The Congress: Structural changes affecting biomedical legislation: an overview, 1965–1981

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Those who seek to inform the U.S. Congress about health and medical public policy are encountering increasing difficulty in having their views heard and absorbed in a systematic, continuous way by experienced senators, representatives, and staff aides.

Most seasoned observers of the congressional system would agree that similar difficulties are faced in all other areas of public policy.

One reason for this situation is that the Congress and its staff have changed profoundly in recent years as a result of the increased federal government role in nearly every aspect of our national economic and social life, forcing congressional attention to an increasing array of issues; and as an outcome of the structural changes in our political system and its institutions, which were developed to deal with the imposed strains.

During 1965–1981, major structural changes occurred in Congress that have had a profound impact on health and medical legislative issues. One such change is the turnover rate among members of Congress, especially among the aides who serve them on health and medical matters.

Federal involvement in health and medicine dates back many decades, but increased massively with the Johnson administration and legislative drive to create the Great Society.

In the early years of that effort, Medicare and Medicaid were developed (with Johnson administration initiative and prodding) in the House Ways and Means Committee and in the Senate Finance Committee. Meanwhile, the legislative committees concerned with authorizing other health and medical programs were also active in developing widespread, complex, and detailed laws. Appropriations for these programs rapidly accelerated, including dramatically increased funding for biomedical research.

The changes in the Congress during this time were as great, perhaps, as in any other 16-year period in our nation's history, not only in terms of membership and staff, but also in fundamental rules governing legislative behavior.

The Senate and House, once considered stable legislative bodies, with long tenure for members and a committee seniority system that ensured enduring power to multiterm members (and especially committee chairmen), underwent significant institutional and membership changes during this period. Instability occurred because of rapid turnover in membership and staff and through rule changes which significantly weakened the seniority system while increasing the independence of the individual member from the party and institutional structures of the Congress.

Of course these congressional changes had significant effects on health and medical legislation as it was developed, periodically reauthorized, and amended. As the programs and issues became larger and more complex, the recollection and understanding of original legislative intentions and subsequent modifications became more important. However, long-term continuous institutional experience to deal with these matters, in fact, has declined markedly.

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A simple membership count is revealing: only 68 of the 435 House members (15%) remain in office from the time Medicare and the large Great Society programs began (1965–1966), and only 13 of the 100 senators (13%) are still in office.

A survey of professional committee staff serving the six committees that originated and funded these programs, and that continue to have jurisdiction over them, shows that not one remains who had a significant role in 1965–1966. Of the personal aides to members of those six committees who served as staff on health and legislation matters, none remain in the posts held then.[1]

Thus, little institutional experience remains from the early, most active period of health and medical legislative development. In a recent, more detailed study of the period 1977–1981, the turnover rate and loss of experience continued. During that time the membership turnover in both the Senate and the House of Representatives approximated 40%, and among legislative aides dealing with health and medicine, 90%. In the six key committees that deal with most health and medicine legislation, membership changes were also extensive,* and turnover rates of those members' legislative aides approached 95%.[2]

Along with these changes, there has been a significant change in the characteristics of the legislative aides. In 1965, compared to 1981, congressional aides to individual congressmen (except those serving congressmen first elected in the Democratic landslide of 1964) generally were older, had more experience in congressional procedures, had longer tenure, and were more likely to have long personal and political relationships with the members they served. Professional committee staff were also likely to be older, to have a legal education supplemented by long experience in drafting congressional legislation, and to be more familiar and comfortable with the earlier congressional processes.

Professional committee staff and aides in congressional offices are younger, more activist (in promoting legislative changes), hold more graduate degrees, and have less long-term experience in congressional matters; yet they are faced with more complex tasks.

Also, between 1965 and 1981, many more staff posts were created and filled. In the House, total staff to individual members rose between 1965 and 1981 from less than 4000 to more than 8500; in the Senate the increase was from about 1700 to more than 4000. This increase paralleled that in professional committee staff: in the Senate the number increased from 509 to 1108 during the same year; in the House, from 571 to more than 1900.[3]

In summary, from 1965 to 1981 there has been a significant change in congressional membership; major rule changes have increased instability; and significant staff changes took place, which included rapid turnover, changes in characteristics, and increased numbers. The result has been that congressional policy developments regarding health and medical issues have been affected significantly by these changes, increasing the difficulty of maintaining continuous contact for those in the fields of health and medicine.

* This tabulation was made with data from the *National Health Directory* for 1977, 1979, and 1981. Information was verified by questionnaire and follow-up phone calls to every congressional office. Data were generated between January 1 and 31 of each year.

References

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