On the Nature and Strategies of Organized Interests in Health Care Policy Making

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Abstract

Relying on a sweeping review of the literature on interest group influence in health care policy making, we propose a basic definition and a typology of interest groups in provincial health care policy making. Then, using Milbrath's communication framework, we analyze organized interests' strategies for influencing policy making. This article is a modest attempt to cross-fertilize the group theory and resource dependency literature. This theoretical framework allows us to explore many of the recurring questions about groups' origins and strategies from an original standpoint.

Keywords

Interest-groups; lobbying; healthcare; policy-making; theory

Introduction

It is common wisdom that all kinds of groups and institutions have an interest in health policies and will attempt to have a say in policy making. At the academic level, however, analysis of this phenomenon is split along disciplinary as well as sectoral boundaries. For example, in addition to the huge body of literature in political science dealing with group theory and interest groups, there is a significant part of organizational analysis that concentrates on relations between organizations and their environments according to various more-or-less compatible frameworks. Moreover, each activity sector (health, environment, industrial policies, etc.) boasts its own analysis of empirical relations between groups and regulatory bodies. To complicate things further, policy making being, by nature, eminently contingent on national, historical, political, and institutional conditions, the external validity of each case study must be carefully examined (Immergut, 1992; Lowi, 1964).

In the context of a larger project on interest groups in Québec's health care policy making, we were obliged to take a stand on the definition of an interest group as well as on the nature, origin, and strategies of those actors. This article emerges from the observation that organizational theories about resource dependency (Pfeffer, 1972, 1973; Pfeffer & Salancik, 1974, 1978), and more generally about the relationship between organizations and their

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environments, in fact have many points in common with the group perspective on politics (Aplin & Hegarty, 1980). The first set of theories studies organizations from the inside and observes how they both depend on and try to influence their environment. The second set of theories analyzes the origins, strategies, and effects of intergroup competition and coalitions in the political arena. However, there seems to be a parallel neglect of interest groups' external dynamics by organizational theorists (Streeck & Schmitter, 1985) and of the internal functioning of formal organizations by group theorists (Salisbury, 1984).

While suggesting potential theoretical bridges, this article is also a contextualized discussion. First, we analyze organized interests in the specific context of health care. As in most countries, the federal and provincial governments in Canada constitute the most influential portion of the external environment of any health care organization, private, public, or nonowned (Leatt & Mapa, 2003). Thus, almost any organization, institution, or group in the health care field will be as sensitive to governmental action as it is active in trying to influence it. We therefore consider the health care field an excellent ground for building a bridge between parallel theoretical views on groups and organizations.

Data Sources

We carried out a computerized search of relevant scientific articles and analyzed their main findings. This work also rests on knowledge of the health care field and institutions developed in previous work (Contandriopoulos, 2004; Contandriopoulos, Denis, & Langley, 2001, 2004a; Contandriopoulos, Denis, & Langley, & Valette, 2004b, 2005).

The first step in the literature review was a computerized search of the major databases of interest, using the combination of *lobby*, *health*, and *policy* as keywords. When search engines accepted wildcards, *lobb** was used instead of *lobby*. We searched the SilverPlatter WebSPIRS databases Canadian Research Index (1982 to present); Econ Lit (1969 to present); International Political Science Abstracts (1989 to present); PAIS International (1972 to present); Philosopher's Index (1940 to present); Social Sciences Index (1983 to present); Social Work Abstracts (1977 to present); and Sociological Abstracts (1963 to present), as well as the OVID databases MEDLINE (1966 to present); CINAHL (1982 to present); and Current Contents/All Editions (1993 to present). After excluding articles in languages other than English, French, or Spanish and those not of interest, we had a set of more than a thousand articles ($n = 1,071$). Relevant documents were then selected by reading the abstract, or by relying on the title when no abstract was provided. This allowed us to identify a set of 248 articles on health policy lobbying.

However, given the keywords used, theoretical groundwork outside of health fields would probably not have been identified through this first step. To include such works, we relied on snowball sampling. While analyzing the corpus collected in the first step, we noted the theoretical works on which the authors relied and, when pertinent, added them to our literature review. We thereby identified 216 other documents, for a total review of 464 documents, mostly journal articles and books. This literature review, though centered on health care, is by no means exclusive to it.

This method cannot guarantee exhaustivity, but although we may have missed some potentially helpful articles, we are confident that no influential articles were overlooked. This method gives a broad view of the field of interest group representation and makes it unlikely that any significant strain of ideas was entirely omitted. The most important limitation in such an effort to survey an academic field is that there are no clear, or even logical, boundaries. For example, in the subfield of pharmaceutical policy, there are articles in political science, but also many in the health policy field, that though not directly dealing with lobbying, bring interesting and original evidence from current policy debates—such as Lexchin’s numerous articles on pharmaceutical companies’ influence (Lexchin, 1993, 1994, 1997, 2001).

Organized Interests: Definitions, Origins, and Networks

Definitions—As stated earlier, in health care policy making, there is a vast array of politically active groups, institutions, and organizations. Our use of the terms *group*, *organization*, and *institution* is deliberate, because many important actors in the field are institutions such as hospital associations, unions, and regional boards. In fact, many influential “interests” in health care policy making are not groups (Salisbury, 1984). A major hospital or a pharmaceutical company, for example, cannot be described as a “group” but nevertheless often intervenes efficiently in policy making (Hart, 2004).

We consequently rely on a broadly encompassing definition of interest groups that includes both membership-based organizations as defined by Pross (1992, pp. 3–11) and “memberless” institutions such as hospitals, private companies, and regional boards. We thus support, to some extent, Salisbury’s “imperialist” definition of an interest group as any “active unit, from the isolated individual to the most complex coalition of organizations, ... that engages in interest based activity relative to the process of making public policy” (Salisbury, 1994, p. 17). At least in the health care field, using more restrictive definitions without valid justification would clearly exclude some actors that exert significant pressure on the policy-making process. Although memberless institutions administratively linked to governments will be constrained in their choice of lobbying strategies, this does not impede their capacity to exert political pressure. Moreover, a membership-oriented definition would consider such institutions as hospital associations to be interest groups, whereas a single hospital would not be so considered, whatever its political involvement or power. Hence, the relevance of that hospital’s action would depend on whether it used its association as a political vehicle. Similarly, a good deal of the political action is carried out by individual member organizations rather than by the association itself. Hence, rather than seeing the decision to join an association as triggering a fundamental shift in the ontological political nature of the institution, we suggest it is more fruitfully analyzed as a decision to join, or not, a particular kind of coalition (Hojnacki, 1997).

The main modification we would make to Salisbury’s definition is that groups be limited to structured organizations that express themselves through legitimate designated individuals (Bourdieu, 1984). This limitation excludes latent interests, unorganized individuals, or noninstitutionalized social movements, all of which can try to influence policy on a personal basis. Even though, as Bentley (1967) noted in *The Process of Government*, there is no clear

boundary to distinguish between institutionalized and noninstitutionalized groups, the distinction can still be used heuristically to identify groups that are at least institutionalized enough to express themselves in the political arena through a designated spokesperson. The potential self-designation of groups' spokespersons, as well as their exact representativeness, remains, however, an open question (Ainsworth, 1993; Contandriopoulos et al., 2004a; Nelson, Heinz, Laumann, & Salisbury, 1987). Finally, as do almost all other definitions, we distinguish between interest groups and political parties, using the rationale that, in the words of Berry, interest groups are *policy maximizers*, whereas political parties are *vote maximizers*:

Political parties are vote maximizers. To win elections they must dilute policy stands, take purposely ambiguous positions on others, and generally ignore some, so as not to offend segments of the population that they need in their coalition. Interest groups are just the opposite. They are policy maximizers, meaning that they do better in attracting members if their outlook is narrowly focused. (Berry, 1997, p. 47)

The end point, then, is the definition of interest groups as any institutionalized organization that engages in political activity relative to the process of making or influencing policy without explicitly trying to obtain or exercise the responsibility of government. Strictly speaking, the interest groups we focus on here sometimes are not groups at all, in which case the term *interest group* is inaccurate. Similarly, these interests are neither as ontologically "vested" nor as "special" as other denominations would imply. The most obvious and precise term would then be *organized interests*. However, our goal not being to add to the stockpile of terms, we will use *interest groups* and *organized interests* interchangeably. As has been well argued by Hart (2004), including memberless groups as hierarchical organizations in the definition necessitates some discussion about group origin and maintenance.

Origins—Contrary to Olson's (1971) view, we do not consider material incentives to be the main explanatory factor for the existence of organized interests in health care politics. Many influential actors are preexisting organizations such as hospitals, public health agencies, or pharmaceutical companies, whose political capacities are—in Olson's terms—a by-product of their broader administrative and managerial capacities. For other actors, such as unions and professional associations, it would also prove quite hard to link either their origin or their membership to material incentives. Both institutional factors (Meyer & Rowan, 1991; Powell & DiMaggio, 1991) and state regulation (Mawhinney, 2001; Walker, 1983, 1991) could probably explain their existence, with their interest group status being a by-product. But more fundamentally, in both cases, they are either memberless groups or compulsory membership groups.

Organizations conceptualized as politically active memberless groups could fall into two categories: utilitarian organizations (Clark & Wilson, 1961) that strive to maximize material rewards (e.g., a pharmaceutical company) and not-only-utilitarian organizations that are concerned about resources but also have nonmaterial goals. In this latter category, we might find hospitals or public health agencies that though interested in obtaining enough resources

from their environment to subsist or grow, also pursue other objectives, such as curing disease, relieving suffering, improving public health, and so on. This typology tallies with R. G. Evans's (1984) typology of for-profit, not-for-profit, and not-only-for-profit actors in health care.

However, in both cases, the incentives are not targeted at the individual level in the same way as posited by Olson (Salisbury, 1984). For all these organizations, the political arena is just a part, sometimes a small part, of their struggle to obtain resources from their environment. All are able to draw the majority of their resources either from the market or from stable public funding, as hospitals do. Their political involvement is thus one lever—among others—for obtaining material resources or, quite often, intangible ones. For example, a hospital could fight politically to its last breath to obtain or maintain its university affiliation, even when this affiliation is unrelated to either volume of service or material resources. If one of these organizations proves unable to fulfill its stakeholders' expectations in regard to its ability to attract resources (whether material or intangible), the executive summit of the organization will probably face sanctions, or at least pressures. However, being memberless groups, the way they redistribute benefits probably resembles more closely the organizational incentive system of Clark and Wilson (1961) than the group-based logic of Olson (1971).

In the case of compulsory membership groups such as some physicians' associations or unions, Olson's subtheory of by-products applies, since, as with the previous category, the group's existence predates the need or will for political action. However, the distinction is that in Canada, wherever there is a professional association or union, membership is compulsory. Thus, members' dissatisfaction with redistribution of benefits or incentives would provoke their voicing these rather than their exit (Hirschman, 1970), with the possible takeover of the union's or association's management. The situation for compulsory-membership associations is thus quite similar to the one prevailing in memberless ones.

Finally, in the case of noncompulsory membership groups, such as patients' organizations, Rx&D,¹ and others, restricting incentives to purely material ones remains dubious. Olson's main objection to the inclusion of intangible benefits is epistemological. A broad conception of costs and gains as both tangible and intangible benefits produces a situation where the existence of politically active groups implies that their subjective perception of gains or costs ought to be high enough; conversely, the absence of politically active groups, notwithstanding objective gains or costs, implies that those gains are perceived as too low. Thus, the existence of politically active groups becomes a tautologically explanatory variable of the existence of their necessary conditions of existence and makes the empirical validation of Olson's viewpoint more difficult. However, even if this criticism is logically correct, and of practical importance in understanding the necessary conditions of political activity, it is much less pertinent when our interest shifts to understanding the nature, form, or extent of a group's political activity. Even if it is somewhat tautological to state, as does Bentley (1967), that "there is no group without its interest," it remains empirically true.

¹Rx&D is the acronym for Canada's Research-Based Pharmaceutical Companies, the national association representing research-based pharmaceutical companies in Canada.

In the context of health care, many groups become politically active either to obtain gains that are public goods and as such, are accessible to everybody and not only to those who have mobilized, or even to obtain gains for groups to which they do not belong. For example, groups that lobby for the accessibility of free drugs for social insurance beneficiaries are often constituted of people who are not themselves social insurance beneficiaries. More broadly, the health care sector in Canada, as in other jurisdictions, is somewhat specific, in the sense that people—whether policy makers, lobbyists, or the “public”—need to behave in accordance with the objectified fact that health is not an ordinary good. Health is generally perceived as intrinsically desirable, its accessibility part of citizens’ rights. Thus, even groups seeking additional resources for themselves—for example, blind people asking for more resources in rehabilitation—will, as long as these resources are health care related, often perceive themselves and be perceived as seeking some kind of public good. This “private” public good is public in the sense that anybody could need it and benefit from it one day. Thus, even though we do not provide such an analysis here, we think that Olson’s postulates would need to be reexamined in the context of health care in order to use a typology of groups based on the nature of their goals.

Networks—The classical corporatist model of group–state relationships posits that core interest groups will be co-opted by public agencies as insiders in the policy-making process. For example, the Canadian Medical Association (CMA) was repeatedly described as having almost an ideal corporatist relationship with government (Taylor, 1960). In contrast, the pluralist model posits an open system in which any interest group can organize itself and enter the political arena to express its views. Notwithstanding their divergences, pluralism and corporatism both share at least the conviction that groups do not exist in a social vacuum but rather with specific relationships among themselves and with other elements of society.

There is, for example, consensus on the fact that groups with interests in a similar field will be aware of each other’s positions and strategies, as well as of the relevant government agencies’ positions (Carpenter, 2004; Heinz, Laumann, Nelson, & Salisbury, 1990). Unfortunately, the names given to this network of actors are tightly linked to specific theoretical standpoints (policy networks, subsystem, iron triangles, etc.). For a brief description of intergroup relationships, we rely on the definition of policy subsystems or domains by Sabatier and Jenkins-Smith (1999), even though, as is usually the case, it does not provide any clear boundary for the relevant domain. For example, should we conceptualize the provincial health care policy-making arena as a specific subsystem with more specific sub-subdomains such as, for example, pharmaceutical regulations? Or is the pharmaceutical regulation arena an international policy subdomain and the specific provincial arena a sub-subdomain? Although there is probably no obvious choice in the conceptualization of the level of analysis for groups’ interactions, this has implications for our capacity to generalize in specific case analyses.

In any case, in their interaction with other elements of society, the groups and public agencies inside a given policy domain can have various relationships ranging from confrontation to collaboration (M. Evans, 2001; Salisbury, Heinz, Laumann, & Nelson, 1987). However, there is some imprecision in the exact nature of interrelationships, because most, if not all, collaborative arrangements are indistinctly described as coalitions (Lowi,

1964, p. 678), even if specific relationships can take many forms. For example, in the health care sector, a frequent specific form of coalition could be called the relay (Burton & Rowell, 2003; Wysong, 1992), an example of which could be the relationship between the pharmaceutical industry and patients' organizations (Herxheimer, 2003). The pharmaceutical industry can have interests in common with some patients' organizations, such as the inclusion of a given drug in the government formulary. Rather than openly forming a coalition, these groups will often feel their interests would be better served by another arrangement. A company might help to hire, fund, and train a given patient organization's staff, but stay away from visibly lobbying for inclusion of its drug on the formulary, which could harm its case more than help it. The patient organization would, however, be there to lobby and would be sufficiently funded and trained to do so. This is thus a relay in the exercise of pressure as well as a reciprocal exchange of commodities, that is, legitimacy for material resources and material resources for legitimacy.

Another level of imprecision can be found in the degree of institutionalization of coalitions. As we have seen, some institutions—for example, hospitals or pharmaceutical companies—are politically active both at the individual organizational level and through membership in organizational associations. The conventional wisdom of group theory is to consider the association as the unit of analysis, thus dodging the question. But if individual organizations or institutions are considered legitimate units of analysis, then associations become institutionalized forms of coalition. However, their institutionalization is not absolute: Organizations sometimes disagree with the association to which they belong and politically oppose it. This conceptualization would add to the fluidity of group population observed by Gray and Lowery (1993) or Salisbury et al. (1987).

Organized Interests' Motivations and Strategies

There is an almost infinite number of ways in which an organized-interest spokesperson, or lobbyist, can try to influence policy. These will be eminently context-specific and sector-contingent. The aim of this section is not to take on the Sisyphean task of listing them all but rather to suggest and discuss an analytical framework, based on the work of Milbrath (1960, 1963).

Group Mobilization

The starting point for analyzing group mobilization is to note that the simplest strategy is probably none at all. Not all groups will mobilize on each issue; some will be inactive. Obviously, this is contingent both on the conceptualization of an issue and on the population of groups considered. The more focused and decision-specific the issue is, the more limited the relevant population of groups will be, the higher the incidence of mobilization inside this population of groups will be, and the greater the number of groups considered irrelevant to the issue and excluded from the population will become. Nevertheless, it is obvious that organized interests can—and often do—opt for inaction as their strategy.

Since the appearance of Olson's pioneering work, the most common frameworks for understanding the determinants of mobilization have been based on economic maximization. As Becker (1983) stated, such an approach "assumes that actual political choices are

determined by the efforts of individuals and groups to further their own interest” (p. 371). In this perspective, groups will form and become politically active only if the gains or costs they can expect from a given policy are concentrated enough to motivate them to invest in political action. This viewpoint rests on a one-shot, zero-sum game conception of policy making, where costs and gains are usually limited to material incentives. Because in a zero-sum game somebody’s gains are always someone else’s costs, policies that would produce both concentrated gains and concentrated costs—a few will gain a lot at the expense of others—are likely to create conditions where groups mobilize both in favor of and against the policy. This would look more or less like a pluralist model of political policy making. At the other end of the spectrum, policies that produce both diffuse gains and costs are unlikely to create the necessary conditions for the political involvement of groups. Finally, a situation in which gains are concentrated and costs diffused, or costs concentrated and gains diffused, is favorable to a one-sided mobilization in support of or against the policy.

In our view, though it is heuristically appealing in its simplicity, this conceptualization is probably also misleading, in the sense that the political process is not, as Salisbury (1994) emphasizes, a one-shot game. If it could be compared to a game, it would look rather like a never-ending one in which today’s winners can be tomorrow’s losers. In the same way, depending on the level of observation, it is unclear if policy making is a zero-sum game or if win-win and lose-lose situations can exist. This is not unrelated to the conception of the policy domain, because the more narrowly a domain is defined, the higher the probability of a nonzero sum outcome occurring through inter-domain resource redistribution. Similarly, taking into account intangible benefits greatly increases the possibility of a win-win situation. Finally, as noted earlier, in the health care sector there is undeniably a valorization of nonmaterial policy outcomes, as well as a complex conception of the public nature of many goods, that complicates the application of an economic approach to group mobilization. In Sabatier and Jenkins-Smith’s (1993) terms, there is a consensus on many core values that contradicts any purely material understanding of incentives. Empirically, many small patients’-rights groups appear to mobilize on a large number of issues where both the absolute level of their gains and their capacity to appropriate those gains are paltry. Their existence and mobilization determinants appear closely related to the existence of a policy entrepreneur in Salisbury’s terms (1969). The entrepreneur’s personal motivation also seems to derive from a broad conception of health as a desirable public good. But obviously, the opposite is also true, where large-membership groups such as physicians associations mobilize efficiently in the material interest of their members each time they have the opportunity to do so. In our view, notwithstanding the amount of literature on this subject, no general theory convincingly explains, in a noncontextually contingent way, the determinants of group mobilization.

Strategies

Following Milbrath (1960, 1963), we distinguish between tactics and strategies, tactics being the tools used within a broader goal-oriented strategy. We also equate here the term *lobbying* with the involvement of interest groups in policy making. More specifically, we define lobbying quite broadly as *any organized interest’s political activity aimed at making or influencing policy*. There are both lobbying strategies and lobbying tactics. Individuals in

charge of designing these strategies and tactics are indistinctly grouped under the term *lobbyists*, even though they would not all fit the legal definition of a lobbyist in a given jurisdiction.

Our discussion of organized interests' strategies is structured by two choices. First, we use the communication framework of Milbrath (1960) to describe and analyze the lobbying process. Second, we propose a modest first step toward a better integration of organizational resource dependence theories pioneered by Selznick (1948) and Pfeffer and Salancik (1974, 1978; Pfeffer, 1972, 1973) and group theory. Hence, we will put the emphasis on the groups' long-term pressures to frame the political agenda, given that an organization strives continuously to optimize its relations with its environment on a long-term, ongoing basis and not only on a one-shot-decision basis.

For Milbrath (1960), lobbying is essentially, if not exclusively, a communication process, mostly because he considers lobbying as the direct or indirect communication of power or, in other words, as the generally subtle ways in which lobbyists raise decision-makers' awareness of the consequences of their acts. There is thus a very fine but interesting distinction between the exercise of power and its communication, because the lobbyist does not always control the power relationship he uses in his communication efforts. For example, a lobbyist who supports a policy option with arguments that rely on the population's dissatisfaction with waiting lists and, implicitly, on the electoral support a reduction of these waiting lists could bring through his proposal, is in fact relying on a long and tortuous causal chain of dubious validity. His communicative power does not rest on his ability to reduce waiting lists, much less to reduce dissatisfaction, but rather on his ability to convince others that there could be a causal link between his pet proposal and electoral support. There is, however, probably a distinction to be made regarding the level of control the lobbyist can claim over the causal relationship on which he relies. For example, threatening a physicians' strike if their demands are not met next week relies on a much more direct causal link than presenting research evidence that higher physician remuneration is associated with higher quality of care and hence public interest. In the first case, the lobbyist's claims are directly linked to events the groups he represents can control, whereas in the second case, the causal relationship is unrelated to group action. In the next section, we will delve somewhat further into this topic, while linking it to the nature of the organized interest in question.

Limits in the choice of strategy—In one of the few empirical studies on interest groups in Canadian health care, Fulton and Stanbury (1985) identify six factors that influence the lobbying behavior of the two groups they compare, the BC Health Association, which represents hospitals, and the BC Medical Association, which represents doctors.

We conclude that there are six crucial factors, some exogenous and some endogenous, that strongly influence the lobbying behaviour of health care organizations. These are the nature of the groups' membership, the focus of their lobbying activities, the cycle of group-government interaction, the length of experience with government as the principal paymaster, the presence or absence of

factions within the group and the values and attitudes of various members stemming from their socialization. (Fulton & Stanbury, 1985, p. 269)

However, one factor that may not be emphasized enough and that appears central in our own analysis is the existence of a hierarchical administrative tie between the organization or group and the government. For example, groups such as medical associations, pharmaceutical companies, or unions are sufficiently remote from the direct administrative authority of the government to adopt the kind of lobbying behavior they feel is suited to their goals. If they wish to enter into a “brute force” relationship, they are able to do so. This does not mean they will favor such relationships, only that these are within the realm of possibility. However, other groups such as hospital associations, regional boards, or community organizations are more directly under the authority and control of the government. They are thus constrained in their lobbying strategies to not-too-conflicting approaches. Although a pharmaceutical company can threaten to pull some of its drugs out of the market if it does not obtain specific concessions, a hospital or hospital association in Canada cannot explicitly state that it will act in such a way as to prejudice the ministry’s or the government’s interest if its demands are not met. The communication of power will thus need to rest on causal relationships in which it appears not to take too active a role. The same holds true to an even greater extent if we extend this notion to intragovernmental lobbying, where, for example, a regional board lobbies the provincial ministry.

This structuring of the potential sources of power according to the nature of groups and their relationships with the government probably also has an impact on the choice of inside- or outside-oriented tactics (M. Evans, 2001; Kollman, 1998; West, Heith, & Goodwin, 1996). Outside tactics are oriented toward the general public as a lever, whereas inside tactics are directly targeted at decision makers. For example, convincing civil servants or a minister of the necessity of proposing a given regulation is an inside tactic, whereas creating a political sense of urgency through the use of mass media is an outside tactic.

Although it is possible to use outside tactics from within the hierarchical realm of the government, it requires a great deal of subtlety in the choice of both message and media. More broadly, it is plausible to think, with Tuohy (1976), that when political systems favor corporatist relationships with dominant interests, as in Canada or the United Kingdom, groups will enter into overt outside lobbying through mass media less often than the U.S. literature suggests. Finally, Lewis and Considine (1999), building on Alford’s (1975) typology, suggest that, in any country, the health care field will be characterized by a structuring of the general political agenda in accordance with the preference of dominant interests to such an extent that many issues never even reach the predecision stage. As we argue later on, this view would also tally closely with the neoinstitutionalist view in organizational analysis (Powell & DiMaggio, 1991). In the next section, we explore in more detail this capacity to frame the political agenda.

Framing the agenda and the policy belief system—At least chronologically, the capacity of organized interests to frame the political agenda is the first way to influence policy making. By framing the agenda we mean, in Kingdon’s (1984) terms, to push one’s own pet problem or pet solution to the forefront of the political scene. What is interesting in

this definition of agenda-framing is that it encompasses both the pressures to create the need for a given decision and the pressures in favor of a given kind of solution. The organizational literature tend to show that it is part of the normal behavior of organizations to work on such long-term, low-profile structuring.

There seems to be consensus that organized interests' capacity to influence the salience of an issue, and thus its political importance or urgency, is one of the keys in influencing policy or decision outcome (Considine, 1998; Kingdon, 1984). However, this assumes that interest groups frame the political agenda, rather than the opposite; it also assumes that interest groups and political agendas do not passively respond to external (social) stimuli (Lowery, 2004). It is also conventional wisdom to consider that in political systems with a parliamentary system and party discipline, as in Canada and Québec, agenda-setting is the most efficient way to affect policy (Deber & Williams, 2003; Lavis, 2002). As stated earlier, we do not wish to enter into a full-fledged description of all lobbying techniques and tactics because others have done that quite well (e.g., Berry, 1997; Birnbaum, 1993; Cigler & Loomis, 1991; Heinz, Laumann, Nelson, & Salisbury, 1993; Hrebienar, 1997; Pross, 1992). What we propose instead is to suggest some promising pathways for analysis that push Milbrath's (1960) communication process framework a little further to connect it with Sabatier's and Jenkins-Smith's (1993, 1999) analysis of the influence of "policy beliefs" as well as with Weiss's (1977) "enlightenment function."

Though they do not give it a preeminent role, Sabatier and Jenkins-Smith, following Heclo (1974), propose the concept of policy-oriented learning as one of the determinants of policy beliefs and policy change.

Within the general process of policy change, the ACF has a particular interest in understanding policy-oriented learning. Following Heclo (1974, p. 306), the term policy-oriented learning refers to relatively enduring alterations of thought or behavioral intentions that result from experience and/or new information and that are concerned with the attainment or revision of policy objectives. (Sabatier & Jenkins-Smith, 1999, p. 123)

Unsurprisingly, our own analysis tallies with the widely accepted view that the belief system on which decision makers build their understanding of a given issue and, more broadly, their field of activity is fundamental in understanding both the agenda-setting and decision processes. What is less often emphasized is the fact that although this belief system is structured according to a highly complex social process, it is also subjected to explicit and deliberate efforts by lobbyists to influence it. Through the diffusion of more or less neutral research results, informal inside communications, outside messages diffused via the mass media, and so on, organized interests all propose an implicit reading of their own environment. The interconnection of the lobbyist professional community (Berry, 1997; Heinz et al., 1993) and the strong interconnections of professions central to the health care field play an important role in the sharing and diffusion of such belief systems. It is also interesting to link this phenomenon with the general notion of marketing, defined as techniques aimed at influencing people's behaviors and opinion. From this viewpoint, Harris (2002), for example, suggests that "lobbying is the application of marketing to the political decision-making process to achieve strategic advantage or gain for the corporation, not-for-

profit, or public sector organization, and is a more covert form of political marketing than electoral campaigning” (p. 987). This can, in turn, be linked to a broader reading of Weiss’s (1977) enlightenment function:

Evidence suggests that government officials use research less to arrive at solutions than to orientate themselves to problems. They use research to help them think about issues and define the problematic of a situation, to gain new ideas and new perspectives. They use research to help formulate problems, and to set the agenda for future policy actions. And much of this use is not deliberate, direct, and targeted, but a result of long-term percolation of social science concepts, theories, and findings into the climate of informed opinion. Because the process is so indirect, it is not easily discernible. Outsiders cannot often trace the effect of a particular finding or a specific study on a public decision. ... To confound the complications, the policymaker himself is often unaware of the source of his ideas. He “keeps up with the literature,” or is briefed by aides, or reads state-of-the-art reviews of research in intellectual magazines or social science stories in the New York Times, Washington Post, or Wall Street Journal. Bits of information seep into his mind, uncatalogued, without citation. He finds it very difficult to retrieve the reference to any single bit of knowledge. (p. 534)

This process of “percolation,” at both individual and policy domain levels, is useful in understanding how some interests become prominent through the dominance of their own set of policy beliefs. As stated earlier, this is very coherent with the neoinstitutionalist view in organizational analysis, which states that organizations will be isomorphic with their environment, because although the environment shapes organizational structure and behavior, powerful organizations are simultaneously structuring their environment. Linking these theoretical viewpoints takes into account both the deliberate part of the process, that is, marketing techniques, and the percolation nature of the communication process. It could also be interesting to link the literature on direct lobbying in the health care domain with the literature about marketing efforts to influence professional practice. For example, Avorn, Chen, and Hartley (1982) show very convincingly that even though physicians feel they are not influenced by pharmaceutical companies’ advertisements and retail representatives, their empirical prescription behavior is much more influenced by these than by scientific evidence. This could be linked to an example of “Weissian” percolation. Because the marketing and government relations departments of pharmaceutical companies are quite well connected, there is some face value to the hypothesis that agenda-framing, in the broad sense defined earlier, is deliberately influenced by organized interests’ marketing of policy belief systems. This perspective is also interesting in its conceptualization of lobbying as a communication process that is also able to communicate Bachrach and Baratz’s (1962) “second face of power” through a percolation of policy beliefs.

Conclusion

As stated from the onset, our aim in this article has not been to offer new conceptualizations but to bring old questions into a somewhat new light. Relying mostly on classic, though not yet dusty, literature in the field of group theory, we suggest and defend a broad definition of

interest groups that includes any politically active organization. This definitional imperialism is both theoretically and empirically based. On the theoretical side, this article is a deliberate first step in a wider attempt to cross-fertilize the group theory and resource dependency literature. But it is also prompted by empirical observations of the health care field that clearly suggest that a purely membership-based definition of interest groups is a sure route to analytical myopia. This broad definition of organized interests, in turn, has allowed us to discuss many of the recurring questions about groups' origins and strategies.

A second contribution of this article is to further Milbrath's (1960) original conceptualization of lobbying as a communication process, by building on the conventional wisdom of resource dependency that organizations strive to influence their environment on a continuous basis. This conceptualization can be used to understand both inside and outside tactics of lobbying, but is particularly interesting because of its compatibility with the concept of long-term influence through percolation of policy belief systems.

In a rather wry introduction to one of their articles, Day and Klein (1992) made a plea in favor of theoretical polytheism:

Going through the literature on health policy is rather like leafing through the back issues of magazines and noting when hemlines moved or male models stopped wearing ties. In the 1950s and 1960s, it was all about pressure groups—a kind of protocorporatism. In the early to mid-1970s, it was all about incrementalism, with just a dash of Marxism. In the later 1970s and 1980s, it was all about corporatism. In the 1990s, we seem to have moved into an era of post-modern eclecticism, marked by the use of the prefix “neo”: so we get neo-elitism, neopluralism, neo-Marxism, and so on. It is therefore tempting to resurrect the conclusion, drawn by one of the authors 17 years ago, that all the theoretical tools “explain something but that none explains everything.” Perhaps we should just reconcile ourselves to theoretical polytheism and abandon hope of explanatory parsimony. Furthermore, it may be argued that the various theories are not necessarily in conflict but may even complement each other. (p. 463)

On a modest basis, this article can probably also be read as an appeal to build bridges in order to benefit from the respective strengths of two complementary strains of literature.

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Biography

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