APPLICATION OPPORTUNITIES IN PUBLIC ISSUES EDUCATION

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What is the role of public issues education in renegotiating the social contract? In trying to answer that question, I have found the 1994 debate on health care reform instructive.[1]

Health Care Reform

People have been trying to renegotiate the health care contract for nearly a century. Failed efforts occurred during the Wilson, FDR, Truman and Nixon administrations.Finally, in 1994, it looked like national health care reform was going to happen. Public opinion supported reform (Schlesinger and Lee; Jacobs; Jacobs and Shapiro). Escalating insurance premiums, exclusionary practices, such as preexisting-condition provisions and cost shifting by employers that made even middle-class families nervous about insurance coverage, combined to produce growing public support for reform, in spite of continued skepticism about government involvement in most other areas (Peterson, 1994).

Interest groups were ready for reform. The solid front of opposition was breaking down, as internal divisions appeared between general practitioners and specialists, for-profit and not-for-profit hospitals, small and large insurance companies, small and large businesses (Peterson, 1993). The American Medical Association finally acknowledged that the health care system had faults that needed correction; insurance companies were realizing that they could not much longer get away with the practice of looking for "ever-smaller pools of healthier people to insure„; businesses were exasperated by ballooning health insurance costs; many small firms were finding that they could no longer afford coverage of any kind for their employees (Skocpol, 1993, pp. 532-33). Lobbyists for education, corrections, welfare and other causes were increasingly critical of a health care nonsystem that sucked resources from their priorities and still left 15 percent of the population without coverage (Brown, p. 200).

Politicians advocated reform, especially after Clinton's victory and Harris Wofford's surprising election to Congress on a health care reform platform. Clinton promised a proposal. But then what happened? The Clinton proposal was delayed, and it was thick and complicated when it did arrive. The very size of the proposal made it vulnerable to criticism. From

the start, the concept was a hard one to communicate. Instead of a simple basic idea, like "prohibit the sale of alcohol" or "guarantee voting rights for minorities," health care reform called for balancing two seemingly contrary objectives, controlling cost and extending coverage (Heclo).[2] Moreover, the Clinton plan relied heavily on regional health care alliances, an unfamiliar mechanism that raised suspicions which were hard to counteract (Skocpol, 1995).

Interest groups mobilized against the plan. "Hospitals [said] they would not have enough money to provide medical care to everyone who [needed] it. Insurance companies [said] that the plan would prevent them from raising enough money to pay the ... bills. Doctors [said] the government [did] not have the right to force them to work for lower wages and that the plan would not give them enough resources to take proper care of their patients. Pharmaceutical companies [said] the price controls would prevent them from developing ... new drugs.... Many small companies [said] the new costs [might] drive them out of business. Larger employers [said] the ... requirements [would give them] an incentive to replace [part-time employees] with [temporaries]" (Castro, pp. 210-12).

In response to these developments, the public (in a public issues educator's nightmare) actually became *de-informed.* In opinion polls, the percentage saying they knew "a lot" about the Clinton plan actually went down when the debate over the plan was in the news. Daniel Yankelovich's commentary about this is interesting (Yankelovich, 1995). Consistent with what he has written elsewhere (Yankelovich, 1991)—namely, that creating awareness of problems is the easy part—he notes that, even though most people claim to be satisfied with their own health care, the sense of a need to overhaul the system had risen to majority levels. But a closer look at public opinion showed that the main concern was the cost of health care, and the solution was to cut the profits of hospitals, lawyers, physicians and drug companies. Yankelovich points out that experts were more likely to blame the aging of the population and the cost of new technology, and to foresee a need to limit care. From that perspective, the public was guilty of "wishful thinking" and failure to grapple with hard choices. Indeed, the more that critics of the Clinton plan raised the specter of tax increases, restrictions on choice of doctors, and employers forced to cut jobs in order to reduce health care costs, the more that public support for reform withered.

Congress began developing alternative plans, which further confused the public, and, in the end, Congress lost the will to act and gave up.

Information vs. Agreement

Did health care reform fail because we didn't know enough? That is not my impression. The problems were well-understood. It is true that there was

uncertainty about likely budget impacts. There was fear that the plan would be too costly, and consensus never developed on just what the impacts would be. But that kind of uncertainty is inevitable.

A better explanation for the failure of health care reform was lack of agreement. The emerging consensus that something needed to be done was what Paul Starr had called a "negative consensus" (Marmor, p. 194, quoting Starr)—agreement that change was needed, but no agreement on what form it should take. Poor information about likely budget impacts may have aggravated the disagreement, but the road between information and agreement runs in two directions. If lack of good information makes agreement difficult, it is also true that disagreement complicates the task of getting good information by giving people incentives to exaggerate and to be less than honest.

Efforts at Agreement

So why was agreement not reached? It looked as if the long-elusive agreement on health care reform was about to happen, but then it fell apart. It appears to me that there were three important efforts at agreement that need to be analyzed. Why didn't they work?

1. The most obvious effort at agreement was the Clinton task force. It was clear that any successful reform effort would require consensus-building. The task force was dominated by government officials and experts—a fact that made it more easily attacked as big government (Skocpol, 1995). It was not a stakeholder group with the various interest groups represented. The interest groups were consulted in order to identify ideas and concerns to take into account, but not for purposes of political bargaining. The task force worked largely in secret. The intention was to "conclude much of the process of compromise before the legislation went to Capitol Hill" (Castro, p. 208). As several analysts have put it, the administration was still working in "campaign mode" (Heclo). The emphasis was on getting a proposal that could be quickly adopted in order to enhance Clinton's re-election prospects. The task force tried to anticipate all viewpoints and work out the necessary compromises before announcing the plan. The key element in the task force's proposal was the concept of managed competition, a "middle-range, mixed public and private" scheme that was considered more likely to succeed than an effort to rally public support behind a full-blown plan of universal, government-funded insurance (Skocpol, 1993, p. 539).

2. Clinton's managed competition concept was borrowed from the Jackson Hole Group, which is the second effort at agreement that is worth looking at. Founded by Dr. Paul Ellwood, and composed of representatives of the major players in health care, the Jackson Hole Group had been

meeting periodically since 1970 in Ellwood's living room in Jackson Hole, Wyoming (Castro; Navarro). Members included representatives of "the large insurance companies, some of the largest employers in corporate America, the pharmaceutical industry and some major professional associations" (Navarro, p. 206). The purpose of the meetings was to air grievances, identify problems and accommodate differences. Whenever unanimity was reached, someone on Ellwood's staff would draft a position paper, circulate it for comments, and then distribute it among health care experts and policy makers. The managed competition proposal was developed through that process in 1991. The Clinton task force adopted the managed competition idea, but then toughened it in response to opposition from advocates of a Canadian-style single-payer plan (Navarro; Castro). The single-payer plan was supported by twenty major unions, senior citizens groups, African American and Hispanic groups, religious organizations and other activist groups (Navarro, p. 211). The administration evidently feared that the Jackson Hole proposal would not extend coverage and reduce costs fast enough to compete with what the single-payer advocates claimed their plan would do (Castro, p. 207). That raises the question of why the Jackson Hole Group's consensus-building did not accommodate the single-payer objections. One possible reason is that labor unions, key supporters of the single-payer plan, did not participate in the Jackson Hole Group (despite Ellwood's constant efforts, according to at least one account—Castro, p. 82).

3. The third effort at agreement worth looking at is the administration's promised grassroots educational campaign. There was to have been public education throughout the country. The purpose most likely was more to sell the plan than to get public input; but, in any case, the campaign never got off the ground (Skocpol, 1995; Heclo). That failure was a factor that contributed to, or in any case failed to counteract, the withering of public support. Ensuing events helped explain why public education and support was important. If public support had gathered momentum instead of withering, it would have kept pressure on Congress to find agreement instead of generating competing proposals and eventually taking the easy way out by doing nothing. Why did the grassroots campaign not get off the ground? One reason was the fact that Clinton's original grassroots plan was criticized as improper use of public funds for what were called "partisan" purposes. So the campaign was moved to the auspices of the Democratic National Committee, where it had less funding, and interest groups found it harder to cooperate without jeopardizing the nonpartisan stance they wanted to maintain (Skocpol, 1995). But the main reason for the campaign not getting off the ground was that there was simply too little time. The "campaign mode" in which the administration's health care plan was developed and promoted meant that there was too much pressure for a quick decision.

The time dimension is important. Big decisions like health care reform require a period of what Hugh Heclo calls "gestation" (Heclo). Heclo says that policy arguments need to be sustained long enough for people to be persuaded that a real problem exists that will not go away unless something is done. Yankelovich adds the point that there also needs to be public understanding of and support for at least the general direction of proposed solutions. The public needs to be aware of costs and trade-offs—they need to get beyond "wishful thinking," and not only recognize a problem, but also come to favor a course of action for which they "accept the consequences." Heclo makes the observation that the Great Society reforms of the 1960s had a "gestation period" in the 1950s, which raises the interesting question of why reforms proposed in the1990s were not effectively gestated in the 1980s. Heclo's answer is that ideological polarization inhibited the genuine exploration of conflicting perspectives that gestation requires.

Welfare Reform

So, now we're debating welfare reform, another major element in the social contract. What are the prospects for a better outcome? I would say zero. The motive for welfare reform is more mean-spirited (although one should never assume that poor people want welfare left as it is). The middle class is not worried about potential loss of benefits for themselves, as was the case, at least initially, in health care reform. Nor is there the structure of powerful interest groups with a stake in the status quo that inhibited reform in the health care field.

But there are similarities as well as differences. The central question in both issues is what society will do for poor people. (Despite the language of universal coverage, it eventually became clear that the most obvious beneficiaries of health care reform would be the poor and the uninsured.) In both issues, there is a high degree of middle-class ambivalence—compassion for poor people, mingled with concern for one's own welfare and an inclination to let the poor fend for themselves. And both issues are greatly affected by ideological polarization over the size and role of the government.

Requirements

What would "renegotiating the social contract" require if it were to be done in a democratically responsible way? My reading of the post mortem on health care reform suggests four things that are needed:

1. Time for gestation. There is nothing (or, at least very little) that educators can do on issues like these, where decisions will come soon. Heclo's "gestation," Yankelovich's "working through" to a "public judg-

ment," and our public issues education (which are all pretty much the same thing) take time. The health care debate does show, however, that decisions may not come so soon after all. There may still be ample time for education on these issues—or at least on a variety of state and local issues related to reform.

2. Consensus-seeking among the active players, with all of them involved. You can't leave out labor, as in the Jackson Hole Group. (If they refuse to come to the meetings, you find some other way to get their viewpoint understood and taken into account.) If competing proposals are going to emerge anyway, people who favor those proposals need to be included in consensus-building efforts from the beginning. In addition, there is also the problem that, whatever happened in the Jackson Hole Group or the Clinton task force, the quality of consensus-seeking certainly deteriorated after the health care debate became public. In my view, that debate is the most compelling evidence of all about the sorry state of our policy making process. If there was ever a situation where everyone agreed that something needed to be done, this was it, and yet nothing was done. The inauthentic politics of ideological polarization reasserted itself, and the debate became yet another knock-down argument in which winning, or making the other side look bad, was more important than solving the problem.

3. Public understanding and support. The public needs to come to grips with conflicts and contradictions regarding the issues. Wishful thinking needs to be replaced by a public judgment—a judgment based on an understanding of conflicting perspectives, and capable of holding up in the face of interest-group counter-arguments. The need for public understanding and support means that the issues cannot be thrashed out in secrecy, beyond the scrutiny of the press and the opportunity for public observation and learning. As Heclo says, secrecy by the Clinton task force "further dimmed the prospects for educating Washington and the public about the difficult trade-offs at stake" (p. 97). In the words of another commentator, "... the administration ended up simply advertising its plan rather than having a real public discussion" (Weir, p. 102).

4. Representation of all sides, including poor people. The poor may have little power in decision making, but the public (bless its heart) continues to persistently care about poor people. On welfare reform, public anger about welfare continues to be combined with strong feelings that poor people should not suffer economic hardship or be left on the streets (Altman). Among the contradictions and trade-offs that need to be weighed in arriving at a public judgment, are the implications of different proposals for poor people. If they were present, the voices of poor people would be a valuable ingredient in forming a public judgment (to say nothing of the fact that programs for poor people might work better if they were designed with poor people's input).

Think of how rarely you hear the voice of poor people in the debate about welfare reform. Articles that rely on interviews with recipients are rare enough that I tend to clip them when I see them. I do not have a large collection. One example is an article about illegitimacy in a recent *National Journal* that begins with an 18-year-old mom's response to the question of whether cutting welfare benefits would discourage her and other teenage mothers from getting pregnant again (Carney). "No," she says, "because some teenagers have children to keep the male friend they're with. Other teenagers have children because they feel that they want something that'll love them back. Other teenagers have children to be accompanied by another person. It's not for the money."One may not like what she says, but that's hardly the voice of someone with nothing relevant to say about welfare reform.

Roles for Educators

Let me turn more specifically to the question of what public issues educators should be doing. Decisions about health care and welfare are coming back to the state and local levels. The failure of national health care reform tells us that, and the trend toward block grants to the states as a key element in welfare reform tells us the same thing. Those trends will give educators working at the state and local levels a fine opportunity to help bring together the major players in state and local issues related to health care and welfare—not the current issues, but ones coming down the road. Educators should use what they've learned about conflict resolution. Get the various players' interests, not their positions, on the table. Help them talk to one another and listen to one another in a safe forum. Help them understand one another and search for solutions they can all live with. Maybe new solutions to contentious issues regarding the social contract can be worked out. Then, sometime in the future, if a need for national action becomes apparent again, solutions worked out in states and localities may get a chance to "trickle up."

There is a need for education of citizens, as well as the active players. Ordinary people need to wrestle with the issues, understand the conflicts and contradictions, and make a public judgment. One useful response by educators would be to sponsor citizen discussion groups on the National Issues Forum (NIF) model. Another important opportunity is for all citizens (not just those who participate in discussion groups) to see the issues discussed in ways that include their viewpoints and bring out the contradictions and possible solutions. This is the opportunity that gets foreclosed when the active players deliberate issues and possible solutions in secrecy. This is also why it's important for public issues educators to build connections with the news media.

Finally, poor people need to be involved. They need to be included in NIF-type discussion groups, and they need to be represented in the conversations among major players. Think how rarely that happens. Making it happen is a big challenge—a blending of empowerment and conflict resolution strategies. I have a colleague, David Pelletier, in the Division of Nutritional Sciences at Cornell, who envisions two basic approaches for bringing the perspectives of ordinary citizens into policy-related discussions. One approach is direct involvement in the same conversations—which Pelletier believes is ultimately the best strategy, but one that is problematic because of inequalities in power, status and self-confidence. The second approach is for the active players to conduct interviews or focus groups with ordinary citizens in order to tap their viewpoints and bring them into the active players' discussions. Pelletier hopes to experiment with both approaches and evaluate their strengths and weaknesses.

Another approach with potential for blending empowerment and conflict resolution is the Citizen Politics model put forth by Harry Boyte and Project Public Life at the University of Minnesota (Boyte; Project Public Life). My reading of Citizen Politics says that it starts with unempowered individuals or groups, such as poor people—or school kids, parents, tenants, etc.—and helps them take the initiative to study an issue, identify and interview the major players, and then bring them together for discussions of the conflict-resolution variety. The end result is the same thing that Pelletier is aiming for (consensus-seeking discussions in which poor people are represented), but in this case the inequality problem is addressed by having poor people initiate the entire process.

The Third Wave

In whatever way it's done, this combination of conflict resolution and empowerment is what I'd like to call the "third wave" of public issues education. The first wave was primarily information provision about public issues (often using the alternatives-and-consequences approach). The second wave, which increasing numbers of educators have been joining in recent years, puts major emphasis on conflict resolution, bringing together people from different sides of the issues to learn, at least in part, from one another. Much of this second-wave work has addressed environmental issues. This has happened, at least in part, because the environmental movement succeeded in demanding a place at the table—they became "empowered"—thereby making the need for conflict resolution obvious to many of the major players. The third wave calls for educators to not wait for unempowered groups, such as poor people or welfare recipients, to empower themselves, as the environmentalists did, but to help with that part of the process as well. What's needed is a combination of empowerment and conflict resolution.

So far, in the absence of such a development, the social contract is being renegotiated with little help from public issues educators. The fault is partly ours. We have often avoided social contract issues entirely, or treated them as problems amenable to solution through education for individual and family decisions, or limited ourselves to "networking" with other professionals in programs designed to address essentially noncontroversial issues, such as service gaps in child care, teen recreation or housing for seniors. (Much of this is good work with beneficial results. I don't mean to be critical. But other things might be more important.) Learning how to combine empowerment and conflict resolution is a daunting task, but I think the stories of health care reform and welfare reform are stark illustrations of the consequences of failing to take on that task.

The fault is not entirely ours, however. We are not always working in a receptive environment. Often, no one is asking for our help, and they may not welcome it when it's offered. For the most part, neither policy makers, other active players, the news media nor the public seem able to envision different ways to make public decisions, so they don't seek the help of educators or anyone else. Policy makers and active players at the national level still seem committed to the politics of winning and losing. At the local level, I think policy makers seem more inclined to see policy making as their exclusive responsibility (and sometimes to resent, rather than welcome, partnerships with educators). The news media's dominant metaphor continues to be the horse race, and the public remains cynical, longing for something better but not knowing what to ask for.

Breakthroughs do occur, however, and I continue to be impressed with the prevalence of favorable responses from nearly everyone who gets the opportunity to participate in educational programs that facilitate learning across conflicting perspectives on contentious issues. We need to continue providing those opportunities for more and more audiences, and we need to accept the challenge of the third wave—turning our capabilities more often to issues involving the social contract.

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[1] Helpful sources include special issues of *Journal of Health Politics, Policy, and Law*, 18 (Summer 1993); *PS: Political Science and Politics*, 27 (June 1994); *Health Affairs*, 14 (Spring 1995); and *Journal of Health Politics, Policy, and Law*, 20 (Summer 1995); various issues of *National Journal* and *CQ Weekly Report*; and the books by Castro and Navarro (which help balance each other's biases).

[2] There was a plausible argument connecting the two goals (although economists tended to doubt that it would work): Cost control would make universal coverage affordable; universal coverage would make cost control possible—by stimulating more preventive care and getting people out of expensive inappropriate health care settings (Heclo; Newhouse).

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