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ABSTRACT

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

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

- Institute of Medicine (1993, p.57)

> *"The immediate objective is the defeat of the Compulsory Health Insurance program in Congress – and there is great urgency in that phase of the problem...The long-term objective is to put a permanent stop to the agitation for Compulsory Health Insurance – and the most vital step in achieving that objective will be an all-out campaign to enroll the American people in Voluntary Health Insurance systems...We want everybody in the health insurance field selling insurance during the next two years as he has never sold it before – knowing that he has the prestige of the American Medical Association, and all its power and facilities, squarely behind him. And we 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."*

- AMA's Plan of Battle, Whitaker and Baxter (1949, pp.3-4)

I Introduction

America is exceptional on several margins, and one of the most prominent is in its financing and provision of health care.[1] 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.[2] Yet health outcomes are often worse on average with substantial variability (Bilinski, Thompson and Emanuel 2023; Chetty et al. 2016; OECD 2023; Papanicolas, Woskie and Jha 2018). Americans also experience higher rates of uninsurance and higher medical debt than citizens of peer nations (Kluender et al. 2021; Osborn et al. 2016; Schneider et al. 2021). This lackluster performance coupled with rising deficits has heightened scrutiny of the current healthcare system, including by leading health economists (*e.g.*, Baicker, Chandra and Shepard 2023; Case and Deaton 2020; Einav and Finkelstein 2023; Ericson and Sydnor 2017).[3] This project steps back from current debates and attempts to shed light on how the U.S. arrived at its present system. We examine a critical period in the development of health insurance in the post-World War II era.

The origins of private insurance for health care in the U.S. trace back to the Great Depression when reduced philanthropic flows to hospitals paved the way for experimentation with pre-payment service plans that would later become Blue Cross.[4] The subsequent take-off in enrollment for medical insurance has typically been attributed to monetary and fiscal policy and the efforts of organized labor. The Stabilization

[1] Brown and Glied (2020, p.495) write: "Most nations ponder what particularistic accent marks to paint on their broad universalist canvas. The United States wonders how its particular parts can be made to sum to something closer to a universalist whole. The United States is then, as everyone knows, an international outlier, an exceptional case in its reliance on weakly regulated private health insurance as its basic source of basic coverage."

[2] The expenditure gap is driven mostly by prices, not quantities (Anderson et al. 2003; Cooper et al. 2019; Reinhardt, Krugman and Frist 2019).

[3] Writing before the COVID-19 pandemic, Case and Deaton (2020, p.186) asked: "How is it then possible that life expectancy at birth has fallen for three years in a row—something that has not happened in other countries and that has not happened in America since the Great Influenza Pandemic of a century ago? The truth is that these horrors are happening not *in spite* of the American healthcare system but *because* of it." The U.S. recorded the largest drop in life expectancy of any OECD country during the pandemic (OECD 2021).

[4] This project focuses not on the early distress-related beginnings of hospital-based plans, which were also seen in Canada and other countries, but rather the increase in enrollment for medical insurance. The relationships between different forms of insurance are discussed in Section II.1 and Appendix Sections F.4 and F.5.

Act of 1942 regulated the wages and salaries of workers but allowed employers to offer fringe benefits. In 1949, the Supreme Court declined to review the *Inland Steel Co. v. National Labor Relations Board* decision, which stated that such benefits could be part of collective bargaining. Most consequentially, a change to the tax code in 1954 affirmed that employers could make tax-exempt payments to private health insurers (PHI) on behalf of their employees (Blumenthal 2006; Brown and Glied 2020; Cushing 2017; Eilers 1963; Helms 2008; Thomasson 2002, 2003). Causal evidence on the importance of these events is limited, with Thomasson (2003) – who studies the immediate effects of the 1954 tax policy change – the notable exception.[5] An important but under-appreciated factor in the proliferation of private health insurance in the U.S. may have been the professionalization of American medicine and how it organized resources to oppose National Health Insurance (NHI), the focus of this paper.

The medical profession consolidated in the decades around the 1910 Flexner report when half of U.S. medical schools closed and state medical boards tightened licensing requirements (Clay et al. 2023). These local and state medical societies were vertically integrated at the national level into the American Medical Association (AMA). Adding to the profession's authority was improved technology that could save lives but also required specific skills. Physician incomes doubled over a five-year period (1940-1945) with growth driven by specialists who came to dominate AMA leadership. As its membership and the power of its members grew, the AMA embraced the view that government sponsorship of insurance was a threat to the profession's medical and financial sovereignty thus vehemently opposed it.

Coinciding with this trend was the emerging industry of political public relations. The husband-wife team of Clem Whitaker and Leone Baxter started the first political lobbying firm in the U.S.: *Campaigns, Inc.* (Cutlip 1994; Johnson 2016; Lepore 2012). The firm was initially based out of California, the breeding ground for progressive ideas due to the state's referendum system, and according to Whitaker, also the "burial ground" due to their efforts (Whitaker and Baxter 1945, p.9). Whitaker & Baxter (WB) mastered *indirect* lobbying – the persuasion of ordinary citizens through mass media with gimmicks and simple messages. Following the Truman administration's embrace of legislation to establish a national health system, the AMA hired Whitaker & Baxter to direct a Campaign: The objectives were to defeat congressional efforts in the short-term and to quash demand for NHI in the long-term. Towards that end, the Campaign sought to enroll citizens in private (*i.e.*, voluntary) health insurance, including medical plans run by physicians via local or state medical societies (*i.e.*, Blue Shield).

The AMA-WB Campaign was comprised of two main components: physician outreach and mass communications via advertising. First, tens of thousands of physicians were tasked with distributing pamphlets and endorsing private health insurance to their patients, as well as serving as liaisons to civic organizations. Second, a massive newspaper ad buy was conducted and focused on themes of freedom, individualism, and the American way – echoing themes in the pamphlets. Policy options were framed in terms of *voluntarism* vs. *compulsion*, not private vs. public.[6] While the public sector was muzzled due to regulatory and budgetary

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

[6]As noted by Paul Starr (1982, p.286) in *The Social Transformation of American Medicine*, "America is frequently described as a less ideological society than Europe, more given to interest-group than ideological politics. The AMA's battle against health insurance is often cited as a premier case of interest-group political influence. But throughout the debate over health insurance in the United States, the conflict was intensely ideological, much more so than in Europe. The interest groups opposed to health insurance repeatedly found it useful to cast the issue in ideological terms as freedom vs. fairness." Starr further notes that both sides have legitimate claims on some "deeply rooted aspect of American belief."

constraints, the AMA spent the equivalent $18 million augmented by another $240 million (both figures in current terms) of tie-in advertising from industry supporters (Begeman 1950; Means 1950).

This project investigates whether and to what extent the AMA-WB Campaign affected enrollment in private health insurance and views on legislative efforts. We also examine the Campaign's effects on direct lobbying during the 1952 presidential election and the narrative surrounding health insurance more broadly. Our study takes place over the critical period 1946-1954 with 1948 to 1950 being the "failed moment" for NHI, according to political scientists Doherty and Jenkins (2009). We compile data we believe are new to the literature, including internal documents on Campaign strategy and operations recovered from the Whitaker & Baxter archives. 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 enrollment information 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 leverage new tools developed to unlock text at scale and use a combination of automated and manual techniques to analyze advertisements from historical newspapers (Shen et al. 2021). Lastly, we use standard sources such as Gallup polls and speeches from the Congressional Record to assess whether pollsters and policymakers adopted the language of the Campaign (Berinsky and Schickler 2020; Caughey et al. 2020; U.S. Congress 1947, 1948, 1949, 1950).

Our primary estimation strategy compares enrollment in PHI and individual citizens' views on NHI before and after the Campaign, across places that differed in its intensity. The Campaign occurred in a brief window relative to the frequency of most outcomes and pursued a common objective. Thus, to construct Campaign exposure, we combine mass advertising (per capita Campaign-related ads scaled by local readership) with physician outreach (per capita Campaign-related pamphlets scaled by local AMA members).[7] Archival documents suggest the Campaign relied on networks of advertising and physicians established in years prior, and more recent scholarship has highlighted rising incomes, unionization, and hospitals as key factors that affected demand for private health insurance (Starr 1982; Thomasson 2002, 2003). Therefore, we include these factors as "design controls" and show that exposure is conditionally as-good-as-randomly assigned. We leverage spatial and temporal variation, allowing us to flexibly control for location and time fixed effects: The former accounts for static features such as frontier experience and the ethos of rugged individualism, while the latter captures secular trends such as advances in medical technology and knowledge (Bazzi, Fiszbein and Gebresilasse 2020; Gross and Sampat 2022, 2023).

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.[8] Empirically, we show that Campaign exposure is not correlated with observable features at the individual or state level in the pre-Campaign period, nor do the dynamics of income or unionization change sharply with the Campaign onset, unlike enrollment in PHI. We conduct various tests for pre-trends (*e.g.*, Roth 2022) and adopt recent suggestions regarding continuous treatments (Callaway, Goodman-Bacon and Sant'Anna 2024).

We find that a one standard deviation increase in Campaign exposure explains about 20% of the increase in private health insurance enrollment in the post-Campaign period on average. Although public support for NHI was strong in the pre-Campaign period, with approximately 70% of those polled by Gallup in favor,

[7] We also estimate a regression with each component separately and fail to reject the null hypothesis of equivalent effects, see Section VI.4.

[8] Targeting was made difficult by the unanticipated election of President Truman in 1948, which caught many, including the AMA, off guard. Further details are provided in Section II.5.

a one standard deviation increase in AMA-WB Campaign exposure led to a five percentage point decline in popular support per survey wave and explains roughly a quarter of the overall decline in support. We also document a positive relationship between Campaign intensity and civic groups passing resolutions favoring PHI. We view such resolutions as a proxy for group level sentiment on the issue. Our findings are robust to a battery of checks including controlling for additional covariates, using alternative samples and exposure variables, and employing different types of estimators. We do not find an association between Campaign intensity and anti-Russian sentiment before or after 1948.

We next estimate the effect of *indirect* lobbying on *direct* lobbying, *i.e.,* presidential campaign contributions. The Whitaker & Baxter archives contain microdata on donations to the 1952 Eisenhower and Nixon ticket. The Republican party adopted a firm anti-NHI, pro-PHI stance in their party platform at the nominating convention. We link the donation data by doctor name, place, and license to the 1950 *American Medical Directory* with 80% of the physicians in the list of donors uniquely matched to an entry in the directory. These data also include the physician's location (office or residence), allowing us to define Campaign exposure at the county level. Our estimates suggest that specialists experiencing a one standard deviation increase in Campaign exposure were twice as likely to donate to the Eisenhower-Nixon ticket than generalist physicians at the mean of exposure.

Finally, we provide suggestive evidence that the AMA-WB Campaign was associated with a shift in the narrative surrounding health insurance, as evidenced by changes in discourse on the congressional floor (U.S. Congress 1947, 1948, 1949, 1950). Specifically, usage of "national" "government" and "state" fell relative to the descriptor "compulsory" in debates on health insurance among the legislature following the Campaign. Polling questions on legislation under consideration mirrored this shift.

Our paper relates to several strands of literature. Most broadly, this study contributes to the burgeoning empirical evidence on the economics of culture. Rugged individualism from frontier exposure and pastoralism has been shown to influence a variety of behaviors today (Bazzi, Fiszbein and Gebresilasse 2020; Grosjean 2014). We build on this literature by examining how the individualistic American stereotype was promoted and exploited by public relations and advertising firms. Campaign messaging was largely uninformative about the product, leveraging anti-communist sentiment to tie together the ideas of *price* freedom (for doctors) and *individual political* freedom.[9] In this sense, the tactics used relate to behavioral models of advertising such as Mullainathan, Schwartzstein and Shleifer (2008) whereby advertisers use "objectively useless information" to invoke coarsened beliefs regarding the state.

We also relate to the literature on lobbying. Much of the empirical work seeks to measure and identify the effects of relationships between policymakers and lobbyists (Bertrand et al. 2020; Bombardini and Trebbi 2020; Snyder and Ting 2008).[10] Our project builds on this important scholarship by highlighting indirect lobbying as an additional tool used by advocates to achieve policy aims.

A large literature in health and labor economics studies physician behavior and occupational licensing. Typically, the former is investigated in the context of clinical decision-making (Chandra, Cutler and Song 2011; Ellis and McGuire 1986), while the latter focuses on the trade-off between higher quality service and lower supply. We examine how physicians behave as a group instead of at the individual level and assess how licensing can create monopolies that exert political pressure to shape the market in their favor (Becker 1983; Stigler 1971). In this regard, our findings contribute to a growing empirical literature on the political

[9] See Larreguy, Marshall and Snyder (2018) for an example of informative advertising and recent empirical examples of political propaganda in economic history (*e.g.*, Wang 2021).

[10] An important exception is Bertrand et al. (2021) who study the effect of corporate philanthropy on rule commentating.

theory of the firm (Cowgill, Prat and Valletti 2023) and a relaxation of the assumption that the rules of the game are "exogenously specified and enforced" (Zingales 2017, p.114).

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

II Historical Background on Private Health Insurance in the U.S.

This section describes the origins of private health care plans, the consolidation of medical power in the AMA, the operations of *Campaigns, Inc.*, and the AMA-WB Campaign against National Health Insurance.[11]

II.1 Origins of Private Health Insurance

In the early 20th century, the major health-related insurance product available to Americans was life insurance. Groups such as the American Association for Labor Legislation (AALL) alongside members of the AMA began to design state-sponsored health insurance plans, but efforts were derailed by life insurance companies due to the inclusion of burial costs and the advent of World War I (Anderson 1968; Rubinow 1934; Hammonds 2003). In the aftermath of the Great Depression, an opportunity to introduce NHI presented itself along with other forms of social insurance.[12] However, for reasons that may have ranged from the personal to the political, President Franklin Delano Roosevelt (FDR) declined to include health insurance in the Social Security Act of 1935, focusing instead on old age and disability insurance (Blumenthal and Morone 2010; Rovit and Couldwell 2001).

Nonprofit hospitals, also hit hard by the Great Depression, experimented with plans eventually known as Blue Cross. These plans allowed consumers to prepay for room and board at local hospitals, and required special enabling legislation to launch, making it difficult for plans to operate across state lines (Eilers 1963).[13] To counter potential government encroachment and hospital pressure, state medical societies began their own prepaid medical service plans (*i.e.*, Blue Shield). The first such plan, the California Physicians' Service, was created by the California Medical Association (CMA) in 1939 in response to an attempt to introduce tax-financed health coverage by Democratic Governor Culbert Olson. In the following decade, Republican Governor Earl Warren would attempt multiple times to introduce similar legislation, only to be rebuffed by Whitaker & Baxter (Johnson 2016).

Spurred on by the Beveridge Report in Great Britain and the high rate (more than one-third) of American registrants examined and deemed unfit to fight by the Selective Service, tax-financed health insurance legislation at the federal level gathered traction in the U.S. Congress (Bachman and Meriam 1948; U.S. Selective Service System 1947). The 1943 Wagner-Murray-Dingell (S.1161-HR.2861) bill broadened the Social Security Act to include tax-financed NHI and enjoyed support from organized labor but events in Europe

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

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

[13] See Appendix Section F.4. Appendix Figure D1 demonstrates the number of prepayment hospital plans at the state level in relation to the timing of the passage of enabling legislation. The data cover 1935 to 1946.

distracted FDR (Corning 1969). An attempt in 1945 to introduce the same bill led the AMA House of Delegates to shift its position from merely endorsing medical insurance to encouraging all state and local medical societies to develop their own plans "as promptly as possible" (Board of Trustees of Mississippi State Medical Association 1965, p.12). Appendix Figure A1 demonstrates that there was a sharp increase in the number of plans immediately following the 1945 directive.

During his January 1944 State of the Union address, FDR appeared ready to embrace NHI and included a right to adequate medical care in his Second Bill of Rights. His death following a successful bid for a fourth term stunned the nation, and after only a few months as vice president, Harry Truman assumed the presidency. Truman quickly revealed himself to be a staunch supporter of NHI, giving the first-ever presidential address on health care in November of 1945 (Corning 1969). In the subsequent midterms, Republicans gained control of the Congress, and Truman had little hope of getting legislation passed during his remaining term (Graf 1947). This changed with Truman's upset victory over Dewey in the 1948 presidential election.[14] As described by Doherty and Jenkins (2009, p.5), the election, "catapulted national health insurance from a longshot idea to a viable possibility almost overnight." Truman worked with members of Congress to craft a comprehensive national health plan, posing the most serious attempt the country had made to having a universal, tax-financed health insurance system.

II.2 Medical Authority, Specialization, and the AMA

The AMA famously opposed the passage of Medicare, but its role in the earlier "critical" period of NHI is less widely known nor, to our knowledge, has it been evaluated empirically. Truman, however, alluded to the subject in his memoir: "I have had some bitter disappointments as President but one that has troubled me most, in a personal way, has been the failure to defeat organized opposition to a national compulsory health insurance program" (Corning 1969, p.69).[15] The AMA was not always so firmly opposed to NHI. Indeed, as mentioned above, in 1916 the AMA established a Committee on Social Insurance to cooperate with the AALL regarding state-sponsored health insurance plans. Yet as the wealth and prestige of the profession grew, so too did its opposition to NHI (Institute of Medicine 1993; Markel 2015).[16]

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

Data we entered from the *American Medical Directories* (Appendix Figure A3) demonstrate that, over

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

[15] See also *Harry S. Truman versus the Medical Lobby* (Poen 1996).

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

the period 1920 to 1950, AMA membership grew by 10.8 percentage points (from 60.6 to 71.4 percent of all US physicians) while the share of physicians who were specialists grew by 21.8 percentage points (from 10.6 to 32.4 percent).[17] Physician incomes also increased from $7,500 to $12,000 in 1950 dollars with much of the growth occurring between 1940 and 1945 (Appendix Figure A6). Then, as now, specialists earned significantly more than generalists (about twice as much) and both earned much more than the average American household (Appendix Figure A7). The high status of specialists was reflected in the leadership of the AMA – presidents were increasingly drawn from a specialist pool of "grass root" practitioners as opposed to the more academically oriented individual or generalist (Anderson 1968, p.75; Appendix Figure A8). The vertical structure used to enforce professional norms and raise incomes was peaking at the time of Truman's election. These resources were deployed by the AMA in the Campaign to defeat NHI.

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

To summarize the above, America's modern private health insurance system was founded by nonprofit hospitals and state medical societies at different times and for different reasons. The former were financially strained and the latter were seeing their finances and power grow. Eventually, these two initiatives (Blue Cross and Blue Shield, respectively) would merge, but over much of the period of this analysis, their major connections were two-fold: First, Blue Cross had started slightly earlier and thus built up administrative expertise in billing that some state physician groups leveraged. Second, the earliest medical services covered included surgical, obstetric, and anesthetic services, and thus proximity to hospitals made insurance for medical services more relevant (though the plans quickly expanded to include outpatient services as well).

A separate question, and the subject of interest herein, is what led to enrollment growth after plans were established? Several supply- and demand-side factors have been hypothesized to have played a role (Thomasson 2002). First, there was a rise in incomes that increased demand for all normal goods, including medical care. On the supply-side, massive war-time public investment spurred technological advances in medicine that made doctors' services more valuable (Gross and Sampat 2023). The Stabilization Act of 1942 froze wages but did not prohibit offering benefits. In the late 1940s, it was clarified that unions could include benefits in collective bargaining agreements (Blue Cross Blue Shield Association 1997; Brown and Glied 2020; Thomasson 2002). Thomasson (2003, p.1373) notes "perhaps most importantly" was a 1954 change to the Internal Revenue Service code that made payments to private health insurance companies tax exempt.

For these and other reasons related to data quality (commercial insurers garner an increasing market share after the tax change and granular data from these entities do not, to our knowledge, exist), we end our analysis in 1954. Yet by that time, many non-elderly White Americans were already enrolled in some form of private health insurance.[18] We return to factors that shaped demand for insurance and Campaign intensity when discussing identification and our empirical approach (see Section V).

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

When faced with a credible legislative threat, the AMA turned to Clem Whitaker and Leone Baxter, the husband-wife founders of *Campaigns, Inc.* for assistance. The duo are credited with revolutionizing political

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

[18] According to survey data used in Thomasson (2003), by 1952, 63% of the households surveyed had some form of insurance for medical expenses.

campaigns through their "rules" (Cutlip 1994; Johnson 2016). First and foremost: Simplify. Whitaker & Baxter remarked, "a wall goes up when you try to make Mr. and Mrs. Average American Citizen *work or think*...The average American doesn't want to be educated; he doesn't want to improve his mind; he doesn't even want to work, consciously, at being a good citizen. But there are two ways you can interest him in a campaign that we have ever found successful. You can put on a fight...or you can put on a show" (Johnson 2016, p.26).

The firm, founded in 1933, was initially based in California, a state that allows citizens to affect policy outcomes through direct democracy (*e.g.,* initiatives, referendums) (Johnson 2016). In such a circumstance, indirect lobbying, or persuading the American citizen via campaigns, was particularly valuable. As Whitaker stated: "California has been the testing ground for a great many visionary schemes and phony movements – but it has also become the burial ground for most of them," taking credit for their demise (Whitaker and Baxter 1945, p.9).

In 1945, California Governor Warren endorsed AB 800, a health insurance bill designed to provide for California's working people, after Warren suffered a kidney infection and became concerned about the high cost of medical care (Johnson 2016; Mitchell 2002).[19] The bill mandated a payroll tax to fund a health plan that would extend to wage earners and cover a variety of medical and hospital services (Dimmitt 2007). In response, *Campaigns, Inc.* was hired by the CMA and launched the California Campaign. Key strategies that would be replicated later on a national scale included labeling the effort an "educational" initiative and focusing on *voluntarism*.[20] The goal was to "secure public action informally through mass persuasion rather than through force of law" (Whitaker & Baxter *Campaigns, Inc.* 1945-1949).

In an April 1947 letter to the president of the CMA, Whitaker & Baxter reported on their progress to date: Governor Warren's 1947 proposal garnered much less support than the 1945 proposal, and supporters of state health insurance went on the defensive (Whitaker & Baxter *Campaigns, Inc.* 1945-1949). The duo went on to found a magazine entitled *CMA Public Relations News* which publicized defeating Warren. The magazine was sent to the offices of state medical societies and to the headquarters of the AMA (Appendix Figure B1). Whitaker & Baxter's partnership became synonymous with success: They won 58 of 63 legislative battles in California by the time they were hired by the AMA (Evans 1949).[21]

II.5 The National Campaign

The AMA had tried to influence public perception in the past: Its in-house lobbying arm – the National Physicians' Committee for the Extension of Medical Service (NPC) – launched a newspaper cartoon contest attacking state-sponsored insurance as early as 1946 (Burrow 1963; Knoblauch 2014; National Physicians' Committee for the Extension of Medical Service 1947-1949; Wehrle 1993). While campaigning for the presidency in 1948, Truman embraced a national health plan crafted by his Federal Security Agency (FSA)

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

[20] For further details on the California Campaign see Appendix Section F.3.

[21] The AMA paid Whitaker & Baxter 1.2 million dollars per year in current terms (Whitaker & Baxter *Campaigns, Inc.* 1946-1973). Regarding their process, an article profiling the duo wrote: "Clem Whitaker and Leone Baxter eat, sleep and breathe public relations. At breakfast, they check over the morning papers to decide how best to align their current publicity programs with the latest news developments. On their way to work, they map out the day's schedule. Stopping to chat with elevator operators, shoe-shine boys and a variety of other people is an important part of their routine. Many of their best ideas stem from these daily samplings of popular opinion" (Evans 1949, p.3). In terms of who is to be credited for the ideas behind defeating state-sponsored health insurance, Clem Whitaker Jr. in an oral history interview for the State of California 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).

Administrator, Oscar Ewing. Truman's surprise victory in November sparked an "Armageddon" mentality at the AMA and a desire to amplify its anti-NHI efforts – launching two special assessments and hiring Whitaker & Baxter.[22] The firm's mandate was to once and for all end "agitation" for NHI by rebranding and expanding the AMA's efforts as the National Education Campaign (NEC). The Campaign consisted of two main components: Physician outreach and mass communications via newspaper advertising.[23]

Building off the earlier activities of the NPC, 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. In addition, physicians served as liaisons to local civic organizations, pushing them to pass resolutions against NHI and then send copies of these resolutions to local officials. The support of such organizations would be "a vital step in broadening the campaign into a public crusade."[24] Figure 1 shows examples of pamphlets designed by the Campaign for distribution to patients by their physician, with the most popular pamphlet entitled *The Voluntary Way is the American Way*. Note that most of these brochures and ads provide little if any information on insurance – who can be covered, what is covered, its cost, and so on.[25] As can be seen from the word cloud in Figure 2 Panel A, the messaging tied together health and medical care with America, freedom, and individual choice (*i.e.*, the voluntary way).

Lockwood-Shackleford, an ad agency based out of California, executed the newspaper advertising component. Specifically, Lockwood-Shackelford decided which newspapers to advertise in, aiming to reach every "bona fide daily and weekly" (Begeman 1950). Based on our analysis of their invoices, the agency in fact advertised in about half of all potential outlets (about 9,000 compared to 20,000 unique newspapers in the *Newspaper Directory*; Ayer 1949). As shown in Appendix Tables G2 and G3, we find few systematic differences in newspapers with and without Campaign ads. Figure 1 Panel C displays an excerpt of the ad they ran.[26] It was large – taking up 980 lines (roughly an entire page) – depicting a bald eagle with large print asking "Who Runs America? the Congress? the President? OR YOU AND THE MAN NEXT DOOR?" The accompanying text emphasized that "in much of the world today, people have resigned from running their own countries, following the false promise of 'security.' " The tagline in the doctors' pamphlets is repeated: "THE VOLUNTARY WAY IS THE AMERICAN WAY!" The citizen-consumer of these materials was instructed to "Ask your doctor" for more information on signing up for private health insurance.

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

[23]At first, Whitaker & Baxter did not plan to take out paid newspaper advertisements citing cost concerns. However, they later directed a large newspaper ad buy using Lockwood-Shackelford while the AMA President coordinated with other businesses on tie-in ads. We could not find consistent documentation of radio or TV programming: In robustness checks we control for trends in both (see Section VI.4).

[24]Medical societies mailed template resolutions and encouraged local civic organizations to pass and then send signed resolutions to their elected representatives. "Letters, memorials, memos, and petitions expressing outrage flowed into Washington" (Blumenthal and Morone 2010, p.91). Appendix Figure B2 shows an example of one such resolution signed by the *Federation of Women's Clubs*. The Campaign also explicitly called upon doctors' wives to be involved and noted they have important roles to play via auxiliary clubs. "Women are reluctant to take direction from other women, but they love to do things for their menfolk...Women have ingenuity and can help you, if they are guided" (Craig 1950, p.13).

[25]Some materials may have been inaccurate. For instance, the pamphlet entitled *The Voluntary Way is the American Way* attributed a quote to Lenin, claiming he said, "Socialized medicine is the keystone to the arch of the Socialist State" (Whitaker & Baxter *Campaigns, Inc.* 1949-1952). According to Blumenthal and Morone (2010, p.93), "Senator Murray asked the Library of Congress to track down the quote, and, as expected, they found nothing like it."

[26]For the full advertisement piece see Appendix Figure B3.

The AMA also tapped allies in industry for tie-in advertising to be scheduled simultaneously with the main ad (Begeman 1950). The AMA directly reached out to approximately 23,000 corporations and 7,000 members of the National Retail Dry Goods Association to elicit support. These firms, trade, and interest groups spent another $19 million in 1950 dollars, or approximately $240 million in current dollars (Begeman 1950).[27] 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 use of such ads has implications for our conceptual framework: Consumers may have been unaware of the coordination among the AMA and other trade groups (see Section III).

To be sure, the Truman administration sought their own campaign for NHI. Zilpha Franklin, the FSA Director of Information, outlined an unprecedented, ambitious program, advising a "state of emergency" for the FSA, and estimated that the plan would need a relatively large team of eight or ten top FSA workers and interagency cooperation (Poen 1996, p.81). However, in part due to concerns about executive lobbying and interagency politics with the Surgeon General, her plan was never realized (Poen 1996).

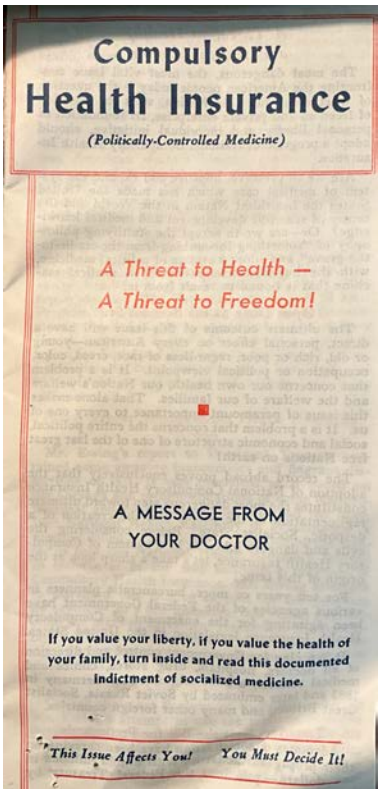
The Committee for the Nation's Health (CNH) also attempted to sway voters in favor of NHI and was less restricted as a non-governmental body. However, they were vastly out-resourced. According to Poen (1996, p.152), CNH took in $104,000 in 1949 with nearly $100,000 spent on its working budget: "like the AMA, the CNH...published and distributed pamphlets, but not in nearly so large a number." Furthermore, the content was quite dry: According to Poen (1996, p.152), "the CNH's pamphlets included *Are Blue Shield Plans Satisfactory?* In which it was argued that they were not; *Restrictions on Free Enterprise in Medicine,* in which the AMA stood accused of monopolizing health services through its control over insurance plans; and *Record of the American Medical Association*, which chronicled the AMA's shifting attitude on the legitimacy of government and private health insurance since the early part of the century." Unions too were limited in their financing of political campaigns following the passage of the Taft-Harley Act of 1947 (Kallenbach 1948) (see also Appendix Section F.7).

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

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

(a) Pamphlet Example 1

(b) Pamphlet Example 2



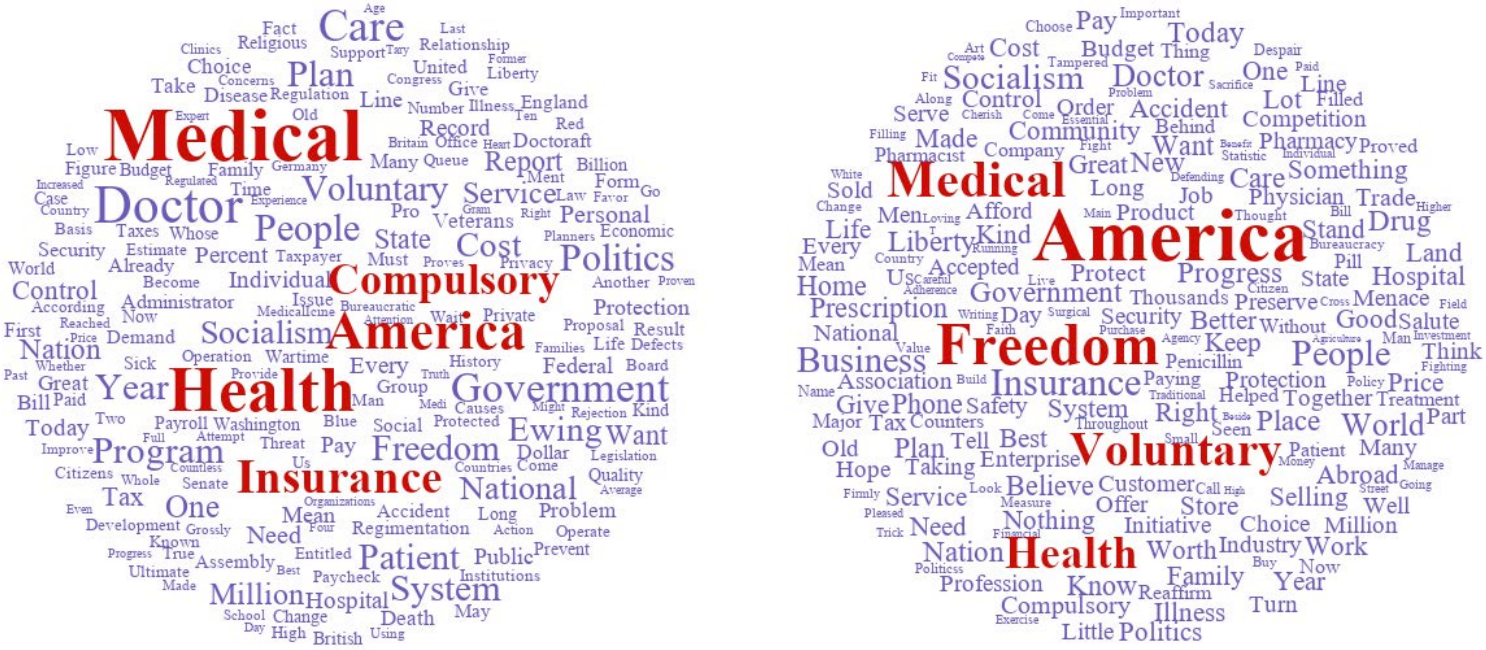
(c) Excerpt of Main Ad

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

Figure 2: 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 *Newspaper Archives*. The top five most frequent words are shown in red bold font.

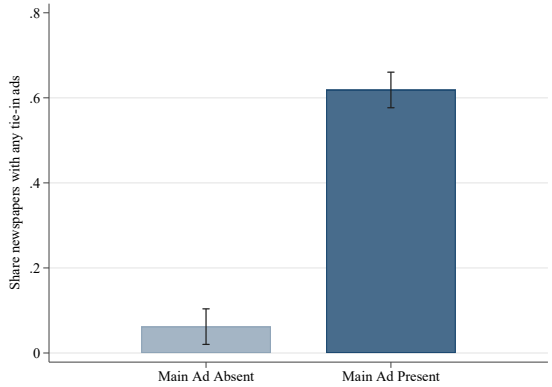
Figure 3: Campaign Tie-in Ads

(a) Walgreens

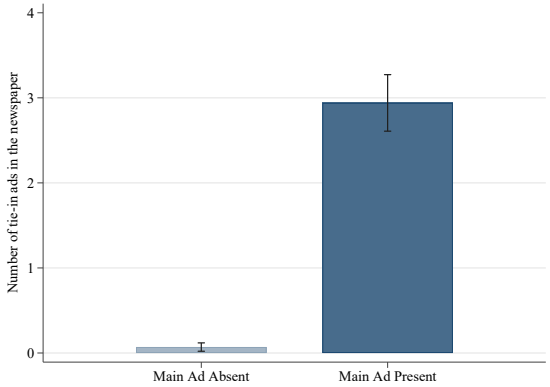
(b) Dillon Implement Co.

(c) Oklahoma State Bank

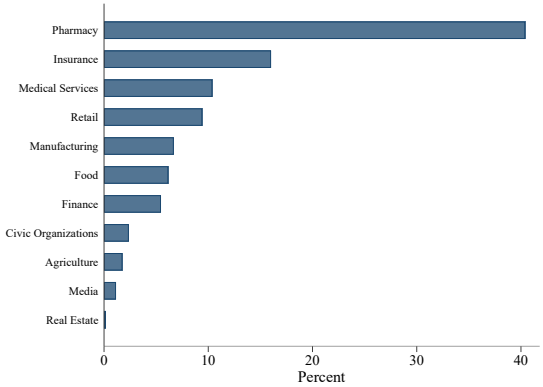
(d) Any Tie-in Ad



(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 (Newspaper Archive 2023). See Appendix Section G.2 for details.

II.6 National Professional Committee for Eisenhower

During the presidential election year of 1952, the AMA focused attention on direct lobbying. To do so, the AMA created a separate lobbying arm called the National Professional Committee for Eisenhower for President (NPCE) because, as noted by Clem Whitaker, "the American Medical Association cannot either legally or ethically, support or oppose candidates for public office" (Whitaker 1950, p.21). However, the NPCE could directly steer campaign contributions. Whitaker became the NPCE's Director, Baxter the General Manager, and former AMA President, Dr. Elmer Henderson, was named Chairman. The NPCE raised approximately $1.5 million in current terms for the Eisenhower campaign (Whitaker & Baxter *Campaigns, Inc.* 1946-1973). The Republican plank adopted at that time 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).

III Conceptual Framework

As discussed above, Whitaker & Baxter are credited with creating the field of political public relations and developing campaigns intended to sway the electorate. In this section, we formalize the notion of indirect lobbying, adapting the insights of Sobbrio (2011) and generate predictions that are then investigated using the strategy presented in Section V.

III.1 Setup

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

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

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

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

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

III.2 Updating

Let π be the voter's prior probability on s_0. We assume the voter is uninformed about the policy and thus model priors as uniform over the unit interval.[28] A private sector advocate and a public sector advocate each

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

send signals regarding the state of the world with the former sending $s = s_0$ and the latter sending $s = s_1$.[29] We posit a straightforward influence function whereby the level of resources (r) determines the number of messages (m) sent by an advocate: $m_j = r_j$ for $j \in \{0, 1\}$ (Becker 1985). After message receipt, the voter updates his belief on s_0 using Bayes' rule: $\pi|(M = m) \sim \text{Beta}(\alpha + m_0, \beta + m_1)$. Messaging by the private advocate also encourages enrollment in PHI, which we assume indirectly decreases the private benefit of the public service *i.e.*, $\frac{\partial x_i}{\partial m_0} < 0$ (Kremer and Willis 2016). The updated payoff structure is therefore:

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

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

III.3 Proposition

Substituting individual preferences with the preferences of the median voter and differentiating D_i yields the following predictions:[30]

a. $\frac{\partial D_v}{\partial m_0} < 0$ messages by the private sector advocate reduce median voter support for NHI due to:
   i. a higher posterior probability $s = s_0$,
   ii. a lower private valuation of the policy, x_i.

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

We can empirically verify or historically motivate many of the assumptions in the model. Given the tight legislative window of opportunity, there was very little scope for strategic responses by advocates. Turning to the assumption of flat priors, health insurance was relatively new and just being introduced and expanded throughout the world, so this seems natural in our setting (Corning 1969). Regarding naivete of the voter, it would have been difficult for the average citizen to be aware of the coordination across industries or the motivation behind the messaging. Lastly, doctors were likely assumed to be a credible source of health-related information. Given the far greater resources the private advocate commanded in our historical context, we focus attention on the first part of the proposition in our empirical analysis.

IV Data

This section summarizes the archival sources, directories, and administrative data we used in this project. Campaign exposure construction and our empirical strategy are delineated in Section V.

[29] 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). With few notable exceptions (*e.g.*, Mullainathan, Schwartzstein and Shleifer 2008; Bertrand et al. 2010; Schwartzstein and Sunderam 2021), we follow most of the theoretical literature by side-stepping what makes a signal persuasive.

[30] Proofs can be found in Appendix Section H.

IV.1 Campaign Components

We first describe the data used to construct the two major components of the Campaign: Physician outreach and mass communications.

IV.1.1 Component 1: Physician Outreach

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

AMA Medical Directories. AMA directories were and still are the most comprehensive database of physicians in the United States.[31] During our period of interest, the directories were published in large multi-volume books in 1940, 1942, 1950, and 1956. We digitize and OCR the 1950 directory and extract several pieces of biographical information on each physician (American Medical Association 1950*a*). Appendix Figure B4 displays a typical entry – small symbols in the book indicate memberships and other important career milestones. We use this information to construct a dataset including physician name, year of birth, specialty, office and home address, and the status of AMA membership for the universe of physicians in the U.S. circa 1950. The final dataset contains about 160,000 observations from 48 states (see Appendix Figure A9). The number of physicians by state from the digitized microdata is close to published aggregates (see Appendix Figure A10). To construct exposure to pamphlets distributed by physicians, we use the 1950 share of doctors that belong to the AMA at the relevant geographic level (see Section V.1 below for further details).[32]

IV.1.2 Component 2: Mass Communications

Campaigns, Inc. Archives. The firm's archives also contain invoices from the Lockwood-Shackelford Advertising Company (see Appendix Figure B5) which provide several pieces of information. First, they are invoiced to the AMA. Second, they confirm the same ad was used in every outlet. Third, they provide details on where and when the ad would appear – including the precise daily or weekly newspaper name, town, circulation and line rate.

Newspaper Directory. We hand-entered the Ayer (1949) *Directory* in order to obtain important characteristics on the newspapers Lockwood-Shackelford advertised in, as well as those it did not.[33] These data include, for each weekly and daily newspaper, its total circulation, political leaning, frequency, subscription price, year of establishment, and formatting information (number of columns, widths, and depth).[34]

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

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

[33] OCR tools did not work well for this exercise given the irregular spacing and text.

[34] We exclude publications entitled with "magazine" or "group" as well as those with a circulation number greater than 500,000 and based in New York City, which we identify as national publications. 94.2% of newspapers in the *Directory* were founded at least five years prior to the Campaign.

Newspaper Archive. There are several potential newspaper archives in the U.S. (see Beach and Hanlon 2023 for a summary). We use *Newspaper Archive*, which is available from the Harvard Library. From the archive, we found over 900 newspapers with at least one issue in 1950, and 751 with at least one issue in October of that year, when the Lockwood-Shackelford ad buy took place. After merging with the Ayer & Son's newspaper directory data, we are left with 628 newspapers of which 540 have the ad shown in Appendix Figure B3.[35] Political leaning and circulation are not different on average across newspapers with and without Campaign ads (see Appendix Tables G2 and G3). Urbanization is different in one of the two table comparisons. One concern might be that we are mis-specifying our exposure variable if tie-in ads were taken out in newspapers other than those with Campaign ads. We show in Figure 3 Panel D that the vast majority of tie-in ads were placed in newspapers that also had the main Campaign ad. Panel E shows there were on average three tie-in ads per paper, thereby magnifying the effect of the Campaign substantially.

IV.2 Outcomes

The AMA-WB Campaign sought to suppress demand for NHI by increasing enrollment in a private alternative. This is our main outcome of interest. We also are interested in assessing whether the Campaign influenced voters or altered the national discourse among pollsters and policymakers. Lastly, we explore the relationship between indirect and direct lobbying.

IV.2.1 Private Health Insurance Enrollment

CMS Annual Reports. We compile data on PHI enrollment from annual reports entitled, *Voluntary Prepayment Medical Care Plans*, published by the AMA's Council on Medical Service (CMS) (Council on Medical Service 1946-1954). The first edition was published in 1946 and thus is the first year of this analysis. We hand enter the number of enrollees from plans covering 48 states between 1946 and 1954.[36] We aggregate enrollment to the state level and divide by state population to construct shares (Haines 2010).

The largest provider of prepaid hospital services was Blue Cross, as discussed in Section II.1. The Blue Cross Commission enrollment numbers by state from 1936 to 1947 were collated and published by the Federal Security Agency (FSA) (Reed 1947). The Health Insurance Council (HIC), comprised of representatives from the commercial life and accident insurance companies, published state level enrollment figures starting in 1952 (The Survey Committee of the Health Insurance Council 1949-1965). Yet industry estimates of state level figures were believed to be inflated, and the FSA took pains to deflate them and adjust for double counting (Reed 1947). Because industry data do not cover the main Campaign period and because the AMA was keen on enrolling patients in medical service plans mostly owned by local and state medical societies, we use the CMS data. However, Appendix Figure A12 shows the HIC enrollment numbers reported in 1952 are highly correlated with CMS hospital and CMS medical service enrollment numbers (Correlation of 0.902, and 0.924, respectively).

Infants, older people, the indigent, women who were unmarried and pregnant, or women who were married but became pregnant within 10 months were not eligible for coverage. Most plans charged higher rates for women than men. Regarding catchment area, most plans operated statewide. One exception was

[35] Details on detecting Campaign main and tie-in ads are in Appendix Section G.3.

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

New Hampshire and Vermont, which combined areas to provide a single plan. Over time, plans were extended to dependents of the policyholder and expanded the services covered.

IV.2.2 Public Perceptions of National Health Insurance: Individual and Aggregate Views

Gallup Polls. To determine whether the Campaign was successful in changing the views of individual citizens we use Gallup poll data. These surveys include questions on policies related to NHI in various waves (Gallup Organization 1945, 1946, 1949, 1950). The questions varied over time (see Appendix Table A1 for precise wording).[37] After 1948, Gallup began using the term "compulsory" almost exclusively to describe the policy (see Appendix Figure A13). Notably, Gallup surveys were sponsored by local newspapers (see Appendix Figure B6). Advertisers might have influenced *how* questions were asked, as found in work by Reuter and Zitzewitz (2006). This should be kept in mind when interpreting coefficients on wave fixed effects or the post indicator. Gallup data include information on sex, race, age, state of residence, phone ownership, political leaning, employment, and (for most waves) union status, which we include in our preferred specification.[38]

Campaigns, Inc. Archives. Public opinion at the group level is sourced from the firm's archives. *Campaigns, Inc.* recorded the name and location of all civic organizations "on record against compulsory health insurance" implying they had passed resolutions in favor of PHI (see example in Appendix Figure B2).

IV.2.3 Direct Lobbying and the Political Narrative

Campaigns, Inc. Archives and AMA Medical Directory. We digitize the list of individuals who contributed to the National Professional Committee for Eisenhower in 1952 (Whitaker & Baxter *Campaigns, Inc.* 1946-1973). These records include the donor's name, address, medical degree (*e.g.*, M.D. and D.D.S.), and amount contributed (see Appendix Figure B7 for example). We exclude entries without an M.D. degree (representing about one-third of the overall sample, the majority of whom were dentists) before linking to the *American Medical Directory*.[39] Given the richness of these data, we are able to link approximately 80% of all physician donors. We create an indicator for whether a doctor donated as well as the amount he contributed.

Congressional Record For a more nuanced measure of policymaker preferences, we explore the Congressional Record, which is "the official record of the proceedings and debates of the United States Congress." We use the Congressional Record to compare how legislators described national health insurance legislation before and after the Campaign (U.S. Congress 1947, 1948, 1949, 1950).[40]

IV.3 Additional Data

We bring in additional variables to serve as important, historically-motivated design controls including union data from Farber et al. (2021), income per capita from the Bureau of Economic Analysis (2023), war bonds purchases from the U.S. Census Bureau (2012), and television, radio and demographic information

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

[38] We use phone ownership as a proxy for income and confirm that phone ownership is a strong predictor of income using the 1960 census 5% sample (the oldest sample we could locate with both variables) – having a phone is associated with $3,539 greater total family income (Ruggles et al. 2023). In April 1946, union status was not asked, so we include a missing indicator for those who were employed in that wave.

[39] Further details on the linkage are provided in Appendix Section G.4.

[40] In Appendix Section E, we explore voting in House of Representative elections.

from the 1950 Census (U.S. Census Bureau 1953; Haines 2010). We also digitize hospital locations and attributes, including Blue Cross status, from the *American Hospital Directory* (American Hospital Association 1948, 1950, 1952).

V Empirical Approach

In this section, we define Campaign exposure and describe the specifications used in the analysis.

V.1 Campaign exposure

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

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

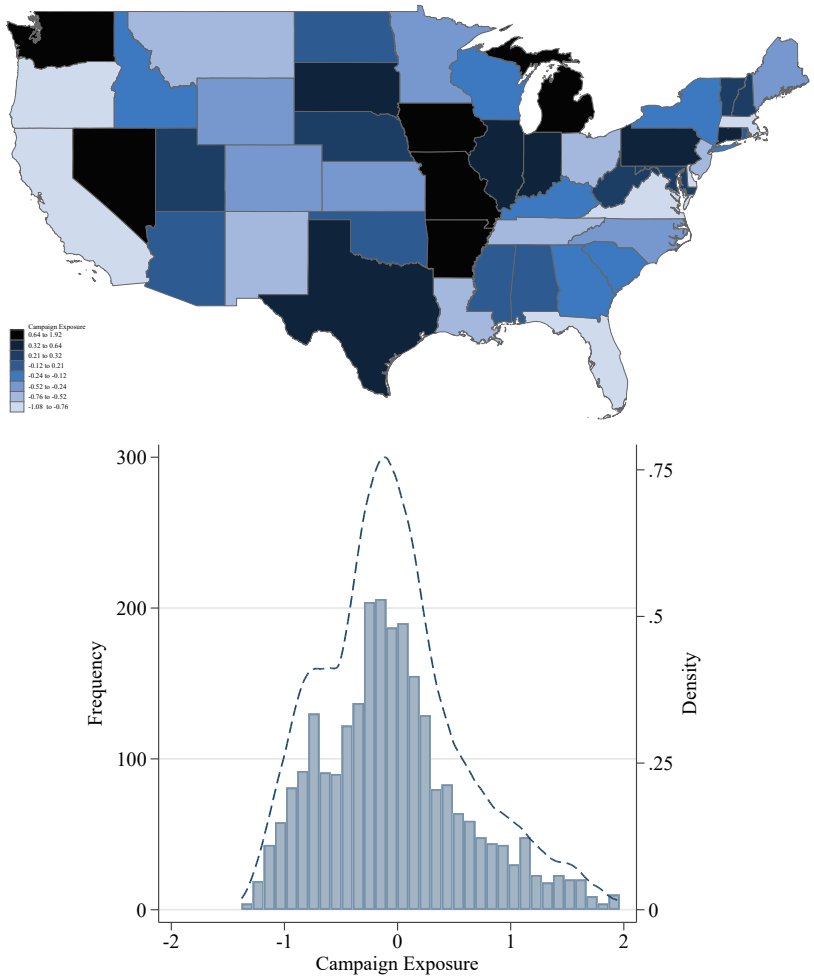
where MD_j represents per capita pamphlets distributed by physicians with links to the AMA: $(\frac{P_s^{\text{Camp.}}}{N_s}) \times (\frac{D_j^{\text{AMA}}}{D_j})$, and Ad_j reflects per capita main and tie-in advertising circulation consumed by local newspaper readers: $(\frac{C_j^{\text{Camp.}}}{N_j}) \times (\frac{N_j^{\text{Educ.>5 yr}}}{N_j^{\text{Adult}}})$.[41] We proxy for readership using the share of adults with more than five years of schooling.

For Gallup and lobbying outcomes, we can assign exposure at the individual level using AMA membership and educational attainment while controlling for individual measures of the same. We standardize both summands in Equation 4, giving each equal weight, and standardize the resultant for ease of interpreting the coefficients. A map of the Campaign exposure at the state level is shown in Figure 4 and at the county level is shown in Appendix Figure A14.[42] The correlation between the two components is 0.120 (p-value = 0.423).

[41] We find similar though sometimes noisier results using an exposure variable constructed with only the printed propaganda material and using other functional forms (see Section VI.4).

[42] Nevada's MD component is winsorized as the amount of pamphlets sent to the state is an outlier relative to its small population size. Results are stronger without winsorization.

Figure 4: Campaign Exposure Distribution and Balance



	(1)	(2)	(3)
	Overall Mean	Coefficient	SE
Panel A: State Level			
Mean PHI Share Enrolled 1945-1948	0.034	-0.012	(0.015)
Mean Share Republican Vote 1940-1948	0.409	0.005	(0.017)
Mean Voter Turnout 1940-1948	0.566	0.005	(0.023)
Share Female 1940	0.494	-0.004	(0.003)
Share Black 1940	0.094	-0.014	(0.015)
Share Employed 1940	0.336	-0.003	(0.004)
Share Urban 1940	0.474	-0.035	(0.022)
F-Stat		0.770	
F-Test *p*-value		0.616	
Observations		47	
Design Controls		✓	
Panel B: Individual Level - Gallup Data			
Approved Truman Health Plan, 1945-6	0.490	0.021	(0.021)
Female	0.465	-0.024*	(0.013)
Age	43.180	0.076	(0.427)
Have a Phone	0.688	-0.027	(0.020)
Voted Republican, 1944	0.545	0.030	(0.023)
Unemployed	0.017	0.003	(0.006)
Union Household	0.191	0.012	(0.011)
F-Stat		1.104	
F-Test *p*-value		0.370	
Observations		1187	
Design Controls		✓	
Panel C: Individual Level - Lobbying Data			
Former Military	0.015	0.002	(0.004)
General Practitioner	0.636	0.003	(0.005)
Surgery	0.152	0.000	(0.002)
Internal Medicine	0.086	-0.002	(0.003)
Other Specialty	0.126	-0.001	(0.002)
Age	47.467	0.240*	(0.132)
F-Stat		1.890	
F-Test *p*-value		0.093	
Observations		166634	
Design Controls		✓	

Notes: Map shows the distribution of the state level Campaign exposure variable, residualized by the 1948 design controls of log income per capita (Bureau of Economic Analysis 2023), number of hospitals (American Hospital Association 1948), and unionization rates (Farber et al. 2021). A probability density function of the Campaign exposure variable at the county level is shown below the map. Tables in Panels A and B report balance tests for Campaign exposure in the pre-period, and Panel C reports a cross-sectional balance test for Campaign exposure. Column 1 reports the sample mean, and Column 2 reports estimates from an OLS regression of variables listed as row headings on Campaign exposure. Column 3 reports the associated robust standard errors. *F*-stat and *p*-value are for an *F*-test of the joint significance of the variables listed. All panels include the design controls of log per capita income, number of hospitals, 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-eligible populations are applied. Panel C reports balance for lobbying, where AMA membership is included as a stratifying variable. The *F*-Test *p*-value without including age as a covariate is 0.879. *, **, *** refer to statistical significance at the 10, 5, and 1 percent level, respectively. Demographics data are from 1940 Census (Haines 2010), turnout data are from U.S. Census Bureau (1948), insurance data are from Council on Medical Service (1946-1954), and individual data are from Gallup Organization (1945, 1946, 1949, 1950).

V.2 Identification

Identification requires that, conditional on a limited set of historically motivated controls, the intensity of the Campaign was uncorrelated with the evolution of potential outcomes, ruling out selection-on-gains into a particular dose group (Callaway, Goodman-Bacon and Sant'Anna 2024). Our main estimating equations (Equations 5 and 6 below) are event studies that leverage both spatial variation in the intensity of the Campaign as well as its timing. The Campaign strategy emphasized leveraging existing networks so as to quickly respond to this unanticipated legislative threat. These networks included AMA doctors and the third party advertising agency, Lockwood-Shackelford. We therefore include variables that could influence the distribution of AMA physicians, newspaper readers, and demand for health insurance: Hospitals, income, and union membership.

Tables in Figure 4 show that Campaign exposure is not generally correlated with the outcome or other observables in the pre-Campaign period conditional on stratification variables or design controls. Furthermore, income and unionization do not change discontinuously after Campaign onset (Appendix Figure D2 Panels A and B).[43] In our analysis, we adopt procedures recommended by Roth (2022), Roth et al. (2023), and Rambachan and Roth (2023) regarding pre-trends and counterfactual trends and use a non-parametric estimator recommended by Callaway, Goodman-Bacon and Sant'Anna (2024). These and additional robustness checks are discussed in Section VI.4. In addition to the design controls, we include time fixed effects that capture broad secular changes in technology or national sentiment as well as location fixed effects that capture slowly evolving cultural attributes.

V.3 Estimating Equations

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

$$\frac{E_{st}}{N_s} = \alpha + \sum_{k \neq -1} \beta_k \cdot \left(I_t^k \times \text{Campaign exposure}_s \right) + \sum_{k \neq -1} \delta_k \cdot I_t^k + X_{st}' \Omega + \mu_s + \epsilon_{st} \tag{5}$$

where k denotes event time, and X_{st} includes the time-varying design controls noted above and μ_s represents state fixed effects.[44] Standard errors are clustered at the state level.

Public Opinion. We use two variables to capture public opinion: (1) an indicator variable for NHI legislation approval from Gallup, and (2) resolutions per capita passed by civic organizations in favor of PHI.[45]

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

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

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

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

$$I_{ist}^{\text{Support NHI}} = \alpha + \sum_{k \neq -1} \beta_k \cdot \left(I_t^k \times \text{Campaign exposure}_{is} \right) + \sum_{k \neq -1} \delta_k \cdot I_t^k + X_i' \Gamma + X_{st}' \Omega + \mu_s + \epsilon_{ist} \tag{6}$$

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

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

$$\frac{O_c}{N_c} = \alpha + \beta \cdot \text{Campaign exposure}_c + X_{cs}' \Gamma + \mu_s + \epsilon_c \tag{7}$$

where O_c is the number of civic organizations at the county level passing resolutions against NHI, and N_c is the county population. X_{cs} indicates the design controls of county level log income per capita, county number of hospitals, and share of unionized households at the state level. μ_s indicates state fixed effects.

Direct Lobbying In this doctor-level specification, our main outcome of interest is an indicator for whether a given physician donated to the Eisenhower-Nixon Ticket in 1952. For doctor i in county of residence c and state s we estimate:

$$I_{ics}^{\text{Donated}} = \alpha + \beta \cdot \text{Campaign exposure}_c \times I_i^{\text{Specialist}} + \theta \cdot \text{Campaign exposure}_c + \rho \cdot I_i^{\text{Specialist}} + X_{ics}' \Gamma + \mu_c + e_{ics} \tag{8}$$

where X_i includes AMA membership, clinically active status, former military physician, and physician age. X_{cs} includes the design controls. μ_c indicates county fixed effects. Standard errors are clustered at the county level. The coefficient of interest is β, the interaction between specialist indicator and Campaign exposure. The main effect on individual specialist status ρ serves to benchmark the magnitude.

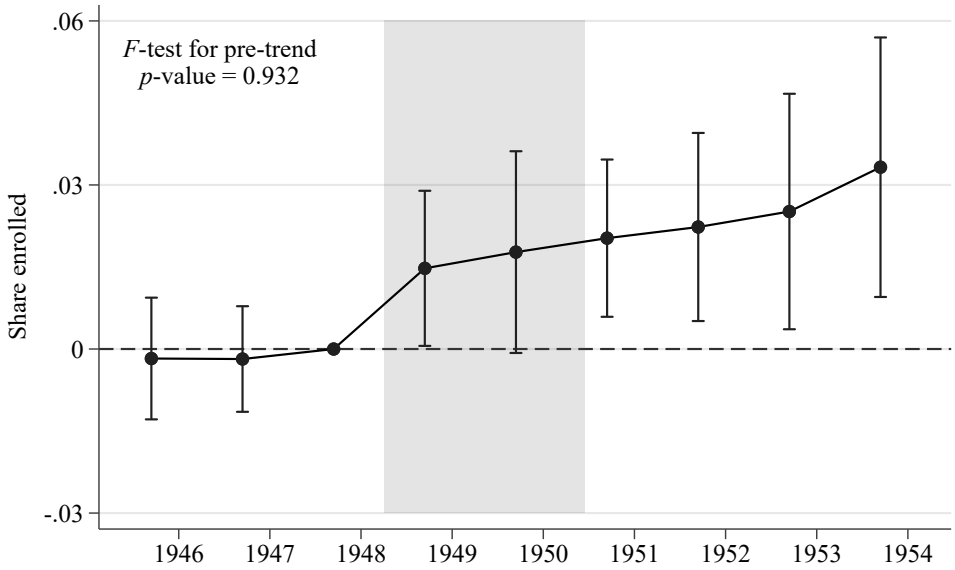
VI Results

We report findings for our primary outcome of PHI enrollment, then move onto secondary outcomes of public opinion and doctor donations.

VI.1 Private Health Insurance Enrollment

Figure 5 plots event study coefficients of Campaign exposure on PHI enrollment between 1946 and 1954. There is an increase in enrollment post-Campaign that appears markedly different from prior years (p-value for F-test on pre-trend = 0.932; expected pre-trend in Appendix Figure D3). PHI enrollment remains elevated until 1954 with increasing magnitude, mirroring increases in dependent coverage available through plans and the collapse of a viable public option. Due to changes in the tax code and the increasing presence of corporate insurers, we stop our analysis in 1954.

Figure 5: Effect of Campaign on Private Health Insurance Enrollment



Notes: Figure plots β coefficients from Equation 5 and associated 95% confidence intervals using cluster-robust standard errors. The outcome is share enrolled in private health insurance. Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. Sample includes the years 1946-1954. Design controls include log income per capita (Bureau of Economic Analysis 2023), number of hospitals (American Hospital Association 1948, 1950, 1952), and share unionized (Farber et al. 2021). State and year fixed effects are included.

Summary measures of the effect of Campaign exposure on enrollment are provided in Table 1. The main effect of Campaign exposure in the pre-period is not statistically significant and the causal estimates of interest appear stable across specifications beginning in Column 1. Column 4 is our preferred specification and includes design controls as well as state and year fixed effects. A one standard deviation increase in Campaign exposure is associated with a 2.3 percentage point increase in share enrolled, on average accounting for approximately 20% of the overall post-Campaign increase in PHI.[46]

[46]See Appendix Section G.1 for comparisons with findings from Thomasson (2003).

Table 1: Effect of Campaign on Private Health Insurance Enrollment

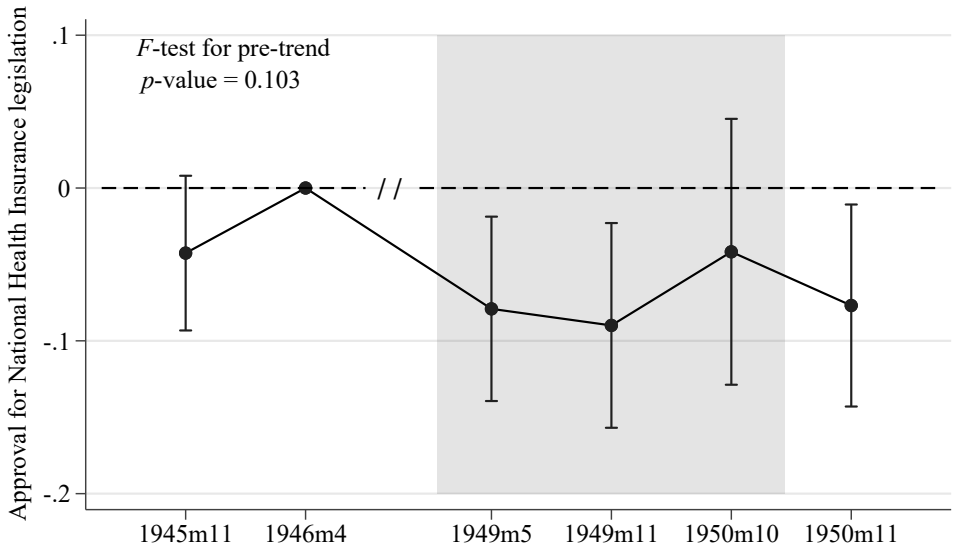
	(1)	(2)	(3)	(4)
Campaign Exposure $\times$ I^{Post}	0.023***	0.023***	0.025***	0.023***
	(0.008)	(0.008)	(0.008)	(0.008)
Campaign Exposure	0.007			
	(0.007)			
I^{Post}	0.102***	0.102***	0.030***	
	(0.008)	(0.008)	(0.006)	
Dependent Mean	0.034	0.034	0.034	0.034
Observations	423	423	423	423
State FE		✓	✓	✓
Design Controls			✓	✓
Year FE				✓

Notes: Table reports results from a regression of share enrolled in private health insurance on the interaction of Campaign exposure and I^{Post}. Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. I^{Post} is an indicator for post-Campaign. The sample includes 48 states from the years 1946-1954, where we collapsed Vermont and New Hampshire (see Section IV). Dependent Mean is the unconditional mean of the dependent variable in the pre-period. Design controls include log income per capita (Bureau of Economic Analysis 2023), number of hospitals (American Hospital Association 1948, 1950, 1952), 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.

VI.2 Public Perceptions of National Health Insurance

We next turn to how the Campaign affected views regarding NHI. Figure 6 presents the event study estimates from Gallup data using Equation 6. There is not a significant pre-trend (p-value for F-test = 0.103) and, if anything, approval for NHI was high (68%) and trending upwards (Appendix Figure D4). Although the survey waves are not evenly spaced, there is an abrupt decline in support for NHI of about five percentage points per wave post-Campaign.

Figure 6: Effect of Campaign on
Approval for National Health Insurance Legislation



Notes: Figure plots β coefficients from Equation 6 and associated 95% confidence intervals using cluster-robust standard errors. The outcome is an indicator for approval for legislation establishing National Health Insurance. Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. Individual level controls include a set of indicators for female, Black, age group, education, having a phone, voted Republican in the last election, employment status, union membership, job class, and urbanicity (Gallup Organization 1945, 1946, 1949, 1950). Design controls include log income per capita (Bureau of Economic Analysis 2023), hospital count (American Hospital Association 1948, 1950, 1952), and share unionized (Farber et al. 2021). Sample weights for the voting-eligible population are applied.

Table 2 provides a summary measure of the Campaign's effect on public opinion. The main effect is again not statistically significant in the pre-period. The interaction of Campaign exposure and post is negative and significant and indicates that a one standard deviation increase in Campaign exposure reduced support by five to seven percentage points. The post indicator is also negative, though this could reflect subtle changes in how the legislation was described in the question text.

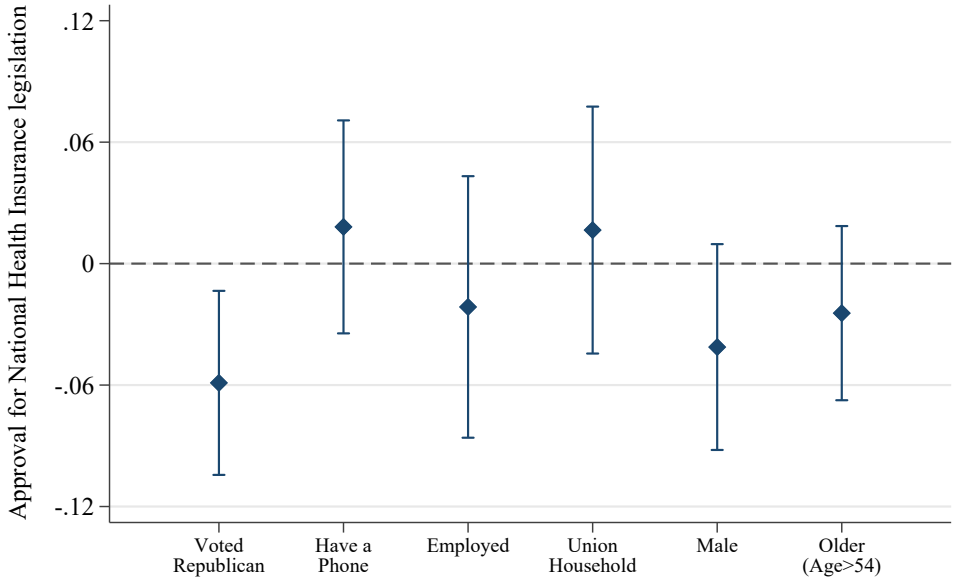
Table 2: Effect of Campaign on Approval for National Health Insurance Legislation

	(1)	(2)	(3)	(4)
Campaign Exposure $\times$ I^{Post}	-0.061***	-0.071***	-0.060***	-0.047***
	(0.018)	(0.018)	(0.017)	(0.017)
Campaign Exposure	-0.016	-0.006	-0.015	0.021
	(0.021)	(0.023)	(0.020)	(0.014)
I^{Post}	-0.263***	-0.109***		
	(0.026)	(0.041)		
Dependent Mean	0.684	0.684	0.684	0.684
Observations	5062	5062	5062	5062
State FE	✓	✓	✓	✓
Design Controls		✓	✓	✓
Wave FE			✓	✓
Individual Characteristics				✓

Notes: Table reports a regression of approval for legislation establishing National Health Insurance on the interaction of Campaign exposure and I^{Post}. Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. I^{Post} is an indicator for post-Campaign. The outcome is an indicator for approval using Gallup data (see Appendix Table A1) (Gallup Organization 1945, 1946, 1949, 1950). Dependent Mean is the unconditional mean of the dependent variable in the pre-period. Individual Characteristics include a set of indicators for female, Black, age group, education, having a phone, voted Republican in the last election, employment status, union membership, job class, and urbanicity. Design controls include log income per capita (Bureau of Economic Analysis 2023), hospital count (American Hospital Association 1948, 1950, 1952), and share unionized (Farber et al. 2021). State fixed effects are included. Sample weights for the voting-eligible population are applied. Robust standard errors clustered at the state-by-urbanicity level are in parentheses. *, **, *** refer to statistical significance at the 10, 5, and 1 percent level, respectively.

Figure 7 examines heterogeneous effects by individual characteristics. Treatment effects are similar across a range of socioeconomic and demographic variables, with the exception of partisan leaning. Repub-lican respondents appear to have been more responsive to Campaign exposure. This finding is consistent with more recent evidence on party affiliation and health insurance take-up (Bursztyn et al. 2022; Lerman, Sadin and Trachtman 2017).

Figure 7: Effects of Campaign on Approval for
National Health Insurance Legislation by Individual Characteristics



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

Table 3 reports results from Equation 7. Columns 1 includes state fixed effects. Column 2-4 add various design controls. The table also includes a test for selection on unobservables, which finds limited scope for bias (Oster 2019). In our preferred specification (Column 4) a one standard deviation increase in Campaign exposure is associated with 2.9 more civic organizations signing resolutions in support of PHI per 100,000 population per county.

Table 3: Effect of Campaign on
Civic Organizations Supporting Private Health Insurance

	(1)	(2)	(3)	(4)
Campaign Exposure	0.029***	0.027***	0.029***	0.029***
	(0.010)	(0.010)	(0.011)	(0.011)
Oster δ for $\beta = 0$	3.817	3.392	3.788	3.832
R^2	0.443	0.443	0.443	0.444
Dependent Mean	0.139	0.139	0.139	0.139
Observations	3002	3002	3002	3002
State FE	✓	✓	✓	✓
Design Controls				
Income		✓		✓
Hospitals			✓	✓

Notes: Table reports results of Equation 7. The outcome is multiplied by 1,000 for readability. Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. Design controls include county level log median income per capita (U.S. Census Bureau 2012) and number of hospitals per county (American Hospital Association 1948, 1950, 1952). Dependent Mean is the unconditional mean of the dependent variable. A parameter representing the scope for selection-on-unobservables is reported (Oster 2019). Robust standard errors are in parentheses. *, **, *** refer to statistical significance at the 10, 5, and 1 percent level, respectively.

VI.3 Direct Lobbying and the Political Narrative

Results on Campaign Donations. We first plot the donation rate by doctor type in Appendix Figure A16. Specialists were about twice as likely to donate than generalists. Turning to the estimation of Equation 8, we again find that specialists are about two to three times as likely to contribute to donate to Eisenhower as generalists (Table 4). Based on estimates in Column 4, a one standard deviation increase in Campaign exposure further increased specialist donations by about 50% (similar results are obtained using amount donated; Appendix Table C1).

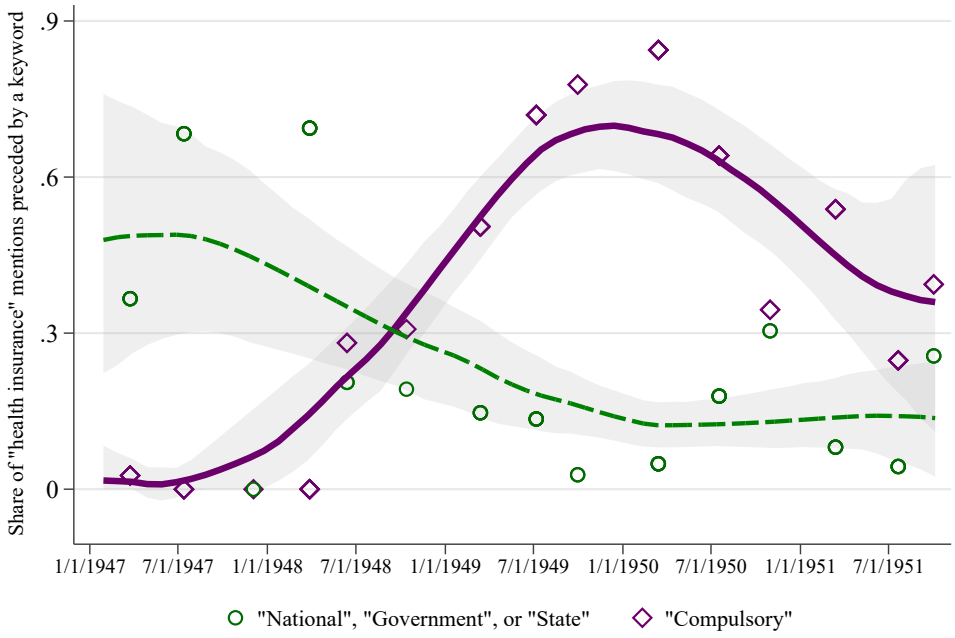
Table 4: Effect of Campaign on
Donating to Eisenhower-Nixon Ticket

	(1)	(2)	(3)	(4)
Campaign Exposure $\times$ $I^{\text{Specialist}}$	0.001***	0.001***	0.001***	0.001***
	(0.000)	(0.000)	(0.000)	(0.000)
Campaign Exposure	-0.000	-0.000	-0.000	-0.000
	(0.000)	(0.001)	(0.000)	(0.000)
$I^{\text{Specialist}}$	0.003***	0.003***	0.002***	0.002***
	(0.001)	(0.001)	(0.001)	(0.001)
Dependent Mean	0.001	0.001	0.001	0.001
Observations	167373	167222	166634	166634
County FE		✓		
Design Controls			✓	✓
Individual Characteristics				✓

Notes: Table reports results of Equation 8. The outcome is an indicator for whether the physician donated to Eisenhower's Presidential Ticket. Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. $I^{\text{Specialist}}$ is an indicator for whether the physician was a specialist. Individual physician characteristics include age, an indicator for being an AMA member, an indicator for having served as a physician in the military, and an indicator for currently being in practice (American Medical Association 1950*a*). Design controls include county level log income per capita (Bureau of Economic Analysis 2023), number of hospitals (American Hospital Association 1948, 1950, 1952), and state level share unionized (Farber et al. 2021). Dependent Mean is the unconditional mean of the dependent variable for generalist 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.

Results from the Congressional Record. The Campaign also appeared to influence debate on the congressional floors of the Senate and House: comparing pre-post means, we find an increase in the usage of the term "compulsory" and a corresponding decline in the words "national" ''state" or "government" when describing health insurance (see Figure 8). We interpret this as suggestive evidence of a change in the narrative surrounding NHI. Consistent with this shift in the legislative debate, we find that the Campaign appeared to benefit House Republicans in the 1950 and 1952 elections, detailed in Appendix Section E.

Figure 8: Terms Used to Describe National Health Insurance
in the Congressional Record, 1947-1951



Notes: Figure plots the time trend of terms used for National Health Insurance in the Congressional Record (U.S. Congress 1947, 1948, 1949, 1950). Green circles are shares of the terms "national health insurance," "government health insurance," and "state health insurance" used over total mentions of "health insurance" in a given part of the record, whereas purple diamonds are shares of the term "compulsory health insurance" used over total mentions of "health insurance." Scatters are the means of 120-day bins. The curves are fitted using the raw data by kernel-weighted local linear regressions, and the shaded areas are the associated 95% confidence intervals obtained from a bootstrapping procedure with 500 repetitions.

VI.4 Robustness Checks

We perform several tests to address possible threats to identification. To address concerns regarding Campaign exposure exogeneity, we show robustness to potentially confounding variables. Appendix Tables C2, C3, and C4 include controls for war bond penetration, which has been linked to Republican electoral success in the 1950s (Brunet, Hilt and Jaremski 2023), unit-year pre-trends, the share of Blue Cross hospitals, the passage of enabling legislation, and trends in the 1950 share of specialist physicians.[47] We also control for linear trends in the share of AMA members and the share educated in Appendix Table C5. Data on sub-national variation in radio advertisements are not recorded in the firm's archives to our knowledge, but our understanding is that the use of radio was limited relative to the other components. Our estimates are similar when including radio and television penetration controls (Appendix Table C6).

Second, we verify that our results are not sensitive to precisely how we define the exposure or out-

[47] As noted by Lee and Solon (2011) and summarized by Goodman-Bacon (2021, p.2561), unit-specific linear time trends "cannot distinguish between time-varying treatment effects and preexisting trends." We follow Goodman-Bacon (2021) and omit these, given that time-varying treatment effects are demonstrated in Figure 5, and instead per Miller (2023), estimate unit-specific pre-trends in Column 1 of Appendix Tables C2 and C3.

come: Using a dichotomous treatment for above and below median produces similar conclusions (Column 6 of Appendix Tables C2 and C3, and Column 7 of Appendix Table C4). Constructing the exposure with printed propaganda materials only leads to comparable estimates (Appendix Figures D5 and D6; Column 10 of Appendix Tables C2 and C3, and Column 8 of Appendix Table C4) albeit noisier for the NHI approval outcome. Separately including Campaign components yields coefficients that are indistinguishable from each other and similar in magnitude for PHI enrollment and NHI approval (compare Column 1 with Column 4 of Appendix Tables C7 and C8). The estimates from the multiplicative form suggest complementarity for PHI enrollment (Appendix Table C7 Columns 5 and 6) and show no strong interaction effects for NHI approval (Appendix Table C8 Columns 5 and 6). One interpretation of these findings is that enrollment in PHI benefited from the interaction of messages from the supply-side and the demand-side of health care, whereas to shift public opinion the source of message was more substitutable.

We estimate effects using deciles of Campaign exposure. Appendix Figures D7 and D8 demonstrate approximately linear dose responsive behavior for PHI enrollment and public opinion. For the outcome of PHI enrollment, we consider an alternate denominator: The total White working-age male population instead of the total population (Appendix Table C2 Column 9). Results are predictably larger but otherwise similar.

To further assess the validity of our identification strategy, we compute the *F*-test on pre-trends in all our main analyses. In addition, we follow Roth (2022) and generate a counterfactual evolution for each outcome: Appendix Figures D3 and D4 demonstrate a marked deviation. We also perform sensitivity analyses as proposed by Rambachan and Roth (2023) allowing for potential parallel trends violations (Column 7 of Appendix Tables C2 and C3), 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 AMA-WB Campaign, perhaps Whitaker & Baxter were copying a common marketing trick at the time which was to use fears of Communism to sell products. To investigate this, we first collect a random sample of ads from the same newspapers that ran AMA-WB Campaign ads a month prior to the dates indicated on Lockwood-Shackleford invoices. We searched for common AMA-WB Campaign phrases such as ''American way", ''freedom", ''socialism" ''socialist" ''communism" ''communist" and ''tyranny". Appendix Table 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 five of these words (Columns 3 and 4). We also drop California given that Hollywood was a target for Red Scare tactics (Humphries 2008). The results excluding the state are fairly similar to our baseline results (see Column 8 of Appendix Tables C2 and C3 and Column 6 of Appendix Table C4).

Lastly, we return to the Gallup data but this time pulling out questions on anti-Russian sentiment. Appendix Figure D9 demonstrates that Campaign exposure is not associated with Russian disapproval before or after the AMA-WB Campaign initiation, while NHI approval is negatively associated with exposure in the post-Campaign period. Taken together, these results suggest that our results cannot be solely ascribed to broader movements in anti-Communist sentiment.

VII Conclusion

Our analyses demonstrate that the rise of private health insurance in the U.S. can in part be attributed to a coordinated campaign against a universal, tax-financed health system. At this critical juncture, when support for NHI was high, had the commitment of the executive branch, a Democratic legislative branch, and was being implemented in peer nations worldwide, efforts to derail implementation succeeded by using the rhetoric of freedom and providing a private alternative that would persist. The Campaign increased enrollment in PHI, reduced support for NHI, and suggestively altered the framing congressional representatives used when debating health insurance legislation. Although beyond the scope of our analysis, the Campaign is also credited with coining terms for NHI that are still used today (Lepore 2012). Furthermore, interest and trade group influence is still present: In 2023, four out of the top ten lobbyists by amount spent are affiliated with the healthcare industry (Appendix Figure A17; Open Secrets 2023). These findings speak to the role of interest groups and indirect lobbying in shaping the trajectory of health policy in the U.S. Per the conceptual framework outlined in Section III, when private resources vastly overpower public resources and can dominate the narrative, the ability to pass legislation that regulates the market may be challenging.

The Campaign may have affected the current U.S. healthcare landscape in other ways not included in our analyses. For example, the growth of private health insurance, and particularly group enrollment through employment, left many retirees aged 65 and above without insurance previously obtained through their employer and may have contributed to the establishment of Medicare (McClellan and Skinner 2006). Future work may elucidate whether the Campaign had effects on other forms of social insurance or wider repercussions for U.S. policy-making.

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Appendix

Table of Contents

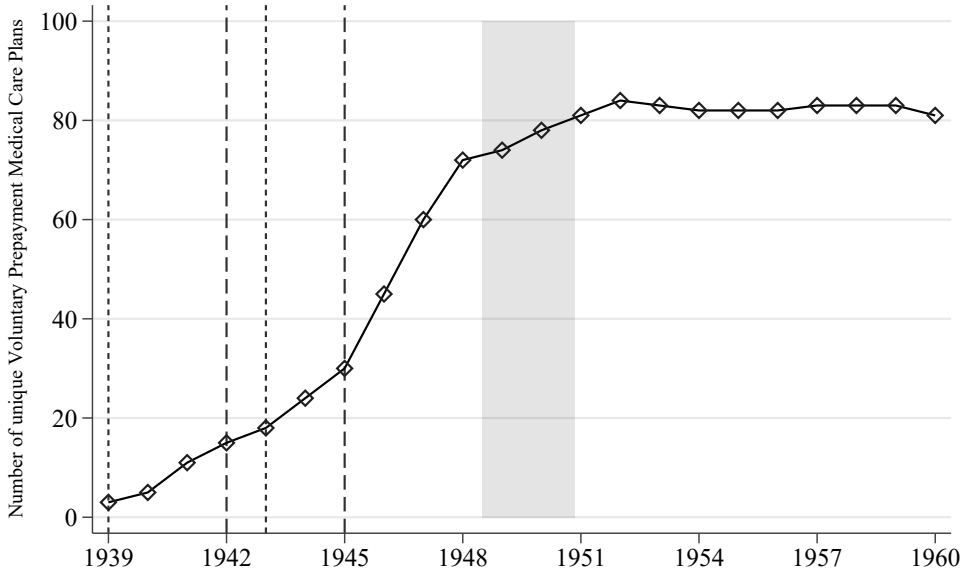
A Descriptive Data Exhibits

Appendix Table A1: Gallup Questions on National Health Insurance

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

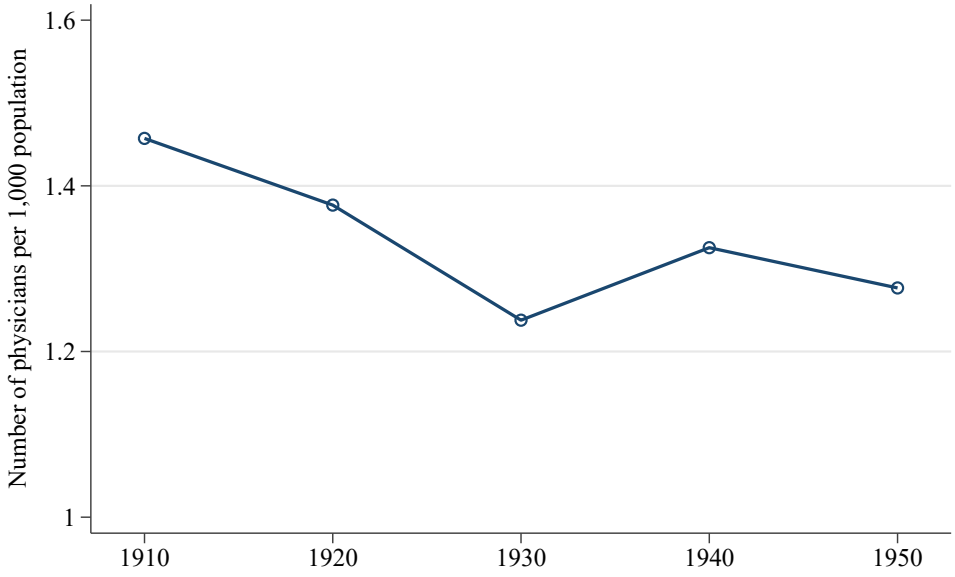
Notes: Table reports the questions Gallup Organization asked respondents over the time period of the analysis (Gallup Organization 1945, 1946, 1949, 1950). In the May 1949 Gallup wave, the question on approval for NHI was asked in two different ways, shown above, as part of a Gallup experiment.

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



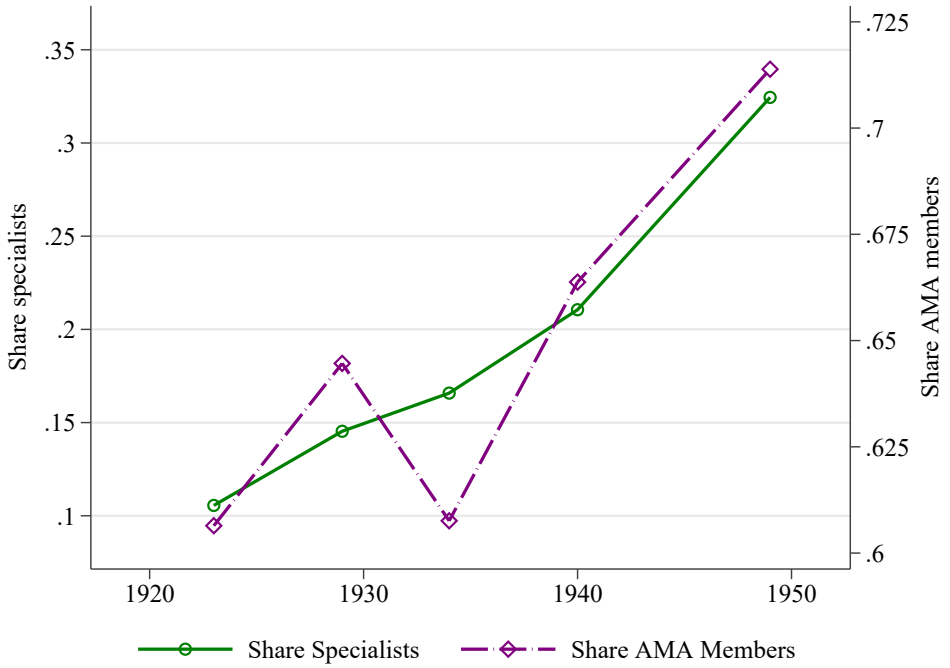
Notes: Figure shows the total number of unique voluntary prepayment medical care plans each year. 1939 marks the formation of the California Physicians Service, the first Blue Shield plan, and California Governor Olson's support of AB 2172 (Board of Trustees of Mississippi State Medical Association 1965;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

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



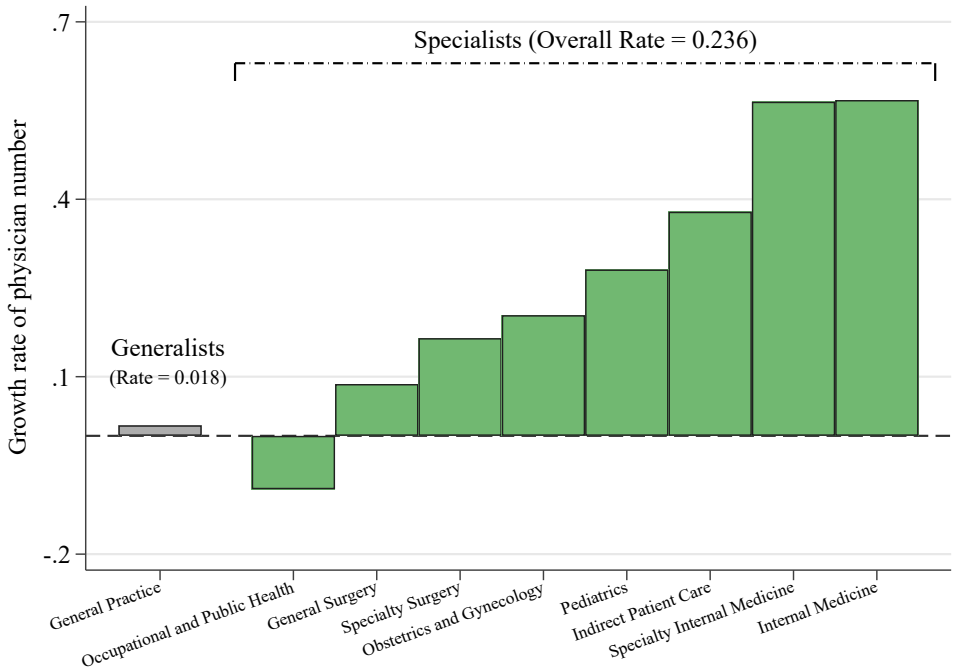
Notes: Figure plots the number of physicians per 1,000 population. Physician data are from the AMA House of Delegates Proceedings (American Medical Association 1910, 1920, 1923, 1929, 1930, 1934, 1940, 1950*b*). Population data are from the 1910, 1920, 1930, 1940, and 1950 Census (Haines 2010).

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



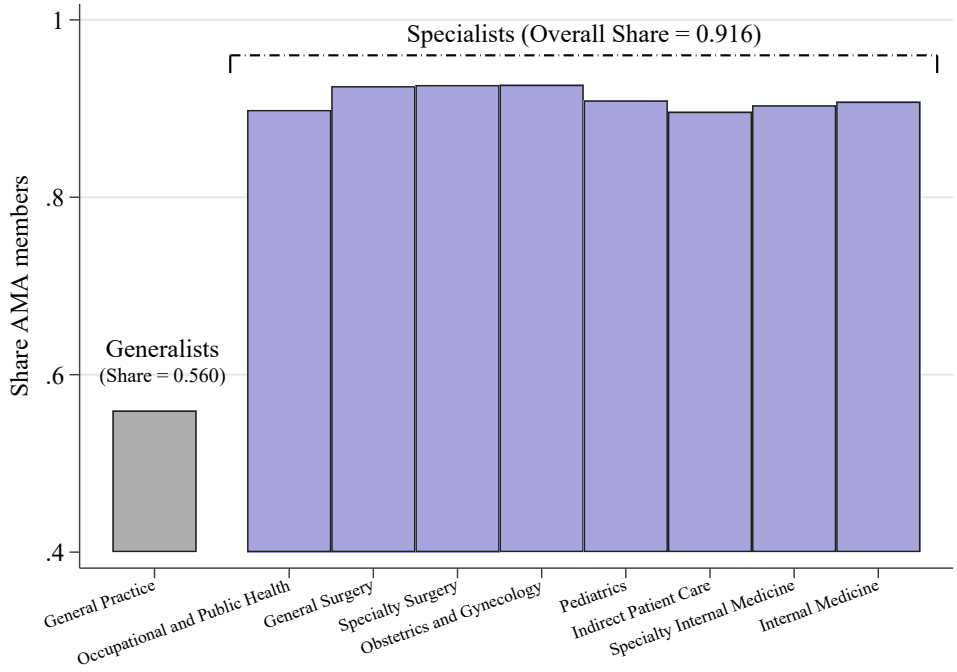
Notes: Figure plots the shares of specialists and AMA members over the total number of physicians in the years 1923, 1929, 1934, 1940, and 1949. Only years with available data on both specialists and AMA membership are included. Data on the number of specialists are from Perrott and Pennell (1957). Data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

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



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

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

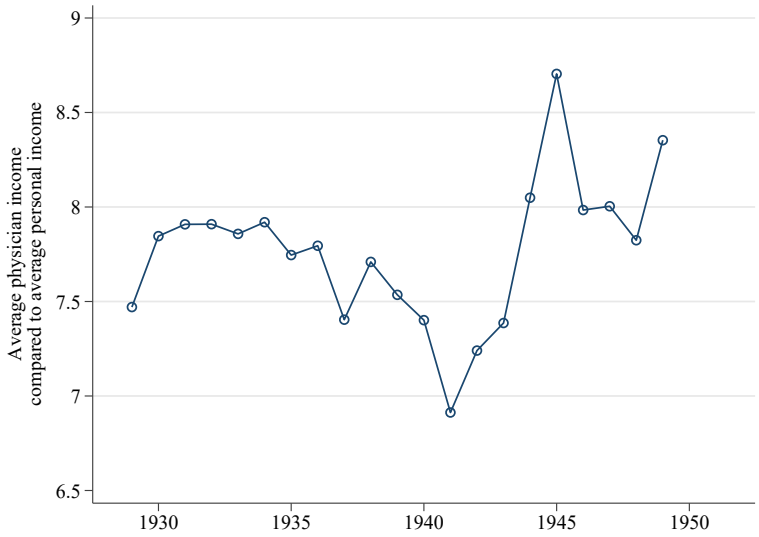


Notes: Figure plots the share of physicians who are AMA members by specialty. Data are from the 1950 *American Medical Directory* (American Medical Association 1950*a*).

Appendix Figure A6: Physician Income Growth, 1929–1949

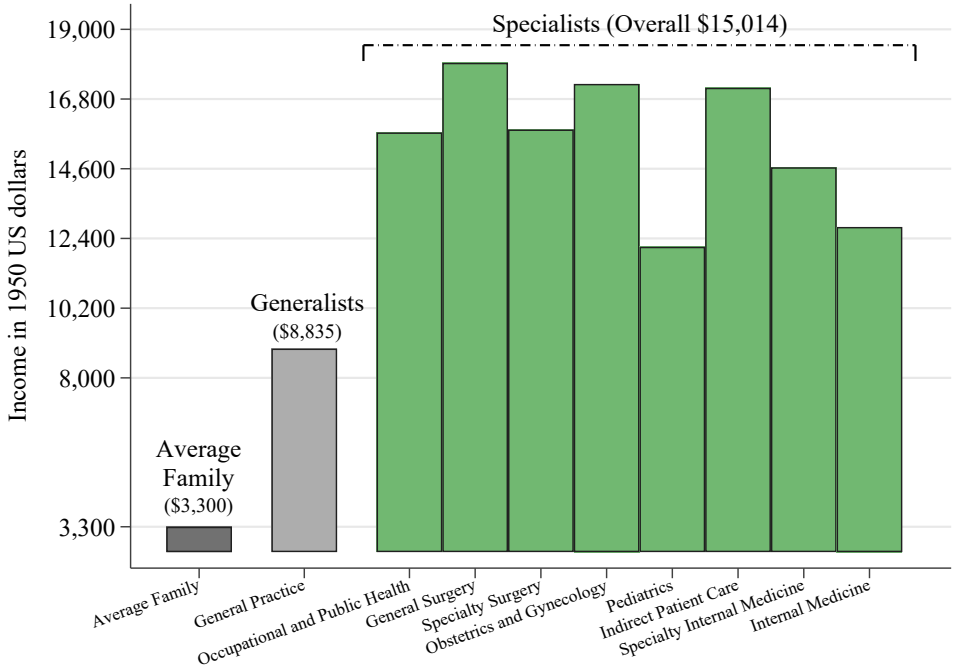
(a) Average Annual Income

(b) Ratio of Physician to Individual Income



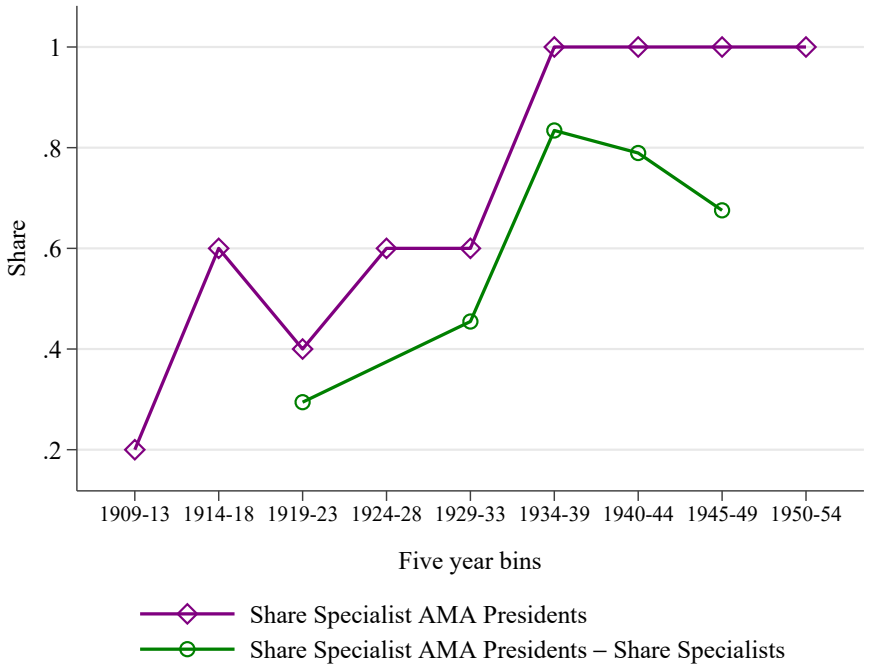
Notes: Figure plots time trends for the average income of physicians from 1929 to 1949. Panel A plots the average income for physicians and all Americans. Incomes are adjusted to 1950 U.S. dollars. Panel B plots the ratio of average physician income to average personal income in the same year. Physician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

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



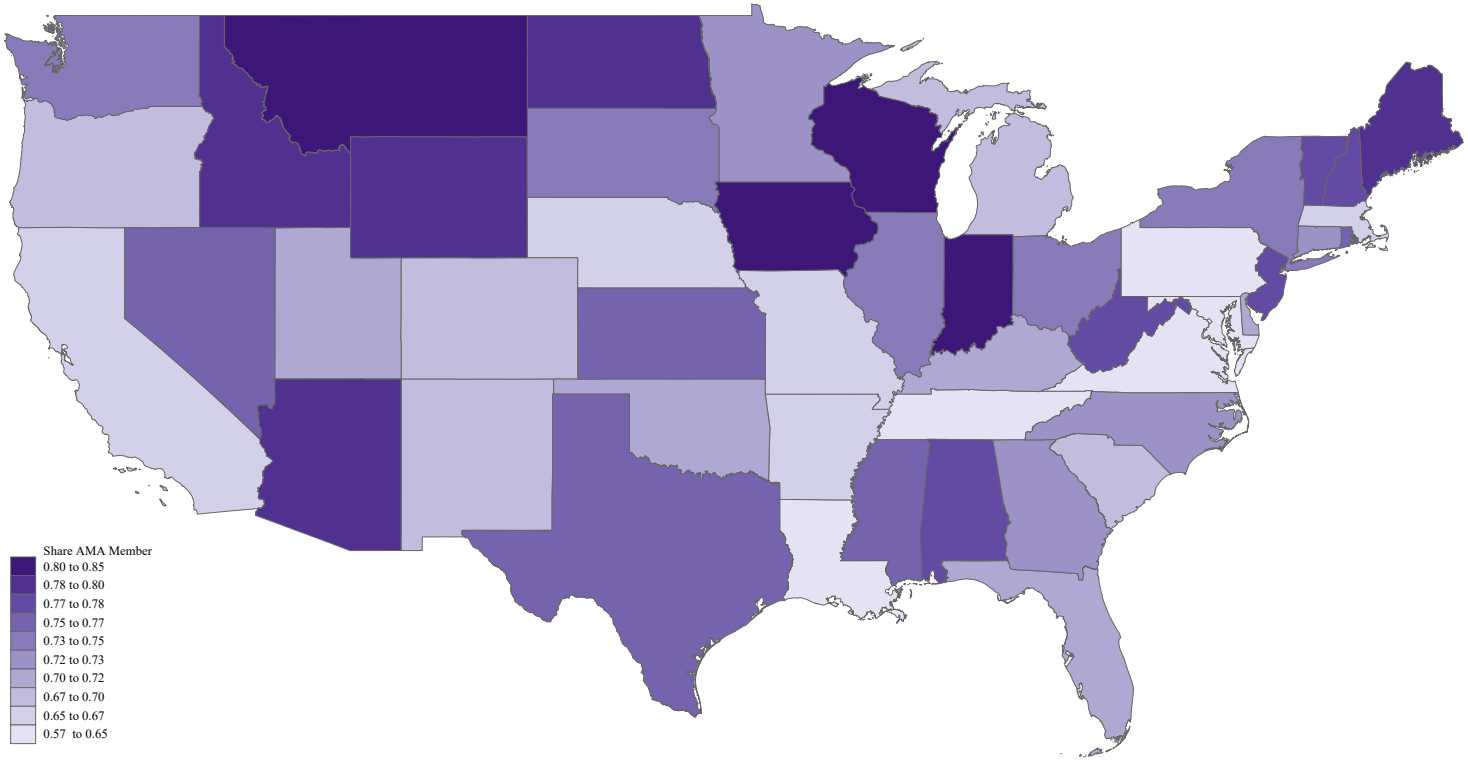
Notes: Figure plots the average annual income for physicians by specialty in 1949 and average annual family income in 1950. Incomes are adjusted to 1950 U.S. dollars. Physician income data are from the Survey of Current Business published by the Bureau of Economic Analysis (Weinfeld 1951). Family income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

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



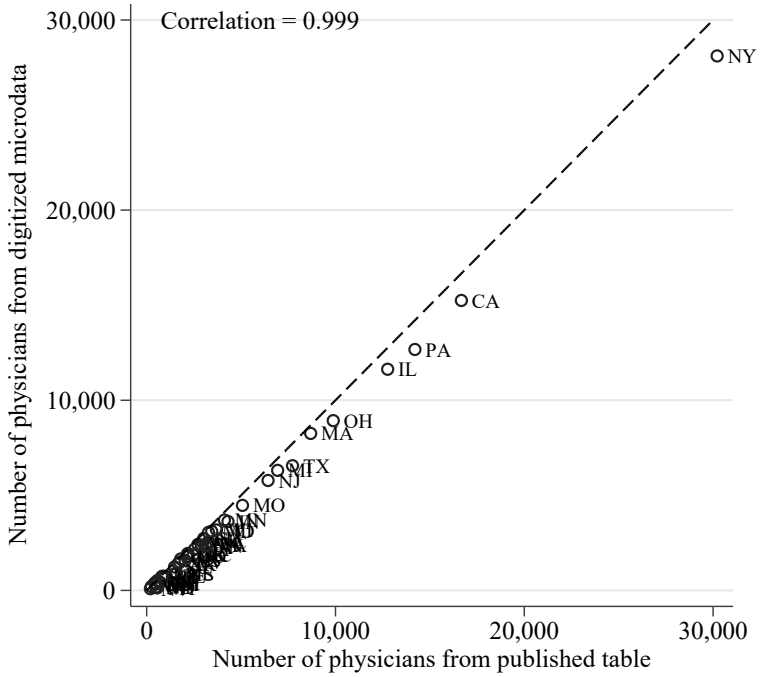
Notes: Figure plots the share of specialists among AMA presidents by decade from 1909 to 1954. The green line with circles plots the difference between share of specialist AMA presidents and the share of specialist physicians. AMA president data are from American Medical Association (1950*a*), and specialist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

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



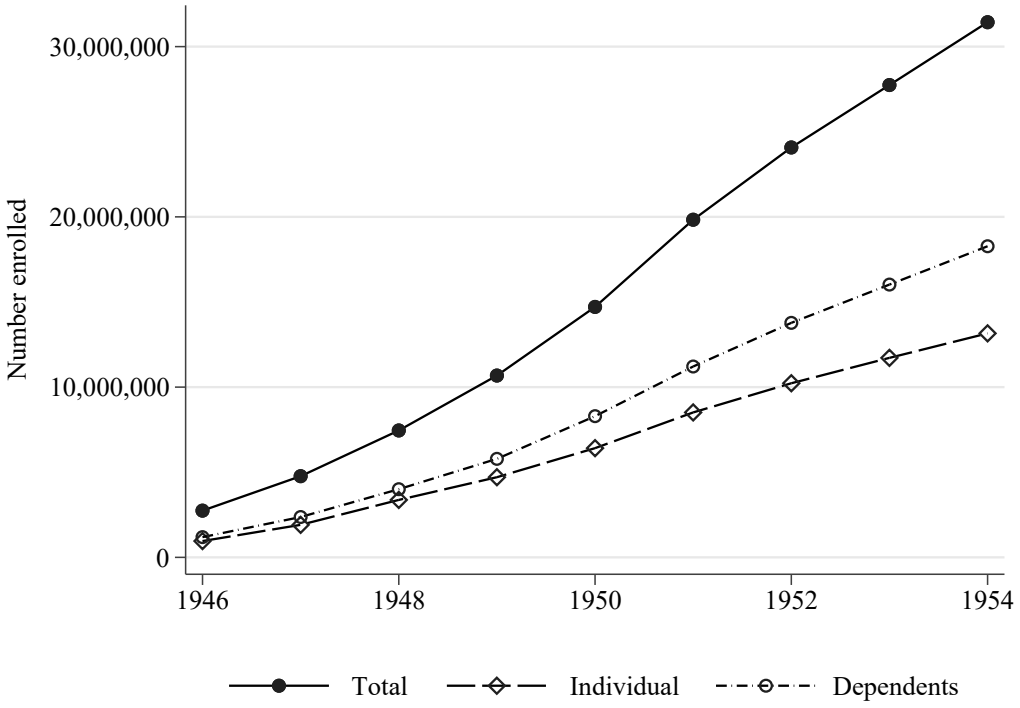
Notes: Exhibit shows the share of total physicians that are members of the AMA as of 1950 by decile. Data are from American Medical Association (1950*a*).

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



Notes: Figure plots the total number of physicians by state, where the 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.

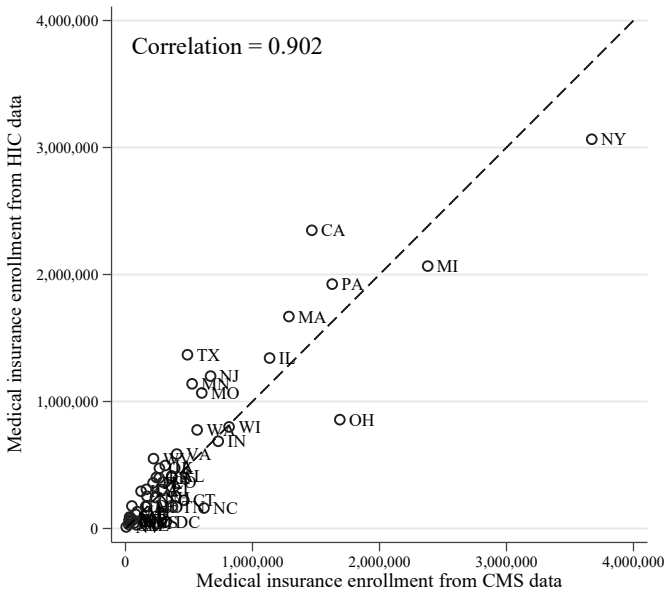
Appendix Figure A11: PHI Enrollment Over Time



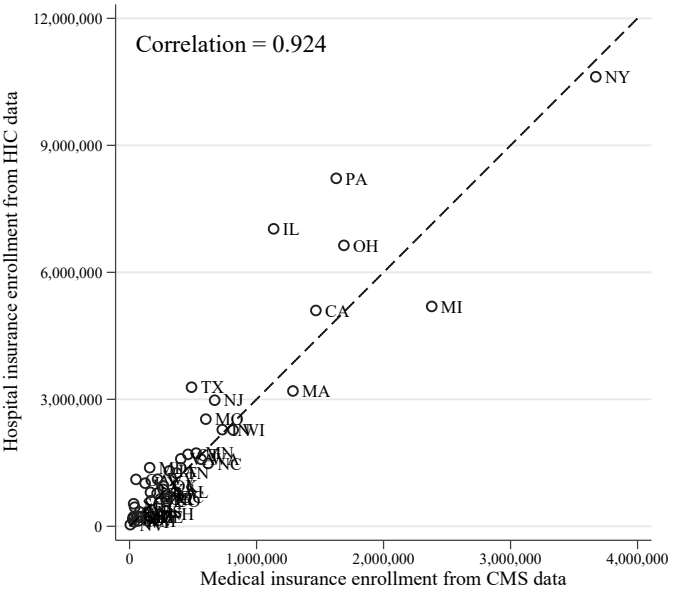
Notes: Exhibit plots voluntary (private) health insurance enrollment over time. Data are from Council on Medical Service (1946-1954).

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

(a) HIC Medical Insurance Enrollment

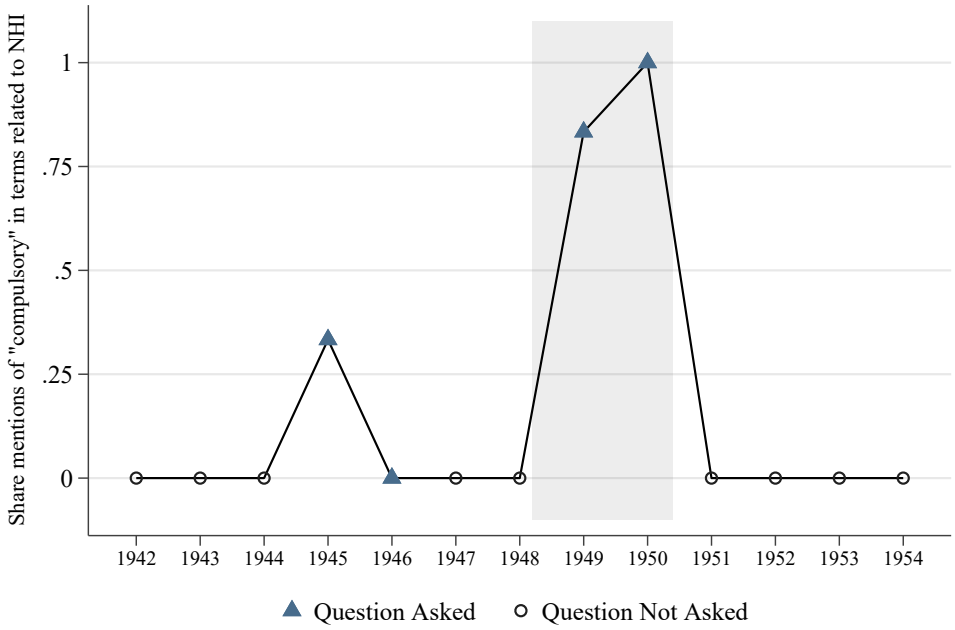


(b) HIC Hospital Insurance Enrollment



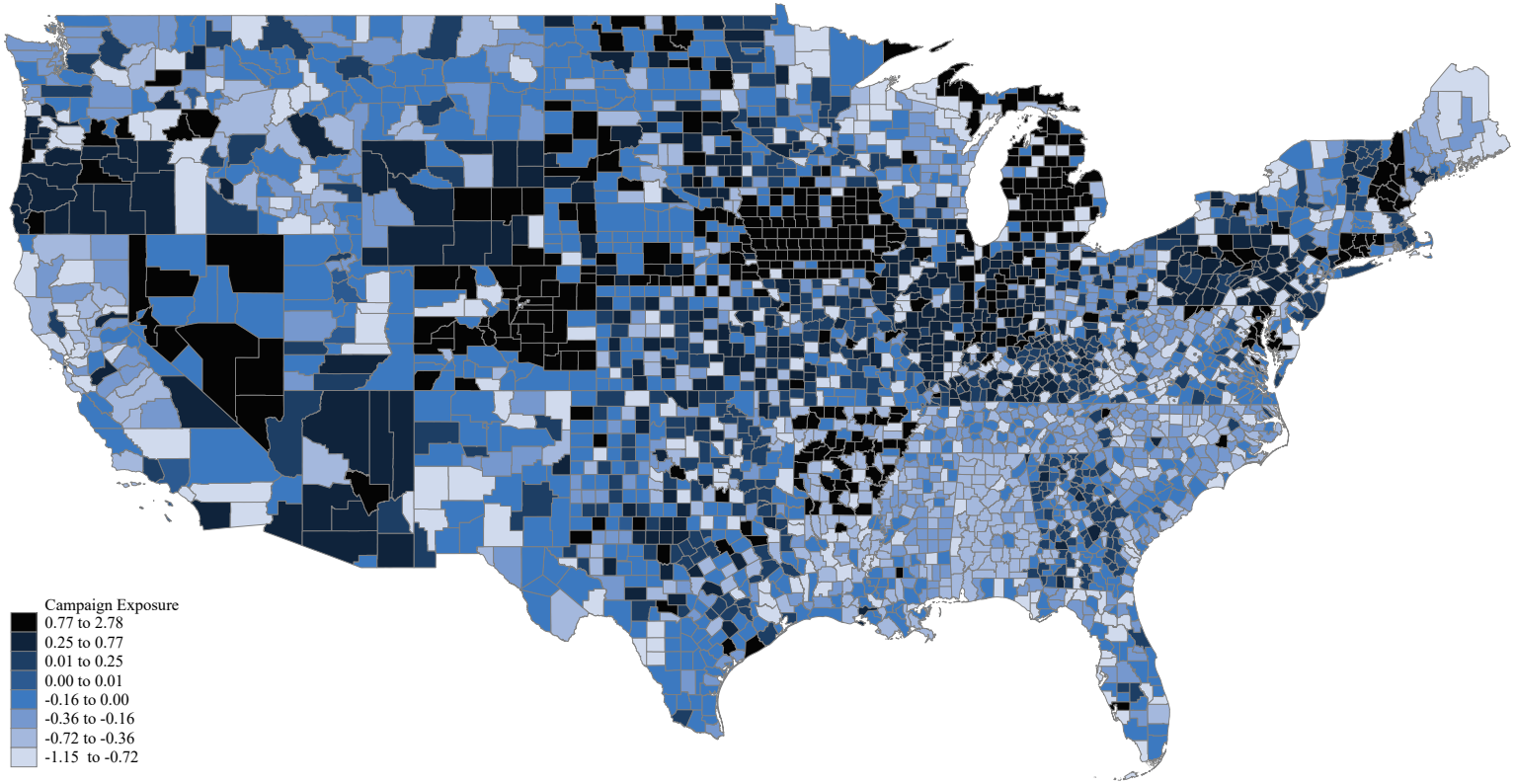
Notes: Figure plots the total number of enrollees. CMS indicates counts from the Council on Medical Service - American Medical Association (Council on Medical Service 1946-1954). HIC indicates counts from the Health Insurance Council (The Survey Committee of the Health Insurance Council 1949-1965). Panel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

Appendix Figure A13: Terms Used in Gallup Polls about NHI



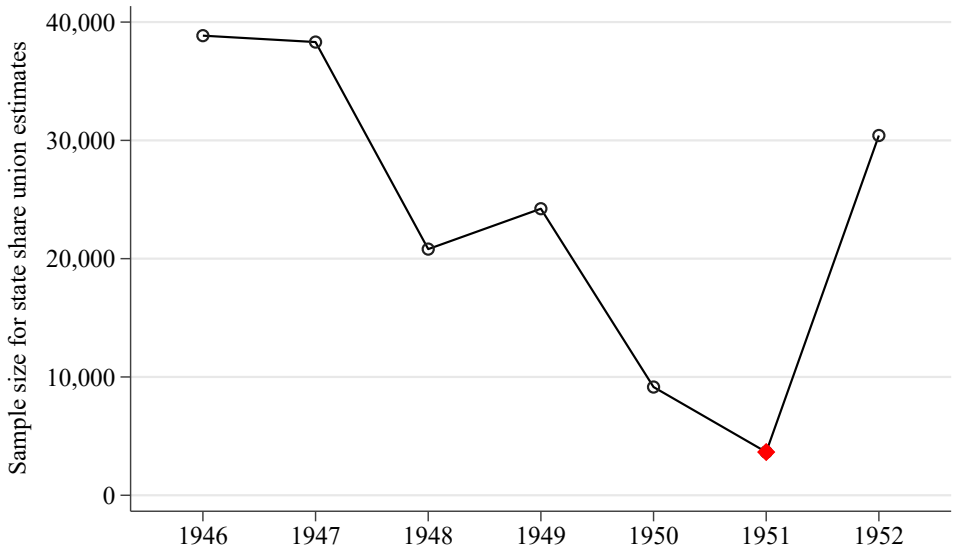
Notes: Figure plots the share of "compulsory" among terms referring to NHI in Gallup poll questions in Appendix Table A1. The numerator is total mentions of "compulsory" in the given questions, and the denominator is the sum of total mentions of "compulsory," "national," "government," and "state." Triangles 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. Circles represent years where Gallup polls did not ask questions about NHI. Shaded area indicates the Campaign period.

Appendix Figure A14: Campaign Exposure, County Level



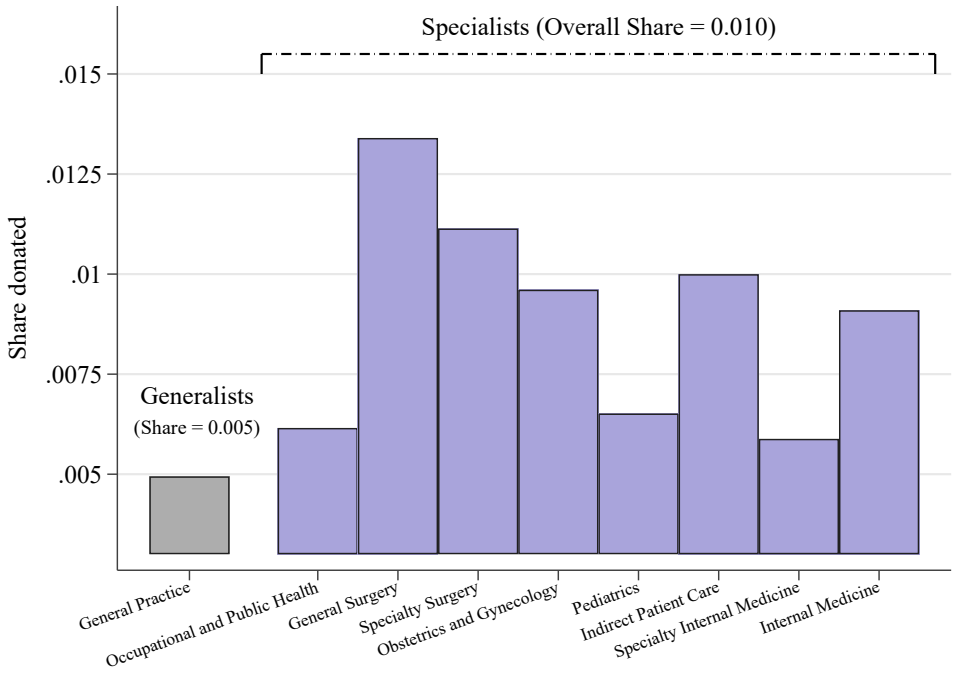
Notes: Map shows the distribution of the county level Campaign exposure variable for data used in the lobbying regressions, residualized by design controls: county level log income per capita (Bureau of Economic Analysis 2023), county level number of hospitals (American Hospital Association 1948, 1950, 1952), and state level share of unionized households Farber et al. (2021).

Appendix Figure A15: Sample Size for Union Household Share Estimates



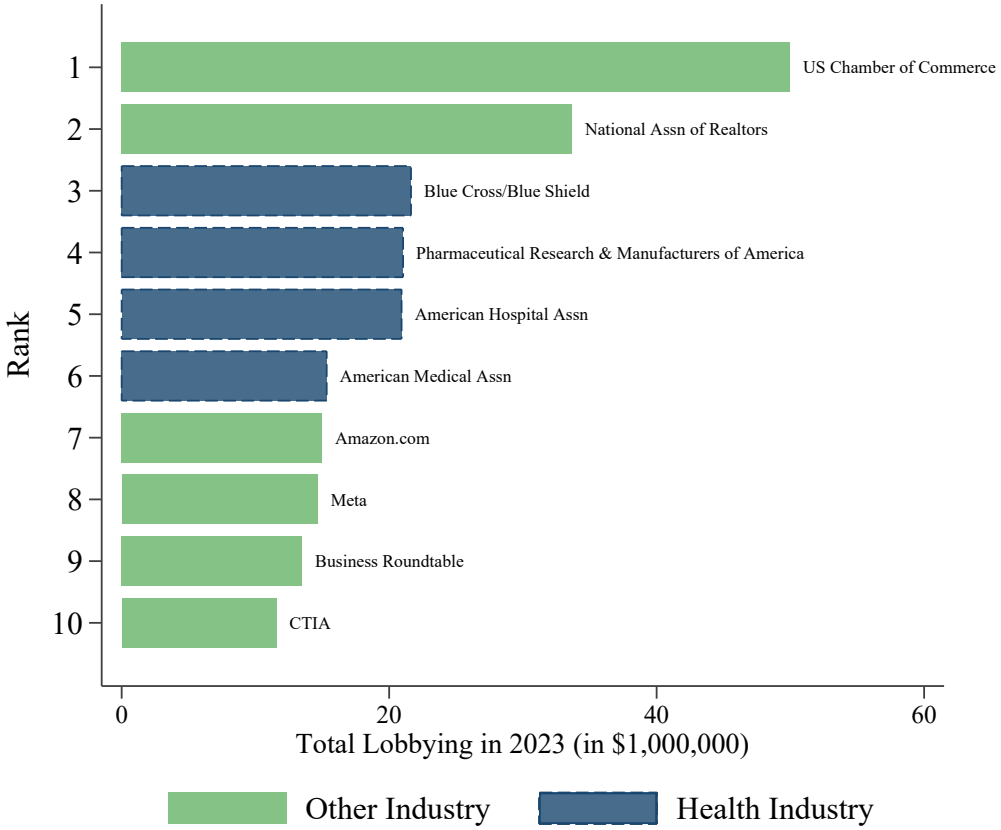
Notes: Figure plots the sample size used for state share union household estimates. Data are from Farber et al. (2021).

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



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

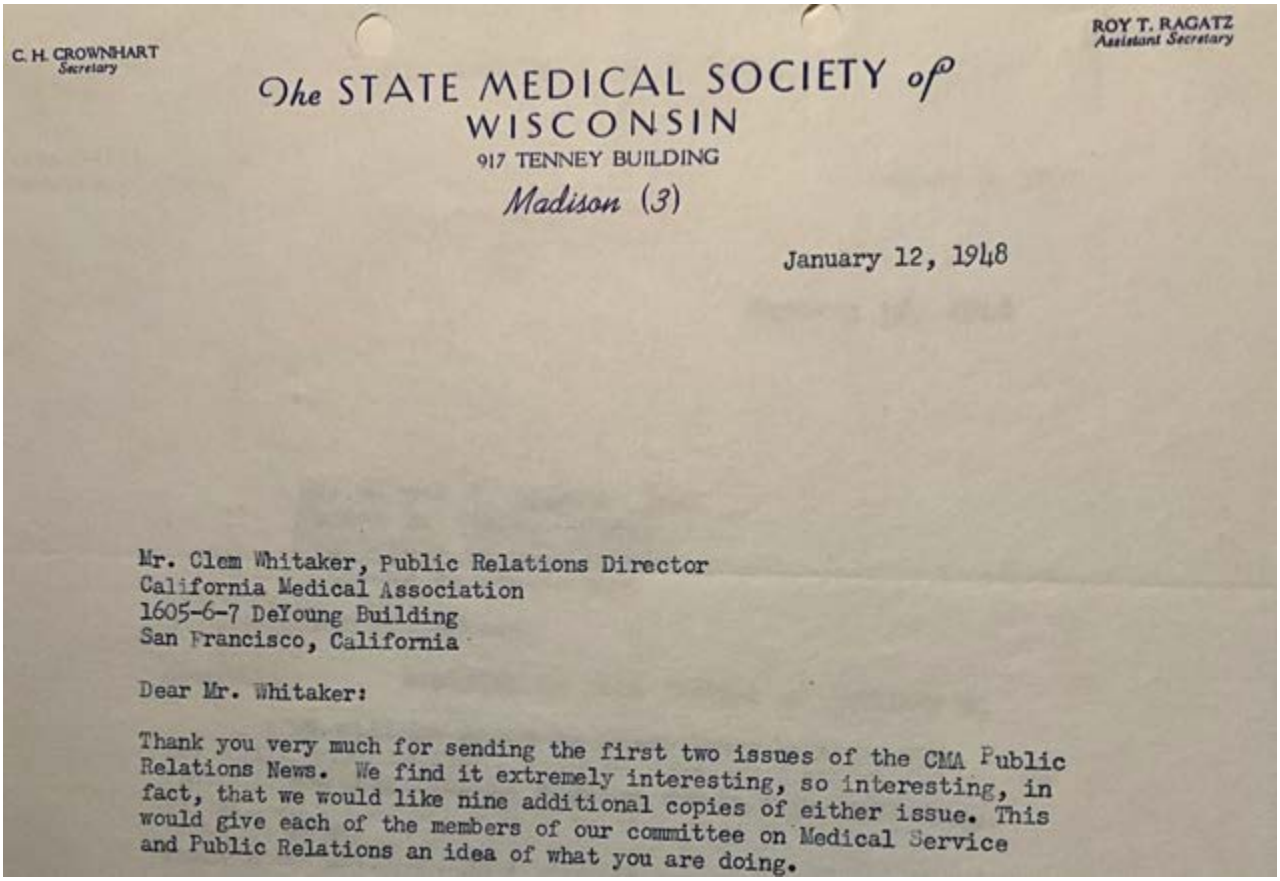
Appendix Figure A17: Top 10 Lobbying Organizations in 2023



Notes: Figure plots the total lobbying amount of the top 10 organizations in 2023 (Open Secrets 2023). Green bars represent organizations from other industries, and blue bars represent organizations from the health industry.

B Primary Source Exhibits

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



C. H. CROWNHART
Secretary

ROY T. RAGATZ
Assistant Secretary

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

January 12, 1948

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

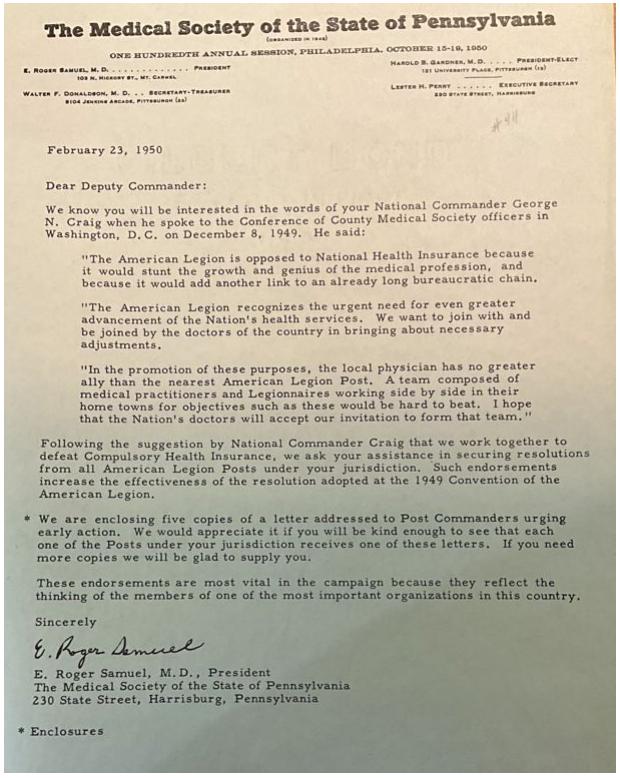
Dear Mr. Whitaker:

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

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

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

(a) Resolution letter



The Medical Society of the State of Pennsylvania

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

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

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

February 23, 1950

Dear Deputy Commander:

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

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

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

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

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

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

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

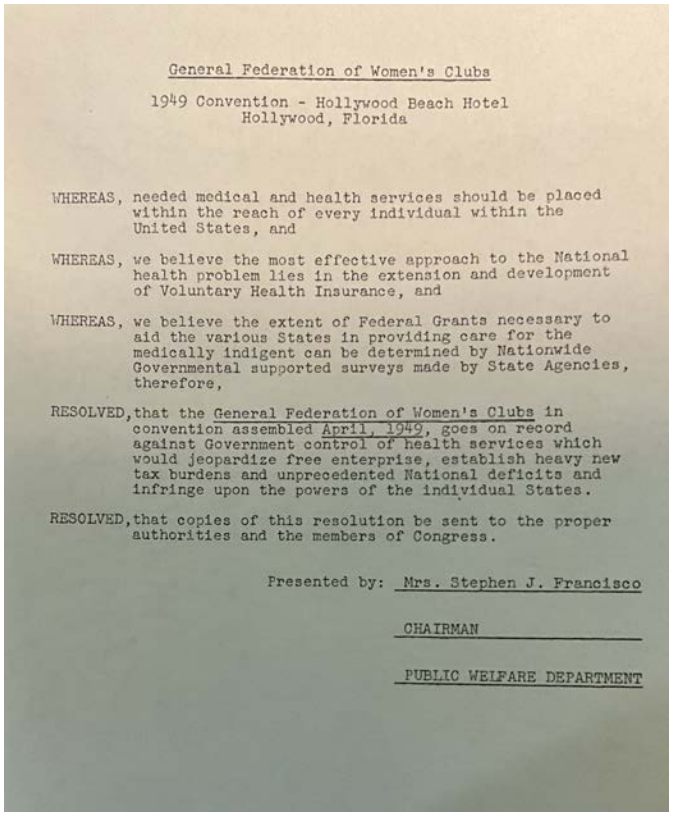
Sincerely

E. Roger Samuel

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

* Enclosures

(b) Resolution text



General Federation of Women's Clubs

1949 Convention - Hollywood Beach Hotel
Hollywood, Florida

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

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

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

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

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

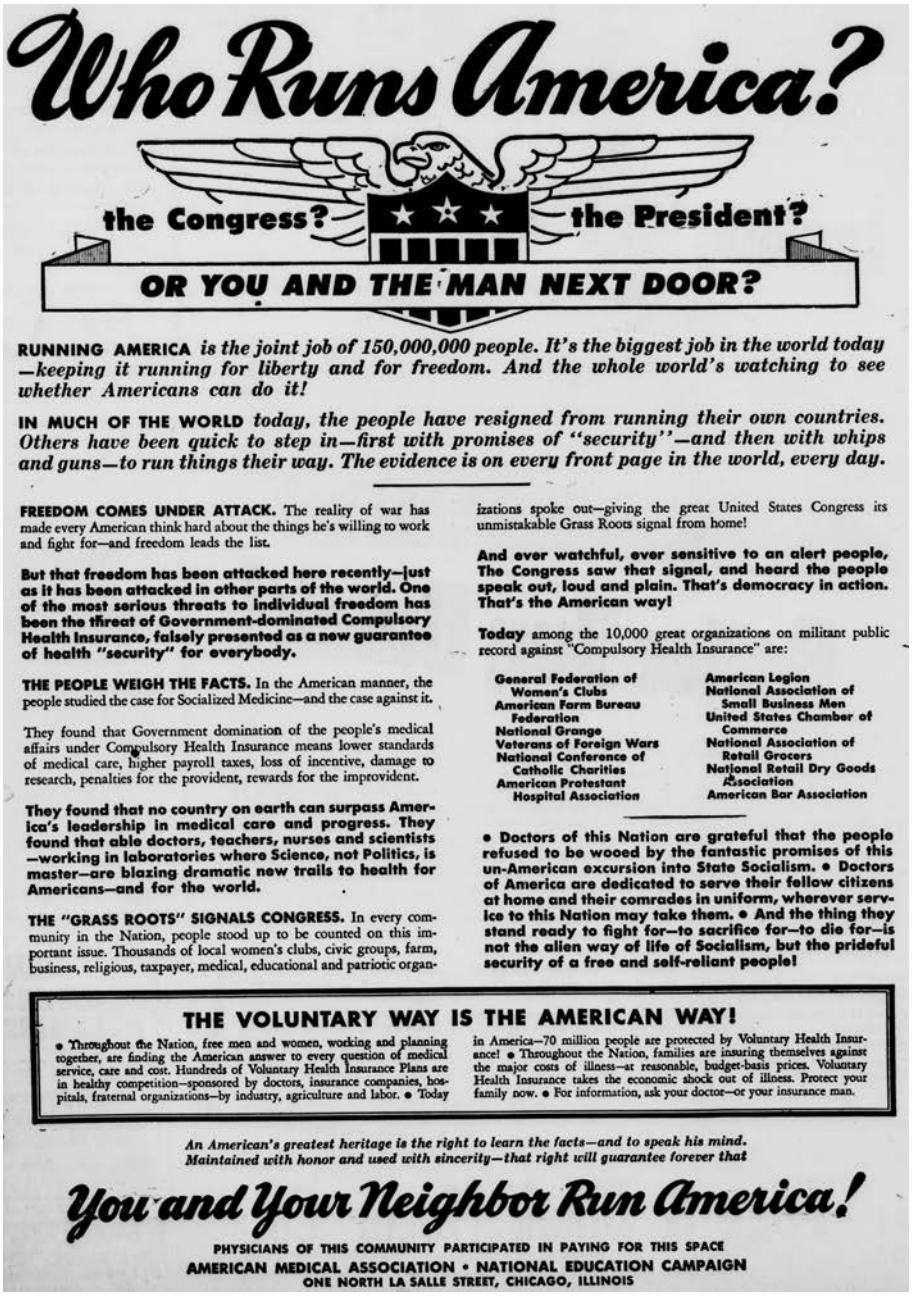
Presented by: Mrs. Stephen J. Francisco

CHAIRMAN

PUBLIC WELFARE DEPARTMENT

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

Appendix Figure B3: Main Campaign Newspaper Ad



Who Runs America?

the Congress? ★ ★ ★ **the President?**

OR YOU AND THE MAN NEXT DOOR?

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

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

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

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

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

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

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

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

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

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

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

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

THE VOLUNTARY WAY IS THE AMERICAN WAY!

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

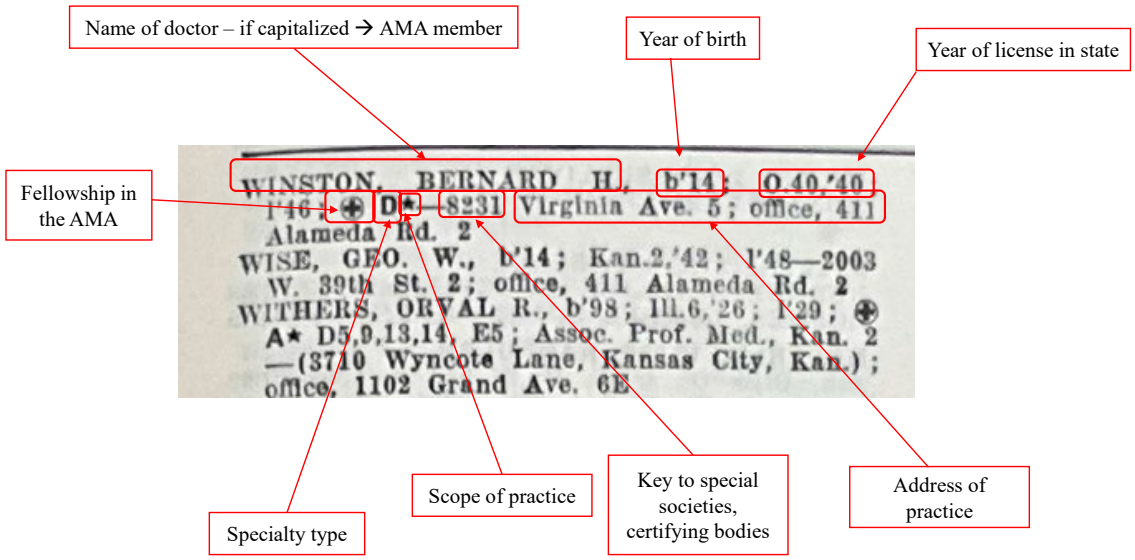
An American's greatest heritage is the right to learn the facts—and to speak his mind. Maintained with honor and used with sincerity—that right will guarantee forever that

You and Your Neighbor Run America!

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

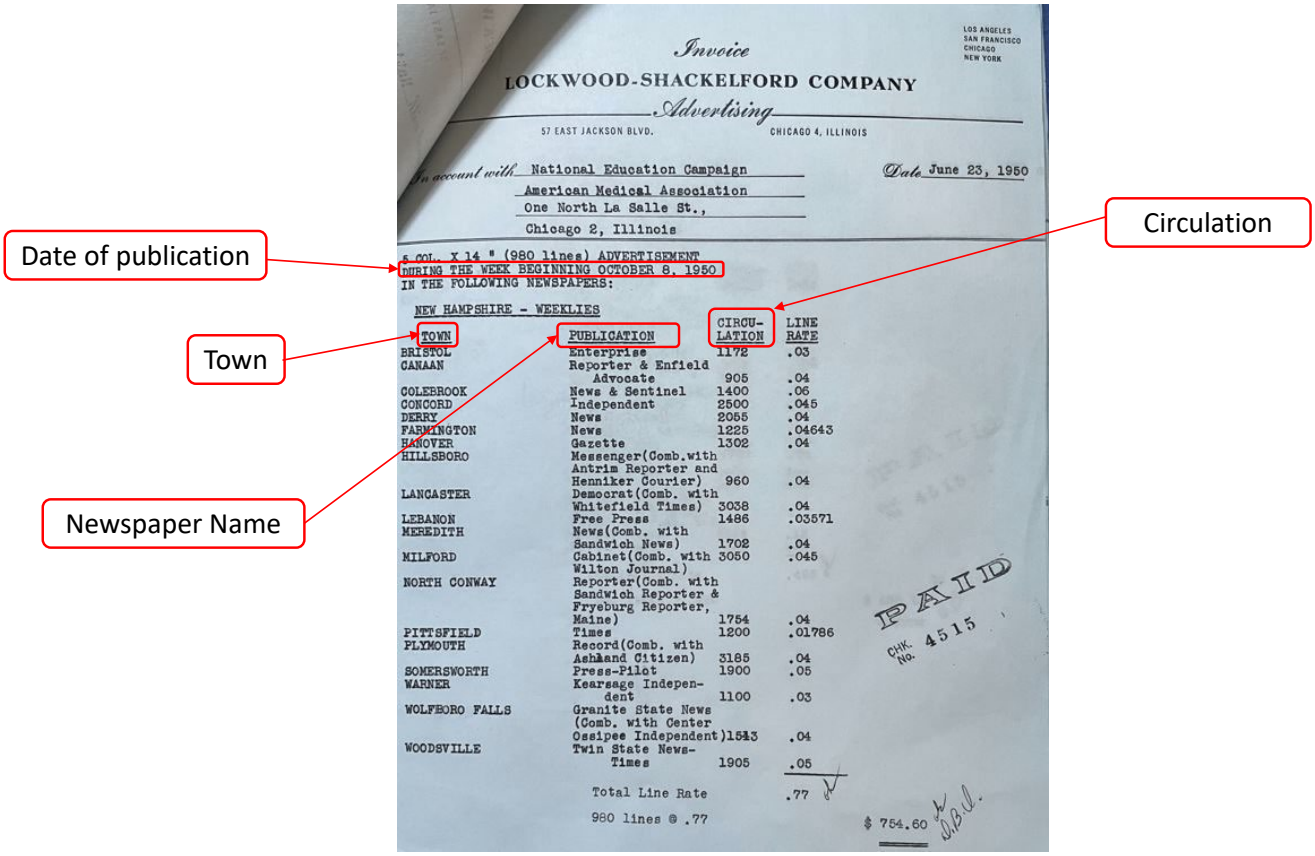
Notes: Exhibit shows the standard template for the main Campaign advertisement which circulated in October 1950. The size and content were constant across newspapers. Example taken from page 16 of the *Athens Alabama Courier* published on October 12, 1950 (American Medical Association 1950*c*).

Appendix Figure B4: Example Records from the American Medical Directory



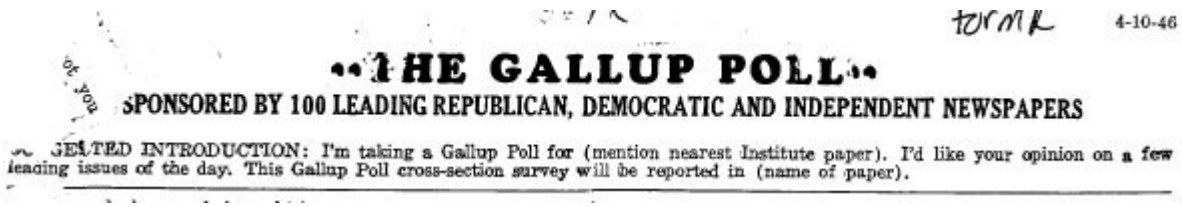
Notes: Exhibit shows example records from the *American Medical Directory* (American Medical Association 1950*a*, p.339).

Appendix Figure B5: Lockwood-Shackelford Advertising Agency Invoice



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

Appendix Figure B6: Gallup Sponsor and Recruitment Instructions



4-10-46

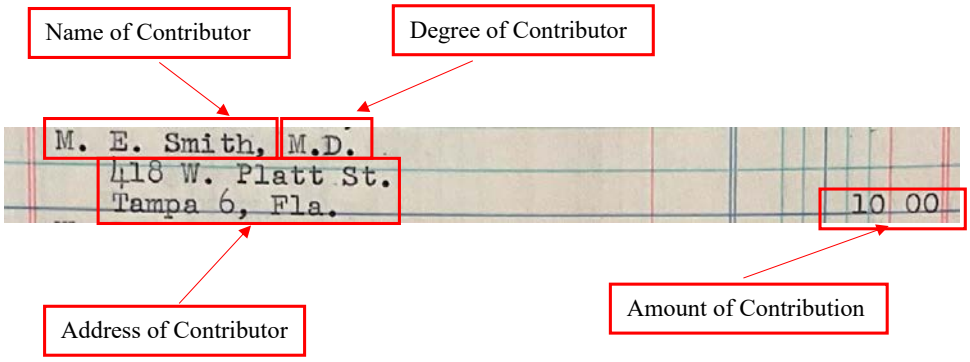
THE GALLUP POLL

SPONSORED BY 100 LEADING REPUBLICAN, DEMOCRATIC AND INDEPENDENT NEWSPAPERS

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).

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



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

C Appendix Tables

Appendix Table C1: Effect of the Campaign on
Donating to Eisenhower-Nixon Ticket, Continuous Outcome

	(1)	(2)	(3)	(4)
Campaign Exposure $\times$ $I^{\text{Specialist}}$	0.004***	0.004***	0.004***	0.004***
	(0.001)	(0.001)	(0.001)	(0.001)
Campaign Exposure	-0.001	-0.000	-0.001	-0.001
	(0.001)	(0.002)	(0.001)	(0.001)
$I^{\text{Specialist}}$	0.009***	0.011***	0.009***	0.009***
	(0.002)	(0.002)	(0.002)	(0.002)
Dependent Mean	0.004	0.004	0.004	0.004
Observations	167373	167222	166634	166634
County FE		✓		
Design Controls			✓	✓
Individual Characteristics				✓

Notes: Table reports specification checks for the outcome of physician donation on the interaction of Campaign exposure and $I^{\text{Specialist}}$ as in Equation 8. The outcome is an inverse hyperbolic sine transformation of the dollar amount each physician donated to Eisenhower's Presidential Ticket (Whitaker & Baxter *Campaigns, Inc.* 1946-1973). Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. $I^{\text{Specialist}}$ is an indicator for whether a physician was a specialist. All regressions control for whether the physician is an AMA member. Individual physician characteristics include age, an indicator for having served in the military, and an indicator for clinically active status (American Medical Association 1950*a*). Design controls include county level log income per capita (Bureau of Economic Analysis 2023), number of hospitals at the county level (American Hospital Association 1948, 1950, 1952), and state level share unionized (Farber et al. 2021). Dependent Mean is the unconditional mean of the dependent variable for generalists. 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 C2: Effect of Campaign on Private Health Insurance Enrollment, Robustness Tests

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
	Additional and Alternative Controls					Design and Inference		Alternative Sample, Outcome, and Exposure		
Specification:	Unit-Specific Pre-Trend	War Bond Control	Blue Cross Control	Enabling Legislation	Specialist Control	Binary Treatment	Potential Trends Violations	Without California	Alternative Denominator	Alternative Exposure
Campaign Exposure $\times$ I^{Post}	0.025***	0.020***	0.022***	0.021***	0.020***	0.024**	0.020**	0.023***	0.057***	0.023***
	(0.007)	(0.005)	(0.005)	(0.005)	(0.004)	(0.009)	[0.005,0.039]	(0.005)	(0.018)	(0.005)
Dependent Mean	0.034	0.034	0.034	0.034	0.034	0.034	0.034	0.033	0.135	0.034
Observations	423	423	423	423	423	423	423	414	423	423
State FE	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Design Controls	✓	✓		✓	✓	✓	✓	✓	✓	✓
Year FE	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Notes: Table reports specification checks for the outcome of private health insurance enrollment. Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. I^{Post} is an indicator for post-Campaign. The sample includes 48 states from the years 1946-1954, where we collapsed Vermont and New Hampshire (see Section IV) (Council on Medical Service 1946-1954). Column 1 reports regression results controlling for unit-specific pre-trends following Miller (2023). Column 2 reports regression results controlling for war bonds (U.S. Census Bureau 2012). Column 3 reports results replacing hospital count in the design controls with the share of Blue Cross hospitals (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 where treatment is dichotomized at the 50th percentile of Campaign exposure. Column 7 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 8 reports results excluding California. Column 9 reports results using total enrollment denominated by the number of White employed males. Column 10 reports results using only published propaganda materials (per capita Campaign pamphlets and per capita circulation of Campaign ads) as the exposure. Design Controls include log income per capita (Bureau of Economic Analysis 2023), number of hospitals (American Hospital Association 1948, 1950, 1952), 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 C3: Effect of Campaign on Approval for National Health Insurance Legislation, Robustness Tests

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
	Additional and Alternative Controls					Design and Inference		Alternative Sample, Weights, and Exposure		
Specification:	Unit-Specific Pre-Trend	War Bond Control	Blue Cross Control	Enabling Legislation	Specialist Control	Binary Treatment	Potential Trends Violations	Without California	Alternative Weights	Alternative Exposure
Campaign Exposure $\times$ I^{Post}	-0.041**	-0.050***	-0.050***	-0.048***	-0.051***	-0.121**	-0.080**	-0.051***	-0.045**	-0.026
	(0.016)	(0.017)	(0.017)	(0.017)	(0.017)	(0.051)	[-0.212, -0.011]	(0.014)	(0.018)	(0.019)
Dependent Mean	0.684	0.684	0.684	0.684	0.684	0.684	0.684	0.698	0.684	0.684
Observations	4931	5062	5062	5062	5062	5062	5062	4654	5062	5062
State FE	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Design Controls	✓	✓		✓	✓	✓	✓	✓	✓	✓
Individual Characteristics	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Wave FE	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Notes: Table reports specification checks for the outcome of approval for legislation establishing National Health Insurance. Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. I^{Post} is an indicator for post-Campaign. The outcome is an indicator for approval (see Appendix Table A1). Column 1 reports regression results controlling for unit-specific pre-trends following Miller (2023). Column 2 reports the results of a regression controlling for war bond purchases (U.S. Census Bureau 2012). Column 3 reports results replacing hospital count in the design controls with the share of Blue Cross hospitals (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 where treatment is dichotomized at the 50th percentile of Campaign exposure. Column 7 reports the Campaign effect in the 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 8 reports results excluding California. Column 9 reports results with sampling weights for all U.S. adults over the age of 21 regardless of voting eligibility (Gallup Organization 1945, 1946, 1949, 1950). The sample includes Gallup polls from November 1945, April 1946, May 1949, November 1949, October 1950, and November 1950 (Gallup Organization 1945, 1946, 1949, 1950). Column 10 reports results using only published propaganda materials (per capita Campaign pamphlets and per capita circulation of Campaign ads) as the exposure. 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 group, having a phone, voted Republican in the last election, employment status, union membership, job class, urbanicity, and education. Sampling weights for the voting-eligible population (VEP) of all U.S. adults are applied all columns except for Column 9 (Gallup Organization 1945, 1946, 1949, 1950). Design controls include log income per capita (Bureau of Economic Analysis 2023), number of hospitals (American Hospital Association 1948, 1950, 1952), 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 C4: Effect of Campaign
on Civic Organizations Supporting Private Health Insurance, Robustness Tests

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	Additional and Alternative Controls					Alternative Sample and Exposure		
Specification:	War Bond Control	Blue Cross Control	Demographic Controls	Enabling Legislation	Specialist Control	Without California	Binary Treatment	Alternative Exposure
Campaign Exposure	0.023**	0.025**	0.021*	0.038***	0.021**	0.024**	0.029***	0.021**
	(0.011)	(0.010)	(0.011)	(0.007)	(0.010)	(0.011)	(0.010)	(0.010)
Dependent Mean	0.139	0.139	0.139	0.139	0.139	0.141	0.139	0.139
Observations	3002	3002	3002	3002	3002	2946	3002	3002
State FE	✓	✓	✓		✓	✓	✓	✓
Division FE				✓				
Design Controls	✓		✓	✓	✓	✓	✓	✓

Notes: Table reports results of Equation 7 for the outcome of civic organizations on record supporting voluntary (private) health insurance from (Whitaker & Baxter *Campaigns, Inc.* 1933-1974). The outcome is normalized by county population and is multiplied by 1,000 for readability. Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. Column 1 reports regression results controlling for 1944 per capita war bond purchases at the county level (U.S. Census Bureau 2012). Column 2 reports results replacing hospital count in the Design Controls with the share of Blue Cross hospitals (American Hospital Association 1948, 1950, 1952). Column 3 reports results controlling for county shares of Black, female, employed, and urban populations (Haines 2010). Column 4 reports results controlling for an indicator for the passage of enabling legislation at the state level. Column 5 reports results controlling for share specialists interacted with a time trend. Column 6 reports results excluding California. Column 7 reports results where treatment is dichotomized at the 50th percentile of Campaign exposure. Column 8 reports results using only published propaganda materials (per capita Campaign pamphlets and per capita circulation of Campaign ads) as the exposure. Design controls include log income per capita (Bureau of Economic Analysis 2023), number of hospitals (American Hospital Association 1948, 1950, 1952), and share unionized (Farber et al. 2021). 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 C5: Effect of Campaign
Controlling for Trends in Share AMA and Share Educated

	(1)	(2)	(3)	(4)
Dependent Variable:	PHI Enrollment	NHI Approval	Civic Orgs.	Share Rep. Vote
	Panel A: Share AMA Trend Control			
Effect of Campaign	0.023**	-0.047***	0.029***	0.008***
	(0.009)	(0.017)	(0.011)	(0.002)
	Panel B: Share Educated Trend Control			
Effect of Campaign	0.021**	-0.049***	0.025**	0.007***
	(0.011)	(0.017)	(0.011)	(0.002)
Dependent Mean	0.034	0.684	0.139	0.404
Observations	423	5062	3002	16404
Design Controls	✓	✓	✓	✓
Additional Controls	✓	✓	✓	✓

Notes: Table reports effects of the Campaign for the outcomes of private health insurance (PHI) enrollment, approval for legislation establishing National Health Insurance, civic organizations on record supporting voluntary (private) health insurance from Whitaker & Baxter *Campaigns, Inc.* (1933-1974), and share vote Republican (Inter-university Consortium for Political and Social Research 1999). Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. Regressions additionally control for trends in share AMA members (Panel A) and share educated (Panel B). Share educated is defined as the share of adults with more than five years of schooling. Trend in share AMA members is estimated using share AMA members interacted with a time trend. Trend in share educated is estimated using share educated linearly interpolated with 1940 and 1950 census data for each state. Design controls include log income per capita (Bureau of Economic Analysis 2023), number of hospitals (American Hospital Association 1948, 1950, 1952), and share unionized (Farber et al. 2021). Dependent Mean is the unconditional mean of the dependent variable in the pre-period. Robust standard errors (Column 3) and robust standard errors clustered at the state (Column 1), state-by-urbanicity (Column 2), and county level (Column 4) are in parentheses. *, **, *** refer to statistical significance at the 10, 5, and 1 percent level, respectively.

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

	(1)	(2)	(3)	(4)
Dependent Variable:	PHI Enrollment	NHI Approval	Civic Orgs.	Share Rep. Vote
	Panel A: Share HH. Owning a Radio Trend Control			
Effect of Campaign	0.023**	-0.052***	0.044***	0.008***
	(0.009)	(0.017)	(0.008)	(0.002)
	Panel B: Share HH. Owning a TV Trend Control			
Effect of Campaign	0.021**	-0.049***	0.057***	0.008***
	(0.009)	(0.017)	(0.008)	(0.002)
Dependent Mean	0.034	0.684	0.139	0.404
Observations	423	5062	3002	16404
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 share vote Republican (Inter-university Consortium for Political and Social Research 1999). Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. Regressions additionally control for trends in share households owning a radio (Panel A) and share households owning a TV (Panel B) (U.S. Census Bureau 1953). Trend in each share is estimated using the share interacted with a time trend. Design controls include log income per capita (Bureau of Economic Analysis 2023), number of hospitals (American Hospital Association 1948, 1950, 1952), and share unionized (Farber et al. 2021). Dependent Mean is the unconditional mean of the dependent variable in the pre-period. Robust standard errors (Column 3) and robust standard errors clustered at the state (Column 1), state-by-urbanicity (Column 2), and county level (Column 4) are in parentheses. *, **, *** refer to statistical significance at the 10, 5, and 1 percent level, respectively.

Appendix Table C7: Effect of Campaign on Private Health Insurance Enrollment, Individual Campaign Components and Interaction

	(1)	(2)	(3)	(4)	(5)	(6)
Baseline	0.023***					
	(0.008)					
Ad $\times$ I^{Post}		0.021**		0.020*		-0.003
		(0.010)		(0.010)		(0.018)
MD $\times$ I^{Post}			0.013	0.011		-0.013
			(0.012)	(0.009)		(0.011)
Ad $\times$ MD $\times$ I^{Post}					0.027***	0.038*
					(0.007)	(0.020)
p-value Ad $\times$ I^{Post} = MD $\times$ I^{Post}				0.567		0.410
Dependent Mean	0.034	0.034	0.034	0.034	0.034	0.034
Observations	423	423	423	423	423	423
Design Controls	✓	✓	✓	✓	✓	✓
Additional Controls	✓	✓	✓	✓	✓	✓

Notes: Table reports results from a regression of share enrolled in private health insurance on the interaction of Campaign exposure components and I^{Post}. All controls in Table 1 Column 4 are included. Ad and MD components in Columns 1-4 are standardized. Interaction in Columns 5 and 6 is the standardized product of non-standardized Ad and MD components. The p-value for the difference between the Ad and MD coefficients is reported in Columns 4 and 6. 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 C8: Effect of Campaign on Approval for National Health Insurance Legislation, Individual Campaign Components and Interaction

	(1)	(2)	(3)	(4)	(5)	(6)
Baseline	-0.047***					
	(0.017)					
Ad $\times$ I^{Post}		-0.022		-0.024		-0.035
		(0.029)		(0.029)		(0.029)
MD $\times$ I^{Post}			-0.037***	-0.038***		-0.042***
			(0.007)	(0.007)		(0.009)
Ad $\times$ MD $\times$ I^{Post}					-0.014	0.025
					(0.025)	(0.022)
p-value Ad $\times$ I^{Post} = MD $\times$ I^{Post}				0.612		0.794
Dependent Mean	0.684	0.684	0.684	0.684	0.684	0.684
Observations	5062	5062	5062	5062	5062	5062
Design Controls	✓	✓	✓	✓	✓	✓
Additional Controls	✓	✓	✓	✓	✓	✓

Notes: Table reports results from a regression of approval for legislation establishing National Health Insurance on the interaction of Campaign exposure components and I^{Post}. All controls in Table 2 Column 4 are included. Ad and MD components in Columns 1-4 are standardized. Interaction in Columns 5 and 6 is the standardized product of non-standardized Ad and MD components. The p-value for the difference between the Ad and MD coefficients is reported in Columns 4 and 6. Dependent Mean is the unconditional mean of the dependent variable in the pre-period. 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 C9: Effect of Campaign,
Nonparametric ACR Estimates

	(1)	(2)	(3)	(4)
	Baseline	Nonparametric Estimator		
Method:	TWFE	Polynomial	B-Spline	Spline
Effect of Campaign	0.023***	0.024***	0.022***	0.022***
	(0.009)	(0.007)	(0.009)	(0.009)
Observations	423	423	423	423

Notes: Table reports effects of the Campaign for the outcome of private health insurance enrollment. Column 1 reports the baseline estimate from Table 1 Column 4. Columns 2-4 report results obtained by implementing the nonparametric estimation procedure proposed in Callaway, Goodman-Bacon and Sant'Anna (2024). Column 2 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.

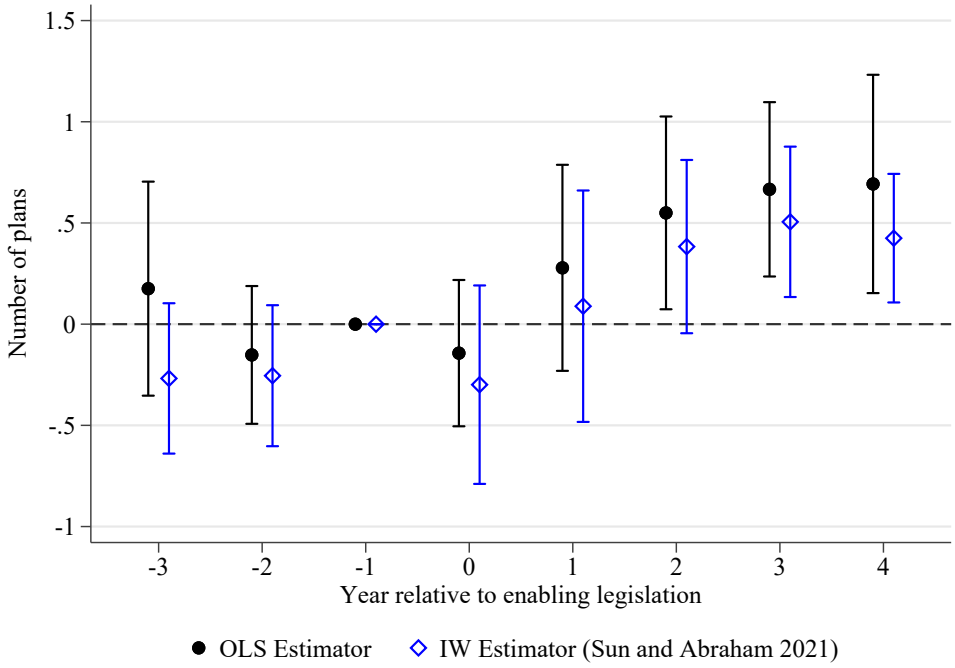
Appendix Table C10: Socialism-Related Terms in Ads

	(1)	(2)	(3)	(4)
Dependent Variable:	Any Keyword		Number of Keywords	
$I^{\text{Campaign Ad}}$	0.887***	0.897***	4.842***	5.953***
	(0.010)	(0.010)	(0.170)	(0.201)
Dependent Mean	0.008	0.008	0.012	0.012
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 dependent variable for the non-Campaign ads. Campaign ads include both the main ad (see Figure 1 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 Newspaper Archive (2023). Robust standard errors clustered at the newspaper level are in parentheses. *, **, *** refer to statistical significance at the 10, 5, and 1 percent level, respectively.

D Appendix Figures

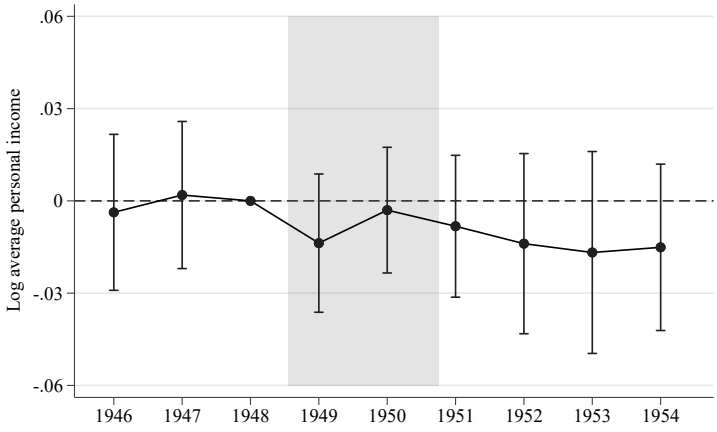
Appendix Figure D1: Effects of Enabling Legislation on Number of Prepayment Plans



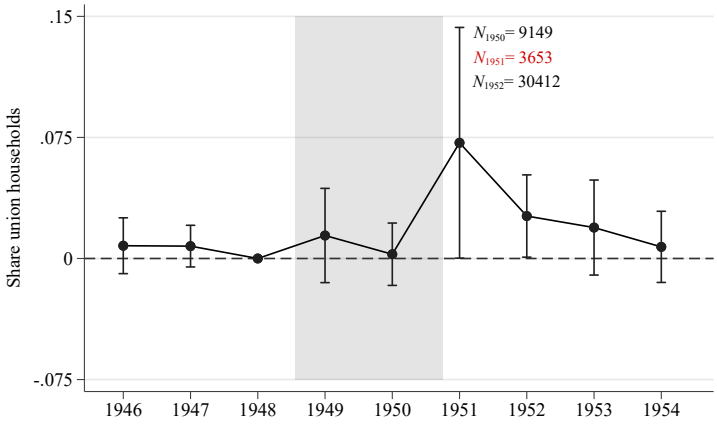
Notes: Figure plots the effect of enabling legislation on the number of prepayment plans (Council on Medical Service 1946-1954), and associated 95% confidence intervals. State and year fixed effects and log average personal income (Bureau of Economic Analysis 2023) are included. IW estimates are computed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

Appendix Figure D2: Effects of Campaign on Log Average Personal Income and Share Union Households

(a) Log Average Personal Income

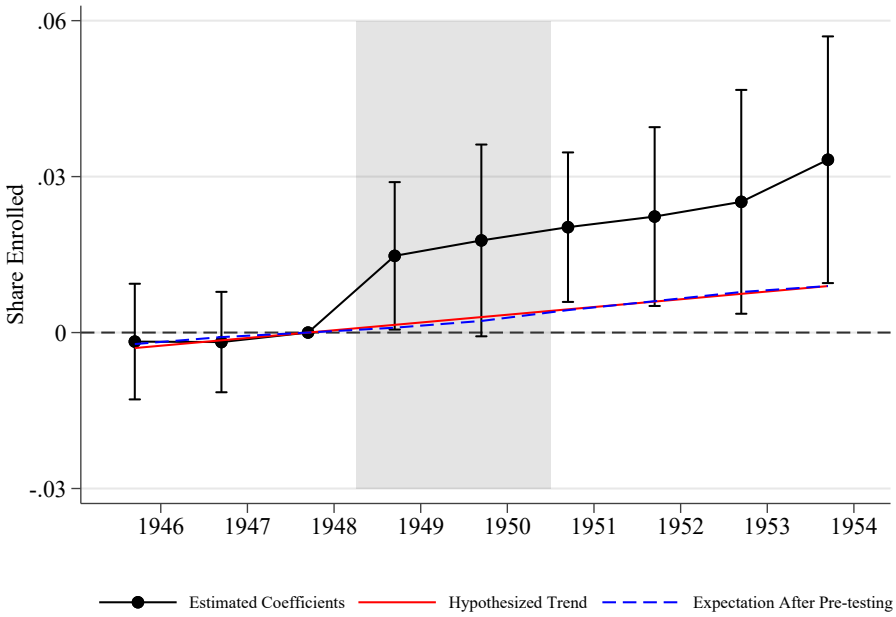


(b) Share Union Households



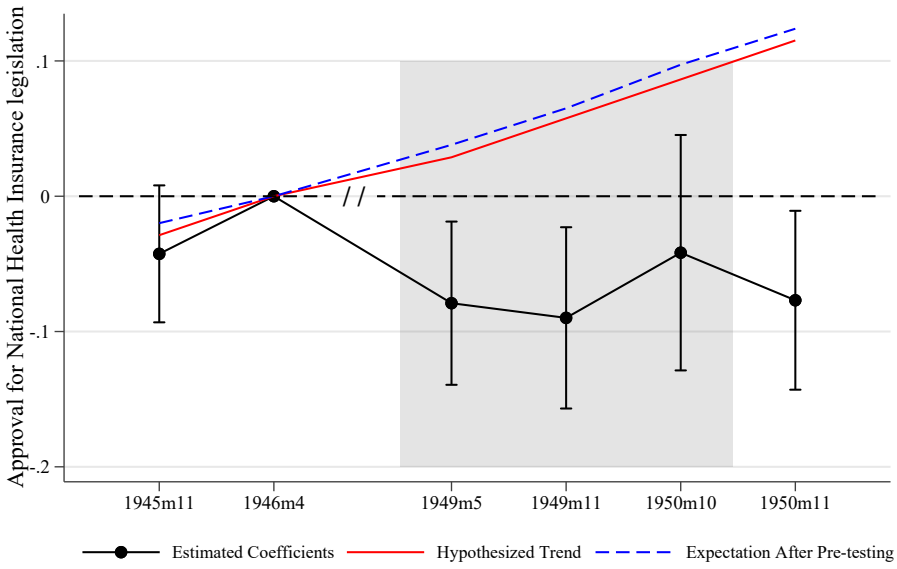
Notes: Figures plot the β coefficients from a regression similar to Equation 5, and associated 95% confidence intervals. The outcome in Panel A is the logged personal income per capita and the outcome in Panel B is the share union households. Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. State characteristics include the number of hospitals and the share of union households for Panel A and logged personal income per capita for Panel B. Union data are obtained from Farber et al. (2021) which is based on Gallup samples which differed over time. The sample size decreased from 9149 in 1950 to 3653 in 1951. Income data are from Bureau of Economic Analysis (2023).

Appendix Figure D3: Effect of Campaign on
Private Health Insurance Enrollment, Pretrend Test



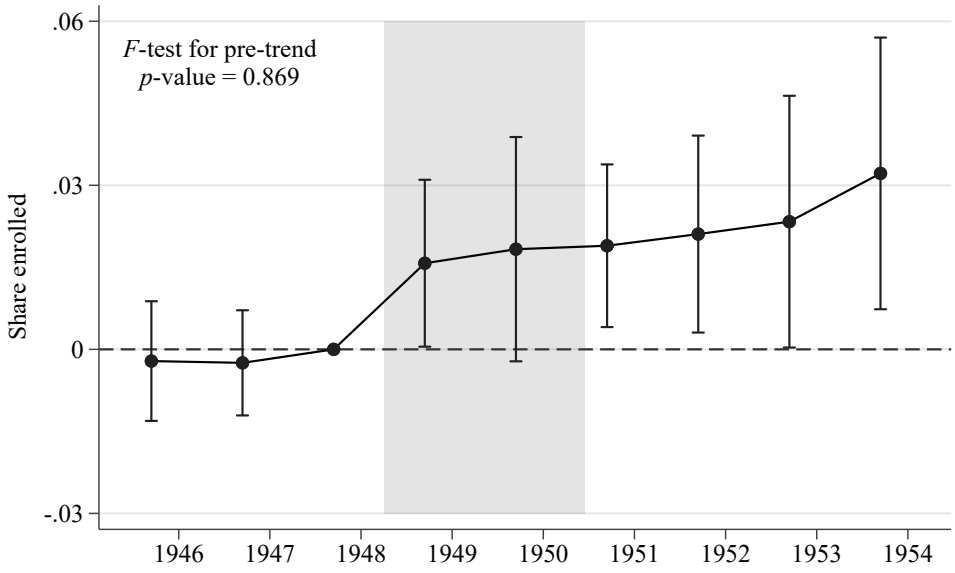
Notes: Figure plots potential violations of parallel trends based on methods proposed in Roth (2022). The coefficients on the interactions are estimated in an event study regression given by Equation 5, and the error bars represent the associated 95% confidence intervals. The red solid line represents the conjectured linear violation of parallel trends with 80% power. The blue dashed line represents the expected values of event study coefficients if the violation were present but undetectable using standard techniques. Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. Design controls include log income per capita (Bureau of Economic Analysis 2023), number of hospitals (American Hospital Association 1948, 1950, 1952), and share unionized (Farber et al. 2021).

Appendix Figure D4: Effect of Campaign on
Approval for National Health Insurance Legislation



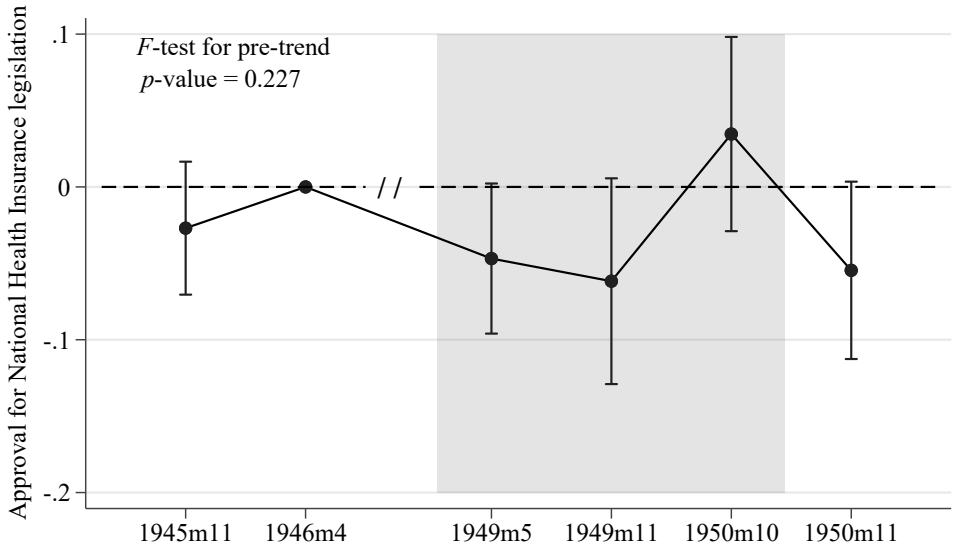
Notes: Figure plots potential violations of parallel trends based on methods proposed in Roth (2022). The coefficients on the interactions are estimated in an event study regression given by Equation 6, and the error bars represent the associated 95% confidence intervals. The red solid line represents the conjectured linear violation of parallel trends with 80% power. The blue dashed line represents the expected values of event study coefficients if the violation were present but undetectable using standard techniques. The outcome is an indicator for approval for legislation establishing National Health Insurance. Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. The sample includes Gallup polls from November 1945, April 1946, May 1949, November 1949, October 1950, and November 1950. Individual level controls include a set of indicators for female, Black, age, education, having a phone, vote Republican, employment status, union membership, and urbanicity, respectively. Design controls include log income per capita (Bureau of Economic Analysis 2023), number of hosptials (American Hospital Association 1948, 1950, 1952), and share unionized (Farber et al. 2021). Sampling weights for the voting-eligible population are applied.

Appendix Figure D5: Effect of Campaign on
Private Health Insurance Enrollment, Alternative Exposure



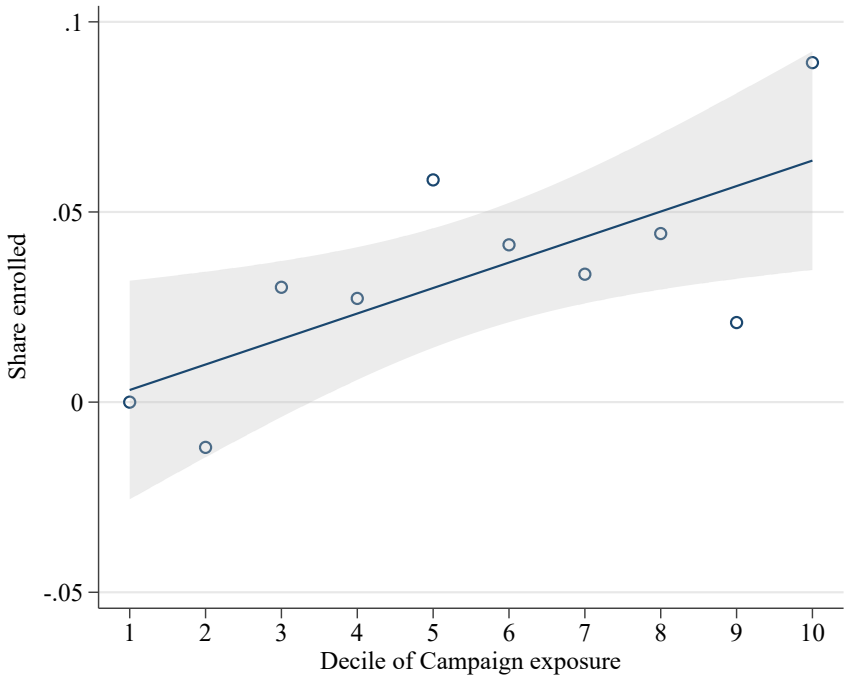
Notes: Figure plots β coefficients from Equation 5 and associated 95% confidence intervals using cluster-robust standard errors. Campaign exposure is constructed using printed propaganda material only (*i.e.,* the standardized sum of standardized per capita Campaign pamphlets and standardized per capita circulation of Campaign ads). All controls in Figure 5 are included.

Appendix Figure D6: Effect of Campaign on
Approval for National Health Insurance Legislation, Alternative Exposure



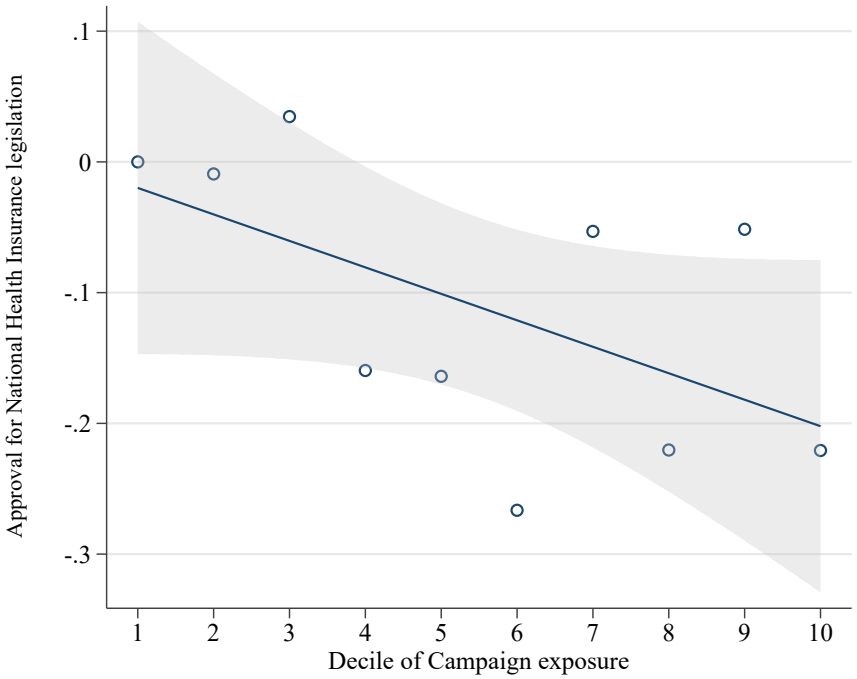
Notes: Figure plots β coefficients from Equation 6 and associated 95% confidence intervals using cluster-robust standard errors. Campaign exposure is constructed using printed propaganda material only (*i.e.,* the standardized sum of standardized per capita Campaign pamphlets and standardized per capita circulation of Campaign ads). All controls in Figure 6 are included. Sampling weights for the voting-eligible population are applied.

Appendix Figure D7: Private Health Insurance Enrollment by Campaign Exposure Deciles



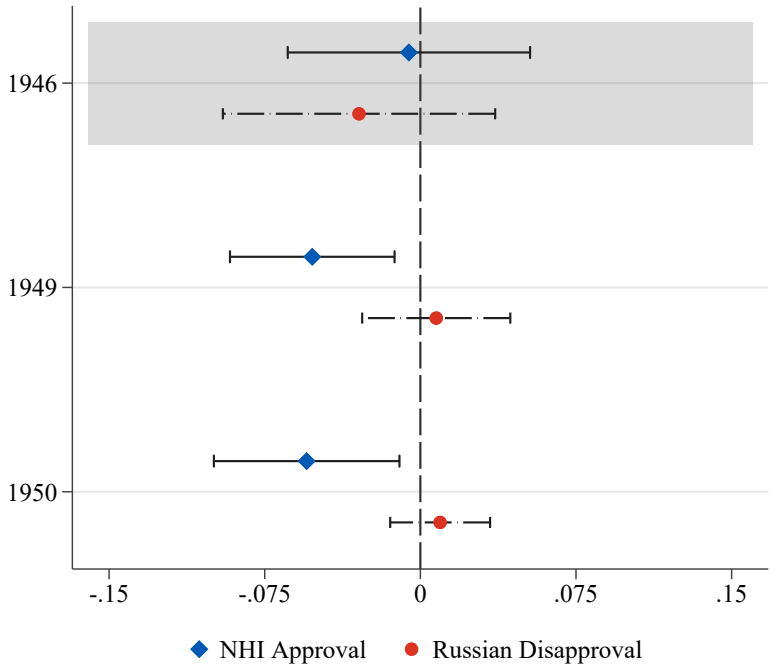
Notes: Figure plots the effect of the Campaign on share enrolled by exposure decile. Dots represent the point estimates of coefficients on the interaction of decile indicators and I^{Post}. The solid lines are fitted linear trends, and the shaded areas are associated 95% confidence intervals.

Appendix Figure D8: 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 D9: Campaign exposure and anti-Russian Sentiment



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

E Additional Elections Analysis

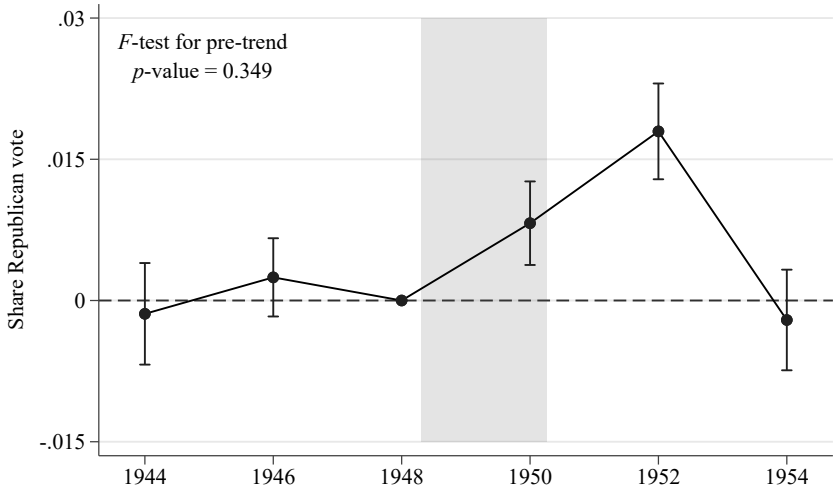
The Campaign may have affected voting behavior, as NHI legislation was associated with members of the Democratic party and major ads were run before the 1950 midterms. Therefore we use the share of votes for Republican House of Representative candidates as our outcome of interest (Inter-university Consortium for Political and Social Research 1999). We focus on elections in the House of Representatives as there are fewer Senate elections due to the six-year terms.[48] Several considerations are important to bear in mind for this exercise. First, redistricting affected House seats in 16 states (U.S. Census Bureau 1950) – motivating our use of county level data. Second, in 1948, the States' Rights Democratic Party (also known as the "Dixiecrats") formed as an offshoot of the Democratic party in the South, opposing civil rights reforms supported by Truman and the Democratic platform (Webb 2013). Therefore, in our preferred specification, we include region-year fixed effects to adjust for region-specific shocks. Third, candidates could have shifted positions on issues without changing party affiliation.

The estimating equation for elections is similar to Equation 5, however the outcome is $\frac{V^{\text{Repub.}}{}_{ct}}{V_{ct}}$, the share of votes for Republican candidates for the House of Representatives over total votes. County fixed effects and region-year fixed effects are included in addition to the usual time-varying county and state level design controls. Our preferred specification also includes lagged vote share for the Republican presidential candidate in the most recent general election.

The AMA-WB Campaign appeared to benefit House Republicans, at least in the subsequent 1950 midterm election and 1952 Presidential election (Appendix Figure E1, p-value on F-test for pre-trend = 0.349). The results are short-lived and dissipate by 1954. There are several potential reasons for the decay that are beyond the scope of our analysis, but, by 1954, NHI was off the legislative agenda. The average effect in the post-Campaign period shown in Appendix Table E1 demonstrates that a one standard deviation increase in Campaign exposure increased the Republican share of the House election vote by about 1 percentage point. These findings are sensitive to region-year fixed effects, which may be attributed to the regional issues described above. Indeed, when we exclude the South, the event study is robust across a range of specifications (additional robustness checks gathered in Appendix Table E2).

[48] Although we don't examine Senate races due to their relative infrequency, the Campaign took credit for defeating two prominent advocates of NHI, Senators Claude Pepper of Florida and Frank Graham of North Carolina, among others (Corning 1969).

Appendix Figure E1: Effect of Campaign on Share Republican Vote, Biennial House of Representative Elections



Notes: Figure plots β coefficients from a regression similar to Equation 5, and associated 95% confidence intervals using cluster robust standard errors. The outcome is Republican vote share. Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. The sample includes the years 1944, 1946, 1948, 1950, and 1954, where 1948 is taken as the base period. Design controls include county level log income per capita (Bureau of Economic Analysis 2023), county level number of hospitals (American Hospital Association 1948, 1950, 1952), and state level share of unionized hospitals (Farber et al. 2021). Election controls include the lagged share of presidential Republican votes Inter-university Consortium for Political and Social Research (1999).

Appendix Table E1: Effect of Campaign on Share Republican Vote, Biennial House of Representative Elections

	(1)	(2)	(3)	(4)
Campaign Exposure $\times$ I^{Post}	0.008***	0.007***	0.008***	0.008***
	(0.002)	(0.002)	(0.002)	(0.002)
Campaign Exposure	0.018***	0.002	0.000	
	(0.004)	(0.002)	(0.002)	
Dependent Mean	0.404	0.406	0.404	0.404
Observations	16404	16644	16404	16404
Region $\times$ Year FE	✓	✓	✓	✓
Design Controls	✓		✓	✓
Election Controls		✓	✓	✓
County FE				✓

Notes: Table reports a regression of county level Republican vote share on the interaction of Campaign exposure and I^{Post} (Inter-university Consortium for Political and Social Research 1999). Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. I^{Post} is an indicator for post-Campaign. The sample includes years 1944, 1946, 1948, 1950, 1952, and 1954. Dependent Mean is the unconditional mean of the dependent variable for the pre-period. Election controls include the lagged county share Republican vote in the most recent presidential election (Inter-university Consortium for Political and Social Research 1999). Design controls include county level log income per capita (Bureau of Economic Analysis 2023), county level number of hospitals (American Hospital Association 1948, 1950, 1952), and state share unionized (Farber et al. 2021). Robust standard errors clustered at the county level are in parentheses. *, **, *** refer to statistical significance at the 10, 5, and 1 percent level, respectively.

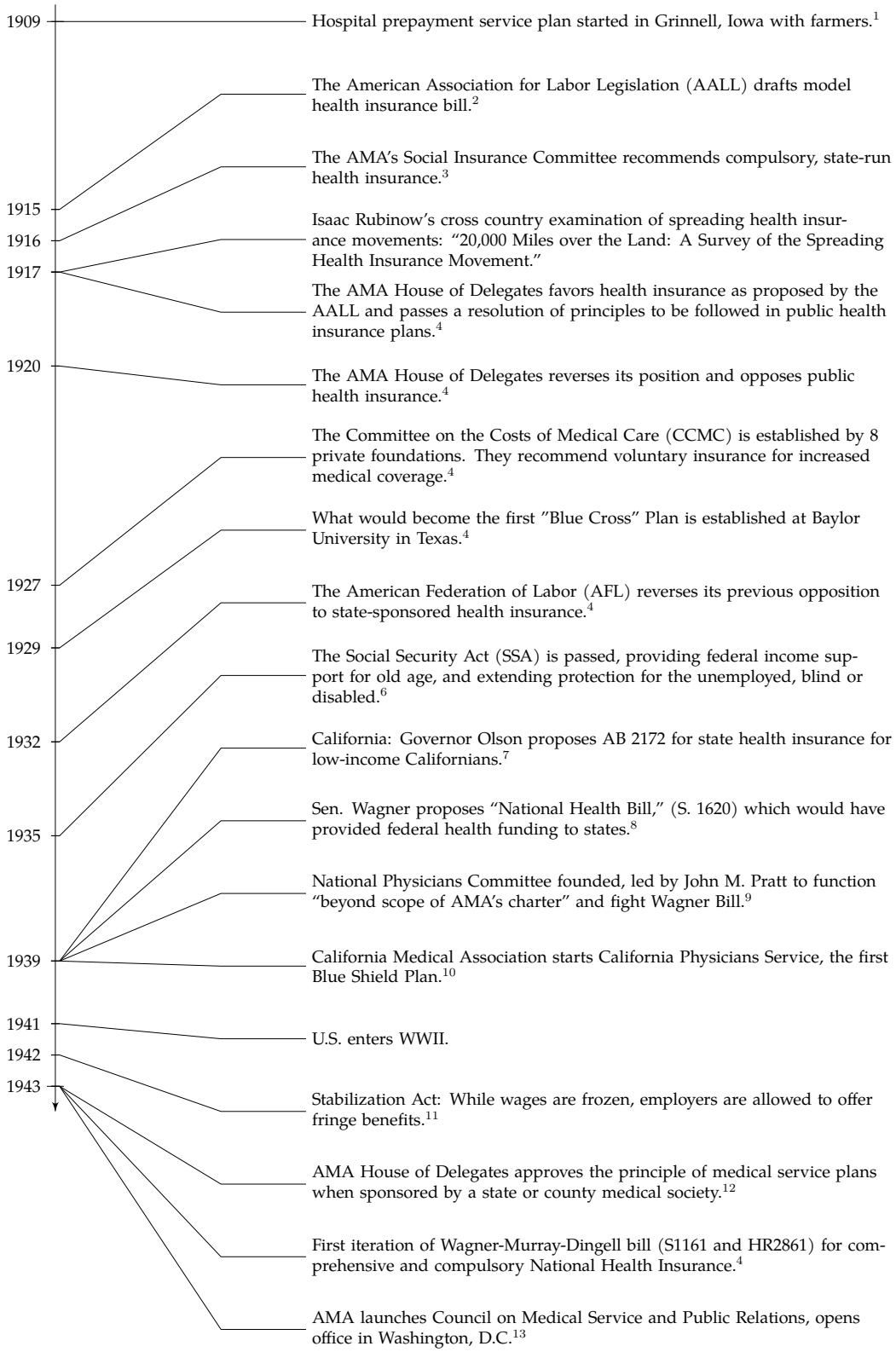
Appendix Table E2: Effect of Campaign on Share Republican Vote, Biennial House of Representative Elections, Robustness Tests

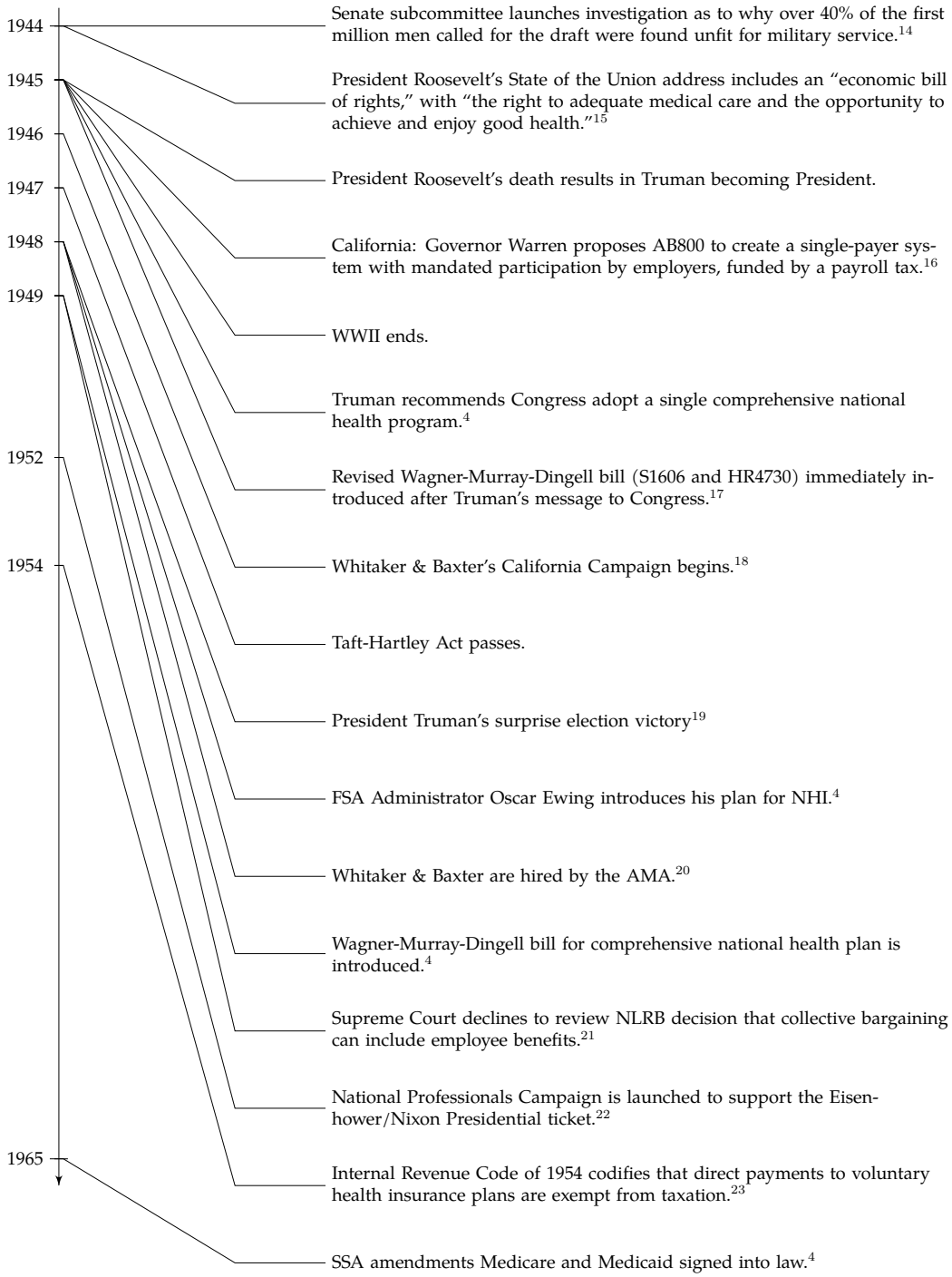
	(1)	(2)	(3)	(4)	(5)	(6)
Specification:	Unit-Specific Pre-Trend	War Bond Control	Without California	Binary Treatment	Blue Cross Control	Binary Outcome
Campaign Exposure $\times$ I^{Post}	0.008***	0.007***	0.009***	0.006*	0.008***	0.009
	(0.002)	(0.002)	(0.002)	(0.003)	(0.002)	(0.005)
Dependent Mean	0.404	0.403	0.409	0.404	0.404	0.481
Observations	16404	13670	16068	16404	16404	16404
County FE	✓	✓	✓	✓	✓	✓
Design Controls	✓	✓	✓	✓		✓
Election Controls	✓	✓	✓	✓	✓	✓
Region $\times$ Year FE	✓	✓	✓	✓	✓	✓

Notes: Table reports specification checks for the outcome of Republican vote share in House of Representatives elections (Inter-university Consortium for Political and Social Research 1999). Campaign exposure is constructed as in Equation 4 and standardized to a mean of 0 and a standard deviation of 1. The sample includes years 1944, 1946, 1948, 1950, 1952, and 1954. I^{Post} is an indicator for the post-Campaign period. Column 1 reports regression results controlling for unit-specific pre-trends following Miller (2023). Column 2 reports regression results controlling for war bond purchases (U.S. Census Bureau 2012; Council on Medical Service 1946-1954). Column 3 reports results excluding California. Column 4 reports results where treatment is dichotomized at the 50th percentile of Campaign exposure. Column 5 reports results replacing hospital count in the Design Controls with the share of Blue Cross hospitals (American Hospital Association 1948, 1950, 1952). Column 6 reports regression results where the outcome is an indicator that equals 1 if the Republican vote share is greater than 0.5. Dependent Mean is the unconditional mean of the dependent variable for the pre-period. Design controls include county log income per capita (Bureau of Economic Analysis 2023), number of hospitals at the county level (American Hospital Association 1948, 1950, 1952), and state share unionized (Farber et al. 2021). Election controls include the lagged county share Republican vote in the most recent presidential election. Robust standard errors clustered at the county level are in parentheses. *, **, *** refer to statistical significance at the 10, 5, and 1 percent level, respectively.

F Institutional Appendix

F.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]
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).

F.2 Health Insurance Prior to World War II

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

Serious movements for state-sponsored health insurance began in the early 1900s with the American Association for Labor Legislation founded by progressive economists John R. Commons and Richard Ely of the University of Wisconsin (Hoffman 2001). As described by Hoffman, the AALL leaders believed in a "security state" that was engaged in regulation and prevention more than direct relief which it thought encouraged pauperism and dependency. According to Hoffman, "Compulsory health insurance also opened another avenue for AALL's belief in the prevention of social ills. Just as workmen's compensation created a material incentive for employers to improve safety, health insurance, reformers thought, would place a monetary value on sickness prevention in the workplace" (Hoffman 2001, p.28).[49] Several elements derailed any legislation from passing – most significantly the First World War allowed those in opposition (including some elements of organized labor under Sam Gompers, some physicians, and the powerful life insurance industry) to defeat all such proposals (Hammonds 2003).[50]

Despite the demise of the Progressive movement and with it plans for state-sponsored health insurance, 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. The system started as community hospitals pulling together and offering services for employed individuals on a pre-paid basis, but community plans often then consolidated and operated on a state-wide basis. There were very few that crossed state boundaries as the plans required state-specific enabling legislation to operate – the plans were typically not actually deemed insurance but rather service products that would operate as nonprofits.

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

[49] Hoffman writes: "AALL leaders never spoke explicitly about excluding Black workers from the health insurance plan. The reformers likely shared the racial assumptions of most Whites of their era – they had no qualms about appointing scientific racist Frederick Hoffman to the Social Insurance Committee" (Hoffman 2001, p.31). Note that Frederick Hoffman was the leading actuary of the time, a German immigrant and vice-president of the Prudential Insurance Company. Along with Metropolitan Life, Prudential had been extremely profitable selling life insurance to blue collar workers during the early 20th century (Starr 1982, p.243). According to Starr, "the fear of a pauper burial was so great that Americans bought $183 million of such insurance in 1911 – about as much as Germany spent on its entire social insurance system." Hoffman's book on *The Race Traits and Tendencies of the American Negro* was published by the *American Economic Review* and is today widely viewed as a racist tome predicting the extinction of Black and Native American populations.

[50] Isaac Rubinow, a physician and economist from Belarus and the leading authority on social insurance for the time, remarked that including a funeral benefit was a "grave tactical error because of the implied threat to the gigantic structure of industrial life insurance" (Starr 1982, p.255). Rubinow dubbed accidents, illness, old age, and loss of a job, the four horsemen of the apocalypse. "These are the Four Horsemen that ride roughshod over lives and fortunes of millions of wage workers of every modern industrial community" (Rubinow 1934, p.20). Rubinow also noted *who* was more targeted by said insecurity: "the ride of the Four Horsemen carries more economic devastation in our era of individualistic family life; and in addition the Horsemen have an uncanny habit of riding with a particular fury through the narrow side-streets and lanes in which the working masses and not the upper classes reside" (Rubinow 1934, p.21).

Rovit and Couldwell 2001).

While not included in the Social Security Act of 1935, support for health insurance legislation within the Roosevelt administration continued. In 1935, the Interdepartmental Committee to Coordinate Health and Welfare Activities was formed. In 1937, it established a Technical Committee on Medical Care, which was authorized to develop a national health program. The Technical Committee's proposal mirrored that of the Committee on Economic Security's, proposing state level health programs. President Roosevelt made public part of the committee's report and convened a National Health Conference in 1938 to discuss the national health program, where delegates largely supported the Technical Committee's program. With this support, President Roosevelt first planned to make health insurance an issue in the 1938 midterm elections, later deciding to wait for the 1940 elections. However, with Democrats losing seats in Congress in 1938 and the advent of World War II, reform became less feasible. Before his abrupt death, President Roosevelt planned to push for health insurance when the war ended and asked Congress to affirm an "economic bill of rights," including medical care (Starr 1982, p.280). In January 1945, FDR included in his State of the Union address an expanded social security program that would include health. Later that year, the *Journal of American Medical Association* would write: "No other year has seen such a demand for compulsory health insurance" (Poen 1996, p.50). Yet in April 1945, FDR died and was succeeded by Harry S. Truman.

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

F.3 California Campaign

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

There were two key pieces of the California Campaign. The first was a series of "Voluntary Health Insurance weeks" designed to raise awareness of voluntary insurance. Mayors were encouraged to declare voluntary insurance weeks and to urge public 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.

F.4 Blue Cross Hospital Service Plans

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

By 1947, several organizations were providing medical care on a "prepayment basis." First in importance were the Blue Cross Hospital service plans sold in nonprofit hospitals.[51] The hospital prepayment service plans started in Grinnell, Iowa with farmers in 1909. Then, during the Great Depression, hospitals experimented with approaches to improve their stream of income. School teachers in Texas approached Baylor University hospital for coverage (possibly wanting maternity care, as "there [was] no mention in the pamphlet of any maternity waiting period" (Reed 1947, p.10)). According to the FSA report, the teachers

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

were considered a "bad risk" – fees were increased and insurance was extended to other groups. However, the precedent was set and many other hospitals followed suit in creating community-based plans (so that the hospitals would not compete within a given catchment area for patients). "In this way, the unethical and unsound features attending solicitation of patients by individual plans would be eliminated and subscribers would retain freedom of choice as to the hospital they desired" (Reed 1947, p.10).

As noted in Section II, the hospitals took the lead on starting the plans, and there were several important facilitating features that the analysis controls for, as noted by the FSA: "Generally the plans have been started by the voluntary hospitals of the area and it is these hospitals which have been identified with and have supported the plans." These are typically places with a "high degree of urbanization and industrialization, and relatively high per capita income" (Reed 1947, p.28). We control for unionization, income, and the number of hospitals 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. "When the attorney-generals or departments of insurance had requested a ruling, they had ruled that group hospitalization constituted the sale of service rather than insurance, and that as such these plans could incorporate under the general incorporation laws and were exempt from the regulations covering stock and mutual insurance companies. This exemption was important since it meant that the plans would not need to make their subscribers liable for assessments, and could start without the sizable capital required of stock companies" (Reed 1947, p.11). Most states followed the legislative template provided by New York in 1934 which specified that 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), including some oversight of the rates charged to subscribers by the insurance department.

Enrollment in Blue Cross: According to the FSA, "The enrollment methods of Blue Cross plans are designed to secure the largest possible enrollment at the least possible expense and to assure actuarial soundness. The last consideration dictates that either enrollment should be through groups, with a sufficient percentage of the members of each group joining so as to assure that those enrolled will comprise a fair selection of risks, or that enrollment of persons on an individual basis should be conducted under methods which will avoid adverse selection of risks" (Reed 1947, p.59).

F.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). An inflection point came in 1939 when Governor Culbert Olson of California – the first Democrat elected in the state in four decades – introduced AB 2172 (Rosenthal) which provided for health insurance integrated into unemployment insurance for workers (and their families) below a given income (Dimmitt 2007). "These two factors" (the growing popularity of prepayment hospital service plans and the Governor's bill) "were primarily responsible for the establishment in 1939 of the California Physicians' Service by the California Medical Association" (Reed 1947, p.137).

As discussed in Section II.1, the AMA was somewhat undecided about insurance in the early 20th century. The attitude of the AMA toward prepayment medical service plans was rather 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.

F.6 Equity Considerations

How did advocates for private health insurance foresee the care for the indigent and for non-White individuals? To gain some insight into this question we consider two sources. The Director of the Bureau of Medical Research for the AMA, Frank Dickinson, referred to an exhibit first published in 1939 when dismissing the notion of the "medically indigent." The figure divided the population by income and divided medical care into mutually exclusive categories: minor illness, major illness, chronic illness, institutional care, and prevention (Dickinson 1949). The chart is shown in Appendix Figure F2 and demonstrates that the indigent sick were designated as a "community responsibility." Institutional care (which would include mental health, convalescence or nursing home care) as well as preventive care were designated to be "provided by local resources." The conclusion of the figure is that there was no need for voluntary plans to cover these income groups or set of health issues.

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

F.7 Role of Organized Labor in National Health Insurance

Labor unions and other organized labor movements in the early 20th century did not fully embrace the idea of comprehensive social insurance for health care. Most prominently, Samuel Gompers, the first president of the American Federation of Labor (AFL) rejected the concept in the 1910s, citing the workers' capability to independently self-organize insurance plans that were paid by union dues (Derickson 1994, p.1337). His aversion to a government-run plan reflected his belief that workers' problems could be solved by bargaining between unions and businesses, without the government's intervention (Schlabach 1969; Yellowitz 1989, p.31).[52] Gompers's death in 1924, the Great Depression, and the subsequent New Deal all laid the groundwork for unions to back governmental involvement in health insurance. In 1935, the AFL officially endorsed "the enactment of socially constructive health insurance legislation through Congress and the individual States" (Derickson 1994, p.1337).

During the 1948 Presidential election, many union groups contributed to President Truman's campaign due to his stance against the Taft-Hartley Act, which the unions wanted to repeal (Leeds 1950, p.213-214). Yet, Section 304 of the Taft-Hartley Law forbade contributions to federal political campaigns by unions. Therefore, the AFL legally bypassed this restriction by creating a new body, "Labor's League for Political Education" (LLPE), financed by AFL members (Leeds 1950, p.208). LLPE disseminated information on the voting records of candidates (Leeds 1950, p.209). AFL also hired a public relations firm to try and influence public opinion. The total amount spent by LLPE was $319,000 for this effort (Leeds 1950, p.211). The "Labor's League for the Election of Truman and Barkley" spent $32,535 (Chang 1953, p.566).

Despite its defeat in Congress in 1948-1950, organized labor continued to advocate for NHI. The Congress of Industrial Organizations (CIO, which would merge later to become AFL-CIO in 1955) held its 14th annual convention in 1952, where "even though various types of health plans had spread in collective bargaining, the 1952 convention of the CIO asserted: 'The CIO reaffirms its support for a national health program which will provide the people of our nation with needed medical services, facilities, and personnel...It must also include a system of national health insurance' " (Shister 1956, p.454). Simultaneously, unions also started

[52]Gompers was also known for his racist actions and comments. As the AFL's president, he openly supported the policy of southern unions that refused to admit Black workers (Mandel 1955, p.54).

Appendix Figure F2: Chart of Medical Services and Economic Status

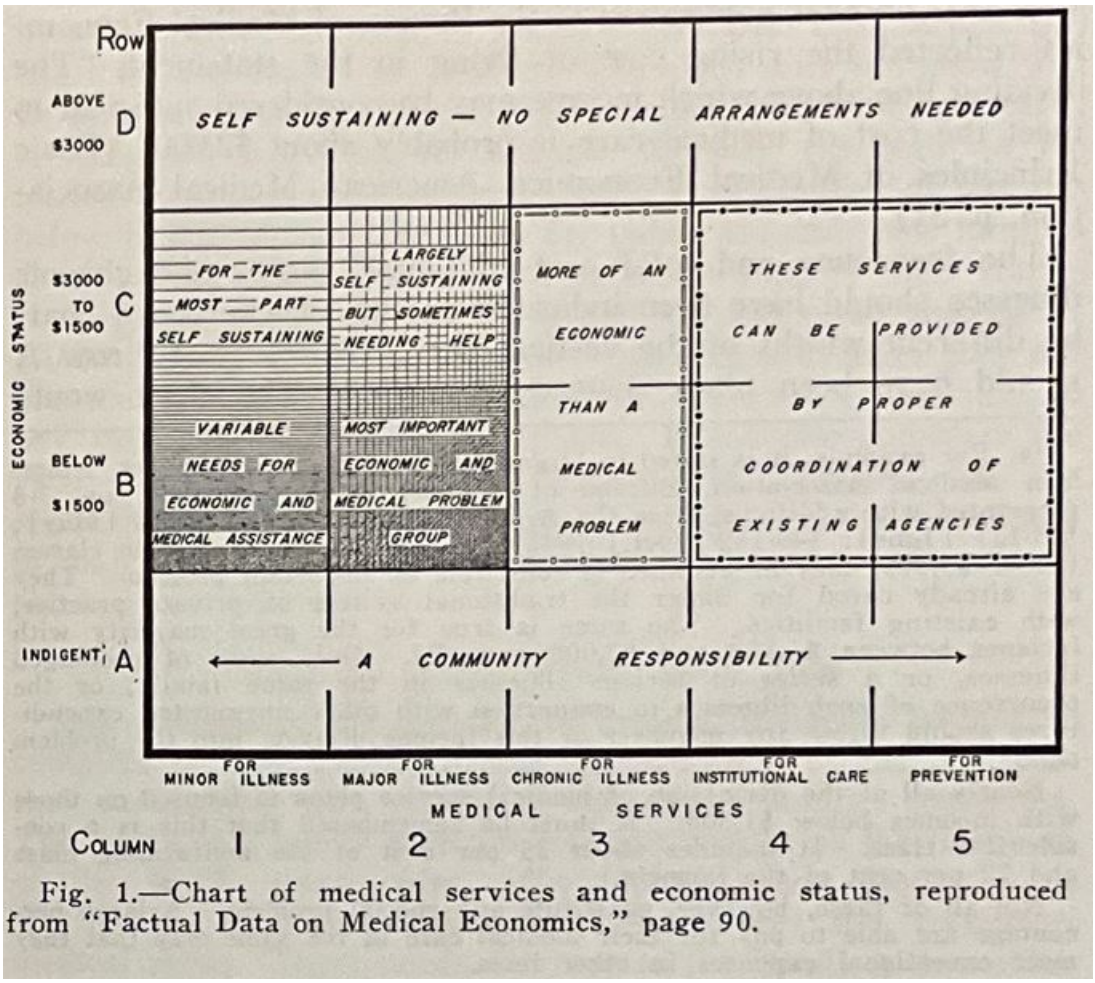


Fig. 1.—Chart of medical services and economic status, reproduced from "Factual Data on Medical Economics," page 90.

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

to negotiate for PHI through employers (Derickson 1994, p.1334). An example is the landmark "Reuther's Treaty of Detroit" negotiated between the United Automobile Workers (UAW) and General Motors (GM) in 1950, which included company-paid healthcare (Harbison 1950, p.405). Other large companies and union groups followed suit.

F.8 Relationship between the AMA and the Department of Veterans Affairs (VA)

The AMA's opposition to government provision of healthcare included opposition to the VA after its establishment in 1930. The consolidation of the former Veterans Bureau into a federal Administration under President Hoover was threatening to the AMA, who feared veterans' care would extend to non-service-related sickness (the VA's care was initially restricted to service-related illnesses) and the construction of VA hospitals (Kendall 1995). In the early 1930s, AMA delegates lobbied against the provision of veterans' care in Congress and proposed that veterans be offered cash to seek a private, fee-for-service doctor. Unsuccessful, the AMA became more concerned with the growing sentiment in Washington in favor of extending the Social Security Act of 1935 (American Medical Association 1972). After WWII and the advent of Truman's NHI plan, the AMA continued to oppose government involvement in healthcare (Kendall 1995; Croatman 1953).

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

G Methods Appendix

G.1 Comparison Calculations

Thomasson 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 (Thomasson 2003). 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. For this calculation we use the 1957 distribution of family incomes from U.S. Department of Commerce and Bureau of the Census (1958) and the 1957 tax schedule from the Tax Foundation (2021), assume that every individual in the household is insured, and use the average 1957 household size of 3.4 reported by Thomasson. The data in the Thomasson study come from surveys asking whether anyone in the family has any medical, surgical, or hospital insurance. To compare with our estimates, we calculate the approximate increase in the number of enrollees for both medical and hospital insurance, using the 2.3 percentage point estimate for each year after the Campaign on the number of medical and hospital enrollees. Hospital data are from The Survey Committee of the Health Insurance Council (1949-1965). This calculation suggests that a one standard deviation increase in Campaign exposure lead to an increase of about 3 million medical and 11 million hospital insurance enrollees.

G.2 Categorizing Tie-in Ads by Industry

We used key words or strings in company names, seen in Appendix Table G1 below, to categorize tie-in ads by industry. Among the 2114 companies with tie-in ads, 1778 were categorized into an industry.

Appendix Table G1: 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.

G.3 Identifying Campaign Ads, Representativeness and Balance Tests of Newspapers

We draw on three archival sources of newspaper data: the Lockwood-Shackelford Advertising Company (LS) data from the *Campaigns, Inc.* Archives (Whitaker & Baxter *Campaigns, Inc.* 1946-1973), *N.W. Ayer & Son's Directory of Newspapers and Periodicals* (Ayer 1949), and the Newspaper Archive (2023). We describe below the process of locating the Campaign ads, linking newspaper level data, and creating Appendix Tables G2 and G3.

Identifying Campaign Ads. Appendix Figure B3 shows the main Campaign newspaper advertisement. We use direct template matching methods to locate the advertisement in each newspaper, 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 (648 newspapers).

Linking Newspapers. To test representativeness, we separately matched two sets of newspapers to the Ayer & Son's Newspaper Directory: newspapers from LS invoices and newspapers from the *Newspaper Archive*. The data linkage can be summarized as follows:

1. Compute the Levenshtein distance similarity ratio between newspaper names from both datasets.
2. Keep the potential matches with a ratio greater than 0.9.
3. For observations with multiple potential matches, look for the pair with the highest ratio.

Appendix Table G2: Balance Test for
Whether Newspaper Contains Main Campaign Ad,
Newspapers Matched in October 1950

	(1)	(2)	(3)
	Overall Mean	Difference	SE
Log Circulation	8.247	-0.321	(0.184)
Urban	0.709	-0.127	(0.065)
Weekly	0.604	-0.091	(0.042)
Established before 1940	0.978	0.040	(0.029)
Leans Republican	0.226	0.091	(0.057)
Railways Crossed	0.994	-0.007	(0.006)
F-Stat		3.164	
F-Test *p*-Value		0.185	
Observations		628	

Notes: Table reports balance tests for having the main Campaign ad shown in Appendix Figure B3. The newspaper sample is from *Newspaper Archive* and includes all 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 full sample. Column 2 reports a regression of newspaper characteristics on an indicator for having the ad, and 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. *, **, *** 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).

Creating Newspaper Exhibits. All newspapers from *Newspaper Archive* with at least one issue available in October 1950 were matched to the *Newspaper Directory*. We kept only the newspapers with all characteristics recorded in the *Newspaper Directory* non-missing, and the final sample consists of 628 newspapers. These data were used for Table G2. We also link newspapers from LS invoices to the Ayer & Son's *Newspaper Directory* using the approach described above, restricting the sample to newspapers with all relevant characteristics recorded in the *Newspaper Directory* as non-missing. This sample includes 14,444 newspapers, where 3,071 of them are linked to the LS data. We use these data to create Appendix Table G3, which shows that the newspapers appearing in the invoices on average were not systemically different from those that did not.

Appendix Table G3: Balance Test for
Whether Newspaper Contains Main Campaign Ad,
Lockwood-Shackelford and Ayer & Son's Directory

	(1)	(2)	(3)
	Overall Mean	Difference	SE
Log Circulation	6.812	-0.005	(0.026)
Urban	0.639	-0.184**	(0.039)
Weekly	0.846	-0.045	(0.028)
Health Related	0.016	-0.006	(0.008)
Lean Republican	0.165	0.047	(0.042)
Lean Democrat	0.169	0.088	(0.100)
Railways Crossed	0.993	0.001	(0.003)
F-Stat		0.758	
F-Test *p*-Value		0.587	
Observations		14444	

Notes: Table reports Balance test for having the main Campaign ad shown in Appendix Figure B3. The sample includes a fuzzy merge between Lockwood & Shackelford records and the Ayer & Son's data as described in Section IV. Column 1 reports the unconditional mean for the full sample. Column 2 reports a regression of newspaper characteristics on an indicator for having the ad, and 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. Health Related is an indicator for whether the industry recorded in the *Directory* contains "health". *, **, *** 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).

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

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

1. Restrict to individuals with an M.D. degree in the donor list. Clean names in both datasets to remove any non-alphabetic characters and account for common abbreviations and nicknames (*e.g.*, so that Chas. and Charles would be considered the same name).
2. Split the AMD dataset into two folds by whether have 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.

H Model Appendix

H.1 Model Details

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

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

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

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

H.2 Proofs

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

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

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

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

□