

**How Agenda-setting Attributes Shape Politics:  
Basic Dilemmas, Problem Attention and Health  
Politics Developments in Denmark and the U.S.**

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## **Abstract**

We propose a new approach to the study of comparative public policy that examines how the agenda-setting attributes of an issue combine with problems to drive political attention.

Whereas existing comparative policy studies tend to focus on how institutional or programmatic differences affect policy and politics, we begin by asking how the issue itself affects politics across nations. We illustrate by comparing health care attention and policy developments in Denmark and the US over 50 years. These two industrialized democracies have very different political and health care systems. Nevertheless, similar trends in political attention to health emerge. We argue that these high levels of attention reflect the issue's political attractiveness with regard to vote-seeking and the fact that neither system has managed to resolve the basic dilemma of how to control costs while meeting public expectations concerning access to services and health care quality.

Key words: Health Care, Agenda Setting, Health Care Policy, Denmark, The US

## **Introduction<sup>1</sup>**

Cross-national studies of public policy agenda-setting are rare, as are studies that trace changing political attention to issues across time. The fact that such studies are rare means that we know little about the extent to which issue politics transcend national boundaries. Although it seems likely that health care or energy issues (for example) are larger than any particular political system, few if any studies attempt to compare how issues affect politics across systems. In this paper, we trace political attention to health in the US and Denmark over 50 years to consider whether this issue has created similar political pressures across two nations.

However, the paper also has a second purpose. A central insight of policy agenda setting research is that political attention affects policy. Thus, a potential contribution of this paper is to provide a new comparative policy perspective which points to changes in political attention as one explanation for policy developments across nations. Existing approaches to comparative public policy studies tend to begin with structural differences. Esping-Andersen's "Three Worlds of Welfare Capitalism" (1990) has been especially influential in this regard. In it, he argues that how social welfare programs are organized is central to understanding their politics. A welfare system based on universal benefits will, for instance, lead to quite different political dynamics compared to a system based on means-tested benefits. The comparative health care literature also tends to begin with difference in structure before drawing on those differences to explain contemporary health care politics and policy developments (e.g. Hacker 1998, 2004; Giaimo 2002, Giaimo and Manow 1999, Wilsford 1995, cf. also Bureau and Blank 2006).

How governments manage welfare or health care programs clearly has important consequences for policy and politics. However, we are interested in variables that affect policy and politics across systems. In particular, the policy agenda-setting literature argues that issues possess "agenda-setting attributes" that affect their politics (Kingdon 1995; Baumgartner and Jones 1993). We consider whether this perspective has value for comparative research. Does an issue's attributes also help to explain changing issue attention and policy responses not just in one nation, but across nations?

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The cases of Denmark and the United States represent very different systems. Both nations are advanced industrialized democracies, of course, but the differences between their political and health care systems are stark. Denmark has a government–sponsored, locally administered public health care system that has been very successful at controlling costs but has faced criticism for rationing services. The U.S. system relies on private providers and has been much less effective at controlling both costs and access to services. Denmark has a unitary parliamentary system while the U.S. has a federal separation of powers system.

Despite these differences, we find remarkably similar trends in health-related political attention over the past 50 years. Even though the national government is not primarily responsible for health care delivery in either system, national political attention to health has risen dramatically in both nations. Thus, we argue that the level of political attention an issue receives “in country” is at least partly explained by characteristics (attributes) that transcend national boundaries and political structures. This finding also suggests that high levels of political attention are endemic to health care politics, regardless of how countries organize their delivery systems or how effective these systems are at controlling costs. This aspect of health care politics is also important because, as we show for Denmark and the US, short term political considerations are often the driving force behind the policy initiatives of national politicians.

### **The Agenda Setting Attributes of Health**

The American literature on policy agenda setting begins with the observation that politics is not simply about left-right policy preferences, but also which issues or dimensions of issues will be the focus of attention (e.g. Schattschneider 1960; Kingdon 1995; Baumgartner and Jones 1993; Jones and Baumgartner 2005; Birkland 1998). Thus, agenda setting studies are often concerned with why, in contexts where resources are limited, decision-makers focus disproportionate attention on some issues while ignoring others. The explanations proposed are wide ranging. Some are structural, emphasizing how institutions are organized to advantage some alternatives or issues over others. Some are cognitive, emphasizing how individuals or even institutions process information in ways that limit what will be addressed at any given time. Others emphasize the role of external events or publics, and how they can combine with political incentives to quickly shift attention in a new direction.

In addition, agenda setting studies point to differences in the issues themselves. Cobb and Elder, for example, argue that issues possess “agenda setting attributes” that influence whether they gain the attention of policymakers as well as how policymakers respond (1983, 94-109). Health is the sort of issue that is especially attractive to politicians with regard to vote seeking. It is a valence issue. No politician wants to oppose health or access to health care. Health affects everyone and is ultimately a matter of life and death. Illness is generally perceived to be something beyond the control of the individual (Stone 1989). Therefore, the publics affected by health care policy decisions are more likely to be seen as “deserving” than may be the case for other issues (Schneider and Ingram 1993). For these reasons, health care politics tends to focus on “connecting solutions to problems” instead of debating whether the problems themselves deserve a response (Baumgartner and Jones 1993, 150–71). Politicians have incentives to offer solutions, and will try to avoid blame for problems or inaction (Weaver 1986). Taken together, these attributes make health the type of issue that can generate exceptional political attention under the right conditions.

## **Problems and Attention**

Although health has the potential to attract considerable political attention, the amount of attention it actually receives is governed by changing perceptions of the “problem.” Attention must be directed to something (Jones and Baumgartner 2005). One persistent problem in this arena has been striking the proper balance between responding to what can sometimes seem to be an insatiable public demand for ever expanding services, and the desire to control how much of its resources society spends on health care. Put another way, there are opportunity costs associated with additional spending on health. A new drug or procedure is a wonderful thing from the patient’s perspective, especially when much of the cost is covered by a third party. For the payer, however, new services can mean higher costs and, as a result, fewer resources available for other purposes.

The health care innovations that have led to significant declines in mortality and morbidity over the past 50 years have created new problems for politicians. For much of the 20<sup>th</sup> century, health care spending represented a small percentage of GDP (less than 5%) partly because available services were limited. By the 1970s, technological advances and decades of efforts to build infrastructure paid off to the point where controlling rising health care costs became a central preoccupation of governments. The problem of rising costs cut across national

boundaries and forced many OECD nations to choose between restricting access to services or devoting ever increasing shares of national income to one policy area (Oxley and Jacobzone 2001: 15).

Economists attribute much of this rise to a combination of increasing demand fuelled by innovation. Specifically, about 30 percent of the difference between health care inflation and general inflation can be explained by demographic trends, while the remaining 70 percent is probably attributable to service innovations and the increased demand that followed from their availability (Newhouse 1996; Peden and Freeland 1995). One way to trace this trend is to consider the number of health care patents issued annually.<sup>2</sup> Figure 1 indicates that until the early 1970s, health-related patents remained relatively stable as a percentage of all patents (about 2 percent). Around that time, the proportion of all patents that were health related began to rise until peaking at about 10 percent in the mid-1990s (a five fold increase).

**Figure 1 here**

The pace of health care innovations is one metric for tracing the growing tradeoffs between costs and other goals. Innovations and increasing demand for them put pressure on politicians in many nations to address a widening gap between public expectations regarding health care and public and private resources (Saltman et al. 1998). As shown in table 1, Denmark and the US have addressed these challenges in different ways. In 1970, Denmark was spending more of its national income on health care than the U.S. Over the next 30 years, Danish health care expenditures increased from 8 percent to 9 percent, while U.S. health care spending more than doubled from 6.9 percent of GDP to 15 percent.

**Table 1: Health Care Expenditures as % of GDP in Denmark and the US.<sup>3</sup>**

	1960	1970	1980	1990	2003
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<sup>2</sup> Because this information is not easily obtainable outside of the United States, we focus on the percentage of U.S. patents that were health related. The percents reported are based on a compilation of “subject classifications” related to health obtained from the U.S. Patent and Trademark Office. Professor Brownlyn H. Hall (University of California) provided the dataset that enabled us to calculate annual patents between 1963 and 2002 (<http://elsa.berkeley.edu/users/bhhall/bhdata.html>).

<sup>3</sup> Unfortunately, internationally comparable health expenditure data for Denmark do not exist prior to 1970.

US	5%	6.9%	8.7%	11.9%	15%
Denmark		8%	9.1%	8.5%	9%

Source: OECD Health Statistics 2005.

Some observers may conclude that Denmark's success in controlling costs demonstrates the superiority of its government-led system to the U.S.'s market-based approach (current projections see costs rising to 20 percent of GDP in coming decades). But did this success lead to substantially less political attention to health? In other words, did Denmark's success at controlling costs defuse health care as a national political issue? We suspect that the answer is no. Denmark has succeeded in controlling costs better than the U.S., but it probably has not resolved the basic dilemma. Instead of making the health care issue go away, Denmark's policies have pushed the challenges, and the political attention, in a different direction.

Our perspective thus suggests three hypotheses in particular that we will examine more systematically in this paper:

1: Health care innovations and rising demand will force politicians in both systems to devote increasing attention to the health care over time, because these changes will make it increasingly difficult to satisfy public expectations while controlling costs.

2: Political attention will become increasingly dispersed as the tradeoffs facing policymakers become increasingly complex over time.

3. The focus of political attention across the systems will diverge in response to how policymakers have responded to these basic dilemmas.

### ***Patterns in Health Attention Over 5 Decades***

The fact that Denmark and the US have very different health care systems, very different political structures, and very different results in terms of cost control would seem to suggest that very different health care politics. We expect commonalities despite these differences. The health care issue possesses attributes that make it politically attractive for vote seeking politicians across systems, and it poses problems or challenges that all systems have difficulty resolving.

But how does one measure political attention to health across time? Our approach draws on the work of the Policy Agendas Project, which uses expert coders to categorize political activities (e.g. the subjects of U.S. congressional hearings) into mutually exclusive topic areas. The broader agenda is divided into 19 major topic areas (e.g. health, energy, defense etc.). Health attention is further distinguished into 20 subtopics (insurance access, health care facilities, medical procedures, etc). We compare political activity over a 50 year time period, drawing on nearly 500,000 events that have been individually inspected and coded. In Denmark, we measure changing political attention to health by the subjects addressed in parliamentary debates (laws, interpellations, resolutions, and governmental accounts) and the questions submitted by members of the Folketinget to the government (<http://www.ps.au.dk/greenp/Research/Agenda.htm>, cf. also Green-Pedersen 2005). In the U.S. we measure attention by the subjects of the bills that individual members of Congress introduce, and by the subjects of the hearings held by congressional committees ([www.policyagendas.org](http://www.policyagendas.org); [www.congressionalbills.org](http://www.congressionalbills.org)).

Our expectations are that relative attention to health care has increased at similar rates in both systems, that the substance of this attention has also become increasingly complex, and that health-related attention across systems has diverged over time. Trained coders read each event (a debate, a question, a bill title, a hearing abstract) and designate it to be primarily about one (and only one) policy subtopic.<sup>4</sup> Our four indicators arguably capture two types of political attention. In the Danish Folketinget, questions to the minister capture attention to issues during earlier stages of the policy process, often prompted by members of the opposition. Debates capture attention in later stages where policy is being developed and there is greater government involvement (cf. Green-Pedersen 2005). Similarly, in the US Congress, congressional bills better reflect the policy and position-taking priorities of individual legislators, whereas congressional hearings better reflect the priorities and governing responsibilities of the majority party and its leaders (Wilkerson et al. 2002).

**Issue Attention.** We begin by examining overall developments in political attention to health across time. According to figure 2, health is consuming increasing proportions of total political

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<sup>4</sup> The coding system is available from [www.policyagendas.org](http://www.policyagendas.org) and the Danish version at [www.ps.au.dk/greenp/research/agenda.htm](http://www.ps.au.dk/greenp/research/agenda.htm).

attention in both systems.<sup>5</sup> In the 1950s and 1960s, the percent of issue attention devoted to health ranged from 1.5 percent to 4 percent depending on the form of activity. By 2002, attention to health had increased relative to other issues in both systems by 300-400%. To be sure, there are differences. The slopes are steeper in the U.S., and the most dramatic changes occur later in Denmark. These differences suggest that there are elements unique to each system that deserve investigation. But there is also considerable correspondence across two very different systems with very different histories of success in controlling health care costs.

Figure 2 about here

**Attention Complexity.** As suggested earlier, health care systems have had to keep pace with dramatic advances in innovation. Governments in particular have been forced to respond not only to the challenges of rising costs and demand, but also issues relating to quality of care and efficiency. These new demands should place increasing pressure on governments to attend to health relative to other issues, and should be indicated by increasing dispersion of issue attention within the subject of health itself. To measure health attention complexity, we calculate entropy scores or h-statistics across the 20 health subtopics (Jones and Baumgartner 2005).<sup>6</sup> With 20 categories, entropy scores can vary from 0 to 3, where a 0 would indicate that activity during a period of time was completely concentrated on a single health subtopic, whereas a 3 would indicate that attention was equally dispersed across all 20 of the health subtopics.

Figure 3 here

Figure 3 confirms that attention to health has become increasingly diverse in both systems. The trend begins during the late 1960s and early 1970s – the same period where other important developments, such as the explosion of innovations and rising costs, begin. This indicates that the effect of innovation is not just increasing attention, but also more complex politics.

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<sup>5</sup> All figures report biennial trends corresponding to a U.S. Congress. Legislative activity varies dramatically between the first and second sessions of a Congress, so the reporting biennial trends effectively smooth these differences that have little to do with the policy attention that is the focus of this study.

<sup>6</sup> This measure is defined as  $-\sum P(x) \cdot \log(p(x))$  where  $\log$  is the natural logarithm and  $P$  is share of attention received by a subcategory.

**The Substance of Attention.** Finally, although the evidence presented above appears to confirm that the health care issue poses similar political challenges across systems, the policy choices made within those systems should also have observable effects for the substance of health-related political attention. This can be seen in table 2, which compares how attention to five major health care issues - procedures, hospitals, providers, liability and personnel - is distributed differently across the systems over the period 1971-2000. Danish national politicians have devoted relatively more attention to hospitals and the availability of procedures (including waiting lists). In the U.S., greater attention has been focused on regulating payments to providers, medical liability and fraud, and health insurance coverage and access (not shown).

**Table 2: Distribution of Attention (bills and questions only) to five Aspects of Health Care in Denmark and the US, 1971-2000.**

	Denmark	US
Procedures	<b>0.28</b>	0.18
Hospitals	<b>0.41</b>	0.22
Providers	0.04	<b>0.27</b>
Liability	0.07	<b>0.14</b>
Personnel	0.21	0.18

These are not surprising findings in light of what we know about these systems. The Danish system manages to control costs while covering everyone by allowing governments to control spending and utilization directly. The U.S. system lacks equivalent mechanisms and, as a result, attempts to manage costs and utilization indirectly through payment procedures and regulations. In addition, the U.S. relies on a combination of public and private health insurance programs that leaves many Americans without coverage.

### **Policy Responses and Changing Political Attention**

Elected politicians' attention to health care has steadily increased over time. This increase is not a function of organizational decisions made in Denmark or the US, and it is not related a

nation's success in controlling overall costs. Such factors do affect the content of attention. It is also important to note that this increasing attention has occurred even though national politicians in both systems are not responsible for many of the decisions about how to allocate benefits and control costs. Such choices are made by local government or private providers. In both systems, national politicians have incentives to delegate difficult health care choices and have done so. But the same politicians have not been able to avoid accountability for the consequences of these decisions to delegate.

Health care policy is made in the shadow of strong political attention at the national level, no matter how systems are organized or how successful they are at cost containment. It has become part of the "macro-politics" of the two countries. The agenda setting literature tells us that policymaking in contexts where political attention is high leads to different outcomes. The purpose of the discussions that follow is to briefly describe how increasing levels of attention have altered policy making and health care developments in recent years in both nations.

### *Denmark*

Health care provision has always been decentralized in Denmark, but the Local Government Act of 1970 delegated additional authority to the counties. For this reason, the formal influence of national politicians has been largely restricted to budget negotiations between the central and local governments. This has meant that the central government had more influence over total health care spending than over how those funds were actually spent. Studies point to this decentralization as central to understanding how Denmark has managed to control health care costs, especially during the 1980s (Pallesen and Pedersen forthcoming; Vrangbæk and Christensen 2005).

Still, decentralization has not diverted health-related political attention to the local level. Political attention to health at the national level has actually increased in recent decades. A national Ministry of Health was created in 1987, and national policies passed by the right-wing governments through 1993 gave patients additional service choice (Vrangbæk 2000). These responses did not address some of the issues attracting public attention, such as waiting lists at local hospitals. From 1992 to 2001, government coalitions led by the Social Democrats responded to concerns about the quality of health care facilities, personnel shortages, and

waiting lists by enacting reforms intended to speed up treatments and provide better care for cancers and other specific diseases (Vrangbæk 2001).

Nevertheless, public dissatisfaction with the health care system contributed to the Social Democrats' defeat in 2001. The succeeding Liberals and Conservatives claimed that they can modernize the health care system and end waiting lists (Andersen 2003). Significantly, one of their initiatives, a major local government reform that was enacted in 2004, gave the central government substantially greater control over health care policy (Vrangbæk & Christiansen 2005).

Altogether, the Danish case demonstrates that the decentralized system of local control created in 1970 was quite capable of addressing the challenge of controlling costs. The Achilles heel of that system, however, was the inability of national politicians to delegate the political heat that this approach to cost control measures generated. National politicians of all persuasions felt compelled to respond, and in many cases did so by liberalizing access to services in response to electorally-based imperatives. Not surprisingly, health care costs in Denmark are on the rise in the 21<sup>st</sup> century.

## *US*

In the U.S., most health care spending is publicly subsidized, while most services are privately provided (Woolhandler and Himmelstein 2002: 91). These features help to explain why U.S. health care costs have increased much more rapidly than any other OECD nation over the past 4 decades (Hacker 2004). Prior to 1965, the federal government's role was largely limited to subsidizing the construction of hospitals, medical schools, and employer-sponsored health insurance, and to providing a safety net for limited populations including veterans, the very poor, and the mentally ill. The enactment of the Social Security Amendments of 1965 dramatically expanded the federal government's involvement by establishing the Medicare and Medicaid programs. With the enactment of these programs that primarily benefit the elderly and the very poor, the federal government got into the 'business' of paying the health care costs of substantial proportions of the population who received their care from private providers. At the same time, the new law specified that providers, not the government, would decide which services were appropriate and what costs were "reasonable" (Wilkerson 2003: 330). Proponents argued that market competition would keep costs down for the government but, less than a

decade later, health care expenditures were rising at twice the rate of general inflation (Patashnik and Zelizer 2001).

Initial cost control efforts attempting to limit utilization in these programs ran into stiff opposition from providers as well as consumers (Weissert and Weissert 1996), and it was not until the early 1980s that the federal government began to regulate what it paid for privately provided services. However, these efforts generated new concerns about health care quality and access that were beyond the immediate control of policymakers. Payment schedules for particular treatments seemed to encourage providers to order more services, while paying per diagnosis raised the possibility that that providers would cut corners in ways that led to lower quality care (Wynia et al. 2000). On the other hand, basing payment structures on past practices risked rewarding the least efficient providers (Wennberg et al. 2002).

More recently, governments and private payers have turned to market-based approaches to put the brakes on rising costs. Beginning in the early 1990's, pre-paid care (managed care) replaced fee for service medicine as the primary form of health care financing. Not surprisingly, this trend has precipitated a backlash. National politicians have responded to complaints that these new health care organizations are managing care by enacting legislation such as the "Patient Protection Act," which creates procedural barriers that make it more difficult for health care organizations to limit access to certain services.

Comprehensive reform is also a persistent undercurrent of US health care politics (Wilkerson 2003). The number of uninsured Americans continues to grow as individual insurance coverage becomes more expensive and as employers and governments scale back benefits, or eliminate coverage altogether. Incremental steps to expand access and coverage have been taken, most frequently for "deserving" populations such as children, the elderly, or employees who switch or lose their jobs (Schneider and Ingram 1993; Patel and Ruschevsky 1995). However, 45 million Americans lack health insurance, leaving many of them exposed financially should they or a family member become seriously ill.

For all of these reasons, health care is never far from the minds of national politicians. Rising costs put pressure on government budgets as well as on the global competitiveness of American industry. Concerns about health care costs and security (insecurity) are a regular topic of national political campaigns. As a result, reforms are as likely to occur under Republican administrations as under Democratic ones. President G.W. Bush's Medicare

prescription drug benefit in 2003 is the most significant expansion of government health benefits of the past several decades, but it is in keeping with previous efforts by his father, and by Ronald Reagan, to inoculate their party against a public backlash on this issue. Concerns about health care costs also recently prompted President G. W. Bush to make reform a centerpiece of his State of the Union address to Congress. Whether his most recent initiatives will gain traction is not yet clear, but it is very clear that health care remains a top political priority of politicians of all stripes in the U.S.

## **Conclusions**

This paper introduces a new comparative politics perspective that considers how the agenda setting attributes of issues affect their politics across nations. Examining health-related political attention over 50 years, we have discovered remarkably similar trends across two very different political structures and health care systems. The proportion of overall agenda space that each national legislature has devoted to health care issues has tripled or quadrupled since the early 1960s. We have argued that this trend reflects the attractiveness of the issue to vote seeking politicians, and the basic dilemma that the health care issue poses in both societies. Specifically, the recent history of health care is one of dramatic innovation, which has increased public expectations for services at the same time that it has led to improvements in health. Not surprisingly, this increased demand has challenged government officials in both nations to find the right balance between satisfying public demands and controlling expenditures.

The perspective also suggests a new approach to conducting comparative policy studies within health care and other policy areas. In a recent review of the comparative health care literature, Marmor et al. (2005: 343) argue that careful cross national comparisons tend to stress the uniqueness of national health care systems from a historical institutional perspective -- the same type of comparative policy logic coming out of the welfare-state literature cited earlier in our introduction. The approach presented here is not a substitute for existing comparative health policy or public policy approaches, but it does offer a different lens for understanding and appreciating local policy developments. Existing comparative studies have tended to emphasize the central role of health interests such as the medical professions. A comparative agenda-setting approach suggests, in contrast, that health care policy developments in Denmark and the US cannot be fully appreciated without considering the political attractiveness of the issue to

national politicians, be they George W. Bush in the U.S., or centre-left governments in Denmark.

Focusing on commonalities may also help to explain one of the most striking features of health care politics. All OECD countries have experienced significant increases in health care expenditure relative to GDP over recent decades (OECD 2005). These developments are typically attributed to changing demographics, increased demand spurred by economic growth, and technological innovations as discussed above. However, the Danish case demonstrates that cost increases relative to GDP are not inevitable. The problem of rising costs is a political problem, not a technical one. It stems from the agenda setting attributes of the health care issue itself. National politicians in Denmark created a structure that successfully controlled costs for many years. However, even in Denmark, national politicians cannot, or in some cases do not want to, avoid responding to the political attention that such reforms inevitably generate.

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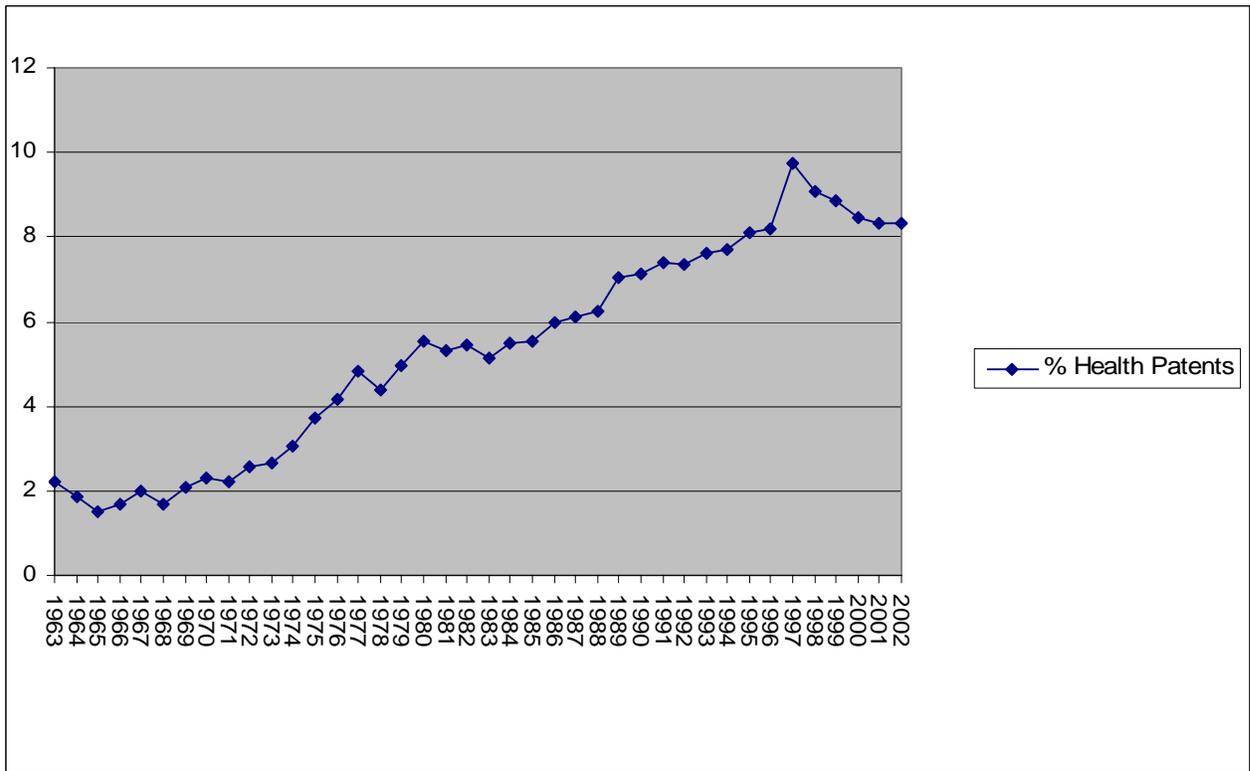
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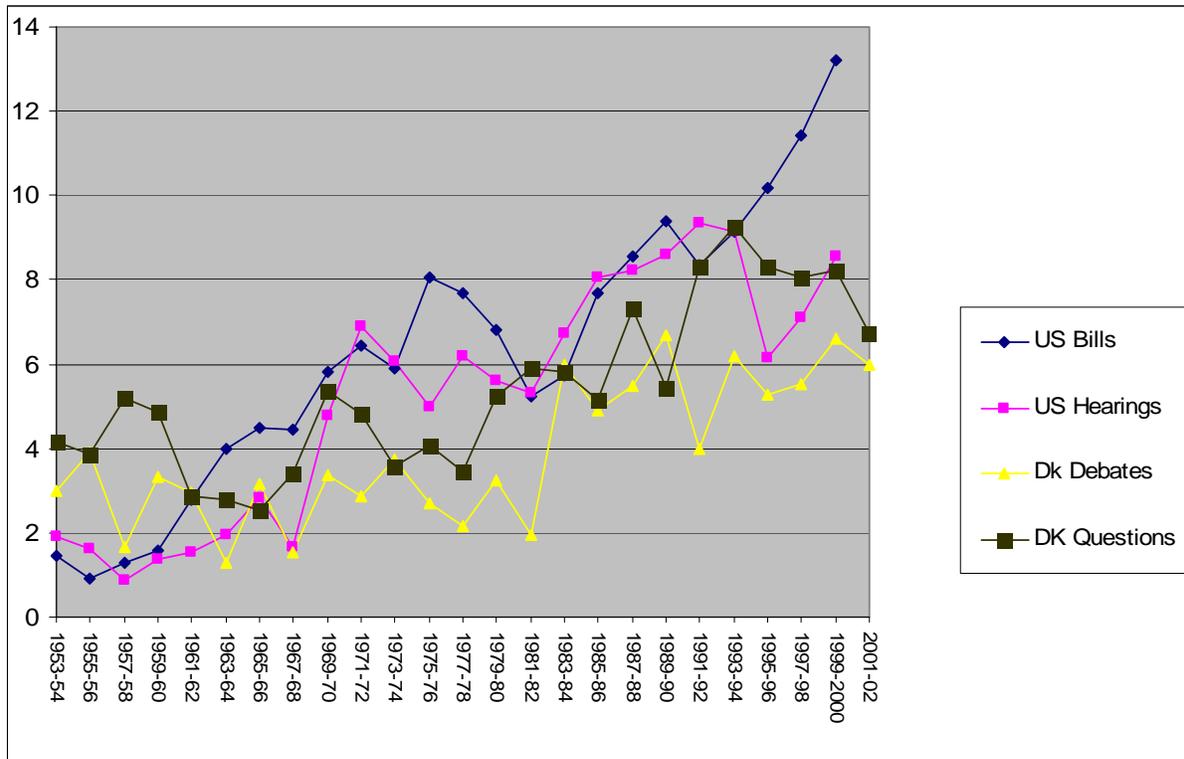
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Figure 1: Trends in Health Care Innovation (Health Patents as % of U.S. Patents).



**Figure 2: Political Attention to Health in Denmark and the US, 1953-2001: Percentage of the total political agenda.**



**Figure 3: Rising Complexity of Health-related Attention in Denmark and the US 1953-2001 (Entropy scores).**

