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## Institutions, Veto Points, and Policy Results: A Comparative Analysis of Health Care\*

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### ABSTRACT

The medical profession is reputed to control decision-making in medical care to such an extent that one can speak of professional dominance. Yet West European health policies have radically changed the working conditions and incomes of doctors in many countries. Why have some governments been able to 'socialize' medicine? This article seeks to refute the view that the medical profession exercises a universal veto power. In contrast to scholars who explain medical influence in terms of singular characteristics of the medical profession or through the historical process of professionalization, this essay focuses on the properties of distinct political systems that make them vulnerable to medical influence. It argues that we have veto *points* within political systems and not veto *groups* within societies. By comparing the lobbying efforts of medical associations in Switzerland, France, and Sweden, the article analyses the role of political institutions in accounting for different patterns of medical association influence on health policy.

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What makes a political system vulnerable to interest groups? In many areas of policy-making, certain groups seem able to control political decision-making – or at least to set up a kind of impassable barrier, a limit beyond which politics may not reach. For many years, a prevailing view has been that the medical profession is one such group, and in many countries – but not all – the wishes of the organized leadership of this profession have constituted an important standard for judging health policies.

But the case of national health insurance poses a puzzle. National health insurance programs engender an inherent conflict of interest

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between governments and doctors. While such programs expand the market for medical care by using collective resources to purchase medical services for persons who could not otherwise afford them, these programs also create fiscal pressures for government regulation of medical fees. Not surprisingly, medical professionals in a number of nations have opposed not only regulatory measures, such as government controls on doctors' fees, but even the introduction of national health insurance programs in the first place. Medical professions have viewed government insurance programs and the increased government regulation that is sure to follow as a threat to professional autonomy. Nevertheless, despite the reputation of the medical profession as an insurmountable political veto group, some European governments have overcome professional opposition to introduce both national health insurance programs and substantial restrictions on the economic activities of physicians. In other nations, by contrast, medical protests have blocked government efforts to introduce national health insurance as well as controls on doctors' fees. Given that medical associations throughout Western Europe possess a legal monopoly of medical practice and are regarded as highly influential politically, how then can one explain the significant variation in West European health policy?

This article investigates a series of reforms in Switzerland, France, and Sweden that established their national health insurance programs, and in the process redrew the boundaries between the public and the private sectors. The cases were chosen because these health systems represent different approaches to government provision of health services. The role of the Swiss national government is the most limited: it subsidizes voluntary, private health insurance carried by mutual aid societies. The French government has established national health insurance, that is, compulsory public insurance for nearly the entire population. In addition, the government limits doctors' fees through negotiated fee schedules. The Swedish government has developed a *de facto* national health service in which the vast majority of doctors work as salaried employees of the government in public hospitals, while national health insurance remains in place to finance a small portion of ambulatory services. Despite contemporary differences, as late as 1929 government health insurance programs in all three nations were limited to government subsidies to voluntary health insurance carried by mutual associations. The outcome of legislative battles over national health insurance, controls on doctors' fees, and salaried employment for doctors caused the subsequent policy divergence. Politicians in all three countries proposed similar changes. Yet by 1970 Swiss politicians remained unsuccessful in their many efforts to enact national health insurance; French politicians had introduced both national health

insurance and controls on doctors' fees; and Swedish politicians introduced national health insurance, fee regulations, and in 1969 placed all hospital doctors on salary, eliminating their right to practice privately.

Swiss, French, and Swedish doctors objected to these reform proposals. Elite private practitioners in each country considered the expansion of government in the health insurance area as a threat to their economic autonomy. These doctors viewed economic freedom as the pre-condition for professional freedom. They wished to preserve the status of physicians as independent practitioners and to avoid complete financial dependence on governmental authorities. The ability of these physicians to impose their views on policy-makers, however, differed radically.

### *Professional Power*

In considering the veto potential of a particular interest group, one should note that the concept of interest group power itself raises some questions. Why should it be possible for members of a group like the medical profession, who, after all, constitute only a very small minority of voters, to influence the decisions of politicians? Would one not expect that politicians who need to attract broad constituencies would respond more strongly to demands from organized groups with large memberships, such as for example unions, than to those of groups with only marginal impacts on elections?

Theories of professional power suggest some reasons why the medical profession might claim a series of privileges from governments, despite their numerical minority. Without extensively reviewing the many different theories of professional power, which has been carried out elsewhere (Abbott 1988; Freidson 1970; Freddi and Björkman 1989; Light and Levine 1988; Ramsay 1984; Sarfatti-Larson 1977; Starr 1982; Stone 1980), one can point to a few key features that are stressed by most accounts. Historical studies of the development of professional power have detailed the processes by which the medical profession established medicine as a distinct sphere of technical expertise, and went on to achieve legal recognition for exclusive training routes and limitations on the right of practice to those holding medical licenses, (Freidson 1970; Starr 1982; Sarfatti-Larson 1977). Other scholars have focused on the narrower economic consequences of the market scarcity produced by these legal barriers to entry. Licensing arrangements limit the number of physicians, and are therefore thought to raise the market value of medical services and to increase the strike potential of the profession, (Berlant 1975; Sarfatti-Larson 1977; Marmor and Thomas 1972).

While it seems reasonable to assume that, as the only persons quali-

fied to carry out medical treatment, physicians should be able to bargain quite successfully for their conditions of practice under government health insurance programs, the above factors do not explain the empirical differences in the influence of physicians' associations on legislative decisions. Although the process of professionalization in Sweden, France, and Switzerland took different paths, by the outset of the twentieth century, each of these medical professions had achieved a legal monopoly of medical practice. In Sweden and France, government bureaucracies were established in 1663 and 1892, respectively, to issue medical licenses and to supervise medical education, (Garpenby 1989; Steffen 1987). In Switzerland, on the other hand, the federal political structure and liberal political ideology delayed national licensing and education restrictions until the 1920s, (Braun 1985; Gebert 1976; Ramsey 1984). Consequently, the numbers of physicians were more stringently controlled in Sweden and France than in Switzerland. In addition, alternate therapies, such as homeopathy and folk medicine, as well as the rights of other medical personnel to prescribe medical treatment (for example pharmacists) were more effectively curtailed in Sweden and France, than in Switzerland. Thus, while professionalization took a 'state-led' path in Sweden and France, professional barriers to entry were more tightly controlled than in Switzerland. Indeed, in terms of market scarcity, the Swedish medical profession was the most advantageously placed of the three, with 1,120 inhabitants per doctor in 1959, as compared to 940 in France and 710 in Switzerland, (Hogarth 1963; cf. Table 1). Nevertheless, although French and (especially) Swedish doctors were more successful than Swiss doctors in establishing legal monopoly on practice and market scarcity – two standard characteristics of professionalization – it was not the Swiss doctors that were the least successful as a political lobby group, it was the Swedish.

In organizational terms, on the other hand, the French medical profession should have been the weakest. The most *generous* estimates place 40% to 60% of the profession as members of medical unions, as opposed to well over 90% in Sweden and Switzerland, (Glaser 1970; Kocher 1972; *Läkartidningen* 1978: 1986–2000; Mane 1962; Savatier 1962; Stephan 1978: 38–9; Wilsford 1986). Moreover, whereas Swedish and Swiss doctors were organized into single medical associations, French doctors were represented by competing organizations beset by political differences. Again however, it was not the French doctors that were the least successful in the political sphere, it was the Swedish. Finally, as far as strikes were concerned, the cases will show that the political victories of physicians' associations were never linked to strikes. Politically influential physicians' associations did not need to resort to strikes. In sum, once we restrict the field of inquiry from the social status of physi-

TABLE I. *Medical Professions Compared*

<i>Doctors per 100,000 Population</i>			
Year	Sweden	France	Switzerland
1958:	89.2	106.7	140.6
1975	171.5	146.3	185.8
<i>Membership in Medical Association</i>			
1930:	76%	63%	—
1970:	92.2%	60-65%	97%
<i>Doctors in Parliament</i>			
Sweden (1960): .....	1%	Belgium (1974): .....	4.3%
France (1973): .....	12.2%	Britain (1974): .....	1.5%
Switzerland (1971): .....	3%	USA: .....	1.5%
Italy (1976): .....	4.7%		

Sources:

Number of doctors: Hogarth 1963: 60, 139, 281; Maxwell 1981: 148-9, 130-1, 151-2.  
 Memberships: *Läkartidningen*, 19 April 1930, p. 516. Meynaud 1958: 66; Stephen 1978: 38-9; Kocher 1972: 25; Swedish Medical Association membership figures  
 Parliamentarians: Sköld and Halvarson 1966: 444, 465; Kerr 1981: 280.

cians to the influence of doctors on legislative outcomes, standard approaches to professional power do not account for differences in the ability of national medical professions to defend their economic autonomy against government intervention.

*Institutions and Veto Points*

In order to explain why a minority can sometimes veto policy proposals, the balance of this essay argues that one should turn from the particular resources of the minority group to the specific characteristics of democratic political institutions. As many scholars have pointed out, it is difficult to obtain majority votes for new policy proposals. For almost any proposal that can garner a majority of votes within a particular political arena, an alternate proposal can be found that will attract an equally large number of votes. It is particularly difficult to draft a proposal that can prevail over the previous *status quo*, (Shepsle 1986). Aside from the inherent problems of majority rule, national political institutions have often been designed in such a way as to impede extreme factions (often popular ones) from introducing radical political changes, (Hammond and Miller 1987). For example, historically, the division of legislatures into two chambers, with different property qualifications or constituency sizes, established an upper house whose members could be counted on to exert a moderating influence by vetoing proposals from the lower house. Political institutions ensure stability in policy outcomes

and institutional arrangements through mechanisms that allow a core of political representatives to veto legislative proposals.

By envisioning political systems as sets of interconnected arenas and examining the rules of representation within each, one can predict where such 'veto points' are likely to arise. Political decisions require agreement at several points along a chain of decisions made in different arenas. The fate of legislative proposals, such as those for national health insurance, depends upon the number and location of opportunities for veto along this chain. The ability of interest groups to influence such legislative outcomes depends upon their access to the political representatives situated at the 'weak links' or veto points in this chain.

In contrast to the American analysis of institutions, which often assumes that the executive brakes change, while legislators or voters promote changes (Hammond and Miller 1987), in the European cases examined here, the political executive was prepared to promote policy changes, while vetoes were made in subsequent arenas. National health insurance legislation was prepared in the executive bureaucracy, after consultation with representatives of interest groups and political parties. The critical difference between the cases turned on the ability of the political executive to ratify these proposals in other arenas. Where the executive government rested on a secure parliamentary majority, and where party discipline was in force, the probability that an executive decision would be overturned by parliamentary representatives was extremely low. Under these circumstances, the political executive was directly related to the partisan composition of the parliament, and one could not expect the majority of MPs (who belonged to the same political party as the executive) to deviate from the executive decision. Thus, the executive could take decisions without fearing parliamentary vetoes, and, consequently, the executive could be considered independent from the parliament. This was the case in Sweden. The Social Democratic executive could rely on representatives in both houses of the parliament to confirm its decisions, because it had obtained electoral majorities in each house. As illustrated in Table 2, this type of system lacked veto points. Further, because executive decisions could not be vetoed elsewhere, political negotiation tended to be contained within the executive arena. This of course privileged groups with executive access, while it disadvantaged those with better contacts or greater sympathy in the parliamentary or electoral arenas.

If, on the other hand, the executive government did not enjoy a stable parliamentary majority, the probability that parliamentary representatives would override executive decisions was much greater. In such a situation, one would expect significant policy changes and even vetoes from parliamentary representatives. This was the case in France. Lack-

TABLE II. *Political Arenas and Veto Points*

ARENAS	MOVES	RESULTS
<div style="border: 1px solid black; border-radius: 50%; padding: 5px; display: inline-block;">Executive</div>	<div style="text-align: center;">↓</div>	<p>Can Members of Parliament Overturn Executive Decision? (Stable Parliamentary Majority? Party Discipline?) → If Yes, then Veto Point</p> <p>→ If No, then Veto Point</p>
<div style="border: 1px solid black; border-radius: 50%; padding: 5px; display: inline-block;">Legislative</div>	<div style="text-align: center;">↓</div>	<p>Can Members of the Electorate Overturn Parliamentary Decisions (Shifting Voters? Referendum?) → If Yes, then Veto Point</p> <p>→ If Yes, then Veto Point</p>
<div style="border: 1px solid black; border-radius: 50%; padding: 5px; display: inline-block;">Electoral</div>		

ing stable parliamentary majorities, the executive was dependent upon approval of policy proposals by the parliament. This veto potential within the parliament made the parliamentary arena a critical decision point in France. Consequently, interest groups with parliamentary contacts had greater influence in France than in Sweden.

In Switzerland, the referendum afforded an unusual opportunity for vetoes in the electoral arena. Even when decisions had been made in the executive and approved in the parliament, a referendum campaign could force issues into the electoral arena. As we will see, interest groups played a key role in calling for referenda, which afforded them an unusual route of political influence. In addition, electoral behavior had some unintended consequences for the development of Swiss health care policy.

In this way, formal constitutional rules and electoral results establish a framework within which policy-making takes place. The key variable is the independence of the political executive from vetoes at subsequent points in the chain of decision. These vetoes do not appear randomly. They can be predicted from the partisan composition of these different arenas and from the rules for transferring decision-making from one arena to the next. From this perspective, interest group ‘power’ is not a property possessed by interest groups by virtue of some characteristic like the number of members they enroll, or the money they collect. Nor, are political institutions (the ‘receiving’ end of political pressure) con-



stantly either open or closed to political influence. Instead, veto opportunities arising from the design of political institutions (combined with current electoral results) explain both interest group influence and the effects of political institutions on policy results. As Harry Eckstein argued some time ago, medical influence, or the influence of any other interest group for that matter, is contingent upon the 'structure of the decision-making processes which pressure groups seek to influence,' (1960: 16; cf. Klein 1979: 484; Glaser 1970; Heidenheimer 1980; Stone 1980). The presence or absence of veto opportunities is a critical aspect of these decision structures. In order to block legislation, interest groups like the medical profession must locate blocks of votes that can overturn executive decisions and persuade those political representatives or voters to do so. In this way, the veto points encourage particular types of interest group behavior. Consequently, in any particular country, successful strategies of medical influence will not appear as uniquely 'professional'; rather, medical lobby efforts will resemble those of other sorts of pressure groups in the same nation. Of course, aware of their consequences, different social groups and government actors struggle to shift the arenas of policy-making and the rules of representation to their own advantage, (Tocqueville 1958 [1856]; Schattschneider 1960; Lipsky 1968). Because these arenas may contain different distributions of representatives with different preferences or with loyalties to different constituencies, the ability to force a decision from one arena to another may significantly alter the policy deliberations and their outcome. Over time, struggles amongst interest groups and other political actors establish characteristic patterns of decision-making, such that policy-making follows different 'rules of the game' or political 'logics' in different nations, (Scharpf 1989; Ashford 1986). In Sweden, the executive could enact legislation without fearing vetoes from the parliamentary or electoral arenas; the lack of a block of opposing votes restricted decision-making to the executive arena. In France, unstable parliamentary majorities shifted decision-making to the parliamentary arena. In Switzerland, decision-making was moved to the electoral arena. The result was three distinct patterns of political behavior and policy results.

### *Three Cases*

#### *Direct Parliamentary Rule*

During the French Fourth Republic, French doctors, as well as several other interest groups were able to gain concessions from the legislature. The French parliament constituted a veto point for several reasons. First and foremost, the French executive government, while designed to be

constitutionally dependent upon the parliament, was, in practice, not based on stable parliamentary majorities. The fragmented party system and the lack of internal party discipline made it difficult to form and to maintain decisive parliamentary majorities. Furthermore, the disjuncture between parliamentary majorities and electoral alliances (related to the two rounds of voting, which kept the smaller parties alive and hampered majorities), meant that a single election result could provide the basis for a wide variety of parliamentary coalitions, further increasing the scope for parliamentary manoeuvring. Thus, while the ideal view of a parliamentary system is that elections establish a distribution of parliamentary seats, and that this distribution is then used to invest an executive, in France, these different political arenas – the electoral arena, the parliamentary arena, and the executive arena – were disarticulated, (MacRae 1967; Duverger 1976; Ehrmann 1976: 298–9). Consequently, any political party or interest group dissatisfied with an executive decision could hope to achieve a different outcome in the parliamentary arena. Furthermore, given the instability of the governing coalitions, renewed discussion in the parliamentary arena might produce not only a change in policy, but it might cause the government to fall. This instability made the executive government vulnerable to members of political parties – particularly those that controlled swing votes in building or breaking a governing coalition – or to interest groups that could claim connections to these MPs. Under conditions of unstable governing coalitions and weak party discipline, where at any moment majorities could unravel or new allegiances could form, the political game became one of disrupting the coalition.

This potential to disrupt the governing coalition was the key to interest group power in the French Fourth Republic. Interest groups aimed their appeals at individual members of parliament, particularly during the handling of policy issues in the parliamentary committees and during local election campaigns, when individual candidates were pressured to declare their allegiance to specific local interest groups, (Ehrmann 1976: 194, 196–7). Success depended upon reaching these individuals rather than upon building centralized interest organizations with large memberships. This strategic context changed the probability that a particular interest group could veto proposed legislation. Consequently, interest groups with access to members of parliament had no reason to be disposed towards cooperation. The medical profession, for example, was highly overrepresented in Parliament, and with doctors spread through several of the parties needed to build governing coalitions, the profession enjoyed the privileges that accrue to swing voters. In the Fourth Republic, physicians and pharmacists together held 5.8% of the seats. More importantly, they constituted 10.5% of the Radicals, 6.9%

of the MRP and 6.5% of the SFIO, (Birnbaum 1977: 50, 71, refer to Table One). Personalized bargaining, without the protection of party discipline, only enhanced this power. Several other interest blocks, such as farmers, small employers, and rather specific groups, such as wine producers, wielded parliamentary clout out of proportion to the number of voters represented by their memberships. With the power to block parliamentary action, and with the parties always seeking to capture new voters, these groups were in a position not only to make demands, but also to escalate these demands at will.

At several unusual Constitutional junctures, however, this parliamentary stalemate was broken by direct action on the part of the executive government. Specific constitutional protections of the Liberation period and the Fifth Republic prevented the overturning of executive decisions by parliamentary representatives. When members of parliament could no longer override the executive, the instability of the parliamentary majority no longer mattered; the veto point was no longer relevant. Consequently, the locus of decision-making shifted from the parliament to the executive, and one witnessed a corresponding change in the dynamics of policy-making. The groups who had been under little pressure to compromise when they could threaten to withdraw parliamentary support from the government were suddenly excluded from executive decisions.

French Social Security was introduced in precisely such an extraordinary period. The executive could issue legislation directly by Ordinance, the parliament was merely consultative, and it was composed, in any case, overwhelmingly of representatives of the resistance coalition. Based on the economic and social program drawn up by the *Conseil National de la Résistance* in the Spring of 1944, the Social Security Ordinances were promulgated directly by the executive on the 4th and 9th October 1945. Despite opposition from employers, the old mutual societies, and private insurance companies, the executive government was able to establish a universal social insurance system that covered all salaried employees for health, old-age, and work accidents. The plan was to establish a single type of insurance fund, called the '*caisse unique*', that would, eventually, cover all French citizens for all risks. The Ordinances extended social insurance coverage to the majority of the working population and greatly improved insurance benefits, (Laroque 1971).

Almost from the start, however, political pressures forced concessions that weakened the administration's scheme. Particularly with the return to parliamentary democracy, interest group bargaining and parliamentary competition increased, opening up opportunities for an onslaught of particularistic claims. The medical profession blocked regulation of doc-

tors' fees by the Ministers of Health, Finances, and Labor, insisting instead on local negotiations between social insurance funds and medical associations. The Catholic Trade Union and the Catholic left party (MRP) forced the government to remove family allowances from the general social security scheme and to introduce free elections for the seats on the governing boards of the social security funds. White-collar employees and the self-employed protested their inclusion in the same insurance scheme as workers, thereby putting an end to the movement for universal coverage under a single scheme, (Galant 1955).

These concessions to special interests created problems that plagued the social security system for the next twenty years. The use of negotiations to regulate doctors' fees did not work; the plethora of special schemes weakened the social security administration; and competition between various unions turned the social security elections into arenas of political competition that hampered unified leadership of the funds.

Although doctors' fees were to be regulated through negotiations between local medical associations and local sickness insurance funds, the medical associations simply refused to negotiate. Consequently, patients did not receive full reimbursement for the costs of medical treatment. In response, the social insurance funds attempted to push for legislation. But elite physicians were well-placed to veto parliamentary initiatives. Visits by the organization of insurance funds (the FNOSS) to the main parliamentary groups resulted in many bills, but no party dared to oppose the medical profession by actually depositing the bill in the Assembly, (Hatzfeld 1963: 78–103; *Revue de la Sécurité Sociale*, March 1957: 9–12; Interview, Clément Michel, ex-director of the FNOSS, 7 June 1984). With unstable governing coalitions, a solid block of deputies, spread through several parties that were regularly included in the government, was in a pivotal position.

The Fourth Republic was equally blocked in the area of hospital reform. Plans for more efficient hospital administration had been submitted to the National Assembly in 1954 and 1957. Hospitals should be freed from local political control by municipal councils and majors; instead professional administrators and prefects should play a stronger role. In the name of efficiency, the reports argued that doctors should no longer divide their time between a number of activities including private clinics and public hospitals, but should work in full-time hospital positions, (Imbert 1958). As in the case of doctors' fees, however, parliamentary stalemate had precluded any action.

With the emergence of the Fifth Republic, however, the rules of the game were radically changed. Under the 1958 Constitution, the executive government was effectively freed from the Parliament. Direct election of the executive, greater possibilities for direct executive legislation

by decree without parliamentary approval, and a strict separation between the Ministries and the Assembly, established an independent executive government, one that would no longer be undermined by the lack of stable parliamentary majorities. This transformed the logic of French policy-making.

Within two years of taking office, the de Gaulle government enacted reforms that completely re-organized the hospital system and imposed a new system of fee controls on the medical profession. All of these reforms were enacted by decree or ordinance, with no parliamentary discussion whatsoever. The first of these, the *réforme Debré*, introduced full-time, salaried hospital practice. As a transitional measure, senior doctors would be able to receive a limited amount of private patients within the public hospitals, but this private practice was to be phased out completely, (Jamous 1969). Doctors' fees would be directly regulated by the government. In order to pressure local medical associations to negotiate official fee schedules, individual doctors would be able to sign contracts with the funds. The patients of these doctors would be reimbursed at more favorable rates than doctors that did not sign contracts. These individual contracts had been demanded by the sickness funds since 1928, but had always been blocked by the French Medical Association. Now, French Medical Association control over the fee schedules was undercut by allowing individual doctors to decide whether or not to sign; the government had added an element of market competition in order to buttress its new institutional framework. In addition, the Ministers of Labor, Health, and Finance would set maximum fees that would apply in the event that no fee schedules were negotiated.

The French Medical Association protested the government's 'politics of *fait accompli*', and charged that as a result of the decrees, 'medical fees will become an affair of the State, and, at the same time, the profession will cease, in our point of view to be a liberal profession, because it will lose, definitively, its economic independence', (Archives 1960: SAN 7515, 24 February 1960). French doctors fought these measures in the courts, the parliament and the market, but without success. The Constitutional Council upheld the *réforme Debré* in January 1960. In the legislature, an absolute majority in the Senate (155 senators belonging to the Independents, the *Gauche Démocratique*, the Peasants or that were unaffiliated, as well as three former Ministers of Health) and an absolute majority in the National Assembly (241 deputies, including about one-half of the Gaullist UNR deputies) presented propositions for new laws to regulate regulations between the medical profession and the social insurance funds, (*Le Monde*, 19 May 1960, 21 May 1960; Doublet 1971: 41). Nevertheless, now independent from the parliament, the executive held firm and refused to reconsider the decrees.

Escape to the market arena proved equally unsuccessful. Pressured by

the Medical Union of the Seine, the French Medical Association launched an administrative strike to block the reform. But this time, in contrast to earlier efforts, the government had succeeded in dividing the profession. The individual contracts allowed the many doctors who would benefit from the system to bypass the medical association leadership. Within a few months the strike was broken. The rift between doctors who were for and against the fee schedules continued to deepen, however. When the French Medical Association signed an agreement with the social security funds in July 1960, the economic liberal faction split off, forming the *Fédération des Médecins de France*.

In the French case, the parliamentary veto point enabled a select set of interest groups to exert legislative pressure through their access to the parliament. Once the executive government was able to circumvent the parliament, however, reforms were passed despite the protests of these traditional veto groups.

### *Direct Democracy*

Swiss political institutions were designed differently from French institutions and had different effects on policy-making. A series of institutional mechanisms restricted the powers of the national government. The jurisdiction of the Federal as opposed to the cantonal governments was limited to areas specifically set forth in the constitution; a constitutional amendment was required to enlarge the scope of the Federal government. The political executive was composed of a seven member council, the *Bundesrat*, which divided power amongst representatives elected by the parliament in proportion to the political parties. The legislative branch was divided into two chambers, one elected by proportional representation, and one elected by the cantons, which would be expected to dampen the effects of proportional representation as the more conservative rural cantons would be overrepresented in the first chamber. Finally, all legislation was subject to direct electoral veto through the referendum.

While all of these provisions slowed policy-making, it was in practice the referendum that constituted the critical veto point. Proponents of national health insurance successfully launched a popular initiative to revise the constitution to allow the Federal government to legislate national health insurance in 1890. At several points, both before and after the second world war, agreement was reached amongst the parties represented in the executive *Bundesrat*, and national health insurance legislation was enacted into law by both chambers of parliament. Nevertheless, national health insurance was subsequently vetoed through referendum challenges.

The referendum had a dual impact on Swiss policy-making. The

referendum effectively moved decision-making from the executive and parliamentary arenas into the electoral arena. In referendum votes, Swiss voters did not follow partisan loyalties. In fact, statistically, referendum votes were more often negative than positive (Aubert 1978: 46, 48–9). These votes followed the predictions of theories of collective action: voters that were affected by the potential costs of legislation turned out at higher rates than voters affected by potential benefits. Furthermore, recent studies of Swiss referenda show voter participation, which averages 40%, to be correlated to socio-economic status, with higher rates of participation for individuals with higher incomes and higher levels of educational attainment (GFS 1988). Precisely these voters, however, were least likely to benefit from national health insurance or other forms of social protection.

The unintended consequences of the referendum go beyond specific instances of defeat, however. Swiss policy-makers were loath to see legislation subject to a referendum challenge after a lengthy process of executive and parliamentary deliberation. Not only was the outcome uncertain, but the chances of failure were greater than those of success. In order to avoid such defeats, they attempted to ensure that legislation was 'referendum-proof.' Ironically, this placed a great deal of power in the hands of interest groups, (Hughes 1962; Aubert 1978; Maurer 1982). Interest groups had sufficient memberships to collect the signatures necessary to launch referenda and the organizational resources to mount referendum campaigns. Although these groups could not control the *outcome* of referendum votes, they *could* control whether or not a referendum was called. Furthermore, whereas the general public did not have a clear channel for expressing its views on legislation, interest groups presented policy-makers with very specific demands to which they could respond. Hence the most efficacious means for policy-makers to prevent a possible veto of legislation was to address interest group concerns early on in the legislative preparations: 'the most successful referendums are those which do not take place. The circles which might have fought the law do not do so because it contains what they want. This is the explanation for the compromise character of a large part of federal legislation; parliament does not make laws in a sovereign way but always under the threat of a referendum,' (Aubert 1978: 48–9).

The ability of interest groups to force issue out of executive and parliamentary arenas and into the electoral arena provided groups with a great deal of leverage over health care policy-making. Even at the executive and parliamentary stages, politicians were forced to consider carefully the views of interest groups. Because even rather narrow interest groups could rely on the referendum weapon, access to policy-making was opened up to a variety of smaller groups. Expert commissions,

rather than counting 10 to 20 members as in the Swedish case, often consisted of more than 50 representatives. Furthermore, as any one group could veto, decision-making had to be unanimous, lest the losing majority would decide to topple the reform at the electoral stage. As in the French case, the possibility of vetoing legislation reduced the incentives for these groups to compromise. Thus, policy decisions were shifted to the electoral arena; many extremely small and minoritarian groups were able to exert a large political influence; and unanimity was imposed as the decision rule.

Swiss doctors were able to wrest many concessions from this legislative process. As in other nations, there were two general areas of concern to the profession: 1) the role of the state in the health insurance market; and 2) the freedom of the profession to determine its own fees. Swiss health insurance was organized around a system of Federal subsidies to voluntary mutual funds. The insured bought their own policies directly from the mutuals. The mutuals were required to be non-profit in order to receive the subsidies, but in practice, many private insurance companies simply opened non-profit divisions that qualified as non-profit carriers. Doctors' fees were to be regulated through agreements negotiated between local sickness funds and cantonal medical societies. But, as in France, agreements were not always reached, and when reached, they were not always followed.

After the second world war, the Federal Office of Social Insurance developed reform plans to expand the role of government by converting the system of Federal subsidies to a compulsory national health insurance plan and to control doctors' fees. While preparing a more general compulsory insurance law, the executive submitted a proposal for compulsory health insurance for low-income earners and a program of x-rays to combat tuberculosis.

Both chambers of the parliament approved the TB-law – unanimously in the cantonally-elected *Ständerat* and by all but three votes in the proportionally-elected *Nationalrat*. But interest groups moved the policy process to the electoral arena, where the law was defeated by a national referendum. Though launched by French Swiss liberals, the Swiss Medical Association played an active role in this referendum campaign, as did the Swiss Employers' Association, the Swiss Farmers' Association, and the Swiss Small Business Association. On the other hand, all of the unions, all of the employee associations, the church organizations, and the association of sickness funds supported the law.

Given the evident fact that the groups that supported this law had much larger memberships than those that opposed the law, how can one explain this defeat? The sickness funds, themselves, wondered why this was the case, and complained that they needed to educate their member-



ship, (KSK 1958–1960: 47). However, while policy-makers, the sickness funds, and union organizations might have understood the collective benefits of national health insurance, and the role of the TB-law as the first step in establishing national health insurance, the TB law had little appeal to the individual voters that participated in the referendum. The law called for compulsory insurance for low-income earners. Anyone with a high income had no particular interest in this compulsion – unless for some reason they were concerned about the uninsured. For those with low incomes, persons that in any case tended not to vote, the law provided only the compulsion to insure themselves, not government financial aid. Moreover, the initial impetus for the law was a popular plebiscite calling for maternity insurance. But the Federal Office of Social Insurance had decided to begin its efforts with health insurance.

Thus, when the issue of national health insurance was moved from the executive and parliamentary arenas – where there was widespread agreement on the law – to the electoral arena, a different set of criteria became relevant. While political elites were concerned with the percentage of the population covered by health insurance, preventative medicine, and their ability to control the overall costs of the system through collective financing and regulating doctors' fees, individual voters viewed the relative costs and benefits of the legislation in individual terms. Further, as key actors in the decision to launch a referendum, interest groups were able to demand concessions from both the executive bureaucracy and the parliament.

This process was seen clearly in the aftermath of the 1949 TB-referendum defeat. On the basis of the defeat, the Swiss Medical Association petitioned the government to withdraw its plans for health insurance reform. In 1954, the Department of Social Insurance prepared a plan for compulsory maternity insurance, increased Federal subsidies for health insurance, and introduced controls on doctors' fees. The Department withdrew its proposals, however, when parliamentary consultations with interest groups indicated that their positions were 'too divided' for the government to pursue reform, (Botschaft 1961: 1418). In a political system where any interest group, no matter how small, could launch a referendum, and given the uncertain outcome of the referendum, it did not make sense to continue deliberations without the unanimous support of these groups. As a total reform of the health insurance system had been shown to be politically unfeasible, the Federal Office of Social Insurance announced in 1961 that it intended to pursue a partial reform, which, "must be designed in such a way so as to assure its prospects of acceptance without a referendum battle," (BSV in Neidhart 1970: 337). To this end, the reform would not include national compulsory health or maternity insurance, or limits on doctors'

fees. The reform would be limited to a large increase in the Federal subsidies to private health insurance. The executive, in other words, was attempting to protect itself from the electoral arena, the veto point. As interest groups could not be denied access – as in the French case – the process was to be closed off by keeping certain issues off the agenda.

Nevertheless, the medical association managed to re-insert the issue of doctors' fees into the debate, and its ability to do so was clearly linked to the referendum threat. The medical association was not satisfied that the government had agreed to drop its plans for controls on doctors' fees, which the Association called, '“the first step towards socialized medicine,”' (cited in *Stenbull SR*, 1962: 119). The Association now wished to obtain a ruling that it was legal for physicians to charge patients different fees according to their incomes, a system of charges known as 'class divisions' or sliding fees. In addition, the medical association demanded that payment from sickness funds to doctors (direct third party payment) be replaced by direct payments from patients, who would in turn be reimbursed by the funds. The Association built up a 'war chest' estimated at 1 million Swiss francs by increasing its membership fees and hired a public relations firm. This strategy emulated the successful American Medical Association's campaign against national health insurance between 1948 and 1952, which was funded by a special assessment of \$25 from each of its 140,000 members, and during which 4.6 million was spent, (Kocher 1972: 147). The Medical Association was not the only group to remind the parliament of its power to veto legislation, however. Swiss chiropractors, who were not recognized by the Swiss Medical Association, collected nearly 400,000 signatures for a petition demanding that treatments by chiropractors be covered on the same basis as treatments by licensed physicians. This created a dilemma, as the medical profession was adamantly opposed to the inclusion of the chiropractors, but with such a large number of signatures, the chiropractors could clearly veto the reform.

The parliamentary treatment of the reform was a long and drawn out process that lasted nearly two years. Although both houses of parliament agreed to increase the Federal subsidies, the issue of doctors' fees created problems. The behavior of the medical association was severely criticized, with one supporter of the physicians stating that the leadership had been 'overrun by a more-or-less radicalized mass', (Obrecht, *Stenbull SR*, 1963: 104). Nevertheless, the final results clearly benefited the groups that could launch a referendum and penalized those that could not. The medical profession was granted freedom to set fees according to income and reimbursement payment. Over the protests of the Swiss Medical Association, chiropractors were incorporated into the system on the same basis as licensed physicians. The victory of the

chiropractors demonstrates that the referendum threat is more essential than professional status. The sickness funds, on the other hand, were dissatisfied. However, at a delegates' meeting of the organization of sickness funds (*Konkordat*) it was decided not to pursue a referendum challenge. As *Konkordat* president Hänggi explained, no party or union would be willing to fight the reform, and the chiropractors, delighted at the outcome, would constitute fierce competition in a referendum battle.

Better a little bit of progress with this revision than none at all . . . For one must be clear about one thing: in a referendum battle, 'medical rights' [fees according to patients' incomes] would not play a major role; instead, the talk would be of the improvements in benefits and Federal subsidies, that is, about the material improvements for the insured. The basic conflicts over medical rights, that are of interest to few, would remain obscure to most people; certainly, they would hardly unleash the groundswell of opposition that would be necessary to topple this law. (Hänggi, 24 March 1964, cited in Kocher 1972: 131)

After more than three years of debate, then, a reform process that was intended to be simple and uncontroversial had become protracted and ridden with conflict. Referendum politics blocked the introduction of national health insurance and hampered subsequent efforts to regulate medical fees. With these early steps effectively precluded, discussion of restrictions on private practice became a non-issue. National maternity insurance, a subject of debate since the constitutional initiative of 1945 had somehow gotten lost in the shuffle. The ever-present possibility to force decisions into the electoral arena discouraged compromises and allowed even very narrow interests, for example the chiropractors, to play a central role in the reform process. In the Swiss political system, the concept of power was defined by the referendum and the rules of the game were set by an interpretation of how the referendum works, just as in the French case, the logic of the system revolved around controlling the unpredictable parliament.

### *Majority Parliamentarism*

In contrast to the French and Swiss political systems, Swedish political institutions provided for a chain of decision with no veto points. The executive government was able to make and enforce policy decisions with little probability of veto at later points in the chain. This was the result of a coincidental combination of features of institutional design with unexpected electoral victories. Political bargains worked out in the transition from monarchical rule in 1866 and in the subsequent extensions of the franchise in 1909 and 1918 had established a system with some of the same institutional checks as in France and Switzerland. The parliament was to balance the power of the executive, while the

indirectly elected first chamber of the bicameral parliament was to restrain the effects of proportional representation. However, whereas in France, conflicts between the political executive and the parliament resulted in stalemate, in Sweden, institutions were developed to mediate these jurisdictional conflicts. The use of Royal Commissions, consultative bodies of interest-group and political representatives appointed by the executive to draft legislative proposals, as well as the associated *remiss* process, during which interest-groups were requested to submit written comments, expanded as the Monarch sought to avoid the parliament and parliamentary representatives preferred that policy negotiations take place outside of the royal bureaucracy, (Hesslén 1927; Kelman 1981; Heclo and Madsen 1987).

In 1932, the unexpected Social Democratic electoral victory and alliance with the Farmers' Party effected a sea-change in the Swedish system that Olle Nyman has called a shift from minority parliamentarism to majority parliamentarism, (1947). The very institutions that were designed to block popular change abruptly switched to the favor of the Social Democrats. The Royal Commissions, introduced to allow the monarchical bureaucracy to avoid parliamentary opposition, now helped to promote Social Democratic legislation. The Upper House of the parliament, long a veto point used by conservatives, suddenly ensured continued Social Democratic rule despite electoral fluctuations.

After this electoral re-alignment, the system worked as though the veto points had disappeared. Once a decision had been taken in the executive arena, the parliament was unlikely to change it, as the executive government rested on stable parliamentary majorities. Similarly, with proportional representation and fairly stable electoral results, parliamentary decisions were generally not challenged by reactions from the electorate. In contrast to Switzerland, interest groups or voters could not veto legislation with referenda; this decision was strictly parliamentary, which in the case of stable parliamentary majorities, meant that the party that controlled the executive could control the use of the referendum. In contrast to France, the electorate did not contain pockets of 'surge' voters tempting politicians to defect from the parliamentary coalitions, (MacRae, 1967). Only in the very rare occasion of an electoral realignment – or the threat of one – did the electoral arena become significant for specific policy proposals. Consequently, policy-making was concentrated in the executive, with interest group representatives under pressure to compromise as the probability was high that executive proposals would pass unscathed through parliamentary deliberations. The political logic of this system entailed building a majority coalition in the executive arena.

Within this political system, the Swedish medical profession was pla-

ced at a disadvantage. In executive proceedings, its views were always weighed against the views of the trade union confederation, the white collar union, and the employers' association. The profession had better contacts in the parliament, but the Conservative MPs that were ready to veto the executive proposals were outnumbered. The profession also had success in obtaining newspaper coverage for its viewpoints, but only in the rare instances when there was an electoral threat was this effective.

As in France and Switzerland, the Swedish government took steps in the afterwar period to expand health insurance and to control doctors' fees. National health insurance was introduced in 1946, when the Social Democrats held a majority in both chambers of parliament. Not every interest group was completely in favor of national health insurance. But in contrast to the French and Swiss cases, doctors, employers and white-collar workers did not have recourse to a veto point. Unable to threaten parliamentary or referendum vetoes, each group expressed misgivings but agreed to cooperate. The Swedish Employers' Federation pointed to the virtues of voluntary insurance and questioned the financial wisdom of immediately introducing national health insurance, but essentially agreed to the reform. The white collar union noted that most of its members would not benefit from the reform, but, in the name of solidarity, it lent its support. The Swedish Medical Association stated that it preferred voluntary to compulsory insurance, and urged the government to concentrate on more pressing public health needs. It would, however, go along, particularly as the proposal provided for a reimbursement mechanism for payment and for a free choice of doctor. In this context, the medical profession – or other interest groups – was not in a veto position. The government had the parliamentary votes necessary to enact the law, and there was no alternate channel of *political* influence – like the French parliament or the Swiss referendum – where the doctors could make their own point of view prevail over a majority consensus.

Two years later, the situation had changed. The opposition parties were gearing up for the 1948 electoral campaign, and hoped that the 1947 balance of payments crisis would erode social democratic electoral support. The release of a government report calling for the creation of a National Health Service, by placing all hospital and office doctors on a government salary and eliminating all forms of private medical practice provided a focus for a conservative backlash. The non-socialist press depicted this proposal, which was known as the Höjer reform, as a doctrinaire call for the immediate socialization of medicine and the downgrading of doctors from free professionals to state civil servants. The Conservative newspaper, *Svenska Dagbladet* editorialized, 'Mr.

Höjer's goal emerges with frightening clarity: the profession's total socialization and the economic levelling of physicians,' (*SvD*, 10 Mar 1948: 3–4). Doctors, employers and the three non-socialist parties – the Farmers, the Liberals and the Conservatives – actively campaigned against the reform. No other legislative proposal received as much nor as critical press coverage in 1948 as the Höjer reform, (*Ög* 1962: 10). But the pattern was the same for economic and tax policy, as well: the non-socialist parties relied on the press to carry out an electoral campaign that has been signled out as being unusually aggressive and ideological in tone, (Elvander 1972).

The potential breakdown of future prospects for Farmer–Labor coalition governments as well as electoral losses placed the Social Democratic Party in a vulnerable position. Although the Social Democratic MPs held sufficient seats to enact any reform, potential electoral losses presented opponents of Social Democratic policies with a veto opportunity. These electoral pressures created a strategic opening for the medical profession. Unlike its grudging acceptance of national health insurance, now the profession declared itself absolutely opposed to the Höjer reform. In face of these electoral pressures, the Social Democratic government backed down completely, not only with regard to the Höjer reform, but also with respect to a controversial proposal for a new inheritance tax, as well as other elements of its economic program.

As soon as this moment had passed, however, the Social Democratic government went ahead with a number of health policies, often without consulting the medical association. The overall direction of these policies was to reduce the market power of doctors, by increasing their numbers and reducing the scope of private practice. Over the opposition of the Association, the number of doctors was increased by a factor of seven between 1947 and 1972. Private beds were removed from public hospitals in 1959, and, at the same time, all hospitals were required to provide public outpatient care. These clinics competed with private office practitioners and with the private office hours of hospital doctors and were therefore viewed as a threat to private practice. Finally, in 1969, private medical consultations were banned from public hospitals, outpatient hospital care was made virtually free of charge by setting patient fees at a flat rate of seven Crowns, and hospital doctors were placed on full-time salaries.

At no time was the profession able to avail itself of a similar strategic opening as that of 1948. In 1969, Conservative MPs supported the profession and voted against the law to eliminate private practice from hospitals and to reduce patient fees to seven Crowns. Nevertheless, with an absolute majority, the Social Democrats had no trouble in passing the reform and did so with the full support of the Center and Liberal parties.

Conservatives complained that the parliamentary vote was, 'a mere formality . . . the real decision has taken place over the heads of the MPs,' (*Riksdagens Protokoll FK* 1969, 39: 72).

The Swedish state was able to take steps to control the medical market because its actions could not be vetoed in alternative arenas. This was not simply a matter of Social Democratic electoral victories. Similar expansions of public health insurance, controls on doctors' fees, and salaried payment had been supported by French Gaullists, and by nearly unanimous votes from the full spectrum of Swiss political parties. The Swedish executive was able to go further than these other governments because the initial policy changes were not blocked, rather, they led to further interventions.

Nor were these policy changes a result of peculiar preferences on the part of the medical profession or a result of any inherent economic or organizational weaknesses. Swedish private practitioners complained that the Seven Crowns reform entailed, 'the total socialization of Swedish health care over night, through changed employment conditions for hospital doctors and the economic freezing-out of private practitioners', (Gunnar Biörck, *SvD*, 17 Nov. 1969: 4). Like French and Swiss doctors, the Swedish private practitioners viewed market autonomy as the key to professional freedom. Indeed, Swedish doctors attacked the medical association leadership for not protesting more forcefully against the Seven Crowns reform. The Association might have been able to organize a strike or some other economic action against the reform. In the past, economic protests had been quite successful. Thus, Swedish medical opinions did not differ radically from those in other countries, nor did the medical association seem incapable of collective action. (For a fuller discussion and alternative interpretations on this point see Carder and Klingeberg 1980; Heidenheimer 1980).

The striking difference between the Swedish medical profession and the others lay in its strategic political position. While strikes had indeed been effective in the past, for example in increasing doctors' fees, these victories were short-lived. After each successful strike, the government took a *political* step to constrain the private market, such as removing private beds from public hospitals or eliminating the fee system entirely, as under the Seven Crowns reform. Despite membership protests, the leadership of the Swedish Medical Association argued that it was 'stuck' in a situation where it was difficult to bargain with resolution and strength, (*Läkartidningen*, 5 November 1969, pp. 4625–8, 19 November 1969, p. 4826, December 1969, p. 4964; Cf. Carder and Klingeberg, 1980). Not only did the Social Democratic government hold the parliamentary votes that would ensure passage of the legislation, but like the de Gaulle government, it buttressed its reform by changing market

incentives to both doctors and patients. In France, the individual contract had assured the widespread acceptance of the negotiated fee schedules by making it much cheaper for patients to go to the doctors that agreed to lower their fees, thereby breaking the French doctors' strike. In Sweden, the Seven Crowns reform made private office practice less attractive to patients, because hospital outpatient care was now virtually free whereas in private offices, patients were required to pay the full fee and were later reimbursed for a portion of the fee. This would make it difficult for doctors wishing to protest the Seven Crowns reform to flee to the private sector.

Thus, the idea that doctors can block any reform by going on strike appears to be a myth. In economic conflicts, the government can use political means to change the terms of the conflict. And we might note that the profession that received the greatest concessions from the government, the Swiss profession, never went on strike, and seems to have profited both from the electoral reactions to health insurance referenda, and the fears of policy-makers that it might launch a referendum. In Sweden, the Social Democratic government was able to convert its electoral gains into concrete policy decisions because political bargains worked out within Royal Commissions were enforced by stable parliamentary majorities, that closed-off veto opportunities for dissident groups. Only when electoral realignments provided a strategic opportunity for veto did interest groups defect from this game of cooperative bargaining.

### *Conclusions*

In studying these episodes of reform, one reaches the conclusion that the medical profession has had less impact on health policy than is generally believed to be the case. To the extent that it has an impact, this has been caused by opportunities presented by particular political systems, and not by differences in medical organizations or differences in the professionalization process. Veto opportunities allow political decisions to be overturned at different stages in the policy process. This has provided interest groups with different routes of political influence in the three systems. In Sweden, decisions were made in the executive arena through a consensual process that depended on majority rule. In France, decisions during the Fourth Republic were made in the parliament, where groups with ties to swing voters were sufficient to veto decisions. When the constitution of the Fifth Republic allowed the executive to circumvent the parliament, this veto power was eliminated. In Switzerland, the ability to veto decisions by calling for referenda allowed opposed interest groups to threaten credibly to veto health insurance legislation. Thus, it



is not the preferences of the profession that have shaped the health systems, but the preferences of a wide variety of groups and strata of the electorate as they are channeled through political processes that are differentially sensitive to pressures.

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