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The American Medical Association and Congress:
Disproportionate Power?

by
Clifford Roy Strachen

Introduction

Probably none of the founders of the American Medical Association in 1847 could have imagined the size and strength the organization would have over a hundred years later (Ippolito and Walker 1980). Over the past fifty years the AMA has become a major influence in health politics in America. From the defeat of President Truman’s comprehensive national health insurance initiatives in the 1940s (Feldstein 1988), to the airline smoking bans in our day (AMA 1989), the AMA has exercised enormous political power in Washington.

Considering that the medical profession can only boast of a few of their associates in Congress (two physicians, a dentist and a public health educator in the 101st Congress) (Duncan 1989), and that physicians themselves are only a small percentage of the total U.S. population, the AMA wields disproportionate influence relating to “the development and implementation of [health] policies” (Ippolito and Walker 1980, 295). I will examine the relationship between the American Medical Association and the Congress of the United States to seek an understanding behind the power of the organization.

In doing so, I will discuss the history of the AMA regarding its efforts to defeat the many national health insurance policies which have been proffered by their proponents. Then I will delve into the American Medical Political Action Committee (AMPAC) to show the enormity of the AMA’s power in electoral politics and its influence on the policy process in Congress. Finally, I will discuss the AMA’s efforts in the 101st Congress and the specific issues being addressed therein.
The AMA as an Interest Group

Professional associations are frequently quite successful in interest group politics. Their influence is important because the professions control some of the most important services available to the American public. How government regulates such activities as the delivery of health care and the distribution of justice has a great impact on the standard of life enjoyed by American citizens. The political activity of such groups, then, has a direct effect on the daily lives of Americans. The professional societies have been relatively effective in pressure group politics for a number of reasons. First, most such groups represent a large segment of the profession, and therefore speak with considerable authority. Second, the professions represent areas of knowledge not readily or completely understood by nonprofessionals. Therefore, government officials are likely to defer to the expertise of the professional association on matters relating to the practice of that profession. Third, the professional societies are comprised generally of high status, well-educated, economically privileged persons. This endows the societies with a very favorable image as well as a reservoir of high quality talent from which to draw. And fourth, the professional societies normally have access to substantial economic resources which may be used to promote the goals of the group. The real key to the success of such groups, however, is the maintenance of high membership rates. For such a group to be consistently effective, it must be able to speak as the representative of the profession, and only earning the allegiance of the members of the profession permits such an advantage. In order to achieve this goal, the professional associations must provide an attractive array of incentives, normally consisting of both material and solidary benefits (Ippolito and Walker 1980, 296-97).

The above quotation outlines some very important features of professional associations like the American Medical Association. First, the AMA represents more than half the physicians in America, as it has since 1912. (Ippolito and Walker 1980). At its peak in the 1960s it claimed as its membership nearly three-quarters of all practicing physicians.

Second, the medical profession is a field which most do not understand or know well. Congress and the Health and Human Services Agency (formerly Health, Education and Welfare) readily allow the AMA to testify before hearings and to offer suggestions on health policy.

Third, even though Dr. Joseph Hatch, prominent in Utah’s state delegation to the AMA, claims that the term "rich doctor" no longer applies in America, medical practitioners still earn higher incomes than most other professionals or laborers. The public still holds the AMA in high regard according to a 1976 Gallup poll which showed the AMA and the American Dental Association holding higher public confidence than the National Rifle Association, the American Bar Association, the news media, labor unions, federal agencies and business corporations (Campion 1984).

Finally, the AMA and the American Medical Political Action Committee (AMPAC) have been able to raise tremendous amounts of money to pursue their agenda. Dr. Hatch (1990) figures that their success lies in collecting dues and donations from only twenty percent of its members.

There is a common perception that "Congress has been afraid to take on runaway physician costs [or many health related issues] because of the immense political clout of the American Medical Association" (Rovner 1989, 387). The AMA led the defeat of Truman’s proposal in the 1940s, Carter’s 1979 bill on hospital cost containment (Feldstein 1988), and a host of other proposals in the past fifty years. The AMA, opposed to government interference and regulation in health care, is responsible for the stigma of "socialized medicine," a label it often used in congressional hearings, and in their media and grassroots campaigns.
against Truman and others (Congressional Quarterly 1968).

The AMA "doggedly fought every major proposal which would lead to a change in the relatively independent status of the individual medical practitioner" (Ippolito and Walker 1980, 294) and continues to look after the "common economic interests of all physicians [and] the maintenance of fee-for-service practice without government influence" (Feldstein 1988, 42). Dr. Hatch (1990) refutes the charge that the AMA "is just out to increase [its] pocket books" by noting AMA efforts at banning smoking on all airline flights, its push for alcohol warning labels, and its pressure for universalizing childhood immunizations.

Yet, while the AMA has been somewhat successful in these policy areas, it has been relatively ineffective, Greely (1989) argues, in promoting its own self-interests. Perhaps the AMA's greatest triumphs came in its ability to rally others around specific causes, especially "social medicine" in the 1940s.

**National Health Insurance and the AMA**

Any discussion on the AMA’s influence in Congress must include, at the very least, a cursory summation of efforts towards National Health Insurance (NHI) in this country (see Appendix). Stunned by Truman's victory in the 1948 presidential race, in which he campaigned for "a package of social benefits that included a program of compulsory national health insurance" (153), the AMA quickly moved "to oppose the enslavement of the medical profession" (154). The AMA has been, and continues to be, the staunchest foe of "socialized medicine."

The key issue in government-provided health care, from its early roots in Roosevelt's Social Security package of 1935 until this day, has been aptly enunciated by Feldstein:

> Should the federal role be limited to assisting the indigent, by means of federal grants to the states under the public assistance (charity) programs? Or should the federal government assume a broader responsibility and undertake to pay for the medical and hospital costs of the entire population, or at least specified age groups, without regard to the financial status or ability to pay of the aid recipient? (1988, 77)

The NHI issue has evolved considerably since 1935. From Truman to Kennedy the debate continued but nothing significant occurred. Bills introduced in Congress usually died in Committee. The battle lines were effectively drawn. Proponents of NHI, including such groups as the AFL-CIO, independent labor unions, and senior citizens groups saw the need to extend health care to the many senior citizens, and poor who could not afford adequate health care. Main opponents of NHI included the AMA, the U.S. Chamber of Commerce, state manufacturing associations, drug companies, and insurance groups (Congressional Quarterly 1968).

Realizing that it was losing ground to NHI momentum, the AMA continued its grassroots letter writing campaign and work on ways to improve health care for the aged. This resulted in the AMA’s "Eldercare" proposals—a voluntary method of health insurance for the elderly (Congressional Quarterly 1968). Throughout the period, the AMA and its allies encouraged voluntary private health insurance and did not oppose federal aid to destitute and low-income persons who would qualify under state welfare programs. In 1950, Congress authorized federal grants to states for medical care for those under public assistance (Congressional Quarterly 1968).
Lobbying efforts in the period 1957-1965 were intense and directed at both Congress (to sway votes) and "at the public to educate and create consciousness" (Ripley and Franklin 1980, 165). At a 1961 hearing the "Secretary of Health, Education, and Welfare, Abraham A. Ribicoff, accused the AMA of using 'a bogeyman of socialized medicine' to frighten people into opposing the administration plan for health care of the aged". President Kennedy countered "the bogeyman" by insisting an "absolute freedom of choice . . . was guaranteed" (Worsnop 1961, 582).

As the 1960s progressed, it became evident that some form of government health program was to become a reality. Still, the AMA fought on, spending $1.2 million in its Washington lobbying efforts and in two nationwide publicity campaigns (Congressional Quarterly 1968). These included (as major efforts do today) letter writing campaigns, media blitzes, visits of association members to their Congressmen, and inducing state and local governments to make statements favorable to the AMA position. The AMA spent $829,484 for exposure in one hundred daily newspapers, radio, and television during the first quarter of 1965 when the Medicare bill was being considered.

Ripley and Franklin quote Theodore Marmor on the Medicare debate:

[The] debate [was] cast in terms of class conflict. . . . The leading adversaries . . . brought into the opposing camps a large number of groups whose interests were not directly affected by the Medicare outcome. . . . Ideological charges and counter-charges dominated public discussion, and each side seemed to regard compromise as unacceptable. In the end, the electoral changes of 1965 reallocated power in such a way that the opponents were overruled. Compromise was involved in the detailed features of the Medicare program, but the enactment itself did not constitute a compromise outcome for the adversaries (1980, 164-65).

In any case, Medicare, and Medicaid soon came into being. With them, health expenditures as a percentage of GNP have risen dramatically in 25 years. Regulation, it seems, has tended to hide symptoms (just as the AMA feared) while exacerbating the real problems, creating a "cartel" for the regulated sectors in the industry (Enthoven 1977). Instead, the AMA argues, we need to be more concerned with types of national health insurance since it now exists in varying degrees and forms for different groups.

The AMA/AMPAC Relationship

As the AMA has grown, its interests, activities, and membership have become diverse. In 1965 the organization created the American Medical Political Action Committee to separate the different aspects of the AMA into cohesive units of operation in the power game. The AMA continues to concentrate on its Washington lobby activities--trying to persuade people through its grassroots movement and by direct pressure on Congressmen. The AMA remains "a distributor of valuable information regarding the status of the nation's health and the diagnosis and treatment of disease" (Ippolito and Walker 1980, 294). Indeed, the AMA recognizes "the political, as well as the societal, advantages for supporting medical research" (Feldstein 1988, 156). The AMA remains the nation's premiere professional association due to its large size, the skill of its organization, and its financial clout. AMA activities continue to include national publicity campaigns in the media, educational and research programs, and especially, its Washington Lobby. AMPAC has become an
effective arm of the AMA. Since AMPAC's domain is electoral politics it has become expert in the tactics of campaigning, raising and spending money, and much more.

As a money raiser, AMPAC has done very well. In 1981-82, $2.5 million was raised; $1.7 million of that was contributed to Congressional elections. These totals were second (in both categories) only to the National Realtors PAC (Sabato 1984, 20-21). In 1983-84, AMPAC raised $4,032,365 of which 46 percent was directly contributed to candidates and another 11 percent was used in independent expenditures (Stanley and Niemi 1988, 147). 1985-86 was an even better year for AMPAC: it raised $5.4 million and contributed $2.1 million to federal candidates (148). AMPAC consistently ranks in the top ten (often in the top five) campaign spenders just as the AMA did before AMPAC. From 1946-1966, the AMA ranked among the top lobby spenders, topping the list four times (Congressional Quarterly 1968). Since its inception in 1965, AMPAC has continued the tradition of strength. Interestingly enough, Dr. Hatch contends that these numbers are being reached from the donations of only 20 percent of the total membership. Per capita (in the AMA), these numbers represent a thirty-six to thirty-eight dollar contribution. AMPAC is raising some $2.5 million dollars per two year election cycle.

Close relationships are important to the AMA and AMPAC since it is these ties that help when the pressure is on for specific legislative measures. Dr. Hatch pointed out that AMA/AMPAC have close ties to many in Congress (some of whom are spouses or children of physicians). One reason ophthalmologists are so involved, he suggested, has been the budget cuts specifically affect-}

ing their specialty. In recent years, Congress has reduced Medicare funding for cataract surgery six times because that line on the budget was much larger than prostate surgery, which affects a larger portion of the population (Hatch 1990).

Dr. Hatch and AMPAC feel fortunate for their close relations with all of Utah's Congressmen. Especially impressive was Hatch's intimation that First District Representative Jim Hansen and Leon Sorensen, an executive vice-president of UMPAC (Utah's Medical PAC), "signed each other's temple recommends," since Bishop Sorenson (in the LDS Church) and Stake President Hansen lived in the same ward. "It is just possible that when those two talk on the phone they understand each other" (Hatch 1990). Moreover, Hatch maintains, the Utah delegation of the AMA has close, personal ties with all of Utah's Congressmen. Incidentally, UMPAC actively supported Dean Bristow, a physician who ran for Howard Nielson's vacated Third District seat. Sometimes, however,

the AMA faces a problem when a doctor runs for Congress and the group's staff prefers his opponent. "We can be under a lot of pressure from our membership to give to the physician," said an AMA official (Congressional Quarterly 1982, 46).

In any case, AMPAC supports favorable Congressional candidates. This is part of "a friendly incumbent policy. We always stick with the incumbent if we agree with both candidates" insists Peter Lauer, executive director of AMPAC (Sabato 1984, 72). However, as Ornstein and Elder point out, "the AMA is especially aggressive" (1978, 62) in pursuing negative endorsements (denying campaign support) in favor of an incumbent's rival. In 1980, AMPAC funds were used to defeat Representative Andrew
MacGuire (D-NJ), because he had proved difficult to work with (Sabato 1984).

On the other hand, AMPAC has rewarded others, who in 1982, voted favorably, or cosponsored a bill exempting professional organizations from Federal Trade Commission regulations: the AMA and the American Dental Association gave more than $1.5 million during the 1982 election (Sabato 1984). In 1964, as an earlier example, AMA funds were used on House Ways and Means Committee members who had opposed Medicare's predecessors in the past. The AMA and AMPAC are notably bipartisan, says Hatch. Ornstein and Elder support this notion "noting that the California Medical Political Action Committee gave money in 1974 to both extremely liberal Democrats (like Ron Dellums) and extremely conservative Republican's (like Barry Goldwater, Jr.)" (1978, 72-73).

AMPAC's Political Activities

AMPAC's activities are probably wider than most people suspect. Dr. Hatch pointed out that there are more activities under the Department of Political Education than under the Department of Political Action. However, one should not lose sight of the obvious imbalance in expenses on the latter side. I have already discussed direct contributions above and must now address independent expenditures and in-kind services.

"In-kind" contributions are those which are tangibles--a service, or activity--rather than monetary. One of the more common examples of this are the "meet and greet" receptions AMPAC hosts (AMPAC 1990) where physicians and politicians meet together in order to discuss politics or medicine, always with the intention of promoting a specific candidate or candidates while encouraging individual contributions. AMPAC places much emphasis on personal relationships with the candidates it backs.

Another effective in-kind contribution AMPAC favors is the "benchmark survey." This is where "AMPAC contracts with nationally recognized consultants to conduct polling on behalf of a Congressional candidate, then presents the results to the campaign" (AMPAC 1990). The law allows a "sixty-one day rule" which "permits a PAC to depreciate the cost of a poll by 50 percent if it waits sixteen days . . . to deliver it, and by a massive 95 percent if delivery is postponed more than sixty days" (Sabato 1984, 94). AMPAC conducted surveys for thirty-six candidates in 1982 at a cost of $380,000 but reported only $89,000 by following these guidelines.

I have mentioned in passing the use of independent expenditures in campaigning. AMPAC's use of independent expenditures began in 1978, and have been very effective for them in a number of campaigns. AMPAC has undertaken, according to the AMPAC pamphlet, "only those expenditures which can be viewed in a positive and informative light" (1990). Independent expenditures are exactly that: independent of the candidates for whom benefit is intended. The AMPAC has made extensive use of television and radio spots, magazines, newspapers, billboards, and mass mailings in campaigns around the country. "In 1982, it spent $212,000 on television and radio spots and targeted direct mail for thirteen House candidates. In previous elections, AMPAC paid for buttons and magazine advertising independently" (Sabato 1984, 107).

Under its political education program, AMPAC seeks to educate the public to the realities of health care and politics and to improve candidates' responsiveness to constituent issues after the election. Of course,
the premise behind these activities is that when the AMA needs to exert its influence, it will have a Congressman who will respond.

AMPAC utilized 50 percent of its budget on political education in 1984. Regional seminars stress voter registration, get-out-to-vote-drives, and telephone contacting. Through activities such as Participation '92, AMPAC encourages physicians and their spouses to obtain delegate status to national party nominating conventions (Hatch 1990).

Dr. Hatch promotes AMPAC's candidate and campaign management schools. He argues that what they do is to give some prime motivation and expertise in running for Congress. Candidate Dean Bristow, whom I mentioned previously, made his decision to run for Congress after attending these programs. Representative John Bryant of Texas commented:

Anytime someone, whether a person or a PAC, gives you a large sum of money, you can't help but feel the need to give them extra attention, whether it is access to your time or, subconsciously, the obligation to vote with them Sabato 1984, 126).

While the idea of a "subconscious obligation" may indeed be a factor, AMPAC President Peter Lauer denies any connection between AMPAC money and legislative issues. Common Cause, however, purports that a significant relationship exists between AMPAC donations and votes in Congress. Sabato writes:

Common Cause cited the defeat of President Carter's Hospital Cost Containment Act of 1977 as an example of AMPAC's influence. Of the 234 House members who voted for a crippling amendment to the act, 202 had been given $1.65 million in contributions during their 1976 and 1978 campaigns, with an average receipt of over $8,100 per member (1984, 132).

Sabato, however, is quick to point out that "correlation does not prove causation" (132).

AMPAC has what Sabato calls, "the most elaborate national-state PAC arrangements" and notes that "several of AMPAC's forty-eight state associates (including those in California, Texas, and Illinois) are among the largest state PACs in the country" (119). AMPAC works with its state counterparts like the Utah Medical Political Action Committee to raise funds jointly. According to their guidelines, however, the two must keep their monies separate and for the purposes intended. The Utah chapter of AMPAC may donate to Utah Congressmen or others in Congress but UMPAC, alone, can donate to campaigns for the Utah legislature. AMPAC looks to its state associates for its grassroots strengths and for information on congressional races (Hatch 1990).

The relationship between the AMA and AMPAC is interesting. According to the campaign reform laws of 1971 and 1976, funding for the two must be kept separate. Each has its specific jurisdiction—the AMA is a lobby and public educator, and AMPAC is a political arm created to influence electoral politics. To this end, AMPAC contributes over $1 million per year (Ippolito and Walker 1980). The technically separate relationship between the two leads to contradicting behavior since the AMA may decide it needs to lobby a specific Senator while AMPAC may find it in its interests to effectively ignore the same Senator. I think, however, that such conflicting behavior is rare.

AMPAC is concerned about campaign finance reform, says Dr. Hatch (1990). He does not like the $5,000 limits on campaign contributions, but recognizes their value in preventing wholesale purchases of elections.
The AMA and the 101st Congress

Health care today, as good as it is for those who have it, is still unavailable to an estimated 33 million Americans who lack the means to qualify for or purchase health insurance programs (Associated Press 1990). Congress, in its efforts to close this gap, has introduced a bill requiring employers to provide basic health insurance to all full-time employees (Fuchs 1990). Fuchs contends that over 80 percent of the uninsured are employed or live in families of employed workers. This problem could be alleviated by the above mentioned bill.

Surprisingly, this bill in many ways parallels the AMA’s latest proposal "Health Access America" which Dr. Hatch discussed in our interview. According to the Associated Press (1990), the AMA plan includes the expansion of Medicaid to all who live below the poverty level; requires employers to provide health coverage and proposes tax deductions to help with costs; provides risk pools for the uninsurable and tax incentives for long term care insurance programs; and changes the malpractice laws. In all, the AMA proposal has sixteen points which, if implemented, would cost an estimated $60 billion. The AMA declined to discuss the financing of the proposal except to say it "would require some increased taxes" (Associated Press 1990).

Perhaps the main difference between the AMA’s proposal and Congress’ is cost containment. Congress has discussed implementing a system based on the Canadian model of a "fee schedule." The AMA, of course, is opposed to most forms of cost containment and would fight hard against it. Many Americans prefer a system like Canada’s but the AMA is quick to point out Canadian weaknesses. James H. Sammons (AMA executive vice-president) notes: "The presumption that an awful lot of people seem to be making is that somehow Canada has solved all of their problems. That is erroneous. . . . It is not all peaches and cream up there" (Rovner 1989a, 391). The AMA particularly dislikes provincial "expenditure targets" which control volume by percentage reductions. Sammons labels them "Russian roulette." Apparently, the AMA has endorsed the Medicare fee schedule, but opposes balance-billing limits and expenditure targets, claiming such methods "lead to rationing of health care, which would have grave impact on the health and welfare of our nation’s elderly" (Rovner 1989b, 588).

The AMA is concerned that Medicare and Medicaid are taking more than their share of budget cuts. It is "a mistaken impression that physicians have been relatively untouched by past budget cutting actions" (U.S. Congress 1989, 140). Since Medicare reimbursements and fees were frozen in varying degrees between 1983 and 1988, physicians have borne the brunt of some of these cuts. The AMA is determined not to be hurt by more. Therefore, it supports a review of physician reimbursement and a revised payment system which would dissipate inequities in the system (U.S. Congress 1989).

Small businesses and other opponents balk at the employer-provided health care proposal since under the proposed guidelines full-time workers (at minimum wage) would be required to spend 19 percent of their wages and half-timers 39 percent for basic health insurance (Gajda 1987). Employers contend that the higher operating costs associated with the proposed insurance programs would put many out of business. At this writing, the program still has not passed and probably will not.
The AMA has been heavily involved in current health care proposals. Major agenda items include pressing for a quality review agency within the Public Health Service, alcohol warning labels, airline smoking bans, new legislation to further reduce tobacco product advertising, more lenient children's disability coverage, and tax incentives for health care providers and self-insurers. The AMA has already secured some victories with regulatory relief from bureaucratic and congressional encroachment. To be sure, the AMA will continue efforts at securing legislation favorable to the improvement of health care in America while resisting government advances into their domain.

Conclusion

From the first time the American Medical Association labeled government provided health care proposals "socialized medicine," the AMA has held a strong hand in American politics. The AMA and AMPAC have been effective in the political process. The AMA with its Washington lobby has done much in the way of public health education in Congress and toward the public.

The AMA has and will likely maintain its status as a major mover for some time. Together with AMPAC, the AMA is one of the largest financial contributors to the election process and the effects of that influence have been, and will continue to be felt for many years.

Having lost the Medicare battle, the AMA has changed its tune in the last twenty years--especially in the last ten. Today, the AMA is concerned with improving the quality of health care for all and easing the financial burden of medical care on the middle and upper middle class. The AMA recognizes that public sentiment leans more and more to NHI alternatives and now seeks the next best alternatives where costs will neither be prohibitive nor government interference rampant.

AMPAC is concerned, too, because more stringent campaigning finance reform laws would obviously weaken their influence and position in the political establishment.
APPENDIX

Chronology on national medical insurance

1935 ..........
Roosevelt administration explores compulsory national health insurance as part of the Social Security Act, but no legislation is recommended to Congress.

1943 ..........
Three Democratic Senators cosponsor a bill to broaden the Social Security Act to include compulsory national health insurance to be financed with a payroll tax. No legislative action.

1945 ..........
President Truman, in his health message, proposes a medical insurance plan for persons of all ages, to be financed through a Social Security tax.

1949 ..........
The Truman proposal is considered and hotly contested in congressional hearings; no legislative action results.

1954 ..........
President Eisenhower opposes the concept of national health insurance as "socialized medicine." He proposes the alternative of reimbursing private insurance companies for heavy losses on private health insurance claims. No action taken on this proposal.

1957 ..........
Representative Forand introduces the "Forand bill," to provide hospital care for needy old age Social Security beneficiaries to be financed through increased Social Security taxes. No action taken by Congress, but heavy AFL-CIO lobbying generates public interest.

1960 ..........
The Forand bill was defeated by the House Ways and Means Committee on a decisive vote (17-8). Chairman Mills opposed the bill.

1960 ..........
As a substitute for the Forand bill, Congress enacts the Kerr-Mills bill, designed to encourage the states to help older, medically needy persons (those not poor enough to qualify for Old Age Assistance, but too poor to pay their medical bills).
1960 . . . . . .
Health care is an issue in the presidential campaign; Kennedy vows support.

1961-1964 . . . .
President Kennedy's version of the Forand bill is submitted annually in the House and Senate, but the House Ways and Means Committee defeats it.

1962 . . . . .
Senate defeats an amendment to a public welfare bill embodying the Kennedy proposal (52-48).

1964 . . . . .
The Senate passes (49-44) a Medicare plan similar to the administration proposal as an amendment to the Social Security Act. The plan died when the House conferees (from the Ways and Means Committee) refused to allow its inclusion.

Jan. 1965 . . . .
The 1964 elections brought many new Democrats to Congress, and the composition of the Ways and Means Committee is finally changed to have a majority of Medicare supporters.

Jan. 1965 . . . .
President Johnson makes medical care his number one legislative priority.

July 1965 . . . .
Medicare bill signed into law after passage in both houses by generous margins.

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