Social Science & Medicine 71 (2010) 1341–1348

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Niche players in health policy: Medical specialty societies in Congress 1969–2002☆

Aaron Rabinowitz [a,*], Miriam Laugesen [b]

[a] Harvard University, Cambridge, MA, USA
[b] Columbia University, New York, NY, USA

ARTICLE INFO

Article history:
Available online 10 August 2010

Keywords:
Politics
Political activity
Interest groups
Lobbying
USA
Physicians
Medical profession
Congress

ABSTRACT

Scholars and commentators alike have long used 'organized medicine' as shorthand for the American Medical Association (AMA). However, organized medicine has increasingly shown signs of fragmentation into specialty societies over the last two decades. While the AMA remains the largest association of physicians, and wields a great deal of influence in political circles, its use as a proxy for organized medicine may warrant reevaluation due to the changing political organization of medicine. We developed a unique database of specialty medical society appearances before all Congressional committees by combining records from Lexis-Nexis Congressional and the Policy Agendas database. Descriptive statistics were used to evaluate the participation of specialty societies by committee and by hearing type. The Herfindahl–Hirschman Index (HHI) was used to measure whether specialty societies develop niche roles with specific committees, and the Chi-Square Goodness of Fit test was used to study the distribution of specialty society testimonies in health hearings more formally.

We found that although the AMA participates in Congressional hearings at a higher rate than any other individual medical specialty society, it accounts for a decreasing percentage of all specialty society appearances over time. In addition, specialty societies have developed niche and monopoly roles in health policymaking as well as relationships with particular congressional committees over time. We conclude that the increasing participation of specialty medical societies in the policymaking process is important because medical societies do not testify solely to promote the economic self-interest of their members. Specialization in medicine has segmented lobbying roles, such that specialty societies have a different focus than the AMA. Thus, 'organized medicine' and the AMA are no longer synonymous.

Introduction

Scholars and commentators alike have long used 'organized medicine' as shorthand for the American Medical Association (AMA). However, physicians and their representative bodies have increasingly shown signs of fragmentation into specialty societies over the last two decades (Mick, 2004; Stevens, 2001). Large-scale changes in health care and Medicare reimbursement policy may have given physicians of different specialties different economic and political interests (Laugesen & Rice, 2003, Peterson, 1993), and surveys of individual physicians show differences in political participation across specialties (Gruen, Campbell, & Blumenthal, 2006). Moreover, physicians increasingly look to their medical specialty organizations for representation (Stevens, 2001). While the AMA remains the largest association of physicians, and wields a great deal of influence in political circles, its use as a proxy for organized medicine may warrant reevaluation due to the changing political organization of medicine.

In this paper we explore the role of different medical specialty societies in the policymaking process by studying specialty society appearances before congressional committees between 1969 and 2002. Using a unique database of AMA and medical specialty society appearances before all congressional committees, we show that specialty societies have developed niche and monopoly roles in health policymaking as well as relationships with particular congressional committees over time. We conclude that specialization in medicine has segmented lobbying roles, such that specialty societies have a different focus than the AMA.

☆ We are grateful to Jared Murdock, M.D. who generously volunteered his time in the early stages of this project and for the assistance of the Faculty Research Grants Program, UCLA Academic Senate Council on Research for the project "Specialty Medical Societies in Congress, 1969–2002".
* Corresponding author
E-mail address: arabinow@fas.harvard.edu (A. Rabinowitz).

0277-9536/$ – see front matter © 2010 Elsevier Ltd. All rights reserved.
doi:10.1016/j.socscimed.2010.06.035

Background

Research on physicians' roles in health policy has examined four dimensions of physician and interest group activity in the policy process, including holding public office, being politically active in one's community or professional society, lobbying legislators, and donating money to political campaigns (Kraus & Suarez, 2004). Physicians are most likely to participate in politics by providing health-related expertise to a local community organization (54.2%), being politically active on a local health care issue (25.5%), or encouraging a professional society to address a public health or policy issue (24.3%) (Gruen et al., 2006). These high overall rates of participation obscure participatory differences across medical specialties: a considerably higher percentage of primary care physicians, including pediatricians (65.2%) and family practitioners (64.1%), participated in community political activities than physicians from specialties such as anesthesiologists (32.8%) (Gruen et al., 2006).

Physicians also try to influence the policymaking process by meeting directly with legislators. One of the few studies to systematically measure the amount of access physician organizations have to legislators in the United States Congress estimated that physicians meet 29,000 times per year with federal legislators (Landers & Sehgal, 2000). During these meetings, physicians primarily lobby legislators on Medicare reimbursement – 81 percent of the legislative assistants surveyed stated that Medicare was the dominant topic in these conversations (Landers & Sehgal, 2000). Managed care reform and funding for medical research were also frequently discussed (Landers & Sehgal, 2000).

Campaign contributions are the primary form of political participation for organized medicine. Indeed, research on the political participation of physician organizations has examined campaign financing more than any other topic, and all studies focus on the American Medical Association Political Action Committee (AMPAC). AMPAC contributions provide access to legislators and are used to help elect or reelect legislators likely to be sympathetic to the economic concerns of AMA physicians (Gutermuth, 1999). AMPAC also contributes more to ideologically conservative incumbents (Wilkerson & Carrell, 1999) and representatives who oppose greater tobacco regulation (Sharfstein, 1998).

The conclusion of these studies is that physicians are politically active on issues at the local and national levels, both in areas related to their economic interests as well as more generally. Yet just as physicians' political activity seems to vary by specialty at the local level, their national role may vary substantially by specialty or at least be shaped by specialty organizations. However, an almost exclusive focus on the AMA, and particularly its role in campaign financing, has skewed the picture of organized medicine in politics. There may be important differences between the AMA and specialty organizations' involvement in policymaking.

If we conceptualize interest groups as traders of information, we might find that physicians have a broader role in the policymaking process than generally assumed. Interest groups compete with each other for influence, and groups have comparative advantages that come from being "niche" issue experts (Peterson, 2001). Creating a unique niche may provide a considerable strategic advantage for groups that operate in a competitive policy arena (Heaney, 2004). Congressional representatives seek expert information from interest groups in most policy areas (Hansen, 1991), which suggests that group size may often be less important than expertise. Specialty medical organizations, therefore, might speak more frequently on highly technical aspects of health policy because they have considerable informational resources in their area of medicine.

The role of specialty organizations has been overshadowed by the historical success of the AMA in shaping health policy. In the 1960s, the AMA indisputably met three criteria identified by Peterson (2001) as hallmarks of a successful interest group: it represented knowledge-based professionals, it was cohesive and projected an image of quasi-unanimity, and it could claim a comparative advantage in information and resources within its field. These characteristics enabled the AMA to use its cultural authority, political leverage, and resources to promote its economic interests in the political process (Peterson, 2001).

Over time, however, several factors coalesced to contribute to the declining influence of the AMA and the proliferation of specialty medical societies. First, the AMA became unable to speak with a unified voice as medicine divided into specialties and subspecialties (Stevens, 2001), a process that was accelerated by the pace of scientific development in the late-twentieth century (Wailoo, 2004). At the same time, its membership became more diverse (Laugesen & Rice, 2003), the health policy issue space became more crowded, and there were more sources of information for policymakers (Peterson, 2001). Thus, physicians had to fight harder to be heard.

Medicare payment changes in the 1990s likely exacerbated a trend toward increasing political participation by specialty societies. In 1989, Congress enacted the Omnibus Reconciliation Act (OBRA 89), which introduced a Resource-Based Relative Value Scale (RBRVS) to redistribute income from specialties that were perceived to be overpaid to those perceived to be underpaid. Thus, OBRA 89 threatened to redistribute income from specialties like radiology and surgery to primary care physicians (Laugesen & Rice, 2003). By definition, the AMA could not represent each of the disparate specialties in this reimbursement climate.

Specialty societies may have also become more politically active in response to discrete events within their areas of expertise. Health activism, for example, may help explain the greater prominence of some medical specialty societies. According to Starr (1982), social activists advanced the interests of numerous constituencies in the sphere of medical care during the 1970s. Thus, health activism likely contributed to the increasing activity of specialty societies as they responded to threats to their autonomy.

These observations do not suggest that there is no role for the AMA in modern health policymaking. To the contrary, the AMA is likely to be most active in modern health policymaking when representing the interests of physicians as a whole, such as efforts to protect patients' rights and regulate managed care pans. When Congress attempted to enact a patients' bill of rights in 2001, for example, the AMA visibly supported the legislation. Similarly, the AMA continues to work with specialty societies against reimbursement cuts to Medicare payments (Laugesen, 2009).

Specialty societies have proliferated to advocate for the interests of distinct medical specialties in any increasingly dispersed professional environment and a more competitive health policy arena. Yet understanding how these specialty societies interact with the policy process and what the relative importance of different specialty organizations is requires studying longer-term trends in society participation in policymaking. One way to understand the role of specialty societies and the nature of "organized medicine" in contemporary health policymaking is to scrutinize their participation before congressional committees.

Committees largely set the agenda on issues within their jurisdiction (Hardin, 1998). In addition, committees mark up legislation and determine which bills make it to the Senate or House for full consideration (Hardin, 2002). The key question in the study of congressional committees is what kinds of information do committees have access to, and is it biased or balanced (Hardin, 2002). Studying the participation of specialty societies in committee hearings appears to be indispensable if we want to understand the role of "organized medicine" in contemporary health policymaking.