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From Setting a National Agenda on Health Care to Making Decisions in Congress

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President Clinton will forever receive credit (or blame) for focusing attention on the problems of health care access. Many were surprised that this surge of attention that accompanied his election brought no solutions in the 103d Congress. Setting a national agenda and making national decisions in Congress are very different matters. Agendas may be set by merely recognizing a problem, but decisions cannot be made until concrete solutions are defined. This is perhaps the most important difference between campaigning and governing.

Setting a National Agenda

Attention was brought to health care after the 1992 election campaign for many reasons, and we will not review them all here (see Laham 1993; Marmor 1994; Schlesinger and Lee 1994; Hacker [forthcoming]). Rather, we want to show how changes in the interest-group system surrounding health care and complexities in jurisdictional control in Congress were important elements in bringing attention to the issue. These same factors subsequently combined to multiply the Clinton administration's problems of coordination once important decisions had to be made.

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Table 1 Growth in the American Interest Group System, 1960–1992

Year	Trade	Agriculture	Education & Culture	Health & Social	All Groups
			n		
1960	2,309	331	563	674	5,960
1970	2,753	504	1,357	1,292	10,785
1980	3,118	677	2,376	2,407	15,794
1990	3,918	940	3,178	3,932	24,508
1992	3,911	1,055	3,185	3,971	24,530
Percentage change	169.4	318.7	565.7	589.3	411.6

Source: Calculated from the *Encyclopedia of Associations*, years indicated.
Note: Total figures do not equal the sum of the other columns because only selected group types are shown.

The Interest-Group Environment

Possibilities for changing health care stem largely from developments in the interest-group environment. Previous attempts to focus public attention on the problems of health care were rarely successful because the dominant associations of health care professionals agreed that government interference would be unacceptable (Alford 1975). In the decades leading to the 1990s, however, the nature of interest-group politics surrounding health care changed dramatically (Mueller 1993; Peterson 1994). Various groups began clamoring for change in the health care system, where once there were only a few conservative associations of professionals (Heclo 1978).

Table 1 shows the overall increase from 1960 to 1992 in health care associations active in the United States compared with other types of associations. Many authors have noted the "interest-group explosion" in general (Schlozman et al. 1986; Berry 1989; Walker 1991), but few have noted the different rates of growth of various parts of the interest-group system. In fact, of all the areas, health care has had some of the most striking growth. This strong growth has been accompanied by the remarkable long-term decline in the representative power of the American Medical Association (AMA). The percentage of physicians who are members of the AMA has decreased from more than 90 percent in the 1940s (Rayack 1967) to only about 50 percent in the 1990s (calculated from National Center for Health Statistics 1994; Organizations of Medi-

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cal Interest 1993). Increasingly, physicians have joined associations of specialists such as the American College of Surgeons or the American Society of Internal Medicine. Furthermore, groups such as the Group Health Association of America, representing physicians working in managed care facilities, have grown dramatically. The legions of health care representatives now active in Washington represent extremely diverse interests, ranging from the American Hospital Association to the American Nurses Association, various professional specialty groups (American Society of Clinical Pathologists, American College of Radiology), disease-oriented charities (American Heart Association, Alzheimer's Association), and other groups. The health care interest-group structure is one of the most diverse, conflictual, and well-endowed of any in Washington (Starr 1982; Salisbury et al. 1987; Wilsford 1991; Heinz et al. 1993; Baumgartner and Talbert 1995).

Changes in the economics of health care, the dangers of cost shifting, and the growth of new forms of insurance combined to change many of the political alliances in the area during the 1980s (Aaron 1991; Peterson 1992). Large businesses offering good insurance coverage increasingly realized the damage of cost shifting. In this case, increasing costs, especially those borne by organizations with the resources to defend themselves in the interest-group system and by direct lobbying in Washington, clearly changed the political calculus. Previously invulnerable groups, such as the AMA, found that they faced serious and well-endowed opponents to the status quo.

Congressional Attention to Health Care

As Figure 1 shows, Congress' attention to health care surged in the 1970s and then again in the 1980s. By the mid-1980s, Congress was regularly scheduling more than 100 hearings on some aspect of the health care industry each year. Clearly the emergence of health care on the nation's political agenda did not happen merely as a result of the 1992 election campaign. Rather, a combination of long-term social, economic, and political forces along with shorter-term electoral campaigns and presidential priorities made health care the pivotal issue for the government in 1993 and 1994 (Skocpol 1994). Little did the administration know that the very forces that pushed the issue so high on Washington's institutional agenda would conspire to make decision making in Congress a nightmare.

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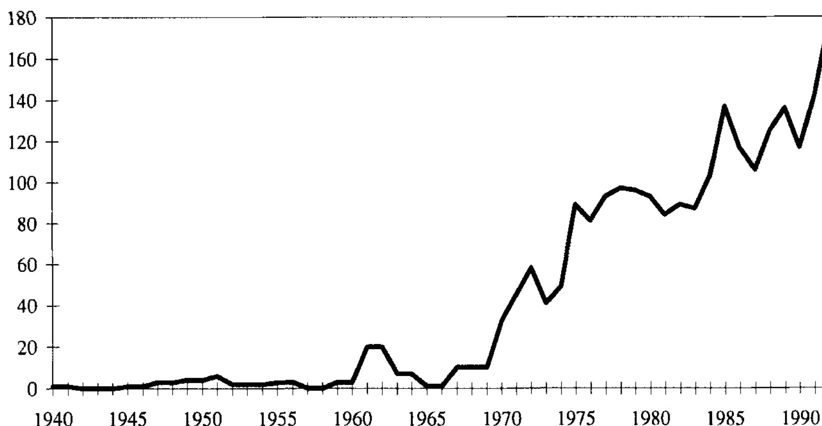

Figure 1 Congressional Hearings on Health Care: 1940–1992. *Source:* Congressional Information Service, Annual. Data were calculated from an electronic search of the Congressional Information Service CD-ROM, using *health care* as the key phrase for yearly searches.

Making Decisions in Congress

As the health care issue emerged on the national agenda during the 1970s and 1980s, many representatives became involved. In this way, Congress reflected the increasingly fragmented structure of interest groups active in the health care debate. As the focus shifted from discussing the problems of health care to deciding which combinations of solutions should be adopted, this fragmentation proved to be even more problematic than was anticipated.

In studies of various issues during the entire post-war period, Baumgartner and Jones (1991, 1993) found that increased congressional attention to a particular problem inevitably is associated with more congressional committees and subcommittees clamoring for a piece of the pie (see also Jones et al. 1993; Talbert et al. 1995). In this sense, the health care example is probably the most extreme of any in American politics. More than any other issue, it attracts a great variety of congressional masters, each with some small (but often important) share of the jurisdictional spoils.

Table 2 shows the nature of congressional consideration of health care, with some other issues for comparison. It compares the number of committees holding hearings in a given year on various topics and shows the percentage of all hearings on those topics that are held by the single committee with the greatest jurisdictional dominance. In a larger project, we

Table 2 The Fragmentation of Decision Makers in Congressional Committee Jurisdictions by Issue Area, 1980–1991

	House		Senate	
Policy Area	Number of Committees Holding Hearings	Percentage of Hearings in Dominant Committees	Number of Committees Holding Hearings	Percentage of Hearings in Dominant Committees
Health Care	10.1[b]	23.6	7.0	27.5
Agriculture	7.2	61.1	6.0	58.0
Education	7.3	71.6	4.1	69.8
All Areas[a]	9.0	38.3	6.6	44.3

a. The mean values for the twenty-two topic areas of the study (Baumgartner et al. 1994).
b. Figures reported are annual averages.

are analyzing every congressional hearing on all topics since 1945 (see Baumgartner et al. 1994).[1] Taking from that project only the data from 1980 to 1991, we can show that health care issues are divided among a greater range of congressional committees than are any other issue in Congress. Whereas 72 percent of hearings on education topics are held in the single-most-relevant committee of the House (with similar totals in the Senate), the committee with the most hearings on health care has only about one-quarter of the annual total.

In health care, increasing attention to the problem over the years and tremendous increases in the size and complexity of the health care industry led to an extraordinary splitting of jurisdictional responsibilities in Congress as entrepreneurs vied with each other to grab or maintain important parts of jurisdiction over the health care issue (see King [forthcoming]).

Table 3 shows the committees that held hearings on health care issues. Nearly every committee in the House held hearings on some aspects of the industry, even if only a few. Even if we consider only those committees that held more than 100 hearings during the 12-year period considered in the table, we still find that four different House committees and three separate Senate bodies are major players, representing more congressional overseers than we can find with any other issue. This high level of fragmentation had obvious political consequences for the Clinton ad-

1. Data presented in this essay on congressional hearings by committee and by issue are from a preliminary analysis from this larger, but yet incomplete, data set. Completion of the data collection effort may require some slight changes to the numbers, but none to the thrust of the findings.

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Table 3 House and Senate Committees Holding Hearings on Health Care, 1980–1991

Committee	Number of Hearings	Percentage of Total Hearings
House		
Select Aging	239	23.9
Energy and Commerce	207	20.7
Veterans' Affairs	132	13.2
Ways and Means	122	12.2
Government Operations	48	4.8
Science, Space, and Technology	45	4.6
Appropriations	44	4.4
Small Business	29	2.9
Budget	25	2.6
Armed Services	16	1.6
Education and Labor	14	1.4
Judiciary	14	1.4
District of Columbia	11	1.1
Seven Other Committees	52	5.2
Total	998	100.0
Senate		
Labor and Human Resources	139	26.9
Finance	113	21.9
Select Aging	104	20.2
Veterans' Affairs	54	10.6
Appropriations	29	5.6
Government Affairs	25	4.9
Judiciary	14	2.7
Budget	8	1.5
Small Business	6	1.1
Agriculture	6	1.1
Six Other Committees	18	3.5
Total	516	100.0

ministration. Opponents were given many venues in which to generate opposition to the bill or simply to delay consideration. Even among the committees that reported legislation, such different solutions were proposed that negotiation for floor votes and in conference only would have offered further opportunities for opponents to defeat the bill. In sum, fragmented jurisdiction made it almost impossible to generate support for a single proposal.

With health care issues divided among so many congressional com-

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mittees and with important government programs already in place that affect every state, coordinating changes to these policies could not be more complex. More than any other issue, including defense, agriculture, education, crime, or immigration, health care legislation is divided among conflicting congressional masters. Forging a consensus in this area proved too difficult for the Clinton administration, but a simple glance at the congressional and interest-group environments surrounding this issue suggests that no president may have done better.

Conclusion

Agenda setting can be driven by social problems. In the decision-making process, however, government must choose among alternative solutions. In the best of cases, problems and solutions are joined before the agenda is set, allowing bold reforms to sweep through the decision-making process easily. The failure to develop a national consensus stemmed from an inaccurate assumption that the massive pressure to solve the health care problem would by itself force rival congressional players to compromise. If a national agenda can be set by bringing increased attention to a problem, congressional decisions can be made only when particular solutions are attached to that problem.

Focusing on problems rather than forging solutions is one reason for the disillusion of newcomers to Washington. It is easy to get Americans to agree that access to health care, high taxes, crime, inadequate educational achievement, or any number of social ills are problems. Candidates can be elected and presidents can be made by focusing almost exclusively on one or a few prominent social problems. Once in office, however, they are faced with a completely different conundrum: achieving consensus on particular government policies to solve these problems. The Clinton administration faces a difficult task as the 104th Congress convenes: building support for proposals to solve the problems of health care in America rather than merely bringing more attention to the issue itself.

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