Interest Group Politics Determines Power Players in Reform Debate

BY JANE H. WHITE

In traditional politics, special interest groups play a key role in shaping major policies legislated by Congress and the states. However, traditional roles have a way of changing. Harvard political scientist Mark A. Peterson defines politics as "an ever-evolving process of perceptions, decisions and adjustments: the conditions that underlie a particular policy area are as crucial to the process, as are the public's interpretation of those conditions and its response to them."[1] Thus, what was once understood as bedrock truth in healthcare politics is now turned on its head in the health reform debate of 1994.

By the spring of 1994, the policy arena for healthcare and its systemic reform has evolved dramatically from the health policy sphere that existed during the 1970s, 1960s, and 1940s. One area of significant change has been the decentralization of Congress and the exponential growth in its staff and committees with overlapping jurisdiction and consequent turf battles. A second area of change—and the focus of this month's column—is the array of special interests in healthcare.

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Evolution of Interest Group Power

Large, Dominant Groups Historically, interest group power in healthcare was solidified in three sectors: providers, insurance, and business. Peterson defines this as an "iron triangle," which was "an autonomous policy community, built on close relations between powerful private interests and an oligarchically organized Congress, which organized medicine and its allies could and did thoroughly dominate." Peterson further delineates between "stakeholders, the interests that benefit by the status quo," and "stake-challengers, the interests that want to change the status quo because they either do not benefit from it or are actually harmed by it."

Stakeholders historically have included the major "peak" associations (a political science term for those groups which claim to represent broad sectors with a degree of unanimity and are viewed by Congress and others as being the aggregated representatives of such sectors). In healthcare, the peak associations include the American Hospital Association, American Medical Association (AMA), Health Insurance Association of America (HIAA), Chambers of Commerce, and National Association of Manufacturers.

Stake-challengers are often not-for-profit groups, consumer alliances, labor unions, and others that challenge the status quo. They are typically less well funded, though they still claim nearly comparable access to members of Congress as do the stakeholders.

Fragmentation Over time, "peak associations found they couldn't take a strong position because interests were divided" among their members, explained University of Maryland, Baltimore County, political scientist Thomas R. Oliver in a conversation. More recently, the healthcare arena has witnessed the proliferation of specialized interest groups that, with their own staff and lobbyists, now augment and often compete with the lobbying efforts of the peak associations. A prime example is the separation of not-for-profit and for-profit groups in home health and hospital systems, who along with public hospitals and academic medical centers promote an agenda and take positions consistent with their set of patients, services, and financial needs.

Another area of divergence among peak associations has been between large and small groups. This split is found both in business and in the insurance industry.

A third reason for the fragmentation of the peak associations has to do with growing specialization in healthcare—among providers, industry, and others. For instance, in addition to the overarching Pharmaceutical Manufacturers Association, smaller groups represent specific niches of the drug industry, such as the Parenteral Drug Association. According to Oliver, these more specialized groups "have realized that they are

better off hiring their own lobbying people, collecting their own data, and presenting their own case" to Congress. Legislators and staff benefit from greater information, and, in exchange for access, smaller interest groups will often provide critical support to push through policies opposed by the larger associations.

Also, as healthcare has grown, new types of organizations and entities have formed, such as managed care organizations. These new groups have added to the cacophony of health reform lobbying.

Coalition Building Although healthcare interest groups have fragmented and proliferated over the past decade or so, a countervailing trend has emerged with some force during the current reform debate. This trend is to build coalitions among like-minded interest groups that may represent different types of sectors, but have some common political agendas. With this trend, one sees an attempt to rebuild the power that has dissipated with the fragmentation. Such coalitions include the National Leadership Coalition on Health Care Reform, the Alliance of Business for Cost Containment, the Interreligious Health Care Access Campaign, and many more. The Catholic Health Association (CHA) has joined forces with the American Nurses Association, American Association of Retired Persons (AARP), and the American College of Physicians, to name a few of the groups that make up the Health Care Reform Project (HCRP).

Beyond more political power, these coalitions can muster more resources for larger advertising campaigns and other lobbying efforts. A prime example is the HCRP's impressive print ad campaign to counter HIAA's effective "Harry and Louise" television ads that attack the health alliance concept of President Bill Clinton's plan (see the inside back cover). In the ad, the coalition of health providers and consumers asks, "Whose opinion do *you* trust?" in an attempt to raise doubts in the public's mind about the insurance industry's position.

Yet there is also a downside to the coalition building. These new groups can be very confusing. People wonder who is with whom. "More important, it becomes difficult to lay out any predictions as to who is a power broker" in the current reform debate, said Oliver.

Effect on Health Reform

What effect does all this fragmentation and new coalition building have on health reform? Recent activities in California can offer some insights here.

Lessons from California Thomas Oliver and Emery B. Dowell, a retired vice president for governmental affairs of Blue Cross of California, reported that "interest-group opposition and other conditions in the political environment combined to defeat the [California Medical Association (CMA)] employer mandate and broader proposals to expand access to health services" in California in 1992.[2] In that debate, CMA, a physicians' group, took the lead among the key interest groups, sponsoring legislation that pushed a "broad but moderate proposal to build on the existing private insurance system." Oliver and Dowell noted, however, that CMA leaders were somewhat more liberal and more enthusiastic than the CMA members about the state reforms.

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Among the other healthcare provider groups, hospitals "stayed mostly on the sidelines" because of "divisions and unwillingness to negotiate concrete measures for cost containment," said Oliver and Dowell.

The California Nurses Association took the most liberal position among health providers by joining the Health Access coalition to support a single-payer plan for the state. This coalition also included consumer groups, labor unions, public health professionals, churches, senior citizens, and academics.

Employers provided "the most intractable obstacle to broad health insurance reform" in California, noted Oliver and Dowell. Insurers' positions were divided and were influenced by insurers outside the state who worried about the effect of California's actions on national health reform. Consumer support for an employer mandate was initially enthusiastic, but then became uneven and waned.

To defeat the state legislation that would have made health insurance a benefit of employment, coalitions were important—both the ones that were formed and the ones that were not. Oliver and Dowell explained:

> Liberals and conservatives combined forces to defeat Proposition 166. The main arguments were that an employer mandate was not sufficient to solve the problems of access to care and rising expenditures, and that imposing a mandate would hurt the economy. The arguments somewhat contradicted each other but were effective because they were aimed at different groups.

Oliver and Dowell also argued that a moderate-conservative coalition, such as physicians (i.e., CMA) with business (i.e., Chambers of Commerce), could have been a winning coalition. However, such a centrist group did not

emerge in California.

California's interest group politics show national health reformers that:

- Centrist coalitions can be key to passing legislation.
- Momentum for reform can disintegrate easily, even among initially strong supporters.
- Business and insurers are divided.
- Consumer support is key to pushing for universal coverage and a broad benefit package.

"Most health care providers have recognized the desirability of expanding both private and public insurance coverage but will staunchly oppose governmental spending limits," concluded Oliver and Dowell.

National Health Reform In looking to the national arena for health reform, interest groups can affect the policy process in a number of ways. As each legislative reform proposal becomes more specific and is vetted on cost by the Congressional Budget Office, interest groups find more details to oppose or support. Such interest group lobbying initially focused on the president's plan, since it provided the most thorough details of how it would work and how much it would cost. As Congress began reshuffling elements of the Clinton plan in spring 1994, interest group attention shifted to specific elements that cut across several congressional proposals—employer mandates, cost controls, financing, benefits packages, and alliances.

Pressure from the panoply of health interests is especially effective on these specific elements. Said Oliver, "Traditional forms of inside lobbying are not viable [in the health reform debate] except on very technical issues that only concern very specialized groups." Interest group lobbying is more influential on specific (and often complex) legislative provisions that will not greatly affect the general public but will noticeably shift costs and benefits among particular groups or organizations.

To shape public opinion on a specific element, such as alliances, a negative campaign need only place doubts in the public's mind. This was amply demonstrated by HIAA's effective television campaign to raise doubts about the "large mandatory alliances." CHA Vice President for the Division of Government Services William J. Cox elaborated on the HIAA strategy in a conversation: "Things like alliances, which are new mechanisms and not well understood by anybody, were an easy target for HIAA. You only need to find one thing wrong with an opponent and repeat it [to be effective]; they made alliances into monsters and forced the White House to rethink its strategy on this." In early April the president shifted from talking about specifics of the plan to "picking out four or five themes to repeat endlessly in order to maintain public support for reform and for himself," continued Cox.

One reason the public will play a more significant role in shaping the outcomes of health reform is that people can grasp how it will affect them.

To seek respite from the intense specialized lobbying, Congress has retreated in spring 1994 to daily closed-door congressional caucus sessions to hammer out compromises and forge plans that can pass votes in the various subcommittees and full committees working on health reform. This may be antidemocratic but probably necessary to achieve any cohesive policy for such a broad-ranging piece of legislation that affects so many interests.

In working out such compromises, members of Congress are sure to take interest group concerns into account in several ways. According to Oliver, policymakers will try to:

> (1) Provide benefits to accompany the costs imposed on important groups (some groups, though deserving, will not count much in political considerations because they lack attentiveness, money, or votes); and (2) Distribute costs (economic burdens, legal obligations, normative standards of behavior) among as many groups as possible, so most everyone ultimately perceives reform as fair, if not desirable.

The Public's Role

As perhaps never before, public opinion and grassroots concerns will have a profound effect on health reform. Power will not be limited to healthcare interest groups.

One reason the public will play a more significant role in shaping the outcomes of health reform is that people can grasp how it will affect them. Many Americans either know someone who is or has been uninsured. They fear losing their health benefits, want to maintain the ability to choose a physician, and want healthcare security. Healthcare affects everyone intimately, and it also makes up one-seventh of the nation's economy. Other policy debates such as the North American Free Trade Agreement may be just as broad-reaching, but average Americans do not intuitively understand how free trade agreements affect them. They do know what health insurance means for their daily lives.

Oliver believes that the broad public scope of this debate affects interest group lobbying strategies: Healthcare "interest groups recognize that they have to put forth their best arguments and mobilize members on the inside, but more than any issue in this generation, they are out there mobilizing the public in a way that few interest groups have done, except maybe the gun lobby."

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hospitals must downsize as more care is shifted to outpatient settings, Kane predicted a need for more inpatient capacity in the first or second decade of the twenty-first century to accommodate the older, sicker boomers. He noted that people over 65 now make up 12 percent of the population, but they account for 44 percent of inpatient days.

To care for aging patients, Kane said, hospitals will need to identify clinical pathways, evaluate prescribing patterns, and reduce iatrogenic conditions that raise costs. They should develop medical group practices oriented toward the aging and initiate staff training programs.

Key to success, Kane insisted, will be forging relationships with various agencies and long-term care facilities to "build internal and external referral networks." *—Judy Cassidy*

ACTION STEPS TO PREPARE FOR THE BOOMERS

- Educate physicians and staff about the elderly's special needs
- Initiate services for the elderly such as geriatric assessment and care management
- Establish clinical and management information systems to support coordinated care
- Build relationships with other providers and agencies
- Provide a user-friendly environment, with special attention to lighting, color, and signs
- Offer patient and family education on care management and prevention

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He predicts that despite interest group lobbying, the health reform question will come down to essentially a public referendum.

It is thus critical for activist reformers such as the Clintons to define their plan in ways that the public understands and supports. A Kaiser Family Foundation and Harvard University poll shows that the public still misunderstands key reform proposals, problems, and terms of the debate.[3] The poll shows that although two-thirds of the public have heard of an employer mandate, fewer than one-third know that the president is its principal sponsor. Only 25 percent of Americans say they understand health alliances.

"Now that the focus is shifting from the President's plan to various congressional alternatives, it's important that the media and policymakers explain the concepts behind the major health reform alternatives and explain how they would affect American families," explained Harvard University's Robert Blendon in releasing the poll's findings.

In March, Kaiser also released an analysis of media coverage of health reform that was prepared jointly with the Times Mirror Center for the People and the Press and *Columbia Journalism Review*.[4] Interestingly a number of the ad campaigns on health reform appear to have had a positive influence on the public's opinion that universal coverage is an important goal and that the health system needs major changes.

About 75 percent of Americans surveyed reported having seen, read, or heard a paid advertisement about health reform in the past six months. The interest group ads mentioned most often were those of the health insurance industry (45 percent), the AARP (35 percent), and the AMA (33 percent).

Mission and Coalition Important

So what does this mean for hospitals—a key interest group in the reform debate? Oliver's advice is to recognize the divisions within the sector and to become "clearer about what your particular hospital's mission is" in making a case to Congress and to the public. In addition to understanding the interest group fragmentation, it is also important to understand who the other players might be in a coalition with not-for-profit healthcare facilities and to understand "how your interests may coincide with other groups of consumers, health professionals, community organizations, etc."

Columbia University political scientist Lawrence D. Brown sums up the importance of interest group politics to the overall health reform debate: "The conflict management that is politics . . . is not some nonrational and inefficient sideshow that threatens the reformist visions of the best and brightest, but rather a challenge central to making health reform come out for the better—indeed, come out at all."[5] □

NOTES

1. Mark A. Peterson, "Political Influence in the 1990s: From Iron Triangles to Policy Networks," *Journal of Health Politics, Policy, and Law*, Summer 1993, pp. 395-438.
2. Thomas R. Oliver and Emery B. Dowell, "Interest Groups and Health Reform: Lessons from California," *Health Affairs*, Spring II 1994, pp. 123-141.
3. Henry J. Kaiser Family Foundation, press release, March 25, 1994.
4. Henry J. Kaiser Family Foundation, Times Mirror Center for the People and the Press, *Columbia Journalism Review*, "Media Coverage of Health Care Reform: September 1-November 30, 1993," March 1994.
5. Lawrence D. Brown, "Who Shall Pay? Politics, Money, and Health Care Reform," *Health Affairs*, Spring II 1994, pp. 175-184.