At the root of its success

AHA’s lobbying muscle comes from strong network of local advocates

As healthcare issues remain close to
the top of the nation’s domestic
political agenda, advocacy organiza-
tions in Washington are always
looking for ways to gain an advantage in getting
their point across. One effective strategy is rely-
ing on grass-roots lobbying by having members
contact senators and representatives directly.

To better understand who wins and loses at
this game, I interviewed 77 congressional staff
assigned to health policy issues during the
spring and summer of 2003. I asked them to
look at a list of 171 interest groups working on
health policy and identify which ones are “espe-
cially well-organized (in their) district or state.”

The American Hospital Association received
the most mentions from staff, with 64 of 77 staff
identifying it as having strong organization at
the district or state level. The AHA was followed
by, in order, the American Medical Association,
AARP, the American Cancer Society and the
National Breast Cancer Coalition.

There are at least four major factors behind
the AHA’s success. First, hospitals have signifi-
cant natural advantages in the advocacy process.
Every congressional district is served by at least
one hospital. Hospitals are both important
providers of care and large employers. The heavy
dependence of hospitals on public pro-
grams, such as Medicare and Medicaid, helps
local board members appreciate the importance
of political involvement and advocacy. Because
hospitals bring together the interests of con-
sumers, business and labor, politicians from
both parties are responsive to their needs.

A second reason for the AHA’s success is
that it effectively facilitates communication
among its members and its national office. As
a representative of a state hospital association
explained, “AHA does an outstanding job in
communicating with us. They keep us in the
loop on a daily basis through e-mails and
advisory letters. We find out first from AHA,
not from the newspapers.”

Effective communication allows the AHA to
avert clashes over divergent interests within
the organization. For example, when it became
obvious that rural hospitals would be big
winners during Medicare reform in 2003, it was
necessary for the AHA to keep urban hospitals
from feeling cheated. It did this by carefully
communicating political events in Washing-
ton to its members.

The effectiveness of this strategy is demon-
strated by the fact that urban hospitals stuck
close to the party line. For example, a rep-
resentative of a prominent teaching hospital
told me, “We understand that the rural hospi-
tals get extra attention because of the com-
position of the Senate. If we think that our inter-
est are not being represented in the long run,
however, we will complain. In the future, we
will say, ‘Remember how we dealt with rural
issues before.’ ”

In many organizations, formal structures
gain in the way of effective communication. But
for the AHA, its organizational structure is a
third major reason it is successful at the grass
roots. Its layered structure includes con-
stituency sections (to address special needs,
such as rural hospitals, children’s health and
long-term care), ad hoc task forces and 52 affil-
iated state hospital associations (including the
District of Columbia and Puerto Rico).

Perhaps the most innovative part of
the AHA’s organization is its regional policy boards.
The AHA used to be governed by a Congress-
like House of Delegates, as is common in large
membership organizations. However, Michael
Guerin, the AHA’s senior vice president and
secretary, explained that the regional boards
replaced the House of Delegates in 1996, which
had become an outdated way of bringing mem-
bers together. Members found that regional
meetings were a better forum in which to voice
their concerns, so the organization decided to
switch to regional policy boards as the principal
mechanism for members to contribute to the
AHA’s policy-making process.

Various state representatives with whom I
spoke agreed on the desirability of the
regional boards. One representative specu-
lated that “although different types of hospi-
tals have different interests, I think the
national office keeps everybody together
because of the regional meetings.”

The unanimous decision by the AHA’s
House of Delegates to replace itself with a bet-
ter system of governance is exceptional in the
association world. Too many associations are
locked into outdated models of organization
because of fondness for tradition.

A fourth reason that the AHA has been effec-
tive is that it works in harmony with other hos-
pital trade associations. Mary Grealy, presi-
dent of the Healthcare Leadership Council,
said: “When I was at the Federation (of Ameri-
can Hospitals), we used to work closely with AHA
because we knew they had a vast grass-roots
network by virtue of being the larger associa-
tion. We encouraged our members to join AHA
to make sure that we had a voice for the
investor-owned hospitals in the association.”

A vice president of another leading national
hospital association told me that “We are able to
focus so clearly on (our issues) in part
because AHA does the hard work on general
hospital issues. I can imagine that if there were
no AHA, I would be able to devote less of my
time narrowly to (our issues).”

The AHA’s broad grass-roots network puts
it in a strong position to serve as a leader in
healthcare policy-making. Yet the notion that
hospitals might serve as brokers for the public
interest does not sit well with everyone. A lob-
yist for a prominent medical specialty society
scoffed at the idea, interjecting that “I don’t
think anyone from within the system can be
tasked with fixing it.”

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