

THE RHETORIC OF THE UNINSURED:  
CLAIMSMAKING IN PUBLIC POLICY RESEARCH

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by  
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CLAIMSMAKING IN PUBLIC POLICY RESEARCH

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and hereby certify that, in their opinion, it is worthy of acceptance.

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.....dedicated to my father, Stan Hudson, who taught me that all things in life are possible if you set your mind to it, and to my mother, Vaughnette Olsson, who has given me the strength to follow in my father's footsteps. This thesis is also dedicated to my wife, Georgia, whose devotion kept me on track and enabled me to complete this endeavor. And to my son, Fox, and daughter, Sierra, who inspire me, reminding me that laughter is often the best way to soothe the soul and revitalize the mind.

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ABSTRACT

Public policy research is often seen as another arena applicable to the objective lens of science, as policymakers weigh “the best evidence,” or scientific facts, about a social problem to determine which solutions are most warranted. Hundreds of millions of dollars are spent annually to determine the prevalence and extent of social problems, such as drug abuse, teen pregnancy and uninsured, to name a few. Yet, much of this data is ignored or even discredited by policymakers, despite the rigorous and rational efforts of knowledge creation employed by scientists, leading many researchers to feel exasperated or frustrated at the public policy formation process.

What many often fail to realize is that public policy research and the public policy formation process are socially constructed by those involved. There are no facts, only claims made by stakeholders with varying interests and values. Claims are not measured on their own merit but rather by how effectively they appeal to the policy formation audience. Claimsmaking theory, therefore, provides a robust theoretical framework for examining the process of how claims are made, received, denied through counter claims, and reshaped. It also illustrates how claims and those who make them interact to formulate public policy

This research explores claimsmaking in public policy formation within a public policy research grant focused on reducing the social problem of the uninsured. Claims were examined across a four year period to understand how grounds, warrants, and conclusions were negotiated through discourse to derive a single policy recommendation.

## **INTRODUCTION**

National grant funding of public policy research often plays an important role in formulating public policy. These activities take a wide variety of shapes and functions but generally bring a diverse number of stakeholders, ranging from medical professionals, corporate interests, advocates, academics, and policymakers together to develop, propose, and sometimes implement policy solutions to perceived social problems.

For health insurance, many states examined expanding coverage through the formal State Planning Grant (SPG) program administered by the Health Services and Resource Administration (HRSA), a division of the U.S. Department of Health & Human Services. This program, which began in 2000 with a Congressional appropriation of \$15 million for its initial year, continued funding new and existing planning grants until 2005. It was heralded as a tremendous resource for states looking to develop new strategies for expanding health insurance coverage. Indeed, all but three of the fifty states (Nevada, Ohio, and New York) along with four U.S. territories took advantage of this opportunity and received planning grant or pilot grant funding during one or more years of the program. The structure and activities of these planning grants varied immensely from state to state, but generally included collecting new data, identifying and studying state and national health insurance trends, and enhancing policy development and consensus-building activities around the issue of the uninsured. As such, many projects focused on bringing a variety of stakeholders together to create a set of formal policy recommendations for expanding coverage.

Although widely used and acclaimed by many in health policy, the SPG program was criticized by the government's own watchdog organization, ExpectMore.gov, operated by the Office of Management and Budget (OMB) as being ineffective.<sup>1</sup> Specifically, the program was cited as failing to:

1. standardize data collection methods which could be used to develop national benchmarks,
2. achieve "its long-term goals of helping States increase health insurance coverage," and
3. provide ample justification of need for such a program.

This third criticism is crucial, as it brings to the front the importance of claimsmaking in health policy, the role of which is the subject of this paper.

In this paper, I explore the role of claimsmaking in the state planning grant process by examining a case study of one state's experience. I examine the types and participation of claimsmakers involved both formally and informally in influencing policy formation and the interaction of these claims and claimants within the health policy arena. This is a chaotic claims environment in which claims from different orientations clash and compete for limited resources. It is an arena of rhetoric, where scientific claims are countered with anecdotal examples and vice versa. Although research has been devoted to understanding the rhetoric of social science (Gusfeld, 1976) and in examining claimsmaking before a broad public audience, few studies have examined the social construction of claimsmaking by public policy researchers.

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<sup>1</sup> State Planning Grant – Program Assessment. ExpectMore.gov U.S. Office of Management and Budget. <http://www.whitehouse.gov/omb/expectmore/summary/10003516.2005.html>.

## **BACKGROUND & SIGNIFICANCE**

### *The Uninsured*

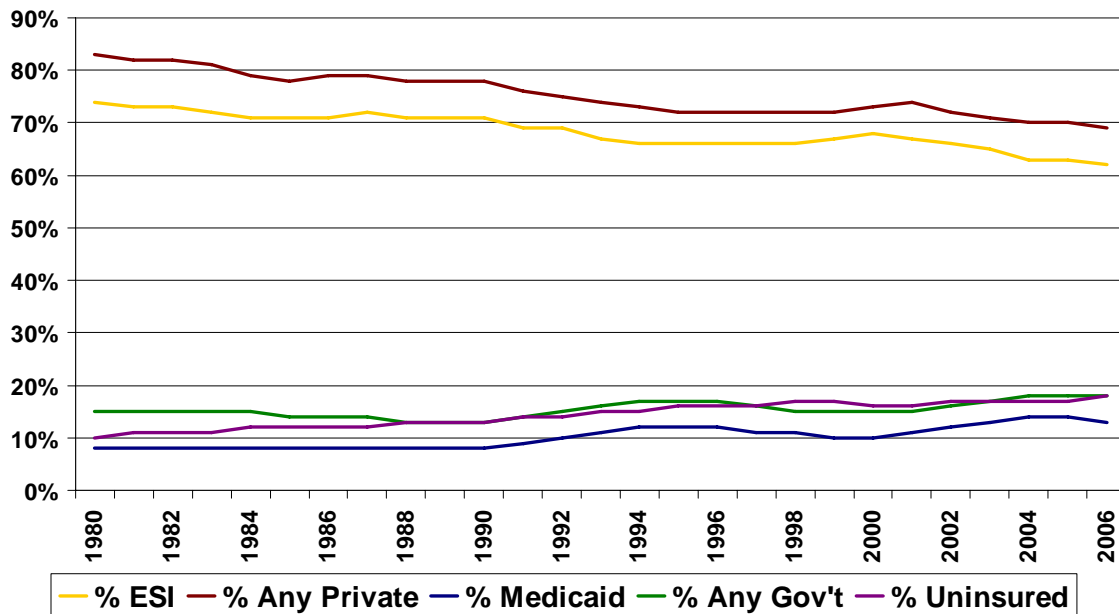
Reflecting similar trends today, during the first part of the 20<sup>th</sup> century, medical advances and the restructuring of health care translated into higher costs for patients. Hospitals embracing these advances shed their “almshouse” stigma becoming preferred places of care for those in the upper and middle class. As price increased, many people found that they could not afford treatment for a serious illness or injury. Private health insurance grew to meet this new market demand. It began humbly at first, with many plans adapted from voluntary “sick funds” organized by unions, fraternal orders and benefit societies. Extensions of these and the creation of new private insurance entities expanded insurance options to more and more Americans. By the mid-1950s, almost two-thirds [63 percent] of Americans were covered by either private plans [29 percent], Blue Cross [27 percent], or by an independent plan, [7 percent] (Starr, 1982). The number of those enrolled in some form of insurance plan was further bolstered in the mid-60s as Medicare and Medicaid provided public forms of medical insurance to the elderly, the disabled, and indigent women and children.

Despite all the forms of insurance that emerged, there was still a significant number of individuals who lacked some form of health insurance. They may not have been able to afford private coverage but made too much money to qualify for public assistance. People may have been locked out of the market due to a pre-existing illness or condition, or they may have even perceived themselves as “young and invincible” and thus not in need of insurance at this time. Regardless of the reasons, many people lacked

health insurance, and this social problem has long emerged and been documented in the U.S. health system even today.

Since most elders qualify for Medicare, they are often excluded from the prevalence data. As shown in Figure 1, the percentage of nonelderly uninsured adults has steadily climbed from 10 percent in 1980 to nearly 18 percent of the population, or roughly 46.5 million Americans in 2006.<sup>2</sup>

**Figure 1: Nonelderly Population by Source of Health Insurance Coverage, 1980-2006**

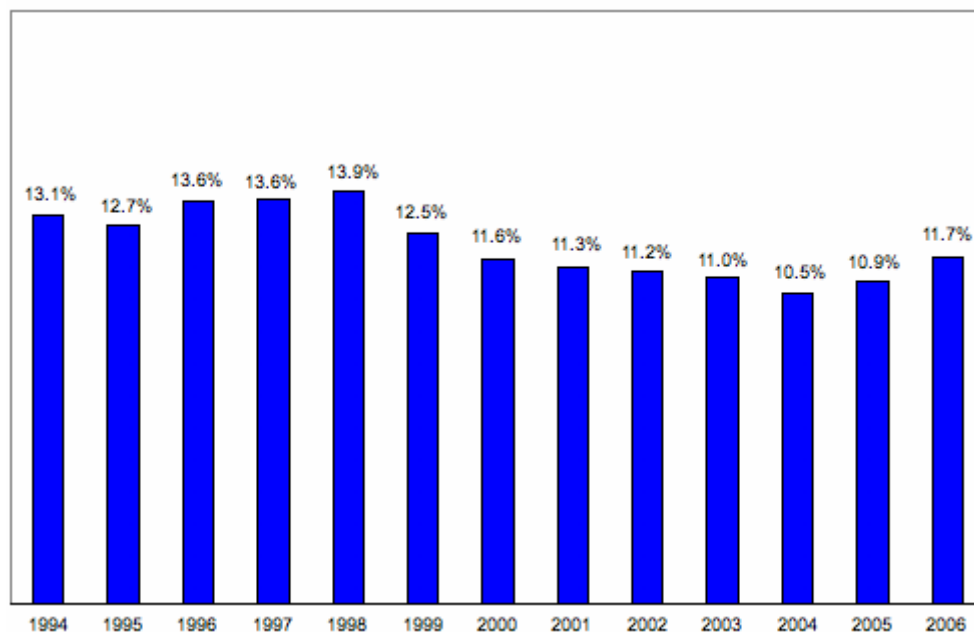


Due to the targeted public expansion of programs aimed at covering children through the State Children's Health Insurance Program (SCHIP) which began in 1997, the percentage of uninsured children is significantly lower than for adults. As illustrated in

<sup>2</sup> Data derived from Employee Benefit Research Institute estimates from the Current Population Survey, March 1980-2007 Supplements.

Figure 2, although the expansion of children's public health insurance had some impact on the decreasing the number of uninsured children, this trend has begun to reverse as tighter budgets have forced state legislatures to limit eligibility for these programs. Thus, the number of uninsured children has decreased only slightly from over 13.1 percent in 1994 to just under 11.7 percent in 2006.

**Figure 2: Percentage of Children Under Age 18 Without Health Insurance, 1994-2006<sup>3</sup>**



Although many warned that the expansion of public health insurance would lead to the socialization of health care in the U.S., this prediction has yet to take place, as movements for reform have been squelched during the policy-making process. Numerous scholars have examined the history of health care reform attempts within and across U.S. history, often by shedding light on parallel developments in the private sector

<sup>3</sup> Data derived from the Employee Benefit Research Institute estimates from the Current Population Survey, March 1995-2007 Supplements. Note: 1994-2003 data are adjusted for Census correction announced in March 2007.

(Gottschelk, 2000; Hacker, 2002; Klein, 2003; Gordon, 2003; Mayes, 2005). These attempts take a more historical and/or institutional approach and most often rest on arguments focused on American incrementalism and path dependency in American politics. More recent work has examined the actions of private interests and their effects in curbing any national tendencies toward a universal system (Quadagno, 2003). While these analyses provide insight into the historical social conditions of the uninsured and provide in-depth examination of organizational and institutional processes, they only partially touch on the social construction of the uninsured and fail to examine the rhetoric or claimsmaking strategies and their relative effectiveness in influencing decision makers in public policy formation.

This is a very brief overview of the uninsured. I could list countless statistics about who the uninsured are, their demographics, and trends. I could cite countless examples of the effects that being uninsured has on individuals, families, communities, even society as a whole. But all of these are really just claims, providing the grounds for the problem, defining the prevalence, growth and extent of the social problem of the uninsured, or as in the case of anecdotal examples, humanizing the problem. Many of these claims will be discussed as they played out in the claimsmaking process under investigation. So, before I continue, let me introduce the theory of claimsmaking.

### *Claimsmaking Framework*

Claimsmaking derives from a social constructionist approach to understanding social problems. Instead of relying on objective facts concerning “rates of incidence, the kind of people involved in the problem, their number, their types, their social characteristics and

the relation of their condition to various selected societal factors,” a social problem exists because it is perceived to be one in a society (Blumer, 1971, p.300). As such, factual statements and scientific analysis that formerly were used to describe the resulting social conditions, become additional claims subjective to the rhetorical presentations and negotiations surrounding the issue. This social constructionist framework is very useful for understanding the public policy arena, and can explain why unfounded anecdotes can easily override rigorous scientific effort and investment. It provides a framework for examining the real world of negotiated order that lies at the heart of public policy formation. Claims about a social problem are not weighed according to their own intrinsic merit, but rather by the values and interests of those interpreting and making them. As Blumer states:

A social problem is always a focal point for the operation of divergent and conflicting interests, intentions, and objectives. It is the interplay of these interests and objectives that constitutes the way in which a society deals with any one of its social problems (p.301).

Public policy is inherently concerned with finding solutions to social problems, thus it is one of the primary claimsmaking arenas as claims are negotiated among legislative boards and executive committees, who devise policy solutions to address them.

Health policy is no exception. As managed care, now in the form of case/disease management has evolved into the dominant health care organizing principle, claimsmaking, per se, has become an art and industry and extends into the planning domains of many other service realms. Employing the theoretical framework of claimsmaking, one can begin to understand how politics can trump, and in recent cases, even have a hand in editing, the published scientific knowledge on leading social problems, such as climate change.



A claim is the rhetoric or basic language used to define a social problem and promote specific policy solutions to address them (Best, 2001). Best developed this analytical framework to analyze knowledge claims inherent in defining social problems. Building on Toulmin's (2003) argument construction, Best (1987) proposed three main types of claims:

- Grounds – set the parameters to the social problem,
- Warrants – draw conclusions from the grounds often by appealing to interests or values to justify a solution, and
- Conclusions – define the solution that will solve the social problem.

Driedger and Eyles (2001) aligned these with Best's (1995) three central questions for analyzing claims.

- What is being said about the problem – defines the problem by grounds,
- How is the problem typified – reveals the warrants, and
- What rhetoric is being used to persuade – identifies which conclusion is justified by the warrants.

The process of claimsmaking in the public policy arena begins with the grounds. These types of claims define the social problem being presented, from facts and statistics that state the prevalence of the problem, to examples which humanize the issue and appeal to values and emotions, to range statements which discuss the extent to which this social problem affects everyone. Once the grounds have been established, warrant statements are used to draw inferences from the grounds to justify a particular solution or set of viable policy alternatives (recommendations). These recommended policy options are the conclusions, or actions that must be taken, to address the social problem.

Much of constructionist claimsmaking research has focused on how particular social problems were constructed. This research has focused on the emergence of claims and social problem activities in the public sphere and provided useful insight into claimsmaking at the macro level. Feree, et. al. (2002) provide an in-depth examination of abortion discourse, examining “religious” claims, those of women, and claims made by the “tradition of the left.” However, much of public policy really takes place at the micro level or in between, at the meso level. Few studies have examined claimsmaking at these levels. What kinds of claims are made in backstage, non public-policy settings such as board meetings, working groups, and official task forces that are created by invitation only? When are different types of claims made and by whom? How are these claims received and what are the responses? All of these represent useful research questions that have the potential to create a better understanding of how public policy is constructed.

## **METHODOLOGY**

It is important to note that this is a case study examining claimsmaking from inside a policy research setting and not a study examining the emergence or construction of the lack of health insurance as a social problem. This case study examines how the social problem of the uninsured was defined through claims by policymakers and other influential actors to result in a specific policy recommendation.

Yin defines a case study as “...an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident” (Yin, 1994, p13). A case

study design was chosen because it met the three primary criteria (Yin, 1994, p.4) for adopting this strategy: the investigator had no control over actual events, the study examined a contemporary phenomenon, and the primary research question attempted to examine how health policy was formulated. This case study attempts to formulate an explanatory model describing the operational links of health policy formation longitudinally and not simply at certain points in time. The case study model is useful in these ends, as it “relies on multiple sources of evidence” and “benefits from the prior development of theoretical propositions to guide data collection and analysis” (Yin, 1994, p. 13).

This case study examines multiple units of analysis. It mainly focuses on the claims during the policy project under investigation. However, since claims do not occur in a vacuum, it is important to also examine the individuals and organizations making the claims and how others receive and react to them. Real life claims gain meaning as they are constructed and reconstructed within the interactions of actors (Berger & Luckman, 1966). They are defined and redefined by the actors involved (Stone, 1997), so I examined the actors and their relationship to power. Actors may be individuals acting on their own behalf, such as a private business owner, or they may be representatives from an organization or even the organization itself. All actors represent claimsmakers in the formation of the proposed policy recommendation. Only by examining claims across units of analysis can one accurately chart their evolution to resulting policy conclusion.

A reflexive process was employed taking advantage of my own experience in state planning grant activities extending across four years and three funding cycles. Many case studies focused on policy research are hampered because they only examine

one or two stages of the process (Smith & May, 1980). One of the strengths of this study is that it examines health policy formation from the agenda-setting of an advisory steering committee and the careful consideration of all alternatives through the selection of a viable policy option and the work of a policy action group to further refine the policy option into a formal recommendation. Across this process, the means and the ends often became intertwined and juxtaposed when compared among stages. A single examination of claimsmaking at any one stage could yield completely different results depending on the actors involved in the process and the political environment and culture at that time. Public policy research can best be understood when claimsmaking is examined across all of these stages to uncover the complex evolutionary process that actually takes place.

Qualitative data were collected from a variety of sources, including, but not limited to: field notes, published minutes, semi-structured conversational but scheduled interviews with state planning grant participants, and formal reports and other documentation associated with the project (agendas, website content, presentations, and handouts). Eleven participants in the state planning grant were asked semi-structured questions regarding their involvement in the project and their perceptions concerning claims, claimsmakers, and the policies or solutions explored. An additional participant, who was not involved in the state planning grant under examination but was heavily involved in state planning grant efforts in a neighboring state, was also interviewed to compare and contrast regional planning activities. A total of 12 participants undertook interviews.

All documents were converted to rich text format and imported into a project in QSR NVivo 2.0. Interviews were transcribed and converted to rich text format and

similarly imported into NVivo. Documents and interviews were then coded using nodes to identify concepts, assign attributes, and explore the linkages or interaction between concepts. Elements of claims were derived from the data through textual analysis of all documentation and interviews. Textual analysis has been proven useful in disentangling the complex construction of claims (Best 1995; Driedger & Eyles 2001).

Numerous studies have examined claimsmaking at the macro level describing how social problems are defined and diffused across society. Traditional materials for deriving claims include: media coverage, scholarly publications, testimony before legislatures or government commissions, pamphlets, flyers and other advocacy materials, public opinion polls, and interviews with claimsmakers, usually advocates or scientists (Best 1995, p.350). Issues for which claimsmaking has been studied include: child abuse (Johnson, 1995); stalking (Lowney, 1995); the medicalization of alcoholism (Appleton, 1995); multicultural education (Nelson-Rowe, 1995); infertility (Scritchfield, 1989); the use of crack cocaine (Reinarman & Levine, 1995); fathers' rights (Williams & Williams, 1995); hate crime (Jenness, 1995); corporate farming (Kunkel, 1995); homelessness (Loseke, 1995; Bogard, 2001); illicit copying of movies (Luckenbill, 1995); Japanese trade competition (Nichols, 1995); missing children (Best, 1987; Best, 1990); abortion (Lee, 2001); gun control (Lilly, 2001); bullying (Furedi, 2001); road rage (Best & Furedi, 2001); sex offenders (Jenkins, 2001); youth music and risky behaviors (Bennett, 2001); organ theft (Campion-Vincent, 2001); sexual harassment (Cahill, 2001); anti-sweatshop movement (Einwohner & Spencer, 2005); morals in popular music (Vander Ven, 2001); pro-immigration movements (Statham, 2001); and the effects of organochlorines used in treating breast cancer (Driedger, 2001).

Claimsmaking is a form of what Blumer (1971) termed the “process of collective definition.” He identified 5 stages within this process:

1. the emergence of a social problem,
2. the legitimization of the problem,
3. the mobilization of action with regard to the problem,
4. the formation of an official plan of action, and
5. the transformation of the official plan in empirical implementation (p.301).

The claimsmaking studies mentioned previously have focused largely on the first three of Blumer’s stages. They examine the emergence of the problem, its legitimization and mobilization. These studies largely focus on macro level analysis. A few will examine policies resulting from mobilization, however they do not take a detailed look at claimsmaking taking place the fourth and fifth stages identified by Blumer.

Claimsmaking theory has the potential to help us understand the meso and micro level activities that dominate these last two stages. More research needs to explore and attempt to understand how claimsmaking works during these stages. This research is one such attempt.

Interviewing claimsmakers within the policy arena, coupled with examining quasi-public documents and reports that are produced for those claimsmakers, has the potential to shed light on how claimsmaking impacts policy decisions at the micro level. In the real world, policy can be decided over a few drinks at a local pub just as easily as in the official halls of government, and some would argue happens more frequently in those informal settings. Knowing how claimsmaking is shaped in the more intimate

public policy setting can provide a richer understanding of the policy making process and why certain policies are chosen over the numerous alternatives.

### *The Case*

The state planning grant that was examined was typical of this type of policy research. Funding was used to hire academics and policy experts to coordinate data collection surrounding issues related to the uninsured. Focus groups, informal interviews, and public forums were conducted to measure perceptions surrounding the lack of insurance and the uninsured. Surveys were administered to determine the prevalence of the social problem. A group of stakeholders was assembled to examine the results of the data, along with state and national trends, to determine a policy option or set of options that could be recommended to the Office of the Governor. All of these activities took place over the course of four years, surviving the political turnover resulting from elections near the end of the second year of funding.

This case has several unique strengths. First, the ability to track and analyze claims throughout the policy process provides powerful insight into policy development. Beginning with a multitude of claims from a wide array of stakeholders through a narrowing of options and interests to recommend a specific policy, this study examines policy development spanning years with a blurring cast of characters and role changes. It is important to understand how claimsmakers adapt and adjust claims at different times during the process, while examining the underlying values and interests to which the claims are appealing.

Second, it provides a unique look at the intersection between the public and the private. Public policy, though aptly named, does not exclude the private. The reflexive perspective of being involved in planning activities on the ground level provides powerful insight not usually captured in more traditional case studies. Often times, claims are shaped and appeals are made “offline,” behind office doors or over dinner. Although the planning grant process was public, many meetings essentially were not; and when a member of the public did show up to voice her claims, action steps were taken to minimize such involvement in future meetings. However, the action steps were never implemented due in part to the clandestine nature of future meetings. Being privy to both meso and micro level planning discussions provided a deeper understanding of the construction of claims in the policy arena. The intersection of public and private is further highlighted by how public claims (even those external to the process) affected the claims of private and expert interests.

Last, this case illustrates how claimsmaking can provide a powerful framework for understanding the real world of public policy research. Objective and functional approaches fail to accommodate the complex web of relationships and mingling of public and private interests. Policy formation is a dynamic process and claimsmaking represents one analytical tool for untangling the labyrinth of claims and understanding, for example, why the same policy option can be heralded as the solution by some states and disregarded completely by others.



### *Definition of Key Concepts*

Claimsmaking was constant throughout the process by various stakeholders internal and external to the planning grant process. Over time the stakeholder group's focus narrowed as negotiations over warrants and conclusions were waged. It was here, as Gieryn (1999) put it, where the "battle lines" were drawn and the credibility of claims was decided. As the claims were weighed and narrowed the group of stakeholders changed and new members more in line with the narrowing claims joined the process. Those who had advocated for universal approaches were either removed from the project or disengaged over time because the solutions put forth did not align with their values, interests, or both. Slowly an option emerged from the negotiations that the stakeholders could agree upon and a conclusion was put forth as a recommendation.

This process is common in public policy and often actors feel that they are subjected to the process. What they fail to realize is that this process is a social construct of the actors involved. It is created by their own actions and negotiations. That is why claimsmaking is so vital to understanding how this process functions. Once claimsmakers realize that the facts they present rely more on their appeal and less on their merit, the more effective they become at influencing public policy. Even if they do not recognize such activities as claimsmaking, they understand the process of developing strategies to "get things done." As stated before, it is important to realize that much of the true public policy formation process happens at the meso and micro levels. The actions of one of the most effective claimsmakers, lobbyists, which are hardly ever public or macro, only further illustrate this point. As Sun Tzu stated in *The Art of War*, "Those who do not know the plans of competitors cannot prepare alliances. Those who do not know the lay

of the land cannot maneuver their forces. Those who do not use local guides cannot take advantage of the ground." To further this analogy, sufficient claimsmakers in the public policy process know the troops, the lay of the land, and the cultural values connecting those troops to their land. They use these to make their "strikes" more effective.

## **CLAIMSMAKING IN PUBLIC POLICY RESEARCH**

### *The Claimsmakers*

Claims are nothing without those that make them. Claimsmakers construct and reconstruct claims. They promote promising claims and tailor claims to appeal to a particular audience. Claimsmakers tend to have a stake in the social problem, but they represent a wide variety of values and interests. Best (1995, p. 103-104) outlines six general types of claimsmakers involved in most claimsmaking activities: victims, activists, specialists, professionals, pressure groups, and officials. Health policy construction usually involves a broad coalition of these claimsmakers. I will discuss each of these groups as it relates to the state planning grant and the social problem of the uninsured.

First, victims can often be absent from much of the process, unlike in more macro social problem activities. Their stories and anecdotes are often introduced by various other claimsmakers throughout the process, but actual citizens are rarely asked to participate in government task forces and advisory groups.

Activists are the second common type of claimsmaker. In relation to the uninsured, activists take the form of citizen's groups and public health promoters.

Private and public foundations also play an activist role. And although no members of private foundations were officially a part of the planning process under investigation, they often played a very influential role in challenging and substantiating claims during the claimsmaking process, both in public and private settings. The government funding agency, HRSA, itself played an activist role to some extent. In putting forth the funding, they claimed that most states did not have the resources to adequately address the problem of the uninsured. In the end, this claim was countered and, as noted previously, became a major criticism, which led to the demise of the SPG program when coupled with others.

Activists and others often hire specialists to help them craft their claims and develop claimsmaking strategies. For example, foundations and advocacy groups will often hire professional media firms to help them influence policy. These specialist are often highly skilled in the art of claimsmaking but they may be less committed to the activist's cause (Best 1995. p 103). However, no specialists were identified to be directly involved in this case.

The fourth type of claimsmaker plays a large role in the public policy setting. These are professionals or experts who can lend the authority of their respective disciplines to claims being made. In health policy, these include scientists such as economists, sociologists, health policy analysts, and health services researchers. But they also include medical professionals, health administrators, insurance actuaries, and lawyers. They play an important role in claimsmaking, by attempting to extend their influence to the social problem; or when this isn't possible, they might attempt to redefine problems already within their domain. This latter approach is more problematic

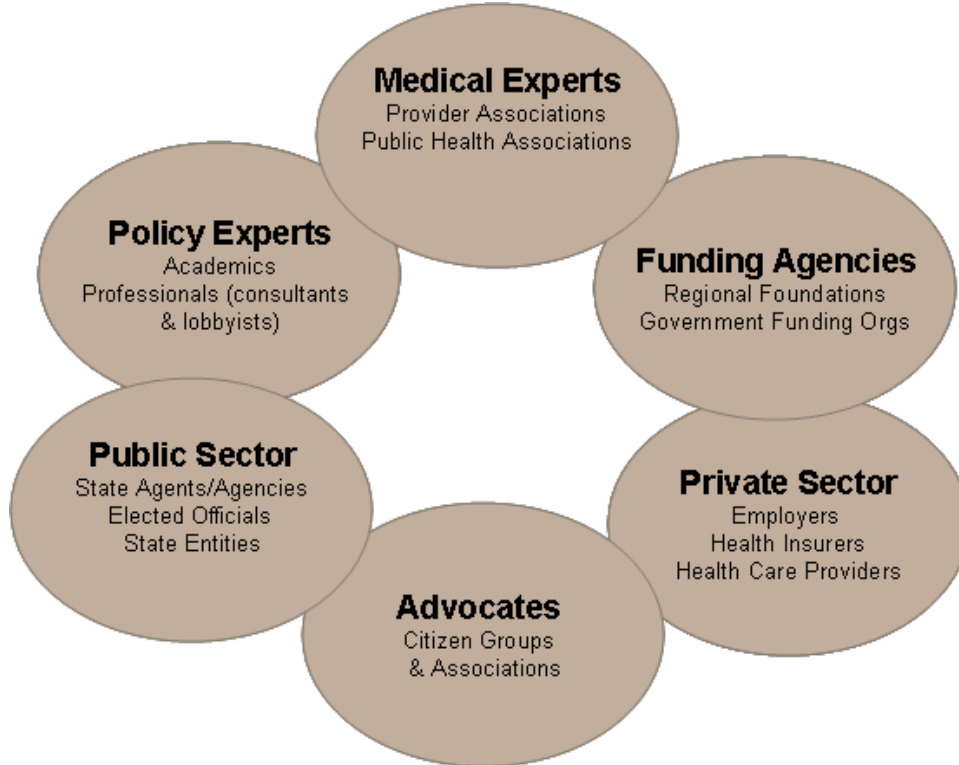
as other claimsmakers are less likely to be willing to restructure their claims to make them similar to the terms of the professionals.

The fifth type of claimsmaker is pressure groups. These have a unique place in the policy making process. Unlike most claimsmakers vying to get the attention of policymakers, these groups often work inside the policy process by exerting pressure on decision-making from the inside through lobbyists and power relations. Since the activities of these groups lie outside the official tables of the formal policy arena, it is often hard to gauge their impact on the process. Their claims take place in backrooms and on golf courses as they often approach policymakers in private. Although many stakeholders in this case represented organizations that control and have access to lobbyists, it was unclear if any of the stakeholders exerted pressure through these unofficial means during the case of study. It is more likely that pressure groups of some sort were able to counter the conclusion or recommendation put forth by the state planning grant, since no policies were implemented in the two years since the recommendations were released to the Governor.

The Governor exemplifies the final type of claimsmaker, and the one most vital to public policy formation; government officials. Officials played a vital role in the state planning grant process. All state agencies and entities that had a stake in the game of uninsurance were represented. Officials tend to protect their turf as others try to expand their influence over various domains (Best, 1995. p.104). These bureaucratic conflicts, which often remain hidden from the public view during macro level claimsmaking, often emerge in policy meetings at the micro level and are important in shaping the negotiations of claims made during policy formation.

To understand the public policy of the uninsured, it is critical to examine this policy domain, or how the political system is organized around the substantive issue (Beustein, 1999). In claimsmaking, this is taken into account by aligning claimsmakers by their respective field of argument within the public policy setting. Best describes these as fields of argument in which, “members hold particular lines of reasoning to be valid” (Best, 1987. p. 108). These fields are defined sociologically by the actors’ social relationship to the problem being addressed. As one policy expert stated, “so many different stakeholder groups [have] their own view of the way they want to do things.” Or as an academic involved in organizing planning activities asserted, “people tend to think that they kind of own the problem and know the problem and so their perception is the right one. And instead of all coming together and figuring out a common solution, we tend to think that anyone else that is working on the problem, well, they don’t know what they are talking about.” Figure 3 presents the types of the actors involved in the state planning grant under study by their respective field.

**Figure 3: State Planning Grant Actors by Field of Argument**



It is important to note that these categories are overarching simplifications and that within each, actors hold a wide range of interests. Generally speaking though, these fields highlight groups that share the same values and thus usually deem the same warrants valid. The attitudes of claimsmakers reflect their orientation to the social problem. The orientation specifies the problem's cause and recommends a solution (Best, 1995). Actors within the same field may have similar orientations and agree on what is causing the social problem but still disagree on the best solution.

Let me clarify this with an example. Actors from the private sector generally accept the claim that rising rates of uninsurance translate into higher premiums for everyone as health systems compensate to recoup uncompensated care costs. This claim appeals to their market values of protecting the bottom line because rising benefit costs affect their ability to compete in the global market. They all deem this warrant to be true

and, thus, it serves as proper justification for some solution. They even agree to some extent on the general type of solution, in this case the private sector field would support a private sector solution. However, they might not agree on the same conclusions (solution) due to diverging interests. Employers might favor subsidies in the form of premium assistance to help them cover uninsured employees. Health insurers might prefer forms of reinsurance so they could develop new insurance products within the market. Small businesses might prefer risk pooling as the vehicle to expand insurance coverage to its employees. Likewise, although policy experts generally hold warrants based on scientific evidence to be valid, they too, depending on their political affiliation might support differing, even conflicting, solutions justified by the warrant.

The previous examples illustrate the primary challenge of claimsmaking in the public policy arena. Stakeholders must agree upon not only which grounds and warrants are valid, but they must also reach a consensus as to which conclusion is best and should be recommended or implemented as the solution. Creating broad claims that are general enough to appeal to all values and interests is next to impossible. Claims therefore go through careful and very complex negotiation. These negotiations can take place in the formal setting of grant meetings and other planning activities, but they can also take place in backrooms and at conversations over dinner outside of the formal structure of the planning grants. Moreover, external actors, not a formal part of the grant, can often impact the claims being negotiated among planning grant members. Unraveling the web of claims in respect to power relationships linking actors both internal and external to the process is vital to clearly understanding the context within which claims and counter-claims are made.

Interviewees described the policy claimsmaking process in a wide variety of ways without using the word “claim” or the concept of negotiated order. One interviewee summed up claimsmaking in public policy rather plainly. ” You know, people worry about something for ten minutes and politics is that way. I mean we look at things for ten minutes, literally, and then we are on to the next controversy. So, I think people like to make a fuss about things but then it’s like nobody really ever sticks with anything.” What is being described here is the negotiations of claims and counter claims as they play out in politics. Often one group will oppose a claim with an alternative that may have no real basis or grounds, but successfully serves to counter a prevailing claim being put forth.

A perfect example of this arose in the state planning grant under examination. As part of data collection, the incidence of the uninsured in the state was determined through a standardized household survey. The findings of this survey became claims statements. More specifically they represented extent statements about the prevalence of the social problem of the uninsured. Most of these statements were not challenged. However, one finding was challenged as soon as it emerged. The surveys revealed that there was a much lower incidence of uninsurance among children (3%) than had been previously recorded in other surveys. Normally this would be good news, and many policy experts around the table interpreted this result as an effect of the expansion of children’s public health programs in the preceding years. As one expert said, “all along, you know if we look at the state, we [expanded coverage of] children up to a certain poverty level, and so, to me, that had an impact on [the number of uninsured children] I would think.”



However, an external stakeholder, who advocated for expanding insurance access to children would not accept the claim because it directly challenged one of their own claims that the number of uninsured children demanded action. As one academic noted;

[The advocates] actually took on their own study to look at the numbers and that [sic] caused some big problems as far as people placing doubt. The advocacy groups got really upset about the way [our] study was done. So they did it and I don't think they found anything really, there was a report on it and really the only thing that they found...it was kind of like it was a big fuss over nothing. [It] was, just like, well, you should have said 3-6%. You should have given a range. It wasn't like they found like 30% of children are uninsured or anything.

As another policy expert noted:

[The stakeholder] is obviously trying to get legislators to provide more funding for health care. So I think it may have gotten in the way of their agenda saying that these children, they need health care and for 3% to stick in the minds of legislators...we don't really have a problem if it's only 3%.

This illustrates how a claim was made, but since it threatened the foundational claims of some advocacy groups, they mobilized counter claims and flatly denied the statistic, regardless of the fact that the prevalence data was derived using sound and acceptable scientific methods. The counter claim was aimed at the credibility of the statistic, to create a suspicion of doubt. The national consultant contracted to conduct the surveys described her frustration at this counter claim:

Once it gets into that debate you just, you can't have the conversation. Because it's technical. So if you want to say and you could go through a bunch of different issues and it just...then it's not about science, it's about politics.

Researchers and academics who fail to acknowledge claimsmaking for the social construction that it is, often become frustrated when good scientific evidence is ignored or flatly denied. Scientific claims are only valid with audiences who

perceive knowledge creation through scientific rigor on its own merits. Politics however, often values other types of claims over those based on scientific evidence. Anecdotes, which provide the audience with a strong human connection to a social problem, can often be a more powerful tool in claimsmaking than calculations made on a slide rule. Very few people are trained in the rigors of the scientific construction of knowledge; however, many rely instead on their “gut” or their emotions to guide them in the claimsmaking process. Only when academics and clinicians are able to see their data and research findings as claims, will they be able to recouch claims and recommendations in manners that stay true to their research while appealing to the interests of their intended audience.

One policy expert was able to effectively spin an emotional appeal into the controversial data surrounding uninsured children. “I mean you miss the whole point that 3% is still a lot of people and they were indicating that this made it sound like there weren’t any children at all.” While acknowledging the prevalence claim, the expert deftly redefined the extent suggesting that even a few children lacking insurance is still large enough of a social problem to warrant a solution.

When claims fall in line with actors’ interests and values, they are seen as credible and co-opted. As one national expert who has been involved in several different states’ planning grants stated, “There have been data surprises, yes. The surveys have turned up something that a state didn’t quite expect. Sometimes, when it was good news, they were inclined to accept it, or as in [our] case...they were skeptical.” This trend to criticize scientific data when it counters prevailing claims and to co-opt the data when it supports claims has been further documented by Driedeger & Eyles (2001). Successful

claimsmakers are able to anticipate how a claim might be received by a particular policymaker and tailor the claim to appeal to their particular values. Taking the time to think carefully about how a claim will be received by various constituents can go a long way toward ensuring cooption of the conclusion/solution being put forth.

Claimsmakers employ differing strategies to try and avoid counter claims so their findings/claims all appear credible. One strategy was clearly delineated by a policy expert, “if you can involve the workgroup in the process, you, number one, reduce the level of rejection of your findings; but, number two, you develop a kind of reasonableness test among you as you go.” As the expert presents basic assumptions about the data, these are presented as claims. The test of reasonableness that is mentioned is what sociologists have called the claimsmaking process. Involving stakeholders directly in the process, often alleviates surprising even contradictory claims, because these are dealt with from the beginning as negotiations are made over which data to examine and which analysis is most appropriate based on stakeholders perceptions.

### *The Claims*

A total of 218 claims were identified from analyzing project reports, briefs, interview transcriptions, meeting minutes and website content. Claims were classified first by type. This included grounds, warrants, and conclusions with further categorization within each of these types. It is important to note that claims statements can express more than one category of claim. For example, a ground statement that provides an orientation to the social problem might also serve as a warrant for a specific conclusion.

## Grounds

Grounds provide the foundation for claimsmaking. They typify the problem through statistics and examples. They set the boundaries, or outline the domain of the social problem. They provide clues as to the orientation of the claimsmaker, characterizing what sort of problem exists. They provide estimates of the prevalence or incidence of the problem, illustrating growing concern and the need to move to action. Last, grounds provide range statements extending the problem beyond the victims to society at large.

With the exception of the previous example related to the incidence of uninsured children, the grounds were generally agreed upon by planning grant members. Growth estimates, such as the rising cost of health care, exacerbated by the increasing number of elderly and disabled, were sometimes initially questioned, but only to the extent of questioning how soon costs would be too expensive for the state budget. Often examples were given to illustrate growth statements. One of the most dramatic examples was provided during a stakeholders' meeting, when an advocate declared that "the sheriff's department [was] releasing inmates early because the county [could] not afford the health care costs." This example is interesting to note, not simply for its attempt to appeal to the value of personal safety, a tactic that had become prevalent in recent national politics. It is also noteworthy because it is in itself a range statement, extending the growth statement of rising health care costs and providing an example of how it could affect everyone in a community, even those who are insured or have enough money to pay for their own health care.

The example further illustrates a trap for claimsmakers in the public policy setting. A claim should not be judged on its accuracy. In claimsmaking there are no facts only claims. Instead, a claim should be judged on its effectiveness. Often policymakers, experts and advocates get caught up in wanting to consider only the “facts.” However, since claims are socially constructed, the objective reality does not matter to a large extent. What matters are the perceptions of those receiving the claim. A public policy expert could provide the most exact data collected through the most rigorous scientific and peer-reviewed processes. If the policymaker doesn’t feel the data is correct, the claim will be ignored. It is that simple. A counter to the first claim with no factual base may be ephemeral and last only a moment, but in the fast-paced, issue-based arena of public policy, you may only need to create doubt to counter a claim at that moment to defeat an issue. Once the opportunity for the claim has passed, it must wait. Policymakers often have claims sitting on their back shelf as formerly developed and propose solutions are denied through claimsmaking. Successful claimsmakers keep these claim attempts handy for when the next opportunity arises.

Since the uninsured do not have the resources to mobilize around the social problem of the lack of insurance, range statements extending the problem to everyone became an integral claim. The very title of the public meetings, “Covering the Uninsured in Your Community: Why it is Everyone’s Problem,” highlighted the claimsmaking campaign created by state agents and policy experts “to determine how the public perceived the problem and what solutions they would propose.” Titling their own research program in such a way only further illustrates the rhetoric of claims and

demonstrates how presenting the “facts” in public policy research can represent much more than simply presenting empirical findings.

The most common logic found in range statements extending the social problem of the uninsured to society (or community in this case) was summed up by the project director in the final report from the public meetings:

Communities are at risk of losing health care capacity because high rates of uninsurance result in hospitals reducing services, health providers moving out of the community, and cuts in public health programs like communicable disease surveillance. These consequences can affect everyone, not just those who are uninsured.

The claim is an attempt to broaden the appeal or range of the problem. Once again it touches on personal values, raising fears or creating concerns over the adequacy of the health infrastructure (both facilities and manpower), the reduction of available services and treatments, and the spread of communicable and unnecessary diseases. It also serves to suggest that action must be taken to implement a solution before it gets too late, which exemplifies the next type of claim to be discussed, warrants.

### Warrants

As stated in a report summarizing public opinion elicited through town hall forums, “[social] problems can be diagnosed according to two factors: agreement on problem definition [grounds] and agreement on possible solutions [conclusions].” When it comes to uninsurance, the stakeholders by and large, with the noted exceptions, agreed on the grounds statements. Warrant statements represent the justification for a specific conclusion. So, negotiations centered largely around these warrants, as debates focused on which conclusions were most acceptable as a viable solution. The warrants of public

policy are where the real speculation takes place and where the rubber hits the road in claimsmaking. Getting all stakeholders to accept the problem may be a task in itself, but providing ample justifications that appeal to all stakeholder values can often pose an insurmountable task in formulating policy. As one policy expert put it, “I think [the stakeholders] really weren’t concerned about the issue and it was only after we got to start talking about policy options that it seemed to matter to [them].” Warrants can be placed into five general categories: associated costs, blameless victims, deficient policies, rights versus responsibilities, and the value of being insured.<sup>4</sup>

### *Associated Costs*

By far the most often cited warrant throughout the planning process was the increased costs of health care due to the uninsured. This warrant took many forms but the basic argument is this. The uninsured, usually lack a regular source of care and do not receive less costly, but necessary, preventive care. Due to this, they wait until health conditions worsen and require costly treatment. Furthermore, the uninsured often seek medical help in the emergency room, one of the most expensive places to receive care. Since they lack insurance, they are unable to pay their medical bills, so providers are forced to raise their fees for everyone, which leads insurers to raise premiums for those who do have health insurance. Thus, in the end we all pay for expensive care that could have been prevented. Or as one state agent stated, “By not being able to invest in prevention, communities experience high costs in the long run.” The complete rationale previously described is implicit in this simple claim.

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<sup>4</sup> Several of these warrants have been adapted from Best’s (1987) warrants on missing children. Although the terminology for some warrants is borrowed from Best (such as blameless victims and deficient policies), the warrants themselves have been reinterpreted as they apply to the issue of the uninsured.

Other examples more explicitly specify each aspect of this claim and serve as warrants for multiple solutions.

Uninsured individuals identified the emergency room as their regular source of care at a disproportionate level compared with their insured counterparts. This finding suggests that strategies to identify regular sources of care for the uninsured, rather than an expensive emergency room, may be a future issue that will need to be addressed - Excerpted from the year one final report.

This claim has become quite popular in health policy and has encouraged the emerging trend of the “medical home” model in largely public insurance plans for those not enrolled in some form of managed care. The underlying assumption is that by establishing a medical home, or center of care, this might increase the patient’s chances of receiving preventive screenings, or, at the very least, provide a less costly alternative to emergency room care when health conditions became urgent. This warrant reflects a recent trend and has been used by medical experts to expand funding for community health clinics which has contributed greatly to the expansion of Federally Qualified Health Centers and rural health clinics since 2000. This has been a popular trend at the federal level because it aligns itself well with pork barrel politics, as legislators are able to gain part of the funding to establish clinics throughout their own districts.

Other warrants documented in the final planning grant report raised concerns over the unanticipated costs associated with being without health insurance.

[Uninsured] parents of [sic] children said they could not afford health care for their children if they were not covered by Medicaid. They also said even if they could not afford health care for their children, they would do whatever was necessary, including writing bad checks and manipulating the system, to ensure their children received health care.



This claim suggests that the lack of insurance could lead to increases in criminal offenses and other deviant behaviors that would be a greater cost to individuals and society.

Still other warrants introduced by academics and advocates focused on the human costs of being uninsured. As documented in the final report, “families lose peace of mind because they live with the uncertainty and anxiety of the medical and financial consequences of a serious illness or injury.” The cost of stress and uncertainty on quality of life was often used in conjunction with the next type of warrant, the blameless victim.

### *Blameless Victim*

The uninsured are often portrayed as being in their position by no fault of their own. Economic circumstances, employer practices, and even health conditions themselves were often blamed for not allowing families to obtain coverage. This warrant took many forms and often used very specific examples to highlight how circumstances beyond the individual’s control made health insurance inaccessible. The principal behind a nationally known consulting firm in health survey research pointed out that survey data demonstrated that:

Some participants do not have the opportunity to enroll as opposed to refusing to enroll. They identify employer situations in which [the] number of hours worked is limited yet linked to opportunity to receive benefits, coverage is not offered and/or affordable especially for small business or the self-employed, waiting periods are lengthy (3-6 months), part-time workers cannot receive benefits, and multiple exclusions exist for pre-existing conditions.

Others stated this type of warrant much more plainly and succinctly. As one member of the public exclaimed in the town hall meetings, “you have no clear understanding of the working class struggle.”

As Best notes, “blameless victims offer rhetorical advantages to claimsmakers” (1987, p.110). Innocent victims have a much greater appeal than those who are responsible for their fate. This warrant is often heavily contested when the solution is focused on some form of public health insurance expansion. The rhetoric of welfare politics rears its ugly head playing on stereotypical examples such as the “welfare queen” that became prevalent in the politics of the 1980’s. This dramatic exaggeration has been used to counter the blameless victim warrant and portray those on welfare according to gender and racial stereotypes. Blaming the victim has a long tradition in spurring counter claims to welfare state expansions. However the uninsured often do not fit the classic welfare stereotype.

Since Medicaid was established, the poor have generally been able to get public forms of insurance, so the problem of the uninsured really falls on those in between, working and middle class families who make too much to qualify for public programs but cannot afford private coverage in the individual market or the plan that is offered by their employer. Prevalence claims were used to support the blameless victim warrant; statistics collected during the project were distributed. According to data collected during the state planning grant, over two-thirds of the uninsured have at least one family member in a part-time or full-time job. So rather than relying on classic welfare counter claims, a more subtle approach was adopted, and it was pointed out that people often fear or take exception to “welfare” programs and will not sign up. As one planning member from the private sector stated:

Many people don’t want to be on a dole. They feel ostracized when they receive public assistance. The community does not accept poor because they are seen as users of the system and not contributors (stakeholder’s meeting minutes).

This sentiment was further documented in the final state planning grant report, “the working poor who participated in [focus] groups expressed resentment at those who do use public programs and do not attempt to work and help themselves financially.” The counter claim here appeals to an individual’s sense of worth while building the comparison on the stereotypical imagery portrayed by the anti-welfare state claims prevalent under the Reagan administration. To be seen on public insurance, puts one at risk of being perceived as a lazy freeloader by neighbors and friends. This example only further illustrates the extent to which powerful claims appeal to socially constructed values and rely less on appeals to scientific logic or the truth surrounding objective social conditions.

### *Deficient Policies*

Another common category of warrants focused on how current insurance policies, both public and private, were inadequate to meet the current and future needs of those without health insurance. In fact, deficient policies were often cited as one of the primary reasons that people could not obtain adequate health insurance. Examples of deficient policies affecting eligibility to public programs were also mentioned. The following are a few that were documented by the project director in the final report.

The majority of uninsured participants in these focus groups reported they made too much money each month to be eligible for public programs, such as Medicaid. In one instance, one participant made 31 cents too much.

Social security payments, or other income, results in ‘too much’ family income, even though the full-time caregiver (who is less than 65 years old) is uninsured. Senior citizens or others who own property, particularly rural

farmland, may be required to sell their assets in order to qualify for public programs.

Programs that do exist are often not known to clients as a result of insufficient program advertisement and/or overwhelming paperwork and complicated guidelines to apply.

Coupled with the prevalence statement that three percent of uninsured children and nine percent of uninsured adults are eligible to qualify for public insurance, these warrants support the conclusion to revise deficient eligibility standards, or to increase funding to outreach and education, which could reduce the social problem of the uninsured.

Claims of deficient policies were not only aimed at the public sector. As one academic at a stakeholders' meeting acknowledged, "companies select who they insure, [there is] no mandate to cover anyone, no incentives for insurers to insure anyone in the state. Incentives, now, encourage insurers to not cover high-risk beneficiaries." And deficient policies claims were not solely targeting employers, claims about private insurance practices were also very prevalent.

Low-balling is a serious issue which has hurt many small businesses in [the state]. The practice of giving initially low insurance rates, only to increase prices dramatically, needs to be dealt with by State insurance regulators – Planning grant final report.

These warrants were usually utilized to support more incremental solutions to health care reform, however, when generalized they were used to support wide-sweeping options.

Here is an example of a public claim made during the town hall meetings by a local physician:

Provision of healthcare coverage is currently after-the-fact...we need to create a culture of health and wellness to ultimately reduce costs. Nobody is currently paying for preventive health and wellness programs, although we all agree it should be done. There is no federal or state support to do it.

The public health infrastructure should be strengthened, rather than dismantled.

It is interesting to note the focus on care delivery coming from a medical expert in a public forum. This warrant also serves as an orientation statement, defining the problem and suggesting that insurance doesn't have to be too costly, if there was only adequate support for public health programs and preventive services. This claim seeks to reshape the culture of health care delivery through reimbursement policy reform. A sentiment that I will revisit when I discuss claimsmaking by field of argument.

What is further interesting about the warrant of deficient policies is how this same general claim can be professed by competing interests to support wholly different solutions. Liberals, on the one hand, often use deficient policy warrants to justify scraping the current system and implementing a more efficient single payer system or other form of universal health care. For example, one early proponent of universal health insurance provided an anecdotal claim to humanize this warrant. The claimmaker, in this case a state agent, described how insurance companies denied a young woman coverage because she had been previously diagnosed with back pain. The agent continues:

They won't cover her. They see her as a risk. And now even though she doesn't go to be treated for back pain...I mean who doesn't have back pain. It's just kind of the things that you say. I mean its not like she has something that's going to be debilitating and she's going to be on disability.

In this case, it is deficient private market policies that go unregulated by the state that disallow an ordinary person with "back pain." The back pain humanizes the problem, after all as the claim states "who doesn't have back pain."

Conservatives, on the other hand, use deficient policies arguments to portray the current public system of health insurance as inefficient and wasteful and laud the powers

of the free market as the solution to expanding coverage and controlling costs. Although, I could find no documented examples of this in my data. It is a fairly prevalent warrant used against creating a government controlled system of care. Take this recent example from an email distribution list of a leading conservative think tank.

During the health reform debate in the 1990s, former Senator Phil Gramm often said that he was working to protect us from a health care system that operated like the post office – with its long waiting lines, inefficiency, and limited services.

Well, we are entering the next round of the health reform debate, and we have a fresh example of why we still don't want our health sector to become a monopoly like the postal service.

Here's what happened: The post office near our offices in Alexandria, Virginia, where we receive our mail, announced this fall that it was moving a few blocks up the street. But then they told us that because *THEY* are moving, *WE* must change our mailing address.

I suspect that some postal service bureaucrat just forgot to tell a vendor to keep the old numbers on the new boxes. No one is taking responsibility, of course. And since there is no competition, we are stuck.

If this were the private sector, they would certainly have figured out a way to let us keep our same box numbers. But it isn't and they didn't. So now we must notify you and all of our colleagues – and also order new letterhead, business cards, brochures, etc.

This is a perfect example of why we don't want the government running our health care system!

Although the actual merit of this analogy can be of much debate, the claim is very appealing to anyone who has had a problem with the post office. This example, coupled with the one above, only illustrate how claimsmakers with very differing interests can lay claim to the same categories of warrants to justify completely separate solutions.

### *Value of Being Insured*

Warrants often relied on the assumption that there was an inherent value to having health insurance. One employer was documented in planning grant interviews as saying:

Luckily, our Board of Directors, as well as our Executive Director, we all see, we all read off the same page and we all think it is not an option. A person has to have insurance to survive in the real world.

The last sentence highlights the value of insurance. Without it one cannot really live. This was a commonly held theme for warrants supporting more expansive reforms. It was also a common theme echoed at the town hall meetings, as academics designing the forum presentation materials included these facts:

- Individuals lose their health and die prematurely.
- Uninsured children lose the opportunity for normal development and educational achievement when preventable health conditions go untreated.
- Communities are at risk of losing health care capacity because high rates of uninsurance result in hospitals reducing services, health providers moving out of the community, and cuts in public health programs like communicable disease surveillance.
- The economic vitality of the country is diminished by productivity lost as a result of the poorer health and premature death or disability of uninsured workers.

These are not facts, they are claims. They all represent warrants that reflect the value of being insured. Many also serve as range statements extending that value from the individual through the community to society. As mentioned in the section on associated costs, there is also a non-monetary value of having insurance on peace of mind and family stability. The public, policy experts and state agents all mentioned the stress and worry that often accompany being uninsured.

The value of being insured warrant also manifested in other forms in relation to other interests, such as employers. During planning grant interviews with small business leaders, “several employers noted that health insurance has become so important that it is often the first thing a prospective employee asks about during interviews.” They continued on to claim that:

Those employers that offer insurance very much want to continue doing so. They realize its importance to the success of their businesses and are not ready to give it up without a fight. Those employers that do not offer insurance have a strong desire to do so.

Therefore, claims can focus on the value of being insured from a variety of perspectives, even providing range statements/warrants that extend the value to the community level or society at large.

### *Rights vs. Responsibilities*

One of the primary warrants related to covering the uninsured revolved around the question of whether health care is a right or a responsibility of citizenship. This question was the focus of the town hall meetings. Throughout the handouts and public deliberation, the issue of health care as right or responsibility surfaced again and again.

As documented in the final report of the town hall meetings:

There are many stakeholders involved from consumers, families, insurance companies, providers, employers, legislators, all of whom struggle to answer the basic question: is health insurance a privilege or a right?

“Privilege” in this case, is a code word or rhetoric for responsibility. It is interesting to note the contrasts between health and other, so-called, privileges. Often the privilege of health insurance relies on analogies to voting or driving rights. These analogies fall flat because, in both cases, individuals are able to obtain the right easily and only lose it after they have done something deemed unacceptable. Underlying the privilege are very high levels of access. Health insurance does not quite fit this model. As identified by a medical expert in the stakeholder’s meeting, “health care is a basic right at some level of benefit.



Currently it is at the emergent care level, everyone has the right to be seen at the emergency room.”

The history of health care has swung back and forth between right and responsibility. The veterans administration of the 1930s was established with claims that those who had fought for their country had earned the permanent right to receive health care services. Similarly, Medicare and Medicaid were founded in the 1960s under an ethos of the right to health care, not privilege. However, more recent attacks on public forms of health insurance have focused more on health care as a responsibility, as programs are restructured to ensure that people make sound choices including changing policies to incentivize healthy lifestyle choices, such as exercise, proper diet and quitting smoking. Claims used to dismantle the welfare system in the 1980s and 1990s revolved around responsibility though they took the form of over-exaggerated examples of irresponsibility. Even today, responsibility is in the forefront of debates over ways to control skyrocketing health care costs as many solutions focus on making patients better “health consumers” or more responsible buyers in the health care market.

Many claims suggested that “people need to take more responsibility for their health;” that individuals need to take a larger role in making sound personal decisions (quitting smoking, exercising, “eating right”, etc.) and stop contributing to escalating costs. The underlying assumption is that irresponsibility leads to waste and neglect which we all pay for in the end. Here is a good example that was documented in the final report.

One key informant said women come in on a regular basis to her clinic to replace lost antibiotics for their children. Because the cost to them is so low, there is no incentive to be responsible for the medication.

The notion of individuals taking responsibility for their own health also serves to counter the blameless victim warrant. As noted previously, those perceived as responsible for their fate, share the blame and thus make it easier for others to dismiss the social conditions resulting from their own bad choices.

Warrants suggesting health insurance as a right were more subtle, often representing the underlying assumptions behind claims statements. The following were documented in public statements from the town hall meetings.

Top level employees receive excellent health insurance packets vs. employees at the lower end of the pay scale who have to struggle to make ends meet. There is a huge inequity that needs to be addressed.

What can be done to look at the company and make it more equitable?  
Premiums should be based on income level of each employee vs. everyone from the CEO to the secretary paying the same premium amount.

Rights and responsibilities should not be seen as dichotomous or polar opposites on a linear scale. In claimsmaking there is a more dialectical relationship between the two as claimants reconstructed claims about rights and responsibilities to suit their interests. Take the following claim by a small business owner, “we need to equal the playing field between small businesses and large businesses so both can provide benefits at a fair and affordable price to both.” In this case, it was not an individual’s right to health care, but a business’s right to compete with other firms, irregardless of scale. This same claimant argued for individual personal responsibility, but believed in corporate rights.

In the end, the only warrants that appealed to a majority of stakeholders focused on an incremental solution, expanding insurance options for small business owners and their employees. The warrants of this claim were the least controversial under the current political culture. For those claimsmakers pushing broader reform conclusions, it

represented a step, albeit small, in the right direction, since some form of expansion would occur. The prevalence was determined – over one-third of employees who worked in firms with 50 or fewer employees, or 389,000 employees, could potentially be covered if a solution was agreed upon, adopted, and implemented. But before I discuss the final conclusion in more detail, it is important to step back and examine the evolution or narrowing of claims that occurred across and within the policy research project.

## Conclusions

### *Initial Solutions Explored*

Initially, a wide array of stakeholders was invited to participate in the policy planning process. The charge of the planning committee during the first two years of the project was to examine all possible solutions for expanding coverage and weigh these, in accordance with national and state health insurance and health care trends, along with the data being collected and analyzed by policy researchers, to determine the most feasible alternative for expanding coverage.

Thus, during the first stage of the project, a myriad of potential conclusions were set forth and claimsmaking focused on negotiating the warrants and domains that justified the most acceptable conclusion. By acceptable, I mean the conclusion that was able to overcome any counter claims that may have been presented against its grounds and warrants. Table 1 presents the primary conclusions that were initially considered through claimsmaking along with the primary reason they were dismissed.

**Table 1: Initial Conclusions Considered by Planning Group by Type and Primary Objection or Counter Claim Employed to End Support**

<b>Conclusion/Solution</b>	<b>Type</b>	<b>Counter Claims</b>
Strengthen Medicaid SCHIP outreach & enrollment	incremental	Cost; political viability; low prevalence
Expand safety net of primary care	incremental	Questioned domain
Reform state high risk pool	incremental	Questioned domain
Expand private definition of dependent to 21	incremental	Dropped off radar
Broaden state continuation of coverage laws	incremental	Dropped off radar
Increase Medicaid reimbursement rates	incremental	Questioned domain
Expand Medicaid eligibility to 21	incremental	Cost; low prevalence
Public funded reinsurance for private coverage	incremental	Not practical
State tax incentives	incremental	Not practical
State funded coverage program	expansive	Political viability
Universal health insurance	expansive	Political viability

Feasibility, in one form or another, was the most common category of counter claim. In the case of public expansion, in any form, feasibility took the form of affordability and political viability. Due to an increasing state deficit, the legislature had enacted cuts in state Medicaid eligibility and programs during the second year of the planning grant. Any forms of expansion were readily dismissed as being too costly for the state in addition to not being politically viable, since such expansion would not only require support of the governor, but of the legislature as well.

Another counter claim stemming from feasibility, questioned the practicality of the conclusion. For example, although there was ample support for some form of tax incentives for the uninsured, once policy experts pointed out that tax incentives, although politically viable in the current climate, were not effective because those with lower incomes who were most likely to be uninsured could not and do not take advantage of these incentives. As stated in the final report, “tax credits is an after the fact – [the

uninsured have to] have the money up front.” Thus, tax credits although politically viable was not a practical solution that would provide coverage to a lot of people.

Many conclusions were dismissed by claiming that it was not within the domain of the planning group to actually address and support the solution. Expansion of access to care or expansion of the safety net, although seen as an important to consider in expanding coverage, was seen as a separate charge. This could have been, in part, due to the fact that HRSA did not provide states with funding to examine the adequacy of the safety net within planning grant activities. Thus, this research question was funded through a local foundation in a parallel study. In the end, planning members could not agree on whether this was within the federal or state domain and the conclusion was dismissed. Similarly, the conclusion to reform the state risk pool was dropped because this was thought to be under the domain of the state department of insurance.

Other conclusions, to put it quite plainly, simply dropped off the radar. They were introduced and discussed with no real opposition or counter claims emerging. These conclusions were often introduced as examples from other states; however, the appeal to members was not great enough to generate ample support and they were quickly forgotten with no claimsmakers championing them throughout the process.

One of the most interesting counter claims focused on expanding public insurance to children. As highlighted in an earlier example, survey data had revealed an unexpectedly low prevalence rate for uninsured children (3%). Despite external efforts by advocates to counter this ground, in the end, the ground itself was used to counter two solutions focused on children – strengthening SCHIP/Medicaid outreach/enrollment and increasing Medicaid eligibility to age 21. The final planning grant report provides a

listing of all options considered along with their “reasons for exclusion.” Under both of the sections on children’s expansion, it asserts, “Given the rate of the uninsured for children in [the state], the subcommittee members were not sure the state needed to do much more at this time.”

### *Narrowing of Conclusions*

As claims were debated, solutions were narrowed down first to only those incremental conclusions and then eventually to a single form of incremental expansion targeting small business owners. This conclusion consistently emerged from the town hall meetings with the public, from focus group data with small employers, and from key informant interviews with employers. Prevalence claims from project survey data found that over one-quarter of the uninsured in the state were working in firms with 50 or fewer employees. This conclusion/option was seen as politically viable in the current climate and no stakeholders presented any prevailing counter claims.

Now that the general approach had been decided, claimsmaking was far from over. Negotiations continued as they discussed the specifics. Would this be a reinsurance package with subsidies for care? Because of the shrinking state coffers, subsidies were not seen as politically viable, and any plan would need legislative approval. Tax credits were mentioned but readily dismissed. After four hours of debate, it was decided that establishing a risk pool for small businesses had the best chance for success. According to the state entity in charge of the state employee plan, where the new pool was to be housed; it was “do-able” from both a practical or economic standpoint and from a political one. Moreover, establishing a risk pool for small businesses was a claim that was

further supported in offline talks between the state agent in charge of the planning process and the governor's office who appeared to support the option at that time.

Once it was decided that this was the general option to pursue, the old group was disbanded and a new smaller working group was appointed by the governor to define the specific option to be recommended for implementation. It is interesting to note that the narrowing of solutions, in this case, also led to a narrowing of the stakeholders or interests involved. Advocates were not included in this working group, while those who had more stake in the game, such as small business owners, who desperately needed such a pool, and private insurers, who might perceive a state-operated pool as competition to current or future insurance products, were given more representation. This narrowing of the players is a common practice in policy because it becomes easier to find agreement around a policy option when there are fewer people who need to agree and their interests are more closely aligned to each other.

Claimsmaking did not stop once the group had selected the same conclusion. The details and specifics of how such a plan would operate had to be delineated and agreed upon. Claimsmaking negotiations determined such specifics as mandates, the size of the businesses allowed to participate, administration of the plan, what was included in the plan, level of employer and employee contribution, any premium offsets or enrollment caps, and other opportunities to improve quality of care and reduce costs for potential enrollees. Claims made at this level were usually more mundane and there was less debate, however, the discussions surrounding the warrants did get heated at times.

For example, the discussion around mandates was quite contentious. During one of the first meetings of the working group, representatives external to the planning

process, largely from business associations, were invited to highlight the insurance products that they had made available to small businesses. During one such presentation several claims were made and documented in the minutes. One primary counter claim to the policy option being developed was “that if you roll small businesses into [the state pool], then you will primarily attract the small employers with sick employees.” Underlying this claim are the assumptions that a state plan would not be able to compete with existing products and thus only provide a viable option to those small businesses who were looking at increased premiums due to the health of their employees, thus exposing the pool to adverse risk selection. Mandates were immediately brought up by policy experts to overcome this counter claim, since mandates represent a way to avoid adverse risk selection. However, mandates were quickly dismissed by the small business interests at the table, who felt “we shouldn’t force any plan on businesses of a certain size.” Mandates were favored by state agents and policy experts because the larger the pool, the more viable the insurance product; however, as was noted in various meeting minutes, “[t]here is some resentment to government programs among small business owners” and there would be considerable political resistance to enacting a mandate for employers of a certain size because it would be seen as government intervention and could be construed as unfairly limiting competition within the free market. After the dust settled, mandates were dropped and other avenues, although less promising, were explored to control for adverse risk selection.



### *Power Relationships and External Networks*

The relationships and networks linking claimsmakers cannot be ignored in research. These linkages, what Best (1995, p. 198) called “connections,” provide further insight into how claims are negotiated. Connections can represent linkages within and across claims, or they can signify the relationships between people, individuals, and organizations. Often these linkages can be hard to examine, as connections, especially those among policymakers, can be more covert when discussions take place offline and behind office doors.

Numerous examples of the connections within and across claims were provided in the preceding sections. So, let me focus on the connections between the claimsmakers themselves. Connections can play a vital role in determining how a claim is received. For example, claims made by those who are perceived as liberal, often fall on the deaf ears of conservatives and might readily be dismissed even before they are made. Conversely, knowing someone and being familiar with them and their politics can facilitate claimsmaking attempts. One medical expert explained it this way:

I have gone to the table and either on a committee or on a local and state initiative, or national initiative, and if you know somebody and you know what they do, [sic] they are predictable, a known entity, and you have a connection with them. It's natural that you go that direction. That's where the communication is.

One policy expert explicitly stressed the role political affiliation, or more specifically, perceived affiliation, played in the planning process.

My history with republican party certainly facilitated the involvement of people like the chamber of commerce, and the National Federation of Independent Business. NFIB probably would have participated anyway, but just getting them into the table probably required that one of us was a republican.

The policy expert reiterated this in an example by recalling how, upon meeting the president of the state chamber of commerce for the first time, the president said that they had checked the expert out with colleagues and heard that he was “okay,” meaning the expert was perceived to be on the same side, sharing the same political values, and therefore assumed to support similar warrants and conclusions. What is key here is perception. The policy expert never stated his actual affiliation, in fact, he keeps it very vague, so that liberals, conservatives and anyone in between might perceive him as being “on their side.” Being perceived as such, establishes trust and gives more credibility to claims the expert may put forth with that audience. Hence, even political affiliation can be socially constructed and adapted to gain appeal in the claimsmaking process, irregardless to the reality of how one actually voted in the last election. In claimsmaking, as in politics, appearance is everything.

In addition to connections, it is also important to note the relation to political power of external groups to the planning process and how that affected their attempts to influence planning members. At many times, groups outside of the process, tried to exert influence on the planning grant activities. In fact, the state agent responsible for securing the planning grant was initially encouraged by a regional foundation to apply for the grant through the inducement of matching funds. What is ironic is that no foundation members were assigned to work on the project and so the foundation was limited to external claimsmaking through parallel studies and reports in hopes of influencing policy formation.

As noted earlier, advocates and a regional foundation strongly countered the grounds stating the low prevalence of uninsured children, even going so far as to fund

their own parallel study comparing the survey data collection methods with other national data sources on the uninsured for accuracy. However, this organization, although well-funded, lacked the political clout or power for its counter claims to be accepted. And in the end their external efforts to debunk the prevalence data failed and solutions focused on children were dismissed as unwarranted.

In interviews many planning members expressed a frustration at what was termed “parallel policy tracks” or “tables.” By this, they were referring to other policy formation groups, some formal, but most informal and secretive. As the principal of a nationally known public consulting firm in health services research noted, “I think the governor had his own plan. And I think that [the planning] group thought that they were the governor’s group. And then there was another governor’s group that was not using this process.” It was hard to determine from my data the actual level of buy-in from the governor’s office to the state planning grant discourse. The fact that the governor was investing political and intellectual capital at other policy tables does signify that he was only partially invested, at best.

Some claimsmakers within the stakeholder group were seen as having more political power because they were perceived to be a part of or providing input into these “other tables.” A physician noted this in interviews about the stakeholder group:

There are times during that process that I felt that those that were involved in [stakeholders’ meetings], those that were in some of the organizations, [sic] who had a seat at our particular table, had a seat at the politics table and the policy table. They were the ones that were really having the dialog.

While some within the room had the political clout, most often felt powerless in the policy process because although the administration knew of the planning grant work, it

was unclear how much, if any, real support these activities had. As one policy expert stated:

While the governor's office came a couple times, they were having a parallel track, doing their own sort of plan, that was sort of similar, but different. Which is, what I can see, two or three people putting that together, and without any involvement, really, from their, even the republican legislators.

Or as one of the medical experts described:

I'm not sure...to what degree the [stakeholder group] and that particular initiative was going to be supported and was going to be continued – whether the administration was going to continue to support it or not.

Even the claimsmakers themselves were aware of their lack of power and often expressed frustration over their perceived influence, or lack thereof. One medical expert put it quite plainly, “I don't know if the rest of the group felt this way or not, but I sensed that there was some frustration as to what are we actually doing, what are the actual outcomes that are coming about.” Or as a state policy expert questioned while being interviewed, “it was a wonderful academic exercise, but you know, what actually came out of that?”

Claimsmaking within this case, although seemingly vital to public policy, may have been mere political frontage, so elected officials when confronted by advocates and those victims recently cut from the rolls of public insurance programs, could point to the “blue-ribbon” commission of experts they had assembled to address this very issue. The activities of the stakeholders' group could serve as a counter claim by their own right. It was not surprising to policy experts that, despite all of the painstaking negotiation of claims by all involved, in the end, the recommendation was not implemented and the policy option was placed on a back shelf awaiting its next opportunity to resurface.

### *Claimsmaking trends by field*

Now you have a better sense of some of the claims (grounds, warrants and conclusions) and counter claims used in the negotiation of public policy targeting the social problem of the uninsured. I have shown, through my data and other examples, how via claimsmaking, options are introduced, debated, dismissed, redefined, narrowed and reformulated into policy recommendations. I have given a sense of some claims made by particular types of claimsmaker, but let me delve further into this and examine specifically how particular types of stakeholders in public policy research construct, present, and receive claims. Although there are many types of claimsmakers in public policy, from advocates to private interests, I am going to focus on the ones that have a primary role in public policy research: medical experts, policy experts, and policymakers.

#### Medical Experts

Medical experts took many forms. The most common were physicians and clinicians, but medical expertise was also provided by representatives from state provider associations and health services researchers. The medical experts involved in this case all had experience in formulating public policy, so they were usually well versed in the art of claimsmaking. They did not call it claimsmaking, but they clearly understood the game. As one physician understood it, “I use the term ‘play the spin’ as it relates to health policy and politics. There’s a certain language and there’s a certain sort of interactive process that goes along with that.” So, some medical experts, especially those who wore a policy “hat” embraced claimsmaking, while others were more surprised by

claimsmaking activities. One academic clinician noted this even within his own discipline:

The politics of academic health care is intense...even more so than I thought it was. I mean I knew it was pretty intense but its phenomenally intense and that kind of politics too with the real politics, you know the socioeconomic politics that are out there it gets pretty intense and makes it difficult to get things done.

Claims made by medical experts, as with other claimsmakers, typically reflected their interests and values. Claims put forth by medical experts focused on “investing in prevention/primary care,” “expanding the safety net,” or developing programs that “focus on wellness (preventive care) and disease management.” Most solutions centered around improving health infrastructure by providing new funding for direct care or by restructuring current reimbursement formulas. Warrants largely highlighted deficient policies and often related more to the adequacy of the health care safety net and had less to do with access to health insurance. From the orientation of the medical expert, health insurance mattered little, if there are no doctors willing or able to see the patient. This claim often manifested in the form of a counter claim against solutions focused on the expansion of public insurance programs.

The concern was voiced that any Medicaid expansion will be limited by access to providers who accept Medicaid. Current rates are not affordable for many providers (e.g.: dentists, pharmacists, mental health providers, etc...) to accept Medicaid or new Medicaid patients. – Planning grant final report.

Here medical experts counter that they do not see expansion of public programs as viable because not enough providers participate in public programs now, due to less than adequate reimbursement rates. This claim is an attempt to connect their conclusion of

restructuring Medicaid reimbursement rates to the problem of the uninsured. In the end, they hitched their claim to the wrong wagon as the political climate was more in favor of limiting rather than expanding Medicaid.

Medical experts attempted to also connect the issue of medical malpractice to the uninsured and proposed tort reform as a potential conclusion. Range statements were employed to extend the problem of malpractice suits to the uninsured by using the classic example of OB/GYN physicians who had to move to another state because they could no longer afford to pay their malpractice insurance, leaving behind holes in the safety net in some communities. The underlying assumption is that if something isn't done about the spiraling malpractice awards, having access to insurance does not matter, since doctors will be forced to practice elsewhere. This claim was countered by pointing out that although their argument was deemed valid, it was not within the domain of the committee's charge to address it at this time.

Since medical experts are largely clinicians, trained in the science of medicine, they were more prone to use and accept claims from academics and policy experts that were based on rigorous scientific method. The recent trend in health policy toward more evidence-based policy solutions largely stemmed from evidence-based medicine and medical claimsmakers asserting their orientation into the policy arena.

### Policy Experts

Policy experts, with the exception of the politicians in the room, were the most adept at claimsmaking activities, yet even they did not recognize it as such. Like medical experts, they clearly differentiated it. One policy expert described his role as helping to “negotiate the politics around the proposal.” A policy expert who was contracted to

facilitate the stakeholders' meeting described his role as "keeping all the players at the table and helping them communicate and understand each other, even though they might have pretty wide differences both in this project and in the broader political philosophy." Since policy experts engage in claimsmaking activity as part of their routine work, it is only natural that they were better able to describe claimsmaking even without knowing the sociological framework. Having seen the process firsthand, they may not recognize the social construction of claims, but they do recognize the negotiated order necessary to achieve a consensus and work accordingly to structure that order and formulate sound and efficient policies.

Policy experts, often claim to be objective, but they also were guilty of introducing claims that clearly supported their own self-interests. A common example of this counter claim that they employed was the need for more information. A need which often, they themselves, were in the best position to answer if only given the funding to do so. Claims such as, "We need to further examine the income breakdown of persons eligible who are not enrolled" suggest that more research is necessary before a sound solution can be adopted. It can be an effective counter to claims speculation. For example, when medical experts put forth warrants to support the conclusion of improving the quality of care, policy experts quickly countered that we "need to collect, analyze, and share the data surrounding the quality of services provided by the costs of providing the services. Then you could devise best practices that are low cost, high quality and promote their use."

Another counter claim tactic that was very cleverly employed by policy experts, was to delay action on a claim until forthcoming research would provide the insight



needed to determine whether the warrants were adequate. Let me explain what I mean by discussing the conclusions focused on expanding public programs. Early in the planning process it became clear that advocates and public representatives (state agents and citizens) favored expanding the eligibility for public insurance. Policymakers and private interests were quick to counter by questioning the political viability and associated costs of such an option. As the debate began to spiral into specifics about what the levels of eligibility and who might benefit, one policy expert deftly tabled all discussion with a simple claim that the:

uncompensated care study data will be available [next month], and should evaluate how much these groups cost to provide health services to now. If results show cost savings, this could support expansion efforts.

This “reliance on data” highlights both a strength and a weakness for the policy expert in political claimsmaking. On the one hand, for those who believe in the value of scientific evidence it provides powerful credibility or merit to the claim. To the contrary, for those who do not espouse the value of scientific knowledge, for example a rural legislator with traditional religious values, such data-based claims might be dismissed as “scientific mumbo-jumbo” and completely ignored.

Despite their expertise and focus on designing the most efficient, evidence-based solutions, claims by policy experts that did not align with the interests of other stakeholders were ignored. One policy expert mentioned that “the most successful states seem to be built on public/private partnerships. [The expert] continued to point out that expansion of SCHIP programs is good because it brings in more matching federal funding for the state to use.” However, as noted previously, any expansion of public

programs was dismissed by most planning members as not feasible within the prevailing political climate, so this option although sound and proven was readily rejected.

When policy experts were able to align their claims/conclusions with the interests/values of the stakeholders, they were more successful. For example, once small businesses were chosen as the target for insurance expansion, there was much debate over how to design the policy option. It was only after policy experts provided data and examples from other states and linked these to statistics from existing state pools, did members dismiss solutions, such as reinsurance and tax credits, and focus on risk pooling as the most viable option.

### Policymakers

Policymakers were the most important claimsmakers at the table. Since they formulate, pass, and implement policy, appeals were primarily crafted for them. Claims are their bread and butter, thus they are the most adept at the claimsmaking process. Policymakers involved in this case can be categorized into two basic categories, elected officials and state agents.

State agents comprised most of the planning group in the early stages, but first let me discuss the role of elected officials, since much of the discussion at meetings focused on how elected officials would react to any proposed solutions. Although, a part of the stakeholders' committee, both legislators and representatives from the governor's office were unable to attend meetings as regularly as other members. Thus, since they were not around, counter claims often focused on what was perceived to be politically viable to them. When present, legislators didn't say much, but when they did counter that a claim

lacked sufficient traction to garner support, that usually marked the end for any further discussion of the option. Unsurprisingly, elected officials were more reactive and did not initially propose any solutions. Instead, as good claimsmakers, they sat back and carefully gauged, not just the claims, but those making them and would only counter when they felt it absolutely necessary, demonstrating very strategic uses of their political capital.

For a politician to be a success, he must be well versed in the art of claimsmaking. Because of this, elected officials were turned to for their strong claimsmaking connections. Politicians use both their relationships or political networks and their ability to co-opt or connect solutions to seemingly unrelated issues and options in order to promote and establish conclusions. Nationally-known policy experts had similar connection skills which might, in part, explain their success in a field that largely relies on claimsmaking.

Elected officials rarely put forth claims by their own right. Instead they would craft claims to appeal to a majority of interests at that policy table. In discussing, tax breaks as the funding mechanism for small business expansion, one democratic legislator quickly countered with the ineffectiveness of tax breaks suggesting that “if we don’t have consumer buy-in, if we can’t get the uninsured, how is our product different from [an existing private plan].” Here the policymaker counters with a claim that aligns with the private interests of insurers. However, he quickly does an about face and suggests that:

HMOs have been pushing for high-deductible plans for a few years and they have been willing in the past to pay a premium tax which could then go to subsidize care for others (estimated at around \$45 million). [A representative from a large insurance company] warned this is a form of cost shifting to current participating employers. [The legislator] replied

that, in order to help small businesses, we must recognize the risk and be willing to subsidize this risk to some extent. The benefit could be to subsidize the high risk for many small businesses.

After countering tax credits, the policymaker proposed a premium tax to fund the expansion, but when that claim was countered by the private interest most effected, the policymaker quickly broadened the appeal of the claim back to the small businesses that risk their livelihood without insurance. The ability to go back and forth between interests with appeals is often portrayed as a vulnerability in the political press. Rarely does an election go by, when one candidate is accused of being “wishy-washy” or “flip-flopping” on issues. However, it is vital in political claimsmaking and when skillfully mastered it can contribute greatly to a politician’s success on the legislative floor.

State agents were much more cautious in their approach to claimsmaking. Since many are appointed or hired by the prevailing executive branch, they had to make sure that any claims they made did not counter those being put forth by the governor. If they did, they risked losing their position. Successful state agents, and here I am measuring success not in terms of claimsmaking but in years of service, put forth more diplomatic claims, being careful to counter on grounds that would not be misconstrued as advocacy. In fact, the state’s own policies prohibit any state agency or agent from advocating on any issue. Thus, the political infrastructure reinforces a more passive-aggressive culture of claimsmaking among state agents. Instead of making claims directly, the state agent in charge of the project, subcontracted a project director who could make claims in lieu of the state agent. State agents often staff and organize these types of planning activities. This allows them less obvious, but substantial control of issues, by determining who is involved or what voices are heard, they determine which claims are allowed to be

presented. Although all members of the planning committee were officially appointed by the governor, the original list of potential appointees was generated by state agents through careful deliberation with policy experts and then submitted to the governor for approval. So, despite their limited abilities in getting involved directly in claimsmaking rhetoric, state agents still play a vital role via indirectly shaping claimsmaking by structuring the players in the game and subsequently the types of claims that are anticipated to be discussed.

### Mixed Claimsmakers and the Irony of Scientific Objectivity

It is interesting to note that several planning members wore “many hats” or represented numerous types of claimsmakers simultaneously, what I called mixed claimsmakers. For example, there were policy experts who were physicians, academics who were clinicians, elected officials from the private sector and elected officials who were medical experts. These individuals were often able to craft claims of greater appeal because they are better connected with the players and interests within and across multiple fields.

Another interesting trend focused on claimsmakers who generate knowledge through the “objective” lens of science, while failing to acknowledge the social construction of policy discourse. Not realizing that their findings are merely claims, they develop justifications that legitimize their research and separate it from “advocacy”. As one national health services researcher acknowledged,

I mean at some point if you want to do something, you’ve got to go do it. You know if you really want to influence policy, you can’t just be an academic. If you’re an academic and you’re a full professor and you don’t

have to worry so much. I mean that's your opinion and that's what you think.

The expert continues on to suggest that, once secure, the academic researcher can become an advocate for specific solutions and use their data to push specific agendas. Advocates and scientists are not at the opposing ends of the spectrum as this statement would lead one to believe. Scientists are advocates, they simply advocate through objectivity. This expert has fallen into this trap, maintaining his objectivity by only presenting "the data" and then letting the stakeholders use that data to justify whatever solutions (conclusions) were warranted by the group. He fails to realize that a social problem is not an objective condition, it only exists because society conceives it to be one (Blumer, 1971). By failing to grasp claimsmaking, the expert frequently expressed the frustration underlying his statement above, suggesting that an objective scientist cannot really influence policy unless they take a stand and advocate a certain position.

## **DISCUSSION**

This case, when examined under the sociological lens of claimsmaking theory, illustrates the social construction of health policy through public policy research. Claimsmaking provides a powerful tool for understanding how stakeholders reach agreement and formulate policy recommendations. It provides insight into why some claims take precedent over others, for which functionalists theories and those based on the objective methods of science fail to accommodate. In claimsmaking there are no objective facts, only claims which are subjective to those receiving them. By acknowledging the social construction taking place, the objective mythic reality of public

policy melts away exposing the values and interests of those involved in shaping and molding the government's response to social issues. It is only by examining these competing interests and their interaction through discourse that we can understand the true motives driving public policy research and policy formation.

This research only provides a sketch of public policy claimsmaking in one environment – that of public policy research. It explores the discourse (or claims) surrounding one social problem, the uninsured, in one public arena, that of health policy. Before real insight can be gained, it is necessary to study more cases within the same arena and compare how claims are constructed around different issues in health policy by the various claimsmakers. It is also necessary to examine differing issues and players in other public policy domains before more conclusive suppositions about claimsmaking can be made.

Another limitation of the study was the lack of involvement from elected officials. Although elected officials played a vital role in structuring claims within planning grant activities, those who participated were hesitant to go on record and would not agree to be interviewed for this project. Therefore all claims data related to elected officials had to be extracted from meeting minutes and official published reports. These types of documents are often sterilized with the most controversial statements removed from the recorded or de-identified document so the public is unable to determine their source. Future research should focus more specifically on claimsmaking by elected officials in the policy process with a special emphasis on examining claims, not just made in formal public settings, but also behind the scene claimsmaking, which leads to the next limitation.

As discussed previously, there were several external policy discussions focused on the uninsured that were taking place during the course of this project of which only certain members of the planning group were perceived to be a part. As one national expert who has participated in numerous states' planning grant activities noted during an interview, "there just seems to be more behind the scenes going on than I have seen in other states." The inability to examine these backroom and offline discussions is another limitation of this study. Although, I was privy to many of the staff planning meetings and gained insight into how the grant was being structured to overcome potential counter claims, many discussions took place privately between planning members and claimsmakers external to formal planning activities that cannot be accounted for in this analysis. These were constantly evident and many of those interviewed expressed a frustration about these discussions and what might be taking place at "parallel policy tables."

One final limitation of note is that the recommended plan was never implemented. This study was limited to formal grant activities and I was not able to adequately identify why the governor, nor any legislators, chose to not move forward and propose small business risk pooling. Instead, within six months of the final recommendations being agreed upon, the governor came out with a different plan that included a form of reinsurance for small businesses. It is interesting to note that the reinsurance package was a private market solution to small businesses that was proposed during planning meetings, but none of the representatives from the insurance companies, citing data documenting the low-take up of offer, thought this a feasible solution. However, when considered by the group, it would have been a completely private entity. As put forth by



the governor, it was a public/private partnership that may have proven more lucrative to insurers. Regardless, even this solution got caught in claims leveled at the larger health expansion package being proposed and the governor was forced to rescind the policy (which was enacted through an emergency executive order) and seek legislative support.

I was unable to examine the “official” plan of action nor understand what, if any, influence planning grant recommendations might have had on the formulation of this plan. Since neither of the plans were enacted, I was unable to examine implementation of any plan, or Blumer’s fifth stage (1971). Research examining how claims get transferred and transformed between stages is crucial to understanding the policy development process.

Despite these limitations, this research can inform our understanding of how public policy is shaped by experts and researchers. It highlights the role experts play in the social construction of public policy through claimsmaking. Going back to my introductory example, the OMB is merely another claimsmaker, in this case, they represent claims made by the President of the United States or his executive office. The Congressional Budget Office (CBO) is also a claimsmaker in public policy, however they represent wholly different interests, those of the legislature. This is why, for the same social problem, the “research findings” of OMB and CBO reports often contradict each other. The data and their conclusions are claims themselves and must not be taken on their own right, but considered within the larger claimsmaking process. They are not presenting objective “facts” about reality, but instead are attempting to construct reality through their own subjective claims. Think tanks, clinical researchers, and social

scientists often stake their reputations on crafting and negotiating claims, even though they do not recognize claimsmaking as central to their work, nor discuss it as such.

Exploring claimsmaking in the public policy research setting has great potential to contribute to future research. First, by comparing cases of claimsmaking within and across differing public policy domains and social problems, and contrasting conditions when certain claimsmakers, especially those who directly create and implement public policy, like elected officials and state agents, accept and reject claims, it is possible to generate a theory delineating when policymakers are more open to accept the claims of social scientists and policy analysts. Understanding this can help social scientists better craft their claims or couch their data, reducing the likelihood their results and conclusions will be ignored. Second, as mentioned previously, it provides a framework for understanding the “process of collective definition” (Blumer, 1971) and how the researcher, scientist or medical expert contributes to the social construction, in this case, the claimsmaking of public policy. Last, it highlights the role of the researcher in translating science into policy practice and stresses the role that reflexivity plays in public policy research.

From a more practical standpoint, this research can inform claimsmakers’ own activities within the public policy arena. Often times, as in the research, organizations focus on claimsmaking at the broad public, or macro level. While these activities establish grassroots movements and help define social problems, once the grounds have been accepted, claimsmaking shifts to the meso and micro levels, as more select groups of individuals and organizations meet to hash out policy recommendations. Foundations,

academics, and advocates who want to really impact policy and see their conclusions adopted as the solution, should target more resources at meso and micro level activities.

Fox (2006) suggests three strategies foundations could employ to have a greater impact on policy. These can provide a useful guide to claimsmakers in the public policy arena. First, claimsmakers need to be responsive to policymakers' needs. This includes not simply becoming a source of information with access to the data and published materials, but also, being aware of the policymakers own claimsmaking position. Knowing what they can or cannot say about an issue can prove vital in shaping an appealing claim. Second, claimsmakers need to engage in circumspection. They need to be aware of the circumstances under which their claims are made to effectively anticipate and overcome potential consequences or counter claims. Third, claimsmakers need to maintain what Fox termed "continuity" but in claimsmaking is more what I term comprehensiveness. Since priorities and problems often arise quickly or change in the policy arena, claimsmakers must keep current on the latest claims and conclusions surrounding a plethora of issues, even those that are "off the radar" because that issue may emerge suddenly as tomorrow's leading social problem. Comprehensive claimsmakers are ready to incorporate these waves and craft new or reconstruct claims to address and co-opt the underlying values being expressed by using arguments that link prior claims to the appeals of the emerging trend. By doing so, they are able to breathe new life into failed claims and resubmit them for consideration. By paying close attention to emerging issues and being willing to adapt former claims to co-opt popular appeals, claimsmakers improve their chances of seeing their conclusions become viable policy options.

Understanding claimsmaking as it plays out in public policy can provide a vital tool. If you understand a claimsmakers values and interests and are aware of their connections to other claimsmakers and other issues, you are better able to predict their reaction to your own claims. You can anticipate potential counter claims that may arise and be ready with further claims to debunk these counters. Lobbying firms and insider groups have made this a true art in public policy and a lot can be learned from applying their claimsmaking strategies and practices. If experts and research scientists want to leave their ivory towers and truly influence public policy, then they need to think like policymakers and couch their data in claims that appeal to the way people in government think and feel about an issue.

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