A View from the Outside: A Contextualization of Group Politics in Canadian Provincial Healthcare Policymaking

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Introduction

In their excellent analysis of what is known about groups' influence in politics, Baumgartner and Leech (1998) conclude that the research agenda should now move toward such questions as "*Which interest groups behave in which ways and under what circumstances? When do they succeed in influencing policy? And when do they fail?*" (1998. p. 127). On a very modest scale, this paper is part of a larger project oriented toward such a perspective. However, in the specific context of Canadian healthcare there is an inescapable first step towards this objective. This is so because there is almost a consensus that interest group nature, influence and strategies are very context specific (Lowi 1964, Immergut 1992). It is thus not easy to grasp what is already known in the specific field of health policy in Canada. Most of the literature is from the US, where both healthcare and political systems are very different from those in Canada. The same is true for most of the EU and in European literature. But even in countries where the political system is not completely alien to that of the Canadian situation – as perhaps in the U.K. or in Australia – the exact level of external validity of the findings in Canada is ambiguous.

Relying on a sweeping review of what is known about interest group influence in healthcare policymaking in Canada, we firstly propose here the construction of a basic definition and typology of groups in provincial healthcare policymaking. Secondly, we suggest a basic framework of organized interests' strategies for influencing policymaking. But this work is also a view from the outside at two levels. Firstly, and most obviously, it is a Canadian look at a largely American theoretical field. As well, however, and most importantly, it is the view of someone foreign to this field since the principle author's training is in organizational theory and sociology of organizations in healthcare. The project originates with the observation that organizational theories about resources dependency (Pfeffer and Salancik 1974, 1978, Pfeffer 1972, 1973), and more generally the relationship between organizations and their environment, in fact have many points in common with the group perspective on politics (Aplin and Hegarty 1980). The first set of theories studies the organizations from the inside and observe how they both depend on and try to influence their environment. The second set of theories, on the other hand, analyzes the origins, strategies, and effects of inter-group competition and coalitions in the political arena. However, there seems to be a parallel negligent

treatment, on the one hand, of interest groups' external dynamics by organizational theory (Streeck and Schmitter 1985), and, on the other hand, of the insides of formal organizations by group theory (Salisbury 1984).

In the Canadian healthcare field, government (federal or provincial) is obviously the most influential part of the external environment of any organization, private, public, or non-owned (Leatt & Mapa 2003). Thus, almost any kind of organization, institution, or group in the healthcare field will be as sensitive to governmental action as it is active in trying to influence it. We thus think that the healthcare field would constitute an excellent ground for building a bridge between these parallel theoretical views on groups and organizations. The present paper is a modest first step in that direction in its ambition of framing a representative view of the foundations upon which political science group theory considers provincial healthcare policymaking as a relationship between groups and their environment.

Interest group influence in politics is an imposing – almost discouragingly so – academic domain both at the theoretical and empirical level. It is a domain fraught with conflicting definitions and conclusions. It is also a domain where theory and empirical observations do not always point in the same direction. As Heinz et al (1993) put it:

> "Data are inconvenient. They interfere with one's theory. Time and again, in writing this book, we devised clever explanations of the nature of national policy making that would neatly encapsulate the process, only to find that important parts of the data did not fit. This is disheartening. Some of us vowed to forswear data collection in the future, opting instead to write heavily footnoted, synthetic essays that allow greater scope for imagination and creativity." (Heinz et al 1993 p. xiii)

While we greatly value imagination and creativity, and while this paper is mainly theory-oriented, we will, however, try to stick to empirically valid observations and typologies. This work rests on three complementary sources of evidence. On the one hand, we have performed a computerized search of relevant scientific literature and analyzed the main findings of these papers. On the other hand, while working on this paper, we were in the process of collecting fieldwork data about lobbying in the healthcare sector in Quebec[1]. Our analysis of the literature has thus been systematically set in relationship to this body of empirical data. Finally, this work also rests on a good tacit knowledge of the healthcare field and institutions developed in previous work (Contandriopoulos 2004; Contandriopoulos et al, 2001 2004a, 2004b, 2005)

Data Sources

The first step of the literature review was to run a computerized search in the major databases that could be of some interest for us. We used the combination

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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). We also searched the OVID Medline, using either the combination of "lobby", "health", and "policy", or "lobbying", "health", and "policy" as keywords. After excluding papers in languages other than English, French, or Spanish, and those obviously uninteresting to us, we gained from this first step a set of over a thousand papers (n=1071). A selection of relevant documents was then made by a reading of the abstract, when present, or by relying on the title when no abstract was provided. This allowed us to identify a set of 248 papers on health policy lobbying.

However, given the keywords used, theoretical groundwork outside health fields would probably not have been identified through this first step. We thus relied on snowball sampling to include such works. While analyzing the corpus collected in the first step, we paid attention to the theoretical work upon which the authors relied and, when pertinent, added them to our literature review. This allowed us to identify 216 other documents for a total literature review of 464 documents, mostly journal articles and books. This literature review, while especially centered on healthcare, is not exclusive to it and is not restricted to Canada in any way. Obviously, while we paid special attention to Canadian work, this was neither a criterion for inclusion nor exclusion. The logic here is the allowance firstly of an understanding of the broad field and then identification of what could be of interest in the Canadian healthcare context.

This method cannot warrant exhaustivity. It is plausible that we may have missed some intelligent papers that would have been helpful. However, it being quite unlikely that we may have completely missed any influential paper, this method gives a broad view of the field of interest group representation and makes it unlikely that any significant strain of ideas be completely 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 sub-field of pharmaceutical policy, there are papers in political science but there is also much work in the health policy field that, while not directly dealing with lobbying, does bring interesting and original evidence from current policy debates -- for example, Lexchin's numerous papers on pharmaceutical companies' influence (Lexchin 1993, 1994, 1997, 2001).

Organized Interests: Definitions, Origins, and Networks

Definition

Given our fear of meeting Jordan's definition of the interest groups student as someone with a "*temperamental disinclination to define*" (Jordan 1984 in Pross 1992 p.13), we will start with a short discussion of the definition of our focus.

As stated earlier, in healthcare policymaking, there is a vast array of distinct kinds of politically active groups, institutions, or organizations. And the use of the three terms "group", "organization", and "institution" is deliberate here since many important actors in the field are institutions such as hospital associations, unions, regional boards, and the like. In fact, many influential "interests" in healthcare policymaking are not groups (Salisbury 1984). A single major hospital, or a pharmaceutical company, for example, cannot be described as a "group" but is nevertheless often both able and willing to intervene efficiently in policymaking.

We thus rely here on a quite encompassing definition of interest groups, one that includes both membership organizations as defined by Pross (1992 p. 3-11), and "member-less" institutions such as hospitals, private companies, or 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 healthcare field, it seems obvious to us that more restrictive definitions would exclude some actors that do exercise significant pressure in the policymaking process without a valid justification. While it is clear that member-less institutions administratively linked to governments will be constrained in the choice of their lobbying strategies, we will stress that this does not impede their capacity to exercise political pressure. Moreover, a membership-oriented definition would consider such institutions as hospital associations as interest groups, while a single hospital would not be so considered, whatever its political involvement or power. Hence, whether the same hospital action would be considered relevant or not would depend on if it used its association as a political vehicle or not. In one of the empirical cases we studied, there was some internal dissension in the provincial hospital association (AHQ). The AHQ backed the position of some of its members at the expense of some of its others. Restricting the definition of interest groups to membership organizations would thus limit our analysis to the political action of some hospitals, while dissident hospitals would be excluded, notwithstanding the fact that in practice their political action is very similar. Moreover, the staff and resources of such associations or organizations are often still administratively attached to one organization. In the same way, a good deal of the political action is done 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 would rather suggest that it is more fruitfully analyzed as a decision to join, or not to, a particular kind of coalition (Hojnacki 1997).

The main modification we would add to Salisbury's definition is that we limit groups to structured organizations that are able to express themselves through the voice of some legitimate designated individuals (Bourdieu 1984). This limitation excludes latent interests, unorganized individuals, or non-institutionalized social movements, which can try to influence policy on a personal basis. Though, as Bentley (1967) noted in *The Process of Government,* there is no clear boundary to distinguish between institutionalized and non- institutionalized groups, the distinction can still be used heuristically to identify groups that are at least institutionalized enough to express themselves through a designated spokesperson in the political arena. The potential self-designation of groups' spokespersons, as well as their exact representativeness, remains, however, an open question (Nelson et al 1987; Ainsworth 1993; Contandriopoulos et al 2004a;). Finally, as almost all other definitions do, we also distinguish between interest groups and political parties. The rationale here is, in the words of Berry, that 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 following 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.* Thus, strictly speaking, the interest groups we focus upon here sometimes are not groups at all. Hence, the term "interest group" is probably inaccurate. In the same way, these interests are neither as ontologically "vested" nor as especially "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 more or less compatible terms, we will quite indistinctively use "interest groups" and "organized interests". What is relevant is that including "member-less groups" in the definition necessitates some discussion about the origin and maintenance of group existence.

Origins

Contrarily to Olson's (1971) view, we would defend here the idea that material incentives are not the main explanatory factor for the existence of organized interests in healthcare politics. First, many influential actors are preexisting organizations such as hospitals, public health agencies, or pharmaceutical companies. For these, their political capacities are – in Olson's terms – a by-product of their broader administrative and managerial capacities. For others 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

(Powell and DiMaggio 1991; Meyer and Rowan 1991) and state regulation (Walker 1983; 1991; Mawhinney 2001) could probably explain their existence and constitute their interest group stature also as a by-product. But more fundamentally, in both cases, they are either "member-less groups" or "compulsory membership groups".

Organizations conceptualized as politically active "member-less groups" could be split between utilitarian organizations (Clark and Wilson 1961) that strive to maximize material rewards (i.e., a pharmaceutical company) and not-only-utilitarian organizations that do have a preoccupation about their resources but that are also preoccupied by non-material goals. In this last category, we could find hospitals or public health agencies that, while interested in obtaining enough resources from their environment to subsist or grow, are also interested in other objectives, such as curing disease, relieving suffering, ameliorating public health, and so on. This typology tallies with Evans' (1984) typology of for-profit, not-for-profit, and not-only-for-profit actors in healthcare.

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 these organizations are able to draw the majority of their resources either from the market or from quite stable public funding, as hospitals do. Their political involvement is thus one lever – amongst others – for obtaining material resources or, quite often, for obtaining 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 services. If one of these organizations proves to be unable to fulfill its stakeholder's expectations in regard to its ability to attract resources (either material or intangible), the executive summit of the organization will probably have to face sanctions or at least pressures. However, being "member-less groups", the way in which they need to redistribute benefits probably more closely resembles the classical incentive system of Clark and Wilson (1961) than the (equally classical) logic of Olson (1971).

In the case of compulsory membership groups such as physicians' associations or unions, Olson's sub-theory 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 the Canadian system, 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 with member-less ones.

Finally, in the case of non-compulsory membership groups, such as patients' organizations, Rx&D, and so on, 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, where 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 practically important if we are interested in understanding the necessary conditions of political activity, it is much less pertinent when our interest shifts to understanding the nature, the form, or the 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.

In the context of healthcare, many groups become politically active to obtain either gains that are public goods and as such accessible to everybody, not only to those who have mobilized, or even 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 healthcare sector in Canada is probably somewhat specific in the sense that people – both policymakers, the 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 that seek to obtain 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 a re-examination of Olson's postulates would be needed in order to use a typology of groups based upon the nature of their goals in the context of healthcare in Canada.

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 policymaking process. For example, the CMA was repetitively described as having almost an ideal-type corporatist relationship with the government (Taylor 1960). By opposition, the pluralist model will posit an open system where any interest can organize itself and then enter the political arena to express its views. Notwithstanding the need to axe whole forests to get the paper to print the innumerable standpoints in the debate between pluralism and corporatism, both share at least the trait that groups do not exist in a social vacuum but rather with specific relationships between themselves and with other elements of society.

There is, for example, a consensus on the fact that groups with interests in a similar field will be aware of each other's positions and strategies; as well, they will obviously be aware of the relevant government agencies' positions (Heintz et al 1990; Carpenter et al 2004). Unfortunately, the name given to this network of actors

is tightly linked to a specific theoretical standpoint (policy networks, subsystem, iron triangles, etc.). To briefly describe the inter-group relationships, we will implicitly rely on the definition policy subsystem or domains of Sabatier & 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 whole provincial healthcare policy-making arena as a specific subsystem and, if needed, focus on more specific sub-sub-domains as, for example, pharmaceutical regulations? Or is the pharmaceutical regulation arena an international policy sub-domain and the specific provincial arena a sub-sub-domain? In our view, while there is probably no obvious choice in the conceptualization of the level of analysis for groups' interactions, this has implications for the capacity to generalize in specific case analyses.

In any case, the groups and public agencies inside a given policy domain can have various relationships ranging from confrontation to collaboration in their interaction with other elements of society (Evans 2001; Salisbury et al 1997). However, there is some imprecision in the exact nature of interrelationhips since most kinds – if not all – of collaborative arrangements are indistinctly described as coalitions (Lowi 1964 p. 678), even though specific relationships can take many forms. For example, in the healthcare sector, a frequent specific form of coalition could be called the relay (Burton and Rowell 2003; Wysong 1992). An example of a relay could be the relationship between the pharmaceutical industry and patients' organizations (Herxheimer 2003). The pharmaceutical industry can have some interests in common with some patients' organizations, for example, the inclusion of a given drug on the government formulary. However, rather than openly forming a coalition, these groups will often feel their interests would be better served by another arrangement. For example, a given company could help to hire, fund, and train a given patient organization staff, but clearly stay away from visible lobbying for inclusion of its drug on the formulary, fearing that open lobbying could harm its case more than help it. The patient organization would, however, be there to lobby and would be correctly funded and trained to do so. This is thus a relay in the exercise of pressure as well as a reciprocal exchange of commodities, giving legitimacy for material resources and material resources for legitimacy.

Another level of imprecision can be found in the level of institutionalization of coalitions. As we have seen, some institutions -– for example, hospitals or pharmaceutical companies – are politically active both at individual organizational levels and through some memberships' 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 to be considered as legitimate units of analysis, then associations become institutionalized forms of coalition. However, their institutionalization is not absolute: some organizations sometimes disagree with the association to which they belong and politically oppose it. This conceptualization would thus add to the fluidity of group population observed by Gray and Lowery (1996) 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. Any of these will be eminently context-specific and sector-contingent, ranging from climbing a gigantic industrial chimney with a banner – as Greenpeace can do -– to chatting with a Minister on a golf course. The aim of this section is thus in no way 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), which emphasizes communication processes.

The identification and categorization of groups' strategies to impact the political process and even more the analysis of their effectiveness are the subject of much controversy in the literature. In our view, one tallying with Baumgartner & Leech's (1996) remarks, these controversies may very well originate from methodological choice as much as or even more than from theoretical viewpoints. For this reason, we will start by briefly reviewing the three principal methods used to identify groups in order to understand their strategies.

The first one is to look at a given health-related policy or decision process and to observe the groups involved. The delimitation of relevant interest groups can be empirically established as those whose activity can be observed one way or another. This method is susceptible to the criticism that a group that does not need to mobilize because it is already able to frame the whole field in accordance with its preferences would go unnoticed (Alford 1975). This is directly related to the perspective implicit definitions of groups' expression of power and as such a simple reformulation of Bachrach & Baratz's (1962) observations. Another similar method could be to establish the foreseeable gains and costs of a given policy and to pinpoint the likely losers and winners. Then all groups expected to be significantly affected by the policy are identified as potentially involved. The probability of these groups effectively mobilizing can be further analyzed according to Olson's (1971) framework. Although this alternative method can help identify dominant interests that could otherwise remain hidden, it is debatable that much could be learned if these dominant interests were really stealthy enough to escape any observation. These two similar approaches are the most prevalent as they are the most obvious and the easiest. However, they suffer from three flaws. The first one is that the ability to obtain a representative sample of groups depends upon the methods used and the effort exercised. Secondly, the external validity of the findings outside the specific context of the case needs to be discussed. Finally, as Baumgartner and Leech (1996) suggest, a one-shot study design bears the risk of focusing on a too-short lapse of time to observe all the different strategies of influence. If these approaches are to be fruitful, then the decision-making or policy-making processes need to be conceptualized in a historical context over a significant period of time (Sabatier and Jenkins-Smith 1993).

The second method is to sample a representative sample of interest groups from any field or sector from some kind of directory or public records. Probably the most ambitious of such attempts would be the work of Heinz et al (1993), but it is

not representative since this kind of method is generally used for quantitative analysis. (For a Canadian instance of such an approach, see, for example, Amara et al 1999). Here, obviously, the representativeness of the sample will depend upon the nature, quality, and exhaustiveness of the directory or record used. This in turn fundamentally affects the way in which the results can be interpreted (Lowery and Grey 2004). Moreover, this approach presents two other potential flaws. Firstly, it is as sensitive as the first one to the time-lapse problem as presented above. Secondly, it is sensitive to a restrictive definition of lobbying as one limited to direct lobbying only.

Even if these approaches rely on somewhat different methods, they share an important common point, their ambition to more or less exhaustively identify the groups active in a given policy-making process. The fourth approach is different in both aspects because, instead of starting from a policy, it starts from one or a few groups, as in Garceau's (1941) classical study of the AMA. For example, in the Canadian context, one expects a few usual suspects to mobilize on any issue regarding professional autonomy or delivery models (Lavis 2002). The selection of the group or groups under scrutiny is thus made on an a priori basis and their political involvement in one or more policies, issues, or decisions is studied. (In Canada, see, for example, Fulton & Stanbury 1985). This method is much less susceptible to the time-lapse bias since it is usually used to study one group from a historical perspective. However, as with other types of case study, the external validity needs to be assessed.

As this presentation shows, the method used to empirically study groups' strategies in fact structures, to a significant extent, the implicit definition of an organized interest as well as the nature and prevalence of their strategies. If, as we are, one is simply interested in establishing a typology of the strategies, it is possible to overcome this bias by aggregating the various findings. However, any attempt at evaluating the relative efficacy of these strategies would have to overcome huge methodological problems.

Group Mobilization

The starting point for analyzing group mobilization is probably to note that the simplest strategy is none at all. Not all groups will mobilize on each issue; some will be inactive. Obviously, this statement 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 higher 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 an economic maximization framework. 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" (Becker 1983 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 policymaking, where costs and gains are usually limited to material incentives. Since 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 some few others -– are likely to create conditions where groups mobilize both in favor and against the policy. This would probably look more or less like a pluralist model of political policymaking. At the other end of the spectrum, policies that produce both diffuse gains and costs are unlikely to create the necessary condition for the political involvement of groups. Finally, the situation where gains are concentrated and costs diffused, as well as the situation where costs are 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 through 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 where today's winners can always be tomorrow's losers. In the same way, depending on the level of observation, it is unclear if policymaking 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 since the narrower a domain is defined, the higher the probability of a non-zero sum outcome occurring through inter-domain resource redistribution. Finally, as we briefly noted earlier, in the healthcare sector there is undeniably a valorization of non-material 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's 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 personal motivation of this entrepreneur also seems to be generally structured by 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 non-contextually contingent way, the determinants of group mobilization.

Strategies

Following Milbrath (1963), as well as any good handbook of military theory, we distinguish between tactics and strategies, tactics being the different 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 the term "lobbying" quite broadly as any *organized interest's political activity aimed at making or influencing policy.* There are thus both lobbying strategies and lobbying tactics. Those 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 Canada.

Our discussion of organized interests' strategies is structured by two choices. Firstly, we will use the communicative framework of Milbrath (1960) to describe and analyze the process of lobbying. Secondly, this paper proposes 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 groups theory. Hence we will put the emphasis on the groups' long-term pressures to frame the political agenda. This choice stems from the fact that, from an organizational standpoint, the organization is continuously striving 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. However, this is so mostly because he considers lobbying as the direct or indirect communication of power or, said differently, as the generally subtle ways in which lobbyists raise decision-makers' awareness of the consequences of their acts. There is thus a subtle distinction between the exercise of power and its communication. This distinction is, however, interesting since the lobbyist does not always control the power relationship that he uses in his communication efforts. For example, a lobbyist who supports a policy option with arguments which 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 so 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 that could be made regarding the level of control the lobbyist can claim in the causal relationship upon which he relies in his communication process. For example, the communication of the threat of a physicians' strike if their demands are not met next week relies on a much more direct causal link than the presentation of 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, while in the second case, the causal relationship is unrelated to group action. In the next section we will delve somewhat further on this topic while linking it to the nature the organized interest in question.

Limits in the Choice of Strategy

In one of the few empirical studies on interest groups in Canadian healthcare, Fulton and Standbury (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 & Stanhbury 1985 p. 269)

However, one factor which is not emphasized and that appears central in our own preliminary 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 suited to their goals. If they are willing to enter into a "brute force" relationship, they are able to do so. This does not mean that they will favor such relationships but just that these are within the realm of possibility. However, other groups such as hospital associations, regional boards, or community organizations are more or less directly under the authority and control of the government. They are thus constrained in their lobbying strategies to not-too-conflicting approaches. While a pharmaceutical company can threaten to pull some of its drugs out of Canadian 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 of lobbying to intra-governmental lobbying, where, for example, a regional board lobbies the provincial ministry.

This structuring in 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 (Evans 2001). Outside tactics are oriented toward the general public as a lever, while 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 a kind of inside tactic, while creating a political sense of urgency through the use of mass media is a kind of outside tactic.

According to Kollman (1998), outside lobbying is especially useful for influencing the decision-makers' view of the salience of an issue. Here again, Milbrath's (1960) framework of communication process is useful for analyzing the two possible ways to push a problem or a solution onto the agenda. The first indirect

tactic would be to rely on media coverage to convince a majority of the population of the salience of an issue. This would in turn push the decision-makers to take some action. The second tactic would be to directly target the message to the decision-makers to convince them of the popular salience of the issue even in the absence of such a salience in public opinion.

> "Effective grassroots campaigns can influence citizens directly or lead elites to conclude that a groundswell of support or opposition to specific policy proposals exists. Misperception is created by targeting key decision makers and by having highly visible events. The impression of a nationwide movement can be projected by tightly focusing the public policy campaign. As described by Goddard, his group's theory was "you go to the people and they go to Congress […]. lsakowitz put it bluntly: 'You don't have to turn around public opinion as long as congressional offices are getting flooded with hundreds of calls.' " (West et al 1996 p. 59)

In both cases, the means is a particular communication of power. The difference is the fact that in the first tactic the power relationship upon which the communication of power rests does exist, while in the second case the communication process relies on an imaginary power relationship.

As we have said, the nature of the relationship between a given interest and the government will influence the choice of inside or outside tactics. While it remains possible to use outside tactics from within the hierarchical realm of the government, it will require a great deal of subtlety both in the choice of the message and the media; more broadly, it is plausible to think, with Tuohy (1976), that the Canadian political system and its more corporatist relationships with dominant interests will mean that groups will enter into overt outside lobbying through mass media less often that the US literature suggests. Finally, Lewis and Considine (1999), building on Alford's (1975) typology, suggest that, in any country, the healthcare 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 pre-decision stage. In the next section we would like to enter into some more details about 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 policymaking. 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 the fact it encompasses both the pressures to create the need for a given decision and the pressures in favor of a given kind of solutions. Our observations as well as 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 quite a consensus on the fact 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

14

1998; Kingdon 1984). However, this implicitly assumes that interest groups frame the political agenda rather than the opposite; it also assumes that interest groups and political agenda do not passively respond to external (social) stimulus (Lowery et al 2004). It is also conventional wisdom to consider that, in the Canadian political system with its parliamentary system and party discipline, agenda setting is the most efficient way to impact policy (Deber & Williams 2003) For example, Van Loon and Whittington suggest that "*When I see members of parliament being lobbied, it's a sure sign to me that the lobby lost its fight in the civil service and the cabinet*" (Van Loon and Whittington 1987, p. 412). As stated earlier, we do not wish to enter into a full-fledged description of all the lobbying techniques and tactics since others have done that quite well (i.e. Pross 1992, Berry 1997, Birnbaum 1992, Hrebenar 1997, Heintz et al 1993, Cigler and Loomis 1991). 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 an extension of 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 and Jenkins-Smith 1999 p. 123

Unsurprisingly, our own analysis tallies with the widely accepted view that the belief system upon 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 process. What is perhaps somewhat less often emphasized is the fact that though 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), as well as the strong interconnections of the various professions central to the healthcare 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 the 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*"

(Harris 2002 p. 987). This can in turn be linked to a broader reading of Weiss's 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." (Weiss 1977 p. 534)

This process of "percolation", both at individual and policy domain levels, is in our view an interesting way to understand the way in which some interests become dominant through the dominance of their own set of policy beliefs. It is interesting mainly because it can rely both on the deliberate part of the process through marketing techniques and on the nature of the communication process. As for the influence of marketing belief in the health care domain, it could also be interesting to link the literature on direct lobbying with the literature about marketing efforts to influence professional practice. For example, Avorn et al. (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 probably be linked to an example of "Weissian" percolation. And since the marketing and government relationships of pharmaceutical companies are quite well connected, it grants at least 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 & Baratz's (1962) "second face of power" through a percolation of policy beliefs.

Conclusion

As an outsider's look on a disciplinary field, this paper has not hoped to bring new conceptualizations to light, but it has tried to bring old questions into a somewhat new one. Relying mostly on classic, though not yet dusty literature in the field of group theory, this paper has suggested and defended a broad definition of interest groups as one that includes any politically active organization. This

definitional imperialism is both theoretically and empirically based. On the theoretical side, it 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 healthcare field which clearly suggest that 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 paper is to build on the resource dependency conventional wisdom that organizations strive to influence their environment on a continuous basis, to contribute to Milbrath's (1960) original conceptualization of lobbying as a communication process. This conceptualization can be used both to understand inside and outside tactics of lobbying but is particularly interesting in its compatibility with long-term influence through a marketing and "percolation" of policy belief systems.

In a rather wry introduction of one of their papers, Day and Klein 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. (Day & Klein 1992 p 463)

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

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