Political Decision-Making behind the Oregon Health Plan: Making the Hard Choice

by

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Abstract:

Oregon has been regarded nationally as an innovative healthcare policy state because of its creation of the Oregon Health Plan (OHP) conceived by State Senator and Governor John Kitzhaber. The OHP was designed and created to help curb soaring healthcare costs and broaden the eligibility of healthcare to the working poor. Developed in 1994, after a drawn-out process and numerous delays, the OHP was crafted using political decision-making determined by different advocacy coalitions. This paper is a historical account and analysis of the creation and political decision-making process used to create the OHP. This paper will discuss the process of the decision-making by government officials, healthcare providers, insurers, and Oregon community members in order to create the OHP. The coalitions that were involved in this process will be examined along with their core policy beliefs. This is an explanatory piece that will help communities and policy-makers better understand the process of coalition building and the healthcare policies they can create. Core policy beliefs will be examined among different coalitions, along with the implications of these beliefs. The process used to create the OHP was unique, using collaborative methods that involved participatory action and high levels of community engagement.

Introduction and Statement of Problem

This essay includes an in-depth analysis of the political process that occurred prior to the creation of the Oregon Health Plan (OHP) and surveys the efforts of key players prior to 1994 in order to address the following questions:

- What coalitions were formed to create the Oregon Health Plan?
- How did coalition building impact the development of the Oregon Health Plan?
- What was the policy process of engagement that created the Oregon Health Plan?
- What communities affected the creation of the Oregon Health Plan?

After describing the methods and approach used, a brief literature review is provided examining the advocacy coalition framework (ACF), Medicaid reform, and collaborative methods of engagement. This is followed by background information, describing the creation process of the OHP in three distinct phases. Then OHP legislation is described, along with the political climate that existed during the creation period. After the legislation is discussed, the application of the ACF is applied to the creation process of the OHP.

The analysis in the discussion section will explore the political strategy of coalition building that occurred during the creation of the OHP. For each coalition, deep core policy beliefs, the secondary aspects of their belief systems, interactions with other coalitions, resources, and policy outputs will be described in detail. Finally, policy recommendations will be made and areas for future research will be addressed.

Methodology and Approach

Information for this essay was derived from a range of sources, including news articles in *The Oregonian,* medical journals, government transcripts of public meetings and hearings in 1991, and interviews with key participants who were involved in the creation process. A document review was important in understanding the political context and events that led up to the creation of the OHP. The government transcripts provide information regarding the revision of the prioritized list of medical ailments. The newspaper and journal articles give accounts of the politics that surrounded the enactment and implementation of the OHP.

Interview data were obtained through in-person and phone interviews with key informants. Purposive sampling technique was used to select the key informants. Purposive sampling is often preferred in qualitative research because the most "information-rich" cases are selected (Patton, 1990). A qualitative research interview was appropriate in this circumstance because the focus of this research is to better understand the events leading up to the creation of the OHP. There were individual historical accounts that were required to explain how the OHP developed and the negotiations that were made.

This research project used interviews to complement participant's perspectives into the findings from the literature. The interview type was semi-structured interviews with predetermined questions; question wording was changed and there were explanations given as necessary. There were ten primary questions asked. Some questions were omitted if they did not seem appropriate, and in some circumstances,

there were one to two supplemental questions added for clarification. Known as snowball sampling, key informants helped identify other members of the population as critical informants throughout the study. This type of sampling proved to be useful because of the difficulty that existed in identifying members from the required population. The interviewees were as follows: one lobbyist, two OHSU physicians, two healthcare activists, one physician, two Department of Human Services (DHS) employees, two Oregon Health Services Committee (OHSC) members, and previous governor and state senator, John Kitzhaber. The participants have been coded throughout the discussion of the essay to protect their identities: Lobbyist; OHSU Physician #1; Healthcare Activist #1; Physician; DHS Employee #1; Healthcare Activist #2; OHSC Committee Member #1; OHSU Physician #2; OHSC Committee Member #2; John Kitzhaber: State Senator, Previous Governor; and DHS Employee #2.

Excerpts from the interviews conducted have been dispersed through the discussion to add substance to individual sections of the essay. There were important insights from many different interviewees that have added richness and strength to the essay. The questions that were asked of interviewees can be found in the appendix.

Literature Review

When examining the literature, there is no lack of research discussing the OHP, applications of the Action Coalition Framework (ACF) in healthcare, Medicaid reform and collaborative methods of engagement. The literature helps explain how coalitions and collaborative methods of engagement played a critical role in the development and implementation of healthcare policy. Despite its importance, most of the professional and

scholarly literature on the creation process of the OHP and healthcare reform has neglected to analyze the coalition building and political process behind creating healthcare policy.

Advocacy Coalition Framework

Understanding of the Advocacy Coalition Framework (ACF), which is based on Paul Sabatier's Advocacy Coalition Framework of Policy Change model (Sabatier, 1993), can provide insight into the political process involving multiple actors from several levels of government that occurred during the creation of the OHP and of the role that coalitions played in policy formulation. Sabatier's model is based on the idea that various players in the policy process, including interest groups, institutions, politicians, bureaucrats, journalists, and researchers, organize themselves into advocacy coalitions based on core and secondary beliefs, and then work to achieve their policy goals (Sabatier, 1993). The ACF presents an overview of the "role of advocacy coalitions within the policy subsystem and the effects of two sets of factors exogenous to the subsystem that affect the constraints and opportunities affecting subsystem actors over time" (Sabatier, 1993:15). The ACF theory suggests that policy participants hold strong beliefs and are motivated to get involved in coalitions in order to translate those beliefs into actual policy. Sabatier's framework stresses certain elements that are common to most cases; therefore, any analysis using the framework will inevitably uncover complications and exceptions that are not directly assessed by ACF.

In the framework, there are typically two to four coalitions that are formed based on shared deep core beliefs, which span across most policy subsystems. Groups come

together to help shape what will be addressed based on their deep core policy beliefs and to determine how any policy will be developed. The next levels are policy core beliefs, which are the applications of the deep core beliefs. Finally, there are secondary beliefs, which are narrow in scope and are more easily negotiated upon. The ACF literature provides a framework for explaining relatively stable parameters, external system events, and long-term and short-term coalition opportunity structures that are helpful when examining the OHP creation process. This essay will focus mostly on the external system events because of the impact that community members had on creating the OHP. This is not to suggest that community members were the only ones that participated, but they did play a significant role in the creation process.

Supporters of the ACF argue that policy formulation and change can be explained by examining how coalitions form, operate, and evolve. The ACF was developed to address how policy knowledge is used by groups in a policy subsystem by finding evidence that the link between policy knowledge and policy change can be found in individual and coalition belief systems (Sabatier, 1988).

However, James and Jorgensen (2009) argue that there are problems with examining policy issues using the ACF and with using coalitions as a way to describe policy formulation. They describe the ACF as inadequate for explaining policy systems. They emphasize that policy knowledge changes public policy when individual and coalition policy beliefs change. James and Jorgensen also argue that the ACF approach emphasizes policy learning at the cost of other knowledge, stresses the psychological characteristics of the policy actors with insufficient attention to information flowing through the system, focuses on when policy knowledge may be used at the cost of which

information decision makers use it and under what conditions, and makes assumptions, rather than exploring empirical questions.

When applying the ACF to the creation process of the OHP, it can be difficult to understand the role that oppositional groups played. James and Jorgensen explain this to a certain degree when they address limitations of the ACF. The theory suggests that there are only three to four coalitions, where in reality there are many factions with differing opinions among coalitions that may be too complex to explain using this theory. The ACF does not address the chaotic complexity of the policy-making process, which is described by James and Jorgensen. The ACF is a valuable theory for examining policy situations, distinguishing core and secondary policy beliefs, and examining how coalitions come together to create policy change. However, there are still areas that are lacking and could be developed further. These areas are: (1) a better understanding of how oppositional coalitions are examined; (2) further details explaining how learning occurs; and (3) how policy outputs are maintained after implemented. In this paper, the ACF is used as a lens through which the creation process and political decision-making that occurred for the OHP will be viewed.

Applications of the Advocacy Coalition Framework

In the last decade, numerous articles on how the ACF has been applied to health-related fields have appeared in Canada, Switzerland, the United Kingdom, and the United States of America. These articles support the use of applying the ACF to healthcare policy research topics, which includes the OHP policy process. These articles tend to address policy-oriented learning and policy knowledge, rather than external shocks or perturbations in policy systems.

For example, Bryant (2002) examines how different forms of policy knowledge influence developing polices through two case studies related to housing and healthcare policy in Toronto, Canada. He applies the ACF, specifically policy-oriented learning, and the framework of the policy change process to describe recent health and social policy changes in Toronto. This case study examines how advocates align their beliefs to influence policy decisions, but does not describe any external shocks that were relevant during the policymaking process. For example, the media played an extensive role as an external shock to this policy process, but were not described by Bryant. However, this study does confirm that different types of knowledge can inform the policy process including scientific studies, anecdotal evidence, and alternative perspectives. The main argument that Bryant made is that different types of knowledge are essential to building a case to achieve specific policy change outcomes.

The result of the first case study regarding the re-structuring of the hospital in Toronto was that rather than shutting down the Women's College Hospital due to a lack of finances, the hospital merged with two other healthcare institutions to stay viable. By merging with other institutions, the Women's College Hospital was able to garner new support and keep its doors open. The success of this re-structuring process was in part because of a vast mobilization of women across Ontario and the coalitions that were created between hospitals who shared similar core policy beliefs. This mobilization can be described through the ACF as an external shock to the policy system because of how agendas shifted and focused the public's attention in supporting the hospital. In 2005, the Women's College Hospital regained its status as a self-governed healthcare facility (Bryant, 2002).

Schofield (2004) aims to better understand the role of knowledge, learning and capacity when health policies are enacted using the ACF. She uses a mix of six variables and processes (learning, structure, bureaucracy, motivation, time and detail) to explore how public managers enacted a new policy initiative in the British National Health Service. By drawing on data gathered from the introduction of capital investment appraisal in the British National Health Service, she develops a model of Learned Implementation that shows how public managers can learn to enact new policy initiatives. The result of this study suggests that public managers and policymakers need to learn how to implement new public policy in a variety of ways, including developing their knowledge and competence. Public managers, government officials, and other rule makers have to learn a range of new and detailed techniques to implement ambiguous policy directives. This study was successful in showing that the structure of working in teams enhances learning and has turned conversion of policy into action by providing a framework for completion. Schofield's study reaffirms Bryant's finding about different ways of knowing as critical to policy change as British National Health Service bureaucrats found that they were better able to implement policy changes by involving affected groups.

Breton et al. (2006) focused on applying the ACF to public health and tobacco policies in Canada. The research team indentified factors that led a regional government (Quebec, Canada) to opt for a reduction of its tobacco tax to combat tobacco smuggling. This study also examined the fallout of Quebec's tobacco-tax rollback on its tobacco control policy by conducting qualitative research using a case study design and multiple sources of data. They found that advocates of the tobacco-tax rollback framed the

contraband problem in a way that won the support of many different actors from a wide variety of backgrounds.

Tobacco companies in Quebec organized their initiatives to appeal to a broader array of actors than did their opponents, which led to their success in reducing tobacco taxes. Tobacco companies were able to persuade influential actors who voiced their concerns over the potential for an increase in crime and the survival of small retailers. Importantly, the promoters of the tax reduction succeeded in conveying their perception of the problem and its solution to voters and rule-makers. On the other hand, groups concerned about smoking related health issues in the smuggling debate had limited funds to make their case to the voters. Consequently, a sizeable proportion of supporters voted in the fall of 1994 and anti-tobacco actors were few in numbers at that election, not having been influenced by an organized message that appealed to their values (Breton et. al, 2005). This research adds information about how financial motivations and resources can be a powerful tool in creating coalitions as well as framing their messages.

When examining the process of policy development, research suggests it is important to identify the key actors, proponents, and opponents of a bill; and it is important to understand the interactions between coalitions. Schorn (2005) applied the ACF to a women's health issue during a study of a bill introduced into the Tennessee legislature in 2005 that would require emergency departments in hospitals and clinics to offer and dispense emergency contraception to sexual assault survivors at risk of pregnancy. Schorn examined key actors in, proponents of, and opponents to this bill, along with constraints to acceptance of the policy. Several advocacy groups collaborated

to form the Women's Health Safety Network for the purpose of communicating as one voice on the bill. The challenge for the advocates on a state and national level was to maintain focus on public health science and on the health and wellbeing of women, while avoiding the abortion debate. The main findings from this study were that multiple voices and many resources relayed a strong message that focused on critical values. These advocacy groups were successful in part because of their strong and cohesive message that focused on core policy values. The Women's Health Safety Network was also successful in part because of the available financial resources they received from supporters to support their beliefs.

Healthcare Reform

Fuchs and Emanuel (2005) believe that healthcare reform is necessary because one in six Americans is without health insurance, medical spending is increasing at an unsustainable rate, costs are too high, and medical errors (including overuse and underuse of medications and procedures) are prevalent. In addition, the Institute of Medicine (IOM) estimated in 1999 that approximately 98,000 Americans die annually from preventable medical errors (Doheny, 2009), which is another supporting fact for why healthcare reform is necessary. Healthcare reform may affect this number by decreasing the number of errors, by creating a more efficient healthcare system. They consider several proposals for incremental reform and three for comprehensive reform: individual mandates with subsidies, single payer, and universal healthcare vouchers. The main conclusion they make is that none of these approaches are likely to achieve universal coverage or slow medical cost issues alone. The authors believe that over the long term,

health care reform is likely to come only in response to a major war, depression, or large-scale civil unrest.

Fuchs and Emanuel (2005) address some of the obstacles that exist in completing Medicaid reform. Some of the obstacles are satisfaction with the status quo, single-issue groups and constituencies, the United States system of government, and differences of opinions. Also, the system of government, with its checks and balances, creates another obstacle to major comprehensive reform.

Baiker and Chandra (2008) believe that there are myths and misconceptions that need to be addressed regarding United States health insurance. They believe these myths are interfering with the diagnosis of problems and hurting the development of productive healthcare reform. The five myths that they identify: (1) sick people without insurance cannot find affordable policies, (2) covering the uninsured pays for itself by reducing expensive and inefficient emergency room care, (3) lack of insurance is the principal barrier to getting high-quality care, (4) employers can shoulder more of the burden of paying for insurance, and (5) high-deductible health plans and competition, not government action, are the keys to lower costs. They argue, however, that: (1) Insured sick people and uninsured sick people present very different public policy challenges, (2) the emergency room is an inefficient and extremely expensive way to provide care for individuals, (3) having insurance may increase the quantity of care you receive, but it is no guarantee of getting high-quality care (the likelihood has more to do with geography than with insurance status or spending), (4) employees ultimately pay for the health insurance they get through their employer, no matter who writes the check to the

insurance company, and (5) greater patient cost sharing is helpful, but not the magic solution some make it out to be.

Specifically, public policy challenges of uninsured and insured people are very different. For insured sick people, the specific policy challenge is not just having insurance that protects against unexpected high expenses in any given year, but also against the risk of persistently higher future expenses in the case of chronic illness. With people who have insurance, there is limited availability of long-term insurance. On the other hand, people who are sick without insurance need health *care,* not health insurance. The policy problem "posed by this group is how to ensure that low-income uninsured sick people have the resources they need to obtain what society deems an acceptable level of care and ideally how to minimize the number of people in this situation" (Baicker and Chandra, 2008:535).

Another issue raised by Baicker and Chandra (2008) is who pays for health insurance. They argue that the misconception that employers pay for benefits out of a pool of profits stems from the view that we can get employers to shoulder the cost of providing health insurance (Baicker and Chandra, 2008). In reality, no matter how much a company profits, benefits are paid for out of workers' wages. They argue that employers make hiring and salary decisions based on the total cost of employment, which includes both wages and benefits such as health insurance, maternity leave, disability insurance, and retirement benefits. Employers provide health insurance as a way to attract workers, just like wages. When the cost of benefits rises, wages fall (or rise more slowly than they would have otherwise), leaving workers to bear the cost of their benefits in the form of lower wages.

Concluding, Baicker and Chandra (2008) believe the solution lies in a comprehensive healthcare reform proposal that aims at extending insurance protections and improving the value of care by those who are insured. Fuchs and Emanuel (2005) explain the many difficulties and obstacles of healthcare reform, varying from satisfaction of status quo and differing opinions on healthcare reform. Overall, with the rising costs of healthcare and many Americans still without healthcare insurance, healthcare reform is necessary (Fuchs and Emanuel, 2005).

Community Engagement

Many authors are examining the role of community involvement in healthcare reform. For example, Hurley et al. (2009) argue that by engaging consumers to be more active participants in their health and healthcare system, communities can align forces and improve the quality and efficiency by promoting public reporting and expanding the involvement of consumers in all areas of their care. They examined how 14 different community-wide programs sought to engage the public about how healthcare affected the United States healthcare system. In each community, work groups were created that included healthcare consumers and advocates; chronic disease specialists; employers; and people with special skills or interest in education, marketing, or media. Importantly, the researchers found that the "community collaboratives comprising multiple stakeholders as a platform to promote this goal is consistent with the widespread view that healthcare is fundamentally a local enterprise" (Hurley, et al., 2009:282). The early experience of these communities provided some insights into the usability of collaborative, public engagement strategies. The research found successful consumer engagement efforts all

undergo considerable customization in development and execution to address specific local needs.

Redden (2002) explores how rationing care through the OHP engaged citizens in decision-making. Despite many fundamental changes in methodology and orientation throughout the process of creating the OHP, she found that commitment to incorporating community values in setting healthcare priorities remained strong over the years. The community meetings organized by Oregon Health Decisions opened up a public debate across Oregon on healthcare priorities and values. Redden compares the theoretical and practical areas of community engagement exercises in healthcare rationing in Oregon with healthcare rationing exercises in Nova Scotia and Saskatchewan. Importantly, this article explains how the Oregon Medicaid reform and community engagement process was successful in engaging citizens in the decision-making process.

In Canada, the system of government results in executive domination of policy processes and healthcare is currently funded through general taxation. This tends to be inconsistent with Oregon's healthcare reform, which used grassroots participation and community decision-making. However, Redden concludes that it might be advantageous for Canada to involve citizens in the decision making on healthcare rationing. Despite the Canadian government's denial that health services are already being rationed, the evidence shows rationing is occurring implicitly and on the demand side of the healthcare equation (Redden, 2002). Canadian government systems reduce their expenses by limiting the services that are provided. This method of rationing is only possible in a single-payer monopoly.

After studying the creation process of the OHP, the Canadian government has now created community governance structures within the regionalized health system, which allowed for effective community input into decision-making about healthcare resource allocation. More specifically, the Blueprint Committee recommended that regional health boards (RHBs) be created to establish, in consultation with the Department of Health, a list of essential core services that would be provided and funded categorically in all regions. These are defined as essential healthcare services that must be provided throughout the province at a consistent standard. The Blueprint recommended that the RHBs and the Department of Health work together to identify core services at the community, regional and provincial levels and to develop a mechanism for funding these services. There were ten provincial governments that decided to pursue organizational reform, which included the creation of regional and community health boards. In Nova Scotia, for example community health boards make difficult decisions concerning issues of distributional equity. The extent to which community health boards across provincial governments are used to make such decisions has not yet been determined.

Oregon Medicaid and the Oregon Health Plan

Key articles have focused on the number of individuals covered, the main goals and the aim of the plan, and specifically how the OHP was created, as well as the creation of the prioritized list, the idea of rationing healthcare, and Oregon's independently homegrown initiatives. For example, Wilson (2008) focuses on background information of the OHP, Medicaid expansion, why the OHP failed for the period of 1995 to 2003, key components of reform, the creation of the prioritized list, the independent innovative

nature of Oregon, constitutional amendments addressing the OHP, and finally lessons learned from the OHP.

The main ideas that were introduced by John Kitzhaber (at the time state senator) and Chuck Kilo (at the time a general internist) give a good understanding of what work had been accomplished for Oregon healthcare reform. Kilo represents physicians who are involved in participating in healthcare reform. He created the Better Health Initiative, which was an independent and influential health reform effort in Oregon. Wilson (2008) explains how both Kitzhaber and Kilo had worked together and independently to launch independent healthcare reform organizations (the Archimedes Movement and the Better Health Initiative), which made efforts to begin healthcare reform at the federal level.

D'Ambrosio et al. (2003) explain how the approval of a Healthcare Financing Administration 1115 Medicaid waiver allowed the state to design and implement an expanded version of the OHP. This explanation helps readers understand the expansion of the OHP, however lacks analysis on how the waiver was secured from the national government and how coalitions interacted.

Leichter's study (1993) includes survey data that indicates a high level of satisfaction among all OHP enrollees within the Oregon Medicaid population. Oregon's experience with healthcare reform has been "instructive for what it suggests about how both public and private sector managed care programs can reduce many consumer concerns" (Leichter, 1993:44).

While many articles give background information regarding the OHP, knowledge regarding the complete process of its development and implementation is lacking. However, we do know some things regarding different types of healthcare reform and

ways of coalition building. We know that by engaging consumers to be more active participants in their health and healthcare system, communities can align forces and improve the quality and efficiency in all areas of their care (Hurley et al., 2009). We also know that there have been successful studies of coalition building that have been used in healthcare scenarios (Breton et al., 2006; Bryant, 2002). Overall, there are many studies addressing healthcare rationing experiments (e.g., Redden, 2002), but there are not many widely applicable, cost-efficient solutions.

Background Information and Reasoning behind the Creation of the Oregon Health Plan

To fully understand the OHP, it is important to examine the historical events and external parameters that led up to its implementation. The following is a brief history of the OHP, describing three phases of creating and implementing the plan: idealistic excitement, revisions, and reality check. Figure 1 is a summary of events leading to the OHP.

Figure 1: Time Table of the Oregon Health Plan

Time Table of the Oregon Health Plan	
1980	John Kitzhaber elected to the Oregon State Senate (1981-1993)
1985	John Kitzhaber becomes President of the Senate (1985-1993)
1987	Oregon Legislature stops funding soft tissue transplants for Medicaid clients; led to Coby Howard Case
1988	Senate President John Kitzhaber initiates Oregon Medicaid Priority Setting Project, laying groundwork for the Prioritized List of Health Services
1988-1989	George H.W. Bush, Republican elected and becomes President (1989-1993)
1989	Oregon Basic Health Services Act passed

1989	The Legislature establishes the Employer Mandate, scheduled to begin January 1, 1994
1989	The Oregon Health Services Commission (HSC) is created to rank medical services from most to least important for low-income populations
1991	The HSC recommends first Prioritized List to Governor Roberts and Legislature, 1st OHP Waiver Attempt
1992-1993	Bill Clinton, Democrat elected and becomes President (1993-2001)
1993	Bill Clinton approves OHP waiver on March 20, 1993
1994	Medicaid expanded to include Oregonians under 100 percent of Federal Poverty Level, providing a Basic healthcare benefit package via the Prioritized List
1994	SB 27: Phase I of the OHP Medicaid demonstration is passed
1994	SB 534: Establishes (OMIP) as a state agency with state funding
1994	SB 935: Employers pay into special state insurance funds offering coverage to their employees
1994-1995	John Kitzhaber, Democrat, elected Governor, inaugurated on January 9, (Served 1995-2003)
1995-1996	Legislature repeals the Employer Mandate since Congress did not grant an exemption from the Employee Retirement Income Security Act (ERISA)
2000-2001	George Bush, Republican elected and becomes President; Bush renews OHP Waiver

***Source: State of Oregon Department of Human Resources**

Phase I. Idealistic Excitement

In 1987, the Oregon Legislature, following the lead of state Senator (and Senate President) John Kitzhaber, stopped funding soft tissue transplants for Medicaid clients. This sparked a debate about what health services Oregon's Medicaid program should cover. That year, Governor Neil Goldschmidt appointed a workgroup of representative healthcare providers and consumers, businesses, labor unions, insurers, and lawmakers. This group developed a political strategy to answer three main questions about Oregon's health plan: (1) who is covered, (2) what is covered and, (3) how it should be financed and delivered (State of Oregon DHS Website, 2006). A substantial part of the uproar over

what Medicaid would cover came in the aftermath of the Coby Howard case. This nine-year-old boy was diagnosed with leukemia in 1987 and needed a bone marrow transplant that was not covered by the Medicaid program in Oregon. His illness and death caused many Oregonians and elected officials to question what should be covered under Oregon's Medicaid program. As a result, government officials came together and agreed that OHP should cover life-threatening illnesses for children.

In July of 1989, the State of Oregon proposed a new method of financing healthcare services for its citizens. This method of financing expanded Medicaid to more people by covering fewer services. By expanding coverage for the working poor, all Oregonians with incomes below 100 percent of the federal poverty level were made eligible for Medicaid, would be made affordable by offering recipients a basic health benefit package, one more limited than traditional Medicaid (Oberlander, 2007). Importantly, the "working poor" were defined as individuals and families that maintain employment, but worked in poorly paid jobs without health insurance. They earned too much to qualify for traditional Medicaid, but lacked health coverage. The majority of these people were (and still are) women with children. Physician #2 said that as of 2007, the Medicaid portion of the OHP delivers medical and dental services to roughly more than 400,000 Oregonians, contracting with health plans, doctors, dentists, hospitals, pharmacists and other medical providers (Interview, 2010).

The Medicaid basic benefit package in 1989 covered fewer services, but increased the number of insured individuals. An example of this rationing method would be that treatment of a common cold would be ranked higher than a treatment for a rare type of cancer. This plan became law in 1989, under the Oregon Basic Health Services Act,

which represented the first state legislation to define an acceptable and adequate minimum standard of healthcare coverage for a large segment of the population (Fox and Leichter, 1991).

Oregon also proposed to fund only the most cost effective services. A lobbyist interviewed has said a key component of the OHP was to "provide the most bang for your buck" (Interview, 2010). In addition to narrowing the offering of health services funded by the state, Oregon proposed to fund all of the state's poor, no matter what their family status. A lobby explained that this broadened the number of poor (everyone at the federal poverty level and below, single or married, with children or without) by offering healthcare coverage for more than 200,000 additional Oregonians (Interview, 2010).

OHSU physician #2 said, "The conceptual goal early on for the OHP was to figure out how to redistribute dollars to cover everybody, rather than give benefits to some and leave others out completely". He described this as a "revolutionary concept that focused on distributive justice and ethical justice. Later on though the goal became to just save the health plan and keep its deep-rooted philosophical beliefs the same" (Interview, 2010).

The Oregon Basic Health Services Act set the framework for the OHP: (1) all individuals (both in families and childless adults) with incomes below 100% of the federal poverty level would be eligible for Medicaid services; (2) there would be a prioritized list of diagnosis-treatment pairs; (3) the state legislature would draw a line on the list below which any diagnosis-treatment pairs would not be available for Medicaid coverage; (4) the legislature would not be allowed to decrease reimbursement rates for care provided to Medicaid recipients; (5) managed care plans would be used to provide

Medicaid services; and (6) employers would be mandated to provide private insurance coverage to their employees, with the prioritized list as the basic benefit package (Garland, 1991).

Thus, OHP is a public/private partnership made up of three main components: (1) Medicaid reform and expansion, (2) private and employer-sponsored insurance subsidies, (3) and the prioritized list of health services established by the Oregon Health Services Commission (OHSC). The first health commission included "five physicians (including obstetrics, prenatal, pediatrics, adult medicine, geriatrics or public health, and one doctor of osteopathy), 1 social services worker, 1 public health nurse, and 4 consumers" (Garland, 1991:142).

The legislation creating the OHP called for the development of an eleven member Oregon Health Services Commission (OHSC). This commission, consisting of both consumers and providers of health and social services, created a preliminary list of prioritized services in 1989, which was implemented in 1991. Basically, aliments were ranked and then a line was drawn between what would and would not be covered by the Medicaid program using a cost-benefit methodology based on available resources. The four main factors used to create this list were: (1) cost, (2) net duration of benefit, (3) physician estimates of the likelihood that treatment could alleviate symptoms or prevent death, (4) and citizen's views on the seriousness of symptoms and functional limitations (State of Oregon DHS Website, 2010). In 1991, the OHSC recommended its first Prioritized List to the Governor and Legislature, which funded through line 587 out of 709 medical procedures as defined by the OHSC (State of Oregon DHS Website, 2010). This original list was criticized by the general public as being unacceptable because of

the quantified method that was used to create the list of ailments and the order in which they were placed. This intense criticism for listing medical priorities that placed headaches and thumb-sucking ahead of diseases like cystic fibrosis and viral pneumonia led to Oregon health officials overhauling the rankings and producing a list that is far more reflective of general consenus, a kind of healthcare by democracy (Egan, 1991).

Phase II. Revisions

Creating a social and political uproar in Oregon, the initial prioritizing of healthcare conditions and treatments pushed many Oregonians to get involved in the decision-making process in order to create a second revised prioritized list in 1992. During the creation of the second prioritized list, thousands of Oregonians across the state were included in the revision process. There were many town hall meetings and public hearings to include as many voices as possible. Parents, community members, special interest groups, and advocacy groups all participated in the process. The policy hearings on what should be included in the prioritized list were conducted across a wide geographic area. More than fifty physician panels were organized, telephone polls were conducted with more than 1,000 state residents, and a series of community meetings and hearings were held in order to get a better understanding of citizen's values. These meetings were organized by Oregon Health Decisions, a community service organization that was dedicated to receiving Oregonians' inputs on ethical issues in healthcare. Primarily based on citizen values that were expressed during the community meetings, the second prioritized list emerged from the public hearings with high ranks given to areas such as preventive medicine and maternity care. Overall, during this time, large numbers of people came together to voice their views and reflections on how the revised

prioritized list should be developed.

Phase III. Reality Check

As the implementation and use of the OHP continued, costs began to increase and more people wanted to be covered by the plan than could be afforded. This amounted to a "reality check" for all involved. As the years continued, the total number of people eligible for the OHP program outgrew the number of available slots. Only about two-thirds of eligible Oregonians were covered by the OHP in the last quarter of 2001 (Figure 2).

Figure 2. Eligible Oregon Population vs. Actual Enrollment in OHP, Oct.-Dec. 2001

Month	October 2001	November 2001	December 2001
Total Eligible Individuals	387,019	393,924	399,180
Actual Enrollment	237,668	242,133	247,656

Source: State of Oregon DHS website (2010).

In 2007, additional State budget reductions resulted in reduced enrollment and coverage in the OHP. "The OHP is not sustainable as it exists today. Our challenge is to set priorities, solicit innovative ideas and build a flexible system that delivers high-quality healthcare while also adapting to a changing economy. This is an opportunity to find a better way to manage within available resources," said Oregon Medicaid Director Lynn Read (DHS Website, 2007). By 2009, with almost 500,000 enrolled clients, the OHP had a waiting list of more than 56,000 people, including 19,000 who opted in from the previous 2008 waiting list (State of Oregon DHS Website, 2010).

Discussion

As described by the ACF, we can identify relatively stable parameters and external events that were a part of the OHP decision-making process, including basic attributes of the problem area, basic distribution of natural resources, fundamental values and social structure, and the basic constitutional structure (rules). Also, there were changes in socioeconomic conditions and the governing coalition that impacted how the OHP was created. During the passage and enactment of the OHP in the early to mid-nineties, the economy was robust and the Democrats were in power. "Oregon's economy was thriving in the 1990s and was one of the most impressive sustained economic booms in history, however this advantage was canceled out by politics," remembers a doctor involved in the OHP (Interview 2010). As the economy strived during the mid-1990s, things moved along pretty well, however warning signs were clear as early as 1996 (Saultz, 2008). As the economy weakened in the late 1990s and early 2000s in response to a series of economic and other crises (e.g., "dot-com" bubble burst, stock market fluctuations, and repercussions of the 9/11 terrorist attack, etc.), it became more and more difficult to maintain the coverage that the OHP supported because of a decreased state budget and increased healthcare costs. Without long-term affordability solutions, it became difficult to have lasting healthcare reform.

Legislation: SB 534, SB 935, SB 27, 1115 Medicaid Waiver

There were three main waves of healthcare legislation that were crucial in the development of the OHP. The first wave was the attempt to get the initial OHP waiver

passed in 1990-1991, which was rejected by the first Bush Administration. The second wave was the adoption of the initial OHP waiver in 1992-1993, which Senator Kitzhaber helped get from the Clinton Administration. The third wave was the renewal of the OHP waiver, approved by the second Bush Administration.

DHS employee #2 described that beginning in 1989 and continuing through 1993, the Oregon State Legislature introduced Senate Bill 534, Senate Bill 935, Senate Bill 27, and the 1115 Medicaid waiver. The supplementary legislation, SB 534 and SB 935, combined with broadened healthcare for the poor (SB 27) covered an additional 478,000 Oregonians and are the three main pieces of legislation that directly correlated with the passing of the OHP at that time (DHS Website).

The Oregon Legislature established the Oregon Medical Insurance Pool (OMIP) as a state agency with state funding in 1989 (SB 534). OMIP offers health insurance to people who cannot buy coverage because of pre-existing medical problems. The main goal of this bill was to supply the funding necessary for the creation of a high-risk insurance pool. Senate Bill 534 achieved these ends by funding the pool using a combination of state subsidies, insurer assessments, and beneficiary or employer premiums with a maximum premium of 150% of the standard market premium. The basic benefit package for this plan would be identical to the prioritized list of medical services created by the Health Services Commission (HSC), which is the basic minimum coverage that all private health insurance plans are mandated to offer to beneficiaries who are enrolled in the small business (SB 935) or high risk (SB 534) insurance pools.

Senate Bill 27, enacted in 1989, extended Medicaid coverage to Oregonians with income below the federal poverty level and established a set of benefits based on a

prioritized list of health services. The eight provisions of Senate Bill 27 include: (1) provide Medicaid coverage for all individuals with incomes below the federal poverty level, (2) to institute a Health Services Commission (HSC) responsible for prioritizing the list of medical services covered by Oregon Medicaid, (3) to prioritize these medical services based on the comparative benefits of diagnosis- treatment pair to the population of interest, (4) to include an estimate of the funding necessary to cover the costs of the medical services provided under the proposed program from an independent actuary, (5) to conduct public forums to obtain public opinion regarding the proposed program, (6) to actively solicit public involvement in the process in order to build consensus on the values and criteria to be used to direct prioritization of medical services and allocation of healthcare resources, (7) to allow the Joint Legislative Committee on Healthcare recommend the proposed plan to the Legislative Assembly and the Governor, and (8) to make the Legislative Assembly responsible for developing a plan to fund the program depending on the resources available within the overall state budget given that the legislature may not make any changes to the priority list without approval from the HSC.

Senate Bill 935 was enacted in 1989 when the legislature established the Employer Mandate, which was scheduled to begin January 1, 1994. It required employers to provide medical insurance to those employees working 17.5 hours or more per week and their dependents. The alternative was to pay into a special state insurance fund that offered coverage to their employees (SB 935). This bill required a Congressional exemption to the Employee Retirement Income Security Act (ERISA) (DHS Website, 2010). Although passed by the Oregon Legislature, it was repealed before going into effect by the federal government for supposed violations of the ADA. The approval of a

Health Care Financing Administration (now called Centers for Medicare and Medicaid Services) 1115 Medicaid waiver in Oregon allowed the state to design and implement an expanded publicly funded health care system, the OHP (D'Ambrosio, 2003). The waiver granted in 1993 by President Clinton expanded the eligibility criteria for Medicaid, which almost doubled the Medicaid population in the state (Deck et al., 2000).

By 1994, these three key pieces of legislation had created what is known today as the Oregon Health Plan (OHP). The OHP is Oregon's version of Medicaid, which is the Federal-state healthcare program created in 1965 that is designed to provide healthcare for the poor. At the time when this Medicaid reform started, over 400,000 Oregonians were without healthcare insurance. OHSU physician #1 remembers that this staggering number of uninsured Oregonians highlighted the need for the healthcare reform in Oregon. Operating under a federal demonstration waiver, the OHP allows the state to offer a smaller benefits package, spread beyond the original population for traditional Medicaid. The money saved by eliminating costly and ineffective procedures at the bottom of the OHP priority list was to be used to provide treatment for more Oregonians. To increase the availability of healthcare for Oregonians, fewer options for treatment would be available through the OHP to the 190,000 who were receiving Medicaid at the time when the plan began. Basically, "…the OHP was designed to stretch public health dollars by spreading them across patients who would otherwise be without any coverage, but with the result that not all medical treatments are available to those under the plan" (Lunch, 2005:245).

Political Climate

It is important to characterize the political climate during the creation of the OHP to better understand the coalition building and policy formation that arose. Without support from Democrats, the OHP would most likely not have passed. Partisan opposition was a big obstacle in the early stages of the OHP. A lobbyist interviewed recounted that there was little support from Republicans in either the state House or Senate (Interview, 2010). Opponents attacked the plan as "rationing," and it took Oregon almost two years, and the election of President Bill Clinton in 1992-1993 to get a federal waiver that allowed Medicaid funds to be used in that fashion. Bill Clinton approved the waiver in 1995, praising the OHP for improving the quality of healthcare system in Oregon. Specifically, he applauded the OHP for reducing welfare caseloads, encouraging managed care, easing charity treatment costs for hospitals, and expanding health insurance (Swisher, 1995).

Former State Senator and then Governor John Kitzhaber played a key role in the development of the Oregon Health Plan (OHP). As the political architect, Kitzhaber's leadership was crucial in both creating the healthcare legislation and in persuading both parties to pass it (Swisher, 1995). While a senator, he initiated the Oregon Medicaid Priority Setting Project, which laid the groundwork for the prioritized list of health services that would be crucial to the creation of the OHP.

Kitzhaber served four terms as president of the state senate, most of the time working closely with House Speaker Vera Katz of Portland, an alliance widely known as "Kitz and Katz" (Interview, 2010). Physician #1 expressed that this alliance was based on shared beliefs of expanding Medicaid for low-income Oregonians (Interview, 2010).

A wide partisan divide between Democrats and Republicans, with Democrats widely supporting the healthcare legislation and many Republicans in opposition, made the passage of the OHP difficult. Kitzhaber framed the issue as an economically efficient and compassionate way to provide healthcare for low-income Oregonians that had been crafted through community participation.

By the time the OHP was passed, a peculiar coalition existed between the Democrats who made up the majority of the supporters, and some Republicans. Their reasons for supporting the OHP were very different. Democrats supported the OHP because it helped to expand healthcare for low-income Oregonians. Those Republicans who did support the OHP did so because they believed it would be more cost efficient than the previous Medicaid program and because it was supposed to reduce healthcare spending (Interview, 2010). For example, the rationing aspects of the OHP and the belief that it was better than a single-payer plan were important to some Republicans. A core policy belief for Republicans during this time was to create a cost-efficient healthcare system in Oregon. However, a core policy belief for Democrats was to expand healthcare to low-income Oregonians (Interview, 2010). Despite the differences in why these two different parties wanted the OHP to pass, they both still wanted the OHP to succeed. Moderate Republicans, such as U.S. senators Bob Packwood and Mark Hatfield, helped to support and lobby for the initial OHP waiver in Washington D.C.; however, without John Kitzhaber assembling the coalitions and developing a framework for healthcare legislation, it is unlikely that the OHP would have been passed into law. Due in part to Kitzhaber's alliances and healthcare knowledge, the OHP was finally implemented in 1994, with strong support from Democrats and moderate support from Republicans.

However, by the 1997 Oregon legislative session, Republicans were arguing against the OHP because it did not reduce healthcare costs and in fact even increased costs. They attempted to repeal the OHP completely, a move that was vetoed by then-Governor Kitzhaber.

During the renewal of the waiver in 2001, Kitzhaber traveled to Washington to gain support from elected officials, including Tommy Thompson then Secretary of Health and Human Services in President GW Bush's Administration. Healthcare activist #1 remembered the "conversations that Kitzhaber had behind closed doors with Tommy Thompson in Washington to get the federal OHP revised waiver passed" (Interview, 2010). During Thompson's time as Health and Human Services Secretary, he announced the approval of Oregon's request to expand health insurance coverage to an estimated 60,000 residents without health insurance under the Administration's Health Insurance Flexibility and Accountability (HIFA) Initiative (2002, USDHHS).

Employer Mandate

The controversial employer mandate waiver of the OHP was difficult to pass and never was implemented. The "original OHP included provisions requiring employers to either provide their employees with health insurance or to contribute to a fund so that they could be covered by the state" (Lunch, 2005:242). U.S. Congressional House Majority Leader, Richard Gephardt told Democrats that the legislation would likely force employers to pay 80 percent of the costs of covering workers and their families (Lunch, 2005). Following the 1994 elections in which Republicans won control of both houses in the state legislature, this mandate hit tough business-backed roadblocks and died in the

1995 legislative session when it was repealed in a deal between Governor Kitzhaber and the Republican legislative leadership. In return, Kitzhaber received funding for the rest of the OHP. Under the ACF, the compromise could be explained as core policy belief and fundamental values that were not changed, but there was negotiation on a secondary policy belief (i.e. the employer mandate, an implementation tactic). Core policy beliefs are more difficult to change, whereas secondary policy beliefs are more likely to be negotiable.

Successes and Challenges

After implementation, the OHP was described as successful in prioritizing healthcare services and immediately providing healthcare insurance to more than 100,000 Oregonians who had not been previously insured. "The percentage of uninsured Oregonians dropped from 18% to 11% and emergency department use decreased by 10%" (Saultz, 2008:434). However, six months after the health plan begun, administrators held a news conference to describe some of the unexpected trends. Projections for enrollment had been for 48,000 additional Oregonians to enroll; however, 81,084 more Oregonians had enrolled as of July 22, 1994 (Muldoon, 1994). Jean Thorne, then Oregon Medicaid Director reported "The crush of people using the OHP makes it clear that there is a healthcare crisis for those without health insurance" (State of Oregon DHS Website, 2010).

Both Thorne and Vickie Gates (an OHP administrator) reported clear successes and problems (State of Oregon DHS website, 2010). Some of the problems include dentists refusing treatment to health plan patients, determining ways to pay for the plan in the

future, and struggling with the controversial employer mandate. Because of rising healthcare costs and the economic recession of 2008-2010, it has been difficult for Oregon to continue to implement some of the plan's key elements. For example, as the state budget decreases the list of ailments that are covered by the OHP may have to decrease.

A lobbyist interviewed said that the "OHP was never able to reach its full potential because of the employer mandate waiver being passed but never implemented, which would have required businesses to provide insurance to their employees" (Interview, 2010). A physician interviewed echoed this belief, "the state never seriously attempted to get the necessary federal waiver to create the employer mandate portion of the program" (Interview, 2010). The lobbyist did acknowledge that successes of the plan include raised visibility and expanded insurance plans to 100,000 more Oregonians.

Theory Application: Application of the Advocacy Coalition Framework

By applying the ACF to the creation of the OHP, readers can better understand the policy decision-making process. Many supporting and opposing groups existed during the creation of the OHP. Specifically, public health officials, government officials including lobbyists (e.g. insurance companies for asthma drugs that wanted to be covered on the plan), policy-makers and counties with funding, business owners, non-profit organizations, health institutions, insurers, doctors, patients, scientists, city commissioners, community members, and non-profits (e.g. Volunteers in Medicine) have all been involved in the creation and implementation of the OHP over the past 20 years.

The four main coalitions being analyzed are: (1) government entities: federal, state, county, and bureaucracies; (2) Oregon community members and groups; (3) healthcare

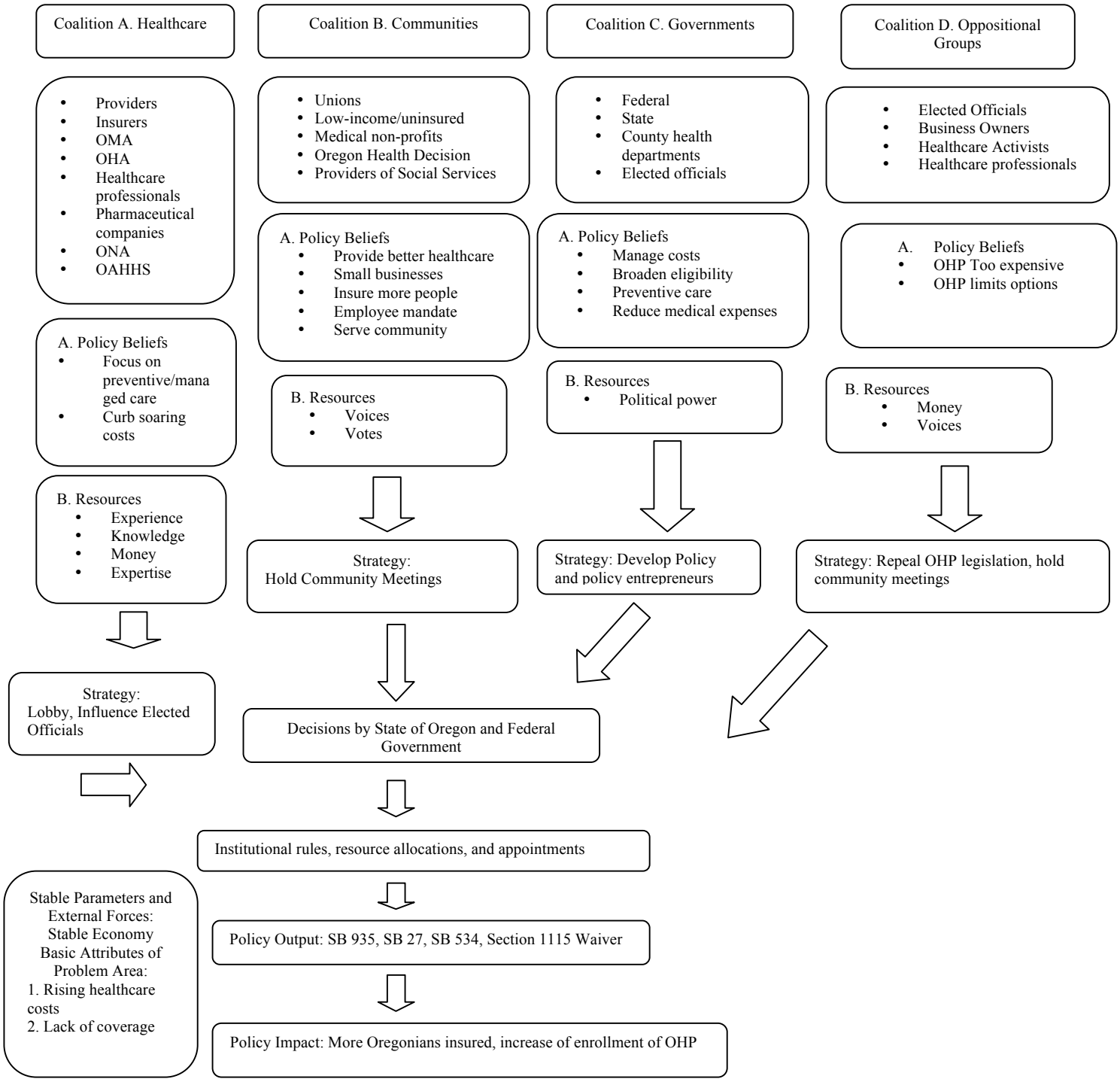
administrators: providers and insurers; and (4) oppositional groups. The government coalition is comprised of the Department of Human Services, bureaucracies, county health departments, and elected officials. The community coalition is comprised of consumer activists (The Oregon Health Action Campaign), labor unions (the Oregon AFL/CIO), low-income and non-insured individuals, interest groups, and others serving the community. The health coalition is comprised of health providers and insurers, the Oregon Medical Association, the Oregon Nurses Association, the Oregon Association of Hospitals and Health Systems, and pharmaceutical companies. The oppositional coalition is comprised of Oregon business owners, elected officials, healthcare activists, and healthcare professionals.

All coalitions, except for the oppositional group, had similar overall policy output goals; however, coalitions did differ on secondary policy beliefs. For example, during the creation of the OHP, there were negotiations stemming from meetings between government and community coalitions over what ailments would be covered by the OHP and how the list would be structured. Compromises were made on secondary policy beliefs, such as the employer mandate and the list of ailments that would be covered in order to advance the passage and implementation of the OHP.

These coalitions were created and grouped together for the purpose of this study by their shared core policy beliefs and shared expertise in their policy domain. Figure 3 is a basic structure for how these coalitions formed and how their ideas were manifest in policy formulation and implementation in the ACF framework. The graphic begins with defining each coalition by who is included. Then, the core policy beliefs are identified for each group, along with their key resources. Next, the table characterized strategies used

by each group to ensure their values were included in the discussions. The coalitions come together at this point to influence decisions that are made by state and federal governmental authorities. Any decisions result in new or changed institutional rules, resource allocations, and appointments. Finally, policy outputs are completed and policy impacts can be assessed.

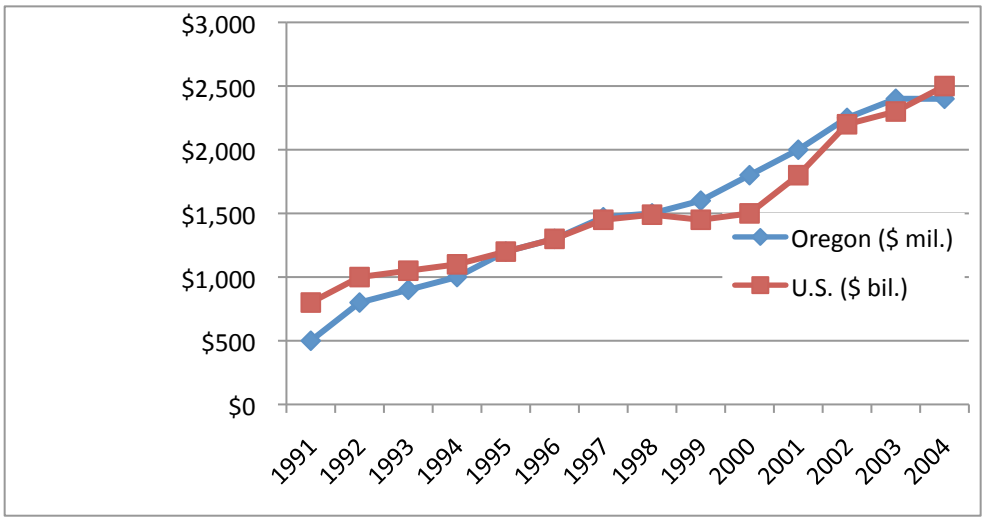
Figure 3. Advocacy Coalition Framework:



These coalitions formed in order to influence public policy regarding healthcare reform in Oregon for the past 20 years. The ACF assumes that the vast majority of policymaking occurs within the policy system and involves negotiations. This, in fact, is how we can characterize what happened during the passage of the OHP.

In Oregon, one stable parameter affecting policymakers was Medicaid expenditures. This graph shows the rising healthcare costs from 1991-2004. The percentage increase of Medicaid expenditures for Oregon and the United States are nearly the same, with Oregon increasing by 112.5% and the United States increasing by 112.8% (U.S. Census Bureau, 2007). When examining the relatively stable parameters in the policy system, such as Medicaid expenditures, the U.S. Census Bureau estimated Medicaid spending in Oregon and the United States from 1991-2004 (Figure 4).

Figure 4. Medicaid Expenditures Oregon and U.S., 1991-2004



***Source: U.S. Census Bureau**

However, the behavior of policy-makers and experts were influenced by exogenous

factors, both stable and dynamic. For example, a stable factor would be the basic attributes of the problem, which in this case would be that healthcare costs are continuing to rise and there is not an efficient program to respond to this problem. An example of a dynamic factor that impacted the creation process of the OHP would be changes in socioeconomic conditions from a relatively prosperous period during 1994 to a national recession from 2008-2010. The following explanations of the four main coalitions and their core and secondary policy beliefs were determined by responses from interviews and public hearing records. Figure 5 is a table of core policy beliefs for each coalition.

Figure 5. Core Policy Beliefs

Government	**Community**	**Healthcare**	**Opposition**
1. Manage costs		Curb soaring costs	Against increased costs
2. Broaden eligibility	Insure more people		Against rationing as unethical/ should not extend healthcare to poor people
3. Reduce medical expenditures		Focus on managed/preventative healthcare	Cannot "manage" healthcare of poor people
	Provide better healthcare	Provide better healthcare	
	Pay employer mandate		Against employer mandate, more cost to employers
	Better serve community	Better serve community	

Coalition A. Government

Government coalitions were crucial in the development of the OHP. Federal, state, local, and bureaucratic governmental systems were all involved in the decision-making

process. The federal government was needed in order to approve the Medicaid waiver. The state was heavily involved in the budgeting process, the allocation of funds, and the creation of healthcare legislation. Locally, county health departments were involved in helping to create the prioritized list. Elected officials, such as John Kitzhaber and Vera Katz played instrumental roles in pushing the OHP politically through the legislature.

Kitzhaber explains how the core policy beliefs of the government coalition members were to manage costs, broaden eligibility for the insured individuals, and to reduce medical expenditures, (Interview, 2010). A secondary belief that the government coalition had was the passage of the employer mandate. The resources that they had were political power and knowledge of the policy process as insiders. The strategy was to align elected officials in favor of the OHP in order to pass the legislation needed. Another strategy they implemented was to use Governor Kitzhaber as a policy entrepreneur or facilitator to aid in negotiations between elected officials. Of course, there were government officials opposed to the OHP, which will be further addressed in the section below on oppositional groups. For example, as previously noted Oregon's elected Republicans turned against the OHP because they believed the OHP was too costly even though they initially supported the OHP as a way to rationalize and reduce costs.

Coalition B. Community

Healthcare Activist #2 and Physician #1 explain how community coalitions involved were composed of unions (The Oregon AFL/CIO), low-income and un-insured individuals, medical non-profits, organizations, providers of social services, and the Oregon Health Decision (Interview, 2010). These groups were placed together in a coalition because of their shared core policy value to expand healthcare insurance to low-

income Oregonians. Oregon Health Decision, for example, is a grassroots, non-profit organization that focuses on healthcare policy in Oregon. One of the more important groups involved in the decision-making process was the Greater Portland Business Group on Health, which provided political support in favor of the creation of the OHP by using its networks of employers who were dedicated to improving the cost and quality of healthcare. The Oregon AFL/CIO, a federation of hundreds of unions and non-represented workers throughout Oregon, supports a wide range of professions, including healthcare (Oregon AFL/CIO Website, 2010). Business owners were also involved in this coalition; however, they were divided on healthcare, as will be discussed further in the oppositional coalition section.

Physician #1 explained that from the public hearing meetings, the core policy beliefs for members of the community coalition were to provide better healthcare to Oregonians, focus on preventative care, insure more people, and better serve the community (Interview, 2010). A secondary policy belief the community coalition had was to reduce medical expenditures and curb soaring healthcare costs (Interview, 2010). Efficient healthcare, providing the "most bang for your buck" and wanting to broaden eligibility to the working poor by rationing benefits were all secondary policy beliefs held by the community coalition, and the coalition compromised on these during the policy creation process. At community meetings, a physician involved in the OHP states, "a lot of community members were asking for healthcare coverage for themselves and their families and saying that the faster the OHP passed, the better (Interview, 2010). This physician also remembers "many disease-based organizations, such as the Susan Kommen Foundation, being afraid of what treatments would lose healthcare coverage"

(Interview, 2010). As a result of these meetings, negotiations were held between coalitions and compromises made over what ailments would be covered by the OHP and how the list would be structured.

The resources of the community coalition were their voices and their votes, which can be described in the ACF as external perturbations or shocks. According to the ACF, in order for a major policy change to occur (i.e., the creation of the OHP) a significant perturbation external to the policy subsystem needs to occur (e.g., external public engagement). The impact that the community coalition had is shown in the revision of the prioritized list, which reflected recommendations from thousands of community members around the state. Their core strategy was to hold community meetings, to lobby at the capitol in Salem, and to rally to get their voices heard. There were community members, specifically business owners who opposed the creation of the OHP that will be described in further detail by the oppositional coalition.

Coalition C. Healthcare

Healthcare providers also played an important role in the community forums that were held to determine revisions of the prioritized list. Healthcare activist #1 described how healthcare activists, (the Oregon Health Action Campaign), as well as healthcare providers, insurers, Oregon Medical Association, Oregon Hospital Association, healthcare professionals, pharmaceutical companies, and Oregon Association of Hospital and Health Systems (OAHHS) came together because of their shared knowledge on healthcare and belief that the OHP would help to reform Oregon's healthcare system (Interview, 2010).

Physician #2 describes that some of the core policy beliefs for participants in the healthcare coalition were focus on managed and preventive healthcare, finding ways to curb soaring healthcare costs, and providing better healthcare insurance for Oregonians, while protecting the existing structure of fee-for-service medicine. A secondary policy belief that the healthcare coalition had was to increase the number of people that are insured. The main resources for this coalition were expertise in the healthcare field, experience and knowledge, and money (Interview, 2010). There were many newspaper articles in *The Oregonian* around 1994 that profiled physicians and other healthcare providers who favored of the OHP because of its main goals. Just one example of this is an article by Richard Hill, which explains the threats faced by the OHP and how physicians were continuing to fight to support the plan (Hill, 1995).

An important healthcare expert in the healthcare coalition is Lynn Read, a state administrator who led the 1994 start-up of the Oregon Health Plan and who in 2007, was named Oregon's state Medicaid director. She joined the DHS Medicaid program in 1980 as a field medical worker to assist people in obtaining Medicaid services. Subsequently, she held several positions including education coordinator for staff and providers, program and policy manager, and fiscal manager. Read was project director for designing, developing and implementing the Medicaid part of the legislatively authorized OHP. During this time, the OHP was the world's first prioritized list of medical conditions and treatments, which emphasized prevention and most effective treatments. Jean Thorne stated in an article in *The Oregonian* that “Lynn Read has a rare understanding of the complexities of Medicaid and the Health Plan that combines a commitment to reaching out and working collaboratively with providers and other

stakeholders" (Thorne, 2004).

Coalition D. Oppositional Groups

Although most healthcare providers, social advocacy communities, and Oregon Democrats supported the OHP, many others had critiques about serving low-income populations through managed care. For example, many business owners were in opposition to the employer mandate portion of the OHP because of the estimated costs to insure their employees. Other elected officials also had critiques regarding the OHP. For example, Physician #2 believed that "Congressman Henry Waxman, from California was against the waiver because of its rationing principles and his belief that it was taking from the poor" (Interview, 2010). One of the opposing viewpoints that stemmed from the oppositional group was that the OHP was unfair and unnecessary in Oregon. Some Oregonians believed that the government should look at other ways of rationing.

Oppositional group leaders on the left, such as Oregon providers, health plan administrators, and social advocates argued that poor people are different from the non-poor in their healthcare needs and lifestyles, which makes it difficult to include them in a managed care system (Leichter, 1999). There were also opponents on the right who were opposed to the idea of an expansion of state-provided healthcare services altogether. There was political opposition to the OHP from those who hoped to move towards universal coverage.

The main resources for this coalition were money, healthcare knowledge, voices and their votes. They had a combination of resources that were not effective in stopping the creation of the OHP. One of the strategies that opponents used that DHS Employee #1 remembers was to frame the OHP as a rationing scheme that would leave the most

vulnerable without benefits, so that community members who were Democrats would be afraid of supporting the plan (Interview, 2010). Another strategy was for elected officials, against the plan to hold meetings in order to try to repeal OHP legislation.

Discussing Interactions between Coalitions

All four coalitions played important roles in the creation process of the OHP. The healthcare coalition and community coalition worked together during the early stages of the creation process to gather feedback on what and who should be covered by the OHP. The government coalition then responded to their feedback and facilitated OHP conversations to help in policy development within their framework of policy goals. As seen in Figure 4, government, community and healthcare coalitions shared some policy goals, which facilitated their collaboration throughout the policy development and implementation. Oppositional groups, on the other hand, stayed involved at each stage of the creation process, including the federal waiver that was needed for the employer mandate, the revised prioritized list, and the structure of who would be covered by the OHP to ensure that their policy goals were not ignored by others as they did not share goals with other groups. All coalitions, except for the oppositional group wanted the OHP to be passed. However, coalitions differed on secondary policy beliefs, which they compromised on in order to advance the OHP. Some of the secondary beliefs that coalitions compromised on were the employer mandate and the list of ailments that would be covered by the OHP.

There were both differences and similarities among members of all four coalitions, but particularly between community coalitions and the rest of the coalitions.

For example, the community coalition differed from the government and healthcare coalitions because of their varied core policy beliefs. The main belief for government and healthcare coalitions was to provide more efficient services, cut costs, and manage spending. However, within the community coalition, insuring more Oregonians and better serving the community was the top priority. Within community organizations and with individual Oregonians, their main objective was to serve the people and provide health insurance to as many people as possible (Interview, 2010). During interviews, it was clear that within the community coalition, members had a lot of passion for serving and caring for people in their community. On the other hand, government and healthcare coalitions had economic agendas that had to be considered that community focused groups were not worrying about. However, despite these differences, the coalitions' shared enough core policy beliefs effectively to collaborate and work together on healthcare legislation.

One surprise in this study was how doctors, politicians, business owners, and community members involved in the creation of the OHP all shared a policy goal to provide better healthcare to more Oregonians. Although, their ideas on how that might happen came from very different perspectives. Furthermore, the constraints on members of each coalition differed. For example, politicians were not only concerned with helping Oregonians and maintaining the state budget, but maintaining political support, satisfying their constituents, and keeping their elected positions. Politicians are constrained by the enormous amount of funding that is required to run a campaign and their decisions are often swayed by lobbyists, with large amounts of money that can be used for or against them, limiting the decisions they are able to make without offending existing and

potential supporters. Healthcare officials are constrained by public consensus, commitments to stakeholders, the industry in their district, and regulatory requirements; and they bring a vested, professional interest, and a level of healthcare knowledge that no other coalition has. Community members and activists are able to express their values and belief, without having to appease their constituents. They are also not held to the same regulatory requirements that healthcare professionals and politicians are held to. Yet community members are the one coalition with members who will be personally affected by changes in how public healthcare is managed in Oregon- it is their children, pre-existing conditions, and financial security at stake in these policy discussions.

Within these defined coalitions, contradictions and opposing ideas occurred quite frequently. One of the opposing viewpoints that stemmed from the oppositional group was that the OHP was unfair and unnecessary in Oregon. DHS Employee #2 believed that some Oregonians believed that the government should look at other ways of rationing, such as by limiting the amount of money spent on administrative costs (Interview, 2010). Business owners were highly opposed to the employer mandate of the OHP, whereas members of the community coalition were strongly in support. Within the same coalition, groups were able to work together because of their shared core policy beliefs and the willingness to compromise on other beliefs that were less important. Also, state elected officials came to the conclusion that the OHP employer mandate was a good policy decision, but they were unable to get federal government support in implementing the mandate. Within the healthcare community, there was controversy among healthcare providers regarding what ailments should be covered and how the prioritized list should be created.

Finally, the OHP was passed in 1989 in an ideal political climate, within a fiscally conservative state that supported a generous benefits package without extensive rationing. There was also a bipartisan coalition of support in the state legislature. All of these coalitions were important in the coalescing process during the early development of the OHP. The OHP reflects the policy goals and negotiations over secondary goals by not including the employer mandate or less important ailments in the revised prioritized list in the final version of the OHP.

Policy Recommendations and Lessons Learned

Oregon Medicaid reform for low-income communities will continue to remain a complex issue. However, many lessons and policy recommendations can be made from the study of this political decision-making process and the experience that Oregon had involving healthcare reform.

Some of the lessons that other states could learn are: (1) it is difficult to have lasting healthcare reform if long-term affordability is not addressed, (2) the political climate must be somewhat bi-partisan, (3) stable parameters that are external to the policy decision, such as a stable economy and lasting funding must be in place, (4) venues for discussion must exist so coalitions can negotiate secondary belief systems, and (5) participatory action within communities can be used to further push key legislation. One of the biggest lessons that Oregon has learned with the OHP is that it is difficult to have lasting healthcare reform if there is not a strategy for weathering tough economic times and there is not enough general revenue funding for healthcare.

By examining what has been successful during the creation process for the OHP, the individual interviews that were conducted for this essay, and research that has

previously been completed on healthcare reform and coalition building, the following recommendations can be made.

Creating

- In order to expand healthcare benefits to more people, limit what is insured by creating a prioritized list of services.
- Capitalize on existing coalitions that are based on core policy values and are able to work together to pass legislation.
- Have a strong policy advocate for healthcare reform (such as John Kitzhaber) who will support the legislation and primary policy goals vigorously over the necessary period of time. An elected official may not always be the best advocate if their continued election is in doubt.
- Address funding issues for the future, in order for the legislation to be successful over time.
- Characterize your own and others' primary policy goals, secondary policy goals; know what you are/are not willing to negotiate.

The public process of how Oregon defined its basic health benefits can be a roadmap for other states to follow. Policy advocates and relevant coalitions played a key role in the complex political decision-making process that led to the creation of the OHP. Therefore, it would be valuable for states examining their healthcare systems to understand the contributions made by these key players.

It is also crucial to form coalitions of support systems that will support the process of policy development. It would be helpful to determine the primary policy goals of the

main advocacy groups that are involved, in order to see if they will line up to work together. Finally, it is important to understand the negotiations that can be made and what different advocacy coalitions are willing to sacrifice.

Implementing

- Create a partnership with the federal government to support needed mandates and legislation.
- Support technological advances in medical professions to help further the progress of creating efficient healthcare systems.
- Focus on passing a set of bills that are uniform and cohesive within the policy domain.

During the implementation process of the OHP, creating and maintaining a strong relationship between the federal and Oregon state government benefited state legislation. The federal government provided needed financial support through the Financing Administration 1115 Medicaid waiver that allowed the state to design and implement an expanded version the OHP. Technological advances, such as online medical records, have increased the efficiency of providing services and thereby reduce costs. Oregon had to restrict the number of eligible individuals enrolled in the OHP; more people could be enrolled if efficiency could be improved through technological advances. Between 1989 and 1993, the Oregon Legislature created a series of laws that collectively became known as the OHP. The coalitions focused on passing these interconnected bills sequentially and in a timely manner.

Communicating

- Utilize universities, school systems, and county health departments as intermediary resources to help overcome the lack of knowledge regarding the state's healthcare system.
- Create public forums where community members can voice their concerns and discuss policy issues with elected officials and state employees.
- Encourage community members who supported healthcare reform to remain engaged after implementation.

By making knowledge regarding healthcare reform more accessible, it may increase public engagement towards healthcare reform issues. Community and healthcare coalitions in Oregon for example, relied on county health departments as a support system to help overcome the general lack of knowledge about healthcare across the state. Country health departments advertised informational meetings to help the public better understand Oregon's healthcare system and get involved in revising the first prioritized list of services.

Monitoring/ Ongoing Revisions

- Create an independent commission or state board that serves as a check-and-balance system for ongoing revisions to the prioritized list.
- Create an independent Health Policy Commissioner position to serve as a representative or policy entrepreneur.

In Oregon, pharmaceutical companies heavily influenced the initial prioritized list through lobbying. As a result, certain ailments requiring specific drugs were ranked high on the list. Also, after the OHP was implemented, new problems arose because physicians did not want to limit medical care for their patients. If an ailment were not covered by the OHP, physicians would sometimes re-diagnose the ailment as a different condition—one that was closely related and covered by the OHP—in order to enable the patient to receive treatment. This was a problem because it did not curb healthcare costs, which was the one of the primary goals of the plan.

Rising from this problem, the board and commissioner would serve as troubleshooters, looking for gaps and problem areas within the plan. For example, this board could include economists and community members from various professions that did not have a vested interest in what was covered in the healthcare policies.

An independent board responsible for administering a healthcare plan could help prevent these problems. A Health Policy Commissioner could be given the power to effectively modify and administer the plan in a way that would make a significant impact on the plan's effectiveness. For example, one way to fix the doctor loophole problem in Oregon would be to reevaluate the whole concept of a list that determines what treatments will and will not be covered by the OHP. Eliminating the list completely would diminish the number of people covered by the plan, but it would also eliminate doctor fraud and cover remaining eligible OHP patients 100%.

Conclusions

The ACF framework served as a useful way of to explain the OHP creation process. Overall, the process by which Oregon passed the OHP relied on communication and extensive interactions between healthcare officials, governmental officials, and community members to build support for its passage. Within the OHP creation process, community engagement that occurred was critical. This engagement process has been carried into policy formulation and government decision-making in today's government decisions in Oregon. As an example of a lesson learned from OHP formulation, the Oregon Health Policy board was recently created and its sub-committees continue to use the tools of community engagement and public meetings.

The development of the OHP using participatory action and involving community members from across Oregon can serve as a model for other states that are looking for change in their healthcare reform policies. Although the OHP was unsuccessful for covering healthcare for every Oregonian, it still made a good effort to a problem that many states are facing.

Thus, lessons from Oregon's healthcare reform efforts can help inform state-level healthcare debates. One question that should be asked is can the design of the OHP itself can be prescribed and implemented by other states to address their healthcare problems? The healthcare debate is clearly not over, and healthcare will continue to be a controversial topic with no easy answers. However, Oregon's historical experience with innovative healthcare reform shows that the future for positive change is great.

Future Research

Hopefully, through this process a deeper understanding of coalition building and community engagement has been shown that will aid others in future research. Future researchers may be able to expand on this information by creating a handbook or guide that looks at political coalitions and the steps they have taken to make policy change. The handbook might include components on what each coalition did and the core policy beliefs they would not compromise on. For future research, some important questions that could be factored into the theoretical framework are: (1) How did different coalitions get their ideas into the policy arena? (2) Were individuals left out of the coalitions? (3) If so, were individuals left out because lack of interest? (4) What is the role of the belief hierarchy? (5) Is there a consensus on the core policy beliefs? (6) How have these coalition relationships changed over time? (7) As the line between who is covered and who is not covered shifts up and down, have groups repositioned themselves inside the coalition? (8) What are the connections between local and national networks?

The results of this essay may spark future questions on how rationing healthcare will be looked at in the future. Future research regarding Canada's system of rationing and how it is related to Oregon's could also be further examined. This could be used for other states that are developing plans similar to the OHP in order to better understand the political decision-making process and how healthcare reform happens. The passing of the OHP legislation shows that coalescing is a good way of enacting policies, which could perhaps be recommended to focus more on coalition building and policy-oriented learning.

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Appendix:

Interview Questions:

1. What were the goals in completing the Oregon Health Plan?
2. What year did the Oregon Health Plan finally become law?
3. Who was involved? What specific state agencies, non-profits, health organizations were involved in the decision-making process?
4. What is your job title or professional role at the time of the creation of the Oregon Health Plan?
5. What was your professional role in the development of the Oregon Health Plan?
6. How long was the development process? Who was included in the decision-making process in Oregon?
7. Can you explain how the prioritized list was created?
8. Is there a way to determine the success economically of the Oregon Health Plan?
9. What was the political culture like? What social and other political ideas and thoughts were going on during this time?
10. What was the severity of the Medicaid system like before the creation of the Oregon Health Plan