ECONSTOR
Make Your Publications Visible.

A Service of

ZBW Leibniz-Informationszentrum Wirtschaft
Leibniz Information Centre for Economics

Immergut, Ellen M.

Working Paper — Digitized Version

Political Arenas: The Effects of Representation on Health Policy

MPIfG Discussion Paper, No. 90/5

Provided in Cooperation with:
Max Planck Institute for the Study of Societies (MPIfG), Cologne

Suggested Citation: Immergut, Ellen M. (1990) : Political Arenas: The Effects of Representation on Health Policy, MPIfG Discussion Paper, No. 90/5, Max-Planck-Institut für Gesellschaftsforschung, Köln

This Version is available at:
https://hdl.handle.net/10419/125897

Standard-Nutzungsbedingungen:

Die Dokumente auf EconStor dürfen zu eigenen wissenschaftlichen Zwecken und zum Privatgebrauch gespeichert und kopiert werden.

Sie dürfen die Dokumente nicht für öffentliche oder kommerzielle Zwecke vervielfältigen, öffentlich ausstellen, öffentlich zugänglich machen, vertreiben oder anderweitig nutzen.

Sofern die Verfasser die Dokumente unter Open-Content-Lizenzen (insbesondere CC-Lizenzen) zur Verfügung gestellt haben sollten, gelten abweichend von diesen Nutzungsbedingungen die in der dort genannten Lizenz gewährten Nutzungsrechte.

Terms of use:

Documents in EconStor may be saved and copied for your personal and scholarly purposes.

You are not to copy documents for public or commercial purposes, to exhibit the documents publicly, to make them publicly available on the internet, or to distribute or otherwise use the documents in public.

If the documents have been made available under an Open Content Licence (especially Creative Commons Licences), you may exercise further usage rights as specified in the indicated licence.

WWW.ECONSTOR.EU

Mitglied der Leibniz-Gemeinschaft

Political Arenas: The Effects of Representation on Health Policy

Ellen M. Immergut

90/5

Visiting professor at the Max-Planck-Institut für Gesellschaftsforschung (June - July 1988)

90/1486
Max-Planck-Institut
für Gesellschaftsforschung
Bibliothek
PLA-7/9005
20855000

Max-Planck-Institut für Gesellschaftsforschung
Lothringer Str. 78
D-5000 Köln 1
Federal Republic of Germany
Telephone 0221/ 336050
Fax 0221/ 3360555

MPIFG Discussion Paper 90/5
ISSN 0933-5668
June 1990

Abstract

This paper reviews a series of episodes of health care policy-making concerning the introduction and revision of national health insurance laws. These cases are optimal for comparison as the interests of the actors are fixed but their strategic preferences vary in response to political institutions. These institutions are considered as sets of political representatives. Consequently, they respond immediately to electoral changes and we can view institutional change in terms of changing strategic environments.

* * * * *

Dieser Essay untersucht verschiedene Phasen von Gesetzgebungsaktivitäten im Gesundheitssektor, speziell die Einführung oder Revision von Krankenversicherungsgesetzen. Unter komparativen Aspekten sind diese Fälle besonders aufschlußreich, weil die Interessen der beteiligten Akteure konstant bleiben, während ihre strategischen Präferenzen in Abhängigkeit von politisch-institutionellen Konstellationen variieren. Diese Institutionen werden hier als "sets" von politischen Repräsentanten verstanden, welche unmittelbar auf Veränderungen des Wählerverhaltens antworten, so daß institutioneller Wandel im Zusammenhang sich verändernder strategischer Umwelten betrachtet werden kann.

Contents*

Abstract 2

List of Abbreviations 4

1. Conceptual Outline 5

1.1 Policy Choices 6

1.2 Policy Results 8

1.3 Medical Preferences 9

1.4 Professional Power 10

1.5 Institutional Design 12

2. The Cases 16

2.1 Direct Parliamentary Rule 16

2.2 Direct Democracy 26

2.3 Majority Parliamentarism 35

3. Conclusions 42

Bibliography 46

---

* I would like to thank Jens Alber, Renate Mayntz, Fritz Scharpf, Brigitte Schenkluhn and Douglas Webber for their excellent comments on earlier drafts of this paper, as well as the members and directors of the Institute for the opportunity to have worked at the Institute and for the collegial help offered by everyone.

List of Abbreviations

ATP, Allmänna Tilläggspensioneringen, Swedish General Supplemental Pension Scheme.

CFTC, Confédération française des Travailleurs Chrétiens, French Confederation of Christian Workers.

CGC, Confédération générale des cadres, French Union of White-Collar Employees (and Managers).

CGMPE, Confédération générale des Petites et Moyennes Entreprises, (French) General Confederation of Small and Medium Enterprises.

CGT, Confédération générale du Travail, General Confederation of Labor (French communist union).

CGT-FO, Confédération générale du Travail-Force Ouvrière, moderate scission from CGT.

CNPF, Conseil national du Patronat français, National Council of French Employers.

CSMF, Confédération des Syndicats Médicaux Française, Confederation of French Medical Unions.

FNOSS, Fédération Nationale des organismes de la sécurité sociale, (French) National Federation of Social Security Organizations.

MRP, Mouvement Républicain Populaire, Popular Republican Movement (French christian democratic party).

LO, Landsorganisationen i Sverige, literally the Country Organization in Sweden (the Swedish trade union confederation).

SAF, Sveriges Arbetsgivarförening, Swedish Employer Association.

SAV, Schweizerische Arbeitgeber Verein, also called Zentralverband Schweizerische Arbeitgeber Organisationen, the Swiss Employers' Association.

SÄV, Schweizerische Ärzteverein, Swiss Medical Association, also called FMH, or Verbindung der Schweizer Ärzte.

SBV, Schweizerische Bauern Verein, Swiss Farmers' Association.

SFIO, Section française de l'Internationale ouvrière, French Section of the Workers' International (French socialist party).

SGB, Schweizerische Gewerkschaftsbund, Swiss Trade Union Confederation.

SGV, Schweizerische Gewerbe Verein, Swiss Artisans' Association.

TCO, Tjänstemännens Centralorganisation, Swedish White-Collar Employees (and Managers) Central Organisation.

1. Conceptual Outline

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.[1]

This paper seeks to refute the view that the medical profession does indeed exercise this type of veto power. The history of national health insurance politics shows that the medical profession has not been universally successful in blocking policy reforms that it opposes. By comparing the lobby efforts of medical associations in different countries and at different points in time, the paper will describe clearly different patterns of medical association influence on health policy decisions. In contrast to scholars that have sought to explain medical influence in terms of singular characteristics of the medical profession, or through the historical process of professionalization, this paper focuses on the properties of distinct political systems that make them vulnerable to medical influence. These vulnerable points, which I will call "weak links" or "gaps" in representation, are the key to understanding the impact of pressure groups. Thus, I argue that we have veto *points* within political systems and not veto *groups* within societies. Following Harry Eckstein's advice, rather than analyzing the internal structure of groups, this comparison examines the "structure of the decision-making processes which pressure groups seek to influence."[2]

---

[1] Hatzfeld 1963; Kocher 1972; Marmor and Thomas 1972; Naschold 1967; Safran 1967; Starr 1982; Steffen 1983 and 1987. Refer to Freddi and Björkman (1989), as well as Light and Levine (1988), for discussions of the limitations of the "professional dominance" or "autonomy" model.

[2] Eckstein's (1960: 16) seminal work has been neglected to a surprising degree by scholars discussing the limits on professional

1.1 Policy Choices

Despite differences in national traditions and political culture, political conflicts concerning health policy in the postwar era have revolved around a surprisingly limited set of issues. Particularly in so far as the ambulatory sector is concerned, the role of the private market versus the role of government has constituted the core dimension of conflict. This dichotomy has emerged with regard to three specific types of policy proposals: the introduction of national health insurance programs; government control of doctors' fees; substitution of government salaries for fees and the enforcement of full-time government employment for doctors.

Of course, these policy initiatives are not unrelated. At the same time, one can also note that the definition of the private market shifts from one type of initiative to another. National health insurance programs simply subsidize the market for private medical services by increasing the number of insured persons. The only restriction on the private market concerns the percentage of the population that is available to buy private insurance coverage or to buy medical services directly, without an insurance intermediary.

Once in place, however, national health insurance programs have tended to lead to further restrictions on the private market. For as soon as governments begin to finance health services, they tend to control the price of these services. The most common reactions have been efforts to control doctors' fees through the establishment of negotiated fee schedules. Here, the free market is defined not by whether the patient is publicly or privately insured, but by whether

---

autonomy. Klein (1979: 484), too, interprets the British pay beds dispute (an issue very similar to the ones reviewed here) as "an example of the importance of politics, in the most old-fashioned and traditional sense of party politics, as against organizational routines or pressure group bargaining." Stone (1980) emphasizes the effects of West German political institutions on the ability of government to control the medical profession. Heidenheimer (1980) breaks with the "doctor-driven" view by analysing shifts in professional power and the role of different levels of the bureaucracy.

the doctor can set the fee freely. Subsidiary issues have concerned: whether doctors may bill the patient directly (reimbursement, *tiers garant*) or whether the insurer will pay the doctor (direct third-party payment, *tiers payant*); and whether the doctor may receive an extra fee from the patient, over and above the prescribed fee schedule (balance billing, "Klasseneinteilung"). What is being restricted here is the amount of money that is being paid directly from the patient to the doctor, as well as the absolute amount paid by government insurance to doctors.

In several cases, disputes over fee schedules have resulted in proposals to eliminate fees entirely and to remunerate doctors with salaries. Salary payment removes all financial transactions between doctors and patients. In addition, salary deprives doctors of the ability to increase their incomes by performing more services. Thus, even in comparison with fee-for-service payments paid by government insurance offices, salaries have been viewed as a more "public" form of payment; salary completely severs the links between individual doctors and the private market. In conjunction with salary payment, governments have often moved to restrict the right of doctors to practice privately, alongside their salaried duties. Generally these restrictions have concerned the outpatient practice of hospital doctors (private consultations). Nevertheless, both salary payment and restrictions on the institutional site of practice have been proposed for doctors in the private ambulatory sector, as well. But such proposals for salaried practice, often in local health centers, have tended to be the form of medical practice that organized medical associations have resisted most vigorously and most consistently.[3]

---

[3] Conflicts over local health centers took place, for example, in France, Britain and Sweden in the 1930s and 1940s, as described in Steffen (1983), Blanpain (1978); Sveriges Läkarförbund (1944). A second example of common preferences is the lower status of public health officers throughout Western Europe.

1.2 Policy Results

Given the fact that national health insurance programs and the government regulations to which they lead engender an inherent conflict of interest between governments and medical professions (as the respective buyers and sellers of medical services), and given the fact that medical associations throughout Western Europe exercise a legal monopoly over medical practice and enjoy a widespread reputation as being politically influential, how then can one explain the wide variation in West European government health policy?

In order to answer this question, this paper compares a series of legislative efforts in France, Switzerland and Sweden. Until 1930, government health insurance programs in all three nations were limited to government subsidies to voluntary health insurance carried by mutual associations. In 1930, France introduced compulsory national health insurance for low-income earners. Similar plans were proposed in 1900 and 1919 in Switzerland and in 1919 in Sweden, but neither was enacted into law. After the second world war, universal and compulsory national health insurance programs were enacted in France and Sweden. National health insurance was also proposed in Switzerland, but failed. Next, all three nations experienced political conflicts over governmental controls on doctors' fees. These conflicts were resolved (partially) in France in 1958 through a series of decrees that established a system of individual and departmental fee schedules (*conventions*). In Sweden, a similar system of fee schedules was established as part of the 1955 national health insurance legislation, but in 1970, fees were superseded by salaried hospital practice. Full-time salaried practice was introduced for many hospital doctors in France in 1958. At the same time, private beds and private consultations were to be allowed only as a transitional measure. These were finally eliminated in 1982, but these laws have since been retracted. Salaried practice for all doctors in the form of a national health service had been proposed unsuccessfully in Switzerland in 1890, in Sweden in 1948 and in France in 1944.

The result of this pattern of failed and successful legislative initiatives is the development of three health systems that today represent three

ideal-type approaches to government provision of medical care. The Swiss government's role remains limited to national subsidies to voluntary mutual funds.[4] France, on the other hand, relies on a national health insurance system with controls on doctors' fees. Sweden has developed a *de facto* national health service, where the vast majority of doctors work as salaried employees of the government, while national health insurance remains in place to finance a small portion of ambulatory services.

1.3 Medical Preferences

The following sections of this paper analyze the reforms in the postwar era that are responsible for these differences. Not only are the initial policy proposals in these three nations the same, but the views of doctors were also extremely similar. Private practitioners - those doctors that had access to a private clientele - were uniformly opposed to government reforms that restricted this market. Doctors that treated a lower income clientele, on the other hand, a group that often included rural doctors and general practitioners, were generally much less resistant to government entry into the insurance market, or even to restraints on fees. For while this intervention reduced purely private forms of practice, government subsidies expanded the total income available to doctors. For these two subsections of the medical profession, their preferences seem to reflect their market interests. Yet a third group, the leaders of medical associations, made their choices

---

[4] Health policy obviously covers a vast number of topics, including public health measures, regulatory policies regarding for example pharmaceuticals and medical technology, and public funding for medical research, hospitals and other health institutions. But, if one focuses on social programs that aim to provide access to medical treatment to the general public, government policies in Western Europe may be grouped into three basic types: financial support for voluntary health insurance carried by sickness funds (mutual societies); compulsory health insurance, generally first introduced for industrial workers and then later extended to cover other occupational groups; direct provision of health care through a national health service.

of which policies to support and which to oppose based on a different set of criteria. Leadership choices, I will argue and substantiate in this paper, are strategic choices based on the opportunities presented by political institutions.

Here, the research design is important. The only way to separate out the effects of strategic environments from the preferences of the actors is to standardize the interests of these actors. This has been accomplished by choosing policy conflicts involving narrow economic issues, where the goal of these governments has been to reduce private medical practice: either by reducing the population in the private market by extending national health insurance; or by eliminating the private part of the doctors' fee by prohibiting extra-billing and imposing fee-schedules; or by eliminating fees entirely and converting payment to a salary system; or by prohibiting private practice from certain institutions such as public hospitals. Here, the market interests of doctors with access to private practice are the same. If one looked at an issue like abortion, there would be more scope both for different interpretations of interests and for cultural differences.

1.4 Professional Power

While the attitude of doctors was similar across the cases, with elite private practitioners prepared to veto any feature of government reform proposals that interfered with private medical practice, the ability of these medical professions to veto these programs varied considerably.

Organizational differences, such as membership figures and associational structure, cannot explain these differences. Figures on French medical unions vary extremely, with *generous* estimates ranging from under 40% to over 60% for the percentage of the profession belonging to medical unions. In Sweden and Switzerland, on the other hand, well over 90% of the profession was enrolled in a single medical association for the entire postwar period. Moreover, French hospitals doctors were organized into different organizations than office practitioners, and within both types of organizations there were political

splits amongst the membership. These resulted in organizational splits in the 1920's and the 1960's - periods occurring before and after the main scope of this study, but these disagreements were apparent to policy-makers. Nevertheless, it is not the French doctors that are the least successful in the political sphere, it is the Swedish.[5]

Instead, these differences in policy results can be understood in terms of the political institutions in these countries. French doctors were the beneficiaries of the problem-riddled parliament of the Fourth Republic. As a group that preferred that the state take *no* action to restrict private medical practice, a parliament that accomplished very little was a boon. A second indirect source of benefit was provided by other interest groups that used this weak institution to protest against social security. Although the aim of these groups was not to help the doctors, their opposition prevented the enactment of programs that doctors, as well, disliked. Finally, French doctors were able to benefit directly from this political arena through their parliamentary contacts. In Switzerland, too, political institutions provided a veto point. This time, national health insurance was vetoed at several points by national referenda. Again, it is the general population, voting against a program that doctors oppose, that accomplish what the doctors want. At the same time, the process of referendum politics provided Swiss doctors with many opportunities to gain special concessions from the government. And, as in the French case, they were not the only group to use the same weak point to demand concessions. In Sweden, on the other hand, these veto points were lacking. Physicians, although equally opposed to socialized medicine, were not at all successful in blocking government programs. Only at a very specific point in time, did a veto opportunity open up. And at that time, doctors, as well as several other groups were able to use this point to gain concessions.

---

[5] On France, see Stephan 1978: 38-9; Glaser 1970, also Wilsford 1986; Mane 1962; Savatier 1962. On Switzerland, Kocher 1972; Braun 1985. On Sweden, statistics from Sveriges Läkarförbund, cf. Läkartidningen (1978: 1986-2000).

1.5 Institutional Design

The balance of this paper seeks to explain why these veto points arise. It presents a strategic view of institutions - and more generally, of political power. It analyses what makes politicians suddenly susceptible to political pressure. Thus, "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) constantly either open or closed to political influence. Instead, the way in which politicians respond to pressures very much depends upon strategic considerations. And if an interest group is able to threaten or improve this strategic position, that is the time when this group is able to exercise power.

One would think that doctors could threaten policy-makers by going on strike. Would a blockage of the entire health system not constitute a political threat? But this is not the case. Doctors have never won a political victory by going on strike. Nor does the threat of a strike make any difference to *political* decisions. Instead what matters are the veto points.

But where are these points? One might envision political systems as sets of interconnected arenas. Each is accessible to different types of political actors, is responsive to different sorts of political strategies, and makes decisions according to different rules. Yet each is connected to the rest through procedures for translating one set of representatives into another. Electorates, legislatures and executives are related by formal constitutional rules as well as informal practices, such as whether voting generally produces a stable parliamentary majority. This "informal" part is obviously greatly affected by both the party system and longstanding relationships between parties and interest-groups, but also by electoral patterns that seem to be characteristic of different countries. This paper argues that a veto point is produced when there is a *gap* in this chain of representation.

One way to envision this gap is to imagine different political arenas as being loosely or tightly coupled. If they are loosely coupled,

strategic uncertainty is created, which provides some interest group with power opportunities. The term gap is used to highlight the fact that no physical connection exists between these arenas. An appropriate metaphor might be that of a battery. When there is a difference in the concentration of negative ions at the two poles, one speaks of a "potential difference." We can look for the same type of potential difference when we compare two arenas within a political system.

If, for example, the executive government in a parliamentary system rests on a stable parliamentary majority, and if there is party discipline, the parliament will not change executive decisions. In other words, there is no potential difference because the votes necessary to overturn the executive decision *do not exist* within the parliamentary arena: the majority of M.P.'s belong to the party that just made the executive decision, and because there is party discipline they cannot deviate from the party line. In a such a situation, there will not tend to be major changes in the parliament, nor calls for re-discussion of executive decisions in the parliament.

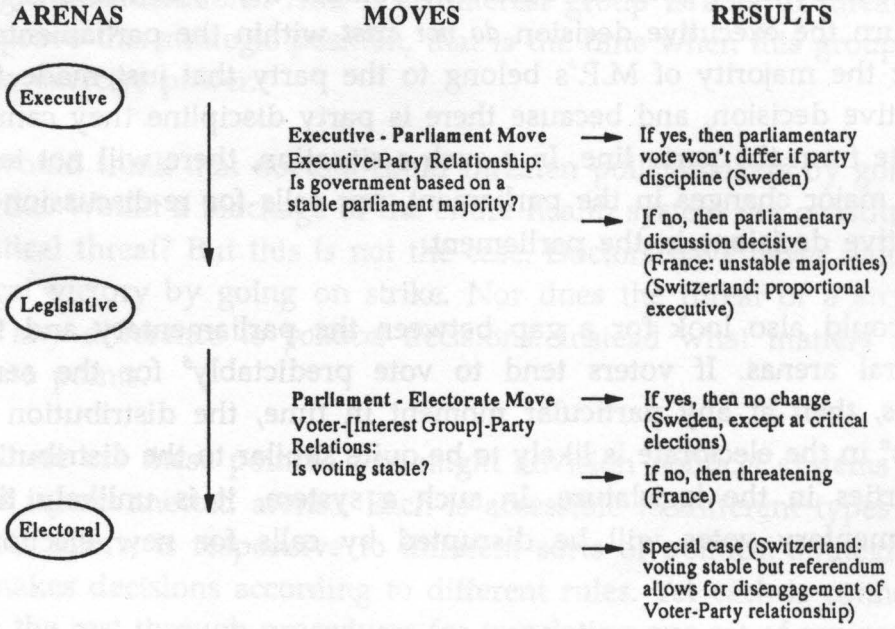
One could also look for a gap between the parliamentary and the electoral arenas. If voters tend to vote predictably[6] for the same parties, then at any particular moment in time, the distribution of "votes" in the electorate is likely to be quite similar to the distribution of parties in the legislature. In such a system, it is unlikely that parliamentary votes will be disrupted by calls for new elections,

---

[6] Although a term like "predictably" sounds vague, variables like voting stability and the stability of governing coalitions are features of political systems that are visible to political actors and agreed upon by outside observers. At any one point in time, anyone can count the number of votes in the parliament and can take a glance at survey results to see whether or not a potential difference exists. None of the political features pointed to here are different from the standard interpretations of these political systems by political scientists. The emphasis on electoral situations as an intervening variable explaining the reactions of politicians to interest group demands allows for a more dynamic view of the institutions of representation.

because unless something peculiar is going on, there should be no difference in result.

In some political systems, there is a relatively smooth and stable transformation (in the mathematical sense) of representatives from one arena to another. These types of systems, I argue, lack veto points; they will be relatively impervious to pressure from potential veto groups. By contrast, in systems where gaps occur, political decisions are vulnerable to veto; and they are vulnerable exactly at these gaps.[7]



Interest groups will of course aim their efforts at any point in the system where they hope for success. Indeed, aware of their consequences, different social groups and government actors struggle to

---

[7] There may also of course be a considerable gap between the general population and the electorate - a gap that depends on electoral laws and voter participation. Competition between parties to extend the franchise is an example of how persons in the population become "powerful" by virtue of their strategic position in light of this gap.

shift the arenas of policy-making to their own advantage.[8] Only where there is a gap, however, will their actions threaten politicians, and it is only then that they exert their veto power.

Speaking metaphorically, power in a political system - as in any social system - gravitates to these points of vulnerability.[9] Over time, the operational procedures used by participants in the policy-making process will be adjusted to take account of these vulnerable points. Thus in different countries we will see characteristic patterns of decision-making that have been produced by the opportunities presented by gaps in representation, on the one hand, and interest groups and political actors, on the other.

One might describe these decision-structures in terms of three dimensions. First, different nations emphasize different arenas for policy-making. Second, different arrays of interest groups participate in political decisions. Third, decisions require different types of agreement, such as majority rule, unanimity and so forth. In other words, one could characterize policy decision-structures in terms of: 1) arena or site rules; 2) the rules of access to decision-making or boundary rules; and 3) the rules of procedure or decision-rules.[10]

---

[8] The classical example of the importance of political arenas is provided by Tocqueville's (1958 [1856]) analysis of the French Monarchy's circumvention of the Parlements, an arena of noble representation, through its shift of administrative tasks to the Intendents, often staffed by members of the bourgeoisie and directly responsible to the Crown. See also Schattschneider's (1960) discussion of the socialization of conflict to include a wider and potentially allied "audience", and Lipsky (1968).

[9] Refer to Shepsle and Weingast (1987) on veto power of congressional committees, and to Crozier (1964) for a discussion of uncertainty and power, as well as to Crozier and Freidberg (1980).

[10] See Scharpf 1988: 11-12; for discussion of rules and its relation to the work of Elinor Ostrom.

	Arena	Actors	Decision	Logic
Sweden	Executive	Those Critical to Executive	Majority Rule	Majoritarian
France IV Republic	Parliament (unstable coalitions)	Those Critical to Parliamentary Coalition	Hierarchy/ Privilege (Degree to which group is critical to regime)	Particularlistic
V Republic	Executive (Rule by Decree)	Critical to Executive		Plebiscitarian
Switzerland	Electorate (Referendum)	Those that can launch referendum	Unanimity	Minoritarian

2. The Cases

2.1 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. Why was a political system based on the idea of direct rule by the parliament so vulnerable to these interest groups? We can identify several points where gaps in representation created strategic opportunities for bargaining. The French executive government was not based on a stable parliamentary majority. Thus, any party or 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 M.P.'s.

Within the legislative arena, the threat of exit to electoral arenas was equally credible, as voter-party relations were also highly unstable. Voters frequently changed their votes; voters frequently changed their interest group affiliations; many voters did not belong to either interest groups or parties; relationships between interest groups and parties were unstable or non-existent. This instability made parliamentary representatives very vulnerable to interest group pressures. Interest groups, in other words, could pressure parliamentary representatives, not only by relying on official interest group-party channels, but simply by carrying out demonstrations. The fear that voters would desert them, or that interest groups could form new parties, entering the legislature as competitors,[11] forced the parties to respond quickly to various forms of "direct action" by pressure groups. Indeed, the shifting electorate - made all the more unpredictable by the lack of large, cohesive interest groups and by the lack of stable interest group-party relationships - provided the political parties with an incentive to dissolve the government. For after a certain number of ministerial crises or votes of confidence, the executive was constitutionally obligated to dissolve the National Assembly; any party that thought that the electorate had shifted to its advantage therefore had an incentive to provoke governmental crises. Thus, 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, made possible by a series of unstable political relationships, changed the structure of incentives to the various actors in France health care policy-making. With legislative policy-making, with access available to non-majoritarian groups, with privileged decision-making, interest groups with veto power had no reason to be disposed towards cooperation. The medical profession, for example, was highly overrepresented in the Parliament, and with doctors spread through several of the parties needed to build governing coalitions, the profession enjoyed the privileges

[11] The Poujadiste movement is an excellent case in point.

that accrue to swing voters.[12] 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. When the locus of decision-making shifted from the parliament to the executive, one witnessed a corresponding change in the dynamics of policy-making. With constitutional protections preventing the overturning of executive decisions by the parliament, the executive was now de-coupled from the parliament. Thus, the gap in representation (the veto point) was in a sense closed. Consequently, many of 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. With the legitimacy of rule based on the need for decisive action in emergency and on popular plebiscites, the executive could take hierarchical decisions rather than waiting for majoritarian compromises. At these points, the beneficiaries of executive privilege depended on political circumstances, with French unions more central in the Liberation period, industrialists in the early 1960s.

---

[12] 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 (Mouvement Républicain Populaire) and 6.5% of the SFIO (Section française de l'Internationale ouvrière) (Birnbaum 1977: 50, 71). In 1973, doctors held 12.2% of the seats in the French parliament, as compared to an average of 3.9% in 9 European and the US parliaments, 1.5% in the US, 4.3% in Belgium, 4.7% in Italy, 1.5% in Britain (Kerr 1981: 280). Figures for Sweden in 1960 were 1.3% and 0.8% for the two chambers (Sköld and Halvarson 1966: 444, 465). For Switzerland in 1971, 3% (Kerr 1981 or Gruner 1973).

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. The Social Security Ordinances were promulgated directly by the executive on the 4th and 9th October 1945, with a minimum of interest-group consultation and parliamentary bargaining - notably just two days before the elections and Constitutional referendum of October 21. The Ordinances established a universal social insurance system that covered all employees for health, old-age and work accidents. The plan was to establish a single insurance fund, or "caisse unique," that would, eventually, cover all French citizens for all risks.

Even in this exceptional context, interest groups appealed for concessions; but the executive was able to pick and choose amongst them. The protests against the system by employers, the old mutual societies and private insurance companies were ignored. The new organization of salaried employees (CGC) was granted a special scheme of supplementary employer benefits for "cadres." The administration bowed to the demands of the Catholic left party (MRP) and the Catholic Trade Union Confederation (CFTC) by removing family allowances, traditionally a Catholic domain, from the "caisses uniques". The MRP and CFTC also pushed for social security elections, under which CFTC representatives hoped to win a larger number of seats than under the administration's plan for delegating representatives in proportion to union membership, (which meant an automatic majority for the CGT, the union with close links to the Communist Party). Here, the administration sided with the CGT, arguing that elections would delay implementation and would merely provide opponents with a pretext to obstruct the scheme.

The medical profession, represented by the CSMF, was granted a concession as well. Medical fees would not be regulated by the

Ministers of Health, Finances and Labor, as intended, but would be negotiated at the local level.[13]

With the return to parliamentary democracy, interest-group bargaining and party competition only increased, opening up further opportunities for an onslaught of particularistic claims. Social Security was debated for the first time in the fall of 1946, shortly after elections to the second Constituent Assembly had left the MRP as the largest party in the legislature, mainly as a result of Socialist losses. Party competition was not temporarily stilled, however, for a new Constitutional proposal was still to be adopted by the Assembly in September and ratified by popular plebiscite in October; new elections for the National Assembly would be held thereafter, in November. The MRP and the CFTC returned immediately to the issue of social security elections, this time winning a large majority in the parliamentary vote; even the Communist deputies, who had an interest in preserving the dominant position of the CGT, did not wish to appear undemocratic by voting against elections.[14] Next, the MRP proposed an immediate extension of the old-age provisions to the self-employed. This attempt to recruit new MRP voters backfired, however. For the "independents" protested immediately. Led by the Confédération des Petites et Moyennes Entreprises (CGMPE), several associations of independents, notably including the French Medical Association (CSMF), formed the Comité de Liason et de Coordination des Classes Moyennes, in order to "limit the growing ascendency of the powers of the State."[15] The independents threatened to block the system completely by withholding their social security contributions. When faced with the outright refusal to pay contributions, the MRP rather opportunistically withdrew its law, substituting special

---

[13] Dr. Paul Cibrie, president of the CSMF, wrote that his lobby efforts were aided by his personal acquaintance with the Minister of Labor; a direct, personal appeal to the administration (Cibrie 1954: 75).

[14] Interview, Laroque.

[15] Cited in Meynaud 1957: 92, cf. 91-3.

retirement plans for artisans, for industrial and commercial professions, for farmers and for the liberal professions.[16]

These concessions to special interests created problems that plagued the social security system for the next twenty years. The use of the conventions 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.

Doctors' fees had created problems for the social insurance system since 1928. Although the fees were to be regulated by local contracts, the CSMF refused to negotiate. Patients simply paid doctors' fees and were reimbursed for only a small portion of these fees. They were denied the 80% reimbursement guaranteed by law. This situation continued after the war. The CSMF denounced the system of fee schedules or *conventions* - a system to which it had already agreed - as early as March 1946, taking advantage of the strategic opportunity presented by attacks on the social security system by other groups. At several points, the CSMF signed framework agreements with the insurance funds, only to denounce them several weeks or even days later.[17]

When negotiations failed, the social insurance funds attempted to push for legislation to control doctors' fees. But the anti-conventionist 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.[18] With unstable governing coalitions, a solid block of

---

[16] Galant 1955: 107-112; Laroque 1971; Hatzfeld 1963 and 1971.

[17] Hatzfeld 1963: 78-103.

[18] Revue de la Sécurité Sociale, March 1957: 9-12; Interview, Clément Michel, ex-director of the FNOSS, 7 June 1984.

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 mayors; 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.[19] 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 "de-coupled" from the Parliament. Direct election of the executive, greater possibilities for direct executive legislation by decree without parliamentary approval or by submitting laws directly to the electorate through popular referenda, 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 conventions 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, rationalized the hospital system by creating an elite tier of teaching hospitals, rank-ordering the rest and placing restrictions on the expansion of private hospitals and clinics. The reform 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

[19] Imbert 1958.

completely.[20] The problem of the conventions in the ambulatory sector was solved by the introduction of maximum fees to be set by the Ministers of Labor, Health and Finances - as called for under the administration's draft of the 1945 Social Security ordinances. Conventions would still be negotiated, but where no departmental convention was in force, doctors would be able to sign individual conventions with the funds. The patients of these doctors would be reimbursed at more favorable rates than the unconventioned doctors. The individual convention had been demanded by the sickness funds since 1928, but had always been blocked by the CSMF. Now, CSMF control over the convention system was undercut by allowing individual doctors to decide whether or not to sign; the government had now added an element of market competition in order to buttress its new institutional framework.

The medical profession was not the only group affected by the Decrees of 12 May 1960. For in conjunction with the measures to control fees - a clear improvement in social security benefits - the government re-organized the administrative structure of social security. The power of the regional social security directors, directly responsible to the Minister of Labor were greatly strengthened at the expense of the elected administrative boards. The social security funds and the unions - the CGT, the CFTC and the CGT-FO - supported the increase in benefits but adamnantly opposed the administrative component of the reform, calling it the "étatisation" of the funds.[21]

---

[20] Jamous 1969.

[21] Because the Minister of Labor had insisted that the two aspects be tied together in a single series of decrees, the unions could not block the administrative changes without blocking the increase in benefits. Obviously, this was not coincidental: "Certainly it appeared to me useful to, in order to assure a more efficient functioning of the public service of Social Security, to restore the authority of the State equally in this domain. But the public, which generally has only a limited interest in technical measures concerning the functioning of Social Security, attaches a greater importance to reforms relating to benefits." Letter from Bacon to Prime Minister, 16 September 1959, reference number W2447, SAN 7515, Archives Nationales, Paris.

These reforms of the hospital and social security system were imposed over and above the objections of the Intersyndicat des Hopitaux, which represented hospital physicians, the CSMF, the Académie de Médecine, all of the unions (CFTC, CGT and CGT-FO), and small employers (CGMPE). The only interest group that supported the reform was the employers' association (CNPF), which was dominated by large industrialists. The CNPF supported both the regulation of doctors' fees and the administrative changes as rationalizing measures that would contain costs.

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 and 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 relations between the medical profession and the social insurance funds.[22] 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 CSMF 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 convention allowed the many doctors who would benefit from the system to bypass the syndical leadership. Within a few months the strike was broken. The rift between doctors who were for and against the conventions continued to deepen, however. When the CSMF signed an agreement with the social security funds in July 1960, the anti-convention faction split off, forming the Fédération des Médecins de France.

Thus, as in the Liberation period, the executive government imposed reforms despite interest group opposition, secure in the knowledge

[22] Le Monde, 19 May 1960, 21 May 1960; Doublet 1971: 41.

that large blocks of voters would welcome the reform, as would the CNPF. Moreover, since the 1930s, provincial doctors had been willing to negotiate conventions, but their views had previously been discounted through the special network of CSMF-parliamentary relations of the Fourth Republic.[23]

In the French case, gaps in representation enabled a select set of interest groups to exert legislative pressure through their access to the parliament. Indeed, by tracing these specific conflicts in one policy domain, one has a clearer idea of why the French Fourth Republic did not "do" much of anything. Any interest group that could cause only a minor delay in the handling of a proposal could be fairly sure that the government would fall before the issue was taken up again. Once the executive government was able to circumvent the parliament, reforms were passed that undermined the syndical unity of the medical profession, and that went against the wishes of traditional veto groups, such as small employers. Unable to rely on firm voter-party and voter-(interest-group)-party ties, however, the executive was continually under pressure to reach out directly to the electorate and to privilege the groups whose support was most essential at any particular moment. And the thing that made a group "essential" was defined by the electoral strategy of the regime, not by any invariant feature of the group or the formal political institutions.

---

[23] These included the rural physicians that supported a system of conventions, whose delegates (representing 12,616 members) had narrowly lost a vote in 1956 (to delegates representing 13,264) over whether to continue negotiations with regard to a governmental proposal, the infamous "Projet Gazier." Despite this close vote, the stance of the CSMF became increasingly intransigent, and it launched a (successful) full-scale attack on the law in the National Assembly and in the press (Hatzfeld 1963). Similarly, with regard to the Debré reform, many provincial hospital doctors supported some of the payment changes (Lemaire 1964). Further, it has been argued that the reform was made possible by a new generation of "young Turks" within the medical profession that were interested in improving the scientific status of the hospitals (Jamous 1963; see also Esprit 1957).

2.2 Direct Democracy

In Switzerland, the politics of the referendum enabled doctors and a host of other interest groups to gain concessions from the state. Why is it that a system based on the ideal of direct democracy has provided such power to interest groups? The Swiss polity is one where electoral patterns and interest group-party relations might have produced a "gapless" system. Voting is very stable. Much of the population is organized into interest groups and these interest groups have fairly stable ties to the political parties. Electoral studies show strong class-based voting, with cross-cutting cleavages based on religion and language.[24] Unionization is higher than in France, and historically there has been some stability in the relationship between the Swiss Trade Union Confederation (SGB) and the social democratic party. To be sure, the Swiss situation is very different from a pattern like the Scandinanvian one. The unions and the social democratic party are not interpenetrated organizations that consider themselves as two arms of the same movement. Unionization figures are much lower and the labor movement is split into religious and secular branches. Similarly, the party system has both an economic and a confessional aspect, clouding the translation of interest group cleavages into party cleavages. Nevertheless, there is enough stability in the system that should the major interest groups and parties agree to a piece of legislation, one would expect a smooth enactment and implementation.

But this is not the case. Swiss political arenas are "de-coupled" from one another. Whereas in the French case, the de-coupling of the executive from the legislature allowed the executive to enact reforms independently from the parliament, in Switzerland, this de-coupling

---

[24] According to one survey, 68% of respondents were members of an occupational association, as compared to the 15-20% of the electorate that had joined a political party, Katzenstein (1984: 112). On interest groups see Meynaud (1963); on voting see Kerr (1974). In a careful study of union and employee association membership figures, Visser estimates the total union/employee association density (members divided by potential members) at 73%, 19.8% and 30.3% for Sweden, France and Switzerland, respectively (1981: 29, 65, 77).

created unusual opportunities for vetoes in the electoral arena. Swiss governments were not based on stable parliamentary majorities, but rather on a proportional, collegial executive, the Bundesrat. Thus, even though stable parliamentary majorities existed, the collegial executive made them irrelevant. The executive was de-coupled from the parliament, but not in such a way as to make it independent, but as to make it more dependent. Shifts from the executive to the parliamentary arena, therefore, enable partisan conflicts to emerge more clearly. At the same time, because many M.P.'s have strong ties to interest groups, parliamentary discussion often emphasizes interest group positions. In considering the shift from the legislative to the electoral arena, one notes again, that although voter-party relations were stable, and were mediated by large and stable interest groups, this stability was irrelevant as the referendum mechanism de-coupled the voter-party relationship. Indeed, parties sometimes hesitate to take a stand on referenda, as their constituencies may differ on the kinds of very specific issues considered by referenda, making interest groups a better vehicle for referenda campaigns. Thus again, this de-coupling rendered members of parliament not independent from the electoral arena but rather more dependent on momentary changes in voter preferences - even though these fluctuations do not seem to carry over into elections.

The ability of interest groups to force issues 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 consist of more than 50 representatives. Furthermore, as any one group can veto, decision-making must 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 reduces 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, at the same time that they profited from the activities of other veto groups. 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 (SÄV) played an active role in this referendum campaign, as did the Swiss Employers' Association (SAV), the Swiss Farmers' Association (SBV) and the Swiss Small Business Association (SGV). 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 membership.[25] One can note that voter participation was only 40% of those entitled to vote, which at the time did not include the female population. We know, as well, that voting participation is biased with regard to socio-economic status. One might also call attention to the fact that the 1949 referendum occurred within a "wave" of referenda that have been interpreted as a reaction to wartime restrictions.[26] Moreover, voters are generally thought to react more strongly to impending losses than to possible benefits. Further, a positive referendum vote requires complete agreement on a policy, while the negative votes may consist of a scattered coalition of people that all dislike the law for different reasons. Finally, we have no comparisons with other countries that would show what citizens in other polities thought about health insurance *before* a law was enacted.[27]

But the most straightforward explanation is that the voters did not like the law. And why would they? It was not in their individual interests. 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, the law provided only the compulsion to insure themselves, not government financial aid. If they had not taken the step of insuring themselves, why would they vote for a law that would compel them to insure themselves? And who would bother to go out to vote for compulsory x-rays?[28] More-

---

[25] KSK 1958-1960: 47.

[26] Gruner 1969: 17-18.

[27] Wilensky (1971) does not find significant variation in public attitudes towards social programs, nor do Shapiro and Young (1989).

[28] One can see that in general, there may be a conflict between protectionist legislation, which intends to overcome market failures and failures of individual effort, and the referendum as a mechanism for ascertaining the general will, as the latter is based on the assump-

over, the initial impetus for the law was a popular plebiscite calling for maternity insurance. But some bureaucratic impulse had pushed the Federal Office of Social Insurance to begin its efforts with health insurance.

Thus, we see that there is a problem of communication between the electorate and the bureaucracy. An unknown portion of the electorate, for unknown reasons, has rejected a specific piece of legislation. Without sufficient information, the bureaucracy must decide how to interpret the popular mandate. This uncertainty, ironically, placed power in the hands of interest groups. For the reaction of the Swiss bureaucracy to nebulous electoral signals was to follow the concrete demands of organized interest groups. While the disorganized general public had no mechanism for presenting clear policy guidelines, organized interest groups voiced specific demands to which policy-makers could respond. In addition, interest groups were able to threaten bureaucrats and politicians because they had the resources (signatures and funding for publicity) to launch referenda. It should be made clear that interest groups cannot control the outcomes of referenda. But they can force a referendum vote. This move from the legislative to the electoral arena is threatening to policy-makers, in both the executive and the parliament, as it places political decisions into an unpredictable arena where discussions are not intermediated through organized and long-standing relations, and where the possibility of veto is high as it is easier to mobilize opponents to legislation than proponents.

This process was seen clearly in the aftermath of the 1949 TB-referendum defeat. On the basis of the defeat, the Swiss Medical Association, and the Employers', Farmers' and Small Business Associations petitioned the government to withdraw its plans for health insurance reform.

In 1954, a new attempt was made to reform the system. This time, compulsory health insurance was left out. Instead, the government proposed to enact compulsory maternity insurance and to double the

---

tion that each individual is the best judge of his or her interests.

size of the Federal subsidies. The main points of contention were the increased federal subsidies, the compulsory aspect of the insurance, and doctors' fees. In order to encourage the signing of contracts to establish schedules for doctors' fees, some sickness funds allowed doctors to vary their fees according to patients' incomes. But this system of "class divisions" was technically illegal. The government hoped to make a trade: class divisions would be legalized for rich patients, if a system of binding fee schedules could be established for low and middle income patients.

Although the government hoped in this way to placate each interest group, after reviewing the formal responses of these groups, it announced that these positions were "too divided" for the government to pursue reform.[29] The executive government bowed to interest groups pressures both in eliminating from consideration the portion of the reform that it thought had blocked passage in the past (compulsory national health insurance), and also by backing down as soon as it became clear that unanimity could not be reached. Though not caused by the medical profession, this combination of interest group intransigence in conjunction with the government's hypersensitivity to interest group opinion worked to the advantage of the profession: compulsory insurance had been eliminated; now, the regulation of fees and federal subsidies were eliminated.

After the failure of the 1954 reform attempt, the Bundesrat proposed a partial revision. Federal subsidies would be indexed to health care costs, now covering a certain percentage of health insurance costs in place of the old system of fixed subsidies; and the minimum benefits required of the funds would be increased. As a total reform of the health insurance system had been shown to be politically unfeasible, the Federal Office of Social Insurance announced 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.'"[30] To this end, the reform would not include national compulsory

---

[29] Botschaft 1961: 1418.

[30] BSV in Neidhart 1970: 337.

health or maternity 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 of the agenda.

Nevertheless, the medical association managed to re-insert the issue of class divisions into the debate, and its ability to do so was clearly linked to the referendum threat. Although the Association had agreed to cooperate with the partial reform, it suddenly switched its position and demanded that the issue of "medical rights" be discussed. Although this sudden about-face was sharply criticized not only by the sickness funds, but also by parliamentarians and the press, the demand was met; the issue of doctors' fees was now to be incorporated into the reform. Interestingly, however, supporters of both the sickness funds and the medical profession agreed to this demand. Supporters of the funds argued that as the reform would increase benefits to the insured, chances of a referendum defeat were slim and that the committee should seize the opportunity to regulate doctors' fees once and for all. Supporters of the medical profession, on the other hand, used exactly the same reasoning to argue that the sickness funds would not be able to launch a campaign against the law and that, consequently, the committee should not concern itself with appeasing the funds. Still other supporters of physicians argued that the results of the Tuberculosis referendum of 1949 demonstrated that no health insurance reforms could be enacted without the approval of the medical profession.[31] Thus, politicians calculate the power of interest groups in terms of the referendum, yet they must make guesses about what is likely to ensue; the threat of referendum is used as an argument for their own positions as well as altering their calculations of how to draft the legislation. But the concept of power is defined by the referendum and the rules of the game are 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.

---

[31] 17 August 1961, Archives 1960: Bd 67.

Once the issue of doctors' fees or medical rights was re-opened, however, the demands of the SÄV began to increase. Not only should class divisions be legalized, but now 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.[32] 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. Differences of opinion among the parliamentary representatives were divided not according to party, but according to support for either the medical profession or the sickness funds. The most ardent supporters of the medical association and the sickness funds, for instance, were both to be found within the Conservative-Christian Socialist Party. 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."[33] Nevertheless, the final results clearly benefitted the groups that could launch a referendum and penalized those that could not. The medical profession was granted class divisions, reim-

---

[32] 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 dollars were spent (Kocher 1972: 147).

[33] Obrecht, Stenbull SR 1963: 104.

bursement payment, no sanctions would be applied if no fee schedules were negotiated. Over the protests of the Swiss Medical Association, chiropractors were incorporated into the system on the same basis as licensed physicians.[34] 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" 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. Moreover, 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. Further, because these groups wielded such influence, issues tended to be discussed in terms of minoritarian interests as opposed to other possible cleavages, such as party color or class position.

---

[34] The victory of the chiropractors demonstrates that the referendum threat is more essential than professional status.

2.3 Majority Parliamentarism

In 1932, the Swedish Farmer-Labor coalition created what Olle Nyman has called a shift from minority parliamentarism to majority parliamentarism. Despite this parliamentary power, however, political decision-making in health has rested on agreements worked out amongst interest groups in the executive arena. Thus, although the political institutions were shaped by ideas about expanding democratic representation to wrest power from the monarchy, in practice, the system depends upon extra-parliamentary agreements.

In contrast to the French and Swiss systems, there are few veto points. Once a decision has been taken in the executive arena, the parliament is unlikely to change it, as the executive government rests on stable parliamentary majorities. Similarly, as voting patterns are stable as well, parliamentary decisions are generally not changed by reactions from the electorate, such as press campaigns, elections, or referenda.[35] Only in the very rare occasion of an electoral realignment - or the threat of one - does the electoral arena become significant for specific policy proposals. Consequently, policy-making has been focused in the executive, with interest group representation concentrated in Royal Commissions, the consultative bodies of interest-group representatives and government officials appointed by the executive to investigate specific policy problems and to draft legislative proposals - as well as the associated *remiss* process, during which interest-groups are requested to submit written comments on policy proposals. The "boundary rules" for this arena require the representation of a broad array of interest-groups, politicians and policy experts. Similarly, the "decision rules" require a majority consensus for legislative action to be taken. The political logic of this system entails building a majority coalition within this executive arena.

The Swedish medical profession was placed at a disadvantage within this political system. In executive proceedings, its views were always weighed against the views of the Swedish Trade Union Confederation

[35] For many years, the bicameral parliament added an additional buffer between the executive government and electoral shifts.

(LO), the Central Organization of Salaried Empolyees (TCO), and the Swedisch Employer Association (SAF). The profession had better contacts in the parliament, but the Conservative M.P.'s 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 to the social democratic party 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. Although its electoral position was strong, there was pressure to act immediately due to Communist gains in the 1944 elections and the party had lost its absolute majority. 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 protest the law. Instead, each group expressed misgivings but agreed to cooperate. The Swedish Employers' Federation (SAF) pointed to the virtues of voluntary insurance and questioned the financial wisdom of immediately introducing national health insurance, but essentially agreed to the reform. TCO, the white collar union, noted that most of its members would not benefit from the reform, but, out of solidarity, it lent its support. The Swedish Medical Association (LF) 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 in other words, the medical profession was not in a veto position. The government had the parliamentary votes necessary to enact the law, other interest groups seem prepared to acquiesce, and there is 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 no matter what the political consensus was amongst politicians and interest groups. In fact, the government had not even found it necessary to include the profession in the preparation of the law.

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. 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.[36] But the pattern was the same in many other policy areas; the non-socialist parties relied on the press to carry out an electoral campaign that has been singled out as being unusually aggressive and ideological in tone.[37]

The Social Democrats governed alone, but the potential breakdown of future prospects for Farmer-Labor coalition governments as well as electoral losses placed the party in a vulnerable position. This provided the medical profession with an opportunity. In contrast to its grudging acceptance of national health insurance, now the profession declared itself absolutely opposed to the Höjer reform and its representatives even issued dissents to the Commission report, a fairly unusual event. Employers, as well, took a harder line. SAF stated that not only was socialized medicine completely unacceptable, but that such expansionary social policies threatened efforts to implement a monetary stabilization program. At the same time, LO was concerned about the costs of the reform, and wondered if it would not be wise to carry out further estimates, so that a real weighing of costs and resources could take place, not only within the health sector, but also between various types of social services.

---

[36] Ög 1962: 10

[37] Elvander 1972.

In face of these electoral and interest group 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.

This is the only time, however, when the medical profession has had this kind of success in blocking a health program in Sweden. And this success as a veto group seems better explained by the existence of an opportunity created by an electoral threat and the simultaneous dissatisfaction of other interest groups.[38]

As soon as this moment had passed, the social democratic government went ahead with a number of health policies, often without consulting the medical association. Over the opposition of the Association, the number of doctors was increased by a factor of seven between 1947 and 1972. The hospital system was regionalized, and steps were taken to reduce private practice. 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 7 Crowns ($1.40), and hospital doctors were placed on full-time salaries.

At no time was the profession able to rouse the kind of political support that it had in 1948. In 1969, Conservative M.P.'s supported the profession and voted against the law to eliminate private practice from hospitals and to reduce patient fees to seven Crowns. Never-

---

[38] This seems to be the case currently for the British medical profession which has not been successful in the past at resisting government health programs, but which now finds itself united in opposition to the White Paper of January 1989 (Working for Patients) with other interest groups and at a time when the electoral situation of the government is precarious.

theless, 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 M.P.'s."[39] Furthermore, in the preparations for the reform, LO and TCO had expressed enthusiasm for the benefit expansion entailed by the changed fees for hospital outpatient care, and SAF had supported the reform as a rationalizing measure that would reduce costs.

Again, the eye of the parties on the electorate is evident. The attacks on the private sector began in 1959, after the resounding SAP victory in the ATP (superannuated pensions) referendum. According to Social Minister Sven Aspling, the Center and Liberal parties were afraid to vote against the Seven Crowns reform, as "the opposition understood that they had burned their fingers in the ATP-conflict."[40] Moreover, many of these politicians held positions in the County Councils, who were pushing for the reform. In contrast to the Swiss case, here the perception is that the electorate is eager for social reforms. However, to be strict in the analysis of representation, one must note that: a) the vote is for pensions not health; b) the ATP choices included clear benefits, not merely a compulsion to insure oneself; c) the Swedish parties put forth the choices rather than de-coupling themselves from the referenda campaigns.

Thus, it seems very clear that Swedish doctors were placed in a weak political situation. Interestingly, they were quite successful in *economic* actions. They carried out a strike in 1957 in which doctors organized an alternative private health service, they reacted to the elimination

---

[39] Riksdagens Protokoll FK (Parliamentary debates of the First Chamber) (1969, 39: 72). Indeed, one M.P. complained that he had been astounded to hear on the television that the Seven Crowns Reform had been passed into law, as he was eating his dinner before going to the Parliament to vote on the reform.

[40] Interview, June 1980; see Immergut (1989) for more detail on Seven Crowns reform; on role of county council "party" see Evjegard (1973) and Heidenheimer (1980).

of private beds in public hospitals by building private clinics in the early 1960s, and they made a strike threat in 1965 that resulted in substantial increases in the reimbursement fee schedule for doctors. Each time, however, the government reacted by taking a *political* step that constrained the private market, and as the preceding analysis has shown, Swedish physicians were politically disadvantaged. The defeat of the Höjer reform was met with the increases in medical school admissions in the 1950s;[41] the 1957 strike was followed by the 1959 Hospital Law; the private clinics were combatted by announcements that the government planned to build local health centers in the mid-1960s; the increases in the fee reimbursement schedule in the late 1960s resulted in the Seven Crowns reform, which eliminated the problem of fee increases by introducing salaries.

It has been pointed out, however, that the leadership of the Swedish Medical Association did not always pursue a hard-line stance against government policies. For example, in the case of the Seven Crowns reform, salaries for hospital doctors were introduced through negotiations between the Medical Association and the Federation of County Councils, which represented the local units of government that owned and operated the hospitals, after the parliament had introduced the seven crowns fee and eliminated private medical consultations. Even when it was attacked by its membership for not being more forceful, the leadership insisted on the importance of cooperation, for it was "stuck" in a situation where it was difficult to bargain with resolution and strength.[42] This attitude of cooperation has been analyzed in

---

[41] It is well worth pointing out that even after the large increase in the number of doctors in Sweden, there were only 13.9 physicians per 10,000 persons, as compared to 15.4 in the United States, 17.8 in West Germany, and also 13.9 in France (Altenstetter 1976: 22). Another source gives 8.92 doctors per 10,000 in Sweden in 1958, as compared to 10.7 in France and 14.1 in Switzerland (Hogarth 1963: 60, 139, 281). While in 1975, the number of doctors per 10,000 had increased to 17.2 for Sweden, 14.6 for France, and 18.6 for Switzerland.

[42] Läkartidningen, 5 November 1969, pp. 4625-4628; 19 November 1969, p. 4826; December 1969, p. 4964. See also Carder and Klingeberg, 1980.

terms of changes in the market position of doctors - the increased number of doctors and the consolidation of the county councils - and also changes in the leadership of the medical association, particularly the emergence of younger doctors in leadership positions.[43] While these may be important factors to consider, they do not seem to be able to explain the Medical Association's actions during this period. With the same leadership in 1946 and 1948, they seem to be uncooperative when faced with a strategic opportunity to protest, but to prefer to cooperate and bargain for concessions at times when they will not be able to affect political outcomes. In 1969, with an absolute majority for the Social Democrats and agreement from SAF, TCO and LO, it does seem that the leadership's assessment of its situation is fairly reasonable; it is indeed "stuck." Moreover, the passage of health care policies fits so closely the pattern of other policy areas, it seems unlikely that any factor peculiar to the medical profession can explain these general patterns.[44]

The state can control the market, in other words, if it has the political support to take action. It is interesting to note that the Swedish government, like the French, solidified its reform by changing the market incentives to both doctors and patients. In France, the individual convention assured the widespread acceptance of the convention system by making it much cheaper for patients to go to the doctors that agreed to lower their fees. 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,

---

[43] Heidenheimer 1980; Klingeberg and Carder 1980.

[44] Interestingly, in 1970 a tax reform was passed in the name of equality through a similar process: no Royal Commission, the Social Democrats were accused of precluding public discussion of the reform, and the reform process was controlled completely from within the government with little input from the political parties. One could also pair the Höjer reform with the defeat of the 1947 proposal for a new inheritance tax, in which the reform was rejected out of hand, the debate was highly ideological with the lines between the socialist and non-socialist parties drawn very sharply, and there was a sudden, new use of the press as a political outlet by the non-socialist parties and business groups. See Elvander 1972: chapters II and VIII.

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; just as the individual convention broke the French doctors' strike. 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, the opinions of other interest groups, 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 the Swedish configuration of interest representation created a forum for majoritarian decision-making, closing off the veto points available to dissident groups and encouraging compromises between these various political actors.

3. Conclusions

In this paper, an effort has been made to show how veto points created by gaps in representation allow political decisions to be overturned at different stages in the policy process. This has provided interest groups with different types of opportunities in the three systems and it helps to explain which groups are essential for any political decision. In Sweden, decisions were made in the executive arena, through a consensual process that depended on majority rule. This meant that if agreement was reached between LO, SAF and TCO, representatives of the medical profession had few options other than to agree to this decision. In France, decisions during the Fourth Republic were made, effectively, in the parliament, where groups with ties to swing voters were sufficient to veto decisions. The decision rule could be termed "hierarchy" or "privilege" because it is the relationship to the regime that determines the veto power of a particular group. Even in the unusual constitutional junctures where the executive government made unilateral decisions, the executive tended to privilege certain select groups, like the unions at the

Liberation or large employers (CNPF) at the start of the Fifth Republic.[45] In Switzerland, the ability to veto decisions by calling for referenda allows any group, by itself, to exert veto power. Consequently, the decision rule is unanimity, as all groups *must* agree with the decision if it is to stick.

	Arena	Actors	Decision	Logic
Sweden	Executive	LO, SAF, TCO	Majority Rule	Majoritarian (looks like "class")
France IV Republic	Parliament (unstable coalitions	CFTC, CGC, CGMPE, CNPF, C S M F, Poujadistes	Hierarchy/ Privilege (Degree to which group is critical to regime)	Particularlistic (looks like "interest groups")
V Republic (Liberation)	Executive (Rule by Decree)	CNPF (CGT, CFTC, CSMF)		Plebiscitarian (looks like "state")
Switzerland	Electorate (Referendum)	SÄV, SAV, SGV, SBV, chiropractors, potentially sickness funds, unions and employee associations	Unanimity	Minoritarian (looks like "interest groups")

In studying these episodes of reform, one reaches the conclusion that the medical profession has less impact on health policy than is generally believed to be the case. To the extent that it has an impact,

[45] Note that neither the size of the group (which implies something about the number of voters it represents) nor the class affiliation of its members nor the importance of the group to the economy, but rather the choice of the executive explains which group is privileged and which not. Further, one can see links between the pattern of interest groups and the factors that influenced individual political decisions. The majoritarian politics of the Swedish system have produced majoritarian groups (LO, SAF); the hierarchical politics of the French system have produced privileged groups whose political power depends upon their relation to the state (CSMF, CGMPE, CGC, CFTC, CGT); the minoritarian politics of the Swiss system have produced very small groups that retain veto power over reforms (chiropractors, doctors, artisans, farmers, etc).

this has been caused by opportunities presented by different political systems, and not by differences in organizations or differences in the professionalization process. 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 these pressures.

Ironically, the mistaken belief that the medical profession can veto any health policy has diverted the attention of both policy-makers and policy-analysts from important issues of health policy. While worries about what the profession will or will not accept have dominated discussions of health policy, with the potential veto power of the profession serving as a kind of "Ersatz" policy standard, more appropriate standards for policy-making may have been neglected. As one reviews these debates, the medical profession and its access to a private market have constituted the centerpiece of much political conflict. Yet there has been much less public discussion about actual *health* and how it may best be achieved.

The similarity in policy proposals raises the suspicion that the predominance of the public/private conflict may in fact be an artifact of these political systems. Attacks or defenses of the private market may capture public attention because they resonate with some of the basic political categories in these systems of representation. It is possible that the drive for market restriction and control of the medical profession may be of a greater symbolic than economic value. But it has also meant the exclusion of more substantive discussions about the goals of health policy.

But ideas about politics, as opposed to ideas about health, have indeed played a critical role. Interpretations of power and political representation have shaped the formation of these political institutions and they re-emerge each time that these actors discuss their strategies. It may be, though, that the ideas that emerge are interpretations of power rather than "real" power, a kind of institutional script that is used to make sense of events after they happen. For power remains an intangible concept, one that people try to grasp in their under-

standings of what is possible, but it remains a factor that cannot be measured.

Bibliography

Altenstetter, Christa, 1976: The Impact of Organizational Arrangements. In: C. Altenstetter (ed.), Changing National-Subnational Relations in Health. Washington, DC: Fogerty International Center and Department of Health, Education and Welfare, 3-33.

Archives, 1960: Bundesamt für Sozialversicherung. Grundsätze und Erläuterungen f.d. Revision d. Krankenversicherung, Archiv/E, Bd. 61-2, Files 21404110-21404114.

Birnbaum, Pierre, 1977: Les Sommets de l'Etat. Paris: Editions du Seuil.

Botschaft, 1961: Botschaft des Bundesrates an die Bundesversammlung zum Entwurf eines Bundesgesetzes betreffend die Änderung des Ersten Titels des Bundesgesetzes über die Kranken- und Unfallsversicherung (vom 5. Juni 1961). In: Bundesblatt 113 (25, I): 1417-1528.

Blanpain, Jan/ Luc Delesie/ Herman Nys, 1978: National Health Insurance and Health Resources. Cambridge, MA: Harvard University Press.

Braun, Rudolf, 1985: Zur Professionalisierung des Ärztestandes in der Schweiz. In: Jürgen Kocka (ed.), Bildungsbürgertum im 19. Jahrhundert. Stuttgart: Klett-Cotta, 332- 357.

Carder, Mack/ Klingeberg, Bendix, 1980: Towards a Salaried Medical Profession: How 'Swedish was the Seven Crowns Reform? In: Arnold J. Heidenheimer/ Nils Elvander (eds.), The Shaping of the Swedish Health System. London: Croom Helm, 143-172.

Cibrie, Paul, 1954: Syndicalisme Médical. Paris: Confédération des Syndicats Médicaux Français (CSMF).

Crozier, Michel, 1964: The Bureaucratic Phenomenon. Chicago: University of Chicago Press.

Crozier, Michel/ Erhard Friedberg, 1980: Actors and Systems: The Politics of Collective Action. Chicago: University of Chicago Press.

Doublet, Jaques, 1971: La Sécurité Sociale et son évolution [octobre 1951-juin 1960]. In: Revue Française des Affaires Sociales 25(2, April-June), 26-60.

Eckstein, Harry, 1960: Pressure Group Politics: The Case of the British Medical Association. London: Allen & Unwin.

Elvander, Nils, 1966: Intresseorganisationerna i dagens Sverige. Lund: CWK Gleerup Bokförlag.

Elvander, Nils, 1972: Svensk Skattepolitik 1945-1970. En Studie i partiers och organisationers funktioner. Stockholm: Rabén och Sjögren.

Elvander, Nils, 1974: Interest Groups in Sweden. In: Annals of the American Academy of Political and Social Science 413 (May): 27-43.

Evjegård, Rolf, 1973: Landstingsförbundet. Organisation. Beslutsfattande. Förhållande till Staten. Stockholm: Landstingsförbundet.

Freddi Giorgio/ James Warner Björkman, 1989: Controlling Medical Professionals: The Comparative Politics of Health Governance. Newbury Park, CA: Sage Publications, Inc.

Galant, Henry C., 1955: Histoire Politique de la Sécurité Sociale Française. 1945-1952. Cahiers de la Fondation Nationale des Sciences Politiques No. 76. Paris: Librairie Armand Colin.

Glaser, William A., 1970: Paying the Doctor: Systems of Remuneration and their effects. Baltimore: Johns Hopkins Press.

Gruner, Erich, 1969: Regierung und Opposition im schweizerischen Bundesstaat. Serie Staat und Politik, no. 7. Bern: Verlag Paul Haupt.

Gruner, Erich, 1973: Politische Führungsgruppen im Bundestaat. Bern: Francke Verlag.

Gruner, Erich, 1977: Die Parteien in der Schweiz. 2nd ed. Bern: Francke Verlag.

Hatzfeld, Henri, 1963: Le Grand Tournant de la Médecine Libérale. Paris: Les Editions Ouvrières.

Hatzfeld, Henri, 1971: Du Paupérisme a la Sécurité Sociale. Essai sur les Origines de la Sécurité Sociale en France. 1850-1940. Paris: Librairie Armand Colin.

Heidenheimer, Arnold J., 1980: Conflict and Comprmose Between Professional and Bureaucratic Health Interests. 1947-1972. In: Arnold J. Heidenheimer/ Nils Elvander (eds.), The Shaping of the Swedish Health System. London: Croom Helm, 119-142.

Hogarth, James, 1963: The Payment of the Physician. Some European Comparisons. NY: Macmillan Co. (Pergamon Press).

Imbert, Jean, 1958: La réforme hospitalière. In: Droit Social 21 (9-10) (Sept-Oct): 496-505.

Immergut, Ellen, 1989: Procedures for Conciliation: National Health Insurance Politics in Sweden. In: Scandinavian Studies 61 (Dec): 146-168.

Jamous, Haroun, 1969: Sociologie de la Décision: la réforme des études médicales et des structures hospitalières. Paris: Editions du Centre Nationale de la Recherche Scientifique.

Katzenstein, Peter J., 1984: Corporatism and Change: Austria, Switzerland, and the Politics of Industry. Ithaca & London: Cornell University Press.

Kerr, Henry H., 1974: Switzerland: Social Cleavages and Partisan Conflict. London & Beverley Hills: Sage Publications.

Kerr, Henry H., 1981: Parlement et Société en Suisse. St. Saphorin: Editions Georgi.

Klein, Rudolf, 1979: Ideology, Class and the National Health Service. In: Journal of Health Politics, Policy and Law 4 (Fall): 464-490.

Kocher, Gerhard, 1972: Verbandseinfluss auf die Gesetzgebung. Aerzteverbindung, Krankenkassenverbände und die Teilrevision 1964 des Kranken- und Unfallsversicherungsgesetzes. 2nd ed. Bern: Francke Verlag.

KSK (1958-1960): Konkordat der schweizerischen Krankenkassen, Tätigkeitsbericht (Konkordat of Sickness Funds, annual report).

Läkartidningen. (Journal of the Swedish Medical Association)

Laroque, Pierre, 1971: La Sécurité Sociale de 1944 a 1951. In: Revue Française des Affaires Sociales 25(2) (April-June): 11-25.

Lemaire, Florence, 1964: La réforme hospitalo-universitaire. Mémoire présenté a l'Institute d'Etudes Politiques de l'"Université de Paris.

Light, Donald and Sol Levine, 1988: The Changing Character of the Medical Profession: A Theoretical Overview. In: The Milbank Quarterly 66, Suppl. 2, 10-32.

Lipsky, Michael, 1968: Protest as a Political Resource. In: APSR 62, 1144-58.

Mane, Roland, 1962: Où va le syndicalisme médical? In: Droit Social 25(9-10) (Sept-Oct): 516-529.

Marmor, Theodore R./ David Thomas, 1972: Doctors, Politics and Pay Disputes: 'Pressure Group Politics' Revisited. In: British Journal of Political Science 2: 421-442.

Meynaud, Jean, 1958: Les Groupes de Pression en France. Cahiers de la Fondation Nationale des Sciences Politiques No. 95. Paris: Librairie Armand Colin.

Meynaud, Jean, 1963: Les organisations professionnelles en Suisse. Lausanne: Editions Librairie Payot.

Naschold, Frieder, 1967: Kassenärzte und Krankenversicherungsreform. Zu einer Theorie der Statuspolitik. Freiburg im Breisgau: Verlag Rombach.

Neidhart, Leonhard, 1970: Plebiszit und pluralitäre Demokratie. Eine Analyse der Funktion der Schweizerischen Gesetzreferendums. Bern: Francke Verlag.

Ög, Anita Jarild, 1962: Diskussion kring Medicinalstyrelsens betånkande, 'Den öppna läkarvården i riket.' Unpublished paper from the pro-seminar in Political Science, Uppsala University.

Riksdagens Protokoll FK (Parliamentary debates of the First Chamber)

Safran, William, 1967: Veto-Group Politics: The Case of Health Insurance Reform in West Germany. San Francisco: Chandler.

Savatier, Jean, 1962: Une Profession libérale face au mouvement contemporain de socialisation. In: Droit Sociale 25(9-10) (Sept-Oct): 477-9.

Scharpf, Fritz W., 1988: Decision Rules, Decision Styles, and Policy Choices. MPIFG Discussion Paper 88/3. Köln: Max-Planck-Institut für Gesellschaftsforschung.

Schattschneider, E. E., 1960: The Semi-Sovereign People. Hinsdale: Dryden.

Shapiro, Robert Y./ John T. Young, 1989: Public Opinion and the Welfare State. In: Political Science Quarterly 104(1) (Spring): 58-89.

Shepsle, Kenneth A./ Barry R. Weingast, 1987: The Institutional Foundations of Committee Power. In: APSR 81 (March): 85-104.

Sköld, Lars/ Halvarson, Arne, 1966: Riksdagens Sociala Sammansättning under Hundra År. In: Samhälle oc Riksdag. Del I. STH: Almqvist & Wicksell, 375-493.

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

Stenbull SR, 1963: Amtliches Stenographisches Bulletin der schweizerischen Bundesversammlung. Ständerat, (Parliamentary debates of States' Council.)

Steffen, Monika, 1983: Regulation Politique et Strategies Professionnelles: Médecine Libérale et Emergence des Centres de Santé. Thèse d'Etat. Institute d'Etudes Politiques. Université des Sciences Sociales de Grenoble II, Grenoble.

Steffen, Monika, 1987: The Medical Profession and the State in France. In: Jounral of Public Policy 7(2), 189-208.

Stephan, Jean-Claude, 1978: Economie et Pouvoir Médical. Paris: Economica.

Stone, Deborah A., 1980: The Limits of Professional Power. National Health Care in the Federal Republic of Germany. Chicago: University of Chicago Press.

Sveriges Läkarförbund (The Swedish Medical Association), 1944: Utredning angående Poliklinikväsendet i Sverige, angiven av Sveriges Läkarförbundspolikliniksakkunige. STH: LF.

Tocqueville, Alexis de, 1958 [1856]: The Ancien Régime and the French Revolution. NY: Doubleday, Anchor Books.

Visser, Jelle, 1984: Dimensions of Union Growth in Postwar Western Europe. European University Institute Working Paper No. 89. Badia Fiesolana, San Domenico (FI): European University Institute.

Wilensky, Harold L., 1975: The Welfare State and Equality. U. of California Press.

Wilsford, David, 1986: French Doctors and the State. Paper presented at the APSR Meetings, August.