Kimble, Lawson C., Comparative Case Study of the American Medical Association's Role and Strategy in Health Care Reform During the Clinton and Obama Administrations. Master of Public Health (Health Policy), May 2010, 49 pp., 6 tables, bibliography, 33 titles. The arena of health policy is always evolving as the players in it evolve. One of the main players is the AMA. This paper takes an in depth look at how the evolution of the AMA has affected health system reform in the United States by examining two story lines of separate attempts at health care reform. Through comparative analysis, conclusions are made as to how the AMA has transformed and positioned itself in a new role within health policy formulation and implementation.

COMPARATIVE CASE STUDY OF THE AMERICAN MEDICAL ASSOCIATION'S ROLE AND STRATEGY IN HEALTH CARE REFORM DURING THE CLINTON AND OBAMA ADMINISTRATIONS

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COMPARATIVE CASE STUDY OF THE AMERICAN MEDICAL ASSOCIATION'S ROLE AND STRATEGY IN HEALTH CARE REFORM DURING THE CLINTON AND OBAMA ADMINISTRATIONS

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CHAPTER 1

INTRODUCTION

Health care reform is currently the most fervently debated topic in American society. The United States is no stranger to this topic of conversation. During the twentieth century seven presidents took on reforming the American health care system and all of those efforts included some form of comprehensive universal national health insurance. The only success to come out of these efforts was the Medicare and Medicaid program that came out of the Johnson administration of the mid-sixties. Franklin Roosevelt chose to keep national health insurance off the table so that Social Security could be passed, even with the asset of Democratic majorities in both houses of Congress. (Litman, 1997)

Why is the United States seemingly opposed to comprehensive national health insurance? Virtually every other industrialized nation provides universal health insurance coverage to its citizens and no nation has sought to take that away once a program is in place. Victor Fuchs in his 1976 article, *From Bismarck to Woodcock: The "irrational" pursuit of national health insurance*, offers four reasons as to why the U.S. last to take up national health insurance.

Figure 1.1

Why the United States is the last industrialized nation to take up comprehensive national health insurance? Adapted from Victor Fuchs, *From Bismarck to Woodcock: The "irrational" pursuit of national health insurance.*
Long standing U.S. tradition to distrust government- the people and the principles this nation was founded upon is deeply rooted in anti-government sentiment. Their oppressive experiences in Europe had led U.S. settlers to fear government rather than look to it for support and protection
Heterogeneity of the American population- a heterogeneous population allows for minority groups to be externalized more so than a nation with a homogenous population such as Japan
A strong voluntary and non-profit presence- U.S. private non-profits play a role in welfare of citizens that often falls under province of the government in other nations
Lessened sense of noblesse oblige- with greater equality of opportunity goes a stronger conviction that the distribution of income is related to effort and ability. Those who succeed in the system have much less sense of noblesse oblige than do the upper classes in Europe, many of whom owe their position to the accident of birth

Most often, the debate is instigated by action or potential action of the government in reforming the system. The Obama administration, throughout the campaign season of 2008, touted health care reform as a top domestic priority. Although the American Recovery and Reinvestment Act of 2009 was the first action addressing domestic policy by the new administration, President Obama kept major health system reform at the top of the policy priority list.

Sixteen years earlier, Democratic President Bill Clinton was facing the same issues of sky-rocketing health care spending and mounting numbers of uninsured individuals in America. (See Figure 1.2)

Figure 1.2

Comparison of Key Factors Affecting the Demand for Health Care Reform, Early 1990s and Today.*		
Variable	**Then**	**Now**
Increase from the previous year in health insurance premiums	14% (1990)	6.1% (2007)
Health care spending as a percentage of the gross domestic product	12.3% (1990)	16% (2005)
Per capita health care spending	$3,167 (1992)	$6,401 (2005)
Number of uninsured	35.4 million (1991)	47.0 million (2006)
Increase from the previous year in the number of uninsured	1.3 million (1989–1990)	2.2 million (2005–2006)
Unemployment rate	7.5% (1992)	4.6% (August 2007)
Federal deficit	$269 billion (1991)	$248 billion (2006)
Percentage of people who say the system needs to be completely rebuilt or needs fundamental change	90% (1991)	90% (2007)
Percentage of people who identify health as a top issue of concern	19% (1992)	27% (2007)

* Data are from the Kaiser Family Foundation, the Organization for Economic Cooperation and Development, the U.S. Census Bureau, the Bureau of Labor Statistics, the Congressional Budget Office, and a poll conducted by CBS News and the *New York Times*.

Both Presidents faced similar pressures: a liberal faction demanding provision of universal health coverage to all residents; and a similarly energized conservative platform appalled by the idea of a "socialized" health care system. Both leaders enjoyed Democratic majorities in both chambers of the United States Congress and had the political will of the people, at least at the beginning of the process.

However, President Obama in his attempts to pass broad sweeping reform had the advantage to learn from the failures and capitalize on the successes that Clinton experienced. Lessons include acknowledging health reform is never inevitable, regardless of momentum; recognition of a majority of Americans satisfied with their current health care arrangements; the power of rhetoric; and the influence of vested interests of political institutions and interest groups. (Oberlander, 2007) The final of these lessons inspires the questions this paper looks to answer. A monumental difference between the two reform attempts in making progress on reform has been the position of one the most powerful interest groups in the country: the American Medical Association (AMA). Historically, the position of the AMA has been adamantly opposed to reform efforts.

Established in 1947, the AMA is the prevailing medical association in the country. State medical associations were alone in the arena until Dr. Nathan Smith Davis set out from the New York Medical Society to establish a national voice for medical educational requirements and licensure. The AMA wields influence, both financial and political, that few other professional associations enjoy. The American Medical Political Action Committee was formed by the AMA in 1961 and, like all other PAC's, is supported by members of the organization or association it represents. According to Opensecrets.org Center for Responsive Politics (2009), the AMPAC has spent at least $15 million annually over the past ten years on lobbying efforts, over $20 million annually the last two years. In recent years the AMA has been losing numbers of members. Various theories are proposed as to why, but it is still the largest physician's association, representing over 25% of the country's 800,000 doctors.

During the Clinton administration the AMA played an important role more for their relative inaction rather than action. The Clinton plan had opposition from the AMA from the start, although the reform's principle was based around universal coverage; something the AMA fully supported. However, the AMA quietly joined the opposition when concepts like employer mandates and cost controls through managed care arose. Instead, the AMA let heavy hitters like the Health Insurers Association of America lead the charge. (Litman, 1997)

In the most recent reform effort, the AMA was an ally to the Obama administration and was working along side the White House to push Congress to action. President Obama's first expansive speech on health care reform efforts was made at the AMA's annual conference in Chicago. The AMA had seemingly reversed its course from reform efforts of the past.

What changed? Why the role-reversal by a key player in such a monumental policy proposal? What, if anything, did the AMA stand to gain or lose that wasn't present in 1994? From a first, casual glance the Obama plan seems to carry many of the same provisions as the Clinton plan and definitely possesses the same goals of providing coverage for the un- and underinsured. Closer examination of this topic is vital to understanding in health policy decision-making. This thesis researches and applies theory based in political and social science to the health care sector and the policy-making process. It does so by examining the American Medical Association's role, action, and influence on two administrations' attempts to reform the health care system in America.

Such a discussion is pivotal for understanding how stakeholders such as physician groups can impede or facilitate health care policy.

CHAPTER 2

LITERATURE REVIEW

Multiple sources of literature in multiple backgrounds were examined to understand the issues of this paper. The key areas are the American Medical Association itself; interest group theory; the Clinton and Obama health care plans and scenarios; and the appropriate research study design. The most straightforward of the priorities was the research design. A case study was the preferred method since a qualitative comparison was the primary means to address the research question. Robert Yin's *Case Study Research: Design and Methods* proved to be fundamental for this study. Information on the AMA and Clinton plan is so abundant; the difficulty was carefully sifting through to make sure the most appropriate sources are included. Conversely, the Obama plan (even in comparison to the Clinton plan) has been well covered but is so current the challenge is not knowing which sources are better than others since much bias has entered the debate whether intentionally or not. The next struggle was finding current, relevant theory regarding interest groups and health care. The theory of interest groups has evolved so much over time, consensus will be difficult to obtain.

In addition, because of the timing of the paper and its study of current events, previous work is non-existent on comparisons between the AMA's actions and priorities amongst the Clinton and Obama reform efforts.

However, there is a vast amount of work that documents and compares the AMA's interaction with previous health care reform attempts and their very active role in the health policy realm. Elements of these comparisons were applied in this paper as well as modified to fit the particular scope of this research.

The American Medical Association

Paul Starr's book *The Social Transformation of American Medicine: The rise of a sovereign profession and the making of a vast industry* (1982) is regarded as a comprehensive history of how physicians came to such prominence in society as well as politics. This selection as a reference for the rise and influence of the AMA is additionally appropriate due to Paul Starr, years after writing the book, participating on President Clinton's health care reform task force.

Starr brings a sturdy historical perspective to how the rise of the physician as an influential player in American society took place. The work takes the reader through America's early resistance to the establishment of medicine as an exalted profession, according to Starr because of the United States' democratic traditions. The profession doesn't gain traction until a sense of uniformity and common interests of the profession is established. Starr notes that it wasn't until the AMA was formed and established a single voice for licensure, medical education requirements, and who was allowed in to the association that physicians truly became widely respected. Lax licensing requirements up until this point flooded the workforce with no consistency of credentials, making it impossible to institute a revered class of doctors.

Even though the AMA was established in the middle of the 19th century, Starr maintains that true dominance wasn't evident until the late 1910's and 1920's. Up until the AMA's work towards blockage of the social health insurance proposal put forth by Theodore Roosevelt and the repealing of the Shepherd-Towner Act (a Federal matching program for states to fund public-run prenatal and child health centers, mainly staffed by women physicians and public health nurses), the AMA had not shown its true influence in the American policy sphere.

Two other articles were reviewed to add perspective on physician influence in health policy although neither was specifically about the AMA. The first is titled *Is the Doctor in? The evolving role of organized medicine in health policy* by Miriam Laugesen and Thomas Rice (2003). Laugesen and Rice examine the changing role of doctors in influencing health policy by conducting a case study of physician payment reform under Medicare. By looking closely at when organized medicine chooses to cooperate and when not to cooperate with government, the authors conclude physicians are going to continue to be influential in health policy reform in the areas of reimbursement, quality, and medical training and education. (Laugesen and Rice, 2003)

The second article is Jill Quadagno's revisit and expansion to Starr (1982) called *Physician Sovereignty and the Purchasers' Revolt.* Her review of physicians' political influence calls into question Starr's observation of the medical profession having absolute power in health policy. Quadagno writes, "My own review of the historical evidence suggests that physicians' political power was more illusory than real, occurring only when their political objectives coincided with those of other influential

stakeholders." (Quadagno, 2004) The author comes to the conclusion that although that organized medicine's authority in influencing health policy is strongest when other interests are aligned; physicians are still a key player in the political spectrum but not to the extent that Starr describes them.

Interest-Group Theory

Due to the aforementioned fluid nature of interest group theory articles from The American Political Science Review, the voice of the American Political Science Association, were used for further understanding. Within its archives, I chose three articles to review for the purpose of understanding interest group theory and interaction with the Presidency.

The first is *Public Philosophy: Interest Group Liberalism* by Theodore Lowi (1967). In this article Lowi speaks to public philosophy as "the legal and moral basis, or principle, on which the power of political class rests." Lowi attributes this "power" can change with time but will often find it being given to those with private interests, instead of goals of governmental efficiency or public well-being. Thus, interest groups are given their political power by acquiescing to the private interests of their membership.

To develop this I reviewed *On the Origins of Interest-Group Theory: A Critique of a Process* by G. David Garson (1974). This article delves into how interest group theory in political science came into being and how it has evolved over time. Garson writes "The case for the pre-eminence of the state, for social planning, for liberal reform, for organizational democracy, for laissez-faire, or for resignation to the mixed blessings of group process may still be made." He continues saying "the actual operation of

American politics displays in varying degrees the practices associated with each perspective… Rather than adopt a systematically multifaceted orientation which incorporates the many strands of our discipline's past, most political scientists remain predisposed to select one or another orientation as 'the most nearly correct framework.'"

Finally, to expand on the interaction of interest groups and the presidency the article *The Presidency and Organized Interests: White House Patterns of Interest Group Liaison* by Mark Peterson (1992) was reviewed. Peterson reviews the Reagan administration while establishing consistency by noting examples from the Carter and Bush Sr. administrations. Peterson's work revealed four kinds of "interest group liaison" within the White House: governing party, consensus building, outreach, and legitimization. This article describes how access to the White House in an administrative role is very limited for interest groups and how interest groups are much more closely associated with Congress. This article must be taken in context since it was written before either Clinton or Obama was in office. Special consideration must be taken since President Obama has been very specific on resisting interest group participation in his administration, however was seemingly open to involvement and concerns of the AMA.

Health Care Reform- Clinton And Obama

Standard journal literature review for the Obama administration health care reform is virtually impossible since the policy process is so recent and for the most part is limited to media publications such as newspaper articles and editorials; radio and television coverage; and internet resources with vested interest in the reform. Observation of media coverage and document research sufficed for the analysis of the Obama plan.

The Clinton reform efforts have had time to air out and were very well documented. I chose Theodor Litman's Health Politics and Policy (1997) textbook and former Senator Tom Daschle's book, Critical (2007), as the most appropriate for review since it covers many areas of the process including the AMA's interaction with reform efforts. The texts offer comprehensive recall of events and barriers but also components of the plan and tactical errors in its attempted passage. In the case of Sen. Daschle's account, he calls on first hand experiences during the Clinton administration and is able to shed light on the inner workings on Capitol Hill as the Health Security Act was unfolding.

Of exceptional importance to this study was the section dealing with the Clinton administration's expectations of various interests. "The Clinton administration appears to have made some rather egregious errors in sizing up which interests could be counted on as allies, and which were likely to be opposed." (Litman, 1997) The AMA may have been the biggest of these. The AMA was, and consistently stated, they are in favor of universal coverage which was the primary premise of the Clinton plan.

Research Design

Robert Yin's *Case Study Research: Design and Methods* is primary source for the methodology of this thesis which will be covered in depth in the next chapter. The literature review of this book did lead however to the formation of the pertinent formation of the research question. Yin insists recognition of a theory in the design of the question is vital as is knowledge of the "rival" theory, or the antithesis. The driving theory in this thesis will be the comparison of the case studies to examine whether the American Medical Association supports health care reform efforts primarily when financial

interests and autonomy of doctors are protected. The rival theory would then be that the American Medical Association does not support health care reform efforts primarily when financial interests of doctors are not protected.

Study Purpose

The purpose of the study seeks to find with whom the AMA aligns its political priorities and examines the shift in the role of the AMA in health policy. With these theories in mind, the research question logically has to question why certain actions were taken in one scenario in comparison to another. This study will examine how and why the American Medical Association is treating health care reform similarly and differently with the Obama administration than the comparable efforts of the Clinton administration.

CHAPTER 3

METHODS

The primary focus of the research question is why and how the American Medical Association participated differently in the development and passage of health care reform in the United States under two different presidential administrations. When deciding among different research strategies it was important to decipher these "root question words". Robert Yin's (2003) book, *Case Study Research: Design and Methods,* provides a chart to highlight the differences in research strategies and corresponding forms of research questions, behavioral controls and whether the focus is on contemporary events. (see Figure 3.1) Yin (2003) goes further and presents a definition for a case study as research strategy: "The essence of a case study, the central tendency among all types of case studies, is that it tries to illuminate a *decision* or set of decisions: why they were taken, how they implemented, and with what result."

When applying Yin's matrix to the research question of this study, a case study is the most apt for all the criteria. Although three different strategies ask the same questions, an experiment requires behavioral control which I did not have; and as some of the events of this investigation unfolded even as this paper was being written, a history as a research strategy becomes inappropriate.

Figure 3.1
Relevant Situations for Different Research Strategies

Strategy	Form of Research Question	Requires Control of Behavioral Events?	Focus on Contemporary Events?
Experiment	How, Why?	Yes	Yes
Survey	Who, What, Where, How Much, How Many?	No	Yes
Archival Analysis	Who, What, Where, How Much, How Many?	No	Yes/No
History	How, Why?	No	No
Case Study	How, Why?	No	Yes

Yin speaks to the differences of a history and a case study and brings into perspective an issue I was confronted with in this instance. "The case study relies on many of same techniques as a history, but it adds two sources of evidence not usually included in the historian's repertoire: direct observation of the events being studied and interviews of the persons involved in the events. Again, although case studies and histories can overlap, the case study's unique strength is its ability to deal with a full variety of evidence—documents, artifacts, interviews, and observations—beyond what might be available in a conventional historical study." (Yin, 2003)

After establishing an appropriate research method, the design of the research becomes equally important. Yin (2003) suggests there are five elements of research

design: study questions; its propositions, if any; its units of analysis; the logic linking the data to the propositions; and the criteria for interpreting results. For each of these mechanisms there is slight adjustment due to the comparative nature of this study. The attempt to reform the American health care system is the "case" in both of the case studies. The unit of analysis being the AMA remained consistent in both cases as well. The measures are the different sorts of political force; whether funding towards or against certain efforts, public statements made or not made, etc. The logic linking the data to the different propositions remained the same as did the criteria for interpreting the results. The impact of comparing two case studies with different criteria would leave the findings void.

Data Sources

Yin (2003) describes six main sources of information when collecting evidence: documentation, archival records, interviews, direct observation, participant-observation, and physical artifacts. Due to the nature of the study, the first three were the only relevant or feasible sources. Documentation was the major source of information. The credibility and the source of the documentation were kept in perspective while the strengths in this sort of information gathering are stability; broad coverage over time and settings; and exact information. Examples of sources I used include journal and newspaper articles; letters, memoranda, and other communiqués; administrative documents and written outcomes; textbooks and reference materials; and formal examinations whether in AMA book or report form. Political journals and newspaper coverage proved appropriate information on events as they occurred and response from involved characters. Especially

relevant was the Journal of the American Medical Association (JAMA) and the American Medical News newspaper, both published and distributed by the AMA to membership. These two sources are used as the Associations most common and frequent tools of communication. Textbooks and other specialty books were a primary source for political and interest group theory. Interview material and speech transcripts used in these studies were conducted or reported by a secondary source, such as journalists, and transcripts or observation from video were also used.

Procedures

Each source was examined for various forms and sources of bias including poor recall, poorly constructed questions, reporting bias, and accessibility issues. Triangulation of multiple perspectives will also be used to determine if the "thesis" or "antithesis" best fits the evidence.

Many decision points were included in process of this paper. An important decision was made about the time-frames under which the AMA's actions were examined since the political process was vastly different between the two reform efforts. During the 1993 and 1994, a health reform bill was never voted on by either chamber of congress. On the other hand, in the last two months of 2009 the House of Representatives and the Senate voted on and passed their respective bills. Due to this, comparison of the AMA's strategies and actions during the current reform efforts are only observed through December 24th of 2009 when the Senate voted on the Patient Protection and Affordable Care Act. It is important to note the final result of each attempt to keep strategies in context for policy implications.

Another pivotal decision point came in deciding what types of external factors were to be included and which fell outside of relevancy to this study. For example, many point to Clinton not putting out a plan sooner being a huge detractor to health reform as priority. Among these distractions were NAFTA, Whitewater, and the war in Kosovo. (Daschle, 2007) Others attribute Clinton health reform falling out of public favor due to a widely popular advertisement campaign funded by the Insurance industry and small business. "Harry and Louise" commercials depicted a lost couple who couldn't navigate the new "Hillarycare". During the Obama experience, the economy and the passage of the reinvestment act as well as the bail out of failing banks quickly influenced the political capital the young administration had. All of these external factors possibly played a role in the fate of the proposed legislations in both instances, however it was decided that they had little impact on the AMA's priorities or actions with regards to reform attempts.

Furthermore, there were activities in between the two health reform eras which were deemed relevant to the AMA's actions and priorities. Discussed in more detail later in the paper, items that were external to the two cases but still held pertinent to the scope of this paper include the rise of managed care and the passage of State Children's Health Insurance Program (SCHIP).

As this paper evolved the research design and methods evolved with it. Although Yin contests that case study research must be driven by a central bi-variant (thesis and antithesis) theory; these particular cases encompassed multiple variables which ultimately led to the research including those in its conclusions. Income and autonomy of physicians

were not the only considerations in the discussion of did the AMA support reform and, if so, why or why not? Cultural changes, ideology, significance of implications, and political landscape were all where taken into account in fleshing out the reasons for the similarities and the differences between Clinton and Obama health reform.

CHAPTER 4

RESULTS

President Clinton's administration came into office with ideas on what reform should look like. During the political process, the President had made an ultimatum stating he wasn't going to sign a bill that didn't guarantee universal coverage. The formulation of his proposal outside of universal coverage was largely left up to the First Lady led Interagency Health Care Task Force. How the bill was best financed and what types of cost controls for the most part were left to the 600 member committee. The administration's job was to sell the findings of this task force to the general public, Congress and outside interests which included the AMA. The resulting proposal was the Health Security Act of 1993. Below are key provisions of the Clinton plan coming from the New England Journal of Medicine in an article by Jonathan Oberlander,(2007) reviewing what can be learned by past reform efforts.

Figure 4.1

Key Provisions of the 1993 Clinton Health Security Act.
• Universal coverage and comprehensive benefits • Mandate that all employers pay 80% of the average health insurance premiums for their workers, with caps on total employer costs and subsidies for small businesses • Cost control through competition among private health plans and federally determined caps on insurance-premium growth • Establishment of regional purchasing pools (health alliances) through which people would enroll in insurance plans • Financing through employer mandate, savings from cuts in projected Medicare and Medicaid spending, and increase in federal tobacco taxes

President Obama carefully laid out concerns and priorities for health care reform but left the intricacies predominantly to Congress. Formulations of proposals were the responsibility of members of both Houses and their charge was to find a politically feasible bill which still fit in the goals set by the White House. The strategy to let Congress work out the passage of a bill was questioned along the way with frequently extended deadlines and the seeming forfeit of a public option. "Where Clinton and his team crafted their health-care reform plan in the executive branch, Obama has left the details of his effort almost entirely to Congress. Where Clinton pursued an ambitious reconstruction of the entire sector, Obama has sought to preserve existing insurance arrangements and win the support of industry players." (Klein, 2009) A compromise was reached with the passage of the Patient Protection and Affordable Care Act with amendments contained in the Health Care and Education Reconciliation Act of 2010. Figure 4.2, below, is a collection of key provisions from the Kaiser Family Foundation (2010) site.

Figure 4.2

Key Provisions of the 2010 Patient Protection and Affordable Care Act.
• Estimates 95% of citizens to have access to affordable health services by requiring most citizens and legal residents to have health insurance • Expands Medicaid to 133% of FPL and provides tax credits for families/individuals with income between 133%-400% when purchasing through newly formed state-based American Health Benefit Exchanges • Contains fines for employers with >50 employees that do not offer coverage • Bans excluding persons from coverage based on pre-existing conditions • Parameters to reduce waste and fraud and improve quality through comparative effectiveness research • Increase funding by $11 billion for community health centers over 5 years • Financed through savings from Medicare/Medicaid and new taxes and fees.

AMA Role In Clinton Health Reform

The May 15, 1991 issue of the Journal of the American Medical Association (JAMA) was completely dedicated to calling for a federal guarantee of basic medical insurance. Although previous actions by the AMA might have signaled the trade association was not for universal coverage, the AMA is and has been a supporter of demand-increasing legislation. Economic theory tells us that with a given supply an increase in demand results in an increase in price, and increase in total revenue, and ultimately an increase in income for the providers. The preferred method of demand-increasing legislation by the AMA would be for the government to provide subsidies for the purchase of health insurance on a sliding scale based on income. (Feldstein, 2005)

Then Governor of Arkansas, Bill Clinton, was campaigning for President and saw promise in pushing for reform of the American health care system. Hesitant at first, Clinton wouldn't lay out a detailed approach. The fear was in tying himself to a particular proposal and then being stuck to it. Ultimately, he came to prefer an idea that fit his New Democrat mantra. Clinton wanted to provide universal coverage while keeping competition and a market approach. He found that union in a regulated fashion of managed care. With the backdrop of Merck Pharmaceuticals, Gov. Clinton delivers a speech calling for principals of managed competition with goals of "personal choice, private care, private insurance, private management, but a national system to put a lid on costs, to require insurance reforms, to facilitate partnerships between business, between government, and health-care providers." (Daschle, 2008)

Shortly after a Clinton victory in the 1992 Presidential election, Ira Magaziner presented a plan to the President in which a bill would be ready by May of 1993. The plan included the establishment of the aforementioned Interagency Health Care Task Force. In a decision that would bring much scrutiny, the President tagged First Lady Hillary Clinton with the responsibility of chairing this task force. At its conception, the Task Force was to be 98 members, mostly White House aides and governmental agency personnel, but that number grew with insistence from the White House to include Congressional staffers of key members, academics, policy experts and physicians. The Task Force grew to over 600 hundred. The importance of its size comes more from who wasn't invited instead of who was. Although individual physicians were a part of the discussion, the AMA was not. Hillary Clinton even declined a written request from the AMA to be involved. (Iglehart, 1994) After much deliberation, and a few distractions to the President's attention, a bill was presented to a joint session of Congress by the President in September of 1993.

Once the torch had been passed to Congress to pass health reform with the guidance of the Clinton administration present every step of the way, the AMA was active in the deal making that took place next. In a later interview, Dr. James Todd, President of the AMA said, "Our access to the White House and the Cabinet departments has been good. It certainly surpasses anything we experienced in the last 12 years." In a report to the AMA Board of Trustees, the AMA states "in response to concern expressed by the medical lobby, the administration had modified its proposal so that physicians and physicians' organizations could collectively negotiate fee schedules for fee-for-service

plans with states and health alliances." (Iglehart, 1994) Other changes were mentioned in response to pressure from physicians included limiting the number of fee-for-service plans in a geographic area and requiring health plans offer a "point-of-service" option.

In December of 1993 in New Orleans the AMA's interim meeting was the final straw turning the Association against any health reform proposals which were catching any momentum going towards the New Year. To this point in the process, the AMA was in the mode of influencing the formulation of proposals that could have their support. When December came the only feasible plan going forward to assure universal coverage, one of President Clinton's demands, included an employer mandate. The AMA had supported an employer mandate since 1989 however at the interim meeting, several state delegations came forward and demanded the board of trustees rescind their support. A study conducted by the AMA's Center for Health Policy found 85% of doctors were part of a practice with 10 or fewer employees. Just like many other small businesses of the time, most practices didn't' offer health insurance to their workers. The study went on to predict a mandate might increase practices' costs by $1,700-$1,900 per employee in 1992. (Iglehart, 1994)

Responding to the AMA urging the Clinton administration to consider alternatives to an employer mandate, the White House organized a media event to "inject new life into the campaign for Congressional passage of the bill (Health Security Act of 1993)." The event included 10 different doctors groups outlining their support for the reform's requirement for employers to buy health insurance for their workers and underline their differences from the AMA. (Pear, 1993)

Clinton used this press conference to play medical organizations off each other and expose the AMA as not the only voice of doctors. "The presence of these physicians here debunks the notion that the plan we have presented is some sort of big-government bureaucratic plan that erodes the doctor-patient relationship," said Clinton. To put into perspective, President Clinton said the 10 opposing groups represented more than 300,000 physicians which is greater than the 296,600 members the AMA claimed at the time. The 10 doctors groups included the American Academy of Family Physicians; the American Academy of Pediatrics; the American College of Obstetricians and Gynecologists; the American College of Physicians, the American College of Preventive Medicine; the American Medical Women's Association; the American Society of Internal Medicine, the American Thoracic Society, the National Hispanic Medical Association and the National Medical Association, which represents black doctors. (Pear, 1993)

In early March of 1994, the AMA, as it had three years previously, went to their membership with a call for action through JAMA. The March 9th issue of JAMA included an article written by AMA leadership called: Shared Sacrifice: The AMA leadership response to the Health Security Act. In the article six areas of concern are highlighted: security, savings, simplicity, choice, quality and responsibility.

The article suggests remedies for each of the issues and reinforced the AMA's willingness to be a more active member in the implementation. First, the security and stability of the plan made the AMA cautious as to the possible fluctuation of reimbursements. The leadership calls for a phase-in approach to allow for better cost

estimates. In addition, they suggest additional revenue required come from Medicaid/Medicare and raised sin taxes.

The next concern raised was expressed as the most alarming to the AMA. The idea of premium caps as a way to save and control costs not only threatens physician income but also minimizes physician autonomy. The contention is that caps will ultimately lead to rationing or price controls at some point and along with the entire managed care system, the rationing might not even be left up to the doctors.

The article was not all negative. The idea of each individual having a health security card and the steps included to streamline the billing process was applauded by AMA leadership. However, the leadership was not content with the extent of simplifying the process. It sought to eliminate paper work and administrative details associated with Clinical Laboratory Improvement Amendments (CLIA), Occupational Safety and Health Act (OSHA), and Patient Reported Outcome (PROs).

AMA leadership was also complimentary of the proposals for quality and responsibility measures. In both instances the AMA was concerned with the lack of physician involvement in the development of these measures. The article sites that professional cooperation is crucial and impossible without physicians crafting the measures to gauge performance and outcomes.

Lastly, the leadership spoke about concerns with choice in the Health Security Act. It was no secret that physicians had been opposed to the managed care aspects of the proposal and framed their concerns as a matter of choice. Once again a threat to physician autonomy, according to the AMA managed care was going to take decisions out of the

doctor-patient relationship and put them in the hands of an insurer with regulated caps making the decisions for them.

The following spring and summer of 1994 for Senate majority leader George Mitchell and House majority leader Dick Gephardt were spent looking to find votes for the Health Security Act. Conservative Democrats were starting to put space in between themselves and the Clinton White House since his popularity was waning after NAFTA and Watergate. House Minority leader Newt Gingrich had done a masterful job in convincing the Republicans not to support any form of the bill and allow the party to reap the benefits in the midterm elections.

While Mitchell and Gephardt were struggling on the Hill to find support, the health insurance industry was dismantling support among the general public. Small insurers were concerned with the effects that managed care would only benefit large insurers; while large insurers were concerned with caps being included that would ultimately limit their profits. With all size insurers adamantly against the Clinton plan, they partnered with small business interests to stifle out any progress with aggressive lobbying and advertising efforts. (Litman, 1997)

Even though the Democrats enjoyed majorities (56-44 in the Senate and 257-176 in the House) no proposals were ever voted on in either chamber. On September 26, Sen. Mitchell held a press conference where he put an end to health care reform. He simply stated he didn't have the votes and "the combination of the insurance industry on the outside and a majority of the Republicans on the inside proved to be too much to overcome." (Daschle, 2008) Gingrich and the GOP were rewarded for their stubbornness

and reclaimed 54 seats in the House and 8 seats in the senate. Majorities in both chambers switched and Gingrich was the new Speaker of the House.

Changes Occurring Between Clinton And Obama Health Reform

After the AMA spent all of 1993-94 adamantly opposing Clinton's proposal of building the health delivery system around managed care, managed care emerged anyway. However, this time it was private interests leading the way to managed care but this time there were no government cost controls to accompany it. Washington Post political columnist Ezra Klein (2007) describes it this way:

> The managed-care revolution of the mid-90s was, by the early years of that decade, clearly inevitable; the financing and delivery of health care could not remain separate forever. But this was a dangerous change. Insurers make money by denying claims. Money they spend on health care is money they lose (they even have a name for it: the "medical-loss ratio"). Private insurance is a bit like a fire department that turns a profit by letting buildings burn down. So Clinton sought to cage managed care inside managed competitions, which would regulate the behavior of insurers and force them to compete for patients. This would give consumers more power against their insurance companies, drive the bad actors from the market and generally protect against the excesses of managed care.

Physicians continued to fight managed care by challenging it in multiple arenas. All throughout the 1990's they sought to eliminate their loss of control over costs and to continually buck the intrusion of non-medical personnel in the decision-making of provision of services. The AMA continued to lobby at the State and Federal levels

against managed care practices and physicians even took to the legal system by allegations of antitrust violations by a few large insurers. (Quadagno, 2004)

The establishment of another public program also became a reality in the mid-1990's. The State Children's Health Insurance Program was enacted in 1997 as Title XXI of the social security act. It was framed and built upon the functions under Title XIX/Medicaid, which was enacted about 10 years earlier. The new program was funded as a capped block grant, with states receiving $40 billion in federal funds over 10 years in which the individual states are to match funds they receive. This program was enacted to provide insurance for low-income children.

By its full implementation over 5 million children and over 600,000 adults were covered under SCHIP and the AMA adamantly supported its reauthorization in 2007. The AMA, as a member of the Health Coverage Coalition for the Uninsured, supported full funding of SCHIP to cover all eligible children and refundable, advanceable tax credits for buying health insurance. (Trapp, 2007) The establishment and reauthorization of SCHIP are examples of the AMA in strong support of a government intervention in the provision of health services.

AMA Role In Obama Health Reform

The experience President Obama had with reform efforts started similarly. In January 2007, 16 groups presented a joint plan to extend insurance coverage to over 20 million people. Integral to this group was the AMA. The plan called for tax incentives for individuals and families and an expansion of CHIP. With such activity present externally,

there was no doubt that health reform would be a heavy topic in the upcoming presidential election. (Pear, 2007)

Later that year on the campaign trail at the University of Iowa, Senator Obama delivered a speech on his hope for the reform of the health care system in America. He highlighted some of his goals like providing basic coverage to every American and reducing cost by improving quality and eliminating waste. Obama acknowledged his predecessors in the fight for health reform but also provided differences between him and the current situation in comparison to the struggles of the past. (Cutting Costs, 2007)

After a victory in the tightly contested primary with health care savvy Hillary Clinton, Obama separated himself from Republican presidential candidate, Arizona Sen. John McCain, by establishing his belief on multiple occasions that access to affordable, quality health care was a right and not a responsibility of an individual. With an economic depression stealing the spotlight from health care Obama was able to wield his way to a convincing victory accompanied by a shift in the Senate to a "filibuster-proof" democratic majority.

Although the economy was in such dismal shape, the Obama administration knew that if they were to repeat the mistakes of President Clinton and wait to come out with a proposal for health reform, the political capital might not be there to get a bill passed. The AMA was cognizant of this fact as well. In April 2009, the AMA sent the White House a letter announcing its "strong support for eight guiding principles against which Obama has said he will gauge the health reform effort". (see Figure 4.3)

The AMA also offered expansions for the guidelines. Proposals expanding on the principles included reforming and improving insurance markets; assisting low-income individuals through cost-sharing and premium subsidies; promoting medical home models; establishing antitrust reforms; and easing the effect of liability pressure on the practice of defensive medicine.

The AMA position wasn't lock step however. The letter stated that the Association supports a national health insurance exchange to ensure coverage choice and portability but didn't comment on a governmental public option plan. Nevertheless, support was duly noted and Nancy-Ann DeParle, head of the White House Office for Health Reform, reached out to the AMA as an ally. The AMA was a specified one of "various groups who I (DeParle) have reached out to or who have reached out to me to talk about how to get this done this year." (Silva, 2009a)

At the AMA annual conference that June, President Obama laid out a revised plan for health reform with more specific guidelines for Congress to work around and build upon. AMA leadership was receptive and in some cases excited by the President's proposal. Following are the principles that were highlighted by the President to the AMA.

Figure 4.3

President Obama's 8 Guiding Principles for Health Reform
1. **Guarantee choice:** The plan should provide Americans a choice of health plans and physicians. People will be allowed to keep their own doctor and their employer-based health plan.
2. **Make health coverage affordable:** The plan must reduce waste and fraud, high administrative costs, unnecessary tests and services, and other inefficiencies that drive up costs with no added health benefits.
3. **Protect families' financial health:** The plan must reduce the growing premiums and other costs American citizens and businesses pay for health care. People must be protected from bankruptcy due to catastrophic illness.
4. **Invest in prevention and wellness:** The plan must invest in public health measures proven to reduce cost drivers in our system -- such as obesity, sedentary lifestyles and smoking -- as well as guarantee access to proven preventive treatments.
5. **Provide portability of coverage:** People should not be locked into their jobs just to secure health coverage, and no American should be denied coverage because of preexisting conditions.
6. **Aim for universality:** The plan must put the United States on a clear path to cover all Americans.
7. **Improve patient safety and quality care:** The plan must ensure the implementation of proven patient safety measures and provide incentives for changes in the delivery system to reduce unnecessary variability in patient care. It must support the widespread use of health information technology with rigorous privacy protections and the development of data on the effectiveness of medical interventions to improve the quality of care delivered.
8. **Maintain long-term fiscal sustainability:** The plan must pay for itself by reducing the level of cost growth, improving productivity and dedicating additional sources of revenue.

The President received ovations from the crowd of doctors with topics of making reimbursement rates based on performance instead of the Sustainable Growth Rate, which is closely to the economy and the federal budget. He also spoke of defensive medicine and liability reform which has been a long time concern of the AMA.

Immediately after the President's address, outgoing AMA President Nancy Neilsen and incoming President James Rohack held a press conference responding to President Obama's remarks. Both leaders commented on their excitement and the AMA's willing participation in health reform. Rohack emphasized the importance of health care reform to the economy and the future of the country and encouraged observers to keep an open mind and not be taken in by false rhetoric or fear-mongering. Rohack also brought up the President's recognition of the role the AMA has in the reform process. "His coming recognizes that doctors are there for their patients, and if doctors don't believe reform will be good for their patients, we'll let our patients know." Nielsen was on the same page. She spent her time talking about being "open to whatever possibilities are actually in play, being considered in Congress, rather than reacting to a label" in response to questions of a public plan option. Nielsen went on to say the AMA will figure out the way it can best help the president reach the goals they share, which is affordable health insurance for all Americans. (Rubenstein, 2009)

Shortly after the President's address to the AMA, a proposal from a House of Representatives Tri-Committee received the AMA's support. The three committees with jurisdiction over health in the House (Energy and Commerce; Education and Labor; Ways and Means) introduced the America's Affordable Health Choices Act on July 14. Two days later the AMA came forward with its support for the measure. "We are committed to passing health reform this year, consistent with principles of pluralism, freedom of choice, freedom of practice and universal access for patients," said AMA President Dr. James Rohack. Rohack made it clear the AMA decided to back the bill only

after the authors made changes including no longer requiring Medicare-participating doctors to accept the new public option plan. The AMA also admitted there was a lot to support in this legislation: reforming Medicare payment plans to align reimbursement more closely with costs of provision; insurance market reforms to cover most Americans; choice of plans to consumers through insurance exchanges; and new money to boost primary care services and address physician workforce issues.

One day after the AMA's announced support, the three House committees approved the legislation for consideration by the full chamber. Rep. John Dingell, a longtime advocate for health systems reform, emphasized the magnitude of the AMA's support calling it a milestone in reform and a testament to the bill not threatening the doctor-patient relationship. (Glendinning, 2009a)

Once the tri-committee bill was on its way to the House floor, the attention of interested groups, including the White House, shifted their attention to the happenings in the Senate. It was known that Sen. Edward Kennedy's Health, Education, Labor and Pensions committee had a plan ready to go but the Finance committee had more of a shot at garnering the necessary support to pass a bill out of the Senate. With every proposal being scrutinized and debated the anti-reform rhetoric began to gain traction with an impatient general public. In early September, President Obama made a speech to Congress in an attempt to thwart some false claims being made about reform.

The interest groups in support of legislation up to this point did their part to cut off the flow of misinformation and slander as well. The AMA, partnered by the American Association of Retired Persons (AARP) and the American Nurses Association (ANA),

held a joint teleconference to put some of their constituents concerns on the table and clarify any fears. Former AMA President Nancy Nielsen was part of the conference. "It's been pretty sad, actually, to hear about the 'killing granny' death committees and to see the fear that's been fostered in people." Nielsen said. "And I think we need to thoughtfully address that and have an honest conversation, not just empty promises." In addition to the teleconference, the AMA had also conducted town hall type meetings for physicians as well as written open letters to Congress that allowed supporters to familiarize themselves on the positions and interests of the proposals and then choose to add their support or not. (Silva, 2009b)

About two months after the President's address to Congress, the House of Representatives passed the Affordable Health Care for America Act with a vote of 220-215. The AMA two days prior to the passage had announced its qualified support of the legislation but did not endorse the entire proposal. This qualified support was the key issue at the November interim meeting of the AMA. Multiple specialty societies and state medical associations came forward with resolutions to AMA policy that would have rescinded the AMA's support of the bill. The delegates reaffirmed their support of the bill and chose not to retract any statement. Critics within the AMA suggested that the qualified support of the bill showed the AMA was dodging the public option included in the bill to not violate AMA policy. The same group of delegates was worried about the image being portrayed, whether intentional or not.

Proponents of the announced support referenced multiple attempts to clarify the Association's endorsement. Leaders of the AMA had appeared on television and held teleconferences to explain their position in detail. Other delegates even came forward suggesting that support should be given when a majority of policy goals are met or can be negotiated with support; suggesting that "holding out for legislation that won't conflict with any AMA policy would brand the Association as an organization that always says 'no'". (Trapp, 2009)

The 2009 interim meeting was also at a pivotal point in the process. When the AMA met in Houston in November, the House had just voted and passed its version. The Senate hadn't voted on its version yet but the timetable was coming to an end. The AMA reaffirmed its support of the House bill and strengthened some policies supporting the reform efforts.

A month and a half later, AMA President-elect Dr. Cecil Wilson appeared with Senate Majority Leader Harry Reid to push the Senate to pass the Patient Protection and Affordable Care Act. This endorsement was not a sure thing as early as a month prior. Dr. Wilson acknowledged revisions made to the original proposal which were important to physicians: retaining a Medicare bonus for some primary care doctors and general physicians; removing a tax on elective surgeries and a fee to enroll in Medicare. The bill also removed a one-year Medicare patch which averted a planned cut in Medicare. Dr. Wilson added, "All Americans deserve affordable, high-quality health coverage so they can get the medical care they need – and this bill advances many of our priority issues for

achieving the vision of a health system that works for patients and physicians." (Glendinning, 2009b)

Similarly, there was a split among the ranks of physicians when approaching President Obama's reform efforts. Although the AMA was supportive in this instance, there were still fragmented voices from medical providers in the battle over how to reform the American health delivery system. In January 2010, the Canadian Medical Association Journal laid out a title for a story which could have fit the episode at the White House in 1993: *US doctors divided over health reforms.* At the beginning of the article it stated, "As the US Congress scrambles to iron the kinks out of its health reform legislation, America's two most influential medical associations remain deeply divided over the merits of changes respectively proposed by the House of Representatives and Senate in late 2009."

The AMA, and its approximately 250,000 members, was pitted against the American College of Surgeons. One of the larger issues of legislative proposals that concerned the ACS was the establishment of an external advisory board, meant to direct and guide physicians accepting Medicare payments. The ACS, with a base membership of 77,000 surgeons and anesthesiologists, was supported on its stance by 19 other surgical associations representing more than 160,000 surgeons. (Webster, 2010)

While the AMA didn't universally agree with all of the pieces of the proposed legislation is has steadily supported its passage at every step through this point. Dr. Cecil Wilson (2009), current AMA president-elect, explains why supporting good but imperfect legislation is more important than obstructing it.

> We chose to support the Senate Bill because we think we can have more influence if we stay at the negotiating table. We are not going to draw lines in the sand publicly until we have to. And that's not going to be until the end. And we're not going to draw lines in the sand on one issue alone. The problem with backing away and saying 'no' on individual items is that you lose your place at the table. The groups who have done that are no longer at the table. They will not have input at the joint conference committee.

At this point in the process, the AMA put its stamp of approval on the Senate version after the Senate scrapped the public option plan, the Medicare buy-in option for people 55-64, and particular provisions that would cut Medicare payments to physicians. Even with the concessions made by the Senate, the AMA still had plans on lobbying for change in regard to the Physician Quality and Reporting Initiative and, the ACS' main contention, the establishment of an Independent Medicare Advisory Board. President-elect Wilson did mention the AMA's support of value-based payments but interjected there aren't "good guidelines for reporting on surgeons and physicians" without serious damage to doctors reputations. (Webster, 2010)

Immediately following the announced endorsement of the Senate package the AMA launched a full-scale advertising campaign to push Senators to pass the legislation. The AMA again found an ally in the AARP. The duo put out multiple television advertisements and co-authored letters to key legislators. Together the AMA and AARP have spent joint resources on issues like cuts to Medicare; increase of funding to the State Children's Health Insurance Program (CHIP); and reforming the Sustainable Growth

Rate (SGR). In response to strong rhetoric from Republican leaders about proposed cuts to Medicare that were part of the Senate proposal, AARP and the AMA ran an advertisement urging senators to pass the bill, because of more prescription drugs and preventive health services being covered under the proposal. (Pear, 2009)

On a rare Christmas Eve special session, the Senate passed the legislation with a straight party-line vote, 60-39. The bill had no public option which carried through the joint negotiations of the House and Senate.

Similarities And Dissimilarities Between Clinton And Obama Eras

The cases above provide multiple similarities, as well as some variability. In some instances, the variability appears within a similar situation. For example, the two cases show a similar experience with varying opinions of physicians as a single profession. The AMA's position within the segmentation was different between the two administrations. During the Clinton administration the AMA sided against reform due to influences internally that were strong enough to sway their stance. Conversely, in the late 2000's the AMA reaffirmed their stance of support even when dissention arose within the Association.

A second example of a similar event with dissimilar variables is the AMA's affiliations during the respective reform efforts. To increase influence it is common to align with groups of similar interest, which occurred in both cases. A shift occurred from the first case when the AMA was more closely affiliated with consumer groups (AARP) and other providers (ANA) during the Obama administration and aligned with big

insurance (HIAA) and business (Chamber of Commerce) in opposition in the early 1990's.

A dissimilarity of the cases is the approach in which the administrations interacted with the AMA and recognition of the AMA's role in the formulation of the plan for reform. Where Clinton's plan was largely mapped out in the Health Care Task Force which had no formal AMA involvement, the Obama administration laid out hopes and goals for reform at the annual conference of the AMA. Also mentioned was the openness of Nancy-Ann DeParle to contributions and concerns from interested groups who had reached out to the White House.

In addition, the AMA was more willing to stay involved in the process, even if certain issues or concerns existed within legislative proposals. The previously mentioned dissimilarity is strongly tied to this trend; however the attitude towards reform in the 90's was set in ultimatums and authority. Leadership of the AMA in the late 2000's was openly more participatory and made it known that although certain policies were of concern to physicians, they were still interested in moving forward with reform.

The AMA did conduct themselves similarly by having physician involvement in the planning and implementation of reform as a high internal priority. At multiple points throughout both cases the AMA speaks to the importance of physician involvement, not only in the formation of the policy but the implementation and the execution of the reform.

It is important to note that because of the comparative nature of this study, the final AMA endorsement and the passage of the Obama reform was not included in the cases. However, in the interest of the policy implications this study has it is important to recognize the passage of the Patient Protection and Affordability Act of 2010 and the AMA's endorsement of that legislation.

CHAPTER 5

DISCUSSION & CONCLUSIONS

Although the development of this thesis evolved, there is still practical application of the original discussion of a dominant thesis versus its antithesis. The antithesis is supported in the case of the AMA's interaction with health reform during the early 1990's. The theory of the AMA's support being primarily contingent on physician income and maintenance of autonomy was supported by actions taken as well as stated position on those issues. Conversely, during the Obama administration the AMA was supportive even in the face of a public option, which possibly threatens income, and quality and accountability changes, which lends to the lose of sole decision-making authority. This evidence would show the driving theory was not supported in the case of the AMA in more recent health reform episode.

Previous Literature

Many of the sources' findings reviewed for this paper are strengthened by the results of this case comparison. Laugesen & Rice (2003) are reinforced by findings presented. On the other hand, the findings would refute the ideas presented in Peterson (1992) and Quadagno (2004).

First, Quadagno (2004) contends that organized medicine has suffered a loss of political influence in comparison to the accounts of Starr (1982) but is still formidable in the realm of health policy influence. Because of this loss of influence, physicians "compensate for the loss of political influence by forming new partnerships, notably with consumer groups." This paper shows instances where the AMA has aligned themselves

with arguably the most influential of consumer groups, the AARP. Through this partnership, objectives were accomplished that may have been too much for a segmented profession to tackle alone.

However, physicians have a place in American society, which Starr highlights, that is not enjoyed by any other profession: the trust of their clients. It would be difficult based on this study to say physicians are weakened because of formed partnerships but instead have realigned their interests away from the payers of the system towards the consumers. In President Obama's address to the AMA, he offered an acknowledgment of physicians' strength of political influence. "I need your help, doctors, because to most Americans you are the health care system. The fact is, Americans -- and I include myself and Michelle and our kids in this -- we just do what you tell us to do. That's what we do. We listen to you. We trust you. That's why I will listen to you and work with you to pursue reform that works for you." (Newshour, 2009) Quadagno does end with recognition that the physicians in the political world are simply "weakened but not vanquished."

Second, Laugensen and Rice (2003) conclude that physicians and their role in health policy is one driven by interest or advantage. Laugensen and Rice (2003) continue on to highlight where leadership from physicians is an appropriate fit:

> The future roles of physicians are likely to be based on leadership within specific domains or niches where physicians have a natural interest and advantage—that is, where they have both reason and the capacity to lead. These niches may be supplemented when an issue makes it necessary and desirable for physicians to

align themselves with other interests such as other providers and consumers. Physicians are likely to be natural leaders in the areas of payment, quality and clinical innovation, and medical education and training.

The findings of this study have apparent ties to the above prediction of physician involvement in health policy. The AMA made certain that physician involvement was considered on the three issues listed and solicited support and recommendations for all as well. Reasons for AMA endorsements of proposed legislation often had to do with legislative attention being given to workforce issues; payment issues with concerns to the SGR; and with quality measures like comparative efficiency research.

Finally, Peterson's conclusions based on the examination of the presidency and organized interests is not supported by the findings presented here. Although, Peterson was sound in his methods, findings and, at the time, his conclusions; there has been a shift in how organized interests are approached by the White House. As examined in greater detail later in this chapter, interest groups which were constructive and supportive of reform efforts were welcomed and positioned strategically by the Obama White House throughout the process. Peterson's assertion that interest groups involvement is more closely associated with Congress is brought into question by the occurrences of the most recent health reform episode.

An Evolving Profession

The first similarity of the cases described multiple voices being involved in organized medicine, shows the shift from the old health policy landscape to a new one. The predominant scene up until the early 60's was a strong and stable "iron triangle".

This triangle featured a small number of powerful interest groups with concordant views that, for the most part, had sympathetic partners in the legislative committees and in the relevant implementing agencies of government. The AMA was as big a part of that triangle as any other interest group. As shown by the splitting groups in both reform cases, this is no longer the case. "Rather than an iron triangle, the contemporary health policy community is more accurately described as heterogeneous and loosely structured, creating a network whose broad boundaries are defined by the shared attentiveness of participants to the same issues in the policy domain." (Longest, 2006)

With more players being involved in health policy domain of influence and the free-for-all structure of that influence, the AMA has needed to change as the market of influence has changed. The number of voices has not only increased in the health policy domain, but both of the cases in question show that multiple voices are present and often pitted against each other within the same profession. Before, one voice, the AMA, could speak, mobilize, and lobby on behalf of all of one profession, physicians. In the new arena of influence in health policy, the AMA is conflicted internally to a point where attempting to please the entire physician constituency becomes improbable, if not impossible.

A Shift in Leadership Strategy

One of the most telling changes from previous AMA involvement in health reform is their new strategy to being an active player in the formation of health policy. In previous reform attempts the AMA has taken staunch approaches to what it wants included or not included in proposals of health reform. Now, AMA leaders and members

are being quoted as saying they would rather "support imperfect legislation and be invited back to the table" and desire not to be "branded as the Association that always says no." (Trapp, 2009) This is a shift of enormous proportions from previous cries of "socialized medicine" in respect to Medicaid\Medicare and even more hostile rhetoric directed at Truman's attempt to reform health systems in the United States.

This shift is out of necessity more than a change in attitude. The AMA has seen a shift in its power and position and has made decisions based on survival and not preference. Part of this act of survival has come from distrust towards the medical profession in recent years. Peterson (2001) brings the issue of societal trust towards physicians into the spotlight in his article, *From Trust to Political Power: Interest Groups, Public Choice, and Health Care.* "The concerted and perhaps increasingly explicit efforts of physicians as an organized interest group to protect their own economic interests, especially when other sources of information began to emerge, some far more objective, made it difficult for them to maintain social trust." (Peterson, 2001) The paper goes on to describe the profession falling out of favor in the health policy spectrum and being "hardly even a recognized player" in health reform in the 90's.

Also encompassed in this shift of strategies and positions is the modification in assumed political affiliation. The AMA has been historically aligned with conservative parties throughout US history and the trend in lobbying dollars has shown this to be true; until recently. According to the Center for Responsive Politics, over the last 20 years, 10 election cycles, the AMA has contributed 60% of its lobbying dollars to Republican candidates. 2008 was the first year in that timeframe where Democrats received a

majority of funds, 56%. Through these shifts in ideology and leadership strategies, the AMA is looking to reinsert physicians as a trusted and respected profession in current society as well as in the arena of health policy.

Administration Approaches

The final comparison worth greater consideration is the approach that each administration took toward its relationship with the AMA. While acknowledging that approaching an ally is more palatable, the Obama administration from the beginning of the process chose to keep the AMA within arm's length. President Clinton's stated most important policy priority was providing universal coverage. As previously mentioned, the AMA called for universal coverage a year before Clinton moved to the Oval Office. With the top of Clinton's and the AMA's list of priorities for reform being identical, one might assume the administration would be more supportive of the Association; and vice versa. However, a non-invite to the AMA to play a formal role in a 600 member Health Reform Task Force sends a clear message.

President Obama, in opposite fashion, formally launched his goals for health reform to an audience of the AMA's annual conference. Pediatrician Rahul Parikh, M.D., a health policy blogger and columnist for the San Francisco Chronicle, wrote an article titled "How Relevant is the American Medical Association?" Parikh (2009), not a member of the AMA, cites that although membership in the trade organization is not where it historically has been, there are two prominent reasons it still wields great power.

> First, the number of doctors who comprise the AMA matters less than their influence in the beltway—they still are a potent Congressional lobby with plenty

of cash to spend. Second, since Barack Obama does his homework, he knows who and what he's up against. During the Great Depression, FDR wanted to make comprehensive health reform part of the New Deal. In doing so, like Obama, he was forced to confront the AMA.

Whether or not the gesture by Obama was to keep his friends close and his (potential) enemies closer, the shift to up-front, public discourse with the AMA is significant.

Implications

Going forward, the AMA can no longer be labeled a blockade to massive health system reform or a barrier to government intervention in health service delivery. Multiple reasons exist why a shift was called for. A shift for the AMA regarding internal concern for dropping membership; allows the Association to be participatory in the implementation of health system reform; and most importantly sets precedence for future efforts in reforming the American health care system.

The percentage of doctors that are members of the AMA has drastically shrunk. In 2005, out of 850,000 MDs and 56,000 DOs 244,005 are members of the AMA. That is a percentage of 29.6% of all physicians; although this figure includes retired physicians, students, residents and fellows. Only 135,300 of those 244,005 are practicing physicians. (Peck, 2006) Even though most physicians stand to benefit from the reform by the increasing number of potential paying clients, the AMA gets to align themselves more closely with patient concerns rather than strictly pocketbook politics. This image is a welcome one for young doctors who have been joining groups like Doctors for America and Physicians for a National Health Program. (Parikh, 2009)

Secondly, the cooperation and endorsements of the AMA positions the Association to be an influential player in the implementation of reform. Pieces of the legislation were altered along the way dealing with participation in the Physician Quality and Reporting Initiative and how doctors' payments are tied to performance measures. (Webster, 2010) As Laugesen and Rice (2003) concluded, physicians are positioned to be natural leaders on issues of quality and clinical innovation and their actions in this last reform period strengthened that position.

Lastly, the AMA has managed to maintain its influence in health policy but this time by different means. In the past the AMA could simply bombard patients with propaganda pushing whatever issue it wanted. These grassroots scare tactics were used towards Roosevelt, Truman and Johnson in each of their respective tries at health reform. (Starr, 1982) Now, with patients rarely being the ones paying the bill, the AMA has been put in a position to align themselves with the benefits of consumers and not insurers. Through this new approach the AMA finds itself in a familiar power position. This position will be called upon in the coming years to continue the discussion of health care for illegal immigrants; continuing reform of reimbursement and payment structures; and the innovation of quality measures.

Limitations

This study did have limitations as well as room for future exploration. As mentioned in the methods section, there was difficulty accounting for bias of primary sources. The two main sources were the journal and the newspaper the AMA publishes in house so there is justified reason to pay close attention to source bias; however using

triangulation addresses this issue. Another possible shortcoming is the sources used for comparison in their time to be reviewed. As for the AMA's role in the Clinton reform era, there has been ample time for peer review and reflection. This is not the case with the Obama reform so there is concern with regard to accurate application with sources used for the Obama era reform.

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