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The Processual Ordering of Mental Health Care: The Dramaturgical Styles of
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Summer 05

The Processual Ordering of Mental Health Care: The Rhetorical Styles of Contending Political Factions

ABSTRACT

The processual ordering branch of symbolic interaction has long recognized the importance of rhetoric and power to the social constitution of reality. However, little systematic effort has been devoted to probing their intertwined effects in the public policy arena.

The purpose of this paper is to employ the processual ordering perspective to examine the dramaturgical styles used in shaping public policy -- expressed in terms of the "public administration" and "realpolitik" forms of rhetoric -- among contending political factions as they negotiate mental health public policy. A latent content analysis of the minutes of key U.S. Congressional debates, augmented with secondary archival material from the press is employed. It is concluded that both forms of rhetoric play a role in shaping public mental health policy and that both factions modify their rhetorical form as the debate progresses. Those modifications strengthen the position of one faction while weakening that of the other. Theoretical implications are discussed.

*Affordability and accessibility, in my view, are the two important words. Forget all the others - - affordability; accessibility . . . I do not want to be misunderstood. [In the Republican minority's proposal] you will not find the National Health Board. You will not find price controls. You will not find mandates and you will not find new taxes. You will not find these because our bill is not based on the principle we have to get more government. I think it is based on the principle that the American people know best. (Senator Robert Dole, Rep., Kansas, *S11012)*

*Health care reform plans designed to make health care more accessible and affordable would continue the discrimination prevalent in private health insurance today. Many plans allow 365 days for in-patient physical care, but only 45 days of in-patient psychiatric care; provide unlimited coverage of office visits for physical care, but only 20 visits for psychiatric care; and provide up to \$1 million in lifetime coverage for physical care, but only \$50,000 lifetime coverage for mental health care. These are discriminations that we cannot let continue, especially if we reform the health care programs, more particularly if we reform the insurance programs of our Nation. (Senator Pete Domenici, Dem., New Mexico, *51849)*

Use of appropriate rhetoric has long been recognized as essential to the social constitution of reality within a number of literatures. For example, the processual ordering perspective (Strauss, 1993; Prus, 1999; Ulmer, 1997) has recognized the importance of rhetoric in probing such forms of human interaction as negotiations, conflict, manipulation, coercion, exchange, and power brokering in the constitution of organizational structures, rules, laws and societal expectations. Similarly, social movement theory (e.g., Clemens and Cook, 1999; Rao et al., 2000) and the emerging literature on deliberative democracy (e.g., Dryzek, 2000; Wolfensberger, 2000) have reasoned that social change and the development of new public policies are influenced by their connection to societal values through use of appropriate rhetoric. And yet surprisingly, given Berger and Luckmann's early observation that institutions are "built upon language" (1966, p. 64), symbolic interaction research directed at probing the role of rhetoric has been generally lacking, especially in examining the role of political language in shaping national policies (Hall, 1997; Prus, 1999). Moreover, while processual ordering theorists (e.g., Hall, 1997; Prus, 1999) have recognized that the application of power must be carefully examined in the social constitution of reality, the intertwining of human agency and rhetoric in the covert exercise of power has received little research attention, especially concerning the formation of

national health care policy (Marmor, 1999). Indeed, this neglect is unfortunate in view of the rise of the “new rhetoric” which focuses its attention on political rhetoric in the hope of isolating genres of discourse which underlie and support various political factions (e.g., Berkenkotter and Huckin, 1995; Freedman and Medway, 1994).

Drawing upon the processual ordering perspective, as well as a select portion of literature dealing with political rhetoric (March and Olson, 1983; Prus, 1999), the purpose of this article is to examine the role of rhetoric and the covert application of power in shaping national policy toward the provision of health care in general, and mental health in particular. We will proceed by examining U. S. congressional debates over a number of sessions in the 1990’s, with reference to such positions taken by political actors as quoted at the beginning of this paper. Rather than being seen as merely interesting theoretical issues, however, rhetoric and power are examined as complicit in not only impacting healthcare fiscal policies, wherein healthcare spending exceeds \$1 trillion yearly, or nearly 15% of the U.S.’s gross domestic product, but also what and how various segments of American society are cared for (Marmor, 1999; Covalski, et al. 1993; Shortell and Hughes, 1988; Weiner and Strauss, 1997).

THEORETICAL FRAMEWORK AND CENTRAL RESEARCH QUESTION

The Processual Ordering Perspective

The processual ordering branch of symbolic interaction (e.g. Strauss, 1993; Prus, 1999; Ulmer, 1997; see also Clark, 1991; Strauss, 1978; Maines, 1982; Maines and Charleton, 1985) is broadly concerned with examining social organization and structure as being mutually constituted with human agency and social interactions. It focuses on the social construction of even a seemingly concrete reality by probing such human interaction strategies as negotiation, conflict, manipulation, coercion, exchange, bargaining, collusion, power brokering and rhetoric, which are circumscribed by, and yet interpenetrated with, existing rule systems, norms, laws and societal expectations (Strauss, 1993, p. 255; Ulmer,

1997, p. 23; Ulmer, 2005). Maines (1982, p. 278) observed that "It is not just that new processes lead to new structural arrangements, or that structural change leads to associated procedural change ... but that structural arrangements exist in and through processes that render those structures operative." Thus conceived, the formal structure of Federal laws and Congressional mandates are not seen as disassociated, or somehow located "out there," apart from, or exogenous to underlying social processes, but rather, must become embodied in these very social processes (Manning, 1992). Although material conditions play a central role, more abstract concerns for symbolic displays are also essential: "All interaction is interpretive, assigning meaning to objects, events, scenes, settings, or contexts and relationships. This interpreting need not be fully conscious, recognized, explicit, but also symbolizing is intrinsic to action and interaction (Strauss, 1995 p. 151). While "processual orders are the outcomes of past interaction processes that have become sedimented into institutional structure" (Ulmer, 1997, p. 25), processual ordering is a living, breathing process by which humans, collectively interacting, engender new working relations in an ongoing process of institutionalizing new structures, rules and laws.

More specifically, processual ordering views human group life as:

(a) inter-subjective and linguistically mediated, (b) having multiple viewpoints and multifaceted notions of reality, (c) reflective, in which humans continually attribute meaning to actions, events and people, (d) action based, (e) negotiable, and (f) processual (Prus, 1999, p. 126). In turn, its basic propositions are that: (1) interaction strategies are essential to the development, maintenance and transformation of institutional arrangements; (2) interaction strategies (e.g., negotiation, manipulation, power-brokering) may be expected to differ in their salience, and (3) specific social settings offer both opportunities and constraints as to the efficacy of particular interaction strategies. Among contextual characteristics that may influence the selection of particular interaction strategies are: the relative availability and attractiveness to social actors; the perspectives and ideologies of actors; the biographical background of actors; the balance of power among

actors; and the visibility of interaction strategies of external constituents (Ulmer, 1997, pp. 24-25).

Strauss (1993, pp. 228-229; the length of the quote should be forgiven given the central role it will play in interpreting the field observations), saw the application of processual ordering as especially useful for addressing a series of questions posed in public policy arenas:

[W]hen representatives claim representation, how are others—both inside and outside the social world or social subworld—to judge their representativeness? Or to be linguistically mischievous, how in the world are the implicated worlds going to judge their representativeness? In these policy arenas, governmental agencies often claim to be neutral. Yet they are scarcely so. Nevertheless, unless they are relatively stable captives of certain organizations, be it business, labor, or whatever, then their participatory role may be more difficult to discern or prove, as arena participants well know. This nonneutrality adds to the turmoil of the arenas, by itself generating a jumble of issues. In arenas, there are no neutral parties, no neutral governments. However strictly objective they may believe themselves, they are embroiled in what is generally called the “politics” of the arena, and are unlikely to be able to stay out of controversy. The larger point is that *representation (i.e., representing) is not simply an issue, but a process* that is basic to arenas.

Here are other important processes. First and foremost in any arena, is probably *the defining of issues*. Given the multiplicity of perspectives of the participants, much of the disputation, maneuvering, persuading, and negotiating has to do with defining the issues.

Another arena process is *the evolving of issues*, for if the policy arena endures very long, then new aspects of issues are likely to proliferate, or new issues are likely to bud off from old ones. This process is accompanied by another: *the matching of social worlds* and their representing organizations *with the issues*. Matching is an active process, carried out by the participants. They select and reject issues, and reshape them in accordance with their own images and aims.

Another process is *the getting involved with alliances*, which brings a continual tension that exists between the perceived advantages of joining coalitions and the tendency toward pulling back into your own terrain. Although the participants may have very different and even conflicting perspectives toward a given issue, nevertheless they may conceive of themselves cooperating in some actions taken toward that issue.

The intersecting of arenas is certainly also among the most consequential of generic arena processes. It is evident that each arena whirls around within a galaxy of other arenas. An analyst must take this into account even if studying not the galaxy but a single arena, just as the participants in each world must take this into account.

Consistent with Strauss (1993), Hall and McGinty (1997) saw public policy as processual in nature in which the intentions of political actors are transformed as they seek to attain practical ends, in part by mobilizing resources and applying power through use of appropriate forms of language. Power, in turn, is being increasingly recognized as important to processual orders, wherein it is "envisioned as a dynamic, socially constructed essence" (Prus, 1999 p. 4; see also Blume, 1954; Goffman, 1959; Klapp, 1964 for early formulations). Power is seen as an inter-subjective and collectively enacted human phenomenon brought into existence in the here and now through negotiation and rhetoric (Prus, 1999).

Interpreting power as relational in his interactionist research on public policy, Hall (1972) recommended that four dimensions of political power be examined: (1) negotiating over material resources; (2) using rhetorical strategies to define the terms of debate and manage impressions; (3) controlling the flow of information; and (4) symbolically mobilizing support in the form of controlling the flow of information. He went on to theorize that while much political bargaining occurs backstage in the form of controlling the flow of information, much of it appears in the public view in terms of symbolically mobilizing support, and it is here that the rhetorical styles used by political factions shape the process and outcomes of debate. Recognizing that a "basic element of politics is, quite simply, talk" (p. 51), Hall briefly observed that two distinctive linguistic or dramaturgical styles are administrative and political languages (pp. 50, 56, 69):

The existence of the two major political parties means that on some level, and for most issues, there are contending definitions of the situation which compete for the attention and acceptance of the populace. Such contending definitions also serve to create the impression that there are real differences between parties, that the political process is open and that members of the society do have meaningful choices. Representatives of each party therefore strive to create impressions, images, and symbols supportive of their position. The verbal battle between those who are in office and those out of office is an ongoing affair. In American society there is unlikely to be a single definition of the situation. The concern of the politicians, however, is to be able to assert the dominant one, recognizing full well that tomorrow may bring a new dominance. The struggle is ongoing therefore as administrations manipulate

symbols in order to mobilize support and deactivate or insulate dissent, while the opposition seeks to expand its support by capitalizing on the alleged failures of the administration and the new issues of the day. At the same time, growing out of the nature of the two-party system, the proposed definitions often are not too dissimilar as they both seek to control the center of the political spectrum. (1972, p. 53).

Hall (1987; see also Hall and McGinty, 1997) concluded that interactionists probing the concept of power have tended to emphasize the overt application of power between contending factions, as between Democrats and Republicans. Instead, he advocated that research could more fully reflect a processual, interaction-orientation by examining the covert application of power, for example, by focusing on the role of rhetoric in passively shaping the terms of debate (see also Pfeffer, 1981). Thus, our analysis does not focus on the political parties involved in the debate over health care, but rather, on the rhetorical strategies employed in representing positions (for illustrative interactionist work examining political parties, see Grills, 1994; Atkinson, 1995). This focus has the potential for extending the processual ordering perspective, where it has been observed that there has been a paucity of qualitative field studies probing the role of rhetoric (e.g. Prus, 1999), especially within institutions where the application of power is more manifest and diverse (Hall and Wing, 2000).

The Voices of 'Public Administration' and 'Realpolitik'

The purpose of an examination by March and Olson (1983) was to examine twelve, twentieth-century comprehensive Federal reorganization efforts with respect to two rhetorical strategies – public administration and realpolitik. According to March and Olson (p. 292):

These two rhetorics exhibit and reaffirm fundamental social values, particularly those associated with personal efficacy, with intention, interest, power and rational choice.

Thus, these two rhetorics simultaneously support an interpretation of American life and serve as a basis for making short-run legislative decisions. Consequently they may prove

potent in influencing not wholly institutionalized policies that are in a state of flux (see also Dryzek 2000; Wolfensberger, 2000).

The first rhetorical strategy used by politicians is **public administration**. This “voice” of reform speaks in terms of structures and procedures for facilitating efficiency and effectiveness of governmental operations, and invokes the decision criteria of rationality, neutrality and objectivity. The aim of this voice is to embody these core values within bureaucratic structures, and their attendant chain of command, authority and responsibility, thus institutionalizing them above and beyond the political fray:

Administrative orthodoxy emphasizes economy and control. It speaks of offices that could be abolished, salaries that could be reduced, positions that could be eliminated, and expenses that could be curtailed. It calls for strong managerial leadership, clear lines of authority and responsibility, manageable spans of control, meritocratic personnel procedures, and the utilization of modern techniques for management. It sees administration as the neutral instrument of public policies, and reorganization as a way of making that instrument more efficient and effective through the application of some simple principles of organizing. [This voice presents and justifies its proposals] in terms of their contribution: (1) to promote the better execution of the laws, more effective management of the executive branch and its agencies and functions, and expeditious administration of the public business; (2) to reduce expenditures and promote economy to the fullest extent consistent with the efficient operation of the Government; (3) to increase the efficiency of the operations of the Government to the fullest extent practicable; (4) to group, coordinate and consolidate agencies and functions of the Government, as nearly as may be, according to major purposes; (5) to reduce the number of agencies by consolidating those having similar functions under a single head, and to abolish such agencies or advisory functions thereof as may not be necessary for the efficient conduct of the Government; and (6) to eliminate overlapping and duplication of effort. (pp. 282-283)

The second rhetorical strategy used by politicians is **realpolitik**. This “voice” of reform holds that bureaucratic structures, claims to neutrality, objectivity and rationality all represent dangerous illusions--in that they “reflect victorious interests and establish a mechanism for future dominance”--unless contained by the values, beliefs and goals of various competing interest groups within the legislative process. According to March and Olson (p. 283), bureaucratic structures and the everyday actions of governments, let alone government policy, are forged through struggle among contending political factions that include both the legislative and executive branches:

The rhetoric of *realpolitik* is an empirical and prescriptive counterpoint to an orthodox administrative perspective. To the emphasis on managerial control, it juxtaposes an emphasis on political control. It argues that any single individual has neither the cognitive capacity, nor the moral and representational standing assumed by the managerial perspective. The dangers of a too powerful executive are real; good government cannot be reduced to good administration; and congressional and interest group or party dominance in administrative affairs is a precondition for a good political system.

Thus, any effort by political actors to modify policies, bureaucratic structures and the like, without attending to established networks of power and vested interests, are destined to failure (see also Clemens and Cook, 1999; Rao et al., 2000).

March and Olson (1983, p. 292) concluded that these two rhetorical strategies are not unique to the arenas of administrative reorganizations, but instead may be generalized to wider realms of American political life. They observed that "it may be possible to extend some features of the interpretation we have made to a more general consideration of political institutions and processes, to the problems of governance." Our purpose is to develop such an extension by examining the role of the rhetorical strategies of public administration and *realpolitik* as contending political actors seek to influence government's role in mental health care.

Integrating the processual ordering perspective and March and Olson's (1983) examination of rhetorical styles, it is possible to state a central research question that will serve as the focus of our analysis:

What roles do the *public administration* and *realpolitik* discursive styles play as contending political factions seek to negotiate, manipulate, delay, coerce, bargain and broker national public policy concerning mental health?

RESEARCH METHODS

Consistent with our social constructionist, theoretical perspective, evidence was gathered through a latent content analysis of archival material. Archival material took the form of both public records (Denzin, 1978), as well as press coverage of the events examined (e.g., Allison and Zelizer, 1999; Altheide, 1996). Public material included:

hearings minutes of the United States Congress relating to debates on health care coverage; position statements and platforms of various political actors; government reports and position statements, as well as response reports critiquing these positions; and press coverage, predominantly from the *New York Times (Times)*, *Wall Street Journal (WSJ)*, and *Washington Post (Post)*.

Latent content analysis, in which the researcher serves as a research instrument in interpreting archival material (Van Maanen, 1988, 1995; Strauss & Corbin, 1990; Fine, 1984), was deemed especially relevant in order to emphasize the inherent character of the archival material rather than on quantitative procedures of analysis. According to Berg (2004, p. 107), latent content analysis represents an "interpretive reading of the symbolism underlying the physically presented data," and thus focuses on "the deep structural meaning conveyed by the message." Although there are dangers inherent in drawing inferences from such symbolism, it is nevertheless a very useful approach in examining archival material suggestive of the exercise of power (Merton, 1968, pp. 366-370). Moreover, these dangers may be mitigated by incorporating independent, corroborative techniques, and including detailed excerpts from material examined to substantiate the researchers' interpretations. In the current study, the primary researchers independently examined material and reached a consensus as to its interpretation--analogous to establishing inter-rater reliability in quantitative analyses, although the processes are more social in character--and multiple archival sources were examined where possible. Quotations from the archival material are presented concurrently with the development of interpretations (Berg, 2004). These efforts extend beyond normal measures for ensuring the trustworthiness of latent content analysis, for in our study, the social processes themselves helped authenticate their own veracity in that they involved a basic dialectic process between contending political factions, between thesis and antithesis, which helped engender our own synthesis (Mitroff and Mason, 1981).

The primary groups of political actors examined were Democratic and Republican members of Congress, who were active in the debate concerning health care coverage in general, and mental health care coverage in particular, as well as the United States President and staff. Congressional leaders included U.S. Presidential hopefuls. Other actors included the press (although newspaper accounts were targeted, it is noteworthy that particular reporters were especially active in covering the events examined), and governmental agencies (e.g., the U.S. General Accounting Office).

January through March, 1994: The Debate Begins and Derails

The debate over mental health “parity,” revolving around the issue of whether mental health care should have the same level of insurance coverage as physical healthcare, has its genesis in the intersection of two series of events: recent advances in treatment of mental illness, and a willingness to consider major changes in the means of paying for health care brought on by the rapid increases in health care costs. Two major issues were debated: (1) should mental illness have the same insurance coverage as physical illness? and (2) assuming that the same coverage is to be provided, who should be deemed mentally ill?

Health care reform, one of several domestic issues emphasized by Bill Clinton during his campaign for the presidency, moved to the top of his agenda in the period between his election in 1992 and the inauguration in January, 1993, due largely to the budget deficit he faced (Starr, 1997). However, the budget deficit was not the only impetus. Large employers had experienced substantial increases in health costs, well above the rate of inflation, throughout the late 1980s and early 90s. A number of major corporations and national labor unions endorsed government regulation to force all employers to pay for their workers’ health care, as a means of leveling the playing field and avoiding cost shifting (Swenson and Greer, 2002). Thus, health reform also served as a point of agreement with a political constituency generally more conservative than the President. This was

particularly important given the narrow margin of the election. President Clinton appointed his wife, Hillary Rodham Clinton, an attorney experienced in public policy matters, to head a task force charged with developing a plan to offer universal coverage to the U. S.

population. Representative Engle (D, NY) observed that:

Whatever bill we pass must have comprehensive mental health benefits. Mental health benefits should not be a second thought; mental health benefits must be on a par with any other benefits that we offer in any final bill that passes this legislature (Congressional Record, House, March 9, 1994, Vol. 140. No. 25).

Universal coverage was expected to be adopted, but perhaps to be curtailed to some degree to reduce the projected budget deficit. Mental health and substance abuse benefits were included initially in the plan on March 16th, but there was doubt that they would survive the legislative process. Mental health benefits were seen as particularly vulnerable:

The fact of the matter is, if you had to find one single piece of the health care proposal which is vulnerable--one single piece of it--it would be mental health. There are a lot of people around this country who are opposed to mental health benefits because they see it as stress in the workplace and not as serious problems. (Congressional Record, March 24, 1994, Vol. 140, No. 35, Senator Rockefeller).

Throughout this period, coverage in the press was mixed. The *WSJ* was adamantly opposed to comprehensive health reform, calling the "Clinton Plan" "pathological" (January 3, 1994, p. 6, col. 1). Another article on the same page written by the mother of a child with severe impairments detailed her experiences:

I can show Mrs. Clinton that programs like hers already exist. I can show her the paperwork, the idiosyncratic rules, the insensitivity, the ill-trained workers and a bureaucracy as deep as the Mississippi at St. Louis. I can show her a system that, much like her proposal, was intended to help. The reality is that help rarely makes it to our Claire.

Other *WSJ* headlines were unremittingly negative (e.g., January 25, 1994, Section B, p. 3, col. 1; January 26, 1994, Section B, p. 2, col. 3). The *WSJ* reported being "stunned" when the American College of Surgeons endorsed the proposal (February 11, 1994, Section A, p. 3, col. 1). The headline "Small Businesses oppose Compromise Health Proposal (though they see it as less onerous than the Clinton Plan)" (February 25, 1994, Section B, p. 2, col.

3) demonstrates the tenor of the *WSJ* coverage. Though this could be interpreted as a reporting of the news, the inflammatory language effectively revealed the *WSJ*'s position.

The *Times* began its coverage (January 3, 1994, Section A, p. 14, col. 3) with an article that predicted major health care legislation. Most of those quoted expected a comprehensive bill to pass, though they predicted that the original proposal would be substantially modified:

Congress will pass a comprehensive bill in 1994. The centerpiece will be universal coverage, perhaps phased in over a decade. The final bill will have a passing resemblance to the Clinton proposal, but it will not be a close copy. . . It will place less reliance on government regulation and will have less bureaucracy than the President's proposal. (Dr. Lonnie Bristow, chairman of the American Medical Association).

Congress will pass a bill assuring health security to every American. Congress will recognize that anything short of that standard will not be viewed as adequate by the American people. (John C. Rother, director of legislation and public policy, American Association of Retired Persons).

Congress will pass a comprehensive bill providing universal coverage. The American people will not allow any other result. It will resemble the Clinton plan more than any other proposal because he faithfully built his plan around Americans' priorities. (Senator John D. Rockefeller, D, WV).

It will be a tough legislative battle. But by the end of the year, we will pass legislation that guarantees health insurance coverage to all Americans. Members of Congress will be reluctant to face voters in 1994 without being able to take credit for such legislation. (Representative Henry A. Waxman, D, CA).

However, there were critical social actors who were less confident of the bill's passage. Of 18 people quoted in the *Times* article, 13 thought legislation would pass and three thought it would not. But among the seven legislators interviewed only four thought it would pass. Senator Nancy Landon Kassebaum (R, KS), ranking Republican on the Labor and Human Resources Committee, predicted that:

I don't think Congress will pass a comprehensive health bill in 1994. There has been considerable slippage in support since the President's speech to a joint session of Congress. The public has grown increasingly confused about the complexity of this issue, and those who are opposed have managed to create further seeds of doubt. The public worries about the cost and the ability to have choices in the system. I'm just finding growing opposition. The question becomes, Should we do interim steps like insurance reform? It seems more likely we will approach it that way.

By January 23, it was obvious that the *Times* had serious reservations about the proposal. A tongue-in-cheek article (Section 13J, p. 13, col. 1, "New Jersey Weekly Desk") presented a series of questions and answers about the plan. It would be nearly impossible to mistake the tone of that article, which concluded that:

Will doctors, employers, patients, and insurers be able to get along happily under the new system? Assuredly. For the first time in the history of New Jersey's health care system, they will cease to be adversaries, since, under the new system, all will be equally confused. Befuddlement will be impartial, without regard to race, creed, class or country of origin. Indeed, universal ignorance of the provisions of the new system will be very much a blessing for all concerned. Because, as everyone knows, ignorance is bliss.

In early February, the *Times* reported that several alternate proposals were advanced and that executives of large corporations opposed the breadth of the Clinton proposal which they felt would slow the economy. In response, President Clinton vowed to veto any bill which did not provide universal coverage (February 2, 1994, Section A, p. 1, col. 4, National Desk).

The *Post* was generally supportive of the Clinton proposal, and focused more on mental health issues than the other newspapers. A January article featured excerpts from an interview with a practicing psychologist who declared the President's plan had "pretty decent coverage" for such acute psychiatric problems as substance abuse, but was "woefully inadequate" to meet the needs of many seeking outpatient services. He criticized the part of the plan that set limits on office visits as a "false economy:"

When the 30 (visits annually) are over, they'll save money in the short run. When we've got to hospitalize this person down the road, they're going to feel the pain, whether or not they're able to make the connection. (January 3, 1994, final edition, p. A9)

April through Early August 1994: Behind the Scenes

The Congressional Record had relatively little material during this period. The debate had been scheduled for mid-August, and work was being done behind the scenes concerning the envisioned bill within committees. Both the House and the Senate developed proposals

competing with the Clinton plan. However, most of the work took place out of the public eye or was not conveyed to the press (Hall, 1972).

Coverage in the *WSJ* during this time subsided somewhat, and the limited discussion that did occur, tended to focus on costs. An April 13 article presented a case for medical malpractice reform (Section A, p. 13, col. 3). By Congressional Budget Office (CBO) estimates, a rival plan would leave millions of Americans without health care insurance and only moderately slow rising health expenditures, but would cut long-term deficits (May 4, 1994, Section A, p. 5, col. 1). A plan proposed by Senator Breaux (D, LA) (May 18, 1994, Section A, p. 2, col. 2) would shelter small businesses from part of the costs of health reform by increasing the contribution from companies with more than 1,000 workers. President Clinton, meanwhile, rejected Representative Gingrich's (R, GA) call for suggestions to shore up Medicare's finances, saying that he would accept Medicare cutbacks only as a part of overall health reform (May 2, 1994, Section A, p. 20, col. 1). An article on May 19 (Section B, p. 8, col. 1) described the results of a study demonstrating that the mental health benefits outlined in the President's plan could be expanded at no extra cost, perhaps surprising in light of earlier coverage of the topic in the *WSJ*.

Between April and July 1994, the *Post* featured articles calling for caution, which focused on potential shortcomings of the proposed legislation. These voiced a concern that current levels of public hospital funding would be insufficient to care for the poor (April 24, 1994, First Section, p. A6), and that the costs of mental health care could not be reliably estimated because coverage of that type had been generally unavailable (July 25, 1994, First Section, p. A6). However, an August 6 letter to the editor (p. A18) disagreed with that claim:

When outpatient therapy is free, 4.3 percent of the population uses it, and the average length of treatment is 11 sessions. Psychotherapy produces a net reduction in health care costs: The most comprehensive analysis, covering 58 studies, shows that on average, outpatient psychotherapy lowers medical utilization by as much as 33 percent; a subset of studies regarding inpatient usage showed a 73.4 percent reduction in hospitalization. A study of 4.5 million military dependents covered by the federal CHAMPUS health

program showed that for every dollar spent on outpatient psychotherapy, four were saved in psychiatric hospitalization costs.

The *Times* provided far more coverage during this period than the other two newspapers. In general, coverage appeared objective and informative, while recognizing the problems the legislation faced in the road to enactment. An editorial in early May (May 11, 1994, Section A, p. 24, col. 1) described Senator Kennedy's (D, MA) proposal as "the first serious effort to reach out to Republicans for a needed bipartisan compromise." A series of later articles (i.e., May 15, 1994, Section 4, p. 1, col. 1; May 19, 1994, Section A, p. 24, col. 1; June 6, 1994, Section A, p. 14, col. 5; June 8, 1994, Section A, p. 1, col. 3; July 21, 1994, Section A, p. 1, col. 1) detailed problems being encountered by the legislation. Two articles (July 22, 1994, Section A, p. 20, col. 4; June 12, 1994, Section 4A, p. 3, col. 1) attempted to help people understand the problems, alternative approaches to a solution, and some of the differences between the various proposals. The *Times* generally appeared to support universal coverage, but not mental health parity.

In early July, the Senate committee developed a plan that would cover 95% of Americans. The *Times* printed a letter to the editor outraged by that plan. The writer proposed that 5% of Senators lose their medical coverage:

If having no health insurance is good enough for more than 17 million Americans, it's good enough for five United States Senators. If it is not satisfactory to the Senate to have five senators in their midst with no health insurance, let Congress pass a system that covers all Americans with complete coverage for mental illness, including the substance abuse disorders coverage that the senators and representatives themselves enjoy. Let the senators walk in the shoes of those they represent. (July 15, 1994, Section A, p. 26)

August 1994: The Universal Coverage Debate

During August, the competing health care reform proposals came to Congress for debate. The lines were clearly drawn. Senator Mitchell (D, ME), the majority leader, introduced the "Mitchell Bill." Using the voice of realpolitik, Mitchell called for significant changes to bring about basic "fairness for all Americans":

Health insurance for all Americans is the key to reform. Without it, we face a continuation of cost shifting and other problems . . . If the states can demand that auto insurers cover the risks resulting from bad driving-behavior that can be controlled and influenced and prevented - it is not beyond our ability to require health insurance companies to cover those whose conditions often do not arise from their behavior but from circumstance and from just plain bad luck (August 2, 1994, Congressional Record, Senate, Vol. 140, No. 104).

However, Senator Mitchell anticipated that the Bill would encounter significant opposition from those wielding the voice of public administration:

Human beings are made anxious by change. It means uncertainty. So that every major change in our Nation's history has been bitterly fought. Those who oppose change have tried to transform people's natural anxiety into fear. It sometimes worked for a while. But when fully informed, Americans have looked to the future with the same optimism and courage that have been our Nation's distinguishing values. I believe it will be so with health care reform, as it was with Social Security and Medicare. They are so strongly supported now that across the distance of history it is hard to figure out what all the fuss was about (ibid).

Senator Kennedy (D, MA) pointed out that every other industrialized nation in the world except South Africa had already acted to ensure that all its citizens have health insurance, and pleaded using the voice of realpolitik:

Every member of the Senate I am sure has talked to as many people as I have, people, who through no fault of their own, have crushing health and financial burdens because the health insurance system has let them down. As we approach each vote, I ask you to remember these individuals. They desperately need your help. They are not Harry and Louise.¹ They have no trade organizations. They have no lobbyists. They cannot spend thousands of dollars in advertisements to fight reform. The only power they have lies in our votes and in our commitment to serve the people, not special interests. We in the Congress are fortunate. We have guaranteed health insurance paid for in large part by our employer. Is it not about time we did the same for the people who employ us (ibid)?

Senator Dodd (D, CT) felt it was important to close the holes in the existing insurance system and felt pressure to do so:

It is an irony that in the America of today, if you are on welfare, you can get health care. If you are in prison, you can get health care. If you are a Member of Congress, you can get health care. But if you are a middle-class American who gets up and goes to work every day to a job without coverage, then you can't get health care. That's what this debate is about . . . We haven't had a debate like this for decades, and if we fail this year, we won't have another one for decades more (ibid).

Senators Dole (R, KS) and Packwood (R, OR) jointly sponsored a counter proposal offering guaranteed access to coverage with subsidies for those with low incomes (August 9, 1994, Congressional Record, Senate, Vol. 140, No. 109). Senator Dole spoke with the voice of public administration:

We are trying to figure out, all of us or most of us, how we can assist those people (who are in great need) without damaging the best health care system in the world . . . Affordability and accessibility, in my view, are the two most important words . . . We believe we can do that without new taxes, without having the Government tell you what will be included in your health insurance, and without, in many areas, putting Federal bureaucrats in charge of your health care system (ibid).

Senator Packwood raised a topic that remains unthinkable to most Americans-- the overt rationing of health care. Using the voice of public administration, he stated:

If we would just sit back and let the market work-it is going to work well for the next 5 or 6 years. The competition is just setting in. The reason I say for the next 5 or 6 years is because at some place you are going to reach an irreducible minimum below which a hospital cannot operate and it goes bankrupt. You are going to reach an irreducible minimum in which a doctor says 'I'm no longer going to practice medicine, I'm going to be a plumber and make more money.' He goes out and becomes a plumber. At that stage, competition cannot squeeze any more out. No bill-not the Mitchell bill, the chairman's bill, not Dole-Packwood addresses the ultimate problem which is really a theological problem. It is not a medical problem. How much of our gross domestic product do we want to spend on medicine? The doctor can tell you, in all likelihood, how long you are going to live or how long your parent might live. The decision whether to keep them alive for 3 months or 9 months, and maybe the difference in 6 months is a couple of hundred thousand dollars, is not a medical decision. Maybe it is a financial one for you, or a theological one. America has not come to that yet. Interesting, most of the socialized countries have. They cannot afford not to. In England, you might not get kidney dialysis if you are over 65. They have better things to do with the money. I plead with this Congress, this Senate; do not pass a bill that attempts to regulate us into what cannot be regulated. And the danger is once we start down this road, as every other country has learned, trying to undo it becomes almost impossible (ibid).

Senator Kerry (D, MA) noted the paradox posed by the two opposing voices, while expressing his own preference for the public administration perspective:

In particular we must take care not to allow the urgent need to subsidize those who cannot pay health care bills to dominate the need to contain costs. Every significant Federal intervention to expand coverage this century -- tax deductibility, Hill-Burton, Medicare, Medicaid -- has increased the demand for expensive care. This demand has increased the availability of expensive health care. Not surprisingly, this has made health care more unaffordable

and we are back where we began -- increased the demand for subsidies (ibid).

Even Senator Domenici (R, NM), noted for his support of health care reform measures, and one of the most active voices of realpolitik, called for caution

Let me state at the outset that I believe we should enact health care reform. I think there are things in the system we ought to correct, and some of those are very serious. I give the President of the United States, Senator Mitchell, Senator Dole, and a myriad of others, credit for putting this at the top of our agenda. But as we move toward reforming our health care system, we in this Congress, like doctors who deliver health care, should take the Hippocratic oath to do no harm (ibid).

Senator Araka (D, HI) presented information from his state's twenty years' experience with universal health insurance, jointly funded by employees and employers. Hawaii's costs were 20% to 30% below the national average, despite its high cost of living. Longevity was high, infant mortality was low, and two recent analyses by independent organizations had rated Hawaii's public health status first in all the U. S. Contrary to dire predictions of the effects on small businesses, small business employment had increased.

Two days later, Friday August 12, it was clear the debate had completely fallen apart. In the Senate, Republicans were filibustering, and Democrats could not muster the sixty votes required to end the filibuster. The House declined to debate an alternate bill that its own members had developed. On September 27, the Senate briefly discussed health care for those with disabilities and psychiatric problems, but again, nothing came to a vote.

Nonetheless, the issue remained. Senator Rockefeller (D, WV) quoted extensively from an election night poll in November 1994. Results showed that Americans supported health care reform and identified it as their number one priority -- above economic stability, crime and taxes. 56 percent of voters said that Congress should take the lead in developing a health care plan. Only 20 percent said that Congress should not try to see that more people have improved access to health insurance. 74 percent said that Congress should either guarantee coverage for all Americans, or at least make a start by covering some

groups who did not have health insurance. A majority of voters favored beginning with children (Congressional Record, Senate, January 4, 1995, Vol. 141 No.1 Part II).

WSJ's continued opposition to health reform can be detected in an article on August 9 (Section A, p. 12, col. 1), which applauded Senator Gramm's decision to "proudly oppose" the Clinton plan, and an article by economist Martin Feldstein which estimated that subsidizing health insurance would cost \$100 billion a year, and raise personal taxes by nearly 20%. *Times'* articles were primarily informational, but some clearly favored the concept of universal insurance while urging caution. An editorial on August 12, 1994, (Section A, p. 23, col. 2) read in part:

The history of the Social Security Act of 1935 suggests the risks of making an excessively rigid commitment to universal coverage. When it was enacted, its benefits fell much shorter of universality than almost any health care measure now debated. Huge categories of people were excluded. When the first pension payments began, they reached fewer than a quarter of all workers and virtually no one outside the labor force. Yet within four years, Congress began to expand the system. Today, Social Security pensions are the closest thing we have to a universal system of social insurance. Whatever its flaws, it is the most popular and politically unassailable social program the government has ever produced . . . On the other hand, the 1965 Medicare Act illustrates the dangers of establishing a principle of entitlement without an adequate structure for financing and containing it . . . The unintended consequences of Medicare are among the causes of today's health care crisis. And they support Mr. Clinton's argument that a system too far from universality could make things worse, not better, for people who need help the most.

An article on August 16, 1994, (Section A, p. 1, col. 4) recounted stories from several Congressional Members being "badgered" by Lobbyists, and another (September 23, 1994, Section A, p. 4, col. 2) reported that at least 20 percent of the money given to Congressional candidates during the election by political action committees and large individual donors came from those opposed to comprehensive health reform. By the end of August, the *Times* accepted that little progress toward that goal was likely to be made, describing Congressional debate as "a last-ditch effort" to persuade members of both parties to adopt a modest proposal (August 25, 1994, Section A, p. 16, col. 1). The *Post*, meanwhile, continued to call for small, incremental remedies to the health care crisis.

1995: The Calm before the Storm

Only two minor actions related to health care reform took place in Congress during 1995, both during January. The Family Health Insurance Protection Act to “provide for health care reform through the health insurance market reform and assistance for small business and families” was introduced. The bill proposed: banning discrimination by insurance companies based on health status; limiting pre-existing condition exclusions to six months; guaranteeing issue of small group policies; permitting insurance companies to refuse to renew coverage only due to nonpayment, fraud or misrepresentation; and requiring insurers to offer a designated plan (Congressional Record, Senate, January 4, 1995, Vol. 141 No.1 Part II). The Equitable Health Care for Severe Mental Illness Act of 1995 was introduced on January 31, 1995. Its intention was to provide, within whatever health reform package was enacted, treatment for severe mental illness “commensurate” with that for individuals with other diseases (Congressional Record, Senate, January 31, 1995, Vol. 141 No. 19). Neither proposal was ever debated in Congress.

The *Post* began the year (January 8, 1995, Outlook, p. C5) with an article outlining a potential Republican strategy:

A Republican version of health care reform would hardly resemble the gargantuan Clinton plan that foundered in the last Congress. But even a plan so lite (spelling in original) it had the flavor of rain water could have a major impact on health care—and on voters. First, it would dramatically show that the Republicans could break gridlock and do something the Democrats had failed to do . . . It would also say to voters—‘see, the GOP has a social conscience, despite the party’s roars about building orphanages and cutting welfare’ . . . Finally, it would leave the Democrats without their prime middle-class issue.

A Paul Samuelson article (October 25, 1995, Op-Ed, p. A19), relying on a voice of public administration, demonstrated that the *Post* thought there was little need for any action because it had already taken place in the private market through admittedly under-researched managed care:

We often miss the most momentous social changes. They occur without a defining event and, once completed, escape notice by their very normalcy. So it has been in health care, which in the past few years has undergone a

revolution . . . President Clinton envisioned such an upheaval in his unsuccessful 1993 health-reform proposal, but it has occurred without federal fiat and with stunning swiftness.

The *Times* polls suggested, however, that a significant majority of citizens still preferred guaranteed health insurance for all Americans.

1996: Success! Success. Success?

Mental health parity and health insurance reform were prime topics in Congress during 1996. The Health Insurance Reform Act was introduced on April 18 (Congressional Record, Senate, Vol. 142, No. 50). The bill guaranteed availability of group coverage for those who start with a new employer; guaranteed renewability of such coverage unless there was nonpayment or misrepresentation; limited preexisting exemptions to twelve months (except in the case of pregnancy, which would be covered immediately); and provided special enrollment periods for those who had changed family circumstances. This bill, known as the Kassebaum-Kennedy Bill, passed the Senate Labor and Human Resources Committee in August by a unanimous vote. It enjoyed broad bipartisan support in Congress, as well as the support of a number of organizations, including several large health insurers and the U.S. Chamber of Commerce (p. 26). Senator Kassebaum (R, KS) was quite direct in her introduction of the bill using a modified form of *realpolitik*. She stated that while it was a limited bill, it was a bill that could pass and would help a large number of Americans:

Only a year after President Clinton waved his veto pen, said he would not sign any bill that did not contain universal coverage, the President now says he will sign this carefully targeted health insurance portability bill. We should take him up on that offer. The bill before us today does not achieve universal coverage. It is a far cry from the comprehensive health reform proposals that were considered by Congress only in the last Congress. However, it would immediately and immeasurably improve the lives of millions of Americans (Congressional Record, Senate, Vol. 142, No. 50).

Senator Kennedy (D, MA) echoed Kassebaum's appraisal, applied a bit of political pressure to help ensure its passage, and cautioned strongly against loading controversial

amendments onto the bill, modifying even further his traditional voice with practical, rational elements of public administration rhetoric:

The Health Insurance Reform Act is a modest, responsible, bipartisan solution to many of the most obvious abuses in the health insurance marketplace today. The bill was approved by the Senate Labor and Human Resources Committee last August by a unanimous vote of 16 to 0. It is similar to proposals made by President Clinton in his recent balanced budget plan. The measures it includes are also virtually identical to provisions of legislation offered by Senator Dole in the last Congress -- legislation supported by virtually every Republican member. Sponsors range from the most conservative members of the Senate to the most liberal—because these reforms represent simple justice. They are not issues of ideology or partisanship . . . I believe it will pass overwhelmingly—unless some in the Senate insist on following the Republican majority in the House of Representatives by addressing controversial and harmful provisions like [here a list appeared] . . . Medical savings accounts, which are included in a major amendment to be offered later in this debate are particularly objectionable. They are opposed by virtually every credible health policy expert. They attract the healthy and the wealthy, and add up to an unjustified \$1.8 billion Federal giveaway to those who need it least. They are a gift to the insurance companies with the worst record of abusive practices—a poorly disguised reward for millions of dollars of campaign contributions. And by pulling the healthiest individuals out of the conventional insurance market, they will raise premiums for everyone else, including those who need coverage most. In fact, the Congressional Budget Office concluded 'In the long run, the existence of any type of catastrophic plus MSA option that would be attractive to a large number of people could threaten the existence of standard health insurance.' Members of the Senate who are serious about insurance reform should vote against all controversial amendments—including medical savings accounts. Senator Kassebaum and I have agreed that we will vigorously oppose all such amendments—even those that we might support under other circumstances (ibid.).

Other co-sponsors of the bill expressed the same sentiment. For example, Senator Rockefeller (D, WV) observed:

The people of our states are still writing, calling, visiting, and asking for help. I am going to do whatever I can do to make sure that we do not let this opportunity pass us by . . . That is why we simply have to also exercise restraint and not kill this bill with extra baggage. It is tempting, but it cannot happen. Amendments, whether they are well-intentioned or not, which are controversial will have the effect of bringing this bill down, and we all know that. We have to be very careful as we go through this exercise that we do not accept controversial amendments (ibid.).

All such calls for caution, however, did not eliminate the threat of amendments.

Senator Jeffords (R, VT, who changed to an independent in 2001) introduced an amendment to require lifetime caps of \$10 million because otherwise, very low limits could

be instituted which would quickly leave people without insurance. Another amendment was proposed to allow the self-employed to deduct the cost of health insurance. These amendments proved not to be controversial and were readily accepted. Two others proved quite controversial, however. Senator Dole (R, KS) introduced an amendment to include MSAs, as did Representative Gingrich (R, GA) in the House, nearly killing the bill, as intended. The Senate subsequently voted against MSAs, but the House included them. It appeared that even establishing a committee to work out the final form of the legislation would be impossible. Only a last minute compromise, which established a demonstration project limited to 750,000 participants from businesses with 50 or fewer employees, bridged the gap.

That MSAs proved controversial is largely because of different perspectives of their likely effects. A report prepared by the Congressional Budget Office, reflecting a public administration form of rhetoric, found that "a major reason for high and rapidly rising health cost is the failure of the normal discipline of the marketplace to limit the quantity of services supplied" (as quoted by Senator Coats (R, MI), *ibid.*). Senator Coats also claimed that MSAs would achieve savings by reducing the administrative burden on our health care system since the number of small claims would be dramatically reduced. The *Times* (January 18, 1996, Section D, p. 2, col. 1) reported a disconnect between the beliefs of Congress and those of health economists. Some members of Congress tended to believe that health care costs were high largely because of administrative costs and consumer choice:

Most of the health care bills before Congress remind us of Henry Ford's philosophy behind the Model-T car. 'You can have any color you want as long as it is black,' (but) health care reform that includes medical savings accounts would represent real consumer sovereignty; patient self-interest would be harnessed to keep costs down, and workers would build up tax-free health care funds for when they were between jobs. Health care security would be enhanced, but not at the cost of quality or freedom of choice (as quoted by Mr. Coats, *ibid.*).

The same article contrasted that belief with the views of health economists. In response to a poll by Victor R. Fuchs, the outgoing president of the American Economic Association and a health economist at Stanford University, 81 percent of health economists agreed that "the primary reason for the increase in the health sector's share of G.D.P. over the past 30 years is technological change in medicine."

The amendment for full mental health parity brought forward by Senators Wellstone (D, MN) and Domenici (R, NM) also proved controversial. Senators Kennedy and Kassebaum opposed it, as they had promised. The essentials of the debate were quite similar to the discussions of mental health care in 1994. One exception related to the cost estimates, which were markedly lower. Estimates for the current amendment amounted to a 1.6 percent increase in insurance premiums (Congressional Report, Senate, April 18, 1996, Vol. 142, No. 50). Additional information about costs in states with parity laws was also presented. In the state of Minnesota, the cost estimate was 26 cents per person (as quoted by Mr. Wellstone, *ibid.*). The sponsors were careful to point out that mental health care could be subject to the same managed controls as physical health care. The same underlying realpolitik argument was used: "parity is an issue of fairness." Several members of Congress told personal anecdotes of those they had lost to mental illness in an attempt to persuade others to support the amendment. However, a public administration emphasis quickly became focused on how limited were the incremental costs -- an about-face from 1994.

The measure was tabled in the Senate on April 18. On May 12 (Congressional Record, Senate, Vol. 142, No. 59) it was reintroduced as part of the Working Families Economic Security Act of 1996, which, among other things, proposed raising the minimum wage. The bill passed, but the mental health portion was deleted. This particularly upset Senator Wellstone, because, he argued, the mental health amendment actually had strong support:

To me it is just unconscionable that this cannot be accepted. I mean it passed by 68 votes. I do not believe that this should now be knocked out of the mix.

Senator Kennedy replied that he supported the amendment in principle, but that for the present, it was better to concede defeat:

I come down on the side [of those who say to dismiss the parity proposal] because I fear, if we do a study, that may very well be utilized as a way to compromise further progress in addressing mental health down the road on some future health care proposal (ibid.)

So, after long debate and dueling cost estimates, mental health parity was not included in the Health Insurance Portability Act. The Act did, however, serve the interests of nearly 25 million Americans with pre-existing health problems who might want to change jobs in the future.

However, only a few days later, Senator Domenici re-introduced the limited amendment he had previously introduced as a free-standing bill. But, this time Domenici used more of a voice of public administration, for example, by presenting CBO cost estimates for the reduced bill were for a 60 cent to 67 cent increase per member per month, even if increased utilization were assumed. Domenici also shared the experiences of the states that had already implemented full parity -- well beyond what was required in his measure -- to emphasize its low cost. Texas (full parity and chemical dependency benefits for state and local government employees) reportedly had incurred a 47.9 percent *reduction* in overall yearly mental health expenditures. Maryland [full parity for all state regulated plans] experienced an increase of 0.6 percent per member per month. Massachusetts [full parity for severe mental illness] showed a 5 percent increase in utilization, but a 22 percent *decrease* in mental health expenditures, and Rhode Island [full parity for severe mental illness and chemical dependency] showed a cost increase of 0.33 percent (Congressional Record, Senate, August 2, 1996, Vol. 142, No. 117). Domenici's new bill was still tabled, despite its reliance on the voice of public administration documenting its low apparent cost.

Finally, on September 5, Senator Domenici attached a mental health parity amendment to an unrelated act, and Senator Gramm (R, TX) attached an amendment to the Domenici amendment which would provide an exemption if costs to a company increased one percent or more, offering that:

I do understand. I grew up in a household with someone who had mental illness. I grew up in a household where nobody had health insurance. We did not have health insurance for physical or mental ailments. But the point is, if you are going to mandate coverage, then you will end up with more people who have no health insurance, and you are going to have more people without jobs (Congressional Record, Senate, September 5, 1996, Vol. 142, No. 120).

Thus, a compromise form of potentially successful mental health legislation was reached and the Mental Health Parity Act was passed to be effective in 1998.

Coverage in the *WSJ* during 1996 continued to oppose health reform measures, largely using a public administration form of rhetoric (e.g., March 19, 1996, Section A, p. 18, col. 1; May 22, 1996, Section A, p. 22, col. 1; May 30, Section A, p. 14, col. 3). Select articles specifically targeted the mental health parity amendment to the Kennedy-Kassebaum proposal, noting fierce opposition by the business community (May 2, 1996, Section B, p. 7, col. 1), or urging caution because mental health is poorly defined and thus insurance coverage is open to abuse (June 13, 1996, Section A, p. 15, col. 1). The *Post*, meanwhile, began the year with a statement of support for incremental health reform, noting that a bipartisan health reform measure, endorsed by the Senate Labor and Human Resources Committee with a unanimous vote, had been kept from the Senate floor for over five months, a clear exercise of covert power. The *Post* called this set of events “remarkable” and asked that the bill be brought to the floor for a vote (January 28, 1996, Editorial, Section C, p. C06). The *Post* later expressed its outrage even more openly:

Only the United States Senate would fix things so that it can't take up a bill for health insurance reform that has bipartisan sponsorship, the backing of 70 members, wide popular support, and the President as chief salesman. The Senate's capacity to gum things up is legendary, but the case of the Kennedy-Kassebaum Health Insurance Reform Act is special. It tells us of the dark underside of the world's greatest deliberative body, where worthy bills are mugged by serial muggers who operate with cloak and dagger under cover of

secrecy and only get shown up when there is a slip-up (February 6, 1996, Section A, p. A02).

Throughout March and April, the *Post* reported alternate proposals on the floors of both houses of Congress (March 28, 1996, Section A, p. A09; March 9, 1996, Section A, p. A08; April 19, 1996, Section A, p. A01; April 21, 1996, Section A, p. A10), and continued to support mental health parity (April 23, 1996, Section A, p. A01; April 26, 1996, Section A, p. A01), while acknowledging business opposition.

While much of the coverage in the *Times* during 1996 was simply a factual reporting of events taking place in Congress, a number of articles expressed an opinion opposing MSAs:

House Republicans know that if they venture much beyond the Senate bill they will lose bipartisan support. Yet their bill would create tax-favored medical savings accounts, which would allow people who buy only catastrophic health policies to sequester funds to pay their ordinary medical bills. This is a bad idea almost certain to be rejected by the Senate. Medical savings accounts would appeal primarily to healthy people, because they would not need to tap most of the money in their tax-advantaged savings account. That would leave less healthy people to buy ordinary medical coverage at elevated prices. The goal of health reform ought to be the opposite—to standardize policies so that everyone buys the same basic package. That way plans would be forced to compete by offering better treatment, rather than by tailoring coverage only to attract applicants unlikely to need treatment . . . If House Republicans are serious about protecting workers who lose or leave their jobs, they will vote for Kassebaum-Kennedy and nothing else. (March 28, 1996, Section A, p. 24, col. 1)

An editorial on May 30 assumed a pragmatic stance—mental health parity is the right thing to do, but this is not the right way to do it—again showing the *Times's* preference for a more comprehensive, rather than an incremental, approach:

The Senate is right that health-care policies should include adequate coverage of mental illness. But the proper way to achieve that goal is for Congress to come up with a cost-effective package of Federally-defined basic health benefits. Piecemeal mandates, conceived in haste, are likely to produce unintended adverse consequences.

1997: Waiting for Godot

1997 was essentially a quiescent time, since mental health parity was to become the law the following January. On January 21, the first session of the 105th Congress, Senator

Kennedy called for another incremental legislative push, to cover uninsured children (Congressional Record, Senate, January 21, 1997, Vol. 143, Number 4):

One of every seven children in America today have no health insurance. Almost all of these children have parents who work. Cutbacks in employer coverage are worsening this problem . . . Providing health care for children is sound public policy and also sound economics. It's an investment in the future . . . The plan does not guarantee every child will have insurance coverage. But it will give every family the opportunity to cover their children at a cost the family can afford.

Again, we hear the voice of realpolitik. But it has become muted and slightly contaminated with public administration rhetoric. Backing away from a call for universal coverage, it seeks coverage solely for those who not only are personally without fault, but whose families also fit the mold -- innocent children whose parents are employed. In addition, it does not argue that costs are unimportant, or even that they are insignificant. Instead, it says that money spent on insurance for children will provide a return -- that it is an "investment."

Coverage in the media was likewise sparse. The *WSJ* carried only five articles about mental health during 1997, two of which were directly related to the Mental Health Parity Act. They reported (November 11, 1997, Section B, p. 6, col. 6) a study in the *New England Journal of Medicine* which found that providing workers with more generous mental health coverage cost only about \$1 per employee per year. In December the second reported that President Clinton had decided that employers must comply with the law before seeking an exemption because of higher costs (December 15, 1997, Section A, p. 24, col. 2).

While not publishing articles on mental health parity, the *Post* (August 20, 1997, Op-Ed, p. A25) did report that the Balanced Budget Act of 1997 would provide \$24 billion over the next five years to insure currently uninsured children. In late October (October 22, 1997, Op-ed, p. A21), a realpolitik-based editorial lamented the current state of health benefits, and requested support for a proposal that would confront some of the perceived

abuses of managed care, despite the expected opposition of business and the insurance industry.

The *Times*, meanwhile had more coverage about mental health, but little of it dealt with the Parity Act. Amid a few articles somewhat related to mental health, the *Times* continued to advocate improved benefits for those with mental illness, but recognized that such change would not be easy. An editorial on December 23 (Section A, p. 19) called mental illness “the last taboo” for those in political office.

1998: “Unintended Consequences” Prevail

It became apparent early in 1998 that the two pieces of already passed legislation would experience difficulty during implementation. On March 25 and 26 (Congressional Record, Senate, Vol. 144, Nos. 35 and 36), the public administration-rooted Nickels amendment to an appropriations bill proposed deleting \$65 million from the budget earmarked for hiring an additional 65 Health Care Funding Administration (HCFA) employees. Without those new employees, enforcement of Kassebaum-Kennedy Bill and Mental Health Parity Act would be curtailed. Some argued that they could shift around employees, but others observed that employees with suitable specialized skills did not already exist within the agency. Others thought that the regulations were too new, and states should be given additional time to address them.

Concern in Congress about cutbacks in mental health coverage became apparent. On Friday, June 5 (Congressional Record, House, Vol. 144, No. 72), Representative Roukema (R, NJ) introduced a study which found that health insurance for mental health was being cut far faster than that for physical injury and illness. While the value of general health benefits had declined 7 percent (from \$2,326.86 to \$2,155.60 per covered person), the value of mental health benefits had declined 54 percent (from \$154.08 to \$69.61 per covered person) between 1997 and 1998. The cost of achieving parity would thus represent a 3.4 percent increase in premiums. Adding substance abuse to parity would require another 3.6 percent increase.

Coverage in the press during 1998 was quite sparse. The *Times* had only one related article that year (December 26, 1998, Section A, p. 1, col. 6) which reported that insurance companies and employers had found ways to “get around” the 1996 law:

Under [The Mental Health Parity Act], group health plans may not set annual or lifetime dollar limits on a member’s mental health care that are less than any such limits for general medical and surgical services. So, many group plans, fearing higher costs, have simply replaced the dollar limits for mental health care with numerical limits: on outpatient visits, treatment sessions, or days in the hospital. ‘The day and visit limits wind up being more restrictive in some cases than the dollar limits for which they substituted’ said Ronald E. Bachman, an actuary at the accounting firm of PriceWaterhouseCoopers. ‘The net impact in these cases is to have less mental health coverage’

The *Post* recognized the problem in an article by noted financial writer Jane Bryant Quinn who listed a number of ways the law could be circumvented and suggested that true parity would not be achieved because of inherent loopholes.

The *Post* never faltered in its call for comprehensive health reform, as shown by an editorial on July 29 (Op-Ed, p. A21):

It is not an accident that every other summer, regular as clockwork, just as Congress is winding down for its longest pre-election break, a major fight breaks out over health care legislation . . . The key dimensions of a realistic discussion are three: cost, coverage and quality. All three are inextricably linked. But Washington has chosen to deal with them one at a time—and by doing so, it has almost guaranteed that realistic solutions will not be found.

In the end, loopholes in the Mental Health Parity Act rendered it ineffectual, and full parity bills introduced in and after 1998 were never subjected to Congressional debate.

DISCUSSION

Our analysis strongly suggests the important role played by the public administration and realpolitik forms of rhetoric in socially constituting the processual order of mental health policy in the United States (March and Olson, 1983; Hall, 1972, 1987). Perhaps not surprisingly, those of the Republican Party appeared to predominantly use the public administration voice to advance their political agenda, while Democrats used realpolitik. What was surprising, however, was the use of a modified form of realpolitik by Republicans

(that they used to augment rather than displace the public administration voice), wherein they voiced concern not for the values and needs of the human citizenry, but the needs and values of employers in resisting progressive and, for employers, costly health care reforms advanced by Democrats. As part of this voice, and apparently unanticipated by March and Olson, Republicans used the concept of efficiency drawn from their public administration rhetoric, but linked it with a rationale of "market efficiency" rather than "administrative efficiency" as a disciplining mechanism for containing health care costs (Berkenhotter and Huckin, 1995; Freedman and Medway, 1994), thus marking an evolution in rhetoric which matched an evolution in the underlying issues (Strauss, 1993, p. 228).

More specifically, an important dynamic of this use of rhetoric involves the relative distribution of power between the two political parties and a general fear of the unknown. Early in the legislative process in 1994, "mental health parity" was generally seen as nearly inevitable. But this position failed to grasp the socio/political dynamics of the situation. Especially prominent here was the way in which the political factions defined the issues differently (Strauss, 1993, p. 228). Bill Clinton had a bare majority of the votes, but acted as though he had a public mandate for dramatic change. Democrats focused their concern on the 15 percent of the population who lacked health insurance, and using the voice of "realpolitik" (March and Olson, 1983; Hall, 1972, 1987), called for radical change to what they rhetorically described as a "severe problem." Republicans interpreted the environment much differently. They saw the "glass" as 85 percent full. In 1994, President Clinton's proposal was seen as radical, especially to the small business community and the insurance industry, who committed themselves to a pitched lobbying effort. Moreover, citizen-taxpayers were mobilized by political actors and described in newspaper accounts (Hall, 1972) as: fearful that they would lose the right to choose their own doctor, that decisions about their care would not be made by their physician but instead by bureaucrats, and that costs, not medical efficacy, would drive those decisions. The rational-appearing voice of "public administration" prevailed, partly because the majority accepted the Republican

definition of the problem, and partly because the Democratic "solution" to the "wrong problem" was described by its opponents as having the potential for making things worse (Strauss, 1993, p. 228). Thus, conservative actions were effectively advanced which can be evaluated and modified incrementally, whereas the Democrats had asked for radical, comprehensive actions from which it would be hard to retreat.

In 1994, no one expected the dramatic economic changes that would take place in health insurance, or the rapid rate of those changes which would drive an evolution in the political issues (Strauss, 1993, p. 229). Managed care redesigned the health benefits landscape in just a few years in what may be seen as an "intersecting of arenas" (Strauss, 1993, p. 229). Under "early managed care," many people had to choose between staying with a family physician and having their health costs paid by their insurance. Many found that care had to be pre-approved, and was at times denied by an anonymous insurance company employee whose training and motivation they questioned.

As managed care became *the* dominant form of insurance over the next few years, the administrative controls and bureaucracy associated with it, previously advanced by Democrats, were no longer regarded as radical. As managed care became institutionalized, the voice of "public administration" no longer railed against it. Managed care was now generally accepted as the new status quo, which the voice of public administration has a general tendency to support (March and Olson, 1983). Thus, the Republicans had actively "matched" their political agenda with the evolving socio/economic world of managed care (Strauss, 1993, p. 229).

Another reason that the Republican change-of-heart was more symbolic than real, is that modifications in the "market mechanisms" under managed care were instituted by insurance companies. Since these changes were "market-based," and Republicans had repeatedly called for "letting the market work" using the transformed version of *realpolitik* they were likely to be regarded as acceptable. Very similar changes advocated by the Clinton plan would have been accomplished outside of "the market mechanism" and thus

were seen as less acceptable by Republicans. In other words, Republicans based decisions about legitimacy more on the process -- the mechanisms employed that expressed a conservative business ethos -- than the outcomes sought.

Another aspect of the modifications made was that early adopters of managed care did indeed experience large cost savings. Later adopters expected similar benefits, and most anticipated the savings to be long term. In the late 1990s, it was not yet apparent that medical costs would begin to rise quickly once the early savings had been wrung out of the system. (It is interesting to note here that Senator Packwood was almost prescient. Indeed, it is almost exactly as he predicted: After 5 or 6 years, the crisis re-emerged and was worse than before, as doctors increasingly left their profession and people scrambled to find basic health care.) The voice of public administration, with its emphasis on rationality and costs, would have had a hard time disavowing the cost savings, record keeping, and data availability associated with managed care. Because they could not wholly control the flow of information, Republicans had to adapt and adjust (Hall, 1972; Hall and McGinty, 1997). Those using this voice would feel a responsibility to spend the government's money wisely and control costs.

When the issue arose again in 1996, the balance of power had swung even more heavily to the Republicans. As discussed above, the Republicans were motivated to bring some health reform to fruition, but to make sure it did not resemble the radical plan for universal coverage offered by President Clinton two years earlier. Democrats still favored more sweeping change, but recognized that nothing would be accomplished unless compromise was reached. It is important, again, to recognize that Democrats rhetorically defined the problem far differently from Republicans, and saw it as far more severe. They were willing to settle for minor change in order to slow the increase in the number without insurance -- a far harder goal to achieve than that of helping those who have insurance to keep it. But, the terms of debate had been fixed by Republicans despite sweeping change in

the environment, and the Democrats had altered their strategy to get something accomplished, albeit in a more modest fashion (Hall, 1987; Strauss, 1993, p. 229).

During the 1996 debate, mental health parity became a symbol of those political differences. Democrats believed that parity was “the right thing to do” and needed a symbolic victory. In turn, their traditional voice of realpolitik was augmented with that of public administration to indicate that Democrats, even Ted Kennedy, were concerned with constraining costs; they saw it necessary to “pull back from their own terrain” (Strauss, 1993, p. 229) and cooperate with Republicans to get something, even a more modest measure, passed. Considering the legislative process, and especially the form of the legislation which ultimately passed, one would have to be naïve to believe that any benefits would actually accrue to those with mental illness. The loopholes in the legislation were substantial and obvious. Circumventing the law during implementation would thus be extremely easy.

In the final analysis, the mental health parity law was doomed to failure. Even in the changed landscape of managed care, parity represented radical change and the unknown. Though cost estimates from reliable sources were consistently *de minimis*, and the experience of states which had implemented parity laws was uniformly positive, even supporters had to admit that estimates were difficult to formulate because such coverage was rare, and because parity would move the health care coverage system into largely uncharted territory.

At a general level, the processual ordering branch of symbolic interaction appears quite useful in understanding the rhetorical/socio-political dynamics of health care reform at the federal level and the issue of parity in mental health insurance. It appears that the use of appropriate rhetoric has strongly shaped the development of national health policy in this arena (March and Olson, 1983; Hall, 1972). More specifically, processual ordering (e.g., Strauss 1993; Maines 1982; Manning 1992; Prus 1999; and Ulmer 1997) has proven useful in gaining a more robust understanding of the social construction of health care legislation

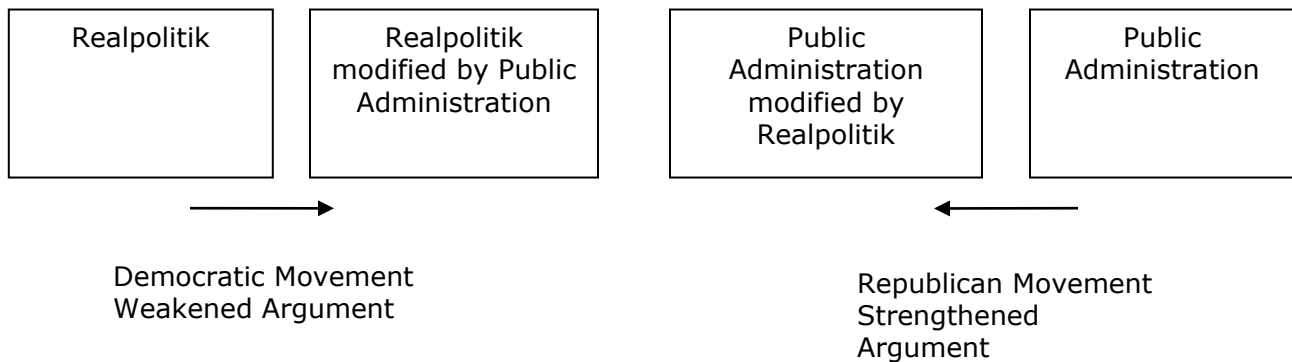
by means of the rhetorical strategies used to condition the strategies of manipulation, exchange relations, bargaining and power-brokering. According to this perspective, the health condition of human existence was indeed found to create a need for political action, and political actions created the material conditions for human existence in the form of providing and withholding financial resources (Hall, 1972; Strauss, 1993) -- thereby affecting human mental health. But here, symbolic displays using specific rhetorical forms were found essential, wherein political and press interactions were largely interpretive, assigning meaning to health care coverage debates and issues (Hall 1972, 1987; Strauss 1993). These interpretations have become "sedimented" into the very institutional structure of regulations that will ultimately influence health care delivery for decades (Hall and Wing 2001; Prus 1999; Ulmer 1997, 2005). Thus, interpretation may be seen not as a product, but a very fluid human social process involving contending political factions (Strauss, 1993, p. 228). Here, defining key, evolving issues, and matching the social worlds of voting constituencies and the press (Strauss, 1993), necessitated the study of power, *and* the use of differentiated language forms, *and* the political actors wielding them (Hall and McGinty, 1997; Prus, 1999).

IMPLICATIONS FOR THEORY

As we had hoped, the Realpolitik and Public Administration forms of rhetoric proved quite useful in understanding how these contending political factions shaped the debate over public mental health policy. It quickly became apparent that the theories of March and Olsen (1983), which continue to describe voices commonly used in our political processes.

The fact that the United States was at a point where political parties had adopted quite polarized initial positions made this analysis even more fruitful from a theoretical perspective than might have been otherwise true. Had this debate taken place some years earlier -- thus the debate undertaken from more centrist positions -- we would have been less able to observe the modification of the pure rhetorical forms into more blended positions. Thus, both the choice to examine a public policy forum, and the timing of the

specific events that were chosen, added elements to our understanding. The timing allowed us to go beyond March and Olsen (1983) and consider the effects of modifying each rhetorical form with elements of the other into a blended, more centrist position. As described more fully below, the effects include changes in perceptions about the factions among the citizenry and changes in their relative power that flowed from those perceptions.



Democrats opened the debate using a pure Realpolitik form of rhetoric. They described the lack of health insurance by about one-sixth of U. S. citizens as a crisis, and the spottiness of mental health coverage even for those who do have health insurance as a moral failing. They compared our health insurance system unfavorably to other developed countries, placing us on a caliber with only South Africa, a country which we tend to look down upon. They did not discuss costs much in the beginning. Such a discussion is a natural part of the rhetorical form of Public Administration but has no place in a moral argument. This form of rhetoric is predictable in the situation, because Democrats were attempting to bring about large changes, and citizens are likely to accept large change under duress, in times of crisis, or because of strong moral beliefs.

Republicans interpreted the situation as a problem but not a crisis, leading them to begin the debate with Public Administration rhetoric. If one-sixth has no insurance, then

obviously five-sixths do have it. They focused on the generally high quality of our health care system, rather than on the specific failings of either the insurance system or the health care system. They blurred the lines between these two systems, so that citizens saw them as one large overly complex system (the Clinton Plan made this very easy to do), as a means of making citizens anxious and confused. Finally, they focused on the largest estimates of cost increases, because we are very tax averse. Republicans apparently agreed with the Democrats that large changes make people uncomfortable. They made the changes look as large, as unnecessary, and as costly, as possible to make them unpalatable.

As the debate evolved, each faction modified its stance by moving toward the center. Democrats added discussions about how minor the cost estimates were. Republicans showed sympathy for those who lacked coverage, but explained that it was unavoidable. The quote from Senator Gramm earlier in this paper (He did understand, but mandating coverage would just make things worse.) exemplifies those modifications.

Thus, each faction moved toward the center as the debate neared its end. However, the effects of that movement were quite different. The Democrats, who had begun their debate from a point of principle, calling for major systemic change, found their position weakened. An argument from principle cannot help but be weakened when costs become the focus of debate, because discussions of costs and benefits are inherently pragmatic. Democrats were perceived as abandoning their ideals, and lost constituency. Republicans, on the other hand, found their position strengthened. Since their primary position was that the status quo was pretty good, the centrist position to incrementally improve the system while causing no harm. They expressed sympathy for those who lacked coverage, in the process appearing more caring and less hard hearted, thus gaining constituents. They were also able to redefine the terms of the debate, to focus on preserving coverage for those who already have it, instead of extending coverage to additional people.

Thus, one addition to theory is that rhetorical voices tend to be modified as debates continue, with differing effects on opposing factions power.

Three additional research questions related to rhetorical styles deserve consideration. All are related to the effects already described. The first is the question of whether the centrist movement typically causes power to swing in the same manner. In this case, the voice of Realpolitik was weakened by modification, but the voice of Public Administration gained strength. Is it typically true, as we suggested earlier, that principled stands are weakened by pragmatic considerations? In other words, are victories by Realpolitik rare? Or, as seems more likely, is it the case that these specific changes were related to the fact that the U. S. is currently a society where business interests often prevail, and Public Administration rhetoric is much more mainstream than Realpolitik. Studies in other cultures, at different times in U. S. history, or of situations where the Realpolitik voice clearly prevailed, would help to answer this question.

Second, if it is true that Public Administration rhetoric will typically prevail over that of Realpolitik, it seems that another voice of debate should emerge. In a political process, society is better served when differing opinions are heard and power is not overly concentrated. Research into the emergence of other voices would be useful.

Finally, it seems likely that factors such as the timing of the change in arguments, or the specific modifications made to arguments, have an effect on the outcome of debates. Further research into the movement from pure to modified rhetorical positions will help to determine these factors.

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