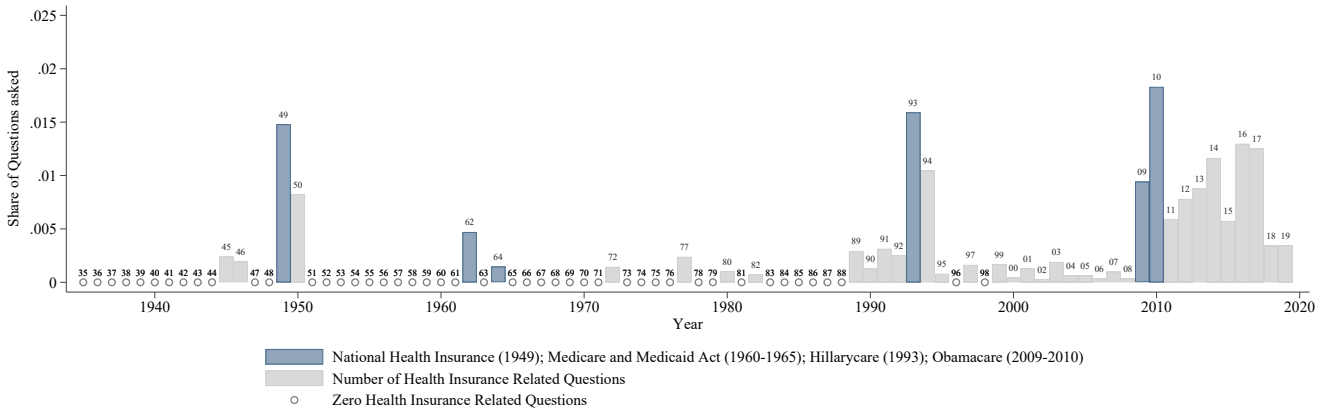
	(1)	(2)	(3)	(4)
Campaign Exposure $\times$ I^{AMA}	0.006***	0.006***	0.006***	0.006***
	(0.001)	(0.001)	(0.001)	(0.001)
Campaign Exposure	0.003***	0.003***	0.003***	0.003***
	(0.001)	(0.001)	(0.001)	(0.001)
I^{AMA}	0.005***	0.005***	0.004***	0.004***
	(0.000)	(0.000)	(0.000)	(0.000)
Dependent Mean	0.001	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 1 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 county level employment rate. 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.

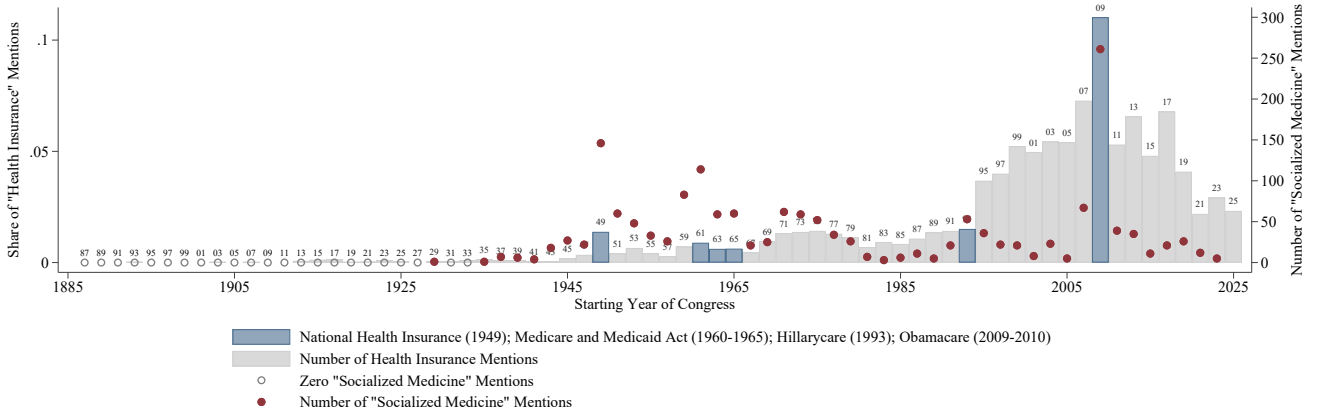
Main Figures

Figure 1: The AMA-WB Campaign in Long-Run Perspective

(a) Gallup Surveys



(b) Congressional Record



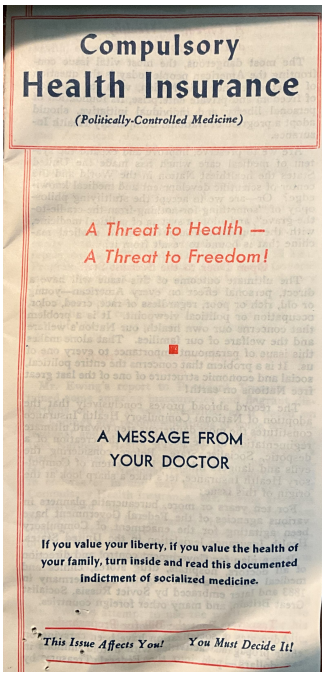
Notes: Exhibit shows the time series of health insurance questions and mentions. Panel A uses data from Gallup survey waves (1935-2017) and plots the share of all questions related to health insurance. Panel B uses data from the *Congressional Record* (1887-2024) and plots the frequency of health insurance mentions on the left y-axis and the frequency of mentions of socialized medicine on the right y-axis. Shading of four eras of health policy form are shown: the debate over the Truman health plan, the discussion of Medicare and Medicaid, Hillarycare and Obamacare. Debates on Medicaid expansions associated with Obamacare are ongoing.

Figure 2: 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 B1. Example taken from page 16 of *Athens Alabama Courier* (American Medical Association 1950*c*).

Figure 3: Campaign Tie-in Ads

(a) Walgreens



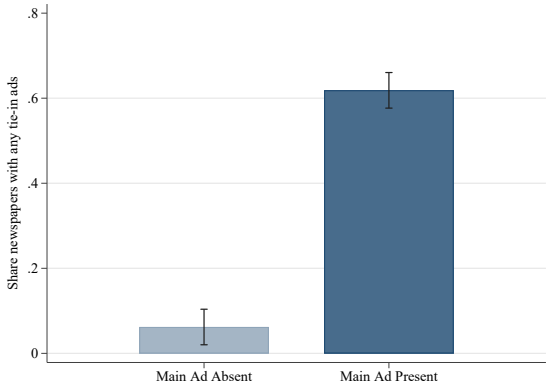
(b) Dillon Implement Co.



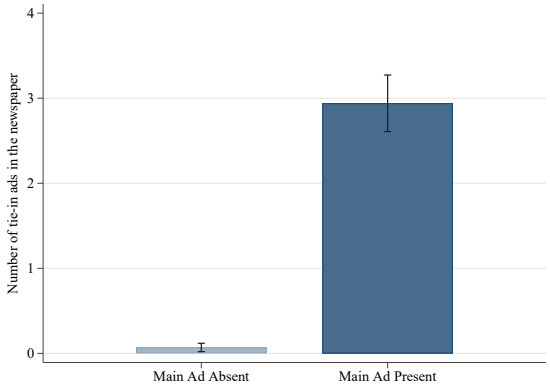
(c) Oklahoma State Bank



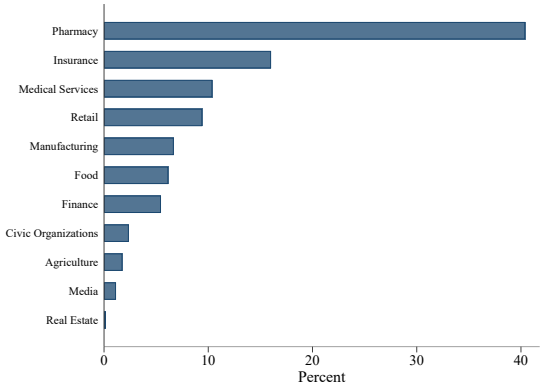
(d) Any Tie-in Ad



(e) Number of Tie-in Ads



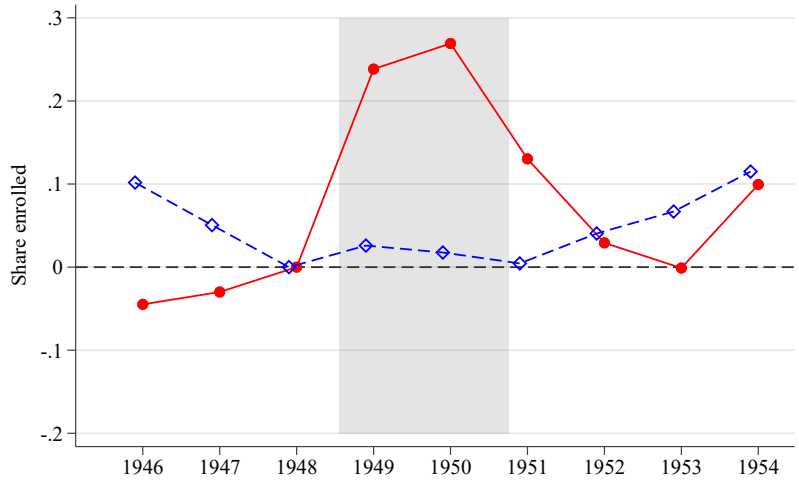
(f) Tie-in Ads by Industry



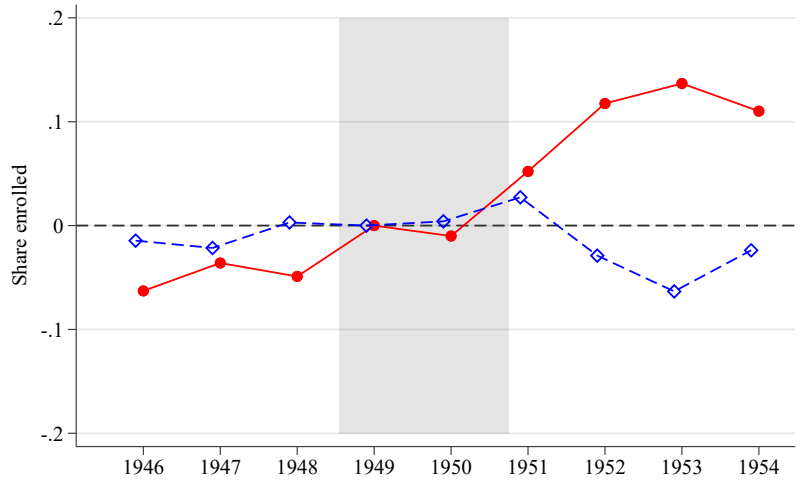
Notes: Panels A, B, and C show examples of tie-in advertisements sponsored by three different companies. While the size and content of tie-in advertisements vary across newspapers and sponsors, the slogan *The Voluntary Way is the American Way* appears in most ads. The examples in Panels A, B, and C 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.

Figure 4: Motivating Campaign Construction

(a) Pamphlets per Population

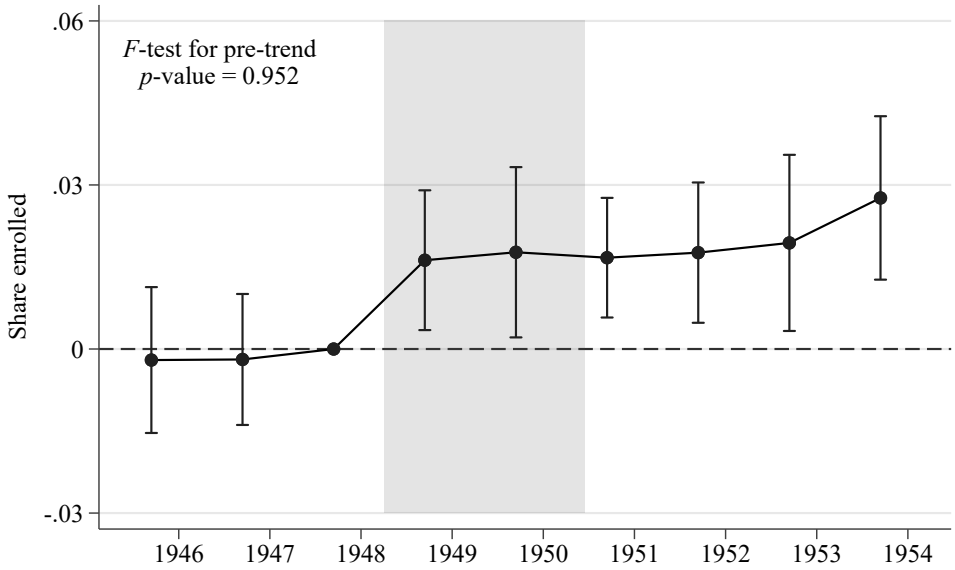


(b) Advertisements per Population



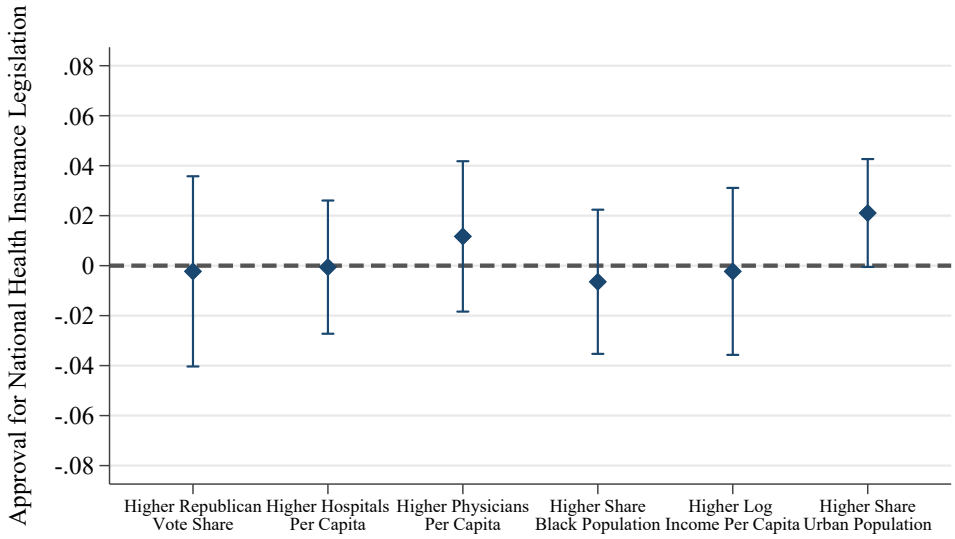
Notes: Panels A and B plot β coefficients based on modified event studies of Equation 1. Panel A interacts pamphlets per capita with event time. Red circles represent states with greater than or equal to mean share physician members of the AMA and blue diamonds represent states with less than the mean share AMA. Panel B interacts ads per capita with event time. Red circles represent states with greater than or equal to mean share adults with at least five-years of education and blue diamonds represent states with less than the mean share educated.

Figure 5: Campaign Exposure and Private Health Insurance Enrollment



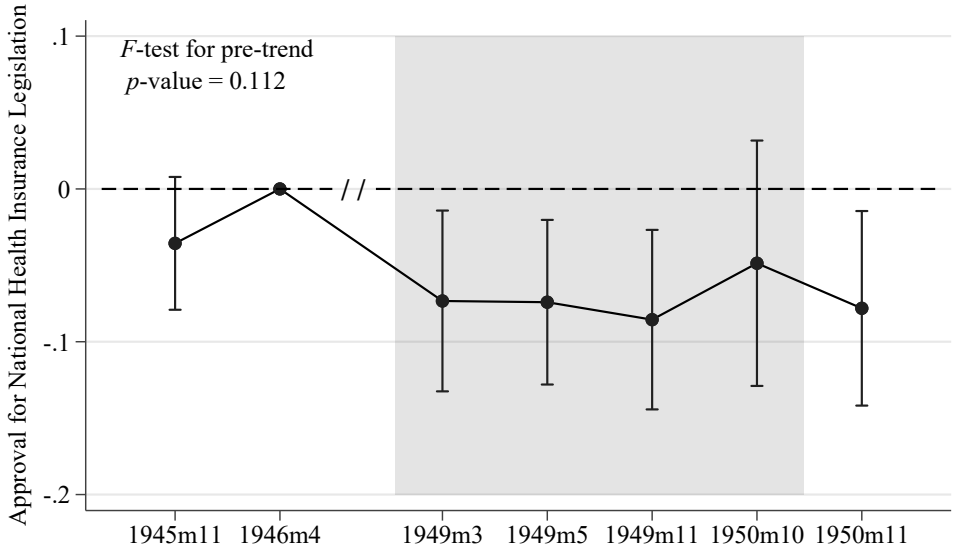
Notes: Figure plots β coefficients from Equation 4 and associated 95% confidence intervals using cluster-robust standard errors. The outcome is share of population enrolled in private health (medical or surgical) insurance. Campaign exposure is constructed as in Equation 1 and standardized to a mean 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.

Figure 6: Campaign Exposure and Private Health Insurance by State Characteristics



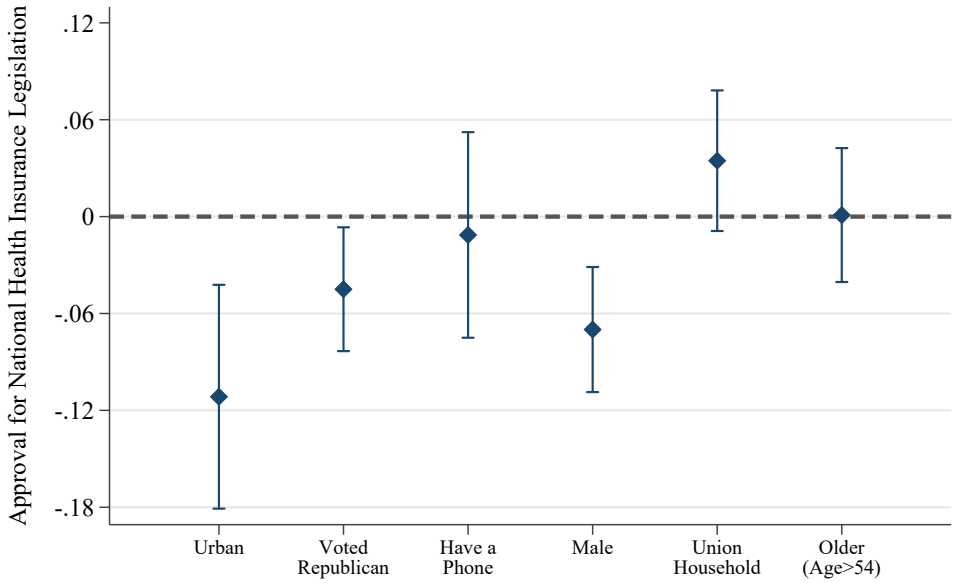
Notes: Figure plots the coefficient on the triple interaction of Campaign exposure, I^{Post}, and the variable on the outcome of PHI enrollment where high is defined as above median. 95% confidence intervals using cluster-robust standard errors are shown. State and year fixed effects are included.

Figure 7: Campaign Exposure and
Approval for National Health Insurance Legislation



Notes: Figure plots β coefficients from Equation 5 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 1 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.

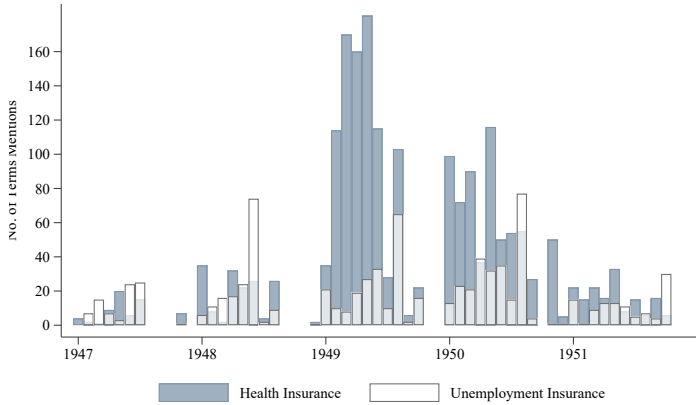
Figure 8: Campaign Exposure and Approval for
National Health Insurance Legislation by Individual Characteristics



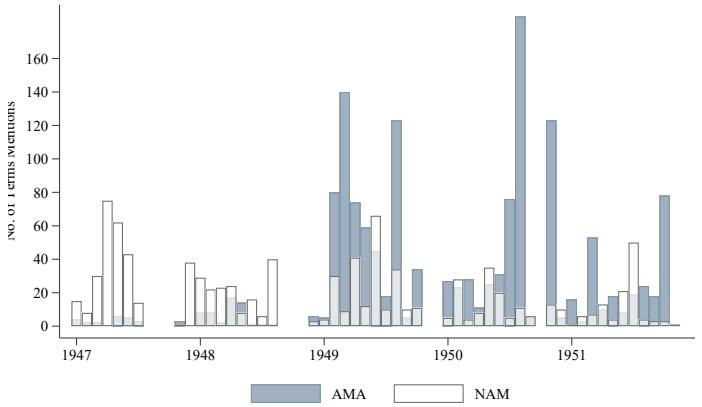
Notes: Figure plots the coefficient on the triple interaction of Campaign exposure, I^{Post}, and the variable on the outcome of approval for National Health Insurance legislation. 95% confidence intervals using cluster-robust standard errors are shown. Sample weights are applied.

Figure 9: Text Analysis of the *Congressional Record*, 1947-1951
and Petitions from the 81st Congress

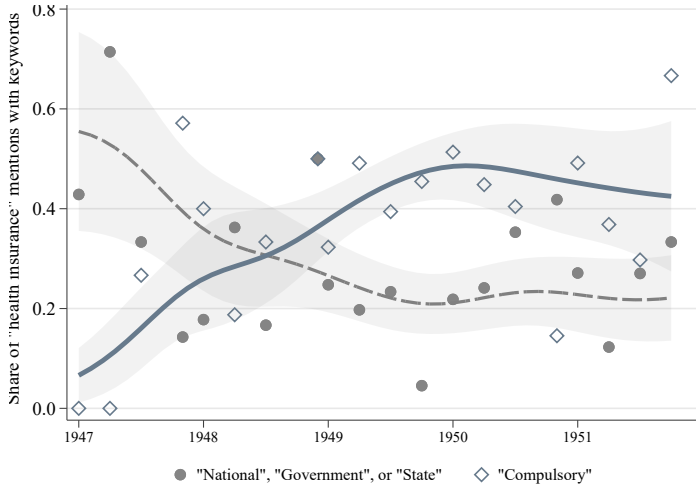
(a) Mentions of Health and Unemployment Insurance



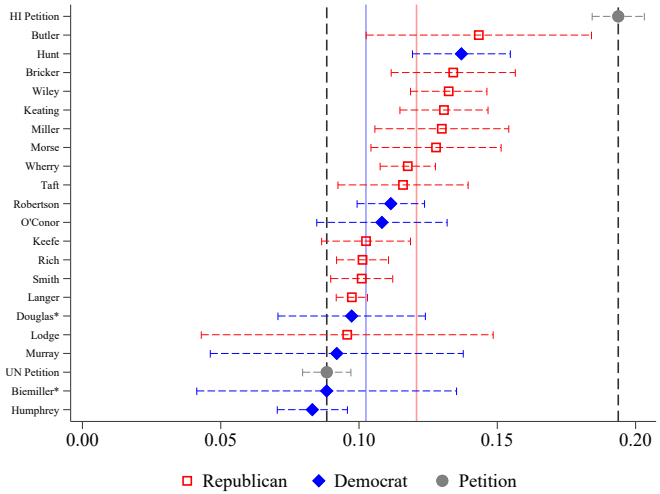
(b) Mentions of American Medical Association (AMA)
and National Association of Manufacturers (NAM)



(c) Descriptors for Health Insurance



(d) Cosine Similarity with AMA Campaign Materials



Notes: Panel A plots the frequency of mentions of the terms Health Insurance (darker blue bars) and Unemployment Insurance (lighter gray bars) from the digitized *Congressional Record* 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 (darker blue bars) and NAM (lighter gray 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). Gray 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 blue 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 materials 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.

Appendix

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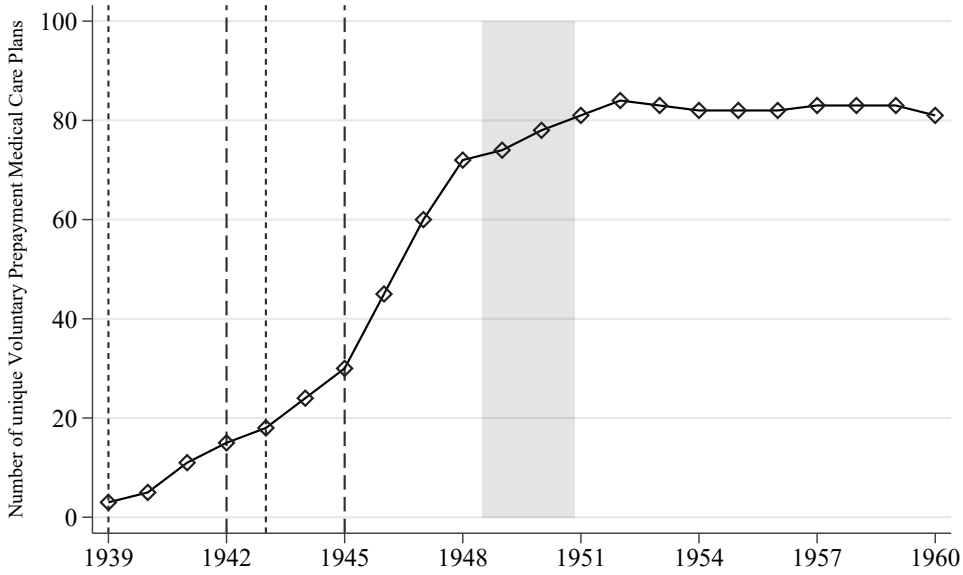
A Descriptive Data Exhibits

Appendix Table A1: Gallup Questions on National Health Insurance

Year	Question Text
Jun 1937	Should the Federal government provide free medical care for those unable to pay?
Jun 1938	Do you think the government should be responsible for providing medical care for people who are unable to pay for it?
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?**
Jan 1949	A bill has been proposed in Congress which would provide medical and hospital care for all employed persons in this country. The cost would be paid by requiring every employed person to pay UP TO $54.00 a year on the first $3600 of wages earned, and the employer would match this by paying an equal amount. Would you favor or oppose such a bill?
Mar 1949	**What is your opinion about it–are you for the Administration's plan (Truman Administration's plan for compulsory health insurance), or not?**
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?**
Oct 1952	Do you favor or oppose a health insurance program run by the federal government and paid for out of salary (wage) deductions?

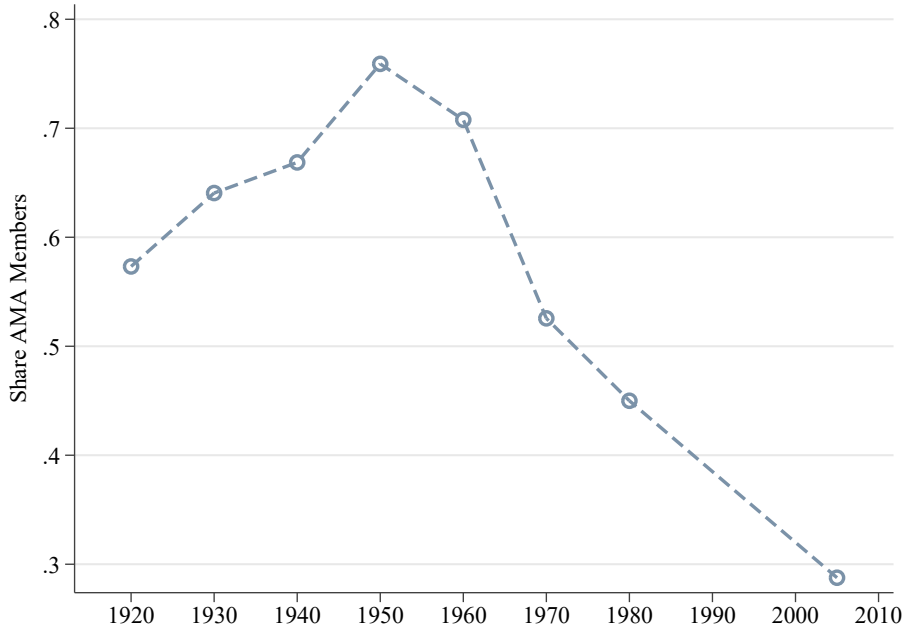
Notes: Table reports the questions Gallup Organization asked respondents over the time period of the analysis (Gallup Organization 1937, 1938, 1945, 1946, 1949, 1950, 1952). In the May 1949 Gallup wave, the question on approval for NHI was asked in two different ways, shown above, as part of a Gallup experiment. The bolded questions are used in the main analysis.

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



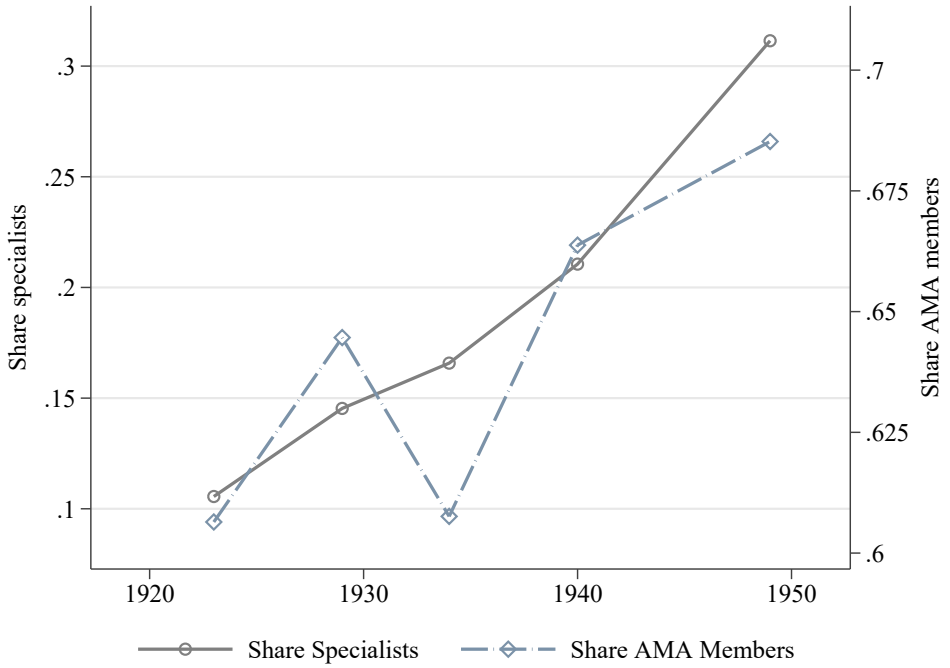
Notes: Figure shows the total number of unique voluntary prepayment medical care plans each year. 1939 marks the formation of the California Physicians Service, the first Blue Shield plan, and California Governor Olson's support of AB 2172 (Board of Trustees of Mississippi State Medical Association 1965; 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: Share AMA Members, 1920-2005



Notes: Figure plots the share of American physicians who were members of the American Medical Association (AMA) from 1920 to 2005. Data for 1920–1970 are calculated as the ratio of AMA members to total active physicians, based on counts reported in AMA House of Delegates Proceedings as well as the *American Medical Directory* (American Medical Association 1910, 1920, 1923, 1929, 1930, 1934, 1940, 1950*b*). The 2005 statistic is based on data reported in Boddiger (2005).

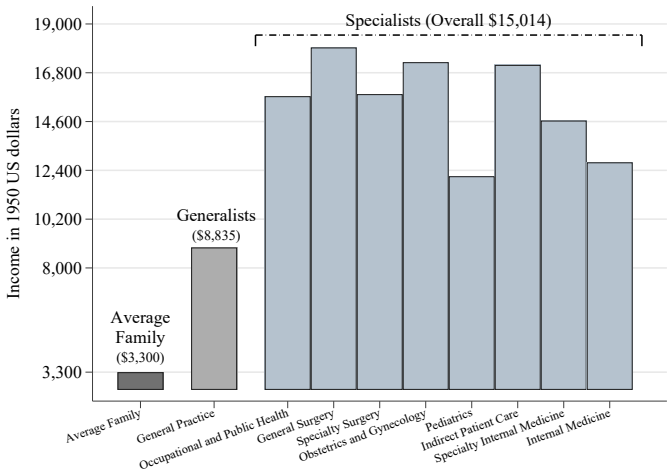
Appendix Figure A3: Shares of Specialists and AMA Members, 1923–1949



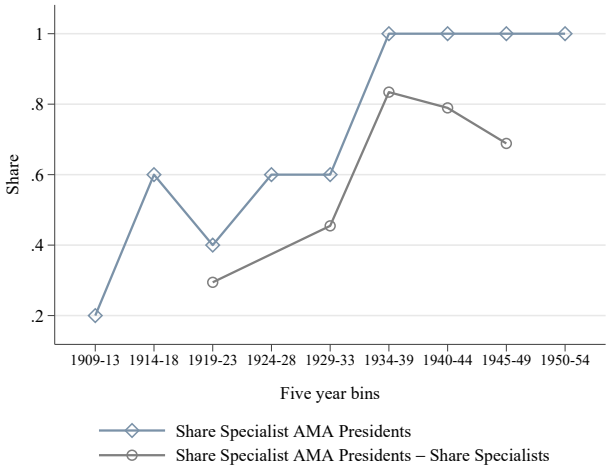
Notes: Figure plots the shares of specialists and AMA members over the total number of physicians in the years 1923, 1929, 1934, 1940, and 1949. Only years with available data on both specialists and AMA membership are included. Data on the number of specialists are from Perrott and Pennell (1957). Data 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: Economic and Political Power of Specialist Physicians

(a) Average Annual Income of Specialist and Generalist Physicians in 1949



(b) Share of Specialist AMA Presidents, 1909-1954



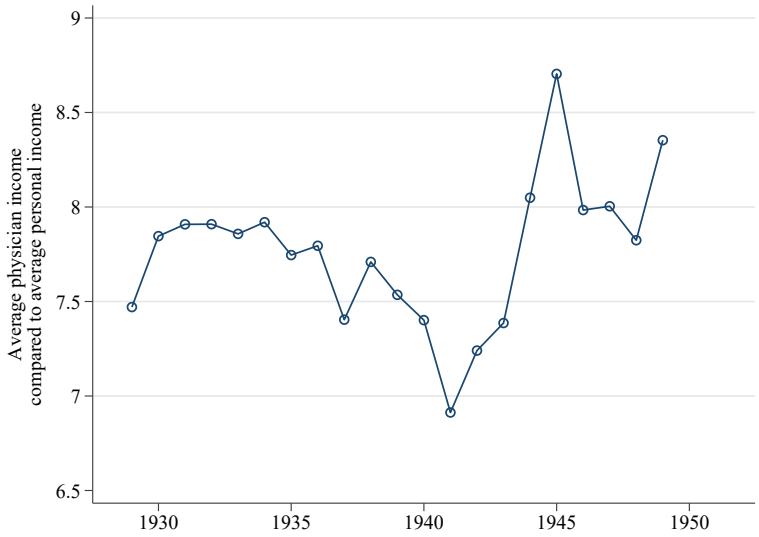
Notes: Panel A plots the average annual income for physicians by specialty in 1949 and average annual family income in 1950. Incomes are adjusted to 1950 U.S. dollars. Physician income data are from the Survey of Current Business published by the Bureau of Economic Analysis (Weinfeld 1951). Family income data are from the Population Report published by the Census Bureau (Peel 1952). Panel B plots the share of specialists among AMA presidents by decade from 1909 to 1954. The blue 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 A5: Physician Income Growth, 1929–1949

(a) Average Annual Income



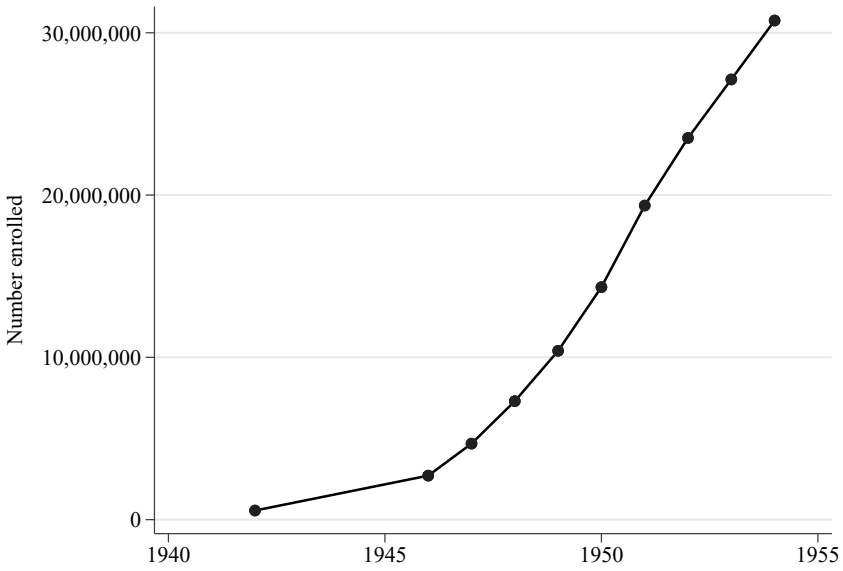
(b) Ratio of Physician to Individual Income



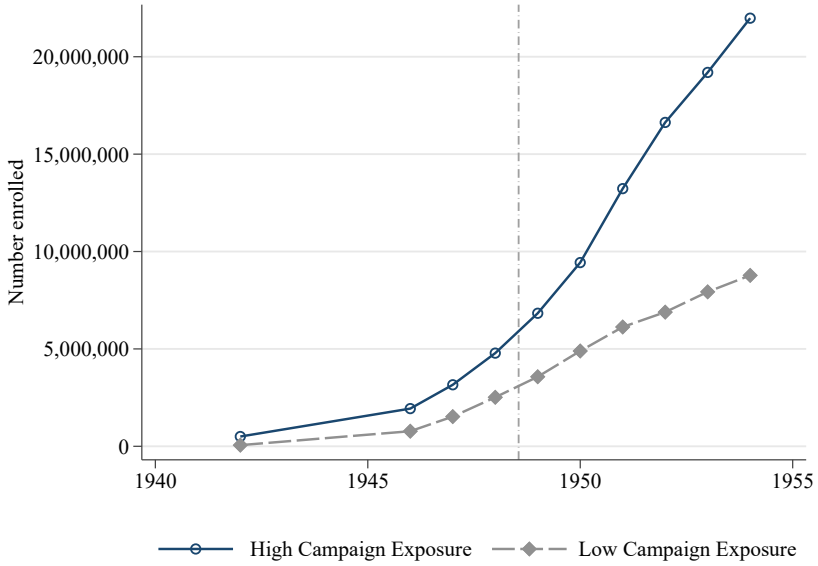
Notes: Figure plots time trends for the average income of physicians from 1929 to 1949. Panel A plots the average income for physicians and all Americans. Incomes are adjusted to 1950 U.S. dollars. Panel B plots the ratio of average physician income to average personal income in the same year. Physician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

Appendix Figure A6: PHI Enrollment Over Time

(a) Total Enrollment



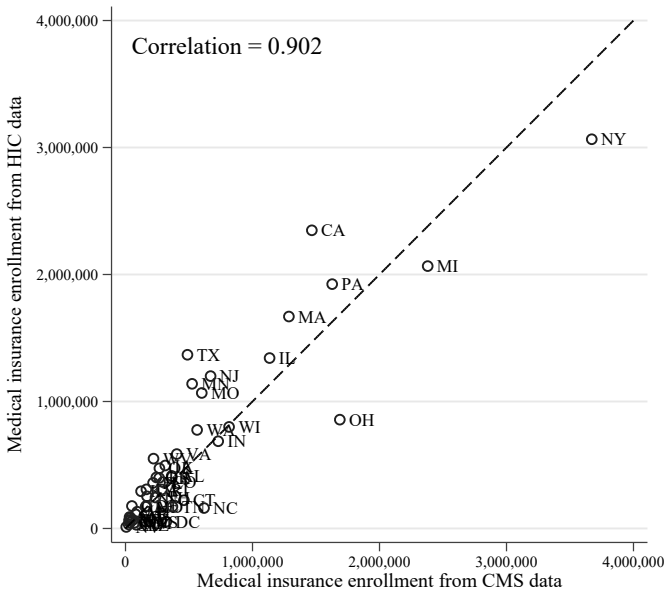
(b) High vs. Low Campaign Exposure States



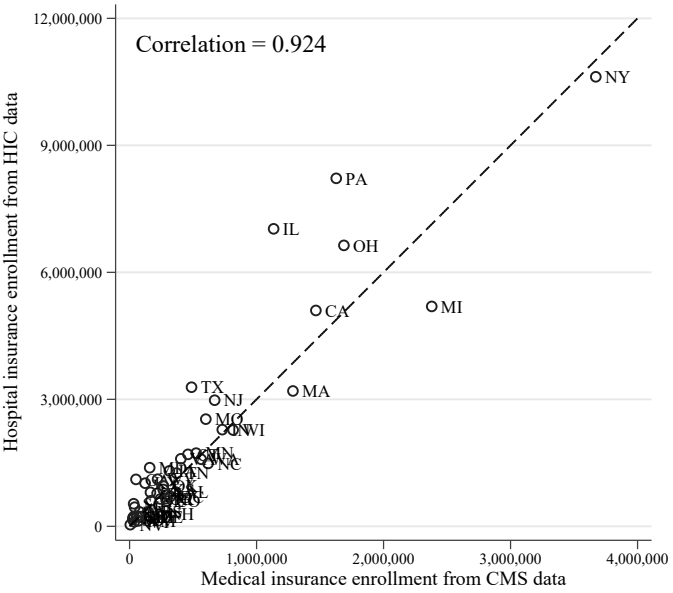
Notes: Exhibit plots voluntary (private) medical and surgical insurance enrollment over time. Data are from Council on Medical Service (1946-1954) for the years 1946-1954. Data from 1942 are from Hospital Service Plan Commission of the American Hospital Association (1942). The blue and grey line in Panel B plots the number of enrolled in states with high and low Campaign exposure, split by the median, respectively. The dotted line indicates Campaign onset.

Appendix Figure A7: Comparison of CMS and HIC Voluntary Health Insurance Data

(a) HIC Medical Insurance Enrollment



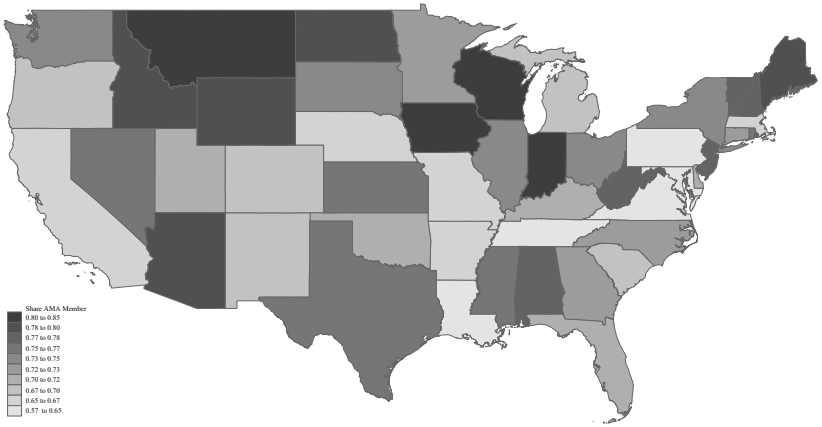
(b) HIC Hospital Insurance Enrollment



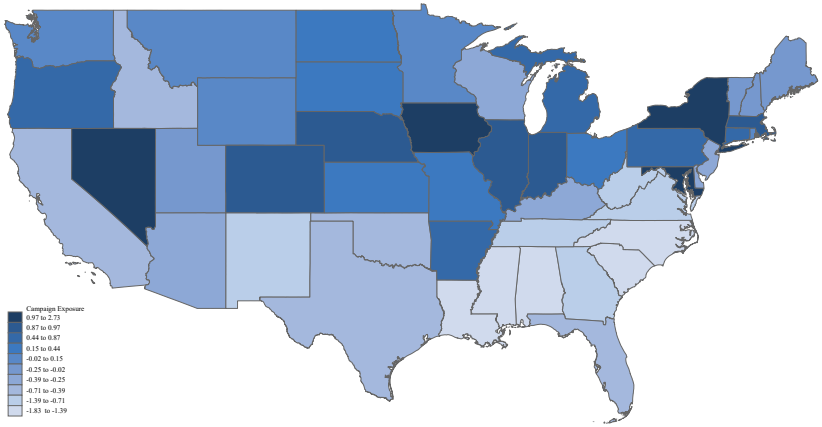
Notes: Figure plots the total number of enrollees. CMS indicates counts from the Council on Medical Service - American Medical Association (Council on Medical Service 1946-1954). HIC indicates counts from the Health Insurance Council (The Survey Committee of the Health Insurance Council 1949-1965). Panel 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 A8: Distribution of Campaign Exposure and AMA Membership Share

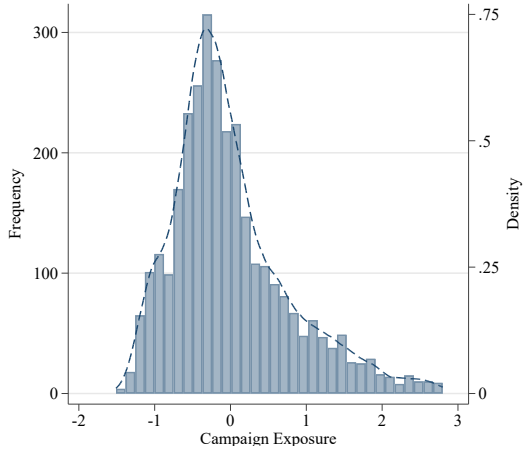
(a) Share of AMA Members by State (1950)



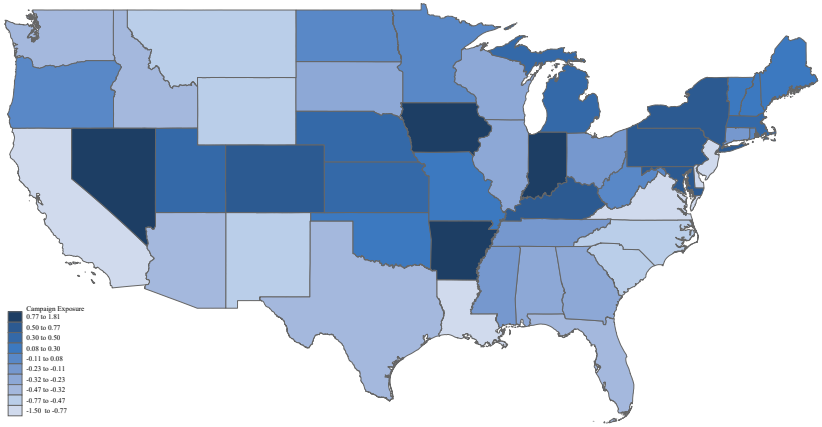
(b) Campaign Exposure by State



(c) Residualized Campaign Exposure by County

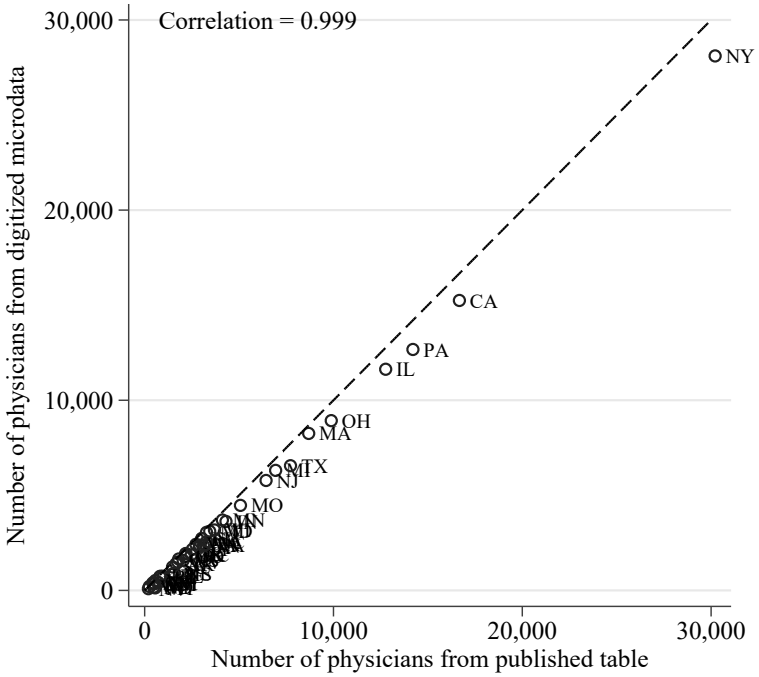


(d) Residualized Campaign Exposure by State



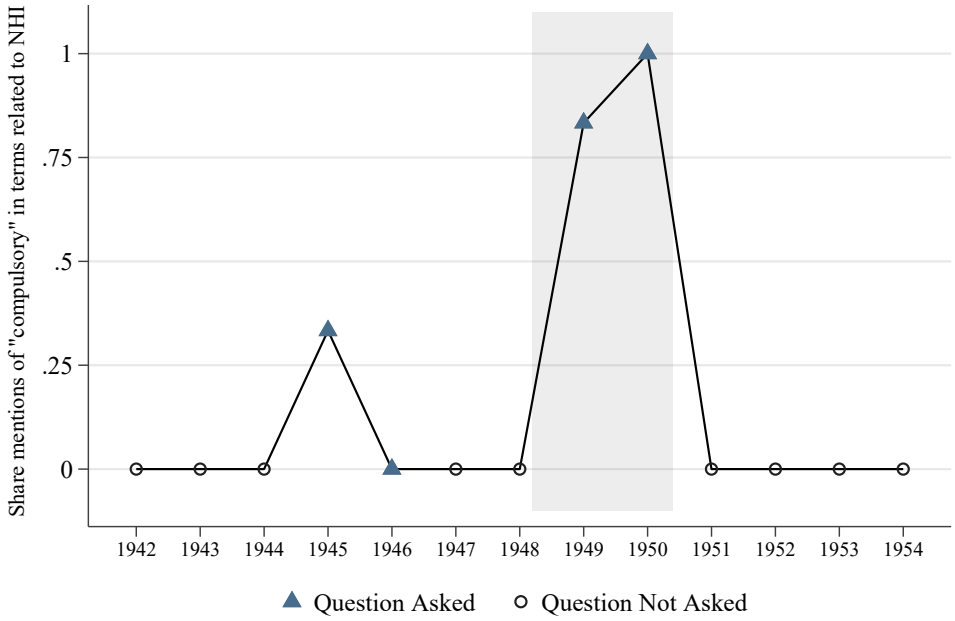
Notes: Panel A shows the share of total physicians that are members of the AMA as of 1950. Data are from American Medical Association (1950*a*). The distribution of Campaign exposure across counties is shown in Panel C, residualized by the design controls of county level income (U.S. Census Bureau 2012) and state unionization rates (Farber et al. 2021). Panel B shows a map of the raw Campaign exposure variable, and the residualized version of the map is shown below in Panel D.

Appendix Figure A9: Number of Physicians by State
from Published Table and Digitized Microdata



Notes: Figure plots the total number of physicians by state, where the y-axis represents the numbers from Tables published in American Medical Association (1950*a*), and the x-axis represents the number 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.

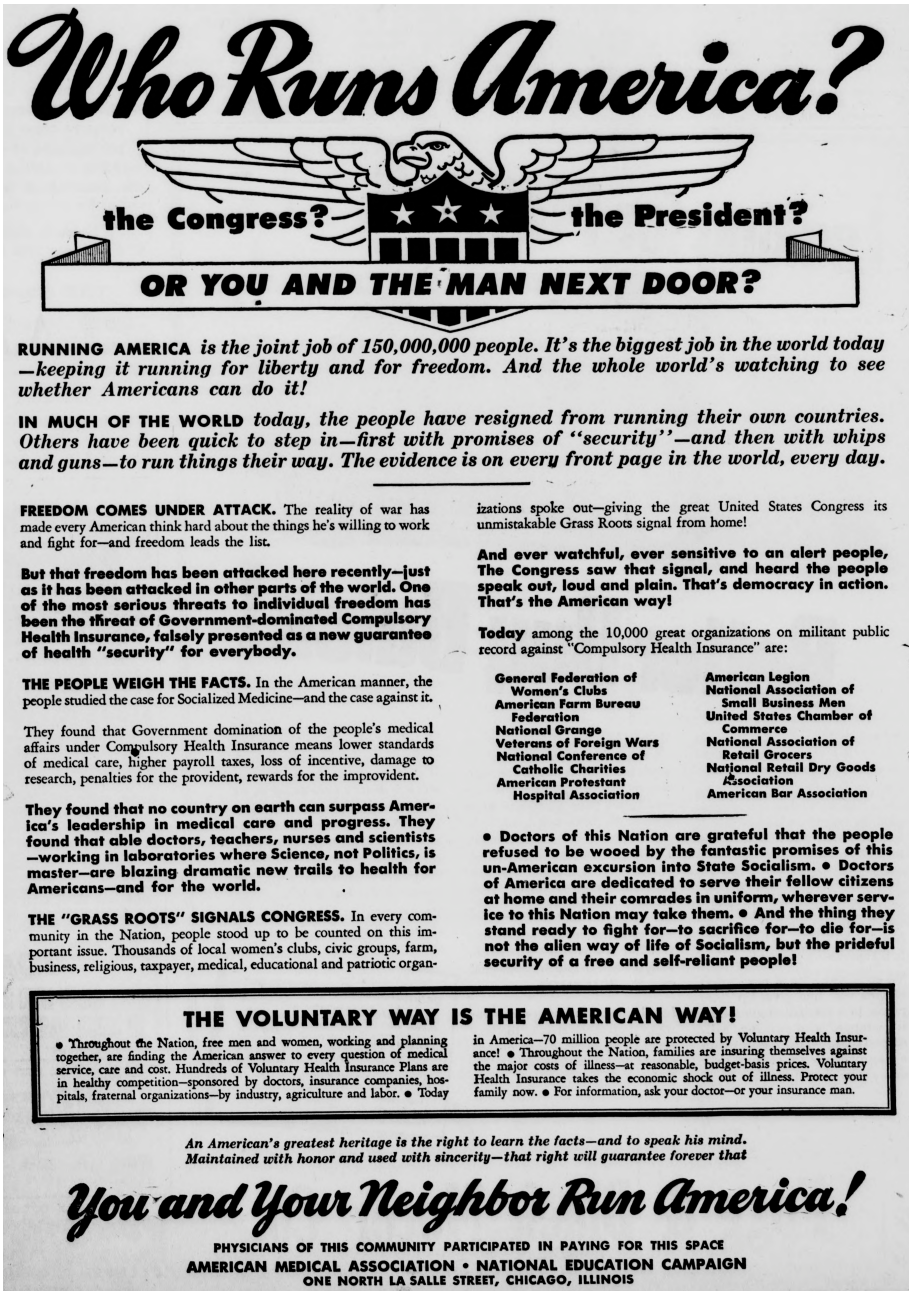
Appendix Figure A10: Terms Used in Gallup Polls Describing NHI Legislation



Notes: Figure plots the share of "compulsory" among terms referring to NHI in Gallup poll questions in Appendix Table A1, bolded questions. 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 the Administration's plans for NHI. Shaded area indicates the Campaign period.

B Primary Source Exhibits

Appendix Figure B1: 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

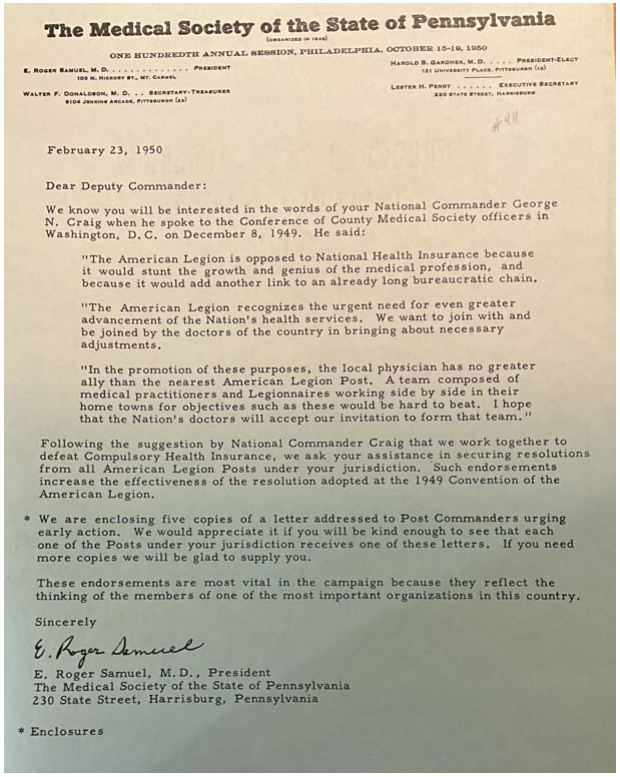
AMERICAN MEDICAL ASSOCIATION • NATIONAL EDUCATION CAMPAIGN

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 B2: Example Solicitation Letter for Civic Organization Resolution & Passed Resolution against NHI

(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

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

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

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

#41

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.

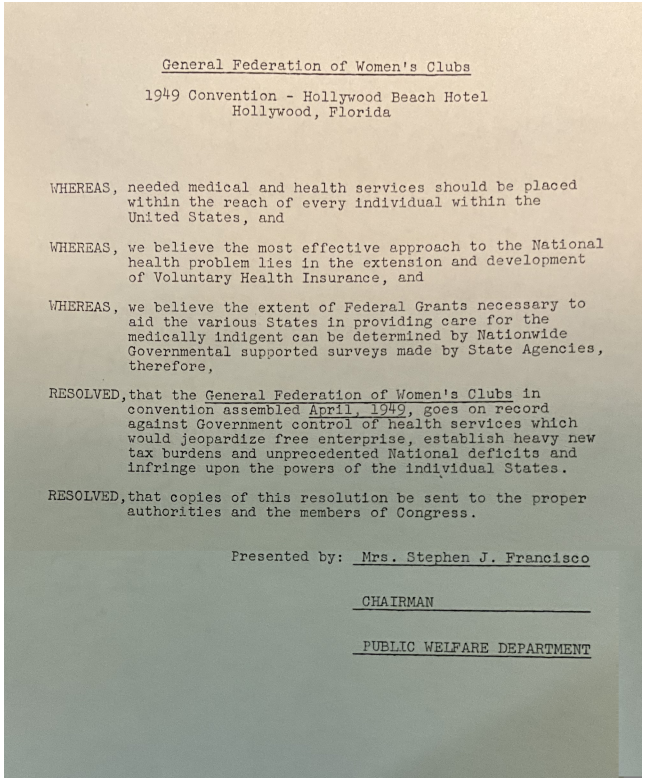
Sincerely

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.

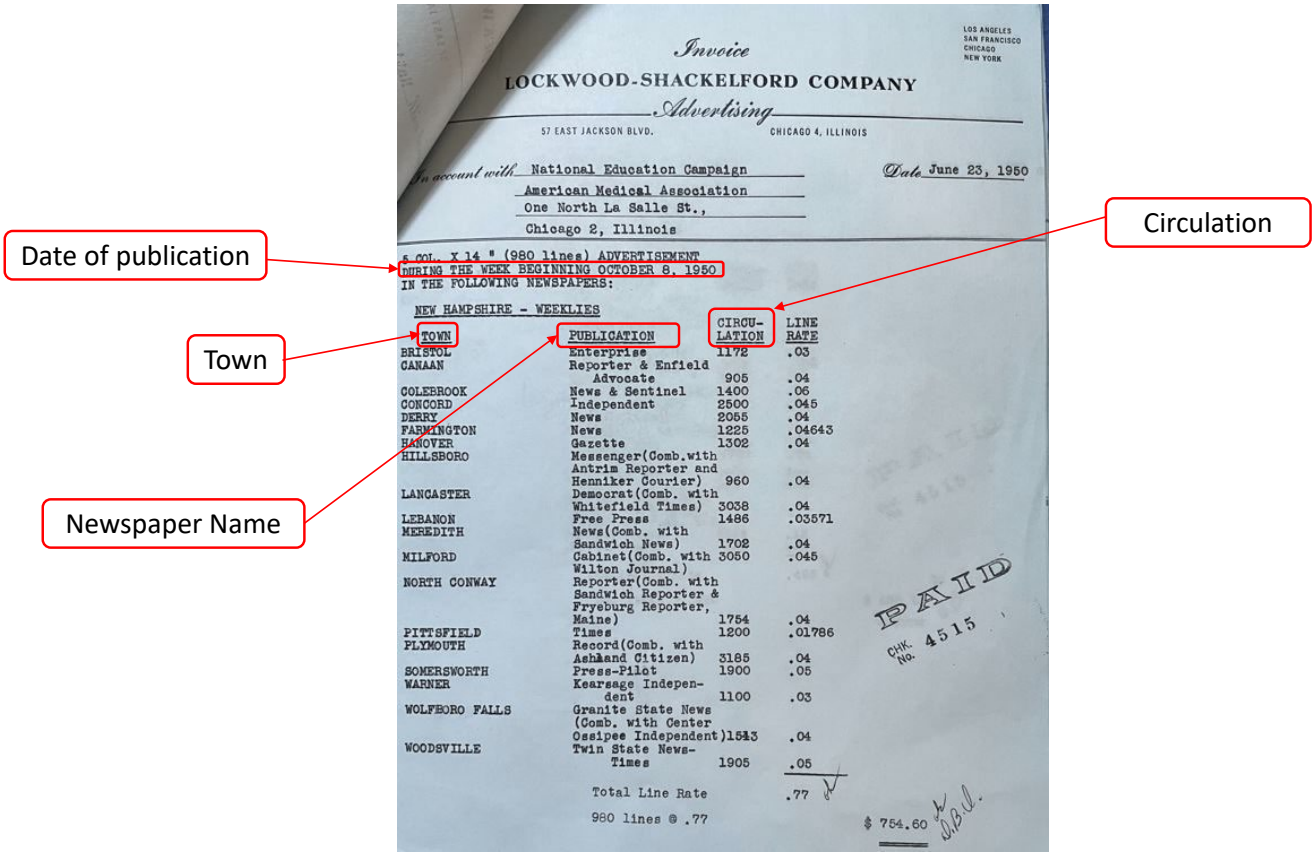
Presented by: Mrs. Stephen J. Francisco

CHAIRMAN

PUBLIC WELFARE DEPARTMENT

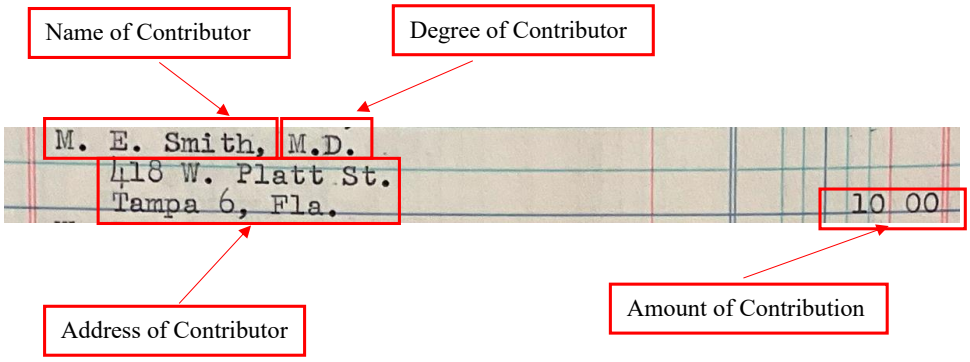
Notes: Panel A shows a request to pass local resolutions against NHI from the Medical Society of Pennsylvania. Panel B shows a local resolution against NHI passed by the General Federation of Women's Clubs (Whitaker & Baxter *Campaigns, Inc.* 1949-1952).

Appendix Figure B3: Lockwood-Shackelford Advertising Agency Invoice



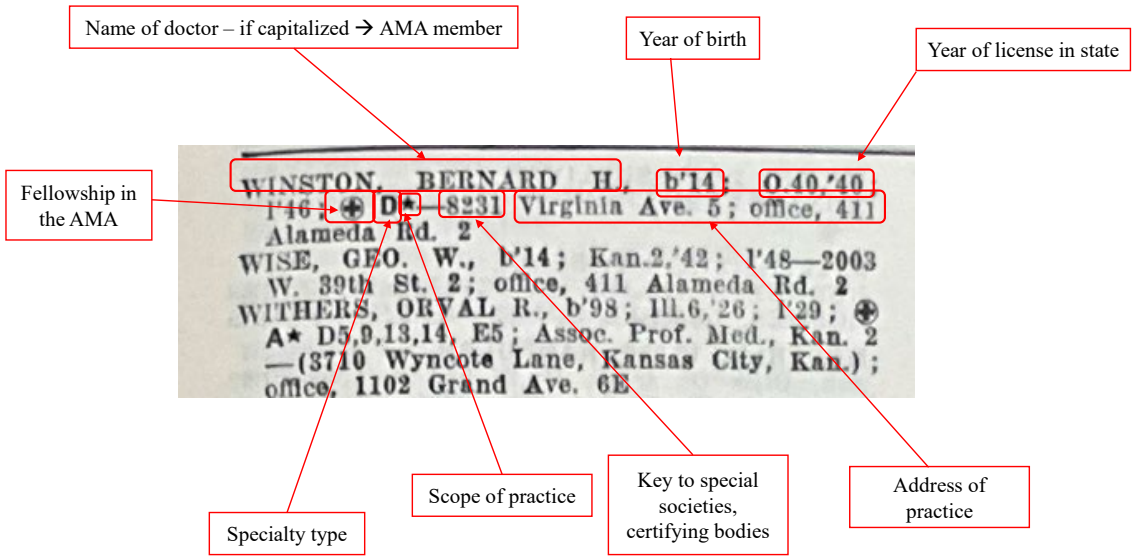
Notes: Exhibit shows an invoice from the Lockwood-Shackelford Advertising Company, outlining the data extracted in red (Whitaker & Baxter *Campaigns, Inc.* 1946-1973). The 980 line advertisement referenced is the main Campaign ad shown in Appendix Figure B1.

Appendix Figure B4: Example Record from National Professional Committee for Eisenhower for President



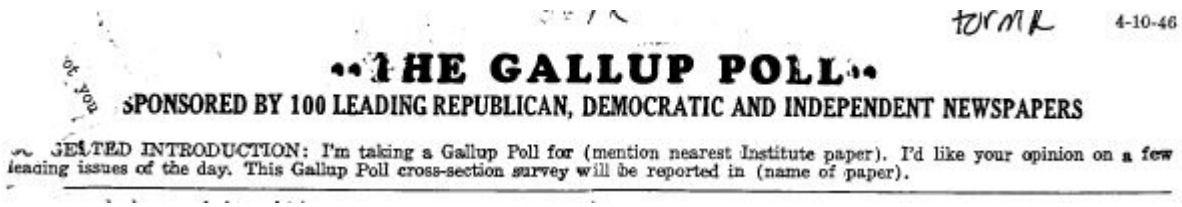
Notes: Exhibit shows an example record from the National Professional Committee for Eisenhower for President (Whitaker & Baxter *Campaigns, Inc.* 1946-1973).

Appendix Figure B5: 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 B6: Gallup Sponsor and Recruitment Instructions



4-10-46

"THE GALLUP POLL"

SPONSORED BY 100 LEADING REPUBLICAN, DEMOCRATIC AND INDEPENDENT NEWSPAPERS

GESTED 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).

C Appendix Tables

Appendix Table C1: Summary Statistics of 1950 American Medical Directory

	(1) Mean	(2) SD
Generalist	0.64	0.48
Urban	0.55	0.50
AMA Member	0.69	0.46
Age	47.44	14.39
Former Military	0.02	0.12
Has Office	0.53	0.50

Notes: Table shows the summary statistics of physicians we digitized from the American Medical Association (1950*a*).

Appendix Table C2: Campaign Exposure Balance

	(1)	(2)	(3)
	Overall Mean	Coefficient	SE
Panel A: State Level			
Mean PHI Share Enrolled 1946-1948	0.034	-0.013	(0.015)
Mean Share Republican Vote 1946-1948	0.426	0.054	(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		1.508	
F-Test *p*-value		0.195	
Observations		47	
Design Controls		✓	
Panel B: Individual Level - Gallup Data			
Approved Truman Health Plan, 1945-1946	0.684	0.021	(0.021)
Female	0.439	-0.001	(0.014)
Age	43.295	0.255	(0.390)
Have a Phone	0.623	-0.016	(0.019)
Voted Democrat, 1944	0.408	-0.040	(0.031)
Unemployed	0.024	0.005	(0.008)
Union Household	0.094	-0.001	(0.007)
Black	0.032	-0.012*	(0.006)
F-Stat		1.625	
F-Test *p*-value		0.131	
Observations		1211	
Design Controls		✓	

Notes: Tables in Panels A and B report balance tests for Campaign exposure in the pre-period. 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. Both panels include the design controls of per capita 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. *, **, *** 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 (1937, 1938, 1945, 1946, 1949, 1950, 1952).

Appendix Table C3: Campaign Exposure and Vote Against FSA and Oscar Ewing in Cabinet

	(1)	(2)	(3)
Campaign Exposure	-0.003		
	(0.019)		
Campaign Exposure $\times I^{\text{Democrat}}$		-0.008	-0.016
		(0.030)	(0.028)
Campaign Exposure $\times I^{\text{Republican}}$		0.005	0.053**
		(0.019)	(0.024)
I^{Democrat}	-0.529***	-0.527***	-0.476***
	(0.042)	(0.042)	(0.045)
Dependent Mean	0.750	0.750	0.630
Observations	412	412	525
Design Controls	✓	✓	✓
Year	✓	✓	✓

Notes: Table reports regression results of Campaign exposure on roll-call vote regarding a resolution opposing the reorganization of the Federal Security Agency into a new Department, which would have elevated NHI proponent Oscar Ewing into the Truman Cabinet. A vote in favor of the resolution is interpreted as disapproval of NHI (Ewing 1969). The analysis pools votes from both chambers and includes year fixed effects as votes took place in different calendar years. Legislators are limited to Democrats and Republicans (which excludes one legislator from the American Labor Party). Columns (1) and (2) only contain the Legislators who were present and whose votes were recorded in the *Congressional Record*. Column (3) also includes those who were not present, such as those who were paired with other legislators (see text for details). The outcome variable of Column (1) and (2) is one if voted on the floor in support ("*yea*"), and zero if voted on the floor against the measure ("*nay*"). The outcome variable of Column (3) is coded as one if voted or would have voted in support ("*yea*"), when explicit in the *Congressional Record*, and zero otherwise. Design controls include state level share unionized for all columns (Farber et al. 2021) and mean income per capita at the state level for Senators and congressional district level for Representatives (U.S. Census Bureau 2012). *, **, *** denote statistical significance at the 10, 5, and 1 percent levels, respectively. Robust standard errors are reported.

Appendix Table C4: Campaign Exposure and Contributions to the 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***	0.004***	0.012***
	(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 amount physician 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 1 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 county level employment rate. 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: Campaign Exposure and 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}	0.029***	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)	(12)
Specification:	Binary Treatment	Potential Trends Violations	Alternative State Controls	Alternative Exposure	Alternative Denominator	Without California
Campaign Exposure $\times$ I^{Post}	0.035***	0.017***	0.020**	0.019***	0.041**	0.020***
	(0.009)	[0.001, 0.032]	(0.008)	(0.004)	(0.017)	(0.004)
Dependent Mean	0.034	0.034	0.034	0.034	0.135	0.033
Observations	423	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 1 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 replacing the state fixed-effects with share AMA and share educated. Column 10 reports results using only published Campaign materials (per capita Campaign pamphlets and per capita circulation of Campaign ads) as the exposure. Column 11 reports results using total enrollment denominated by the number of White employed males. Column 12 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 C6: Campaign Exposure and Approval for National Health Insurance Legislation, Robustness Tests

	Additional and Alternative Controls					
Specification:	(1) Unit-Specific Pre-Trend	(2) War Bond Control	(3) Blue Cross Control	(4) Enabling Legislation	(5) Specialist Control	(6) New Deal Spending
Campaign Exposure × I^{Post}	-0.043***	-0.060***	-0.051***	-0.052***	-0.053***	-0.050***
	(0.014)	(0.015)	(0.014)	(0.016)	(0.015)	(0.016)
Dependent Mean	0.686	0.684	0.684	0.684	0.684	0.684
Observations	6219	6465	6465	6465	6465	6465
State FE	✓	✓	✓	✓	✓	✓
Design Controls	✓	✓		✓	✓	✓
Individual Characteristics	✓	✓	✓	✓	✓	✓
Wave FE	✓	✓	✓	✓	✓	✓

	Design and Inference			Alternative Sample, Weights, and Exposure		
Specification:	(7) Binary Treatment	(8) Potential Trends Violations	(9) Alternative State Controls	(10) Alternative Exposure	(11) Alternative Weights	(12) Without California
Campaign Exposure × I^{Post}	-0.133***	-0.073***	-0.069***	-0.008	-0.047***	-0.048***
	(0.050)	[-0.193, -0.009]	(0.016)	(0.019)	(0.016)	(0.015)
Dependent Mean	0.684	0.684	0.684	0.684	0.684	0.697
Observations	6465	6465	6414	6414	6465	5940
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 1 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 replacing the state fixed-effects with share AMA and share educated. Column 10 reports results using only per capita Campaign pamphlets and per capita circulation of Campaign ads as the exposure. Column 11 reports results with sampling weights based on voting eligibility (Gallup Organization 1937, 1938, 1945, 1946, 1949, 1950, 1952). Column 12 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 C7: Campaign Exposure and Resolutions Passed by Civic Organizations, Robustness Tests

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
	Additional and Alternative Controls							Alternative Sample and Exposure		
Specification:	War Bond Control	Blue Cross Control	Demographic Controls	Enabling Legislation	Specialist Control	Alternative State Controls	New Deal Spending	Alternative Exposure	Binary Treatment	Without California
Campaign Exposure	0.048***	0.047***	0.043***	0.078***	0.055***	0.114***	0.046***	0.082	0.033***	0.038***
	(0.016)	(0.016)	(0.016)	(0.011)	(0.018)	(0.016)	(0.015)	(0.051)	(0.012)	(0.012)
Dependent Mean	0.138	0.138	0.138	0.138	0.138	0.138	0.140	0.138	0.138	0.139
Observations	3101	3101	3101	3101	3101	3101	3047	3101	3101	3043
State FE	✓	✓	✓		✓		✓	✓	✓	✓
Division FE				✓						
Design Controls	✓		✓	✓	✓	✓	✓	✓	✓	✓

Notes: Table reports results of resolutions passed by civic organizations per 1,000 population on Campaign exposure. Campaign exposure is constructed as in Equation 1 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 (American Hospital Association 1948, 1950, 1952). Column 3 reports results controlling for county shares of Black, female, urban populations, and total churches (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 replacing the state fixed-effects with share AMA and share educated. Column 8 reports results using only 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 9 reports results where treatment is dichotomized at the 50th percentile of Campaign exposure. Column 10 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 C8: Campaign Exposure Controlling for Presence of Radio and Television

	(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	0.020***	-0.055***	0.084***	0.006***
	(0.007)	(0.015)	(0.012)	(0.001)
	Panel B: Share HH. Owning a TV Control			
Effect of Campaign	0.016*	-0.053***	0.093***	0.006***
	(0.008)	(0.015)	(0.012)	(0.001)
Dependent Mean	0.034	0.684	0.138	0.001
Observations	423	6465	3101	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 1 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 C9: Campaign Exposure and Private Health Insurance Enrollment, Nonparametric ACR Estimates

	(1)	(2)	(3)	(4)
	Baseline	Nonparametric Estimator		
Method:	TWFE	Polynomial	B-Spline	Spline
Effect of Campaign	0.020***	0.023***	0.022***	0.022***
	(0.007)	(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 estimates 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 adopted 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 C10: Socialism-Related Terms in Ads

	(1)	(2)	(3)	(4)
Dependent Variable:	Any Keyword		Number of Keywords	
$I^{\text{Campaign Ad}}$	0.887***	0.896***	3.871***	4.798***
	(0.010)	(0.010)	(0.142)	(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 2 Panel C) and tie-in ads (see Figure 3), 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.

Appendix Table C11: (Proxies for) Private Health Insurance Enrollment and Support for Federally-Sponsored Health Insurance Reforms

	(1)	(2)	(3)	(4)
	Support Gov. vs MD or Ins. Co. (Apr, 1946)	Support Medicare (Mar, 1962)	Support Hillarycare (Jul, 1991)	Support Obamacare (Jun, 2010)
Have Private Health Plan	-0.133***		-0.120**	-0.081**
	(0.025)		(0.055)	(0.036)
Age 19 - 31		-0.084***		
		(0.025)		
Age 32 - 42		-0.039		
		(0.024)		
Age 43 - 55		0.028		
		(0.023)		
Dependent Mean	0.396	0.619	0.599	0.465
Observations	2435	2990	997	782
Individual Characteristics	✓	✓	✓	✓
State FE	✓	✓	✓	✓
Urban FE	✓	✓		

Notes: The table reports regressions of support for federally-sponsored health insurance on (proxies for) enrollment in private health insurance. The outcome variables are from Gallup questions: "*If You Had To Make A Choice, Which Would You Prefer To Have Run Such A Plan* (*Health Insurance Plan Which Would Pay All Doctor, Hospital And Dental Bills*)*–The Government, The Insurance Companies Or The Medical Profession?*" (Column 1); "*Two Different Plans Are Being Discussed In Washington For Meeting Hospital Costs For Older Persons One Plan Would Let Each Individual Decide Whether To Join Blue Cross Or Buy Some Form Of Voluntary Health Insurance. The Other Plan Would Cover Persons On Social Security And Would Be Paid By Increasing The Social Security Tax Deducted From Pay Checks. Which Of These Two Plans Would You Prefer?*" (Column 2); "*Do you think that the federal government should provide health insurance to all Americans*" (Column 3)"*Thinking about the health care bill currently being considered by Congress, do you think if it is passed into law it will make things better, make no difference, or make things worse for the United States as a whole*" (Column 4) 1 if Make things better and 0 if otherwise. Individual characteristics include: race, gender, and age (continuous, except for Column 2) and party affiliation. Urban indicators are not available in the 1991 and 2010 waves. Robust standard errors in parentheses. Sample weights are applied.

Appendix Table C12: Advertising Exposure and Clinton Healthcare Reform Support (Oct. 1993)

	(1)	(2)
Heard Ad	-0.084**	-0.063*
	(0.036)	(0.035)
Dependent Mean	0.490	0.485
Observations	906	876
State FE	✓	✓
Individual Characteristics		✓

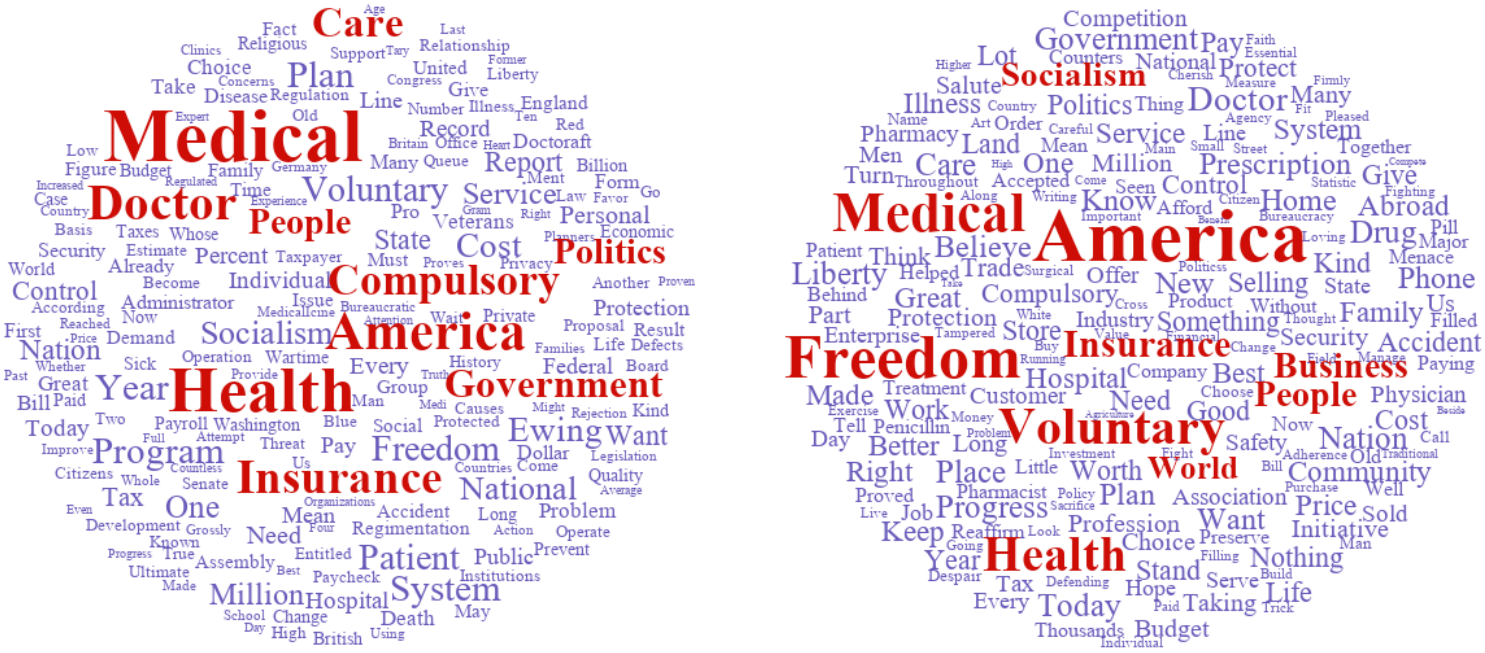
Notes: Table shows the relationship between support for the Clinton era healthcare reform and Ad exposure. The question asked is: *From everything you've heard or read about the plan so far, do you favor or oppose President Clinton's plan to reform health care?* Coded 1 if Favor and 0 if Oppose. Heard Ad is coded from: *Have you heard, seen, or read any advertising which talks about President Clinton's health care plan?* Coded 1 if Yes, 0 if No. Individual characteristics include race, gender, age (older than 54), education, and party affiliation. Robust standard errors are shown in parentheses.

D Appendix Figures

Appendix Figure D1: Word Cloud of Campaign Pamphlets and Ads

(a) Campaign Pamphlets

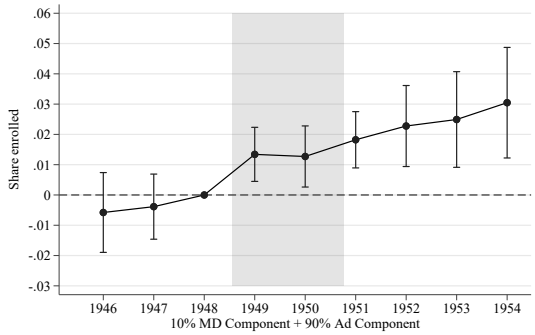
(b) Campaign Ads



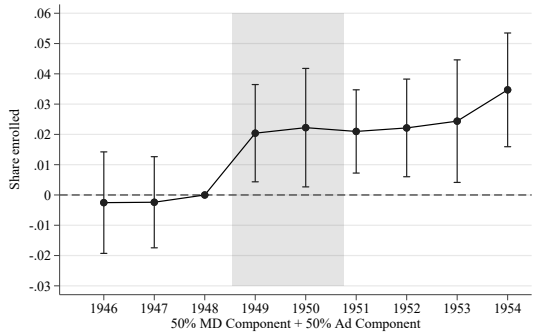
Notes: Panel A shows a word cloud made from text in Campaign pamphlets. Panel B shows a word cloud of newspaper main ads and tie-in ads from NewspaperArchive (2023). The top ten most frequent words are shown in red bold font.

Appendix Figure D2: Varying Weights on Campaign Components

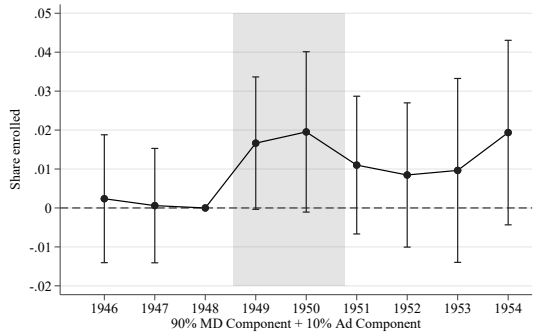
(a) weights 0.1 MD + 0.9 Ad



(b) weights 0.5 MD + 0.5 Ad



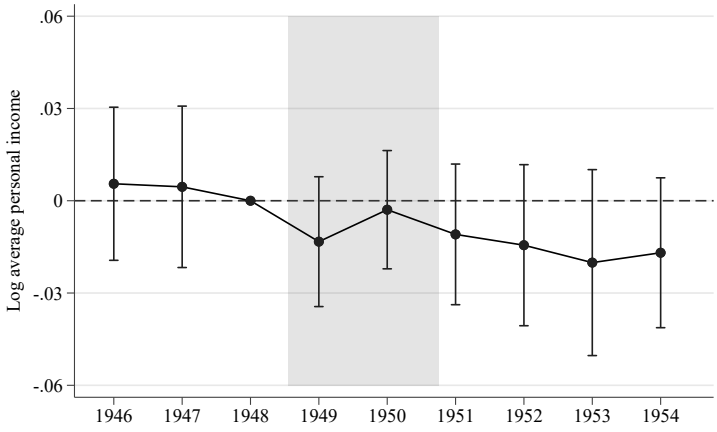
(c) weights 0.9 MD + 0.1 Ad



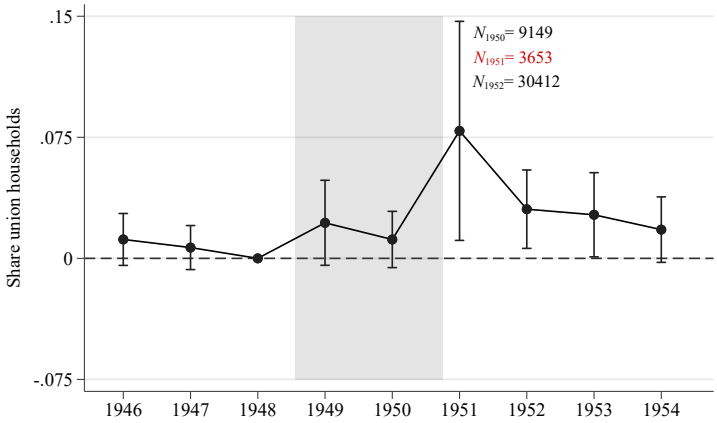
Notes: Figure demonstrates effect of varying weights on the components of Campaign exposure in Equation 1 for the outcome of private health insurance enrollment. Panel A places 0.1 weight on the MD component and 0.9 weight on the Ad Component. Panel B places equal weight on both components. Panel C places 0.9 weight on the MD component and 0.1 weight on the Ad component. Robust standard errors are clustered at the state level.

Appendix Figure D3: Placebo Tests of Campaign on Log Income and Unionization

(a) Log Average Personal Income

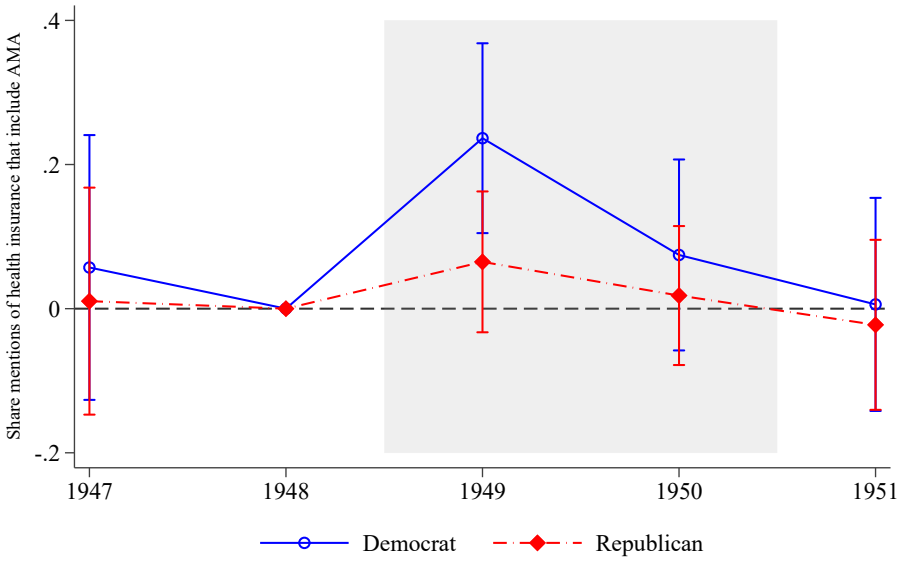


(b) Share Union Households



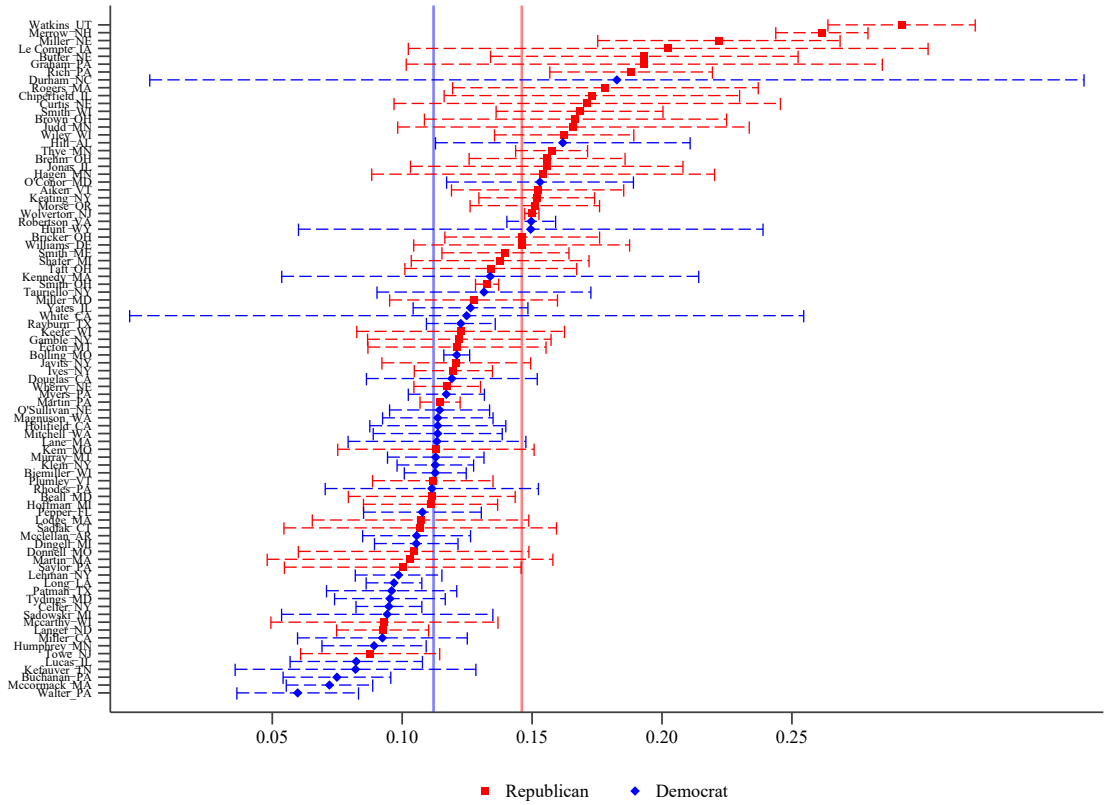
Notes: Figures plot the β coefficients from a regression similar to Equation 4, and associated 95% confidence intervals. The outcome in Panel A is the log personal income per capita and the outcome in Panel B is the share union households. Campaign exposure is constructed as in Equation 1 and standardized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

Appendix Figure D4: Mentions of AMA by Congressional Members, by Partisanship



Notes: Figure plots coefficients 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.

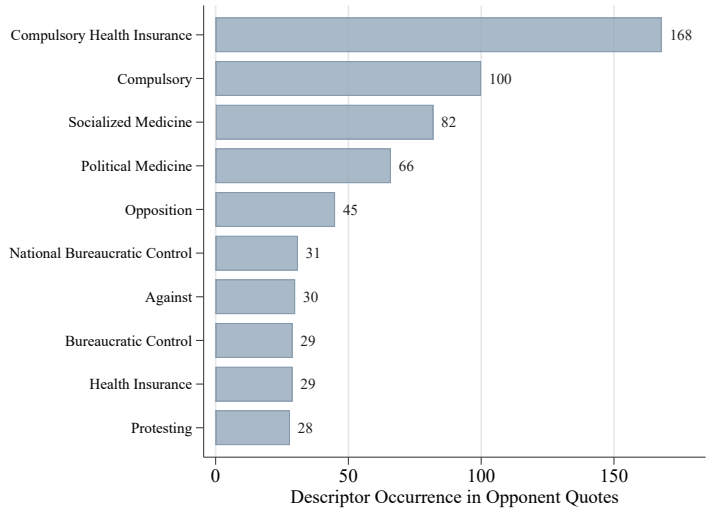
Appendix Figure D5: Cosine Similarity of Legislator Text with Campaign Materials



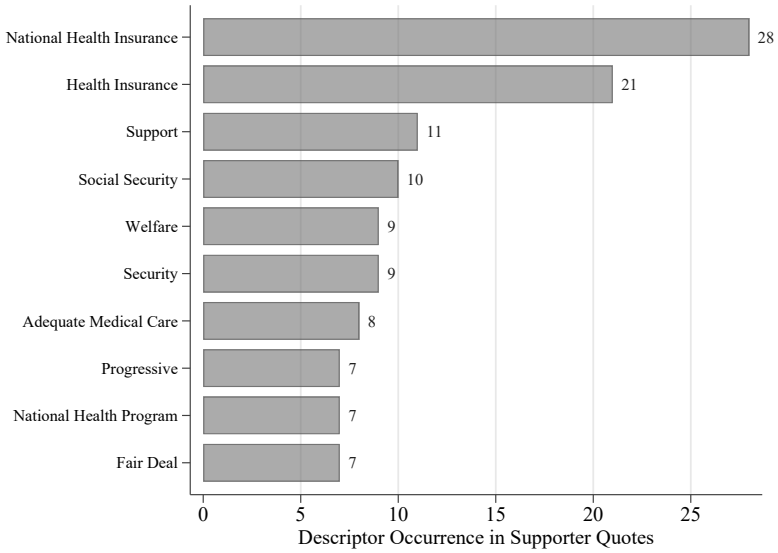
Notes: Figure plots the mean of cosine similarity for quotes in Column 5-6 of Table 4. Confidence intervals are obtained from a bootstrapping procedure with 100 repetitions. Red squares refer to Republicans, and blue diamonds refer to Democrats. The blue (left most) and red (right most) vertical lines represent the average cosine similarity across Democratic and Republican legislators, respectively.

Appendix Figure D6: Top Occurring Descriptors in Legislator Quotes

(a) Descriptor Occurrence in Opponent Quotes

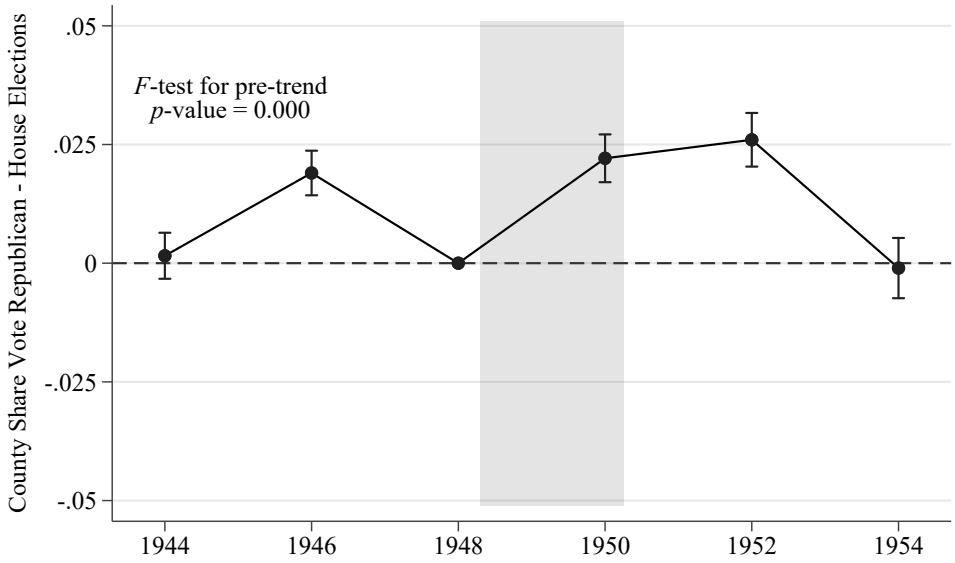


(b) Descriptor Occurrence in Supporter Quotes



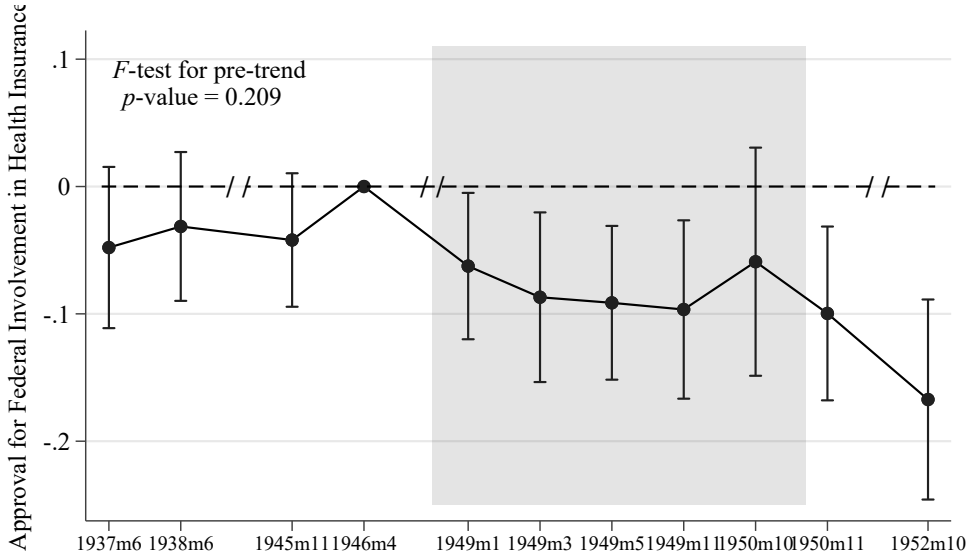
Notes: This figure presents the frequency of the ten most commonly used descriptors from legislator quotes expressing opposition (Panel A) and support (Panel B) toward the Truman Plan for NHI. See Appendix for further details.

Appendix Figure D7: Campaign Exposure and House Election Outcomes



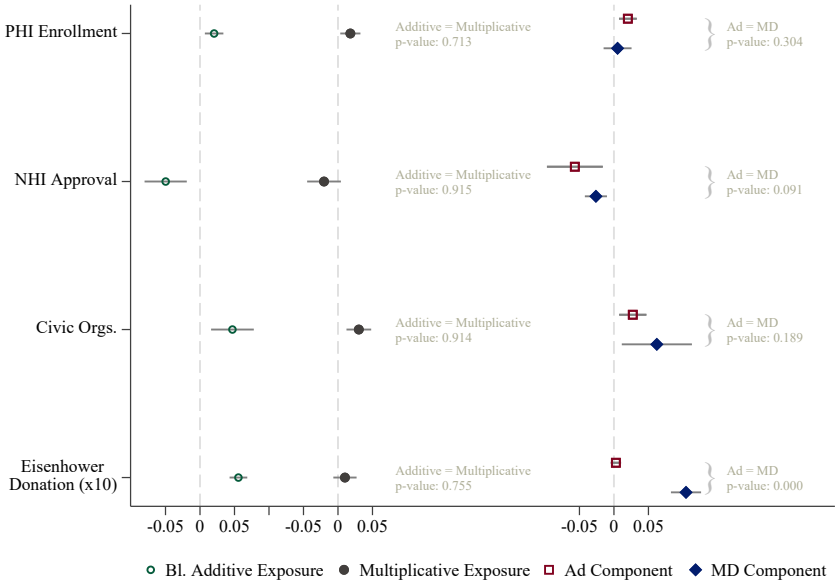
Notes: Figure plots β coefficients from event study of House election outcomes and associated 95% confidence intervals using county-level cluster-robust standard errors. The outcome is the share of Republican votes at the county level. Campaign exposure is constructed as in Equation 1 and standardized to a mean of 0 and a standard deviation of 1. Campaign period is shaded in gray. Sample includes the years 1944-1954. 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.

Appendix Figure D8: Campaign Exposure and
Approval for Federal Involvement in Health Insurance



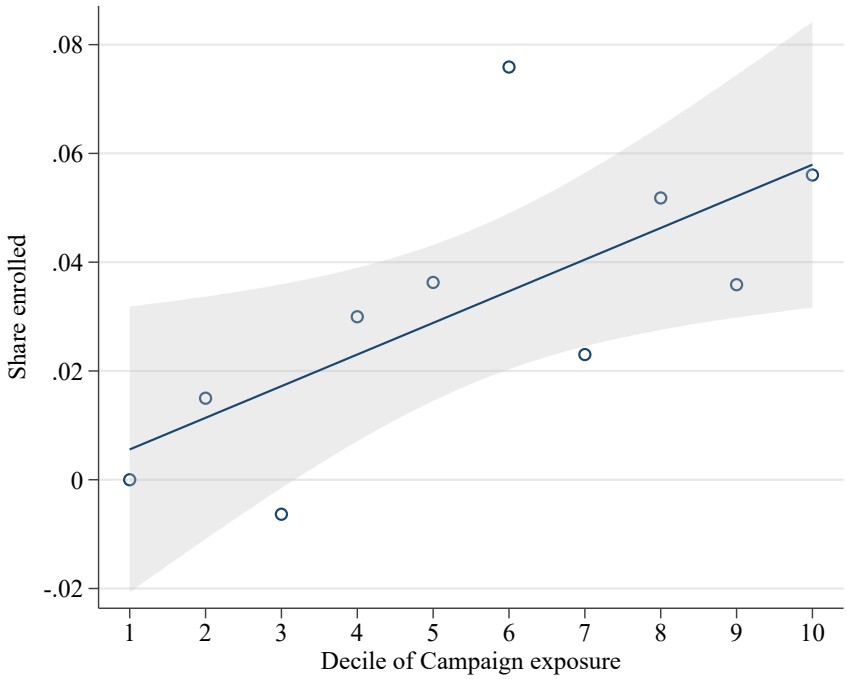
Notes: Figure plots β coefficients from the main specification and associated 95% confidence intervals using cluster-robust standard errors. The outcome is an indicator for approval for federal involvement in health insurance. Campaign period is shaded in gray. The questions for the newly added waves are : *Should the Federal government provide free medical care for those unable to pay* (1937m6) (1 as Yes, 0 as No), *Do you think the government should be responsible for providing medical care for people who are unable to pay for it* (1938m6) (1 as Yes, 0 as No), *A bill has been proposed in Congress which would provide medical and hospital care for all employed persons in this country. The cost would be paid by requiring every employed person to pay UP TO $54.00 a year on the first $3600 of wages earned, and the employer would match this by paying an equal amount. Would you favor or oppose such a bill?* (1 as Favor, 0 as Oppose) (1949m01) and *Do you favor or oppose a health insurance program run by the Federal government and paid out of salary* (*wage*) *deductions* (1 as Yes, 0 as No) (1952m10). Phone ownership is not included because the 1952 wave does not have this variables and education is not available in 1937 and 1938. All other covariates are the same as in the event study in the main text.

Appendix Figure D9: Individual Campaign Components and their Interaction



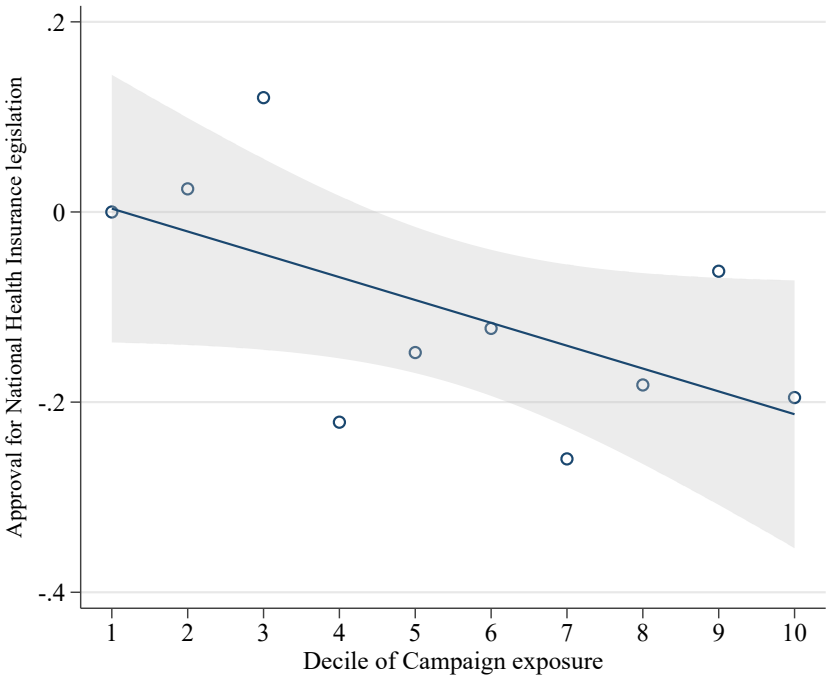
Notes: Figure plots β coefficients on Campaign components as per our main specification. The open green circle markers plot the additive exposure used in the main analysis. The closed gray circle displays the estimates of the multiplicative interaction of Ad and MD components. The red squares and blue diamonds are the separate Ad and MD estimates, respectively.

Appendix Figure D10: Private Health Insurance Enrollment by Campaign Exposure Decile



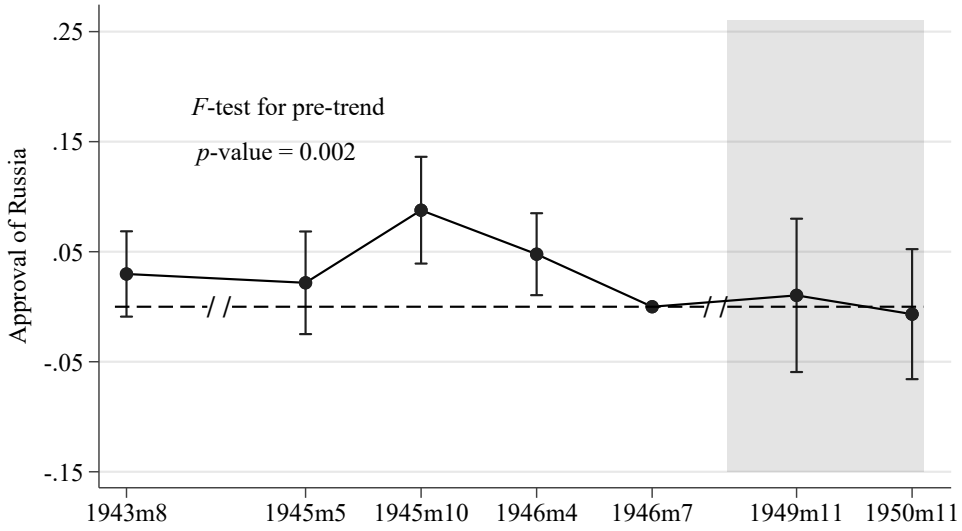
Notes: Figure plots the effect of the Campaign on share enrolled by exposure decile. Dots represent the point estimates of coefficients on the interaction of decile indicators and I^{Post}. The solid lines are fitted linear trends, and the shaded areas are associated 95% confidence intervals.

Appendix Figure D11: Approval for National Health Insurance by Exposure Deciles



Notes: Figure plots the effect of the Campaign on approval for NHI legislation by exposure decile. The full set of controls is 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.

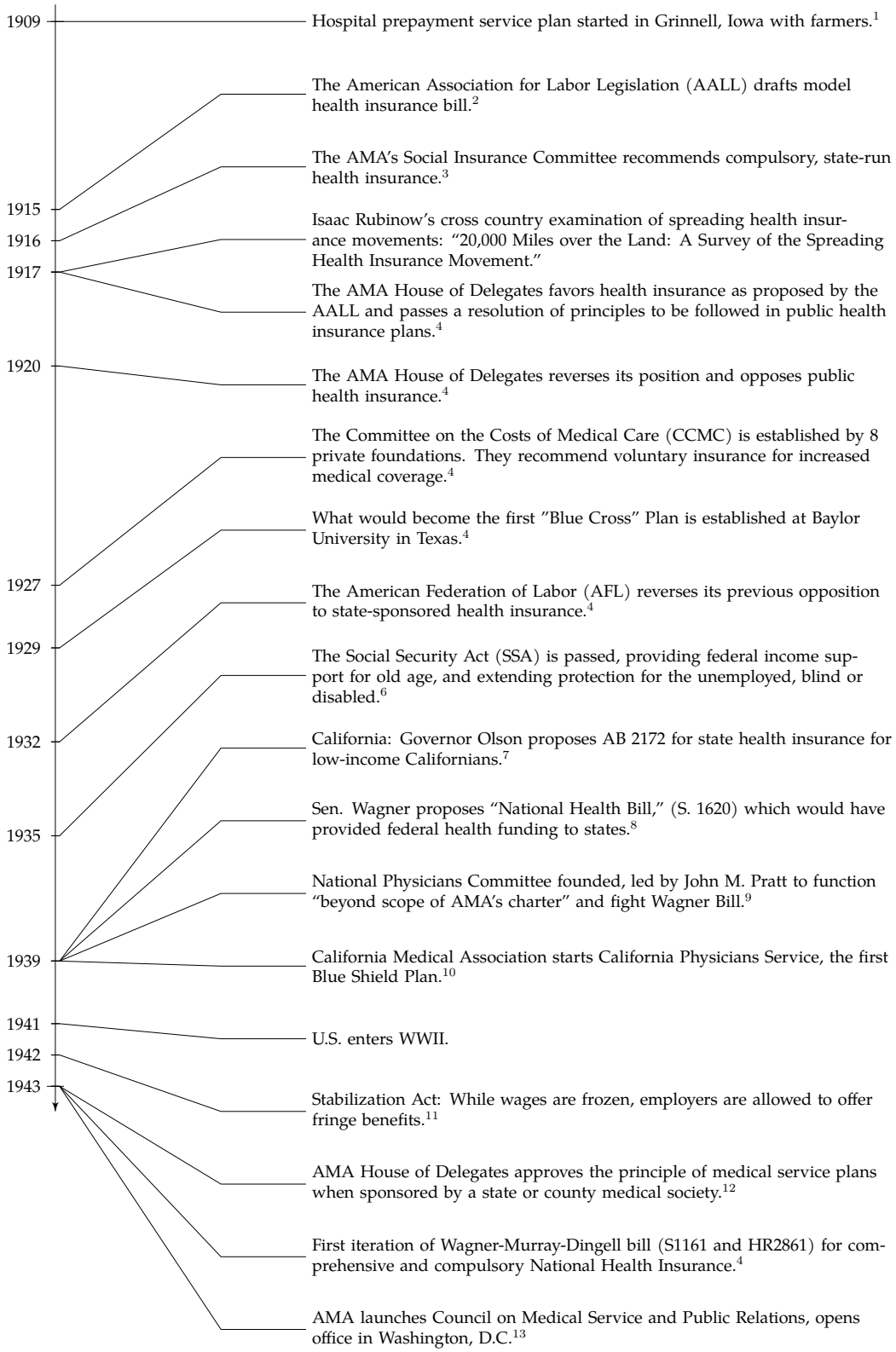
Appendix Figure D12: Campaign Exposure and Russia Sentiment

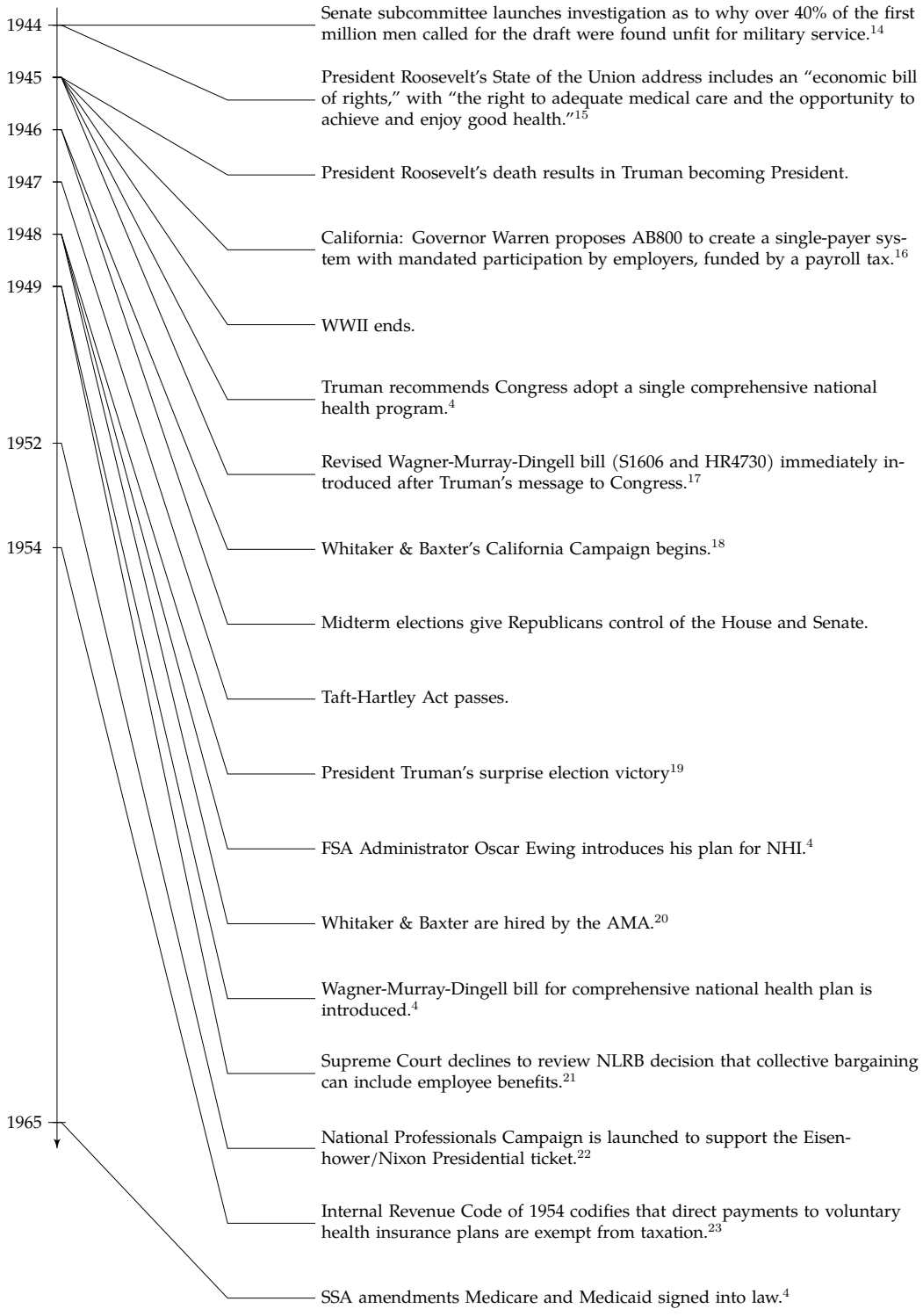


Notes: Figure plots β coefficients from the main specification and associated 95% confidence intervals using cluster-robust standard errors. The outcome is an indicator of a positive view of Russia. Campaign period is shaded in gray. The questions for each waves are: *Do you think Russia can be trusted to cooperate with us after the war is over* (1 if Yes, 0 if No) (1943m8), *Do you think Russia can be trusted to cooperate with us after the war* (1 if Yes, 0 if No) (1945m5), *Do you think Russia will cooperate with us in world affairs* (1 if Yes, 0 if No) (1945m10), *Do you think Russia will cooperate with us in world affairs* (1 if Yes, 0 if No) (1946m4), *As you hear and read about Russia these days, do you believe Russia is trying to build herself up to be the ruling power of the world, or is Russia just building up protection against being attacked in another war?* (1 if Protection, 0 if Ruling Power) (1946m7), *As you hear and read about Russia these days, do you believe Russia is trying to build herself up to be the ruling power of the world, or is Russia just building up protection against being attacked in another war?* (1 if Protection, 0 if Ruling Power) (1949m11), and *As you hear and read about Russia these days, do you believe Russia is trying to build herself up to be the ruling power of the world, or is Russia just building up protection against being attacked in another war?* (1 if Protection, 0 if Ruling Power)(1950m11).

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 program.[4]
Revised Wagner-Murray-Dingell bill (S1606 and HR4730) immediately introduced after 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]
FSA Administrator Oscar Ewing introduces his plan for NHI.[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); Doherty and Jenkins (2009). [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]Truman Library (2023). [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 the Truman Administration

Serious movements for statutory health insurance began in the early 1900s with the American Association for Labor Legislation (AALL) founded by progressive economists John R. Commons and Richard Ely of the University of Wisconsin. As described by Hoffman (2001), the AALL leaders believed in a "security state" engaged in regulation and prevention more than direct relief which it thought encouraged pauperism and dependency. The demise of the Progressive movement paused state-sponsored health insurance, but medical costs continued to rise as technology improved. This, alongside the Great Depression of 1929, inspired a handful of nonprofit hospitals to experiment with pre-payment schemes – which eventually became known as the Blue Cross System.

Franklin D. Roosevelt (FDR's) New Deal afforded another opportunity for the potential incorporation of health insurance into the landmark Social Security Act of 1935, but ultimately the focus was on old age security. While not included in the Social Security Act of 1935, support for health insurance legislation within the Roosevelt administration continued. 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.

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 health care 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 California Medical Association 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, such as 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

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. Hospitals took the lead on starting the plans and typically in 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 enabling legislation as they were deemed not to constitute formal insurance. Most states followed the legislative template provided by New York in 1934 which specified that group hospital services were not insurance but must be considered a charitable organization (therefore tax exempt) and abide by certain rules in terms of structure (*e.g.*, trustees must include hospital administrators).

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 but grew out of logging communities in the Pacific Northwest and were generally met with skepticism by physicians, who eschewed the idea of contract work (Reed 1947). The attitude of the AMA toward prepayment medical service plans was crystallized by passage of a resolution in the House of Delegates in December 1945 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 its emphasis upon the nation-wide organization of locally administered prepayment plans sponsored by medical societies"(Reed 1947, p.147). Out of this was formed the Associated Medical Care Plans Inc., to perform the same duties of coordination as the Blue Cross Commission. The Blue Shield Seal of Acceptance was established in 1946. The 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 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). 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).

Despite its defeat 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 it 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 also started lobbying for benefits that would include medical insurance.

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 2.6 percentage point estimate and dividing it by the total post effect of around 12.8 percentage points (post and post interacted with Campaign, Table 1 Column 1). This calculation suggests that a one standard deviation increase in Campaign exposure led to an increase of about 20% in enrollment, which translates into about 4.4 million medical and 8.5 million hospital insurance enrollees. Hospital insurance data are from the Survey Committee of the Health Insurance Council. 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).

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 as reported by Thomasson.

F.2 Categorizing Tie-in Ads by Industry

We used 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," "Greenshouse," "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, Linkage 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 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 B1 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 Lockwood- Shackelford invoices and newspapers from *NewspaperArchive*.

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	(0.223)
Urban	0.707	-0.045	(0.065)
Weekly	0.551	-0.086	(0.069)
Established before 1940	0.985	0.029	(0.021)
Leans Republican	0.228	0.092	(0.062)
Railways Crossed	0.993	0.008	(0.014)
F-Stat		1.542	
F-Test *p*-Value		0.186	
Observations		615	

Notes: Newspaper sample is from 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 *NewspaperArchive* 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 ratio was greater or equal to 0.9 and the city and state were exactly the same. 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	0.009	(0.012)
Lean Republican	0.202	0.014	(0.039)
Railways Crossed	0.993	-0.000	(0.002)
F-Stat		5.094	
F-Test *p*-Value		0.000	
Observations		11667	

Notes: Table reports differences between newspapers having the main Campaign ad shown in Appendix Figure B1 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 NPCE PAC 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 folds by whether 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 counted mentions of keywords, extracted the date and the last names of speakers from the text using the regular expression from Judge-Lord (2022). The last names are then linked with legislator information from the Inter-university Consortium for Political and Social Research (2010).

Most closely related to our procedure is Gentzkow, Shapiro and Taddy (2019) who obtained digital text from HeinOnline, and parsed out speeches on the floor of Congress. We used the speeches and petitions from 547 voting members of Congress and also included the Congressional Appendices in our work.[33]

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.

F.6 *Congressional Record* Sentiment Classification Procedure

We classified legislators' sentiment toward NHI by analyzing individual quotes from the *Congressional Record* with health insurance mentions using GPT-4o. GPT-4o is a frontier large language model developed by OpenAI that has been shown in prior studies to achieve high reliability and consistency in qualitative classification tasks (Lagakos, Michalopoulos and Voth 2025). Each quote was entered into GPT-4o with a standardized prompt that instructed it to assign legislators' sentiment as Support, Oppose, or Neutral, and to identify five representative descriptive terms or phrases used by the legislator. The prompts are shown below:

GPT-4 Instructions
Analyze the following quote and determine the legislator's sentiment toward Truman's national health insurance plan.
Respond strictly using the format below without numbering, extra text, or explanations:
Sentiment: <Support/Oppose/Neutral>
Words: word1, word2, word3, word4, word5

[33]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).

Instructions:

- If Sentiment is Oppose, list the top 5 words or phrases opponents use to describe Truman's national health insurance.
- If Sentiment is Support, list the top 5 words or phrases supporters use to describe Truman's national health insurance.
- If Sentiment is Neutral, list the top 5 words or phrases the legislator uses to describe Truman's national health insurance.
- Please note that sometimes people cite the American Medical Association (AMA). When they are talking about the American Medical Association (AMA), they might be quoting them in a disparaging way.

Now analyze the following quote: {*quote*}

G Model Appendix

G.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:

$$U_i(P, d_i) = -(P - d_i)^2 \tag{6}$$

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 $(-\delta)$:

$$I(s) = \begin{cases} -\delta, & \text{if } s = s_0. \\ \delta, & \text{if } s = s_1. \end{cases} \tag{7}$$

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

G.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.[34] A private sector advocate and a public sector advocate each send signals regarding the state with the former sending $s = s_0$ and the latter sending $s = s_1$.[35] 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

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

[35]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).

benefit of the public option *i.e.*, $\frac{\partial x_i}{\partial m_0} < 0$. The payoff is therefore:

$$U_i(x_i, m|P, s) = \mathbb{E}[\pi|m] \times \left(-[P - (x_i - \delta)]^2\right) + (1 - \mathbb{E}[\pi|m]) \times \left(-[P - (x_i + \delta)]^2\right) \tag{8}$$

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

G.3 Proposition

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

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 $s = s_0$.

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

$$\begin{aligned} U_i(x_i, m) = &\left(\frac{1 + m_0}{2 + m_0 + m_1}\right)[-(P - (x_i - \delta))^2] \\ &+ \left(\frac{1 + m_1}{2 + m_0 + m_1}\right)[-(P - (x_i + \delta))^2] \end{aligned} \tag{9}$$

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:

$$D_i = 2x_i + 2\delta\left(1 - 2\mathbb{E}[\pi|m]\right) - 1 \tag{10}$$

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

$$\textbf{FOC: } x_i + \delta\left(1 - 2\mathbb{E}[\pi|m]\right) > \frac{1}{2} \iff D_i > 0 \tag{11}$$

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.

G.4 Proofs

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

$$\begin{aligned} \frac{\partial}{\partial m_0}\mathbb{E}[\pi|m] &= \frac{\partial}{\partial m_0}\left(\frac{1 + m_0}{2 + m_0 + m_1}\right) = \frac{1 + m_1}{(2 + m_0 + m_1)^2} > 0 \\ \frac{\partial}{\partial m_1}\mathbb{E}[\pi|m] &= \frac{\partial}{\partial m_1}\left(\frac{1 + m_0}{2 + m_0 + m_1}\right) = \frac{-(1 + m_0)}{(2 + m_0 + m_1)^2} < 0 \end{aligned} \tag{12}$$

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

$$\begin{aligned} \frac{\partial D_v}{\partial m_0} &= 2\frac{\partial x_v}{\partial m_0} - 4\delta\frac{\partial}{\partial m_0}\mathbb{E}[\pi|m] < 0 \\ \frac{\partial D_v}{\partial m_1} &= -4\delta\frac{\partial}{\partial m_1}\mathbb{E}[\pi|m] > 0 \end{aligned} \tag{13}$$

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