Mobilizing, Framing, and Leading: Three Policy Thought Experiments for *Covering America*

by Edward F. Lawlor and Ann Dude

Background

Seven years after the Clinton health reform saga, the political environment for health policy is best described as one of stalemate and pessimism. The long economic recovery of the 1990s (and the fiscal resources that went with it) appears to be over; incremental efforts at expanded coverage, such as the Medicare prescription drug benefit and the State Children's Health Insurance Program (S-CHIP) expansions, have struggled; and federal priorities have shifted to national security (defense), homeland security, and tax relief. The fiscal constraints imposed by recession, scheduled tax cuts, and the proposed ramp-up of defense and security spending leave little room for expansionary domestic policy, much less the political time and attention needed to enact major reform. Strong ideological currents also press against the prospects for significant initiatives to expand coverage. The health policy and health politics literature provides an extensive and sophisticated account of the obstacles to and constraints on enacting comprehensive health reform in the United States. The Clinton reform experience itself spawned much literature documenting both its history and the contemporary obstacles to reform.[1] In the aftermath of this experience, a number of arguments make up the conventional wisdom about the stalemate of U.S. health reform, both at a moment in time and historically. Students of agenda formation emphasize the need for political and contextual factors to come together to produce the right chemistry for reform.[2] Agenda formation involves having policy ideas and interests lined up for the right moment when the political environment is ready, when the classic "window of opportunity" exists. The role of public opinion in agenda formation, as well as influencing the President and Congress to act, has received significant attention in the literature, though, as observers like Lawrence Jacobs have illustrated, public opinion in health has its own complexities of interpretation and connection to actual congressional behavior.[3]

Students of institutions emphasize the structural impediments—for example, the realities of congressional committees and behavior—in shaping the possibilities for reform ideas to make their journey from political will to actual legislation.[4] Other structural arguments look more closely at the influence of existing policy, the bureaucracy, programs, and infrastructure on the opportunity set for reform. The idea here is that existing policy creates its own future policy possibilities, and that reform opportunities are path dependent. Students of health care's political economy emphasize the tremendous role that money, power, and influence—the medical industrial complex—play in protecting insurance, provider, pharmaceutical, and

[1] Haynes Johnson and David S. Broder. *The System: The American Way of Politics at the Breaking Point.* Boston: Little Brown, 1996; Theda Skopol. *Boomerang.* New York: W. W. Norton, 1997; Jacob S. Hacker. *The Road to Nowhere.* Princeton, NJ: Princeton University Press, 1997.

[2] John W. Kingdon. *Agendas, Alternatives, and Public Policies.* New York: Harper Collins, 1984.

[3] Lawrence Jacobs. *The Health of Nations: Public Opinion and the Making of American and British Health Policy.* Ithaca, NY: Cornell University Press, 1993; Lawrence Jacobs and Robert Shapiro. "Don't Blame the Public for Failed Health Care Reform." *Journal of Health Policy, Politics, and Law 20* (2) (Summer 1995): 411–23.

[4] Sven Steinmo and Jon Watts. "It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America." *Journal of Health Policy, Politics, and Law 20* (2) (Summer 1995): 329–72.

professional interests. For example, the Center for Responsible Politics estimates that pharmaceutical interests spent $19 million on campaign contributions and $68 million in lobbying activities in 1999–2000, creating undeniable influence over the prospects and feasible options for Medicare prescription drug coverage.

In addition to these formal explanations for America's health policy stasis, a number of more casual explanations are found in the lore of U.S. health care reform efforts. Some observers believe in the historical cycles phenomenon of health policy: every 30 years or so, a confluence of ideological commitments and political pressures produces a significant comprehensive reform effort. Others believe in the power of a single charismatic and committed leader as the key explanation for policy failure and the key requirement for advancing universal coverage. Others have likened health care reform debates to competing "theologies," with little possibility for rational and open-minded deliberation.

The Plan of this Chapter

As The Robert Wood Johnson *Covering America* project demonstrates, there is no shortage of good ideas and analytic support for significant reform. The 10 proposals represent reasoned, analytically defensible approaches that take due account of the evidence and institutions that lie in the background of health care reform. However, the ongoing and daunting question that remains is how to reformulate or reframe the reform project to achieve universal coverage so it stands some positive chance of legislation and implementation.

This chapter looks to examples of policy making and political organization from outside the world of health reform for lessons and insights that are applicable to contemporary health reform. The idea is to step outside the usual confines of health policy and politics discussion and see if ideas for reframing health care coverage can be garnered from successful examples of policy making elsewhere. Can directions for policy design, political strategy, and evaluation of reform alternatives be developed from examination of other policy domains? Are there different ways to think about the existing set of reform proposals that recast them in political terms?

Such an exercise is obviously fraught with political naiveté and analytical risk, but the goal is to stimulate some fresh thinking about the design and strategy of health care reform. Such an exercise also runs the risk of trivializing or oversimplifying what are very complex politics and policy processes.[5] But it also holds the promise of changing some of the policy formulation mindset. This chapter is meant to be deliberately provocative. The idea is to create the kind of self-awareness among health policy analysts and economists that John Kingdon created in his comparative analysis of transportation and health care in the 1980s. For example, by looking carefully at the narratives of transportation and health care, Kingdon observed the mantra of "access, cost, and quality" that so drives the conceptual frameworks and analysis of health care was nowhere present in any of the discourse about transportation policy.

The examples take the form of several mini-case studies of recent policy that, by some measure, have been "successful," meaning that significant legislation and commitment of public resources has occurred, in spite of the obstacles and pessimism that characterized these issues ex ante.[6] We have chosen examples of policy development at three levels of scale and ambition, from down-on-the-ground social movements to, arguably, the most significant example of economic policy making in the last decade.[7] The criteria for selection of these

[5] For an extended discussion of these hazards, see Richard Rose. *Lesson Drawing in Public Policy: A Guide to Learning Across Time and Space.* Chatham, NJ: Chatham House, 1993.

[6] One of the obvious observations coming out of this exercise is the absolute paucity of "big policy" accomplished in the two decades. Unlike the Johnson or, arguably, the Nixon administrations, there simply are few examples of significant domestic legislation committing substantial resources to a public purpose. Contrast this era with the policy making of the Johnson administration: on the walls of the Johnson Presidential Museum in Austin is an exhibit of the 100 major pieces of legislation passed during his term, including Medicare, the Voting Rights Act, the Clean Air Act, etc.

[7] It is interesting to note that the search for examples of significant federal legislation that might serve as useful analogies or heuristics for envisioning health reform actually produced few good candidates. The "War on Drugs," which has captured some $30 billion of federal resources and a cabinet-level appointment, mostly directed at interdiction activities, is a possibility and may be worth further discussion. (One of my

cases include the scale of their impact (either in resources or potential behavioral change) and their extension of the reach or capabilities of the state (as opposed to legislation that could be interpreted as taking away federal or state benefits or authority). Each case study comes from recent political history. For these reasons of selection, we examined and rejected for inclusion in this chapter creation of the Office of National Drug Control Policy (the so-called drug czar), the 1996 welfare reform legislation, and the Adoption and Safe Families Act of 1997.

It is worth noting that the analysis of "unsuccessful" policy initiatives can be useful as well to develop new strategy for universal health coverage. Jacob Hacker's analysis of the Clinton health reform experience, for example, provides an effective counterbalance to the literature in the aftermath of that experience that concludes, in one way or another, that significant health reform in the United States is "doomed" or preordained to fail.[8] Although the Clinton experience provides an always-tempting and relevant stockpile of political analogies and lessons, this chapter purposefully looks elsewhere for evidence that the health reform project is necessarily deterministic, static, or bounded by the certainties that seem to rain down from the many post hoc explanations of reform failures. As Hacker concludes,

> Retrospective certainty has, of course, also been a prominent feature of the prolific commentary on the health care reform debate. The burial of health care reform in 1994 prompted a barrage of "defeat was inevitable" arguments from the nation's political scientists, many of whom implied, without much subtlety, that anyone who really understood politics would have known that the Clinton plan and its alternatives were doomed from the start. These arguments go beyond the claim that the health care reform was unlikely to pass to the more suspect claim that it was destined to fail. In doing so, they degenerate into mechanistic and static characterizations that fail to capture the uncertainties and strategic complexities of the debate.[9]

The concept of this chapter is to provide heuristics, not necessarily formal analogies or determinative lessons from other policy developments, but with an eye toward countering the deterministic and even fatalistic mindset of most political analysis of contemporary health reform. The goal is to stimulate some reframing of the sources of political action and change, to reconsider the sources of political influence in health reform, and to challenge some of the political truisms that have taken hold in the backwaters of the Clinton reform effort.

The case studies include the following: (1) The dramatic commitment of regulatory and law enforcement tools to reducing the incidence of drunk driving, and its related injuries and deaths, as a result of significant grassroots social mobilization. This case illustrates the existence and potential role of social movements in producing reform "under the radar," but with potentially significant results. (2) The recent federal education legislation, "No Child Left Behind," which illustrates the most recent example of policy framing and compromise across ideological and partisan lines at the federal level. (3) The North American Free Trade Agreement (NAFTA), which profoundly altered the terms of trade in North America, despite the vigorous opposition of organized labor, particular industries, and an apparent lack of public opinion mandate.

The plan of the chapter is as follows: The case studies are interspersed with discussions of mobilizing, framing, and leading the campaign for universal coverage, taking account of all the well-known constraints and obstacles. The goal of these exercises is not to pass judgment on the underlying merits of the resulting education, drunk driving, or trade pol-

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colleagues calls this achievement the triumph of criminalization and militarization in framing a policy agenda.) Welfare reform, which also may deserve more thinking for this paper, may be more an example of "takings," in Richard Epstein's parlance, than it is a positive assertion of new policy and entitlement that is helpful for understanding health care reform. Federal child welfare legislation, namely, the Adoption and Safe Families Act, embodied a set of goals for family re-unification and swift movement to permanent adoptive homes—a philosophy of service—as well as a strong model of delegation and financing to state administration. Its politics and design reflect many idiosyncrasies of the substance and populations involved in child welfare.

[8] Jacob Hacker. "Learning from Defeat? Political Analysis and the Failure of Health Care Reform in the United States." *British Journal of Political Science 31* (2001): 61–94.

[9] Ibid., pp. 93–4.

icy, but rather to look briefly at the political anatomy of these recent or relatively recent policy initiatives for ideas about new ways to construct and "market" health care coverage. In the case of drunk driving legislation and regulation, we are exposed to the underground phenomena of social movements—also lurking in states as potential players in promoting models of health care coverage. In the case of education reform, we become sensitized to the possibilities for bipartisan compromise around a set of vague but important notions of school accountability, as well as the pathways around important ideological symbols such as vouchers. Finally, by examining the anatomy of NAFTA, we come back full circle to realpolitik and consider the power and possibilities of legislation (actually ratification) in spite of what appears to be overwhelming opposition from organized, populist, and special interest forces, and even initial policy ambivalence by the President.

Mobilizing: Mothers Against Drunk Driving, Social Movements, and Health Care Coverage

Many progressives look to bottom-up social movements as potential vehicles for health reform. Examples from the civil rights movement, the women's movement, the movement for support of HIV/AIDS research and coverage, and the environmental movement all have salience in thinking about engagement of the public in issue advocacy and political influence. Discussion of national health care reform has been surprisingly immune from broad-based, value-driven, social movement politics. The language and rationale of rights has never taken serious hold in U.S. health care, identification of health coverage with particularly compelling and visible populations has never occurred, and an organized advocacy with "voice" has arguably never really developed. But, as this section demonstrates, organizing around health care coverage is occurring in cities and states, though almost without connection to the reform ideas trafficking in Washington.

As a heuristic for understanding the role and behavior of social movements, consider the remarkable evolution, visibility, and policy consequences of the movement to reduce the incidence of drunk driving, largely mobilized by the group, Mothers Against Drunk Driving (MADD). The origins of MADD can be traced back to two tragic accidents in 1979 that severely injured one child and killed another. The mothers of these children, Cindy Lamb and Candy Lightner, sought out key leadership in Congress and simultaneously began a national grassroots organizing campaign. The movement was publicly launched in October of 1980 at a press conference convened by then Congressman Michael Barnes (D-MD), during which the two founding mothers called for the creation of a Presidential Commission and a broad-based campaign at the federal and state levels to raise the minimum drinking age to 21.

The tactics and institutions that MADD (and its affiliated organizations) have subsequently used are mulitifaceted: the original Presidential Commission evolved into the permanent National Commission on Drunk Driving, the policy emphasis on a minimum drinking age broadened as zero-tolerance standards were implemented for teenagers, more stringent blood-alcohol limits (0.08) were adopted in states, aggressive measures such as checkpoints became accepted law enforcement tools, and financial incentives were directed at states to change the minimum drinking age when direct federal jurisdiction over drunk driving is not available. MADD and its affiliated organizations have also promoted technological interventions, such as sobriety monitors on cars and sophisticated electronic scanners for identification (ID) cards.

The campaign against drunk driving has morphed and grown along with its success and visibility. For example, beginning in 1999, MADD embraced prevention of youth alcohol abuse as a defining program area and set about to create the grassroots support and policy advocacy to move an agenda of legislation and intervention directed at teenage drinking, not drunk driving per se. MADD has introduced educational programs in high schools and colleges and has begun to monitor and counter advertisements and marketing.

The movement against drunk driving is even

more interesting for its effects on the hearts and minds of citizens than for its considerable legislative and regulatory accomplishments. Informal practices, such as designated drivers, have clearly changed behavior on a broad scale and influenced social norms. The idea of the designated driver, which has now become inculcated into the social life of the nation, was created by this movement. The idea of the designated driver is reinforced in the advertising campaigns of beer distributors. On holidays, public transportation agencies and even private taxi associations have taken up this idea with free or subsidized transportation as a socially sanctioned and convenient substitute for driving while drunk.

Advocates claim that the policy to raise the minimum drinking age to 21, as well as the various sanctions on drinking and driving, have reduced highway deaths due to alcohol by 1,000 per year, a reduction of about 40 percent from 1980 through 1996. All told, advocates take credit for saving 18,000 lives. All of this occurred without necessarily a politically supportive or ideologically compatible environment. Ronald Reagan, for example, a strong proponent of state's rights and devolution, became a champion of the movement against drunk driving and a supporter of federal legislation imposing a minimum drinking age of 21 across states.[10] These changes have occurred despite the expectations we have of young people to serve in the military, to vote, to be married, and to be treated as adults in virtually all other aspects of life and responsibility at the age of 18. If one steps back from this movement, its effectiveness in changing norms and policy is quite remarkable.

Are there analogous movements in health care? Many movements in health care and health services are defined by interests in particular diseases and domains of health care: cancer, reproductive health, AIDS/HIV, alternative health, etc. Sherry Glied has described how ACT UP and the AIDS lobby transformed research into and coverage of HIV care from traditional disease-specific lobbying to a movement basis, in some ways providing a political road map for other causes and coverage, such as coverage of experimental autologous bone marrow transplantation for breast cancer.[11] In national health coverage, the best example of a large-scale movement to enhance coverage is found in the history of the End Stage Renal Disease Program, where, again, the political concern and the nature of coverage turn out to be disease-specific. The translation of concern, motivation, and even congressional theater is much more direct when constituents bring the experience of struggling with a disease into the political process. The most recent example of this phenomenon, albeit with less fanfare and congressional involvement, is the extension of Alzheimer's coverage in Medicare.

However, the movement for universal coverage in health care, per se, has been extremely diffuse and fragmented. Pockets of organization lie in professional groups, such as public health professionals, religious communities, and community-based organizations. At a minimum, it is curious that organized medicine has not mobilized more effectively in the last two decades to secure universal coverage. With the exceptions of relatively small groups and movements, such as Physicians for a National Health Plan, the organized efforts of physicians have largely been directed at reimbursement, regulation (for example, patient's rights in managed care), or specific domains of coverage that go along with specialty interests. Some specialty groups, such as the American Academy of Pediatrics, have engaged in public policy work and issue advocacy around topics of concern, but this activity has not reached a scale and level of organization across medicine to be a force for promoting health care coverage.

More grassroots organization around health issues does exist in states and cities, but often without a connection to national organizations or policy discussions. One such organization in Illinois illustrates its version of a social movement approach to universal coverage, albeit seemingly out of sight of the development of national reform proposals in Washington.

In 1999, a coalition of activists sponsored an advisory referendum in state elections, called the

[10] Michael Barnes. "Complacency Is Largest Threat: War Against Drunk Driving Enters Third Decade." *Washington Post,* no date.

[11] Sherry Glied. *Chronic Condition, Why Health Reform Fails.* Cambridge: Harvard University Press, 1997, pp. 167–68.

Bernadin Amendment after the beloved late Cardinal of the Archdiocese of Chicago. The amendment was dedicated to Bernadin and tied to his 1995 pastoral letter, *A Sign of Hope.* In his letter, Bernadin wrote,

> I was deeply disappointed by our inability as a nation to move forward with systematic reform of our nation's delivery of health care. While now is not the time to attribute blame, I am troubled that our constitutional process for decision-making seems increasingly incapable of addressing fundamental issues. . . . If justice is a hallmark of our community, then we must fulfill our obligations in justice to the poor and the unserved first and not last.

After his death, a group of activists took up Bernadin's call for universal coverage and began a statewide movement for a constitutional amendment. As it appeared on the state ballot, the Bernadin Amendment had the following text:

> Health care is an essential safeguard of human life and dignity, and there is an obligation for the State of Illinois to ensure that every resident is able to realize this fundamental right. On or before May 31, 2002, the General Assembly by law shall enact a plan for the universal health care coverage that permits everyone in Illinois to obtain decent health care on a regular basis.

The amendment was supported by an average of 71 percent of the electorate in counties (83 percent in Cook County) in the April 1999 Illinois elections.

This movement for a constitutional amendment has been reinforced by classic organizing and a model of a social movement approach to universal coverage, known as the Gilead Campaign in Illinois. Gilead (taken from the traditional hymn, "There is a balm in Gilead, to make the wounded whole") is organized by a coalition of 330 churches, community organizations, labor unions, hospitals, and clinics known as United Power in Action. The Campaign receives financial support and leadership from mainstream provider associations, such as the Metropolitan Chicago Health Care Council, and major systems, such as Advocate Healthcare and Blue Cross/Blue Shield of Illinois. The Campaign itself is an amalgam of practical programs and services designed to get families registered for existing insurance (for example, S-CHIP, Veterans Administration programs), expand availability of low-cost primary and preventive care, and expand insurance coverage using both public and private insurance products. As it has evolved, the Campaign has brought together a broad spectrum of interests in health care coverage and efficiency in health care delivery, from business interests, to providers, to insurers, to grassroots organizers. Its focus has largely been practical initiatives, such as expansion of KidCare at the state level, that elicit broad support within the coalition. Not surprising, the Campaign has struggled for resources, struggled to balance the often conflicting interests of its members, and struggled to maintain the leadership and policy infrastructure that high-level influence on health policy requires.

While in many respects, social movement activity for coverage in health care is a humble enterprise, without anything like the resource base of the pharmaceutical or insurance industries, it is interesting to observe how disconnected this movement is from the concepts and strategic thinking about how to achieve universal coverage. This is a two-way street: many in the health policy community are virtually unaware that this strata of political activity even exists, and many organizers are completely unaware of the thinking and design work going on in the professional and academic health policy community. It is worth asking whether, as part of the program to promote reform, some effort and resources should be devoted to better understanding and, perhaps, closing this gap. At a minimum, it suggests that renewed attention should be paid to the city, county, and state levels of health care politics and their organization.[12] It also may be worth asking again whether there are ways to engage physicians, other professionals, and providers in new and creative ways to be effective constituents when health reform reappears on the agenda.[13]

[12] For an extensive description and analysis of health politics at these levels see John E. McDonough. *Experiencing Politics.* Berkeley: University of California Press and the Milbank Memorial Fund, 2000.

[13] See, for example, David Rothman and Tom O'Toole. *Redefining the Dimensions of Care: Physicians and the Body Politic.* Baltimore: Open Society Institute, 2001.

Education Reform: The Role of Framing and Compromise

In December 2001, Congress passed the "No Child Left Behind" Act, which President Bush signed into law in January 2002. This education reform bill shepherds in a new era of regulation and accountability in public education, along with increased levels of federal government funding for education (a projected $22.6 billion for 2002).

The education bill is an interesting case for this project because it asserts new federal authority in education, presents an interesting example of policy framing, and illustrates successful political tactics in the most recent presidential/congressional environment. Politically, the bill serves as a good example of bipartisan compromise on an issue that has been a vexing federal problem over the course of several administrations, with these latest reforms representing the most wide-reaching federal initiatives since the Johnson administration.

The bill itself provides new federal funding for education, requirements for testing students and reporting school performance, plans at the individual school level for students to achieve "proficiency" on a national test, and provisions for addressing the performance of "failing" schools. In exchange for removing the block grant and voucher proposals advocated by some Republicans, the bill includes a more modest provision to pilot block grants in only 150 school districts. The legislation features significant targeting of federal funds to low-income students and schools. To satisfy the diverse ideological and program interests in education, the legislation included an unusually large number of special provisions, from hate crimes prevention to school computer Internet filters.

One major reason the bill was able to pass through both chambers of a tightly balanced Congress was that it attracted a few key sponsors in both the Senate and the House, supporters who represented moderates of both parties. Critics of the bill, however, maintain it achieved full bipartisan support only because moderate influences allowed the most controversial initiative—and the reform with arguably the greatest potential for true change—vouchers, to be excluded from the final version. Vouchers would have provided funding for children in failing schools to transfer to any other school, public or private, thus injecting a sense of competition into the public system. While voucher schemes are already in place in several locales, the proposal proved to be too controversial at the national level.

The background, processes, and outcomes of this recent education bill present some intriguing parallels for health reform. Wholesale education reforms have run into opposition from powerful groups heavily invested in maintaining the status quo, including state governments, that fear more regulation from the federal level without additional funds, and the teachers' unions. While the role of the federal government in education, relative to health, is a small one, changes at the federal level involve shifts in inter-government responsibility and tilt against established interests and educational philosophies. The education bill that resulted bears out some of Chubb and Moe's analysis of the inevitable ingredients of reform in a mature educational system.[14] In brief, they argue that educational reform inevitably will involve a mixture of institutional, political, and economic incentives, as well as increased systems of accountability that include reading, testing, and teacher proficiency.

One important implication for health reform that follows from the experience of "No Child Left Behind" is the treatment of controversial and ideologically charged issues that can doom reform efforts: how to use policy ambiguity and finesse to move along the path of reform.[15] In the recent education debate, voucher schemes maintained support from conservative congressional members who sought to inject market competition into inefficient education bureaucracies and from the grassroots—some parents and local education boards, especially

[14] John Chubb and Terry Moe. *Politics, Markets, and America's Schools.* Washington: Brookings Institution, 1990.

[15] For an extended discussion of the uses of ambiguity in striking compromise, see Deborah Stone. *Policy Paradox: The Art of Political Decision Making.* New York: W.W. Norton, 2002, pp. 157–62.

in certain large cities. While President Bush had a strong commitment to choice and to vouchers, he chose to compromise in the face of opposition from Democrats (who feared a backlash from the teachers) and from others who worried about the potential for a Supreme Court challenge based on issues surrounding the separation of church and state. The measure was left out of the final version, but the bill still allows room for this particular innovation to be implemented at the state level.

One wonders if a similar strategy could be used for health care: broadly defining the goals of reform at the national level, then leaving states room to work out the details, especially regarding controversial issues such as employer mandates, which Congress could encourage by relaxing ERISA strictures. Several *Covering America* proposals represent opportunities for some level of federal ambiguity and state variation in design and implementation. This approach might make it more likely that Congress could pass something at the national level, despite opposition regarding controversial topics. The major political obstacle to this approach would be the opposition of national firms that provide coverage and purchase health care across many states. For these interests, variations are a costly aspect of doing business, and standardization itself is a major goal of reform. Because the federal government plays a larger role in health care than in education, it might arguably have more influence on states in matters of health than in matters of education, and thus could pass more substantial changes as long as reformers avoided the most controversial topics. The danger in this logic, however, can be seen in the major criticism of the education bill: federal reformers, trying too hard to avoid controversy, passed a bill that does not really fix anything.

Another proposal that failed to make the final version of the education bill was the effort spearheaded by Senator Jim Jeffords (I-VT) to establish funding for special education as an entitlement. This proposal elicited resistance from states and from conservative members of Congress fearful of a potentially expensive, uncontrollable spending mandate.

The context of the 2002 election year was probably also important in promoting action on education this year. Education receives intense and ongoing media scrutiny and still sits at the top of most polls as a concern of voters. Federal reform served as a cornerstone of both presidential candidates' election platforms in 2000. The new bill provides one opportunity for a legislative success this election year, and for President Bush to fulfill his promise to "change the tone" in Washington. School reform and vouchers also had the express support of President Bush, who had pursued similar (largely successful) reforms in Texas.

Finally, it is worth reflecting on what turned out to be the conceptual core of the education bill: promoting accountability, standards, and performance in the educational system. Many of the resources, and much of the framework, of the bill are devoted to state and national testing in reading and math; a program of financing, remediation, and accountability for "failing" schools; and standards and resources for upgrading the quality of teaching. Thus, the bill is framed around a concept of accountability and a philosophy of school reform that enjoys widespread support, if not some controversy within educational circles. This approach may be contrasted with many proposals for increasing health care coverage that lack clearly developed provisions for quality improvement, performance, and accountability. In political terms, education reform exploited the symbolic value of accountability, choice, and quality without the ideological baggage of vouchers. As a matter of strategy, health reformers may also want to invent and emphasize such symbols to go along with the benefits of expanded coverage, per se.

NAFTA: Economics, Power, and Leadership

A third example, leading to a profoundly different perspective on the crafting and management of the legislative process, is the ratification of NAFTA in late 1993. Perhaps more than any other recent piece of legislation, NAFTA revealed the power of strong-arm, classical horse trading. It also demonstrated the assertion of presidential will in spite of strong

opposition by labor, particular industries (especially agriculture), environmental groups, and critics of globalization. This was all done under the specter of coming elections facing members of Congress. NAFTA was ratified in spite of the drumbeat of a broad-based populist campaign, which included such visible and diverse figures as Ross Perot, Patrick Buchanan, and Ralph Nader.

NAFTA was passed after an extended period of trade negotiation with Canada and Mexico, a hand-off of the bill across administrations—from George Bush to Bill Clinton, and an often bitter ideological and regional debate that crossed party lines.[16] Certain business interests, especially those organized around the group USA*NAFTA, invested considerable political and financial capital in the effort to get NAFTA ratified. This included the work of executives from such major U.S. firms as Allied Signal, General Electric, and Kodak.

NAFTA was ratified with support from many diverse points of view in the political spectrum—many finding common ground and justification in the merits of free trade—and some engaged in game-theoretic strategy over a broad political calculus.[17] In the end, for example, the NAFTA vote in the House included 132 Republicans and 102 Democrats in favor, and 156 Democrats, 43 Republicans, and one independent opposed. In this case, the administration sided with Newt Gingrich and was opposed by key party stalwarts, especially in the Midwest and South.

NAFTA is interesting for our purposes because it illustrates the significance of technical and institutional policy moves, the potential power of stewardship and leadership (in spite of organized opposition and public opinion), the role of political economy in modern congressional and presidential policy making, and the power of an important symbol—in this case free trade—in overcoming apparent partisan and ideological barriers. NAFTA was ratified in an era during which Congress had become increasingly assertive over trade policy, and, in theory, had created numerous structural obstacles to presidential policy leverage over trade policy. In all of the accounts of NAFTA's negotiation and enactment, the granting of an extension of fast-track authority in 1993, allowing presidential latitude in trade negotiation, is regarded as crucial. In other words, a seemingly technical and obscure change in the institutional environment—in the rules of the road—opened the possibility for such a large-scale and comprehensive trade bill. Frederick Mayer describes the significance of this extension of fast-track authority:

> As formulated by E.E. Schattschneider, and as explicated by the mainstream literature on trade policy ever since, the core problem in international trade policy is overcoming the tendency of concentrated interests in protection to overwhelm the more general interest in free trade. If policy is made piecemeal, establishing the level of protection one sector at a time, for example, gains to protection will be concentrated for firms in that sector, while the losses will be diffused among the unorganized consumers. Given the much greater problem of collective action for the many small losers, the concentrated protectionists' interests will be more successful in bringing political pressure to bear on trade policy makers. Attempts to negotiate away these barriers one by one encounter the same problem: Concentrated interests are thus often able to prevent international agreement. Comprehensive trade negotiations, those that deal with the many sectors simultaneously, help balance the contest of interests by adding together the many small benefits from each sectoral liberalization. But if Congress can subsequently revisit the terms of an agreement one sector at a time, the comprehensive agreement will unravel as concentrated insiders block pieces of the agreement one by one. . . .
>
> The fast track process largely solves this problem.[18]

NAFTA is also interesting for us because it reveals sophistication in framing and reframing. The issues raised by NAFTA were wide-ranging: immigration, environment, public health, drugs, human rights, and, of course, the economy. For

[16] For a detailed analysis of the crafting of the NAFTA agreement itself among Canada, Mexico, and the United States, see Maxwell Cameron and Brian Tomlin. *The Making of NAFTA: How the Deal Was Done.* Ithaca, NY: Cornell University Press, 2000.

[17] This interpretation is presented in Frederick Mayer. *Interpreting NAFTA.* New York: Columbia University Press, 1998.

[18] Ibid., p. 95.

many of these issues, analyses and evidence could be marshaled on either side of the question. Some of the controversy over these issues was effectively deflected merely by creating other avenues for discussion—for creation of a separate "Action Plan" for environmental concerns—and some of these issues were effectively discounted by analysts and NAFTA advocates. Many issues were defused with the argument that the consequences of NAFTA were minimal in the context of activity in the whole macro economy. Much of the debate about NAFTA focused on the question of net jobs and their migration. While this question is controversial enough, political opposition to other dimensions and consequences of the agreement never gained momentum.

The contest for public and congressional support centered on these questions of employment effects and the benefits of free trade. Both sides created imagery and examples. Rarely was the concept of free trade an abstraction in the debate leading up to NAFTA's passage. In a famous exchange during the 1993 debate between Al Gore and Ross Perot, Gore provided the example of a firm (and its executive, Norm Cohen) that had moved its production from North Carolina to Mexico to avoid trade barriers. "If NAFTA passes, Norm Cohen has plans right now to shut that factory in Mexico down and move 150 jobs back to Charlotte, North Carolina."[19] This imagery was reinforced, of course, by examples of benefits to particular industries, such as automobiles, as well as references to selected studies showing significant benefits in employment (for example, 200,000 net jobs added to the U.S. economy in each of the first two years), balance of trade, and prices.

The movement of the Florida congressional delegation, for example, from virtually unanimous opposition to grudging support, occurred because special deals were struck to protect sugar, citrus, and winter vegetable crops from Mexican competition. Presidential leadership and management of this process of political bargaining were aggressive and sophisticated. Mickey Kantor, the trade representative; Bill Daley, the brother of Chicago Mayor Richard Daley; Bill Frenzel, a former congressman and trade specialist; and other administration leaders were engaged to lobby and make deals with members.

NAFTA illustrates political success in spite of opposition from many different sources. Although President Clinton came to support ratification grudgingly, in the end, he put enormous personal energy and leadership into its enactment. NAFTA illustrates political dynamics and tactical success at the opposite end of the political food chain from such grassroots efforts as the Gilead Campaign. The success of NAFTA required the most sophisticated political management and strategy, as well as effective use of media, symbols, and imagery. NAFTA's support cut across traditional party and ideological lines; it mobilized some of the most powerful commercial and economic interests in the country.

As a model for thinking about health reform and coverage, the NAFTA experience raises all the high-game questions of the political economy that surrounds the health sector. As the prolonged prescription drug debate has illustrated, without good answers and strategy for responding to the interests of the health care industry, and without power, political will, and political resources to engage the industry, it is hard to overcome its resistance. The implication of this heuristic for filtering and considering the *Covering America* proposals is to analyze very carefully the industry interests in play across these proposals. In many respects, health care reform should be thought of in the same terms as NAFTA, as one of the most significant pieces of economic policy that can be envisioned, with vast consequences for the economy of insurers, providers, suppliers, and other stakeholders that make up the sector.

Discussion

In an era of divided government, widespread cynicism, and unfavorable economic conditions, it is useful to look at the counterfactuals: examples of policy or policy development that cut against the grain of the recent legislative and policy stalemate. This chapter has attempted to provide three very different examples that imply different strategies for framing reform. These heuristics provide significantly differ-

[19] Quoted in Paul Blustein. "NAFTA: Free Trade Bought and Oversold." *Washington Post,* September 30, 1996, p. A1.

ent touchstones for prospectively analyzing universal coverage proposals. A social movement approach implies greater attention to bottom-up policy development, looking to both the values and concepts expressed in state and local initiatives. The illustration of MADD is instructive, because it highlights the possible roles of motivated leadership, innovation, and tactics, particularly as they operate in subterranean policy contexts. MADD and other successful movements have made use of the passion, the personal investments and commitments, and the broad-based support of community, advocacy, professional, and other organizations.

It is interesting that universal coverage movements—such as the Gilead initiative described earlier—in the United States are so disconnected from academic, professional, and policy discourse. It would be interesting to connect the dots between developing proposals for expanding coverage and the values and concerns of social movement players in health care. At the same time, it would be useful to envision how social movement players in health care can be better connected to the technical and formal discussion of health policy emanating mostly from Washington. National health policy initiatives (with the significant possible exception of Medicare) have not been particularly adept at or astute in relating to social movements.

The motivations and politics of social movements tend to operate in a middle ground between the large-scale (and often diffuse) goals of universal coverage proposals and the felt need of individuals, families, and providers who encounter risks, difficulties, and hardships in providing access to care. This is why movements tend to coalesce around particular risks or diseases—such as AIDS/HIV, multiple sclerosis, or Alzheimer's disease—or groups, such as children, who have been the focus of S-CHIP expansions. Indeed, some of the patchwork of the U.S. entitlement to health care reflects exactly the disproportionate pressure that has been exerted when individuals and groups experience direct and dramatic consequences from a lack of coverage. Although many of the goals and tactics of comprehensive reform are in significant tension with this form of disease-specific entitlement, it is worth asking how the passion and investment that lie in movement politics can be mobilized toward the agenda of universal coverage. Large contemporary groups (for example, persons with diabetes, dislocated workers under age 65), as well as their families and caregivers, have the motivation for social movement engagement in health reform, but do not have obvious vehicles for political action.

The recent education reform experience highlights the interplay among framing, compromise, and presidential stewardship, if not leadership in a successful congressional strategy. The final bill capitalized on important symbolic common ground between Republicans and Democrats, finessed the ideologically charged issues of vouchers and choice, and featured the most visible examples of political compromise, including the joint appearance of Senator Ted Kennedy and President Bush in Boston promoting the legislation. As a work of inter-governmental design and negotiation, the Education Bill conceptually has issues in common with health coverage proposals that seek to integrate with Medicaid, state insurance initiatives, and safety net providers. Alas, health care coverage does not appear to engender the same commitment and personal interest from President Bush as education reform.

Clearly, the success in producing education reform raises the question of the role and importance of bipartisanship in promoting health reform. Political scientists have much debated the importance of bipartisanship in producing large-scale legislative wins, especially in the modern era. As both the education reform and NAFTA experiences recounted in this chapter demonstrate, however, bipartisanship can take many forms and occur at different moments of the political process. It is helpful to have symbols (for example, accountability, free trade) that can be embraced across ideological lines, as well as leadership that is willing to make compromises on programmatic and technical issues. While bipartisanship has been difficult to achieve in recent health policy, including legislation for patients' rights in managed care and prescription drug coverage, it is worth noting that these other policy heuristics involve some of the same principals (and principles) as health reform. Education reform, for

example, involved the leadership and compromise of President Bush and Senator Kennedy.

The successful enactment of NAFTA is interesting because it reveals the ingredients of big policy enactment against the odds, and against significant and passionate opposition. Again, NAFTA was built around the presumed benefits of free trade, and it exhibited extraordinary bipartisan and ideological mixing. NAFTA represents, among other things, an exemplar of power politics, worth considering as a counterexample to the presumed stranglehold by the powerful economic interests of insurance, providers, pharmaceuticals and medical suppliers, and even state governments on reform efforts.

Several final observations for the coverage proposals in The Robert Wood Johnson project emerge out of this excursion into alternative policy development. *Health care proposals read as if coverage is a sufficient justification for policy.* What if a broader social justification or motivation is required to elicit bipartisan consideration and consensus? It is worth asking whether, at this late hour in the development of U.S. social policy, a more robust justification is necessary to motivate action and achieve consensus. Human capital or human potential benefits of coverage? Efficiencies in the health sector? Accountability and outcomes? Has the proposal been framed, positioned, and articulated with all due respect to the symbolic and political touchstones of our time? Are there ways to think about universal coverage as a contributor to individual and family opportunity, personal responsibility, transitions, or other contemporary values receiving widespread expression in other arenas of social policy? To be more pragmatic, is it possible to think of universal coverage, at least in part, in the context of security, or a strengthened public health system? Even recently, examples of framing of health initiatives appear to exploit the symbols and rhetoric of the time. Edwin Park and Leighton Ku's proposals for Medicaid reform qua stimulus package fit almost perfectly Kingdon's idea of attaching policy approaches to the "problem environment" that presents itself. Their proposal is tailored in both its public finance and coverage features to complement the larger agenda of economic stimulus and recovery of the moment.[20] In the current environment, framing many issues around the federal preoccupation with security is another example. Policy strategists have even joked about ways to reframe the Medicare prescription drug benefit as a key element of national security. In Chicago, for example, the City Department of Public Health is literally going through a process of reformulating the "paradigm" (its word) of public health, to capture resources and opportunity provided by the current emphases on bioterror, emergency preparedness, and security.

A clearly important element in the political success of coverage proposals will be the degree to which an issue is constructed in symbolic, rhetorical, and public interest terms. The balance for health care between symbols that promote the cause and possibilities for reform and symbols that elicit the traditional ideological and "theological" responses is tricky. Deborah Stone has written about the need to find symbols that both bring together disparate interests and provide sufficient ambiguity to allow consensus to form around an initiative.

A number of symbols can be observed in recent legislation in social welfare and the human services. The idea of "opportunity," usually meaning mobility and employment, is a core feature of recent welfare reform, housing policy, child welfare, and employment and training. Closely related to the symbolic ideal of opportunity is the concept of transitional assistance, which is either explicit or implicit in much of recent social policy. In the federal HOPE VI housing initiative, for example, much of housing assistance is to be "transformed" from building and maintaining a stock of public housing, to giving residents the wherewithal to move (soon) into private housing. The wraparound services in this model (for example, employment, service connectors) have the goal of supporting residents in their transition, not necessarily supporting their long-term tenure in public housing. This philosophy is obviously fundamental to the time limits in Temporary Assistance to Needy Families (TANF) and can be seen in the philosophy and design of modern child welfare policy,

[20] Edwin Park and Leighton Ku. *Temporary Medicaid Improvements as Part of a Stimulus Package.* Washington: Center on Budget and Policy Priorities, October 9, 2001.

where the primary goal is to move children quickly either to family reunification or to a permanent adoptive situation—what is called "permanency planning" in the jargon of the child welfare field.

Also closely related to opportunity in the modern construction of social policy are notions of responsibility, voluntarism, and normative ideas about what makes for a civil society. Welfare reform was framed around the concept of personal responsibility; the President now asserts that every citizen has the responsibility to provide the equivalent of two years of voluntary service. The public intellectuals promoting versions of a civil society have been creating a larger construct for social policy that may yet have implications for how health policy is interpreted.

Clearly, the importance of framing health care reform has not been lost on the architects of earlier attempts. Indeed, the imagery of the Clinton plan around health "security" is an illustration of this strategy, and the President's rhetoric and use of symbols (for example, the health security card) revealed appreciation of the importance of symbolically framing reform, at least initially.

From the perspective of other domains of social policy, it is interesting to note how seemingly little attention is being paid to the symbolic construction and framing of health care reform, despite the sophistication of policy design and economic analysis under way. Many possibilities exist: Universal coverage can be framed in human capital and/or human potential terms; in terms of distributional justice, rights, or responsibilities; in terms of public accountability (as education reform has most recently been framed); or in efficiency terms (cost effectiveness, mobility of labor, etc.). It may be worth considering the *Covering America* proposals more explicitly in these symbolic terms, or through these symbolic lenses.

As a final observation from these three case studies, it is worth asking about the state of advocacy and political organization for health reform. The MADD experience suggests there is power in commitment and mobilization, however quaint and naive those ideas may appear in the modern political economy. Very few vehicles exist for mobilization of political support for health reform. The grassroots examples, such as Gilead, described in this chapter, operate at a considerable distance from the machinery of federal reform and the debates of the academic policy community. A proposition that comes out of this chapter is that the sources and potential impact of advocacy and political organization for health reform—outside the Beltway—may not be sufficiently appreciated, or certainly supported, in terms of requisite resources. It may not be enough to try to reach the public with advertising and such large (diffuse) political interests as labor and AARP. Intermediate organizations, often operating at the state and local levels, may be worth further investigation and support in the name of building a robust political agenda for reform.

The *Covering America* proposals are clearly strong in their conceptual development, specificity, and articulation of potential benefits. Indeed, the framework of the project has imposed a kind of discipline that requires descriptions of the approach, interactions with government and health stakeholders, funding, etc. The proposals emphasize the rational and structural features of reform. Largely missing from the public presentation of these proposals are ties to politics, social, and ideological undercurrents for reform and the symbols or meanings that might be attached to the ways in which health reform is undertaken or to the features of specific proposals. ■

Lawlor and Dude

Commentary Abstract

Edward Lawlor and **Ann Dude** look at three successful non-health-related policy reforms to see what lessons can be learned about reformulating health reform strategies to enhance the chances for achieving universal coverage. The three initiatives are the efforts by Mothers Against Drunk Driving (MADD) to pass legislation to curb alcohol-related driving injuries; the 2002 education reform act known as "No Child Left Behind"; and the 1993 NAFTA trade act.

About the Authors

EDWARD F. LAWLOR is Dean of the School of Social Service Administration and Associate Professor at the School and at the Irving B. Harris Graduate School of Public Policy Studies at the University of Chicago. From 1990 to 1998, he was the director of both the Center for Health Administration Studies and a graduate program in Health Administration and Policy at the university. He is the founding editor of the *Public Policy and Aging Report.* For 10 years, Professor Lawlor was a member and Secretary of the Chicago Board of Health and has served on numerous policy and advisory bodies in the fields of health care and aging. He is currently a member of the Chapin Hall Center for Children, the Board of Trustees of the NORC, the National Center on Women and Aging, and Operation ABLE. Professor Lawlor has published widely on health care administration and policy for the aged and the poor, medical indigents, hospital reimbursement, and health care reform. His book *Redesigning the Medicare Contract: Politics, Markets, and Agency* is forthcoming from the University of Chicago Press in 2003.

ANN DUDE is a Ph.D. candidate in the Irving B. Harris Graduate School of Public Policy and a medical student at the Pritzker School of Medicine, both at the University of Chicago. Her interests include health politics and comparative health policy. She has a B.A. in biology and English from Lawrence University in Appleton, Wisconsin, and an M.A. in Health Policy from the University of Kent in Canterbury, U.K.