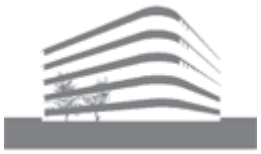

Medical markets and professional power : the economic and political logic of government health programs

Author(s): Immergut, Ellen M.
Date 1991
Type Working Paper
Series Estudios = Working papers / Instituto Juan March de Estudios e Investigaciones, Centro de Estudios Avanzados en Ciencias Sociales 24 (1991)
City: Madrid
Publisher: Centro de Estudios Avanzados en Ciencias Sociales

MEDICAL MARKETS AND PROFESSIONAL POWER: THE ECONOMIC AND POLITICAL LOGIC OF GOVERNMENT HEALTH PROGRAMS

Ellen M. Immergut

Estudio/Working Paper 1991/24
June 1991

Ellen M. Immergut is Associate Professor of the Department of Political Science at the Massachusetts Institute of Technology. This working paper was presented at a seminar held at the *Center for Advanced Study in the Social Sciences* of the Juan March Institute in Madrid on April 19, 1991.

ABSTRACT

This paper discusses the implications of government health programs for professional power. It argues that programs for public provision of medical care are resisted by medical professions because they interfere with the economic autonomy of the profession. Section One reviews different theories of professional power and shows that economic autonomy is a distinct dimension of professional autonomy. While theories of professionalization have tended to focus on the development of medical monopoly, medical professions in the twentieth century have been equally concerned about protecting their economic autonomy by preventing the development of government monopsony through collective financing for medical care.

Section Two provides an overview of the political history of national health insurance programs in Western Europe. It shows both how the issue of economic autonomy was relevant to these political conflicts, but, nevertheless argues that issues outside the purview of the profession-- specifically, more general questions of political representation and governance- were critical for the ultimate resolution of these conflicts. In nearly every country reviewed, the same policy proposals were suggested: government subsidies to voluntary mutual aid societies, national health insurance, national health services. And the same professional objections concerning medical payment, private practice, and professional freedom were raised by doctors in each country. But the political motivations for enacting these programs and the political factors that decided whether the programs would indeed be enacted varied enormously. Furthermore, these programs had implications for and were affected by many political, social, cultural and economic relations well beyond the realm of professional issues. Freedom of association, industrial relations, national security, and changing conceptions of social equality were as important, if not more so, than the autonomy of the medical profession. Thus, the political logic of government health programs is independent from the economic logic of these programs.

Section Three provides a typology of the main public programs in health that resulted from these political conflicts.

Introduction*

It is intuitively obvious that the medical profession should be a dominant actor in health policy-making. After all, government health programs directly affect the working conditions and incomes of doctors; Doctors are also the sole experts qualified to judge the effects of these public programs on health; Finally, these programs depend on the cooperation of doctors, for government health programs are meaningless unless doctors will agree to treat the patients covered by these programs. Because the central role of medical professionals to health policy appears so self-evident, many analyses of health policy have followed two strategies. Either, they assume that professional dominance is a fait accompli and they research the demands of the medical profession and the influence that professional demands have had on health policies. Or, they do not particularly probe the demands themselves, but go on to search for the underlying roots of the ability of medical professionals to exert a dominant voice in negotiations over health policy. Sometimes, the two strategies are combined in studies that explain, first, how medical professionals came to achieve professional dominance, and, second, then trace the ways in which professional demands have shaped health policies. In all three cases, the working assumption is that doctors control health policy outcomes.

This essay provides an alternative analysis of professional dominance and its impact on health policy. First, it asserts that the demands made by medical professions deserve a closer analysis. There is an economic logic that has informed both the programs drafted by government policy-makers and the interpretation of professional interests by medical associations. From the late 19th century through the 1960s, government programs in health expanded the market for medical practice. Yet, despite this expansion, medical associations throughout Western Europe opposed such government programs. These doctors developed an ideology of "liberal medicine" and tried to defend the private market against state intervention. Why was this the case? It will be argued here that doctors opposed government expansion

* This paper was prepared at the Max-Planck-Institut für Gesellschaftsforschung, Cologne, Germany, while funded by a grant from the German Marshall Foundation of the United States.

because greater government financing and direct involvement in health care delivery entailed greater government regulation of the medical profession. This regulation threatened the status of doctors as independent professionals. Consequently, medical professions looked to the free market as a guarantor of professional freedom; they aimed to preserve points of economic independence in face of increasing government financing, regulation, and ownership of health facilities. Thus, there is a consistency to medical demands in this period that can be understood in terms of the economic autonomy of the profession.

Second, this essay argues that while there may be an economic logic to medical demands, economic interests alone cannot explain the political logic of government health programs. Health programs were enacted for a wide variety of reasons, whose political aspects had little to do with the specific technical goals of the programs, or with medical demands. In order to understand the political logic, one must widen the frame of analysis from the medical profession to include many other political actors. Hence, the economic logic of government health programs can provide a guide to the motivations of medical professions and government health bureaucracies with regard to health policies. But the final policy outcome depends as much on factors relevant to the political as opposed to the administrative wing of the state, and on the role played by various political and social movements in the struggles over health programs.

Theories of Professional Power

Theories of professional power have been developed to explain the pivotal role of doctors, not just for health policy, but for modern societies more generally. The independence of the medical profession, or professional autonomy as it has been called, is viewed as the key to the privileged position of doctors by this literature, although each theory analyses the sources of autonomy differently. Early studies of the medical profession saw autonomy as crucial for the social functions performed by doctors. Curing the sick requires a relationship of trust between doctor and patient that must be protected by measures to ensure that doctors are qualified and

To this end, doctors need to be not only specially trained, but free from outside pressures. Writers like Talcott Parsons viewed the traits of professionalism- special training, codes of ethics, supervision only by professional colleagues- as arising out of social necessity.[1] This approach to professional power, in other words, explains professional dominance in terms of the functions performed by the profession.

Later views of professional power criticized this notion of social necessity. Not every socially necessary occupation was granted the same autonomy and privileges as the medical profession. Moreover, the medical profession had not always been equally well-respected or autonomous. These criticisms led to alternative views that focused on the historical processes that resulted in professional autonomy. According to Eliot Freidson, the critical aspect of autonomy is that only fellow members of the profession are recognized as capable to judge the technical aspects of medical work. Although technical autonomy may now appear as self-evident, Freidson argues that this was not always a natural state of affairs. Rather, the unique professional status of physicians was achieved through campaigns by the profession to prove to governments the efficacy of medicine as a scientific body of knowledge and to convince these governments to approve exclusive routes for medical training and licensing. Many occupations, in other words, require specialized training, but the medical profession is one of the elite few that successfully convinced governments to require legal licenses for practice and asserted its right to technical autonomy in all spheres of medical practice.[2] Here, professional power is based on defining the "cognitive" boundaries of the profession by defining medicine as a unique branch of knowledge and protecting the exercise of medicine against competing therapeutic ideas as well as competing practitioners.

An offshoot of this view focuses more squarely on medical licensing. Following the Weberian tradition, Berlant and Larson, for example, regard medical organizations as a kind of modern guild. The key to professional autonomy in their view is not technical expertise, which by itself is quite hard to define, but market monopoly. Once the medical profession managed to control entry into the profession through licensing-a feat these writers agree with Freidson was

achieved through political skill and historical luck- the profession could use its monopoly position to increase doctors' incomes, require direct payment, and improve the social status of doctors. Likewise, several economists- including Adam Smith- have viewed medical licensing as a barrier to competition that generates an economic advantage to physicians; this liberal profession is based on not-so-liberal market arrangements.[3]

A fourth approach focuses on the process by which medical professions have achieved legitimacy in the eyes of the public. Paul Starr, for example, points out that the American medical profession is a case apart as the early democratic political culture in the United States eschewed the role of the state that made European educational and licensing controls possible. It took a series of broad social and cultural changes, as well as political campaigns to reform medical education and establish both general and specialty licensing, in order for the profession to achieve what he calls its "cultural authority." This concept encompasses the status of physicians but stresses in particular the authority of the profession to define medical issues and even the language permitted to discuss health, an authority that underlies the political role of the American Medical Association.[4]

Whatever the historical origins of professional autonomy, whether its roots lie in technical expertise, market monopoly, or broader cultural factors, the implications of these studies is that once established, professional autonomy would place the medical profession in a unique position as a political lobby group. If government health programs require the cooperation of physicians as the only group qualified to carry out medical treatment, then doctors should be able to bargain quite successfully for their conditions of practice under these programs. "As producers of a crucial service in industrial countries, and a service for which governments can seldom provide short-run substitutes, physicians have the overwhelming political resources to influence decisions regarding payment methods quite apart from the form of bargaining their organizations employ.... Hence whatever the political and medical structure

of the western industrial country, medical preferences determine the methods of payment used in public medical care programs."[5]

While these studies provide helpful insights regarding the origins and nature of professional power, however, they fail to address the link between professional power and government intervention in medical markets. That is, why should medical professions oppose programs that would guarantee them a clientele? Why have so many political conflicts over government health programs centered around the role of the private market versus the role of government? And why have medical associations sought to defend the private market?

Monopsony v. Monopoly

It is the premise of this paper that these disputes about market and government are based on a conflict of interest between the buyers and sellers of medical services. As buyers of medical services, governments hope to reduce the price of these services. To the extent that payments for medical services become consolidated in the hands of government, governments can use their power as payor to enforce price controls and other forms of public management of the health sector. In other words, the position of government as a buyer is strengthened to the degree that the government becomes the sole buyer of services, i.e., to the extent that government achieves a position of monopsony. This monopsony power of government is confronted, however, by the monopoly power of doctors, as they are the sole providers of medical services. The position of doctors is strengthened if they can sell their services not to a single buyer, but to many buyers.

Government health programs have two, contrary, implications for this confrontation. Government health programs comprise an entry point for governments into the health services market. Such programs are therefore a step towards monopsony. At the same time, government payment for medical services greatly expands the market for medical care by using government resources to purchase medical care for persons that otherwise could not afford it. Government health programs thus increase both the financial resources available for medical

treatments and, at the same time, such programs increase the leverage of governments over health care providers. Once governments pay for medical services, in other words, they are bound to try to lower the price of those services. And, further, if these government payments are centralized, for example into a central budget, and if these governments are the sole source of financing for medical services, then the pressure on government to control costs as well as the ability of government to control costs is increased. At some point, the interest of government as payor in regulating service providers is bound to collide with the interests of doctors in maintaining a position as independent professionals. Because government health programs generally pay for hospital treatments and pharmaceuticals, similar conflicts between these providers and governments have also arisen. But here the focus will be on conflicts between governments and doctors.

While in theory there have been many different ways in which governments and medical professions might have resolved their differences, between 1930 and 1970, medical professions in a number of different countries focused on one particular strategy. The liberal model of medicine looked to the free market as a realm of protection for the autonomy of the medical profession. Medical associations throughout Western Europe fought the entry of governments into the health insurance market; they fought subsequent government efforts to control medical costs by regulating doctors' fees and changing methods for paying doctors to more "collective" forms, such as salaries; and they fought prohibitions against private practice for doctors employed in the public sector. In each case, a different aspect of the health market was labelled "private" and was defended by the profession. Although many of these proposed changes entailed increases in the absolute amount of government, financing-- even the fee regulations were often combined with increases in the total amounts governments were willing to pay--medical professions took the position of defending the status quo against increases in government intervention with regard to financing and regulating the health sector. Professional associations stressed the need for independent physicians to assure quality care. Financial independence, and in particular the right of doctors to receive payments directly from patients without intervening bodies such as government agencies or insurance companies, was

incorporated into several medical codes of ethics on the grounds that economic independence was critical if medical judgments were to be made on purely medical grounds. Patients would trust doctors only, it was argued, if they felt sure that doctors were completely loyal to them, and not to an outside party that was paying the bill.[6]

This defense of the "private" was not simply a defense of a foregone past status; nor did the private merely represent additional income; instead, keeping some form of private practice open was economically rational as it prevented governments from achieving a position of monopsony. By maintaining different private forms of practice within health systems that became ever more dominated by government payment systems, these medical professions protected their ability to exit from the public sector.[7] This potential to leave the public sector forced government health authorities to compete with private buyers (private insurance companies, private patients, private hospitals), thereby strengthening the bargaining power of physicians. Even for those that did not actually leave the public sector to go into private practice, the possibility that they might exit was an important strategic factor in negotiations regarding fees and salaries in the public sector. Indeed, it is important to note that it would not have been possible for all doctors to go into purely private practice. Government health programs expanded the demand for health services far beyond what patients could afford to pay directly, out of their own pockets, at the time of treatment. But by retaining small amounts of private practice, doctors nevertheless forced the buyers of health services to compete, thereby breaking up government monopsony.[8] Thus, although medical associations initially fought the enactment of national health insurance because they feared that, in the future, governments would begin to interfere with physicians' economic and perhaps clinical autonomy, once a program was in place, these associations adjusted to the influx of new resources. At this point, the associations turned their efforts to maintaining pluralistic financing, pockets of private practice, and to avoiding government regulation of fees and medical decisions. In short, the key goal of the liberal model of medicine was to avoid total financial dependence on government health authorities. For this specific period of time, a number of medical professions defined their interests in terms of the free market; economic autonomy became, in their eyes, the necessary

condition for professional autonomy.

This view of professional strategies deviates from the standard views of professional power, which emphasize functional needs, technical autonomy, the development of professional monopoly through medical licensing, and legitimacy. Doctors fought the battles to consolidate medical knowledge into an officially-recognized skill and for legal restraints on unqualified practitioners from the 16th to the 19th centuries. By the mid-nineteenth century, professional monopoly was an established fact in Europe, though interestingly enough, not in the United States.[9] But, efforts to establish collective financing for medical care in the late nineteenth century brought the issue of the private market versus government into professional politics as a new dimension. It therefore makes sense to separate the "classical" issues of professionalism, such as the historical process by which medicine was established as a science-- which established what one could call the "cognitive boundaries" of the profession- and the political efforts to establish a legal monopoly on medical practice- which set the "credentialing" boundaries of the profession- from later struggles over purely economic issues. In fact, some theorists of professionalism have explicitly distinguished the cognitive and credentialling aspects of professionalism from economic autonomy. For example, Eliot Friedson specifically says that "technical" autonomy should not be confused with economic autonomy; "[S]o long as a profession is free of the technical evaluation and control of other occupations in the division of labor, its lack of ultimate freedom from the state, and even its lack of control over the socio-economic terms of work do not significantly change its essential character as a profession. A profession need not be entrepreneur in a free market to be free."[10]

While some writers have indeed discussed the classical professionalization process to establish medical licensing in terms of "market" monopoly, the late nineteenth and early twentieth centuries brought a new type of "market" issue into play. In addition to the idea that doctors as a group held a monopoly over practice, the role of doctors as "entrepreneurs"

became a central issue in national health insurance debates. Moreover, the conflicts over public programs in health stimulated a growth and re-structuring of pre-existing medical associations as they moved to defend the market interests of the profession. Even among physicians with the same status as fully-licensed practitioners, new subdivisions emerged between private office practitioners, doctors with insurance practices, full-time hospital practitioners, part-time hospital practitioners with private office hours, private doctors working in private clinics, doctors employed by local health centers, and public health officers. The goal of the emergent medical associations was to ensure that these new forms of public employment for doctors did not eliminate private practice and to use these subdivisions to prevent government monopsony; they wished to prevent public employment from becoming the norm for all doctors.[11]

The conflicts over government monopsony were fought over three basic types of government programs: government subsidies to voluntary mutual aid societies; compulsory national health insurance; national health services. In programs of government subsidies to voluntary mutual aid societies, governments merely provide financial aid to private mutual aid societies. In order to receive these subsidies, the mutual aid societies were required to register with government health authorities, and to comply with regulations concerning minimum benefits and financial practices. The mutual aid societies were free to make independent arrangements with doctors for treating their members at discounted rates. Thus, programs for government subsidies to mutual aid societies did not entail a direct relationship between governments and doctors. Governments paid the mutual aid societies and the mutual aid societies paid the doctors. Conflicts over the working conditions and economic autonomy of doctors were strictly between the mutual aid societies and the doctors.

National health insurance programs entailed a greater financial and administrative role for governments. Governments required citizens, or portions of the population, such as low-income earners, to join public health insurance programs. Governments often provided some financing for these programs, but the bulk of financing was usually through a payroll tax shared jointly

by employers and employees. The administration of the programs was traditionally left to bodies outside the state but under state direction. In practice, this often meant converting the old independent mutual aid societies into quasi-public administrative entities and consolidating the societies. Under such programs, doctors faced a more unified payor than the mutual funds: the social insurance or national health insurance administration. While legally not part of the state, the state determined the extent of the program- who was required to be insured, and how much employers, employees and the state would contribute to financing. With this new political responsibility for health insurance, governments also began to intervene on issues concerning the payment of doctors by the public health insurance carriers.

The third type of program, national health services engendered an even greater financial and administrative role for governments. Rather than subsidizing private insurance, or creating a public insurance program, governments provided health services directly, through nationalized hospitals and doctors paid by a salary. In some cases, national health services were organized without direct government ownership or employment of doctors; instead, contracts between the state and private hospitals and between the state and private doctors took the place of direct government ownership of facilities and employment of doctors. In either case, governments had a greater direct financial interest in the health sector, because payments were made directly from government budgets, rather than from independent mutual aid societies or quasi-public health insurance administrations.

Medical professions fought each step towards a greater financial and administrative role for governments, because they wished to avoid increasing government incentives and instruments for regulating the profession. They preferred programs subsidizing voluntary mutual aid societies to programs of national health insurance. In turn, they preferred programs of national health insurance to programs of national health services. Not only did doctors oppose the transition from one basic form of government program to the next, but micro-conflicts about the ways in which doctors would be paid within each type of program also reflect this basic conflict over monopsony.

Under programs of government subsidies to mutual aid societies, doctors fought for guarantees that would protect them from the monopsony power of the mutual aid societies. Relations between the mutual aid societies (mutuelles, friendly societies or sickness funds, as they were variously called in different countries) and doctors had generally been far from friendly. In order to economize, the funds hired doctors at a discount on a contract basis. They often paid doctors at a flat rate per fund member (capitation) and limited fund practice to a "closed panel" of doctors that agreed to these bargain rates. Doctors did not want the funds to have the power to exclude doctors that refused to work for lower rates from fund practice. They wished to force the mutual aid societies to compete for doctors, rather than being able to form a payor cartel that could dictate the rates of payment to the doctors. Therefore, they campaigned for a "free choice of doctor." Patients should be able, in the eyes of the doctors, to go to any physician that they wished. In addition, doctors with sickness fund practices began to organize themselves to present a unified front against the funds. These doctors attempted to decide on the minimum acceptable rates for medical treatment and to police themselves to be sure that no doctor agreed to treat patients at lower rates.

Disagreements over the fund practices were one (but not the only) stimulus for the transformation of pre-existing medical associations. While earlier medical associations can be described as learned societies that disseminated information and represented the academic elites of the profession in such matters as licensing, university policy, and public health matters, now the mid-to-lower stratum of the profession began to demand a form of economic representation. This unleashed a debate about the nature of professionalism: should these associations take on a more "union-like" role? The older organizations either incorporated the general practitioners and their demands for action against the funds into their organizations, or alternatively, were forced to compete with new associations that now promoted the interests, and in particular the economic interests, of the mass of practitioners. For example, the British Medical Association was founded to represent the general practitioners alongside the older Royal Colleges of Physicians and Surgeons; the "Verbands für die Ärzte Deutschlands zur Wahrung ihrer wirtschaftlichen Interessen" (the "Association for the Protection of the

Economic Interests of German Doctors") or Leipzigerverband. later called the Hartmannbund. was added to the corporatist Ärztekammer. in which membership was required by the state for licensing and ethical matters; in France, Sweden and Switzerland, too, practitioner organizations (the French Union des Syndicats Médicaux Français, the Läkarförbund. and the Swiss Ärzteverein) formed at the end of the nineteenth century to represent doctors in economic matters and in political lobbying efforts regarding government health programs.[12] Leaders in these associations complained that contract practices turned physicians into employees of the sickness funds, and took steps to prohibit the signing of contracts or to improve the conditions set forth in the contracts. This, of course, meant penalizing doctors that agreed to fund demands.

To medical professions, compulsory health insurance laws represented both a potential liberation from the sickness funds and a future subordination to governmental authorities. National health insurance was viewed differently by three strata of the profession. For the non-elite doctors that treated poorer patients, insurance practice was an economic necessity, and national health insurance might free these doctors from the control of the sickness funds, and, at the same time, better guarantee their incomes. The elite physicians who had a private clientele, on the other hand, viewed national health insurance as a threat to their private practices and were concerned about the advent of future governmental controls on the profession. These were the advocates of the "liberal model," who wished at all costs to avoid dependence on the state. Medical associations leaders juggled the interests of these two groups and, simultaneously, as oligarchs they worried about the effects of medical policies on their associations. These leaders were extremely sensitive to political constraints and strategic opportunities for enforcing a medical veto. Their assessments of the views of other interest groups and the access of these groups to political decision-making weighed heavily in their calculation of professional interest. The decisions of these leaders to back down and seek small concessions or to fight to the ultimate moment were, in other words, made with an awareness of the system of interest representation and the design of national political institutions.[13]

In political negotiations over national health insurance programs, doctors preferred as pluralistic an administrative structure as possible, and they sought to avoid governmental controls over fees. They preferred reimbursement systems of payment, under which they would receive fees directly from patients, and patients would be reimbursed later by the insurance authorities. Most insurance authorities, on the other hand, preferred direct third-party payment, so that they could pay doctors directly and resolve any fee disputes directly with the doctors.

National health services were the form of government health program most disliked by doctors. They preferred the more diluted financial relationships engendered by programs of subsidies to voluntary mutual aid societies and national health insurance. Under national health services, the issues of contestation have been the level of government that is to finance and administer the health service, and the employment relationship of the doctor to the health service. Doctors have varied with regard to the level of government that they prefer. Centralized financing seems to have resulted in tighter financial controls over the health services, as in Britain. But, while local autonomy over financing or spending decisions has often resulted in greater fiscal laxity, the interference of local political authorities in the daily running of the health system seems to be greater than for central authorities. Doctors preferred to work for national health services as subcontractors rather than full-time salaried employees, and to maintain the right to a part-time private practice. The status that doctors seemed to have worked hardest to avoid is salaried employment by local health centers. Even in countries with national health insurance or mutual aid society legislation, doctors made eliminating the possibility for health insurance carriers to form local health centers with salaried doctors the number one priority, even higher than avoiding fee controls or the blocking the introduction of national health insurance. A recurring political issue has been the right of national health service doctors to treat private patients or to maintain private beds within public hospitals. These conflicts have also arisen under national health insurance systems in countries with public hospitals.

The concept of monopsony allows one to understand the reaction of doctors to a wide variety of different, specific issues in the area of health policy. For any given reform proposal, one can predict the reaction of doctors by evaluating the impact of the reform on government monopsony. While theories of professional power have been very interested in the concept of medical monopoly, and the creation and limitation of medical markets, they have neglected the issue of monopsony and its consequences for the economic autonomy of the profession.

Nevertheless, to lay out the economic conflict engendered by government health insurance programs does not predict or explain the politics of enacting and modifying these programs. In the first place, one can conceive of many possible strategies for both doctors and governments even within the stark economic framework that has been set forth. Governments might have decided to rescind physicians' monopoly on medical treatment, opening up this market to anyone. This strategy has indeed been suggested by economists at many points in time, and was in fact one of the grounds for the political debate that resulted in Britain's General Medical Act of 1858.[14] Nevertheless, this route has not been pursued; legal medical monopoly was maintained throughout Europe. A second hypothetical strategy might have been a collectivist rather than a liberal movement amongst physicians. Rather than blocking government intervention, physicians might have focused on the absolute increase in resources permitted by government programs and elected to pursue a larger "economic pie" divided evenly amongst physicians rather than the intra-professional inequalities and uncertainties implied by a market system. And again, this strategy was recognized by some medical leaders, and it is today seen by many as a fruitful strategy for physicians.[15] But this strategy is neither inevitable now, nor is it something new. For the last hundred years, it has been a potential professional strategy. Nevertheless, European medical associations insisted on the liberal and not the collectivist route. In other words, many potential strategies can redress the same basic conflict of interests.

More importantly, conflicts over the roles of governments and doctors in the health market were not fought out exclusively in market arenas. The decisions to enact national health insurance laws and to change them in ways that restrained the economic activities of physicians were made in legislative arenas. And in legislative arenas, governments and doctors faced one another not as buyer and seller, but as executive government versus interest-group. In legislative arenas, doctors had no choice but to rely on their ability to exert political pressure on politicians. Contrary to what is often believed, medical monopoly is not a key element in influencing legislative decisions. The exclusive right of doctors to treat patients was off-limits in these debates- and in that sense, professional autonomy was entirely successful in all of the countries studied- but this professional autonomy did not translate into political influence concerning the economic aspects of national health insurance. The ability to call for a medical strike was equally irrelevant in this political context. Strikes may or may not be a useful weapon in administrative conflicts with government agencies; medical associations have launched both successful and unsuccessful strikes. But when it comes to making a law, none of these politicians let themselves be held hostage to a striking interest group, at least not by the medical profession. Instead, in the legislative arena what matters are votes by politicians. Even though one might hypothesize that a medical strike might inconvenience voters, and therefore discredit or pressure elected officials, the historical evidence does not support this hypothesis. Indeed, voters generally blame doctors and not politicians for medical strikes.[16]

Despite the fact that medical professions reacted to government proposals for health care programs in similar ways, and despite the fact that governments proposed similar policy proposals, the results of political conflicts over government health programs are very different. The following section of this paper reviews the history of these government health programs in several Western European countries. It will show that while the issue of monopsony provides a guide to understanding what is at stake both for government bureaucracies and doctors, monopsony does explain what finally happened in each case. Instead, one must also include purely political factors and the role of other social and political movements in the analysis.

The Political Origins of Government Health Programs

While one can classify different health systems according to the logic of government intervention, the health system in any one nation is the product of many years of historical development. As one Swiss politician out it, "Were it necessary to draft a health insurance bill today, I would never come up with the insane idea of proposing our current system. No one would design such a complicated system from scratch."[17] Instead, the organizational features of public and private health insurance as well as public and private hospitals and doctors' offices have been patched together by unconnected pieces of legislation, whose effects have interacted with private initiatives by a diverse group of actors. Just as some analysts describe political systems in terms of an archaeology of development, so too can health systems be described with reference to layers that reflect the political and social circumstances of different historical periods. If one wants to know why governments decided to finance medical programs or why the programs took the particular form that they did, one must dig into the archives that record the political motivations and the political struggles that explain each individual reform. Although there are policy motivations for these legislative initiatives, such as providing access to health care or controlling costs, these were rarely the sole impetus for legislation. Indeed, those directly concerned with managing public health care programs often had tremendous difficulties in convincing heads of governments or their ministers that health administration was of any interest. Health policy reforms were nearly always linked to larger political questions; this was the main opportunity for health administrators to capture the attention of those in the political, as opposed to the administrative, wing of the executive.

The pattern of hospital ownership, for example, has been highly influenced by conflicts between Church and State. Originally built by religious orders in the middle ages, hospitals became a prize in struggles to establish secular power. In Northern Europe, hospitals were taken over by public authorities through the seizure of Church property Europe, hospitals were

taken over by public authorities through the seizure of Church property during the Reformation or, as in France, during anti-clerical revolutions. In Southern Europe, where the Catholic Church maintained a stronger role in hospitals, ownership was later transferred voluntarily to the State, as in Spain and Italy. William Glaser points out that it is only in the countries with several religions, such as the Netherlands, Germany, and Switzerland, that government ownership of hospitals was viewed as a "loss of a highly visible evidence of good works," and, consequently, religious leaders fought to maintain private hospitals.[18] The practical meaning of public versus private ownership has of course changed significantly as public funding has gradually come to be responsible for large portions of hospital expenditures in both sectors. Nevertheless, even though the significance may change over time, these enduring patterns do affect contemporary health policies because they affect the basic structure and organization of national health systems.

Political factors have left their imprint on systems of health insurance, as well. The roots of health insurance lie in popular movements of the nineteenth century. Unions, political parties, and social movements founded self-help associations called "mutual aid societies," "friendly societies," or "sickness funds" that provided financial aid to sick members. These resembled the voluntary associations initiated by guilds and religious orders during the middle ages-- although some societies claim to trace their origins back to religious cults of the Romans.[19] In some cases, as in Prussia, the societies were not voluntary, but required by legislation establishing a new form of guilds for skilled workers, as well as by municipal and local statutes.[20] These societies provided a useful organizational base for the nascent popular movements. Sickness funds served as a selective incentive to attract members. The monies they collected were sometimes diverted to other ends, such as strikes. In some countries, e.g., France, these associations initially had a clear political purpose and were often quite radical. In others, the mutuals were viewed by governmental authorities as a tame alternative to other forms of working class organization that was to be encouraged. The earliest government

initiatives in the health insurance area were laws that regulated the activities of these mutual societies. Depending upon the interplay between these popular movements and these early efforts at government intervention, the mutualist movement acquired a nationally-distinct political character.

These political links changed the dynamics of health insurance policymaking in different nations. This early period established the political actors relevant for health politics: sickness funds, unions, employers' associations, medical associations, other interest groups (including the private insurance industry), and political parties. Conflicts over health insurance were not the only policy issue that had an impact on the ways in which the potential members of these groups chose to organize themselves. But it was one of several issues that shaped Western European systems of interest representation. The work of Stein Rokkan has outlined the impact of a series of such issues on European party systems.[21] In the area of health insurance, one can note that interest groups as well as public and private agencies for the delivery of services were as affected as the political parties. In other words, the transition to democracy molded not just the party system, but also the overall structure of interest-groups, specific policy agencies, and the broader set of political institutions. In particular, the constitutional links between the parliamentary and executive branches of government, as well as between national and subnational political and administrative bodies, set the rules of the game for future policymaking.

While these early conflicts concerned similar health programs, the different connections between popular democratic movements and sickness funds affected the political meaning of the programs. It might be tempting to label mutual fund legislation as a "conservative" approach to health insurance; national health insurance as "liberal;" national health services as "socialist." Current political categories do not fit the historical facts, however. Partisan politics regarding the sickness funds are better understood through a relational approach; party stances depended on the allegiances of the parties to different branches of the sickness fund movement and on the ties between the sickness funds and other popular movements. In a general sense, the growth of government financing for health insurance was

indeed a response to the threat of working class unrest. But the specific political reactions are more complicated; the political history of health insurance is not simply the history of socialism.

From this complicated pattern of historical events, one can extract some generalizations about the development of national health insurance. The basic programs that were considered are similar in many ways. Many nations enacted government subsidies in the nineteenth century, then converted these programs to compulsory health insurance for low-income earners in the period before and after the first world war. A wave of reform took place after the second world war as well, with many countries extending older programs to entire populations, or enacting new universal insurance programs. France, for example, began with a system of subsidies to mutual aid societies; enacted compulsory insurance in 1928; was forced to repeal the law and enact a new one in 1930 (because of employer and medical opposition to the first law); and introduced compulsory social security to cover health, old-age, invalidity and family allowances for all salaried employees and their dependents after the second world war. Britain, on the other hand, also began with a system of registration and some financial privileges for mutual aid societies, and enacted compulsory health insurance for low-income earners in 1911. After the second world war, however, a Labour government enacted the National Health Service.[22]

(Table One)

Table One shows that the same policy proposals have been presented in a number of European countries. Nearly every country listed in the table enacted laws governing the mutual societies and most provided subsidies to the mutual societies. All countries examined other than Switzerland enacted national health insurance. National health insurance was proposed in Switzerland at many points (1900, 1920, 1947, 1972, 1986), but each law failed. National health services are more rare, they were enacted only in Britain, Spain, and Italy. In Sweden, a proposal for a national health service failed in 1948, but the national health system has since been modified so that it is now a de facto national health service; nearly all doctors work as

TABLE ONE				
Country	Mutual Aid Society Legislation	National Health Insurance	National Health Service	Failed Legislation (incomplete)
Britain	1793, 1815,..., 1850, 1896	1911	1946	
Italy	1886	1944	1978	1919
Spain	1839, 1869	1942	1988	1931
Norway		1909, 1953, 1956		1893-6
Denmark	1892	1971		1919
Sweden	1891, 1910, 1931	1946		1919, 1948
Germany	municipal legislation	1883		
Austria		1888, 1939, ...		
France	1834, 1852, 1898	1930, 1945		1928
Belgium	1849, 1898	1944		
Netherlands	na	1913/1929, 1943		
Switzerland	1911, 1964			1900, 1920, 1947, 1972, 1986

TABLE ONE - DETAILED

Country	Mutual Aid Society Legislation	National Health Insurance	National Health Service	Failed Legislation (incomplete)
Britain	1793 #+ 1815 * 1850 *# 1896 and others	1911 o$+	1946 o*	
France	1834 o 1852 $o#*+ 1898 $#*	1930 o$+ 1945 o$#	1798 * 1958 +	1928 +
Germany	municipal legislation	1883 o$+		
Belgium	1849 $# 1938 $#*	1944 o$#		
Italy	1886 #$*(o)	1944 o$#	1978 o*$+ (#)($)	1919 +
Netherlands	na	1913/1929 $+ 1948 o$+		1919
Denmark	1892#*$	1971 o$*	*	1919 +
Sweden	1891 #$ 1910 *#$ 1931 #*$	1946 o$*	1633 * (1858 #) (1969 +$)	1919 + 1948 *
Switzerland	1911 #*$(o) 1964 $*#			1900 +,1920 +, 1947 +, 1972 +, 1986 $
Spain	1839 o 1859 o#+	1942 o$# 1967 o$#	1985 o*3$	1931 +
Austria		1888 o$+ 1939 o$#		

Mutual Aid Society Legislation Symbols:
o Political Controls
Registration of Sickness Funds
* Regulation of Funds
+ Special Interest Rates
$ Government subsidies

National Health Insurance Symbols:
o Compulsory Health Benefits
$ Compulsory Cash Benefits
+ Compulsory for low-income earners
# Compulsory for all salaried employees and dependents
* Universal for 100% of the population

National Health Service Symbols:
o National Health Service created
* Government ownership of hospitals
§ Contracts with private sector
+ Full-time salaries for hospital doctors
# Restrictions on private beds in public hospitals
§ Restrictions on private practice in public hospitals

Failed Reforms Symbols:
+ Compulsory health insurance for low income earners
* NHS
$ Compulsory cash benefits only

salaried employees of the government as a result of a 1969 reform. In France, too, the idea of a national health service was discussed after the second world war, but it was never pursued. Subsequent legislation, however, introduced full-time salaried practice for hospital doctors in 1958. Thus, the ideas for reform are comparable, but the legislative results differ.

In order to explain these different results, one must examine the political conflicts regarding specific government legislative proposals. For there is no general model that can explain the results. In every case, a look at the legislative process reveals an imbroglio of political parties, executive governments, and organized interest groups. The partisan impulse for national health insurance legislation varied widely and depended on interrelations between the mutual aid society movements, unions and other political movements. Further, motivations for enacting health insurance legislation changed over time. The early sickness fund laws were part of the process of modern nation-building; enmeshed in these political conflicts were questions of nationalism; the role of the state; freedom of association; and the public household. Compulsory health insurance laws tended to be more directly concerned with class issues, and, unlike the government subsidies, which were directed at the artisanal constituency of the mutual societies, these laws targeted the core of the impoverished industrial workforce. The German legislation of 1881 was an early example of such "class" legislation; most such laws, however, were concentrated between 1910 (when a series of general strikes broke out in several countries) to 1919 (when the political effects of the first world war brought voting rights and social insurance to the forefront of legislative debates). Conflicts over industrial relations pervaded national health insurance debates; unions and employer associations were at the center of discussions about compulsory contributions and fund administration. Sickness funds, private insurance companies, and medical associations were equally concerned. Both voluntary mutual aid societies and the private insurance industry combated proposals that sought to dislodge them from their market niches. The dynamics of these conflicts were colored, as one might expect, by the previously-described political relations between parties, funds, and popular movements. Furthermore, early government intervention had shaped the development of the insurance market, affecting the extent of mutualist and private insurance. One can see

the effects of these various political relationship on the development of government health programs by examining some examples from the history of these programs.

Early sickness fund laws were motivated by the wish of executive governments--in this period often a monarch or a "state-builder"-- to control associational life.[23] The laws dating from the end of the eighteenth and beginning of the nineteenth centuries concerned the right to exist and the legal status of these societies. Government recognition of the societies was a means of supervising the societies, in return for which the societies received some legal advantages. Or, where free association was illegal, registration was enforced by the threat of criminal penalties. Later laws added financial inducements for registration and regulated the financial practices of the societies. In some cases, the funds were allowed to make deposits at national banks at favorable interest rates; in others, they received direct government subsidies. Typically, the subsidies were set at a flat rate per enrolled member. In return, the funds were required to register with government agencies and to comply with government regulations. These regulations stipulated conditions for membership, sound financial practices, minimum benefits the funds were required to provide, and they regulated competition amongst the funds, for example by limiting the number of officially-recognized funds within a given geographic area.

Government policies for the sickness funds had several aims, in other words. First and foremost, they provided a means for governments to monitor these popular associations. In some cases, the policies went further and directly intervened to derail the political activities of the funds. Only as a later goal did the laws strive to protect and improve the benefits of the insured and to improve health insurance coverage. Under the latter laws, governments provided subsidies to the funds to encourage the expansion of fund membership, and, hence, health insurance coverage. By linking these subsidies to new regulations, these policies aimed to guarantee benefits to the insured and to stabilize the financial situation of the funds. National sickness fund laws were enacted for the first time in 1793 in Britain; 1839 in Spain; 1849 in Belgium; 1834 in France; 1886 in Italy; 1891 in Sweden; 1892 in Denmark; 1911 in

Switzerland.[24] Generally speaking, laws passed before 1850 emphasized the registration and monitoring of the sickness funds. Beginning in 1850, subsidies became more common, and the rate of growth of the mutuals began to increase. The laws of the late 19th century and early 20th century were most oriented to improving insurance coverage and benefits. The position of political parties on these questions depended more on specific political circumstances than on party ideology. To Liberals, for example, the principle of self-help endorsed by the funds resonated well with their ideals, but an expansion of the role of government did not. French and German liberals opposed Conservative efforts to co-opt the mutuals, while in Sweden and Switzerland, it was the Liberals that championed government support to the funds in opposition to Conservatives arguing for fiscal prudence. In Britain, partisan interest in the friendly societies passed from a conservative to a liberal political interest during the course of the nineteenth century.

In Britain, the country with the earliest sickness fund legislation, government interference with the funds was minimal. The 1793 Act on Friendly Societies simply provided for registration of the funds with the justices of the peace. Unregistered societies were completely legal, but were not considered legal persons, which meant that the funds were not protected from unscrupulous officers.[25] Between 1793 and 1875, 19 different Friendly Societies Acts were passed; the main changes had to do with the conditions for registration and the registering authorities. Registered societies were granted the benefit of exemption from the stamp act and could make deposits at savings banks and the national debt commission at advantageous interest rates. The early societies, like the Oddfellows and the Ancient Order of Forresters, were founded as social clubs that often held their meetings in taverns. Insurance benefits were added much later. According to the Webbs, the early history of British trade unions was intertwined with the development of the friendly societies, with many unions having their origins in a friendly society and vice versa. However, union leaders never made the provision of benefits their first priority; they felt free to use these funds for strikes or other, (in their view), more pressing ends. Registration as a friendly society, however, provided a convenient means to avoid the Combination Acts. After the decision that a trade union was

nor a friendly society, in the case of Hornsby v. Close (which had to do with embezzlement of funds), the trade unions and the friendly societies went their separate ways. In 1871 the Trades Unions Act introduced provisions for registering a trade union similar to those for friendly societies.[26]

During the course of the nineteenth century, both the character of the Friendly Societies and the attitude of public authorities to the societies changed. Until 1830, the societies were viewed with some suspicion by political elites as agents of revolution.[27] The gentry and the clergy were enlisted through the agency of the justices to supervise the societies. Nevertheless, there was an interest in the supposed moral uplift that the fellowship of the societies provided, and the hope, as well, that benefits societies might help to reduce the poor rates. There was even discussion of compulsory membership for the poor, which might entail paying part of the poor law benefits directly to the friendly societies. With the passage of the Poor Law Amendment and the Reform Bill in the early 1830s, the desire to cut the rates and the fear of sedition were lessened. Subsequent friendly societies legislation stressed the independence of the societies; legislation spelling out actuarially-sound practices was repealed, and the interest rate paid to the societies was reduced on the grounds that it was beyond the scope of government to subsidize the societies.[28]

Thus, the British liberalism famous for the Poor Law Amendment, nevertheless supported the friendly societies as an alternative form of social protection. What is striking is the way in which political philosophy and the development of government strategies for the supervision of popular movements shaped the benefits societies. The friendly societies were tolerated, and, guided by liberal principles, government intervention was kept to a minimum. Nevertheless, as Gosden points out, the replacement of supervision by justices of the peace with the office of the Friendly Societies Registrar was one of the vehicles for the expansion of the central governmental agencies at the expense of the older, local pattern of justices and parish political authority.[29]

In sharp contrast to the British pattern of tolerance, the Continental model was based on more interventionist legislation. Notably in France, mutual legislation included provisions concerning the political activities of the funds. Banned after the Revolution, mutual aid societies-- like other voluntary associations, including medical guilds-- crept back during the Restoration. The French mutuals were workingmen's associations with a clear political purpose, in the tradition of the sans-culottes. Held responsible for some of the activities of the 1830 Revolution, unauthorized mutual societies were banned by an 1834 law that strengthened the provisions of the 1810 penal code against associations of more than twenty persons. The fortunes of the mutuals rose and fell with France's sequence of political regimes. With the birth of the Second Republic in 1848, the mutuals were legalized. As the Republic drifted towards the right, however, restrictions on the mutuals were added, coupled with direct government subsidies for the funds. This approach reached its culmination in the Second Empire with Napoléon III's decrees of 26 March, 1852. These decrees permitted only mayors and curés to form mutual societies. The statutes were to be registered with the Minister of the Interior; the president of the society was chosen by the president of the Republic; and the funds were required to accept a certain percentage of "honorary" members. The latter were wealthy patrons that paid large contributions but did not draw benefits. In return, these members were entitled to a disproportionate number of votes on the fund governing boards. Supervision by representatives of the executive, the clergy, and local notables, as well as forced bourgeois membership in the mutuals was intended to quench class conflict. Control over the mutuals was a means for the executive to enforce social order; conversely, greater political freedom for the mutuals became a sign of Republican liberalization.[30] With the formation of the Third Republic in 1870, the mutuals were allowed to elect their own presidents, but it took until the Law of 1 April 1898 for the mutuals to become completely independent from the political supervision by the state. By this time, however, the relationship between the mutual societies and the working class had been completely severed. Leftist unions maintained a hostile relationship to the mutuals, and a negative stance towards government intervention in this area that was to color future health insurance debates.

The introduction of compulsory health insurance by the German Reich in 1883 marks the beginning of a dramatic shift in the history of health insurance. Chancellor Bismarck announced the intention to enact health insurance, accident insurance, and old-age and invalidity insurance through the "Royal Message" (Kaiserliche Botschaft) of 1881. Bismarck was clearly concerned about class unrest and the formation of a social democratic party in 1869. The social insurance laws, which aimed to ameliorate the material needs of the growing industrial proletariat and, in addition, to foster their loyalty to the state, were accompanied by the suppression of the social democratic party organization, (although socialists could still run for office, and held parliamentary seats). Investigations of the roots of the 1883 health insurance law, however, show that Bismarck had been preoccupied with the class question as far back as the 1840s. Moreover, for decades, he had wondered if the working class could serve as a potential ally for the state against the liberals. Thus, while health insurance was indeed a class issue, it was equally a weapon in Bismarck's manoeuvering to build a strong national executive government, with just enough parliamentary cohesion to support his initiatives, but not so much that the parliament threatened the executive or the monarchy. Bismarck had allied with the national liberals for the unification of Germany. Now the liberals, however, opposed social insurance on the grounds that the fiscal role of the executive would expand; as did the Catholic Zentrum party (on the grounds of federalism); and also industry, agriculture, and the private insurers. It was only after the failure of the Kulturkampf against the Catholics, and the growth of protectionist sentiment in both industry and agriculture, that Bismarck turned his parliamentary tactics around, using the catholics and conservatives to forge the famous coalition of "iron and rye." As Zöllner writes, on the basis of the historical work of Vogel, "This change of course had far-reaching political consequences. The tariff policy enabled Bismarck to create a different political situation. He turned away from general political and politico-economic liberalism and thereby gained freedom of action for the anti-socialist law (October 1878) and for legislation on social insurance."[31]

During the negotiations over health insurance, Bismarck was able to maintain the

principle of compulsory insurance. State subsidies and a government insurance bureaucracy were blocked by the liberals and the catholics, however. As a political expedient, the final law established employer and worker contributions (rather than payments by the executive) to finance the scheme, and it left administration to the pre-existing range of sickness funds: the miners' Knappschaften. guild funds, factory funds, workers' Hilfskassen. as well as a newly created "territorial" sickness fund (Ortskrankenkasse). Some of these funds had been administered by representatives of the insured and of the employers. The principle of "self-administration" was not controversial, and in fact fit both the Catholic and conservative views on corporatist self-regulation. After these compromises, the socialists and the progressives were the only members of parliament that voted against the health insurance law. Ironically, the socialists later turned the legislation against Bismarck by infiltrating the territorially-based funds. This created a German tradition of close ties between the unions and the sickness funds. Many funds were founded by unions and the elections for positions within the fund administration served as an important political training ground for future union and party leaders.[32]

The German example provoked increased discussion of social insurance throughout Europe. Interest in the "social question" was everywhere a central concern, yet in each country political bargains and pre-existing patterns of sickness funds left their mark on the legislation. Austria and Switzerland moved almost immediately to enact legislation along the German lines. The Austrian compulsory health insurance law was enacted by a conservative government in 1888; thereafter it was extended in steps, including the extension to family members and dependents after the Anschluβ in 1939. In Switzerland, on the other hand, liberals successfully enacted a compulsory insurance law in 1900, only to see it felled by a national referendum. Government subsidies to sickness funds were introduced in 1911-- with strictures against political activities to avoid a repetition of the German experience-- but despite several efforts (in 1920, 1947, 1972, and 1986), no national health insurance has been enacted.

In Britain, on the other hand, the Bismarckian legislation did not result in immediate policy action. National health insurance was not enacted until 1911, when, as in Swtzerland, it

was the liberals who proposed social legislation both in response to the General Strike of 1909, and out of concern, as well, with the poor condition of British soldiers that became apparent in the Boer War. In France, too, concerns with working class unrest and issues of national security were the impetus for the transition from mutual fund legislation to national health insurance. In the French case, however, the national security interest was of a unique sort. With the return of the provinces of Alsace and Lorraine after the first world war, political leaders from a number of competing parties realized that political stability depended upon integrating the citizens of these German-speaking provinces, who had previously received a full set of health insurance benefits from the German state, into the French nation. The extension of health insurance benefits to the entire French population was thus a matter of national security; to put it abstractly, this served the interest of the nation-state. The French program of health insurance for low-income earners was extended to the entire population for similar motives of national interest after the second world war. In this case, the Social Security Ordinances were legislated directly by General de Gaulle only a few days before elections would take place to ratify the Constitution of the Fourth Republic and elect the first parliament. It was hoped that national health insurance legislation would legitimate the new regime and result in electoral gains for the center-left parties.

The Scandinavian nations also followed the German example by considering compulsory health insurance in the 1880s. In these countries, like Switzerland, liberals rather than conservatives or socialists championed reform. As Stein Kuhnle points out, Norway, the country with the least developed sickness fund movement, stuck most closely to the German model. Although compulsory health insurance failed in 1893, 1894, 1895, and 1896, the program was finally adopted in 1909. Voluntary membership for persons above the income-limit for compulsory coverage steadily increased the number of insured persons. Consequently, the enactment of compulsory insurance for all salaried persons in 1953 and the revision of the scheme to a fully-universal program for all members of the population in 1956 was a continuation of a trend, rather than an abrupt shift in policy. In Sweden and Denmark, efforts

to enact compulsory health insurance in the 1890s and in the 1910s failed owing to political opposition and financial problems. Denmark, with a widespread sickness fund movement tied to unions- as in the German case- resisted national health insurance until 1971; government subsidies to the Danish mutuals allowed the social democratic unions to maintain control of the health insurance administration. In Sweden, the sickness funds were not as prevalent as in Denmark, but more so than in Norway. In contrast to the Danish funds' social democratic and union orientation, the Swedish funds tended to be affiliated with the Temperance movement, which had a liberal bias, although many members of the social democratic and farmers' parties were committed to temperance, as well. At the same time, unions and a few industries, such as mining and forestry, established some funds. Swedish liberals fought for government subsidies for the sickness funds. Swedish unions, on the other hand, preferred to remain active in the unemployment funds, and even today, Swedish unemployment insurance is administered by union funds.[33] Thus, even though the Scandinavian nations have in common a long history of significant social democratic political representation, only Norway enacted compulsory health insurance in the pre-world war one period. Proposals for national health insurance failed at that time in Sweden and Denmark, and both countries maintained a system of government subsidies for voluntary mutual funds. National health insurance was enacted in Sweden in 1946, but only in 1971 in Denmark.

In other countries as well, political conflicts and nationally-distinct constellations of interest groups and parties were responsible for early health insurance legislation. In contrast to the Scandinavian nations, where the issues of religious freedom and private schools made few inroads on the party system (apart from the liberals), confessional cleavages were central in both Belgium and the Netherlands. In Belgium, the imposed Napoleonic code prohibited mutual aid societies. Increasing associational freedom and partial government funding for mutual aid societies was provided in 1849; more substantial subsidies were provided for approved societies in 1898. The sickness fund movement that developed had strong ties to the political parties. Perhaps as a consequence of this party interest in an independent fund administration, national health insurance was delayed until 1943. Belgium is unusual in that

even post-war sickness funds have been attacked as the "bankers" of the political parties, and they retain strong allegiances to Catholic, Socialist, Liberal and Non-partisan associations. In the Netherlands, about half of the funds were founded by doctors in order to provide collective financing for their patients. The remaining two large fund associations unite a) the Catholic and b) the secular funds-- the latter mixing union and employer funds, repeating the Dutch pattern of denominational pillars that, because of the union representation found within each, allows for surprisingly strong class representation. De Swaan notes that health insurance was debated by a constellation of interest groups and parties that had been forged by the school issue: Catholics, Protestants and secular (Liberal and Social Democratic). A law compelling compulsory insurance for low-income earners for cash benefits only was enacted in 1913, but implemented only in 1930. Under the German occupation, compulsory health insurance was extended in 1941 to include medical and hospital care, and to cover a larger proportion of the population. In the Netherlands, income-limits on the public insurance system have reserved approximately 30% of the population for private insurance. It is plausible that the doctors' funds may have fought to keep compulsory insurance limited to cash benefits in 1913, and to maintain such a large group available for private insurance; these laws protected pluralistic financing and kept the government at arm's length from physician services. Only a separate historical study could answer such questions, however. In the late 1960s, the sickness funds were regulated by new legislation (1966), and catastrophic health insurance was introduced for the entire population (1967). Proposals to replace the current system of public and private insurance with universal national health insurance were rejected in the 1970s.[34]

In Spain and Italy, the mutualist movement developed slowly as restrictions on association were lifted and small government subsidies added. By the end of the nineteenth century, the mutual societies were mixed between liberal and (predominantly) Catholic funds. In Spain, the Republican Constitution of 1931 committed the state to a complete program of social security including health, but compulsory health insurance was first introduced by the Francoist state in 1942. In Italy, liberals, socialists and conservatives had debated converting

the mutualist based system into a compulsory national health and social insurance scheme from 1917 to 1919, but it was only under a fascist regime that this legislation was enacted in 1943. The transition to democracy brought with it renewed discussion of the health system. In Italy, no parliamentary coalition was able to agree to health insurance reform until a pact between the PCI and the DC in 1978 established the Italian National Health Service. Spain also converted its social security system to a national health service in 1986, this time under a socialist government. In both countries, the private sector is large, with public and private medical practice related by a complex system of contracts and part-time work.[35]

By contrast, Britain's National Health Service, which was enacted after the second world war by an all-party coalition, was based on nationalized hospitals, while general practitioners were brought into the system as private contractors, paid on a capitation basis. In Sweden, hospitals had been almost exclusively public institutions, since the appropriation of church lands during the Reformation. Nevertheless, despite holding a large parliamentary majority, the Social Democrats were unable to introduce a national health service after the second world war, due to protests from doctors, employers, the Farmers' Party and units of local governments. Although the protests of the interest groups were more public, the opinions of the local governments, who owned and administered the vast majority of hospitals, were probably more critical. The local governments stated that if hospital doctors were denied a private practice and were required to work as full-time, salaried civil servants, they would exit from the public sector and go into full-time private practice. The local governments urged that the national government greatly increase the number of doctors before attempting any such move to a national health service, because the shortage of doctors would make it impossible for the local governments to implement a national health service. Subsequently, the Swedish government increased the number of doctors by a factor of seven, and then introduced a reform in 1969 that eliminated private practice from public hospitals and placed all hospital doctors on

a full-time salary. Thus, without formally introducing a national health service law, the Swedish system was transformed into a de facto national health service.

Even in North America, proposals for government health programs have much in common with the European examples. In the United States, mutual funds were introduced by fraternal orders and ethnic associations. Possibly because these mutual aid societies never received government subsidies, as in Europe, the mutualist movement was eventually supplanted by employer health insurance programs. National health insurance was proposed in the United States by Progressives in 1919, and by the Democratic Party in 1948, but these attempts failed. Government health insurance has been limited to the Medicare and Medicaid programs introduced by Democrats in 1965. In Canada, national health insurance was introduced in steps, each of which was politically controversial. In 1947, a socialist Co-operative Commonwealth Federation (CCF) government introduced compulsory hospital insurance for all residents. After several other provinces followed this example, the Federal government introduced government subsidies to cover 50% of the costs of provincial hospital insurance in 1957. A similar cycle began in 1961, when Saskatchewan introduced universal, compulsory medical insurance to cover physicians' services in 1961, despite a doctors' strike. A national health insurance program, which followed the previous model of providing Federal subsidies to provincial plans that met standard requirements, was introduced in 1966, as a result of liberal and Conservative competition.

Proposals for government health programs throughout Western Europe, and even to some extent in North America, have been quite similar. Government subsidies to mutual aid societies, national health insurance, and national health services have been proposed or at least mentioned in nearly every country reviewed. Because these programs affect doctors in similar ways-- specifically because they alter the economic autonomy of the profession in similar ways-- the same issues of medical payment, private practice, and professional freedom were at stake in each country. But the political motivations for enacting these programs and the political factors that decided whether the programs would indeed be enacted varied enormously.

Furthermore, these programs had implications for and were affected by many political, social, cultural and economic relations well beyond the realm of professional issues. Freedom of association, industrial relations, national security, and changing conceptions of social equality were as important, if not more so, than the autonomy of the medical profession. Thus, while an understanding of monopsony and its implications for professional economic autonomy can usefully be added to the theories of professionalization, which have generally been focused more exclusively on medical monopoly, the political logic of government health programs is independent from the economic logic of these programs.

A Typology of Government Programs

The results of these political conflicts are health systems that resemble three ideal types: 1) government subsidies for private health insurance; 2) national health insurance; 3) national health services.[37] Each ideal type entails different a different financial role for governments. The financial role of government with regard to medical services, however, has implications as well for governmental regulatory capacity over the health system. In addition, these financial mechanisms have implications for the role of government as an owner of health facilities and as an employer of doctors. These dimensions of government intervention affect the main providers of health care-- doctors, hospitals, and insurers-- to different extents.

The relationship between government and market in each of these systems is different. But these differences are complex. In a system of the first type (government subsidies to private insurance), one cannot simply assume that the private sector is "large" while the public sector is "small." Nor in a system of the third type (a national health service) is it the case that the public sector is "large" while the private sector is "small." Instead, one observes discrete variation along the four dimensions. Public financing, public regulation, public ownership, and public employment are distinct ways in which one can define the role of government health care. These dimensions facilitate or impede the ability of political authorities to govern the health sector. Consequently, it is the four dimensions taken together, or the overall

"governance" role, that has aroused the greatest political opposition, especially from doctors. Thus, from a public management perspective and from an interest in analyzing political conflicts, efforts to increase or decrease "governance" are of a central significance. The organizational arrangements used to finance and deliver health care will be set forth using these four dimensions of comparison.

Mutual Aid Society Legislation

Government subsidies to voluntary mutual aid societies comprise the most limited form of intervention. Governments provide funding or various financial and tax advantages to voluntary organizations called mutual societies or sickness funds that insure their members for medical care, death benefits, and, occasionally, some form of old-age assistance. Governments exchange this funding for the right to regulate the mutual societies. Various aspects of the activities of the mutual societies, such as the conditions for membership, the financial practices of the societies, the types of benefits they are required to provide, as well as competition among the societies, are regulated by government. This form of government intervention in health care provision can be viewed as relatively limited, however. First, the absolute amount of government spending is generally minimal. The subsidies do not necessarily-- and in fact only rarely--cover the full cost of mutual fund insurance. Second, membership in the mutuals is voluntary; the role of government is restricted to reducing the cost of membership through subsidies, but does not go so far as to compel membership. Third, these laws do not directly address the delivery of medical care. The mutual societies make their own arrangements with physicians for providing health care to their members. Governments do not interfere with the fees that doctors charge or with the contracts signed between mutual societies and doctors. In other words, laws that subsidize private mutual societies increase insurance coverage by reducing the costs of membership. In some cases, they provide incentives for the re-structuring of voluntary health insurance. But they stop short of interfering with the provision of medical

services. If one divides the role of government into that of payor, regulator, owner, and employer, mutual society legislation increases the role of government as payor for services; somewhat increases its role as regulator; and does not necessarily entail a new role as owner of health facilities or as employer of physicians. If a particular national government already owns some hospitals and enacts mutual society legislation, the legislation would tend to affect the initiatives of the mutual societies but not the pattern of hospital ownership. Given the limited increase in government intervention implied by mutual society legislation, it is perhaps not surprising that doctors' associations fought efforts by mutual societies to hire them on a contract basis as full-time employees, but were not particularly concerned about government subsidies to the mutual societies.

(Table Two)

National Health Insurance

National health insurance, the second type of program, implies a more active role for government. Rather than subsidizing private arrangements, governments create their own public insurance programs that citizens are required to join and to which employers are required to contribute. The role of government is greatly expanded when compared to that under mutual society legislation along the dimensions of payment, regulation, ownership, and employment. By directly providing public insurance, governments take on greater political responsibility for health insurance. The amount of direct government financing, however, varies with the specific program. The proportion of financing paid for by general tax revenues may be large, or, the bulk of the financing may be through a payroll tax, which is the more common form of financing. In terms of regulation, national health insurance laws affect both consumers and providers. National health insurance programs are compulsory, not voluntary. Governments decide which groups are to be covered by public insurance. Early health insurance programs were generally earmarked for low-income wage-earners. Later programs, especially those enacted after the second world war, tended to include all salaried employees. Farmers and

TABLE TWO
Role of Government

Program	Financing	Regulation	Ownership of Facilities	Employment of Doctors
Mutual Fund Subsidies	Government subsidies to private organizations	a) Insurers: yes (if wish to receive subsidy) b) Patients: no (not compulsory) c) Doctors: no d) Hospitals: no	No: public ownership of hospitals possible, but unrelated to mutual society legislation	No: program of public health officers or other public employment possible, but unrelated to mutual society legislation
National Health Insurance	Government levies payroll tax to pay for public insurance	a) Insurers: now part of government or highly regulated b) Patients: yes, compulsory membership; voluntary for portions of the population c) Doctors: yes, usually efforts to regulate doctors' fees d) Hospitals: yes, usually efforts to limit payments to hospitals	No: possible, but unrelated to NHI legislation	No: possible, but unrelated to NHI legislation
National Health Service	Government tax revenues pay for all health expenditures	a) Insurers: NHS obviates need for insurance; Insurance possible on purely private and voluntary basis, although may remain subject to government regulations completely unrelated to NHS b) Patients: yes, compulsory for all citizens. c) Doctors: yes, efforts to establish full-time employment and salaries d) Hospitals: yes, efforts to establish public ownership or place hospitals under contract to public sector	Yes: although contracts with private facilities may substitue for direct public ownership	Yes: although contracts with private doctors may substitute for direct public employment

other self-employed groups were often added in the 1950s. The compulsory health insurance of the United States-- Medicaid and Medicare-- can be considered as a form of national health insurance. However, these programs are unusual in that they cover only the aged and those falling below an income limit. Today, the term "national" health insurance generally connotes "universal" programs that cover entire populations at all ages for medical care. To the extent that these government programs compel citizens to insure themselves, they cut into the available clientele for private insurance policies. Depending upon what types of health benefits are covered, the public programs determine how much scope there will be for supplemental, private insurance.

The increased government role as payor under national health insurance affects the relationship between governments and health care providers such as doctors, hospitals, and manufacturers of pharmaceuticals and medical technology. For once governments pay for medical services, they have an incentive to control the price and supply of these services. Depending on the financing of the program, however, this incentive will affect different actors. In the case of payroll taxes collected by an independent social security or health insurance administration, it is generally this administration-- which may be para-state-- that pressures political leaders to control the costs engendered by providers. One issue of intense political conflict has been doctors' fees. A common method for controlling doctors' fees has been the introduction of fee schedules-- lists of standard fees that are usually negotiated between representatives of the medical profession and government insurance agencies. Nevertheless, simply because the idea of controlling doctors' fees is bound to come up when governments pay for and administer public health insurance programs does not mean that regulation follows automatically. Separate political conflicts have been fought over, first, the decision to enact a national health insurance program to begin with, and second, the types of controls over doctors' fees that governments hope will reduce the costs of these programs. Depending upon how these conflicts have been resolved, and also on practices that existed prior to the enactment of these regulatory measures, national health insurance programs in different countries vary widely in the ways they affect doctors' fees. In the Federal Republic of Germany, for instance,

medical associations and public health insurance authorities negotiate a total lump sum that is then distributed to doctors according to the number and types of services they have performed within a given period. If doctors increase the number of services, then the fee they receive for each service is correspondingly decreased. This system is considered to be quite successful in containing costs for physician services.[38] In France on the other hand, the medical profession has vehemently opposed all attempts to "collectivize" payments to doctors in this manner. The profession has insisted that patients pay doctors directly. These patients are then reimbursed by national health insurance. Since 1970, a national fee schedule has been negotiated between the French medical association and national health insurance authorities. Not all physicians that treat publicly-insured patients are required to abide by this fee schedule. Thus, even though France and the Federal Republic both rely on national health insurance to finance medical care, the regulation in place for doctors' fees is rather different. These differences may be traced to the kinds of specific political conflicts discussed in the previous section. Analogous conflicts have taken place concerning government insurance payments for hospital treatments, and for drugs and technology. National health insurance, in sum, entails a greatly expanded role for government as the payor for medical care. This in turn creates pressures for government regulation of the price and availability of services. Nevertheless, the mode of regulation may vary from country to country. Finally, under national health insurance, governments do not directly provide these services themselves through government facilities or publicly-employed doctors. As in the case of mutual society legislation, if public facilities and publicly-employed doctors predate the legislation, national health insurance neither eliminates nor extends public ownership or employment; it merely creates financial incentives for governments to regulate public insurance payments to health facilities and doctors.

National Health Services

The national health service, the third type of program, is based on yet a different mode of intervention. Rather than subsidizing private insurance or introducing public insurance, governments directly provide medical care to all citizens through nationalized hospitals and

publicly-paid doctors. Fully "socialized" medicine might entail government ownership of all hospitals and doctors' offices, with full-time employment for doctors as government civil servants. This has been the thinking behind government-run health systems in Eastern Europe, the Soviet Union, China and Cuba.[39] Nowhere in Western Europe is this the case, however. Instead, many political conflicts have concerned the preferred mix of public and private health care provision within national health services. In other words, the idea of a national health service is that health care is fully provided through the public sector: through public financing, public facilities, and public doctors. However, in reality, some systems of publicly-financed health care rely on contracts with private facilities and with private doctors in order to provide these services.

The British National Health Service, which was introduced in 1948, is the most commonly cited example of this approach. According to William Beveridge, the direct provision of health services is more egalitarian than an insurance system, under which contributions establish an actuarially-earned right to the benefit. The British National Health Service embodies the ideal that social protection should be a right of citizenship and that these social benefits should be equally distributed regardless of one's ability to pay. Under this system, government tax revenues finance nearly all health expenditures, whether for visits to doctors' offices, for hospital treatments, or for pharmaceuticals. Patients do not pay for services at the time of treatment. To the extent that a central source must approve the total health budget, the budgetary process affords a powerful mechanism for containing costs, as health expenditures must compete with other government outlays. Whereas the British National Health Service relies on such budgetary centralization, other health services, such as the Swedish and the Italian, relegate greater spending authority to local governmental units, possibly accounting for why these health services are correspondingly more expensive than the British.

Under a national health service, the government becomes the dominant payor for health services, even though in practice pockets of private medicine remain. The government comes close to achieving a monopsony. This increases both the incentives and instruments for greater government regulation of health care consumers and providers. In comparison to either

mutual society legislation or national health insurance, a health service places greater obligations on patients and providers. Whereas some national health insurance systems allow for voluntary participation for citizens with incomes above certain limits (e.g., in Germany or the Netherlands), national health service taxes are usually obligatory. For those that chose to purchase a private insurance policy or attend a private clinic outside the national health service, these private payments are an extra cost over and above the health service taxes that have already been paid. The health service is viewed as a collective expense, not as an individual policy.

Direct government provision of services politicizes the relationship between doctors and government health authorities. Under national health insurance, doctors' fees might be regulated, or the insurance might cover only a standard fee with the patient left to pay the remainder. If governments rather than private patients or different public and private insurance carriers are to pay doctors, however, the employment conditions for doctors become the subject of more far-reaching regulation. One issue has been the time commitment of doctors to the public system. Should doctors be considered as government employees or as private contractors to the public system? Can the government demand a full-time commitment, or may doctors in public hospitals and public offices receive private patients as well? These questions of employment relations have provoked conflicts as well over the form of payment for doctors. Particularly as a consequence of widespread disputes over doctors' fees, many planners have argued that doctors should be paid a salary rather than on the customary fee-for-service basis. Similarly, as employers of doctors, governments become even more directly concerned with the availability of doctors, and often interfere with medical education. They have increased the number of doctors, and have attempted to steer physicians to choose some of the less popular areas of medical specialization and to practice in regions where there are shortages of doctors. Even in nations lacking a national health service, governments have come to be concerned with these issues. However, as these governments do not directly employ doctors, they encounter: a) less pressure to solve these problems, because they are not directly responsible

for the Nation's health system; and b) greater difficulties in solving them, because, as they are not the direct employers of doctors they cannot easily steer doctors to new regional locations. And this, precisely, is where "exit" comes in. If a doctors that works for a national health service is dissatisfied, then the possibility of private practice, either in a private hospital or a private office, makes a tremendous difference. The private market allows the doctors to leave the public sector entirely; or, more conveniently, to threaten to leave the public sector unless the grievance is redressed.

The national health service affects the relationship between governments and hospitals as well. In Britain, introduction of the national health service entailed a transfer of hospitals from private to public ownership. In other health services, like the Italian or the Spanish, the government provides health services through both public hospitals and private clinics under contract to the public system. Even in countries like France without a national health service, however, efforts have been made to integrate public hospitals and private clinics into a what they have called a "public health service" for planning purposes. The French idea is to include total health care resources and not just public sector resources in plans aimed at promoting a better distribution of hospital beds and medical technology. At the same time, the private clinics retain their independent status both legally and financially. This independence, and in particular, the different financing system for the private sector, has hampered this coordination effort, however.[40]

This aspect of the French case makes a point that bears repeating. Public financing, public regulation, public ownership, and public employment are four distinct aspects of a health care system. In the French case, the increased financial responsibility of government for health care, public ownership of hospitals, and political pressures on government to ensure citizens' access to high quality health care have influenced the development of a policy aimed at regulating the provision of both public and private hospital services. At the same time, because financing and ownership are not as centralized as they are in a national health service, increasing the regulatory capacity of government through planning policies is more difficult.

This brief overview has focused on the main public programs that aim to provide access to treatment to the general population. Governments also provide significant financing to the hospital sector, often by underwriting hospital deficits. This form of financing tends to be less visible to the public than a social program like national health insurance, but it is nevertheless a critical component of the extent of government involvement in the health sector. This participation of government in the hospital sector should be added to the analysis of financing, regulation, and ownership for any specific health system.

Regardless, under a national health service, this underwriting of the hospital sector is part of the concept of a national health service. In countries with mutual society or national health insurance legislation, on the other hand, this government financing of hospitals would tend to be carried out under separate auspices-- and generally through different parts of the bureaucracy-- than the insurance program. In fact, these "dual" payment systems tend to result in complicated payments between different branches of government, or between private insurers and government. Consequently, the role of government in financing is fragmented, and hence the power of government as a single or dominant payor is diluted. In turn, the regulatory capacity of government may be reduced. The role of government as an "owner"" becomes complicated because one may have private hospitals that receive such extensive public payments that the meaning of the word "private" is unclear. Similarly, to determine to what extent this form of ownership affects the role of government as an employer of doctors, one would need to look at a specific health system. In the Swedish case, for example, although most hospitals were publicly-owned by local units of government, hospital doctors were paid for outpatient care on a fee-for-service basis by national health insurance and private patients.

To reiterate, one fruitful dimension of comparison between health systems in various nations is the extent and type of government financing of the health system. A second dimension is the type of government regulation of the health sector, which this financing structure may encourage or facilitate. A third dimension is government ownership; a fourth,

government employment of doctors. These interconnected dimensions are the concrete policy consequences of the political debate about market and government. As far as their impact on the health sector is concerned, the dimensions of financing and, especially, regulation are particularly significant for what one could call the political "steering" or governance of the health sector. Indeed, current health policy researchers are beginning to concur that government ownership of health facilities or the size of the public sector is not especially critical as a variable. Not only are the lines between the public and the private sectors blurred, with the same doctors dividing their time between the two and with the same patient dividing his or her medical bill between public and private payors, but the consequences of public ownership per se do not by themselves appear significant. Instead, it is the ability of governments to regulate directly various parts of the health sector that is critical for planning, for the efficiency of the health sector in providing medical treatment to more persons at a given cost, and for overall health care costs.[41] Furthermore, this governmental regulation does not necessarily imply regulation by a "command-and-control" approach. In the Swedish case, the social democratic government used market incentives to re-adjust the balance between ambulatory and hospital care, and to pressure doctors to agree to changes in the payment system.

Conclusions

Systems of government subsidies to voluntary mutual funds, national health insurance, and national health services are not monoliths. These systems do not come ready-made; nor are they introduced at one in time as integrated wholes. Instead, these three forms of government financing are basic approaches to providing citizens with medical care that give us a first approximation about the extent of government intervention in the health system. The financing system provides incentives for further regulation of health care providers and, at the same time, the mode of financing may facilitate certain forms of regulation. Regardless, both the decisions to change the financial role of government in the health care sector and the subsequent decisions to increase government regulation have been the subject of extensive

political conflicts. In order to analyze the way in which any particular health system is organized one must look at the specific details of public financing, regulation, ownership, and employment. In order to understand the origins of these specific details, one must look into the specific political conflicts responsible for each law.

NOTES

1.Talcott Parsons The Social System (Glencoe, Illinois: Free Press, 1951), pp.428-79.

2.Eliot Freidson Profession of Medicine: A Study of the Sociology of Applied Knowledge (New York: Dodd, Mead & Company, 1970); Cf. J. Ben David, "Professions in the Class System of Present Day Societies," Current Sociology 12 (1963-4): 247-98; Everett C. Hughes, "Professions," Daedalus 92 (1963): 655-68; Harold Wilensky, "The Professionalization of Everyone?" American Journal of Sociology 70, no. 2 (September 1964): 137-158.

3.Jeffrey Berlant Profession and Monopoly (Berkeley: University of California Press, 1975); Sarfatti-Larson 1977; cf. Terence J. Johnson Professions and Power (London: Macmillan, 1972); on Adam Smith and the British medical profession see A.P. Carr-Saunders and P. A. Wilson The Professions (Oxford: Oxford University Press, 1933); on licensing as a barrier to competition Milton Friedman Capitalism and Freedom (Chicago: Chicago University Press, 1962), pp. 149-60.

4.Paul Starr The Social Transformation of American Medicine (NY: Basic Books, 1982)

5.Theodore R. Marmor and David Thomas, "Doctors, Politics and Pay Disputes: "Pressure Group Politics' Revisited," British Journal of Political Science 2 (October 1972): 436-437.

6.The definition of "liberal" used here is the standard European economic liberal tradition, as defined by writers like Adam Smith. However, it should be noted that these writers considered economic freedom to be the pre-condition for political freedom, as do contemporary economic liberals, e.g., Milton Friedman. Similarly, medical associations that promoted the "liberal" model of medicine, considered economic autonomy for doctors to be essential for achieving non-economic ends: therapeutic freedom; trust of the patient; freedom from bureaucracy; maintaining medicine as an interpretative art where treatment must follow the individual needs of the patient and not government directives; doctors' freedom over their own time. These issues have been touched upon in chapter one and will be returned to in more detail in the subsequent chapters. William A. Glaser discusses inclusion of economy autonomy in the World Medical Association's code of ethics, Paying the Doctor: Systems of Remuneration and their effects (Baltimore: Johns Hopkins Press, 1970), pp. 99-100; Odin Anderson discusses the medical profession's seemingly universal preference for fee-for-service payment, in opposition to planners that prefer salary in Health Care: Can There Be Equity? The United States, Sweden and England (New York: John Wiley, 1972), p. 196.

7.Hirschman's terms exit, voice and loyalty have been used to analyze the behavior of consumers vis-a-vis public health systems, particularly in the work of Rudolf Klein. In this book, rather than focusing on the ability of patients to exit from the public system, the focus is on the ability of doctors to exit. Furthermore, in contrast to the fear of "brain drain," which emphasizes the ability of doctors or other highly skilled professionals to exit from a particular country, exit to the private sector, or partial exit, which takes place for example when a publicly-employed physician treats a private patient in a public

hospital or, more abstractly, when a publicly-insured patient must pay a partial private fee directly to the doctor, is much more convenient for the doctor.

8.The possibility of pockets of private practice within public systems is actually caused by the economics of government health programs. By subsidizing the health sector, these governments increased the demand for health services. Yet by attempting to push prices below their equilibrium point, they created market pressures for increased supply of services. This provided an opportunity for the private sector.

9.Starr, Social Transformation. On professionalism in Europe see Matthew Ramsey, "The Politics of Professional Monopoly in Nineteenth-Century Medicine: the French Model and its Rivals," in Gerald Geison, ed., Professions and the French State, 1700-1900 (Philadelphia: University of Philadelphia Press, 1984), pp. 225-305.

10.Freidson Profession of Medicine, p. 25. Technical autonomy goes beyond the legal requirement of the license to the everyday acceptance that the individual doctor has the autonomy to make medical decisions free from the supervision of other occupations in the division of labor. In his extremely interesting book, The System of the Professions (Chicago: Chicago University Press, 1988), Andrew Abbott extends this concept by looking at how competing professions-- such as doctors, psychologists and social workers-- continue to fight battles over jurisdictional territory.

11.A second new dimension to professional politics concerned the development of specialty licensing in the early 20th century. As Rosemary Stevens has commented, "Whereas the theme of medical history of the nineteenth century was the integration of diverse skills into one medical profession, the theme of twentieth-century medical practice is a fragmentation within the profession," Medical Practice in Modern England: The Impact of Specialization and State medicine (New Haven, CT: Yale University Press, 1966) p. 3. Fragmentation according to market position is one line of cleavage; stratification according to functional specialty is a second and distinct cleavage that affected the internal structure of the profession. Neither one is a rep

12.See Alexander Morris Carr-Saunders and Paul Alexander Wilson, The Professions (Oxford: Oxford University Press, 1933); Deborah A. Stone, The Limits of Professional Power. (Chicago: University of Chicago Press, 1980); Monika Steffen, "The Medical Profession and the State in France," Journal of Public Policy, 7, 2, (1987): 189-208; Rudolf Braun, "Zur Professionalisierung des Ärztestandes in der Schweiz," in Jürgen Kocka, ed., Bildungsbürgertum im 19. Jahrhundert (Stuttgart: Klett-Cotta, 1985), pp. 332-357; Hans Berglind and Ulla Petersson, Omsorg som yrke eller omsorg on yrket (Stockholm: Sekretariatet för framtidsstudier, Trosa Tryckeri, 1980); Lakartidningen, 75, no. 2 (1986): 1986-2000.

13.For more in-depth discussion of these issues see my article, "Institutions, Veto Points, and Policy Results," Journal of Public Policy, Vol. 10, no. 4, (1991), and my forthcoming book, The Political Construction of Interests, Cambridge and New York: Cambridge University Press, 1992.

14.On Medical Act see Carr Saunders and Wilson, Professions, and Ramsey, Politics of Professional Monopoly. The Act provided for a general Medical Register that listed licensed practitioners. The Register was supervised a board that included the old licensing bodies, the Royal Colleges, who remained responsible for granting licensing. No license was required for medical practice; anyone could practice medicine. But only doctors licensed and listed in the General Medical Register could hold government positions.

15.Refer to essays in Giorgio Freddi and James Warner Björkman, Controlling Medical Professionals. The Comparative Politics of Health Governance (London: Sage Publications, 1989), particularly that of Marion Döhler, "Physicians' Professional Autonomy in the Welfare State: Endangered or Preserved?" pp. 178-197.

16.For a description of the attempt to block the first compulsory hospital insurance law through a doctors' strike and its failure, see C. David Naylor, Private Practice, Public Payment. Canadian Medicine and the Politics of Health Insurance, 1911-1966 (Kingston: McGill-Queen's University Press, 1986). There is no example of a strike being used to block legislation by a secure government that introduces national health insurance, or other new programs, or controls on doctors' fees, salaried practice, or restrictions on private medical practice. There are only two counter examples to my knowledge, and in each case there is a political factor that explains the weakness of the governments in imposing reforms on the medical profession. William Glaser, Paying the Doctor, pp. 134-6, discusses the success of the Belgian medical association in launching a strike against a government reform in the 1960s, but notes that the government coalition was falling apart; thus there was a political factor that allowed the strike to make an impact. Similarly, in the 1920s in Germany, a doctors' strike was successful in getting the government to address doctors' grievances against the sickness funds, but again, only for political reasons. The sickness funds were a Social Democratic domain, and politicians of the right and center wished to undermine this source of Social Democratic organizational power. See discussion in Bernd Rosewitz and Douglas Webber, Reformversuche und Reformblockaden in deutschen Gesundheitswesen (Frankfurt: Campus, 1990).

17.Federal Councillor Tschudi in 1962, cited in Gerhard Kocher, Verbandseinfluss auf die Gesetzgebung. Aerzteverbindung, Krankenkassenverbände und die Teilrevision 1964 des Kranken- und Unfallsversicherungsgesetzes, 2nd ed. (Bern: Francke Verlag, 1972), p. 17.

18.William A. Glaser, Social Systems and Medical Organization (NY: Lieber-Atherton, 1970) p. 35, cf. 32-5, 80.

19.P.H.J.H. Gosden, *The Friendly Societies in England 1815-1875* (Manchester: Manchester University Press, 1961), p. 1. Cf. Gösta Lindeberg, Den Svenska Sjukkasserörelsens Historia (Lund: Svenska Sjukkasseförbundet/Carl Bloms Boktryckeri, 1949). While many persons, both historians and members of the sickness fund movement have seen a relationship between guilds, unions and voluntary mutual associations, attempts to trace the origins of the funds and of the unions to guilds have not turned up sufficient records to prove a continuity.

20.J. Tempke, "Bismarck's Social Legislation: A Genuine Breakthrough?" in W.J. Mommsen (ed), *The Emergence of the Welfare State in Britain and Germany 1850-1950* (London: Croom Helm, 1981), pp. 71-83.

21.Stein Rokkan, "Dimensions of State Formation and Nation-Building," in Charles Tilly, ed., The Formation of National States in Western Europe (Princeton: Princeton University Press, 1974), pp. 562-600. The Rokkan model is used in this historical section as a convenient map for describing these developments, without necessarily adhering to the causal model he proposes.

22.The 1944 White Paper was produced under a coalition government. See Harry Eckstein, Pressure Group Politics: The Case of the British Medical Association (London: Allen & Unwin, 1960) and Rudolf Klein, The Politics of the National Health Service (London: Longman, 1983).

23.This coincides with the statistical findings of Peter Flora and Jens Alber, "Modernization, Democratization, and the Development of Welfare States in Western Europe," in Flora and Heidenheimer, eds., The Development of Welfare States in Europe and America (New Brunswick, NJ: Transaction Books, 1981) pp. 37-80; Social insurance is established earlier and expands more quickly in nations with conservative monarchies than under those with parliamentary democracies-- a legitimacy trade-off.

24.Sickness fund laws were enacted in: 1892 In Denmark; 1891 in Sweden; 1911 in Switzerland; 1894 in Belgium; 1852 in France; 1886 in Italy. See Flora and Alber, "Modernization, Democratization, and the Development of Welfare States." Different sources sometimes give contradictory dates, because the content of the laws varies and in many countries a series of sickness fund laws were passed. Some of the earliest laws provide only provisions for government registration of funds but no subsidies.

25.J.M. Baernreither, *English Associations of Working Men* (London: Swann Sonnenschein & co., 1889, republished by Gale Research Company, Detroit, 1966), p. 300. Courts held that embezzlement from unregistered societies was not punishable by law.

26.Gosden, Friendly Societies in England, p. 9.

27.Gosden, Friendly Societies in England, p. 156.

28.J. Reulecke, "English Social Policy around the Middle of the Nineteenth Century as seen by German Social Reformers," in W.J. Mommsen, ed., *The Emergence of the Welfare State in Britain and Germany 1850-1950* (London: Croom Helm, 1981), pp. 32-49; Sidney and Beatrice Webb *The History of Trade Unionism* (NY: Augustus M. Kelley, 1965 [1894]), pp. 261 ff. especially, also 19-25; Baernreither, *English Associations of Working Men*; Henry Pelling, *A History of British Trade Unionism, Fourth Ed* (London: Macmillan, 1987)p. 11, pp. 62 ff. Gosden, *Friendly Societies in England;* Bentley B. Gilbert, *The Evolution of National Insurance in Great Britain. The Origins of the Welfare State* (London: Michael Joseph, 1966).

29.Gosden Friendly Societies in England, pp. 177-8.

30.The fact that the Socialist government of François Mitterand took the immediate step of restoring free elections in the social security funds seems a continuation of this historic pattern, analogous to the legalization of the mutuals in 1848.

31.Detlev Zöllner, "Germany," in Peter A. Köhler and Hans F. Zacher, eds., The Evolution of Social Insurance, 1881-1981. Studies of Germany, France, Great Britain, Austria and Switzerland (London: Frances Pinter, NY: St. Martin's Press, 1981), p. 17; Cf. Gaston V. Rimlinger, Welfare Policy and Industrialization in Europe, America and Russia (NY: John Wiley & Sons, 1971), pp. 102-122.

32.Arnold J. Heidenheimer, "Unions and Welfare State Development in Britain and Germany: An Interpretation of Metamorphoses in the Period 1910-1950," International Institute for Comparative Social Research Discussion Paper, no. IIVG/dp/80-209 (Berlin: IIVG, SP-II, Wissenschaftszentrum Berlin, 1980); see also Rimlinger, Welfare Policy and Industrialization.

33.Bo Rothstein, "Unemployment Insurance and Labor Market Control," in Sven Steinmo and Kathleen Thelan, Historical Institutionalism (NY: Cambridge University Press, forthcoming).

34.Abram De Swaan, In Care of the State, Health Care, Education and Welfare in Europe and the USA in the Modern Era (Oxford: Polity Press/Basil Blackwell, 1988) regrets the lack of scholarly work on the early history of Dutch social insurance and the mutualist movement. His account re-caps only events from 1913 on. On Belgium see William A. Glaser Health Insurance Bargaining: Foreign Lessons for Americans (NY: Gardener Press, 1978), pp. 57-8; On the Netherlands, ibid., p. 81; and de Swaan, op. cit., pp. 210-214; on the Dutch system of representation, the classic work is Arend Lijphart, The Politics of Accommodation: Pluralism and Democracy in the Netherlands (New Haven: Yale University Press, 1968). On current health policy in the Netherlands, see Nico Baakman et al., "Controlling Dutch Health Care," in Freddi and Björckman, Controlling Medical Professionals, pp. 99-115.

35.On Italy, See Maurizio Ferrera, "Italy," in Peter Flora, Growth to Limits. The Western European Welfare States Since World War II. Vol. 2. Germany, United Kingdom, Ireland, Italy. European University Institute. Series C. Political and Social Science. 6.2 (Berlin, New York: Walter de Gruyter, 1986), pp. 385-482, and his "The Politics of Health Reform: Origins and Peformance of the Italian Health Service in Comparative Perpsective" in Freddi and Björckman, Controlling Medical Professionals,. On Spain, Josep A. Rodríguez and Jesús de Miguel, "Del Poder de la Corporación: El Caso de la Profesión Médica Española," in Manuel Pérez Yruela and Salvador Giner, La Sociedad Corporativa (Barcelona: Ariel, 1988), pp. 229-271.

36.Details about the politics of enacting national health insurance in Canada can be found in my paper, "The Politics of Collective Choice: Current Health Reforms in Canada, the Netherlands, West Germany, France, Sweden, Britain, and Italy," Instituto Juan March Working Paper, no. 1990/5, Madrid: Instituto Juan March de Estudios e Investigaciones, 1990.

37.Odin W. Anderson, Health Care: Can There Be Equity? The United States, Sweden and England (New York: John Wiley and Sons, 1972); Glaser, Paying the Doctor; Mark G. Field, Success and Crisis in National Health Systems: A comparative approach (New York: Routledge, 1989).

38.Jens Alber, "Die Gesundheitssysteme der OECD-Länder im Vergleich," Staatstätigkeit, Politische Vierteljahresschrift, Special Issue 19, (1988): 116-150.

39.Mark G. Field, Doctor and Patient in Soviet Russia (Cambridge, MA: Harvard University Press, 1958); Milton Roemer, Comparative National Policies on Health Care. (New York: Marcel Dekker, 1977).

40.Ministère de la Santé publique et de la Sécurité sociale. Pour une politique de la Santé. Rapports présentées à Robert Boulin. Tome III. L'hôpital. Présenté par M. Roger Grégoire, Conseilleur d'État (Paris: Documentation Française, 1971); Jean de Kervasdoué, "La Politique de l'Etat en Matière d'Hospitalisation Privée, 1962-1978," Annales Economiques 16 (1980): 23-57; Paul Godt, "Health Care: the Political Economy of Social Policy," in Godt, ed., Policy-Making in France (London and NY: Pinter Publishers, 1989), pp. 191-207.

41.As J. Rogers Hollingsworth, Jerald Hage and Robert A. Hanneman, State Intervention in Medical Care: Consequences for Britain, France, Sweden and the United States, 1890-1970 (Ithaca: Cornell University Press, 1990) have pointed out, the results of public ownership of the health care sector are quite distinct from the results of government regulation of prices and personnel. If one is interested in the "social efficiency" of health care programs, as they call it-- i.e., the delivery of the greatest improvement in mortality to the largest number at the lowest cost-- they argue that one should focus on the regulatory aspects of government rather than the expansion of public ownership and provision of services.