The rules of the game: The logic of health policy-making in France, Switzerland, and Sweden

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Explaining change is a central problem for institutional analysis. If institutions are purported to have a kind of staying power, then how can the same institutions explain both stability and change? If institutions limit the scope of action that appears possible to different actors, why can they sometimes escape these constraints? This essay uses the case of national health insurance politics to show how institutions can explain both policy stability and policy change. The key to the analysis is a break with "correlational" thinking. Rather than analyzing policy-making in terms of correlations between policy inputs (such as demands from various social groups or past policy legacies) and policy outputs (such as specific pieces of legislation) the strength of institutional analysis is to show why policy inputs and policy outputs may be linked together in different ways in different political systems.

THE PROBLEM

National health insurance constitutes an excellent case for institutional comparison. Nearly every West European government has considered proposals for national health insurance, that is, compulsory public programs that insure citizens for medical treatment. Although the same health programs have been proposed, however, the policy results differ. Political conflicts over national health insurance have resulted in large differences in the role of government in health care provision. The causes of these different results are not self-evident. Not only have policy-makers deliberated quite similar proposals, but similarly situated interest groups seem to have interpreted their interests in similar ways. Doctors, in particular, have traditionally viewed national health insurance programs as a threat to their professional independence. For while these public programs ex-

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pand the market for medical care by using collective resources to pay for medical services, they also generate financial incentives for governments to regulate the medical profession.

Once governments begin to pay for medical services, they inevitably take steps to control the price of these services and hence to control the incomes and activities of doctors. National health insurance programs thus engender an inherent conflict of interest between governments and doctors as the respective buyers and sellers of medical services; these programs menace the economic autonomy of doctors. Nevertheless, despite the reputation of the medical profession as an insurmountable political veto group, some European governments have overcome professional opposition to introduce both national health insurance programs and substantial restrictions on the economic activities of physicians. In other nations, by contrast, medical protests have blocked government efforts to introduce national health insurance as well as controls on doctors' fees. Given that medical associations throughout Western Europe possess a legal monopoly of medical practice and are regarded as highly influential politically, how then can one explain the significant variation in West European health policy? Why have some governments been able to "socialize" medicine?

This essay compares the politics of national health insurance in France, Switzerland, and Sweden. Politicians in all three nations proposed national health insurance as well as controls on doctors' fees. From similar starting points, however, the health systems of France, Switzerland, and Sweden developed in divergent directions as a result of the specific legislative proposals enacted into law in each country. In Switzerland, national health insurance was rejected. Consequently, the role of government in the health care market is limited to providing subsidies to private insurance. In France, by contrast, the government succeeded in introducing national health insurance, a compulsory public insurance program that pays for medical treatment by private doctors, as well as limited controls on doctors' fees. The Swedish government has gone the furthest, first establishing national health insurance and then converting this program to a de facto national health service that provides medical treatment directly to citizens through publicly employed doctors working in public hospitals. The policy results of this series of political conflicts are three health systems that represent the two extremes and the center of government intervention in health: The Swedish can be considered the most socialized health system in Europe, the Swiss the most privatized, and the French a conflict-ridden compromise between the two. Consequently the economic autonomy of doctors has been most restricted in Sweden and least in Switzerland.

The balance of this essay argues that these divergent policy outcomes cannot be explained by differences in the ideas of policy-makers, differences in political partisanship, or differences in the preferences and organization of various interest groups. Instead, it argues that these outcomes are better explained by analyzing the political institutions in each country. These institutions establish different

rules of the game for politicians and interest groups seeking to enact or to block policies. De jure rules of institutional design provide procedural advantages and impediments for translating political power into concrete policies. De facto rules arising from electoral results and party systems change the ways in which these formal institutions work in practice. Together these institutional rules establish distinct logics of decision-making that set the parameters both for executive action and interest group influence.

ALTERNATIVE EXPLANATIONS

One leading explanation for health policy is the theory of "professional dominance." By achieving a monopoly of medical practice, doctors are thought to be able to set the limits to health policy and to determine their conditions of practice under government health programs. Doctors are the sole experts qualified to judge the effects of these public programs on health. Further, these programs depend on the cooperation of doctors, for government health programs are meaningless unless doctors will agree to treat the patients covered by these programs. As the ultimate political weapon, doctors should (in theory) be able to block any health policy proposals to which they are opposed by calling for a medical strike.[1]

Medical dominance does not, however, explain empirical differences in the ability of the French, Swiss, and Swedish medical professions to influence legislative decisions. The first reason, as the following case studies will establish, is that doctors' opinions regarding national health insurance and restrictions on doctors' fees were nearly identical: Swiss, French, and Swedish doctors all objected to these reform proposals. More precisely, elite private practitioners in each country considered the expansion of government in the health insurance area a threat to their economic autonomy. These doctors viewed economic freedom as the precondition for professional freedom. They wished to preserve the status of physicians as independent practitioners and to avoid complete financial dependence on governmental authorities. The ability of these physicians to impose their views on policy-makers, however, differed radically.

Second, the resources available to these doctors do not account for their different degrees of success in blocking proposals for socialized medicine. Although the process of professionalization in Sweden, France, and Switzerland took different paths, by the outset of the twentieth century each of these medical professions had achieved a legal monopoly of medical practice.[2] Indeed the numbers of physicians were more stringently controlled in Sweden and France than in Switzerland. Consequently, in terms of market scarcity, the Swedish medical profession was the most advantageously placed of the three, with 89 doctors for every 100,000 inhabitants in 1959, as compared to 107 in France and 141 in Switzerland (see Table 3.1).[3] Nevertheless, although the Swedish doctors were in shortest supply, it was not the Swedish doctors that were most influential, it was the Swiss.

Table 3.1. *Market scarcity, organizational resources, parliamentary representation of doctors*

	Sweden	France	Switzerland
	89.2	106.7	140.6
	171.5	146.3	185.8
	Membership in medical association (%)		
	76	63	—
	92.2	60-5	97
	Doctors in Parliament (%)		
	Doctors per 100,000 population Year		
1958			
1975			
1930			
1970			
1970	1	12.2	3

Sources: 1. Number of doctors. James Hogarth, *The Payment of the Physician. Some European Comparisons* (New York: Macmillan, Pergamon Press, 1963), pp. 60, 139, 281; R. J. Maxwell, *Health and Wealth. An International Study of Health Care Spending.* (Lexington, Mass.: Lexington Books, D. C. Heath and Company for Sandoz Institute for Health and Socio-Economic Studies, 1981), pp. 148-9, 130-1, 151-2.

2. Memberships. *Läkartidningen* (Journal of the Swedish Medical Association), April 19, 1930, p. 516; Swedish Medi cal Association membership figures; Jean Meynaud, *Les Groupes de Pression en France.* Cahiers de la Fondation Nationale des Sciences Politiques No. 95. (Paris: Librairie Armand Colin, 1958), p. 66; Jean-Claude Stephan, *Economie et Pouvoir Méd ical* (Paris: Economica, 1978), pp. 38-9; Gerhard Kocher, *Verbandseinfluss auf die Gesetzgebung. Aerzteverbindung, Krankenkassenverbände und die Teilrevision 1964 des Kran ken- und Unfallversicherungsgesetzes,* 2d ed. (Bern: Francke Verlag, 1972), p. 25.

3. Parliamentarians. Swedish figures for 1960, Lars Sköld and Ame Halvarson, "Riksdagens Sociala Sammansättning under Hundra År," in *Samhälle och Riksdag. Del I.* (Stock holm: Almqvist and Wicksell, 1966), pp. 444, 465; Henry H. Kerr, *Parlement et Société en Suisse* (St. Saphorin: Editions Georgi, 1981), p. 280.

In organizational terms, on the other hand, the French medical profession should have been the weakest. The most generous estimates place 40% to 60% of the profession as members of medical unions, as opposed to well over 90% in Sweden and Switzerland. Moreover, whereas Swedish and Swiss doctors were organized into single medical associations, French doctors were represented by competing organizations beset by political differences.[4] Again, however, it was

not the French doctors that were the least successful in the political sphere, it was the Swedish. Finally, as far as strikes were concerned, the cases will show that the political victories of physicians' associations were never linked to strikes. Politically influential physicians' associations did not need to resort to strikes. In sum, medical monopoly, market scarcity, strikes, and organizational strength do not account for differences in the ability of national medical professions to defend their economic autonomy against government intervention. Instead, strategic opportunities arising from the design of political institutions explain the extent to which doctors could veto proposed health policies.[5]

A second possible explanation might focus on political demands for national health insurance programs, particularly from unions and leftist political parties. There are differences in both the degree of unionization and the votes received by socialist parties in these countries. But they do not conform either to the policy outcomes or to the political process in these countries. As Table 3.2 shows, Swedish workers and employees were more highly unionized than the French or Swiss. Swiss workers, in turn, were more highly unionized than the French. Yet, for reasons related to the organization of Swiss political institutions, Swiss unions were less effective than French unions in demanding health insurance reform. Thus, while levels of unionization can potentially explain why the Swedish government might be under more pressure to provide extensive public programs in health, they cannot explain the difference between the French and Swiss results. Moreover, the factor of unionization does not enter the political contests over national health insurance in a manner compatible with the ' 'working-class power' ' thesis. All three governments appeared eager to enact national health insurance programs, indicating that in all three nations electoral pressures were sufficient to place the same health policies on the political agenda. The difference between the cases hinged not on the initial pressures for health policy but rather on how these pressures were brought to bear on politicians during the legislative process itself.

Political partisanship, on the other hand, is more convincing as an explanation. The combined vote for Socialist and Communist parties does fit the policy outcomes. However, evidence from the actual political debates discredits this hypothesis. While parliamentary votes and political allegiances structured the political decision-making process, a simple model of partisanship does not capture the texture and substance of these conflicts. National health insurance politics did not boil down to a confrontation between parties of the Left versus those of the Center and Right. Swedish Social Democrats did not triumph over the bourgeois parties by outvoting them. All of the Swedish parties agreed on national health insurance and the earliest steps in this direction had been taken by the liberals. French Communists and Socialists did not band together against Gaullists and the Catholic Left; French health insurance initiatives were imposed by de Gaulle through executive fiat. Swiss Social Democrats were not overcome by the Radical Democrats and Catholic Conservatives; rather, a coalition for

Table 3.2. *Working-class strength (unionization and left voting)*

	Union membership as percentage of labor force			Total union/employee association density (%)	Left voting Socialists (%)/ Communists (%)	
	1939-40	1950	1960	1960	1944	1959
Sweden	36	51	60	73	46.5/10.3	47.8/4.5
France	17	22	11	19.8	23.8/26.1	15.7/19.2
Switzerland	19	29	28	30.3	28.6/—	26.4/2.7

Sources: 1. Union membership. John D. Stephens, *The Transition from Capitalism to Socialism* (London: Macmillan, 1979), p. 115; Jelle Visser, "Dimensions of Union Growth in Postwar Western Europe," European University Institute Working Paper No. 89 (Badia Fiesolana, San Domenico (FI): European University Institute, 1984), pp. 29, 65, 77.

2. Left vote. Peter Flora et al., *State, Economy, and Society in Western Europe, 1815-1975. A Data Handbook in Two Volumes. Vol.). The Growth of Mass Democracies and Welfare States* (Frankfurt: Campus Verlag, 1983), pp. 115, 143, 147. Swedish figures from 1944 and I960; French from 1945 and 1958; Swiss from 1943 and 1959.

national health insurance composed of all three parties was defeated in a popular referendum. Thus political parties across the board were interested in national health insurance programs, and some of the most important initiatives came in fact from nonsocialist parties. Institutional dynamics specific to these three political systems determined to what extent executive governments were able to introduce proposed reforms. These institutional mechanisms - and not the number of votes going to the Left - set the limits to what was politically feasible in each country.

A third approach to the politics of enacting social programs has focused on the state. Both actors within the state, such as bureaucrats, and the institutions of government themselves are said to shape policy conflicts to such an extent that policies are no longer recognizable as products of the demands of various social groups. Such an outlook has variously stressed the role of civil servants, state administrative capacities, policy legacies, state structures, and the more classical issues of state, such as the national interest and political legitimacy. If applied in a static manner, however, such an approach cannot explain legislative changes. The health policies of France, Switzerland, and Sweden shared common starting points but diverged when new laws were introduced. Policy legacies or path dependency cannot account for such watersheds. Neither can state capacities explain health policy outcomes. Switzerland has a federal form of government, yet federalism was not the obstacle to national health insurance. France has a centralized state, but regulation of the medical profession proved politically impossible for many years. Furthermore, unless state structures change each time that new policies are proposed, it is unclear why administrative struc-

tures or state capacities sometimes limit the scope of policy-making and sometimes do not.

The institutional analysis elaborated here emphasizes the importance of executive power for policy-making. The motivations for pursuing national health insurance legislation were indeed linked to questions of political rule. But in order to understand the factors that facilitated or impeded executive governments in enacting their legislative programs, one must consider the ways in which political institutions mediated specific political contests. There is no direct link between a given set of political institutions and a particular policy result. Institutions do not allow one to predict policy outcomes. But by establishing the rules of the game, they do enable one to predict the ways in which these policy conflicts will be played out.

THE RULES OF THE GAME

In order to explain differences in the ability of interest groups to obtain favorable policy outcomes and in the ability of executive governments to enact their legislative programs, this essay analyzes the institutional dynamics of political decision-making. I use a formal perspective on institutions, stressing constitutional rules and electoral results, to show why political decision-making follows characteristic patterns in different polities. Political decisions are not single decisions made at one point in time. Rather, they are composed of sequences of decisions made by different actors at different institutional locations. Simply put, enacting a law requires successive affirmative votes at all decision points. By tracing the formal structure of these decision points as well as examining the party allegiances of the decision-makers at these points, one can understand the logic of the decision-making process.

Political decisions require agreement at several points along a chain of decisions made by representatives in different political arenas. The fate of legislative proposals, such as those for national health insurance, depends upon the number and location of opportunities for veto along this chain. If the politicians that occupy the executive are to enact a new program, they must be able to muster assenting votes at all of the decision points along this chain. Conversely the ability of interest groups to influence such legislative outcomes depends upon their ability to threaten the passage of the law and, hence, to convince those representatives holding critical votes to block the legislation. The probability of veto is not random, however. Vetoes can be predicted from the partisan composition of these different arenas and from the rules for transferring decision-making from one arena to the next. Constitutional provisions create veto opportunities by setting forth procedural rules that establish a division of power amongst elected representatives. Formal rules, such as the separation of executive and legislative powers or the division of legislatures into two chambers determine the number of decision points required for legislative enactment, and therefore

the number and location of potential vetoes. Second, veto opportunities are affected by electoral results and features of the party system that affect the distribution of partisan representatives into the different political arenas; political power depends on votes, but votes as they are distributed within distinctly organized political systems. Thus the essence of a political system is the way in which political institutions partition votes into different jurisdictions in combination with the partisan distribution of these votes. These straightforward political and institutional factors produce complex logics of decision-making that provide different opportunities and constraints on both political leaders and interest groups.

The rational choice literature provides some important insights for understanding these decision-making logics. According to these theories, majority rule is insufficient for reaching political accords. With diverse dimensions of political preference, majority votes for a given policy proposal can always be countered by alternative majorities. Institutional mechanisms put a stop to this so-called cycling of preferences by restricting unlimited choice, and therefore allow binding decisions to be made. In other words, the normal political condition is not consensus; the normal condition is a diversity of preferences. Institutional rules resolve conflicts by limiting the points of decision where alternative proposals can be considered. This is how they forge consensus. American studies of institutions have analyzed some examples of the ways in which institutional mechanisms lead to stable outcomes by restricting choice. Executive vetoes allow the executive to block legislative proposals and therefore to maintain the status quo. Or, historically, the division of legislatures into two chambers, with different property qualifications or constituency sizes, established an upper house whose members could be counted on to exert a moderating influence by vetoing proposals from the lower house. Congressional committees, whose members are self-selected to share some preferences in common, are able to propose changes and get them through the legislature, because they can veto alternative proposals from the full house. Such institutional mechanisms ensure stability in policy outcomes and institutional arrangements because they allow a core of political representatives to veto legislative proposals.[6]

In turning to European cases, however, some revisions must be made in the starting assumptions of institutional analysis. While American studies have often assumed that the executive brakes change while legislators or voters promote changes, in the European cases examined here, the political executive was prepared to promote policy changes while vetoes were made in subsequent arenas. A second difference is the importance of political parties and party discipline in reducing choice by binding representatives to a particular party line. Third, some veto points were created by the concentration of politicians with particular interests in a given political arena such as a parliamentary committee or an upper house. But equally important to these cases were veto points that arose in places where majorities were not limited, and where one can observe exactly the cycling of preferences predicted by rational choice theory. Both the classical veto points

and the latter points of uncertainty were critical for interest-group influence in these cases. Rather than focusing on one particular institutional mechanism, this study examines political systems at work during the policy process and shows how distinctive mechanisms were relevant to the outcomes in each case. We can understand the political systems and the specific mechanisms that arise within them by spelling out the effects of constitutional rules and electoral results.

Figure 3.1 illustrates the impact of constitutional rules and electoral results on political decision-making. The ability of an executive government to introduce a policy depends on its capacity for unilateral action - that is, on the probability that the executive decision will be confirmed at subsequent points of decision. If the executive is constitutionally independent from the Parliament - that is, if its decisions do not require parliamentary approval - the executive may take direct action without concern for the Parliament. In this case the executive decision is the final decision; the Parliament does not have veto power.

But if the constitution requires parliamentary approval, the decision-making process moves to the Parliament. Here, however, partisanship and party discipline make a difference. If the executive government enjoys a stable parliamentary majority and party discipline is in force, the probability that an executive decision would be overturned by the Parliament is extremely low. Under these circumstances, one cannot expect the majority of members of Parliament (MPs who belong to the same political party as the executive) to deviate from the executive decision. Thus, although the Parliament is formally required to ratify the executive decision, the effects of partisanship will lead the Parliament to rubber-stamp the legislation; the executive arena will remain the effective point of decision.

If, however, the executive is not supported by a stable parliamentary majority, or if party discipline does not require members of Parliament to vote with their fellow party members in the executive, the probability that parliamentary representatives would override executive decisions is much greater. In such a situation, one would expect significant policy changes and even vetoes from parliamentary representatives; the Parliament would emerge as a veto point.

Similar factors govern the relationship between the parliamentary arena and the electoral arena. In most political systems, parliamentary decisions are the last step in enactment of laws. However, where the possibility for popular referenda on legislative decisions exists, this formal constitutional rule allows the electorate to override parliamentary decisions. In such a case, the electoral arena becomes an effective veto point. Or, when electoral shifts or approaching elections make members of Parliament especially sensitive to voter reactions, the electoral arena may become a de facto point of decision in a particular political system.

In sum, constitutional rules and electoral results produce different constraints on the ability of executive governments to introduce new policies. These institutional and political hurdles direct decision-making along different paths in different polities. Opportunities for veto determine whether the effective point of

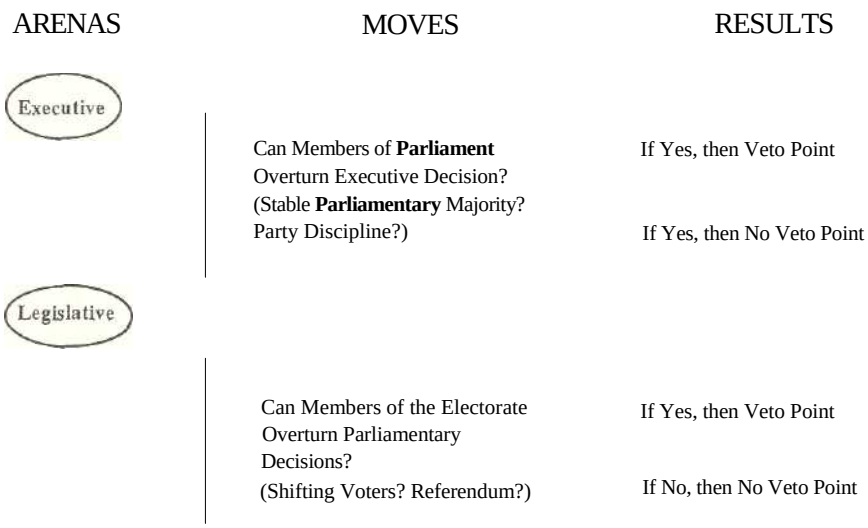

Figure 3.1. Political arenas and veto points

decision will be the executive arena, the parliamentary arena, or the electoral arena. The specific mechanisms for veto determine precisely which politicians or voters have the power to ratify or to block policy proposals. As described, the veto points are not physical entities, but points of strategic uncertainty that arise from the logic of the decision process itself. Even a small change in constitutional rules or electoral results may change the location of the veto points and their strategic importance. In this way, formal constitutional rules and electoral results establish a framework in which policy-making takes place. This is the context for interest group influence.

Interest-group "power" is not a property possessed by interest groups by virtue of some characteristic like the number of members they enroll, the money they collect, or even the contacts they have with politicians. Although efforts have been made to understand interest-group influence in terms of the social or economic position of these groups as well as their organizational resources, factors exclusive to these groups are insufficient for explaining influence. Political influence comprises the relationship of these groups to the political system, and hence, it cannot be understood without an analysis of the receptivity of political institutions to political pressures. The response of politicians to interest groups, it will be argued here, does not depend upon the social origins or the personal weaknesses of these representatives. Instead, specific institutional mechanisms structure the decision process in a given polity, and by so doing, provide interest groups with different opportunities for influencing political decisions. Depending

upon the logic of the decision process, different political strategies are available to interest groups, and different groups are privileged by the political institutions in each country.

The following sections of this essay show how such standard political factors affected health policy-making in France, Switzerland, and Sweden. Irrespective of differences in partisanship, all three executive governments were prepared to enact national health insurance and to restrict the economic independence of the medical profession. National health insurance legislation was prepared in the executive bureaucracy after consultation with representatives of interest groups and political parties. The critical difference between the cases turned on the ability of the political executive to ratify these proposals in subsequent arenas.

In Sweden the political executive could count on decisions being routinely confirmed by the parliament. This pattern of executive dominance was made possible by institutions established to conserve the power of the monarchy and the Conservative Party during the transition to democracy. Proportional representation and an indirectly elected first chamber helped the Social Democrats achieve stable parliamentary majorities. Because the executive government rested on secure parliamentary majorities, executive decisions were automatically ratified by parliamentary votes. This combination of institutional design and electoral victories effectively constrained decision-making to the executive arena. But in this context, Swedish doctors were politically disadvantaged. In the executive arena, their views were outweighed by those of the main producer groups - employers and trade unions - and, in contrast to French and Swiss doctors, they did not have recourse to an alternative veto point to override the executive-level consensus.

In France the Parliament of the Fourth Republic offered unexpected opportunities for interest group influence. Unstable parliamentary coalitions and lack of party discipline impeded executive governments from enacting legislation. Executive proposals were not supported by parliamentary votes; instead, each proposal was countered by alternative parliamentary majorities. Consequently the Parliament became a bottleneck in the French political process and hence the de facto point of decision. This unique decision structure was the context for French interest-group influence. French doctors profited from their parliamentary contacts to demand legislative concessions, and as a group that generally wished to block legislation rather than to see it enacted, these doctors were inadvertently advantaged by the difficulty of French parliamentarians in reaching any binding decision at all. The same features of the political system benefited and disadvantaged other groups. Interest groups important to the members of the governing coalitions, such as small businessmen and Catholics, wrested legislative benefits, while those with party affiliations outside the governing coalitions, such as the Communist union, had little influence. Only when the executive resorted to constitutional change in order to circumvent the parliamentary veto point could French health legislation be enacted.

In Switzerland the constitutional right of voters to challenge legislation through referenda pulled decision-making into the electoral arena. In this arena the instability of majority rule proved a deterrent to proposals for policy change; referendum votes were more often negative than positive. Consequently the referendum was viewed as a threat to legislation. This created a strategic opportunity for the interest groups, like Swiss doctors, who found that they could use the referendum threat to gain concessions from policy-makers. Swiss doctors never resorted to medical strikes; they simply threatened to block legislation by calling for referenda. Other interest groups as well, like chiropractors, relied on the referendum threat to obtain policy concessions. Unions, by contrast, were disadvantaged by this mechanism. To groups that wished to promote legislation, the referendum mechanism could provide only Pyrrhic victories.

In each case institutional rules established a distinct logic of decision-making that set the parameters both for executive power and interest-group influence. Consequently the institutions determined where the balance point between different interest group demands and the programmatic goals of the executive was to be found. In contrast to some of the other analyses in this volume, such as those by Hall, King, and Weir, this essay does not argue that institutions screen out or encourage certain policy ideas. Nor does it argue that institutions change the subjective perceptions of political actors about their interests. This is not to say that institutions could never exert such effects. Rather, selecting a case where both the policy ideas and the views of politicians and interest groups happened to be similar allows these factors to be held constant.

This study singles out the impact of political institutions on the ability of each of these actors to prevail in policy conflicts. By providing different opportunities for vetoing legislation, the institutions change the relative weights of these actors as well as the most opportune strategy available to these actors for promoting similarly defined interests (as in the essays by Dunlavy, Hattam, and Rothstein). In Sweden the executive could enact legislation without fearing vetoes from the parliamentary or electoral arenas; the lack of a block of opposing votes restricted decision-making to the executive arena. In France unstable parliamentary majorities shifted decision-making to the parliamentary arena. In Switzerland decision-making was moved to the electoral arena. The rules of the game established distinct political logics that account for three distinct patterns of political behavior and policy results.

THREE CASES

Direct parliamentary rule

During the French Fourth Republic, French doctors as well as several other interest groups were able to gain concessions from the legislature. The French Parliament constituted a veto point for several reasons. The Constitution of the

Fourth Republic, like that of the Third Republic, was based on the principle of direct parliamentary rule. The executive government was dependent on the Parliament because it was invested by parliamentary coalitions and it could not take action without parliamentary approval. In practice the weakness of the system stemmed not from these constitutional provisions but from the fact that the French electoral system and party practices did not produce stable parliamentary majorities. Had this been the case, the executive government would have had a clear mandate for policy decisions. Instead, the fragmented party system and the lack of internal party discipline made it difficult to form and to maintain decisive parliamentary majorities. Furthermore, the disjuncture between parliamentary majorities and electoral alliances (related to the two rounds of voting, which kept the smaller parties alive and hampered majorities), meant that a single election result could provide the basis for a wide variety of parliamentary coalitions, further increasing the scope for parliamentary manoeuvering.

Thus, while the ideal view of a parliamentary system is that elections establish a distribution of parliamentary seats, and that this distribution is then used to invest an executive, in France these different political arenas - the electoral arena, the parliamentary arena, and the executive arena - were disarticulated.[7] There were virtually no restrictions on the alliances that could be formed or the policy proposals that could be considered. The parties were free to change their positions, and often did so as the unstable electoral situation encouraged opportunistic ploys to attract new voters. Consequently any political party or interest group dissatisfied with an executive decision could hope to achieve a different outcome in the parliamentary arena. Furthermore, given the instability of the governing coalitions, renewed discussion in the parliamentary arena not only might produce a change in policy, but it might cause the government to fall. This instability made the executive government vulnerable to members of political parties - particularly those that controlled swing votes in building or breaking a governing coalition - or to interest groups that could claim connections to these MPs. Under conditions of unstable governing coalitions and weak party discipline, where at any moment majorities could unravel or new allegiances could form, the political game became one of disrupting the coalition.

This potential to disrupt the governing coalition was the key to interest-group power in the French Fourth Republic. Interest groups aimed their appeals at individual members of parliament, particularly during the handling of policy issues in the parliamentary committees and during local election campaigns, when individual candidates were pressured to declare their allegiance to specific local interest groups.[8] Success depended upon reaching individuals central to the coalitions rather than upon building centralized interest organizations with large memberships. This strategic context changed the probability that a particular interest group could veto proposed legislation. Consequently interest groups important to members of Parliament critical to the governing coalitions had no reason to be disposed toward 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 that accrue to swing voters. In the Fourth Republic, physicians and pharmacists together held 5.8% of the seats. More important, they constituted 10.5% of the Radicals, 6.9% of the Catholic left party (the MRP), and 6.5% of the Socialists (the SFIO; refer to Table 3.1).[9] Personalized bargaining, without the protection of party discipline, only enhanced this power. Several other interest blocs, such as farmers, small employers, and special interest groups, such as wine producers, wielded parliamentary clout out of proportion to the number of voters represented by their memberships. With the power to block parliamentary action, and with the parties always seeking to capture new voters, these groups were in a position not only to make demands, but also to escalate these demands at will.

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

French national health insurance was introduced in precisely such an extraordinary period. The executive could issue legislation directly by ordinance, the Parliament was merely consultative, and it was composed, in any case, overwhelmingly of representatives of the resistance coalition. Based on the economic and social program drawn up by the *Conseil National de la Résistance* in the spring of 1944, the Social Security Ordinances were promulgated directly by the executive on October 4 and 9, 1945. Although employers and preexisting health insurance carriers (the old mutual societies and private insurance companies) protested, the executive government utilized the route of direct legislation to introduce a universal social insurance system that covered all salaried employees for health, old age, and work accidents. The plan was to establish a single type of insurance fund, called the *caisse unique*, that would, eventually, cover all French citizens for all risks. The ordinances extended social insurance coverage to the majority of the working population and greatly improved insurance benefits. In an obvious electoral manoeuvre, the executive seized the opportunity to introduce the legislation only days before the first parliamentary elections and the referendum to ratify the Constitution were to be held.[10]

Direct executive privilege was short-lived, however. Almost from the start, the need to make concessions to constituencies of the Liberation coalition weak-

ened the administration's scheme. Particularly with the return to parliamentary democracy, party competition increased, which opened up opportunities for an onslaught of particularistic claims. The medical profession criticized the national health insurance program and blocked regulation of doctors' fees by governmental authorities, insisting instead that local negotiations between health insurance funds and medical associations be used to establish doctors' fees. The Catholic Trade Union and the Catholic left party (MRP) forced the government to remove family allowances from the general social security scheme, and to introduce free elections for the seats on the governing boards of the social security funds. (Free elections would increase the number of Catholic representatives, at the expense of the Communist CGT.) White-collar employees and the self-employed protested their inclusion in the same insurance scheme as workers, thereby putting an end to the movement for universal coverage under a single scheme.[11] The lack of a firm parliamentary coalition provided the opportunity for this interest-group log-rolling.

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

Although doctors' fees were to be regulated through negotiations between local medical associations and local sickness insurance funds, the medical associations simply refused to negotiate. Rural doctors were in principle prepared to negotiate; their patients could not afford the high fees charged by urban specialists in any case. But the urban elite pressured medical association leaders not to negotiate. Consequently patients did not receive full reimbursement for the costs of medical treatment. In response the social insurance funds attempted to push for legislation. But elite physicians were well-placed to veto parliamentary initiatives. Visits by the organization of insurance funds (the FNOSS) to the main parliamentary groups resulted in many bills, but no party dared to oppose the medical profession by actually depositing the bill in the Assembly.[12] With unstable governing coalitions, a solid bloc of deputies, spread through several parties that were regularly included in the government, was in a pivotal position.

The Fourth Republic was equally blocked in the area of hospital reform. Plans for more efficient hospital administration had been submitted to the National Assembly in 1954 and 1957. Hospitals should be freed from local political control by municipal councils and 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.[13] As in the case of doctors' fees, however, parliamentary stalemate had precluded any action.

With the emergence of the Fifth Republic, however, the rules of the game were radically changed. Under the 1958 Constitution, the executive government was effectively freed from the Parliament. Direct election of the executive, greater possibilities for direct executive legislation by decree without parliamentary approval, and a strict separation between the ministries and the Assembly established an independent executive government, one that would no longer be undermined by the lack of stable parliamentary majorities. In the case of health policy, the most important provisions were those that allowed the executive to impose legislation without parliamentary ratification. This transformed the logic of French policy-making.

Within two years of taking office, the de Gaulle government introduced reforms that completely reorganized the hospital system and imposed a new system of fee controls on the medical profession. All of these reforms were enacted by decree or ordinance, with no parliamentary discussion whatsoever. The first of these, the Réforme Debré, established full-time, salaried hospital practice. As a transitional measure, senior doctors would be able to receive a limited amount of private patients within the public hospitals, but this private practice was to be phased out completely.[14] Doctors' fees would be directly regulated by the government. In order to pressure local medical associations to negotiate official fee schedules, individual doctors would be able to sign contracts with the funds. The patients of these doctors would be reimbursed at more favorable rates than doctors that did not sign contracts. These individual contracts had been demanded by the health insurance funds since 1928, but had always been blocked by the French Medical Association. Now French Medical Association control over the fee negotiations was undercut by allowing individual doctors to decide whether or not to sign; the government had added an element of market competition in order to buttress its new institutional framework. In addition the ministers of labor, health, and finance would set maximum fees that would apply in the event that no fee schedules were negotiated.

The French Medical Association protested the government's "politics of fait accompli," and charged that as a result of the decrees, "medical fees will become an affair of the State, and, at the same time, the profession will cease, in our point of view to be a liberal profession, because it will lose, definitively, its economic independence."[15] French doctors fought these measures in the courts, the Parliament and the market, but without success. The Constitutional Council upheld the Debré reform in January 1960. In the legislature an absolute majority in the Senate (155 senators belonging to the Independents, the Gauche Démocratique, the Peasants, or that were unaffiliated, as well as three former ministers of health) and an absolute majority in the National Assembly (241 deputies, including about one-half of the Gaullist UNR deputies) presented propositions for new laws to regulate relations between the medical profession and the social insurance funds.[16] Nevertheless, now independent from the Parliament, the executive held firm and refused to reconsider the decrees.

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

The medical profession was not the only group affected by the decrees of May 12, 1960. For in conjunction with the measures to control fees - a clear improvement in social security benefits - the government reorganized the administrative structure of health insurance and 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. Like the solution to doctors' fees, the administrative reform was not a new idea; it had been debated since the introduction of the social security system and was the preference of both members of the Ministry of Labor and employers. Previous political circumstances had not permitted administrative reform, however. Now it was imposed from above. The social security funds and the unions - the CGT, the CFTC, and the CGT-FO - supported the controls on fees as an increase in benefits, but adamantly opposed the administrative component of the reform, calling it the *étatisation* of the funds. At the same time, small employers opposed the reform because they would lose some of the privileges of their separate health and social security scheme. The only interest group that supported the reform was the employers' association, which was dominated by large industrialists. The industrialists supported both the regulation of doctors' fees and the administrative changes as rationalizing measures that would contain costs.[17]

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

Direct democracy

Swiss political institutions were designed differently from French institutions and had different effects on policy-making. A series of institutional mechanisms restricted the powers of the national government. The jurisdiction of the federal as opposed to the cantonal governments was limited to areas specifically set forth in the constitution; a constitutional amendment was required to enlarge the scope of the federal government. The political executive was composed of a seven-

member council, the Bundesrat, which divided power among representatives elected by the parliament in proportion to the political parties. The legislative branch was divided into two chambers, one elected by proportional representation, and one elected by the cantons, which would be expected to dampen the effects of proportional representation because the more conservative rural cantons would be overrepresented in the second chamber. Finally all legislation was subject to direct electoral veto through the referendum.

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

The referendum had a dual impact on Swiss policy-making. The referendum effectively moved decision-making from the executive and parliamentary arenas into the electoral arena. In referendum votes Swiss voters did not follow partisan loyalties. In fact, statistically, referendum votes were more often negative than positive.[18] These votes followed the predictions of theories of collective action: Voters who were affected by the potential costs of legislation turned out at higher rates than voters affected by potential benefits. Furthermore, recent studies of Swiss referenda show voter participation, which averages 40 percent, to be correlated to socioeconomic status, with higher rates of participation for individuals with higher incomes and higher levels of educational attainment.[19] Precisely these voters, however, were least likely to benefit from national health insurance or other forms of social protection.

The unintended consequences of the referendum go beyond specific instances of defeat, however. Swiss policy-makers were loath to see legislation subject to a referendum challenge after a lengthy process of executive and parliamentary deliberation. Not only was the outcome uncertain, but the chances of failure were greater than those of success. In order to avoid such defeats, they attempted to ensure that legislation was "referendum-proof." Ironically, this placed a great deal of power in the hands of interest groups.[20] Interest groups had sufficient memberships to collect the signatures necessary to launch referenda and the organizational resources to mount referendum campaigns. Although these groups could not control the *outcome* of referendum votes, they *could* control whether or not a referendum was called; interest groups were thus the gatekeepers to the referendum. Furthermore, whereas the general public did not have a clear channel for expressing its views on legislation, interest groups presented policy-makers with very specific demands to which they could respond. Hence the most efficacious means for policy-makers to prevent a possible veto of legislation was

to address interest-group concerns early on in the legislative preparations: "The most successful referendums are those which do not take place. The circles that might have fought the law do not do so because it contains what they want. This is the explanation for the compromise character of a large part of federal legislation; parliament does not make laws in a sovereign way but always under the threat of a referendum. ' '[21]

The ability of interest groups to force issues out of executive and parliamentary arenas and into the electoral arena provided groups willing to block the legislation entirely if their demands were not met 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 ten to twenty members as in the Swedish case, often consisted of more than fifty representatives. Furthermore, as any one group could veto, decision-making had to be unanimous, lest the losing minority would decide to topple the reform at the electoral stage. As in the French case, the possibility of vetoing legislation reduced the incentives for these groups to compromise. Thus policy decisions were shifted to the electoral arena; many extremely small and minority groups were able to exert a large political influence; and unanimity was imposed as the decision rule.

Swiss doctors were able to wrest many concessions from this legislative process. As in other nations, there were two general areas of concern to the profession: (1) the role of the state in the health insurance market, and (2) the freedom of the profession to determine its own fees. Swiss health insurance was organized around a system of federal subsidies to voluntary mutual funds. The insured bought their own policies directly from the mutuals. The mutuals were required to be nonprofit in order to receive the subsidies, but in practice, many private insurance companies simply opened nonprofit divisions that qualified as nonprofit 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 (under the direction of the Bundesrat, collectively governed by three Radical Democrats, two Catholic Conservatives, one Social Democrat, and one member of the Citizens', Farmers', and Artisans' Party) 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 - the cantonally elected

Ständerat approved it unanimously and the proportionally elected Nationalrat gave approval by all but three votes. But interest groups moved the policy process to the electoral arena, where the law was defeated by a national referendum. Though it was launched by French Swiss liberals, the Swiss Medical Association played an active role in this referendum campaign, as did the Swiss Employers' Association, the Swiss Farmers' Association, and the Swiss Small Business Association. On the other side, supporting the law were all of the unions, all of the employee associations, the church organizations, and the association of sickness funds.

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

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

This process was seen clearly in the aftermath of defeat of the 1949 TB referendum. 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 the Department of Social Insurance prepared a plan for compulsory maternity insurance, increased federal subsidies for health insurance, and introduced controls on doctors' fees. The Department withdrew its proposal, however, when preliminary consultations with interest groups indicated that their positions were "too divided" for the government to pursue reform.[23] In a political system where any interest group,

no matter how small, could launch a referendum, and given the uncertain outcome of the referendum, it did not make sense to continue deliberations without the unanimous support of these groups.

As a total reform of the health insurance system had been shown to be politically unfeasible, the Federal Office of Social Insurance announced in 1961 that it intended to pursue a partial reform, which, "must be designed in such a way so as to assure its prospects of acceptance without a referendum battle."[24] To this end, the reform would not include national compulsory health or maternity insurance, or limits on doctors' fees. The reform would be limited to a large increase in the federal subsidies to private health insurance. The executive, in other words, was attempting to protect itself from the electoral arena, the veto point. As interest groups could not be denied access, as in the French case, the process was to be closed off by keeping certain issues off of the agenda.

Nevertheless, the medical association managed to reinsert the issue of doctors' fees into the debate, and its ability to do so was clearly linked to the referendum threat. The medical association was not satisfied that the government had agreed to drop its plans for controls on doctors' fees, which the association called "the first step toward socialized medicine."[25] The association now wished to obtain a ruling that it was legal for physicians to charge patients different fees according to their incomes, a system of sliding fees known as class divisions. In addition the medical association demanded that payment from sickness funds to doctors (direct third-party payment) be replaced by direct payments from patients, who would in turn be reimbursed by the funds. The association built up a war chest estimated at 1 million Swiss francs by increasing its membership fees and hired a public relations firm. This strategy emulated the successful American Medical Association's campaign against national health insurance between 1948 and 1952, which was funded by a special assessment of $25 from each of its 140,000 members, and during which $4.6 million was spent.[26] The Swiss 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 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: The medical profession was adamantly opposed to the inclusion of the chiropractors, but with such a large number of signatures, the chiropractors could clearly veto the reform.

The parliamentary treatment of the reform was a long and drawn out process that lasted nearly two years. Although both houses of Parliament agreed to increase the federal subsidies, the issue of doctors' fees created problems. The behavior of the medical association was severely criticized, with one supporter of the physicians stating that the leadership had been "overrun by a more-or-less radicalized mass."[27] Nevertheless, the final results clearly benefited the groups that could launch a referendum and penalized those that could not. The medical profession was granted freedom to set fees according to income and reimburse-

ment payment. Over the protests of the Swiss Medical Association, chiropractors were incorporated into the system on the same basis as licensed physicians. The victory of the chiropractors demonstrates that the referendum threat is more essential than professional status. The sickness funds were dissatisfied, however. But at a delegates' meeting of the organization of sickness funds (Konkordat) it was decided not to pursue a referendum challenge. As Konkordat president Hänggi explained, no party or union would be willing to fight the reform, and the chiropractors, delighted at the outcome, would constitute fierce competition in a referendum battle.

> Better a little bit of progress with this revision than none at all. . . . For one must be clear about one thing: in a referendum battle, "medical rights" [fees according to patients' incomes] would not play a major role; instead, the talk would be of the improvements in benefits and Federal subsidies, that is, about the material improvements for the insured. The basic conflicts over medical rights, which 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.[28]

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

Majority parliamentarism

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

the Parliament resulted in stalemate, in Sweden institutions were developed to mediate these jurisdictionaî conflicts. The use of Royal Commissions, consultative bodies of interest-group and political representatives appointed by the executive to draft legislative proposals, as well as the associated *remiss* process, during which interest groups were requested to submit written comments, expanded as the monarch sought to avoid the Parliament and parliamentary representatives preferred that policy negotiations take place outside of the royal bureaucracy.

In 1932 the unexpected Social Democratic electoral victory and alliance with the Farmers' Party effected a sea change in the Swedish system that Olle Nyman has called a shift from minority parliamentarism to majority parliamentarism. The very institutions that were designed to block popular change abruptly switched to the favor of the Social Democrats. The Royal Commissions, introduced to allow the monarchical bureaucracy to avoid parliamentary opposition, now helped to promote Social Democratic legislation. The Upper House of the Parliament, long a veto point used by Conservatives, suddenly ensured continued Social Democratic rule despite electoral fluctuations.[30]

After this electoral realignment, the system worked as though the veto points had disappeared. Once a decision had been taken in the executive arena, the Parliament was unlikely to change it, as the executive government rested on stable parliamentary majorities. Similarly, with proportional representation and fairly stable electoral results, parliamentary decisions were generally not challenged by reactions from the electorate. In contrast to Switzerland, interest groups or voters could not veto legislation with referenda; this decision was strictly parliamentary, which in the case of stable parliamentary majorities meant that the party that controlled the executive could control the use of the referendum. In contrast to France, the electorate did not contain pockets of "surge" voters that tempted politicians to defect from the parliamentary coalitions.[31] Only on the very rare occasion of an electoral realignment - or the threat of one - did the electoral arena become significant for specific policy proposals. Consequently policy-making was concentrated in the executive, with interest-group representatives under pressure to compromise as the probability was high that executive proposals would pass unscathed through parliamentary deliberations. The political logic of this system entailed building a majority coalition in the executive arena.

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

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

Two years later the situation had changed. The opposition parties were gearing up for the 1948 electoral campaign and hoped that the 1947 balance-of-payments crisis would erode Social Democratic electoral support. The release of a government report calling for the creation of a National Health Service, by placing all hospital and office doctors on a government salary and eliminating all forms of private medical practice, provided a focus for a conservative backlash. The nonsocialist press depicted this proposal, which was known as the Höjer reform, as a doctrinaire call for the immediate socialization of medicine and the downgrading of doctors from free professionals to state civil servants. The Conservative newspaper, *Svenska Dagbladet*, editorialized, "Mr. Höjer's goal emerges with frightening clarity: the profession's total socialization and the economic levelling of physicians."[32] Doctors, employers and the three nonsocialist 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.[33] But the pattern was the same for economic and tax policy, as well: The nonsocialist parties relied on the press to carry out an electoral campaign that has been singled out as being unusually aggressive and ideological in tone.[34]

The potential breakdown of future prospects for Farmer-Labor coalition governments as well as electoral losses placed the Social Democratic Party in a vulnerable position. Although the Social Democratic MPs held sufficient seats to enact any reform, potential electoral losses presented opponents of Social

Democratic policies with a veto opportunity. These electoral pressures created a strategic opening for the medical profession. Unlike its grudging acceptance of national health insurance, now the profession declared itself absolutely opposed to the Höjer reform. In face of these electoral pressures, the Social Democratic government backed down completely, not only with regard to the Höjer reform, but also with respect to a controversial proposal for a new inheritance tax, as well as other elements of its economic program.

As soon as this moment had passed, however, the Social Democratic government went ahead with a number of health policies, often without consulting the medical association. The overall direction of these policies was to reduce the market power of doctors, by increasing their numbers and reducing the scope of private practice. Over the opposition of the association, the number of doctors was increased by a factor of 7 between 1947 and 1972. Private beds were removed from public hospitals in 1959, and, at the same time, all hospitals were required to provide public outpatient care. These clinics competed with private office practitioners and with the private office hours of hospital doctors and were therefore viewed as a threat to private practice. Finally, in 1969, private medical consultations were banned from public hospitals, outpatient hospital care was made virtually free of charge by setting patient fees at a flat rate of 7 crowns (kronor), and hospital doctors were placed on full-time salaries.

At no time was the profession able to avail itself of a similar strategic opening as that of 1948. In 1969 Conservative MPs supported the profession and voted against the law to eliminate private practice from hospitals and to reduce patient fees to 7 crowns. Nevertheless, with an absolute majority, the Social Democrats had no trouble in passing the reform and did so with the full support of the Center and Liberal parties. Conservatives complained that the parliamentary vote was "a mere formality . . . the real decision has taken place over the heads of the MPs."[35]

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

Nor were these policy changes a result of peculiar preferences on the part of the medical profession or a result of any inherent economic or organizational weaknesses. Swedish private practitioners complained that the Seven Crowns reform entailed "the total socialization of Swedish health care overnight, through changed employment conditions for hospital doctors and the economic freezing-out of private practitioners."[36] Like French and Swiss doctors, the Swedish private practitioners viewed market autonomy as the key to professional freedom.

Indeed, Swedish doctors attacked the medical association leadership for not protesting more forcefully against the Seven Crowns reform. The association might have been able to organize a strike or some other economic action against the reform. In the past, economic protests had been quite successful. Thus Swedish medical opinions did not differ radically from those in other countries, nor did the medical association seem incapable of collective action.[37]

The striking difference between the Swedish medical profession and the others lay in its strategic political position. While strikes had indeed been effective in the past, for example in increasing doctors' fees, these victories were short-lived. After each successful strike, the government took *apolitical* step to constrain the private market, such as removing private beds from public hospitals or eliminating the fee system entirely, as under the Seven Crowns reform, Despite membership protests, the leadership of the Swedish Medical Association argued that it was "stuck" in a situation where it was difficult to bargain with resolution and strength.[38] Not only did the Social Democratic government hold the parliamentary votes that would ensure passage of the legislation, but like the de Gaulle government, it buttressed its reform by changing market incentives to both doctors and patients. In France the individual contract had assured the widespread acceptance of the negotiated fee schedules by making it much cheaper for patients to go to the doctors that agreed to lower their fees, thereby breaking the French doctors' strike. In Sweden the Seven Crowns reform made private office practice less attractive to patients, because hospital outpatient care was now virtually free, whereas in private offices patients were required to pay the full fee and were later reimbursed for a portion of the fee. This would make it difficult for doctors wishing to protest the Seven Crowns reform to flee to the private sector.

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

CONCLUSIONS

In studying these episodes of reform, one reaches the conclusion that the medical profession has had less impact on health policy than is generally believed to be

the case. To the extent that it has an impact, this has been caused by opportunities presented by different political systems, and not by differences in medical organizations or differences in medical licensing and market monopoly. Veto opportunities allow political decisions to be overturned at different stages in the policy process. This has provided interest groups with different routes of political influence in the three systems. In Sweden decisions were made in the executive arena, through a consensual process that depended on majority rule. In France decisions during the Fourth Republic were made in the Parliament, where groups with ties to swing voters were sufficient to veto decisions. When the constitution of the Fifth Republic allowed the executive to circumvent the Parliament, this veto power was eliminated. In Switzerland the ability to veto decisions by calling for referenda allowed opposed interest groups to threaten credibly to veto health insurance legislation. Thus it is not the preferences of the profession that have shaped the health systems, but the preferences of a wide variety of groups and strata of the electorate as they are channeled through political processes that are differentially sensitive to these pressures.

Constitutional rules and electoral results set distinct limits on the ability of executive governments to introduce reforms. These barriers, in turn, served as useful tools for interest groups that wished to block legislation or that were willing to threaten to stop the process unless their demands were met. Consequently the peculiarities of these institutional mechanisms changed the array of relevant political actors and the implicit decision rules in each case (see Figure 3.2). The Swiss referendum allowed even very small groups to veto legislation unilaterally; this allowed such groups to resist pressures for interest aggregation, and unanimity was imposed as the decision rule. In France opportunities for parliamentary concessions privileged those groups central to the coalitions: Catholic unions, doctors, small businessmen. By contrast, direct executive rule privileged unions at the Liberation, industrialists in the Fifth Republic. In Sweden executive decision-making privileged the large producer organizations, who alone needed to agree for a majority decision to be made and to be enforced. This system of open but narrow channels of access to the state encouraged aggregation of interests and the massive organization-building known as Organization Sweden.

In each case, distinctive patterns of policy-making emerged as politicians and interest groups strove to use the institutional mechanisms in each system. By making some courses of action more difficult and facilitating others, the institutions redefined the political alternatives and changed the array of relevant actors. The institutions, in other words, established a strategic context for the actions of these political actors that changed the outcome of specific policy conflicts. This view of institutions breaks with a tradition in institutional analysis. Some of the most compelling arguments about institutions have viewed institutions as an independent variable. For example, electoral laws predict levels of voter turnout; corporatist institutions predict levels of inflation, economic growth, and citizen unruliness.[39]

	Arena	Actors	Decision
Sweden	Executive	LO, SAF, TCO	Majority Rule
France IV Republic V Republic (Liberation)	Parliament (unstable coalitions) Executive (rule by decree)	CFTC, CGC, CGMPE, CNPF, CSMF CNPF (unions at Liberation)	Hierarchy/ Privilege (degree to which group is critical to regime)
Switzerland	Electorate (Referendum)	SÄV, SAV, SGV, SBV, chiropractors (if willing lo veto, potentially sickness funds, unions, and employee associations)	Unanimity

Figure 3.2. Arenas, actors, and decision rules. *Sweden:* LO, Landsorganisationen i Sverige (Swedish Trade Union Confederation); SAF, Sveriges Arbetsgivarförening (Swedish Employer Association); TCO,Tjänstemännens Centralorganisation (Swedish White-Collar Employees [and Managers] Central Organization). *France:* CFTC, Confédération Française des Travailleurs Chrétiens (French Confederation of Christian Workers); CGC, Confédération Générale des Cadres (French Union of White-Collar Employees [and Managers]); CGPME, Confédération Générale des Petites et Moyennes Entreprises ([French] Genera! Confederation of Small and Medium Enterprises); CNPF, Conseil National du Patronat Français (National Council of French Employers); CSMF, Confédération des Syndicats Médicaux Française (Confederation of French Medical Unions). *Switzerland:* SAV, Schweizerischer Arbeitgeberverein, also called Zentralverband Schweizerischer Arbeitgeber-Organisationen (the Swiss Employers' Association); SÄV, Schweizerischer Ärzteverein (Swiss Medical Association), or Verbindung der Schweizer Ärzte; SBV, Schweizerischer Bauernverein (Swiss Farmers' Association); SGV, Schweizerischer Gewerbeverein (Swiss Artisans' Association).

This essay, by contrast, relies on a two-step causal model. It makes a clear distinction between political actors and their strategies versus the institutional frameworks within which this action takes place. The actors formulate their goals, ideas, and desires independently from the institutions. The institutions become relevant only in strategic calculations about the best way to advance a given

interest within a particular system. Over time, there may of course be some spillover - if a particular goal is unachievable, it may after a while be dropped. But at a given point in time, the model presented here does not depend on actors socialized by institutions to restrict their goals or interests.

The origins of the institutions, as well, are chronologically independent from the actors and their strategies. That is, institutions are most certainly created by social actors engaged in a struggle for political power. However, the actors that participated in the battles over institutional design are not necessarily, and in fact only rarely, identical to those that participate in later policy conflicts. Thus the view that institutions are somehow congealed social structure is not especially helpful. To understand the impact of institutions on contemporary policy conflicts, one must analyze the incentives, opportunities, and constraints that institutions provide to the current participants.

Within these institutions, more than one course of action was possible; the unfolding of events depended as much on historical accident and the inventiveness of these actors as on the institutional constraints. Moreover, these actors often made mistakes. The institutions tell us what courses of action are likely to bring success or failure, but they do not predict the final choices made by these actors. Thus the social logic of history is not to be replaced by a new efficiency of history based on political institutions.

Political institutions can be thought of as the outermost frame for political conflicts. The institutions help to define the terms of these conflicts by shaping the practical meaning of political power and providing the basis for developing the rules of thumb of political strategy. The institutions explain many aspects of the life within them - the types of interest organizations that will be successful, the pressures to consolidate interests, the usefulness of membership mobilization, and the degree to which cooperation versus defection is likely to be a fruitful strategy. But the interests, strategies, and resources of political actors cannot explain the institutions, so I prefer to start thinking about politics with the institutions. But no view of politics can rely exclusively on either institutions, on the one hand, or interests and actors, on the other; both components are necessary to our understandings of the past and to our role as the subjects of the future.

NOTES

1 For reviews of theories of professional power see Andrew Abbott, *The System of the Professions. An Essay on the Division of Expert Labor* (Chicago: The University of Chicago Press, 1988); Jeffrey Berlant, *Profession and Monopoly: A Study of Medicine in the United States and Great Britain* (Berkeley: University of California Press, 1975); Giorgio Freddi and James Warner Björkman, eds.. *Controlling Medical Professionals: The Comparative Politics of Health Governance* (Newbury Park, Calif.: Sage Publications, 1989); Eliot Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (New York: Dodd, Mead, 1970); Donald Light and Sol Levine,

"The Changing Character of the Medical Profession: A Theoretical Overview," *The Milbank Quarterly* 66, Suppl. 2 (1988): 10-32; Theodore R. Marmor and David Thomas, "Doctors, Politics and Pay Disputes: 'Pressure Group Politics' Revisited," *British Journal of Political Science* 2 (1972):421-42; Magali Sarfatti Larson, *The Rise of Professionalism. A Sociological Analysis* (Berkeley: University of California Press, 1977); Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982); Deborah A. Stone, *The Limits of Professional Power* (Chicago: Chicago University Press, 1980).

2 Legal monopoly of medical practice, supervised by government bureaucracies, and including penalties for unlicensed practice was established in Sweden in 1663, and in France in 1892. Coordination of cantonal licensing requirements was established in Switzerland in 1867, but not all cantons participated, no bureaucracy controlled the numbers of physicians and no sanctions were in place for unlicensed practitioners. Several cantons used the institutions of direct democracy to introduce legislation allow ing unlicensed practice. Consequently medical monopoly was not firmly established until the 1920s, when two cantons revoked legislation permitting unlicensed practice, and when the Swiss Medical Association became a more effective licensing body. Entry barriers to practice remained lowest in Switzerland, as evidenced both by weaker laws and by the resulting high numbers of doctors. On Switzerland and France, Mat thew Ramsey, "The Politics of Professional Monopoly in Nineteenth-Century Medi cine: The French Model and Its Rivals," in Gerald L. Geison, ed., *Professions and the French State* (Philadelphia: University of Pennsylvania Press, 1984), pp. 225-305; on France, Monika Steffen, "The Medical Profession and the State in France," *Journal of Public Policy*, 7, no. 2 (1987):189-208; on Sweden, Peter Garpenby, *The State and the Medical Profession. A Cross-National Comparison of the Health Policy Arena in the United Kingdom and Sweden 1945-1985* (Linköping: Linköping Studies in Arts and Sciences, 1989). For more discussion of these issues, as well as the case studies, see my book, *Health Politics: Interests and Institutions in Western Europe* (Cambridge: Cambridge University Press, 1992).

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4 William A. Glaser, *Paying the Doctor: Systems of Remuneration and Their Effects* (Baltimore: Johns Hopkins Press, 1970); Gerhard Kocher, *Verbandseinfluss auf die Gesetzgebung. Aerzteverbindung, Krankenkassenverbände und die Teilrevision 1964 des Kranken- und Unfallversicherungsgesetzes*, 2d ed. (Bern: Francke Verlag, 1972); *Läkartidningen* (Journal of the Swedish Medical Association) 1978: 1986-2000; Ro land Mane, "Où va le syndicalisme médical?" *Droit Social* 25, (1962):516-29; Jean Savatier, "Une Profession libérale face au mouvement contemporain de socialisation," *Droit Social*, 25 (1962):477-9. Jean-Claude Stephan, *Economie et Pouvoir Médical* (Paris: Economica, 1978), pp. 38-9.

5 This is the argument made by Harry Eckstein in *Pressure Group Politics: The Case of the British Medical Association* (London: Allen and Unwin, 1960). See also Arnold J. Heidenheimer, "Conflict and Compromise between Professional and Bureaucratic Health Interests. 1947-1972," in Arnold J. Heidenheimer and Nils Elvander, eds., *The Shap ing of the Swedish Health System* (London: Croom Helm, 1980), pp. 119-42; J. Rogers Hollingsworth, *A Political Economy of Medicine: Great Britain and the United States* (Baltimore: Johns Hopkins University Press, 1986); Rudolf Klein, "Ideology, Class and the National Health Service," *Journal of Health Politics, Policy and Law* 4 (1979):484; Stone, *Limits of Professional Power.*

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38 *Läkartidningen,* November 5, 1969, pp. 4625-8, November 19, 1969, p. 4826, Dec. 1969, p. 4964; cf. Carder and Klingeberg, "Towards a Salaried Medical Profession. "

39 I am thankful to Fritz Scharpf for this point, including these examples. For his discussion of the issues of strategy and institutional constraints, see Fritz W. Scharpf, *Crisis and Choice in European Social Democracy*, trans. Ruth Crowley and Fred Thompson (Ithaca, N.Y.: Cornell University Press, 1991), pp. 7-14.