Health Care Reform: Strategies and Successes of the Campaign for Better Health Care

By Andréa Taylor

This article explores the strategies and successes of the Campaign for Better Health Care (CBHC), arguing that the CBHC is employing effective organizing strategies to build a strong coalition across many domains, both public and private, in order to increase health care for the poor. By forging improbable relationships among disparate groups, the CBHC successfully addresses many traditional critiques of community organizing efforts. While the legislative goals of the CBHC still face significant challenges, the campaign provides a critical model for community organizing in a modern context.

Community organizing has a long and somewhat convoluted history in the United States. Models of organizing run the gamut, from working with the system and traditional power structures to turning those structures upside down through disruptive practices. A study of history demonstrates that place, time, and goals greatly affect which approach will be most successful for a range of community initiative efforts. This article explores the strategies and successes of a community initiative in Illinois, the Campaign for Better Health Care (CBHC). This evaluation suggests that the CBHC is employing effective organizing strategies to build a strong coalition across many domains, both public and private, in order to increase health care for the poor.

THE HEALTH CARE CRISIS

Health care and the growing number of uninsured people in the U.S. have been hot topics in election campaigns over the last few years (Commission on Presidential Debates, 2004). The increasing attention on growing rates of uninsured people is due to many factors, including the shifting economy, the

2004 presidential election, and the efforts of community organizers. But how serious is the problem?

According to study by Families USA, about a third of people living in Illinois (3.5 million) were without health insurance for all or part of 2002-2003 (Families USA, 2004). The U.S. Census Bureau reports that half of this population, 15 percent of Illinois residents, had no health insurance at any point during that time (DeNavas-Walt, Proctor, and Mills, 2004).[1] Not surprisingly, low-income families in Illinois are much more likely to be uninsured than their higher-income neighbors: almost 60 percent of Illinois families with incomes at or below 200 percent of the federal poverty level are uninsured. By contrast, 20 percent of those with incomes above 200 percent of the poverty level are uninsured (Families USA, 2004).

Important trends have been garnering the attention of Illinois' legislators and community activists recently. One such trend is the steadily increasing number of uninsured residents. According to Families USA, the number of nonelderly Illinoisans without health insurance rose 13 percent (408,000 people) from 2000 to 2004 (CBHC and Families USA, 2004). Another key trend is that minorities are far more likely to be uninsured than white residents. In fact, in Illinois, Hispanics are the most at risk to lack health insurance. Twenty-nine percent of Hispanics are uninsured. Twenty-three percent of black non-Hispanics are uninsured, and 19 percent of other minorities (including multiracial) are uninsured. By comparison, 10.5 percent of whites lack health insurance (Families USA, 2003). Immigrants are also at great risk of having no access to insurance. In Illinois, legal immigrant children are eligible to be covered under KidCare but their parents are not. Even with the state-funded KidCare program, one in 10 Illinois children are not enrolled in any health insurance plan, and this number is higher for immigrant children, both legal and undocumented (CBHC and Families USA, 2004).

Labor trends and shifts in the U.S. economy are also crucial components of the health care problem. Because of rising health insurance premiums and decreasing profit margins, U.S. employers are less likely to offer health coverage than in the past, and even if they do, employees may not be able to afford it. The average amount paid by an employee for health coverage increased by 36 percent between 2000 and 2004, while average wages increased by only 12.4 percent (Families USA, 2003; CBHC and Families USA, 2004). Families with at least one full-time worker make up 51 percent of the uninsured population; families with at least one part-time worker account for another 28 percent (Families USA, 2003). Industries least likely to offer health insurance are also in some of the lowest-paying employment sectors: employees in construction, manufacturing, retail, health care, food services,

and waste management top the list of uninsured workers. In 2003, only a third of low-income Illinoisans received employer-sponsored health plans (CBHC and Families USA, 2004). Additionally, the Illinois economy sustained increased layoffs and a rising unemployment rate over the last 5 years (Illinois Department of Employment Security, 2004*a*, 2004*b*). These events have taken a toll on health coverage; workers are unlikely to be covered by health insurance while between jobs, and many skilled workers have been unemployed for lengthy periods of time as manufacturing jobs continue to move out of the United States.

Legislators at both the national and state levels have been active in health care policy issues over the last decade. There are several safety net programs for low-income Illinoisans, including KidCare and Family Care (Illinois' version of the federal State Children's Health Insurance Program and Medicaid program). Illinois has taken steps to protect small business employees by implementing policy which bars insurance companies from denying small businesses who want to buy insurance plans and from canceling insurance when an employee on the plan gets sick (CBHC and Families USA, 2004). Additionally, the Health Care Justice Act of 2004 (IL Public Act 093-0973) was recently passed by the Illinois General Assembly. It mandates a state-wide review of feasible plans to ensure Illinois residents universal access to health care.

THE CAMPAIGN FOR BETTER HEALTH CARE

Community activists and organizers have long advocated universal health care access for low-income and working-class people. In Illinois, one of the loudest voices in these discussions has been the CBHC, which began as a grassroots coalition and has grown to become an umbrella group with over 300 member organizations. Members of the coalition include community groups, health care providers, labor unions, disability rights organizations, religious communities, and city and state government agencies (CBHC, n.d.).

The CBHC was founded in 1989 with only two staff members. The group's mission statement affirms that the CBHC's stated goal is to "help create and advocate for an accessible, quality health care system that provides for all" (CBHC, n.d.). The organization employs a coalition-building organizing strategy that has assembled a membership of over 300 dues-paying member groups (and about 500 total partners) in the last 15 years. It has forged unlikely alliances among such groups as the Illinois AFL-CIO, UnitedHealthcare, Chicagoland Chamber of Commerce, and Christian, Jewish, and Muslim organizations (CBHC, n.d.). The CBHC coalition

mirrors the famous Back of the Yards Neighborhood Council, organized by Saul Alinsky in the Depression era, in its ability to unite organizations across shared needs. Alinsky (1941) writes of this phenomenon in his own organizational work:

> This common immediate stake for church, business, and labor transcended doctrinal differences and has resulted in the development of an unusual understanding between them. It is this unity of purpose, this organized sentiment and opinion that generates an almost irresistible force. (p. 802)

This force of unity and a common identity located in shared concerns has allowed the CBHC to gather an extraordinary number of powerful partners committed to working together on what is framed as a community issue.

Framing the Problem

Successful social organizers and policy advocates understand the importance of framing the problem they hope to address. The sources and level of support they garner depend largely on how the problem is framed and presented. Leaders of the CBHC have carefully framed health care shortages as both a community crisis and a human rights issue. For example, the organization's Web site states, "Accessible, affordable, quality health care is a basic human right for ALL people," and that, "A health care system that serves the people must come from the people" (CBHC, n.d.). In this way, the discussion is structured such that the interests of the entire community frame both the problem and the solution.

The coalition further implicates the entire community by highlighting the importance of "community health and wholeness" and addressing "the social roots of ill health: poverty, unemployment, poor housing, inadequate education, environment degradation, racism, sexism and homophobia" (CBHC, n.d.). Through this presentation of the problem, the CBHC has tied health care to human rights, social justice, labor, housing, gay rights, education, minority rights, gender, and environmental protection. It is hard to imagine that there are many people who do not claim some affiliation with at least one of the above interests.

For the CBHC, two additional key elements of the health care issue are the cost-effectiveness and public health components of providing preventative health care. In an editorial, coalition leaders assert that having uninsured residents costs more for the community overall and drives up health care costs for everyone (Blackshere et al., 2003). Further, the editorial reports an estimate

from the Institute of Medicine that $99 billion is spent annually nationwide on health care for uninsured people and that this cost is expected to increase by at least $34 billion every year. The editorial authors also claim that, "There is a greater success rate for public health and other population-based prevention and early detection strategies," and that access to regular sources of health care increases "opportunities for cost-saving disease management strategies" (Blackshere et al., 2003).

The CBHC's chief solution for the health care crisis is to implement a single-payer system in Illinois before expanding it to cover the United States. In the CBHC vision, this system should provide universal and comprehensive coverage, equal access, and culturally sensitive, community based care. It should also be funded by government through taxation. Beyond this, the organization's stated solutions are rather vague and mixed in with goals: to "make regulatory and legislative changes," and to "create and advocate for an accessible quality health care system that provides for all" (CBHC, n.d.).

While implementing a single-payer health care system would bring about the CBHC's goal of universal care, a single-payer system is not likely to be supported by many in the health care and business communities. By framing the problem in the language of economics, human rights, and community health, the CBHC has increased the potential advocate base to include organizations and individuals that may not have previously considered health care a priority. This has enabled the CBHC to bring in groups that have traditionally been in opposing camps.

Leveraging Political Power through Coalitions

In an influential argument, social activists and theorists Richard Cloward and Frances Fox Piven (1999) claim that poor people's movements cannot make up with numbers what they lack in political power. They write, "To be poor means to command none of the resources ordinarily considered requisite for organization and influence: money, skills, and professional expertise, access to the media, and personal relationships with officials" (p. 168). Thus, in order to achieve political change, these organizations and movements must include "cross-class voting blocs" (p. 168). They also state that community organizing is hampered by its "localistic character" (p. 168). The major victories for low-income, low-power populations have come in national legislation, and national legislative achievements are out of reach for most community efforts.

Consciously or not, the CBHC has integrated these correctives into the organizational strategy without necessarily sharing Cloward and Piven's conclusion that disruptive action is vital to success. Rather than relying on a

member base of individuals, the CBHC set up the initiative as a coalition-building campaign and brokered relationships with powerful organizations. Through this strategy, the CBHC works within the system of "conventional political resources" to leverage power (Cloward and Piven, 1999, p. 169). Such a structure may help them avoid the pitfalls, such as member attrition, lack of media attention, and limited reach, that other groups face.

This strategy has so far met with success, creating committed partnerships with key players who bring a wide variety of resources to the coalition. Major political partners include the Chicago Department of Public Health, the Cook County Bureau of Health Services, Chicago Mayor Richard M. Daley, and Illinois Governor Rod Blagojevich. Major health care providers, including UnitedHealthcare, the Illinois Hospital Association, and the Illinois Academy of Family Physicians have also partnered with the CBHC, as have representatives of the business community (e.g., the Chicagoland Chamber of Commerce). To this same coalition, the CBHC has brought labor unions, including the AFL-CIO, and activist groups, such as the Urban League and the Chicago Coalition for the Homeless. Through strategic framing of the problem and partnership building, the CBHC has tied in the interests of the middle class and brought together many parties that don't often find themselves on the same side of an issue. The coalition has framed health care access as a cross-class issue, leveraging money, professional expertise, national influence, and social capital not available to many community organizations.

Major successes of the CBHC underscore the importance of the coalition's base. Backed by political clout and major voices in the health care industry, the CBHC helped to push through state legislation including the Health Care Justice Act of 2004, successfully oppose major Medicare and Medicaid cuts by the U.S. Congress, and prevent the closing of public health clinics in Chicago (CBHC, n.d.). The CBHC Web site also reports that the group helped to organize the National Call in Day for Universal Health Care, negotiate better outcomes for consumers in two hospital mergers, delay two other mergers, and expose Medicare abuses by managed care companies in Illinois (CBHC, n.d.). In 2002, the executive director of the CBHC was recognized by health policy group Families USA as Health Care Activist of the Year, and organization leaders have been appointed to both city and state policy taskforces (CBHC, n.d.).

Staying on Track

Access to power and success in the legislative arena does not guarantee, however, that organizational goals are being met. These advantages can actually

distract organizations from their original purpose. It is important to consider how well the CBHC's goals fit the strategies employed. The goals of the CBHC are to sponsor "a tenacious grassroots campaign to educate and involve health care consumers, build coalitions with other organizations who share our commitment to social justice, and make regulatory and legislative changes in the current health care system at the local, state, and national levels" (CBHC, n.d.).

When a universal health care system is in place, the CBHC's goal will become "to monitor and protect the quality, accessibility and affordability" of the system (CBHC, n.d.).

The coalition-building strategy that the CBHC has employed fits well with its goals and has enabled the organization to accomplish several objectives within a relatively short time. There is an inherent tension, however, in bringing big players to the table to broker deals for poor and disenfranchised populations. It is not clear what is meant by "grassroots" in the original formation the CBHC's vision statement nor if the organization has achieved this identity (CBHC, n.d.). It is possible that, by relying on relationships with powerful business and political interests, the CBHC has lessened the directive voice of its poor and uninsured constituents. In spite of access to traditional power sources, the CBHC may have lost a key feature of grassroots initiatives: the power to mobilize communities on the ground.

BUCKING THE SYSTEM: CHALLENGES OF COMMUNITY ORGANIZING

While the CBHC has enjoyed considerable success in the last decade, it also faces many challenges to its community organizing efforts. A primary challenge is ensuring that all voices are heard and truly represented. Ideally, the community initiative would leverage political power in order to bridge the traditional resource gap between the haves and have-nots. That power would provide political access to the poor and disempowered. The risk, however, is that powerful interests will play a larger role in making the CBHC's decisions and the less-organized (and less-powerful) community members will take back seats in the bargaining room. While system change is always difficult, it may be impossible to accomplish by working through the system. Compromises made to engage the business and health care communities may cost the CBHC the support and energy of the uninsured population.

Another challenge confronting the CBHC is the Bush administration's opposition to a single-payer system. The administration instead promotes private-public options, such as tax-free individual health savings accounts and

increased bargaining power for small businesses (Republican National Committee, 2005). While local efforts to regulate Medicaid managed care facilities and to investigate state health care reform options for Illinois are important, these actions do little to bring about national legislation that will provide health care for the uninsured. It is unlikely to happen during the Bush administration; federal policy is actually moving toward increased privatization of health care and more cuts in the Medicare and Medicaid programs, shifting resources and people away from the existing programs (Andrews, 2005; Stolberg, 2005). This will make it increasingly difficult for the CBHC to advance its agenda on the national scale.

The pace of system change can also be a challenge. The process is often slow, particularly when groups are simultaneously working on local, state, and national levels, and when so many competing interests are involved. While the CBHC is pursuing a universal health care plan for Illinois and the United States, the number of people without health coverage continues to rise (DeNavas-Walt, Proctor, and Mills, 2004). The victories along the way do little to actually provide health care for families going without it. The challenge, then, is to maintain motivation and a sense of progress when the numbers aren't changing and so many coalition members don't feel a direct positive impact.

Another key hurdle for the CBHC is the difficulty of uniting groups across class, race, and citizenship. As discussed above, the CBHC's leaders have done an impressive job of bringing capitalists and middle-class blocs into the coalition. However, inadequate access to health care is not just a class issue; it also has racial and citizenship components. It can be difficult to unite across these groups. Additionally, immigration status has become a legal barrier in access to health care. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (U.S. Public Law 104-193) gave states the power to deny benefits (including Medicaid and Medicare) to legal immigrants. At the same time, the act also handed states the responsibility of funding those benefits. Illinois continues to cover legal immigrants under the age of 18 through KidCare but no longer covers adult members of those families or childless adults, regardless of income (Illinois Department of Public Aid, 2004).

These are significant challenges, but coalition leaders can take several crucial steps to maximize the health and vitality of the initiative. A possible first step is to ensure that the uninsured have voices at the CBHC's table and can take a leading role in setting priorities for the campaign. In addition, the CBHC is in a position to forge relationships between members of the uninsured community and the health care industry. By working together toward a common goal of improving health care access, these two groups will

likely minimize efforts (and success in attempts) to demonize each other. Most importantly, the CBHC must be clear about what a grassroots approach means for the organization's identity and must regularly assess whether or not it is maintaining that identity in practice.

Immigration and racial issues can be at least partially addressed by successfully partnering with groups that represent those populations to ensure that their concerns are considered. Important steps in the right direction include partnerships with the Urban League, the Asian Health Coalition of Illinois, Asian Human Services, and many neighborhood groups and community health clinics in immigrant-heavy areas of Illinois. In addition, the CBHC recently conducted an education campaign to increase the cultural competency of health care providers that work with minority and immigrant children covered under KidCare (CBHC, n.d.).

Another potential step for the CBHC is to continue to strengthen relationships with major political operatives during the Bush administration. Though federal health care policy may move against the CBHC's goals for the next few years, the organization can continue to lay the groundwork for major initiatives in 2008. With the right relationships in place and a history of impressive accomplishments, the CBHC may be able to leverage more federal influence in the future. The organization also has an opportunity to frame the way that access to health care is understood in upcoming elections. It must continue to highlight every success along the way and maintain strong coalition relationships.

CONCLUSION

The Campaign for Better Health Care has become a major player in the health care reform field in Illinois over the last decade. Beginning as a small group of concerned individuals, the CBHC has grown into a coalition of over 300 member organizations, leveraging power and influence where it counts most for health care reform: among health providers, business, and labor interests, as well as in politics. The strategic coalition building and commitment to partnerships has allowed the CBHC to win victories in each of these spheres, but the hardest work is still ahead. Establishing a single-payer health care system, maintaining a grassroots identity, and uniting constituents across race and citizenship status are exigent challenges that may require new strategies and organizing skills. The CBHC may have to adapt to changing economic and political structures in order to remain effective and to achieve the organizational goals. ■

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NOTE

[1] It is important to note that these statistics reflect the population under 65, as people 65 and over are covered by Medicare.

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