

Welfare State Eras, Policy Narratives, and the Role of Expertise: The Case of the Affordable Care Act in Historical and Comparative Perspective

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Abstract This article presents a way of understanding the linkage of expert and public opinion through a focus on policy narratives, which serve as deliberately crafted rhetorical bridges between expert discourses and broader cultural experiences. Across advanced nations, the dynamics of this bridging function has differed in different phases of policy development (such as welfare-state establishment, retrenchment, and redesign), depending on the state of discourse in each realm. In the establishment phase in which most programs of universal health care coverage were adopted, expert discourses were relatively synchronized with but subservient to broader policy narratives about collective and individual rights and responsibilities. The United States, in contrast, pursued its final sprint toward universal coverage in a later phase, in which the policy analysis community had greatly expanded and expert discourses had evolved to focus on specialized issues of system redesign. The resulting highly complex technical design did not readily align with an epic narrative of public purpose. Advocates instead relied principally on two narrative lines: an aggregation of anecdotes that was vulnerable to the simpler opposition narrative of an overweening state, and a crusade narrative that met the opposing narrative of patriotic resistance on its own terms but could not allay partisan polarization.

Keywords policy narratives, policy analysis, Affordable Care Act, politics of health policy

How did the Affordable Care Act (ACA), which extended health insurance coverage to something on the order of 6 percent of the American population, become a fulcrum of ferocious political opposition to the Obama presidency? Why was the level of conflict so disproportionate to and disconnected from the material implications of the policy, and why, despite the

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large body of expert analysis that underlay the legislation and the relative consensus of support among health care elites, did its proponents find themselves at a disadvantage in the public arena? One way of unraveling these puzzles is to explore the power of narratives in public policy, and in particular their implications for the linkage of elite, expert, and public opinion. In different welfare-state eras, policy makers crafted “policy narratives” that bridged with varying degrees of success the expert, science-based discourse of policy analysis and the cultural and experiential narratives prevailing in society as a whole. But the “goodness of fit” of expert and public discourses has varied over time, and I argue here that a disjunction between the two realms lies at the heart of the puzzle of the politics of the ACA.

In most other advanced nations, universal health care coverage was adopted in founding moments of welfare-state establishment, in which expert discourses were relatively synchronized with but subservient to broader policy narratives about collective and individual rights and responsibilities that connected to “grand” cultural narratives of the time. The United States, in contrast, pursued its final sprint toward universal coverage in a later phase of welfare-state development, in which the policy analysis community had greatly expanded and expert discourses had evolved to focus on specialized issues of system redesign. The ACA was an expert-driven, highly complex technical compendium of policy changes, whose advocates struggled to find a narrative purchase on the public imagination and whose attempts proved vulnerable to a simpler opposition narrative of an overweening state.

The Power of Narrative in the Policy Process

The term *narrative* is widely used and much abused in discussions of the policy process. It is often used as synonymous with *rationale*. But these concepts belong to distinctively different spheres of discourse: a rationale is grounded in logical argument; a narrative exists in the realm of the collective imagination. As a distinctive form of discourse, a narrative takes the form of a shared *story* that engages the imagination by appealing to aspects of lived experience. It sets a context, follows a plot, and typically involves the personification of forces in characters who (individually or as groups) may be heroes, villains, or victims. By sharpening certain features of reality and suppressing others, it can serve both as a means of communication (as a form of rhetoric) and as a method of cognitive organization in the face of ambiguity or complexity (Jones and McBeth 2010;

Hajer and Laws 2006). Other rhetorical devices can also perform these communicative and cognitive functions, but as I discuss further below, they lack the distinctive dynamic tension of a narrative.

Narratives may be organic or crafted, although this distinction is best thought of as a continuum rather than a dichotomy. Organic narratives arise and evolve in conversation and exchange within communities of discourse as humans seek to find order in their shared experience. Religious and national myths of origin are quintessential examples of such cultural narratives, as are more contemporary and more transient “viral” stories that spread on social media and/or face-to-face conversation (Akerlof and Shiller 2009). Crafted narratives, on the other hand, are deliberately created for a purpose—to persuade, to enlighten, to entertain, and so on.

Policy narratives are a form of crafted narrative, developed to present a policy problem and proposed solution. They are thus framing devices of a particular type. Other framing devices include metaphor, synecdoche, and signal. A policy *metaphor* presents a frame for a particular policy by likening it to another, familiar social institution. For example, health care may be described as a “right,” thus evoking a comparison to a constitutional order (Schlesinger and Lau 2000). *Synecdoche* uses (and typically exaggerates) one feature of a policy to stand for the whole, often using stereotypes, to symbolize what is good or bad about it (Stone 2012: 168–71). For example, the individual mandate in the ACA was presented by opponents as symbolizing government overreach. *Signals* are “hidden messages”; the use of numbers and mathematical constructs (such as “bending the cost curve”), for example, can signal the authority of the presenter (Stone 2012: 193–97). A policy narrative may use such rhetorical and signaling techniques, but it has its own separate character and power.

The power of policy narratives derives from two distinctive features, each of which engages the imagination and emotions in ways intended to make the audience *care* about the outcome. First, policy narratives follow a storytelling arc, describing the “plot” that has generated the problem and offering a satisfying resolution of the tension thus created. These stories may be sweeping epics or more intimate anecdotes. In Deborah Stone’s (2012: 158–65) terms, some are “stories of rising,” instilling hope; other are “stories of decline,” instilling despair or fear. Second, narratives have the capacity to evoke *empathy* for certain characters, even within more modest story arcs.

The narrative theorist Suzanne Keen has usefully distinguished between various types of narrative empathy: “bounded” empathy within an in-group,

“ambassadorial” empathy evoked by representing members of one group to a broader audience, and “broadcast” empathy connecting with universal aspects of the human condition. Different narrative techniques can evoke empathy by inviting the audience to identify with characters in the story and/or to situate themselves within the narrative (Keen 2006, 2011). Keen’s work concerns narrative fiction, but in the policy context these different types of empathy have especially important implications for coalition building, as coalitions form around and are held together by shared story lines and compete with one another to “organize a policy domain” (Hajer and Laws 2006: 206). Her three types of empathy differ in the scope of their reach and in the robustness of their appeal. In particular, she argues that broadcast empathy has the capacity to “emphasize commonalities that persist across time, distance, and cultural barriers.” Bounded empathy, while less sweeping in scope, “may rely on accustomed, routine, or even proverbial understandings shared by the in-group to which it is addressed.” Conversely, ambassadorial empathy must overcome higher barriers to the flow of “fellow feeling”: it cannot rely on such commonalities or understandings and “needs to *explain* as it renders the situation to strangers” (Keen 2011: 371, emphasis added).

Even as they divide by forging contesting coalitions, narratives can also serve a bridging function across communities of discourse. Of particular relevance here is the capacity of crafted policy narratives to bridge from the world of science and empirical analysis to the sphere of experientially based public discourse by connecting to organic narratives that have cultural currency. As Fischer (2009: 192) puts it, “Ordinary actors—citizens and politicians—largely connect the two spheres through a narrative form of understanding . . . [testing scientific knowledge] against their narrative interpretations of social purposes, political intentions, underlying motivations, and basic value orientations.” Policy narratives can thus be seen as integrating the two forms of knowledge identified by Allen Schick (1991) as essential to the legislative process: policy research and the biased, unsystematic observations of everyday life that he terms “ordinary knowledge.”¹ Narratives and counternarratives select and augment the empirical evidence within different narrative frames.

With this understanding of policy narratives, this article offers four arguments to illuminate the struggle of advocates of the ACA to gain public support. First, policy narratives attempt to situate policies within prevailing

1. Although this article focuses on the role of policy narratives in communication and mobilization, the cognitive function of narratives in shaping the way policy makers think presents an equally important set of research questions.

cultural narratives.² Second, policy narratives make these connections by engaging other narratives on their own terms—that is, as stories with common elements (arc, plot, characters, etc.)—rather than by attempting to prove or disprove the validity of narrative claims through other means such as adducing scientific evidence. Third, different narratives may be more or less effective depending on the type of empathy they evoke. Fourth, notwithstanding their structure as stories, policy narratives retain their footing in the world of policy design. The challenge of crafting effective narratives will therefore depend on the goodness of fit among the design of the policy in question, the policy narrative, and the prevailing cultural narratives of the time.

Policy Narratives and Expert Discourse in Different Phases of the Welfare State

The welfare state in advanced democracies evolved through three broad eras, defined by agendas of establishment, retrenchment, and redesign—each marked by a distinctive type of politics. This evolution progressed in a broad historical sequence from the middle decades of twentieth century to the present, marked by some periodical cycling. The initial establishment phase evinced the classic redistributive form of politics, marked by class conflict, ideological debate, and contests among peak associations representing powerful interests (notably business coalitions, labor federations, professional associations). The retrenchment era, in contrast, characterized by a politics of “stealthy” changes to distribution formulas and/or blunt changes to budgets, encountered opposition from now-entrenched interests, both providers and beneficiaries of welfare-state benefits. The era of redesign, which flowed from dissatisfaction with the ineffectiveness and political costs of retrenchment policies, created opportunities for new ideas, new combinations of instruments, and new coalitions of interest (Pierson 2001).

Each era also has had a distinctive set of policy narratives, crafted by policy makers to link policy objectives to the broad cultural ethos (or grand narrative) of the time. Among other things, those policy narratives mediated the role of expertise in the policy process. Over the same time period, expert discourse among policy analysts evolved as well, through phases roughly contemporaneous with those of welfare-state evolution. Glied and Miller (2015) have insightfully traced the progression the discipline of

2. This is analogous to the way that policy metaphors draw their strength from likening a given policy to a familiar and popular social institution (Schlesinger and Lau 2000).

economics through three overlapping phases over the twentieth century: detailed descriptive institutional research (in the first five decades), theory building (in the middle three decades), and applied empirically based estimation of the effects of policy parameters (in the last two decades and into the millennium). With only modest adaptation, these phases capture the nature of the evolution of the policy-relevant social science enterprise more generally and cross-nationally. From a slim foundation in the periodic social surveys and administrative data in the first half of the twentieth century, the empirical base for policy-relevant research mushroomed during the century. In the latter three decades computational technology exponentially increased analytic capacity. The sheer size and complexity of the “policy sciences” exploded. In each welfare-state era, the role and impact of expertise in the policy process have depended on the state of expert discourse at the time, the fit of that discourse with the broad agendas and politics of establishment, retrenchment or redesign, and the capacity of policy narratives to provide rhetorical bridges between expert and public discourse.

The Era of Establishment

In most advanced nations, the modern welfare state took its fundamental shape in the mid-twentieth century, at a time when large swaths of the population had lived experience of the disruptions of economic depression and war. Policy agendas were dominated by national projects of rebuilding the physical and social infrastructure. The political climate in which these projects were undertaken was marked by the broad politics of redistribution as classically described by Lowi (1972) and by contesting grand narratives about the success or failure of the state and social institutions and about the resilience of individuals and societies. In this crucible, different nations came to different settlements that would set the parameters of the welfare state and the understanding of the bounds, rights, and obligations of social citizenship. In almost all advanced nations except the United States, universal or quasi-universal coverage for health care services was established as part of these settlements. Each of these different settlements in turn offered a new narrative—a “founding myth” of the health care state. A comparison of Britain, Canada, and the United States can illustrate this point.

Britain. In Britain, the elements of a vision for the postdepression, postwar era were set out in the hugely influential Beveridge Report of 1942. Lord Beveridge framed his recommendations within an epic narrative of

combating “five giant evils”: want, idleness, disease, squalor, and ignorance. He looked ahead to the end of the war and depicted combating these evils as the nation’s next challenge in a grand postwar reconstruction project: “Now, when the war is abolishing landmarks of every kind, is the opportunity for using experience in a clear field. A revolutionary moment in the world’s history is a time for revolutions, not for patching” (Beveridge 1942: 6).

The extent to which this narrative connected with the British wartime zeitgeist is evidenced by the massive and incongruous popularity of the report. Whiteside (2014: 1) records that “queues at the government bookshop signaled the eventual sale of half a million copies, outselling any official report on any topic to date” and that “a shortened version was distributed by the Ministry of Information to British troops to foster morale.”

The Beveridge Report proposed to combine the piecemeal congeries of means-tested benefits then in existence into a single plan of compulsory social insurance distinguished, in Beveridge’s words, by the fact that “it is compulsory and that *men stand together with their fellows*” (Beveridge 1942: 13; emphasis added). Although most benefits were to be tied to compulsory contributions within classes defined by relationship to the workforce, for health care even the contributory principle was dropped: health care would be provided to for all citizens by a national health service “where needed without contribution conditions in any individual case” (159).

The narrative empathy created by Beveridge’s formulation was of the broadcast form described by Keen: an appeal to universal aspects of the human condition, albeit within the bounds of a single nation-state. All citizens were experiencing the disruptions of war and looking for the promise of postwar reconstruction. In the public imagination, the decoupling of contributions from both means and risk and, in the case of health care, the complete decoupling of benefits from contributions came to mean that benefits would be provided “as of right, based on need” to all citizens “from cradle to grave” (Whiteside 2014: 6).

The expert evidence to support this narrative was assembled by the civil service staff that supported Beveridge’s inquiry. It was very much of the “institutional research” type described by Glied and Miller (2015) as characteristic of the time. It was aimed at demonstrating both the need for a universal program (drawing on administrative data on current coverage from various sources, survey data on household expenditures and demographic projections), and the wherewithal to provide such a program (drawing on administrative data on current and projected costs of existing programs, including evidence from other nations).

In the postwar election in 1945, the Labour Party wrapped itself, as Steven Fielding colorfully puts it, not in the flag but in the “pages of the Beveridge report” (Fielding 1992: 633–34). Labour’s landslide victory solidified the grip of the Beveridge narrative on the public imagination. In health care in particular, the very language of the new model—the National Health Service (NHS)—signified the founding myth of the NHS as a national institution. The persistent power of this myth is reflected in a continuing public reverence for the NHS manifested by the featuring of an NHS sequence in the opening ceremonies of the London Olympics in 2014.

Nonetheless, had the Beveridge vision for health care not been anchored in a durable structure, incorporating the principal providers into a quasi-corporatist, regionally tiered hierarchy, it would likely have gone the way of the rest of his recommendations before the power of the myth could become embedded in the public imagination. Without such an anchor, the cash benefit components of his plan “drifted back towards more traditional systems of welfare administration in the decades following the war” (Whiteside 2014: 12).

Canada. The Canadian single-payer model of universal hospital and physician services insurance was also the product of its time, in this case the buoyant economic conditions of the 1960s, an extraordinary period of province building and cooperative federalism and the uplifting narrative of a nation coming of age as Canada approached its centenary in 1967. It was in this crucible that the major pillars of the federal-provincial architecture of the contemporary Canadian welfare state—contributory public pensions, social assistance, and universal physician services insurance³—were established in an extraordinary spate of landmark legislation in 1965 and 1966.

In health care, the vehicle for expert input into this process was the 1961–64 Royal Commission on Health Services, chaired by the eminent jurist Emmett Hall. Evidence was gathered through two distinct streams: a series of cross-country public hearings held by panels, including all or most of the seven commissioners, and research conducted or commissioned by the commission’s research directorate. The streams were connected largely

3. A federal-provincial framework of universal hospital insurance had been put in place in the late 1950s, but in the 1950s and 1960s hospitals in Canada, as in the United States, functioned essentially as “physicians’ workshops” or “physicians’ cooperatives” under the de facto control of their medical staffs (Pauly and Redisch 1973). Governmental hospital insurance essentially underwrote the costs of these “workshops” while still leaving patients at risk for the costs of the medical services provided therein. It was therefore the adoption of physicians’ services insurance in 1966 that transformed the profession-state relationship and instituted the modern Canadian health care state.

through the commission's chair; the other commissioners were less inclined to read the voluminous research output (Boan 2009: 542).

The growth and maturation of the health policy community over the two decades after the 1940s are evident in the Royal Commission's reliance, to a greater extent than had Beveridge, on academic expertise, and in particular in its greater reliance on health economics. The research director was an academic sociologist, and the six research consultants included five with either current or future academic bases—three economists, one political scientist, and one physician—plus a practicing lawyer. The voluminous report included twenty-six commissioned studies that drew on the state of the art that also characterized expert discourse in the United States at the time (as discussed below). Accordingly, the preponderance of evidence and analysis still rested in the “institutional description” mode identified by Glied and Miller (2015), but some studies also reflected the emergence of theory building, especially regarding the economics of health care as an investment in human capital, as well as other economic benefits.

As in Britain, these studies provided evidence of both the practical need and the wherewithal for universal coverage. Data on demography, income distribution, and insurance costs were adduced to argue for a universal program on the grounds that “the number of individuals who would require subsidy to meet total health services costs is so large that no government could impose the means test procedure on so many citizens, or would be justified in establishing a system requiring so much unnecessary administration” (Royal Commission on Health Services 1964: 743–44). Similarly, the report recommended wrapping the existing hospital insurance program into a new, more comprehensive model “in order to achieve full integration of all health services, and thus to obtain the most efficient administration of all sectors of the proposed health services program” (744).

But the rhetorical centerpiece of the commission's report—a Health Charter for Canadians—emerged not from the research directorate (to whom it came as a somewhat unwelcome surprise [Boan 2009: 543]) but from Hall himself, drawing on the discourse of human rights that had gained prominence in the postwar period. More even than Beveridge had done for Britain, Hall situated Canada in the context of an international community of democratic nations. He referenced Canada's membership in various UN organizations and cited both the right to health enshrined in the 1946 constitution of the World Health Organization and the 1961 papal encyclical *Mater et Magistra*. Invoking the threat of totalitarian regimes he argued that, “if a democracy fails to meet the legitimate aspirations of its people there can be few who doubt that alien philosophies will win the

right to try” (Royal Commission on Health Services 1964: 6). Even more than in Britain, this was an evocation of universalizing broadcast empathy.

Nonetheless, the Health Charter was presented as the narrative spine of a story of distinctively Canadian compromise of “private practice, public payment” (Naylor 1986): between left and right, individual and collective responsibility, personal choice and social cooperation, professional freedom and public finance, and provincial jurisdiction and federal financial assistance under certain unifying principles. Those principles included universal and comprehensive coverage but also commitments to “free and self-governing professions” and (echoing Beveridge) to the responsibility of individuals not only to cooperate in their own health care but also to “allocate a reasonable share of [their] income (by way of taxes or premiums or both) for health purposes” (Royal Commission on Health Services 1964: 12).

In contrast to Britain in the 1940s, however, universal health care did not figure prominently in the popular cultural narratives of Canada’s coming of age in the 1960s. Public opinion polls showed a landscape of opinion about health care quite similar to that in the United States at the time, namely, a balance of opinion that favored voluntary insurance with government support for the poor (Tuohy 1999: 114–15). Rather, the establishment of the Canadian single-payer system was elite driven and hammered out in negotiations between and within the executives of the federal and provincial governments. The simplicity of the federal “principles” such as universality and comprehensiveness that would govern federal transfers was a tactical choice within that context.

But the Hall Commission had succeeded in crafting a policy narrative that linked the everyday experiences of Canadians to an epic of emerging democratic rights, to create expectations about health care rights and responsibilities that became the founding myth of the contemporary Canadian health care state. Over time, this distinctive Canadian model became, like the NHS in Britain, a national icon and a defining feature of Canadian identity (Tuohy 2018: 124). Yet, also as in Britain, it was sustained not only in the public imagination but also in the particular institutional dynamics it created: it established a bilateral monopoly over physician and hospital services between the state and the medical profession that would persist as the central political axis of Canadian health care.

The United States. There were two moments, close in time, when universal health care might have been adopted in the United States within a sweeping response to an epic national challenge. The first was Franklin Delano Roosevelt’s New Deal response to the Great Depression in the 1930s. But

health care was not yet seen as linked to economic recovery: employer-based coverage was not widespread, and health costs were not seen as a drag on the economy. For these and other reasons that continue to be debated among political historians, health care was omitted from the New Deal centerpiece, Social Security. Health care was centrally taken up by Roosevelt's successor, Harry Truman, who situated universal coverage within a national postwar rebuilding epic (as in Britain) and explicitly linked it to the emerging discourse of universal rights (as in Canada two decades later). Truman seized upon a narrative frame introduced by Roosevelt a year earlier to present "health security for all" as a component of an "Economic Bill of Rights" (Truman 1945). In the face of entrenched opposition, not least within his own party, Truman failed in this attempt. What flowed in the wake of these two moments were partisan epic narratives of universal health care as the object of a struggle and a fight. For Democrats, this was a narrative of unfinished business; for the Republicans, it was about resistance to creeping socialism. These polarizing narratives never yielded consensus and fed a media preoccupation with scorecards of wins and losses.

The one major advance in public coverage for health care—the establishment of government programs of Medicare for the elderly and Medicaid for social assistance recipients in 1965—was accomplished in a context of expert and public discourse quite different from those in either Britain or Canada. The expert community, chastened by failure in the Truman era, had narrowed its sights to focus on coverage for the elderly. In the broad public realm, rights discourse principally connoted civil rights, and invoking health care in that context was counterproductive, triggering fears (especially in the American South) of desegregated health care facilities (Marmor 2000: 88). Rather than evoking a broadcast empathy of universal needs and rights, the American narrative was therefore one of "ambassadorial" empathy for the aged (and to a much lesser extent for the poor). But it also appealed to self-interest: one's own contributions to the social insurance plan would secure one's own benefits in the future. This narrative was also presented as a distinctively American story of the continuity of the American insurance-based system.

President John F. Kennedy's rhetoric in support of his Medicare proposals combined anecdotes about older Americans exhausting their savings to cover health care expenses with arguments about the relative modesty of a plan that would build upon the established (and popular) Social Security program to provide compulsory contribution-based coverage for the elderly (Hopper 2017: 117). Kennedy's effort failed, but he had established the

narrative lines of empathy for the elderly and fidelity to an American insurance model that would continue under his successor. President Lyndon Johnson, signing the Medicare/Medicaid legislation in 1965, briefly invoked universal principles of solidarity (citing scripture) but then emphasized the insurance function, characterizing the legislation as ensuring that “every citizen will be able, in his productive years when he is earning, to insure himself against the ravages of illness in his old age” (Johnson 1965).

However, the principal narrative arc of Johnson’s address, comprising more than half of the 2,550-word text, was the long struggle for passage of national health insurance. Johnson acted out that narrative by signing the bill in Independence, Missouri, in order to honor former President Truman in his home town, and by calling the “honor roll” of others who had fought for government insurance, including fourteen other Democratic members of Congress and the administration, and President John F. Kennedy. This essentially partisan narrative of struggle against opposing forces in the American political system is hardly one of national solidarity. But it was to take hold as a cultural narrative within the Democratic Party and to persist as an ongoing theme of discourse in the decades ahead.

Meanwhile, the founding myth of the US health care state as “insurance” established itself in the public imagination and was reinforced by a structure of interests in which private insurance remained the norm (and Medicare itself was carried by private insurers). Medicare drew its legitimacy not from its base in the state but from its conformity to the prevailing private insurance model.

The expert discourse of the day, which was still principally located within Glied and Miller’s (2015) descriptive institutionalist mode, was congruent with but subservient to a policy narrative of evolutionary change within the American insurance-based system. Writing at the time, Odin Anderson (1966: 11) remarked on the “instrumental” nature of policy-relevant research, arguing that research typically followed the lines of policy debate and that “systematic data-gathering and research do not appear until a public policy consensus emerges providing a framework for social and economic research bearing on policy.” In Anderson’s account, the ideological contests of the 1940s were reflected in research activities as well and largely blunted any independent impact that research might have had.⁴ Subsequently, however, the growing consensus around voluntary private insurance as the norm for coverage and the focus of public policy

4. For example, studies of health care as an “investment” in human capital were inextricably bound to advocacy for increased public coverage (Fox 1979: 320–22).

on coverage for the elderly provided a common channel along which research (largely in the “instrumental” institutionalist mode) could flow, funneling into the policy process through vehicles such as the White House Conference on Aging in 1961 and, importantly, administration insiders with academic connections. The quintessential example of such an insider was Wilbur Cohen, the ever-pragmatic economist who moved between academic bases and increasingly senior positions in the Department of Health, Education, and Welfare in the Kennedy and Johnson administrations.

Medicare was enacted just at the time that health economics was transitioning from its institutionalist to its theory-building phase. Daniel Fox describes two national conferences on health economics in 1962 and 1968 (thus bracketing the point of Medicare enactment) that dramatically illustrate this transition. In 1962 the papers presented discussed “practical issues in organizing and financing care, the cost and efficiency of hospitals, and the evaluation of programs . . . [using] mainly qualitative methods.” By 1968, “the contributors worked with the dominant, mainly mathematical methods and concepts of the discipline” (Fox 1979: 323). This shift to model building came too late to affect the Medicare process, but it signaled the beginning of a transformation of the role of academic expertise in the policy process in the age of redesign.

The Era of Redesign

The period of health-care-state establishment was followed by an overlapping sequence of retrenchment and redesign. In the 1970s and 1980s, as health care generated steadily rising costs to the public treasury and periodic economic shocks together with the rise of tax-reduction agendas curtailed the increase in revenues, governments found themselves in a fiscal squeeze. The first response was retrenchment (Pierson 1994), the timing of which varied across nations and policy sectors. Under an overall cross-national policy narrative of an overextended state, served by evidence of current and projected public revenues and expenditures, retrenchment was marked by blunt across-the-board cuts as well as stealthy, less visible strategies aimed at cost shifting among payers and adjustments in payment formulas. Although initially accomplished largely through complex budgetary politics conducted for the most part out of broad public view (Hacker 2004; Tuohy 2003), retrenchment encountered strong opposition from now-entrenched interests, both providers and beneficiaries, especially as it became less stealthy and more overt in the 1990s. As Pierson (1994, 2001) and others have demonstrated, the welfare state on balance proved

remarkably durable in the face of these attempts at retrenchment, although there were significant variations across nations.

During the 1980s and 1990s, the ineffectiveness and political costs of blunt retrenchment measures led increasingly to a search for ways to improve the effectiveness and efficiency of welfare-state programs through redesign, focusing on altering incentives and triggering a miscellany of reforms. Both the Right (Reagan in the United States, Thatcher in the United Kingdom, and Lubbers in the Netherlands) and the Left (Clinton in the United States, Blair in the United Kingdom) embraced a reigning policy narrative that came to be epitomized by books such as Osborne and Gaebler's *Reinventing Government* (1993): the old debates about the size of government were stale, and what was needed was to make government "smarter" and more effective, often by leveraging resources in civil society and market dynamics rather than through direct action.

Among the coalitions of interest and advocacy that characterized the redesign era was an academic community of policy analysis transformed almost beyond recognition, in both size and sophistication, from that which had existed in the mid-twentieth century. From the 1940s to the present, for example, the number of scholarly publications and reports in health economics and health services research grew by factors of about 300 and 600, respectively (figure 1), reflecting the growth of academic inquiry as a whole.⁵ One of the principal focuses of inquiry was the understanding of incentive structures in health care delivery systems, insurance markets, and public programs. One of the principal results of this focus, from a policy perspective, was the growing interest in "market-oriented" reforms of public services in many Organisation for Economic Co-operation and Development nations (see, e.g., Saltman and von Otter 1992; Peterson 1998; Ranade 1998; Rice et al. 2000). Ideas emanating from the academy came to dominate policy discourse, none more than Alain Enthoven's proposals for "managed competition" (Enthoven 1978). Intriguingly, Enthoven's ideas found their greatest policy purchase outside the United States, where they influenced the redesign of systems of universal or near-universal coverage in the United Kingdom and the Netherlands (Tuohy 2018).

It was the fate of the United States that, were it finally to achieve universal health care coverage, it would have to do so in an era dominated not

5. Figure 1 shows counts of publications in academic journals, books, conference proceedings, dissertations, and reports. The inclusion of "reports" recognizes that foundations and think tanks as well as universities have provided significant bases for policy-relevant research, especially in the United States and the United Kingdom.

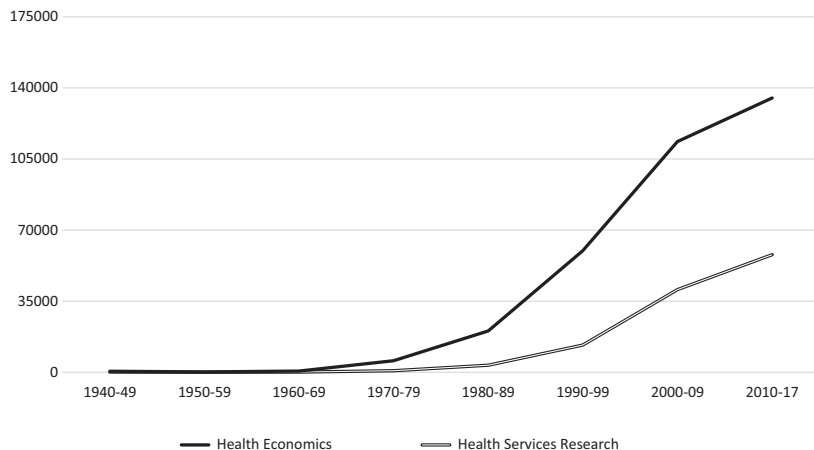


Figure 1 The Growth of the Academic Health Policy Community, 1940–2017: Scholarly Publications and Reports in English, by Subject, 1940–49 to 2010–17

by grand epic narratives of national solidarity or universal rights but by an expert discourse of market-oriented redesign. By the time Bill Clinton picked up the torch in the early 1990s he could draw on a substantial body of expertise in universities and think tanks, sufficient to populate a “task force” process involving more than five hundred analysts.⁶ And although there were most definitely divisions of opinion within that community, including different ideological positions, it was dominated by a subscription to models of regulated and subsidized private insurance as the route to universal coverage. The growing sophistication of econometric methods noted by Glied and Miller (2015) fueled the production of estimates of the effects of various models, including fiscal impacts as well as coverage implications. Importantly, an institutional venue for feeding such calculations into the policy process had arisen in the form of the Congressional Budget Office, an agency that had not existed before 1975.

In the case of the Clinton plan the dynamic that had characterized the establishment of universal health coverage in the mid-twentieth century in other nations was reversed. Rather than enlisting expert evidence in the service of a broader narrative of solidarity and rights, this was a case of an

6. The task force itself was a small group of twelve, chaired by Hillary Rodham Clinton and comprising the members of the National Economic Council and the secretary of health and human services (Jacobs and Shapiro 2000: 364). The task force commissioned a broader advisory process led by Ira Magaziner and organized into thirty-four working groups.

expert-driven plan in search of a narrative, and finding a narrative that could render the framework understandable to a public already daunted by the growing complexity of health insurance options proved impossible.

The Clinton plan was, conversely, easy to caricature, as famously demonstrated by the “Harry and Louise” advertising campaign of the then Health Insurance Association of America, which anecdotally depicted a suburban couple who are initially supportive of presidential action on health care reform. Confronted with the insurance options that would purportedly be available to them under the Clinton proposal, they turn against the plan and complain, “Having choices we don’t like is no choice at all.” The narrative moved the couple from concern for those without health insurance to concern about the impact on people such as themselves who currently had health insurance—in Keen’s terms, it sought to engage the broad swath of the population in a shift from ambassadorial empathy (using the characters as a situational bridge to others less fortunate) to bounded empathy (through identification with the characters themselves). The running of the ads was correlated with a reversal of a trend of increasing support for the Clinton initiative (Goldstein et al. 2001). The causality behind that reversal is open to dispute, but there is no doubt that it was credited in elite opinion (including reporters, legislators and their staffs, and administration officials) with contributing to the demise of the Clinton plan (West, Heith, and Goodwin 1996; Jacobs and Shapiro 2000: 184; Singer 2009).

The Affordable Care Act

At first it appeared that Barack Obama, one of the most gifted orators in American presidential history, might be able to forge a compelling narrative drawing on both epic challenges and empathy-evoking personal stories. These two quite different narrative techniques characterized much of Obama’s public statements on health care, although the balance between them shifted over time.

Obama was a master of the sweeping historical narrative, as evidenced in a preinauguration trip from Philadelphia to Baltimore to Washington touching the bases most closely associated with America’s founding myth—the writing of the Declaration of Independence in 1776 and the site of the defeat of British troops in the 1812 battle memorialized in the American national anthem. In Baltimore he paid tribute to the “patriots” of each of those events and vowed to “take up the cause for which they gave so much,” to issue a “new declaration of independence,” and to meet the

severe challenges of the current moment—economic crisis, foreign wars, and global warming (Obama 2009d).

In other venues, Obama sought to link health care to the overarching economic challenge, largely by pointing to the burden of health costs on the federal deficit, on business bottom lines, and on household budgets and to the precariousness of employer-based coverage for workers whose jobs were at risk. Leimbigger and Lammert (2016) demonstrate the dominance of this frame in Obama’s speeches prior to the passage of the ACA. But although the challenge of health care coverage could be presented in these epic terms, the policy response favored by the Democrats did not fit.

Disconnect with the Policy Response

The policy response drew upon the universe of ideas about market-oriented reform that had continued to develop since the last attempt at universal coverage in the 1990s. Cross-nationally, universal systems were engaged in redesign to incorporate market principles within the public sector and/or to integrate public and private finance in tightly regulated markets. But in these cases the principle of universality was taken as given.⁷ Designing these market-oriented models—and understanding the resultant designs—required an appreciation of incentive structures in health insurance markets and health care delivery. The health exchanges, individual and employer mandates, and overall regulatory architecture of the ACA were all conceived within this context.

In the United States this was a context marked by “conceptual pluralism” (Hoffman 2011), with at least three dominant rationales for reform in some tension with each other. A “health promotion” focus held that health insurance would encourage individuals to seek care early and thus most cost-effectively. A “financial security” rationale saw insurance as necessary to limit financial risk from unexpected costs. A “brute luck” rationale was that insurance should protect individuals from circumstances beyond their control but should also include incentives for them to take what steps they could to mitigate risk. A similar discordance across objectives was evident in surveys of panels of health care opinion leaders regarding the ACA that was conducted for the Commonwealth Fund. One, in March 2010, found broad consensus about the potential of the reform package to improve access to insurance for the previously uninsured, but also found

7. Indeed, in social insurance systems such as Germany, the Netherlands, and France, *de facto* universality was being institutionalized *de jure*.

considerable skepticism that it would improve affordability for those already insured or begin to control costs (Commonwealth Fund 2010). Nonetheless, and notwithstanding some differences in the intensity of support for the various elements of the ACA, a second panel of opinion leaders favored its implementation by substantial majorities ranging from 64 to 86 percent (Commonwealth Fund 2011).⁸

Once again, as in the Clinton case, this was an expert discourse and an expert-driven plan in search of a compelling narrative bridge to public acceptance. The lingua franca of the expert community was marked by idioms and catchphrases that belonged to the world of science. This was not a knowledge base that yielded its own publicly accessible narrative explanations. “Bending the cost curve” might be thought of as a story (“costs have been rising, and we’re going to bring them down”), but it evoked the language and tools of economics, not an understandable plot.

The very modesty and disparity of the proposals also presented a challenge. They fitted poorly with the “yes we can” epic narrative of Obama’s campaign and early presidency, which called for a resurgence of the American spirit to tackle unresolved national problems.⁹ To invert Beveridge’s phrase, the ACA amounted to “patching,” not “revolution.” It is nonetheless conceivable that the patches could have been sewn together in Obama’s “new declaration of independence” narrative as providing a “right” to health care. In his September 2009 address to Congress outlining the key elements of the proposed legislation, Obama quoted Ted Kennedy’s presentation of extending health care coverage as “above all a moral issue; at stake are not just the details of policy, but fundamental principles of social justice and the character of our country” (Obama 2009a).

But the rest of Obama’s Baltimore address dealt with “the details of policy”—an enumeration of the elements of the proposed reforms. In addition, in part to defend against a Republican counternarrative of “socialized medicine,” the ACA was presented in Obama’s congressional address and elsewhere, as Medicare/Medicaid had been in 1965, as the next incremental step in the evolution of a system in which private insurance was and would remain the norm. Famously and fatefully, Obama repeatedly promised that “if you like your health care plan you can keep it.”¹⁰

8. Given the response rate of about 15 percent, it is possible that these levels of approval are somewhat upwardly biased.

9. Even in Obama’s stirring inaugural address, however, there were intimations of the agenda of “redesign”—notably in his statement that “the question we ask today is not whether our government is too big or too small, but whether it works” (Obama 2009c).

10. In 2013, when this promise became contentious, Politifact identified thirty-seven times on which Obama or others in the administration had made a version of this statement (Politifact n.d.).

Ambassadorial Stories

The “patching” changes of the ACA invited not an epic but smaller, anecdotal stories using “ambassadorial” techniques to evoke empathy for those individuals who were currently disadvantaged and who would gain coverage under the legislation. Leimbigler and Lammert (2016) suggest that such stories came to dominate the economic epic frame only after the passage of the ACA, although Obama used such techniques from the beginning. Indeed, Obama was explicit and deliberate about his cultivation of empathy as a civic virtue (Leake 2016). To enable the more privileged members of his audiences to identify with characters whose situation was more precarious, Obama invited his audiences into the narratives by situating himself within them, in conversation with their subjects. In the Baltimore speech described above, he invoked the stories of individuals he had met in his campaign. He also sought to go beyond ambassadorial empathy to weave the stories into a broadcast frame involving all Americans who, notwithstanding their different stories, constituted “a people of common hopes and common dreams” (Obama 2009d).

Obama invoked individual stories as well in his speech upon signing the ACA legislation, citing his own mother’s experience and recognizing by name a small businessman seeking to provide coverage for his employees, a woman in hospital without insurance, and a young boy whose mother died lacking insurance coverage (Obama 2010). Individual stories were also invoked by proponents of the ACA. Indeed, the actors from the original “Harry and Louise” ad campaign returned in a new campaign sponsored by a pro-reform coalition. This time Harry and Louise recaptured the ambassadorial evocation of empathy for the uninsured that they had abandoned for self-interest in the Clinton-era series (Singer 2009).

Meanwhile, Republican opponents seized on a classic trope of health policy contests in the United States and cross-nationally—the specter of “socialized medicine”—to depict the Democratic plan as un-American. Republican talking points portrayed the ACA as a government take-over of health care. The “socialized medicine” charge was particularly prominent in the summer of 2009, when Tea Party opponents were mobilizing in town hall meetings with members of Congress (Hopper 2017: 125–26). This rather hoary debate was given a fresh twist with Sara Palin’s depiction of the ACA provision for coverage for end-of-life counseling as a recipe for “death panels.” In the polarized media (including social media) environment, these epithets were reinforced in some outlets and debunked in others (Hopper 2017: 127–29).

Like others before them (and indeed, like earlier advocates of universal health insurance in Britain and Canada) the Democrats themselves essentially “fact-checked” these claims to show why the proposal *was not* socialized medicine. Doctors would not be employed by, or hospitals owned by, the state. Individuals would be free to choose among health plans. End-of-life counseling was not a plan for “death panels” (Hopper 2017: 125–34). But unlike the British and Canadian cases, both the substance and the context of the proposed reform made it difficult if not impossible for the Democrats to present a positive defense against the charge of socialized medicine by describing what their new regime *was*.¹¹ There was no counterpart to the platforms for redistribution erected by Beveridge’s assertion that “each man stands with his fellows,” or Hall’s Health Charter for Canadians. Moreover, as experts created a Democratic scheme of multiple interlocking provisions and intraparty deals added extraneous features, a colloquial narrative of a complex and gargantuan monstrosity began to take hold, fed by Republican opponents who presented themselves as bulwarks against socialism and tyranny. In Palin’s (2009) words, “We know from long experience that the creation of a massive new bureaucracy will not provide us with ‘more stability and security,’ but just the opposite.” A Gallup poll in 2013 found that, among the 55 percent of respondents who at that time opposed the ACA, by far the most common reason cited in an open-ended response was “government interference/forcing people to do things” (Gallup n.d.).

The ambassadorial empathy evoked by an aggregation of individual stories was not powerful enough to counter this epic of resistance to tyranny. The high barriers to “fellow feeling” that ambassadorial empathy must leap were raised even higher by the racialization of attitudes toward health care, exacerbated when the policies were associated with Obama (Tesler 2012). Even when the subjects of the stories were white, the principal storyteller (the conduit of empathy) was still black. Furthermore, even if successful, any single anecdote could at best build support for the particular feature of the ACA that it portrayed—such as banning lifetime limits, or enabling small business owners to provide coverage to their employees. And indeed, public opinion consistently showed that approval of distinct elements of the legislation far surpassed approval of the

11. Hall’s Canadian report similarly abjured “state medicine, a system in which all providers of health services are functionaries under the control of the state,” but also presented a positive counterweight, describing his plan as a *social* project: “a course of action based upon social principles and the cooperation and participation of society as a whole” (Royal Commission on Health Services 1964: 13).

legislation as a whole, among both Republicans and Democrats (see, e.g., Gramlich 2016; Kaiser Family Foundation 2017). Only the employer and individual mandates failed to gain majority support among Republicans, and only the individual mandate lacked support of a majority of the population overall.

But no compelling narrative was told about how those pieces fit into an overarching common project of universal coverage. As Theodore Marmor (2011: 567) argued, advocates of the ACA paid strikingly “little attention . . . to general philosophical principles and what particular conception of social justice the reform was meant to serve.” Similarly, John McDonough (2011: 141) noted that despite “the most thorough revamping of Medicaid in its history . . . there was no Democratic senator who articulated a vision—or even just an explanation—of what was being done and why.”

The Democratic Crusade and Combat Narratives

The only overarching narrative presented by the Democrats was one that met the Republican resistance narrative head-on, by broadcasting the Democrat’s own cultural narrative of a long crusade for universal health insurance against just such intransigence. As in past episodes, universal health care coverage was presented as an unrequited quest of American policy makers, and especially of Democrats. Obama often presented the current episode within a long historical arc. Leading an ailing Ted Kennedy, longtime champion of universal insurance, into a health care forum with key interests in March 2009, Obama assured him before advisers, “Ted, we’re gonna get this done” (quoted in *Washington Post* Staff 2010: 14). In public addresses Obama also gave evidence of his growing sense of history and his role in it. In September 2009 in a joint address to Congress he averred, “I am not the first President to take up this cause, but I am determined to be the last” (Obama 2009a). Obama included Republicans in that history, and the official Republican response to this address, offered by Rep. Charles Boustany, was relatively conciliatory, stating that “Republicans are ready—and we’ve been ready—to work with the President for common-sense reforms that our nation can afford” (ABC News 2009). Sarah Palin’s 2009 Facebook post, however, was more indicative of the Republican stance in the future, castigating the Democrats for “forcing a conclusion in order to claim a ‘victory.’”

Six months later, on signing the ultimate legislation in March 2010, Obama stated proudly, “Tonight, we answered the call of history.” But that history now had a more partisan shading. As noted above, he recalled the stories of individual people, some of whom were present or represented at

the signing, who would gain coverage under the legislation. But he also invoked the narrative of the epic Democratic crusade for universal coverage. Just as Johnson had hailed and honored Truman fifty-five years before, so Obama paid tribute to past Democratic presidents (and one Republican) and others engaged in the long fight: “I’m signing this bill for all the leaders who took up this cause through the generations, from Teddy Roosevelt to Franklin Roosevelt, from Harry Truman to Lyndon Johnson, from Bill and Hillary Clinton to one of the deans who’s been fighting this so long, John Dingell, to Senator Ted Kennedy” (Obama 2010).

Not surprisingly, this “combat” narrative, and the Republicans’ intransigent response, fed a media obsession with strategies, wins, and losses. A glimpse of this effect is provided by a study of the coverage of the ACA from Obama’s first joint address to Congress on February 24, 2009, through to the signing of the legislation on March 23, 2010, in two major newspapers, the *New York Times* and the *Washington Post* (Brown 2013). While these two publications are hardly ideologically representative of the media spectrum, they are newspapers of record and might be expected to give substantive treatment to major legislation. Yet even in these outlets, the dominant frame for reporting and commentary in both newspapers over the legislative period was a “game” narrative: three-quarters of the articles published referred to the tactics, wins, and losses of various players, while substantive aspects of the legislation were addressed in 41 percent. It is not surprising, then, that public attitudes to the ACA remained sharply divided by party (Kaiser Family Foundation 2017).

It is indeed a symptom of the absence of a coherent unifying policy narrative for the ACA that no “branding” symbol for the legislation could be found other than Obama himself. The “Obamacare” brand, developed first by opponents, was deliberately and strategically embraced by the Democrats (Hopper 2017: chap. 2). But this branding reinforced the narrative of epic struggle and could hardly appeal across the partisan divide.

The Future

The poverty of American health care narratives is apparent in the Republican attempts at ACA repeal after gaining unified control of government in the 2016 election. A story of unrelenting resistance yields no basis for positive action, let alone a compelling public case for action that will remove benefits from millions of people. As those benefits came to be experienced, the balance of opinion in favor of the legislation began to rebound from a trough reached after the botched launch of the healthcare.gov website in

October 2013. By the beginning of the Republican repeal effort in January 2017, support for the ACA exceeded opposition by 5–10 percentage points, close to the peak enjoyed immediately after its passage (Kaiser Family Foundation 2017). If the bulk of the provisions of the ACA survive long enough to take hold in the experience and conversations of Americans, they may yet generate a cultural narrative of a distinctively American kind of solidarity and rights. No less a conservative commentator than Charles Krauthammer (2017) has pointed to the emergence of an historically new “broad national consensus . . . that health care is indeed a right.” In that case it is possible that Democrats may yet find the cultural footing to present the expert-designed ACA within the story of a shared American project, as Marmor (2011: 570) earlier hoped: “Over time, experiential knowledge can often shift mass opinion in favour of the moral justifications [of reform] originally offered by political leaders. . . . Having neglected a clear account of why universal health insurance was justified, [Democrats] must now offer that account postenactment.” But these are precarious and polarized times. The most likely outcome is a continuation of the long epic saga of never-ending struggle and resistance.

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