Practice is, in fact, ultimately the only satisfactory basis for a definition of DC. But if so then certain things follow:

1) The question arises of how much of practice is to count? Does it include the whole of 'apparatus politics' and the leading role of the party?

2) Practice will vary, in great or small matters, from party to party. And even allowing for the fact that a spokesman such as Paul Laurent is inevitably aware of the political value of situating the PCF's DC in a wider framework and so will emphasize those aspects of the party's practice that it shares with other parties, there will nonetheless be local presuppositions and local practices that will be part of the PCF's definition of DC. There are, in short, broadly-shared assumptions about DC, but also customs and folkways, local notions and practices that might be particular to a single party. The conventional wisdom about the uniformity of communist political organization emphasizes the broadly-based assumptions. It is perhaps time to explore the folkways, so as to winnow out shades of interpretation of DC that are the fruit oflocal custom. I do not undertake to do this in this paper, but I recommend it as a profitable line of enquiry.

A final approach for an understanding of DC is to examine its obverse. That obverse, for the ex-Comintern parties, is fractionalism. (8)

The taboo on fractional activity has accompanied DC throughout its history. They are related to each other as chaos is related to order, and indeed they are clearly envisaged in terms of chaos and order in

what has become the orthodox interpretation of DC. Fractionalism means setting up autonomous groups in the party subject to their own discipline, and its emergence in the demonology of the communist movement (or of the dominant strand within that movement) can be dated precisely to the Bolsheviks' tenth congress in 1921. The ban on fractional activity was to become, in the words of Ralph Milibrand, the 'sacred cow' of orthodox communism (9).

It might seem that here we are on firm ground. Fractionalism means organizing within the party; DC thus means an emphasis on the collective, on unity and discipline. This is indeed the case. But this conclusion is deceptively simple for at least two reasons:

1) Factional strife is a problem for any political party and any political party has to set limits on it if it is to survive at all let alone pursue its goals. The important question is what is to be the balance, precisely, between centralism and democracy and to what lengths is the party prepared to go to maintain any particular balance. Soviet orthodoxy, transmitted in a first stage through the Comintern and in a later stage through the adoption of the Soviet model by the revolutionary elites of a number of less developed countries, clearly involves an unusually marked skew towards executive authority; and since a cardinal feature of that orthodoxy is that it values orthodoxy, not much variation is to be expected. Variation does exist, nonetheless, and particularly in the WECPs. Thus, the Finnish party has for years managed to live in a satte of permanent schism, and seems almost to have institutionalized it. The Italian party's ritual invocations of DC suggest a continued subscription to the orthodox skew towards

unity and discipline, yet that party secretes clearly defined groups and alliances. The recent attention that WECPs have been giving to radical groups concerned with issues of peace, the ecology and women's liberation may be expected to produce further variation, and has already powerfully affected the Netherlands party.

Worth attention also is the range of political activities that a given party sees as fractional. The establishment of groups with a defined membership and leadership, and an independent programme is the primary target of the ban. At this end of the range there is little to separate a communist party from other political parties. More interesting are the cases where it is not clear that a group is involved at all, but only the expression of an opinion that is judged by the leadership to presage the formation of a group. Thus, in an extreme case an article or book can be seen as fractional activity: 'A text is a positive act and contrary to our statute. Its target is to contest the policy of the democratic movement which has been worked out at its congress, and to contest the movement's leadership. It is a fractional activity' (10).

2) As far as the concept of DC itself is concerned the experience of the orthodox parties is only a part of the story. As we saw, Gramsci's view of DC is hard to reconcile with a taboo on fractional activity. So, too, is the view of DC taken by the Trotskyist parties which expressly reject the historical legacy of the 1921 ban (11). Space does not allow further treatment of this point here (12) but it is of the greatest importance in any full account of the concept of DC. What we are normally dealing with under that rubric is a particular conventional interpretation which at present bears the stamp of orthodoxy. Other interpretations have, however, existed and exist today.

In conclusion, the definition of DC is by no means a straightforward matter. If precept is involved it is precept that has grown out of custom. That custom is by now well implanted. And custom is an intricate affair in which practices, attitudes and ritual are intertwined. The problem of definition - finding answers to the question 'what is DC?' - cannot be tackled merely lexicographically by providing paraphrases nor by listing a series of practices that have come to be attached to the term. Also very much involved are mental associations that the enunciation of the term evoke including the negative associations that attach to fractional activity. It remains to add that the term, with all these psychological and practical associations, forms part of a discourse, a matrix of meanings. When the Spanish party abandoned the term 'Leninist' in its description of itself, or when numerous parties gave up reference to the dictatorship of the proletariat, the impact of these innovations was not restricted to those two terms. The whole matrix of meanings of which DC is so significant a part could not but be affected. If a definition of DC is not easy to distil this is at least partly because of the multiple links of the term within the matrix formed by the discourse of the communist movement.

2) The Historical Dimension

Ever since the turning-point of 1956 the WECPs have been engaging in a scrutiny of the Stalinist period and of the chain of events that led from the splitting of the European Left in and around 1920, through the Manichean period of monolithic communism and its unsettling demise, to

the emergence of Eurocommunism. This interpretation has naturally concerned the practices that go on under the rubric of DC. My intention in this part of the paper is to indicate areas in which enquiry might be fruitful given the new light that today's circumstances casts on the history of DC.

The decisive factor in communist history since the Russian revolution has been the confluence of Marxism-Leninism with the search for political and economic independence (or merely the search for legitimacy) by the elites of less-developed countries. An element of the politics of development is clearly discernible in the political forms that the Bolsheviks adopted in the early years of the Soviet regime, but it was powerfully enhanced in the Stalinist period. The impact of this on the WECPs has been a complex matter. For present purposes we must be content to note that by 1956 the WECPs had realized the problems that the great detour of communism into the developing world was creating for them. The problems, given the geography and the history of the thing, appeared to them in the form of their relationship with the Soviet Union - a perception that their opponents were only too happy to exploit. No treatment of the transmission of Soviet DC to the WECPs can afford to ignore the implications of this aspect of the history of communism.

The conventional view that the WECPs acquired their political forms through the agency of the Comintern is, of course, fundamentally correct. But the manner of that transmission, the period of time over which it took place and the moments during that period that were the most decisive - all these questions need further attention. The conventional story of strains and debates around 1920 followed by a process of

Bolshevization accompanying the upheavals caused by the internal dispute in the Soviet Union in the mid-1920s is also substantially correct, but again requires refinement. What I shall be suggesting is a particular emphasis, a reordering of our perceptions of communism in the 1920s and 1930s. I shall be making connections rather than offering new evidence. The support for what I shall put forward lies in the recent history of the movement and recent historiography on the Soviet Union.

Two developments in particular force a new perspective on the 1920s and 1930s. The first is the re-emergence of Trotskyism after 1956; the second is the attention that has been given to the five years that were decisive in the shaping of Soviet political forms -the period from 1928 to 1932, when the politics of development were finally instituted.

A simple chronology will serve as a framework for what follows.

1917	Russian Revolution
1920	Comintern's second congress; the twenty-one conditions.
1924	Comintern's fifth congress; Trotskyists outcast.
1928-32	First five-year plan; Stalinism takes its definitive form.
1956 and after	WECPs rethink the path followed since 1920; Trotskyism re-emerges.

If the decisive moment in the formation of the Stalinist system of politics was 1928-32, are we to continue to see the period 1920-25 as decisive in the formation of the politics of the WECPs? Is there a useful distinction to be made between the 'Bolshevization' of the earlier period and the Stalinisation' of thelatter? These are aspects of the larger question that I now address: how and when was DC transmitted to the WECPs?

It is as well to start the discussion by listing those features of party life in the WECPs today that are associated with DC and which - as noted above - form a better basis for a definition of DC than do the party statutes themselves. We can then ask when each of these features was acquired.

DC involves a set of political practices, but also a psychology.

The psychology is one which puts a particularly high value on organizational unity. I have illustrated elsewhere how Soviet sources see the party (and in their case society too) as an organism, the well-being of which ranks above the well-being of the parts, and which is seen as being subject to good and ill health. Fractionalism is seen as disease, a maljunctioning of the organism (13).

WECPs moreover share with the CPSU a view of scientific socialism and of the relationship between theory and practice that invests the party' policies and its leadership's answers to problems that arise with a massive authority. If it was one prominent Bolshevik who said that you cannot be right against the party, there have been very many who have endorsed that idea (14). Such an extreme position cannot be taken to be universally held - and I return to this below - but the tradition of thinking that produced it undoubtedly values the collective authority of the party extremely highly. In the Soviet Union this view of unity and solidarity has been projected onto society as a whole, DC being now a constitutional principle at the level of the state.

This psychology informs, legitimates and explains the whole series of political practices associated, in the Soviet Union and in the WECPs, with DC. It is most clear in the taboo on fractional activity; it

invests the leadership with an authority that rests on far more than the majority principle; it correspondingly converts a minority into something less than that principle suggests - into an 'opposition' that is associated first with blindness to the laws of history and secondly with treachery to the political organism. And it goes a long way to explaining why the WECPs have been so resistant to change. In the words of MacEwen:

> In practice, the insistence on lower bodies submitting to higer bodies and minorities to majorities, the outlawing of 'fractions' ... and the obligation fo fight for majority decisions made it impossible for the membership to change the party's policy or the leadership. All change had to come from the top downwards, and this explains why, even when changes are made in communist parties, they tend to be precipitate (often the result of belatedly recognising previous mistakes) or too late, or both (15).

These are the same practices that Althusser labelled 'cementing' in his broadside against the PCFs political norms in 1978 (16). The effect of such practices and of this psychology is well summed up by Kardelj though this time with reference to the ruling League of Communists of Yugoslavia:

> We communists most pose the question of how ... we can overcome the historical practice ... under which every political change imposed by the course of events in a socialist state, be it a change of government or of political policies, is always attended by political disturbances reminiscent of a coup d'etat (17).

Turning from the psychology of DC to political mechanisms, the following features of the political life of WECPs are frequently associated with DC by both dissidents (who object to them) and by party spokesmen (who see them as part of the party's historical identity):

1) The eclipse of representative bodies by executive bodies; the limitation of party congresses and conferences to ratification of of decisions previously arrived at elsewhere in the party's structure.

2) The pruminence of the party's paid professional within the party.

3) The control that the partys's leadership exercises over opportunities for the exchange ofopinion, associated with a deprecation of 'discussion clubs'.

4) The list system of elections which allows for a filtering of candidates. (18)

To what extent, it must now be asked, do these mechanism and the psychology that informs them stem from the thinking and the practice of the CPSU, and how and when did any such transmission take place? Space will not allow a full treatment of these questions; I shall hope, however, to indicate some lines of enquiry that might fruitfully be taken further.

1) It is tempting to attribute the 'absolute verticality' of DC in the WECPs, together with prominent role of the apparatus, to a transfer of norms which the CPSU acquired during the rigours of its construction drive. Yet historians more often date the transposition to the process of 'Bolshevization' of 1924/25. There is, in fact, no conundrum here. It was not a matter of the WECPs acquiring the CPSU's political norms in a single package once and for all. The process of transposition was a continuous one. Crudely, what happened was that, through the agency of the COmintern, the WECPs followed the evolution of Soviet DC. Borrowing a term from the economists, they were indexed to it. The major turning-points of this evolution are listed above: the splitting of the Left in and around 1920 (the date of the Comintern's second congress); the impact of the Trotskyist opposition; and the final formation of the Stalinist political system in 1928-32. I shall advert here only to certain points of interest in this story:

a) The initial repercussions of the twenty-one conditions of 1920 were, of course, momentous in terms of the choice that socialist parties of the time had to make. But despite the call for 'iron discipline bordering on military discipline' in the twenty-one conditions (19) it was some time before the affiliating groups and parties were brought, or brought themselves, to conform to Bolshevik practice. Despite the rigour of the campaign to base party organization on cells in factories, by 1931 only 1 in 23 members of the CPGB was enrolled in a cell, whilst in Czechoslovakia the percentage of members in cells fell by two-thirds between 1926 and 1930 (20). In 1924 the PCI was still split into three quite distinct factions. In the PCF, in 1925 and 1926 party members were not only contributing to the dissident Bulletin communiste and Révolution prolétarienne, but were even serving on the editorial boards of these journals. And in 1925 Pyatnitsky was chiding the CPGB and the PCF for having no paid full-time officials (21).

But if the process of transposition of Soviet norms was a long and gradual one, and was in some areas quite widely resisted - particularly the insistence that the party be organized in cells - it was helped along precisely by the crises and splits listed above. Already the twenty-one conditions had caused socialists to take up a position; those who sought affialiation were by that fact disposed to conform to Bolshevik practice. At the time of the Comintern's fifth congress the nervousness caused by the rift in the international movement led to a further pressure either to conform or face expulsion. The Conference on Organization held in Moscow in 1925 is a mark of the tightening of discipline at this

time (22). Then, after 1928 and especially in the 1930s, the WECPs were subjected to the same stringent discipline that was being exacted of the membership of the CPSU, and indeed of all Soviet citizens.

Finally, if this complex story throws up relatively late examples of lingering diversity, it also presents cases of very early reproduction in Western Europe of the psychology that lies behind Soviet DC:

> In our party, which the revolutionary struggle has not yet completely purged of its old social-democratic deposit, the influence of personalities still plays too great a role ... It is only through the destruction of all petty bourgeois survivals of the individualist 'I' that we shall form the anonymous iron cohort of French Bolsheviks (23).

b) In the debates concerning the Trotskyist opposition we can see how a contradiction had emerged between the party as a government and the party as an agent of revolution. Since 1917, and particularly since 1921, the CPSU had undergone powerful changes that stemmed from its governmental role (see the criticisms made by the Democratic Centralists recorded above). The WECPs did not ~~need~~ have to link support for Soviet power to an unconditional imitation of the CPSU's political practices, for they were not subjected to the pressures of government. That they did so, fatefully, is a mark of:

i) the overwhelming authority that the Bolsheviks enjoyed as a result of success in revolution;

ii) the equally impressive success of the Bolsheviks in setting up an authoritative international organization - itself, with its organizational norms, an illustration of the development of orthodox DC.

What could not possibly have been foreseen at the time was that Stalinist Bolshevism was indeed to be a revolutionary force, but in the very different framework of poor nations against rich, of the world against the West - a framework in which insurrectionary revolution and a military form of political organization adapted to the tasks of national construction in an unlettered and poor society had a logic that was sure to wrong-foot the WECPs in the end.

By the time this logic became clear the linking of their support for the Soviet Union to their imitation of the CPSU's practices had led them into something of an impasse. It had also left the field open for a revolutionary tendency to arise in Western Europe in the 1950s which could be ambivalent in its attitude to the Soviet Union, could condemn the CPSU's political practices since 1921 and could invoke a concept of DC based upon the practices of the Bolsheviks before the exercise of the government and the strains of a developmental drive perverted those practices. What is surprising is that it took so long for this revival of Trotskyism to take place.

c) Having in this manner attached themselves to the CPSU's view of DC the WECPs then underwent the process of Stalinization that affected their mentor in the years from 1928, and were caught up in the purges of the 1930s, and also in the tergiversations of Soviet foreign policy which they duly endorsed until the Comintern, having become an embarrassment to Soviet policies, was abolished in 1943. It is probably to this period that the full development of orthodox DC should be dated. Borkenau puts in strong terms:

> Between 1929 and 1934 the communist parties finally and definitely transformed themselved into quasi-military organizations ready to obey anything. The structure did not change: at the top a burearcracy from which every single man likely to oppose orders had been weeded out; in the middle a small stratum with an absolute unquestioning faith in every order; at the bottom a shifting mass ... They had become an obedient army of crusaders (24).

The question that then arises is what change has taken place since that dismal period.

2) It is a standard criticism made of the WECPs by dissident members that DC by its very operation makes change difficult to propose and to implement. Nonetheless, there has been change, and there is today variation in the political practices of the WECPs. Moreover, to say that the WECPs acquired their political practices by a simple graft from those of the CPSU is basically true, but requires refinement. The reasons for saying this are as follows:

   a) Above all, there is the inevitable difference between the CPSU as a ruling party and the WECPs as non-ruling parties. The interesting point here is that the WECPs at times behave as if they were ruling parties, as in the case of the PCF's treatment of Marty and Tillon, which had all the appearance of a show trial. But the CPSU can ensure conformity not only in its own ranks but in the social environment as a whole. This a non-ruling party cannot do. The most it can do is to closet itself off from the rest of society and treat those who step over the threshold (for instance to publish in the non-party press) as traitors. Indeed, one of Althusser's charges in 1978 was that the party is not 'strictly speaking a state, but everything happens as if, in its structure and hierarchical functioning, it was closely modelled at one and the same time on the apparatus of the bourgeois state' (25)

   That said, some of the chief characteristics of Soviet DC cannot be reproduced in NRCPs. The role of paid officials in the WECPs is a pale shadow of the role of the apparatus in communist party

states. Again, membership of a ruling party is, at least to some extent, a necessary ticket to social and political advancement, and thus has a very different significance from membership of an NRCP, in which turnover is often extremely high, and in which there is often a significant element from disgruntled sections of society.

Finally, the rethinking that has gone on since 1956, and the real upheavals that have accompanied it have tended to push the WECPs in all but a few cases away from this tendency to behave as if they were ruling parties. The most important development here is quite simply that the WECPs have had to modify their traditional view of the party's privileged role by accepting the principle of alternation in office. This, admittedly, has yet to be put to the test, but it can be argued at least that the same pressures that led to this change in a given party will continue to operate after the party has come to power.

b) Since the major turning-point of the formation of the Stalinist political system in the period from 1928, party life throughout the whole range of parties, from the CPSU through the parties of Eastern Europe to the WECPs, has undergone change. This change, however, has been slight and has not affected the basic ideas and practices associated with DC, nor has it been accompanied by any downgrading of the symbolic value of DC.

As far as concerns the WECPs, the most evident changes are the most recent: the whole chain of development in the PCI stemming from

Togliatti's leadership (which, taken together with the long-lingering factionalism of the PCI in the 1920s and the eclipse of the party during the fascist period, leads one to ask to what extent the PCI ever did conform to a Stalinist model); the vigorous debates within many parties which, even if they do not change much, do at least go on within the party's established organization; the adjustment of the rhetoric in the abandoning of reference in non-technical senses to the dictatorship of the proletariat, or even to Lenisism; and indeed everything that is associated with Eurocommunism. Those who still assume that DC spells uniformity and conformity with Soviet practice might reflect on the election of Alessandro Natta as General Secretary of the PCI by a show of hands in the central committee, with a recorded vote (227 for, none against, eleven abstentions).

It must be asked, however, how much of this affects the meaning of DC in theory or practice.

It affects the psychology of DC hardly at all; but there has been something of a shift in the practices associated with DC. Fractional activity is deplored as vehemently as ever; and yet much of what would have been labelled fractionalism earlier no longer is. Also, as mentioned above, certain WECPs have come to live with fractionalism as part of their existence, however much it is deplored.

These changes are familiar to all, and have been a standard part of the discourse on communism in Western Europe. There are, however, other changes that occurred in a not-too-distant past but which

are much less frequently remarked. There was once a whole vocabulary of deviations and the party line that dominated the rhetoric of WECPs as it dominated that of the CPSU. It has now more or less vanished from the scene. Again it must be asked what change, if any, this represents. The answer has to be that not much has changed but that something, nonetheless, has. What is most affected here is the idea of the party's role as privileged interpreter of the movement of history, and thus the ability of the leadership to label opposing views as incorrect. This has clearly been modified, at least to some extent. Garaudy's works earned him expulsion from the PCF, but his portrayal of the Manichean nature of the party's past was well-founded (26), and despite his expulsion the party's present is, after all, somewhat different from that past.

The ideas and practices associated with DC were transmitted, then, to the WECPs from the CPSU through the agency of the Comintern. This process was a lengthy and intricate one, following different rythms in different parties, and in the different areas of party life, but it followed, in general, the development of party life in the CPSU itself. Apart from the process of affiliation to the Comintern in the early 1920s, two other events exerted a decisive influence: the rift associated with the Trotskyist opposition, and the final formation of the Stalinist political system from 1928. Since then there has been some change, but that change has not modified in any radical way either the psychology or the practices of democratic centralist orthodoxy, but it merits further attention nonetheless. I anticipate that other contributions to this workshop will offer far more detail than this synoptic paper has presented.

Conclusion

In 1924 Ramsey MacDonald said 'Communism as we know it has nothing practical in common with us. It is a product of Tsarism and of war mentality'.(27) In 1920 Osinskii, a member of the Democratic Centralist opposition in the infant Soviet Union remarked: 'We do not need militarization (during the Civil War) because within our civilian apparatus there is an organic gravitation towards military methods of organization' (28). Althusser in 1978, as noted above, claimed that everything in the PCF happens as it it were 'closely modelled on the apparatus of the bourgeios state and on the military apparatus' (29).

DC has been defined in various ways, but more importantly it has served various purposes. At the point of its origins in 1905 it acknowledged the dawning in Russia of the change to organise freely for political ends. That chance proved illusory; and the history of the concept was to be shaped by the pressures to which the Bolshevik party was subjected after its accession to power. The authoritarian practices associated with the concept in the Stalinist system, and the psychology of unity and solidarity that informed those practices were to prove productive as other communist parties came to power in other less-developed countries.

The transposition of the concept to the WECPs through the agency of the Comintern led to a dissonance between that psychology and those practices on the one hand, and the political cultures of Western Europe on the other. Despite that dissonance and despite a certain degree of change in the political practices that are conducted under the rubric of DC the WECPs still exhibit a striking degree of uniformity

in their political practices. These practices are an important part of their identity. They are, nonetheless, a source of problems today for these parties. It remains to be seen whether an awareness of these problems, and of the factors from which they spring, will lead to further and more significant change. Should this happen, the history of the concept of DC, but also the very statutes that WECPs have drafted for themselves, offer many points of reference for a renovation of the concept.

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8. Waller, op. cit., p. 38 and passim.

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29. See note 25.

APPENDIX

Communist Party of the Soviet Union. Rules adopted 31 October 1961

III Organizational Structure of the Party. Inner-party Democracy

19. The guiding principle of the organizational structure of the Party is democratic centralism, which signifies:

a) election of all leading Party bodies, from the lowest to the highest;
b) periodical reports of Party bodies to their Party organizations and to higher bodies;
c) strict Party discipline and subordination of the minority to the majority;
d) the decisions of higher bodies are obligatory for lower bodies.

Parti communiste français. Statuts de 1964

II La Vie Intérieure du Parti: le Centralisme Démocratique

Art. 5 Le centralisme démocratique constitue le principe fondamental sur lequel repose la vie intérieure du Parti. Basé sur la théorie révolutionnaire du Parti, le centralisme démocratique conditionne la cohésion idéologique et politique du Parti, son unité d'action. Les principes du centralisme démocratique sont les suivants:

a) La discussion de tous les problèmes est libre à tous les échelons, sur la base des principes acceptés par les communistes lors de leur adhésion. Une fois les décisions prises à la majorité, elles sont appliquées par tous. L'organisation et l'activité de fractions sont interdites parce qu'elles saperaient l'unité du Parti et compromettraient l'efficacité de son action.

b) Les organismes dirigeants des différents échelons du Parti sont élus démocratiquement par les assemblées de cellules, les conférences de sections, de fédérations et les Congrès. Leur activité est fondée sur les règles de la direction collective, garantie essentielle de décisions justes, correctement appliquées. La direction collective n'exclut pas mais implique la responsabilité personnelle de chaque dirigeant.

c) Les directions élues responsables devant leurs mandants doivent rendre compte régulierement de leur activité.

d) Les décisions des organismes supérieurs sont obligatoires pour les organismes inférieurs.

Cette discipline librement acceptée par tous les communistes fait la force de leur Parti.

e) La critique et l'autocritique s'exercent librement sans considération de personne dans toutes les organisations du Parti. Faites de façon franche, constructive, elles permettent de corriger les défauts et les erreurs, de surmonter les faiblesses et les insuffisances.

CAPITULO III

O CENTRALISMO DEMOCRÁTICO

Art. 11.º — A estrutura orgânica do Partido assenta nos princípios do centralismo democrático, que são os seguintes:

a) A eleição de todos os organismos dirigentes do Partido, da base ao topo;

b) A obrigatoriedade de os organismos dirigentes prestarem contas da sua actividade às organizações respectivas e darem a máxima atenção às opiniões e críticas que estas manifestem ou façam;

c) A submissão da minoria à maioria;

d) O carácter obrigatório das resoluções e instruções dos organismos superiores para os inferiores e a obrigatoriedade para estes de relatarem a sua actividade aos organismos superiores;

e) A disciplina rigorosa no acatamento dos princípios orgânicos e disposições estatutárias do Partido e a proibição da existência de fracções ou quaisquer actos fraccionários.

Art. 12.º — A título provisório, podem ser utilizadas a cooptação ou a designação para a constituição total ou parcial de organismos partidários.

Art. 13.º — Em conformidade com a necessidade do funcionamento e vida das organizações à escala nacional, o Comité Central determina a esfera de acção de cada uma das suas organizações.

Art. 14.º — Dentro da esfera da sua acção, todas as organizações do Partido devem ter a mais ampla iniciativa, desde que as suas resoluções não contradigam a linha do Partido e resoluções dos órgãos superiores.

O organismo que dirige um determinado sector é considerado superior a todos os que dirigem uma parte desse sector.

Art. 15.º — A discussão franca e livre em todos os organismos do Partido dos problemas da política do Partido e da actividade das organizações respectivas é condição fundamental para o desenvolvimento e melhoramento da actividade do Partido, para o estabelecimento da unidade de pensamento e de acção de todo o Partido, para a existência de uma forte e consciente disciplina. Depois da discussão em cada organismo, as resoluções tomadas são obrigatórias para todos os seus membros.

Art. 16.º — O Partido conduz toda a sua actividade segundo o princípio leninista da direcção colectiva, desde o Comité Central aos organismos de base, educa os seus membros no espírito do respeito pelas opiniões e decisões colectivas e condena o trabalho individualista e o culto da personalidade.

Todos os organismos do Partido têm responsabilidade colectiva de direcção, que não elimina, antes pressupõe, a responsabilidade individual e o espírito de iniciativa de cada membro do Partido.

Art. 17.º — A crítica e a autocrítica devem ser aplicadas e estimuladas em todos os organismos e organizações do Partido, como método de aperfeiçoar o trabalho, vencer deficiências, corrigir os erros e educar os quadros.

Art. 18.º — O Partido deve realizar uma justa política de quadros, sendo rigoroso no conhecimento, selecção e promoção dos quadros, eliminando severamente as preferências por motivo de amizade pessoal ou de parentesco, promovendo os homens e as mulheres firmes, modestos, fiéis ao Partido, ligados às massas, que tenham revelado capacidade, dedicação e espírito combativo.

AIMS & CONSTITUTION of the COMMUNIST PARTY of Great Britain

1. NAME

The name of the party shall be the Communist Party of Great Britain.

2. AIMS

The aim of the Communist Party is to achieve a socialist Britain in which the means of production, distribution and exchange will be socially owned and utilised in a planned way for the benefit of all.

This necessitates a revolutionary transformation of society, ending the existing capitalist system of exploitation and replacing it with a socialist society in which each will contribute according to ability and receive according to work done.

Socialist society creates the conditions for advance to a fully communist form of society in which each will receive according to need.

Only a socialist Britain, co-operating with all other peoples of the world in close, friendly, free and equal association will be able so to develop and plan the use of all Britain's material, productive and scientific resources, that every citizen will be guaranteed security, the right to work and leisure, a steadily rising standard of living, full democratic rights, and equal opportunity to enjoy a full and happy life.

The Communist Party is guided by the theory and practice of Marxism-Leninism and its members are united in working for the achievement of socialism. Believing that socialism can be attained only by the will and action of the majority of the people, led by the working class, the Party shall:

(a) work to strengthen the organisation, political understanding and united action of the workers by hand and brain for the advancement of their standards and conditions in the struggle against capitalism, for the realisation of world peace and for the achievement of socialism.

(b) work to maintain, defend and extend all democratic rights of organisation, demonstration, strike, public speech, press, assembly, secret ballot, representation in Parliament and local authorities and by developing the mass struggle on all the issues that concern the people and constantly spreading socialist ideas, work to achieve the unity of the working class and a broad democratic alliance around the working class, so that such a united struggle is expressed in a Parliamentary majority of Socialists and Communists pledged to a genuine socialist programme. With such a majority, based on the strength of working people, and on continuing struggles inside and outside Parliament, end the economic and political power of the capitalist class, establish the rule of the working people, and begin to build socialism;

(c) work for the removal of all discrimination based on race, colour, sex or religion;

(d) support the national liberation struggles of all colonial peoples and recognise our special responsibility towards the liberation struggle of all peoples within the sphere of British imperialism;

(e) co-operate with the peoples of all countries for the defence of peace, for national independence, for the advance of democratic rights and the improvement of social and economic conditions.

The Communist Party bases its international outlook on the common interests and aspirations of the working class in all countries, on international working class solidarity, and has fraternal relations with the Communist and Workers' Parties of other countries for the victory of the common aims of the working class.

The achievement of these aims is not possible without a strong Communist Party and Young Communist League, conducting continuous activity and education, working closely with the people, knowing their views and needs, and able to express Communist policy and aims.

3. DEMOCRATIC CENTRALISM

To conduct organised activity, and to give leadership in all circumstances of the class struggle, the Communist Party bases itself on the theory and practice of Marxism-Leninism and must be able to act as a single unified force. Therefore the Communist Party bases its organisation upon democratic centralism, which combines the democratic participation of the membership in Party life with an elected centralised leadership capable of directing the entire Party.

Democratic centralism means that:

(a) All leading committees shall be elected regularly at shall report regularly to the Party organisations which h elected them.

(b) Elected higher committees shall have the righ take decisions binding on lower committees and orga tions, and shall explain these decisions to them. S decisions shall not be in conflict with decisions of National Congress or Executive Committee.

(c) Elected higher committees shall encourage lowe committees and organisations to express their views questions of Party policy and on the carrying out of policy.

(d) Lower committees and organisations shall c out the decisions of higher elected committees, and have the right to express their views, raise problems, make suggestions to these committees.

(e) Decisions shall be made by majority vote, minorities shall accept the decision of the majority.

4. CONDITIONS OF MEMBERSHIP

Membership shall be open to persons of eighteen ye and upwards, who accept the aims, constitution and po of the Party, pay their dues regularly and work in a Pa organisation.

5. MEMBERSHIP DUES

Membership dues shall be 60p per month. The annual shall be allocated: £2.25 to the Executive Committee, to the District or Scottish or Welsh Committee, £1.25 t branch, and 45p to the Central Election Fund. Members dues of unemployed members, pensioners and other non-w earners, apart from students, shall be 10p per month after

6. THE STRUCTURE OF THE PARTY

(a) The supreme authority of the Party shall be the Nation Congress.

(b) The Executive Committee shall in England constitu Districts of the Party and shall ensure that in each Distr a District Congress is convened every two years.

This District Congress shall elect a District Committee.

(c) The District Committee shall constitute Party Branch based on a place of work or a locality, and shall ensure th each Party Branch shall hold an Annual General Meet which shall elect a Branch Committee.

(d) District Committees may, with the agreement of the Executive Committee, constitute Area Committees, and shall define their functions and powers in accordance with the Rules of the Party.

(e) In Scotland and Wales the Executive Committee shall ensure that in each country a Congress is convened every two years. These Congresses shall elect a Scottish and Welsh Committee respectively.

(f) The powers and responsibilities of the above Congresses and of the Scottish and Welsh Committees shall be as defined in Rule 12.

7. THE NATIONAL CONGRESS

(a) The National Congress shall be the supreme authority of the Party and shall be responsible for the adoption of the policy of the Party.

(b) The National Congress shall be convened by the Executive Committee every two years, and shall be composed of:

Delegates from Party Branches, elected in accordance with their numerical strength, on a basis to be determined by the Executive Committee.

Delegates from District Committees.

Members of the retiring Executive Committee and Appeals Committees, who shall have full right to participate in the work of Congress, including the right to participate in the work of Congress Committees when elected by Congress as Executive Committee representatives to such Committees, but shall not have the right to vote in full Congress unless elected as full delegates from a Branch or a District Committee.

(c) The Executive Committee will seek the views of districts and branches by issuing to the Party 8 months before Congress a short statement setting out its first views on the main questions which should be the centre of debate at Congress. The agenda, draft resolutions and preliminary materials for the Congress shall be issued to Party organisations 3 months before the date fixed for the Congress. Resolutions for the Congress agenda and amendments to draft resolutions issued by the Executive Committee may be sent in by Party branches and District committees up to 6 weeks before the date of Congress.

(d) Procedure for the conduct of pre-Congress discussion shall be according to the provisions of Rule 17(a) and 17(d).

(e) The National Congress shall elect, from nominations made by Branches and District Committees, an Executive Committee, an Appeals Committee, and two Auditors. Members of the Appeals Committee and the Auditors shall not be members of the Executive Committee.

(f) The Executive Committee shall have the power convene a special National Congress, composed in the sa way and with the same powers, as the National Congr The Executive Committee must convene such a spe National Congress on the request of not less than one- of the branches or one-third of the District Committees.

8. THE EXECUTIVE COMMITTEE

(a) The Executive Committee shall have full respo sibility for the direction and control of the work of the Pa and for the formulation of current policy, in accordance the decisions of National Congress. It shall guide and di the work of all Party organisations, assist the work of P members elected to Parliament, direct and control the P press, publications and other Party enterprises, and ma the central funds of the Party.

(b) The Executive Committee shall also have powe decide on new policy, where events make this necessary.

(c) Whenever possible, the Executive Committee sh when taking decisions on new policy between Congress consult Party organisations and initiate discussion throug the Party.

(d) At its first meeting after its election the Execu Committee shall decide upon its regular meeting date, shall elect the officers of the Party and a Political Commit

(e) The Political Committee shall have the responsib for giving prompt and effective leadership in between meeti of the Executive Committee. The work of the Politic Committee shall be subject to control by the Execut Committee.

9. THE PARTY DISTRICT

Districts shall be constituted by the Executive Committ to include all Party organisations and members living working within a defined area.

10. THE DISTRICT CONGRESS

(a) In each District a District Congress shall be convene every two years. This Congress shall be composed of: De gates from Party branches in the District, in accordan with their numerical strength, on a basis to be determined the District Committee in consultation with the Execut Committee: Delegates from those Area Committees whe District Committees, in consultation with the Execu Committee, so decide. Members of retiring District C mittees shall have similar rights at Congress to those of the E.C. at National Congress: see Rule 7 (b).

(b) The District Congress shall discuss and take decisions on the implementation of national policy in the District.

(c) The District Congress shall elect from nominations made by branches, and from any area committees given full delegate rights as defined in (a), a District Committee and District auditors, and the auditors shall not be members of the District Committee.

11. THE DISTRICT COMMITTEE

(a) The District Committee shall, on the basis of national policy and the decisions of the District Congress, guide the work of the Party organisations in the District, assist Party members elected to local government and other public bodies, direct and control District Party enterprises, and manage the District funds of the Party.

(b) The District Committee, at its first meeting after election, shall elect District Officers and a District Secretariat, and shall decide upon its regular meeting date.

(c) The District Secretariat shall have the responsibility for giving prompt and effective leadership in between meetings of the District Committee. The work of the District Secretariat shall be subject to control by the District Committee.

12. SCOTLAND AND WALES

(a) The Scottish and Welsh Congresses and the Scottish and Welsh Committees shall be deemed to have all the powers and responsibilities allocated throughout these Rules to District Congresses and District Committees in England.

(b) The Scottish and Welsh Congresses in addition shall discuss, take decisions and formulate policies for Scotland and Wales in accordance with the general lines of policy decided at the National Congress.

13. THE BRANCH

(a) The basic unit of the Party is the Branch. Such basic units shall be organised, on the authority of the District Committee, based upon a place of work or study, that is a workplace Branch; or based on a locality, that is a local Branch.

(b) A workplace Branch shall comprise all Party members employed in a particular factory, pit or other place of work.

(c) A local Branch shall comprise members living, or in some cases employed, in a defined area, with the exception of those members organised in a workplace Branch.

(d) Every Branch shall hold an Annual General Meeting which shall discuss a report of branch work in the previous year, receive a financial statement, discuss the lines of branch activity for the coming year, and elect a Branch Committee.

14. THE BRANCH COMMITTEE

(a) Each Branch Committee shall meet regularly and shall elect a Chairman or Chairwoman, Secretary, Treasurer and such other officers as required.

(b) Each Branch Committee shall be responsible for calling regular branch meetings of which every member is informed; shall report committee decisions and proposals; and shall guide and develop all branch activities in accordance with Party policy and branch decisions, including the sale of the *Morning Star* and Communist literature, public and electoral work, and the winning of new members.

(c) Decisions of the Branch Committee may be overruled by a majority vote of the Branch meeting provided that decisions of bodies higher than the Branch Committee are not thereby violated.

(d) Each Branch Committee shall be responsible for appointing membership stewards to ensure efficient collection of dues and political contact with every member; shall manage branch funds, and shall assist all members to carry out their Party activity and to study Marxism-Leninism.

(e) A workplace Branch Committee shall maintain contact and co-operation with the local Branch in the area in which the workplace is situated, and shall encourage members of the workplace Branch to help the Party in the areas where they live.

(f) A local Branch Committee shall encourage and help its members to build the Party where they work, and shall assist all efforts to build new workplace Branches and strengthen existing ones in the area.

15. THE DUTIES OF MEMBERS

Party members shall have the duty, with the assistance of the Party:

(a) To take part in the life and activities of their Party Branch and to attend its meetings whenever possible.

(b) To read the *Morning Star* and to help in every way the circulation of the paper.

(c) To improve their political knowledge and their understanding of Marxism-Leninism, to take part in the discussion and formation of Party policy, to win support for the aims and policy of the Party, and to win new members to its ranks.

(d) To equip themselves to take an active part in the working class movement, to belong to and assist the work of their appropriate trade union or professional organisation, and their co-operative society.

(e) To fight for the decisions of the Party, to observe Party discipline, and to fight against everything detrimental to the interest of the working class and the Party.

(f) To produce their Party cards for inspection whenever required to do so by a Party organisation or membership steward.

16. THE RIGHTS OF MEMBERS

Party members shall have the right:

(a) To take part in their Party Branch in the discussion and formation of Party policy and the carrying out of such policy, in accordance with the procedure defined in Rule 17.

(b) To elect and be elected to all those leading Party Committees defined in Rule 6.

(c) To address any question or statement to such leading Party Committees up to and including the Executive Committee.

(d) To reserve their opinion in the event of disagreement with a decision, while at the same time carrying out that decision.

17. PROCEDURE FOR DISCUSSION

Exercise of the right and duty to take part in the discussion and formation of Party policy shall be in accordance with the following procedure:

(a) During the period of pre-Congress discussion members shall have the right to express their views on any aspect of Party policy in their Branch meeting, or at any other meeting convened for that purpose on the authority of the District and Executive Committees; and the Executive Committee shall ensure the maximum possible discussion and provide the maximum possible space in the Party press for the printing of contributions from Party organisations and members.

(b) In between Congresses decisions of the last National Congress and the Executive Committee are binding on all members and Party organisations. Members who consider that new circumstances have developed which make it necessary to change such decisions or to take new ones may raise the matter in their branch unless they are members of higher committees. If the Executive Committee considers that it is necessary to hold an inner Party discussion on some aspect before the next period of pre-Congress discussion is due it shall give guidance on pre-

(c) If the member obtains the support of the Branch then the latter may submit a resolution for the attention of the District Committee or Executive Committee. Whatever the decision of the Branch, the member may still exercise the right under Rule 16(c) to communicate with the District Committee or Executive Committee on the matter. During the time the matter is under discussion it is the duty of all members of the Branch to carry out to the full the policy of the Party until a final decision is taken.

(d) Members of elected leading committees who are in disagreement with any decisions taken by the committee in question or with any other aspect of Party policy shall have the right to express such disagreement first in that committee and then to a higher committee. During the period of pre-Congress discussion such disagreements may be expressed first in the committee in question and then in the appropriate Party branch or in communications to pre-Congressdiscussion in the Party press.

18. THE ADMISSION OF MEMBERS

The following procedure shall be adopted in the admission of new members:

(a) Applicants shall immediately be interviewed by a representative of the Branch or other leading committee concerned, who shall report back so that the committee may discuss and decide upon the application. Immediately on acceptance the committee shall take steps to ensure that a Party card is issued, with a copy of the Party rules, information provided of Branch activity, and a welcome given to the new member at the next Branch meeting. Upon the issue of a Party card the record form shall be filled in and returned to the committee concerned.

(b) If the applicant is refused admission by a Branch Committee, it shall be the responsibility of the latter committee to inform the District Committee of the reasons for its action. A decision of the Executive Committee on an application for admission shall be final.

19. APPLICATIONS FROM FORMER MEMBERS

The following procedure shall be adopted in the case of applications from former members to rejoin the Party:

(a) Where the applicant was expelled from the Party then no decision shall be taken without the consent of the Executive Committee.

(b) Where the application is to rejoin the former branch, and the applicant is known to the present members of the Branch Committee, then the application shall be considered by the Branch Committee and their decision shall require the endorsement of the District Committee.

(c) Where the applicant is not known to members of the Branch Committee concerned then the latter shall consult the District Committee before considering the application. The District Committee shall provide the Executive Committee with a record of decisions taken on such applications.

20. THE TRANSFER OF MEMBERS

(a) Members transferring from one Party Branch to another shall be responsible for informing their Branch Secretary of their intention.

(b) The Branch Secretary shall immediately send the District Secretary the record card and new address of any member transferring out of the Branch.

(c) A Branch Secretary shall obtain from the District Secretary confirmation of the membership position of any transferred member before accepting the transfer.

21. LAPSING OF MEMBERS

The decision to lapse a member of the Party for non-payment of Party dues is a serious step which shall be taken only after the most careful consideration by the Party Branch Committee, and the following procedure shall be operated:

(a) Members who are more than thirteen weeks in arrears shall be considered for lapsing by the Branch Committee if it is established that regular visits over a period have failed to produce any result, and that no special circumstances or difficulties prevent such members from carrying out their financial responsibilities to the Party.

(b) Any such decision to lapse shall be reported by the Branch Committee to the higher Party committee for endorsement before it is operated, and the latter shall satisfy itself that the procedure in (a) above has been observed, following which the decision shall be communicated to the member in writing.

22. BREACHES OF PARTY DISCIPLINE BY PARTY ORGANISATIONS

The Executive Committee shall have the right to apply disciplinary measures to any Party organisation which fails to carry out Party decisions. Such disciplinary measures may include partial reorganisation of its Party Committee, or dismissal of this Committee and the appointment of a Provisional Committee, or dissolution of the entire Party organisation and re-registration of its membership.

23. BREACHES OF PARTY DISCIPLINE BY INDIVIDUAL MEMBERS

Action against any member guilty of breaches of Party Rules or any other conduct detrimental to the Party shall be carried out according to the following procedure:

(a) The Party Branch shall have the power to remove from office, to suspend from membership for a period not exceeding three months, or to recommend to the District Committee expulsion, on the decision of a majority of the members attending a Branch meeting, of which all members have had written notice at least seven days in advance of the issue to be discussed, and where the member concerned has been given the opportunity of attending and stating his case.

(b) The Executive Committee or District Committee shall have the power to remove or suspend from office, suspend from membership for an initial period not exceeding three months, or expel, and shall explain the reason for this action at a meeting of the Party organisation concerned.

(c) In the case of suspension from membership the member's card shall immediately be handed to the suspending organisation, and it shall be the responsibility of the Party organisation to have discussions with the comrade concerned before the period of suspension is at an end.

(d) All disciplinary actions shall be notified in writing through the District Committee to the Executive Committee.

24. PROCEDURE FOR APPEAL

(a) Party members shall have the right to appeal against any disciplinary action taken against them by their Party Branch to their District Committee. Members shall have the right of appeal against a decision of the District Committee to the Appeals Committee.

(b) The Appeals Committee shall consider all such appeals, taking into account relevant information from the Executive Committee. A decision of the Appeals Committee shall be final, save that a member may appeal to the subsequent National Congress.

(c) In the case of action taken by the Executive Committee under Rule 23(b), the decision taken by the Executive Committee shall be final save that a member may appeal to the subsequent National Congress.

(d) All appeals shall be made in writing to the committee concerned, within fourteen days of the member's being notified in writing of the decision appealed against.

25. INTERPRETATION OF RULES

The Executive Committee shall have authority to interpret these Rules and to lay down procedure in all matters not specifically covered by them.

26. ALTERATION OF RULES

The Rules may be amended by the vote of a majority of delegates at a National Congress, provided that the following procedure be carried out:

(a) Proposed alterations to rule shall be submitted by Party Branches and District Committees to the Executive Committee.

(b) All such proposed alterations to rule for consideration by Congress must be received by the Executive Committee six months before the date of that Congress.

(c) All such proposed alterations shall be considered by the Executive Committee and circulated to Branches with its comments.

(d) Alterations to rule may also be proposed by the Executive Committee. Such proposed alterations shall be circulated to Branches as part of the material for the National Congress.

HEALTH CARE AND PARAGOVERNMENT IN THE NETHERLANDS

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Paper to be submitted to the ECPR joint sessions at Barcelona 1985. Workshop: the politics of health

HEALTH CARE AND PARA GOVERNMENT IN THE NETHERLANDS

by Nico A.A. Baakman x

Section 1: Introduction

This paper is on the interrelationship between state and society in Dutch health care. Health care has become quite dear to us. In 1953 we spent 3.3% of our GNP on it and in 1981 almost 10%. That development has become a cource of increasing worry. At present we suffer from a major economic set back. Many a newspaper article even refers to a crisis of the welfare state. And indeed, many things seem to go wrong. There is a huge national debt, unemployment figures are high, economic growth has been at best marginal over the last couple of years and we hear of many criticisms regarding virtually all policy fields, including health care. The welfare state formula, so it is claimed, does not work any more.

So something has to be done. The present Dutch government is convinced that the main reason for our difficulties is to be found in the role the government plays in society. Therefore it wants to make itself less dominant by three ways. It wants to cut public spending, diminish and simplify state regulations and transfer tasks from the public to the private sector of the economy. More society and less state, that is the general idea. Or, in the words of the Christian Democratic Party leader Bert de Vries: to change the welfare *state* into a welfare *society*.

So far the government has not been very succesful. It has realised a number of financial cuts, mainly by lowering subsidies and other kinds of payments, but hardly by policy termination. On the whole little progress has been made. The welfare society has not yet been proclaimed, so to say.

One can easily understand why not. First of all, it is beyond any government to decide effectively on its entire role in society. Granted, every policy field consists of numerous political and bureaucratic decisions. But that does not imply that the sum of those policy fields

x) I would like to thank Antoinette Sanders for being a great help

being more or less the welfare state can be subjected to political and bureaucratic decison making. What is true regarding the parts does not have to be true in regard of the whole. The government may be able to retreat from one field, but it can be - and has been - forced to advance in others. For example to implement cuts in spending.

This is all very obvious. More interesting is however the following. One of the most fascinating peculiarities of the Dutch welfare state is that it has not many features of a state at all. Major policy fields like social insurance, housing, education, social welfare and many others are not administered by the state in a direct sense, but by countless bodies which are legally of a private nature. The organs of the state are of course, juridically spoken, public. This also applies for health care.

There is, in other words, no clear cut borderline between state and society in the Netherlands. It would be more apt to say that the two spheres gradually dissolve into each other. In view of this, one might wonder what the slogan 'less state and more society' may mean. On crucial spots in a majority of the policy fields of the Dutch welfare system one cannot tell the difference.

It would therefore not be very fruitful to try and analyse the Dutch health care system on the basis of the juridical dichotomy public versus private law, or by means of one of its (not matching) derivates state versus society, budget versus market or collective versus private. Neither can a therapy based on this line of reasoning be very effective. There are so many borderline cases, which we can only label statal or societal after complicated and not seldom artificial juridical hair splitting, that we are in need of a new conceptual frame work.

I propose to use three related concepts, namely core government, para government and non government. Para government, being the link between core and non government can take different forms. The three concepts build together a continuum, expressing degrees of statelikeness. They are introduced and elaborated in section 2. With the aid of these concepts and the empirical findings to be presented in section 3 I hope to anser two questions in the final section. Has the Dutch health care system become more statelike over the years, and if so, in what respects? Can this development be held responsible for the ever rising costs?

Section 2: A general account of state and society

The juridical approach

At first sight the question of the limits of government does not seem to be much of a problem at all. The Dutch *Grondwet* (Constitution) contains the general features of the state apparatus and its tasks. It is elaborated in a few other laws, like the *Provinciewet* (Province Law) and the *Gemeentewet* (Municipal Law) and is in this respect simple enough. These laws say how the government on central, local and regional level shall be organised and has to operate. The Netherlands are a gedecentraliseerde *eenheids*staat (a decentralised unitary state) which means that there is central administration for the country as a whole, and a number of decentralised administrations of various kinds, having a more limited jurisdiction.

The Dutch legal system makes a clear and important distinction between *publiek recht* and *privaat recht* (public and private law). Public law organisations are engaged in making and maintaining the law, private law organisations and natural persons are subjected to it. So private law does not deal with the state organs as such, but only with natural persons and their organisations in so far as the latter have obtained a legal autonomous status of their own. That is, can legally enter contracts etc. The legal expression for this status is *rechtspersoonlijkheid* (corporate body) meaning litterally: having become like a person by means of the law. Rechtspersoonlijkheid exists in six different forms namely *maatschap* (partnership), *vereniging* (association), *stichting* (foundation), *commanditaire vennootschap* (limited partnership), *besloten vennootschap* (Ltd company), and *naamloze vennootschap* (public company). I shall not go into the differences between them. It suffices to know that they are all private law organisations, whereas the state organs fall under the realm of public law. So far it is all relatively straight forward.

The point is that there are complications. By means of seperate laws numerous government agencies have been created to fulfill a specific (or sometimes rather unspecific) task. Nowadays, around the constitutional state

organs a whole belt of administrative bodies exists, all exercising public authority, but not mentioned in or created as a direct consequence of the Grondwet. They do, however, fall under the realm of public law. Scheltema (1974) has proposed to call those bodies *zelfstandige bestuursorganen* (autonomous administrative bodies). They form the first complication.

The second is that the government also created, used or even took over preexisting 'rechtspersonen' to perform its function. So we have constitutional government organs, 'zelfstandige bestuursorganen' and private law bodies in various forms, controlled by the government. Then there are a number of organisations which are pro forma independant, but financially at the mercy of the state, and performing all kinds of public tasks.

The conclusion is that the neat legal distinction between private and public law does not seem to cover the reality of the state society relationship of the Dutch welfare state. There are too many organisations legally of a dubious nature, or even clearly private, performing important public tasks.

Let us therefore avoid the legal difficulties and niceties as much as possible and try to develop a different perspective.

A social science approach

First of all I will restate the problem in terms of system analyses.

A system is defined by its elements and the relations between them. The Netherlands can be considered as a social system, consisting of its inhabitants, their organisations and the relations between them. As elements I only count those organisations which are legally autonomous (as you see I cannot do completely without legal stuff).

Some of these organisations are clearly and unambiguously government organisations. Together they form the sub system 'state' or 'government'. A sub system is an element or a functional component of a larger system. It fulfills the conditions of a system in itself, but also plays a role in the functioning of the larger system. It is simply at a lower

resolution level (Young 1964).

We can also identify a second sub system. There are a number of organisations which are undoubtedly private. Together with all natural persons they form the sub system 'society'. The problem of the jurists is that we empirically are left with a big category that falls in neither of the two, having some features of both the sub systems. I shall call it para government, but jurists have to decide. It is either private or public with them. Tertium non datur. Therefore they have to engage in complicated reasoning to decide the matter. I shall not do so.

The thing is that the matter cannot satisfactorily be solved at the sub system level. We will have to use the concept aspect system.

An aspect system is also defined by its elements and the relations between them, but, if we stick to our case, those elements are not distinctive organisations or persons. The aspect system elements are properties or functions thereof, not the organisations or persons themselves. As such, an aspect system cannot function. It has no (relative) autonomy of its own.

The difference will be clear. In the sub system approach we label organisations as a whole; the aspect system approach only looks at one or some relevant properties. It is quite possible that sub system and aspect system coincide - after all, the whole is defined by all its properties - but in this case it does not. Remember: private bodies, fulfilling public tasks.

I propose to leave the private / public dichotomy aside, as well as its derivatives like state and society, budget versus market and collective contra individual, and opt for the aspect system approach, the relevant property being the degree of statelikeness. We do not have to fear that we will lo se sight of the political scientists' favourite pet,the state. After all, there is nothing more statelike than the state.

So I will not try to classify organisations as a whole, but only look at one aspect: its degree of statelikeness. It can be divided into three sub categories, namely core, para and non state or government. Together they form a continuum, ranging from full to complete absence of statelikeness.

Now our problem has become how to define the aspect statelikeness?

What properties are we looking for? We will have to develop a set, as there is a great variation in the organisations we are interested in. What we need is a set of properties of which one can say that core government has them all, para government has them in varying degree, ranging from all minus one to only one, and non government has none.

This may seem a complicated question, but I think the answer is easily found. Since Max Weber it is generally accepted that the hallmark of the modern state is the legal monopoly of violence, which it uses to take unilatterally authorative decisions, binding in principle all of the citizenry and maintaining itself by the use of resources which are collected on a compulsory basis, mainly consisting of taxes. From this it is easy to deduce the wanted set of properties.

1. The first is the partaking in the monopoly of violence. This is rarely seen, however. The core state guards its monopoly anxiously. One example concerns people who are placed under custody, because of mental illness and their being dangerous. They are deprived of all their civil rights. Yet the Dutch *Krankzinnigenwet* (Law on the mentally disabled) states clearly and unambiguously that they are preferably placed under the custody of private (which in the Netherlands usually means confessional) mental hospitals.

2. The second property is having the right to take unilatterally authorative decisions. That is,decisions which are binding and can in principle be enforced by the monopoly of violence. These cases are abundant in The Netherlands. Take for instance the *Gemeenschappelijke Medische dienst GMD* (Common Medical Service). Its employees decide on degrees of disableness in case of a social security claim. The GMD was set up by cooperation of the *Bedrijfsverenigingen* (Industrial Boards) of which each itself is a joint venture of unions and employers organisations, created to implement social insurance laws.

3.The third property is having a monopoly created by law. Any monopoly infringes on the freedom of anyone willing to engage in or depending on the activity which is monopolised. In the liberal ideology it is one of the state's tasks to hold the natural monopolies. So it is very plausible to say that any monopoly created by law is para government. In The Netherlands academically trained doctors have the legal monopoly of

practising medicine. This may not seem very important, but one should bear in mind the enormous amount of money involved in public health care on which virtually only doctors decide, and the importance of their professional opinion in, for example, the granting of a social insurance claim.

4. The fourth property is the production of a pure collective good. It is defined by the quality that, when produced, no consumer can exclude himself, nor can the producer exclude anyone. Forced consumption of a non marketable good. Economists are still looking for a clear and unambiguous case of a pure collective good, like they have been searching for years for a perfect market. Yet one must keep in mind that there are cases with so much externalities that a close approximation of it may be said to exist. I think prevention of contagious diseases is such a case. In the Netherlands the *Kruisverenigingen* (Cross societies, see below) play an important role in it.

5. The fifth property is being almost entirely dependent on (financial) resources which are collected - not nessecarily by the organisation itself- on a compulsory basis. That means: not as a price paid for services rendered or as a voluntary contribution. Taxes or premiums. Of course, this is the mildest case of para government, but it is not without importance. About 75% of all the money that is involved in Dutch health care is collected on a compulsory basis. That is over 7% of GNP.

So this is the set of properties which defines the aspect statelikeness. It is possible to differentiate between full, partial and absent resemblance. Now we can return to the Dutch health care system and repeat the questions we are interested in. Has it become more statelike over the years? And if so, in what respects? Can that development be held responsible for the main problem of this policy field, being the ever rising costs? It is to the empirical data, needed to answer those questions, that we now turn.

Section 3: Historical development

On the following pages I shall present a long term overview of the development of the Dutch health care system. I have chosen 1813 as a starting point. In that year the present Dutch unitary state was founded. As a rule I shall present my findings in a chronological order, not making any sub divisions in the health system as a whole.

1813 - 1865

When the French withdrew from the low countries in the year 1813, they left some unfinished business. Although they had taken a number of steps to centralise and unify the various Dutch administrations, they had failed to create a *Geneeskundige Staatsregeling* (Medical Statute). Yet government had repeatedly been asked to do so by progressive doctors. In this field much remained the way it was during and before the *Bataafse Republiek* (Batavian Republic 1795 - 1801). There were all kinds of local and former guild regulations in existence, stating which persons were allowed to practise where and under what circumstances what branches of medicine, what qualifications were required, etc.

Standards were low in those days, and the entrance to the profession was easy. The Constitution of 1798 had abolished all guilds for being contradictory to the principles of the revolution, but only in 1820 their liquidation was completed. There were two consequences to it. It made the entrance to the profession still somewhat easier, as we can deduce from the growth of the number of practitioners between 1800 and 1865. Secondly it finished off the guild's sick funds, which were in many instances the poor man's last resort in case of illness or death. This task was partly taken over by private entrepreneurs, who were only in the fund business for the money. That became in a number of cases very clear. Several scandals sprang from their greed and in 1841 a governmental investigation committee was set to work. It reported in 1842 on many serious abuses, but the central government prefered to remain idle for ideological reasons. In fact, between 1813 and 1865 (in which year a decisive step was taken) it did hardly anything at all.

In 1814 a royal decree made the vaccination against smallpox compulsory for all children in orphenages, workhouses and the like and children whose parents were living on poor relief. The measure seems not to have been very effective.

Four years later, in 1818, a bill was enacted, containing a Geneeskundige *Staatsregeling*, but it merely codified the existing situation. No less than fourteen different kinds of practitioners were admitted, many of dubious qualifications. The law underwent minor changes in 1838, 1841 and 1863. Control remained in the hands of local committees, composed of various practitioners, which was only slightly better than no control at all.

In 1841 Parliament rejected a draft of a new, more strict *Geneeskundige Staatsregeling* for being too radical. On two other instances between 1813 and 1865 Parliament acted with regard to health care. In 1851 it passed the *Gemeente wet* (Municipal Law) of which one of the minor articles contained the obligation for the local authorities to make public health care (contagious diseases and epidemics) its business. At the time nobody gave it much thought, but later on it proved to be of some importance. Shortly after that, in 1854, the *Armenwet* (Poor Law) got enacted, making health care for the poor also a local affair.

Financially this must have been of substantial importance, at least for some cities, for we know that in 1855 25% of the Amsterdam population qualified for it. In that year the city spent 200.000 guilders on health care for the poor. It mainly went to the *Gasthuizen* (Infirmaries, litt. Guesthouses or hospitals). At the time, these were not the therapeutic institutions we know today, but places were the homeless sick were kept from society in circumstances that were not seldom prison like. They existed of old in many towns and were as a rule set up and run by the local government.

So government remained idle in a very substantial degree, yet private initiative did not.

In 1837 the rev. Stuart lectured at a meeting of the *Hollandse Maatschappij der Wetenschappen* (Dutch Society of Sciences) on nursing the sick. His plea was to take a French roman catholic organisation that had started to nurse the sick at home as an example. Yet it were not

the protestants who responded first. In 1839 the Sister of the Congregation of Love from Tilburg set up a centre in Amsterdam. They took care of the sick in their own lodgings regardless of their persuasions. From this initiative the Dutch *wijkverpleging* (home nursing) originated, which is now part and parcel of the job the *Kruisverenigingen* (Cross Societies, see below) do. In 1844 Amsterdam witnessed the founding of the *Amsterdamse Vereniging voor Ziekenverpleging* (Amsterdam Society for Sick Nursing) by a medical doctor. It set as its task to train young women to nurse the sick at home and look after their families as a matter of charity. In 1850 already 185 families of all religions had received assistence from it in one form or the other.

When in 1842 the report on the *Ziekenfondsen* appeared, the government not reacted and scandals kept coming up, a number of young doctors started the *Algemeen Ziekenfonds Amsterdam* (General Sick Fund Amsterdam). They went not into the fund business for the money, but for idealistic reasons and professional interest as well. Since a number of practitioners had become involved in fund scandals, they felt the reputation of medicine was at stake and wanted to restore as much of the damage as possible. In the first decades of the twentieth century doctors and *Ziekenfondsen* would find themselves in a serious conflict of interests, but at the time they were hand in glove.

Physicians also founded in 1849 the *Nederlandse Maatschappij ter bevordering van de Geneeskunst* (Now *Royal* Dutch society for the advancement of Medicine) KNMG. It had two aims. Firstly, it wanted to promote the enacting of a new *Geneeskundige Staatsregeling*. Because of the easy entrance to the profession there were to many physicians, amoung which were many charlatans. They were competing with the serious doctors and caused a lot of unnecessary suffering. Besides, they were giving medicine a bad name. So the academically trained practitioners wanted to get rid of them, altough in those days academic medicine had still very little to boast of. The second reason for founding the society was the wish to further the interest of medical science and its servants, being of course the members of the *KNMG*. The society still exists, and its two formally independant branches the *Landelijke Huisartsenvereniging LHV* (National GP's Association) and the *Landelijke Specialistenvereniging*

(National Specialists Association) are very influantial indeed.

1865 - 1945

In 1865 Parliament passed four bills which jointly contained a new medical statute. The KNMG finally got what it wanted. Because of the international events Parliament had become stronger and more progressive. The Netherlands turned into a constitutional monarchy in 1848, and under the strong leadership of prime minister Thorbecke many new beginnings were made, also in health care.

The new statute gave

- uniform rules for the training needed to enter the profession,
- academically trained physicians the legal monopoly in practising medicine and put severe penalties on unqualified performing the art of healing,
- the *Geneeskundig Staatstoevoorzigt* (state health inspection) the task to supervise health care, taking control out of the hands of the profession.

These were important changes, but it took some time before the laws became fully effective. Only after 1900, for example, the academic monopoly was a fact. It took more than 35 years before death and retirement had put those who failed to meet the new standards but were admitted before 1865, out of business. Moreover, the new health inspection was to advise local government on public health care. Contagious diseases and health care for the poor had been made one of their responsibilities by the *Gemeentewet* and the *Armenwet*. The local authorities, however, saw it as their prime task to keep the cost of government down, not worrying too much about their other obligations or the advise of the health inspection. The latter received hardly any support from the central government, so the municipalities did on the whole as little as they could which was, in a number of cases, very little indeed.

To sum up the state of affairs in 1865: healing had legally become a monopoly in the hands of academically trained physicians under supervision of the state. Curative health care was wholly a private

matter, whereas public health and health care for the poor had become a usually neglected task of the local government, advised by a national health inspection.

The main medical problems of those days were poverty, leading to very bad hygienic circumstances and because of that the regular outbreak of epidemics of contagious diseases. Therefore in 1872 a new bill was enacted giving the local government, especially the mayor, new competences in isolating the sources of infection, More importantly, it made smallpox vaccination compulsory for all school children and their teachers. The vaccination was to be free, If needed, the local government could get financial support from the treasury. It is doubtful whether the measure was very effective, for too small a proportion of the population was actually vaccinated to prevent an epidemic, but it did certainly nothing to curb poverty.

In that same year, the Chief Health Inspector wrote a letter to all local governments advising them to stimulate the establishment of local *Ziekenfondsen* for the poor. It was only an advice, no obligation. We had to wait for the Germans to make insurance against the costs of health care compulsory for most wage earners. That happened in 1941.

But long before the compulsory insurance was introduced *Ziekenfondsen* mushroomed in The Netherlands. Churches, companies, unions, doctors, neighbourhoods, political parties, all kinds of organisations were active in this field, but I know of no *Ziekenfonds* set up by any government in those years, so the inspector's advice was probably not generally taken.

Local government remained passive, even in fulfilling its assigned task public health care. The inspection lacked the power to force them, the central government the political will. Understandably, this was a steady source of frustration to the health inspectors. One of them, dr. Penn, inspector of the province of Noord Holland, therefore founded in 1874 the *Noord Hollandse Vereniging Het Witte Kruis* (North Holland Society The White Cross). It set as its task to do what local government did not, financing its activities with member contributions, donations and collections.

Many more organisations followed suit, becoming the principle actors in preventive health care in The Netherlands. In 1904 central government for the first time subsidised the *Kruisverenigingen* (Cross Societies) as they are called. Right now, they are united in one national society, which has

regional and local departments. Finance comes from the funds of one of the social insurance laws, and from member contributions. About 80% of the population is a member.

The *Witte Kruis*, as the *Kruisvereniging* does now, also nursed the sick at home and was among the first to hold that nursing is a normal social profession, not a matter of charity, requiring training and normal payment.

In 1893 the city council of Amsterdam decided to establish a *Gemeentelijke Gezondheidsdienst* (Municipal Health Service). It was the first to take its health care tasks serious. Other cities lagged way behind.

The first social insurance law, the *Ongevallenwet* (Law on accidents) was passed in 1901, drafted by Talma. It not only covered the loss of income after an accident on the job, but also the costs of medical care needed to recover as soon as possible, be it only for a small proportion of the labour force. A draft of the *Ziektewet* (Illness act) of 1904 showed the same coverage: loss of income and medical treatment in case of illness. It was not enacted, however. A different *Ziektewet* came into force in 1930, but it did not include medical care. Especially the KNMG opposed the proposed law of 1904. It was strongly against compulsory insurance with the *Ziekenfondsen*. Rather it had as many privately paying patients as possible, partly because theirs would be a weaker bargaining position than the *Ziekenfondsen* would have as they would experience considerable growth because of obligatory membership. Furthermore, the doctors organisation was not against *Ziekenfondsen* as such, but it did have strong feelings about *Ziekenfondsen* without doctors on the board.

The *Onderlinge Ziekenfondsen* (People Funds, most of them having at least ideological ties with the labor movement) wanted to employ doctors but keep them from having any say in the funds business.They argued that doctors on both sides of the bargaining table would naturally not keep the premiums for the members as low as possible. Quite a serious and long lasting conflict grew out of it.

In 1913 the KNMG founded the *Centrale Organisatie van Ziekenfondsen* (Central Organisation of Sick Funds), which tried to establish funds everywhere. The *Onderlinge Ziekenfondsen* also united, and the KNMG started a boycott, forbidding its members to cooperate with any *Ziekenfonds* that refused doctors on its board and consequently was not a member

of the *Centrale Organisatie*.

The *Ziekenfondsen* and the *KNMG* fought over several issues:
-who was to control the *Ziekenfondsen*, the members or doctors,
- the tariff doctors could charge members of the *Ziekenfondsen*,
- the maximum wage one couldearn and still be a member,
- wether or not a member was free to go to any doctor of his choice.

The prolonged struggle gave conservative forces a good excuse to oppose any regulation of the insurance against the costs of health care for those on low wages.

In 1919 the central government offered to contribute annually ten million guilders, so that doctors could be rewarded amply, premiums would be modest, and the coverage of the compulsory insurance could be extended to hospitals and tuberculosis infirmaries. A compromise lay within reach, but when minister Aalberse in 1921 had to announce that he could not afford to spend the money because of the recession, which asked for fiscal austerity, consensus was gone. Parliament did not act. The Dutch had to wait for the Germans to decide the matter. Till the fifties the KNMG kept fighting that decision.

In 1920, however, the central government was forced to take a strategic decision. At that time, The Netherlands had been facing terrible outbreaks of tuberculosis for a couple of years, and something had to be done. The central government was aware of its responsibilities partly thanks to the fact that one of the ministers had suffered badly form the disease himself.

So far the *Kruisverenigingen* and the *GG&GD's* (municipal health services) had fought it. In 1920 the *Kruisverenigingen* had together 870 local departments (most of them in the countryside) and there were 27 cities who had followed the Amsterdam example of 1893 in founding a municipal health service. Yet they lacked the means to tackle the disease properly. The situation really looked bad.

The *Kruisverenigingen* had for the first time in 1904 received a small subsidy from the central government conditional on their campaign against tuberculosis. The municipalities were doing a little more in the meantime. In 1910 about 10% of the income of the *Kruisverenigingen* had as its source local government. In 1920, however, matters looked so much worse that

there were only two options left: either a substantial raise of the subsidies or the establisment of many more *GG&GD's*.

Many people, including MP's argued in favour of the municipal services, following the German example. In the end, however, it was decided to raise the subsidies for two reasons. The first was that it would be cheaper because the *Kruisverenigingen* had income of their own (member contributions, donations and the like) whereas the *GG&GD's* were totally at the expense of the treasury. Secondly it was argued that it would be easier to end a subsidy after tuberculosis was curbed than to dismantle an integral part of the state apparatus.

The years between 1920 and 1945 were silent years in the field we are interested in. The national health inspection suffered many financial cuts in those years because of the crisis and the prevailing idea's about the balanced budget.

The major change was made by the Germans as I have stated before. Under their rule the *Ziekenfondsenbesluit* (decision on the sick funds) was taken, although it had been drafted by Dutch civil servants before the war. It made insurance against the costs of health care compulsory for all employees already insured by the *Ziektewet* (see above) of 1930.

The premium, being a percentage of the wage sum to be set each year anew by the government, was to be paid by employee and employer in equal shares. The *Ziekenfondsen* who were to implement the decision, were placed under the supervision of the state.

A very important event, one hundred years after the first report to the government on abuses with the funds. The number of insured rose from 39% of the population before the obligation to about 60% thereafter. As I said before, the KNMG kept fighting it, and it was only in 1966 with the *Ziekenfondswet* (Sick Funds Law) that a more definite legal arrangement was made.

1945 - today

The war did great damage to the Dutch economy. It is therefore understandable that the main policy target of the immediate after war years was to keep the costs of labour down in order to stimulate investments and new economic growth. In the field of health care it was done by a number of ways.

Hospital tariffs were under strict control as were all prices. There was a year budget for the (re)construction of hospitals, and the *Ziekenfonds* premium was set at the lowest possible level. Tariffs of GP's became fixed, and central government gave as little subsidy to the *Kruisverenigingen* as it politically could afford to.

So financially the government made the rules of the game, and it did so very strict, but it failed to plan the structure of the health system. That really was too bad, for at the time it could be done. At the moment we have no alternative left, but now it is so much harder to do so. Changes have to be brought about in a system which according to one author has close resemblance to a bucket full of living eel, that is, is essentially a non system.

During the after war years an important change took place in Dutch health care. The hospital changed from a place to nurse the sick into a therapeutic institution. Before the war, the bulk of health care was delivered by GP's. After it, hospitals and specialists took over. They could do so for technical reasons, but also because hospital care was paid for by the *Ziekenfondsen* since the *Ziekenfondsbesluit* from 1941. This development had an explosion of the costs and a steady growth of the number of specialists as a consequence.

Again it was private initiative which took the lead, using public money of course. In 1950 only 37 of the 250 hospitals belonged to the state, whereas 112 were run by roman catholic, 43 by protestant and 58 by neutral private organisations. Between 1940 and 1960 the number of available hospital beds rose from 32.000 to 58.000.

Existing hospitals were enlarged and new ones built at places where private organisations thought it proper. Not where they might

be needed most. Building went on till the year budget was spent without any regard to national priorities as the central government had none. After the whole budger was spent, the next applicant simply had to wait till the following year. One can easily understand that this kind of 'planning' created a very odd distribution of facilities. It went not unnoted.

In 1949 minister Joekes (social democrats) tried to get a planning bill enacted. He failed however, because of strong opposition of the confessional parties - mainly the catholic one - who had and have close ties with the *organisaties van het particuliere initiatief* (private initiative organisations). They were well established.

Very often these organisations were competing each other on the local level. Muntendam, once the highest civil servant of the health department, presents us a nice example. A small town in a protestant region had a wellfunctioning roman catholic hospital. It had been there for decades and recreted staff and patients from the region. So many were protestants. The mayors of the surrounding municipalities supported by the local churches wanted a second and wholly protestant hospital. To everybody involved it was clear that, would they succeed, one hospital would be ruined in the end. It proved to be very painstaking to convince the zealots that such would be a waste of public money. Muntendam had no legal means to stop them, so they had to be bought off. They got a protestant *verpleegtehuis* (chronic ill hospital). It prevented the bankruptcy of a hospital, but did little to stimulate balanced development of the health system.

Private, that is confessional, organisations had become rather powerful, not in the last place because they had strong backing in Parliament, since many MP's also held positions in the various organisations.

Public health care had virtually become the monopoly of the *Kruisverenigingen*. But they became more and more dependant on government subsidies. The subsidy they got was conditional upon their combat against tuberculosis, although they performed many other tasks as well. They wanted the condition mentioned before skipped in which they succeeded in 1952. The *Kruisverenigingen* were pleased with that, of

course, but not at all satisfied. They prefered a more reliable flow of money from the government to an uncertain subsidy which was decided on each year anew. A subsidy law would suit their longings, or to become a part of the coverage of the social insurance system. Eventually the latter happened, but that was in the seventies.

Yet we are still in the forties. In 1947 the *KNMG* (doctors association) gave in an official report as its opinion that the *Ziekenfondsbesluit* from 1941 could not be maintained as the basis of a workers insurance against the costs of health care. The *Ziekenfondsen* felt differently and founded in the same year the *Centraal Overleg Ziekenfondsen COZ* (Central Consultation of Sick Funds), which started to negotiate GP's tariffs with the GP's branch of the *KNMG* on a national level.

In 1949 the *Ziekenfondsraad* (Sick Funds Council) was established as the official advisory board of the cabinet on all sick funds matters and once a year on the premium rate. As the reader will recall, the premium is a percentage of the wage sum below an upper limit, of which half is paid by the employer and half by the employee.

Yet the *Ziekenfondsraad* was not the only advisor of the minister in this field. The *SER* (Social Economic Council, a corporatist body) advised on all prices, since there was a strict price control. Often it advised a lower premium rate than did the *Ziekenfondsraad*, because it wanted to keep the costs of labour down. The cabinet always followed the *SER*'s advice.

The same policy was adopted with regard to the hospital tariffs: they were set a low as could be, forcing the hospitals and the sick funds to use up their accumulated savings. This was only accepted because price control was generally considered to be one of the major pillars of reconstruction. This could not last, however.

In 1950, the *Centrum voor Staatskundige Vorming* (the scientific staff bureau of the catholic party) produced a report on health care. The christian democrats were fed up with government interference in health care although it did not go really far beyond price control. Yet the private initiative organisations wanted the territory to be theirs and government to provide the money. The report has been the

foundation for Dutch health politics for many years.

In the same year - 1950 - the *Centrale Raad voor de Volksgezondheid* (Central Council for Health Affairs) was set up. A typical example of the cooperation of the private organisations and the government. The consultation of the relevant interest groups was institutionalised, but no attempt to restructure the field was made. The *Centrale Raad* was to advise the government - and its advice was virtually always taken, because of the strong backing up by the confessional parties in parliament - notwithstanding the fact that the organisations which were working together in the *Centrale Raad* often were competing each other on the local level. In Amsterdam in those years, they were not only competing each other, but also local government institutions. Remember that the city ran several hospitals and was the first to establish a *GG&GD*.

In 1959 the social democratic - catholic coalition which had ruled the country since the end of the war split up. The years of reconstruction were over and the christian democrats could now do without the socialists. So they took over, supported by the liberals (which are in the Netherlands really conservatives, although less so in the immediate after war years). That meant the end of the little government control that existed at the time. The building and the tariffs of hospitals became 'liberated'. That came down to the following. If you could raise the funds - and banks were happy to provide them for no health institution in the Netherlands ever went broke - and you got a building permit from the local government, nothing could stop you to start a hospital. Tariffs were negotiated between the Ziekenfondsen and the hospital organisations the former always being the weaker party. Because the law guaranteed the insured medical care, and not a (maximum) of costs, the hospitals always could corner the Ziekenfondsen, for they had to implement the law. In case of no agreement, the Ziekenfondsen would have got hold of the wrong end of the stick.

The lasting quarrels were endangering the quiet in the field and finally the minister made the two parties understand that if they would not develop stable forms of cooperation he would do it for them. Parties responded and in 1965 the *Wet Ziekenhuistarieven WZT* (Law on

hospital tariffs) was enacted. It may sound fierce, but it was not. It provided some control over the tariffs, but not over medical consumption, which proved to be the real problem. As a consequence of the law, the *Centraal Orgaan Ziekenhuistarieven COZ* (Central Organ Hospital Tariffs) was established, made up by the Ziekenfondsen and the hospital organisations. They set jointly the tariffs, while the minister could overule its decisions refering to the national economic situation. He never did so, however. The COZ ruled supreme. The COZ was a stichting, i.e. a private law body. In the years after 1965 it saw a slow but steady growth of its tasks. Although functioning on a very weak, if not imponderable, legal basis, it decided on more and more prices in health care. It could only do so because it had become somewhat detached from the organisations that composed it.

Yet the costs did not go down. In 1966 the *Ziekenfondswet* replaced the *Ziekenfondsbesluit* from 1941, but the new law merely codified the existing situation. The government produced in that same year the *Volksgezondheidsnota* (White paper on health care). It contained the state of affairs, but no political choices were made. So nothing changed: every opportunity for growth was made use of by the organisations in the field, without any thoughts about a structure or a national plan.

In 1967 the *AWBZ* (General law on special health care costs) was passed by Parliament. It supplements the *Ziekenfondswet* covering heavy risks like prolonged treatment for the whole population. It is implemented by the Ziekenfondsen and the commercial insurance companies. The premiums are paid for by... the employers as a percentage of the wage sum. Since the first of january 1980 the bulk of the costs of the *Kruisvereniging* are met this way. It was done so partly for optical reasons: subsidies appear on the budget, but social insurance premiums do not. Yet the Dutch could not go on deluding themselves. In 1970 the first serious attempt to structure the field was made by enacting the *Wet Ziekenhuisvoorzieningen* (Law on Hospital facilities). It would only come into force after the drafting of a national hospital plan and forbade the building of a hospital not included in the plan. The planning procedure was made so complicated (because every organisation in the field had to have a say in it) that no plan was ever established.

It was changed in 1979, but still not very effective.

In 1974 it became clear to everyone that the time had come to put a stop to the growth of the costs of the system for macro economic reasons. So under minister Hendriks published a new paper, called the *Structuurnota* (structure report), which was approved of by Parliament unanimously. Very remarkable, for it stated that more government intervention was needed, and promised to enlarge the influence of the local and regional governments. It put heavy emphasis on the so called *eerste-lijnszorg* (frontline care) to keep patients from the hands of the expensive facilities. More preventive and non residential care, that is: more GP's and *Kruisverenigingen* care. The over all number of hospital beds had to go down, the *Wet Ziekenhuistarieven* (law on hospital tariffs) had to be expanded to cover all health care prices, and the *Wet Voorzieningen Gezondheidszorg* (Law on health care facilities) would have to replace the *Wet Ziekenhuis Voorzieningen*.

In 1982 the *Wet Voorzieningen Gezondheidszorg* was passed. It will come into force in two steps. First it will expand the regime established under the *Wet Ziekenhuisvoorzieningen* to all health care facilities. The second step will be the construction of local and regional systems of integrated care, including government planning.

Also in 1982 the *Wet Tarieven Gezondheidszorg* came into force. The thereby created *Centraal Orgaan Tarieven Gezondheidszorg COTGZ* fixes all tariffs and is the successor to the *COZ*.
Right now it is impossible to say whether or not these laws are going to bring the changes we need if we are not willing to spend half of our GNP on health care in a couple of years. We will have to wait and see.

Section 4: Conclusion

If you are dazzeled by the previous section you have my sympathy. The facts are unfortunatly that the simplest thing one can say about the Dutch health system and its development is that it is a rather complicated matter. It requires a greater literary talent than mine to give a vivid and comprehensible description of it. It is a piece of good luck that we don't need all the details to answer the questions we started with, i.e. has the system become more statelike over the years, if so, in what respects and can that development be held responsible for the alarming rise of the costs?

At first sight the state is nearly absent. There are only a limited number of *GG&GD's* (municipal health services), a few academic and municipal hospitals, and a state health inspection. The *Gezondheidswet* (Medical Statute) is implemented by the state apparatus, but other important laws regarding health care by private law institutions. The *Ziekenfondswet* (Law on sick funds) by the *Ziekenfondsen*, the *AWBZ* (General law on special health costs) by the *Ziekenfondsen* and the commercial insurance companies, the *Wet Tarieven Gezondheidszorg* (Law on health care tariffs) by the *COTGZ*, which is a stichting, that is a private law body. Public health care is practically in the hands of the *Kruisverenigingen*. They are not a state institution either. G.P.'s and specialists are private entrepreneurs, and only a small part of the public money involved in health care appears on the budget Parliament decides on. The *Ziekenfonds* money is not accumulated in funds, but remains in steady flow, not through state channels, however, while the *AWBZ* money is used for fund building, but the fund has a legally autonomous board and is a stichting as well.

On the other hand, health care in the Netherlands is not a wholly societal matter eiter. There are all kinds of laws and public money involved, there are legally created obligations and competences.

So again I ask the question I started with: what may the slogan 'more society and less state' mean in this field? As, om crucial spots in the system, it is impossible to say which is which, I am inclined to say: very little indeed.

But of course that answer is conditional on using the traditional dichtotomies like private versus public law, state versus society, price versus budget sector, etc.

If, however, we apply the conceptual tools I have forged in section 2, we can see things differently.

To begin with, we can state that core government is not dominant in Dutch health care, but that para government is. Those of you who while reading the last section had kept in mind the properties we developed earlier (partaking in the monopoly of violence, having a legally created monopoly, provision of a pure collective good, the taking of authorative dicisions and compulsory finance) will agree.

Indeed, the system is rather statelike. We find all the qualities Max Weber ascribed to the modern state also in one form or the other as properties of the present Dutch health system, be it dispersed at different organisations.

The basis of the whole system is the monopoly of 1865. The exclusive right to practise medicine was given in that year to academically trained physicians. A second monopoly was created by the *Wet Ziekenhuistarieven* (Law on hospitals tariffs). The thereby created Central Organ got the monopoly on the fixation of hospital tariffs. Later on, the law was changed, the Central Organ also, and the monopoly extended to all health care prices.

Partaking in the monopoly of violence is also a feature of the health system, be it limited to mental health care. In 1884 the *Krankzinnigen-wet* (Law on the mentally disabled) got enacted. It enables the authorities the deprive people of all their civic rights and place them in the custody of mental institutions. Very often, these are of a private, that is, in most of the cases, confessional, nature. It will be clear that in these institutions the medical staff rules supreme, as it does of course in the state infirmaries.

As I stated earlier, it is doubtful whether an unambiguous case of a pure collective good exists, but close approximations may be found. The prevention of epidemics of contagious diseases is such a case I think. In our country it started with the compulsory vaccination against smallpox for children on poor relief in 1814. It was expanded

by the *Besmettelijke Ziektenwet* (Law on contagious diseases) of 1872, and culminated in the nationwide crusades of the *Kruisverenigingen* against tuberculosis in this century.

As unilateral authorative decisions are concerned, one might say that authority is the essence of the system.Not only in the very unequal doctor patient relationship, but more specifically with regard to all kinds of social benefits. It is doctors who actually decide on social insurance claims in case of disablement or sickness. Officially they only advise, but which civil servant - or judge for that matter - dares to ignore a medical advice? The only possible appeal is with other members of the same professional group, which has not a reputation for letting its members down.

Featuring very prominantly, of course, is obligatory finance. It started very modestly with the free medical care for the poor, which was paid for out of local taxes, than the free vaccination against smallpox of 1872, the slow but steady growth of government subsidies to all kinds of private organisations. Highlights were of course the *Ziekehfondsbesluit* from 1941 and the *AWBZ* from 1967, both of them encompassing obligatory finance. Right now, about 75% of the money involved is compulsory cashed, being about 7% of GNP.

But what about the costs? Can the growing resemblance between the health system and the state be held responsible for its becoming more expensive?

We can start with the simple premise that the total costs are the product of price and volume. Prices in health care are under control, as they have been in the Netherlands since 1945, but medical consumption is not. It is the medical profession which decided on wat performances are needed, and it is conventional wisdom that in health care supply determins demand, not the other way arround. If the facilities are there, they are bound to be used to the full.

Also the incentive structure of the field stimulates further medical consumption. Let us take a GP with Ziekenfonds patients and privatly paying patients as an example.

Because he gets a fixed amount per Ziekenfonds patients each year,

regardless of the patients shows up daily or not at all, it is the GP's economic interest to have as many Ziekenfonds patients as he can get, and see of them as little as he can manage. It is more rewarding to spend time with privately paying patients, for in this case there is a possitive correlation between effort and income. But the Ziekenfonds patients are a reliable source of income, so the GP does not want to lose them. So when faced with demanding patients, the economically wise thing to do is to refer them to a specialist. Everybody is happy this way. The patient knows his complaints are taken serious, the GP got rid of him, without losing his annual pay, and the specialist can get to work.

Alas, he is paid per performance, so it may take quite a while before he has exhausted his diagnostic facilities and treatment can start, or a colleague specialist take over the patient. A persistant patient may get a long way in this manner, issuing vague complaints originating in all kinds of problems but physical ones.

Of course, there is no conspiracy or extreme wickedness involved. It is all very natural. The patient has no incentive to restrict his medical consumption, for a visit to the doctor does not even cost him the money for the loss of labour time. On the other hand, there are all kinds of social incentives to become ill in case of any hardship. The sick person is less demanded of, and can count on sympathy and attention. Doctors, as all professionalists, only want the best for their patients, and as they know he will only suffer financially for it in a very indirect way, who cares about the costs? In case of any doubt, their professional inclination is to prolong treatment or to run a few extra tests.

So it is evident that if one wants to curb the costs, price control simply is not enough. The number of performances has to be kept within limits as well. I cannot go into how this will have to be brought about, but there is no doubt in my mind that it cannot be done without much more interference of the core state organs. Left to itself, the health care system will expand and nothing but expand in a very unbalanced way, as we have witnessed in the years after the war.

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POLITICIZING MEDICINE AND MEDICALIZING POLITICS:

PHYSICIAN POWER IN THE UNITED STATES

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I. Introduction: A Vantage Point on 'Control'

Political control involves power which is the ability to influence patterns of behavior and to make others do (or not do) what they would rather not do (or do). A power-relationship is inherently asymmetrical; if both parties to the relationship have equal power, neither can make the other change behavior patterns. Different methods exist of holding others accountable for their actions, methods which can non-exclusively be classified as political, economic, bureaucratic, professional, and legal accountability (Björkman and Altenstetter, 1979).. In terms of resources for sanctions and decision-rules, these mechanisms rely respectively on political norms (e.g. majority voting or civil obedience), bi-lateral exchange (e.g. money), hierarchical authority (e.g. rules), social status (e.g. self-policing), and the rule of law.

The members of any profession — or at least its preponderant majority — have "some common ways of perceiving and structuring problems and of attacking and solving them; ... are likely to share their views of the world and of the place of their profession in it; [and] ... are likely also to share a common, and more or less unique, bundle of techniques, skills, knowledge, and vocabulary" (Mosher 1978:147). These shared attributes are generated and sustained by self-recruitment, by educational training, and by socialization on the job within a given organization or series of organizations. Professional education is particularly important because the pressure of university academics has generated more and more theoretical and research-oriented knowledge as well as more and more fragmented subspecialties. It has been increasingly observed that such highly specialized university training does not provide much that is useful to effective practice; but corrective action takes place on-the-job as freshly-minted apprentices "un-learn" and re-adapt their knowledge. Nonetheless, most professions continue to stress their links to specialized higher education and pressures continue to make educational requisites ever higher and more specialized. These links are still needed to justify a profession's claim to exclusivity, eliteness, autonomy, and self-governance.

Professionals who believe in the rectitude and relevance of their specialized knowledge, influence the course of governmental action and policy implementation individually as well as in concert with others. The principal (though not necessarily mutually exclusive) channels whereby they do so are:

1) through the appointment or, more rarely, election of professionals to high office;

2) through effective control by individual professions of the significant managerial positions in administrative agencies;

3) through professionals who operate within agencies which they do not directly dominate;

4) through indirect pressures brought to bear on political executives and legislative bodies — that is by lobbying, professional associations, mobilized experts, the media, publication of research results, etc.; and

5) through the network of professional ties ('old-boy,' school, associational) across the boundaries of separate governmental organizations and agencies.

Drawing on a series of symposia in the Public Administration Review, Mosher (ibid:146) subjectively classified a dozen professions by the relative importance of these five channels of influence and concluded that, of these, "the control of a specialized professional agency is the most frequent, and probably most important, channel of professional influence."

Professionals, while very important for the implementation of complex policies, cannot be politically controlled the way democratic theory ideally sets up accountability systems. For example, majority voting does not and cannot direct expertise; the former is too crude, too fickle, and sometimes quite wrong in terms of canons of received scientific opinion. Of course, majority voting can restrict professionals from practicing altogether by banning their activities or even their existence; and majoritarian law can levy penalties and sanctions that set broad parameters of conscionable conduct by professionals. But expertise is not subject to validation (or disproof/rejection/falsification) by majority voting.

Economic accountability would seem a more likely method to control professionals, at least if a balanced market for exchanges could exist. But given the specialized knowledge and expertise on which a profession is based, the relationship between providers and consumers is inherently imbalanced. With few exceptions, the exchange relationship is asymmetrical; and it tends toward monopoly control of passive recipients. This asymmetry is particularly acute (and increasingly evident) in the health sector where conditions of disease, illness and/or death elevate the provider to semi-divine status while simultaneously reducing the patients to a state of dependency. The claims of knowledge and expertise produce a self-fulfilling prophecy.

How much political control, then, do physicians wield in society? What changes, if any, have occured in the autonomy and self-regulation of medical professionals? Are professionals in public service subject to any degree of political control? If so, how? If not, why not? These broad questions are addressed by reviewing aspects of the American case. Since the topic is so vast and since micro-behavioral measures (not to mention empirical data) are in short supply, this paper will at best provide questionable answers to these perhaps unanswerable questions. But the challenge of understanding and accounting for the (changing) power of physicians is a welcome one — and every journey begins with one step and then another. First, I will provide a brief background of my own interest and perspectives on this topic. Second, I will briefly review the growth of the power of medicine in the United States and how reciprocally the politics of medicine inexorably entered the public arena. Third, I will itemize some major legislative initiatives of the past twenty years that deal specifically with the power of physicians and their professional autonomy. Fourth, I will explore three successive government efforts to monitor and control the practice of medicine. And fifth, I will try to reach some closure on the two-way tendency to not only politicize medicine but also to medicalize politics.

II. Background and Contextual Perspective

To summarize, during the past decade I have conducted several different research projects on the politics of the health sector. The initial projects dealt with the impacts of intergovernmental relations on health care in the United States (Altenstetter and Björkman 1978) and with the political context of comparative health planning (Altenstetter and Björkman 1981). The former examined the effects (direct, indirect, and reciprocal) of changes in child health policies at federal and state levels over forty years; and the latter examined problems of effectively implementing health planning programs in Europe and the United States. A second undertaking has investigated who governs the health sector in Western industrialized states (Björkman 1985a). And a third project is examining how health resources are allocated in Third World countries (Björkman 1985b).

Since 1978 particularly, my field research has been investigating the degree to which comparative policies for representing interests and for decentralizing activities in health planning, financing and operations, affect modes of decisionmaking, the degree of accountability, and public acceptance of decisions. Behind this research lies an explanatory political model, which derives from an observation that the health sector has historically been a "private government." With few exceptions the provision of medical services has until recently been a private matter between supplier and consumer, between doctor and patient. Power over "well-being" or personal health status was exercised by an active agent with specialized knowledge over a passive recipient without such knowledge or expertise. The concept of self-care obviously lies outside this political framework, although one might argue that the very act of removing oneself from a dyadic relationship is itself a political act. The novel change in recent history has been the willingness, the readiness of governments to enter the domain of hitherto private relationships in order to regulate behavior of both sets of actors (providers and patients). The political mandate of proactive governments is exercised through their administrative machinery. In the present era, government agencies take the form of bureaucracies comprised of specialized roles based on the division of labor; these agencies, in turn, are hierarchically arranged and accountable both within the organization and sometimes externally to political leaders.

Consequently, there are four broad categories of relevant actors in the health sector of contemporary nation-states. These categories are (1) the political leaders or politicians who represent — whether badly or adequately — the preferences and views of the 'people;' (2) the administrators or bureaucrats who serve — whether badly or adequately — the political leadership; (3) the professionals who, based on their expertise and training, provide the health care — usually medical services per se; and (4) the patients or clients who receive and/or consume these health services. Since all flesh is mortal and subject to disability, decay and ultimately death, this forth category subsumes all previous three categories at some time or another in the lifecycle. Hence the fourth category is also equivalent to the public who comprise the whole population. However, given the automatic constraints or liabilities of attentiveness (distraction) and size (disorganization), the fourth category is residual in the political model of the health sector (Krause 1977; Björkman and Silver 1978; Leichter 1979).

Given that all humans have health needs at one time or another in their lives, each of these broad categories of actors has specific roles (i.e., expectations as well as patterns of behavior) attached to it. The politicians set the stage by choosing among alternatives (if any) in order to establish the goals for health care; they thereby legitimate the system of health services. Politicians also raise and allocate resources (financial, material, and human) to the health sector — which is necessarily in competition with other sectors of government that seek these resources. The politicians can set the stage by inaction as well as by action, since the former either acknowledges and reinforces the status quo or by default delegates the decisionmaking to other actors in the system. By their own actions in seeking help, members of the public can influence the pattern of health services; they can also raise some resources independently of the government (e.g., voluntary labor or direct payment). Sometimes the government and the public are at loggerheads in that the former tries to change the latter's behavior. For a variety of reasons, however, most of the public acquiesce to government decisions although they do not necessarily support them actively. Also, if the political leaders in government exceed the limits set by an acquiescent, tolerant people, then those leaders will be replaced. At least in the relatively democratic polities under consideration, these assumptions seem necessary and viable.

The roles of the bureaucrats are somewhat simpler, although they, too, can by default resemble those of the politicians. That is, while a bureaucracy is intended to be instrumental in carrying out the orders of the government (themselves based, however tenuously, on public mandates), the bureaucrats also can and often do pursue political roles. The study of implementation in the policy process has clearly suggested that even more political activity occurs within the bureaucracy and among administrators in relation to their peers and outside pressures (e.g., interest groups) than occurs in the phase of policy formulation and legislative legitimation. Aspirations among bureaucrats and administrators to obtain recognition as professionals further complicate their roles in the health system.

The professionals who provide health (medical) services have critical roles in the whole health system. As long as health care remians invasive, based on specialized knowledge, and the product of dyadic relationships, the medical professionals will continue to influence the health sector. Some of the providers of health care are 'less professional' in the sense that they have less training and greater interchangeability; but all providers (1) aspire to, if they are not already recognized as holding, professional status; and (2) are the point of first contact for a patient in the health system. That is to say, whether curing or helping or even just caring, the health provider sits at the center of the system. Try as they will, the politicians and the bureaucrats cannot replace the functions of the health professionals; and this centrality of function has been a source of power over all other actors. To be sure, various sanctions, penalties, incentives and rewards exist which can be used to channel and direct the behavior of health providers. But — to belabor the obvious — one cannot provide personal health services without providers. Only the consumers or the patients themselves have the power to by-pass the professionals by taking care of themselves; and such self-care, while possible through public education, widely disseminated information and shared knowledge, is really only supplemental to the direct invasive provision of health services.

Finally, the residual roles of the public are germane to the health system, but are more properly the province of medical sociology. General habits and attitudes toward health care do shape health behavior — sometimes to the chagrin, lament and disgust of professional providers, bureaucrats and politicians. Hence, health care patterns must be understood and appreciated in psycho-social (cultural) context, whether one is looking at single case studies or in comparative terms. The one subset of patients or consumers of health care that merits special attention includes those who organize themselves into self-conscious, energetic

groups. Each of the preceding categories — politicians, bureaucrats, and professionals -- can also be internally divided into competing parties, associations, or interest groups; and such organization (usually) increases the power of these actors in the health system. Among the general public, however, the incidence of organized consumer groups is relatively rare and requires only occasional monitoring. Consequently, the patterns of performance in any health system can best and most efficaciously be described and predicted through the activities of relatively few active elite players operating within the contexts of culturally prescribed human behavior.

III. Growth of the Power of Medicine in the United States

A. CONTROL OF MEDICAL STANDARDS AND PERSONNEL

When the American Medical Association was founded in 1847, medical doctors (MDs) were only one of several types of medical practitioners using the designation "doctor." By modern standards medical practice at that time was primitive. Blood-letting and amputation were common cures for a variety of ailments while surgery was performed by barbers. As an association, the AMA sought to improve the practice of medicine and to standardize the requirements of medical education. It sought to become a profession.

The first step in this process was a political effort to convince state legislatures to license physicians. During the Jacksonian period of populist democracy, many legal requirements for engaging in professional practice had been abolished in favor of an egalitarian 'anyone-can-do-it' ethos (Gerstl and Jacobs 1975). From 1847 to 1900, medical examining boards were created in all the states. These medical boards were, of course, manned by physicians.

With control over the practice of medicine established through state regulation, the medical community pursued its educational goals. Although the attempt to raise the educational standards of medical schools was portrayed as an effort to protect the public's health, historians have argued that the AMA's chief concern was the number of physicians in practice and therefore in competition (Shryock 1967). The AMA tied standards to the health issue by arguing that many physicans were poorly educated and that the nation only had resources to produce a limited number of quality physicians. The public would be better off with fewer, better-trained physicians.

Numbers are important, and their changes over time tell an interesting story. In 1904 the United States had 164 medical schools, many of which were proprietary. Because a proprietary school increased its income by accepting more students, it had an incentive to increase the size of its student body and to produce physicians as quickly as possible. According to the AMA, this mill-like production of physicians led to low quality practice, the very evil that needed to be eradicated. In 1906 the AMA Council on Medical Education examined the medical schools of the United States and found that only 80 met the criteria of what a medical school should be (Berlant 1975). Furthermore, 32 schools were completely unacceptable (Kessel 1959). However, using such information to restrict the supply of doctors was not feasible because the AMA might be perceived as seeking economic gain for physicians at the expense of the public.

To solve this credibility problem, the AMA persuaded the Carnegie Foundation for the Advancement of Teaching to examine medical schools. The Carnegie Foundation in turn hired Abraham Flexner to do so, who was assisted in this effort by the AMA staff; he also had access to the AMA's 1906 data. The conclusions of Flexner's report in 1910 on medical education could have been written by the AMA itself. Flexner concluded that too many doctors diluted the quality of medical care. The public would be better served by fewer, better trained doctors. Accordingly, many of the existing medical schools should be closed while those that remained open should restrict their admissions and adopt the uniform curriculum recommended by the AMA.

Armed with the Flexner Report as well as control over state medical examining boards, the American Medical Association proceeded to restrict entry to the medical profession (Kessel 1970). State medical boards required that a person graduate from a 'Class A' medical school before he or she would be allowed to take the state medical exam. A 'Class A' medical school was one approved by the American Medical Association or the American Association of Medical Colleges. The schools on both lists were identical.

The AMA also asserted control over the internship process. Serving an internship with a hospital was a prerequisite to licensing. Hospitals — at least those controlled by physicians — required that a student graduate from a 'Class A' medical school in order to receive an internship. In combination these two

factors restricted entry to the medical profession. A graduate of a nonaccredited medical school would have difficulty finding an internship at an approved hospital. Without an internship, the student could not sit for the medical exam. Even with an internship at another hospital, the student might not be allowed to take the state exam because he or she failed to graduate from a 'Class A' medical school. The noose was complete.

The impact of these policies on medical education was striking. Faced with a system that refused to accept their graduates, proprietary medical schools closed. From 164 medical schools in 1904, the number dropped to 85 in 1920 and 76 in 1930 (Frech, 1974: 124). Schools with AMA approval restricted admissions dramatically. In 1905, 26,000 students were enrolled in medical schools, and 4,606 students graduated. By 1920 enrollments had been cut to 14,000 with 3,047 graduates — and yet, logically, the war in Europe should have increased rather than decreased demand for medical services. The impact of these cutbacks was so effective that the 1905 levels for students were not reached again until 1955 (ibid.). Not until the health care explosion of the 1960s that was inspired by federal government expenditures under Medicare and Medicaid did major increases in medical school enrollments occur.

The economic impacts of such restriction on entry to schools and, thereby, to the profession were dramatic. Physicians engaged in price discrimination by adjusting their fees to the income level of the patient. Some argued that such income-related fee-adjustments allowed cross-subsidization wherein the relatively more well-off financed access to medical services for the poor. This was the classic posture of the Brothers Mayo in their Rochester Clinic — and the public approved. But as part of this desire to set prices arbitrarily without outside intervention, the medical community opposed innovations in health care delivery that were not based on individual-fee-for-medical-service arrangements. Prepaid health care plans were opposed by local medical societies, and doctors who participated in them were ostracized and denied hospital privileges (Kessel 1959: 33-41). Likewise, the AMA opposed free medical care for veterans in Veterans Administration hospitals as well as Medicare and Medicaid (Marmor 1973). The physicians engaged in a series of state level battles with chiropractors, podiatrists, osteopaths, and midwives in order to restrict and even to eliminate these professions (Akers 1968).

In effect, medicine became a closed society as far as consumers were concerned. It was not unknown, for example, that a doctor testifying for a patient in a malpractice suit would have future difficulties in using hospital facilities (Kessel 1970). Ironically, despite stated intentions to the contrary, all these restrictions did not result in health care indices superior to those of other, less restrictive nations. Although certainly crude measures of health, US infant mortality rates and average life spans fell far short of comparable indicators in many European countries. Possibly one reason why quality did not improve faster was the notorious 'grandfather clause.' By exempting current practitioners from new standards of training and performance, any impact of improvements on quality could only be incremental. Milton Friedman (1962) feels that AMA-imposed restrictions on entry have had such deleterious consequences that the nation would be better served if medicine were deregulated and the licensing of physicians were abandoned.

Medicine illustrates how a profession uses regulation that was proposed in the public interest for its own benefit. The situation in medicine was dramatically altered in the 1960s when the federal government became active in health policy. With the implementation of Medicare and Medicaid as well as various federal programs to expand health care, health resources and health planning, control of the profession by the AMA was weakened. Health policy became too important to be left solely in the hands of doctors — although they still retain the preponderant influence (Fuchs, 1975). Two indicators of federal impact on physicians' power over the supply of personnel are the increase in medical schools to 127 in number and the increase in medical students to over 66,000 today.

On the other hand, the shape of medical practice itself is changing. As specialization has occured, new organizations of specialist practitioners have been founded which are increasingly in competition with the AMA itself. And when the State Medical Societies in the 1960s dropped the requirement that their members must also be members of the national association, the AMA experienced a dramatic decline in membership. Today less than half of America's certified physicians belong to the American Medical Association.

B. CONTROL OF MEDICAL FEES AND PAYMENT MECHANISMS

In 1900, before the advent of health insurance or federal regulation, doctors stood in direct relation to their patients as healers and benefactors. Neither private insurance companies nor government at any level had many regulations to guide medical practice. The demand for private health insurance became much greater after 1920 and intensified in the 1940s. It originated in the breakdown of the household economy as

families increasingly came to depend on the labor of their chief wage earner for income. In addition, the ability of doctors and hospitals to provide efficacious medical treatment increased as the result of advances in medical technology and education. These two factors in turn caused the demand for more health insurance as the public sought to share risks.

Interesting, from the vantage point of political analysis, the health insurer began to take on social and political roles as the importance of health insurance increased (Law 1974). From the viewpoint of physicians, all such private insurers represented an intrusion and a distinct break from tradition (Averyt et aliter 1976). The 1940s and 1950s were a period of increasing constraints on the physicians, primarily through increased controls by the private insurers — among which Blue Cross and Blue Shield accounted for the greatest, most pervasive activity. The federal role was still very minor. Unlike the European nations, the United States took no action at this time to implement a national health insurance program to subsidize voluntary funds or to make sickness insurance compulsory.

"In 1900, American government was highly decentralized, engaged in little direct regulation of the economy or social welfare, and had a small and unprofessional civil service" (Starr 1982:240). At the national level, government had little to do with social welfare, and its health activities were minor. In some minor attempts, Congress approved aid to mental hospitals in 1854, only to be vetoed by President Pierce; and it created the National Board of Health in 1879 but abolished it in 1883. Also, in 1798 hospitals for the merchant marine had been authorized and a number were subsequently built. Not until 1870, however, was the Marine Hospital Service formally organized as a national agency with a central headquarters. In stages in 1889, 1902, 1912, 1930 and 1944 Congress expanded the Marine Hospital Service and established the Commissioned Corps. But it gave them few functions and little authority; government health services were, in a word, minimal (Raffel 1980:534-565).

Long before the debate for a national insurance program to protect the elderly and indigent against the cost of medical care became an issue, the American public and Congress had engaged in a series of debates that addressed broader questions related to health insurance (Skidmore 1970). Serious public discussion of compulsory health insurance in the United States started around 1910, and continued in the 1930s and 1940s. When it was realized that compulsory health insurance would not pass if it were applied to everyone, a special tie-in with the aged emerged during the 1950s. By the end of that decade, health care for the aged had become a national political issue. It was tied to or embedded in the question of poverty, since many of the old were poor or — if not initially poor — many of the elderly became poor as they paid their expensive bills for increasingly needed medical care.

Immediately after his election, President Kennedy delivered to Congress the first Presidential message ever devoted exclusively to the need for a health program. In the message he strongly urged that hospital insurance for the aged be added to the Social Security system. After five years of intense congressional and public debate — and after the national trauma of a presidential assassination followed by an overwhelming electoral victory by the Democratic Party — the final Medicare legislation passed in 1965. National health insurance had come of age in America, even if for only a segment of the total population.

In establishing Medicare, Congress and the Johnson Adminstration wanted to gain the cooperation of doctors and hospitals. To obtain this cooperation, two major decisions were taken. The first was to set up intermediaries to pay the hospitals. The advantage of using fiscal intermediaries was that it allowed for almost immediate implementation of the program, and it eliminated the need for a separate government administrative bureaucracy.

The second decision involved the rules of payment for hospitals under Medicare. The legislation adopted the practice followed by Blue Cross of paying hospitals according to their costs. In basing reimbursement procedures on reasonable costs and charges, Congress also facilitated program implementation. However, as time amply demonstrated, this reimbursement methodology contained no incentives for providers to control costs. In its desire to ensure access to care, Congress altogether ignored the problem of costs in the original legislation. This issue of cost control became the focus of many subsequent attempts to improve the program. Concern with access and quality of care soon gave way to legislative efforts to control program costs with a concomitant effect on the Medicare program and its beneficiaries.

IV. Legislative Initiatives and the Power of Physicians

It has been frequently argued that during the 1960s access was the most important concern, while during the 1970s and 1980s cost containment has become paramount. Federal legislation and, more importantly, federal regulations have mirrored these concerns. Federal trends from the early 1970s until the present clearly emphasize cost containment, although one must remember that prior to this time there had been very little federal regulation of health issues in the United States. Most federal health programs had been voluntary and in fact patterned after the usual practice of federal-state cooperation in formula grants. The Hill-Burton Act of 1946 and its subsequent renewals provide the classic case (Raffel 1980:588). Initially federal regulation was insignificant because the federal government itself had a limited role. Most power lay in the hands of the providers themselves. As the federal role increased, the decision to use the same system as private insurers and to use private insurance companies as intermediaries or fiscal carriers also tended to minimize government intervention. Consonant with its traditional political preference, the United States engaged in government-by-contract rather than direct government through state agencies. However, as government began to take the lead in cost containment efforts in the health sector, federal intervention increased. And the provision of medicine became increasingly politicized.

The federal government's involvement in health financing has grown enormously over the past twenty years as federal programs have assumed responsibility for financing medical care to the elderly, the disabled, and the poor. Entitling these segments of the population to mainstream medical care has incressed their use of services and improved their health. This also has increased the nation's total health bill. Likewise, public along with private insurance has fueled rapid increases in medical prices and promoted increasing sophistication in medical care (Zubkoff 1976). As a result, the percent of the gross national product (GNP) devoted to health care has grown each year to where it now represents 10.5 percent of the GNP.

Furthermore, health care cost inflation annually outpaced the average Consumer Price Index for the past two decades. Although the rate has slowed in recent years, medical and hospital inflation still exceeds general inflation by more than half; in 1984 medical costs rose 6.1 percent (including a 7.4 percent rise in hospital room rates) while the Consumer Price Index for all items rose only 4 percent (Pear 1985). Unsurprisingly, as early as 1969 the Secretary of the Department of Health, Education and Welfare (DHEW) called for measures to control health care cost inflation. Rising costs brought medical care under more critical scrutiny, and the federal government, as the major buyer of health services, began to intervene in new and unprecedented ways. The politicization of medicine continued.

As experts and politicians began to question whether more expensive services were worth the cost, the issue of "cost containment" supplanted improvements in access and quality on the federal policy agenda of the 1970s. During the first half of the decade Congress passed a great deal of complicated legislation, among which were temporary price controls as well as amendments to the Social Security and Public Health Service Acts. A brief chronology and discussion of these legislative enactments follow.

(1) In August 1971 a general wage-and-price freeze brought a profound, but temporary, reduction in medical inflation. The wage-and-price freeze limited doctors' fees to annual increases of 2.5 percent and hospital charges to an increase of 6 percent. The general freeze was lifted in January 1973 but it was maintained for health care until 1975. Health care was singled out for special attention and additional regulation (Zubkoff 1976).

(2) In 1972 Congress passed a package of amendments to the Social Security Act that directly addressed the problem of rising health care costs and their effect on federal expenditures. Four major initiatives were involved that dealt, respectively, with hospital payments, capital formation, physician payments, and self-regulation of providers.

(a) Some initial constraints were placed on federal payments to hospitals under the various programs of the Social Security Act. Section 223 authorized the Secretary of HEW to establish methods for determining "reasonable cost" of health services that take into account "various types or classes of institutions, agencies, and services." An interim schedule of limits on hospital inpatient costs was published in the Federal Register in June 1974. Providers of health services immediately objected to these regulations as a method of imposing mandatory cost controls on the nation's hospitals and as a means of meeting budgetary goals rather than screening for inefficient hospitals.

(b) At the same time the federal government became involved in regulating health care capital formation and medical practice. Section 1122 of the 1972 Amendments gave HEW power to deny full Medicare and Medicaid reimbursement to hospitals and nursing homes for any capital investment not approved by state planning agencies. For the first time, capital was something which the government monitored. As a consequence, health planning agencies achieved a negative or 'veto' power over health care providers who received any federal funds under Social Security Act programs — although proposals for capital expenditures under $100,000 were exempted.

(c) The 1972 Amendments also imposed ceilings on Medicare payments to physicians. The Secretary of HEW was authorized to develop an economic index for use in determining the amount of increase in physicians' fees that would be recognized for reimbursement purposes. Congress included this amendment in response to the astounding inflation in fees for physician services that had occured since the passage of Medicare. Congress instructed HEW to create an index that would measure the increase in physicians' practice costs (such as the rental of office space or the wages of nonphysician labor) and thereby permit an annual increase in income derived from Medicare payments that would be commensurate with the general rise in earnings in the United States. This Medical Economic Index has been updated annually since its implementation, but the amount of increase in "allowed charges" has consistently fallen behind the Consumer Price Index for all services and for physician services. That is to say, the actual increase in fees for physician services has always surpassed the percent increase allowable under the Medical Economic Index.

Furthermore, Section 227 changed the basis for reimbursing teaching physicians in contrast to attending physicians. The original legislation (PL89-97) specified that all hospital services of physicians, except for residents and interns, would be reimbursed under Part B of the Medicare program. Hereafter teaching physicians would be reimbursed on a cost basis under Part A (mandatory hospital insurance) rather than Part B (optional physician insurance). The proposed regulations for implementing Section 227 required a professional test (based on the physician-patient relationship) and a fiscal test (based on the payment profile of patients in the setting) in order to determine whether the billing allowed would be fee-for-service billing for attending physicians or cost-only billing for teaching physicians.

The opposition from organized medicine against Section 227 of PL92-603 was so vehement that Congress again passed legislation in 1974 delaying implementation of Section 227 until 1 January 1975. In the interim Congress authorized the National Academy of Sciences to conduct a study of appropriate and equitable methods of reimbursement for physician services under Titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act. Although these studies were conducted, opposition to the limits imposed by Section 227 continued. So-called 'final' regulations for this controversial measure were issued in the Federal Register on 11 March 1980, but never implemented. Instead the Omnibus Reconciliation Act of 1980 (PL96-449) repealed Section 227 altogether.

(d) Finally, Public Law 92-603 established Professional Standards Review Organizations (PSROs) in order to ensure that reimbursed services were medically necessary, provided in accordance with professional standards, and rendered at the appropriate level of institutional care. The country was thus blanketed with a network of PSROs. The law required that local groups of physicians be established to review the use of medical services and to control unnecessary utilization via either inappropriate admissions or unnecessarily long lengths of stay. Since local standards were used to determine the applicable criteria, differences in (for example) the average length of stay of more than two days between the east and west coasts were accepted. It is important to contrast this arrangement with the new prospective payment legislation (discussed more fully below) which, after an initial period of phase-in, is designed to have a single national standard. The regulatory process has moved from significant local autonomy where physicians established the standards to a more national direction with national standards.

The 1981 Omnibus Budget Reconciliation Act (PL97-35) required the Secretary of HHS (formerly HEW) to assess the relative performance of the PSROs. Numerous evaluations before and after the law indicated that the PSRO program was only marginally effective. Consequently the 1982 Tax Equity and Fiscal Responsibility Act (TEFRA) repealed the existing PSRO program and instead established the Utilization and Quality Control Peer Review Organization Program (UQCPRO). Since the acronym is unpronounceable, the name has been generally shortened to PRO. The new PROs are defined as either an entity composed of a substantial number of licensed physicians practicing in an area or an entity which has sufficient physicians available to conduct adequate peer review of medical services.

(3) Consonant with America's faith in economic liberalism, the discipline of the market place was also invoked in order to control health costs. The Health Maintenance Organization (HMO) Act of 1973 and its 1976 revisions were aimed at stimulating competition among provider organizations. There has also been a trend toward 'deregulation' elsewhere in the economy that has had indirect impacts. But interestingly, even business interests usually favorable to deregulation prefer to maintain some regulation (or even re-regulation) over the health sector (Pear 1985; The Economist 1985).

(4) Finally, and very briefly, the early '70s saw the passage of yet another law for systematic health planning (see Altenstetter and Björkman 1981). The National Health Planning and Resources Development Act of 1974 (PL93-641 was actually signed into law by President Ford in 1975) established a tiered network of local and state health planning agencies which were guided by national directives promulgated by the Secretary of HEW. The Act absorbed, abolished and/or reformulated several previous efforts at health planning — among them the Hospital Survey and Construction (Hill-Burton) Act of 1946; the Regional Medical Program of 1965; the Comprehensive Health Planning Act of 1966; plus various others — and divided the country into 'health service areas.' Each area was staffed by a 'Health Systems Agency' which produced local long-range health plans and annual implementation plans, all of which plans were reconciled by a state-wide health coordinating committee within federal guidelines. Although extended and amended several times, the 1974 planning act was chronically underfunded and it had little, if any, fiscal power. Its major leverage was to deny approval to capital expenditure projects financed by federal programs under the Social Security Act. Nonetheless, PL93-641 was considered important (a) because it monitored, albeit inadequately, the pluralistic American health sector and (b) because it was presumed to anticipate the structure for an 'inevitable' national health insurance. Wishfulfillment notwithstanding, national support for PL93-641 has now been terminated.

During the second half of the 1970s there was no major health legislation.
Most of the political activity in health care financing involved implementing the Social Security Amendments of 1972, such as tightening existing regulations to lower the maximum payment amount paid to hospitals under Section 223. President Carter made hospital cost containment a high priority, but Congress repeatedly rejected versions of his proposal (Abernethy and Pearson, 1979). Many factors led to the demise of hospital cost containment legislation, including its complexity. Equally important, however, were the opposition of the hospital industry and the lack of significant taxpayer support. Because of the importance placed on the passage of hospital cost containment, no other significant legislative and regulatory initiatives occured during the Carter administration.

The federal government's inability to contain either public or general medical costs reinforced general reluctance to increase federal spending on health care. Certainly escalating health costs were a major impediment to the adoption of national health insurance during the 1970s. Neither national revenue controls nor national health insurance were enacted before President Carter left office, and the decade ended as it began — with health care abosrbing a growing share of personal income and government budgets. The providers remained in control.

Nonetheless, thoughout the 1970s prominent spokespersons for both political parties as well as a variety of analysts and commentators had advocated broader federal involvement in the control over health care financing. The differences among them concerned the methods used to control spending. Some advocated regulatory strategies; others sought the shock theraphy of market discipline; still others pushed 'health education' so consumers and providers alike would practice self-restraint. The Reagan administration's objectives differed from earlier administrations in their emphasis on minimizing federal regulations, increasing responsibilities of the states and the private sector, and promoting competition and market-oriented reforms to promote efficiency.

The first major health legislation passed after President Reagan's election
was the Omnibus Budget Reconciliation Act (OBRA) of 1981, which increased the responsibilities of the states and reduced federal regulation substantially. For example, states are now given much more latitude to design their own payment systems to pay providers in the Medicaid program. Federal oversight and review procedures have been drastically reduced. OBRA was the first attempt of the Reagan administration to minimize federal regulation and to shift responsibility to the states.

Passage of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) initiated the next major reform of health regulations and the power of providers. One of TEFRA's most important changes was Section 101, whose primary purpose was cost containment. Section 101 established new Medicare cost limits, effective

October 1982, on total inpatient operating costs. The previous limits (from Section 223 mentioned earlier) applied only to routine hospital costs and did not apply to ancillary services, which constitute about one-half of a hospital's bills. The TEFRA limits are established for each hospital under a case-mix index based on diagnosis-related groups (DRGs). In philosophical terms, TEFRA established the proposition that Medicare was buying a product from the hospital and that product is the treatment of patients with a certain medical condition (Marone and Dunham, 1984).

Section 101 and other important provisions of the TEFRA legislation -- such as elimination of the routine nursing differential, prohibitions of payment under Medicare for Hill-Burton free care, and recognition of the Secretary's authority to publish regulations eliminating the Medicare subsidy for medically unnecessary private rooms — all still maintained the principles of retrospective cost reimbursement. While TEFRA was an important first step in controlling the providers of health care, an additional step was required in order to obtain a full prospective payment system.

During 1982 the desire for increased competition and financial controls dominated thinking about federal regulations, and a series of subsequent health regulations were issued which had a significant impact on physicians and on the management of payments under Medicare. Two regulations stand out in particular. In order to implement Section 108 of TEFRA, the Federal Register of 2 March 1983 published final regulations entitled "Payment for Physician Services Furnished in Hospitals, Skilled Nursing Facilities, and Comprehensive Outpatient Rehabilitation Facilities." The regulations distinguish in a very complicated way between physician services under Parts A and B of Medicare and between teaching and nonteaching hospitals. In effect, however, by altering the computation of charges and determining the maximum allowable compensation, Medicare will not allow the nonteaching hospital to make a profit from physicians' services either.

The most dramatic and long-lasting change in reimbursement policy occured in January 1984 with the publication of final regulations on Medicare payments to hospitals under TEFRA's diagnostic-related-groups. The new DRG system has a transitional phase-in period of three years, but will produce profound changes in hospital behavior. DRGs may also establish effective control over the fees of American physicians (see below, Section V-D). One of the many studies mandated by Congress under prospective payment will explore the feasibility as well as the advisability of using a DRG-based approach to pay for physicians' in-hospital care of Medicare patients. While there are many fascinating questions in this study to be addressed by epidemiologists and accountants, the overriding political question is whether it is practical to link physician payment to DRGs. The Deficit Reduction Act of 1984 (PL98-369) requires the Secretary of the Department of Health and Social Services to report to Congress by 1 July 1985 on the feasibility of DRG payments for physicians' services to hospital inpatients, but deadlines are often elusive. However, whatever the timetable, clearly the medicalizing of politics is proceeding apace.

On reflection, the history of Medicare and its impact on health care providers brings to light the evolutionary character of this particular government program. The original design of Medicare, although never altered in its essentials, has been refined and modified to respond to the major health policy issues facing the nation at different points in time. The original concern with providing access to needed care produced a program that covered the most costly forms of care (like hospital and skilled nursing services) and provided funds to support hospital and facility construction. The desire to protect other vulnerable members of American society such as the disabled and those afflicted with chronic kidney disease also resulted in the expansion of eligibility requirements for Medicare. However, the increasing cost of health care services and the proportion of those costs borne by the federal government have led to legislative and executive efforts to control costs through both new laws and supplemental regulations which limit reimbursement to providers and physicians. The current deficts in the federal budget have produced renewed efforts to achieve savings or reduce social expenditures by a combination of provisions that include increased cost sharing among beneficiaries, risk sharing on the part of providers, and cuts in the proportion of capital expenditures paid by the federal government.

V. Experiments in Controlling the Practice of Medicine

During the past twenty years the core political issue of the health care debate has been transformed from equity in access to containment of costs. Egalitarian principles were realized during the 1960s when public policy embraced the "right to health care" in the Medicare and Medicaid programs. The demand for services generated by Medicare and Medicaid resulted in a gradual, but vast expansion of the nation's health

care delivery system. The expansion in demand led, in turn, to soaring health care costs and growing fiscal concerns. By the mid-1970s national concerns had shifted from expanding access to health services to coping with the uncontrollable health care expenditures that resulted. By 1980, a seemingly irreversible political demand for health care budgetary restraints emerged in response to medical care inflation.

In traditional analysis, cost containment strategies can be subsumed under three categories: competition, public utility regulation, and centralized national health insurance (Marmor and Christianson 1982). In the past 15 years Congress has attempted to control costs through a number of regulatory mechanisms associated with the first two categories. These regulatory efforts have met with limited success (Saltman and Young 1980). Policy makers and health economists attribute the apparent failure of regulatory approaches to the fact that such mechanisms do not address the underlying problems associated with health care inflation, most specifically "the unusual system of supply and demand" (Enthoven 1978). Unlike the pure market economy, where price is the controlling factor in decisions regarding the supply and demand for goods and services, consumers and providers in the medical market have been insulated against cost by third party payment mechanisms and cost-based reimbursement. Moreover, whereas demand is controlled by consumers in the competitive marketplace, physicians make the major decisions regarding consumers' need for goods and services. These perverse incentives operating in the medical marketplace have led to "market failure" in the health care industry.

Since the categories of competitive and regulatory solutions have not worked well (perhaps because they are more often than not mutually exclusive) and since a solution via centralized national health insurance has not been (and most probably will not be) tried in the United States, a fourth approach to controlling costs has emerged — that is, by limiting physician autonomy and the technical aspects of medical work. Congress has passed laws and authorized regulations that address the physician's central role in ordering medical services. As will be argued, state intervention has followed an increasingly intrusive path into the physician's once private world of technical autonomy. The drive to control physician autonomy highlights the political nature of autonomy itself. Physicians control approximately 70 percent of health care resources by virtue of their legal monopology over medical care (Nobrega and Krishnan 1983). Controlling the major group of controllers of health care resources is a public policy response to the cost containment imperative; limiting technical autonomy is the method.

A. AUTONOMY: THE POLITICAL BEDROCK OF PROFESSIONAL CONTROL

Until recently, physicians have enjoyed the privileges of professional autonomy on a comprehensive scale, including control over methods of payment; control over the social organization of their work; and exclusive control over the content of their work, or technical autonomy. Four more privileges can be derived from technical autonomy: freedom from competition from non-physician personnel; freedom to self-regulate; freedom to regulate the work of other related occupations, such as respiratory therapists; and freedom to regulate patients (Freidson 1975).

Based on the classical attributes of the definition of a "profession" — that is, special knowledge and a public service ethic — an assumption is made that the physician should act as an agent for the patient in ordering care and should be the final arbiter of medical work. This forms the ideological foundation of health services. However, these claims must bear a political endorsement through a government grant of autonomy before they can be translated into professional power and control over resources. Within antebellum America, for example, medicine's claim to the classical attributes was rejected by popular opinion, alternative practitioners and politicians alike (Gerstl and Jacobs 1975). Yet by the late 19th and early 20th centuries, faith in medicine's special expertise had replaced this distrust; the change was signified by state licensure laws and medical education reforms (Starr 1982).

The point is that in order to secure autonomy, the medical profession had to enter the political arena and act as an interest group seeking to influence public policy to its own advantage. Much of the medical profession's power is based on the legally supported monopoly of practice which operates through a state government system of licensing, and that bears the privilege of exclusive patient management. Physicians have had an exclusive legal right to offer medical services and control access to the resources necessary to managing medical problems related to those services.

In order for medicine to maintain autonomy, physicians must continually re-enter the political arena to enlist the support of political decision makers in maintaining their pre-eminence. Claims to special knowledge and a public devoted ethic can be viewed as resources which, used initially to convince decision

makers that autonomy should be granted, again are used to buttress claims that it ought to be maintained. The role of the state is to maintain non-interventionist policies relative to health care services programs. In a pluralistic political system, policy is a result of bargains struck among vested interests, with no one interest consistently dominating the decisionmaking (Feingold 1977). Physicians' interests have traditionally been recognized in the policy making process.

However, to the degree that medicine is dependent on governmental units for its professional power, its autonomy is vulnerable to manipulation. The expansion of patient rights through the courts, which alter the doctor-patient relationship, is illustrative (Starr 1982:388-391). The current Medicare restrictions on fee increases is another. In sum, it is not the medical profession which has sovereignty; rather it is the State that has sovereignty "and grants it conditionally" (Freidson 1975:24). Autonomy is the political core of the medical profession, and it can only be understood "as the outcome of a political struggle to control key resources," including the autonomy itself (Björkman 1982:415).

The issue of physician power and medical autonomy is always complicated because doctors practice in two distinct, if overlapping, arenas: the self-standing clinic (whether solo or group practice) and the hospital. Since much of the health money is channeled through hospitals, their internal power structure needs to be understood. Drawing on Crozier's model of organizational behavior being determined by a conflictive power equilibrium, the hospital as a decisionmaking organization contains six major occupational groups: physicians, administrators, nurses, medical technicians, clerical personnel, and service personnel (Saltman and Young 1981). Each group has a stable but flexible group strategy designed to maximize its authority over decisions which affect that group. Each group attempts to increase its latitude within the hospital by maximizing other groups' uncertainty that it will perform its function as expected; but no group pushes its interest to the point of threatening organizational survival.

The primary decisionmaking struggle exists between physicians and administrators, a contest which effectively orders all other intergroup relations within the hospital. For example, physicians order relations through issuing medical orders, while administrators order relations by managing resources through a hierarchical chain of command. Physicians, however, are not a part of the hierarchical chain of command because they are paid by sources external to the hospital. As the folk formula puts it: "only doctors have patients; hospitals have only doctors." The power struggle which emerges from this structural relationship is discussed below.

By virtue of their control over the major sources of unpredictability within the hospital's production process, physicians are perceived to be at the apex of power. Physicians are able to carve out their zone of autonomy through exclusive control over patient care: admissions, diagnosis, orders for tests and procedures, decisions on levels of care, and discharge. They therefore control three of the hospital's critical cost and revenue generating variables: admissions, clinical resource consumption, and length of stay. These are the central sources of unpredictability in the service production function. Besides the short-term impact on hospital production and finances, physicians exercise control over most capital costs, especially new services and technology. In terms of the financial survival of the hospital, physician behavior is <u>the</u> critical variable.

The key decisionmaking struggle between physicians and hospital administrators pivots around the control of the variables that comprise the central source of unpredictability in the production function. These two major actors pursue different interests and are unequal in resources as they vie for control over the decisionmaking proceses. The power equilibrium between the two changes only as the resources of one or both are altered.

The foundation of the physicians' crucial role in the hospital is their monopoly over technical expertise which effectively frees them from supervision by hospital management. By operating within a "black box" filled with the special knowledge that governs the medical decisionmaking process to which only they are privy, physicians are able to "maximize the uncertainty that they will perform their function as anticipated" (Saltman and Young 1981: 408).

In order for hospital administrators to strengthen their control over the hospital decisionmaking process, they must have access to the special knowledge
comprising medical expertise. The same may be said of any would-be external regulator. With access to knowledge, norms could be developed by which physician performance could be measured, and management tools could be developed by which the degree of unpredictability in the production of hospital services could be

decreased. One other requirement would have to be fulfilled before administrators could develop and apply these management tools — namely the political endorsement or stimulation of such activities. During the past two decades there have been three successive attempts in the United States to monitor medical practice and reduce physician autonomy.

B. UTILIZATION REVIEW

Medicare was the culmination of a 35-year ideologically polarized battle over national health insurance in the United States. The Democratic landslide of 1964 enabled the 89th Congress to pass that legislation, and both Congress and the Johnson Administration were eager for the program to be implemented quickly and successfully. To ensure the cooperation of physicians and hospitals who would provide medical services to the beneficiaries, Congress essentially grafted the Medicare program on to the existing health care delivery system. Congress declared its intention of noninterference with the health care system in Section 1801 of the law entitled "Prohibition Against Any Interference." This so-called 'AMA clause' prohibited the federal government from exercising "any supervision or control over the manner in which medical care services were provided ... or ... over the administration or operation of any ... institution, agency, or person" providing health services (Thompson 1981:159).

This noninterference contract between the federal government and providers was backed up by a number of attractive incentives. The primary incentive was that payment rules were to conform to principles of payment being used by third party payers, particularly Blue Cross and those condoned by the American Hospital Association (Feder 1977:1). This amounted to reimbursement for 'reasonable costs' through hospital-nominated fiscal intermediaries. Programmatic responsibility was given to the Social Security Administration (SSA), which was the bureaucratic base of several Medicare strategists; and the majority of hospitals chose Blue Cross — their own creation and long-standing ally — to act as buffer between the hospitals and the well-disposed federal agency. Similarly, physicians were to be paid according to their 'usual, customary, and reasonable' fee through an intermediary, the majority of which turned out to be Blue Shield (Starr 1982:375).

Both the physicians and hospitals stood to benefit enormously from the increased earnings and guaranteed revenues to which few requirements were attached. Payments for care that once fell under the heading of non-reimbursed charity care were now ensured through a fiscally irresistable program provided by the federal government. "As a result, the administration of Medicare was lodged in the private insurance systems originally established to suit provider interests. And the federal government surrendered direct control of the program and its costs" (Starr 1982:375). Yet as Congress and the Administration had wished, the Medicare program was launched quickly and successfully.

Despite the noninterference contract of 'AMA clause,' however, two requirements were built into Public Law 89-97. One concerned certifying hospitals which had to meet minimal quality standards; the other was Utilization Review (UR). The purpose of the UR program was to ensure that physicians engaged in cost-effective treatment practices so that hospital resources would be used efficiently. Since physicians control approximately 70 percent of medical care resources via their exclusive control over patient management, it was clear to Representative Wilbur Mills — the powerful chairman of the House Ways and Means Committee — that controlling medical care costs required influencing physician behavior (Anderson and Shields 1982:26). Utilization Review was the lever supplied.

The Medicare law mandated two types of review: general reviews of practice patterns in order to assure quality, and specific reviews of long stays in order to monitor the use of resources. As expected, organized medicine opposed Utilization Review from its inception on the grounds that it transgressed professional boundaries of autonomous control of medicine; specifically technical autonomy and self-regulation. After the law was passed, the American Medical Association (AMA) supported only reviews to assure quality because it regarded quality assurance as an educational activity. But the AMA remained unalterably opposed to utilization review of resources which it considered an illegitimate policing activity by the government (Feder 1977:34-35).

Meanwhile, the Social Security Administration had no precedent from which to derive guidance in setting up such a review system. Previous quality review activities within the medical community were limited in number and in scope, and almost none existed before Medicare whose activities were directed toward efficient use of hospital resources (Covell 1980). Traditionally cost had not entered the physician's clinical decisionmaking process. Hence, not only were there no precedents but also no standards by which to measure inappropriate resource use.

However, the SSA had a third option for meeting the legal requirement of Utilization Review: the monitoring function could be delegated to state health agencies and/or fiscal intermediaries. The AMA, the AHA and Blue Cross strongly opposed federal government involvement via state agencies. It was argued that if state oversight was chosen, Medicare officials would evaluate utilization review and their disallowances would threaten reimbursement. By contrast, reliance on fiscal intermediaries would tie oversight to the payment process itself. While the latter was in effect devoid of an enforcement mechanism, the role of Blue Cross would expand if fiscal intermediaries were used — as would their revenue (Ensign 1978:188-191).

However, the primary objective of the Social Security Administration was to implement Medicare; and implementation required support from the providers. Furthermore, there were neither precedents for how to develop the program nor criteria by which to measure medical care utilization. From past experience with the social security trust funds, SSA was a payment processing agency; the monitoring of physicians was clearly out of its area of expertise. Consequently the SSA took the path of least resistance offered through a balancing strategy to achieve its objectives.

The balancing strategy resulted in a review system developed and controlled by committees composed of physicians at the hospital level. State agencies were authorized to conduct procedural reviews of Utilization Review committee activities, but primary responsibility for substantive evaluation was given to the fiscal intermediaries. The claims review process of these intermediaries did not include a substantive review of practice patterns, the lack of which incapacitated any potential enforcement of the law.

All of this was consonant with the non-interference clause of the Medicare law. Presumably Utilization Review was included in the PL89-97 because of Congressional concern about potential increases in cost. However, enforcement of this provision of the law would have required that SSA challenge the medical community and thereby undermine the overriding objective: implementation of a federal health insurance program in the United States. Political costs would have greatly outweighed political benefits. By delegating program responsibility to fiscal intermediaries and independent Utilization Review committees, the Social Security Administration avoided such a direct challenge of physician power. Indeed, a passing remark by Representative Mills clarifies the intent of Utilization Review and conveys the spirit of the entire Medicare Act:

> Shortly after the passage of the Medicare Act, one of the architects of that legislation was asked the following question: In the preamble to the Medicare Act there is a statement that the Act will in no way interfere with the private practice of medicine, yet in a few paragraphs later there is mandated that each hospital set up utilization review committees to monitor length of stay. 'Is this not interfering with the private practice of medicine?' Rep. Mills smiled and leaned back in his chair: 'Oh, no, that provision in the law is simply to make doctors talk to each other' (Anderson and Shields 1982:126).

During these first years of the Medicare program, physicians and hospital administrators shared a coincidence of economic interests under cost-based reimbursement operations. Physicians earned more for providing services in the hospital than in an outpatient setting. Additionally, the greater the volume of services and the more complex the individual procedures, the greater the compensation earned. Maximizing the key clinical variables — that is, admissions, diagnosis, levels of care, tests and procedures, and length of stay — could be translated into maximum earnings. Simultaneously maximizing physician income also meant maximizing hospital revenues. The prescribed reliance on fiscal intermediaries for oversight left control over Utilization Review activities within the hospital itself; and the results were as expected.

During the era of Utilization Review, physicians generally did not criticize each other, especially given the conditions of clinical uncertainty under which they operate (Blumstein 1976:264). The overlay of Medicare financing incentives did not enhance the atrractiveness of this proposition. Yet there were no agreed standards governing the clinical variables of patient care by which criticisms of overutilization could be lodged. If the Social Security Administration had wanted to intensify Utilization Review activities — which it did not — lack of knowledge would have provided a formidable contraint, if not indeed one that would have made this venture impossible.

As Medicare became an "uncontrollable" budget expense, policymakers had to confront choices about utilization and payment schedules more seriously than they had in 1965. But government officials were not alone in their desire to control the health care sector. The 1970s were characterized by increasingly

enlightened consumers who demanded accountability from a health care system perceived to be inequitable, inefficient, and of questionable utility (Krizay and Wilson 1974). Employers paying high health premiums as well as the commercial insurance industry concerned with its own competitive edige against Blue Cross, also began to favor comprehensive reform (Starr 1982:383-388). Furthermore, health services research began to report that physicians scheduled unnecessary surgery and that hospitalization rates varied sharply across regions. It became increasingly clear that the role of the physician was central to any public consideration of limiting medical expenditures. And a political coalition was coalescing to attempt greater control over the practice patterns of physicians.

C. PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

Proposals for review of medical care began to surface in the late 1960s from various quarters, including federal agencies and the AMA itself. But the major impetus for change emerged primarily from Senator Wallace Bennett of Utah, the ranking Republican member of the Senate Finance Committee (Feder 1977:43-45). Bennett's objective was to control medical services by influencing medical practice, and he proposed that the review process be conducted by local physician groups accountable to a federal agency rather than by the fiscal intermediaries. The AMA objected to provisions of his proposal involving government ownership of records, mandatory advance approval for elective surgery, and national norms for health care. But with several modifications, Congress enacted the Professional Standards Review Organization (PSRO) program in the Social Seurity Amendments of 1972.

The modifications secured by the AMA were critical to physicians maintaining control over the technical aspects of their work. The status of pre-admission certification for elective surgery was changed from mandatory to voluntary. The final legislation restricted PSRO responsibilities to institutional service, thereby constraining the scope of review activities. Furthermore, only physicians could participate in program decisions; and the government would not own the data. Altogether medicine managed to retain control over the PSRO program.

Nonetheless, members of the medical community expressed indignant outrage both before and after the PSRO legislation was passed. They protested that the law would ultimately force physicians to practice medicine by averages; that the program's primary objective was cost-control rather than quality assurance; that the program put the doctor-patient relationship and its confidentiality into jeapardy; and that the program would cost more than it would save (Lebish 1982:992).

The legislation itself clearly contained conflicting goals of quality assurance and cost containment, but the Congressional Record records that Senators Bennett and Russell Long advocated an educational emphasis for PSROs. This attitude evolved into the articulation of quality of care as the primary objective of the new law. Like administrators of the Utilization Review program, officials of the Office of Professional Standards Review — OPSR was the federal agency implementing PSROs — adopted the posture that Congress had advocated. Their pliancy dovetailed well with the AMA position that, under conditions of conflict between cost and quality issues, maintenance of quality was to be the primary objective of peer review (Blumstein 1976:248-249). Also the AMA insisted on local decisionmaking about norms of medical care rather than the imposition of national or even regional standards.

Implementation of the PSRO program was marked by considerable delay. Program administrators, hospital review committees and PSROs themselves were uncertain about how to proceed. Lack of a model system for monitoring medical care accounted for the delay as much as resistance by the physicians. As it turned out, neither of the two major methodological options for setting standards — empirical or statistical — produced reliable indicators. And the computerized utilization review system developed by OPSR required technology that many hospitals did not own at the time (Thompson 1981:144-145).

Consequently, despite claims (or fears) to the contrary, PSROs did not impose negative sanctions on physicians. The educational slant of the program, the conceptual quagmire of setting standards, the technicalities written into the law by Congress, and the political constraints involved in peer disapproval, all contributed to the de-emphasis on sanctions. Furthermore, federal administrative activities were confined to procedural matters rather than substantive concerns; and federal administrators had little control over the program.

Early in the Carter Administration the PSRO program was found to be cost ineffective because its emphasis on quality assurance tended to inflate services rather than constrain them. In response to this

criticism, the program was relocated in the Health Care Finance Administration (HCHA) in 1978. Despite intensified adminstrative efforts to induce PSROs to conduct vigilant reviews or "be defunded and replaced," relocation had little effect on changing the program emphasis from quality to cost control (Lebish 1982:992). A Congressional Budget Office Report in 1979 condemned the program as a cost-containment failure; and it was slated to be phased out by 1981 under President Reagan's proposed economic recovery act.

In the cases of Utilization Review and PSROs, program outcomes are consistent with historic government action in the health system. State authority was simply delegated to the medical community. Physicians were responsible for developing, implementing and overseeing the programs; and the federal government, in the main, served merely to endorse their activities. Most of this delegation (or abdication, as some would have it) of authority was not inconsistent with Senator Bennett's vision of the PSRO program. The point of the legislation was to place peer review under physician control in order "to enhance their (physicians') stature as honorable men in an honorable vocation" and to protect the public interest in cost containment and quality assurance "while at the same time, leaving the actual control of medical practice in the hands of those best qualified — America's physicians" (quoted in Blumstein 1976:248). Yet Bennett and others also viewed the PSRO program as the last opportunity for the medical community to take control of the quality and costs of medical care before someone else assumed responsibility for those objectives.

Like Utilization Review previously, the PSRO program was absorbed by the power structure of hospitals. The resistance to the program by both physicians and administrators derives from their desire to maintain and increase their zones of autonomy, and from each group trying to maximize its control over decisions which affect it. Any externally imposed review system injects an element of uncertainty into the hospital revenue maximizing scheme, and reduces the administrators' already limited control over the major variables of the production process. Hence the American Hospital Association demanded that PSRO review responsibilities be delegated to the hospital committees just as it had resisted oversight in the Utilization Review program.

Resistance by physicians to the program emerged from the limits to technical autonomy imposed by an external review system. PSRO utilization activities concentrated on admissions and lengths of stay; PSROs used regional norms and standards adjusted to local conditions to determine the appropriateness of the clinician's judgment (Goran 1979). Resistance to the program revolved around the questions of who is clinically correct: the individual practitioner, the local group, the regional aggregate, or the national average. Opposition to PSROs was thus in part a manifestation of professional resentment to external supervision of a process that had traditionally been insulated from outside review.

A more principled objection concerned the underdeveloped techniques for measuring efficiency in medical care. There simply were no operational definitions for over- and under-utilization of services. The norms were based on averages which imply a judgment that the average case is of adequate quality (Anderson and Shields 1982:125-153). Both the PSRO officials and the federal administrators were sensitive to this problem, as were the local physicians to whom the review system was applied. Since individual physicians are (or were) the only owners of medical knowledge and judgment, they have a duty as final arbiters of medical care to employ those faculties when confronted with an individual case.

Little information has been collected on changes in physician behavior as a result of the PSRO program; and the validity of those evaluations conducted are questionable (Rosen 1978:48-63). Each hospital and each physician has a profile of statistical information that the PSRO gathered, but this information is confidential. Once the data are aggregated to the point where individual hospitals and physicians are not recognizable, they can be published. But aggregate shifts on the macro level do not permit analysis for change on the micro level. Hence it has not been possible to assess the program's impact on physician practice patterns.

Several things, however, are known for certain to have changed. First, technical autonomy was indeed decreased under PSROs. Clinical decisions of individual physicians were reviewed by physician groups, including Medicare-related (after the fact) admissions, level of care determinations, and lengths of stay for outliers. Previously physicians had enjoyed the professional prerogatives of individual self-regulation within formal and informal constraints. Formal constraints included legal and professionally promulgated ethnical rules; informal constraints included the exclusion of 'bad physicians' from peer referral. PSRO activities transgressed all these boundaries.

Second, PSRO brought about massive physician participation in peer review activities. For the first time physicians on a grand scale reflected on their practice patterns in terms of cost versus benefits to the patient. Quality and utilization review techniques evolved from a point of little precedent to computerized profile analysis and problem-oriented quality review. In sum, the PSRO program accomplished the hope that Representative Wilbur Mills had for its Utilization Review predecessor: it got physicians to talk to each other.

D. MEDICALIZING POLITICS: PROs AND DRGs

During the 1970s and into the 1980s medical care inflation continued at double-digit rates. These heightened demands for government intervention to control health care costs, which became a prime focus of attention in the political arena. Employers, the insurance industry, the health care critics, all disillusioned with previous regulatory efforts characterized by provider dominance and regulatory ineffectiveness, demanded a more potent cost containment solution. If costs were to be controlled, government was expected to find the way.

Against the background of demands, Congress was confronted simultaneously by an exorbitant health care bill and an ever-widening gap between federal expenditures and revenues. Medical care inflation was outpacing inflation rates in the rest of the economy, and doing so against what appeared to be a shrinking economic context. One of the most visible aspects of high inflation was the greater than average inflation in the hospital sector. The cost-based reimbursement system was perceived as supplying perverse incentives which fueled the inflationary trend. By the late 1970s pro-competitive theories of health care economics were becoming popular (Enthoven 1978). Furthermore, the Medicare trust fund was being depleted. The political summation of these various factors led Congress to seek a solution in the form of prospective payment limits.

The solution was the Prospective Payments System (PPS) based on Diagnostic Related Groups (DRGs) plus the Peer Review Organization provisions of TEFRA. Under PPS, hospitals are paid according to a prospectively determined fixed price per discharge for 467 different categories of illness. PPS is based on the theory that efficient hospitals whose costs per case are less than the standardized government payment will be rewarded; inefficient hospitals whose costs are more than the fixed price will be penalized. This pricing mechanism of 467 Diagnostic Related Groups will be phased in over a period of three years, during which time the payment amount will consist of a blend of national, regional and hospital-specific rates. Between fiscal years 1984 and 1987, the basis for payments will be transformed from primarily hospital-specific local rates to entirely national rates through the increasing assimilation and reconciliation of regional norms. All prices are to be based on statistical norms developed from Medicare billing statements (Hunt 1983).

The 1982 Tax Equity and Fiscal Responsibility Act (TEFRA) created a mechanism for overseeing the application of DRGs to medical practice. The Utilization and Quality Control Peer Review Organizations — or PROs, for short — are organizations of or sponsored by private physicians that contract with the Health Care Financing Administration (HCFA) in order to conduct quality assurance and utilization review activities. Most PROs are a combination of state medical societies and former PSRO groups which merged into a single state-wide organization (Wallace 1984). PROs are based on the same theory as the now-defunct PSRO program. If a rational basis can be found for judging the quality and quanitity of medical services, then a national basis can be found for justifying the cost of those services (Anderson and Shields 1982:127). By implication, this rational basis could also serve to justify <u>not</u> providing services deemed inessential; therefore it could serve as a justification for withholding payments and reducing costs.

As conditions of their two-year federal contracts, each PRO is required to (a) review the reasonableness, necessity and appropriateness of hospital admissions; (b) review the completeness, adequacy and quality of care provided; (c) validate the diagnosis and procedural information that determines reimbursement; and (d) review the necessity and appropriateness of care for outliers for which payment is sought. Indeed, against a list of predetermined criteria, the physician must receive PRO approval for admission of patients or the hospital may not be paid for services rendered. These requirements are operationalized through PRO procedures designed to review and control, under specified conditions, all of the variables which together comprise medical care management — that is, admissions, diagnosis, tests and procedures, levels of care, and length of stay. Spokesmen for organized medicine argue that these criteria and requirements assume overutilization with its attendant ill effects on cost and health alike; and they argue that the objectives are based on standards and norms for which no professional consensus exists (Boulanger 1984).

The PRO can apply penalties or negative sanctions in a variety of ways if physicians fail to follow the bureaucratically prescribed path of process and/or adherence to standardized norms. For example, physicians may be disqualified from participation in Medicare — and last summer the Wisconsin PRO made an example of at least two physicians (WiPRO Reviewer 1984). However, it is the hospital (and some patients) which usually will be penalized for what HCFA considers to be service errors, through payment disallowances for resulting hospital costs that are greater than DRG payment.

The most outstanding aspect of the DRG program is the transfer of power by Congress from physician and hospital providers to the federal bureaucracy. Like Utilization Review and the Professional Standards Review Organizations, the DRG solution emerged from within the federal government; but this time it was the federal bureaucracy, and not Congress, which produced the solution. In 1982 Congress had ordered the Secretary of Health and Human Services to develop a prospective payment system for Medicare; and the Secretary responded with DRGs taken from the New Jersey experiment in which HCFA had been the least obvious but one of the most influential actors (Marone and Dunham 1983).

Diagnostic Related Groups encapsulated a fairly attractive political package to policymakers who had moved beyond the cost crisis rhetoric to the issue resolution stage. First, the DRG mechanism fit the description of the Congressional mandate; it was prospective. Second, it appeared as a viable tool by which the federal government could control Medicare costs. Third, it would not appear to equity-conscious consumer groups — particularly the aged — as a direct cut in access. Congress could control costs by capping 467 different treatment categories instead of limiting total costs and thus having to deal publicly with the trade-off between access and cost.

Finally, it was a solution that was available for an enormously complex public problem. Legislators rarely have the incentives, time or expertise to master the intractable problems plaguing the health sector. Furthermore, despite ten years of PSROs as well as extensive committee hearings on Medicare payments during which Congress repeatedly told the AMA and other groups in organized medicine to develop a solution, the medical community had produced no cost containment strategies whatsoever. The DRG solution emerged in a kind of policy vacuum, and Congress turned to its traditional source of expertise and advice: the bureaucracy.

Hearings before the Subcommittee on Health of the Senate Finance Committee on 2 February 1983 reveal how the positions of the AMA and the Congress were juxtaposed. Based on its traditional opposition to rationing necessary medical care for cost containment purposes, the AMA stoutly opposed DRGs; it argued that while the method may appear politically expedient, DRGs were as yet unproved in their effect on medical care. Organized medicine recommended a period of experimentation and demonstration projects before DRGs were implemented. AMA spokesmen also recommended that Congress postpone action until the AMA had finished a research project currently underway, at which time Congress could then consider a proposal developed by those with special knowledge. Senator Robert Dole (Republican from Kansas and now Senate Majority Leader) responded:

> Our problem is that Medicare is going to sink one of these days if everybody comes up here and tells us not to do anything this year, do it next year, or don't do it at all. If we think Social Security is in trouble, we ought to look at Medicare trust funds in the next 4 or 5 years. We have a very heavy responsibility on this committee to try to somehow get a handle on health care costs. They are about to eat us up. And we would hope that those who are directly involved would do more than suggest we delay it for another year. We can't delay it for many more years. We won't be around — Medicare won't be around.

Unquestionably Congressional interest in doing something about cost control outweighed any concern for the interests of the medical profession. The AMA "party line" had lost its erstwhile persuasive appeal.

Somewhat in contrast, the official stand of the American Hospital Association was favorable to DRGs, but this position must be seen in light of limited policy choices, a divided industry, and credibility issues. DRGs turned out to be the least coercive, and therefore the most desirable, alternative that HCFA had considered during 1982 (Marone and Dunham 1983). Furthermore, competition in the hospital sector stimulated during the past few years was already having a divisive effect on a once united industry. Perhaps the most important and least obvious reason for the official AHA stance is credibility. Hospitals had received sustained severe criticism in the press for their unreasonable rates. Hospital beds and services were more

expensive than accommodations at luxury hotels. The usual industry response to the public and Congress was that hospitals had no incentive to keep costs down. "Here's one," said the Senate Finance Committee with reference to DRGs; and the hospital industry had to swallow the bitter pill in order to save face.

The DRG scenario does not fit the usual American pluralist model animated by civic interests approaching the state with demands and solutions, wherein the Congress responds by distributing benefits to each major interest group so that each gains a little and the status quo persists (Lowi 1979:271-248). Rather the DRG program represents the growing tendency to centralize authority at the federal level, a tendency abetted by the rise of a professional-bureaucratic complex. To cite Beer (1978:423) at some length:

> I would remark how rarely additions to the public sector have been initiated by the demands of voters or the advocacy of pressure groups or the platforms of political parties. On the contrary, in the fields of health, housing, urban renewal, transportation, welfare, education, poverty, and energy it has been, in very great measure, people in government service, or closely associated with it , acting on the basis of their specialized knowledge, who first perceived the problem, conceived the programs, initially urged it to the President and Congress, went on to help lobby it through to enactment, and then saw to its administration.

With Congressional prompting and support, HCFA proposed, developed, and implemented DRGs as a solution to controlling Medicare costs despite the opposition of providers. In the process, professional autonomy was curtailed. While the AMA and the AHA conducted their business as usual, HCFA officials quietly developed their own expertise over several years through involvement with the regional PSROs, the Yale University team which developed the DRGs, and the New Jersey State Health Department where experimental trials were conducted (Dunham and Marone 1984). Indeed, DRGs originally were developed through PSRO-related research efforts to assist in the development of norms and standards. As the mounting federal deficit plus economic pressure on the private business sector strengthened the resolve of key Congressional personnel to control Medicare costs, the opposing provider interests became more expendable. No private interest came forward with a viable alternative solution while HCFA and its professional associates were prepared with one.

Indeed, it may be stressed that, from a financing perspective, the DRG solution was not a radical one. It presents yet another incremental change from rate setting strategies of TEFRA and the earlier 1972 Social Security Amendments, both of which contained forms of prospective reimbursement. But DRGs are special because they involve an all-inclusive payment rate per discharge which does not allow for "add-ons." However, the political question is who has the power to determine the mechanism and the conditions under which it is operationalized. The answer is clearly HCFA, a federal agency which is in effect authorized by Congress to replace the traditional authority of the local hospitals to determine reimbursement rates. HCFA was ordered to devise a new mechanism for prospective finance as well as the standards on which it could be based. HCFA has emerged as a well-insulated bureaucratic agency with a 'public service' mission and a formidable set of skills. The traditional health care providers, who have just as high a stake as HCFA, can no longer rely on support from their long-standing Congressional allies — especially because the Congress now has an obvious stake in cost containment. It is also probable that most members of Congress do not understand the complexities of the law they have passed, and therefore have left the real battles of implementation to be fought by others.

Peer Review Organizations, which are to monitor the application of DRGs, provide an equally compelling story about the simultaneous limitations on and expansion of professional power. After years of progressively limiting PSRO funding, HCFA had finally eliminated it altogether from the D/HSS program budget. PSRO activities had not proved to be worth the costs of funding them (Lebish 1982:996). However, the Chairman of the Senate Finance Committee and other significant members were concerned about the 'quality aspect' of DRGs and were sympathetic to assuring the quality of care. At the Chairman's prompting HCFA created a second generation of PSROs, now called PROs or "PSROs with teeth." Compared with their PSRO predecessors which were more or less federally chartered, quality assurance and utilization review activities are now contracted out to single state-wide physician-sponsored organizations.

More importantly, the transition from PSROs to PROs has been accompanied by a shift in guidance. PSROs were relatively independent of national standards, largely because they were provider-dominated and fit some aspects of the pluralistic model. The PSRO program had delegated effective control to local physicians because the AMA had gone to the Congress, bargained for autonomous control, and received what it sought. The federal administrators served more or less routinely to approve decisions made at the local level; any state agency involvement was largely limited to educational activity.

However, PROs contrast with their predecessors in critical ways, particularly their dependence on HCFA for standards. Furthermore, the demand for continuing PSRO activites came from — in addition to the powerful Senate Finance Committee Chairman — private groups and others without a major constituency. It was not the AMA which asked for their continuance; it was a subset of physicians who were in the business of reviewing their peers ... or intervening on behalf of their peers, depending on how you look at it. PSROs had been starved for resources and were facing extinction. While Congress ensured that PSRO-like activities would continue, the solution really emerged from HCFA which once again stepped into the policy vacuum. HCFA's major ally or fellow-thinker was the American Medical Peer Review Associates — a group of physicians whose primary interest lay in evaluations and methodology.

HCFA established tight central control by contracting under stringent conditions determined by the federal agency's vision of the program. These were then written into the law. Unlike Utilization Review or PSRO, program authority was not simply delegated to private providers. The contracts contain measurable goals plus a promise (threat) by HCFA of non-renewal if the PROs do not meet expectations. In some sense, PROs now do have advantages for they will be better insulated than their predecessors. They also have accumulated significant resources to carry out the tasks including the expertise developed over the years through PSRO review activities, the special knowledge required to review medical work, the necessary funds adequate to the task, the technological resources such as computers and associated software, and, not least of all, the power of the state to enforce their decisions. Given these resources plus the fact that physician groups had to bid for contracts and agree to their terms, it seems somewhat less likely than usual that the regulators (the PROs as HCFA agents) will be easily captured by the regulated (the local physicians and the hospitals through which they work).

In short, the state is no longer totally dependent on organized medicine for the special expertise required for trenchant review activities. HCFA not only has established norms and standards against which to measure medical practice. HCFA also can rely on a faction of physicians, who do not represent a consensus of professional opinion, to enforce them (Boulanger 1984; Anderson and Shields 1982). HCFA may have learned the merit of a divide-and-rule strategy in a profession increasingly divided against itself. PROs certainly give those physicians who are ideologically sympathetic to centralized control of medicine an opportunity to practice their beliefs — with themselves at the controls! [This situation is not unlike the opportunity provided by HMO laws to physicians who desired group practice.] But it cannot and should not be asumed that PROs are monolithic nor united in their intent.

Indeed, a less sanguine view can be taken of HCFA's ability to impose its authority directly through PROs and thereby limit the autonomous control of individual physicians over clinical decisionmaking. Large bureaucracies necessarily experience span of control problems with their associated loss of information and loss of hierarchical control (Ostrom 1983). The structure of the PRO program assumes that physician implementors — the PRO officials — have the same incentives as HCFA officials. For the program to be successful, the structure assumes that local physicians will cooperate or can be forced to cooperate through threat of and/or application of sanctions. It further assumes that the power struggle between hospital administrators and physicians has been resolved.

Faced with the inevitable, AMA officials have encouraged medical societies to "make the best" of an external review process and its limits on individual self-regulation. The AMA has encouraged state medical societies to bid on PRO contracts. But what does "make the best" mean? Perhaps it means that some PRO physicians will remain protective of professional interests and act as a buffer between community physicians and the state, bending the rules in favor of local needs. Perhaps it means that some PRO physicians are not sympathetic at all to the PRO mission and will try to sabotage it. As a conduit for flows of information between the local physicians and the state, PROs will have ample opportunity for turning control toward their own ends. Whatever "the best" means, it is not clear that PRO physicians will act as a cohesive cadre of HCFA agents.

In order to be effective, the PRO physicians must elicit the cooperation of local physicians — unless, under extreme circumstances, PROs are willing to disqualify large numbers of physicians from Medicare participation. But one outstanding revelation of PSRO-related research was the pervasive variation in clinical practice and the high degree of clinical uncertainty of which the variation is, in part, a result (Wennberg et aliter 1982). Medicine remains more art than science, and patients and their clinical surroundings are more variable than had previously been realized — or at least acknowledged. Between two obvious and rather crude extremes of over- and under-utilization there lies a discretionary range of medical judgment. The question is then once again raised as to what is the acceptable level of quality of care.

What is the "necessary margin of inappropriate use which must be tolerated in as complex an area as health care?" (Anderson and Shields 1982:132). There is neither a concensus among experts as to what is an adequate volume of services nor guidelnes for most procedures.

But HCFA, like Congress, is interested in paying the least amount for care; it wants, as Eisenhower used to say, to obtain the most bang for the buck. The standards and norms which are the foundation for the payment and review systems have been developed in this context. The norms represent a bureaucratic judgment that the average amount of care is adequate. Indeed the lowest possible use of services becomes the target. The norms themselves are statistical artifacts that may bear no resemblance to clinical efficacy but instead reflect the demands of the federal budget.

Conflict between PROs and the physicians will be over the acceptability to physicians of these norms that the PROs must enforce. The physician acts as the patient's agent in ordering care which he/she provides to the individual according to a patient-centered ethic and under conditions of uncertainty. On the other hand, providing care according to externally imposed standards requires that the clinician act indirectly as HCFA's agent rather than solely as the patient's agent. This conflict of interest centers on the physician's traditional role in which he/she exercises autonomous clinical judgment. We have returned to the heart of a profession (Freidson 1970:83-84).

Consequently, recast in political terms, the conflict over norms and standards is a conflict of claims between two camps of experts. One set of experts -- who are experts in cost containment and resource management -- demands the right to determine the norms because it holds the purse strings and has the power of the state behind it. The other set of experts — the heterogeneous group of practicing physicians — demands the professional right to practice according to internalized norms, transmitted to them through education, precept and practice, because they are the trained professionals and because they have the patients. In sum, the conflict between HCFA-agent and patient-agent will be played out in the battle over norms. Since there is no 'ideal type' of medical model which absolutely maximizes health and since the pluralistic political model is likely to continue in the US, the outcomes will necessarily reflect a compromise among professional, financial and — not least of all — patient expectations. However, whatever autonomy physicians lose will be absorbed by HCFA and its PRO agents, as representatives of the state. Authority, once delegated to doctors via autonomy and monopoly, may be returning to its point of origin.

Finally, to carry the bureaucratic logic one step further, HCFA will require a monitoring mechanism — a super-PRO — to monitor the PROs and to ensure that they are acting faithfully. Such a super-PRO would present two countervailing forces, one which would tighten HCFA control through another insulated layer of expertise in the areas of utilization review and quality assurance, while the other would weaken HCFA control through yet another bureaucratic layer of officials with their own interests. If HCFA is not successful in containing costs — which requires, fundamentally, changing physician behavior — then questions will emerge about the cost effectiveness of its DRG and PRO programs. However, as the history of PSROs has shown, once organizations infiltrate the political system, they somehow find the means to sustain themselves. Controlling physician behavior seems to be a lucrative occupation.

It might also be noted in passing that, among other things, computers made DRGs possible (Robinson 1982; Dudley 1984). The case mix data necessary for managing DRGs provide administrators with information about the practice patterns of each physician. Combined with the incentive to use the information, this is sufficient for the administrator to try to influence the medical staff in order to alter their practice patterns in favor of the hospital (Lebish 1982:991-998). This means that physicians will be asked to force a fit between their practice patterns and the practice norms established by HCFA. And computers will keep track of the points -- game, set and match!

VI. Summary, Conclusions, and Reflections

Since 1965 the American federal government has moved incrementally through a series of programs which have progressively encroached upon the professional perogatives of physicians in terms of their technical autonomy. This intrusion began with Utilization Review (UR) which did not, in effect, limit technical autonomy. However, for the first time organized medicine was put on notice by its long-standing allies in Congress that technical autonomy was fair game for administrative review. Also, UR brought about the development of a hospital committee infrastructure for a physician practice review system that grew through PSROs and persist in the DRGs monitored by PROs.

When UR failed to contain costs, Congress developed a more extensive solution through the Professional Standards Review Organizations program. Three of the five major categories of patient care management variables were brought under review, and data were aggregated to permit the development of standards and norms against which physician practice patterns could be measured. An unanticipated result of the research efforts to help the PSROs develop norms and standards was the appearance of Diagnosis Related Groups (DRGs). Throughout the era of UR and PSRO, the constraint of insufficient knowledge proved to be a formidable obstacle to the development of norms and standards. Lack of sufficient knowledge of what constitutes an acceptable level of quality in care resulted in an inability to assess a reasonable trade-off between cost and quality.

Nonetheless, fiscal exigencies required drastic action. Cost cutting measures were undertaken in the form of DRGs which use averages derived from Medicare billing data as a proxy of reasonable cost and, by implication, reasonable quality of care. PSROs were replaced by the Utilization and Quality Control Peer Review Organization (PRO) program, the latter having much greater power to penalize providers. PROs are better insulated against local forces, and they account for the full range of clinical management variables. Unlike PSROs which relied on the hospital committees to perform review activities, PROs send their own employees into the hospital in order to conduct their own more stringent reviews. Since PSRO-like activities are also being maintained within the hospitals' utilization review and quality assurance committees, the new DRG committees have been added to a lengthening list of committees reviewing physician practice patterns.

In 1965 physicians were practicing medicine with almost complete technical autonomy over clinical decisions. Now, in 1985, the fears expressed by outraged physicians in response to the 1972 PSRO program seem to have been well founded in political reality. The quasi-governmental penetration into the realm of physician practice patterns has been substantial with the development of norms and standards based on averages. Physician practice patterns with costs repeatedly above the average are assumed to represent overutilization of resources and therefore unnecessary care. Since the overriding objective of PROs and DRGs is cost containment, these changes mirror the fears of physicians about where PSROs would lead. The government's promise of non-interference with medical practice that enveloped the spirit of the 1965 Medicare law was inevitably undermined by the fact that utilization review was part of that legislation. The cost containment imperative is the driving force behind the government's incursion into medicine, and controlling the technical autonomy of physicians is its lever over costs.

Despite all this, physicians still have an escape hatch. Just as hospital administrators engage in cost-shifting, physicians can switch from in-patient service to provide more care in their unregulated out-patient settings. This in fact already appears to be occuring. The AMA prints a Unified Health Insurance Claim form as a for-profit service to physicians (who can purchase them at a discount) and a variety of third party payers. Demand for out-patient forms has increased exponentially since DRG regulation was implemented (Marone and Dunham 1984). It may be a mistake, however, to assume that physicians and hospitals will continue to have this safety value. DRGs and PROs constitute a sizeable increment, if not a leap, in government surveillance of medical practice patterns. Of course, organized medicine has an impressive historical record of parrying and deflecting proposals which would undermine its professional autonomy and control. Indeed it is important to remember that the DRG legislation initially contained a provision that would have mandated prospective pricing for physician fees, an omission from the final legislation which was a concession to the AMA. But HCFA is in the process of developing DRG-like fixed payment rules for out-patient medical services as well. Given the cost containment imperative, areas where physicians can exercise professional prerogatives — such as outpatient services for piecework fees — are a prime target for further regulation.

It is sometimes said that any doctor worth his degree can beat the system. DRGs and any additional stringent reulation of out-patient fees will seriously test this proposition. The danger is that physicians will try to evade each governmental effort aimed at limiting their autonomy, which may provoke both parties to engage in an extended regulatory battle for control over medical resources until the goal of rationalizing physician behavior overwhelms any remaining concerns for quality and access. The regulatory path from UR to DRGs is clearly marked both by government attempts to apply increasingly stringent controls to physician autonomy, and by physicians' attempts to evade those controls.

The United States is currently attempting two simultaneous but contradictory approaches to the problems of the health sector. One is its traditional preference for pluralism; the other is the siren song of an orderly imposition of centralized standards. A pluralistic system in which change is made incrementally is

self-correcting; it is meliorative since it fixes what went wrong or attends to issues formerly not considered as interest groups make their demands known to policymakers. But could a pluralistic political system moved by incremental decisionmaking lead to a health care system suffocated under a quagmire of regulations that are insensitive to concerns for quality and access? Can cost be controlled while quality and access are retained and even enhanced? The current answer seems to be: "let's try."

Because of the complexity and high degree of specialized knowledge required to understand the cost containment problem and its associated trade-offs, this task has been handed over by Congress to the bureaucracy. HCFA has obtained an enormous amount of power to make decisions in this area, but bureaucracy tends by its very nature to impose solutions. Furthermore, bureaucracy generally has not been known for its permeability to public concerns or to organized interests not already aligned with its official and unofficial goals. The question is whether the American health care system now remains sufficiently pluralistic for the self-correcting effects associated with pluralism to occur, or whether the constriction wrought by the newly empowered bureaucracy will so centralize the system that it eventually crumbles under its own weight. Until the present, the autonomy of physicians had accounted, in large part, for both the flexibility in the health system and the gigantic national health care bill. The question is: what next?

To return in closing to more general themes, 'politicizing medicine' is a reasonably clear process in the US and elsewhere. Some might observe that medicine has always been political in several senses. Certainly physicians have always wielded power in the sense of advising, directing, and sometimes changing the behavior of patients. Also physicians have historically organized and fought to retain self-regulation and the existence of a 'private' government with internal controls over membership. But most clearly of all, medicine has been 'politicized' as the public and its governments have sought to control and regulate the behavior of physicians — and these physicians and their organizations have fought back with counter measures including lobbying, publicizing, proselytizing and campaigning in overt politics.

More problematic is the concept of 'medicalizing politics,' but the evidence accumulates on at least two fronts. First, there is simply the quantity or proportion of politics and political activity that is devoted to medical matters. Almost every major newspaper as well as broadcast journalism contains daily reports on health politics from local issues through national concerns. The activities of 'politicized medicine' (or 'organized medicine,' as some would put it) contribute to this increasing proportion of medical issues among the general issues of public debate. If measured in the passage, repassage, and refinement of laws alone and the time spent debating them in legislative chambers and executive corridors, there is ample evidence that medical affairs have entered the very substance of politics. Likewise the literally volumes of regulations and guidelines on health care that are proposed, revised, finalized and published, attest to the medicalization of politics.

Second, however, politics has been medicalized in an even larger philosophical sense. As the American 'health care crisis' has become chronic, it has generated an impressive array of palliative reforms — for example, equal access; improved quality; cost containment; consumer participation; ethics committees; and preventive health. At the same time, the hegemony of the therapeutic ideology articulated by the 'helping professions' has steadily increased. Each reform contributes to this hegemony. For example, achieving equal access broadens the clientele of medicine while establishing medical service as a legal right. Insuring quality care intensifies popular beliefs that professionals know what care is. Cost control assures not health but a rationalized guarantee of the medical system's income. Consumer participation co-opts potentially disruptive citizens by providing participation in medical matters as a substitute for political action. Ethical issues expand medical hegemony by concluding that issues like abortion and life prolonguation are medical questions. And 'preventive health' can make every person a patient each day of his/her life. "Each reform, therefore, represents a new opportunity for the medical system to expand its influence, scale and control" (McKnight 1975:5).

The political functions of this chronic health care crisis may be obvious but merit reiteration. As new needs are created by expanding alternative medical systems, citizens develop an increased sense of deficiency and dependence. As dependency grows, so do medical resources devoted to 'curing' the health problems. Likewise, political energies are increasingly consumed in efforts to reform the medical system. Yet the growth of medicalized politics induces a further popular acceptance of expertise. People act less as citizens and more like clients, that is those people who believe they will be better because someone else knows better. Viewed in these terms, the medicalization of politics involves the propagation of a therapeutic ideology; only the professional few understand so medicine becomes the paradigm for modernized domination (Edelman 1974; Ehrenreich 1978).

But what about physician power per se? What about the frequently heard assertion — so frequent, in fact, that it has almost become folklore — that doctors dominate the health system and always receive the most benefits? In the United States at least, organized medicine — while unable to prevent some major legislation -- has nevertheless been able to use the power of withdrawing its labor (vital to society by virtue of professional expertise) in order to obtain substantial concessions based on aspects of professionalism. The AMA has been able to retain vital levers of control through concessions claimed on the grounds of professionalism. Of course, things aren't as easy as they used to be. In 1934 a quiet word persuaded the House Ways and Means Committee to drop even its 'directive' to the proposed social security board to study the matter of national health insurance. But while the failure of organized medicine to prevent the Medicare and Medicaid legislation in 1965 may be seen as a decline in its power, "the provision for paying doctors under part B of Medicare reflected the legislators' fears that doctors would act on their repeated threats of non-cooperation in implementing Medicare." Thus no fee schedule was prescribed and the doctors of Medicare patients were to be paid their usual and customary fee (Dyckman 1978). The professional claim to demand fees for service — a major aspect of the status (and hence power) of professionalism — was preserved by the fact that "it was not required that the doctor directly charge the insurance company intermediaries who were to handle the government payments; he could bill the patient, who, after paying his debt, would be reimbursed by the insurance company" (Marmor 1976:81).

The claim that physicians control the health sector, therefore, requires some modification. In so far as they retain and exercise major aspects of professionalism, they control vital aspects of the health sector. But the extent to which these aspects add up to total control of health services varies. Certainly many features of professionalism are under challenge. The professional right to define 'health' itself has been disputed by alternative formulations, not to mention the overall dilemma for medical dominance posed by the persistent problem of escalating health costs. Control over the supply and number of doctors available is also increasingly subject to political rather than professional decisions. The increase in the number of doctors has been the result of governmental response to public expectations of more and better health facilities. The fears of a 'doctor surplus' on the part of organized medicine reflects not professional control (or means of control), but professional concern in the face of the political decision to cut back in all fields of public expenditure. Finally the latitude of physicians to determine the acceptable range of fees for service is slowly lessening; the technical autonomy upon which professional power is founded, is being eroded by information retrieval and refined computational capacities.

Apart from these constraints, the medical profession in the United States would appear to have retained a sufficient number of the characteristics of professionalism, to be said to dominate the health sector, if not completely control it. In matters of cost, peer review, health planning and resource allocation, the American profession remains well placed due to the continued pluralistic structure of the health system.

One final point might be made about the power of physicians in the United States and the growing constraints being placed upon it. Clearly medicine is politicized while politics has a very large and increasing component of medical care issues within its ambit. But the obvious point — perhaps so obvious that it is sometimes overlooked — is the evident American willingness to use state power to address a social and economic dilemma. The sequential existence of UR committees, PSROs and PROs/DRGs with their impact on technical autonomy and physician practice patterns, is all the more remarkable because Americans generally dislike power [or, as Anthony King once quipped, like it so much they don't want anyone else to have any] and try to limit it through the classical separation of powers and complicated intergovernmental relations. Evidently there is still a pioneering spirit, a brashness in action, a sense of "can do" and "fix it" rather than fatalistically accepting things as they are. In the US, 'politicized medicine' and 'medicalized politics' seem to add up to a slow but inevitable diminution of physician power.

As an afterthought to stimulate comparative inquiry and debate, perhaps European states have not been as aggressive in attempting to control their professionals of the medical persuasion because the United States has always existed as an 'exit' option (Hirschman 1970) for the latter's practice of medicine. Given its preponderant economic size and relatively permeable boundaries, the American economy has served from a distance to shape governmental policies about the health sector in Europe. Certainly this point seems true of the United Kingdom in so far as the most outspoken critics of state medicine are those British doctors who have come to the 'freedom of the States' in order to get away from the bureaucracy of socialized medicine. There have been many fewer articulate spokesmen or advocates of the National Health Service available in the US speaking out on behalf of greater state control of this otherwise 'private government' called the American health (non)system. Thus, while European states have attempted structurally to control

physicians through the appointment and deployment of personnel, the centralization of finances and even influencing the preparatory curricula, they have not disciplined practitioners by monitering their technical practice (and thus challenging their autonomy) for fear they would leave. Now that the US has acted, however, the 'exit' option has been constricted — though not, of course, altogether eliminated. Thus the alternative option of giving 'voice' (if not 'loyalty') has appeared wherein government policies are implemented to control the powerful medical profession.

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POWER DISTRIBUTION IN THE ITALIAN NATIONAL HEALTH SERVICE : CENTER VERSUS PERIPHERY, POLITICIANS VERSUS TECHNICIANS

the case of Tuscany

by

Valeria Fargion

paper prepared for the workshop on
"Health politics"

The Italian National Health Service has been the subject of so much debate in these last few years that it surely deserves a mention in the Guiness Book of Records for the most heavily criticized social reform.

The charges brought against the present organization of health policies in Italy are so numerous and divergent that it is rather difficult to disentangle them. The Central Government accuses the local health districts of patronage and of wasteful use of public resources, while the latter rebuff this accusation and accuse the State of excessively tight budgeting and total lack of coherent planning.

As the controversy between center and periphery heats up, an equally explosive conflict flares between service providers and politicians who are on the executive board of the health districts.

Moreover, an increasing diffentiation of interests and views is emerging within the ranks of phisicians and between medical personnell and paramedics.

The situation seems to be so critical as to make it very difficult for anyone to be optimistic about future developments in the field. Unfortunately we have to rule out the possibility of abolishing the system altogether, in order to start once again from scratch. Under these circu;stances, we have no other choice but to concentrate on today's ills and complications. A better understanding of why things do not work as they should could hopefully help to improve the quality of the decision making process in such a crucial area of public policy.

However, the extent of regional disparities in the management of the health service hinders any comprehensive assessment. To avoid hasty conclusions, the paper focuses only on a limited geographical area so that it can attempt to pinpoint the structural blockages embedded in the present institutional setting. To put it in a different way, my purpose is to shed some light on the actual power the various actors have to solve the major problem of the moment, namely to achieve a correct balance between cost containment and the provision of an adequate level of service (both in terms of quantity and quality).

Since the emphasis is on existing opportunity for doing something about current troubles, I thought it best to pay attention to a region actively engaged in the reform process. Available options can only refer to central and northern parts of the country, given the disastrous state of affairs in this field throughout southern Italy.

Easier access to data led me to choose the Region of Tuscany. While there was a practical reason for my decision, nevertheless, I should like to stress that over the past years Tuscany has proved to be fully commited to the implementation of the National Health Service. Its Minister of health, for instance, has been and still is the representative for all the regions vis-a-vis the Central Government. That is to say, the political climate in this area was extremely favourable to the pursuit of the very ambitious objectives laid down in the law establishing the National Health Service.

However, I should like to add that in I980, when the new system went into operation, Tuscany was in a better position than many other regions.

If we take indicators such as per capita expenditure, stock of hospital beds and the ratio of phisicians to total population into account, we can see that Tuscany ranks above the national average (see table I for a regional compairison of per capita expenditure levels by major components in I98I).

As there are severe financial problems in the public sector as a whole, the latter remark clearly suggests that this region needs to rationalize the use of available resources, rather than to expand total outlay. A closer look at the internal distribution of health expenditure in Tuscany (see table 2) confirms that territorial unbalances do exist and that some effort should be done to reddress them.

Summarizing, structural and political conditions in Tuscany give scope for reorganization along the lines advocated by the health reform. The following sections attempt to assess what could be done within the existing legislative framework and what actually occured both at the regional and local level.

Table n. I: Per capita health expenditure by Region, 1981.

	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII	XIII
Piemonte	160.568	1.070	78.242	20.646	45.349	35.752	3.357	10.037	5.321	2.173	2.911	3.957	369.238
Valle d'Aosta	179.174	4.297	53.035	24.987	41.993	2.406	2.122	8.193	22.564	861	3.666	3.746	347.039
Lombardia	166.784	6.237	78.913	23.913	51.994	31.462	2.398	18.709	5.682	1.216	1.610	8.781	387.054
Provincia di Bolzano	177.513	15.941	98.190	17.292	33.354	38.830	1.836	12.226	9.421	4.874	10	1.995	411.475
Provincia di Trento	277.549	2.423	86.484	23.049	43.707	34.267	5.146	11.828	18.897	2.204	-	4.205	509.754
Veneto	219.667	2.443	100.249	21.811	48.050	16.952	2.907	11.297	7.773	3.321	5.046	8.440	447.952
Friuli Venezia-Giulia	250.749	9.702	101.687	20.472	47.641	39.515	3.041	11.521	7.681	1.994	2.921	2.215	499.133
Liguria	209.625	2.714	78.919	22.600	69.778	57.065	4.777	21.565	7.178	3.840	3.675	2.608	484.339
Emilia Romagna	218.263	2.698	87.557	23.542	59.789	25.057	3.718	15.078	11.105	2.570	5.518	1.923	454.818
Toscana	205.945	9.284	83.673	20.058	65.846	24.494	3.240	22.193	12.599	1.678	502	1.292	450.914
Umbria	212.848	3.401	74.007	19.778	64.211	10.937	3.414	16.381	6.113	3.579	4.993	719	420.376
Marche	217.691	2.047	78.771	19.380	57.416	29.185	2.821	16.599	10.794	1.709	2.016	697	439.118
Lazio	157.639	578	56.044	22.848	57.785	107.733	5.527	51.039	12.283	485	572	184	474.086
Abruzzi	189.560	937	67.440	19.360	48.233	34.303	2.013	21.924	19.786	1.353	2.602	1.070	410.578
Molise	146.052	3.480	56.667	17.033	41.668	18.902	2.519	9.793	19.782	767	1.753	4.401	322.812
Campania	149.357	60	48.445	13.189	72.119	46.729	3.590	45.693	1.588	3.066	-	2.031	385.862
Puglia	169.954	1.451	47.289	18.537	56.997	51.842	2.559	26.787	5.561	4.583	992	894	387.439
Basilicata	137.030	1.477	65.268	24.694	47.024	34.763	1.295	11.356	11.430	396	2.996	562	338.285
Calabria	156.364	1.078	40.224	25.478	61.768	36.822	6.269	26.454	11.776	363	652	846	367.088
Sicilia	143.146	262	41.139	23.490	72.736	27.451	3.061	25.981	9.540	2.357	-	7.941	257.100
Sardegna	181.309	1.544	47.353	22.194	45.587	29.821	4.016	18.411	8.890	2.881	20.681	7.566	390.171
TOTALE	178.303	2.945	68.795	21.086	57.723	39.892	3.415	23.989	8.297	2.182	2.571	4.038	413.243

Fonte: Ministero della Sanità

Legenda:
- I personnel
- II extra benefits for specialist care provided by salaried staff
- III goods and services
- IV general care
- V pharmaceuticals
- VI private hospitals
- VII specialist care provided in public health centers
- VIII specialist care offered in private practices
- IX other benefits
- X loans and interest
- XI transfer payments
- XII other
- XIII total

Table n. 2: Per capita health expenditure for Tuscany, by health districts, 1981.

	I	II	III	IV	V	VI	VII	VIII	IX
1- Lunigiana	148.230	1.425	21.316	6.642	59.299	18.360	107.041	86.651	341.923
2- Area di Massa e Carrara	261.098	1.426	20.197	21.255	60.838	5.694	112.178	129.970	612.656
3- Versilia	156.812	1.506	17.244	27.768	67.990	21.190	136.066	74.229	367.106
4- Garfagnana	157.583	5.193	24.971	644	61.143	-	91.971	59.573	309.128
5- Media Valle del Serchio	168.178	1.419	23.505	7.157	66.383	154	98.618	84.398	351.194
6- Piana di Lucca	253.968	2.817	20.072	17.876	76.939	13.204	130.921	90.093	474.982
7- Val di Nievole	110.703	1.732	21.625	32.452	72.591	21.558	150.243	79.108	340.053
8- Area Pistoiese	167.563	2.444	19.939	21.828	64.595	13.200	122.006	89.416	378.984
9- Area Pratese	110.309	2.387	18.046	28.891	63.686	9.994	123.027	70.270	303.606
10- Area Fiorentina "A"	300.743	4.629	28.943	37.314	126.543	49.529	246.957	149.514	697.214
10- Area Fiorentina "B"	169.459	1.365	17.770	22.784	73.959	25.089	141.973	79.108	390.541
10- Area Fiorentina "C"	206.577	10.282	19.451	23.423	49.873	2.563	105.662	100.352	412.592
10- Area Fiorentina "D"	631.492	5.508	15.726	31.218	57.863	119.702	230.016	347.411	1.208.919
10- Area Fiorentina "E"	317.525	6.123	16.902	43.115	72.459	31.336	169.934	98.197	585.636
10- Area Fiorentina "F"	18.723	1.815	19.215	37.704	65.994	4.684	129.411	26.159	174.293
10- Area Fiorentina "G"	80.765	348	17.732	34.345	58.660	15.183	126.370	54.846	261.981
10- Area Fiorentina "H"	130.832	120	19.159	25.016	53.048	33.279	130.618	121.036	382.484
11- Mugello Val di Sieve	54.467	5.403	22.003	20.508	63.123	35.683	146.823	96.460	297.750
12- Area Pisana	299.791	4.337	18.951	24.556	73.941	12.526	134.317	151.627	585.734
13- Area Livornese	224.007	3.817	18.893	35.233	78.981	11.677	148.611	83.742	456.360
14- Bassa Val di Cecina	125.823	816	22.540	16.055	71.796	-	111.206	54.400	291.429
15- Alta Val di Cecina	634.800	1.234	35.642	1.416	63.444	7.658	109.393	299.543	1.043.735
16- Val d'Era	174.083	2.336	19.969	11.758	71.925	3.769	106.832	71.096	352.011
17- Valdarno Inferiore	129.081	793	19.457	9.145	64.195	-	93.590	61.622	284.293
18- Bassa Val d'Elsa	114.672	1.589	19.085	12.217	64.881	9.516	107.288	67.211	289.171
19- Alta Val d'Elsa	152.121	5.110	19.751	9.383	53.123	2.304	89.708	84.320	325.149
20A Valdarno Superiore Sud	178.204	2.253	20.291	13.759	56.042	4.794	97.138	73.875	349.217
20B Valdarno Superiore Nord	157.691	297	18.698	8.998	61.472	1.891	91.356	89.032	338.080
21- Casentino	184.709	2.528	21.254	1.551	47.735	574	73.042	68.271	326.022
22- Val Tiberina	174.573	2.639	24.058	8.991	67.264	3.406	106.358	77.390	358.322
23- Area Aretina Nord	319.432	5.052	16.375	21.977	54.659	21.367	119.431	106.414	664.707
24- Val di Chiana Est	159.079	1.093	22.098	4.672	49.533	257	77.653	67.130	303.866
25- Val di Cornia	190.544	3.293	25.295	13.529	71.983	6.320	120.496	74.167	505.627
26- Arcipelago Toscano	114.859	2.414	19.937	13.280	59.810	4.001	99.441	49.979	264.280
27- Colline Metallifere	136.877	2.920	20.146	10.428	63.202	-	96.988	67.593	301.458
28- Area Grossetana	218.290	5.342	21.600	23.337	64.479	7.537	122.412	93.479	93.479
29- Colline dell'Albegna	182.949	1.381	25.337	5.038	56.190	1.112	89.287	79.516	351.753
30- Area Senese	463.798	6.718	20.560	16.658	57.122	13.801	114.859	212.889	791.546
31- Val di Chiana	165.903	3.451	23.887	13.422	55.948	1.384	98.092	142.414	406.409
32- Amiata	169.527	2.833	15.389	1.661	47.993	4.576	72.506	55.428	297.461
TOTALE	210.646	3.210	19.879	21.758	65.846	16.304	127.049	102.620	567.312

Legenda:
- I Personnel
- II Specialist care provided in public clinics
- III General & paediatric care
- IV Specialist care offered in private practices
- V Pharmaceuticals
- VI Private hospitals
- VII Total contracted services, II-VI
- VIII Other items
- IX Total per capita expenditure

Health expenditure trends in Tuscany

A good starting point, in order to understand the development of health politics in Tuscany, from the outset of the new institutional system in I980, is probably offered by a close examination of how resources have been allocated in thus field.

According to regional legislation issued in I979, Tuscany's territory was divided into 40health services - i.e. the assembly and the executive committee - took office during the first months of I980, but only acquired full juridiction over the sector towards the end of the year. By I98I most responsabilities had been trasferred from the municipalities, the provinces, the insurance finds, the region and the hospital agencies to the new local units.

Although I98I can still be considered under many respects a transitional period, it definitely represents a better reference point than I980 to evaluate expenditure trends by the newly established health authorities.

As a consequence, table 3 shows the change in aggregate regional spending by major components, from I98I to I983, i.e. the last year for which detailed statistics are available. Figures relate to absolute values of appropriations made by the forty health disticsts and are expressed in current lire. In order to complete the picture table 4 shows the relative proportions of each category of total expenditure for both years.

Table n. 3: Total health expenditure by major component for Tuscany, I98I and I983 (in current million lire)

	I98I	I983	% var.
Personnel	725.807	I.004.622	+ 38
General care	7I.625	I63.79I	+ I28
I	II.568	27.786	+ I40
Specialist care II	79.2I3	63.322	- 20
III	33.I49	60.865	+ 80
Pharmaceuticals	236.984	373.333	+ 57
Private Hospitals	58.409	72.799	+ 24
Medical supplies techn. equip.	I22.655	I8I.748	+ 48
* Food, fuel, util. rent, mainten	I46.000	I36.8I8	
Professional training	4.565	I3.596	+ I97
Political bodies	2.o74	2.263	+ 9
* Others items	89.782	209.792	
Total	I.58I.835	2.3I0.76I	+ 46

* For these categories no correct compairison can be made because of considerable changes in the list of items included under both headings.

Table n. 4: Percentage distribution of total health expenditure for Tuscany, by major component, I98I, I983.

	I98I	I983
Personnel	45.9	42.9
General care	4.5	6.7
Specialist care I	0.7	I.I
Specialist care II	5.0	2.7
Specialist care III	2.I	2.4
Pharmaceuticals	I5.0	I6.3
Private Hospitals	3.7	3.7
Medical supplies techn. equip.	7.7	8.4
Food, fuel, util. rent, maintenance	9.3	6.I
Professional training	0.3	0.6
Political bodies	0.I	0.09
Other items	5.7	9.0
Total	I00	I00

At a first glance we can see that total outlay has increased over the pe iod by nearly 40% keeping inflation in mind, the rate of growth in real terms is in fact much lower and moreover below the National average. Nevertheless we are confronted with an expansion in the flow of public money going to health care. However, aggregate figures can only help us very little in grasping the rationale underlying the rise in health costs. If we are to attain such an objective we need to examine separately at least the more relevant categories mentioned in the table.

I. Personell

Looking first of all at personnell, which represents the largest expenditure item on the list, we must take into account the following:

a) as of I98I the ratio of salaried personnel to total population for the whole of Tuscany was I2/I000 compared to the national average of I0.9/I000; i.e. when the new system went into operation it was overstaffed.

b) As national legislation forbade the hiring of additional personnell, this led to a reduction in the regional roll of permanent staff of about I.700 units over the period I98I-83. The total figure fell from about 43.000 in December I98I, when the roll was first established to 4I.367 at the end of I983.

c) the "freezing" of the number of permanent positions imposed by the central government was circumvented at the local level by the opening of temporary jobs for about I.800 people. This occured primarely in order to replace staff going into retirement. The other alternative was to transfer people from health districts with excess personnell to districts with excess personnell to districts experiency shortages, but was severely limited by labour aggrements, as it was only viable on the basis of individual decisions.

d) besides permanent staff and personnell hired on a temporary basis, the health districts had on their payroll II00 people under contract with those agencies whose health functions have been trasferred to the new local units.

According to the data we have just examined, the total amount of salaried personnell working for the health districts remain ed substantially the same over the period. As we have seen, the reduction in permanent positions was balanced by an increase in temporary jobs. A part from financial aspects, this point requires to be further commented.

The new positions were not covered through public competitions at regional level. The selection was instead carried out directly by the health districts, allowing for quite lax procedures in the assumption of personnell by the relevant political bodies. Although it is hard to ascertain the extent to which clientelism has influenced hiring

procedures, we can safely say that all these people will soon be granted permanent job tenure avoiding public competition, due to a bill at present under debate in Parliament.

Fortunately enough, from a financial point of view, the consequences are not so dramatic. The total number of people involved only represents about 4% of permanent staff. If we relate the latter remark to the overall expenditure trends for personnell, this component does not appear to play a major role in using costs.

Summarizing, the basic reason for higher spending in this sector lies in the wage increases granted by the labour contract of 1983, which was agreed upon at national level. As far as labour costs are concerned, local authorities only have leeway in respect to the amount of overtime allowed.

Data provided in tables n. 5 and n.6 support this point. As we can see there is only a minor difference in average basic wage per employee among the forty health districts. This can be explained primarely with reference to the different composition of categories of staff. On the contrary, average per capita payments for overtime display a wide variation, ranging from a minimum of 385.000 lire to a maximum of 2.250.000 lire. Executive Committees are certainly in a position to exert control over this category of expenditure, since it is heavily dependent on overall efficiency in work organization within the health districts.

Table n. 5: basic wage and overtime pay per employee for Tuscany, by health district, I98I

Health districts	basic wage	overtime pay
1- Lunigiana	12.019.149	1.170.213
2- Area di Massa e Carrara	12.514.219	1.126.340
3- Versilia	13.282.754	470.762
4- Garfagnana	13.500.000	727.941
5- Media Valle del Serchio	12.391.850	438.871
6- Piana di Lucca	12.896.360	767.452
7- Val di Nievole	12.406.154	1.044.615
8- Area Pistoiese	13.282.478	751.499
9- Area Pratese	12.424.018	157.153
10- Area Fiorentina "A"	12.120.227	577.579
10- Area Fiorentina "B"	10.990.012	494.382
10- Area Fiorentina "C"	15.519.621	243.572
10- Area Fiorentina "D"	10.902.932	1.356.117
10- Area Fiorentina "E"	18.925.490	846.405
10- Area Fiorentina "F"	5.841.121	14.019
10- Area Fiorentina "G"	9.700.000	202.632
10- Area Fiorentina "H"	11.046.296	529.321
11- Mugello Val di Sieve	10.399.361	309.904
12- Area Pisana	12.545.313	551.282
13- Area Livornese	13.345.024	374.397
14- Bassa Val di Cecina	13.032.053	265.306
15- Alta Val di Cecina	14.540.295	283.768
16- Val d'Era	13.441.832	506.832
17- Valdarno Inferiore	12.700.997	574.751
18- Bassa Val d'Elsa	12.985.782	158.768
19- Alta Val d'Elsa	13.751.185	381.517
20A Valdarno Superiore Sud	12.910.758	480.440
20B Valdarno Superiore Nord	11.841.317	742.515
21- Casentino	12.605.634	701.408
22- Val Tiberina	12.514.107	796.238
23- Area Aretina Nord	13.996.288	795.864
24- Val di Chiana Est	13.200.341	296.837
25- Val di Cornia	12.782.673	566.814
26- Arcipelago Toscano	13.531.707	448.780
27- Colline Metallifere	13.618.343	742.604
28- Area Grossetana	13.575.436	-
29- Colline dell'Albegna	13.807.466	294.695
30- Area Senese	12.978.077	340.119
31- Val di Chiana	13.583.636	805.445
32- Amiata	15.652.778	430.556
TOTALE	12.867.827	639.147

Table n. 6: Basic wage and overtime pay per employee for Tuscany, by health districts I983

Health districts	Basic wage	Overtime pay
010	17.249.973	1.251.300
020	16.632.872	1.409.123
030	16.966.726	633.593
040	17.661.974	1.469.081
050	16.651.888	1.077.486
060	16.830.349	727.547
070	15.395.318	881.566
080	16.734.096	709.716
090	17.770.670	604.881
100	17.299.079	1.190.115
101	15.734.225	472.172
102	16.687.714	889.407
103	15.511.321	908.453
104	16.213.184	697.672
COMUNEFI	15.975.108	871.755
105	13.386.418	508.547
106	17.490.142	369.740
107	17.084.196	560.689
AREA FI	16.112.278	805.287
110	18.436.813	739.642
120	17.136.955	900.486
130	16.634.385	599.985
140	16.860.805	318.304
150	18.898.421	287.392
160	16.686.618	818.368
170	16.101.381	1.143.273
180	18.500.229	432.129
190	17.325.395	385.404
200	17.605.873	1.145.062
201	17.567.703	1.495.274
210	15.768.041	1.132.347
220	16.178.754	1.579.201
230	18.510.690	955.561
240	17.133.556	1.336.884
250	16.463.359	717.506
260	17.741.017	2.309.025
270	17.297.209	2.256.134
280	16.926.917	704.627
290	16.875.148	2.331.140
300	16.623.174	1.300.449
310	17.072.833	868.736
320	16.235.426	2.026.862
TOTALI	16.803.600	915.174

Nevertheless, we should keep in mind that on one hand only I,5% of total outlay is allocated for this purpose, and on the other hand that greater labour mobility has to be achieved. The distribution of staff among the various health districts is far from being satisfactory; this in turn creates great difficulties in the districts which are understaffed. As of I98I (see table n. 7) the ratio of personnel to total population varied widely across the region.

A number of steps have been taken by the regional government in order to reddress the major umbalances, both with respect to the rationalisation of the hospital system and the closing down of mental homes; both of which are crucial for the correct distribution of personnel. However, the resistance put up by staff and in particular by head phisicians has severely hampered the process.

To sum up, politicians at regional and local level will not be able to make a substantial improvement as to labour cost containment and organizational efficiency without the greater collaboration of unions and staff.

Table n. 7: Distribution of permanent staff, under major category headings, in Tuscany within health districts, I98I.

	I	II	III	IV	V	VI	VII
1- Lunigiana	63,83	-	28,52	7,23	0,24	100,00	8.4
2- Area di Massa e Carrara	60,09	-	28,16	9,24	2,51	100,00	14.3
3- Versilia	64,32	-	24,94	7,99	2,75	100,00	8,3
4- Garfagnana	64,71	-	27,94	5,51	1,84	100.00	6,2
5- Media Valle del Serchio	63,32	-	29,78	5.02	1,88	100,00	9.9
6- Piana di Lucca	64,07	-	22,31	10,79	2,83	100,00	14.5
7- Val di Nievole	62,00	-	23.51	13,07	1,38	100.00	6,2
8- Area Pistoiese	62,43	-	24,52	11,59	1,47	100,00	9,3
9- Area Pratese	60,46	-	29,67	8,31	1,56	100,00	5,5
10- Area Fiorentina "A"	50,86	0,08	24,37	14,30	4,39	100,00	
10- Area Fiorentina "B"	50,50	-	30,13	10,75	2,62	100,00	
10- Area Fiorentina "C"	55,75	-	27,74	14,34	2,17	100,00	20.2
10- Area Fiorentina "D"	60,40	-	32,56	6,72	0,32	100,00	
10- Area Fiorentina "E"	51,77	-	31,37	13,59	3,27	100,00	
10- Area Fiorentina "F"	58,88	-	11,68	23,83	5,61	100,00	2,5
10- Area Fiorentina "G"	52,63	-	38,29	8,03	1,05	100,00	6.9
10- Area Fiorentina "H"	58,33	-	28,76	12,81	0,10	100,00	8.6
11- Mugello Val di Sieve	49,43	-	22,68	17,89	-	100,00	3.6
12- Area Pisana	01,51	-	24,17	11,44	2,88	100,00	10.6
13- Area Livornese	53,27	-	31,78	11,57	3,38	100.00	11,8
14- Bassa Val di Cecina	58,98	-	34,22	9,39	0,41	100.00	6,8
15- Alta Val di Cecina	71,96	-	20,77	7,27	-	100,00	32.2
16- Val d'Era	60,27	0,12	27,85	9,04	2,72	100,00	8,7
17- Valdarno Inferiore	60,80	-	30,07	8,30	0,83	100,00	6,8
18- Bassa Val d'Elsa	60,55	-	26,54	9,95	2,96	100,00	6.4
19- Alta Val d'Elsa	58,29	-	34,12	7.35	0,24	100.00	7,8
20A Valdarno Superiore Sud	65,89	-	25,06	8,44	0,61	100,00	9,8
20B Valdarno Superiore Nord	64.07	-	26,65	8,03	1,20	100.00	8.9
21- Casentino	59,44	-	30,42	9,58	0,56	100,00	10.2
22- Val Tiberina	64,58	-	22,26	11,28	1,88	100.00	9.8
23- Area Aretina Nord	58.54	-	26,40	10.55	4.51	100.00	10.2
24- Val di Chiana Est	64,23	-	25,79	8,76	1,22	100,00	8,8
25- Val di Cornia	55.65	-	33,77	8,52	2,06	100.00	10,6
26- Arcipelago Toscano	51,22	-	36,10	10,73	1,95	100,00	7.0
27- Colline Metallifere	57,99	0,30	31,95	8,87	0,89	100.00	7.4
28- Area Grossetana	52,92	-	30,17	13,80	3,11	100,00	12.8
29- Colline dell'Albegna	52,40	-	37,92	8.64	0,98	100,00	9.1
30- Area Senese	61,63	0.07	29,31	8,27	0.72	100,00	25.6
31- Val di Chiana	59,46	-	32,91	7,27	0,36	100,00	8.7
32- Amiata	60,42	-	30,21	9,37	-	100.00	7.7
Non attribuili alle USL	5,84	-	15,33	78,83	-	100.00	0.4
TOSCANA	59.48	0,01	28,42	10,15	1,94	100.00	11.5

Legenda: I = "ruolo sanitario", the category includes doctors, phisicians, nursing staff and medical technicians
II = "ruolo professionale"; other non-medical professionals (architects, lawyers)
III = "ruolo tecnico" this category includes sociologists, social assistants along with genitors, maintenance and catering staff
IV = "ruolo amministrativo" administrative staff
V = Employees who have not yet been classified
VI = Total
VII = ratio of total personnel to I.000 inhabitants

II. General care.

General and paediatric care is not provided by the district personnel, but contracted to general practitionaries and paediatricians, who visit patients in their own practice or at the patient's home. Overnight, week-end and holiday services are guaranteed by a separate group of doctors under special contract with the local health authorities.

This whole area - including financial aspects is regulated in detail by a national agreement of I98I, which leaves practically no room for local decisions on the subject. Therefore, turning to the expenditure trends presented in tables n. 3 and n. 4, we can safely maintain that local health authorities were charged with a much heavier burden, without having a say in the matter. Total spending for this category rose from approximately 7I billion lire in I98I to over I63 billion in I983. As a result in I983 general care accounted for almost 7% of the total budget as compared to 4.5% in I98I. Actually, the enourmous increase occured in I982, when the national agreement of the previous year came into full operation and provided for an unprecedented pay increase (see table n. 8).

Besides rising costs for this category of expenditure, the way the issue was handled at national level - primarely by the Minister of Health - caused two other major negative consequences that need to be mentioned.

Table n. 8: Expenditure for general and paediatric care in Tuscany, by health districts, I982 (in billion lire)

Health dis.	gen. paed. care	night week-end service	As % of tot exp.	% var 8I-82 col.I	% var 8I-82 col. II	tot. per cap exp.
1	1896	469	9.56	105.19	83.92	42396
2	5394	482	6.08	105.72	46.50	39328
3	5754	697	9.11	106.38	6870.00	39843
4	1199	295	11.55	113.35	11.32	45383
5	1043	231	8.43	76.48	35.09	39562
6	5842	422	6.56	94.09	87.56	38908
7	3518	380	8.98	101.03	-27.34	37087
8	5476	470	7.73	99.34	-2.89	36709
9	7247	431	9.80	108.67	99:54	37319
10A	3765	144	6.49	89.86	234.88	56823
10B	2657	132	7.38	112.22	109.52	38417
10C	2616	109	7.46	137.82	-61.21	35485
10D	4032	221	7.29	114.93	198.65	35219
10E	4537	167	6.72	124.94	271.11	39705
I.FI	17607	773	4.72	113.99	52.77	40182
10F	3100	180	15.58	127.61	-27.71	38401
10G	3590	405	9.88	109.70	82.43	36364
10H	2553	419	7.80	102.30	142.20	39366
11	3100	560	12.03	190.65	51.76	41972
12	7338	600	5.95	106.30	.....	42247
13	7206	467	7.11	119.76	65.02	39670
14	2669	663	12.87	127.92	44.44	45957
15	936	264	3.89	109.40	-50.65	43898
16	3204	651	9.87	134.38	211.48	41505
17	2901	322	10.11	90.86	475.00	36534
18	4590	370	10.52	115.19	-5.13	37583
19	2001	258	10.19	130.26	32.99	41843
20A	2899	391	9.21	94.56	92.61	39449
20B	1196	193	9.29	73.08	.....	37352
21	1197	232	9.75	102.54	55.70	41074
22	1156	268	9.69	112.50	11.67	43945
23	3951	358	5.82	107.29	.....	36994
24	1534	301	9.97	100.00	14.02	39241
25	2420	652	9.71	103.36	51.28	48134
26	978	277	11.20	120.77	105.19	43059
27	1669	480	12.06	101.57	370.59	47158
28	3735	725	7.85	113.67	52.31	43436
29	1925	654	10.69	123.84	15.96	46375
30	4510	950	4.66	133.56	55.99	44405
31	2193	420	8.44	97.75	6.87	41488
32	1307	501	12.31	131.33	.....	49818
REGIONE	128834	16211	7.44	112.00	67.31	40293

First of all, as of today no standardized control has been introduced over the number and quality of prescriptions issued by general practitioners and over the lab test or specialist examinations they ask for their patients. According to the provisions laid down in the national agreement, the ministry of health was supposed to furnish the guidelines for the local management of such control (the so called "protocolli diagnostici e terapeutici"). However, no official act has been produced so far, making it quite impossible for the health authorities to riview phisician's behaviour under this respect. If we simply consider that italian doctors prescribe drugs for their patients at a rate two to three times higher than do the British, the financial repercussions of this governmental default become quite clear.

The second negative consequence that I whish to emphasize bears on the overall atmosphere of working conditions in the health districts and within hospitals in particular. The granting of such high rewards to general practitioners has caused a turmoil within hospital staff. Corporatist tendencies have substiantially increased, further undermining the possibility for Collaboration between hospital doctors and paramedic staff.

III. Specialist care.

Within the present legislative framework three different arrangements exist for carrying out specialist care:

a) specialist care can be provided directly by salaried staff. In this case phisicians and paramedic personnel are paid extra money according to the number of services rendered.

b) this function can be performed in public health centers by specialists who have an agreement with the public health service and are paid on a time basis. Under these circumstances, the local health units are responsible for the organization of nursing and clerical staff, equipment and medical supplies. On the whole, this arrangement is a continuation of the old form of care given by the various health insurance funds before they were abolished.

c) Finally, this type of medical assistance is offered by private clinics or by individual phisicians visiting patients in their own practice. Under this alternative, the services are reimboursed by the health districts according to professional fees. Although patients need special authorization by the health authorities in order to make use of these services free of charge, they are certainly granted greater freedom of choice. Nevertheless, this alternative is the most expensive for the public budget.

Having provided the basic information on option for specialist care, we can now turn to a closer examination of what happened in this field over the period I98I-I983. To start with, we should stress that at the outset of the National Health Service the bulk of expenditure for this purpose went to private practices. Going back to table n. I we can see that national average per capita expenditure for this category was almost 24.000 lire as opposed to 3.400 for specialist care in public health centers and less than 3.000 for extra benefits granted to salaried staff.

If we now turn to Tuscany, we can see that per capita allocations for the latter category amounted to 9.000 lire in I98I. This figure clearly shows a greater emphasis was placed in this region on direct management of this type of medical assistance. This trend becomes even more visible during the following two years. By comparing data presented in tables n. 9 and n. IO, we can easily note a considerable reduction in the level of expenditure for services provided outside public facilities. A shift of resources occurs from the latter category of expenditure to both services provided in public health centers and within hospitals. However, the increase witnessed in these two sectors outstrips the decrease in expenditures for services offered in private practices. As a result by I983 the allocation of resources for specialist care displays a quite different pattern from I98I, altogether total spending goes up by nearly 30 billion lire.

Table n. 9: Per capita expenditure for specialist care in Tuscany, by major components and health districts, 1981

	I	II	III	IV	V
1- Lunigiana	1.425	6.909	8.334	10.863	19.197
2- Area di Massa e Carrara	4.126	21.503	25.629	13.411	39.040
3- Versilia	1.566	27.897	29.463	8.212	37.675
4- Garfagnana	5.193	664	5.857	9.270	15.127
5- Media Valle del Serchio	1.419	7.218	8.637	10.025	18.662
6- Piana di Lucca	2.817	18.261	21.078	6.043	27.121
7- Val di Nievole	1.732	32.556	34.288	4.272	38.560
8- Area Pistoiese	2.444	21.877	24.321	1.808	26.129
9- Area Pratese	2.387	29.140	31.527	2.984	34.511
10- Area Fiorentina "A"	4.629	37.571	42.200	9.643	51.843
10- Area Fiorentina "B"	1.365	23.000	24.365	12.784	37.149
10- Area Fiorentina "C"	10.282	23.620	33.902	8.972	42.874
10- Area Fiorentina "D"	5.508	31.427	36.935	29.750	66.685
10- Area Fiorentina "E"	6.123	43.525	49.648	4.213	53.861
10- Area Fiorentina "F"	1.815	37.891	39.706	-	39.706
10- Area Fiorentina "G"	348	34.538	34.886	1.338	36.224
10- Area Fiorentina "H"	120	25.189	25.309	5.366	30.675
11- Mugello Val di Sieve	5.403	20.589	25.992	724	26.716
12- Area Pisana	4.337	24.807	29.144	16.623	45.767
13- Area Livornese	3.817	36.161	39.978	14.261	54.239
14- Bassa Val di Cecina	816	16.483	17.299	9.445	26.744
15- Alta Val di Cecina	1.234	1.488	2.722	16.333	19.055
16- Val d'Era	2.336	11.908	14.244	15.074	29.318
17- Valdarno Inferiore	793	9.303	10.096	13.496	23.592
18- Bassa Val d'Elsa	1.589	12.330	13.919	6.634	20.553
19- Alta Val d'Elsa	5.110	9.402	14.511	9.383	23.895
20A Valdarno Superiore Sud	2.253	13.915	16.168	10.055	26.223
20B Valdarno Superiore Nord	297	9.025	9.322	8.090	17.942
21- Casentino	2.528	1.580	4.108	12.551	16.659
22- Val Tiberina	2.639	9.022	11.660	7.365	19.026
23- Area Aretina Nord	5.052	22.235	27.286	10.035	37.322
24- Val di Chiana Est	1.093	4.801	5.894	8.338	14.232
25- Val di Cornia	3.293	13.950	17.243	11.500	28.743
26- Arcipelago Toscano	2.414	13.866	16.280	7.657	23.937
27- Colline Metallifere	2.920	10.357	13.457	2.898	16.355
28- Area Grossetana	5.352	23.403	28.755	8.699	37.454
29- Colline dell'Albegna	1.381	5.128	6.509	11.528	18.037
30- Area Senese	6.718	16.836	23.554	21.070	44.624
31- Val di Chiana	3.451	13.406	16.857	5.693	22.550
32- Amiata	2.833	1.661	4.494	2.615	7.109
TOTALE	3.211	21.985	25.196	9.200	34.396

Legenda: I specialist care provided in public health centers

II specialist care offered in private practices

III total contracted services

IV extra benefits for specialist care provided by salaried staff

V total per capita expenditure

Table n. 10: Per capita expenditure for specialist care in Tuscany, by major components, and health districts, 1983

	I	II	III	IV	V
1	5199	7440	12638	16779	29418
2	8279	12175	20454	19068	39522
3	5781	20073	25854	12315	38169
4	1823	1033	2855	11847	14702
5	2919	4316	7235	16862	24097
6	5708	16603	22311	19100	41411
7	5033	21113	26146	11227	37373
8	6884	20478	27362	15379	42741
9	6931	32089	39021	11622	50642
10A	10670	28215	38885	8199	47083
10B	5110	22012	27122	17356	44478
10C	17580	17788	35368	19091	54459
10D	11660	28636	40295	38896	79191
10E	12804	35206	48010	7808	55818
T.FI	11762	27402	39163	19483	58647
10F	7610	28614	36224	667	36891
10G	6244	36082	42327	6363	48689
10H	7550	14689	22239	12755	34995
11	12018	20069	32087	3360	35447
12	9936	21022	30959	34498	65457
13	8810	26134	34944	18012	52956
14	3862	3117	6979	14758	21737
15	3805	3146	6951	27985	34936
16	5609	5373	10982	28553	39535
17	2947	9295	12242	17525	29767
18	4425	10866	15291	11457	26748
19	14318	3723	18041	14448	32489
20A	4628	9868	14497	13621	28118
20B	2635	4410	7045	13338	20383
21	5958	2299	8249	18137	26386
22	7252	5802	13054	19072	32126
23	9186	19652	28838	23901	52739
24	3956	4919	8875	18712	27587
25	5233	8069	13303	22954	36257
26	5730	7034	12763	12729	25492
27	7373	10116	17490	3116	20606
28	10859	17676	28536	15339	43875
29	5071	6779	11850	15752	27602
30	11890	8539	20429	30075	50504
31	9161	7891	17052	9796	26849
32	8239	2425	10664	14246	24909
EGIONE	7719	17591	25310	16908	42218

N.B.: see table n. 9 for legenda.

Going into detail, expenditure for specialist care contracted to phisicians working in public health centers shows a much higher rate of growth than expenditure for extra benefits to salaried staff (I40% as opposed to 80%). Although in absolute terms this sector still ranks below expenditure for direct management of specialist care (due to ist very low starting point) we need to explain why it received so much attention.

The stated goal of regional policies in this field was to cut down on all forms of contracted services, primarely for financial reasons, since their cost is higher compared to the cost of services directly provided by salaried staff. So why did this category of expenditure continue to rise at such a fast rate? Once again, the answer brings us back to decisions taken at national level. In October I98I a national agreement was signed by health authorities and the union representing phisicians engaged under contract in public health centers. According to the regulations laid down in the act local health authorities could not reduce existing levels of activity by the phisicians under consideration. Moreover, in the event of an expansion in the amount of specialist care provided by the health discrits, at least 50% of the new services had to be reserved to this category.

Summarizing, local authorities wishing to channel the flow of public resources to direct management in specialist care were forced to meet these requirements, thus limiting the extent of the shift away from contracted services. Quite apart from this comment, we need to add that greater emphasis on direct management or at least on the provision of services within public health centers does not necessarily entail greater quantity and better quality of medical assistance. And as results show, data provided by the regional department of health appear to be quite alarming.

According to statistics elaborated at this level, the total expenditure for specialist care in public health centers increased between I982 and I983 by 59%, while the relative increase per service rendered was as high as 79%. A similar trend emerges with respect to specialist care provided by salaried staff: during the same period total expenditure for this sector rose by 33.9%, whereas if we look at cost increases per service the figure is 5I%. This means that cost increases where not generally matched by an equivalent increase in the amount of specialist care offered under these two arrangements. Moreover, since wide variations exist among the health districts, we can conclude that much still remains to be done in order to achieve a correct balance between expenditure and service standards.

According to what we have said so far it looks as if tighter control is needed over the operation of public health centers and the organization of specialist care to outpatients by hospital doctors. But is it

right for politicians who sit on the executive board of local health authorities to put under scrutiny the behaviour of technicians? Are they competent to exert this kind of control? I shall try to briefly comment on this point in my final remarks.

Conclusion

Although I have not covered all aspects connected to the performance of health districts in Tuscany, the paper certainly sheds some light on the crucial issues of the day. According to the data I have presented it does'nt look as if there is much leeway on the allocation of resources by local health authorities. Regional estimates indicate that political bodies at district level can actually make decisions on a very limited proportion of the total budget, ranging from I2 to I8%. Despite the fact local .authorities have full responsability for the management of the health service, they are continually confronted with decisions that are taken over their heads. Current legislation renders decision-making extremely difficult at local level if local politicians are desirous to become involved in improving the present situation. However, it must be added, that they are also free to do nothing at all. And for many this is an eas y way out.

Under these circumstances, the greatest effort should be made to rationalize the use of available personnel and increase the overall efficiency of the organization of work. Nevertheless I feel that politicians should strictly limit themselves to set the goals and control

their attainment, without beeing involved in technical decisions. Such goals should be set on the basis of well defined standards in the quantity and quality of the services that are to be provided. The responsability for elaborating standards should lie with the national and regional governments. Planning of health services, including the location of public facilities (hospitals, health centers etc.) and the consequent distribution of staff should lie in the domain of politicians. However tighter control over the behaviour of medical staff, which represents the crux of present inefficiency, should be self-imposed and supervised within the various professional associations. "Peer Review", which is the common procedure in many other countries, might be accepted grundgingly ba medical staff, but certainly has greater chances to be implemented than any other alternative that has a political flavour. The whole system has been overloaded with rights, it is time for some duties and sanctions to be introduced.

THE WELFARE STATE AS A PRIVATE-PUBLIC MIX

By

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PREFACE

In my work I am concerned with altruism in society.The presentation of this paper may better be explained in terms of egoism and exchange theory:
I am in the middle of my data-collection and want to collect good ideas and comments from colleges in political science,working on health politics.
It is important for political scientists to contribute in the private-public debate(also in the health sector).This is the legitimation for presenting my paper.

The debate -and its primitive level-is my point of departure.
Then I am trying to show one possible track into the jungle who can give some new information on the complicated interplay between private and public systems.
As a final remark I have put forward some of my anticipated findings.

Comments are wanted at any level,and constructive ones are especially welcomed.
The partially unfinished form of the paper makes it easy to perform some academic cannibalism,but I feel confident that political scientists will stay away from such a temptation.

THE WELFARE STATE AS A PRIVATE-PUBLIC MIX

1.Introduction

In text-books concerning the development of the welfare state,authors often stress the recognition of public responsibility for individual problems(poverty,housing etc) as pivotal(Briggs 1972 ,Flora and Heidenheimer 1981).

Before this breaktrough the individuals and their surrounding network had to solve the problem in the way they managed.
Even if public responsibility became very visible after the industrial revolution,and the establishing of the welfare state may be located in time to this century,it may be be shown that this development historically came stepwise as an evolution over centuries(Seip 1981,Kluge 1972)

For my purpose the important thing is the contemporary presence of two helping systems side by side;one public and one private.
This is a main feature of all the western welfare states:the private and the public system working in the same field.
While the presence of the two systems are common for all the welfare states,the blend and relationship between them will be unique for each country,depending on historical events,cultural background and existing power structures.

In some ways the position of the countries will depend on the used measures,but the scandinavian countries(especially Sweden) often turn out with a large public sector (measured for instance as the proportion of GNP spent by public authorities),and USA turns out with a small public sector.

It is a matter for comparative studies to define the common elements and uniqueness between the countries.One common pattern seems to be that during the years with stable growth in most of the western economics,few people were interested in the interplasy between the two systems.

The fact that we seemed to need both systems put into the shadows any doubt about possible antagonism between them,or problems in fitting together.

But in the last years with economic recession,the coexistence of the two systems has been attracted considerable attention.
A heavy ideological wave has doubted the very existence of the public system.Milton Friedman may be a spokesman for people who want the market and individual free choice to solve any distributional problem(Friedman and Friedman 1980)But even if they do not go that far,many analysts seem to agree that governmental regulations and activities represent a too heavy burden upon the market:It is necessary to restore the market-mechanisms to restore the vitality of the economy.Both Reagan,Thatcher and the conservative governments in W-Germany,Denmark and Norway gained the power with this message,and a rather heavy support from the profession of economists.

Still other economists claim that the solution of the present problem may as well be more government(Miller and Tomaskovic-Devey 1983,Levitan and Johnson 1984,Ackerman 1984).
Public government is, according to the critics, both disturbing essential mechanisms in the economy,a waste of money,and it is

destroying private initiatives -even in the caring sectors.

The recipe must be to cut the budget of welfare programs(housing,nutrition,day-care etc.)This will both reduce the deficit and revitalize the capacity of private caring-networks.In Reagonomics this is one of the outspoken goals:
"We need only to believe in ourselves and to remember that the true strenght of this country lies in the minds,the motivation,and in the faith of people like yourselves,notthe bureacracy in Washington D.C.

(T)here are just some areas where the Government has been trying to do things that the Government was never set up to do,and those things belong back here in your States and in your communities"
(Reagan,October 4.1982)
"The truth is that we let government take away many things we once considered were really ours to do voluntary"
(Reagan,Sept 24.1981)
(Levitan and Johnson 1984p.75)

In spite of little systematic knowledge about the interplay between the private and public caring systems,a lot of hypothesis concerning this relationship are frankly put forward in political debates.
If we turn to sosiological research it is possible to find support for quite contradictory statements concerning the relations between the systems.

According to Nisbet,the expansion of governmental power causes disintegration in the commmunities:
"The conflict between the central power of the political state and the whole set of functions and authorities contained in the church,family,guild,and local community has been,I believe the main source of those dislocations of social structure and uprootings of status which lie behind the problem of community in our age"
(Nisbet 1962)
Some authors suggest that statutory welfare systems subvert or destroy informal care in a more direct sense(Abrams 1980),others that we find a kind of innocent neglect,caused by the fact that formally organized services seem to ignore or take for granted family and neighborhood care(Grant and Wanger 1983).
On the other hand some authors do not find the systems to be antagonistic,they may instead be seen as complementary:people need both of them,and use them for different purposes(Richardson 1983).

It is possible to test the hypothesis which are implied in this discussion:If the antagonism between the private and the public system is real,then we must expect a growth in one system to go together with a decline in the other;the growth of the public system goes together with a decline in the private system.

Since private non-profit organizations is an important part of the private caring system,at least in the United States,a comparision of the situation for these organizations in a period of public growth,can be used to test the hypothesis.

Data shows that more than 60% of the non-profit-organizations in USA have been created since 1960 -exactly the period with the highest growth in public welfare spendings(Salamon 84).

In Norway the role of the voluntary organizations is less important,but we find the same trend:A rapid growth in in their budgets from 1971 to 81:From 249 mill.N.Kr. to 455 mill.(Kolberg 84 A).
The data from USA too shows that the government plays a substantial role in the financing of non-profit activities(Salamon 84).

This confirms our prelimenary conclusion and gives no support on this level for the antagonistic statement.
The data goes the other way:it seems to be an interplay between the two systems.In his discussion

Salamon pinpoints that private organizations can not compensate the decrease in public capacity,caused by
Reagans budget cuts(Salamon 84).

One reasonable conclusion so far seems to be that if we do not want to cut the service-capacity of the welfare state(and this is not pronounced by anyone),cut in governmental spendings is not a solution.

We need a more sophisticated understanding of the interplay between the two systems.
Before we move deeper into this jungle of rather confusing statements and lack of firm empirical knowledge,let me put forward some of my presumptions of the phenomenon:

1.The debate on the private and public systems is not a discussion about either or:both will be on the stage,but their contact may take different forms:
-melting together
-cooperation
-parallell work
-conflict
-hostility
What kind of relation we actually find,depends on the area, the actors and the context.

2.The different systems have different possibilities and limitations.None of them are preferable to the other without mentioning the kind of problems to be solved.
3.Using a system-perspective,even in a very unpresise way,implies some sort of rational behavior.

If we view the actors within the systems as behaving at least partially rational,this implies for instance that it is unreasonable to that one system(the public) can totally block the activity of the other.Actors with a rational behavior,even limited,will interact in terms of more or less continous adaption to the situation;if their activity is prohibited in one field the resources will be transferred to another area,albeit the level of the activity may be varying.

Some of the confusions in the discussions of private or public help may be traced back to the very use of the concepts.

2.The concepts of private and public

It is difficult to use this concepts because they often are connected to certain political values.
Sometimes public can be given a positive content(private property is robbery),contrary to Reaganomics where it undoubtedly is given a negative one,representing limited individual freedom,high taxes and waste of money.

The original meaning of private,current in the fifteenth and sixteenth centuries,was,according to the Oxford English Dictionary "not holding public office or official position"
The term stems from the Latin privare,that is to deprive or to bereave.

This original meaning survive today in the army where "private" is the ordinary soldier,the lowest rank.Thus for men private indicates the lowest level on the social ranking(Hirschman 82).For the other sex "public woman" has been used as a synonym for a prostitute.The difference reflects the gender gap,restricting the public area to a male one.

Many authors have pointed out that the private/public dichotomy simplifies the complex interplay we find in reality(Rein/Rainwater85,Kolberg 84 B).

If individuals or firms give money to private organizations,money that otherwise would be taxed,is it then partly public money?In the defense sector we find private firms producing only for the government,and the production is partly ruled by public bodies - shall it then be labeled private or public?

Privatization in its political use today seems to include at least two distinct phenomenons:

1)First we find ther desire to give tasks and responsibility back to family,friends and charity(the social network).This may be labeled a conservative privatization.

2)Then we find the desire to restore the market-mechanism and leave more of the welfare-distribution here.This may be labeled a neoliberal privatization.

Using privatization as one term with a distinct meaning may then be rather confusing(Kolberg 84 A).

If we then accept the impossibility of using public-private as an unidimensional concept,the next step is to single out the most relevant dimensions for mapping asn act(effort) as private or public.Lorentzen uses three variables in his categorization;governing,responsibility and financing(Lorentzen 84).

Using this multidimensional approach makes it possible to label an act as public on one dimesion and private on another.
We may add other variables here;execution(hidden/visible) and consequences(for whom).Evenhere we may run into complications;private obligations to make decisions may be circumscribed by general rules(restrictions for non-professionals,rules for treating the clients etc.)

For my purpose the important thing is to state than any meraningful discussion of private and public must take into consideration the multiplexity of the concepts.

In their discussion of the private/public interplay in social protection,Reinand Rainwater are focusing three main institutions for the distribution of economical resources to individuals or nuclear families:The kinship system,The economy and The state(Rein and Rainwater 85).

They put their main attention to the interplay between the market(The economy) and the public expenditures,not so much on the impact of the social network.

The private-public interplay may be discussed in different perspectives.

One approach is to view it in a cultural context and give attention to a historical dimension;the choice of private and public solutions today is a product of a development where we can find the origins in The Old Testament and the classical Athens.The formal divisions today may be partly understood in this perspective(Barrington Moore jr.84).

The choice of solutions may be seen as a cyclical movement too,where disappointment with the present situation(and choices) over time causes a change(Hirschman 81)

In my investigation I have restricted myself to the interplay between a public bureaucratic caring system and the private network consisting of family,friends,neighbors and charity organizations.

My argument is that the real interplay between the systems can only partly be understood from the use of the general concept.
We need a better understanding of what kind of mechanisms are functioning in the concrete situation.
Then we need to understand the resources and limitations of both systems,their different rationality and the dynamics between them.

I hope to gather knowledge about this through a case study on the caring of elderly people in a Norwegian community.

Let us start with the archtypes.
In the caring sector a public agency implies:
a)full or part-time staff
b)professional /special trained staff
c)the expenditures of the agencies are financed by public money,and the fundings depends on political decisions.
d)the relationship between caretaker and caregiver is regulated by bureacratic and/or professional rules.
e)Staff are formally governed by democratic elected boards.
f)the care-givers relation to the caretaker is impersonal,limited and restricted to treating the problem.

On the other hand private systems may be described in an opposite way:
a)normally unpaid people working voluntarly
b)the care-givers have no professional training
c)the cost of helping is financed by the helpers themselves or by private funds distributed through organizations.
d)the contact between caretaker and caregiver is regulated both by the demands and the relations between them at any time.
It may too be regulated by the rules and the involved and the involved organizations.
e)there is usually no supervision of the interaction between caretaker and giver.
f)the caregivers relation relation to the caretaker is usually personal,unlimited and unrestricted

These criteria describe differences that are frequently between the two types,but it ought to be kept in mind that they are idealtypes and not necessarely corresponding to reality.

3.The community

My community,South Valley,is part of a municipality with 4000 inhabitants.The municipality is the neighbor of a town with 20000 inhabitants.,and is located in the southern part of one of the main valleys in Norway.South Valley is a distinctive part of the municipality,located in its south end and with 350 inh. altogether.

8.5% are 75 years or more,which implies a rather high proportion of elderly people;the average for the nation is 5.1%.

For work,a lot of people are commuting to town,which implies a 20 minutes drive each way.Besides there is some farming with small farms covering the sunny side of the valley.Only a few farms give full time employment,the majority is working parttime.

Rapid technological development after the Second World War has created some visible changes in patterns of communication;the growing number of cars and the use of tank-trucks for the delivery of milk has caused broad roads outside and around most of the farms and houses..The tank-trucks need roads which are not too steep,and the dairies make certain demands for the standard of the road before they sign an agreement on delivery.

The past roads went up and down(developed for horses and walking),passing by the houses.This,combined with less stress of time,gave people possibilities for social contact.The new roads with their large loops and nice curves go around,leaving fewer possibilities for contact.In their comparition of the old times and today,the elderly often mentioned this as one of the most remarkable(and negative) trends of the development.

There is a school in the community and a parish house for common activities as Christmas- parties and community gatherings for other purposes.The use of the parish house is restricted for desirable purposes.

The religious activity in the community must be labeled as relatively high.Hundred people are members of the parish with the house(the Friends),while 75 are members of another parish(the Missionairs).Both these groups are working with elderly people,and are the most active organizations in the field. Most of the other members of the community belong to The Protestantic Church(The public norwegian church),and some of them areactive in the organizationwithin theparish(20 persons),doing some work for the elderly.

There are two more organizations working with elderly:a "house-wives club"(2 branches),and a nursery organization. Both of them are recruiting home-working women and consisting of 10-15 members(each branch).

A majority of the elderly have relatives in the community. If people who grow up in the community want to settle,housing has been a minor problem;there is usually space available for new houses.But difficulties in finding suitable jobs has caused many to move.

The young generation in the community(below 30) therefore is a mixture of grown ups and foreigners who found the community

convenient for settling down.
Compared to many communities which are"one-generation-societies(Schiefloe1975) South Valley is a good blend of generations with a high potential for caring and helping between them.

4.Research design

We started our work in South Valley as a pilot-study with a practical aim:How can elderly people get more help from each other,from younger people,and from the public system?
During our work in the community for three years we have learned to know the elderly people of the society well.In addition my partner on the project has lived in the community for her whole life(50 years).She has the administrative responsibility for the day-to-day work,While I am supposed to have the professional responsibility.

This give us the possibility to draw a small and suitable sample for our purposes.
We want few cases possible for examination in detail on the existence of private care,the interplay between private and public,and what kind of effect the public system may have on the private sector.
Within the group of elderly(more than 67 years) we have singled out 10 singles and 10 couples in such a way that half of each group consists of people who have asked for help from the public system.while the other half has not.
Within the sample we want to match the groups in such a way that they are similar according to occupation and other relevant background variables.

5.Private networks

The existence of private networks are essentialfor the care of adult people.In Norway The Central Bureau of Statistics have been doing time budget surveys with ten years intervals.Here we can find a nationwide estimate for time used on caring of adults.
If we multiply the average time used by working days and the number of people involved,then we get the amount of private care. Translated into full time jobs,this is equivalent to a working force of 102000 people,compared to the 200000 people working in the public social and health sector altogether in 1980(Kolberg 84 A,Grund 1982).

Sundstrøm has argued that little evidence is found for proclaiming any dramatic decline in private care.(Sundstrøm 1980).

Some of the changes can easily be explained in demographic changes;a larger proportion of elderly compared to women in the "caring age"(35-55)Other investigations too underline the vitality of the networks.It seems to be evident that both the private and public system are functioning,even if the use of their capacity may be varying.

Our main interest in the network is the capacity for caring of the elderly.The resources may then be divided into elderly people(helping other elderly),younger people and private organizations.

a.Elderly vs.elderly
It is important to pay attention to the fact that elderly people help each other quite a lot.Some times we meet with stereotypes indicating that the elderly only can be receivers of care/services.

We did a starting survey in the community.Here one-third of the elderly mentioned lack of social contact as the main thing they missed.This need can probably best be met by other elderly people,because they may be at the same age,sharing values and experiences.They may as well have some time for meeting other people because they are retired(this not meant as stereotyping retired people as non-busy).

We also asked people what kind of favors they needed and what kind of favors they would like to do to others.The answers indicate that it is some free capacity for social exchange within the group of elderly.It is easier to do a favor than to receive it;more people respond that they will give rather than receive. The limitation of a survey is that it is not taking into account the social constraints on interaction:you need a friendly relation and sometimes closeness in space.

But some of the capacity is used today;people are helping each otherin a lot of different ways.One has a car,he asks the neighbors if they want a lift to the grocery store.A single man helps a single woman with cutting wood(for heating in the winter),she gives him meals and bread.Elderly people who can walk and move easily are visiting others who are not mobile,and so on. These helping activities are developed over time,depending on earlier social experiences,present capacity and needs,filtered through a social context

b.Younger vs.elderly people
There is a lot of intergeneration caring in our community.The majority of the elderly has younger relatives within the community(70%).Thetraditional daughter(or daughter-in-law)/parents relation is still working.

We made a post-enquete including everybody between 20 and 67 in the communityThe majority in this group is helping elderly people,or they want to do it(75%).

We wanted to estimate available resources in improving the caring of elderly.
44% of the group said they were able to use 2-5 hours weekly for caring(more than they used today),and 7% responded capacity for more than 5 hours weekly.

Together this means a significant potential for caring.
some findings question if admittance to private resources sometimes is a condition for public help,and state a cumulative relationship:private help gives you more public help.The private system then functions as a lawyer,claiming the rights of the "client"(father/mother)(Wærness1984).

The situation when a caretaker is given public help by professionals is important from our point of view.We have to map what is happening:is the private system withdrawing its help,or does it transform the help into other tasks?.When the old mother is brought to the nursing home,will the daughter then relax or

will she consentrate more on social and psycological aspects,like talking and bringing friends?

It is possible to use different theoretical approaches to understand the helping activity in the community.
Exchange theory is one such framework.But it is difficult to regard the relations mentioned above only as exchange relations.Sometimes it is difficult to find the reciprocity in them;a healthy man is visiting another linked to his bed without any concrete repay.We could push the model hypothesizing that the visitor feels good in doing the other this favor.In this way the exchange theory will be tautological.

We found it convenient to use the term "solidarity" for this kind of activity;helping other members of the community without any necessary visible or particular reward.The reason for helping can be loyalty to the community as well as friendship to the receiver.If you are a member of the community you will be interested in its survival,and that may be a good reason for altruistic behavior.

The important thing in terms of social policy is the act and the functions it covers in the community.
It is unquestionable that these unformal activities are important for the the running of the community and the wellbeing of the individuals.

In our survey we tried to test the trust in solidarity;we asked the elderly people if they thought they would get help if they ran into an acute crisis.Almost everybody did,and the majority trusted relatives and/or neighbors.But some expected the public system to be the main helper too.
This underlines two points:

First:Most people feel "safe"-in the sense of care,and secondly:The private and the public system share the responsibility,from the elderlies point of view.

c.Private organizations
The third and last element in the private system is the private organizations mainly concerned with the welfare of elderly.These organizations have already been mentioned in the text.

6.The public system

This system has two subsystems relevant for our study;the health- and the social-subsystem.
The health part includes the hospitals ,and they are of course important for elderly people.When they are frail they can be moving back and forth between hospitals and nursinghomes,and between nursing homes and their apartments.

There is a big hospital in the town,and we will include this as a part of the public sector.But we will put most attention to the gatekeeper of the institutionalized health-system,namely the doctor in the community.This because he is functioning inside the community.

There are three doctors serving the municipality on full time,and people are free to choose either of them.But they have a geographical division of labor,and one has located his office in

such a way that it is clearly meant to serve South Valley.He is more or less "the doctor".

The municipality is running a nursing home with 30 beds.This gives a coverage of 5.6% of the population beyond 70 years,while the accepted nationwide standard is 7%(The municipality will get reimbursement from the government up to that coverage).

There has been made demands for a new nursing home in addition to the existent,but The Municipality Board did not give it priority. The nursing home is located 6-7 miles from South Valley.Here is the rest of the health system located too:The home-nursing office has an administrative leader and five nurses on full time.The home-nursing office is also responsible for the distribution of the home-help done by non-nurses.With one exception(a man) these are house-wives given an introductory course of 10-15 hours.People in South Valley are given 35 hours help in the home weekly.

As an experiment the helpers are cooperating in our community,and in common meetings they try to figure out(within the limited hours) how they best can use the resources.

The social service staff consist of one leader,one case-worker and one secretary.They too have their offices 6-7 miles from South Valley.
Together these people,their services and the laws and rules that regulate and restrict their activity (and others),are the public system in our analysis.

7.Collection of data

We will have to examine the cases in detail,and the following questions should be answered for everyone(this is a guide,not a questionnaire):

1.What kind of public help do they get
b.What is the experience with the help
c.Has there been any change over time?

2.Mapping the social network:
-Relatives
-Friends
-Neighbors
The survey can be used as a starting point.
b.What kind of interaction do they have with their relatives/friends/neighbors?
c.Do they have other people doing favors regularly(we have discovered the mail-man as an important social service worker)
We want to give special attention to situations of crisis:When a person suddenly gets ill,or is moving home from the nursing home-who is helping then?

3.When it has been a change in the needs
a.What kind of adaption do we find in the public system
b.In the private system
c.Can we observe any communication between the systems in these situations?

4.Do we find any dissatisfaction with
a.The public services
b.The private services
c.Do we find any cooperation between them(do they compete in any sense-or do they supplement each other)?

5.Do any member of systems report any dissatisfaction with what they have to do,are allowed to do-compared to what they want to do?

6.Do the members of the public systems have unfullfilled expectations of the contribution from the private network?
b.If yes:What kind
c.Has there been any change over time?

7.What is the overall situation for the elderly?
b.Do they feel satisfied with the situation
c.Do they have the feeling of ruling their own situation,or do they have the feeling of being governed by others
c.Is it a discrepancy between the actual situation,and how they would like it to be?

8.If the situation today is felt satisfactory,what is the reason?
b.Who is contributing.What are the conditions for the present situation.
c.What kind of change may interrupt this?

9.What kind of tools/strategies do the public and the private system have in this particular situation
b.What kind of resources do they have to adapt to a change in the situation
c.What kind of interests do the the different actors have in the situation?

For the private organizations we first need some basic information:
-Number of members
-Economical resources
-Professional resources
-Time resources(Volunteer work capacity).
Questions:
1.Is there any formal or unformal contact or communication between the organizations concerning the elderly?
b.If yes:What kind of contact?

2.Can the different organizations do what they want to do for the elderly?
b.What are done
c.If no:what kind of restrictions do they pay attention to
d.If no:How can they improve their activity(and what is the goal)

3.If they had been the only org. working with the elderly,could they have done more then?
b.Do they feel other org. as a restriction?

4.Has there been a change in the activity of the org. over time (money collected,numbers of meetings,members etc.)?
b.What has been the reason for this change

5.Asking the caretakers:Have they been in touch with some of the org.s?

7.A final remark:Some anticipated findings.

In lack of firm empirical conclusions ,I will conclude my paper with some anticipated findings.Hopefully the premises may be found in the preceding text.

1.The private and the public systems have different forms of rationality that makes cooperation difficult.

2.Different kinds of behavior(or policy) from the public system can limit or stimulate the amount of private activity.
We may think in a two-way-relationbship here;the existence of of the private network may support the efforts of the public system,or it may undermine or destroy them.

3.For an effective use of the total resources(both systems) it is necessary with transforming link close to the caretaker.

4.Formal responsibility(for the public system) and moral responsibility(for the private system) can only partly explain the composition of care we find in a concrete case.
Randomness and garbage can models may be used to explain the outcome.

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LOCAL GOVERNMENT HEALTH POLICY AND THE STATE

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INTRODUCTION

If health care is to be provided publicly, then how is the public provision of this service to be organized? Is a public health system entirely a matter for the central government or is health care to be regarded as a local (or regional) public good to be provided for in terms of some decentralized system of government? This problem of the proper level of government for the provision of health will be dealt with below using the Swedish system as a point of reference.

There appears to be a tension between the need for nationwide coordination in a public system for health care and the drive towards regionalization. It may be argued that the administrative contradiction between centralization and decentralization is inherent in the nature of health care as it is neither a pure public good nor strictly a local good. Thus, it is difficult to apply the framework of fiscal federalism (Oates, 1972). The outcome of the tension will be less a matter of considerations of administrative rationality than a question of political circumstances involving the shifting power relation between central and local government.

PUBLICIZATION AND CENTRAL GOVERNMENT INVOLVEMENT

Any modern society with a reasonably advanced economy faces two options in relation to the need of its citizens for health care in its various forms. Firstly, these types of services may be provided privatly or publicly, by means of the market or in terms of government and bureaus. It seems to be difficult to derive any implications about the choice between state and market from an analysis of the nature of health care as a kind of good or service. There are clear externalities involved as well as a certain amount of jointness which would favor public resource allocation. It is also possible to argue for market provision given an advanced economy where individuals may wish to make their own choices. It used to be the case that there was a certain mix of private and public organizations in the area of health care in most West-European nations. The overall trend has been publicization, however, or more and more reliance upon the state instead of the market.

Secondly, given the fact that health care is provided basically by means of a public administration system one may ask for the division of functions between various levels or kinds of government. What is at stake is the degree of decentralization on both sides of the public finance household, the financing of the good and the provision of the good. There are no doubt numerous alternatives in mixing taxes and charges with levels of government provision, but typical of West European systems is a combination of taxes and charges as well as of central and local government involvement.

In Sweden we find both a process of strong publicization as well as an effort to decentralize. There used to be a vital private health care system including both numerous practitioners and private hospitals. However, the expansion of the welfare state has made the county councils almost the sole monopoly supplier of health care. At the same time the market for health care services has been closely regulated by a fixed system of renumeration. Since 1955 the state has paid a part of the bill by means of insurance. The rise of the county councils as the main or sole provider of health care is conspicuous. In 1960 the 23 county councils allocated about 2.3% of the GNP, in 1970 4.6% whereas in 1982 no less than 11.4%. Roughly 85% of their budgets are allocated to health care. Their function as a regional employer is matched by few private firms. In 1968 there were 136 000 employees in the county councils which by 1982 had risen to 385 000, mostly women. More than 4/5:s of the employees within the health system are employed by county councils. As a result of this process of publicization there are only remnants left of the private system. At the same time the growing importance of the county councils has been accompanied by demands for regionalization meaning that the national government should lessen its grip on the county councils providing these organizations with more of autonomy.

The organizational development of the county councils is a combination of a process of volume expansion and of the transfer of tasks from the state and the private sector to this regional part of the local government sector. In 1928 the county councils were obliged to supply closed health care and in 1959 the responsibility for the open health care of hospitals was placed with the county councils. In 1951 the long term treatment care had been transferred to the county councils. At the same time nationwide planning was initiated in 1958 by the division of the county into health care regions.

The process of publicization of the provision of health services has no doubt been governed by central government policy-making, planning and coordination of activities in the area of health. However, the demand for decentralization has a strong financial aspect as the county councils pay most of their budgets by means of their power to tax. At the same time the organizational strength of the county councils has been balanced by a strong Ministry of Health and Social Affairs as well as a large central bureau, The National Board of Health and Welfare. What is the role of central government in a public administration system providing health care services?

Typical of the Swedish system of health care is not only the public orientation but also the focus on hospital care. Whereas the proportion of GNP allocated to health care is about the same in Sweden as in similar rich countries the health care programs are more oriented towards hospital care than in other countries. Let us look at some data.

Table 1 shows the process of cost expansion in terms percentage of the GNP. It also indicates the process of publicization.

Table 1 in here

The private health care sector is smaller in Sweden than in other similar nations. The dimensioning of the health care inside and outside hospitals distinguishes Sweden as there is a much heavier emphasis on hospital care (Table 2).

Table 2 in here

Hospital treatment consists of three kinds of care, basically. Somatic short term treatment is distinguished from somatic long term treatment, both of which are separated from psychiatric care. The relative size of these basic modes has changed over time (Table 3).

Table 3 in here

The amount of resources allocated to somatic long term treatment has been increased very much at the same time as the number of nursing places in the two traditional types of hospital care have gone down. The explanation is a combination of a demographic changes, technological innovations and political emphasis. In the last decade the national health care planning has attempted to transfer resources from closed to open health care. The so-called primary care has been expanded but not as much as the center wished.

The county councils provide for about half of the dental care in the county, the other half being private but regulated in detail. The so-called peoples' dental care was introduced in 1938 and has been expanded into a general system for dental care for all children up until 19 years of age. Besides the county council dental care covers specialist treatment and voluntary care for grown ups.

STRUCTURE OF THE PROVISION OF HEALTH CARE

It must be underlined that the supply of health care in the Swedish system has been much hospital based. It is not only the case that public provision has expanded at the expense of private, but it is also the case that there has been a strong process concentrating resources to hospital organizations. Of course, the two processes are related as it was natural for an expansion of the public health sector to occur within large scale operations.

There can be no doubt as to the success of this structuring of the health supply in meeting basic needs in the industrial society. A number of indicators may be employed to describe outcomes of the build up of the health care system that show that the population has a health condition that is high in an

international perspective. However, there is now evidence to the fact that rising health care costs do not result in an improved health condition. It is no longer the case, for example, that the death rates in various age cohorts decline, yet the costs of the operations keep increasing. The emerging emphasis on nationwide planning has been accompanied by a drive for a reorientation of the health care supply.

Central authorities argue more and more for innovations along the following three lines:

(a) Preventive health care, allocating resources to the ex ante in stead of the ex post predicament.

(b) Open health care, transferring resources to primary care from closed hospital care.

(c) Comprehensive health care, integrating the treatment of diseases in a " total" perspective on the predicament of the patient.

At the same time the county councils face general financial problems as well as demands for more of specialization which requires advanced and expensive technology. Thus, the traditional health care policy of expanding the supply of health care in order to guarantee that each part of the county has a more or less complete set up of clinics and specialities can no longer be resorted to. It will become necessary to restructure supply towards a more heterogeneous structure, involving moving resources from closed hospital care to primary care as well as advanced specialities. There is a basic change in demand for health care that must be recognized. On the one hand, the growing age of the population - as manifested in the average age of those economically active as well as of those more than 65 years of age - has implications for the structuring of supply. On the other, the development of society and its economic basis also conditions the demand for health resources.

The death rates in various age groups are low compared with most European nations. It appears that the death rates are somewhat higher for men than for women in all age groups. The same applies to those not economically active and those successfully employed. More than half of all deaths are caused by cardiovascular diseases like cancer and lung diseases. The main categories of death causes include suicide, heart failure and traffic accidents. If the occurrence of alcoholism and the consequences of the use of liquor are taken into account, then it is evident that it is a basic cause of death. It is a fact that mortality rates are higher in the metropolitan areas than in the rural areas.

Taking a broad view on the aetiology it may be stated that three types of categories constitute the most frequent symptoms and troubles: psychiatric disturbances, problems concerning the muscular organs and cardiovascular diseases. And there is a clear

social dimension in the occurrence of these symptoms and troubles as they are more frequent in the working classes as well as among those not married. Correspondingly, it is argued that the supply of health care services should be reoriented towards preventive care as well as open care in relation to these categories of diseases.

Cardiovascular diseases are most frequent in the age groups above 45 years of age, in particular among men between 45 and 65 and among women among those 65 years and older. On the other hand, psychiatric problems in a wide sense are the main causes of death among those below 45 years of age. Muscular diseases cause a large number of grown ups 45 years or older to take early retirement. Whereas the occurrence of psychiatric diseases has less of a social dimension the incidence of cardiovascular diseases as well as muscular problems is more typical in the lower social groups. Politics is involved in several ways in the public supply of health care. There is not only crucial problems concerning how to pay for health care, how to mix various programs as well as how to reach an effective relationship between inputs and outputs. There is also the distributive aspect as the need for health care has a conspicuous social dimension. In Sweden health care problems occur more frequently among the lower social classes. Public health care is a kind of merit good or categorical redistribution, but which public body should allocate the good?

COUNTY COUNCIL DISCRETION

The explicit policy emphasis on decentralization must be interpreted in terms of the structure of the local government system. The formal organization of intergovernmental relations is contradictory as it is based on a tension between two legal principles: the constitutionally guaranteed rule that a local government may take care of its own affairs and the general principle of Parliamentary legislative power meaning that the central government may introduce directives as to <u>what</u> the county councils should do (primary autonomy) as well as <u>how</u> they should do it (secondary autonomy). Thus, we find that county councils enjoy a broad taxation power to pay for a large program structure involving besides health care and its modes educational, cultural and sports activities. However, we also find that the central government governs these activities in various ways. There used to exist a detailed system of rules that restricted the discretion of the county councils both with regard to what they may do as well as how they may go about doing things. Basically, a distinction may be made between two kinds of legal restrictions.

On the one hand there is the health care legislation which obliges these organizations to take measures to provide publicly for basic services in this area. The health care law is the core of the directives laid down in the center as to how these regional organizations are to handle the provision of health

care. This set of directives includes both accompanying laws as well as bureaucratic norms. On the other hand, there exists a set of legal interpretations of the nature of the discretion involved in the autonomy clause "to handle their own affairs". National administrative court decisions have stated what "their own affairs" amount to. As a result of these two sets of legal restrictions though very different in nature it was readily apparent that the county councils did not possess farreaching discretion. Their financial and organizational status was not matched by institutional autonomy. No doubt this discrepancy between economic resources and power is one source of the growing demand for the regionalization of the health care system, manifested in the 1982 legislation increasing county council discretion. There is also a quite substantial central government support for the drive towards regionalization, partly a result of the state financial crisis which began in 1976.

The state has been much more involved in the output of the county councils than in the input of resources. About 60% of the resources of the county councils are derived from the county council tax. Roughly 20% consists comes from the state, about 10% from charges and 10% derives from various other sources including borrowing.

Given the existence of governmental involvement may we conclude that the county councils are all similar? It seems important to distinguish between state dominance and county council similarity. If the county councils all persued the same policies, then we could safely conclude that discretion mattered little. But even if there is a substantial policy variation between the county councils we may not conclude that state directives do not matter. If the program variation is a function of environmental factors, because the central directives tie program outputs to key situational variables, then policy variation may coexist with central government dominance.

COUNTY COUNCIL POLICY VARIATION

The growth of the county councils has meant that these organizations are in a position to pursue a number of policies in various areas although their main field is health care. The public health care system includes besides the 23 councils three municipalities - Gothenburg, Malmö and Gutland - which carry on health care besides other local government functions. Roughly 85% of the budget of various county councils are allocated to health care and this proportion has hovered little over time. One indicator on policy variation is the cost per capita variation though it may be pointed out that it is by no means the only or the most important indicator on county council policy-making. Describing health care policies in a regional perspective we may take into account various service level indicators as well as measures on access and satisfaction. However, the cost variation may be regarded as one important policy indicator as it allows us to describe how the effort to provide health care may vary regionally. Should one predict the extent of variation on the

basis of the strong demand for regionalization one would guess that the per capita cost varied little as a result of centralized standardization. This is the case, too.

In 1981 the average cost per capita in the county councils (N=22) was 8127 kr with a standard deviation of 727 kr. The distance between the maximum - 9972 kr - and the minimum - 7284 kr - does indicate some variation but it is not extensive. The coefficient of variation is 9.0 which indicates that there is a real cost variation but also that it is not extensive. It seems as if the strong state involvement has been conducive to making the county councils more alike. In 1973 the average cost per capita amounted to 2093 kr, the standard deviation was 212 kr meaning that the cv-score was 10. The process of standardization may be contrasted with the process of organizational growth of the county councils. Organizations that grow in resources may find it increasingly difficult to accomodate to an organizational environment in which they are not allowed to make their own decisions (Starbuck, 1965).

Although we do not find extensive policy variation there is enough cost variation to the search for environment conditions. Though recognizing the extensive state involvement in the county council operations - particularly in the legal system between 1962 and 1982 - it may be hypothesized that county council budget making is also a function of other factors than state directives. Not only is there the varying meeds of the population but as popular organizations political preferences may also matter.

The basic political cleavage in the county councils follows the traditional national one, i.e. the socialists compete against the so-called bourgeoise parties for power in elections that take place simultaneously with the national elections. There is some evidence for the thesis that politics matter in local government health policies, if one looks at the surface. Table 4 has the data.

Table 4 in about here

All the statistics about the two sets of county councils - county councils with a stable socialist dominance and county councils with a stable non-socialist dominance - indicate that left-wing preferences are conducive to a higher spending effort. The average budget is typically larger if there is a socialist dominance. The minimum values and the maximum values are smaller if there is a bourgeoise dominance. But this finding has to be checked in order to control for the operation of other factors.

What factors may have an impact on the size of the county council budgets besides party preference? The regional provision of health care services and other activities must somehow be related to regional needs (number of elderly), regional resources (taxation capacity) and regional structure (density of population, area). In order to estimate the partial contribution

of these various factors - political and environmental ones - two types of regression analyses were made; firstly, a pooled regression including the county council budgets between 1974 and 1981 was conducted (N=176) and then, secondly, a series of cross-sectional analyses were made (N=22). The findings of the pooled regression analysis are stated in Table 5.

Table 5 in here

It appears that the political factor is of no importance in explaining the cost variation between the county councils over time. In a model that includes both resources (taxation capacity), needs (proportion of elderly) as well as structure (area) more than half of the variation may be accounted for. The findings hardly support the Politics does matter theme, but a pooled regression may be biased by the dynamic dimension in the data. Whereas the political factors change little the budgetary expansion means that the over time development of the cost variation will dominate at the expense of the space dimension of the variation. A cross-sectional approach is more suited for a test of the contribution of the political variable. Table 6 has the data.

Table 6 in here

The various models presented in the Table are those that explain most of the variation. This means that the political factor should only be included in the model for the 1979 and 1981 data. It appears that environment variables are more important than the political factor. However, one word of caution is necessary. There is a correlation between area and the political factor (r=.58) meaning that it may be difficult to separate the role of the political variable. In any case, it appears that the county council policy-making is not only a function of state directives. Regional resources, needs, structure as well as politics must be taken into account. Maybe what matters more than all these factors is the ambition of the county councils as democratic organizations to determine their outputs, particularly when they have expanded into large scale organizations. What is the nature of the state - county council relationship? We may guess that county council policy variations will increase as institutional autonomy is argumented.

REGULATION BY LAW

Whereas the local government law makes it possible for the county councils to take action regarding their own interests the health legislation restricts the alternatives of action. The extent to which the national legal framework delimits the autonomy of the county councils depends on the structure of the legal system. In 1982 a revision of the existing legal framework was introduced

based on a reconsideration of the relationship between the state and the county councils. The preceeding legal framework - the 1962 legislation and its addition - expressed a quite different model of state - county council interaction than implied in the 1982 legislation.

The 1962 system ("Sjukvårdslagen 1962:242", "Sjukvårdskungörelsen 1972:676", "Folktandvårdslagen 1973:547", "Folktandvårdskungörelsen 1973:637") was oriented towards detailed regulation and close supervision. The main Parliamentary law contained 36 paragraphs supplemented by 39 paragraphs in the supplementing government directives. These 75 rules not only laid down comprehensive duties on the part of the county councils to provide for hospital care but also specified in great detail how this general duty was to be carried out. Thus, the 1962 framework stated what hospital care amounted to, how the county council was to govern hospital care as well as how the county council administration was to be structured. Moreover, the position and duties of the doctors were minutely regulated distinguishing between various kinds of physicians and identifying their various responsibilities. Several rules governed the conduct of hospital care from the admission of patients, the recruitment of doctors, the treatment of patients and their release from hospital. It was hardly possible to describe the relationship between the state and the county councils as one of local government autonomy.

REGULATION BY CONTROL

Given the strong emphasis on hospital care in the Swedish system of health care two factors are of central importance for the development of the system: the building of hospitals and the recruitment of physicians. In the 1962 system the center exercised considerable control over these two factors. Up until 1982 the county councils had to apply for the permission to build new buildings from the central authorities, mainly the Board for Health and Welfare; the central scrutiny was close and concerned both medical and financial aspects. The supply of doctors had a large impact on the county councils as there used to be a severe shortage meaning that county council developmental plans were hampered. The center controlled the supply of physicians in two ways: on the one the center determined the number of physicians examined each year including what kinds of physicians the public education system produced; on the other hand the center had to approve of the requests of the various county councils for establishing new positions. Whereas it is still the case that the center controls the training of the physicians it is no longer up to the center to decide about the introduction of positions as physicians. The regional distribution of positions as physicians is the outcome of a process of negotiation where in the end each single county councils make their own decisions.

It should be underlined that the control exercised in the 1962 system and abolished in the 1982 system was of a passive kind.

The center awaited for initiatives from the county councils about investment in capital and personnel which the center were to examine and approve. There was not a kind of active control meaning that the center would direct the county councils how to expand their budgets. The removal of the central control over buildings and physicians has not meant that all mechanisms of central influence on county councils have been abolished. Besides, the shortage of physicians has been transformed in a more balanced supply and the period of large scale investments in hospital buildings has also ended.

REGULATION BY REVIEW

If the center no longer can control decisions about new investments and new positions it still exercises a kind of review influence over the operations at the county councils. There is a central agency (The Health and Medical Services Disciplinary Board) that upholds certains rules that protect against maltreatment. Thus, the state exerts a strong control over the public provision of health by means of a review process involving the possibility of legal action against maltreatment. According to the so-called Lex Maria the chief administrator of the county councils was under the obligation to bring cases of maltreatment to the attention of the Board of Health and Welfare as well as the Police in order that legal action be initiated. Besides the severe treat of a court procedure examining the possible occurrence of maltreatment each and every patient could file a complaint to the central agency which had the power to issue a statement against the practioner. If several such statements were made the practioner could be prohibited to serve. It should be emphasized that these central instruments of review were effective in establishing national rules of conduct in the provision of health care. Although there were not many cases of legal action under the Lex Maria and few practioners had several statements made against them the possibility of such severe sanctions was no doubt a strong treat. These review functions have not been decreased in the 1982 system. The new rules replacing Lex Maria ("Tillsynslagen 1980") strengthens and widens central audit functions.

The central review of the county councils was not only limited to protection against maltreatment, but the National Board of Health and Welfare had a general right to supervise the county councils:

> "Fifth Paragraph: The supreme duty to supervise the provision of health care by the county councils rests with the Board of Health and Welfare."

This general supervisory role of the center in relation to county council health provision has been maintained in the 1982 system (Paragraph 18) but practice is different. Whereas the Board used to conduct a number of inspections it is now less frequent.

REGULATION BY MONEY

Although the county councils have never been highly dependent on state funding it is still the case that state money matters on the margin. The state has two means of directing the activities of the county councils: either by giving special grants to the kinds of health programs it wishes to see in the county council budget or by framing special conditions in the state insurance system which make the county councils more interested in certain programs. Both of these influence mechanisms have been employed for various proposes. State grants have been channeled to psychiatric care as well as preventive care whereas the insurance system has been employed to subsidize the provision of open health care.

REGULATION BY PLANNING

The provision of health care by the county councils used to be governed by the state by the control of the Board of Health and Social Welfare of the implementaiton of a detailed system of regulations. A number of directives stated responsibilities and proper patterns of conduct in: hospital care, prevention of deceases, dental care, psychiatric health, abortion, sterilization and drugs. The 1962 framework was basically increased when the sphere of activities of the county councils expanded as a result of the process of transferring tasks from the state to the local governments. Thus, the open health care system outside of hospitals was transferred to the county councils in 1963 and the psychiatric care in 1967.

The response to the expansion on the part of the county councils has been planning. Each county council has a five year planning system integrating the yearly budget plans. Five year planning documents developed during the seventies. There was no legal regulation of these plans, but the introduction of planning was guided by norms developed by the Federation of Swedish County Councils - Landstingsförbundet. The national association of county councils is a heavily staffed interest organization operating in the center as a representative of the county councils negotiating with the state and participating in the national policy process. The Landstingsförbundet in collaboration with the National Board of Health and Welfare conducts long-term planning on the basis of the planning documents of the county councils (LKELP-system). Moreover, it issues a large number of recommendations to the county councils in order to standardize their patterns of operations. Often these recommendations have been negotiated with the central bureaucracy. The emergence of health care planning was typical of the seventies as more and more of health care activities were entered into county council planning in accordance with norms and criteria recommended by the national association, the central bureaucracy or the semi-public Institute for Health Planning and Rationalization (SPRI).

THE 1982 SYSTEM

The revision of the legal framework defining the role of the county councils in relation to the state may be interpreted in the light of the trends described above. The continuous expansion of the county councils has been accompanied by a growing demand for a redefinition of center-local relations. The 1982 health act attempts such a redefinition.

The large number of rules in the 1962 system is replaced by a small number of paragraphs stating the overall objectives of the health care system as well as outlining the main organizational structure of the organization of the system. Detailed central regulation and close supervision is to be replaced by central broad planning and coordination.

The county councils are to be responsible for the overall health of their inhabitants - not only hospital care. The county councils are to structure the health provision in terms of some basic goals:

(1) satisfy the needs of the patients for safety and quality in the health care
(2) a comprehensive approach to the conditions of the patient
(3) provide a health care that is close to the patient as well as readily accessible
(4) respect the rights of the individual to self-determination and integrity.

Although the 1982 framework contains rules concerning the organization of the health care system as well as the conduct of health care itself the emphasis is on the governing of the county councils by means of general goals. Thus, decentralization is to be combined with goal governance replacing the 1962 system and its centralization and rule governance. Detailed regulation and close supervision and control was typical of the centralized model whereas planning is to be the mechanism for steering the country councils in the future. The planning systems of the country councils are to be integrated in a national planning system.

PLANNING HEALTH CARE

The basic transformation of the relationships between central authorities and the county councils under the ideal of decentralization amounts to a shift from <u>control</u> to <u>negotiation</u>. A large set of central directives is to be replaced by central coordination and negotiations between the national government and the county councils.

The central planning system involves the Riksdag and the government that are responsible for the identification of goals. The special Delegation for Health Care within the Ministry of Social Affairs is the chief planning body consisting of politicians, bureaucrats, and representatives of the

Landstingsförbundet as well as of the chief trade unions. The central authorities publish planning documents regularly. These documents screen a number of aspects of the health care system on the basis of commissioned reports about the existing situations and attempts at innovation. Thus far it is no exaggeration to claim that the main reports - Health Care in the Eight by the Board as well as Health Care in the Nineties by the Delegation - have played a role in determining the plans of the county councils. Although it is a matter of recommendations as to the future developments of the health care system the statements of the these reports have an impact on the yearly decisions of the county councils through its impact on their five year planning documents.

Even if the National Board of Health and Welfare has been reorganized in the early eighties it is still the case that it is an important bureau exercising supervision over the county councils. However, as the amount of detailed regulations has been reduced sharply the functions of the Board are being reoriented toward planning. Thus, an official document states:

> "It dwelves upon the Board to take care of matters relating to the national planning considering the needs of individuals, the requirements of coordination and the supply of educated personnel as well as to support the regional and local planning." (SOU, 1979:78: 159-160).

It may predicted that the role of the Board will decline as a result of the transformation from detailed supervision of the center to coordination and negotiation. The standard description of the central planning system is one of harmony. Besides the central authorities there is the top organizations of the county councils, the Landstingsförbundet and the Spri. Even if it is true that there has not been major divergencies in the principal documents of these major planning bodies it may be expected that the future will see more open clashes between the state and the county council top organizations.

A rather large number of central agencies besides the Board of Health and Social Welfare are involved in the central steering of the public provision of health care: the Board for Social Insurance, the Labor Protection Board, the National Laboratory of Bacteriology, the Board for the Further Education of Physicians, the Sanitary Board, the Responsibility Board and the Board for the Expansion of the Teaching Hospitals.

The two central agencies that are private or semi-private in nature - the Landstingsförbundet and the Spri - enter this coordination - negotiation system. These two bodies play a major role in creating national norms for the structuring of the health care system. They operate by means of investigations, recommendations and advice. But their points of view are often more authoritative factually speaking. This applies in particular to the national association which not only participates in a number of commissions and boards but also negotiate in a real

sense with both the government and the trade unions.

DECENTRALIZATION AND MECHANISMS OF CONTROL

Interpreting the changing relationship between the state and county councils calls forth all the difficulties involved in the planning concept (Wildavsky, 1973). The kind of planning relevante here must in some way be compatible with decentralization, otherwise there will be a sharp conflict with regard to the ambition to reduce state control and increase county council autonomy. "Dirigiste" planning is out of the question and the problem is whether "indicative" planning may be employed in a decentralized system of health care provision. This raises a number of questions as how the central authorities may influence other levels of government. A distinction may be made between regulation and negotiation. And one may suggest that influence may be a function of both regulation and negotiation meaning that they are substitutory mechanisms. Thus, we have a system of iso-influence curves:

Diagram 1 in here

A reduction in the amount of regulation does not necessarily mean that the center refrains from influencing regional or local government. The same amount of influence may be exercised but by means of a different kind of mechanism. Whereas strong central regulation is expressed in a legal framework that is in contrast to the demand for autonomy a negotiated order where the state gives advice a lot to say may be acceptable in a policy to decentralize. It all boils down to how effective the planning is for the state as well as how acceptable it is for the county councils.

Consider a situation as in the 1962 system where the state concentrates on regulation developing little in terms of planning. The state may be able to reach a certain level of influence on county council activities - locus G in the Diagram. As the state engages in new planning techniques it may increase its capacity for planning meaning that a higher amount of influence becomes possible - locus H. It all depends on the effectiveness of the national planning system. It is also conceivable that the transfer of resources from regulation to planning results in a reduction of influence on the part of the state towards the county councils. If planning is illusive and the reduction in regulation simply means of a loss of influence without a corresponding gain from planning then we end up in locus F.

The quest for decentralization often involves different things. It may simply involve an emphasis on the periphery or the hinterland, a complaint about the ongoing concentration of resources to the metropolitan areas. Or the quest for decentralization may mean a demand for a widening of local

government functions. Thus, the demand for a decentralization or regionalization of the public provision of health care may involve that the supply of such resources should be available as locally as possible or that local government is the proper supplier. However, these somewhat vague senses of "decentralization" must be supplemented by a decision interpretation of the concept. What matters most is the question of who decides. Even if there is a close local provision of health care or a transfer of functions from the state to the county councils it is still an open question where the main decisions are taken governing the provision of health care.

The public provision of health services involves two steps that may be distinguished for analytical purposes: the enactment of broad policies and the implementaion of these policies in the day-to-day practice. Two models may be identified on the basis of the Swedish experience. The regulatory model means that the state is heavily involved in the implementation process governing several aspects of the public provision in a minute way while refraining from identifying the basic goals at stake. The planning model involves that the implementation is left practically without restrictions to the county councils whereas the state concentrates on the enactment of overall objectives. The regulatory model focuses on the means whereas the planning model emphasizes the goals. Both models have their pros and cons. The regulatory model may achieve a standardization of procedures which results in regional similarities as well as strict protection of the patients. However, it may fail to identify the aims of the regulation of the means as well as prevent the implementation agencies to take action in response to local needs and circumstances. The planning model opens up the possibility of flexibility in the implementation process, but the role of central government becomes uncertain as the step between grand objectives and local government practice may be large. How is the state to secure influence by concentrating on planning?

There is a variety of planning models, from the classical close control models to the mere projective prognistic ones. The planning model envisioned in the 1982 Swedish health care system is based on the distinction between ends and means in combination with the distinction between central policy-maker and local implementor. Thus, we have a 2x2 Table:

	ENDS	MEANS
THE STATE	I	II
LOCAL GOVERNMENT	III	IV

It is believed that the public provision of health care will become more rational if the state acts as policy-maker stating the overall objectives and outline the main features of the structure of the system while the county councils act in the role

as local implementors with a large degree of autonomy in the choice of means. The basic problem in combining such a distinction between ends and means with an organizational separation is that there is no guarantee that there is a link between the ends and the means.

If the state refrains from laying down any directives as to the means of public health, then it may find itself in a position where it is left with the statement of lofty objectives. The shift to legislation by objectives may simply mean that the state states trivialities. Look at the 1982 health act:

> "Health and medical services are aimed at assuring the entire population of good health and of care on equal terms." (Paragraph 2)

Planning by objectives may involve concentrating on the obvious while leaving the controversial to the choice of means the implementor making the real decisions.

COUNTY COUNCIL ORGANIZATIONAL GROWTH

The reorientation of the relationship between the state and the county councils as manifested in the 1982 legislation cannot simply be interpreted as an intended outcome of rational considerations about the division of functions and competences between the center and a branch of the local government system. The demand for regionalization has to be related to the organization that benefits from such a policy and to its capacity to mobilize strength behind demands that further its organizational targets. We must distinguish between structure and function. The county councils have developed into full scale bureaucracies with independent needs for organizational survival and growth that may come into conflict with rational planning considerations about the provision of health care as such.

The county councils used to be rather small organizations, run by laymen and a small administrative body. The process of publicization of the provision of health services almost abolishing the private side has been accompanied by a process of bureaucratization in which the administrative body has expanded at the expense of the operative functions. As of to day the county councils comprise a sizeable administrative staff placed at various levels of the operations and the administrative component of the county councils have developed planning and coordination techniques of their own meaning that they can challange the overall national planning.

Two types of administrative staff may be identified within the county councils. On the one hand, there is the central administrative body close to the political machinery of the county councils. Data indicates that the size of this central administrative body has expanded more rapidly than overall operations. Table 7 presents information about this development

of bureaucratization distinguishing between the huge county council of Stockholm with its own accounting system and the remaining county councils.

Table 7 in here

The costs for the central administrative body has expanded relatively, from roughly 1.5% of the total cost to about 2.5% since the early sixties. Since the absolute increase in the overall operations of the county council amounts to more than a doubling six times - from 1.4 billion to almost 10 billion Swedish crowns - it is a question of a strong expansion of the administration. On the other hand, we must also take into account the administrative resources that are more closely connected with the on-going operations. Each hospital has an administrative body and there is a variety of administrative personnel in close contact with the various clinics. Table 8 shows the development of the various kinds of staff of the county councils including in the set of administrative staff the personnel at the central administrative body.

Table 8 in here

At the same time as the county councils have developed into a major regional employer - from 154 000 full time jobs in 1974 to 227 000 full time jobs in 1981 - it is also the case that the administrative component has expanded relatively speaking. In 1974 it constituted about 8% whereas in 1981 it made up 9% of full time jobs (except the county council of Stockholm).

The combination of a process of publicization - the public or the budget driving out the private or the market - and a process of bureaucratization - the administrative component expanding at the expense of the operative functions - means that the county councils have developed into huge organizations searching for protection against uncertainties and identifying secure functions. Given a large planning bureau within the county council it is little wonder that these organizations claim more power. But is the logic of the provision of health care as a good or service in harmony with the organizational interests of the county councils?

NATIONAL VERSUS LOCAL GOODS

Any discussion about the proper relationship between the state and the county councils in relation to the provision of health services must consider the nature of the good or utility itself. The theory of fiscal federalism implies that local goods should be provided by local governments, but how about health services? Can we describe health care in its various forms as a local or regional public good meaning that it is characterized by

jointness that tapers off as one moves away from the local or regional center? Or is there a set of externalities involved that may be internalized by the local community? What is at stake here is not whether health care is to be interpreted as a local or regional good as it were but whether it is not a national good. Allowing for the theory that health services do involve enough of jointness and externality in order to motivate a public provision it is still far from obvious that it is enough of a local or regional good in order to warrant the sole reliance on county council supply. There are two different things involved here, one concerning the interpretation of health care as a type of good in a public finance framework, whereas the other refers to the division of competence between the state and the county councils. The first problem may have a solution that is not in agreement with a division of functions between the two organizations that is the outcome of their organizational strength.

The characterization of health care as more of a national good than a local good may run against the power trend of regionalization. Consider a simple 2x2 Table combining the goods distinction with the organizational distinction:

	NATIONAL GOOD	LOCAL GOOD
STATE	I	II
COUNTY COUNCILS	III	IV

Both systems considered here, the 1962 system and the 1982 system, involved a combination of roles of the state and the county council. In the 1962 system the state was very much involved in running the operations of the county councils which is different in the 1982 system where the role of the state has shrunk to that of the guardian of overall objectives. Are we to conclude that this decentralization process is based on a more clear recognition of the nature of health care as a regional or local good?

TECHNOLOGY OF HEALTH CARE SYSTEMS

A public health care system involves a number of organizations and clients. It seems very difficult to derive any simple solution to the structuring of the system given so many demands to be recognized. Consider the Swedish health care system on a unit level. The system consists of a large number of hospitals organized in terms of the county council system. The hospital system involves three layers: regional hospitals (N= 8), county hospitals (N= 26), local hospitals (N= 89) and mental hospitals (N= 19) as well as long-term treatment institutions (N= 247). The number of private hospital institutions is 207 as these units are typically very small. Besides there is a rapidly developing system of community health clinics constituting the so-called

primary care. Who is to decide about the size and orientation of these units?

If health care was only a matter for a regional group of citizens then everything could be left with the county councils. However, this is not the case. The provision of health care concerns more people than those that happen to live in a certain area at a particular time. The citizens may find it difficult to accept that moving to a new county may mean a very different kind of health care - thus there is a demand for standardization. Moreover, there is also an externality involved meaning that it is in the interest of all citizens that people in various areas are provided a basic health care. The emphasis on equality becomes even stronger when one considers the costs for regional health care provision. However strong the demand for a regionalization of the health care provision may be it is also the case that it is not considered acceptable that citizens in various regions pay differently for such a basic welfare system due to circumstances that happen to pertain in a single region or county. Thus, the drive for state grants and state supervision of the quantity and quality of health care.

The strong national goods characteristics of the health care is at odds with the strong organizational emphasis upon the regional principals, the county councils. The inherent conflict between the type of goods involved and the organization structure becomes even more pronounced when one considers the logic of health care technology. The interpretation of health care as more of a national than a local public good is not stationary but is affected by the evolution of health care technologies. It is no exaggeration to claim that health care develops in a way that makes it less dependent on local resources. It becomes possible to treat more and more patient with ever more advanced technologies at shorter times of treatment meaning that the local supply of health care may involve serious inefficiencies. A local or regional provision of health may fail to ripe considerable scale economies. This works in two ways.

An allocation of the health care resources in terms of a national perspective will mean that it may prove advantageous from a technological point of view to concentrate some of the resources at certain places in order to make the specialization of health care economically feasible. This process works both within the regions and between the regions. It is no longer economically defensible to tie large amounts of resources in community hospitals when there is access to both county hospitals and regional hospitals. Actually, the needs of the patient may imply that it is not appropriate to treat certain types of deseases at community hospitals or even county hospitals when advanced treatment is available at the regional hospitals. However, it is far from obvious that the organizational structure emphasizing decentralization is accessible to such regionwide considerations. This is even more acute when it becomes necessary to plan the health resources in such a way that some resources have to be concentrated at some special regional hospital. How is this kind

of nationwide coordination to be become a possibility when the power of the center is weakened in terms of an extensive decentralization process?

Not only between county concentration may be hampered by the process of decentralization, but it is also likely that within county concentration meets with strong resistance that is more probably successful in a decentralized system. There will simply be too many other kinds of circumstances for the county council to take into account when allocating health care resources besides the logic health care technology and economy. In county council decision-making it has until now been the case that the major organizational units - the major hospitals - have proved strong enough to resist major structural innovations stemming from the need for new forms of health care. The traditional hospital based structure may resist the requirements for change based on considerations of between county as well as within county coordination. Thus, organizational structure may work against the needs of health care in relation to a rapidly developing health technology.

CONCLUSION: THE LOGIC OF HEALTH CARE PLANNING

If health care is to be provided by means of a public administration system, then the norm of rationality however weakly interpreted requires that the public body makes both supply and demand considerations. On the demand side the public body would wish to be informed about needs. Thus, it will:

(a) identify and catalogue the health conditions of the citizens

(b) create norms concerning the ends of the public supply, i.e. stating desirable outcomes

(c) calculate the technological implications of the objectives.

Moreover, the public body has to structure the output in terms of a refined program mix. Thus, it faces serious problems of considering an allocation of health care resources to:

(d) different geographical areas

(e) different kinds of treatment: preventive care, treatment, rehabilition and nursing

(f) primary care and hospital care

(g) various kinds of medical specialities.

These problems - (a) - (g) - are endemic to the public policy of health care. There is perhaps the even more difficult problem of arriving at an appropriate decision and implementation structure for the public administration of health care. What is the public body in the public administration system? The state, the

regional or local government or some other alternative. Recent trends emphasize decentralization to the local government system. However, the nature of health care provision may require more of the state than can be accomodated in a decentralized structure.

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Table 1. Health Care Consumption. (Current prices; million kronor)

	1970	1975	1981
Private consumption:			
total:	1 737	2 355	4 432
thereof: Drugs	485	625	1 095
Private phys.	100	153	287
Public consumption:			
total:	8 139	17 385	42 312
Subsidies to private physicians and pharmacies	690	2 299	4 297
Total private and public consumption	10 566	22 039	51 041
GNP	170 836	299 821	569 220

Source: National Accounts (Statistiska Meddelanden N, 1983:2.5. Appendix 1)

Table 2. Number of visits at doctors

Year	Public			Private	Total	
	At hospitals	Outside hospitals	Total		Public & Private	Per person
1960	5,6				15,3	2,0
1970	8,8	5,6	14,4	4,8	19,2	2,4
1973	9,3	6,3	15,7	4,3	20,0	2,5
1976	10,4	7,0	17,4	3,6	21,0	2,6
1977	10,7	7,4	18,1	3,4	21,5	2,6
1984	12,7	11,4	23,5	-	-	-

Table 3. Types of hospital care 1960–1977

Nursing places	1960	1970	1975	1977	1984
Somatic short term	50 300	49 400	47 100	46 300	46 100
Somatic long term	18 600	33 600	40 300	41 800	55 900
Psychiatric care	34 500	37 000	36 300	34 500	25 900
Total	103 400	120 000	123 700	122 600	127 900

Table 4. Total costs per capita of the set of socialist county councils (N=11) and of the set of non-socialist county councils (N=7) 1972-1981

	Socialist set				Non-socialist set			
	min	X	max	VC	min	X	max	VC
1972	1699	1887	2106	7.3	1462	1683	1908	9.3
1973	1859	2109	2411	9.2	1778	1943	2120	6.6
1974	2281	2520	2753	6.9	2154	2382	2676	8.9
1975	2778	3105	3367	6.9	2661	2983	3417	9.6
1976	3470	3859	4288	7.5	3266	3723	4200	8.4
1977	4304	4810	5455	7.9	4039	4581	5171	8.4
1978	5002	5705	6650	8.7	4736	5247	5948	7.7
1979	5697	6573	7664	9.0	5441	5936	6490	5.9
1980	6548	7396	8671	8.3	6311	6755	7270	5.3
1981	7656	8423	9972	8.4	7284	7664	8107	4.2

Source: Kommunernas finanser 1972-1981.

Table 5. Pooled regression analysis of county council budget-making 1974-1981. (N=176)

Variables	Significance	Beta
Taxation capacity	.000	.59
Proportion of elderly	.000	.39
Area	.000	.34
Density of population	.042	.14
Constant	.000	

Table 6. Cross-sectional regression analysis of county council budgets (N=22)

1973:

Variable	Significance	Beta
Area	.010	.53
Taxation capacity	.124	.30
Constant	.344	

R^2 = .35 (Adj. R^2 = .28)

1976:

Variable	Significance	Beta
Area	.023	.49
Taxation capacity	.647	.09
Constant	.061	

R^2 = .25 (Adj. R^2 = .17)

1979:

Variable	Significance	Beta
Proportion of socialist votes	.006	.58
Density of population 1975	.164	-.28
Constant	.000	

R^2 = .34 (Adj. R^2 = .27)

1981:A

Variable	Significance	Beta
Area	.000	.76
Proportion of elderly	.139	.24
Constant	.000	

R^2 = .50 (Adj. R^2 = .47)

1981:B

Variable	Significance	Beta
Proportion of socialist votes	.005	.57
Density of population	.060	-.35
Constant	.000	

R^2 = .39 (Adj. R^2 = .33)

Table 7a.Average total costs and administrative costs per capita 1950-1982 (In 1983 prices)

All county councils except Stockholm

		1950	1954	1958	1962	1966	1970	1974	1978	1982
(1)	Total	582	817	1 060	1 452	2 373	3 870	6 008	9 038	9 853
(2)	Central administration	9	15	15	22	51	97	147	220	252
	(2) in percentage of (1)	1.57	1.78	1.37	1.52	2.16	2.50	2.43	2.42	2.54

Table 7b. Total costs and administrative costs per capita 1950-1982 of the Stockholm county council (In 1983 prices)

		1950	1954	1958	1962	1966	1970	1974	1978	1982
(1)	Total	658	912	1 370	1 738	2 742	3 841	7 442	10 004	11 817
(2)	Central administration	16	35	19	34	112	190	470	674	304
	(2) in percentage of (1)	2.43	3.84	1.39	1.96	4.08	4.95	6.32	6.74	2.57

Source: Kommunernas finanser 1950-1982.

Table 8a. Average total number of full time employees and administrative staff 1973-1983 (All county councils except Stockholm).

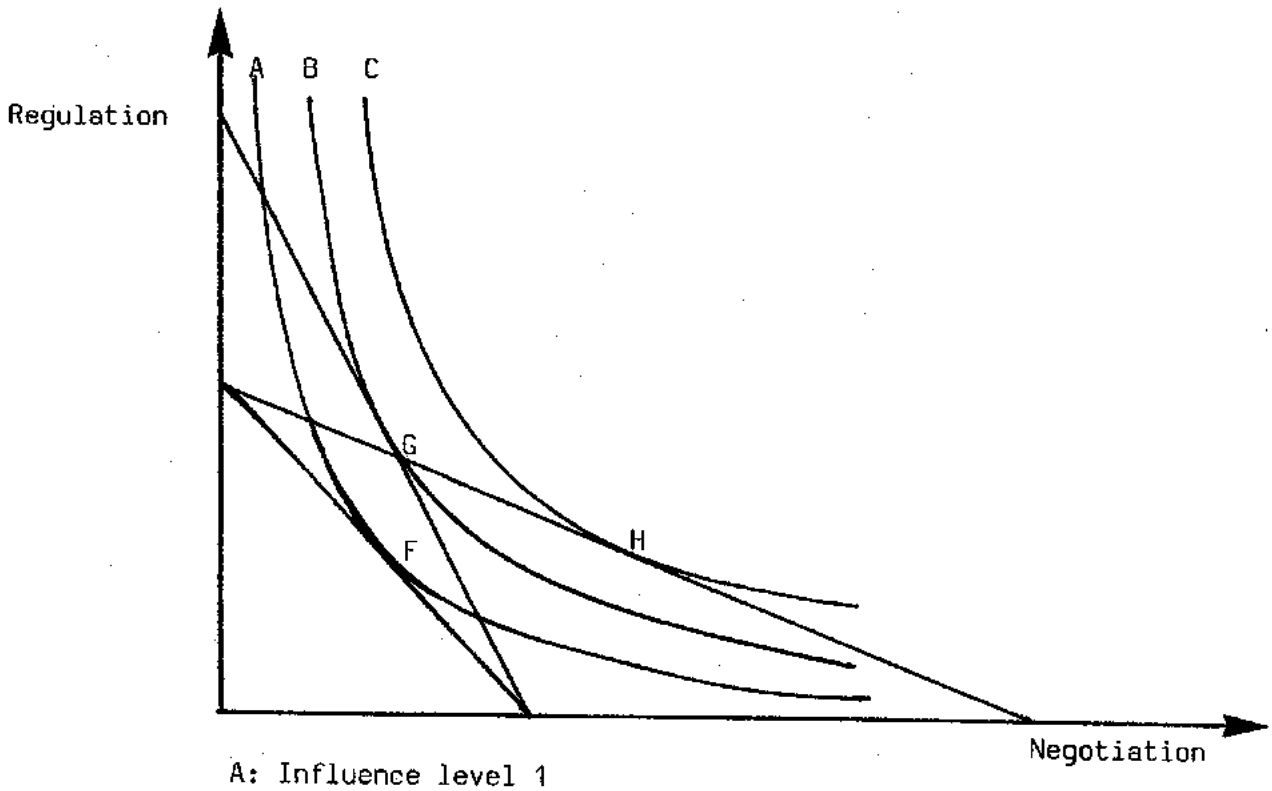
		1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983
(1)	Total	6 567	6 988	7 189	7 799	8 259	8 957	9 447	9 933	10 332	10 504	10 888
(2)	Administrative staff	534	569	591	659	711	783	839	878	907	925	962
	(2) in percentage of (1)	8.05	8.07	8.14	8.36	8.56	8.69	8.84	8.77	8.74	8.76	8.78

Table 8b. Total number of full time employees and administrative staff 1973-1983 of the Stockholm county council

		1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983
(1)	Total	34 750	39 168	40 568	42 605	44 653	48 380	51 211	52 931	56 380	63 470	64 937
(2)	Administrative staff	4 079	5 019	4 693	5 012	5 320	5 559	5 961	6 086	6 221	7 204	7 537
	(2) in percentage of (1)	11.74	12.81	11.57	11.76	11.91	11.49	11.64	11.50	11.03	11.35	11.61

Source: Landstingsanställd personal 1973-1983, Landstingsförbundet

Diagram 1. Center Influence Levels



A: Influence level 1

B: Influence level 2

C: Influence level 3

The politics of health reformism: the establishment of the Italian SSN in a comparative perspective.

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Summary

Introduction

According to the historical tradition of Western European continental countries, until the second half of the 1970s Italy's health system followed the tracks of the social insurance model, i.e. a model based on a multiplicity of occupational schemes administered by relatively autonomous quasi-governmental funds (casse mutue). As a result of numerous coverage extensions, three main types of insurance schemes had emerged: a general scheme insuring all employees of the private sector and their dependents (since 1943); a number of special schemes for public employees, for the self-employed and for particular occupational categories (partly founded between the wars and partly during the 1950s and 1960s); a special scheme insuring against tuberculosis (since 1921). These schemes provided cash benefits and direct health care by means of contracts with doctors, hospitals, pharmacies etc. Regulations were varied, both in terms of the range of offered benefits and in terms of their level/quality(1)

In 1978 a sweeping reform led to the establishment of the Servizio Sanitario Nazionale (SSN), i.e. a single unitary scheme covering all citizens and replacing all previous schemes (except for the tuberculosis scheme). The SSN has taken over the provision of all benefits in kind, which are offered free of charge (or with a small fee) to all citizens; all special regulations have been abolished. The 1978 reform also brought profound changes in the financing and overall administration of the public health sector,

suppressing all the casse mutue and conferring extensive organizational powers to the regions and local governments.

How did the health reform come about? What political dynamics could lead to an institutional innovation of such a vast scope? There is little need to underline the importance of these questions. With rare exceptions (typically the British reforms of the late 1940s and, to a lesser extent, the restructuring of the Scandinavian welfare states during the 1950s and 1960s) welfare reformism has tended to proceed in all countries at low speed, in a process of slow incremental adjustments highly constrained by the pressure of countervailing forces -and this seems especially true for the health field, which is characterized by a dense constellation of actors with diverging interests. Institutional incrementalism has in fact been the prevailing mode of change in other sectors of the Italian welfare state. The 1978 reform thus constitutes an interesting departure from national as well as international styles of social policy development.

The aim of this paper is to cast some light on the political syndrome which brought to this departure, in a comparative perspective. The first section will identify the constellation of actors which are most likely to influence the politics of health reformism in developed welfare states and will then sketch a brief profile of the interactions among these actors in a number of countries, in order to offer a minimum of comparative background (both analytical and substantive) for a closer inspection of the Italian case. The second sec-

tion reconstructs the politics of Italian health policy since World War II, describing the emergence and consolidation of the reformist coalition and its struggle against the counter-reformist front, until the final victory of 1978. The third section sketches an overall profile of the Italian experience, raising some general questions of a comparative nature.

The comparative background

Health systems are dense and complex arenas, comprising many different actors located on different "discs" (1). In recent years a growing body of literature has started to explore the intricate interactions which take place in this arena, with a view to identifying those tensions and alliances which have accompanied major "reforms" of the past, i.e. those broad institutional changes which have substantially modified the "rules of the game" in the arena, normally extending the scope of public regulation over the sway of market actors and forces (3). On the basis of this literature (but with no ambition at systematic generalisation) it seems reasonable to say that health reformism can be adequately analysed in terms of the power relationships among the following actors: political parties (per se and as occupants of representative institutions); the medical profession; the bureaucratic apparatus, especially that segment which is responsible for health affairs; and

local jurisdictions -especially in those countries where they are conferred competence in the health field by the constitutional framework or the administrative tradition.

Left parties have everywhere tended to favour developments in an étatist direction, promoting the extension of compulsory insurance, strengthening public regulation and curbing medical autonomy, especially on economic grounds. Centre and conservative parties have on the contrary tended to be more cautious and sensitive to private interests: although they have also contributed in fact to the expansion of the public side of the system when holding office, they have been more respectful of liberal principles of professional autonomy and market choice. Jealous of its own *esprit de corps* and of its socio-economic status, the medical profession has generally defended the market orientation of the system (or at most public financing of private practice), from which it obviously draws conspicuous benefits. Bureaucrats have displayed more ambiguous interests: on the one hand, they have "naturally" tended to oppose any alteration of the hierarchical status quo and of administrative routines; on the other hand, they have occasionally manifested an interest in expanding their own resources and powers through an extention of public regulations and interventions. The centre-periphery relations may finally "disturb" the game of alliances of the previous actors and have normally influenced institutional outcomes in terms of centralization/decentralization.

This checklist of actors may certainly seem over-simplified if one is interested in explaining punctual decisions or

particular aspects of a given reform. However, an analysis of the power network among the mentioned actors can already tell us a great deal if the aim is simply to understand the features of the macro-institutional framework (the public/private mix and, subsidiarily, the centralized/decentralized structure) of the health system in a given country or at a given point in time.

The balance of powers among these actors has historically tended to display only slow and marginal alterations: as already said, institutional change has normally followed an incremental path of gradual adjustments largely reflecting oscillations in the distribution of power. The experience of the North European countries shows however that the balance may in some instances markedly shift in favour of a single actor (e.g. left parties holding office, promoters of a more or less radical "socialization" of medicine), thus originating pervasive institutional changes, such as the establishment of a national health service or the transformation of doctors into salaried employees.

Post-war Britain constitutes in this respect a paradigmatic example. The political syndrome which brought from the sickness insurance system introduced by Lloyd George in 1911 to the NHS can be summarized as follows: 1) the gradual weakening of the British Medical Association, largely hostile to the reform, but torn by internal strains and profoundly dissatisfied with respect to the existing system (particularly because of the contrasts with the friendly and other approved societies); 2) a strong labour party

(both at the electoral and at the parliamentary level), highly committed to welfare ideals (in a climate of intense, war-induced national solidarity) and backed by a strong union; 3) a "neutral" bureaucracy, relatively depoliticized but partly sensitive to union pressures; 4) weak local jurisdictions, whose involvement in health affairs was strongly opposed by the medical profession. As is seen, the emergence of favourable conditions to the establishment of the NHS can be attributed to the marked weakness of one of the relevant actors as much as to the particular strength of the other. The fourth condition largely explains the centralistic orientation of the original NHS, until its 1974 re-organization(4).

The "silent socialization" of the health system in Sweden originated from a somewhat different political constellation. In the aftermath of World War II the association of Swedish doctors was stronger and more cohesive than its British counterpart and was thus able to resist the first serious attack to professional self-government and private practice represented by the Höjer reform plan (5). During the 1950s and especially the 1960s the SMA underwent a process of internal division, due to the increasing aggressiveness of younger doctors. The reformist wave of the 1960s, which culminated in the Seven Crowns Reform of 1970 (almost completely "socializing" Swedish medicine) was however made possible by a sort of "iron alliance" between the other three actors: the socialdemocratic Minister of Social Affairs, the hospital authorities of the major municipalities and

the Federation of County Councils. The "debts" of the socialdemocratic government vis-à-vis its allies in the struggle to tame the medical profession were "paid" through a considerable expansion of resources for hospital care and extensive decentralization of the health jurisdiction to the counties(6).

If Britain and Sweden show how the balance of powers may in some cases shift in a direction favourable to "socialising" reforms, the United States constitute a typical counter-example. As is well known, democratic administrations have repeatedly tried after World War II to introduce compulsory health insurance, but all their attempts failed and the only significant innovations have been the (limited) programmes of Medicaid (for the poor) and Medicare (for the aged) in 1965: U.S. doctors have succeeded to transform their professional association (the AMA) into an organizationally cohesive and politically aggressive centre of power, even nurturing at its side a strong ally, i.e. the network of private insurance companies. The democratic party has always been in its turn much weaker and more permeable on the organizational level and much less committed to welfare objectives on the ideological level than European reformist parties. Finally the federative structure and the extreme fragmentation and overlap of local jurisdictions have considerable reduced the structural relevance of the other two actors, thus impairing the emergence of anything that could even vaguely resemble to a coalition for health reform(7).

In the countries of continental Europe, the equilibrium between the main actors of the health arena has tended to

be more stable and balanced, thus leaving little room for the introduction of grand reforms (or, in a negative direction, for the boycotting of a gradual but still increasing extension of the public hand). It is true that some countries have indeed displayed visible strains at certain points in time, resulting in a substantial alteration of the distribution of power: for instance the Debré reform of 1958 and the Social Security Reform of 1967 in France, which conspicuously curbed the traditional strength of the medical profession. But these have tended to be relatively isolated episodes, of a limited scope in comparison with North European reformism, which have not undermined the basis of the prevailing institutional framework. In other continental countries the political temperature of the arena has remained even more lukewarm, in a climate of general consensus which has tended to re-inforce the status quo (or at most to support its marginal adjustment). This seems for instance the case of Germany, where the institutional framework created at the end of Allied occupation has received high consensus on the side of all actors and the issue of "socialising" reforms has never really acquired a political saliency comparable to that of other countries, not even within the SPD(8).

The great continental exception is then represented by Italy. Although very brief and rough, this comparative survey suggests where one must look in order to find an explanation.

The politics of Italian health policy

The post-war history of Italian health policy, can be subdivided into three distinct phases(9)

The first phase started in 1948, with the new centrist coalition's rejection of a reform plan drawn by a Parliamentary Commission, reccomending a thorough re-structuration of the social security system, including the extension of health insurance to all workers, pensioners and dependents.(10) Following this choice for the maintenance of the status quo, during the 1950s the health sector developed in a fragmented and uncoordinated way, through the proliferation of separate funds (under strict DC control) for each pfofessional category. By the end of the 1950s, the casse mutue had become a major pillar of the Italian welfare state. The establishment of the Ministry of Health in 1958 did not substantially curb their powers (at least until the mid 1960s): as was said at the time, the real Minister was not the person sitting in the cabinet, but the president of INAM (the largest cassa, insuring all private employees). The doctors were the strongest allies of the DC and its policy, and actively participated in the system of public health insurance, although being in principle opposed to it. The government guarenteed to maintain their private professional status and lured them into acceptance by means of generous monetary and normative rewards. Placing reliance on the Catholic background and orientation of most doctors, the DC allowed them to share in the health spoils (posts on the health boards and other health agencies etc.). Doctors even acted often as patrons in the the vote relationship, especially in the South and countryside.

At this time the Left opposition was active but still quite uninfluential. In its 1956 Congress, the PCI demanded a thordugh reform of the health system which largely repeated the proposals of the 1948 parliamentary Commission. At the same time the PSI was gradually elaborating the idea of a national pension and health insurance. In 1957, the leftist union CGIL submitted a law proposal for the establishment of a national health service: the first to be presented to parliament. In 1959 CNEL (a composite organ which represented the views of the top levels of ministerial buresucracy and partly of the academic intelligentsia) timidly proposed the universal extension of hospital insurance, but immediately qualified this by warning of the financial burdens involved. The idea of a health reform was slowly, but tangibly gaining ground.

The birth of the Centre-Left in 1962 opened the second phase of the history of Italian public health. The theme of health reform occupied a top position in the first planning documents prepared by the Republican and Socialist parties. In 1963 CNEL publicised its plan for a reform of the social security system, which contained a fuller formulation of the 1959 proposal of a national hospital insurance, coupled with a comprehensive rationalisation of the health funds. From their now stronger position, the unions renewed their pressures on the government and in 1965 the PCI submitted its own reform proposal for a national health service to parliament. In the same year, parliament approved the first five year plan, prepared by the socialist Mi-

nister for the Budget, Giolitti and approved by the entire Centre-Left cabinet. The plan explicitly committed itself to the realization of a national health service and the socialist minister for Health, Mariotti, subsequently drafted a more concrete proposal. Conditions seemed to favour the establishment of a national health service; but this was not entirely the case.

The plan (especially in its health section) was the object of heated debate. The Republicans, the Bank of Italy and CNEL all expressed their serious misgivings as to the financial aspects of such a development. But it was the DC in particular that withheld support, under pressure from the health funds' bureaucracy, the doctors (and less overtly the entrepreneurs). Though not openly opposing the idea of a national health service, the DC tried to give a very restrictive interpretation to this notion, i.e. not as a national insurance system, broadly decentralised and replacing the health funds, but as a complement to them, in the form of a national agency with the task of prevention, coordination and sanitation controls. At most, the DC was prepared to accept a rationalization of public health insurance, by fusing the numerous existing funds in three larger health funds (supermutue), which covered private and public employees and the self-employed respectively. The attempt by the DC to guarantee the survival of the mutue was obvious. During the first half of the 1960s, the latter had in fact witnessed a gradual weakening of their powers, owing to the new political and institutional climate: as a member of the coalition, the PSI

was particularly influencial in the Ministry of Health; autonomous regions were particularly active in the health field and the coalition was committed to establishing ordinary regions, to which the Constitution entrusted jurisdiction over health policy. Acting through the DC, the health funds were thus strenuously fighting to regain and preserve their institutional and political strength, and fiercely opposed any reform plan which would entail a restriction of their competence, let alone their abolition. The doctors viewed the establishment of a national health service as a powerful threat to their professional autonomy and economic privileges. Though none of the reform plans (and certainly not the governmental one) envisaged the transformation of doctors into salaried employees, the medical associations denounced the "manoeuvre to nationalise the profession" and submitted a memorandum to CNEL in which they thoroughly criticised the Mariotti plan.

The opposition to the establishment of a national health service was then still quite strong and included (in addition to those forms of opposition already mentioned) the right-wing parties and the entrepreneurial associations (especially in the pharmaceutical industry).

If the reformist front was still too weak to impose the introduction of a national health service, it was however sufficiently strong to impose a hospital reform, which thoroughly revised in 1978 the institutional setting and the operating procedures of hospital care.(H) The interest constellation was in this sector quite different from that of ambulatory care. The state of the Italian hospital system had

been continually worsening during the 1960s as a result of the increasing demand for care. Still formally considered as charitable institutions enjoying relative autonomy, hospitals were run according to strict principles of medical hierarchy, with a fairly effective but increasingly rigid organizational performance. A thorough revision of their status had been proposed (together with universal coverage for this type of assistance) even by a "neutral" organization such as CNEL, and evidently some sort of change was also in the interests of counter-reformers.

For the health funds, in the first place. Their financial situation was deteriorating rapidly, largely due to increasing hospital costs (on which they had little control). Budget deficits had already reached worrying levels by 1965 (250 billion lire) and had increased to 500 billion in 1967. For the medical profession itself, in the second place: or better, for that segment of younger doctors which was rapidly growing due to the opening of medical schools. Younger doctors were developing a more modern and "socially oriented" outlook; but they were, above all, starting to resent the hierarchical status quo which did not grant them sufficient career prospects and not even security of job tenure. Unionization rates markedly increased within their ranks and pressures for a "democratization" of hospital structures rapidly mounted, producing growing strains within the medical component of the hospital sector(12)

The status quo coalition presented thus a much lower degree of cohesiveness in this sector: either because of the financial

weakness of one of its partners (the mutue themselves), which even made desirable an alteration of the institutional setting, or for the internal conflicts of another partner, i.e. the medical profession.

Given this situation, a concrete bargain could start on a reform in which all actors expected some gain. The left parties and the unions saw it as a first step after a series of long and frustrating debates and as an important improvement faute de mieux; they also hoped to gain new support from social strata which had traditionally been rather distant (such as doctors and paramedical staff). The health funds were badly in need of financial relief from their debts vis-à-vis the hospitals and were by this time prepared to accept a change in the situation. Doctors (and more generally health workers' unions) hoped to gain power and jobs. Provided that a few "vital" conditions were met (e.g. the protection of private and Catholic clinics) the DC was not opposed to a reform from which it hoped to draw fresh spoils to spend on the vote market. The electoral deadline completed th process and in February 1968 the law was passed to everybody's satisfaction. The "only small inconvenience of it" as an observer has subsequently put it, was that "hospital costs triple in only five years" (13).

The hospital reform marks the end of the second phase. The third is characterized by the entry of new and powerful actors: ordinary regions, whose councils were first elected by popular votes in 1970.

The birth of the regions greatly strengthened the constituency for the national health service. Immediately after

their establishment, the regions initiated a fight against the central administration in order to force it to accomplish the transfer of functions (first of all, health policy) foreseen by the Constitution. This transfer offered a unique institutional and political opportunity for a thorough reorganization of the health system, the abolition of the health funds and the establishment of a national health service. Not surprisingly, however, resistance to this idea was slow to wither away. The regional elections had revealed the much feared strength of the left in local government, which had resulted in the appearance of some "red regions". In this context, a health reform was not merely a matter of funds, doctors and costs: it was a political question of prime importance, involving the "gift" (or the "conquest") of substantial resources for the opposition.

Thus central government (but again especially the DC) attempted a last move in defence of the health funds (now experiencing critical financial difficulties, largely as a result of the regulations introduced in 1968!), with a plan to transfer hospital assistance to the regions, thus relieving the health funds of their most costly burden, while at the same time delaying the transfer of other type of assistance and postponing sine die the liquidation of the mutue. The plan was supported by the smaller centre parties, which were not particularly in favour of the health funds, but were at the same time concerned (and given subsequent events, not without reason) about the spending capacity of the regions.

Nevertheless the plan failed, due to the strength of the reformist front: The unions, regions, the left (especially t

the PCI) and the overall social and political temperature of the early 1970s together created such a pressure for reform that in 1974 a law was passed which contained extraordinary provisions to repay the hospital deficit, transfer jurisdiction on hospital assistance to the regions and (most disputed point) fix a deadline (June 1977) for the definitive liquidation of the health funds. This law was the result of one of the most heated parliamentary struggles of the whole history of the Italian welfare state.

Not long afterwards, the government itself submitted its own reform proposal for a national health service. The parliamentary proceedings lasted four years: not only because they were interrupted by the anticipated end of the legislature, but because at this point every actor was fighting to maximise gains. The PCI (which became a member of the majority coalition in 1976-without holding ministerial posts-and saw the national health service as a "socialist reform in a capitalist setting") pressed for the extension of decentralization and democratic (i.e. union/party) participation. The DC fought to limit the extent of the "nationalization of health" and to preserve the status of private clinics and institutions and the professional character of medical services (as well as the level of their fees). Only CNEL and the smaller centre parties (were among the few who) tried (and failed) to equip the reform with some adequate tools to stimulate and control economic and administrative efficiency. On December 1978, twenty-one years after the first reform proposals, with the support of all parties partaking in the

"national solidarity" coalition (extended to the PCI), the Italian parliament approved law no. 833, establishing the first national health service of continental Europe.

Conclusions

Although very sketchy, our reconstruction of the main phases of Italian health policy allows us to grasp at least *prima facie* the most salient traits of the political syndrome which originated the 1978 reform. These traits can summarized as follows:

1) the marked strengthening of the major party of the Italian Left, coupled with the profound social and cultural upheavals of the 1970s. The growth of the PCI and its quasi-inclusion in the governing majority greatly enhanced the reform potential not only because this party was ideologically committed to the SSN, but also because it had acquired a prime political interest in its implementation (with respect to other social reforms): the health reform transferred in fact substantial assets (but very limited liabilities!) to regional governments, and many of these were dominated by the PCI.

2) the gradual weakening and fragmentation of the medical profession. Starting from the mid-1950s, ambulatory physicians underwent a process of progressive "bureaucratization", subordinating themselves to the *mutue* system

(despite repeated lip service to the sacred principles of free medicine) in exchange of economic and normative incentives, but loosing any capacity of self-government and of professional assertiveness (e.g. in matters regarding the organization of service delivery and the direction of medical training). The crumble of the traditional hierarchical structure within the hospital sector and the mobilization of younger doctors destabilized in its turn the other relevant component of the profession. Bureaucratized and fragmented, Italian doctors could only serve as "stone guests" in the public debate which accompanied the reformist wave of the 1970s and practically delegated to the Catholic party (as already in the past) the task of defining and defending their interests;

3) the organizational, but especially financial disarray of the health bureaucracy, which gradually eroded the credibility (and even the sheer viability) of the *mutue* and their veto/pressure powers.

4) the establishment of ordinary regions. This was the last but probably decisive drop: in fact it offered the institutional opportunity (or even stronger, it set an institutional obligation) for a broad structural re-organization, it raised the stakes of all actors (providing new stimula especially to political parties) and finally originated a "horizontal alliance" (periphery vs centre) which cut across and thus weakened further the "vertical" counter-reformist alliance.

Our reconstruction is too superficial and the comparative evidence is still too scant (at least regarding other continental countries) for us to venture into a close comparison between the Italian experience and that of other countries. With respect to the British and Swedish "paths" to a national health service there are prima facie both remarkable elements of affinity (e.g. the weakness of the medical profession and the role of local jurisdictions) and remarkable elements of diversity (the extreme disarray of the health bureaucracy and their "iron alliance" with the counter-reformist party; the presence of both a Catholic and a Communist party). Only future, more detailed research will be able to assess more carefully the weight and relevance of all these elements, with respect to both the pre-conditions and the institutional outcomes of the reform.

If it seems too early to suggest comparative assessments, it may be worthwhile to conclude by pointing out some first indications as to the focus of further comparative exploration. The immediate temptation would be to compare Italy with countries such as Britain and Sweden, given the similarity of the terminus ad quem. If the aim is however to arrive at a comparative explanation of the emergence of the health service, rather than its performance or its prospects, it seems certainly more useful to contrast the Italian case with other continental cases, thus maximising the affinity of the terminus a quo. In particular a close comparison between Italy and Germany might lead -we believe- to interesting results, since the two countries built during the 1950s a fairly similar system, grounded on an administrative background which had in both cases been heavily moulded by an authoritarian regime. Which factors are responsible for the divergence of the two countries during the 1960s and 1970s? How could the German system consolidate and prosper, combining (rather successfully, it would seem) professional autonomy, financial and administrative viability, relative high standard of performance in a context of growing "publicisation" of health? What specific factors account for the gradual erosion of the Italian building, especially its medical and bureaucratic pillars? These are crucial questions, which should receive high priority in the comparative analysis of European health policies.

Footnotes

1) For a more detailed illustration of the Italian health system and more generally of the Italian welfare state see M.Ferrera, Il welfare state in Italia, Bologna, Il Mulino, 1984.

2) In describing the evolution of the Swedish health system Heidenheimer has identified (with a Dantean expression) three "discs, intersecting on a common hinge, each of which supports a distinct set of structures": the political administrative disc; the professional education and status disc; the health care delivery disc". This distinction can probably be extended to any developed health system. Cf. A.J.Heidenheimer, "Conflict and Compromise between Professional and Bureaucratic Health Interests 1947-1972", in A.J.Heidenheimer and N.Elvander, The Shaping of the Swedish Health System, London, Croom Helm, 1980, pp.119-141.

3) It would be impossible to offer here a representative bibliography of this growing research field. Among the most interesting contributions, we may mention at least R.R.Alford, Health Care Politics. Ideological and Interest Group Barries to Reform, Chicago, University of Chicago Press; C.Altenstetter, Health Policy-Making and Administration in West Germany and the United States, Beverly Hills, Sage, 1974; R.H.Elling, Cross-National Study of Health Systems. Political Economies and Health Care; W.A.Glaser, Health Insurance Bargaining. Foreign Lessons for Americans, New York, Gardner Press, 1978; A.J. Heidenheimer, "The Politics of Public Education, Health and Welfare in the USA and Western Europe: How Growth and Reform Potentials Have Differed", in British Journal of Political Science, 3, 1973, pp.315-341; D.Stone, The Limits of Professional Power, Chicago, University of Chicago Press, 1980.

4) On the emergence of the British NHS see especially J.Brand, Doctors and the State: the British Medical Profession and government action in public health, Baltimore, The Johns Hopkins Press, 1980; R.Klein, The Politics of the NHS, London, Longman, 1983; R.Levitt, The Reorganised NHS, London, Croom Helm, 1979; M.Navarro, Class Struggle, the State and Medicine, London, Robertson, 1978; B. Watkin, The NHS: the First Phase, 1948-1974, London, Allen & Unwin, 1979.

5) The proposals launched by the Commission chaired by the director of the Board of Health Axel Höjer reccomended a broad re-organisation of the Swedish health system, through a wide delegation of responsibilities to the counties, an increase of the number of district physicians and establishing a fixed schedule for doctors's fees. See U.Serner, "Swedish Health Legislation: Milestones in Reorganization since 1945", in A.J.Heidenheimer and N.Elvander, op.cit., pp.99-117.

6) On Sweden see especially the various contributions collected in A.J.Heidenheimer and N.Elvander, op.cit.

7) On the US health system, see especially B.&J. Ehrenreich, eds., The American Health Empire: Power, Profits and Politics, New York, Vintage Books, 1970; J.G.Freyman, The American Health Care System: its Genesis and Trajectory, Huntington, Krieger, 1977; Marmor, The Politics of Medical Care, Chicago, Aldine, 1973; P.Starr, The Social Transformation of American Medicine, New York, Basic Books, 1982.

8) On France, see V.G.Rodwin, "Management without objectives: the French Health Policy Gamble", in G.Mclachlan and A. Maynard (eds.), The Public/Private Mix for Health, London, Nuffield Provincial Hospital Trust, 1982, pp.289-325. On Germany, see especially C.Altenstetter, op.cit.; H.M. Leichter, A Comparative Approach to Policy Analysis. Health Care Policy in Four Nations, Cambridge, Cambridge University Press, 1979.

9) Historical and sociological studies on the evolution of the Italian health system are not numerous. See Berlinguer, Medicina e Politica, Bari, De Donato, 1973 and Una riforma per la salute, Bari, De Donato, 1979; S. Caruso, Il Medico della Corporazione, Milano, Feltrinelli, 1977; S.Delogu, Sanità pubblica, sicurezza sociale e programmazione economica, Torino, Einaudi, 1967 and La salute dietro l'angolo, Roma, Napoleoni, 1978;

D.Francescone, Lavoratori e organizzazione sanitaria, Bari, De Donato, 1978; G.Freddi, 'Conclusioni: il SSN come sistema politico-amministrativo', in G.Freddi, ed., Rapporto Perkoff: salute e organizzazione nel SSN, Bologna, Il Mulino, 1984, pp.213-291; S.Paderni, Il processo di decisione in sanità a livello di macrosistema, Roma SCPS, 1981; A.Pizzorno, "Medici e Stato in Italia", in PP.Donati, La sociologia sanitaria, Milano, Angeli, 1983,pp.141-163 and "La politica sanitaria", in U.Ascoli, ed., Welfare State all'italiana, Bari, Laterza, 1984, pp.153-184.

10) In the Spring 1947 a Parliamentary Commission was set up, chaired by the socialist senator D'Aragona, to examine in detailed the problems of the Italian social security system. A year later, the Commission submitted its proposals for a thorough restructuring of the system. The main points of the proposals were: 1) institutional simplification and centralization, according to a one-risk/one-scheme approach; 2) extension of coverage to all employees and self-employed for health care, old age, invalidity and accident insurance and to all employees for unemployment insurance, sickness and family cash benefits; 3) introduction of a single scheme for old age pensions; 4) introduction of earnings-related benefits. The Commission's proposals were nto a Beveridge plan; nevertheless their approach was markedly innovative and inspired by principles of equity and efficiency. The change in political climate resulting from the 1948 elections and the deterioration of the economic situation prevented these proposals from materializing.

11) The hospital reform law included the following provisions: change in the legal status of public hospitals, with heavier state regulation; standardization and regulation of the administrative and organizational structure of public hospitals; introduction of hospital planning; introduction of new financing regulations: hospital must charge all patients a fee equal to the total operating costs divided by the number of beds; establishment of a state-financed National Hospital Fund to cover hospital deficits and promote hospital modernization.

12) For a more detailed treatment of this point, see G. Freddi, op.cit.

13) M.Salvati, Alle origini dell'inflazione italiana, Bologna, Il Mulino, 1981, p. 110.

THE POLITICS OF HOSPITAL PRODUCTIVITY

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Copenhagen

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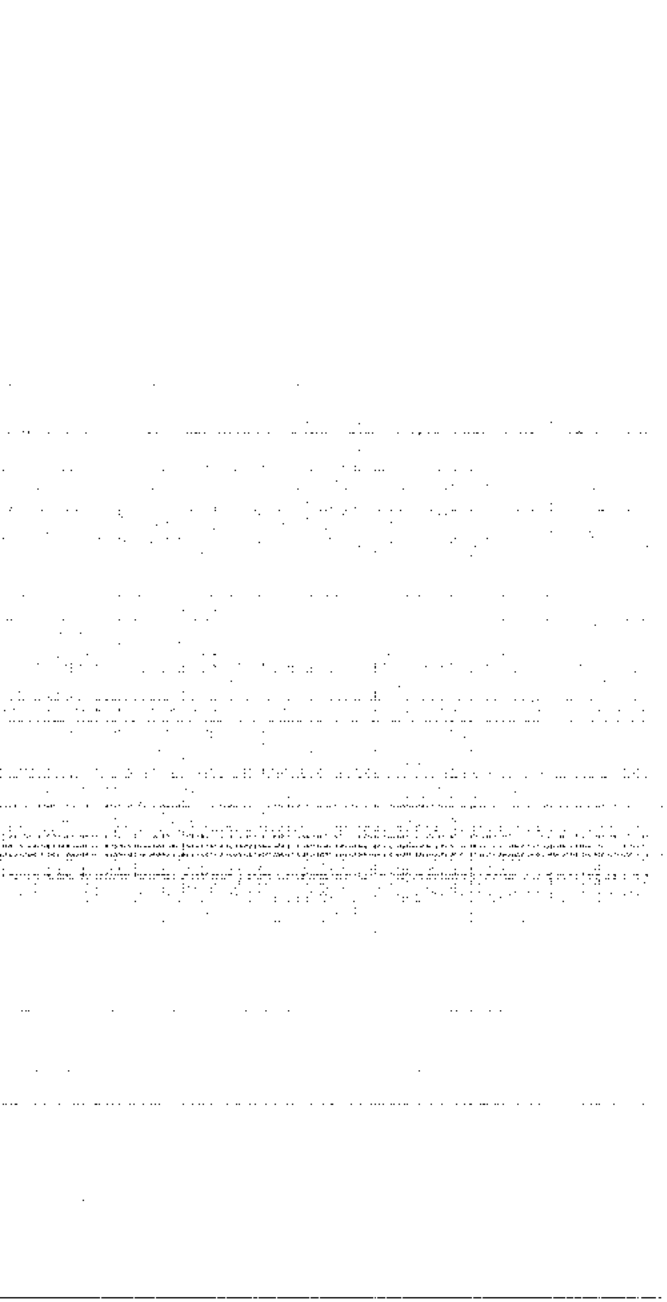


1. The Taboo of Public Sector Productivity

Are public employees as efficient as ten or fifteen years ago? An odd and ill-placed question perhaps. But consider for a while the constant and rapid rise in public sector employment. Consider then the varying, but year after year increasing manpower productivity in the private sector.

Questions like this a few years ago puzzled a Danish economist. He was fully aware of the growth rates for public sector employment. He only added the question whether output had increased at the same rate as input. Sector by sector he therefore defined a set of crude output measures. They were confronted with figures for the number of full-time employees within the relevant parts of the public sector.

His conclusions were striking. In most cases input in terms of manpower had grown at a higher rate than output. So, according to traditional economic concepts, productivity had decreased. This conclusion was even more striking because from 1966 to 1977, manpower productivity had been dramatically increased in the private sector. In industrial production the average rate of productivity growth had been 5.5 per cent per year. In farming the rate was 6.7 per cent, and private service provision had on the average increased its manpower productivity with 2.5 per cent (Nordstrand, 1981).

Naturally, there were reservations to be taken in that kind of an analysis. Could output, e.g. be measured in the crude terms proposed? And what about output quality? Would it not be plausible to explain the apparent fall in public sector productivity with an equivalent rise in the quality of its output? These and other - relevant - reservations were extensively discussed. They were neither overlooked nor discarded. The pertinent question raised against them was only whether these reservations had enough weight to ignore that the Danish public sector might have got a problem of productivity.

The economist responsible for the study was working for a research institute which gets its funds from the powerful organizations representing the interests of municipalities and counties. Here the conclusions were not well received, and as a matter of fact the institute was either not allowed to or anticipated the negative reaction to publishing the report. The point of view was that the report would be misunderstood and abused by journalists and politicians. Further, it was claimed that an economist lacking an insider's knowledge to the specific policy areas which were under scrutiny in the report would not be able to grasp the special conditions characteristic of each policy.

In spite of all these warnings Rolf Nordstrand, who had written the report, decided to have it published. His general point of view was that readers would be able to recognize the reservations towards conclusions drawn from simple arithmetics where two figures are divided with each other. As his own institute did not find it opportune to publish it, it was published by the economic institute at the University of Copenhagen.

The event is mentioned in this context for two reasons. First, it shows the sensitive nature of the question of public sector productivity. Until now, it has not been accepted that there might be a problem, and that it might be possible to base a discussion of this problem on an empirical analysis. Second, the problem of public sector productivity has been neglected by the social sciences. Both economics and political science show a growing interest in the public sector. But their interest has generally focussed on other issues. There has been, at least, a tacit recognition of the many reservations made against productivity measurements in the public sector. In this way economists and political scientists have unconsciously contributed to the taboo-like status of the whole issue. This paper sets out to challenge this traditional view. To give substance to our argumentation, we will present a case-study of productivity in Danish hospitals.

2. Health Care in the Social Sciences

2.1. Health Care Economics

The problem is not that economists have paid no interest to health care policy. Exactly the opposite is true. A growing number of studies focus on the economics of health care policy. Typical fields of interest have for years been the private-public mix in health care policy (e.g. Maclachlan & Maynard 1982), the implications of different health care schemes for social equality (Le Grand, 1982), the economic implications of the introduction of more and more advanced technology in modern health care (Aaron & Schwartz, 1984), or the demand for health care in the population (Krogsgaard Jensen, 1985).

Economists have also paid interest to the problems of effectiveness and efficiency in health care. But here the problems begin. There are a lot of studies focusing on the costs and benefits in health care. In most cases, however, it is theoretical studies. They discuss at great length what constitutes the benefits of health care. The conclusion logically is that there are a lot of methodological difficulties connected with the construction of quantitative measures for the benefits of health care. For this reason, cost-benefit studies never come to any conclusions as to the balance between the costs and benefits (Neuhausen, 1977; Abt, 1977; Pliskin & Taylor, 1977).

The difficulty in measuring the benefits of health care does not by itself invalidate attempts to analyze the productivity of health care personnel, e.g. the productivity of doctors and nurses. The definition of appropriate output measures may be difficult. Still, the definition of output measures does not imply the economist to take a position on the benefits patients derive from a given type of output or a given volume of output. The output measures used in the analysis of e.g. hospital productivity must only be

operational measures of those services which are directly provided to patients. When economists do not go into that kind of analysis, a decisive reason may be that traditionally they have not recognized the existence of any problems of productivity in the public sector. In national account statistics, e.g., the value of public services is defined as identical with the costs of production. Further, macro-economic models used in economic planning base their prognoses of future economic growth on assumptions as to the change in productivity within the private sector. For the public sector no such assumptions are made on manpower productivity. Public sector productivity, until now, has not attracted any interest among economists, a conclusion which is also valid for economic studies of health care economics.

2.2. Policy Studies of Health

Among political scientists there have also been a growing interest in health care policy. There are, of course, a bulk of case studies analyzing national systems of health care provision, be it the semi-public, semi-private American system, or be it public systems as the British National Health Service.

Political scientists have in their studies concentrated on the autonomy of the health sector and especially on the role of the medical profession. This is also true for the bulk of comparative studies published during the latest decade. In these, different systems are compared; differences in structure, financial systems, coverage and costs are pointed out and attempts are made to explain why the costs of running very different health care systems have constantly increased in spite of these differences and apparently in spite of any initiative to stop further uncontrolled growth through structural reforms. (See e.g. Klein, 1983; Leichter, 1979; Heclo, Heidenheimer & Adams, 1984).

Like economists, however, political scientists have ignored the problems of efficiency. Manpower productivity in hospitals and generally in health care has been accepted as a non-issue.

2.3. Propositions

The narrow approach to health care policy has severe implications. If, at all, social scientists ask what people get for their money in hospitals, they deal with the problem in extremely abstract terms. There may be a lot of problems connected with an empirical analysis of economic performance of hospitals. As long as economists and policy analysts with a background in political science totally ignore the whole problem of economic performance in hospitals, they legitimize the view that it would not be possible to make any valid estimates of productivity in the public sector. Our propositions are: 1) that

under some well-specified restrictions it will be defensible to give approximate measures of hospital productivity; 2) that the methodological restrictions on the use of these measures are of exactly the same nature as productivity measurement in private enterprises, and 3) that strong professional groups have a political stake in arguing that it is not possible to make valid and reliable analysis of productivity within the public sector.

In section 3, we shall discuss how to measure manpower productivity in hospitals and the problems connected with the use of these measures. In section 4, these methods will be used in a casestudy of productivity in Danish somatic hospitals. This analysis of the development in hospital productivity is followed (section 5) by a general discussion of factors influecing productivity and explaining variations over time and between individual hospitals. The results presented in section 4 were presented in the report prepared by a government committee set up to investigate productivity in Danish hospitals* (Organization and Economy in Hospitals, 1984). When this committee was set up by the Minister of the Interior, who is responsible for health care policy, it aroused strong protests from especially The Danish Association of Medical Doctors. The negative reaction was even stronger when the committee's report was published last autumn. These reactions are the empirical basis for a discussion of some typical arguments used against productivity analyses in the public sector (section 6).

3. Measuring Productivity in Hospitals

The constant growth in hospitals expenditure raise two questions concerning the ability of hospitals to apply their economic (and personnel) resources in a satisfactory way. One question is whether patients receive services which are satisfactory to them in terms of quality and volume. Technically speaking, this is the question of effectiveness. The other question is whether there is a satisfactory connection between the input of economic resources in hospitals and patient-related activities in these hospitals. This is the question of efficiency, or as we prefer to phrase it, the question of productivity.

Both questions are of considerable societal relevance. It is also true that it is difficult to give reasonable answers to both types of questions. The former question presupposes both a valid measurement of the effect of the services which are provided by hospitals to their patients and the existence of precise and unequivocal goals for their activities. These conditions raise a lot of serious methodological problems of a nature which have not allowed economists to treat the balance between costs and benefits of

*Jørgen Grønnegård Christensen was chairman of the committee. Lars Nørby Johansen was member of its secretariat.

health care policy as more than a topic of theoretical interest. The latter question also raise severe problems. In this case, however, they are limited to a discussion of the possibility of defining valid and reliable measures of hospital costs and of the patient-related activities of hospitals. In neither case, the difficulties of an operationalization should be underestimated.

On the input-side these difficulties are of a purely technical nature. They present few problems for an empirical analysis. In our analysis, a distinction is made between three types of resources:

1) Financial resources as defined by total operational costs as shown in the annual accounts. Budget figures are ignored as unreliable measures of actual costs.

2) Manpower resources as defined by the number of full-time employees in hospitals. These figures are based on the annual statistical reports of the national health authorities. Hospital employees are for our purpose divided into three subcategories, viz. doctors, nurses, and a residual category comprising the numerous other, but comparatively small professional groups employed on modern hospitals.

3) Physical capacity as defined by the number of beds. The number of beds is a rather imprecise indicator of a hospital's treatment capacity. As an indicator of the amount of capital bound in a hospital, it gives, however, an idea of the outer framework of the services provided by the hospital. With the increased application of new diagnostic and treatment methods which allow hospitals to avoid hospitalization of patients it is not a very good indicator of total capacity. In this context, it should, however, be remembered that the gradual change in medical methods places most of the burden of adaptation on bed capacity. In productivity analyses, it will, therefore, be of interest to focus upon a hospital's ability to adapt to changes in the need for hospital beds.

On the output side problems are considerable. Which activities should be considered as the most appropriate output measures? Ideally, the output measures chosen for the analysis of hospital productivity should satisfy two criteria. One of these criteria concern the effect of medical treatment on patients. The second criterion is the linkage between patient related activities and the pull of these activities on different types of hospital resources. A measure meeting both of these criteria is the number of patients which has gone through a finished period of medical treatment on the hospital. The problem with this measure is, that it is practically impossible to tell when a specific period of medical treatment starts and when the treatment is definitely closed. Many

patients who have been treated for a suffering at one time will later return to the hospital to be treated for the same suffering again.

To avoid arbitrary distinctions of this kind, we are forced to use more simple measures. Official medical statistics include information on the number of in-patients, the number of out-patients, and for in-patients, information on the number of beddays produced by the hospital. For these three measures it is, furthermore, possible to break down the information on the level of specialized units in each hospital, e.g. gynaecology and obstetrics within the field of surgery and gastroenterology within the field of medical treatment. These crude measures of activity tell nothing about effects on patients, let alone the benefits of the treatment. But how crude the measures may be, they meet the latter criterion: The use of all types of hospital resources vary with both the number of in-patients and the number of beddays as well as with the number of out-patients. So, for many analytic purposes, it is defensible to claim that they are valid indicators of the pull on the resources of a hospital.

New problems arise when input has to be linked with output. Most of these problems follow from the comparatively old-fashioned and unsophisticated management systems used in Danish hospitals. First, it is not possible to break down operational costs on the specialized departmental units which are the basic functional unit in Danish hospitals. It is only possible to get information on financial costs at the level of the hospital as a whole. Second, specialized departmental units integrate the treatment of both in-patients and out-patients; it is the same doctors and in most cases the same nurses, who take care of both types of patients. Third, the management systems in use do not permit separation of costs connected with in-patient treatment and out-patient treatment.

The implications are severe for the definition of valid productivity measures, and we have to admit that the measures used here are open to criticism. However, we will argue that under some explicit restrictions they are valid and reliable measures of hospital productivity. As is seen from fig. 1, we propose to use three different measures of productivity:

1) General productivity, i.e. patient related costs
2) Manpower productivity, i.e. output per doctor, nurse etc.
3) Exploitation of bed capacity

The restrictions related to the application of the proposed measures of productivity should not be reduced to a matter of statistical technicalities. They follow primarily from the fact that hospitals belong to the most complex organizations of modern society. Both the "production process" in a hospital and hospitals' output are very complex; they

Fig. 1. Measuring Productivity in Hospitals

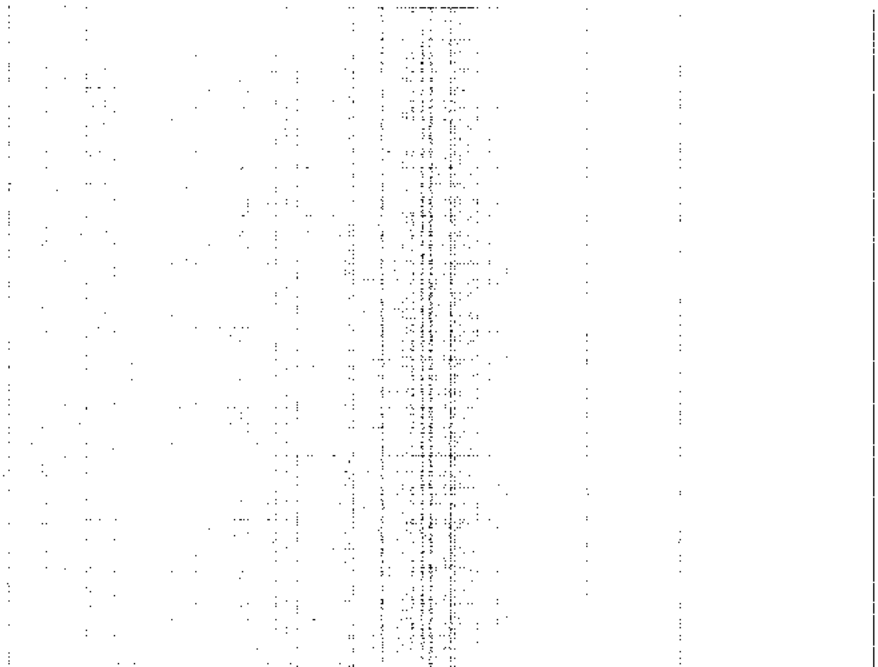
Input	Output	Productivity Measures	Restrictions
1° Financial resources: Operational costs as shown in official accounts	1° Number of in-patients	1° Operational costs per in-patient	1° Short term analyses
2° Manpower: Full-time employed - Doctors - Nurses - Other personnel	2° Number of out-patients 3° Number of bed-days for in-patients	2° Operational costs 3° Number of in-patients per - doctor - nurse - other personnel	2° of comparable units - productivity at one unit over 3-5 years - departmental units at equivalent level of specialization over 3-5 years - hospitals at equivalent levels of specialization over 3-5 years
3° Physical capacity: Number of beds		4° Exploitation of physical capacity - % of beds occupied - in-patient turnover - number of beddays per in-patient	3° No conclusions to be drawn on marginal and/or fluctuating changes 4° Complementary meaures to be used

are furthermore subject to permanent change due to the progress in medicine, and due to technological innovations which lead to the introduction of new and more effective diagnostic techniques and to the introduction of many new and powerful drugs. The implication is that the quality of modern hospitals' services must be assumed to be subject to constant change. Sufferings treated in one way just a few years ago will today be treated in a totally different way. So, only a few years ago gastric ulcer was treated by surgical operations followed by a prolonged stay in a hospital bed; this expensive and painful treatment is now normally substituted by medical treatment, which due to innovations within the drug industry is at one and the same time both more cheap and more effective. Or to take another example: Many sufferings were not treated at all ten years ago; with today's techniques, however, these sufferings can be treated more or less effectively. For all these reasons it would be premature to draw any conclusions concerning the evolution of productivity over a comparatively long period of time. It would not be possible to decide whether output was qualitatively comparable. Neither would it be possible at the level of aggregate analysis to tell whether these changes in quality taken together should be expected to make hospitals more or less productive. When a number of restrictions, all listed in figure 1, are observed, it is, however, possible to neutralize the disturbing effect of quality changes.

An often repeated objection against productivity analyses in the public sector is that improved productivity is not necessarily associated with improved effectiveness. The tacit implication is that under these circumstances policy analysts as well as bureucrats should abstain from investigating productivity. This argument is not without sense (cf. Rosen, 1984, for a balanced discussion of the pros and cons in the productivity debate).

An increasing number of beddays or an increasing number of in-patients per doctor will be interpretated as an increase in productivity according to the measures set up above. It would, however, be dangerous to conclude that, taken alone, this indicates that hospitals are fulfilling their societal role in a satisfactory way. It could just indicate that hospitals are keeping their in-patients longer than necessary from a medical point of view or it could indicate that hospitals treat patients which could receive better and cheaper treatment at doctors working outside hospitals.

How sensible this argument may sound it does not invalidate analyses of productivity in hospitals. Productivity analyses can tell, how given resources are exploited. They make it possible to compare the economic performance of different hospitals, of departmental units at equivalent levels of specialization, and they allow us to compare economic performance over time. Economic performance, of course, is only one aspect of a hospital's performance; our claim is that it is too important an aspect to be neglected.



4. Productivity in the Danish Hospital Sector: A Case Analysis

Time has now come to present the main results from an analysis of recent developments in hospital productivity in Denmark. The analysis covers only a relatively short period of time, 1979-82. However, this short span of time is deliberately chosen so as to minimize the control problem in measuring productivity. Further, it goes to assume that there have been no significant changes in the trade-off between in-patient and out-patient hospital treatment during this period. The latter assumption is also important because costs accruing from the two forms of treatment are not recorded separately.

The strategy of analysis to be employed in the following will depart from some rather general measures, and, then, subsequently explore more and more input-specific measures.

The most general measure, and the one which is also applied in measuring productivity in the private sector, is costs per output unit. The costs incurred in the production of hospital services may aptly be measured by operational costs at constant prices. Operational costs constitute by far the largest cost item amounting to about 95 per cent of total costs. This means that only about 5 per cent of total costs are being allocated to investments. The proportion of investment expenditure to total hospital expenditure has declined from 15 per cent of total costs over the last decade. It is more difficult to choose one single best output indicator. There are at least two relevant possibilities. One is "bed days". The other one is the number of in-patients. Both indicators point to the total capacity of the hospital sector. This leaves us with two productivity measures, costs per "bed day" and costs per in-patient. However, these measures are not equally sensitive to changes in other output indicators, i.e. their external validity is different. Thus, the former is rather sensitive to changes in average time spent in the hospital. And average time spent in the hospital has been steadily declining over the last decade partly as a consequence of the increased emphasis on out-patient treatment in contrast to in-patient treatment. Consequently, the production of "bed days" has decreased as well. Yet, it would be haphazard to expect that these structural changes in the forms of treatment and the reduction of produced "bed days" automatically are materialized into reduced costs. Average costs per bedday should as a matter of fact be expected to rise. In sum, a productivity measure based on costs per "bed day" will, most likely, underestimate hospital productivity. Costs per hospital admission is more robust to changes in average time spent in hospital and the production of bed days. The validity of costs per hospital admission is therefore higher. Both measures are appplied in table 1 which shows the development of hospital productivity from 1979 to 1982.

Table 1. Productivity of Somatic Hospitals

	1979	1980	1981	1982	1979-1982
Operational Costs per Bedday					
- constant prices (1982)	1626	1687	1783	1850	
- annual growth in %		3,8	5,7	3,8	13,3
Operational Costs per In-patient					
- constant prices (1982)	16.412	16.657	17.061	17.087	
- annual growth in %		1,5	2,4	0,2	4,1
Mill. outpatients	3,264	3,295	3,254	3,338	

Source: Sundhedsstyrelsen: Aktiviteten i sygehusvæsenet.

As expected, costs per "bed day" display a more dramatic decline of productivity compared to costs per admission. However, the latter and more valid measure reveals that productivity has been going down by an average of 1 per cent per year.

Operational costs per in-patient are admittedly a rather crude measure. But even if we take into account the methodological pitfalls alluded to above, this measure does nevertheless convey meaningful information. Controlling for changes in quality, and controlling for structural changes in forms of treatment, the public provision of hospital services has absorbed more and more societal resources. Or put differently, the provision of the same amount and the same quality of hospital services requires more and more final government consumption, which, in turn, absorbs more and more of the entire economy. And given the amount of resources which is at stake here - total hospital expenditure amounts to about 5 per cent of GNP - the 1 per cent productivity decline adds up to something. It is also worth noting that the Danish health care system is a rather mature health care system. That is to say, the real boom and rapid expansion took place in the 60's. Investment expenditure has for many reasons been on the decline since the mid-seventies. We are also dealing with a health care system in which political priorities point to a further dvelopment of the primary health care sector to the detriment of the secondary, hospital sector (Bet. nr. 809, 1977). On this background, the reported decline of productivity becomes rather striking.

Working expenses at constant prices per hospital admission may be considered a catch-all productivity measure. It may very well conceal variations across regions,

across types of hospitals, and across types of various combinations of input-factors. In order to dig further into the question of hospital productivity this over-all measure will be broken down according to type of hospitals, and type of input factors.

Variations across Types of Hospitals

Variations among hospitals in productivity may be related to the simple fact that hospitals are performing different functions. Especially so in a hospital system like the Danish one, where hospitals are performing different functions and offering different services according to national directives. In order to compare hospital productivity it is therefore necessary to focus on hospitals that are performing similar functions or hospitals that are characterized by the same degree of specialization.

The Danish Health Board uses a three-fold classification of hospitals based on degree of medical specialization (number and kind of specialities). This classification is also applied in official health statistics. The point is that the classification employed in table 2 allows for productivity comparisons within each category.

Table 2. Spread in Operational Costs per In-patient. Different Types of Hospitals. Constant 1982-prices

	1979	1980	1981	1982
National hospitals				
Highest costs/in-patient	26515	25958	27515	27964
Lowest costs/in-patient	13717	14444	14672	13688
Average costs/in-patient	19082	19386	19739	19460
County hospitals				
Highest costs/in-patient	25851	25213	27552	30137
Lowest costs/in-patient	11910	12471	11873	12298
Average costs/in-patient	15149	15743	15743	15978
Local hospitals				
Highest costs/in-patient	20817	21171	22718	22181
Lowest costs/in-patient	8388	8482	8585	8719
Average costs/in-patient	12828	13067	13406	13720

Source: Sundhedsstyrelsen: Aktiviteten i sygehusvæsenet.

Table 2 shows that the productivity has been declining for all types of hospitals. The

table also shows, however, that productivity losses are bigger for smaller hospitals, i.e. hospitals with a low degree of specialization. Thus, at hospitals with the highest degree of specialization costs per admission increased only by 2 per cent from 1979 to 1982 in contrast to hospitals with the lowest degree of specialization, where costs per in-patient grew by 7 per cent.

More importantly, variations in productivity within each category are striking. For hospitals with the highest degree of specialization the most "expensive" hospital is almost twice as expensive compared to the hospital with the lowest costs. And these variations among hospitals with the highest and hospitals with the lowest costs per in-patient become even more pronounced for hospitals with lower degrees of specialization. One should not, however, lose sight of the basic fact that no category of hospitals witnesses decreasing costs per in-patient. The decline of productivity is a general, but highly varying phenomenon.

Variations across Types of Input Factors

The productivity measures used so far do not tell whether the general drop is "caused" by changes in the production of output-units, changes in production methods, or changes in costs of input-factors - or some combinations thereof.

The production of output-units, in this case in-patients, was constant from 1979 to 1981, but increased slightly from 1981 to 1982.

Given the short interval of time it appears reasonable to assume that changes in productivity is not, in any significant way, related to changes in production methods.

As a consequence, it may be expected that the general drop of hospital productivity from 1979 to 1982 is linked with changes in the amount or cost of input-factors, or to be more precise, that more or more costly input-factors are needed to produce the same amount of hospital admissions.

Given the changes in forms of treatment that have taken place during the last decade one would expect that the use of the physical equipment - the one important porduction factor - has become less efficient: As alluded to above, these changing forms of hospital treatment involve an increased weight attached to out-patient treatment in contrast to in-patient treatment, a reduction of the average time spent in the hospital and a reduced production of beddays. Given the complexity of big organizations such as hospitals, it may be expected that these changes in forms of treatment will lead to a less efficient utilization of the capacity of hospital beds. Or to put it in a simple way, that more hospital beds are left empty and unused. This hypothesis is tested in table 3.

Table 3. Association between Percentage of Beds Occupied and Bedtime. Average for All Somatic Hospitals

	1979	1980	1981	1982	1979-82
% of Beds Occupied					
Bedtime	7,44	7,57	7,59	8,13	
Growth in %		1,7	0,3	7,1	3,0
Empty beds*	3,35	3,31	3,56	3,12	

*Empty beds $= \frac{100 \times L}{B} - L = \frac{365 \times S - Sd}{I}$

where L = average bedtime
B = average % of beds occupied
S = number of beds
Sd = number of beddays
I = number of in-patients

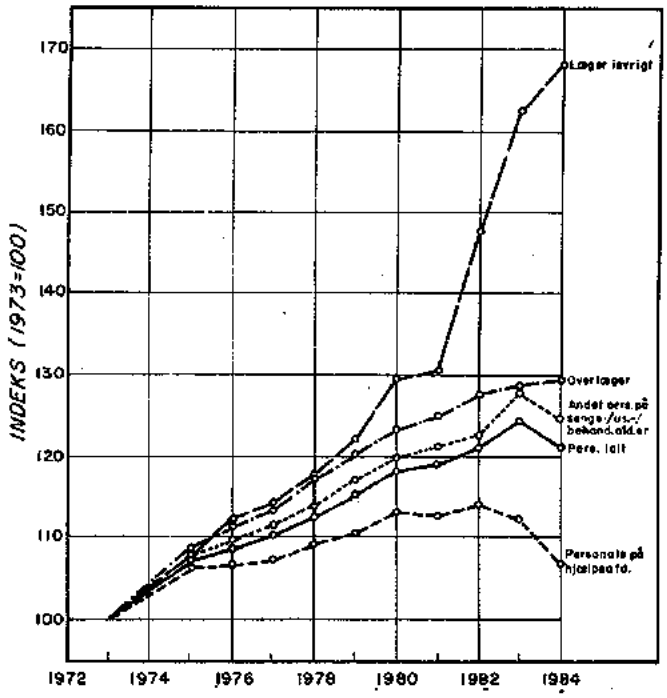
Source: Sundhedsstyrelsen: Aktiviteten i sygehusvæsenet.

Table 3 shows the density ratio (the extent to which hospital beds are occupied) combined with the average time spent in the hospitals. This may be taken as a measure of the degree of utilization of the physical equipment. Contrary to our expectations, table 3 clearly demonstrates that the hospitals have in fact been able to adjust their physical capacity to the reduced need of hospital beds. The utilization of the physical capacity in terms of hospital beds has become more efficient. This result is bolstered by another indicator, the "empty bed-time", which measures the amount of time per hospital bed that passes from the discharge of one patient to the admission of another. If the argument set up so far is correct, we can rule out changes in the production of hospital services, changes in the quality of services, changes in production methods, and changes in the one basic input-factor, the physical equipment, in our search for explanations of the observed productivity loss. This leaves changes in labour - the other basic input-factor - with a pivotal role.

Labour is usually measured in terms of working-time: working-hours, working-days, working-years, etc. (Rosen, 1984). In this context, we can only apply number of full-time (or converted to full-time) jobs. This measure of labour is evidently more blunt than working-hours. But number of full-time jobs is in no way useless as a labour measure. The point is that number of full-time jobs is correlated with the other and more disaggregated measures of labour.

Let us first look at the development of various types of hospital jobs in absolute numbers. This is done in fig. 2.

Fig. 2. Hospitals' Use of Manpower for Different Professional Groups 1973-1984



Note: Part-time employees recalculated to full-time employees.
Source: Sundhedsstyrelsen, personale- og økonomistatistik.

The message in fig. 2 is unambiguous: a dramatic increase in the number of hospital jobs from 1972 to 1984. If we focus on the period under consideration, the picture is more varied. The number of those who are employed in service departments etc. has in fact gone down. The increase of the number of chief-doctors and nurses has been modest, but the increase in the number of younger doctors (not permanently employed as opposed to chief-doctors) has been explosive.

These tendencies are reflected in table 4 which shows the productivity, i.e. hospital admissions per employee, for various personnel groups.

Table 4. Productivity for Different Professional Groups in Somatic Hospitals. 1979-1982

	1979	1980	1981	1982	realvækst 1979-82
In-patients per doctor					
Total	152,7	148,9	139,8	131,7	
Growth in %		-2,5	-6,1	-5,8	-13,8
In-patients per nurse					
Total	19,2	19,0	18,6	18,5	
Growth in %		-1,0	-2,1	-0,5	- 3,6
In-patients per employeee at technical departments					
Total	40,8	40,5	40,0	41,2	
Growth in %		-0,7	-1,2	+3,0	1,0
In-patients per emplpoyee					
Total	12,0	11,8	11,6	11,6	
Growth in %		-1,7	-1,7	0,0	- 3,3

Source: Sundhedsstyrelsen: Aktiviteten i sygehusvæsenet samt personale- og økonomistatistik for sygehusvæsenet.

The loss of productivity for hospital doctors amounts to an astonishing 13.8 per cent. And this is predominantly related to the massive intake of younger doctors. The decline of productivity for nurses is somewhat lower, whereas those employed in service departments boast a productivity gain. The over-all loss of productivity per hospital employee is 3.3 per cent or about 1 per cent per year. Given the negligible importance of the other relevant components of the productivity ratio, we may conclude that the over-all drop in hospital productivity from 1979 to 1982 is inextricably related to a massive increase of new openings for hospital doctors - particularly younger doctors.

It should also be noted that this increase in the number of doctors is not compensated by lower average labour costs. From 1981 to 1982, labour costs for y ounger doctors increased by 250 mill. D.kr. - or 1 per cent of total working expenses - in excess of salary increases for other professionals.

We have by now located the observed drop of hospital productivity from 1979 to 1982. We have not, however explained why this could happen. This is the topic for the following section.

5. Explaining Hospital Productivity

The following attempt to explain the drop in hospital productivity in Denmark from 1979 to 1982 will only take the form of a sketchy survey of some of the major factors involved. Even though the explanatory efforts inevitably will be tentative, the argument that will be put forward will nevertheless provide a first clue to the question why hospital productivity and productivity measures themselves have become politicized.

Explanations of hospital productivity may be divided into three categories. The first one departs from differences between public and private (service) production. The usual low productivity in publicly run hospitals compared to private hospitals, or other kinds of private service production, is, in essence, explained by the lack of a market mechanism in the former. The lack of competition and the separation of financing from production of services lead allegedly to supply-induced demand and inefficiency. Explanations of this kind are too general to explain the specific productivity drop in the Danish hospital sector from 1979 to 1982. But it is important to keep in mind that the functioning of the more specific factors introduced below take place within a set of institutional factors that systematically weaken incentives to increased productivity (Kristensen, 1985). It is also worth recalling that the Danish hospital sector is totally deprived of even fragments of a market mechanism. The hospitals are run by regional counties and financed out of taxes levied by the counties. There are not even third parties in the form of sickness funds. And there are no direct flows of money between the patient and the hospital. Not even symbolic payments as is the case in both Norway and Sweden.

The effects of the absence of a market mechanism will be demonstrated in one area: hospitals seem unable to adjust to changes in demand.

The second category of explanations refers to organizational problems, i.e. the very complexity of hospitals, and the ways in which the complexity is managed, engender another set of contraints for hospital productivity. We will deal with the management structure and the effect of medical specialization.

The third category of explanations covers the political context of the hospital. Among the many relevant factors emphasis will be put on the system of collective bargaining between younger doctors and the public employers.

Adjustment to Changing Demand

One of the major characteristics in a public health care system is the difficulty, if not impossibility, of establishing genuine consumer preferences, and thus, defining the proper demand (Kristensen, 1984).

There is one area, however, where it is, in principle, possible to estimate changes in the demand. And that is within the field of gynaecology-obstetrics. 75 per cent of all births take place in departments attached to this medical specialty. Over the last decade the demand for the services offered by these departments has decreased in tandem with the decreasing birth and abortion rates. Table 5 provides some key-figures.

Table 5. Activity and Resources within the field of Gynaecology-obstetrics 1979-82. Index 1979 = 100

	1979	1980	1981	1982
Beds	100	98,3	93,3	90,6
Beddays	100	95,9	90,8	86,9
Discharges	100	100,5	98,1	97,5
No. of doctors	100	100,5	97,6	125,7
Births at hospitals	100	96,3	89,3	88,5
Births at gyn.-obs. departments	100	98,5	93,5	94,7
Abortions	100	100,6	98,2	92,5

Source: Sundhedsstyrelsen: Aktiviteten i sygehusvæsenet, Medicinsk fødselsstatistik samt Lægestillinger og sengepladser på institutioner.
Statistisk tiårsoversigt.
Statistiske efterretninger: Befolkning og valg.

Table 5 shows that the number of births decreased by 11.5 per cent from 1979 to 1982; that more and more women deliver at specialized hospital departments of gynaecology-obstetrics; that the physical capacity in terms of beds and "bed days" adjusts nicely to the reduced demand; and that the number of doctors within this specialty explodes by 25 per cent.

The ensuing, dramatic drop in productivity is shown in table 6.

Table 6. Productivity and Capacity Exploitation at Gynaegological-Obstetric Departments 1979-83

	1979	1980	1981	1982
Beds per doctor	8,1	7,9	7,8	5,9
Births per doctor	104	102	99	78
Beddays	2.456	2.345	2.286	1.698
Out-patients	813	821	831	621
Empty beds	1,2	1,3	1,3	1,4

Source: Sundhedsstyrelsen: Aktiviteten i sygehusvæsenet, Personale- og økonomistatistik for sygehusvæsenet samt Lægestillinger og sengepladser på institutioner.

All productivity measures used in table 6 tell the same story: a dramatic drop of productivity within the field of gynaecology-obstetrics.

Let these figures suffice to illustrate that changes in the demand for hospital services - in this area where the demand may be estimated in meaningful way - have no or little effect on the production of these services.

Complexity of Organization and Productivity

Hospitals are very big organizations, and, hence very complex. This complexity is further exacerbated by the fact that hospitals have an obligation to serve the citizenry on a 24 hours basis. Running hospitals therefore poses a great challenge to management and leadership.

The structure of leadership in Danish hospitals is not conducive to productivity - quite to the contrary. First, there is mis-match between the economic-administrative structure of leadership and the professional leadership structure. The two layers in the organization are not only rather autonomous, they are also characterized by different degrees of centralization. The economic-administrative structure is highly centralized with the final responsibility for the budget resting with the executive manager. In contrast, the professional leadership structure is decentralized with the department as the basic functional unit. Each department is built up around a medical specialty and run by a chief doctor. The chief doctor is responsible for disposals and activities in the department. He is not, however, responsible for the budget. There is, thus, no or only weak incentives for the chief-doctor to employ a cost-saving behaviour.

The mis-match between the economic-administrative leadership structure and the professional management-structure is further aggravated by a mis-match between the doctors' leadership structure and that of the nurses. It is not only that the two professional groups are very autonomous and surrounded by two separate and water-tight sub-cultures; it is also that the doctors' decentralized leadership structure centered around the department chief-doctor is met by a centralized management structure for the nurses under the direction of the hospital matron. This mis-match between the two major professional groups' management structures makes cooperation and cost-saving obsolete - at the level of the hospital and at the level of the individual department.

Hospitals are, like most other big and complex organizations, characterized by a high degree of specialization and functional division of labour. Hospital specialization reflects medical research interests, and medical career systems. The point is, that medical specialization also materializes into departmental specialization. That is to say, a medical specialty will, regardless of how inferior it is, tend to have its own department with its own chief-doctor and its own staff of younger doctors and nurses. This is illustrated by an analysis of the relationship between degre of specialization, number of doctors and number of patients. The main results are summarized in table 7.

Table 7. Specialization and Number of Doctors at Alternatives Sizes of Hospitals

	Size 1 (4.000-5.000 surg. in-pat. per year)	Size 2 (6.000-8.000 surg. in-pat. per year)
No specialization	19 doctors	25 doctors
2 spec. departments	28-29 doctors	39-40 doctors
3 spec. departments	38 doctors	48-49 doctors

One would assume that the degree of hospital specialization is related to the size of the constituency of patients. The larger and more specialized hospital takes a larger constituency of patients (and often a larger geographical area as well). If we want to analyze the effect of the degree of medical specialization on the consumption of medical man-power we will therefore have to control for the size of constituency. This is done in table 7 by keeping the size of patient constituency constant. The table shows how the number of doctors increases by the degree of specialization keeping the size of patient constituency (size of hospital) constant. The result is striking: hospitals with a patient constituency of about 4-5,000 patients per year and with no specialization (i.e. only one

broad surgery department) take 19 doctors. Specialization into two departments take 22-29 doctors, and specialization into 3 departments take 38 doctors. The same tendency towards multiplication of doctors is found for hospitals with a somewhat larger patient constituency (6-8,000 patients per year).

The reason why medical specialization results in departmental specialization and thus in an over-proportionate use of medical man-power has to be found in conditions outside the very hospital. It is a question of the professional organization of doctors and the system of collective bargaining.

Professional Unions and the System of Collective Bargaining

It was shown above that the increase in the number of younger doctors was the single most important factor in "explaining" the general loss of productivity in the Danish hospital sector.

The capacity to decide on the use of medical manpower does not belong to the hospital itself. The executive-manager of the hospital has no competence in staffing the department. Neither has the chief-doctor. And the political leaders in the county who have the final responsibility for running the hospitals in the county are also without much direct influence on the use of medical manpower.

The decisive actors are the younger doctors' professional union and the counties' national association. These negotiating associations enter collective agreements which in detail regulate working hours, working conditions and questions of medical man-power. The result of these negotiations which take place every two years is given by the associations' relative political strength and negotiating skills. And the collective agreement which was reached in 1981 after some of the most dramatic and turbulent negotiations in the Danish health care history was a tremendous victory for the younger doctors. This conflict and the resulting collective agreement has been analyzed elsewhere (Heidenheimer & Johansen, 1984). Suffice it to note here, that this new agreement resulted in 1800 new openings for younger doctors which is tantamount to an increase, by one stroke, of about 40 per cent of younger doctors.

If anything, this agreement and the many new positions it engendered is the single most important factors in explaining the drop of hospital productivity from 1979 to 1982.

It follows that factors conducive to hospital productivity are primarily located outside the hospital. It also follows that these factors in essence are poitical. Hospital productivity is a question of organizational and professional strength, negotiating skills and political struggles. This is why productivity and measuring productivity is a political game. The next section will further analyze the politics of productivity measurement.

6. Hospitals' Productivity as a Political Issue

In section 4 productivity measures defined above were used in an analysis of productivity in Danish hospitals over a period of four years. The conclusion was that productivity had decreased irregarding the measures used. In section 5 we then discussed some tentative explanations of this decrease in productivity. Here the conclusion was that different professional groups, and especially the medical profession, have a strong political stake in the present organization of Danish hospitals. Our proposition is that given this stake, these professional groups will fight any attempt to use productivity analyses as an indication of hospitals' economic performance. Any other strategy on their side would be tantamount to admitting that hospitals could provide the same amount of services at the same level of quality to less costs and with less manpower. This defensive strategy was naturally brought in operation when the conclusions summarized in section 4 were published last autumn as the premises for a proposal to reorganize the organization and management structures currently applied in Danish hospitals. In this section we briefly present the standard arguments used against productivity analysis in hospitals by the Danish Association of Doctors and to some extent by the Danish Council of Nurses.

The standard arguments raised against the analysis of hospital-productivity can be grouped under four headings:

1) For the moment it is impossible to measure output
2) Don't forget the quality dimension
3) With the right definitions the problem disappears
4) Forget everything about productivity and let us talk about something else.

ad 1. One of the favourite arguments against the analysis of productivity presented above was that output measures are poorly developed. The measures applied in the analysis do not consider the complex character of the services provided by a modern hospital. What is needed therefore is the definition of new and more sophisticated measures of hospital output. Instead of analyses based on the primitive output measures used in medical statistics, economists and political scientists should set up totally new measures which would make allowance for the true and complex nature of hospital output. But as, until now, nobody has developed such more sophisticated measures, it is not possible to rely upon productivity analysis. Some doctors go even further. They argue that productivity analysis is impossible because the demand for hospital treatment changes over time in an unpredictable way (Steensen, 1984, 3958).

ad 2. Another strategy of attack is to focus on the dimension of quality. At this point doctors and nurses agree with each other. What matters, according to their argument, is

not the relationship between input and output, but the quality of hospital services as measured by the effect of hospital services as part of the total health care system. It is, then, admitted that at the present moment it will not be possible to make any precise statements on these effects. But the point is that effect-indicators measuring the benefits of health care should be developed. As long as these effect indicators have not been developed, the most clever thing would be to let the whole issue of hospital economics rest.

ad 3. A third strategy resorted to is to propose the basic definitions of output changed. In section 5 the limited adaptation capacity of hospitals was discussed. The proposition was that generally it is futile to talk about demand for public services provided freely to consumers. It was, however, also argued that for some hospital services this was not the case. Women who are pregnant, and who either have to bear, or who want an abortion, present hospitals with a demand for treatment which is totally unconnected with hospitals' supply of treatment within the fields of gynaecology and obstetrics. In most other fields of hospital treatment a natural suspicion would be that the demand for treatment will to a large extent be influenced by hospitals' supply of specific offers for treatment. Due to the combined effect of the falling birth-rate and a decrease in the number of women wanting an abortion demand for treatment within the gynaecological-obstetrical field has declined, while at the same time the number of doctors working in these specialized units has continued to increase. This conclusion provoked a vivid discussion with the medical profession. Here it was argued that a broader indicator of demand had to be applied, namely the total number of in-patient discharges from gynaecological-obstetrical departments. With this change in the basic indicator of demand the types of output which are determined by a hospital's supply of services would be included in demand. With this revised definition it was then possible to demonstrate how output apparently had increased within this area; and also how gynaecological-obstetrical departments had been able to increase manpower productivity (Berget, 1985, 208-210).

ad 4. The favourite strategy is to ignore the problem of productivity and instead to talk about something else. In the case of this productivity report, doctors clearly followed this strategy. Their point of view was that a reform of the management structure at Danish hospitals would solve most problems, including future problems concerning economic performance. A new management structure, where doctors were represented at the top management level at hospitals, would according to the doctors solve most problems of economic performance.

7. Concluding Remarks

Public sector prpoductivity has acquired a taboo-like status. The reasons given for not discussing the problem of productivity are primarily methodological. The claim is 1) that output cannot be satisfactorily measured, and 2) that productivity analysis redirects the analytic focus from the more important problem of policy effectiveness.

In this paper, we have shown how the traditional reservations raised against productivity analysis by especially economists are not fully justified. It is possible, even on the basis of official statistics, to set up valid output measures which allow for an analysis of the relationship between input and output within the public service sector and in our case at hospitals. To the extent this is not done, public sector economists as well as policy analysts will unwittingly play the game of professional interests within the public sector which have a strong political stake in protecting their field of operation against any analysis of economic performance. The methodological and technical arguments which e.g. the medical profession use against productivity analysis at hospitals should primarily be seen as a strategy for avoiding any polltical focus on their economic performance.

At this stage, it has only been possible to present a preliminary analysis of hospital productivity. Ideally, there is a need for a refinement of hospital statistics, e.g. allowing for a separate analysis of the costs of in-patient vs. out-patient treatment. But even at the basis of existing hospital statistics would it be possible to go further into causal analysis of the variations in productivity between hospitals at the same level of specialization., Another logical step in this causal analysis would be to compare productivity at one or two Danish hospitals with foreign hospitals placed at the same level of functional specialization and being equally advanced in their use of modern medical technologies. A comparative analysis like that would facilitate an analysis of the importance of different organizational set-ups, variations in management systems and differences as to which staffing has been regulated through collective agreement with the health professions.

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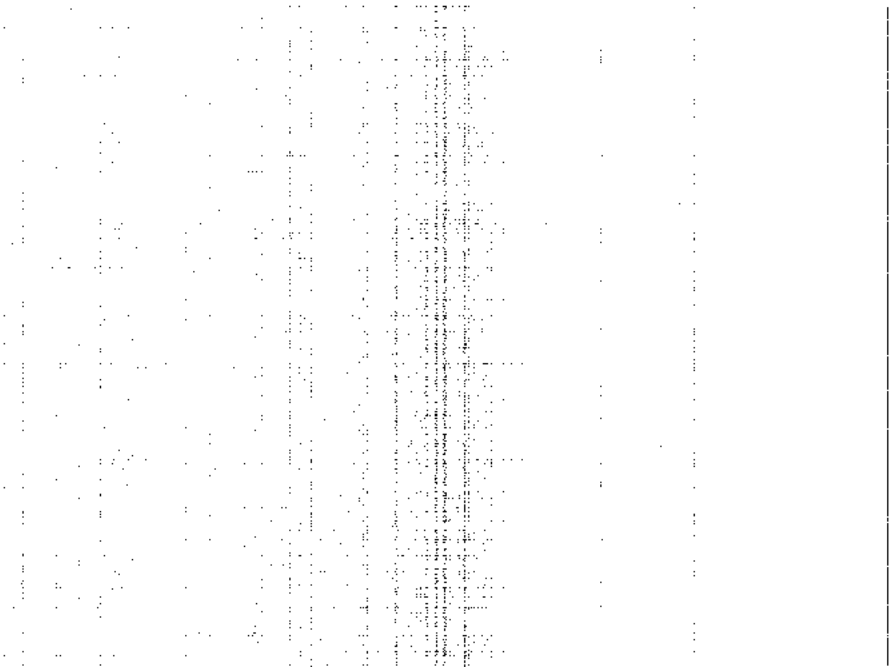

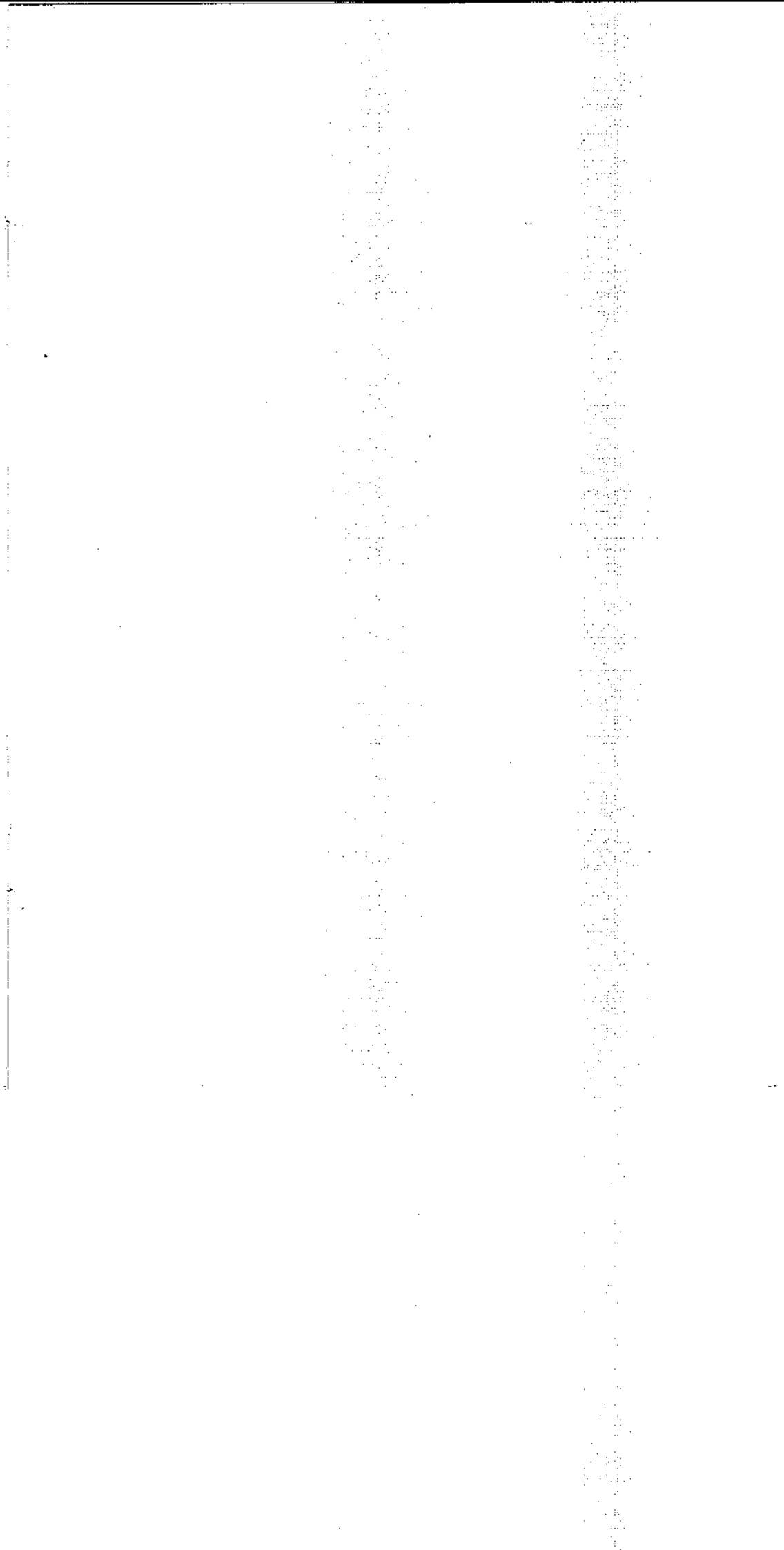

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MEDICAL PERSONNEL POLICIES IN ITALY: PROBLEMS AND PROSPECTIVES

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The Law n.833 which in 1978 established the Italian National Health Service (Servizio Sanitario Nazionale or, from now on, SSN), exemplifies, in an excellent way, a very common error which characterizes too many public policies carried out in Italy. That is the discrepancy, if not the contradiction, between stated ends and means. Such discrepancy is due not only to the insufficient allocation of financial resources,but especially to the establishment of an organizational-institutional apparatus which is patently unfit to carry out the desired ends.

In this paper,I will concentrate upon a particular component of health policy in Italy: namely, on medical personnell policies. To this purpose, in the first part, I will describe today's regulations in terms of income and work-conditions for the doctors. In the second part, I will analyze the shortcomings of such regulations thanks to the insights provided by the analytical models based on the logic of economic and professional conduct. In the third one, I will offer a few suggestions as far as what concerns possible reforms.

Today's medical personnel policies

Following the Law 833, income and work conditions for the doctors are regulated by two kinds of contracts: one carried out with the categories of doctors who practice privately under a contract by the SSN; the other with the doctors who are, they themselves, public employees. The managerial responsabilities for all doctors are, on the contrary, defined by the law itself.

The contract with the indipendent G.P's. Succintly such a contract establishes that the G.P's income is made up of:

1) a capitation fee for each patient on the list
2) an allowance for professional risk and a professional cost refund
3) an allowance to account for cost in living increases
4) a payment to cover social security payments
5) few other remuneration such as incentives to practice in difficult areas and fees for occasional visits.

More particularly, the capitation fee is slightly a function of the age of the patients and of the seniority of the doctor. The capitation fee goes from 16.531£,(1000 Liras correspond approximately to a bit more of 1/2 American dollar.)for a young doctor with no seniority and for a patient between age 12-60; to 19792£ for a doctor with 13-20 years of seniority and for patients in the same age cohort as above; to 25.602 £ for a doctor with more than 20 years of seniority and for patients above 60. The professional cost refund is established in the measure of 7000£ for the first 500 patients; and of 5000£ for the other patients. The same figures also apply to the risk allowance. Asfar as the first kind of expenditure, the doctor is obliged to document the expenses really undertaken. In the second case, there is no such obbligation. Cost of living increases cannot outweigh those allowed for the manufacturing sector.

These provisions (which were passed under the first contract after the establishment of the SSN) made possible, for the doctors, an increase of 60% in their remuneration. Remunerations, by the way, which have to be reviewed every three years.

Furthermore, the contract establishes a strict incompatibility between being a G.P. and being a specialist either practising in his own ambulatory or in a public multi-purpose outpatient clinic.
Inthe contract, however, there is no provision for the implementation of such an incompatibility. Also doctors who already work for more than

40 hours weekly or work in clinics under contract with the SSN cannot be part of the contract.

G.P's cannot have more than 1500 patients. There cannot be more than 1G.P for every 1000 people. Everybody can practice privately once the obligations towards the SSN have been fulfilled. But, also in this case, the contract does not give any real sanctioning control to the SSN. Only a commission entirely made up of doctors can check the G.P's behavior.

The contract with consultants working in their own ambulatory.

These specialists are payed by a system of fee-for-service, according to a price list which is uptodated every three years. As far as what concerns incompatibility, please consult Table n.1 with the same caveat as the one expressed in relation to the case of the G.P's(in the sense that incompatibilities are not checked). Patients, theoretically, can resort to a private ambulatory only if the public structures cannot satisfy their demands within three days. In this case there is however again, no control.

The contract with consultants working in public structures.

Such a contract establishes that specialists be payed according to an hourly fee which goes from 15.000£ for doctors with no seniority to 19800£. for doctors with 20 or more years of seniority 19.800£. For incompatibilities, please consult, again the already mentioned Table 1. There are also other indennities to allow for increases in the cost of living, for productivity awards and for practising in difficult areas.
As far as what concerns the work condition, the specialists should follow the USL (Local Health Unit) guidelines, for example, disfavoring unnecessary hospitalization; carrying out epidemiological statistics; keeping continous connections with the G.P's. Mobility within areas is consented with no further requirement; while mobility among areas is subject to the approval of an Area Committee made up by four rappresentatives of the USL and four rappresentatives of the doctors. This same committee may also function as a consulting body on the overall matters concerning the appli-

cation of the contract.

The specialists under this contract also committed themselves to develop health profiles and to offer all the information necessary to carry out a 'good' health planning and to evaluate the efficiency and the effectiveness of medical care supply.

The contract with the public employees of the SSN.

Such a contract inserts the public consultants contract within the general contract of all the personnel employed by the SSN. It establishes 11 levels of remuneration, the consultants belonging to the last three levels in the hierarchical ordering. For everybody, doctors included, the agreement decrees:

1) the centralization of all agreements except for what concerns matters dealing with the scheduling of timetables; the identification of the main procedural standards to follow;
2) the planning of manpower distribution;
3) the duty of increasing the quality and the quantity of the services produced;
4) the limit of the work to be carried out after the regular worktime- such a limit is set in 100 hours yearly;
5) the foundation of an incentive fund aiming at favoring efficiency- the access to this fund is guaranteed to those who accept to work for a certain number of hours- no more than eight hours per month after the normal schedule.
6) the establishment of a productivity award of 40% of the total saving realized;
7) the realization of a complete system of monitoring and controlling.

For what concerns the consultants, more specifically, the agreement states that:

1) those working full time,can dedicate four out of the thirthy-eight weekly hours to continuing education; while those working part-time, have to fulfill the latter obbligation outside their 28 hours weekly

engagement;

2) all doctors can exercise in their private practice, once they have complied with the SSN requirements;

3) for those working full-time, the salary,net of any additional remuneration, is about 27.000.000 £; for the ones working part-time, it is about 13.000.000;

4) all doctors have additional indennities of various kind.

This provisions gave an overall increase of 36% to the doctors (For the full-time doctors,was about 50%).

Doctors'role in the government of the SSN.

The Law 833 drastically restricts medical participation in the government of the SSN. Doctors,as such, are not members of the two main governing board of the USL: the General Assembly and the Executive Commitee (which are respectively made up by the Town Council and by the members by this latter elected. Thus, doctors do not have any managerial responsability. Similarly, doctors do not belong to the regional policy-making bodies and consequently, cannot directly partecipate in the settling of such delicate matters as the identification of therapeutic standards, the determination of manpower distribution, the definition of investment policies and the overall organization of ambulatories and hospitals.

Doctors are present only in the National Health Council and in the High Institute of Health Policy, the two bodies which respectively have to consult the functionaires of the SSN in the elaboration of the National Health Plan and have to give technical and scientific advise to the Regions. In all these instances, doctors do not occupy a central position. Furthermore, they partecipate in another consulting body,the High Council of Health Policy. The law,thus, even though clearly praising professional autonomy seems,however, to conceive the medical role as an activity, among others, to be subordinated to the leadershipand guidance of the political/bureaucratic machine.

A critical evaluation.

If the final end of medical personnel policies is, as it is and should be, the realization of the promises of the SSN, concerning the efficient and effective delivery of health assistance to all who are in need, then the regulations above described are, doubtlessly, wanting. Doctors continue to overprescribe drugs and diagnostic tests, which often turn out to be quite useless; to resort to hospital assistanceeven when alternative ambulatory or/and socialservices options.i.c.in the case of the elderly-would not only be more efficient but likely also more effective; — todisdain the rules of incompatibility and to be excessively biased towards private practice, thus delivering care more according to the income and status of the patients than to the need.

Are all these perverse and unexpected effects? My hipotesis is that such outcomes far from being casual and impedictable could've been, at least, approximately, anticipated. To this purpose, instead of believing that increases in remuneration would have automatically produced doctors loyalty to the objectives of the SSN, the leaders of the SSN should have taken into account, on the one side, the role played by economic incentives doctors' behavior and, on the other, the specificity of professional logic.

The doctor as homo oeconomicus.

If we extend the economic modee to the analysis of doctors' behavior or in other words, if we postulate the maximization/satisfaction of private ends as central argument of the utility function of every economic agent, we immediately perceive, in the existing regulations, a great discrepancy between the incentives which they offer to pursuit of collective interests of the SSN and to the private ones of doctors, such as income, leisure and prestige.1)

Let us consider, first, the system of remuneration.[2] The capitation fee for the G.P's, establishes a gap between the time of the remuneration and that of the delivery of service, denying any right to the private appropriation of the possible difference between revenues and costs. Thus, such a sistem acts as a dangerous incentive, for the G.P's to discharge the burden of assistance upon other more expensive productive factors. And in fact, we are all well aware of the effects of overprescription and overutilization of structures endowed with an high capital content. These effects would occur both for minimizing the psichic and physical costs linked to the therapeutic activity and, expecially for what concerns the young doctors, to attract patients, relying on the very commonly held prejudice according to which high cost/quantity necessarily means high quality of care-while, on the contrary, excessive medicalization often implies useless assistance if not increases in the risk of iatrogenic diseases.[3]

The fee for service, adopted for the "external consultants" seems, on the contrary, questionable in so far as it offers a powerful stimulus to the multiplication of services, since the income of the physician is, indeed, a function of the quantity of services produced. Such an outcome is possible thanks to the agency relation, which I've previously mentioned in the case of the capitation fee, that characterizes the health transaction. In other words, exploiting the monopoly power deriving from the asymmetry in information, doctors are able to induce additional demand-naturally, never endlessly but according to a degrees empirically variable.[4]

The salary for consultants in hospitals and the hourly fee for internal consultants, embody a strong incentive to private practice, with negative effects on the whole SSN. The reference is to phenomena such as the disaffection towards the public sector and the consequent progressive dequalification of the SSN; the inducement of additional demand for the private sector through the manipulation, more or less consciously, of the information offered to consumers and/or through the increases in queuing; the increases in the overall costs of the SSN both in the short-run-because [illegible] structures is under contract with the NHS -

and in the long run, through the additional demand created by the increases in private structures (see the Rohmer law).[5]

In all four systems of remuneration, then, no provision is made to guarantee the satisfaction of the objective of equality of treatment according to need established by the L.833. On the contrary, some arbitrariness in the tratment of patients would seem to constitute an intrinsic corollary not only of the processes above described of dischargment of costs on non-economical structures, of demand-inducement and of wide recourse to private practice. But, also, would seem a factor unavoidably present in any unregulated agency relationship in which those who have more information succeed in discriminating demands in order to privilege the cases which appear more interesting and/or prestigious.[6]

Similarly incongruent, appear to be the remaining norms attaining the career patterns which, based as they are on automatic and guaranteed progression, do not stimulate compliance with the collective objectives of the SSN.

It is true that one could object that the different contracts establish norms and incentives aimed at controlling the perverse effects above mentioned. And ad hoc committees of doctors and representatives of the SSN, the Regions and of the USL have been established with the same goal of monotoring and checking. But, also to this regard, the economic model allows us to identify other two fundamental short comings.

First, some predispositions are simply wrong. For example, in the definition of the incentives fund, no attention is given neither to the composition and the quality of the output to be produced nor to the risk that the desire of additional pay, lead both a reduction in the productivity

during regular work-time and to an inefficient distribution in the supply of labor - for example, through an excessive concentration in those specialties with high elasticity of demand and an insufficient one in those which are highly inelastic. Also, it would seem very naïve to believe that the significant monetary increases given to doctors, could automatically stimulate optimal behavior.

Second, many of the remaining norms seems to be mere wishful thinking in so far as there is no organizational devise attached to them. To this purpose, let us ponder, even briefly, on the scarse significance of the productivity awards, in a system where there is no obbligation t keep some sort of cost-accounting. Or, on the weakness of norms such as those related to continuing education, to the incompatibilities, and to medical audit in the absence of pertinent systems of control.

These problems, according to the economic model, would seem to be particularly serious since they cannot be dealt with through either good will or experience. Doctors, in fact, enjoy a great power aymmetry vis á vis the political -bureaucratic machine of the SSN, since they have more information and more threatening power. And, thanks to such an aymmetry, feel much stronger incentives to collective action. In other terms and more specifically, we live in a pluralistic society in which the duty of the government is to protect, register and mediate the different preferences, rather than realize a collective good a priori defined, even against given interests. In this context, it seems very natural that the winning demands are those of the groups for which the benefits from public policies are concentrated and the costs diffuse rather than those of the groups which ask for public goods whose costs are concentrated and the benefits diffuse, such as, for example, would be the case for policies

aimed at controlling doctors´behavior.[7]

The doctor as a member of a profession.

While the economic model forces us to concentrate on the kind of incentives influencing the pursuit of private interests on the part of doctors, the model based on the professional behavior forces us to examine the tensions unavoidably taking place between a political-bureaucratic organization such as the SSN and a profession, like the medical one.
The result is that, according to this model, the current shortcomings in medical personnel policies derive from the attribution of the overall government functions to the political-bureaucratic apparatus. And the political-bureaucratic apparatus behaves accordingm to a logic which drastically differs from professional logic.

On the one side,indeed, such an apparatus which is much more sensitive to the pressures of different interest groups and the changing contingencies of various political games, tends to act according the logic of bargaining. On the other, politicians and bureaucrats, not only are not competent enough in health matters ,but they also behave according to a synoptic and deductive decision-making model that aims at pursuing uniform, general and predictable standards of behavior and at organizing the work relationship according to hyerachycal patterns.[8] Consequently, politicians and bureaucrats too often tend to define health plans that precisely define standards of behavior and hyerarchycally set ad hoc controls, to 'bureaucratise' the medical role, obliging the doctors to spend a great deal of their time in administrative procedures, to follow rigid career patterns equal to those followed by all the SSN personnel and to organize the overall working-environment in ways that doctors deem deficient. And, all this is deeply resented by the physicians, with negative ripercussions on the delivery of public care, even if it is only pro-

fessed by words (in so far as the doctors may be able to resist the implementation of 'dangerous' policies, as it would be shown by the economic model).

To avoid these consequences, the fathers of the SSN should have acknowledged the specificity of professional logic. In other words, instead of presupposing that the interests of the SSN and those of the doctors could have been easily harmonized through authoritative decisions, they should have taken into account, first that the physicians possess the monopoly, not only of a generic knowledge, but of a knowledge that is both continously progressing through processes of an inductive and incremental kind and is often both uncertain and incomplete. Thanks to this monopoly, doctors tend to exhalt the sophisticated and exclusive character of their competence; the unavoidable necessity to collect new information and to experiment all possible therapies; the peculiarity and, thus, the non-homogeneous character of the diseases and the artistic-intuitive nature of medical performance.[9]

Second, doctors are traditionally moved by an ethic of full committment to the single case, which is wholly alien from more global considerations of social justice. In other words, involved in agency-relationships which are personal and highly emotional, the physicians feel that their fundamental responsibility is to try everything possible for each patient. No matter if, in so doing, they use resources which could be more efficiently, more effectively and even possibly more justly destined to fulfill other needs. What is important for each doctor is the health of the single client and not that of an impersonal, distant and for him, hypothetical patient.

Third, doctors exhibit a strong sense of belonging to a profession, which makes them very hostile to any practice of bureaucratization. Fourth and last, for the same reasons, doctors deeply resent any external control. That is, they are 'cosmopolitans' intrinsecally unable to give in to the orders, unavoidably 'provincial' of a bureaucratic organization such as the SSN, to which their loyalty can, even in the best case, be only partial.[10]

Some suggestions for reform

Contracts and regulations which give doctors too much freedom in the satisfaction of their private interests and, which, at the same time, do not sufficiently acknowledge the role of professional autonomy. If these are the shortcomings today afflicting medical personnel policies are we not facing contradictory diagnoses? and, if this is so, how should we behave in defining which reforms to follow?

It is my conviction that, far from having absolute validity, the two models above considered represent two different lenses through which we can observe reality. Both are usefule for understanding the problems under examination. And, both are insufficient if utilized in an exclusive way. In other words, I think that the doctors are, at the same time, homines oeconomici as well as professional actors and that any reform which aims at being successful should recognize both aspects.[11]

To this purpose, the first task would be that of a more precise identification of the fundamental objectives of the SSN. To decree that we want equality in needs´satisfaction and that professional

individual rights in the fulfillment of one's own interpretation of need, efficiency and effectiveness are to be greatly valued as the L. 833 affirms is not enough. We have better to specify in some new sort of health contract, the meanings of equality, of individual rights, and of the acceptable levels of efficiency/effectiveness as well as to differentiate between ultimate goals, that act as constraints on all other objectives, and intermediate goals. That is to say, for example, individual rights might mean also the right to a meaningful comumication between doctors and patients and professional autonomy cannot be held as an obstacle to social justice in health care.

Second, and consequently, we should aim at realizing those organizational perequisites which seem apt to guarantee a closer harmonization between the pursuit of doctors' private interests and the collective interests of the SSN, full acknowledgment being given to the role of medical logic. This, would mean, on the one side, to identify and to establish new forms of doctors' corresponsabilization in the economic implications of the different therapeutic behaviors.[12] For example, for what concerns the G.P's, one could experiment, also in our country, forms of Health Maintenance Organizations[13], congruently modified so to take into account the reality of the SSN. To this regard, each GP could be given a capitation fee plus a percentage of the savings he realizes in comparison with the average expenditures induced by the ensemble of the G.P's for the particular class of patients and/or deseases. To make the proposal more clear, let us suppose that the pharmaceutical expenses caused by all G.P's for the elderly is 1000.000 £ for year. Doctor A prescribes to Patient B, seventy years old, drugs for a total of 60.000 £. Doctor A would then receive from the SSN the sum of 4000£, equal to the 10% of the savings realized.[14] Or, for what concerns the consultants in hospitals, one could try new ways of

partecipationin clinical budgeting such as the ones tried out in the famous experiment of the Westminster hospital.[15] Or, similarly, as it happens in Germany, Belgium, United Kingdom and Australia one could fine the doctors who significantly deviate from the average patterns of prescription.[16]

All thesemeasures, obviously, would need apposiste standards of reference. Otherwise, nothing could guarantee that the incentives to saving do not bring about perverse effects such as the dequalification of care and/or the denial of assistance to the more expensive cases. Thus and third , as the model based on professional logic teaches us, it would be necessary to ensure phisycians partecipation, for example, through the establishment of peer rewiews and Professional Standard Rewiew Organizations.[17] But, as this same model also shows, the self-governing medical bodies tend to underestimate the role of efficiency and of effectiveness vis àvis that of quality and to overlook the requirement of equal treatment for equal need. Furthermore, as the economic model teaches us, notwithstanding the role of ethical and professional codes, the doctors are nevertheless economic agents pursuing more or less explicity their private ends. It would, then, seem necessary to guarantee an intelligent public guidance

I've written "intelligent". With such a word, I mean a guidance that is able to develop new administrative procedures apt, on the one side, to acknowledge the empirical and experimental character of health care policy and thus, to decide according to criteria of an inductive and pragmatic kind. And, on the other, to take into account the specifity of professional logic and, without be subordinated to it, to establish new forms of coordination and collaboration, fully respecting the different competences.

This means, for what concerns, standards' definition, to be fully aware of:

1) the impossibility to define efficiency indicators, which are uniform and defi-

nitive;

2) the great degree of ignorance and uncertanty concerning the effectiveness of the various medical procedures;
3) the ambiguity of the concept of equality, when we move from the macro-level of resource allocation to the micro-level of doctors' decisions vis àvis the particular patient;
4) the possible perverse effects associated to standards' development since indicators may not only favor excessively uniform behaviours, but may also hamper medical progress;
5) the power and the strenght of the personal liason linking doctors and patients;
6) the presence, among doctors preferences, of private and corporate interests which are to be contrasted and of ideological beliefs such as the trust in medicalization, which have , on the contrary, to be constantly verified;
7) The consequent necessity to create a system, flexible and progressively capable of self-correction and self-amelioment in which, doctors and bureaucrats, both more aware of the problematic character of means and ends, be fully involved into a new dialogic practice.

Doctors, moreover, should participate in the government of the SSN, from which they are, today excluded. The goal to this purpose, would be that of allowing doctors both to express their voice and to bring their competence in the SSN and to develop a new awareness, of the practical dilemmas facing the SSN.

Lastly, it would seem necessary to modify the doctors' educational curricula in ways more congruent to the new medical role advocated in these pages. To this purpose, attention should be specifically concentrated upon the development of procedures of clinical evaluation and on the analysis 18)
of the ethical dilemmas facing the doctors, thorn as they are between the traditional responsibilities towards each patient and the new responsibilities towards the collective goals of the SSN.
At this point, three

At this point, three objections could spontaneously come out. First, the modifications that Ihave prompted are too vague. For example, how can we differentiate between egoistical interests and correct professional demands? Or, how specifically, should we reconstruct the political-bureaucratic machine? And, how to carry out, in details the difficult process of coordination between doctors and bureaucrats?

Furthermore, for a follower of the economic model, the whole proposal could sound rather utopistic. How could we expect, this followerwould argue, that doctors would comply with the changes above described? And, finally one could object that the health system is much more complex than I've described it, made up as it is of a moltiplicity of interdependent actors whose role and behaviour I have overlooked. For example, to control doctors shouldn't we, also establish ad hoc incentives so that if the patients themselves restrict their demands?

Starting form the latter objection, the answer is simple. Certainly, the analysis carried out is limited, but limited, by necessity, was the perspective of this paper. Similarly, the suggestion offered necessitate to be empirically specified. But my intention rather than aiming at defining a detailed scheme of the different practical measures to undertake, was directed towards showing the utility of the economic and professional models for reducing the ends/means discrepancy which characterizes most public policies carried out in our country. To this regard, I think that I have been able to show the fertilityf both models in allowing us to elaborate medical personnel policies more satisfactory than the actual ones.

I still have to face the second objection. Also in this case, we cannot deny that doctors have more incentives to collective actions than the other actors in the SSN. But the asimmetry doesn't necessarily mean that no change is possible. On the contrary, preferences can be modified and collective interests when cogently defined and consistently specified, can significantly strenghten the visible hand of government. If this is true

then, the proposal sketched in these pages seems very attractive. Based ass it is on the necessity both of developing anew serious and systematic confrontation between doctors and SSN and of promoting new educational curricula, this proposal, could, on the one side ease the spontaneous consent on the part of the doctors. On the other side, if this consent did not widely develop, the new dialogic practice above described could allow to denounce to the public opinion the"egoistical" interests of doctors, thus increasing the collective consent towards the legitimacy of public intervention in health care , which, at the moment being, wouldn't appear an irrelevant result.

TABLE 1

Incompatibilities and restrictions in medical practice, in 1981

Categories of doctors	PUBLIC SECTOR							PRIVATE SECTOR			
	General Practitioners	General Paediatricians	Specialists		Public hospitals		Other public health serv.(1)	Private hospitals			Free practice
			in public clinics	in private ambulatories	full time	part time		full time	part time	fee for service or hourly fee	
General Practitioners		I	I	I	I	R		I	R(2)	(3)	(3)
General Paediatricians	I		I	I	I	R	I	I	R(2)	(3)	(3)
Specialists (in public clinics)	I	I		R	I	R	I	I	R(2)		
Specialists (in private ambulatories)	I	I	R		I	R	I	I	(2)		
Public hospitals (full time)	I	I	I	I		I	I	I	I	I(4)	I(4)
Public hospitals (part time)	R	R	R		I		I	I	I		
Other public health serv. (1)	R	I	I	I	I	I		I	I		
Private hospitals (full time)	I	I	I	I	I	I	I		I	I	I(4)
Private hospitals (part time)	R(2)	R(2)	R(2)	(2)	I	I	I	I		I	
Private hospitales (fee-for-service or hourly fee)	(3)	(3)			I(4)			I	I		
Free practice	(3)	(3)			I(4)			I(4)			

Source: CREDOC Report, 1981

Notes : I = Incompatible post or job

R = Compatible post or job, but under specified restrictions (in the number of patients on the list, hours of activity etc.

(1) Community doctors

(2) Incompatible post or job if the private hospital has a contract with the NHS

(3) Free practice is not allowed for patients on the list

(4) Free practice is incompatible, but in fact is carried on

FOOTNOTES

1) See, for example, R.Evans, "A Behavioral Cost Function for Hospitals", Canadian Journal of Economics, maggio 1971; M.Feldstein,"The Rising Price of Physicians'Services", Review of Economics and Statistics, 52, 1970; J.Newhouse, The Economics of Medical Care: A Policy Perspective, Addison-Wesley, 1978; -------, " A Model of Physicians Pricing", Southern Economic Journal, 37,1 970; M.Pauly, Doctors and their Workshop: Economic Models of Physicians Behavior University of Chicago Press, 1980; M.Pauly e M.Redisch "The Not-for Profit Hospital as a Physicians Cooperative",American Economic Review, 1973 e US Department of HEW Resource Administration, The Target-Income Hypothesis and Related Issues, 1980.

2) See W.Glaser, Paying the doctor, J.Hopkins Press, 1970;M.Hornbrook, " Allocative Medicine: Efficiency, Disease Severity and the Payment System", The Annals of the American Academy of Political and Social Science special issue on Health Care Policies in America 468, 1983;M.Pauly, (1980), op.cit.; U.Reinhardt, "Alternative Methods of Reimbursing noninstitutional Providers of Health Care Services", Institute of Medicine. Controls on Health Care National Academy of Science, 1975.

3) See A.Cochrane, Effectiveness and Efficiency: Random Reflections on Health Services, Nuffield Provincial Hospital Trust, 1972; T.Mckeown, The Role of Medicine, Blackwells, 1979; F.Brearly et al., The Social Context of Health care, M.Robertson, 1978.

4) See R.Evans, "Supplier Induced Demand:Some Empirical Evidence" M.Perlman(ed.), The Economics of Health and Medical Care, Wiley, 1984; J.Green, "Physician-Induced Demand for Medical Care", Journal of Human Resources, 13, 978; V.Fuchs, "The Supply of Surgeons and the demand for operations", Journal of Human Resources, 3, 1978; G.Monsma, "Marginal Revenue and the Demand for Physician's services", F.Klarman(ed.), Empirical Studies in Health Economics,J. Hopkins Press, 1970; U. Reinhardt, " The Physician as generator of Health Care Costs", Health Care and the American Economy: Issues and Forecast, Health Services Foundation, 1978; J. Newhouse, op.cit.; S.Ross,"The Economic Theory of Agency", American Economic Review, 3, 1973. For what concerns specifically the Italian case, see M.Ferrera and G. Zincone, La domanda sanitaria in Italia, Centro Einaudi, 1983

5) See M.Roemer, "Bed Supply and Hospital Utilization: a Natural Experiment", Hospitals 35, 1961.

6) See M.Feldstein, op.cit.; R.Andersen et al., Equity in Health Service Ballinger, 975; J.Le Grand, Strategy for Equality, Allen e Unwin, 1982; P.Davidson, Inequality in Health Penguin, 1982.

7) For what concerns, in general, the economic approach to the analysis of collective action, see behind the seminal work of M.Olson, The Logic of Collective Action, Harvard University Press, 1965 and the many analyses of the School of Public Choice, J.Q.Wilson, The Politics of Regulation, Basic Books, 1980 and C.Schultze, The Private Use of Public Interests, Brookings 1976. For what concerns, specifically, the medical profession, see M.Friedman and S.Kuznets, Income from Independent Professional Practice, National Bureau of Economic Research, 1945; R.Alford, Health Care Politics, University of Chicago Press, 1976; P. Feldstein, Health Associations and the Demand for Legislation, Ballinger, 1978; E.Feingold, "Who Controls the Medical Care System," Annals of the Academy of Political Science, 1980; R.Klein, The Politics of the NHS, Longmans, 1984; T.Marmor et al., " Politics of Medical Inflation", Journal of Health, Politics and Law, spring 1976; H.Hiatt, " Protecting the Medical Commons: Who is Responsible?", New England Journal of Medicine, 1975.

8) For what concerns the limits of the proto-bureaucratic model for delivering complex personal services, see G.Freddi,"Bureaucratic Rationalities and the Prospect for Party Government", E.U.I. Working Paper 57, Firenze, 1983 and the wide bibliography reported; N.Luhmann, Teoria Politica nello Stato del Benessere, Milano, 1983; J.Mishaw, Bureaucratic Justice, Yale University Press, 1983.

9) On the peculiarities of medical professional logic, see G.Freddi, op.cit.; -------"Conclusioni: il Servizio Sanitario come sistema politico-organizzativo", G.Freddi, (ed) Rapporto Perkoff:Salute e Organizzazione nel Servizio Sanitario Nazionale, Il Mulino, 1983; S.Berki, "Health Care Policy: Lessons from the Past and Issues of the Future", Annals... (1983); G.Calabresi, P.Bobbit, Tragic Choices, Norton, 1978; P.P.Donati, "La trasformazione del rapporto comunicativo nella relazione interpersonale medico-paziente", in Rassegna Italiana di Sociologia, n.4, 1984; A. Freidson, The Professional Construction of Concepts of Illness, Dodd and Mean, 1973; V.Fuchs, Who shall live?, Basic Books, 1975. See, also, the seminal T. Parsons, The Social System, The Free Press, 1951.

10) For the distinction between "cosmopolitans" and "provincials", see R. Merton, "Patterns of Influence:Local and Cosmopolitan Influentials" in R.Merton, Social Theory and Social Structure, Free Press 1957; P.Blau, Exchange and Power in Social Life, Wiley, 1964.

11) For example, for what concerns the bureaucratization of doctors' behavior, the followers of the economic model would be partially right in pointing at the preferences of physicians for comfortable work-conditions as an important cause of the bureaucratization process itself. But, would also be partially right who, following the professional model, would attribute the main responsabilities for this process, to the myopic character of proto-bureaucratic intervention.

12) This position, by the way, is largely shared by the most recent literature in health matters. See, for example, A. Maynard and G.Mclachlan (eds.), The Public/Private Mix, Nuffield Provincial Hospital Trust, 1982; The Annals, (1980).....op.cit.; D.Mechanic, Future Issues in Health Care, Springer, 1980; T. Marmore,and J.Christianson, Health Care Policy. A Political Economy Approach, Sage, 1982; J. van der Gaag, and M.Perlman, (eds.), Health, Economics and Health Economics, North Holland, 1981. For what concerns more radical positions not analyzed in this article in so far as incompatible with the maintenance of the SSN, see A.Enthoven, Health Care Plan Addison Wesley, 1980; C.Havighurst, Deregultating the Health Care Industry, Ballinger, 1982.

13) See, R.Luft Health Maintenance Organizations:dimensions of performance, Wiley, 1981. L.Brown, Politics and Health Care Organization: HMO's as Federal Policy, Brookings 1984.

14) See C.Hanau, Indicatori di bisogno, manuscript

15) See J.Wickings et al. The Effects of Presenting Management Information to Clinically Accountable Teams, Health Information Unit, Brent Health District. 1975.

16) See A.Maynard and G.Mclachlan, op.cit.

17) See C.Havighurst and C.Blumstein, "Coping with quality/Cost Trade-offs in Medical Care: the Role of PSRO's", Northwestern University Law Review, 70, 1; PSRO, Health Care Financing Research Report, 1979 Program Evaluation. HCFA P.N.03041

18) See M. Drummond, Principles of Economic Appraisal in Health Care, OUP, 1980; -------- Studies in Economic Appraisal in Health Care, OUP, 1981.

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PHYSICIANS' PROFESSIONAL AUTONOMY IN THE WELFARE STATE: ENDANGERED OR PRESERVED?

A comparative analysis

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1. The Problem: Physicians and the "Welfare State Dilemma"

Throughout western welfare states physicians are being confronted with increasing pressure on their professional autonomy. This development is due to a mechanism which could be described as the "welfare state dilemma". If the physicians of a country agree to participate in a publicly, or at least para-fiscally financed health insurance programme, this will significantly change the conditions of their professional activities. On the one hand the doctor's "market capacity" will be considerably expanded, however, on the other hand physicians will become the object of economically motivated attempts by welfare state agencies to control their behavior. This has been the case particularly since the maturation of the welfare state has led to a significant resource transfer into the health care system, whereby the clinical working process has lost its purely medical character and become a measure of macroeconomic significance. For this reason great public interest is arising.

In fact, the complete history of relations between doctors and the welfare state could be interpreted in the light of - the mainly unsuccessful - efforts to subordinate the "contrariness" of physicians under the economic requirements of welfare state developments.[1] But since the "crisis of the welfare state" has, in the long run, reduced the scope of financial transactions in the health care system, it is to be expected that public control efforts would reach a new degree of intensity.

This assumption is not only based on the fact of economic constraints, but on two additional factors. First, the decline of the formerly high esteem of doctors' activities. This societal value change was caused when the limitations of orthodox medicine became apparent, such problems as iatrogenesis, and the generally decreasing margin utility of public health care investments, as has been critized, for example,

in the popular books of Ivan Illich or Thomas McKeown. The declining trust in modern medicine is significant in so far as it is shattering one of the most important legitimation shields for the superior position of physicians in the health care system - their medical expertise. Now clinical decisions are being exposed to the pressure of economic constraints. Secondly, the scientific and technological developments in the area of electronic data processing have made verifiable the whole medical working process. This is also increasing the possibility of standardizing medical procedures in their economic aspects.

Following the dictum of Robert Klein, "the Welfare State is the residual beneficiary of the Growth State" (Klein 1980, p. 29), control procedures which reach to the core of the professional autonomy were superfluous as long as economic growth rates were counterbalancing the costs of the medical working process. In the absence of such growth rates, and a concurrently enhanced public involvement in the financing of health services, distributional conflicts are occurring. Therefore, the physicians freedom of medical choice is inevitably becoming a focal point for public cost control activities.

1.1. The Meaning of "Professional Autonomy" for the Health Services

The term "professional autonomy" refers in this case to the ability of the physician to make autonomous decisions concerning the contents and the conditions of the medical working process (Freidson 1970, pp. 368). Correspondingly, a loss of professional autonomy occurs when the physician is forced to take into account external, especially economic decision-making calculations. This might be the case if utilization reviews, systems of economic monitoring or therapy plans, based on "efficiency" criteria, are imposed on the physicians'

medical decision-making process. Although economic factors were never completely absent from medical decision-making process (Luft 1983), they never had a dominant influence.

What then might be the consequence of a reduced professional autonomy for the health policy field in general? Undoubtedly, the most drastic outcome will be concerned with the quality of medical care. To the extent that economic rationality is entering the medical working process, medical and social considerations will be pushed back. Even if the economic "domesticization" of the medical profession is viewed as an appropriate instrument to reduce the frequently deplored professional dominance in the patient-physician relationship or to smash the veto-power of doctors against alternative forms of health service delivery, there are indispensable elements of professional autonomy which may not be sacrificed without endangering the quality of medical care.

Therefore, because the economic domesticization of physicians may not be viewed as a desirable aim (Moskop 1981), the following considerations have the additional aim of defining conditions which are favorable both to professional autonomy and to a sufficient level of welfare state services.

1.2. Defining the Research Questions

In comparing some important welfare states (cf. part 2), it could be indicated that, despite frequent efforts to reduce professional autonomy, physicians have to a large extent been able to preserve their autonomy, with one exception: For some years doctors in the USA have been exposed to a severe challenge to their professional autonomy, especially concerning the medical decision-making process.

These results are, for the moment, astonishing because for a long time US-physicians were regarded by medical sociolo-

gists, political scientists, and economists as the best example of a profession which was able to successfully achieve their goals (Alford 1975; Goodman 1980). Furthermore, a restriction of professional autonomy was usually considered as the outcome of state interventions, as in the case of a publicly organized health care system. However, one of the most remarkable features of the US-health care system is precisely the non-existence of a national health insurance and related welfare state interventions as comparable with western European conditions.

Interestingly enough, the assumption that professional autonomy in particular is restricted by the integration of the physician into the machinery of welfare service production is not only a vital part of the belief systems of the medical profession itself, but also a commonly held opinion within the social sciences, mostly with reference to evidence from individual countries (Charles 1976; Björck 1977; Baier 1978; Tiemann 1983). The term "socialized medicine", mostly used in a negative way, is the terminological product of this view. This thesis is generated from the more general contention that state interventions almost automatically reduce the autonomy of professionals (Johnson 1982).

The above mentioned welfare state dilemma also seems to buttress this assumption. According to this, a relative "distance" of physicians to the welfare state is enhances professional autonomy and vice versa, i.e. relative "closeness" to welfare state agencies inevitably reduces the scope of professional autonomy. But there are two factors which put into question the relevance of this assumption. First, the already mentioned example of the predominantly privately organized US-health care system which ought to preserve a high degree of professional autonomy. Secondly, there are several, mostly critical, research reports which indicate that the medical profession in different countries, despite a highly organized welfare state bureaucracy, was able to preserve its autonomy

in the clinical working process (Mechanic 1976, p. 30).

Because of these apparently contradictory facts and opinions it seems to be necessary to analyze the correlation between the organizational density of the welfare state and a loss of professional autonomy. This problem will be examined in the subsequent considerations in the light of the following questions.

1. To what extent were physicians able to preserve their professional autonomy in welfare states with different degrees of organizational density?

2. On which mechanisms is the stabilization or the destabilization of professional autonomy based?

3. Which conditions must be fulfilled to preserve professional autonomy to an extent which does not affect the quality of health care?

2. The Professional Autonomy of Physicians - an International Comparison

The countries which are integrated into the research are the USA, the Federal Republic of Germany, Great Britain, France, and Sweden. This choice is based on the health care system typology of Mark Field (Field 1980). In accordance with this typology, welfare states with a low (USA), a medium (FRG, FR), and a high degree of organizational (GB, SW) density have been chosen. The differentiation between different degrees of organizational density is based on the level of market domi-nance or state dominance in the health care system. Therefore, three ideal types could be identified (Martinelli 1983, p. 127). First, a mainly market-based model with no comprehensive public health insurance, secondly, a restricted market model in which, due to the existence of a national

health insurance, i.e. a monopolistic payer structure, only the sector of health care providers has retained some market mechanisms, and, finally, a state-dominated model in which both sectors are a public responsibility.

Because the following factors are held responsible for determining the degree of professional autonomy, every country will be analyzed under the criteria of (1) the organizational structure of the health care system, (2) the dominant health policy and welfare state ideologies, (3) the power position and structure of the major medical associations, and (4) existing procedures and mechanisms for negotiating doctors' remuneration and supervision or monitoring systems for clinical decision making. As far as possible, only office-based physicians will be taken into consideration because the working situation in hospitals usually differs significantly from that in private practices. Of course, this subdivision is feasible only in countries with clear boundaries between the two sectors, as is the case in Germany.

2.1. The United States of America: Physicians and the Free Market

The US-health care system is the only one which could still be defined as "pluralistic", following Fields typology (Döhler 1984a, pp. 9). This means in particular that in the USA there is no publicly organized health insurance scheme which covers the vast majority of the population like in the western European welfare states. Rather, the US-health system is organized in a mostly private and highly decentralized manner. Although the federal government finances a significant part of the health services, control over these public funds is left extensively to the private sector.

In this environment the medical profession held a very influential power position in the health care system for a long

time which was unique in the western world. For example, under the pressure of the physicians' well organized and powerful lobby organization, the "American Medical Association" (AMA), several attempts to introduce a national health insurance were thwarted, as these would have unavoidably led to greater public control competences (Starr 1982). On the basis of these lobbying capacities of the AMA, the health insurance programs Medicare (for the old) and Medicaid (for the poor), introduced in 1965, were not connected with an intensified public authority to control physicians behaviour either. To receive the agreement of the AMA for the passing of the Medicare/Medicaid bill, legislation constructors were forced to concede to the medical profession permission to charge fees under the provision that they would be "usual, customary, and reasonable" (Marmor 1973, p. 80). Because, moreover, both programs are administered through "fiscal intermediaries", consisting of private health insurance carriers, the government's ability to control the costs of these programs is decreased even more.

The fact that Medicare and Medicaid were mostly responsible for a rapid cost explosion in the health care system which put increasing strains on the federal and the state budgets, however, led to the passage of a bill in 1972 which was designed to build up so-called "Professional Standards Review Organizations" (PSROs). In order to ensure a high quality of care, these regulatory agencies should monitor physicians' bills for Medicare and Medicaid patients. But in fact they were designed for the purpose of cost control. Because the AMA was able to influence the legislative process, the administration of the PSROs was left entirely to regional medical societies (Starr 1982, pp. 400). Therefore, the PSROs were hardly equipped for cost control. Similar judgements could be made about other regulatory laws which were enacted subsequently, such as the Health Planning Act of 1976 (Starr 1982, pp. 401).

The political power of US-physicians is mainly based on their potential ability to refuse to participate in publicly organized health programs and, additionally, on deeply rooted public and congressional ressentiments against state interventions which could easily be mobilized. This veto-power corresponds to the fact that welfare state agencies in the USA have hardly any instruments to influence or even to monitor physicians' behaviour. In so far as fee schedules for the reimbursement of federal or state-financed health care programs actually exist, they are usually based on measures laid down by regional medical societies (Glaser 1978, pp. 182). In other words, state interventions up to now have not entailed a restriction for physicians' professional autonomy, mainly because they could be either neutralized or completely rejected by the AMA.[2]

However, the inability of the federal government to control the health care cost explosion caused two developments which constitute a serious challenge to physicians' professional autonomy. First, since the mid-seventies private business firms have developed an intensified interest in holding down the cost explosion. This involvement is based on the fact that employers in the USA most often pay up to 80 or 90% of the health insurance premiums of their employees. Now private firms are trying to curb health care costs in a more radical way than public bureaucracies ever could do. Business interests are now entering the clinical working process of physicians in various ways. They are trying to negotiate directly with providers, i.e. physicians and hospitals, to accomplish cheap methods of diagnosis and therapy. Private peer review firms are appointed to control and if necessary to "adjust" the behaviour of physicians. Business Coalitions, i.e. voluntary associations of business enterprises, educate their members to deal with reluctant physicians and hospitals and the like (Döhler 1984a; 1985).

The rapid cost explosion, secondly, has transformed the health care sector from a "cottage industry" into an attractive object for commercial investors (Döhler 1984a, pp. 128). Because of the underdeveloped welfare state density in the USA and the preference of the incumbent conservative health policy makers for commercial health care providers and insurers, there is hardly any resistance against the economization of good health. Therefore, over the past few years a rapidly growing "medical industrial-complex" (MIC) has been evolving, consisting mainly of hospital and HMO chains, whose economic orientation, backed by an increasing oversupply of medical graduates, is forcing physicians into the position of salaried wage earners (McKinlay 1982; Derber 1983).

Because profit or, in other words, the cheap "production" of health, is the driving force in commercial health care facilities, physicians are exposed to intensive monitoring of their diagnosis and therapy patterns by sophisticated computer information and utilization review systems. These control mechanisms present a serious challenge to the professional autonomy because physicians are forced, for example, to comply with fixed therapy plans which reduce their freedom of clinical decisions (Fuchs 1981; 1982). Otherwise doctors are simply dismissed.

Thus, physicians' victories of the past shaped the defeats of the present: "The great irony is that opposition of the doctors and hospitals to public control of public programs set in motion entrepreneural forces that may end up depriving both private doctors and local voluntary hospitals of their traditional autonomy" (Starr 1982, p. 445). Accordingly, the very thing that physicians sought to prevent, i.e. a close control of their professional autonomy by public authorities, brought them under the much more vigorous control of private enterprises.

It could be concluded that the worsened situation of U.S. physicians was caused to a great extent by their inability to achieve a moderate increase in fees and their successful resistance against public cost control efforts which, in turn, has led to a distinct withdrawal of the federal government from the cost containment business and the taking up of this function by private organizations. On the political and ideological level the process of subordinating the medical profession under economic constraints is supported by the currently prevailing market reform advocates in the Reagan administration and in Congress (Döhler 1984a). Their major aim is to dismantle the welfare state and to reinstall market forces in the health care system. But in contrast to traditional conservatives, market reformers are not committed to consider the autonomy of physicians. Therefore, the erosion of professional autonomy will continue in the near future.

2.2. The Federal Republic of Germany: The Advantages of Health Policy Corporatism

The German health care system, as opposed to the American, is mainly based on a national health insurance (NHI) which covers the vast amount of the population. The German NHI is the prototype of a social insurance system (Stone 1980), consisting of nearly 1.300 sickness funds, which have the status of bodies of public law, and which are financed in equal parts by the premiums of employers and employees. The dominant ideology is the so-called "self-administration" which means that the sickness funds are administered by equally represented and elected officials from the associations of employers and employees. The self-administration ideology also holds for physicians organizations. This system is due to a very complex legal code, the "Reichsversicherungsordnung" (RVO), which regulates in detail the functions and competencies of the different agents in the German health care system.

This highly legalized health insurance scheme has also engulfed the medical profession - but not to their disadavantage (Stone 1980; Glaser 1978, pp. 97). Physicians in Germany are represented by a very complex three-tiered organizational system which is also the result of the the self-administration ideology (Rauskolb 1976). First, every physician is a compulsory member of a physicians chamber ("Ärztekammer") which mostly deal with professional matters such as professional ethics, the continuation of medical education, professional tribunals etc.

Secondly, physicians who want to participate in the NHI programme must be members of a regional as well as a self-administrated, i.e. solely by physicians, "Kassenärztliche Vereinigung" (KV), the association of fund doctors. The most important function if the KV is to negotiate physicians' reimbursement with the regional associations of sickness funds and to administer the "aggregate reimbursement" (Gesamtvergütung) (Schülke 1977) which, as a result of the annual negotiations, is transferred from the sickness funds and used to pay the fund doctors according to the services they have rendered to the insured patients (Glaser 1978, pp. 98; Stone 1980, pp. 95. The reimbursement is a conversion factor of two different fee schedules which are based on the centralized negotiations between the "Kassenärztliche Bundesvereinigung", the federal association of fund doctors, and the federal associations of sickness funds. Additionally, the KV is responsible for the sufficient provision of ambulatory medical services in the area of their competence. Thus the economic performance of ambulatory health care - the hospital sector is run on a different basis - is left almost entirely to the physicians' organization with only minor involvement of the sickness funds. This is also true in the case of economic monitoring, which is also processed by the KV (Stone 1980, pp. 105).

Whereas both the above mentioned organizations also have the status of bodies of public law, the third tier of physicians' organizations, the various medical associations, is based on the status of private law. The medical associations are mainly organs to represent and to articulate physicians' political interests.

In German health policy, to a significant degree due to the firm establishment of the profession in the differentiated welfare state apparatus, almost nothing functions without or against physicians. This could be verified throughout the history of the NHI. As far back as in the Weimar Republic, physicians successfully defeated the efforts of the sickness funds to partially "socialize" the health care system by means of establishing health centers with salaried physicians (Döhler 1984, pp. 293). In the post-war period physicians actively promoted the reconstruction of the traditional organization of the German health system with a legally and economically privileged position for office-based doctors (Kirchberger 1979). And again in the following decades medical associations achieved significant impact on federal legislation concerning methods of remuneration and status privileges vis-á-vis other health professions, for example psychologists, and the like (Rauskolb 1976, pp. 231.)

Therefore, it is not surprising that German physicians were able to preserve a high degree of professional autonomy. However, recent legislation, especially the "Health Care Cost Containment Act" (HCCCA) of 1977 which was enacted to cope with health cost explosion, has been interpreted by several authors as a severe threat to the clinical freedom of physicians (Baier 1978, pp. 115; Hamm 1980; Nord 1982, p. 63), because an expenditure "cap" is imposed on physicians' reimbursement which apparently forces doctors to take economic measures into account. In fact by the HCCCA, a corporatist negotiating system, the "Konzertierte Aktion im Gesundheitswesen" (KAG) was introduced (Wiesenthal 1981) which might in

theory have threatened the professional autonomy of physicians.

The major function of the KAG, in which the associations of physicians, hospitals (since 1982), sickness funds, and the different levels of government are represented on a voluntary basis, is to "recommend" once a year an annual increase of health care expenditures, including physicians reimbursement, which is linked to the annual average increase of wages and salaries ("Grundlohnsumme"). The sickness funds and KVs are expected to negotiate fee increases according to this measure. Although this subordination of the health care system to measures of economic development represents a striking turning point in German health care policy, it may not be viewed as an assault on professional autonomy. There are two arguments against this assumption. First, the KAG only has the competence to recommend, but not to enforce, a certain level of health care expenditures. If the recommendation is exceeded, no sanctions against physicians are possible. Therefore, the modest success of this corporatist arrangement is mainly based on a "moral susasion" mechanism. Secondly, the participation in the KAG is voluntary and physicians still possess the "exit option" (Hirschmann), i.e. to leave the KAG.

The German case indicates that especially the organizational integration of physicians into the network of a corporatist welfare state negotiating institution serves as a "buffer" against possible threats to professional autonomy, as might be the case with fee schedules, economic monitoring, and reimbursement methods. The agreement of physicans to participate in the cost control activities of the KAG, i.e. to accept the primacy of macroeconomic data, has the remarkable effect that changes in the power structure are dropped from the health care agenda, for example, the granting of more comprehensive supervision rights to sickness funds, i.e. the monitoring of physicians' prescribing patterns. Thereby, the

legal staus quo is maintained and the RVO ensures that welfare state interventions, such as the above mentioned monitoring of prescribing patterns, which might otherwise impair physicians' clinical freedom, are channeled through the responsible organizations, in this case the KVs which are controlled exclusively by physicians.

2.3. Great Britain: Physicians and "Socialized Medicine"

Since the turn of the century the medical profession in Western countries has successfully applied the term "socialized medicine" to prevent policy developments which might lead to greater public authority in the health care system. From this point of view the introduction of the British "National Health Service" (NHS) in 1948 is a unique achievement among capitalist nations. Until Italy launched its "Servicio Sanitario Nationale" (SSN) in 1980, the NHS formed the only health care delivery system among Western nations which was based on a centrally administered and determined budget, almost completely financed by general taxation, and intended to provide free provision of medical services to the entire population (Klein 1983). This function is carried out by a complicated and hierarchically ordered administrative structure which is part of the central government. Market forces and even the insurance principle, sometimes viewed as the organizational basis of the modern welfare state, are completely excluded from health care, with the exception of a small but increasingly important private sector.

However, even if the term "socialized medicine" might be an appropriate characterization of the NHS, some major limitations should be emphasized. First, on the level of ideology, the NHS is not simply a socialist victory, but moreso the outcome of a "radically managerial ideology" (Klein 1983, p. 25), arising from the intellectual consensus of both parties. This "non-socialist" orientation is openly reflected,

for example, in the politics of prevention. Whereas the Italian SSN is devoted to a radical environmental approach for the prevention of disease, an individualist model of prevention is still predominant in the NHS (Taylor 1984). Therefore, it could be argued that the NHS is not challenging the human costs of the capitalist production process, as is the case with the Italian SSN. Secondly, the British health care system was not entirely socialized by the introduction of the NHS. This was only the case with hospitals. Physicians were dealt with in a different way.

To understand the current situation of the medical profession within the NHS, it is necessary to mention the three different groups of physicians. First, there are the general practitioners who serve as "gatekeepers" to the NHS (Klein 1983, p. 87) and are represented by the "British Medical Association" (BMA). They are usually the first point of contact between the patient and the medical system. If specialist services and access to sophisticated medical technology are needed, the general practitioner has to refer the patient to a specialist. The specialists and, if located in a teaching hospital, the so-called "consultants" represent the second group of physicians whose professional association is the "Royal College of Physicians". Since the mid-sixties, when the first major payment dispute occurred (Marmor, Thomas 1973, pp. 428), the Royal College left the negotiating function to the more militant BMA (Glaser 1978, pp. 156). Specialists are partly, and consultants exclusively located in a hospital setting where their specialist services are rendered. On average it takes 5 to 8 years and the passing of several hierarchical stages after graduation until a junior hospital doctor attains the highly prestigious position of a senior, i.e. a consultant (Levitt 1977, pp. 98). Finally, the third group are the community physicians who are chiefly engaged in administrative and planning positions in the NHS (Levitt 1977, pp.101).

Only the community physicians are employed on a salaried basis by the NHS. Consultants and specialists have the option to work as part-time or full-time employees for the NHS with a fixed salary. The hospital doctors income, however, is not entirely dependent on the fixed NHS budget. This is the consequence of the most important and still disputed concessions which were made to secure the agreement of the medical profession for the introduction of the NHS: the right of hospital doctors to maintain highly profitable private beds in public hospitals for the use of privately-insured or fee-for-service patients (Klein 1983, pp. 118). As opposed to this, the general practitioners are not directly employed by the NHS, but on a contract basis. Depending on the panel list of their patients, usually about 2.300, they receive a capitation payment from the "Family Practitioner Committee", the administrative tier of the NHS which is responsible for securing ambulatory care.

Since the introduction of the NHS modalities and amounts of remuneration for physicians have been negotiated directly by the agents involved. This period of negotiations between the federal government, represented by the "Department of Health and Human Services (DHHS), the BMA and the Royal College was terminated in 1962. Since then, annual increases in salaries and capitation payments have been determined by the "Review Body for Doctors' and Dentists' Remuneration", an independent but state-financed agency which consists of a chairman and six "eminent persons of experience in various fields of national life" (Glaser 1978, p. 164), who are appointed by the Cabinet, usually with the approval of the BMA, and are supported by a civil servant staff from the Cabinet Office. The Review Body stands in the tradition of the so-called QUANGO's ("Quasi-Autonomous National Governmental Organizations"). Therefore, the agency is independent of governmental orders, but, on the other hand, its decision-making power does not include the right to fix physicians' remuneration. The function of the Review Body is solely "to advise the Prime Mini-

ster on the remuneration of doctors and dentists taking any part in the National Health Service" (Levitt 1977, p. 105). Only if the recommendations are accepted by the Cabinet can they come into force.

The Review Body determines doctors' remuneration by weighing the demands of physicians' associations, mainly the BMA, the proposals of the DHHS, current budget plans, and the evaluation of statistical material, such as changes in the cost of living or expenses for the general practice (Levitt 1977, p.105; Glaser 1978, pp. 169). Although the intention is that these recommendations represent a kind of "common denominator" between physicians and the government, it is clear that the calculations of the Review Body have to take into account economic measures which are inextricably entangled with the logic of the NHS. Under the rule of this system the feasibility of a physician-induced cost explosion is, to a large extent, eliminated, chiefly by methods of remuneration, i.e. salary and capitation, which create no financial incentives for the doctor to prescribe more than necessary, and the mechanisms of determining physicians remuneration by an independent agency, which is inevitably forced to consider the fixed budget of the NHS. The latter serves especially as a mechanism to channel the sometimes aggressively demanded income increases into the realms of the ecomomically "feasible".

Therefore, it seems to be a logical development that British physicians still enjoy a very high degree of clinical autonomy (Elston 1977; Tolliday 1978), and, although the clinical autonomy of physicians in the NHS has aroused vehement criticism (Robson 1973) for disregarding consumer needs, it is among the most sacrosanct ideologies in health politics. Review agencies or mechanisms for controlling the prescribing patterns of physicians are largely unknown in Britain. This is due to the fact that "because the NHS has a strict system of financial control over the total amount of resources allo-

cated, it has so far not had to devise a system of trying to control individual medical decisions" (Klein 1977, pp. 172). Interestingly enough, the only prescribing reviews - however, constituting no real threat to physicians' autonomy - are imposed on the general practitioners, that group of physicians in the NHS who are the least integrated into the bureaucratic structure of the British welfare state (Klein 1977, p. 173). Although British physicians have to pay a high price for preserving their professional autonomy, their income, as compared to other nations, is among the lowest in the Western world.[3]

2.4. France: "La Médicine Libérale" and National Health Insurance

Of all the countries reviewed in this analysis, the French health insurance system comes closest to the German especially with respect to the basic organizational principles of the health insurance. Approximately 99% of the French population is covered by a compulsory health insurance scheme consisting of three national sickness funds, of which the "Caisse Nationale d'Assurance Maladie des Travailleurs Salariés" (CNAM), insuring about 75% of the population, is the most important (Rodwin 1981, p, 19; Godt 1984, pp. 11). The different "caisses" are financed by the contributions of employers and employees and, therefore, are also administered by both agents. This centralized arrangement has been in effect since the Social Security Reform of 1967 succeded a highly decentralized, confused, and badly managed mixture of local sickness funds.

The reform of 1967 has not only strengthened the centralized control of the government over the health care system by subordinating the sickness funds under the direct supervision of the ministries of health and finance but has also brought about a significant change in the administration of the

funds. The labor-dominated boards were replaced and since then labor unions and employers have been represented in equal parts (Godt 1984, p. 11). The consequently "neutralized" fund administration was made available for direct state interventions. For physicians the 1967 reform became equally important. Instead of regional health insurance organizations, from which they had won significant concessions in previous years, they now had to face a powerful bargaining agency, the CNAM, with, as a result of the close ministerial supervision, an increased interest in cost containment.

The current form of the French health care system is the result of the historical struggle between those interests which are represented by the two conflicting ideologies "liberalism" and "solidarity" (Cohen/Goldfinger 1975, pp. 59; Rodwin 1981, p. 18). Since the French state abandoned its laissez-faire attitudes towards health policy after World War II (Rodwin 1982), liberalism is now only present in the concept of "la médicine libérale". This term refers to a set of rules which physicians regard as indispensable for sufficient medical care: "the patient's free choice of doctor, the physician's freedom of prescription, professional confidentiality, and the fee-for-service payment" (Godt 1984, p. 14). The concept of solidarite, on the other hand, was one of the most influential values leading to the introduction of a national health insurance in 1945. This extended responsibility of the state to ensure access to a sufficient level of medical care for the whole population, the simultaneous commitment to health care as a right for everyone and la medicine liberale served as the basis for most health policy conflicts (Sandier, Stephan 1983, p. 67).

One of the most striking examples is the involvement of the government in the area of regulating physicians' fees, starting with the May 1960 Decreé as a result of which, for the first time, the medical profession was forced to accept departmental negotiations over fee-schedules between the medi-

cal union, the "Confédération des Syndicats Médicaux de France" (CSMF), and regional social security authorities (Steudler 1977, pp. 190), on the condition that the agreement ("convention") received the approval of the government. The convention lays down in detail the relations between physicans and sickness funds and also contains the "nomenclature", an annually renewed fee schedule (Glaser 1978, pp. 40). The crucial innovation in the 1960 Decreé was that, if no collective agreements could be reached, physicians would be allowed to contract on an individual basis with the governmental bargaining agent. Because this rendered the CSMF superfluous and because physicians until that time were free to set fees, the medical profession came into serious conflict about the issue of accepting the conventions. Although the conventions contained a ceiling for fees, and thereby deviated from the sacred principles of la médicine libérale, most physicians prefered to accept the conventions. However, the CSMF became divided for this reason and those physicians who rejected the system of regional conventions, for the most part affluent urban specialists, formed the insurgent "Fédération des Médicaux de France" (FMF).

It was not until the 1971 negotiations about a new convention that the CSMF regained the function of speaking for physicians vis-á-vis the government. Nevertheless, the medical profession was seriously weakened by the internal cleavage between the two rival associations. Although the CSMF achieved a significant success by "a solemn commitment of the government" (Godt 1984, p. 14) to respect the concept of la medicine liberale in the 1971 convention, in the 1976 negotiations the FMF signed the agreement alone, thereby forcing the CSMF to follow suit. The same happened in the 1980 negotiations (Godt 1984, p. 21).

But not only the division between the two medical unions reduced the bargaining power of the medical profession. Because the convention of 1971 was negotiated as a national agreement

which applied to all office-based physicians, the ability of the medical union to avoid conventions on a regional level was wrecked. Additionally, by applying a national agreement on physicians' fee increases, cost control efforts became a matter of concern with macroeconomic significance, especially since the oil crisis of 1974 marked the end of post-war economic prosperity. The result of the declining growth rates was an increased interest of the government to reduce the upward spiral of health care costs.

As in other welfare states, the increase in coverage of the population, the proliferation of expensive medical technology, rising labor costs, including physicians fees, and other factors like these contributed to an accelerating cost explosion during the 1970s (Cohen/Goldfinger 1975, p. 78). Cost containment, therefore, became a major issue in French health policy. As a result of this and due to the already mentioned cleavage between the two medical unions, in 1977 physicians were not able to negotiate fee increases above the inflation rate and their income for the time declined in real terms (Godt 1984, p. 17). Still facing an ever-growing budget deficit, the CNAM, since 1978, has been trying to keep the fee increases below the inflation rate. Finally, after the 1981 socialist election victory, a fee schedule was introduced in the 1981 convention, which was closely linked to government-fixed economic measures. This cost containment policy proved successful enough to balance the 1983 budget (Godt 1984, p. 27) and relieved physicians from pressure on their autonomy. Although a reduction of the professional autonomy is frequently viewed as possible (Rodwin 1981, p. 38; Herzlich 1982 p. 252), French physicians hitherto have preserved the principles of la médicine libérale.

It could be concluded that the relative success of governmental cost containment has played an important role in protecting physicians from an intensified economic monitoring which was made possible by the 1971 convention. Since then,

individual "medical profiles" of each participating physician could be derived from the data pools of the sickness funds. The original aim of the profiles was to generate "self discipline" within the medical profession by submitting data about excessive prescriptions to the physicians concerned (Godt 1984, p. 15). Although this was largely a symbolic enterprise, the technical tool for restricting the therapeutical freedom of physicians was irretrievably created (Herzlich 1982, pp. 251; Rodwin 1981, p. 31).

Following the line of arguments which are elaborated in this paper, at first glance, it simply seems that, in France, the interventions of a strong welfare state into the health policy field (Steudler 1984) have abolished the physicians' bargaining power in order to achieve moderate increases in fees, and, due to their relative success, have thereby reduced the need for interventions into professional autonomy: "on a technical level, physicians had total control over medical treatment; their therapeutical freedom was left untouched. But their economic freedom was undoubtedly limited" (Herzlich 1982, p. 250).

This conclusion is plausible to a large extent. However, it should be mentioned that, despite apparently compelling fee schedules and considerably weakened bargaining organizations, physicians were capable of securing some "loopholes" to retain a certain degree of economic freedom. For example, physicians could be granted permission to charge fees over and above the valid schedule. Originally created for exceptional use to attract physicians with outstanding qualifications, the "dépassement permanent" was granted so inordinately that, by the mid-seventies, roughly 20% were privileged (Godt 1984, p. 19). Another method of increasing the income, despite binding fee schedules, was simply to multiply the number of procedures. The government's cost containment policy of the 1970s, which ended in subordinating physicians' fees to the economic prosperity, was largely an answer to

these counterproductive proceedings. Therefore, they still incorporate a potential cause for government-induced restrictions to therapeutical freedom.

2.5. Sweden: Toward a Salaried Profession

The health care system in Sweden bears some resemblance to the British NHS. Although there are still some elements of the former health insurance model, since the mid-seventies the health care system has been transformed, by a "silent socialization", into a quasi-public health service, i.e. a system with a very high degree of welfare state density (Glaser 1978, p. 134). This could be verified by three different factors. First, the main ideological orientation of Swedish health policy is based for the most part on the government's commitment to secure equality of access to the full range of medical care for the entire population. Therefore, all Swedish citizens are covered by a compulsory health insurance consisting of 23 regional sickness funds. These sickness funds, which evolved from the private health insurance carriers during the fifties, are public agencies which have merely retained the function of collecting the contributions from employers and employees and allocating these funds for the payment of medical services. They are under the close supervision of the national government and have no significant decision-making rights of their own (Glaser 1978, pp. 137).

Secondly, the percentage of physicians in private practices is declining steadily. Today there are less than 7% who are not employed by the state. The same is true in the case of hospitals of which only 5% are run by private owners (Hammerström/Janlert 1982, p. 244). As a result of the high degree of specialization and the outstanding importance which the hospital has in Swedish medicine, physicians are mostly employed in (state-owned) hospitals. Only a small percentage

practises as office-based "district physicians" providing primary, i.e. non-specialist, care or as private physicians.

Thirdly, the far most important agencies for the health care system are the 23 regional county councils ("landstingen") who are responsible for planning, financing, and supplying hospital as well as primary medical care in their area. This means that no para-fiscal, quasi-public or even private institutions but rather a regional branch of the state is responsible for the supply and allocation of health services. As of the mid-sixties these functions were transferred to the county councils in order to achieve a more equal distribution of health services. (Hessler/Twaddle 1982, p. 444). Therefore, the counties run most hospitals, health centers, and, additionally, employ the district physicians. These services are financed by the contributions which are collected by the sickness fund, by taxes levied by the counties, and by additional grants from the national government (Bendix/Klingeberg 1980, p. 146). All together, these ideological and organizational principles form a health care system which is close to the ideal type of a national health service.

In accordance with the Swedish health care system, especially the predominantly salaried status of physicians, the medical profession is organized in the trade union-like "Swedish Medical Association" ("Sveriges Läkarförbundet"/SMA) which has about 90% of all physicians as members. As a result of this, the SMA has a representation monopoly for negotiations over salaries and working conditions with public employers (Glaser 1978, p. 139). Worth mentioning, the SMA is the only medical association in this study which coordinates its bargaining activities with the professional workers' bargaining organization, the SACO (Glaser 1978, pp. 140).

However, as in most other countries, there are some tensions between junior and senior hospital doctors as well as between office-based and hospital-based physicians. Their interests

are represented within the SMA by the association of district, private, senior hospital and junior hospital doctors. Due to their growing number, the most important group which challenges the traditional politics of the SMA, and has therefore shaped the current situation of Swedish physicians, is the "SYLF", the association of junior hospital doctors. Although the SYLF, as an autonomous organization, has no bargaining functions and all their members are simultaneously in the SMA, it has exerted great influence on the health policy attitudes of the SMA. Since the mid-fifties the SYLF-members have attained a significantly increased presence in the SMA's executive committee (Heidenheimer 1980, p. 126). The SYLF leaders contributed considerably to the transformation of the SMA from a professional association into a trade union with "lesser concern with protecting professional 'autonomy' or the status distinctions between medicine and other occupational groups, and greater concern with successful economic bargaining results" (Heidenheimer 1980, p. 135).

It is necessary to mention the SYLF-dominance within the SMA to understand the modes of policy-making surrounding the so-called "Seven Crowns Reform" (SCR) of 1970, the most important post-war legislative action concerning the situation of Swedish physicians. The outcome of the SCR was that government-employed physicians, i.e. 90% of all physicians, were totally excluded from financial transactions with the patient. Prior to 1970, physicians had been allowed to practice part-time on a fee-for-service basis. The patient had to pay the physician directly and was then reimbursed at a rate of 75% of the fee schedule by the sickness funds. Henceforth, the fee-for-service principle was eliminated by putting government-employed physicians on a full salary and prohibiting at the same time the charging of additional fees. Instead the patient had to pay a fixed fee of seven crowns for each outpatient visit which has since been increased considerably. Furthermore, the income differences between the various groups of physicians, which have caused internal conflicts

within the SMA during the sixties, were reduced. Almost needless to mention, the SCR was the reaction to the unsuccessful efforts to control the health care cost explosion by means of fee schedules (Shenkin 1973, p. 557).

Although this radical change in physicians' remuneration was somewhat disputed within the medical profession, especially because of income reductions for some specialists with above average incomes and the abolition of the fee-for-service principle, the SMA finally accepted the SCR. The agreement of the medical profession, to be almost entirely socialized, is only understandable if one imagines the slow transformation of the SMA toward a professional trade union. This has led to a situation in which, "from the the perspective of the SMA leadership (under the influence of the SYLF. M.D.), the SCR provided an opportunity to solidify and institutionalize the new role" (Bendix/Klingeberg 1980, p. 169).

Even though it is assumed that, at the latest since the SCR, Swedish physicans have been under total government control (Björk 1977), their professional autonomy has been left untouched (Twaddle/ Hessler 1982, pp. 16). Of course, the ability of physicians to determine their income was strongly reduced by the elimination of the fee-for-service principle. But, on the other hand, while the welfare state received a great opportunity to control physicians' income via negotiations over salaries with the SMA, other forms of health care cost controls, possibly challenging physicians' autonomy, have been neither debated nor practised, mainly because cost containment is orientated toward physicians' salaries. The SCR established the foundation needed for a stable, organized negotiating system.

3. Discussion

The first conclusion which could be drawn from the previous chapters is, as opposed to the commonly held opinion, that there is no positive correlation between the degree of welfare state development and a reduced professional autonomy of physicians. There is even some evidence which might facilitate the reverse argument, i.e. that professional autonomy is protected best in those countries where the welfare state has developed the most, as is the case in Britian. However, such a longe-range thesis would require additional research, especially by analyzing some more countries.[4] Anyway, the question of this paper is a different one, namely to find out and to explain those factors of welfare state development which influence, either in a negative or a positive way, the professional autonomy of physicians.

Prior to answering this question, it is necessary to make reference to the limitations of the research findings we have to hand. First of all, physicians by themselves, and also most economists, tend to define "professional autonomy" also, or mainly, as economic freedom. However, because this prevailing definition is derived from a historical situation which has not had the experience of a matured welfare state and could therefore not be applied to the current stage of welfare state development (Johnson 1982, p. 207). The previous assumptions arose from a more restricted definition which only included the conditions of professional work, chiefly the freedom of clinical decisions, and were therefore only valid if this definition was accepted. It should also be distinguished from the term "deprofessionalization" which usually refers to the erosion of professional ethics (Bollinger/Hohl 1981).

Secondly, a restriction of physicians' autonomy could also be caused by factors other than welfare state interventions. To mention only the most important: An integration of physicians

into greater medical facilities, like hospitals or health centers, might be connected with increased control of the clinical behaviour either by peer review or administratively-imposed control mechanisms. Furthermore, physicians' decision-making functions might be restricted by the penetration of para-professionals into the area of medical care or an increased consumer participation (Haug/Levin 1983). Finally, the physicians' rights to decide autonomously over patients' treatment might be, and actually are, impaired by court decisions, as is the case in the USA with an expanding number of malpractice suits, or by the growing number of laws (Müller 1979). If professional autonomy is restricted in a country, factors like the above mentioned have to be distinguished from those of the welfare state.

As was already mentioned at the beginning of the paper, and after an additional verification of those welfare states considered in this study, it could be ascertained that, with the exception of the USA, physicians' professional autonomy, as defined here, has been largely preserved. This assumption gives rise to the question about the factors which are responsible for the stabilization or destabilization of professional autonomy.

On reconsidering the problem, it seems that physicians must inevitably become more and more exposed to the consquences of economic scarcity. On one hand, a return to the free market in health care, i.e. a major withdrawal of the state, is only possible to a very slight extent, chiefly because medical care has become so costly that public financial assistance can not be abandoned from the health care field. On the other hand, public health care budgets have come under rising pressure, as a consequence of longer-term reduced growth rates. Additionally, because health policy decision-makers in all countries have become aware of the fact that "throwing money at the problem" is no longer a feasible strategy, mainly because it has become obvious that investing more money in

health care does not necessarily result in better health, interventions into physicians' autonomy are no longer sacrosanct. But it is not simply the power-hungry welfare state which is endangering professional autonomy. Since the whole economy entered a distributional zero-sum situation, with a new winner and loser constellation, physicians have had to reduce their income expectations. Otherwise cost control efforts would be increasingly aimed at their professional autonomy.

As a result of these considerations it could be concluded that physicians' professional autonomy is not fundamentally endangered by the welfare state, but rather by physicians' pursual of economic advantages which comes into conflict with national economic constraints. This outdated attitude has been inherited from the economic prosperity of the past. Accordingly, a reduction of professional autonomy could be avoided best if physicians were able to restrain or at least postpone economic demands. Or to put it simply: The professional autonomy is preserved best where physicians' financial freedom is restricted most. This is due to the fact that physicians themselves are obviously unable to lower their expectations. Thus, to achieve a rise in income which is not in conflict with increasingly limited health budgets, either public or private, institutional structures and regulations are required which would facilitate the management of those income increases, not exceeding a "crucial point". Such income increases might otherwise lead to strict controls on physicians' behaviour, as is the case in the USA.

Therefore, the main argument to explain the conditions for preserving professional autonomy is an institutional one, namely that physicians must be integrated into a stable institutional framework for determining their income, for example by negotiating mechanisms, like in Germany, France, and Sweden, or an income-determining institution, like the British Review Body, which is linked to global health budget con-

straints. If such a network is lacking, as in the USA, there is no organizational basis for communication between physicians and public or private agents which may possibly challenge professional autonomy. Although the AMA has retained a significant degree of lobbying power within the US-Congress, this centralized power channel is ineffective vis-á-vis highly decentralized and fragmented private businesses. Physicians in Germany, France, Britain, and Sweden are integrated into public organizations which are responsible for cost containment and are therefore able to preserve their autonomy by means of negotiations, whereas in the USA there are no organized negotiations in which the reduction of physicians' autonomy could be made an issue.

The mere existence of such an institutional network, however, is no indication of the real efficiency of those mechanisms of cost containment (cf. table 1). For example, in Germany the cost explosion has not been halted by means of the KAG, but the participation of physicians in a "national effort" for cost containment has served as a highly symbolic mechanism for demonstrating to the public that physicians are aware of the cost explosion and are willing to share the burden of cost containmemt by accepting a ceiling on their income. This fact is a convincing argument against those who advocate reducing physicians' autonomy in order to reduce overall health care expenditures. Additional evidence for the assumption that physicians could secure their professional autonomy to a great extent by accepting the, either voluntary or compulsory, integration into cost control institutions is provided by the national differentiations of physicians' income which has no relation to the reduction of professional autonomy.

But physicians within a "sheltering" organizational network must also be careful not to violate the above mentioned "crucial point", i.e. the willingness of the public to pay for health services without having control mechanisms imposed on

physicians' behaviour. This might be the case in France and Germany where physicians income determining mechanisms include some "loopholes" which nevertheless make it possible to avoid strict income limitations. An interesting point, relating to this problem, is that it is more difficult to impair physicians' autonomy in the more "extreme" welfare states, Britain and Sweden, due to a simple technical reason. The fee-for-service of physicians' remuneration in France and Germany requires complex data processing systems to register every single procedure (Rodwin 1981, p. 28). As a consequence, the sickness funds have to establish large data pools. As the experiences with the use of computerized data in other areas have shown, such information almost inevitably includes the risk of improper use. The mode of remuneration in Britain and Sweden, salaries and capitation, does not include this danger.

Especially this problem gives support to the conclusion that physicians frequently fight on the "wrong front". All over the world the medical profession is found to be on the side of political conservatism, fighting against a further expansion of the welfare state, against a salaried status, against the "socialization" of medicine, and fighting for an increased private responsibility (Weller, Manga 1983, pp. 496). However, because these demands comply with the restoration of market mechanisms in the health care system, and can not be separated from a simultaneous commitment to expose the medical profession to economic, instead of professional or even scientific calculations, the ideological attitudes of physicians tend to support those forces which are more devoted to the reduction of the professional autonomy, as is the welfare state.

4. Conclusions

There can be no doubt that economic decision-making rights as well as the ability to define health policy goals significantly shifted away from the medical profession as the welfare state expanded, and there is still the impending danger of extra-professional control of physicians' clinical behaviour. But, as has been argued in the previous sections, physicians by themselves have the opportunity to preserve their professional autonomy. If they are able to reduce their income demands, professional autonomy might be preserved despite economically constrained health care budgets. Thus it could be concluded that, contrary to physicians own beliefs, it is the welfare state which provides the institutional conditions for adjusting physicians' income to economic constraints.

Notes

1) A theoretical outline of this problem is provided by, to mention only a few references, Björkman (1982), Johnson (1982) or Wirt (1981).

2) A significant deviation from this rule, which could be viewed as an indication to a reduction of AMA's lobbying-power, has occurred with the introduction of the so-called "Diagnostic Related Groups" (DRGs). After an unusually short period of congressional discussions, the DRG scheme was enacted in 1982 as an amendment to the Medicare bill. DRGs are designed to be a prospective payment mechanism for hospital services which are paid by the Medicare program. As opposed to the former retrospective payment mechanism, DRGs categorize all clinical procedures into 467 diagnostic groups with a fixed price for each. This is widely interpreted as a revolution in health service payment because the state determines, by price-setting, the worth of a medical therapy and thereby penetrates the clinical decision-making process. Cf. Morone/Dunham 1984.

3) Cf. table 1. Unfortunately, no more recent data about physicians' incomes are available. But it may be presumed that no major change have occured since 1974.

Table 1: Ratio of physicians' income as related to the average per capita imcome

Great Britain	(1973)	4.5 : 1
Sweden	(1974)	4.6 : 1
USA	(1974)	6.7 : 1
France	(1974)	7.0 : 1
Germany	(1973)	8.5 : 1

Source: OECD (ed.), Public Exenditures on Health, Paris: OECD Studies in Ressource Allocation No. 4, 1977, p. 24.

4) An extremely interesting country for further research would be Italy. This case might be analyzed in order to illustrate to what extent the socialization of the health care system by the introduction of the "Servicio Sanitario Nationale" in 1980 has altered physicians' professional autonomy. Although it seems as if Italian physicians' have been able to preserve their autonomy (Piperno 1983; 1984), it might be too early to make a definite pronouncement.

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FINLAND

LEGAL GUIDE-LINES FOR THE DEVELOPMENT OF THE FINNISH HOSPITAL SYSTEM

CONTENTS PAGE

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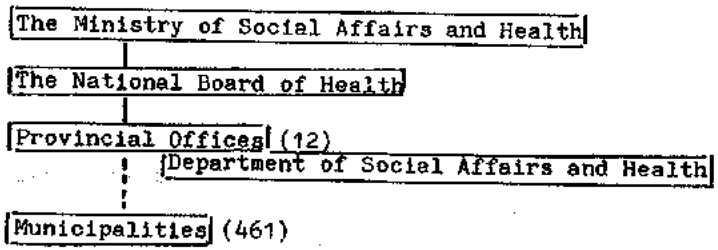
I. INTRODUCTION

The aim of this paper is to analyze the legal guide-lines for the production and distribution of hospital services in the Finnish health care system. Health care is one of the public policies the modern state carries out in order to satisfy the needs of its citizens. How do needs change into the form of a public policy? A simplified picture of the process could be delineated like this: first, a certain need has to be recognized and appreciated by the public authorities. Within hospital policy there has not been much disagreement about the fact that there exist illnesses which can and must be cured, and that hospital care is a relevant way of doing this. In general, the development of hospital care reflects the readiness of the state to introduce new services, i.e. the development of the present wellfare society.

Once it is recognized that a certain need exists, the formulation of means to satisfy them follows. The main elements of a public policy formed to satisfy specific needs are (i) how to satisfy these needs and (ii) to what extent these needs are satisfied. The same formulation could be divided into a qualitative decision, what are to be considered as health services, and quantitatively, how are health services to be distributed (Berg 1980,227). The answer to the first question lies, in fact, in the very concept of "hospital care", but however, the content of the care is dependent on medical

decisions and principles of health policy.The second elemant mentioned above depends on the resources the society has available for hospital care, what is relation between the public authorities and private agents etc? The supply of public health services is not purely dependent on the demand for these services, but is aswell based on the evaluation of needs (Vauhkonen-Bäckman 1973,145). Traditionally the basic quantitative goal of health care has been to offer all citizens equal access to services. This can be understood both relation to the costs of the services and regionally in the distribution of services in different parts of the country.

Decisions concerning the content and the implementation of a specific public policy are finally formulated into a piece of legislation. Before analyzing in detail the legal guidelines of the Finnish hospital policy, a brief look at the Finnish system of public administration is necessary:



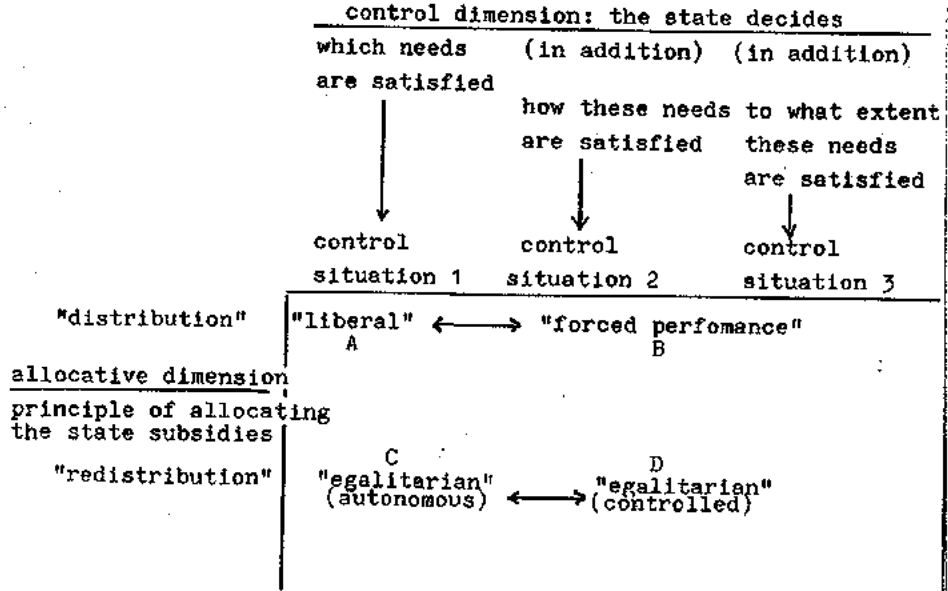
Finnish municipalities are administered on the basis of self-government by their inhabitants. In spite of their autonomous status, the municipalities take care of several routine implementation tasks based on legislation. The division of

labour between the state and the municipalities is decided by legislation and follows the principle by which municipalities take care of tasks that require knowledge of local conditions and local expertise, while the state, on the other hand, takes care of tasks that require national expertise.

In analyzing the production and distribution of public services in the Finnish administrative system, the starting points are: (i) the control dimension explaining the division of labour between the state and the municipalties,
(ii) the allocative dimension explaining the division of costs between the state and the municipalities.

These factors are interrelated since both are based on legislation and support each other. First comes the legislative decision, how and to what extent needs are satisfied, then follows the decision about the division of the costs.

The following policy-typology describes these dimensions:



The liberal policy-type refers to the system which is based on the "market mechanism" in relation to the production and distribution of public services, i.e. both the state and the municipalities have a free hand in offering services and no general principles or guidance exist. The controlled egalitarian policy-type, on the other hand, refers to the policy where the governmental definition of needs and redistributive allocative system are combined(Martikainen-Yrjönen 1974,73-80). The policy-types are not purely empirical ones, so various combined situations can and do exist. Using the frame-work described above, it is possible to analyze the development of governmental intervention, as the introduction of legal guide-lines can be interpreted, in the production and distribution of public services. In this paper the specific focus is hospital policy. In the following chapters I shall first delineate the development of the hospital system before legislative guidance and after that, concentrate on the legislative level, aiming to point out how governmental intervention has effected the decisions within the public administration determing the production and distribution of hospital services.

II THE DEVELOPMENT OF THE FINNISH HOSPITAL SYSTEM

II/1 The formation of the hospital system

The first hospital in Sweden-Finland was founded in 1752 in Stockholm. The money required for the foundation was collected by voluntary donation and compulsory taxation. A few years later,

the first hospital in Finland was opened (Pesonen 1980, 10-11,419). These hospitals served as a part of organized medical care, they were places for education and competed with the still common quackery (Vauhkonen 1961,38-39). From the end of the 18th century district hospitals were founded by local iniatives and were maintained by local financial support. During the late 19th century the government started to intervene in the administration of district hospitals, the hospitals were supported with an annual subsidy and the number of hospital beds in each hospital was officially confirmed. Finally, the financial responsibility as well as the responsibility for running the district hospitals was totally taken over by the state (Vauhkonen 1961,41). The need for hospital care gradually expanded and the network of district hospitals could no longer satisfy it. One by one, so-called general hospitals were founded in areas situated far from the regional capitals. (Vauhkonen 1961,49).

The municipalities were practicing some forms of medical care, though often temporary, but it was not before 1881 that the first local hospital (municipal) was founded, when the iniative was taken by a local doctor. Already in the following year the local hospitals were offered a state subsidy for capital and running costs. The number of local hospitals was rapidly expanding. To receive the subsidy the government required that no chronically ill or mentally ill people were allowed to be treated in the hospital, that the hospitals should be controlled by the medical authorities and that an annual report had to be given. The amount of the state subsidy remained at the turn

of this century at approximately 25% of the total costs. Usually the hospitals were founded by private persons and their financing was arranged differentely in each case (Pesonen 1980, 407). In practice, the general conditions and the actions of the municipalities largely dominated the development of local hospital services. The introduction of state subsidies can be seen as a means of speeding up this development, on the other hand, the government was not able to effect the municipal activities in any other way(Niemivuo 1976,30). The period clearly resembles the liberal policy-type since the decisions based on questions such as "what needs exist?" and "how can these needs be satisfied?" dominated and only loose guidance was practiced in order to effect these decisions. The quantitative development of the hospital services clearly depended on the activity of private persons, doctors etc.

In the beginning of this century the hospital system was still primitive and large areas of the country lacked services alltogether. Because of incidental and uncontrolled development, the division of labour between the state and the municipalities remained unclear: the major responsibility for hospital care was given to the state, but the situation among the municipalities varied greatly.

II/2 Introduction of legal guidance

Discussion on the relation between the state and the municipalities regarding hospital policy continued after

Finland gained independence in 1917 and different organizational solutions were proposed. In the middle of the long period of war, the government introduced the first legal guidelines for the hospital system. Behind this law lay the government's intentions (1) to expand the number of hospital places, (2) to diminish regional differences and (3) to change the division of costs between the state and the municipalities. The new law aimed at forming a network of central hospitals covering the whole country. These hospitals were owned by the municipalities in that particuler region. Each municipality was obliged to provide a certain number of beds in relation to the amount of inhabitants and accordingly it was obliged to share the costs. The law gave the municipalities the possibility to maintain local hospitals, however, these enjoyed a discretionary state subsidy (Asetuskokoelma 413/1943). In practice economical calculations led municipalities to prefer intensive central hospital care to basic local hospital care.

The founding of the central hospitals was realized in an exceptional way: in 1950 the government introduced a law, which enumerated the 18 central hospitals in order of preference and defined the time-table the building would follow (Asetuskokoelma 337/1950). From the political point of view the decision to bind the financial resources of the state for such a long period(15 years) could be criticised, but, however, from the quantitative point of developing the hospital system, the "program law" was effective.

The municipal obligation to provide a certain number of hospital places served the quantitative goals of hospital policy, but, at the same time it worked in a qualitative way: legislation and economic calculations led to the division of hospital care into intensive care represented by the central hospitals and less-valued basic care represented by the local hospitals.

II/3 Unifying the hospital system

While discussion and the work of several government commissions on the relation between the state and the municipalities continued, the government introduced a new law to renew the administration of the hospital system. The effects of this new law were mainly the following (Asetuskokoelma 49/1956):

(i) earlier, the central hospitals were owned by the state and the municipalities shared in the costs according to the number of places they provided. Now the ownership was given to the joint municipal authorities which were supported by the state,

(ii) the local hospitals were finally legally entitled to state subsidies and at the same time a small step towards a redistributive finance system took place by approving a a higher subsidy for rural municipalities.

In relation to the guidance of the hospital system, the law meant quite a change. In order to receive the state subsidy, the local hospitals had to maintain a certain medical level and so all the hospitals in the country were inspected.

The National Board of Health was given the right to decide whether a particular hospital was necessary from the national viewpoint and to examine plans for its establishment and maintenance. As a result, municipalties ceased to found new hospitals without mutual agreement with the state - state subsidies were fundamentally important for the economy of local hospitals.

In the late 1960's it became more clear that the prevailing subsidy system was unable to level the differences in the municipal hospital policy. The municipalities were not developing hospital care according to needs, but rather, according to economic considerations about the costs of different types of hospitals. At the beginning of the 1970's, a major reform of the subsidy system took place. All the municipalties in the country were classified into 10 categories according to the economic resources of each municipality. Accordingly, the amount of state subsidy to the local hospitals varies between 70% (category 10) and 39% (category 1). Later, the reformed subsidy system was critisized because it could not operate according to the aims given to the system, it was not possible to guide the development of public services in a nationally and regionally rational direction (Niemivuo 1976,285-287).

Paradoxically, when the network of hospitals was finally completed, the running costs placed a considerable strain on society. In the early 1970's, the public health system could

be characterised as an inverted pyramid; there were only scanty primary care and open care services, but plenty of specialised and institutional services. The National Board of Health demonstrated at the end of 1970's that the hospital system had reached approximately the quantitative goals set three decades earlier. No new hospitals or extensions were plannes for the future, but already existing hospitals would have to be more effective (SVT XI 1977-1978,188-189).

Finally, I shall briefly analyze two reforms that took place in the early 1970's. First, there was a change in the basic principles of public health care with the Primary Health Care Act in 1972. The goals of this act were: coverage of the entire population, comprehensive care comprising a broad variety of integrated primary services, equality in the distribution of resources, free services for the individual, community participation in the development of the services through close contact between the inhabitants and health personnel (Asetus-kokoelma 66/1972, Ståhlberg 1983,445-446). In practice these goals were implemented by creating a network of health centres, at the same time, the number of local hospitals was reduced considerably by merging them administratively with the municipal health centres. The act specifies that the centres provide a broad spectrum of services including primary medical care, health education and maternal and child health care. The reform concerned the whole of public public health care and the role of hospital services was adjusted only at the local level.

central government, the resources can be effectively directed to the problematic_areas of health care (Pekonen 1975,20-21).

III CONCLUSIONS

Before trying to sum up the preceeding historical review, I shall return briefly to the process by which needs change into a policy, as discussed at the beginning of this paper. The three-stage process was delineated as (1) what needs exist?, (2) how are these needs satisfied ? and (3) to what extent are these needs satisfied ? I shall first analyze how these questions have been dealt with in the legal guide-lines for the hospital system. It should be noticed, however, that even a particular act may prove to be problematic when defining its actual goals and measures accurately, not to speak of a succession of laws to evaluate the hospital policy in the long term. Each individual act has to be studied in its prevailing context, which depends on economical, political and, in this case, medical conditions.

In the following figure, the individual acts are compared in relation to the three levels of policy formulation:

THE MAIN GOALS OF LEGAL GUIDANCE

	no guidance	-43 law	-50 law	-56 law	subsidy reform	health care act	planning system
what	(X)					X	
how	(X)	X		X		X	X
to what extent	(X)	X	X		X	X	X

However, from the point of view of allocating resources for the health care, the act clearly effected the"how to satisfy the needs"type of questions.

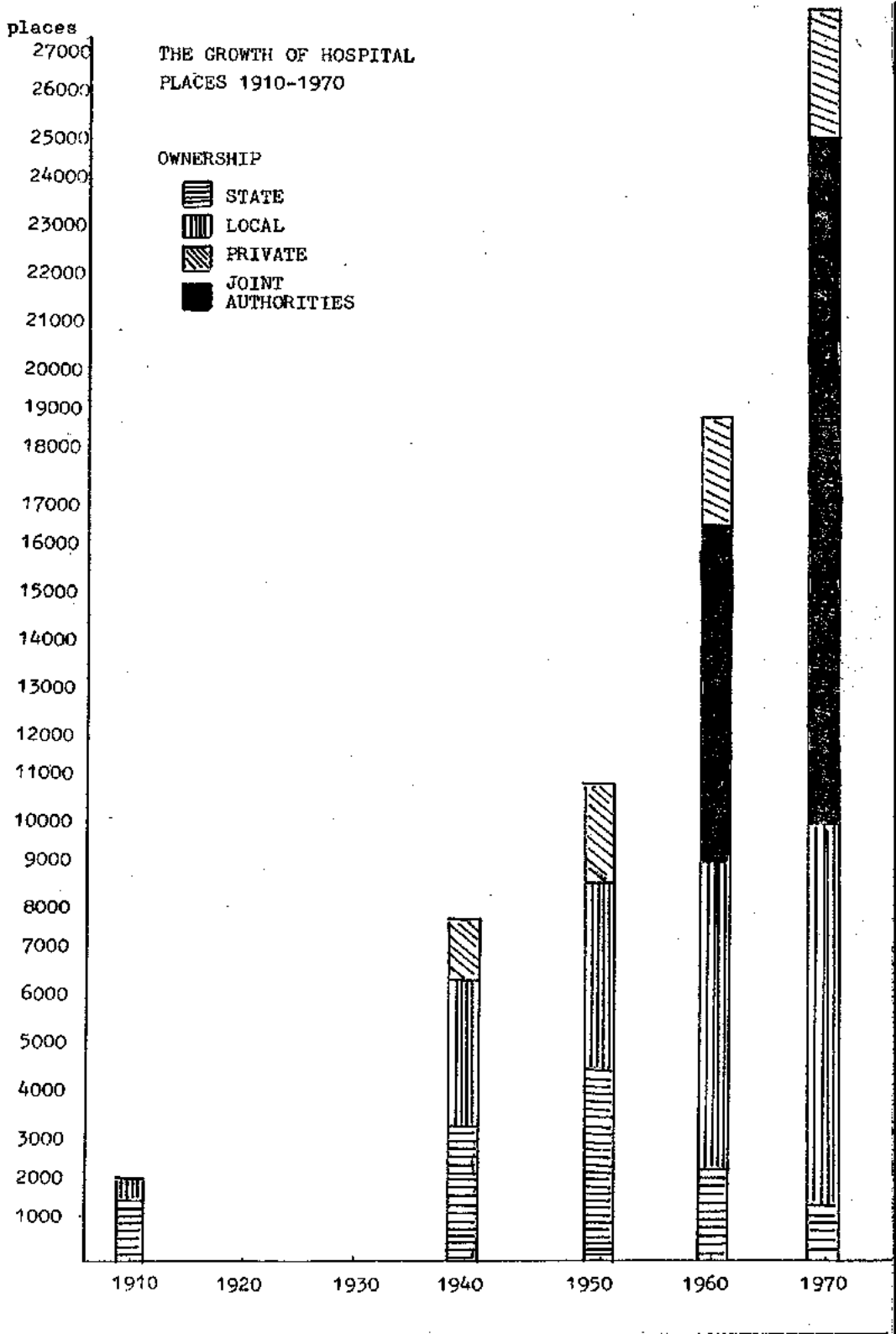
Second, and of greater importance for this paper, a planning system was introduced the same year, 1972. The municipalities and joint municipal authorities were now obliged to adapt their hospital policy to the national framework and to present exact plans for the following five years. The introduction of the planning system can be seen as an attempt to make the regional divisibility of hospital places more effective and, on the other hand, to use scarce resources in a more efficient way. The state commission preparing the reform claimed that by making the planning of activities more effective, the rate of growth of health care costs could be essentially slowed. In pratice, the national plans mainly contain principles of health policy, the local and regional plans concern the distribution of health services. In this paper, I shall not go deeper into the functioning of the planning system. It has been pointed out that there are serious disparities between the aims and reality of the system, i.e. technically orientated planning does not function in political context (Ståhlberg 1981, 151-171). Especially from the point of view of the municipalities, the planning system seems to contain several problems. However, from the national perspective, planning promotes the rational running of the public health system: by holding the functions and expenditures of health care firmly in the hands of the

According to this rough characterization of the main goals of the individual laws, it can clearly be seen that the legal guide-lines for the hospital system have not formed any coherent system. The emphasis has been on quantitative guidance, but decisions concerning how needs are satisfied have also been common, i.e. decisions concerning the hierarchial structure of the hospital care, and even the question "what needs should the public health care system be concerned with" clearly was present in the Public Health Care Act.

Concerning the level of decisions guiding the production and distribution of hospital services, it was noticed that on one hand, that the development led from the divided structure of production to a concentration of nearly the whole of production on the municipal level. On the other hand, at the same time the municipal actions were bound by more precise legislation. The final feature of this development was the introduction of planning system, which created a uniform hierarchical structure for hospital policy. Comparing this development to the model that was presented on page 3 it can be noticed that the legal guide-lines for hospital policy have roughly followed the direction $A \rightarrow B \rightarrow D$, however, the changes from one stage to the other are not clearly definable.

Finally, I shall briefly point out some possible explanations for governmental intervention in health care: first, the introduction of legal guidance in 1943 has to be seen against the historical background and the prevailing situation. During the first decades of independence, much preparative work was done for the introduction of legal guidance: several state commissions were making proposals and individual municipalities were already co-operating with the governmental hospitals. Alltogether, dissatisfaction with the preceding unstable and incidental development of hospital services made changes inevitable. The final timing can be seen in the context of war time, the large amount of war wounded needed immediate hospital care.

Second, medical considerations have to be included in the background factors: with the development of medicine, the hospitals became larger and more specialist, doctors had to give decisive power to administrators (see Berg 1982,251). At the national level this shift already took place in the late 19th century, whereas at the local level, the hospitals finally submitted to governmental inspection in the 1950's. In general, as the importance of the public services in economic , social and purely political meaning increases, national goals are set and the actions of the municipalities in that specific sector are controlled more precisely (Martikainen-Yrjönen 1977,148-149).



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NEW PATTERNS OF DECISIONAL POWER IN THE HEALTH SERVICES SYSTEM IN THE NETHERLANDS

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CONTENTS

New Patterns of Decisional Power in the Health Services System in the Netherlands

0. Introduction

This paper concentrates on the changes which have taken place in the pattern of decisional power in the Dutch health services system in the past decade. First there will be an outline of the characteristics of Dutch health care and the problems in this sector. This will be followed by an extensive survey of the new laws which Government has introduced to solve these problems; for each law we will establish which decisional powers lie with the government and which formal options social interest groups (organizations of health care institutions, professionals, financing bodies, employers, employees and consumers) have to influence these powers. The final section will deal with the consequences of this new legal system for the influence of government and social interest groups on health care in the Netherlands.

1. Characteristics of Dutch Health Care

1.1. Delivery of health services

Traditionally, the Netherlands have a private health care system. This means that, as far as personal curative care is concerned, the majority of services is rendered by independently practising professionals and juridical corporative bodies, administered by independent private boards, both in hospital care as well as in ambulatory care. Therefore, personal health care is regulated by the market mechanism. Until the seventies government interference in health services was restricted to a small number of tasks, namely:

* Quality control
  This task was initiated as early as the 19th century. Independent and well-equipped inspectorates were established, which operated from national and regional offices, supervising medical and mental care, medicines, food and veterinary products. Since 1956 the tasks, qualifications and competences of inspectorates and inspectors have been regulated by the Health Act. This act also regulates tasks and qualifications of a number of advisory councils in health services.
* Prevention
  Government engagement is limited to organizing and financing preventive care as far as it is directed to the people collectively. Personal preventive care is left to the private sector.
* Environmental protection
  Measures concerning environmental protection are deve-

loped and drawn up by the government, which also controls and supervises the enforcement. All costs involved are covered from general taxations and special levies.

* Creating the conditions for health care.
  Although the government's attitude towards private care itself has been marked by reservedness, it has long been striving to create the necessary conditions for an optimal health care system. This has been done by the introduction of a number of laws. To protect the quality of health care three laws have been introduced: The Medical Practice Act and the Paramedical Professions Act (regulating the qualifications and competence of physicians and paramedical professionals) and the Medical Discipline Act.

Two important laws apply to the field of financing, but these will be dealt with in detail in section 1.2.
In spite of the legislative measures taken by the government, the period until the seventies is characterized by a reserved government approach to health care policy. Before that time the health system went through a period of autonomous growth. The course was set by the professional organizations and the Sick Funds. The influence of these organizations was extended through their advisory role when decisions were taken by government on matters concerning the health care policy. And finally there are the interest groups and advisory bodies which voice the influence of private enterprise. Section 1.3. will elaborate on this aspect.

1.2. The financial system

The financial system is composed of various insurance systems, different systems of payments and different financial sources.

Insurance systems

About 70% of the Dutch population is insured with the Sick Funds. These Funds are independent juridical corporative bodies, which operate the social insurance system of the Sick Fund Act (1964), which replaced the Sick Fund Decree of 1941. The activities of these funds are supervised by the Sick Fund Council, which is composed of (representatives of) organizations of employers, employees and physicians.

The Sick Fund Act distinguishes 3 different insurance schemes
- compulsory insurance
- voluntary insurance
- old age pensioners insurance

The compulsory insurance scheme covers the (families of) employees in the private sector under the age of 65 and with a yearly income of Dfl. 47,850.-- or less (1984 figures). People over the age of 65 and with a yearly income of Dfl. 23,685.-- or less (1984 figures) are covered by the old age pensioners scheme. The voluntary insurance schemes is for those who do not come under either of the two schemes mentioned above and whose yearly income is below the figure set for the compulsory insurance scheme (income here is family income). Civil servants are excluded from the Sick Fund insurance scheme, and are covered by a special civil servants scheme.
The Sick Funds are financed through premiums, which consist of a percentage of the income of the insured. The premium for the compulsory scheme is a fixed percentage (9.2% in 1985, met jointly by the employee and the employer) throughout the country; the percentage for the voluntary insurance scheme varies according to the Sick Fund. The old age pensioners premium does not consist of a percentage but is a fixed amount for each income category. In addition, there are subsidies paid by the government towards the voluntary insurance and the old age pensioners schemes.
The premiums are levied by the trade organizations and paid to the Sick Fund Council, which pays the individual Sick Funds. The premiums for the voluntary and old age pensioners schemes are levied by the Sick Funds themselves.
The other 30% of the Dutch population must insure privately against health care expenditures. They pay a nominal premium. The amount payable depends on the type and coverage of the services offered under the insurance scheme. Insurance against 'higher risks', i.e. for exceptional expenses, such as those incurred by patients in institutions for long-term patients, is governed by the Exceptional Medical Expenses Act (1967). This act applies to all residents of the Netherlands. The premium is a percentage of a person's wages of income, (4,24% in 1985) and is paid by the employer. The premiums are levied by the inland revenue, which pays the total amount to the General Fund for Exceptional Medical Expenses, which is managed by the Sick Fund Council. The Sick Fund Council pays to the executive bodies.

Systems of payment

The independently practising professionals, as well as the ambulatory services and hospitals, acquire their incomes by means of a system of tariffs, a system of budget-financing or a mixed system of the two. There are three tariff units: a fixed price per bed/day, per consultation and per performance of a service.
Hospitals are dependent on the reimbursement of a fixed price per bed/day. Until 1982 the price regulation for hospitals was based on the Hospital Tariffs Act (1965). In 1982 this act was replaced by the Health Care Charges Act.

Since 1983 every hospital is given its own budget for the following year, which is based on the level of income and expenditure in the year before. But it is not only the budget system which is important for the hospitals. The activities of the medical specialists are even more important, because they determine the rate of activities per patient.
The specialist receives a fixed amount of money for each Sick Fund patient referred to him by a general practitioner, who issues a so-called referral card, for which amount one month of outpatient treatment, that is to say consultations and minor operations, is given. For major performances the specialist receives a fee for service. In the private sector the specialist demands a fee for each service that is given to a private patient. The institutions and professionals in ambulatory health care are involved in many different financing systems. The general practitioner is paid through a capitation system: he receives a fixed amount of money per year for every Sick Fund patient in his practice. In the private sector he demands a fee for service. Until 1980 the institutions of ambulatory care were dependent on subsidies from the public authorities. Since then they have gradually been brought under the Exceptional Medical Expenses Act.

Financial Sources

One can distinguish five different financial sources:
- The State Government
  Transfers to the social insurance funds, contributions to teaching hospitals, subsidies to a number of institutions of ambulatory care, contributions to medical education, health research and -indirectly- the costs of health policy making on the national level.
- The Provincial Government
  A limited amount of subsidies and the costs of health policy making on the provincial level.
- The Municipalities
  Some municipalities contribute to the costs of municipal hospitals. There are only a few such hospitals in the Netherlands, almost all hospitals are private organizations. All municipalities pay for the municipal health services and preventive care, both aimed at the collective population. In future the municipalities will spend more money on health policy making on the municipal level.
- Families and individuals
  Families and individuals pay their premiums to public or private insurance funds.
- Organizations (industrial and civil services)
  The employers pay a part of the public insurance premiums. They also spend a certain amount of money on industrial health care services and on the protection of food and drinking-water.

1.3. Interest groups

From the above one may conclude that there isa large number of different organizations and individuals involved in the Dutch health care system. This involvement takes shape against a background of individual positions and interests, and it may come as no surprise that a large number of interest groups have emerged, each playing an individual role in the health care itself and/or the development of the health care policy. These interest groups can be subdivided into: (individually practising) professionals, institutions, financing bodies (Sick Funds and private insurance companies), patients/clients, employers and employees.
Below we will give a survey of the most important interest groups in the Dutch health services system.

The professionals

One of the most important organizations here is the Royal Dutch Medical Society (Koninklijke Nederlandse Maatschappij ter bevordering van de Geneeskunst), which was established to protect (the interests of) the medical profession and watch over the professional standards.
Membership of the RDMS covers nearly all Dutch physicians, both those working intramurally and extramurally. To cater for specific needs there are - within the RDMS - three different so-called 'social organizations'; from a medical as well as from a socio-economic point of view, these organizations serve the interests of medical specialists working independently in intramural care, the general practitioners, and employed physicians. Membership of these organizations - the National Specialists' Association, the National General Medical Practitioners' Association, and the National Association of Employed Physicians - is linked to membership of the RDMS. The first two of these negotiate on tariffs with the Sick Funds. In addition there are a number of organizations furthering the interests of various paramedical professionals, such as the physiotherapists (the Netherlands Physiotherapy Society) and pharmacists (the Royal Dutch Society for the Advancement of Pharmacy).

Health care institutions

The institutions for intramural health care are organized in the National Hospital Board. This board has a high level of organization as all hospitals are members. The aim of this organization is to promote an optimal system of intramural health care and to serve the interests of its members. The field of ambulatory health care has a number of organizations fully or partially involved in the furthering of interests, e.g. the National Cross

Organization and the National Union of Ambulatory Mental Health Care.
These interest organizations count among their members all provincial and regional cross organizations employed in social health care and private institutions or executive bodies in ambulatory mental health care.

Insurance companies

The Sick Funds are united in the Dutch Association of Sick Funds. The aim of this Association is to serve the interests of both Sick Funds (all of which are members) and the people insured with the Sick Funds. The private insurance companies come together in the Contact Group of National Organizations of Health Insurance Companies. This Contact Group, to which nearly all private health insurance companies belong, serves the interests of its members, but also aims at improving the cooperation with other organizations and more generally at an adequate system of health care.

Patients/Clients/Consumers

At the national level there is the General Association of Patients' Interests. This Association is subdivided into provincial divisions. Hitherto this association has not shown itself to be a powerful forefighter of patients' interests. Besides this there are a number of different specific patient organizations at the national, provincial and regional levels, such as a heart patients organization, a diabetics organization, an asthmatics organization, etc. The most important tasks of these organizations are:
- improvement of patient's rights
- development of information material and information service to patients
- improvement of patient participation in health care policy.

Employers and employees

The interests of employers and employees are mainly of a financial nature. After all, it is they who pay the premiums necessary to maintain the insurance system. The employers are organised in the Dutch Business Union and the Christian Employers Organization; the employees in the Federation of Dutch Trade Unions and the Christion National Trades Union.

All of the organizations above take part in the various advisory bodies involved in the health care policy. These legally appointed advisory bodies such as the Sick Fund Council, the National Health Council, the Board for Hospital Facilities and the Provincial Council for Health, form the official channels of influcence; their power lies in the (requested or unrequested) advice they give to the

authorities involved in policy making.
Section 4 and following will deal in more detail with the advisory structure in Dutch health care policy.

2. Problems of Dutch Health Care

From section 1 the Dutch health care system emerges as a social sector which is relatively unstructured and diversified, with a complex and incoherent financial system and a variety of participants and interests; a sector which allows relatively autonomous developments and lacks a clear policy.
The early seventies saw the emergence of the problems which are the result of this, and since then these problems have become increasingly more prominent. They can be summarized in three categories:

Disproportionate cost increase

Health expenditures are growing disproportionately in comparison with other sectors and are exceeding the economic possibilities of the country.

The extreme growth of costs of health care is illustrated in table 1

Table 1

Costs of Health Care in the Netherlands

	1958	1963	1968	1973	1978	1983*
Dfl.	1.4bn	2.2bn	5.3bn	12.2bn	23.7bn	35bn
% GNP	3.8	4.3	5.9.	7.2	8.4	9.2
mutation		+0.5	+1.6	+1.3	+1.2	+0.8

Source: E.W. Roscam Abbing, Bouw en werking van de gezondheidszorg in Nederland, 1983.

* Estimated
GNP = Gross National Product

This financial problem became more important in the context of the economic recession, which set in in the second half of the 1970s. Besides, since the same period the effect of health care on the health of the Dutch people has shown diminishing returns. The limits of health services seemed to have been reached.
As a result the demand for care kept rising without much improvement of health status in general.
Because of the fragmented structure of the financing of health care, it is very difficult to control cost development. Instruments for this are still inadequate and partly

lacking altogether, both with respect to the whole and with respect to the individual parts.

Lack of coherence

Not only the financial system is fragmented. The system of care itself also displays insufficient cohesion. Functional cohesion, both vertical and horizontal, is lacking, the result being an independent functioning of services alongside one another. Cooperation between the executive institutions of health care and the other welfare services are often absent, as is the coordination of the policy to be followed.

Unbalanced growth

Until the beginning of the 70s the institutional health care could expand unlimitedly, while preventive care and ambulatory health services developed insufficiently. A short-term narrowing of this gap is not to be expected, despite the fact that for many years authorities as well as private institutions have expressed a willingness towards strengthening of ambulatory and preventive health care. But the practice of policy making and the financial system do not support these conceptions.
This conclusion can be derived from the figures in the so-called "Financial Survey', which is published every year with the annual budget of the Ministry of Welfare, Health and Cultural Affairs. Some of these figures are shown in table 2, which has been taken from the Financial Survey of 1985.

Table 2: The costs of health care 1978 - 1983

	1978		1979	1980	1981	1982	1983*	
	mln Dfl							
Intramural health care	13,785	(59.0%)	15,032	16,411	17,659	18,859	19,537	(59.4%)
Specialist help	1,567	(6.7%)	1,681	1,786	1,819	1,964	1,989	(6.1%)
Medicines and artificial and auxiliary aids	2,299	(9.8%)	2,434	2,604	2,817	3,065	3,186	(9.7%)
Extramural health care	3,744	(16.0%)	4,101	4,510	4,510	4,810	5,068	(16.0%)
Collective preventive care	598	(2.6%)	661	713	741	771	768	(2.3%)
Policy, administration, management, ambulance transport and other health care services	1,375	(5.9%)	1,494	1,647	1,794	1,982	2,128	(6.5%)
Total	23,368	(100%)	26,403	27,671	29,640	31,709	32,880	(100%)

*Provisional figures

As has been said before the problems of the health care system became gradually more noticeable since the early 1970s. The functioning of the health care system became a matter for concern. The major cause for concern was the substantial increase of the costs of health care, from 5.9% of GNP in 1968 to 7.2% in 1973, together with the expectations for the years to come. Government decided to set as its target that in 1980 the share for health care of the Gross National Product should not exceed 8%. Radical reorganizations to improve efficiency and curb cost development were deemed necessary. In line with the then prevailing ideas about the role of government in a welfare state it was only natural that this task was thought to be one for the government. In 1974 the then Minister of Health published the Note on the Structure of the Health Care System, an inventory of the problems of the Dutch health care system with a recommendation as to the way these problems should be approached and which role the government should play in this process. Apart from the three major problems described above the Note mentions a number of other problem areas, such as:

- a less than optimal geographical distribution of facilities, especially in the case of mental health care.
- insufficient community participation in the development and functioning of health care.

This last problem area should be seen in the light of the 'democratization movement' which spread over the Netherlands in the seventies. In view of the problems/problem areas outlined in the Note, the intention was laid down to restructure the entire health care system. The state government was to take the initiative. In addition there were clear ideas as to the procedure to be taken in this restructuring and the final results.
Restructuring should take place along five lines:

1. Regionalization
   The country was to be divided into regions, within which a clearly recognizable and coherent health care system would function, enabling a structural and functional control under government responsibility.
2. Echeloning
   A high degree of integration of facilities with the same functional characteristics and aims.
3. Administrative organization
   Reinforcement of the position of the authorities, especially of (cooperative) municipalities, which would perform their tasks within the directives set by the state government. Furthermore streamlining of the advisory structure by the institution of a coherent organizational framework for the advisory bodies to work in.
4. Democratization
   This process had two aspects: one, bring about a change in attitude, and two, provide a method of organizing and policy-making.

5. Legislation
   Legislative changes were necessary to allow the development and completion of the processes mentioned above.

Since the publication of the Note on the Structure.. the terms 'regionalization' and 'echeloning' especially have become the keywords - almost magic words - of the Dutch health policy making system.
Cost control, through price and financing measures, and controlability, by matching supply and demand in health care, were the underlying aims. Since the publication of the Note (1974), government interference in the Dutch health care system has increased considerably. The Note was the starting point for a wave of new laws on health care, which in turn were instrumental to the creation of new patterns of decisional power in the Dutch health care system.
Below we will elaborate on this.

3. New Health Care Acts

Among the most important acts regulating the supply, costs and tariffs are the Hospital Facilities Act, the Health Services Act, and the Health Care Charges Act. These acts were passed by Parliament in 1979, 1981, and 1982 respectively.
A National Health Insurance Bill, comprising a major restructuring of the financing system, was never introduced, because at the time political support for such an insurance scheme was deemed insufficient. As a result, the two existing social insurance acts - the Sick Fund Act and the Exceptional Medical Expenses Act - remained in force.
In the sections below we will discuss the new acts and the powers of the various authorities laid down in these acts. In addition there will be a description of the ways in which organizations (of health care institutions, professionals, financing bodies, employers, employees, and consumers) can influence the use of these powers. We will concentrate mainly on the national level. A thorough insight in the legislation on financing, briefly outlined in section 1, is indispensable for a proper understanding of the Dutch health care system; therefore we will trace for each of these laws the powers laid down and the possibilities for influence.

The diagram below will serve as a guideline:

Aspects of control	Act	Powers
Supply	Hospital Facilities Act Health Services Act	Planning, Building-Permit
Costs, Tariffs	Health Care Charges Act	Tariffs, Budgets
Financing	Sick Fund Act, Exceptional Medical Expenses Act	Coverage and Financing decisions

These acts cover most of the health care system; some parts are excluded, e.g. the Basic Health Care, which is paid for by the municipalities.

4. Control of Supply

Control of the quantity, structure and quality of the available facilities comes under two acts: the Hospital Facilities Act and the Health Services Act.

4.1. The Hospital Facilities Act

The Hospital Facilities Act aims at the establishment of an efficient system of hospital facilities.
The act came into existence in 1971, in anticipation of the Note on the Structure of the Health Care System, but did not come into force until 1979. The reason for the delay was the national planning scheme which formed part of the original draft, but proved unfeasible and needed to be replaced by a regional planning system subject to the Minister's approval. The act now prohibits the establishment of hospitals without ministerial approval and, moreover, gives the Minister the power to close down hospitals. Besides hospitals, the act also applies to nursing homes, psychiatric institutions, and institutions for the mentally handicapped. Teaching hospitals and military hospitals are excluded.

The most important ministerial powers (instruments) concern the planning of hospital capacity, the issue of building permits and the closure of hospitals.

Planning

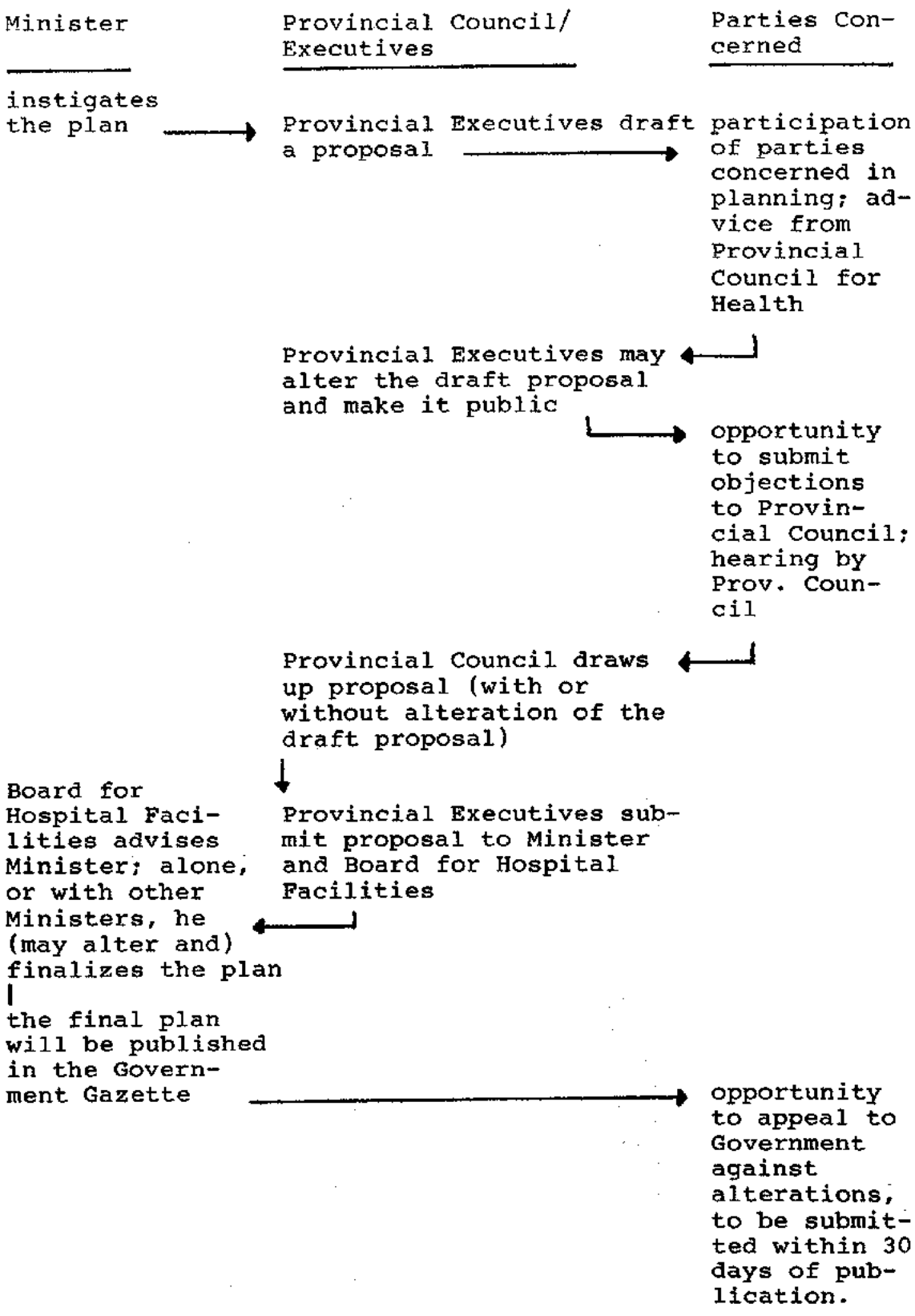
Regional hospital planning is done by the provinces at the

Minister's request. This request indicates the types of hospital facilities (hospitals, nursing homes, etc.) and the region(s) to be covered by the plan, and specifies the financial limits.
The plan involves the capacities and functions of hospital facilities, states the optimal future level of facilities and indicates the way(s) to achieve this aim.
For the purpose of the planning the Minister has divided the country into 25 regions (for a definition see p. ..).
In a number of cases a region crosses provincial boundaries (there are 11 provinces). In these case the provinces involved will be instructed to prepare - in close cooperation - a plan covering the part of the region within their boundaries.

There is a set planning procedure, fixed by law.
The Minister will first order the Provincial Council to draw up a plan. The Provincial Executives draft a proposal, after consultation of the Provincial Council for Health (an advisory body to the Provincial Council).
This draft proposal is made public and parties concerned may raise objections to the plan and submit them to the democratically elected government of the province (Provincial Council). The objectors are then invited to elaborate on their complaints in a hearing, after which the Provincial Council will draw up a proposal.

This proposal is sent to the Minister and the Board for Hospital Facilities (an advisory body to the Minister).
Having been given the advice of the Board for Hospital Facilities, the Minister will finalize the plan. If the final version contains alterations of the proposal, parties concerned may appeal to the Government. Governmental approval will render the plan definitive and valid for a period of four years.

Schematically:



Source: De planning van ziekenhuisvoorzieningen, Ministerie van Welzijn, Volksgezondheid en Cultuur, 1984 (The planning of hospital facilities, Ministry of Welfare, Health and Cultural Affairs, 1984).

Directives

The province cannot act freely when drawing up the proposal. The ministerial directives serve as a guideline, and later form the basis for the Minister's finalization of the plan. These directives are manifold and highly detailed.
They comprise directives as to the structure of the plan (prospects, aims, etc.) and directives on specific types of hospital facilities (general hospitals, nursing homes, etc.).
The latter type of hospital directives will contain, among other things:
- maximum number of beds per region (3,7 o/oo for general hospitals)
- minimum and maximum number of beds per hospital
- obligatory and optional hospital functions

The directives will not be concerned with facilities of national importance (such as heart surgery and kidney transplants) and heavy medical equipment, for which plans are drawn up by the Minister.

Closures

If a particular hospital facility does not/no longer fit in the offical hospital facilities plan, the Minister may decide to close down (part(s) of) the hospital. The same may be done if a hospital is no longer recognized by the Sick Fund Act or the Exceptional Medical Expenses Act (see section 6). Before taking a decision of this kind the Minister will have to consult the Board for Hospital Facilities and the Provincial Council involved, the latter in turn will have to consult the hospital involved and the local authorities of the town where the hospital is situated.

Permit

The last important instrument is the permit. The law says that the construction of new hospitals and the extension, renovation, replacement, and alteration of existing ones, are subject to ministerial approval.
A permit is not required if the building costs are less than Dfl. 120,000 (1984 figures) and the capacity or function remains unchanged.
Requirements for the issue of a permit:

a. a ministerial statement that the construction etc. is in accordance with the plan for hospital facilities, or, in the absence of a plan, in accordance with the directives.
   The Minister's decision is taken after consultation of the Council of the province involved and the Board for Hospital Facilities;
b. the set of building requirements must be approved by the Minister;
c. the draft design must be approved by the Minister;
d. the construction plans must be approved by the Minister

On b., c., and d. the Minister will ask the advice of the Board for Hospital Facilities.
Parties involved may appeal against any or all of the decisions taken.
The issue of a permit does not automatically entail the beginning of the construction phase; there is a restriction on building projects which require investment of Dfl. 10m or more.
Every year the Minister establishes the maximum amount available for the construction of hospital facilities (the so-called construction ceiling) and will publish a list of priorities containing the names of the institutions and the year in which they may commence construction.

The instruments of permit and closure play a role in the execution of the plan. The plan can only be carried out if private institutions take the initiative for construction, renovation, etc. The Minister may close down a hospital, but - as said above - only after consulting the parties involved. In the execution of the plan the Minister is highly dependent on private institutions.

State of affairs

By early 1985 the Minister had ordered 32 plans for hospital facilities to be drawn up by Provincial Councils. Four proposals have been drawn up and 1 plan has been finalized. These data should not lead one to conclude that provinces show hardly any activities as to the reorganization of the supply of hospital facilities. Most of the provinces have submitted proposals for a reduction of the amount of hospital beds, based on a section in the Act dealing with the closure of hospitals.
These proposals however were not the Provinces' own initiatives but were prompted by the Minister. The Minister had decided - in 1982 - to accelerate the reduction of the surplus of hospital beds in the Netherlands and published a list of hospitals and departments to be closed.
Under pressure of, especially, the hospitals the Minister withdrew his proposals and agreed to wait for proposals on reduction of beds by the provinces.

Influence of social interest groups

Amongst the interest groups in the planning of hospital facilities are: organizations of hospitals, medical professionals, financing bodies (sick funds and private health insurance companies), employers, employees, and consumers, all of them organized on a national level. We regard them as potentially influential when they occupy an official position inside the bodies involved in the decision-making process. From the above it has become clear that the Minister takes the final decisions on planning, permits and closures. He does not do so in isolation but takes advice from (among others) the Board for Hospital Facilities and the Provincial Councils involved; the latter, in turn, are advised by the Provincial Council for Health.
Before the Minister finalizes the hospital facilities plans he entrusts the preparation of the decisions largely to the Provincial Councils.
Once the decisions concerning permits and closures have been taken natural persons and corporate bodies whose interests have been harmed may appeal to government. The planning provides for an objection procedure, which enables interested parties to express their views during the decision-making process. Interested parties may influence the decisions both beforehand (through the advisory bodies and objection procedure) and afterwards (appeal).
Whereas every interested party may use the objection and appeal procedures, which renders them formally equally influential, this is not the case with the advisory bodies. As mentioned above, two advisory bodies play an important role in the planning (including permits and closures) of hospital facilities: at the national level there is the Board for Hospital Facilities and at the provincial level there is the Provincial Council for Health.

Board for Hospital Facilities

The task of the Board for Hospital Facilities is to advise the Minister on the implementation of the Hospital Facilities Act. The Board consists of 25 members. The Chairman is appointed by the government, the members by the Minister.
Apart from two independent members the Board consists of representatives of organizations of hospital facilities, medical professionals, financing bodies, municipalities, provinces, employers and employees.

The internal distribution is as follows:

Organizations of:

hospital facilities and medical professionals	11 (44%)
financing bodies	7 (28%)
provinces + municipalities	3 (12%)
employers	1 (4%)
employees	1 (4%)
others (independent experts)	2 (8%)
	25 (100%)

It is striking that the organizations of hospital facilities and medical professionals occupy nearly half the amount of seats. If we realize, moreover, that medical professionals are often represented in the organizations of financing bodies, we may conclude that the suppliers of hospital facilities have an important influence on the decisions taken by the Board for Hospital Facilities. On the other hand, the influence of employers en employees is minimal, which probably explains why the seats reserved have not been taken (1983). Consumers have no representation in the Board at all.

Provincial Council for Health

Although we restrict ourselves to the influence of interested parties on the national level, it is important to describe briefly the task and structure of the Provincial Council for Health; the reason being the function of this Council in the process of hospital planning.
Provinces (and municipalities) are legally obliged (Health Act 1956) to consult the Provincial Council for Health. The Provincial Council for Health (there is one for every province) is established by the Provincial Council, which also decides upon the number and type of respresentatives, powers and procedures.
The Health Act rules that the Council for Health should in any case have representatives from:
health care institutions
individual medical professionals
consumers
financing bodies
municipalities
institutions for social service
Although the distribution of representatives may differ per province, one may conclude that here too the suppliers of hospital facilities have sufficient opportunities to further their interests.
In contrast to the Board for Hospital Facilities, consumers are represented in the Provincial Councils for Health, but employers and employees are not.
The degree of influence depends strongly on the powers endowed to this body by the Provincial Council.

4.2. The Health Services Act

The supply of facilities is controlled by another important law, the Health Services Act. This act was passed by Parliament in 1982 and aims at: decentralization, democratization, and cohesion, in order to achieve greater manageability and better cost control.
In other words, the aim is a wide one, reaching beyond mere volume control.
The most important powers laid down in this law concern planning and recognition of facilities, based on

institutions, building permits, settling of individual professionals, and quality standards.
In principle the act applies to all health care facilities. Eventually the Hospital Facilities Act, discussed in the previous section, will merge with this act. At present, however, the Health Services Act is not yet in force.
The act will come into force as follows:
- the act will first come to apply to basic health care and primary care.
- next, the Hospital Facilities Act will gradually merge with the Health Services Act.
- in three experimental regions the act will apply to all health services from the start. Here the Hospital Facilities Act will be abolished immediately.

The sectorial and integral introduction of this act, however, will require the creation of an administrative infrastructure. Decisions will have to be taken as to who will be responsible for the planning of particular services, what the advisory structure will be and where the necessary information can be obtained.
In connection with the establishment of these conditions a number of draft proposals have seen the light, none of which have been officially ratified.
It is interesting to note that, in spite of the rapid progress of the activities surrounding the preparation of the introduction of the act, a committee of independent experts has been asked to advise on the feasibility of the planning system laid down in the act.
Hence, it remains uncertain whether the act will be introduced in its present form. Consequently, everything that is written below will have to be regarded as provisional.

Planning and Recognition

Under the Health Services Act, Government, Provinces and Municipalities will be given the task to prepare plans for health care facilities; a specification as to who plans what will be included.
In principle, municipalities will be responsible for the planning of primary care facilities, provinces will take care of intramural care, and Government will plan the special facilities. Since most Dutch municipalities are too small to draw up these plans independently they will be expected to work in cooperation with others.
A plan contains a description of the demand for particular facilities and what alterations may have to be made in the facilities available in order to efficiently meet the demand.
The plans will have to comply with the ministerial directives, which are concerned with the demand, distribution, and cohesion of facilities, and the financial limitations for particular facilities. The plans will also

have to consider the rights of the people insured under the Sick Fund Act and the Exceptional Medical Expenses Act (see section 6).

The government plan is finalized by the Minister, the provincial plan by the Provincial Council, and the municipal one by the Municipal Council.
The provincial plan needs governmental approval, and the municipal one must be approved by the Provincial Executives. While the plans are being drawn up, interested parties may express their opinions on the subject. The planning procedures offer a number of opportunities for participation (through advisory committees, objection procedures).
The three diagrams below will illustrate the planning procedure on the provincial, municipal and national levels respectively.

Diagram 1: Provincial planning procedure

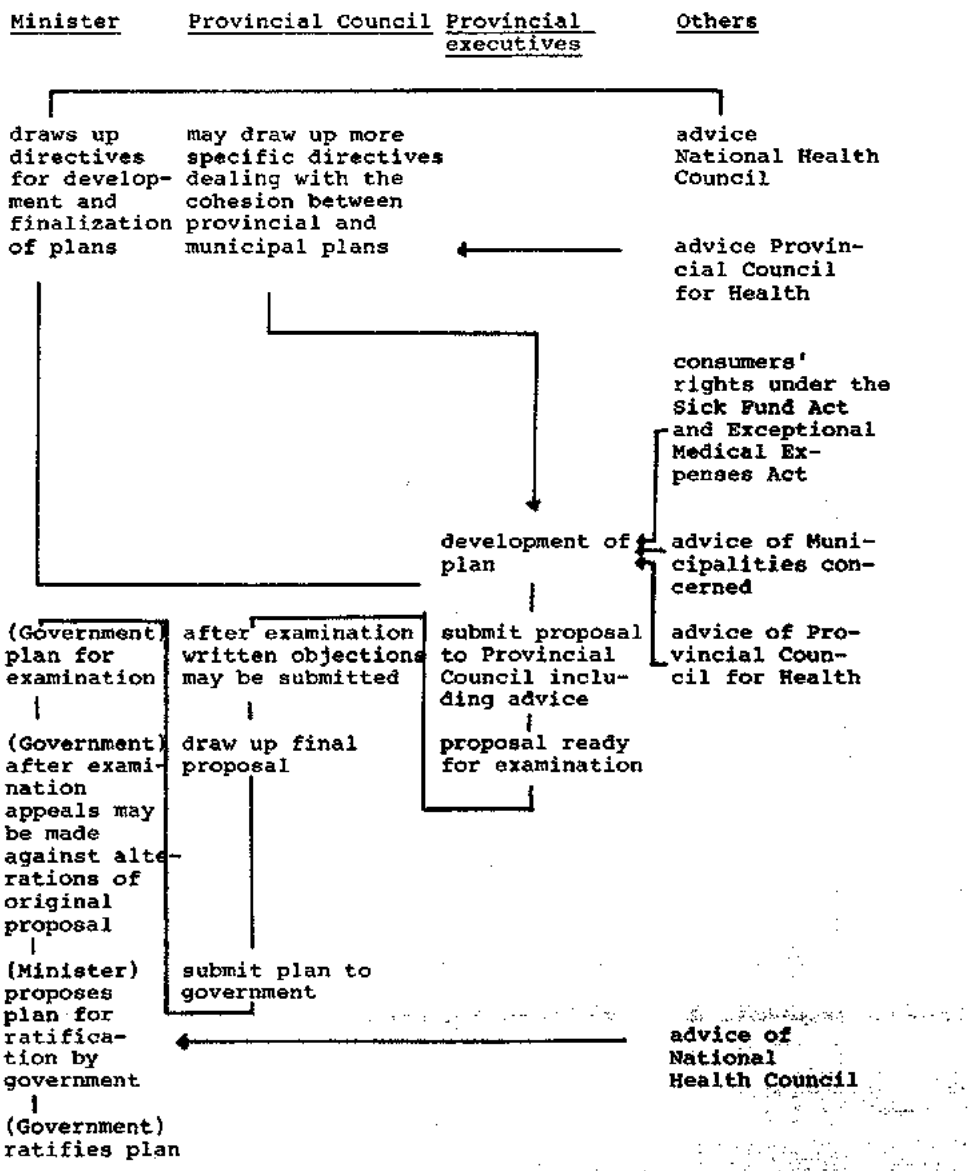


Diagram 2: Municipal planning procedure

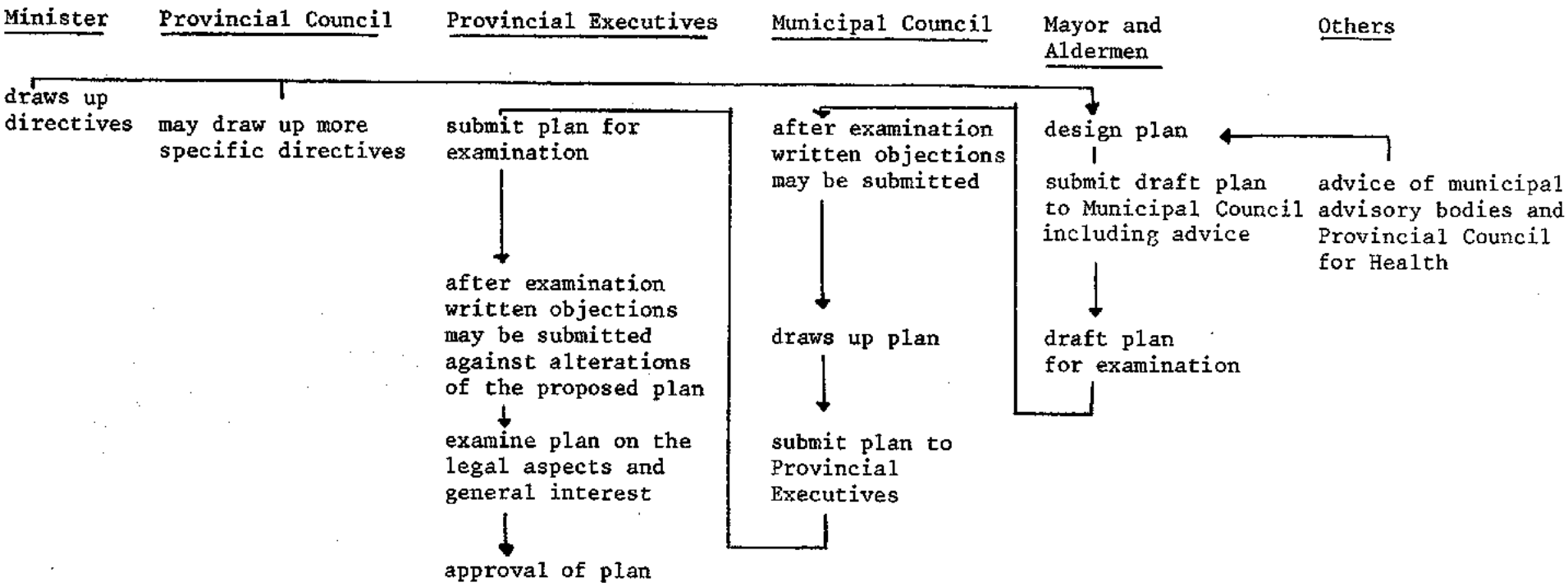
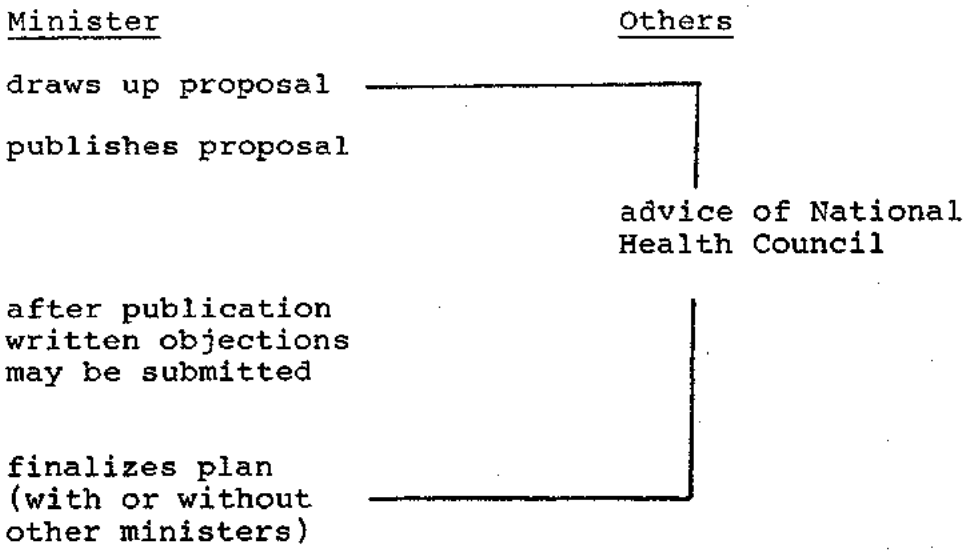


Diagram 3: Government planning procedure



Source of the three diagrams: E.W. Roscam Abbing, Bouw en Werking van de Gezondheidszorg in Nederland, 1983.

Settling and size of practice

Health care services offered by independent medical professionals are not covered by the planning procedure. Volume control in this area is achieved by separate regulations in the law.
These regulations deal with settling and size of practice. It can be dictated by law that a specific category of medical professionals is not allowed to set up practice in (part of) the country without a permit.
The Minister decides upon the issue of permits in the areas for which he is responsible; in other cases this will be done by the Provincial Executives or the Mayor and Aldermen. In addition there may be limits as to the maximum and minimum size of a practice. On implementing the regulations on settling and size of practice the responsible authorities will have to consult a committee with representatives of the profession(s) involved, financing bodies and consumers.
The Minister may separately declare these settling regulations applicable to a particular profession. He can only do so after consultation with the profession(s) involved.
In July 1983 such a proposal was put forward regarding general practitioners.
A definitive decision has hitherto not been taken.

Quality standards

Under the Health Services Act, Government is entitled to draw up quality standards to be met by health services offered by institutions. These quality standards cover areas like staffing,facilities, effectiveness and efficiency, patient rights (permission for treatment, complaints procedure, privacy, etc.) and a democratic structure.
Apart from the demands concerning patient rights and democratic structure these standards already apply to institutions recognized by the Sick Funds Act and the Exceptional Medical Expenses Act and are laid down in the conditions for recognition.
Besides institutions, certain quality standards also apply to indivudal medical professionals.

Influence of social interest groups

Besides financing bodies, consumers, employers and employees, all institutions and individuals involved in health care may be considered interested parties in facilities planning and settlement regulation.
The Health Services Act gives Government extensive decisional power. It is authorized to draw up quality standards, finalize plans, issue building permits and recognitions, grant settlement permits, etc.
In general it is the type of facility which decides whether decisive power lies with the Minister, Provincial Executives/Provincial Council or with the Municipal Council/Mayor and Aldermen.
Leaving aside the objection and appeal procedures surrounding most decisional processes, we may state that formal participation in the decisions takes place within the executive bodies which play an important role in the implementation of the Health Services Act: at the national level this is the National Health Council, at the provincial level the Provincial Council for Health and at the municipal level the local advisory bodies.
We will restrict ourselves here to the national level.

National Health Council

The National Health Council has been charged with the task to advise on the implementation of the Health Services Act. In this context we need to add that if decisions on the implementation concern facilities which are paid for under the Sick Fund Act and the Exceptional Medical Expenses Act, the Sick Fund Council will have to be consulted too (see section 6).
Advice on the Health Services Act is not the Council's only tasks. More in general the Council advises on the structure, implementation, quality, legislation and efficiency of health care, as well as on all matters concerning health care.

In addition the Council will have to further cooperation between the authorities and private enterprise.
The Council has 45 members and consists of representatives from

Organizations of	
health care institutions and medical professionals	30
financing bodies	4
provinces and municipalities	4
employers	2
employees	2
consumers	3
	45

However, the number of votes differs from the number of seats. The votes of the representatives of the financing bodies, provinces, municipalities, employers, employees and consumers count double. So in essence their votes taken together match those of the suppliers of health care.
When discussing the structure of the Board for Hospital Facilities we observed that the medical professionals were also represented in the financing bodies.
Taking this into account we may conclude that in the National Health Council too the suppliers of health care have a majority. This enables them to steer the Council's advice.

Summary

The Hospital Facilities Act and the Health Services Act have given the government a number of new decisional powers to regulate the supply of health care.
The Hospital Facilities Act has given the Minister the power to establish the capacities and functions of hospital facilities by allowing him to finalize the plans.
The preparatory task of the Provinces in this process is an important one, but necessarily limited to a large extent by the ministerial directives.
If a particular hospital facility does not/no longer fit in the plan the Minister may close down (part of) the institution. At the same time he has the power to establish and distribute the total building volume.
The intention is to extend - with the Health Services Act - this system to practically all health care institutions; this plan envisages decentralization of decisional power to the provinces and municipalities. The law also endows the Minister with the power to intervene in the supply of health care by medical professionals.
Finally, the Act rules that institutions need offical recognition before they can apply for a financing scheme; in

order to qualify they must conform to certain quality standards.
All of the different decision making processes allow interested parties a number of ways to express their opinions. At the national level too, there is ample opportunity for various parties to further their interests; organizations of health care institutions and medical professionals are given considerably more room to do so than organizations of employers, employees and consumers.

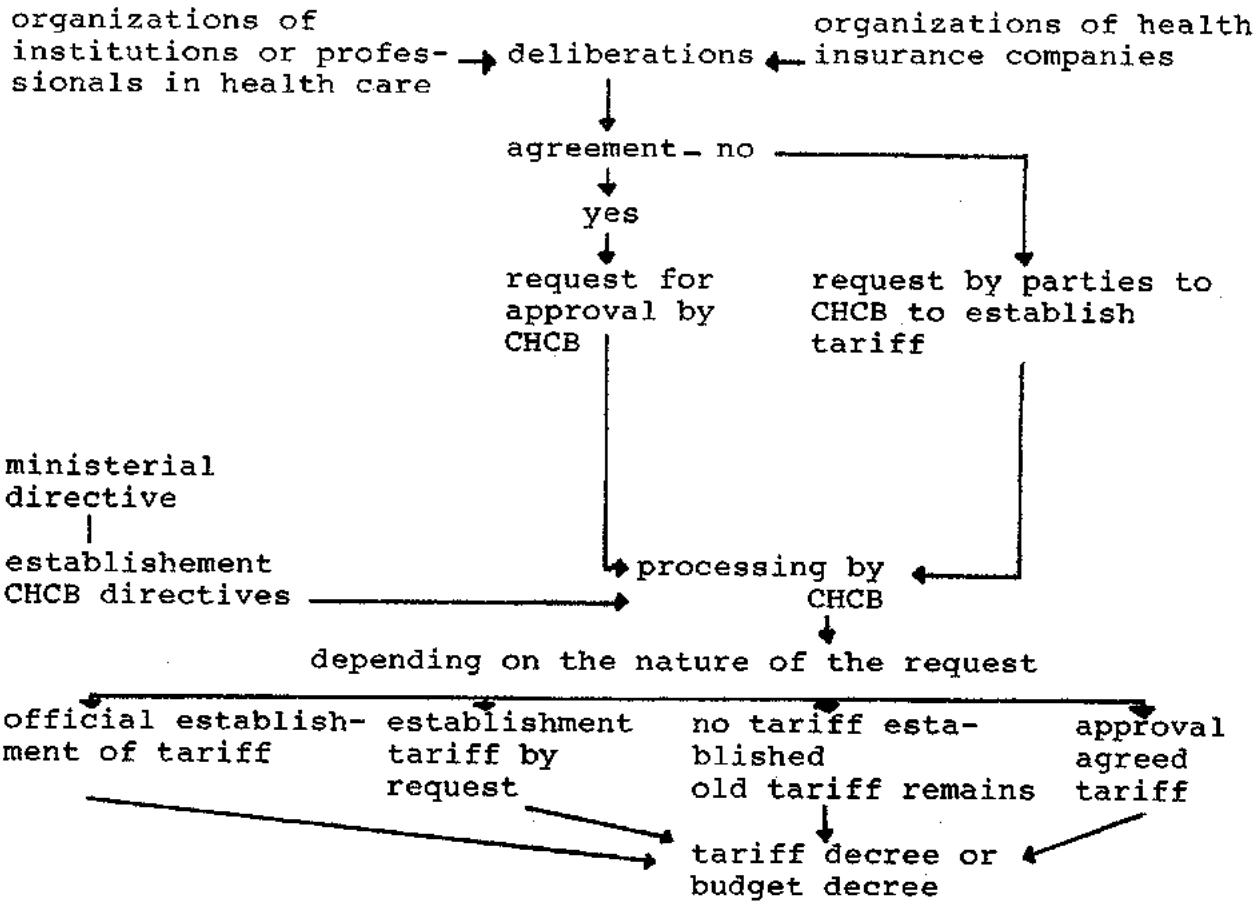
5. Price and Cost Regulation

Health Care Charges Act

The regulation of prices charged for medical services, is dealt with by the Health Care Charges Act. This Act was fully implemented in 1982 and replaces the Hospital Tariffs Act. The Hospital Tariffs Act only allowed control of the tariffs of intramural health care. The more extensive Health Care Charges Act applies to the entire field of health care and part of the field of social services.
The act aims at the constitution of a balanced system of tariffs and fees in health care.
The act rules that all tariffs and fees need the approval of the Central Health Charges Board, which is in charge of the implementation of the Health Care Charges Act.
It is not allowed to charge tariffs which have not been established or approved under the act.

There is a set legal procedure for the establishment of tariffs
(See diagram below)

Diagram 4



Source: based on
Naar een geintegreerde en gedereguleerde uitvoering van de AWBZ, WTG, WVG, WZV en ZFW, Ministerie van Welzijn, Volksgezondheid en Cultuur, 1984.

In principle the organizations of institutions and medical professionalswill first meet with the organizations of financing bodies to discuss tariffs. If they agree, the tariff wil be submitted for approval to the Central Health Charges Board. If the parties cannot reach an agreement, the Central Board may officially or by request establish the tariff. If they wish, the parties concerned may be heard.
The Central Board will then examine the tariff on the basis of directives as to the height, structure and calculation of the tariff. The directives are, as it were, the limits within which the parties are free to bargain.

The directives are established by the Central Board itself, independently or on ministerial guidelines (as to the content). This can be the Minister of Health and/or the Minister of Economic Affairs.

The directives will have to be ratified by the Minister. Decisions taken by the Central Board on tariffs may be suspended or nullified by government at a later stage on the grounds of their being against the law or against general interest. In addition, anyone whose interest is harmed by a decision on tariffs may appeal to the Professional Appeals Board.

Budgeting

In 1983 hospitals left the tariff system and adopted the system of budget financing. This was done because of the enormous share of hospitals costs out of the total costs for health care. From 1984 budget financing has also come to apply to all other intramural health care.
The term budget financing stands for a system by which institutions receive a budget in advance from which to finance the health care services. It is important that costs do not exceed the limits, in order not to jeopardize future budgets.
Budgets are fixed by the Central Health Charges Board after consultation of the institutions and financing bodies.
However, budget financing cannot achieve total control of intramural health care costs, since the system does not cover the services of medical specialists.

Incomes

On the basis of the Provisional Act for the Standardization of Incomes of Independent Professionals, the Minister of Economic Affairs has the power to establish standardized incomes. Under the Health Care Charges Act the Minister of Economic Affairs and the Minister of Health together may instruct the Central Health Charges Board to take note of these standardized incomes when establishing the tariffs. This applies, amongst others, to specialists.

Financial Survey of Health Care

Since 1977 the government has published the annual Financial Survey of Health Care, mentioned in section 2.
The Financial Survey gives an overall view of the costs and financing of the entire health care system.
It not only contains an analysis of costs made, but also estimate the costs of the five years to come. This estimate is the framework within which any switches between government and social insurance funds may be accomplished. The framework is a target for the government and an indicator for the social insurance institutions. The intention is to make the framework act as a target for the entire field of health care. At present it also serves as the basis for the ministerial directives mentioned above,

Influence of social interest groups

The Central Health Charges Board plays an important role in the process of price regulation. It approves/establishes tariffs, develops directives, and advises the government on all subjects concerning price development in health care.
The Central Board consists of 18 members. Of these 18 six are appointed by the government, four by the Minister after consultation of the organizations of health care institutions and medical professionals, another four after consultation with the organizations of financing bodies and the final four after consultation with the organizations of employers and employees. The last group however, has not made use of this opportunity.
The law rules that the members of the Central Board may not be professionally involved with the organizations of the institutions, professionals and financing bodies which participate in the discussions on tariffs.
They can be members of these organizations though.
Nomination by the various interest organizations is not binding; members to the Central Board are appointed after consultation.
The distribution of representatives in the Central Board is as follows:

Organizations of:

health care institutions and medical professionals	4 (22%)
financing bodies	4 (22%)
employers	2 (11%)
employees	2 (11%)
others (independent experts)	6 (34%)
	18(100%)

There are six committees for various categories of health care institutions which come under the Central Board. The members of these committees are representatives of the organizations of health care institutions, medical professionals, and financing bodies. The first two and the last have an equal amount of seats. Members of the committees need not be members of the Central Board; they are nominated by the aforementioned organizations and appointed by the Central Board. The only task of these committees is to advise the Central Board on directives. They are not involved in the establishment of tariffs.

Although the members of the Central Board are not directly the representatives of the interest organizations which recommended them for membership to the Minister, they are part of them. We may assume that they will consider the

interests of the people in their organization, and hence we will consider them to be interested parties when decisions are taken.
Striking is the fact that consumer organizations are not represented in the Central Board. Also, the suppliers of health care have a considerably lower number of seats (proportionally) than in other advisory bodies and independent experts play a more important role. So the influence of suppliers and financing bodies is limited, that of consumers nil.
The committees, whose role in the development of directives is not unimportant on the other hand allow the suppliers and financing bodies to have a much stronger influence. Here both occupy half the total amount of seats.

Summary

Prices in health care are not established by government but by an independent corporate body, the Central Health Charges Board. Government powers are restricted to the suspension or nullification of established prices and the provision of directives beforehand to the Central Board as to the limits within which the organizations of health care institutions and medical professionals and financing bodies may come to agreements on prices before submitting them to the Central Board for approval. These directives may be based on the government income policy for medical professionals or on the Financial Survey. The limits (directives) are established by the Central Board and need ministerial approval. Organizations of health care institutions, medical professionals and financing bodies play an important role in the settlement of prices.
They also have opportunities for influencing the establishment of prices and directives, albeit that their influence is not decisive. Among the other social interest groups the organizations of consumers have no influence at all, and the organizations of employers and employees, also because of the decision of a number of these organizations not to nominate representatives, have very little influence.

6. Regulation of Financing

As mentioned in section 1 the Dutch health care system has three different financing systems:
- social insurance schemes (Sick Fund and Exceptional Medical Expenses Act)
- private contributions (private insurance schemes, etc.)
- government subsidies.

About 70% of the total cost is financed by the Sick Fund Act and the Exceptional Medical Expenses Act. Almost 25% comes from private contributions and ca. 5% from government. We

will concentrate here on the financing system of Sick Fund Act and Exceptional Medical Expenses Act.

Sick Fund Act

The Sick Fund Act dates from 1964 and gives those insured the right to medical care. The term medical care comprises medical and specialist treatment, obstetric, hospital and psychiatric treatment, etc. The nature, content and amount of medical care is described in a decree which accompanies the act, the so-called coverage decree. Implementation of the Sick Fund Act rests with the sick funds; it is their duty to ensure that people insured with them can exert their right to provisions covered by the act. Sick funds are private corporations. In all there are 66 (1983). The sick funds themselves do not supply health care, they have contracts with organizations and individuals providing health care. Each sick fund is compelled to close a contract with each general practitioner, specialist etc., practising in the area covered by the sick fund. Negotiations about the contents take place between the sick funds and the organizations of health care institutions. When agreement has been reached, the contract (except the part dealing with the tariffs) is submitted to the Sick Fund Council for approval (see below). The part dealing with tariffs is to be approved by the Central Health Charges Board (see section 5). A recent article in the law has given the Minister the power to grant dispensation to the sick funds from the obligatory contracts. The Minister may do so if he is satisfied that patients rights to medical provisions are sufficiently guaranteed by existing contracts. In 1981 dispensation was granted for physiotherapists and in 1984 for dentists. A patient may claim medical treatment if he is registered with a sick fund; he then turns to an institution or medical professional who has a contract with this sick fund. In other words there is no financial relationship between the person requesting treatment and the provider.

Changes in sick fund insurance scheme

The Minister's long-term social insurance policy aims at the creation of a national health insurance scheme for 'uninsurable' risks. The risks meant here are presently part of those covered by the Exceptional Medical Expenses Act (see below). The remainder, supplemented by those risks presently covered by the Sick Fund Act, will come under a compulsory insurance scheme, while other risks may be insured privately.
This policy entails the abolishment of two out of the tree insurance schemes, i.e. the voluntary insurance and the old age pensioners insurance (see section 1).
This is what the Minister proposed to Parliament in 1984.
His proposal envisaged the abolishment of both insurance schemes from 1 January 1985; the old age pensioners insurance was to become part of the compulsory insurance and the voluntary insurance clients were to be referred to the private insurance companies.
However, both the voluntary and the old age pensioner schemes still exist .
Abolishment at such short notice proved unfeasible.

Exceptional Medical Expenses Act

As stated in section 1, the Exceptional Medical Expenses Act (1967) deals with the insurance of all residents of the Netherlands against exceptional medical expenses.
The act applies to facilities and services such as nursing and treatment in hospitals and psychiatric institutions longer than 365 days, nursing and treatment in mental institutions, etc.
Implementation of the Exceptional Medical Expenses Act rests with the sick funds (66), private health insurance companies (82) and executive bodies of civil servant health insurance schemes. (13).
It is their duty to ensure that people insured with them have access to the provisions covered by the Exceptional Medical Expenses Act.
Like the executive bodies of the Sick Fund Act, the executive bodies of the Exceptional Medical Expenses Act do not themselves provide health care either, but have contracts with recognized health care institutions. In this scheme too, the insured can only apply for health care if he is registered with one of the executive bodies and approaches an institution which is recognized by the executive body (i.e. has a contract).

The Sick Fund Act and the Exceptional Medical Expenses Act state that every institution which offers health care and requires financing from the funds of the Sick Fund Act and the Exceptional Medical Expenses Act, must have ministerial recognition.
The Minister grants recognition mainly on the basis of quality criteria (see section 4.2.).
Prior to taking a decision on recognition the Minister will ask the advice of the Sick Fund Council.

Influence of social interest groups

Advice on the Sick Fund and Exceptional Medical Expenses insurance to government and the Ministers of Health and Social Affairs is given by the Sick Fund Council.
Other tasks, beside the giving of advice, comprise:
- supervising the administration of sick funds and executive bodies of the Exceptional Medical Expenses Act.
- administration of insurance funds
- approving of agreements between executive bodies of the Sick Fund Act and the Exceptional Medical Expenses Act on the one hand and health care institutions and professionals on the other.
- approving of the premium of the voluntary sick fund insurance scheme.

The Sick Fund Council has 39 members, appointed by the organizations of employers, employees, sick funds, private health insurance companies, health care institutions and

medical professionals. In addition there is a number of independent experts appointed by the Minister.
Distribution of representatives is as follows:

Organisations of:

health care institutions and medical professionals	9	(23%)
financing bodies	9	(23%)
employers	7	(18%)
employees	7	(18%)
others (independent experts	7	(18%)
	39	(100%)

The Minister may advise the Council on the performance of its task. Decisions taken by the Council, if incompatible with the law or general interest, may be suspendend or nullified by government. Interested parties may appeal to government against a number of Council decisions (e.g. those on payments to executive bodies).

The distribution of representatives in the Council shows a bigger influence of employers and employees on the decisions taken by the Sick Fund council than they have in other advisory bodies. The number of their seats almost equals that of the other interest groups; we may therefore conclude that there is a fair representation of interests. The only group which is not represented is that of the consumer organizations.

Summary

Implementation of the Sick Fund Act and the Exceptional Medical Expenses Act is not in the hands of the authorities but in the hands of private organizations. It is their duty to ensure that the people insured have access to the services they are entitled to under the acts.
The organizations are supervised by the Sick Fund Council, whose task also includes the approval of agreements reached between executive bodies and health care institutions and medical professionals.
Government powers here are restricted to the setting of directives to the Council beforehand, or the suspension or nullification of Council decisions afterwards.
Government does not participate in the Sick Fund Council.
The decisions of the Council can be influenced by various interest groups. The interests of organizations of health care institutions, medical professionals, financing bodies, employers and employees are sufficiently represented. However, there is no consumer participation in the decision making process.

7. Other Legislation

Above we have discussed the most important laws which apply to the regulation of volume, quality, prices an financing. Obviously these are not the only laws. We would like to mention a few other laws, which are at present in preparation.

Patients

Since the publication of the Note on the Structure of Health Care (in 1974), government has had a special interest in the position of the patient.
The Note observed that patients are in too dependent a position and that consumer influence should be encouraged.
A number of policy notes which have been developed since then, contain proposals in this direction. They envisage better patient information on disease and treatment, better patient rights, better patient participation in administration and policy making at various levels, and financial support for patient organizations.
These notes mention a Patient Rights Act and a Consumer Participation Act, both of which are, it is understood, to be submitted to Parliament in the near future.

Professionals

Dutch legislation already provides a number of laws regulating the medical professions. These laws, mentioned in section 1, are partly obsolete. They are to be replaced by one new law, which will cover the registration of health professions, legal protection of medical titles, quality of professional care and disciplinary jurisdiction, etc.

Medical training

In the Netherlands suitable qualification is no guarantee for admittance to medical training courses.
On the basis of a so-called "Temporary Authorization Act" the Minister of Education and Science - professional medical training institutes do not come under the Minister of Health - may limit admittance to medical courses. The reason for limitation is not the present surplus of physicians but the limited capacity of medical courses.
On the basis of the law the maximum amounts of students are fixed annually for general practitioners, pharmacists en dentists.
For some years now the idea has been gaining popularity that one should not only consider training capacities but also social need. In 1982 the Minister of Health instituted an advisory committee (Advisory Committe on the Needs Analysis of General Practitioners), whose task is to inform the Minster of Health on the present and future need for

general practitioners.
The committee published its first advisory report in 1983, and recommended that - on the basis of estimated future needs and present amount of students in this field - medical training courses for general practitioners should be limited even further. In addition the committee deemed continuous manpower planning absolutely vital.
Inspired by this advice the Minister of Education and Science has decided to decrease the number of medical students further. There is however as yet no manpower planning. The fixed intake of students at medical schools coincides with a limited admission of students to specialist courses. This limited admission was the initiative of the medical professionals themselves. Finally, as to the government interference in the contents of medical training courses, it should be observed that the Minister of Education and Science proposed in 1983 that two medical training courses should concentrate more on primary care. In addition he invited all medical training institutes to coordinate the tasks in the fields of research and patient care.
In 1987 this policy should result in a structural saving of Dfl 100m.
In 1984 the Minister and two aforementioned medical training institutes reached an agreement on an alteration of the curriculum in favour of a programme concentrating on primary care.

8. <u>The Consequences of New Health Care Laws on the Influence of Government and Social Interest Groups</u>

The profuseness of government in the development of new laws on health care since 1974, expecting to achieve a better control of supply, costs, prices and financing, is sharply contrasted by the lack of activities in the preceding years (1960-74).
In this period of economic expansion, which showed an uncoordinated and unplanned growth of the health care system government was mainly concerned with the provision of the necessary financial conditions and quality control.
It did not have the instruments to direct this chaotic growth of health care. Government used to have these instruments: after WWII (145-60) it had followed a strict policy on prices, building and financing, in order to keep rates and taxes to a minimum and create favourable conditions for business and industry.
After 1960, when the economy started to show signs of improvement, the policy on prices, building and financing was opened up, resulting in an unbalanced growth of the health care system.
Eventually this growth gave rise to a number of problems, which became clearly apparent when the economic growth slowed down while the costs of health care continued to increase.

These problems have been described in the Note on the Structure of Health Care, extensively discussed in section 2.
As a solution to the problems (rising costs, disproportionate growth of the hospital sector, and lack of functional coherence of health care) the Note proposed to provide government with new instruments for control.
The Note is generally seen as the starting point of renewed government interference in health care.

In this final section we will discuss a number of characteristics of the control system (the sum total of the control instruments), which is the result of the Note on the Structure; this will be followed by a description of the position of government and social interest groups, based on the observations in sections 4 to 6. Finally there will be a number of conclusions.

Characteristics of the control system

The control system envisaged by the government in the Note consisted of a system of laws and regulations to control the supply, prices, costs and financing of health care, with a leading role for government.
The note announced:
on the supply of health care (including organization and quality): the Health Services Act and a revision of the Hospital Facilities Act;
on prices/costs:
replacement of the Hospital Tariffs Act by the Health Care Charges Act;
on financing:
General Health Insurance Act.
Except the General Health Insurance Act, which as stated above, was never submitted to Parliament, all acts came into force around 1980.
Apart from the Health Services Act they are all operational.
This means that the Netherlands have a new health care control system from the beginning of the 1980s, at least as far as supply, prices and costs are concerned. The system for financing which applied at the end of the 1960s and was laid down in the Sick Fund Act and the Exceptional Medical Expenses Act will continue to apply.
Before discussing the influence of government and social interest groups in this system, we will first mention two general characteristics of the system which are essential for a proper understanding of the influence of government and social interest groups. These characteristics concern the relation between the control instruments described in the different laws and the distribution of powers.

Coherence

A recent study by the Ministry of Health on the internal coherence of the control system has provided a number of interesting conclusions, which have been laid down in a report ("Towards an integrated an deregulated implementation of the Exceptional Medical Expenses Act, Health Care Charges Act, Health Services Act, Hospital Facilities Act and Sick Fund Act," 1984).
The report mentions numerous examples of insufficient coherence. The two mentioned here are more or less representative:
Whereas the planning decisions taken under the Hospital Facilities Act do determine the hospital capacities (e.g. amount of beds), they fail to state the Medical production to be obtained and the costs involved.
But these decisions are taken on the basis of certain expectations on the future cost developments.
The relation between planning, costs and financing is unclear. But the reverse occurs too. Decisions taken on the basis of the Sick Fund Act and the Exceptional medical Expenses Act on services covered may result in costs which were not previewed in the planning phase.
One of the causes of this lack of coordination lies in the fact that the Hospital Facilities Act concentrates on the production capacities necessary in health care and the Sick Fund Act/Exceptional Medical Expenses Act concentrates on health care itself. They approach health care from different angles.
A second example of lack of coherence between the legal control instruments is connected with the absence of a uniform terminology.
It seems natural that the Health Care Charges Act would determine the prices of services covered in the Sick Fund Act and the Exceptional Medical Expenses Act. However, this is not the case, for the simple reason that the Health Care Charges Act defines these services differently.
The result is an unclear relation between the regulation of prices and financing. The two examples illustrate the lack of coherence between the various forms of regulation.
The Ministry's approach to this problem is to create one single focus for all laws (health care instead of volume) and a uniform terminology (function).
The implications for institutions - according to the ministerial report - will be that each institution will annually agree upon a fixed number of functions (under the Hospital Facilities Act/Health Services Act). Multiplication - functions x volume x actual prices - will then produce the operational costs involved (under the Health Care Charges Act); these will then be the input to health care institutions (under the Sick Fund Act/Exceptional Medical Expenses Act). But this will require substantial changes of the pre-

sent regulatory system, something that cannot be expected in the near future. Consequently the Netherlands will continue to have a control system which, from a technical point of view, shows insufficient coherence.

Distribution of powers

In the Dutch health care control system the powers of the different bodies are distributed unevenly.
The main decisional powers in the field of supply control lie with the national government, whose intention it is to transfer part of these powers to the provinces and municipalities. Supply control will thus be largely decentralized in the near future.
Considering the field of regulation of prices, costs and financing, we see that major decisons here are not taken by government, but on the national level by non-government organizations (Central Health Charges Board and Sick Fund Council), and government interference takes place beforehand or afterwards. This situation will apparently not be changed in the near future; the organizations have no plans to transfer powers to government or decentralize power.
In short there is duality of decisional power.
On the one hand powers rest with government bodies (supply control) and non-government organizations (control of prices/financing) and on the other hand power is both decentralized (control of supply under the Health Services Act) and centralized (control of prices/financing). As a result the decentralized planning system appears to be an ill match for the centralized financing system.
It is thought that the solution to this problem may lie in the setting of financial limits (based, among others, on the Financial Survey) at an early stage in decentralized health care planning. In practice this solution proves difficult to achieve. For one this will require additonal regulations, which will be anything but a simplification of the control system.

The lack of coherence between the various legal control instruments and the allocation of decisional powers to both government and non-government bodies on centralized and decentralized level have resulted in an extremely complex control system, which constitutes a serious impediment, especially for government, to the efficient and effective control of the health care system.

Government influence

Let us consider the ways government may influence the health care system.
The descriptions of the control systems on supply, prices, costs and financing (sections 4-6) show three different developments in connection with the position of government.

Firstly, the new laws give government powers it hitherto lacked. As an example there is the Hospital Facilities Act, which allows the Minister to take decisions on the capacities and functions of hospital facilities and - if necessary - on the (partial) closure of hospitals.
The Health Services Act has recently given the Minister the power to also determine the volume of individual professionals, by enabling him to prohibit the settling of professionals in certain parts of the country and establish minimum and maximum size of practices.
So in principle government has the power to determine production volume in health care.
Since the Health Care Charges Act came into force, government can also indirectly influence prices.
This is done by the establishment beforehand of the limits of free bargaining on tariffs and the scrutiny afterwards of decisions taken on tariffs.
Although government does not establish the actual limits (directives), they need government approval; this, together with the possibility to give advice beforehand gives government a considerable influence.
Basing this advice on the Financial Survey and the established standardized incomes of individual professionals, government also has the power to control to some extent the costs of health care.

Secondly the application of existing powers has been extended.
A ban on the construction, renovation, etc. of a hospital without ministerial approval (Hospital Facilities Act) may be extended under the Health Services Act to all health care institutions.
The same applies to volume control (planning) and closures.
It must be observed however, that the system laid down in the Hospital Facilities Act has not been taken over by the Health Services Act without alterations. The power to grant permits and regulate volumes has been decentralized and now lies with democratically elected administrative bodies. So in fact there has been an extension of the application of existing powers and an allocation of new powers (to provinces and municipalities).
The application of the Health Care Charges Act has also seen an extension. Formerly, only tariffs on intramural health care required approval of the responsible body; today this applies to all health care tariffs.

Finally there has been a transfer of powers from the Sick Fund Act/Exceptional Medical Expenses Act to the Health Services Act.
At present institutions applying for financing from the social insurance funds under the Sick Fund Act/Exceptional Medical Expenses Act require ministerial approval. Approval will be given if the institutions meet the quality criteria.

However, this instrument will be transferred from the Sick Fund Act/Exceptional Medical Expenses Act to the Health Services Act.
It will then come to apply also to institutions requesting government financing; at the same time other quality criteria will be added to the present ones.
Official recogniton will then no longer be the Minister's prerogative; this may also be done by the provincial and municipal councils.
These shifts too, lead to an extension of the application and the allocation of new powers.

The three developments observed above support the conclusion that government influence has been reinforced. In the near future the major decisons on supply and quality of health care will be taken by government, whereas the present influence on control of prices, costs and financing is potentially greater than it used to be.
But since the supply of health care services in the Netherlands is in the hands of private organizations, government is dependent on these for the execution of its decisions.

Influence of social interest groups

The increase of government powers has resulted in a decreasing autonomy of the organizations of health care institutions and individual professions. Where in the past decisions could be taken relatively independently, they are now dependent on government. This is the case particularly on the supply side of health care (including quality and organization). Where prices, costs and financing are concerned government influence is still limited and that of private enterprise considerable, as can be inferred from the above. But in the field of health care supply too there are ways open to the organizations of health care institutions and individual professionals to influence the process.
We will now establish for each of these organizations and the other social interest groups (organizations of financing bodies, employers, employees and consumers) what their influence is in the new control system.

From the description of the ways open to social interest groups to influence the decisons taken on the various types of control (section 4-6), the following facts have emerged: where the supply of health care is concerned there is a heavy bias towards the organizations of health care institutions and medical professionals to the disadvantage of the organizations of employers, employees and consumers.
The financing bodies are somewhere in the middle.
If we add some of the seats taken by the organizations of financing bodies (in which the medical professionals are also represented) to the ones taken by the organizations of

health care institutions and professionals, the latter form a majority. This means that they have a dominant influence on the advice on control of volume, quality and organization and this way indirectly on the costs of health care.
The opportunities for organizations of health care institutions and medical professionals where price regulations are concerned are limited. Their seats together with those of the organizations of financing bodies do not amount tot half the total number of seats in the Central Health Charges Board. The position of organizations of employers en employees is weak, while consumer organizations are not represented at all.
Finally, the opportunities of various interest groups to influence regulation of financing is adequate. All groups are more or less equally represented in the Sick Fund Council, with the exception of consumer organizations. The last have no seat in this body either.

Summarizing the participation of each interest group in a table, we get the following picture:

Table 3

	Board for Hospital Facilities		National Health Council *		Central Health Charges Board		Sick Fund Council	
Organizations of:								
health care institutions and individual professionals	11	(44%)	30	(50%)	4	(22%)	9	(23%)
financing bodies	7	(28%)	8	(13%)	4	(22%)	9	(23%)
employers	1	(4%)	4	(7%)	2	(11%)	7	(18%)
employees	1	(4%)	4	(7%)	2	(11%)	7	(18%)
consumers	-	(0%)	6	(10%)	-	(0%)	-	(0%)
government	3	(12%)	8	(13%)	-	(0%)	-	(0%)
others (independent experts)	2	(8%)	-	(0%)	6	(34%)	7	(18%)
	23	(100%)	60	(100%)	18	(100%)	39	(100%)

* distribution of votes

On the basis of the table we can calculate the average percentages of seats for each interest group.
The percentages are:

Organizations of:	
health care institutions and individual medical professionals	35%
financing bodies	21%
employers	10%
employees	10%
consumers	3%

The above shows that the organizations of health care institutions and professionals have the strongest representation. Table 3 shows that this is the case expecially in the National Health Council and the Board for Hospital Facilties, where their amount of seats adds up to half and nearly half respectively.
About a quarter of the total number of seats is occupied by the organizations of financing bodies, in all of the bodies except the National Health Council, where they have only half that number.
The organizations of employers and employees each have an equal share, from one seat each (Board for Hospital Facilities) to nearly 20% of the total number of seats in the Sick Fund Council.
The organizations of consumers are only represented in the National Health Council, and their influence is on the whole very limited.

The new legislation has brought about a number of changes in the advisory structure.
The National Health Council, established under the Health Services Act, succeeds the Central Health Care Board (* 1956).
The Central Health Charges Board replaces the Central Hospital Tariffs Board (* 1965). The other two have remained. Eventually, when the Hospital Facililties Act has merged with the Health Services Act, the Hospital Facilties Board will become a department of the National Health Council. But we will not consider this here.
It is not impossible that the changes in advisory structure have brought about new opportunities for certain interest groups to influence policy.
To find out, we will compare the present advisory structure with the one that existed before 1980.

Distribution of seats of advisory bodies before 1980:

Table 4

	Board for Hospital Facilities		Central Health Care Board		Central Board for Hospital Tariffs		Sick Fund Council	
Organizations:								
health care institutions and individual medical professionals	11	(44%)	18	(47%)	11	(41%)	9	(23%)
financing bodies	7	(28%)	1	(3%)	11	(41%)	9	(23%)
employers	1	(4%)	-	(0%)	-	(0%)	7	(18%)
employees	1	(4%)	-	(0%)	-	(0%)	7	(18%)
consumers	-	(0%)	-	(0%)	-	(0%)	-	(0%)
government	3	(12%)	19	(50%)	1	(3%)	-	(0%)
others (independent experts)	2	(8%)	1*		4	(15%)	7	(18%)
	25	(100%)	38	(100%)	27	(100%)	39	(100%)

* no vote (counted as 0)

On the basis of this table we come to the following average percentages of seats per interest group:

Organizations of:

health care institutions and medical professionals	39%
financing bodies	24%
employers	5%
employees	5%
consumers	0%

Comparing table 4 with table 3 we can see a decrease of the share taken by the organizations of health care institutions, professionals and financing bodies, and an increase of the share taken by organizations of employers, employees, and consumers. Tables 3 and 4 show that this is the result of a halving of the number of seats occupied by the organizations of institutions, professionals and financing

bodies in the Central Health Charges Board. At the same time the financing bodies have strengthened their foothold in the National Health Council.
Organizations of employers and employees, which did not have any seats in the Central Board for Health Care and the Central Board for Hospital Tariffs, do have seats in the successors of these bodies.
We may conclude that the opportunities for influence are more equally divided among various social interest groups.

Conclusions

Government intentions to curb cost increases in health care, slow down the disproportionate growth of the hospital sector, and improve the functional coherence, has led to a number of new laws. These laws together comprise a new regulatory system for supply, quality, organization, costs and prices of the health care system.
These laws have given the authorities a greater influence on health care. Under the Hosptial Facilities Act and the Health Services Act, government has the power to take final decisions on volume, quality and organization of supply of health care, while under the Health Care Charges Act government has more opportunities to influence prices and costs (indirectly) than it used to have.
In all, government's potential influence on health care has increased. It must be remembered, however, that the Act which gives government the most farreaching powers - the Health Services Act - is not yet operational.

The fact that government has more opportunities to influence health care does not neccessarily imply that it makes effective use in this power. The use of this power is restricted in two ways.
Firstly, as a result of the preservation of the financing system, i.e. the Sick Fund Act and the Exceptional Medical Expenses Act, there is a complex control system. On the one hand this system is characterized by decentralized planning (still under development) and on the other hand by centralized financing and price regulation. At present the two are technically and administratively unrelated.
As a result government probably has/will have problems realizing its plan to regulate health care. It is not impossible that these problems will cause the emergence of more rules on planning (regulation of supply) as well as on regulation of financing and prices. This is in turn will result in an overly bureaucratic control system, which is an impediment to the realization of government targets.
Secondly, the effectiveness of government actions is restricted by the powers of social interest groups to influence health care policy. Government sees itself surrounded by a number of non-government bodies (National Health Council, Board for Hospital Facilities, Central Health Charges Borad, and Sick Fund Council), all of which have important tasks in the preparation and implementation of health care policy.
These bodies are administered by representatives of

organizations of health care institutions, medical professionals, financing bodies, employers, employees and consumers.
Close examination of the distribution of power in these bodies has learnt that there has been a more balanced division of powers among the various interest groups. Through participation in these bodies these interest groups - especially those of organizations of health care institutions and medical professionals - have the opportunity to influence government regulation of supply, costs, prices and financing of health care. In other words, they can seriously restrict government regulation.
We may conclude by saying that in the Netherlands government has more decisional power in the field of health care, but we must add that the use of that power is limited by a complex control system and the influence of social interest groups.

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PHYSICIAN AUTONOMY DEFINITIONS IN A NATIONALIZED AND A COMPETITIVE HEALTH SYSTEM: IMPLICATIONS FOR HEALTH POLICY DEVELOPMENT

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Abstract

Clinical autonomy has been a sacred tenet of the medical profession in most countries. However, there has been little attention to its definition or justification. The authors report on two exploratory surveys; one among 87 doctors in England and the other among 850 doctors in United States. Results suggest that doctors in both countries have difficulty articulating what they mean by clinical autonomy. Doctors in both surveys tend to believe that it includes freedom to order whatever the doctor finds is important to patient care, including nursing and other services. However, beyond that, there is little similarity. U.S. doctor respondents report freedom of choice by and of patients and freedom to charge are important. On the other hand, a substantial number of U.K. doctor respondents believe freedom from clinical performance monitoring, i.e. peer review, is important. We suggest clinical autonomy is largely a fading illusion in United States and increasingly under examination in the British National Health Service (NHS). We conclude that policy makers will need to see to it that clinical autonomy is defined for what it is and is not, and that appropriate accountabilities to patients, medical peers and payors be established.

Health care services represent one of the most important issues facing policy makers in Western nations. Rising health care costs have contributed to government fiscal crises. An aging population requires and demands more care. Medical technology is increasing rapidly and application of such advances to entire populations is fiscally impossible in most countries. Moreover, as medical knowledge advances, there is increasing concern whether or not it is being applied, and being applied judiciously. While policymakers who have the burden of paying for health services attempt to implement efficiencies, consumer and medical provider groups impede changes that might affect status-quo and historical benefits they have derived from an expanding system. Among the most powerful and vocal have been physicians who decry any changes that would alter their clinical autonomy.

The collective power of physicians through their medical associations has been widely discussed by such authors as Eckstein in Britain,[1] Rayock,[2] and Starr[3] in United States and Stone in Germany.[4] In this paper, however, we focus on individual physician power which is one of the foundations for collective power but has received little investigation.

There are many definitions of power,[5] and it is not the purpose of this paper to explore these. A general definition will suffice: "the ability of those who possess power to bring about the outcomes they desire."[6] Certainly control over patient relationships and resources to serve patient needs is evident at the individual doctor level even though the individual doctor may not be able to control patient health outcomes.

One determinent of individual physician power is the autonomy that has been granted to them, i.e., the right not to have power exercised over them. This is frequently referred to as clinical autonomy or clinical freedom. Freidson,[7] defines physician autonomy as control over technology (methods of work), social and economic organization of work. He states (p. 45) that control of technology leads to control over technical resources. With control of technology, patients, payors and governments have delegated control over resources and their use to physicians. Medicine differs from other professions such as law and accountancy in that medical technology is more complex. Medicine differs from other high technology industries in that outcomes and even processes in relation to task requirements are difficult to measure. As a result there appears to have been little structured interference. In addition, the gatekeeping authority of doctors over patients entry into and use of services is noted by Starr[3] as a major factor in physician dominance and autonomy. This gatekeeping function gives physicians power over hospitals and other suppliers of resources as well as patients, payors and government regulators.

Among the few empirical investigations into clinical autonomy at the individual doctor level, are studies by Engel[8] and Mechanic[9]. Engle surveyed perceived autonomy of doctors in three types of settings in United States 1) non-bureaucratic, i.e., solo or small group practice 2) moderately bureaucratic, i.e., a privately owned, closed panel medical clinic and 3) highly bureaucratic, i.e., a federal government owned medical organization. She examined three dimensions of autonomy, i.e., innovation (e.g., instigating changes in work tasks), individual responsibility (e.g, defining work goals and ability to work and think without interference), and free communication

(e.g. ability to communicate without interference or obstacles). Of the 684 physicians responding to her survey (42 percent of those surveyed), she found that those associated with moderately bureaucratic setting are most likely; and those in the highly bureaucratic setting least likely, to perceive themselves as autonomous.

Mechanic[9] in his 1966 survey of general practitioners in Britain and 1970-1971 survey of primary care physicians in United States found that while about 75 percent of the British doctors surveyed reported it is proper for government physicians to attempt to evaluate quality of care in general practice, only 26 percent of American non-group practitioners and 35 percent of group practitioners agreed. On the other hand he reports that 87 percent of primary care physicians surveyed in United States approved of peer review of medical work in the hospital, 56 percent approved of peer review of medical work in the doctor's office and 44 percent approved of peer review of hospital work by physicians from outside one's community. Apparently the discrepency in American doctor attitudes toward freedom from quality controls relates to who does the quality review.

Tolliday[10] in reference to doctors in the British National Health Service (NHS) states that clinical autonomy arises as the consequence of policy to provide personalized care for patients. The first component of clinical autonomy is "the right to independent practice which precludes management of the practitioner by a manager carrying responsibility at a higher level for the work done." The second is that "clinical autonomy entails the right of the client or patient to choose his practitioner and the right of the practitioner, in his turn, to refuse an individual as his client or patient". The third component is "allocation of prime responsibility for each patient's care to a specified practitioner, although prime responsibility may be reallocated from one practitioner to another,and will involve the coordination of other professions in the provision of care to specific patients." A fourth component is "primacy of knowledge"; medical knowledge is held to be more encompassing than that of other health professions.

Thus doctors seem to enjoy considerable independence even though they function in complex organizational settings and have major influence over both the health and economic status of individuals and populations. Moreover, clinical autonomy appears to have been largely preserved in spite of current economic crises. Before one can address the justification for clinical autonomy or its implications for policy makers, it is important to consider the meanings of clinical autonomy. Health policy changes affecting doctors are frequently met with wails from organized medicine that they will harm clinical autonomy. What do they mean by clinical autonomy? Is there general agreement among doctors as to what freedoms are important? Are there differences in definitions between doctors in different specialties, age groups, or in private and public systems?

SURVEY OF DOCTOR'S CLINICAL AUTONOMY DEFINITIONS IN UNITED STATES AND ENGLAND

In response to the above questions, the authors surveyed doctors in Madison, Wisconsin USA, a competitive health service system, and in the nationalized health service in England. We do not claim our samples are necessarily representative of nationalized and competitive systems or even of

U.S. and U.K. in general, nevertheless, except for certain community characteristics we see no reason why our samples within specialties and practice organizations should vary with other parts of the two countries. An important caveat is that the surveys investigate what doctors say and this may or may not correspond with beliefs or behavior.

U.S. Survey

Madison Wisconsin is located in midwestern United States about 100 miles from Milwaukee and Chicago. It has a city population of over 173,000 with a metropolitan area of about 324,000 people. Madison is the state capital of Wisconsin and home of the University of Wisconsin-Madison with 44,000 students. The state government and university are the largest employers representing 25 percent of the workforce. Other industries include meatpacking, insurance, and a variety of small high-tech and white collar service industries. It would differ from most other American communities in that it has higher education and income levels. It is also generally a liberal voting community. Medically, Madison is influenced by the teaching and research programs of the University of Wisconsin Medical School. There is a 548 acute bed university teaching hospital which serves as a referral center for the state and region although most of its patients are from the Madison area. There are also 1135 acute beds in three private community hospitals, and another 325 in a federal Veteran's Administration Hospital. All hospitals have teaching affiliations with the Medical School. The medical community in Madison might also differ from other communities in that about 75 percent of primary care physicians are based in group practices of four or more doctors whereas nationally less than 25 percent are in group practices. Moreover, there is a much higher use of health maintenance organizations (HMOs) in Madison than elsewhere in United States.[11]

The sample for the study was all 850 physicians in active practice who admit patients to one of the community or university hospitals. In United States typically all doctors in active practice including general practitioners will admit patients to hospitals, consequently using hospital medical staff rosters gave us access to active physicians. Although it would have been interesting to have been able to compare doctors in a nationalized system in United States with NHS doctors, doctors who practiced exclusively in the Veteran's Administration Hospital had to be excluded because clinical autonomy questions were inserted into another physician survey project which did not include V.A. doctors.

Questions for the U.S. survey were developed from a pilot interview survey of about 10 practicing physicians and another 4 spokespersons for organized medicine nationally of what they thought were most important physician freedoms. These unstructured interviews suggest that doctors would define clinical autonomy in relation to freedom of the doctor to order whatever he or she felt was important for the patient, freedom of choice for both the doctor and patient, and freedom of the doctor to charge whatever he or she believed was reasonable. Freedom to order whatever they wanted for patients includes dimension of ordering drugs, tests, staff services such as nursing, and freedom from cost and quality control constraints.

Clinical autonomy is usually described by doctors in terms of virtues for good patient care. There are of course other dimensions such as doctor's working conditions, inclome and independence as a goal in itself. Nevertheless to focus on social welfare objectives and to put it in terms believed to be most comfortable for doctors, they were asked to define clinical autonomy in relation to freedoms important to good patient care. The overall survey question was therefore: "Clinical autonomy might be defined in terms of freedoms important to your practice. In that context, how important to good patient care is each of the freedoms listed below."

1. Freedom to order whatever you believe will help the patients
2. Freedom to ignore cost of care in treating patient's needs
3. Patient's freedom to choose a doctor
4. Doctors freedom to reject patients for non-clinical reasons
5. Freedom from peer review medical audit
6. Freedom to decide which services nurses can and should provide to patients
7. Freedom to charge whatever you believe is reasonable
8. What other freedoms do you believe are important to clinical autonomy?

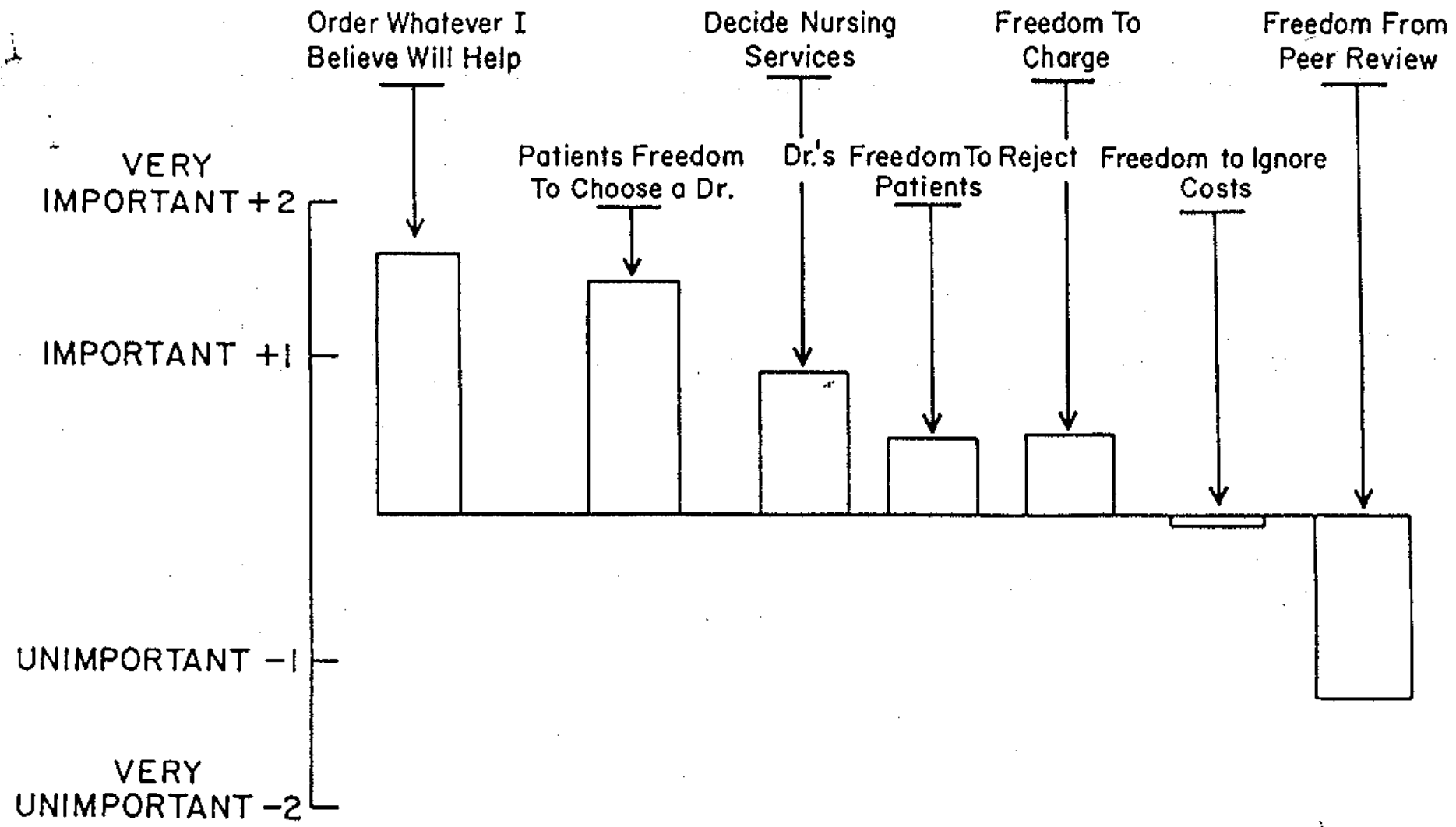
They were given a scale of: 1. very important, 2. important, 3. unimportant or 4. very unimportant.

The survey was pilot tested then mailed to the 850 doctors in Madison in January 1984. After one followup mailing to non-respondents from the first mailing, 481 or nearly 57 percent responded. Based on experience of American Medical Association and other investigators this is a high response rate for physician mail surveys. Comparing respondents with all physicians in the sample we found no practice setting or specialty biases for respondents.

Figure 1 graphically portrays results from the 481 respondents. Rankings were scored as plus 2 points for very important, plus 1 for important, minus 1 for unimportant, and minus 2 for very unimportant. Mean scores for all respondents ranked freedom to order whatever they believed would help the patient first, freedom to choose a doctor second, freedom to decide which services nurses can and should provide to patients third, freedom to reject patients fourth, and freedom to charge fifth in importance. Freedom to ignore cost of care tended to be unimportant and freedom from peer review very unimportant. Nearly 20 percent, i.e., 93, doctors responded to the open ended question of what other freedoms do you believe are important. However, 68 of the responses were elaborations of categories in the questionnaires; for example, 35 concerned freedom to refer to physician consultants of their choice which we would interpret as being related to freedom to order whatever they believed would help the patients. About 20, however, related to working conditions of freedoms to select practice settings such as practicing with whomever they chose and ability to create own office routines and schedules. Three doctors expressed freedom from malpractice suits important and two felt freedom from excess paperwork or other bureaucratic processes to be important.

One might expect to find some clinical freedom priority differences between specialties, male and female doctors, age, university and community based physicians, and group versus solo practice doctors. Somewhat surprisingly however, there were few differences significant at .05 or less. The only significant difference within freedom to order whatever I believe

FIGURE 1: SUMMARY OF CLINICAL FREEDOM PRIORITIES AMONG MADISON DOCTORS



will help patients was for pediatricians who rated it of higher importance than other specialties. As might be expected, patient's freedom to choose a doctor was rated as more important by solo practitioners and physicians in groups of only 2 or 3 doctors and doctors over 60 years of age. There were no significant differences in the above variables for freedom to decide which services nurses can and should provide. Doctors freedoms to reject patients for non-clinical reasons was more important for OB/GYN practitioners than other specialties, and for community than university based physicians. As might be expected, freedom to charge whatever is believed reasonable was significantly more important for doctors in solo or group practice with 3 doctors or less and for community physicians than for university based practitioners. It was also more important for OB/GYN practitioners. Freedom to ignore costs was more important for females, for university based, and for pediatricians. Finally, while all groups found freedom from peer review to be unimportant, physicians in solo practice and in groups of 3 or less and doctors over age 50 found it to be significantly less unimportant.

Conclusions from U.S. Study

It seems clear that among the physicians surveyed, clinical autonomy is defined within a narrow frame of freedoms, of which the most important is the ability to order whatever the doctor as the expert believes will help the patient. However, the doctors themselves do not see this as an unlimited license. For example, the survey shows that respondents look favorably upon peer review surveillance and control which can limit this freedom. In United States there is a government mandated prehospital admission review for non-emergency Medicare and Medicaid cases, there is also a concurrent and retrospective review required by the Joint Commission on Accreditation of Hospitals (JCAH) as well as for Medicare and Medicaid patients through Professional Review Organizations (PRO). The JCAH also requires that through a peer review system, hospitals define privileges of doctors, i.e., what they can and cannot do in the hospital. The implication is that these limitations are seen as legitimate. However, except in HMO practices cost and quality audits are limited to inpatient services. Ability to order whatever the doctor thinks will help the patient is also tempered by cost of care which this survey suggests doctors recognize. Acceptance of drug formularies in many hospitals and clinics, i.e., drugs will be provided by generic rather than brand name, is evidence of such limitations on a doctor's freedom to order anything. Furthermore, doctors rely on consultations from other specialists as medical knowledge advances resulting in joint rather than unilateral decisions.

Freedom of choice has been and still is important to doctors in United States. An ostensible purpose of freedom of choice is to help insure that the patient has confidence in the doctor's ability and interest in helping him or her, and freedom of choice by the patient may be an incentive to doctors to insure they focus on the patients needs and expectations. The traditional fee-for-service (FFS) system in United States may have helped to insure doctor responsiveness to patients rather than to someone else who may control payment. FFS however has led to other abuses, that is, excessive use of service contributing to health service cost escalation. The effective freedom of patients to choose physicians is constrained by the former's lack of knowledge of medical competency or any other way to evaluate physician

services than how they are treated as a person. It is interesting to note that in a companion survey of 1500 state and university employees in Madison, that only 13 percent said "freedom to choose whatever doctor I wish" was unimportant in selecting their health insurance plan.[11] However, as reported previously in this paper, freedom of choice is more important to older doctors and those in solo or small group practice, consequently, as more doctors join HMOs and larger group practices freedom of patients to select physicians and physicians freedoms to reject patients are likely to diminish. Moreover, it may be that the publicity material employed by HMOs will provide better information upon which the patient choice may be based.

Doctor autonomy in relation to other health team members is seen as important but less so than freedom to order and patient's freedom of choice. This too has diminished in recent decades with advanced training for allied health personnel, more female assertiveness, and more team rather than unilateral doctor decisions.

In group practices and corporate systems in United States, freedom to charge whatever the doctor believes is reasonable is constrained by organizational policies as well as by the reimbursement policies of third party payers. Consequently as these systems grow, physician freedoms for setting fees will diminish within constraints of organization policies.

In summary we suggest that clinical autonomy of doctors in United States--a so called free enterprise health system--is substantially, and will be increasingly, constrained. The next section contrasts clinical autonomy in the United States with that of the Nationalized British Health Service.

U.K. Survey

Is clinical autonomy a principle of medicine that transcends national and system boundaries? Do doctor definitions of clinical autonomy differ between a free enterprise competitive system in United States with that of the government operated NHS?

In 1983-1984 about the same time as the Madison study, 87 doctors in six Health Districts in England were interviewed to help define clinical autonomy priorities among NHS doctors.[12] Districts were selected to be generally representative of the NHS geographically (excluding London), teaching and non teaching, and management innovation reputation with some being as comparable as possible to Madison, Wisconsin. The six districts are Dewsbury, Western Leeds, Huddersfield, Gloucester, Liverpool and Southend. They range in population from 165,000 to 519,000. Two are teaching districts. However, socioeconomically only one might be comparable to Madison. Of the 87 doctors interviewed, 29 are general practitioners, 22 of whom are in group practice. Of the other 58 consultant specialists, 19 represent surgical specialties, 13 represent medicine, 7 represent geriatrics and psychiatry and 19 represent anesthesia, radiology, pathology or other diagnostic specialties. Doctors were randomly selected for interview within each District and specialty and any who declined were replaced also at random. Of those invited to participate in the study some 80 percent agreed to participate and were interviewed. Interviews were conducted in doctor's offices and took between 35 to 45 minutes. The interview instrument was minimally structured around

eight general areas related to clinical autonomy. A copy of the instrument is available from the authors. While analysis of the U.K. study is not yet complete and the relatively small sample and different question format and administration prevents quantitative analyses between the two surveys, some general comparisons can be made.

Over 97 percent of doctors interviewed stated clinical freedom was in general important, with over 73 percent stating it was very important; however, respondents had difficulty articulating what it was. As in the U.S.A., U.K. respondents would agree to the importance of being able to order whatever they believe will help the patients but also recognize limitations. Over 52 percent of those interviewed reported fiscal constraints legitimately limited their freedom, 18 percent mentioned facilities and about 17 percent reported constraints such as government decisions concerning contract and employment conditions. Even fewer doctors mentioned constraints due to time (13 percent), patient (13 percent), manpower (7 percent) and litigation (7 percent), limitations. Over 8 percent were unable to name any constraints on their clinical freedom. There were, however, substantial differences in constraint rankings between specialties and districts.

Doctors in the NHS also appeared to agree with their U.S. counterparts that the doctor is captain of the health team and should have freedom to decide which services nurses can and should provide to patients. However 43 percent of U.K. respondents were generally favorable to expansion of nurse "clinical freedoms" while 40 percent were opposed to any expansion.

Beyond the importance of being free to order, there was no relationship between U.K. and U.S.A. clinical autonomy responses. Freedom of choice for patients and doctors which are important to U.S.A. doctor respondents, were hardly mentioned by U.K. doctors, although within limits, patients in the NHS do have choices of doctors and doctors can (though rarely do) reject patients. Freedom of choice is just not an issue for clinical autonomy in U.K. as it is in U.S.A. Freedom to charge was also not volunteered as a component of clinical autonomy in the NHS even though opportunities for some private practice exist, and indeed were engaged in by some 75 percent of respondents.

Another major contrast between U.K. and U.S.A. respondents is freedom from peer review. While most doctors in U.S.A. have lived with, and come to expect and probably respect peer review, as a formal process it would be an anathema to many NHS doctors. While nearly 62 percent of the NHS respondents favor administrative monitoring of clinical expenditures and another 17 percent are ambivalent about it, only 42 percent favor clinical audit (e.g., by peer review) while 34 percent are opposed. Nearly 40 percent stated clinical audit would interfere with professional rights and 16 percent dislike it because it creates dissension. However, 38 percent said it would help to assure quality and 38 percent said performance feedback is helpful. As with other freedoms there were substantial differences between districts (although not necessarily whether they were teaching or not), between specialities (with internal medicine and solo general practitioners being most opposed), and age (with older practitioners being more opposed to clinical audit/peer review). A recurrent theme in oppostion to audit was that it would reduce job satisfaction. Findings of considerable opposition to peer review are also

evident from other U.K. studies that for example reported only 17 out of 70 districts surveyed had implemented medical audit.[13] However, this conflicts with Mechanic's[9] finding that three quarters of general practitioners reported it was "proper for government physicians to attempt to evaluate quality of care in general practice." One might wonder if this discrepency related to changes in attitudes since 1966, to differences between general practitioners and consultants, or to differences in survey methods.

Why has peer quality review been supported in U.S. and apparently not in U.K.? Two important reasons appear to be different approaches to quality control and different relationships with government. Firstly, quality control in Britain is approached from a structural basis while in United States from a process viewpoint. In Britain only consultants, who have received training even more lengthy than their American specialist counterparts, may admit and treat patients in hospitals. In most United States hospitals any licensed doctor including general practitioners may admit and treat patients, but privileges of which procedures they may or may not do are defined and monitored through formal medical credentialing and peer review processes. Once a doctor in Britain achieves consultant status he or she may have almost unlimited autonomy. Nevertheless, quality controls are administered informally through general practitioners referring patients to consultants they perceive to be competent and to varying degrees by professional colleges' educational activities, peer reviews in some hospital departments, "three wise men" system for counseling doctors suspected of being incapacitated, and informal protective practices by junior doctors and nurses.

Secondly, there are differences which arise from the different ways in which the two health care systems are financed. In the U.K., the NHS represents the vast bulk of the health care sector, and its total expenditure is therefore controlled by governments; in such a context, it is not necessary to invoke micro control processes to limit expenditure. In the past, therefore, governments have not felt it necessary to become much involved in what the expenditure was used for, and indeed it can be argued that the understanding that individual clinical judgment would not be routinely monitored was an essential component of doctors' consent to the establishment of the NHS.[14] By contrast, the proliferation of sources of payment for health care in the U.S. means that total spending cannot be controlled, and it is therefore necessary to resort to detailed control through processes such as peer review.

CONCLUSION

This paper is exploratory and further research is needed to investigate more micro aspects of autonomy such as remuneration, time and task assignment, and methods freedom, autonomy in other systems, and geographic locations. Nevertheless, certain tentative conclusions are offered. First of all we suggest that the concept of total clinical autonomy is not widely held in United States and is likely to decrease in importance for the medical profession elsewhere. As reported above, doctors in U.S.A. are already heavily constrained by peer review and fiscal constraints from ordering anything they want for the patient. If the reorganization of health services into corporate practices such as closed panel HMOs materializes, this is likely to increase, and in addition, freedom of choice for patients and

freedoms to charge will be substantially limited. Doctors appear to recognize this as much less is heard about clinical autonomy in United States than in Western Europe. Doctors in United States have apparently sacrificed a great deal of clinical autonomy in comparison to their European colleagues in order to retain economic autonomy, and access to hospital medical staff privileges for all doctors. Indeed, with industrial-medical corporatization in U.S.A.,[15] doctors may in the medium term need more protection. Leaving aside philosophical or ethical considertions, one might ask how this has occurred.

Firstly, control over technology, as suggested by Freidson[7] has probably been the primary reason doctors have been delegated or have been able to acquire autonomy. However technology has advanced well beyond the control of any individual doctor. Doctors must rely on assistance from consultants and other team members to apply advancing technology. Rapidly advancing medical knowledge requires diligence in continuing medical education to insure doctors are equipped to apply advances. Furthermore, medicine is still an art as well as a science. Variations in medical practice[16] and controversies over differing modalities as in the case of coronary care[17] attest to a lack of scientific principles in medical care. Such advances coupled with medical uncertainties argue against the individual doctor as the sole purveyor and controller of medical care.

Secondly, medical care also represents too much of a developed country's resources to grant autonomy to physicians for unlimited consumption of those resources. Experiences in United States, West Germany and Sweden have demonstrated the insatiable appetites of patients and doctors when consumption is determined primarily by users. Britain has limited resources going into the health system, but doctors have power and autonomy on how those resources will be spent.[18, 19] The NHS is now attempting to establish expenditure controls and accountability at the district and unit level through a general manager and clinical budgeting which may limit individual doctor autonomy,[20] and it remains to be seen whether a convergence with U.S. practice will occur. The United States on the other hand has had a peer utilization review monitoring system which limited physician autonomy in ordering services for patients, but had little effect on rising costs. It has more recently added new hospital reimbursement schemes through Prospective Pricing System (PPS) based on Diagnostic Related Groups (DRG) payments which may be extended to physician reimbursement. Government is a primary payor or at least protector of resources and access to health care services, and is beginning to recognize it cannot delegate autonomy over major resources to provider and patient users.

Thirdly, a changing patient role also suggests some modification of clinical autonomy. Patients are becoming better educated to take more responsibility for their own health care and its costs. Rising educational levels of the general population have contributed to the erosion of physician authority.[21] It is also clear that life style is more important to health of populations than medical care services. Patient demands also have a major bearing on costs. In the United States, a major study has shown co-payments by patients will reduce demand for, and cost of, medical care with negligible affect on health status.[22] Patients need to take an active role in their own care not only in terms of a healthful life style and to help evaluate and

manage quality and efficiency, but to help manage their own treatment. Norman Cousins has popularized the role of the activated patient in his books Anatomy of an Illness[23] and in The Healing Heart.[24] Patients will no longer delegate all decisions and autonomy to their own doctor. Second opinions are essential before risky and costly medical and surgical interventions. Patients will demand to participate in decisions that involve options, and they have a major role in treatment success through their attitudes and behavioral compliance and self help routines.

IMPLICATIONS FOR POLICY MAKERS

In this final section we predict that policy makers will increasingly expose and define clinical autonomy and establish and facilitate formal accountabilities to patients, payors and peers.

Autonomy is granted either by omission of any restraints or by commission such as licensing laws. In Britain, as in many other countries, clinical autonomy is an undefined, but widely accepted notion, though as noted above, this is increasingly under challenge. The problem which remains is one of how to balance interests: how to allow for individual treatment of individual patients, the exercise of sincere and informed professional judgment, and the pursuit of reasonable economy and efficiency.

It is important that doctors have autonomy to apply their technology by ordering services that the patient needs in order to be cured or at least cared for. However, what that means and how it should be implemented will have to be defined.

Patients' freedom to choose a doctor and a doctor's freedom to reject patients also seems to be legitimate components of clinical autonomy. Care will suffer if the patient and doctor are incompatible. However, there are limits to freedom of choice by unavailability of options due to geographic or referral constraints. Limits of choice due to inability to pay or other socio economic disparities are likely to develop into significant political issues.

Doctors' freedom to decide nursing and allied health services will not be as easy to define. Along with women's rights movements, nurses no longer want to be physician handmaidens; they see themselves as having unique professional skills too. This has been a serious area of conflict in American medicine.

Issues concern not only patients and professional rights and quality of care, but cost of care. Freedom to charge what they believe is "reasonable, customary and usual" appears to be unique to doctors in United States. These historical practices were built into original Medicare legislation in 1966, but are now fading under prospective pricing systems with DRGs and competition through HMOs and PPOs.

Freedom from peer review is still important to most doctors in the British survey. Freedom from cost and quality review are legitimate areas for policy maker challenge.[25] Processes to define clinical autonomy, patient, payor and government rights will need to include joint participation by representations of these groups.

Finally, policy makers will need to address issues of accountability. Doctors' accountability to patients in United States has been implemented through fee-for-service and malpractice litigation systems, both of which have been abused. It would seem, however, that patient's rights need to be defined along with clinical autonomy. Furthermore, policy makers can assist patients implement their rights by providing means and education on how to evaluate access (e.g. self help manuals) and quality of care (e.g. exposing quality review data). Policy makers can also provide incentives to patients for accountability for efficiency of care such as has been done in United States through co-payment and competing HMO systems. Doctors also need to be accountable for efficiency of care to those who are paying for it and where this is a third party, there is a potential clash of interests. Policy makers can provide health services research resources to evaluate new technologies and cost benefit/cost effectiveness of different approaches to delivering health services, and in such a context policy makers will be able to provide for accountability to physician peers for quality of care since peer groups will continue to be the holders of advancing medical knowledge. To insure advances are applied when appropriate, peer review-medical audit systems are essential.

Clinical autonomy has been a primary source of physician power though only recently has it been raised as an issue and challenged as a major impediment to efficient health service delivery systems. While it is appropriate to have it challenged, it is important that its components first be defined and accountabilities facilitated. The medical profession will naturally resist incursions into what it considers its domain, and the potential threat of doctors withholding service has deterred many policy makers. Nevertheless, current cost, access and application of advancing medical technology necessitates addressing these issues.

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The Politics of Information in the British National Health Service

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It has always been a tenet of political philosophy that the possession of information contributes to power. The power of information has traditionally lain in relative scarcity, which made it a highly valued commodity. Thus, within the British National Health Service (NHS), the power related to information is often restricted to those who control and use it by restricting others' access. So, medical information is defined, used and controlled by the medical profession; administrative information (on day to day resource consumption and service delivery) is mainly the province of planners and administrators; and mangerial information, though limited in quantity, and often quality, is the concern of those who make policies in the NHS - the lay members of the health authorities and the members of the service management committees, those in the DHSS, and in government.

This is the present picture, but two major changes have occurred in the NHS, which appear to be radically affecting the value of information as a commodity in the NHS. Firstly, there has been a change in the "philosophy" of management. The introduction of general managers, following the Griffiths

Report, has confirmed the idea of responsible and accountable management. (Griffiths, 1983). The power to make decisions is now embodied in general managers who are hierarchically accountable through the NHS organisation of units, districts and regions, to a supervisory board and a management board at the Department of Health and Social Security (DHSS). This new management philosophy appears to be highly dependent upon regularly produced statistical information to monitor resource usage (of all sectors, including the medical profession) in order to ensure accountability to the centre for actions taken at the periphery of the organisation. Though the precise techniques for creating statistics are not yet clearly defined, the potential uses of information have increased its value as a management tool, and therefore, its potential political significance.

The second change has been the explosion in information technology (IT). Micro-computers have been bought into the NHS by the thousand. The computerisation of medical records is either occurring or scheduled to occur in every district. Millions of pounds are being invested in computing equipment. The potential to collect, to generate and to communicate vast quantities of information about the workings of the NHS therefore exists, if only in embryonic form. Information, if handled by technology, could become a very common and easily accessible commodity, and this, in direct contrast to the traditional model of information, would produce an equally dramatic change in its political value. Access to medical information by patients could change the relationship between doctors and patients, managers could monitor more closely the behaviour of doctors towards their patients, the role of doctors may be radically revised with the development of computer assisted diagnosis and easy and rapid access to the banks of medical

information which at present is hard to obtain.

This is all some way in the future. Information technology still has some way to develop before such changes can be realised. However, it is now evident that the NHS cannot ignore the onslaught of the new technology, and is at present having to learn about the new technology and accomodate to the changes in organisation and functioning which occur with its introduction. Information technology has tended to appear first in organisations in areas concerned with routine, administrative tasks such as payroll and accounting systems. The next step is usually an emphasis upon the production of statistical information which can be used for management purposes. (Masuda, 1980). Coinciding, as this stage does, with the new management philosophy, it is perhaps not surprising that the NHS is now embroiled in choosing an approach to the information technology which will assist management practices.

The potential increase in the value of information as a management tool is occurring, therefore, at the same time as there is a potential reduction in its scarcity. (Tinbergen, 1983). This may seem like an economist's conundrum - it is in fact the key to a highly complex debate about the organisation of information in the NHS.

This paper will discuss the organisational stresses which are now appearing within the NHS as it attempts to devise a strategy for handling the large-scale introduction of information technology. The first part of the paper examines the history of IT in the NHS and explains why the need to develop a strategy for information is now perceived as urgent. The second part of the paper is exploratory - it brings together ideas which are included in my

present research study, and which are still to be worked upon. It looks at issues which have to be taken into account in developing and implementing a coherent strategy and suggests that the traditional issues discussed in policy making are not sufficient for studying IT and information policies.

The Need for an Information Strategy.

The use of statistical information for monitoring the functioning of the NHS can be traced back to the beginnings of organised health care. Chadwick's survey of the sanitary conditions of the working poor and the discussions of the Poor Law guardians about the use of workhouse resources are perhaps the earliest examples, followed by the development of central and local government reports on the state of health services and the health of the population. After the inception of the NHS, the collection and compilation of statistics covering a variety of aspects of the health services became routine at the central government level. Incremental additions of information over a century led to a complex structure of overlapping and inappropriate statistics which, by the 1960s, were causing concern at both central and local level. Implementing a planning system, as originally suggested in 1972, proved almost impossible because of the lack of health services information. Most districts were unable, or unwilling, to complete the information profiles called for in the early years of the planning initiative. The complaints continued throughout the 1970s, culminating in the major criticisms of the Royal Commission in 1979. Changes in the type and nature of information collected were frequently discussed, but no serious attempts were made to develop a more coherent and relevant set of statistical returns to central government.

In order to overcome these criticisms, the DHSS set up a review of the information requirements of the health services, and as a result a permanent committee to review information matters was called for. A joint NHS/DHSS Steering Group was formed in 1980, under the chairmanship of Mrs Edith Korner to define a common core of information for district management, derived from the data needed to run all parts of the basic health service, which could be aggregated for use at regional and DHSS level. At about the same time another, separate, initiative was set up - to devise performance indicators to compare health authorities as part of the drive to improve the efficiency of the NHS.

Although the work of the Steering and the Performance Indicators Groups were separate, they had one thing in common. Both started with a view that the information with which they were concerned should be derived from the day to day information needed to run the health districts. This latter form of information is, for the most part, produced at the "grass-roots" of the NHS which is where the introduction of computers has had the greatest impact so far. Day-to-day information is needed in order to keep the component parts of the NHS in operation and is, for the most part, concerned with manpower related and patient activity information.

These so-called operational systems derived, not from a concern about management information, but a concern about enabling or directing service delivery. They were, and still are, simply automated data processing units, which store data, such as payroll, patient records and those relating to accounting matters which primarily depend on complex manual systems, very amenable to computerisation. The story of operational systems begins with

the early developments in computing which began in the NHS two decades ago.

In the 1960s it was hoped that one computer system for each major administrative function performed by the health service would be created which would be used by every district. Considerable investment was made by the DHSS in experiments to find the "best" computer system for the job. But these "experiments" were superseded by the NHS regions, who, perceiving the advantages of computing for some functions, developed their own computing services. It was therefore decided that the DHSS should abandon its highly centralist role in determining computing developments, and should work with the NHS in defining and implementing an agreed strategy for computing.

This decision reflected not only the diminishing ability of the DHSS to control NHS computing developments, but also the mood of the time. There was a general consensus that central control should lessen in many areas of the NHS and computing was to be no exception. However, it was not clear whether the NHS as an organisation, or the regions or districts, should in fact be the main parties in making decisions about computing, which as will be seen later, has and still is causing considerable tensions within the NHS. The feeling appeared to be that although the DHSS was not a suitable organisation to control developments, there were good reasons for having uniform decisions about computing which would affect the whole of the NHS.

The first and most pressing reason was that a number of reports produced in the early 1970s claimed that computer systems were being duplicated and some systems were more successful than others. This process seemed to be leading to a waste of time and effort, and one thing that the NHS was becoming

increasingly short of in the 1970s, was specialist computer manpower. In consequence, the advisory committee on medical computing (AMAC) was set up to plan the future of computing developments, and at the same time the Secretary of State commissioned a review of the future direction of NHS computing.

The review group, consisting of management consultants, DHSS and NHS staff, chose to answer the question "what programme of computing should the NHS have?". (DHSS, 1972). They recommended that a number of standard operational systems should be developed which would be available for the NHS, thus preventing the duplication of effort in system design. To achieve this they recommended there should be a national programme consisting of three stages - experiment, development and implementation - which would be conducted mainly through regional computer centres.

At the same time, the government decided to implement a procurement policy which standardised hardware, based on ICL 1900 Series computers. This is now referred to as a standardisation policy, though in reality it was a series of loosely formed objectives, which attempted to obtain advantageous procurement terms for the NHS whilst advancing a British computer company. In addition, it would "achieve a compatibility of equipment and systems...economy in the development and operation of computer systems...improved facilities for the transfer of information required for the administration of the NHS" (Arthur Anderson, 1984).

The objective of standard operational systems to run on standard machines turned out to be impossible to achieve. The eight main development projects included in the standard systems programme were estimated at their start to

cost £6.8m over the period 1969-74. By 1975 it was apparent that they would cost in 1978 nearly £20m - even allowing for inflation, they would be double their original cost estimates (PAC, 1976). All projects were also progressing much more slowly than initially planned.

It was also becoming apparent that there was little control of specific developments outside the programme and computer systems were being designed at regional (and even district) level, with no regard for the work being funded by the central organisations. At the same time, changes in the technology were occurring which appeared to be likely to make computers even more easily accessible, cheaper and therefore less controllable than either the central committees of the NHS or even at the regional level.

The 'rational' approach to controlled development in the 1960s and early 1970s had not been successful and it was decided to revise the committee structure which, in theory at least, controlled the development of computing. A review group was set up to design a new committee structure.

This group decided that the committees should be restructured in order to enable all policy matters to be agreed with the NHS by only one body. However, it was felt that the policy had to be supported by an appropriate research and development programme and a coordinated standardisation programme. Therefore three new committees were recommended: a computer policy committee, a research and development committee and a system standardisation committee. (DHSS, 1976).

The research and development committee came to an unhappy end when nearly

half the members resigned. Complaints were made that "the NHS is being used to develop the computer industry rather than the other way round" (Lawrence, 1981). The computer policy committee fell into a state of disarray as the members could not agree on solutions to the NHS computing problems. Yet again the national committee structure failed, but was not abandoned.

In consequence, a new, revised, NHS Computer Policy Committee was set up in 1981. This new committee was to be a totally NHS committee with NHS secretariat and charged with the development of policy on those aspects of computing best considered on a supra-regional or national basis, avoiding DHSS involvement in NHS computing. However, the DHSS retained some health services computer policy areas which the new NHS/CPC did not take over. Such is the curious organisation of the NHS, that some services related to the provision of health care remain outside of the NHS. These, such as the family practitioner committees, family practitioner services, dental estimates and the prescription pricing authority continued to be administered by the DHSS.

The NHS/CPC and the DHSS therefore both had a responsibility for developing computing policy. The role of the CPC was never entirely clear. In 1983 it became a "collective mechanism for formulating policy through a representative policy making body which does not itself have the executive power to implement the policies but which does have a duty to persuade the health authorities to implement them". (NHS/CPC, 1983). The DHSS has the power to develop guidelines for all policies, which though muted in the later 1970s and early 1980s because of the move towards decentralisation of decision making, has been reinforced with the creation of the new Supervisory

and Management Boards within DHSS.

The need for standardisation of hardware and therefore standard systems was primarily a feature of the technology of the early 1970s. There were relatively few machines which were very expensive. The need diminished as smaller, cheaper and more powerful machines were produced. As the costs of hardware decreased, so the cost of software development leapt upwards. Software has to be designed by people, and the costs of employment increased as labour costs soared and as the demand for software specialists increased in other sectors. Though the need for standard software is still perceived, by many people who work in the NHS, the emphasis upon its development has receded as more and more districts have chosen to buy in their own machines and to develop their own software. The policy concern appears therefore to have moved from one of efficiency and economy in development to ensuring that the data used in the systems is standard in order to enable the systems that are used to communicate and to integrate.

The technology and the knowledge at the beginning of the 1980s is now being reflected in a desire within the NHS to integrate computer systems and to develop the uses of computers to create information systems. Changing technology has meant that widespread communication, information storage and retrieval and manipulation are simultaneously possible. There is a desire to rationalise and link information about patients and service activities within a health district in order to create what is now referred to as a district information system. In addition there is also the growing need for complex information to support the new management philosophy. In theory, these two needs, (of the operational system and the management philosophy), should be

compatible, though in practice compatibility appears hard to achieve. It has often been assumed that the computerising of the operational systems will lead to the generation of management information.

This is easily achievable for limited amounts of information derived from single, simple operational systems. But the new management philosophy demands a more complex approach to handling combinations of data from many sources which the unlinked and statistically unsophisticated operational systems are not designed to achieve. A new way of thinking about linked operational systems and ways of providing management information systems needs to be found. This will require not only an understanding of the technical issues, methods of capturing data and ways in which information is used and flows in the NHS, but also a set of decisions about how such a system should be introduced into the NHS.

The NHS has no experience in handling issues as complex as this. Historically, the operational systems computing policy and the information policies evolved entirely separately, as shown above. Though it was known that there might ultimately be some relationship between them, the precise form was unclear. A report in 1976 stated "there will be progress in computer based information systems during the next decade, but it is too early to identify fully the implications this will have for computer developments". (DHSS, 1976).

The design of an information strategy involves taking decisions on three separate though related areas. These are technological developments, a view of the desired form the information system will take, and the means by which

the strategy will be implemented.

1. THE TECHNICAL ISSUES

The ways in which technology will develop are not always clear. Policy about technology has to be based upon a view of whether technology will be readily adopted and used. This raises the question as to whether policies should be designed to "find what solutions there may be through practice and experience, or whether there will always be conscious attempts made to develop society in ways which will both ease the problems themselves and develop answers to them (Alexander 1983). This can be expressed more simply as "wait and see, or predict and prepare, or make it happen". (Roberts, 1982).

Devising an information strategy which combines computing policy and information policy might seem at first glance to require a perfect knowledge of the likely developments in technology and what it will be able to achieve. Within the NHS, the view that this pessimism is unnecessary is gaining ground. There is a growing belief that if data items are standardised across the whole of the health service, then data can be moved from machine to machine with minimal disruption to the service or the information base. Therefore, whichever technology developments are likely to occur, the information system will continue to be structured in the same way. Secondly, it seems unlikely that there are going to be any really significant changes in information processing in the forseeable future. Smaller and more powerful machines are inevitable, voice processing is likely to be possible soon, but these are "icing on the cake" and will not create significant changes in the tasks to be performed. It is argued that the technology of

the twentieth century industrial revolution is more predictable than that of the nineteenth century. In a sweeping generalisation it is possible to see that the nineteenth century suffered from problems of the order in which innovation would occur. Although it is apparent that the present industrial revolution is lacking a communications infra-structure for IT similar to the function performed by the electricity grid system today, though slightly different in that it needs to handle two-way transmissions of information, and secondly, the appropriate theoretical understanding of information flows, it is felt to be significantly different from the nineteenth century in that this lack of understanding is appreciated, and concerted efforts are being taken by the computer industry to overcome them.

It is argued by many concerned with IT in the NHS that it is unnecessary to have a precise view of future technology to develop an information strategy; the vague awareness of future possibilities will suffice. For example, one area which is exercising the minds of IT specialists is that of intelligent systems, and the NHS is slowly beginning to address the possibilities that this could afford to the delivery of health care. The significant problem, however, which is only just starting to be addressed, is not "what will the technology do", but "to what use should information technology be put", and "what will the environmental effects of its introduction be?" It is already becoming clear that the introduction of remote communications may well alter the ways in which services are traditionally provided, though exactly what these changes will be is not clear.

2. THE LACK OF SPECIALIST RESOURCES

The lack of specialist staff within the NHS involved in computing has meant

that the demands of the districts to introduce operational systems have been greater than those which the regions can in general satisfy. Dissatisfaction with regional performance has caused districts to seek out their own solutions, often by purchasing these from the private sector. This has resulted in a proliferation of independent computer systems, which are incompatible with each other.

This present behaviour conflicts with the knowledge that there is a need to conserve the limited NHS resources available for IT. Part of the present dissatisfaction is that the regional computer centres are at the limit of their potential resources to install and implement the technology which is available, let alone to consider what the future of information systems will be.

The autonomy of the districts, growing because the inability of regions to supply their increasing demands, is also intrinsically strong with regard to IT policy. Districts have become used to negotiating their own policies with regard to IT and also IT policy tends to resemble a day to day activity which districts are used to determining themselves. Changing the perspective of districts from operational processes towards an information system which is an integral feature of the organisation and design of the NHS is proving complex and difficult.

THE FORM THE INFORMATION SYSTEM SHOULD TAKE

The present desire to link information about patients and service activities has given rise to the idea of a district information system mentioned earlier. However, if the potential to do this exists within a district, the

communications network could be extended to link districts together thus allowing any patient's record to be accessed wherever in the country he/she appeared for treatment. The form of the information system to be followed depends upon the view that is adopted about the coverage of the communications abilities within the NHS. In some districts the advantages of linking information systems with the local authority personal social services departments have been perceived and are being pursued.

The return of statistical information for management purposes to regions and to the DHSS could be speeded up and simplified if the communications abilities between districts and the higher organisational tiers existed. Similarly, there could be automatic transmission of information from the higher to the lower levels.

If a wide-reaching and extensive communications system is required, then the standardisation of data for the whole of the NHS becomes imperative. it is necessary to have a single agreed approach to the definition and structuring of data held within the information system. Although the technology has still to develop to enable this to happen, the NHS will be ready to accommodate it if standardisation of data is achieved.

This view is resisted by those who feel it is necessary to place boundaries around the coverage afforded by information systems, which should be limited in order to safeguard the privacy of both the individual patients and the organisations involved. Much of the difficulty experienced in deciding upon the form the information should take is due to the lack of precise objectives for the NHS. The NHS appears to be implementing a system which reflects a

lack of objectives.

Whichever view of the nature of technological development and the form of the information system is adopted, the NHS has yet to find a means of implementing it.

DEVELOPING A STRATEGY

In addition to deciding at which level responsibility for controlling the development of IT policy should lie, it is apparent that there are a number of possible approaches to the development of an information strategy. These derive from the existence of different views about the future of technological development and accommodation of IT in the NHS and the form that the information system could take. As there is no consensus view at any level of the NHS (down to unit or even individual consultants) about either of these, an approach must be decided upon which will either impose or create an information strategy to at least the level chosen to be responsible for decision making about IT policy.

A number of models for the development of an information strategy are at present available within the DHSS/NHS. One is to <u>impose</u> a single view from the centre which ensures that the NHS conforms as in the case of the Griffiths management recommendations. The second is to impose a view, but in a more flexible way, providing considerable resources to <u>encourage</u> enthusiasm and support in the NHS for the strategy. To a large extent this was the view adopted by the Steering Group on Health Services Information, which devoted considerable effort to publicising its work and creating support. The third

is to attempt to generate a consensus view of an information strategy within the NHS. This is, in fact, the approach at present adopted by the NHS/CPC. The fourth approach is to support the various component parts of the NHS in uninhibited development.

Even within districts there is a lack of consensus about the development of an information strategy. Therefore, even if the responsibility for policy making is centred on the district, there will be a need to find a mechanism for evolving a coordinated approach to information policies.

The choice of models can be summarised as:
Dirigistic - central control of the development of information systems aiming at a coherence in approaches to policy development;
Synergistic - the component parts of the organisation (vertical and hierarchical) will work together to produce successful policies;
Autonomistic - that each component part will develop freely to its own best result.

There are powerful arguments in favour of the dirigistic central control over information policies.

The new management philosophy depends upon comparing information from districts and regions, and using variations in performance to control district behaviour. There has been a growing realisation that if every district develops a unique information system there will be compatability of data across districts and regions. Data will not therefore be comparable and without this, the centre will be unable to exercise control over districts

and regions by pointing out variations in their behaviour. This therefore argues in favour of creating national data standards for the whole of the NHS.

Even if national central decision making is rejected, dirigism within districts may be necessary. Standard data are needed if districts are to have wholly linked information systems. It is unlikely that technological development will permit independent systems to be connected easily. Thus, if each information system within each district holds data defined and structured in different ways, the possibility of creating a linked or integrated information system will be made difficult and prohibitively expensive if not impossible.

A dirigiste policy assumes that there will be firstly an accepted method of devising and implementing an information strategy. Though in the new management climate this is possible, the regions and the districts have evolved their own approaches to purchasing computers and to introducing information policies. Within districts, units and departments have also become used to selecting and purchasing their own equipment. Some regions charge districts for computing services, and therefore the districts have experienced no qualms about buying in their own computers and outside advice. Similarly with districts, some units have become used to controlling their own budgets.

Synergy is beginning to appear in the NHS. Regions and districts are forming consortia for the development of specific systems. In the case of district consortia, districts are combining with districts of similar size and health

service needs to produce their own systems and thus ignoring regional and DHSS advice and guidelines. Thus, across the country it is possible to see decision making mechanisms evolving which do not reflect geographical proximity but similarity in views of information and computing systems.

In contrast to these views is that IT policy cannot be prescribed, except at a very general level. "It is proposed that a district approach to IT implementation should be incremental and progress should be made by controlled evolution. Unlike major organisational change which demands great expertise from senior officers at the highest management tiers, the incremental approach is dependent upon projects and ideas coming from the operational level." (Steering Group, 1983). This approach would be part of the district's strategic plan, recognising its own needs and priorities, rather than as a part of a national approach to IT. Whichever level is awarded responsibility of developing IT policy, its role would be restricted to advice and support rather than controlled direction.

Autonomistic development of IT policies at the district level is supported by many districts. The NHS is not a single coherent organisation. Districts, and regions, have a tradition of evolving their own policies within broad centrally determined guidelines. In addition, it is the policy of the government of the day to encourage the development of relationships between the private and the public sectors, and this allows the districts the opportunity to implement their own decisions about IT. Even if a national strategy were determined, the resources to ensure that the districts were conforming would not exist.

DISCUSSION

The formation of an information strategy requires three types of decision to be taken: technological, form and organisational. Different views about the best approach exist for each type of decision.

Given that the future of technology cannot be guaranteed, all policy decisions in this area must include a degree of uncertainty. It is possible that under these circumstances it would be better to have a standard approach to tackling the development of information systems. "For facing uncertainty, standardisation may be more effective than prediction" (Simon, 1981). However, whether this is better at the national, regional or district level is not clear. This depends upon whether a national information system for the NHS is seen as desirable, or indeed achievable, given the technological difficulties and the improbability that all districts will conform to such a policy. And whatever the final form the information system for the NHS should take, it is not clear what mechanism should be used to design and implement it.

Information is becoming an increasingly valuable commodity. However, its value can only be maximised if it becomes easily accessible to those who need it. Determining who "needs" it is an issue which the NHS has not confronted yet, but doubtless will have to in the design of information systems. Creating the environment in which information can be collected and handled to its best advantage is proving very sensitive and complex. The design and implementation of an information system appears to cut across the traditional decision making structures and approaches of the NHS and there is little

knowledge or experience of how to create a new approach to the policies of information. Similarly, analysis of the issues involved in making such policies appears to require an approach which is different from that traditionally used.

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Workshop : The Politics of Health

HOSPITALISATION IN DOMICILE

THE "POLITIQUE" OF ALTERNATIVE HEALTH CARE IN FRANCE

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Our current research project focuses on alternatives to traditional health care : home health care for patients who would normally be hospitalized as well as home health care for the elderly, the handicapped and psychiatric patients.

Our approach doesn't consider medicine as the sole object of study, but rather inserts it in a more general context; a context of public policy analysis according to research conducted at the CERAT. Our research is based on two observations : first, political dimensions are not treated in most studies conducted on health and medicine; second, in political sciences, the action of the state has been little studied. In the analysis of public policy (which includes health policy) we are trying to construct a general, theoretical approach toward the contemporary state. This approach studies the significance of the developments of public policy in modern society, and the transformations that it implies in the relations between state and society.

The medical system creates its own dynamic, but the physiology of the sector is not the result of professional strategy alone. The politics of health are part of the whole of social policy. Thus, each era defines its own conception of health and social problems according to society's demands. The modalities of health care developed since the 1950's with their underlying egalitarian ideology, their notions of "professionalism" and a desire to minimize risk - marked by free access to health care, a centralized administration and a development of heavy and expensive structures - are characteristic of the welfare-state. Inversely, the quest for alternative health care - marked by an effort to favor a more social orientation toward medicine in a more open setting - as well as the difficulties posed by these new orientations, are tied to the crisis of the welfare-state.

THE PROBLEM

The social and the medical "inflation" engendered by the welfare-state was acceptable as long as it had social consensus : the inequalities of the workplace and of the market seemed to be at least partially compensated for by the equality of social protection; the professionals and the health industries found a protected and an expanding market; the state's intervention in the social domain as well as its non-intervention in the market was legitimate.

Today, this compromise no longer holds : economic stagnation no longer allows that social welfare expenses be made on a demand basis; the social inequality in the face of illness was not curbed by more expenses and a particular cultural current most clearly expressed by I. ILLICH in his denunciation of perverse and antidemocratic results

of the policy of "assistance". One denounces thus, the monopoly of professionals in medicine, iatrogenetic illnesses (illnesses engendered by medical treatment for another disorder) and the denial of individual choice through "heterogenous" techniques. Furthermore, the development of university hospital complexes has rendered ineffective the internal regulation of the medical profession (rapid increase in the number of doctors and a decline of the economic and social status for certain branches of the profession. Social protection as well finds itself without any internal balance as there is a growing chasm between the number of beneficiaries and the available finances.

In the health "politique" the alternatives turn around the notion of a redistribution of priorities. Hospitals held a privileged position in the sixties and the seventies and now absorb half of health care expenses; an effort has been made since to redefine the role of the hospital within the health care system: Internal reforms (overall budget and departmentalization) aim to put into place external control over the hospital's activities; various formulas of health care and home maintenance aim to limit the hospital's function to a narrowly defined, technical role.

This orientation toward health care in a more open milieu supposes an opening of the hospital toward the outside world and a restructuring of its environment. Limiting recourse to a hospital must be preceeded by a revalorization of primary medical care and a modernization of its modes of practice : group practice (where doctors are self employed), comprehensive health centers (where doctors are salaried), or local associations of health care professionals (where private practitioners, generally in group practice, work together on a contractual basis), seem to be better adapted to relieve hospitals than the traditional isolated private practitioner.

Furthermore, a tight coordination is necessary between hospital personnel, social workers, and private doctors and paramedical workers. This implies as well a tight collaboration between the organizations that employ professionals or finance their services. Finally, it will be necessary to develop a system of information, regional and local health observation structures ("observatoires de santé"), charged with gathering and treating local hygienic and social information without which a rigourous program of alternatives to hospitalization at a local level, would be difficult. We will consider these different health structures as tools of the alternative "politique". As such, they should be treated in our analysis.

The "politique" of alternatives in medicine is part of a broader notion of social action. It comprises the cases of the handicapped, the elderly, and psychiatric patients. This new model of social politique was constructed in the later nineteen sixties. X. GAULLIER (2) contrasted the new model with the former model of assistance.

New social Action Model	Former Social Assistance Model
Comprehensive action	Fragmented services
Concerned with the entire population	Concerned only with the indigent population
Open milieu	Closed milieu
Prevention	Cure
Social reintegration	Assistance
Community	Individualism
Collective social administration	Importance of the family
Social integration	Social exclusion

One could deseign a similar table for medicine which would oppose purely medical technology and preventative health care, medical treatment and pluri-professional action, and the sick individual versus the family and community.

Although some progress has been attained in different sectors of social action, putting into practice a global approach to socio-hygeinic problems comes up against administrative fragmentation, the common recourse to heavy and segregative structures, as well as the weakness of the systems of information and piloting (3). In the health domain the stumbling blocks seem as ominous as the medical dimension seems strong. "Hospitalization in domicile" is making only timid progress. For outpatient clinics ("hôpital de jour") even the definition remains vague and it's impossible to evaluate its importance. For hospitalization in domicile, the principle of which was admitted by hospital legislation in 1970, the legal red tape has never been completed. On the other hand home nursing care has been the object of several texts, but this concerns mainly maintaining the elderly at home and has influenced little, up to now, the function of hospitals. A bill is currently being written with the objective that hospitalization in domicile and home nursing care be defined under the sole heading of "graduated care in domicile". For primary health care, structural changes are also slow to come about. The new modes of practice in pluridisciplinary teams don't seem to have the support of the leftest government as had hoped their promoters. The health observation structures ("observatoires de santé") recently put in place in almost all regions in order to become the key element of the regionalization of the health "politique" are uncertain of their future, in the absence of assured public finances.

RESEARCH OBJECTIVES

We in France have at our disposal case studies and analyses limited to only certain aspects of the problems. Such studies most generally fall under the heading of "social management" and aim to reduce dysfunction of certain institutions. A systematic comparison of broad policy orientation of different sectors of social and health policies has not yet been undertaken. It would seem then, necessary to conduct such a study in order to go beyond a mere accumulation of case studies to a more theoretic understanding of the sector.

The study of alternative policy orientation, in its national elaboration and local application, should enable us :

- to analyse political and administrative constraints that weigh upon the practice of the alternative "politique";

- to cast a new light on the clivages in the medical corps as well as health professions in general;

- to observe the conditions of collaboration bnetween private and public organisms;

- to explore areas of innovation, to identify new actors in the health sector (as well as to identify excluded actors), to understand how these actors are made and how they were accepted into a sector which is traditionally rather closed;

- to study the relations (undoubtably very complex), between the national and local levels in the health "politique".

HYPOTHISES

This comparative study attempts to test the following hypotheses : putting this new approach into action proves difficult because the social coalition in favor of the alternatives and the consensus on the issue remains weak. These innovations come up against the same political and administrative difficulties.

1/ The institutional and financial separation between the social, health, and medical sectors (5) hinders comprehensive action; administrative codes (definitions, service rates, day-only rate, etc...) influences professional practice, orients the beneficiaries and ratifies the barriers between professional groups, thus perpetuating their protectionism. Some examples would include that of doctors or biologists vis-à-vis nurses, or nurses vis-à-vis nursing aids and domestic workers.

2/ The alternative "politique" is making difficult progress because it comes up against the hierarchy of professional agents and the practices oriented to this hierarchy. One could formulate the following hypothises : hospitalization in domicile (HID) will develop only to the degree that it allows the elite of the hospital milieu to extend its influence; the less strictly medical aspects of health care (prevention, maintenance in domicile) will develop only to the degree that it allows doctors in private practice to find a new source of revenue and to improve their professional status in a context of growing competition between the public and private sectors.

3/ The development of alternatives depends on local coordination. The idea that local action would necessarily be comprehensive might be wrong. Social security, local government, public and private organisms for health and social action, and professional organizations all function in their own way and have their own specific goals. Thus, developing these alternatives implies the existance of a coordinating body. Also, innovation is more effective if it can deployed simultaneously in several sectors (the elderly, medicine and psychiatry for example).

4/ The alternative "politique" may have success or failure depending on the local conditions. For example, the local medical demography, the health traditions of the municipality, the existance of health observation structures ("observatoire de santé"), health centers or private group practices, the political parties, etc... can exert either a positive or a negative influence on the development of alternatives. The local political setting does not necessarily reproduce the "rapports de forces" at the national level. The schism between the local and the national has widened in France. The election of a socialist president and a left-wing National Assembly was immediatly followed by the election of right-wing local assemblies. At the same time, the new legislation on decentralization gives important responsabilities in health and public welfare to those local authorities. Will this local autonomy prove to be a hindrance to the alternative orientation, or will it prove to be a source of dynamism ?

THE ALTERNATIVES TO TRADITIONAL HOSPITALIZATION IN THE MEDICAL DOMAIN

Outside consultations

Public hospitals are obliged by law to offer outside consultations for all their medical specializations.

The patients in such consultations benefit from the high level of competence required of hospital doctors (selected by severe standards in the French system) as well as the higher technical capacity of the hospitals. These patients generally come directly to the hospital for consultation; even for the initial consultation. A study conducted in Parisian hospitals showed that more than forty percent of the patients came directly to the hospital for consultation. Only nine percent had been sent by their general practitioner (6). The rates are less than conventional rates of the private sector. Also, the attitude of private practitioners toward outside consultations (something that has been developing in the past ten years or so) is rather ambivalent. They see on one hand the "unfair" competition presented by the public sector. On the other hand they gratefully accept to work within the setting of a hospital for consultations in order to

develop their professional contacts. For hospital doctors, the out-side consultations help them to "recruit" patients for their hospital and select the most interesting cases. Up until the present, the development of hospital consultation has not gone along with a reduction in the number of hospitalizaitons.

Hospitalization on an out-patient basis ("Hôpital de jour")

This form of treatment was first developed in psychiatry, where it has been used for about twenty years. Hospitalization on an out-patient basis is useful in cases where medical examinations or therapies can be concentrated into several hours : the cases that are too time-consuming to do on a consultation basis but that nevertheless don't need surveillance throughout the night. Hospitalization on an out-patient basis is well suited to certain pathologies : the treatment of cancer, hematology, functional re-education, geriatrics and pediatrics. Nevertheless, surgery on an out-patient basis, though highly developed in the United States, in England and in Canada is still very rarely practiced in France.

It is difficult to assign a precise definition to hospitalization on an out-patient basis. The cases so treated are highly diversified and the line between out-side consultations and hospitalization on an out-patient basis is very blurred. On the other hand, because of the importance of the treatment given, hospitalization on an out-patient basis must remain hightly integrated in a classical hospital setting, in order to, at any given moment confront a crisis.

Hospitalization on an out-patient basis is not very important compared to standard hospitalization. At the "Assistance Publique de Paris" (the Parisian Public Hospitals), which comprises seventy percent of the capacity to hospitalize on an out-patient basis, hospitalization on an out-patient basis only represents three out of one thousand days of traditional hospitalization. Most often, hospitalization on a day patient basis is used for preliminary diagnostic examinations for a normal hospitalization. Also for the moment, the creation of day or out-patient services has not brought about a reduction in the number of traditional hospitalizations.

Dialysis and Respiratory Assistance in Domicile

The perspective of a real alternative to hospitalization came about with the arrival of a technology that permitted the treatment of kidney problems and chronic respiratory diseases at home. Such treatment in domicile is financed by social security, sometimes in conjunction with other associations (7). There exists no administrative barriers to treatments in domicile. They are conducted under the direction of the family doctor.

Though the development of treatments in domicile was rapid at the onset, it has stagnated since the end of the seventies. In 1979, The French Health Insurance financed the treatment of about 50,000 patients who had chronic respiratory problems. In 1981, only about 6,000 people were treated at home. As for kidney insufficiency, 10,000 people were treated on dialysis machines in 1981 of whom only 1,900 in domicile. However, the cost of dialysis at home represents only about one third of the cost of the same treatment performed in a dialysis center (8).

The obstacles to the development of these treatments are yet to be analysed. The studies that have been conducted indicate that "anxiety" plays a role; anxiety in the patients' environment (9) as well as that of the general practitioner who treat the patients (10).

Hospitalization in domicile or H.I.D. ("Hospitalisation in Domicile")

This alternative concerns all types of pathology. Hospitalization in domicile would follow normal hospitalization at a point where the more critical phases of recovery have passed. Hospitalization in domicile would almost never preceed a normal hospitalization. The observations made of such treatment are unanimous in their praise of the quality of care and the cooperation between the hospital doctors, the family and the doctors treating the patients at home.

Organization : The possibility of hospitalization in domicile was created by article 4 of the hospital legislation of 1970 : "Hospital services may be continued in the domicile if the patient or his or her family consents. A doctor freely chosen by the family collaborates". No precision regarding how this was to be applied was issued. It was the National Health Insurance ("la Caisse nationale d'Assurance Maladie") on October 29, 1979 who actually defined how hospitalization in domicile was to function. H.I.D. can be initiated by public hospitals after an OK from the "Commissaire de la République Départementale" and the regional health insurance. Private clinics participating in public service and some private associations can also initiate hospitalizations in domicile. The regulation in these cases is, however, more complex. The number of beds available for H.I.D. (nor for dialysis treatments in domicile) are not counted in the "carte sanitaire". This provides a "loophole" through which to avoid directives of the national planning for hospital equipment.

The second point that remains poorly defined concerns medical responsability : a patient's treatment is initially set by the hospital doctor but must be continued at home under the direction of the family doctor who is freely chosen by the patient. It is he who prescribes and follows home treatments "in conjunction with the hospital doctor". Services of H.I.D. generally use their own nurses and nurses aids, sometimes staff to help with household tasks as well, but H.I.D. can also collaborate with private para-medical

professions as well (physical therapists, nurses) and domistic workers (employed by organizations of social welfare). Services of H.I.D. organize the coordination of these different roles, the patient follow-up and the provision of equipment. Organized on this basis, H.I.D. means collaboration between public and private structures, which is rare in France.

This public/private dichotomy poses further problems in health insurance coverage. A daily rate is negotiated between Social Security and the H.I.D. services. It covers equipment, nursing care and nursing assistance. But doctors' actions, tests, and prescriptions are reimbursed individually, according to the standard procedure.

The development of H.I.D. has been slower than expected. At the end of 1981 H.I.D. services numbered twenty-six; nineteen of whom were private and seven were public. More than half of these places are located in the Paris area. The number of days of H.I.D. only represents 0.65% of standard hospitalization, and the number of H.I.D. has only slightly increased in the past few years. Two-thirds of the patients are over sixty years old. The illnesses most often treated in domicile are cancer, cardio-vascular diseases, neurological applications and muscular dysfunctions. These cases are generally very serious as is indicated by the reasons of departure. According to a report written by l'"Inspection Générale des Affaires Sociales et Sanitaires" (National Health Inspection), more than fifty percent of H.I.D. patients leave the H.I.D. service by reason of death or re-entry into the hospital (11).

Health insurances are rather cautions with regard to H.I.D. It is difficult to control the duration of H.I.D. and to find the fine line between strictly medical care and more socially oriented care. The latter concerns more dependant patients (i.e. the handicapped, or the elderly) and the financing of such care is the domain of other social welfare organizations. Actually the report previously cited of l'"Inspection Générale des Affaires Sociales et Sanitaires" (12) indicates that one of the major problems with H.I.D. "is the tendancy to continue care beyond the recommended period so as to avoid abandoning the patient even if he or she no longer needs the medical care. The duration of H.I.D. is too often several months or even years". Although deseigned as a substitute for hospital stays of average duration, H.I.D. has a clear orientation toward chronique pathologies and the problems of the elderly. Thus, economic comparisons are difficult to make; the costs of a day of H.I.D. are obviously lower than standard hospitalization, but the duration is much longer. One has not yet observed any corresponding reduction in the number of hospital beds used. Their availability is however, necessary considering the frequency of re-hospitalization and the gravity of the illnesses treated in domicile.

Obstacles and opportunities

A certain inertia prevails among the principle actors. Hospital physicians and private practitioners are often little informed about H.I.D. and how it functions. Hospitals are not financially motivated to promote this alternative because they have been paid according to the "daily costs" and the number of days in the hospital. It is too early to analyse the effect the new mode of financing will have. This new mode finances by a general budget and has been in application for only one year. The National Health Insurance has feared the development of two sectors (the home and the hospital), and that the development between the two would be in function of what is convenient for the family and the interest of the professionals. Public officials are starting (fifteen years after the fact) to prepare a bill which should define the scope, the workings, and the financing of the whole of home health care facilities. Private para-medical professions, notably nurses, are opposed to the development of these structures. They fear the competition of their salaried colleagues of the public and para-public sectors. However, doctors in private practice have long held this fear and they are actually taking initiatives to promote H.I.D.. Several articles which have appeared recently in professional journals manifest an interest on the part of private practitioners since the socialists came to power. Opposed ,for the most part, to the health care orientation articulated by the socialists, private practitioners have nevertheless supported these orientations in order to avoid leaving a potential market for the public hospitals.

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Our preliminary exploration of the terrain indicates conflicting attitudes. The numerous declarations and reports recently in press seem to indicate interest in, and a favorable attitude toward health alternatives. Yet, they are also making little impact in health care and there are information and regulation gaps.

Public officials and professionals insist on the economic and social advantages; the alternatives are thought to be less expensive for the community, and patients would benefit from a more "human" care at home with their families. However, due to imprecise definitions and statistics it is difficult to actually compare the costs of the different orientaitons. Certain studies even indicate that the alternatives could be more expensive. Furthermore, public opinion doesn't seem convinced. Maintaining a patient at home can be an agoniging responsability, particularly for the patient's family. There is also the problem of the training of general practitioners who are not always esteemed capable of taking over ~~for~~ from a hospital physician..

To understand the gap between the rhetoric and the slow pace of real change and the apparent consensus between the socialists and the doctors, one must understand the competition between public hospitals and private practitioners. Undoubtably, the uncertainty as to the fine line between what is "medical" and what is "social" plays a role as well. H.I.D., which was thought to be a substitute for hospitalization of average length, in reality concerns more chronic cases which have little hope of recovery. To delegate the daily care of dependant people to private structures and to the family, allows the welfarestate in its current state of crisis, to rid itself of some of its burden. It also discharges professionals of some of their less gratifying tasks. This "community" perspective satisfies at the same time the economic demands confronting the state and the resource limitations that plague health care professionals. This more participative ideology, though long feared by the professionals, now permits them to reanalyse and reorganize the scope of their activity. At the same time, they can expand their activity through the "medicalization" of home health care.

Experimenting with such alternatives on a grand scale has been possible essentially because of new technology : dialysis, respiratory assistance, and the use of new, effective drugs in the field of psychiatry. Will the community orientated ideology prove sufficient to overcome the anxiety caused by complicated medical apparatus in the home ? Can one expect a society which has revered independence and the individual, and who requires a greater and greater mobility, to accept now the responsibility of a growing dependant population ? Will new ideologies such as neo-conservatism, religious fundamentalism and the renewal of the family prepare the way for such alternatives ?

NOTES

(1) Bruno JOBERT, "Les politiques sanitaires et sociales" in Traité des Sciences Politiques, Volume IV (to be released 1985).

(2) Xavier GAULLIER, Politique de la vieillesse, Paris, Fondation des villes, 1979, multigraphié, p. 30.

(3) Bruno JOBERT, Pour une approche politique de l'élaboration des politiques publiques, Symposium of the Evaluation of Public Policy, December 1983, p. 2.

(4) Le Monde, 8 juin 1983.

(5) In France, the financing of health care is dispersed between several organizations and institutions with generally little relations between them : health insurance reimbourses medical intervention, according to a fairly precise nomenclature (such as a doctor's consultation, a doctor's visit in the patient's home, lab work, X-rays, surgery, dental work, etc...). The DDASS ("Direction Départementale des Actions Sanitaires et Sociales), a branch of the Ministry, finances prevention. Organizations such as the organisms of Family welfare and Retirement, the departments and communes finance social welfare.

(6) Revue l'Hôpital à Paris, n° 64, July 1981.

(7) For the dialysis, the costs of installing the machine in the home are financed by associations created for this purpose.

(8) R. CAQUET, S. KARSENTY, Les alternatives à l'hospitalisaiton, rapport de mission, présenté au Ministère du Plan et de l'Aménagement du Territoire, December 1982, p. 31.

(9) Idem, p. 32.
A brief study conducted in Paris indicated that 75% of people living with people dependant on kidney dialysis take tranquilizers, and 25% consult a psychiatrist.

(10) J. FERRY, J. PIERRET, Représentation des insuffisants rénaux chroniques en hémodialyse itérative, CEREBE, Paris, 1975, multigraphié.

(11) Inspection Générale des Affaires Sociales et Sanitaires, Rapport sur l'hospitalisation à domicile, February 1978.

(12) Idem, pp. 60-61.

EUROPEAN CONSORTIUM FOR POLITICAL RESEARCH

JOINT SESSIONS OF WORKSHOPS

Barcelona, March 1985

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WORKSHOP ON THE POLITICS OF HEALTH

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KEEP POLITICS OUT OF HEALTH!

Alan Williams, University of York, England

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1. Before you reach for your pen, or telephone, or the microphone, to tell me that it is impossible (and probably even undesirable), to "keep politics out of health", let me say immediately that I agree. But many members of the medical profession do not share our views, and even some health service administrators (who should know better) bemoan "political interference" in the running of health services. So it is a slogan worth examining to see what fears lie behind it, and whether they can be assuaged constructively.

2. The reasons why politics intrude so prominently into health matters are because: a) health is important to people b) health care is costly c) it invariably requires public regulation d) it increasingly attracts public subsidisation e) it is often provided by institutions which are publicly owned. Against that background, how is it that anyone could imagine that it could be insulated from "politics"?

3. Part of the explanation lies in a commonly drawn distinction between "policy making" and "politics". No one believes that one should keep "policy making" out of health. But "politics" is different ... politics is what politicians do, and politicians are wayward, shortsighted, unscrupulous, untrustworthy, axe-grinders who seek and wield power for the sheer satisfaction of doing so, without any longterm commitment to the welfare of the sick. Doctors, on the other hand, are dependable, able to take a long view, highly principled, impeccably trustworthy, altruists whose whole lives are dedicated to the welfare of the sick. So it is clearly better to leave policymaking to doctors, and

keep politicians out of health. In between the doctors and the politicians stand (or lie) the administrators (and accountants) who, in this caricatured scenario might be seen as stereotypical bureaucrats, trying to maintain order in a system which is constantly tending to breakdown because of the sheer complexity of the tasks it faces and the impossibility of exercising direct managerial control over the main deliverers of care. In that difficult situation the bureaucratic response is to fall back on the rule book and/or to withdraw into the formal organisational structure, and just try desperately to keep track of what is happening (even if you can't control it), and, above all else, be sure to say no whenever anyone suggests anything that is likely to make life even more difficult. It is not a pretty sight!

4. An interesting insight into these subcultures can be gleaned from Henric Hultin's* classification, which is presented in a slightly modified form in Table I, and really requires no further explanation.

[TABLE I TO BE INSERTED HEREABOUTS]

Hultin comments:

"All three groups of actors are used mainly to do their own work each by themselves .... However, they are now forced to take part in the problems of each other, and co-operate in a way for which they have no rules. The co-operation is made more difficult by the fact that they are representing different 'cultures.'"

I think a fourth distinct sub-culture needs to be added to the 3 identified by Hultin, namely that of the accountant. Its corresponding characteristics are respectively:

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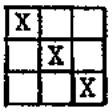
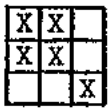
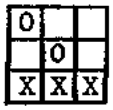
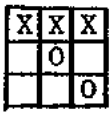
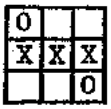
* Henric Hultin (North District, Alvsborg County, Sweden) "How to achieve organisational effectiveness in health care". Paper presented to a Seminar on Ethics and Efficiency in Health Care, Turku, Finland, October 1984.

Education/Career	Uniform, narrow
Principals	Health Authority Accounting Profession
Guiding principles	Systematic Order Principles
Working organisation	Functional specialisation
Working forum	Arithmetic Budgets Audit

It will be noted that, though it shares more characteristics with the administrative subculture than with either of the others, it differs from it in some significant respects, and derives its power from insisting on functional specialisation, which is designed to shroud finance with an air of mystery which only the initiated can penetrate.

5. Suppose for a moment that we could exclude the politicians from the running of the health care system, what scenarios would this leave us to consider? Continuing in the vein of parody, let us play a game of noughts and crosses, where 0 = responsibility without power, and X = power and responsibility, and the 3 x 3 grid has the following coordinates:

System / Actor	Adminis-trative	Financial	Medical
Adminis-trator			
Accountant			
Doctor			

The classic division of power and responsibility, that of mutually exclusive domains (Model A), can then be represented as:  . Its problems in a changing environment, are conflict, lack of coordination, and lack of adaptability, with enhanced interprofessional tension and mistrust as each group tries to "capture" the (absent) political role. If the administrators and accountants form a coalition, so that we have a "management versus doctors" model (B), it can be characterised thus  . It increases the likelihood that the "management" will capture the (absent) political role, whereupon the doctors will try to undermine its legitimacy by appealing directly to the electorate, playing on the latter's fears as actual or potential patients. The next model (C) is that of medical imperialism, in which the doctors infiltrate the top positions in all three systems, leaving the administrators and accountants in a purely executive capacity. This model may be characterised thus  . At the other extreme from this model are two medical nightmares. The mildest one, model D, characterised thus  , has the administrators running the whole system, and doctors doing as they are told. The more severe version, model E, characterised as  , has the accountants running the show. These last two models might even make politicians seem an attractive prospect to doctors, but in any case the doctors are likely to manipulate the situation through direct appeals to the electorate as with model B above. So I see the desire to keep politicians out of health as a means by which each of the other actors hopes to play the politicians' role as well as their own.

6. An alternative to this struggle to capture the commanding heights might be to delineate areas of <u>shared</u> responsibility, and to offer incentives to work towards cooperative problem-solving. But that in turn requires a classification of problems to be solved. Obviously these are myriad, so I will concentrate on a handful of the strategic types of decision which characterise the system. These are:

a) What is the best treatment for a particular individual?

b) Which individuals should have priority in treatment?

c) What quantity of work is the system capable of operating efficiently?

d) What facilities should be provided?

e) Who is going to pay?

Historically the medical profession has claimed competence at all of the first four levels, but especially at a) and b), which they would reckon to be "reserved" territory (i.e. others are excluded by appeal to the dictates of clinical freedom and medical ethics). Administrators are likely to see c) as primarily their territory, possibly shared with the finance people, whilst the latter would claim preeminence in d) and e), though drawing on information provided by the others. The one decision the other actors are happy to leave largely to the politicians is e).

7. But I believe that medical dominance of a) and b) should also be questioned, and I have elsewhere argued that "the best treatment for a particular individual" should take account of the cost-effectiveness of the available alternatives (not just their medical effectiveness), and so should the setting of priorities between patient groups.* The basis of this claim is, in summary, as follows: doctors' specialist skills lie in their ability to diagnose and to know the effects of various courses of action which might then be adopted; and in their ability to implement, or to arrange to implement, whichever course of action the patient selects. They have no legitimate claim to impose their judgements about the relative valuations of different courses of action upon their patients. Moreover, the "various courses of action which might then be adopted" depend upon prior decisions by others about the facilities to be

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* See, for instance, Alan Williams, "Medical Ethics, Health Service Efficiency and Clinical Freedom" Nuffield/York Portfolios No. 2, Nuffield Provincial Hospitals Trust, London, 1984, and "Coronary Artery Bypass Grafting: An Economic Analysis", British Medical Journal, February 1985.

provided, which were made by management on certain assumptions about the social value of certain activities rather than others. If doctors then use those facilities in ways which are not consonant with those assumptions, the system's objectives will be undermined. Finally, each time a doctor "advises" (and implements) a particular course of action for one patient, some other patient is deprived of the use of those resources, so that each treatment decision has both efficiency and equity aspects (i.e. it is both about not using more resources for each patient than is necessary, and about ensuring that the "right" patients get what resources there are). The latter is a social policy decision, with high political salience, which has not been explicitly delegated to doctors, but which they took responsibility for initially because nature abhors a vacuum. Now by custom and practice, they regard it as properly within their domain.

8. All this leads me to the view that in a well-run health service there should be considerable interpenetration of territory by the different actors, with none of them having exclusive control over any bit of the system (not even the accountants over finance!), but with some having more influence at some levels than others, according to the kind of information and skill that is relevant at that level. But since the actors will not, and cannot, be actually present in all decisionmaking situations, then the system has to develop the education and training of each group so that they are not only capable of deploying this "external" information effectively but also motivated to do so. This means devoting considerably more attention to individuals' career development and to more flexible and imaginative organisational structures and styles of behaviour than has typically been the case hitherto in many countries.

9. As an example of what I have in mind as a practical example of this "power" sharing solution to the politics of health, I will briefly outline what is involved in a comprehensive clinical budgeting system, such as the CASPE

project* in the UK. This centres on the devolution of some budgetary control to "clinical teams" in hospitals (which may comprise an individual doctor and the nursing and other staff working with him, or a group of such people constituting a whole specialty), in exchange for which the clinical team discusses with the management its plans about the volume and pattern of work over the forthcoming year, and possible resource redeployments which might enable that work to be performed more efficiently. These discussions lead to a "PACT" (Planning Agreement with a Clinical Team) and if the team is able to deliver the planned "efficiency savings" it may redeploy a proportion of them (say half) in any service development it prefers, the other half accruing to the management for redeployment within the system according to their priorities. It is a system of management which places a high premium on negotiating skills and the creation of an atmosphere of information sharing and trust (initially, the confidence that PACT's will be honoured, so far as is feasible, by both sides).

10. It is not without its difficulties, of course, as may be gleaned from Table II which summarises the kinds of problems that can be encountered. It provides added emphasis to Hultin's conclusions about powersharing in modern health services, which he poses as a series of "provocative" questions, which I have paraphrased thus:

Doctors, are you willing and able to

- act both as doctors treating individuals and as experts offering help in planning and priority setting?
- step outside your own specialty when discussing priorities?
- consider both benefits and costs in making medical decisions?
- offer your knowledge and authority when cutting back in times of stringency?

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* CASPE is an acronym for "Clinical Accountability, Service Planning and Evaluation", and a fuller account of what is involved is to be found in the writings of its leader, Iden Wickings, and his colleagues, e.g. Wickings, I., Coles, J.M., Flux, R., and Howard, L. "Review of Clinical Budgeting and Costing Experiments" British Medical Journal 1983, pp. 575/8.

Administrators, are you willing and able to

- be positive mediators, rather than just saying yes or no?
- generate competent cost-benefit assessments to help all participants in the decisionmaking process?
- ensure that the administrative process is itself cost-effective?

Politicians, are you willing and able to

- engage in direct open dialogue both with administrators and doctors?
- devote time to learn about the problems of the health care field in depth?
- get more time to do this by delegating decisions wherever possible?
- influence and control developments at a much earlier stage by getting involved long before the time when decisions are needed?
- ensure that pressure group demands are always considered in the broadest possible context?
- accept public responsibility for any restrictions that have to be imposed for reasons of economic stringency?

"Each separate question is certainly difficult and inconvenient to every group of actors involved. Even so, a guide to being able to answer yes, and act accordingly, is perhaps to consider the alternative ...."

11. To conclude I must return to an issue that I mentioned in passing earlier, namely, the fact that the decisions we are considering involve both efficiency and equity considerations. My general view is that matter of equity are essentially for the political system to resolve, whereas matters of efficiency

could be left to the other actors in the system to sort out, under the pressure of (politically determined) resource constraints. Prima facie this suggests a clear division of labour, which, unfortunately, cannot easily be implemented because politicians cannot in practice choose which actual patients shall be treated and which not. They can only lay down broad guidelines which they hope will be put into effect by the doctors, etc. But doctors then see themselves in an ethical dilemma, because they are strongly indoctrinated with the view that their duty lies in doing the best they can for the patient in front of them no matter what the cost (i.e. no matter what sacrifices other patients thereby have to bear). But distributive justice dictates that there must be some balancing of the good and bad effects on different individuals in accordance with the ethical position adopted by the community which is being served, as articulated by its political representatives. Thus if we leave doctors as the advocates of the ethic of duty, management as the advocates of efficiency, and politicians as the advocates of distributive justice, we are back at the beginning once more with a new variant of Model A!

12. So, if my agenda for a more cooperative style of health service operation is not already daunting enough, we can add to it the need to indoctrinate doctors with the ethic of distributive justice, to set alongside the ethic of duty, and to help them come to some socially acceptable resolution of the conflict between them! Thus far from keeping politics out of health, if politics means "equity" considerations, my preferred strategy would be to have politics permeate the whole system so thoroughly that we don't need to leave it all to the politicians. Indeed we might have politics permeating health, yet not a politician in sight!

TABLE I DIFFERENCES IN CULTURE IN THE COOPERATING SYSTEMS OF HEALTH CARE.

	Political System	Administrative Stytem	Medical-Professional System
Education/Career	Party work Election speeches	Varying "curved" ways	Uniform, deep, one-tracked.
Principals	Electorate Party	Health Authority	Patients Medical Science
Guiding principles	Justice Feasibility Social Progress	Systematics Order Principles	Quality Standards of specialty
Working organisations	Government power or Effective opposition	Hierarchy	Authority by means of knowledge
Working form	Party bargaining Voting	Collection of material Analysis Memoranda	Action Decision making

TABLE II

OBSERVATIONS: No system of planning or resource allocation in the NHS will work well unless it:	CASPE meets these desiderata in principle in the following ways:	The problems that seem to arise in Practice are:
1. Elicits the co-operation (active or passive) of most doctors.	Rewards are offered to doctors in their role of practice managers if they come up with more cost-effective ways of running their activities.	Faced with general cuts, management may renege on delivering the promised rewards. Excessive caution may so circumscribe the scope of rewards that they cease to be attractive enough.
2. Keeps strategic decision making out of the hands of any one professional group (Esp. Doctors).	Part of any savings so generated are put into the central "pool" for redeployment across the entire system in accordance with centrally determined DMT priorities.	Management may not have sufficient drive or sense of purpose to suggest ways in which resources may be saved, or be unable to respond constructively if proposals involve other budget holders so nothing significant emerges for redeployment.
3. Is seen to be genuinely participative at all levels by those whose activities are being planned.	At "practice" level the expectation is that nurses and other non-medical will be involved in decision making about pacts and about how rewards are to be spent.	Consultants are still not used to sharing decision making with non-medical staff; nurses tend to be defensive even to the point of obstructiveness, if nursing levels are up for discussion.
4. Generates a sense of realism at all levels about resource constraints.	By devolving budget responsibilities people "lower down" in the system are put in a similar position to that faced by the DMT.	Certain contextual limitations (e.g. nationwide freezes on certain resources) may be imperfectly understood at lower levels; finance roles may be played in a negative/obstructive manner rather than a positive constructive one.
5. Keeps itself free of artificial constraints which needlessly frustrate people's aspirations.	The traditional rules designed to maintain "control" are flexed by agreement to generate "efficiency" with the latter getting priority over the former when they conflict.	If defensive attitudes prevail because those running the system are insecure and/or inexperienced, a sense of disillusion and being taken for a ride follows.

CONCLUSIONS

1. CASPE is a system that makes much possible, but what it actually achieves depends on the strength of purpose, initiative and energy of the participants.

2. Everybody can get something valuable out of it, but only if they are willing to put something into it, viz:

   (a) Doctors get greater freedom over the deployment of practice resources in exchange for accepting responsibility for observing agreed levels of workload and resource use.

   (b) Nurses get greater say in the conduct of medical practice as it bears on nursing in exchange for sharing with doctors control over nursing levels (and also sharing in the rewards generated by resource redeployment).

   (c) Administrators Get more information about practice plans and an ability to influence those at a formative stage in exchange for agreeing to devolve more detailed responsibility for resource use to practice level.

   (d) Treasurers get offered savings initiated at practice level in exchange for greater flexibility in "traditional" virement restrictions.

3. It takes only one of the above groups to dig in their heels and refuse to play ball to make it no longer worthwhile for the others to continue to put in the effort required of them.

ALAN WILLIAMS
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The Selection of Candidates: An Analytical Framework

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CANDIDATE SELECTION: An Analytical Framework

Existing studies of the selection of candidates (at least those in English) have not employed any rigorous theoretical or analytical frameworks. Yet without such an apparatus the prospects of truly comparative work remain poor. Even single-country studies cannot advance much beyond the descriptive, narrative, anecdotal or case study levels. It was perhaps inevitable that pioneering work on selection in Britain by Ranney(1) and Rush(2) should concentrate on documenting and describing the more formal constitutional aspects of selection, on describing the participants (in these two cases, really the aspiring candidates) and upon assessments of the outcomes. This is not to say that these studies are not sophisticated and rigorous on their own terms. Both were a necessary prelude to further work and reflected the state of the art at the time. Ranney and Rush obviously saw the selection process as playing 'a vital role in the British system of government'.(3) Ranney indeed outlined what he saw as 'some of the principal aspects of that role'(4). Amongst these he suggested that in 'Safe seats, selection is election'(5); thus selectors in these seats in effect choose, and know they are choosing an MP. Secondly, he claims that,'in marginal seats and in by-elections [the candidates selected] may make the difference'.(6) Thirdly Ranney suggests that, 'In all seats and elections selection sustains party cohesion [in Parliament]'(7). Lastly he asserts that 'who controls selection controls the party'.(8) It could be argued that such a series of statements might constitute a sort of analytical framework, but they are not, apparently, used as such. Indeed in Ranney's 'Conclusions' the only aspect of the role of selection that explicitly

survives is 'contribution to cohesion'.(9)

A later publication by Alsion Young on reselection attempts to place that practice in the context of a theory of party government, but the author's material is very much in the case study category and the theory very narrowly drawn.(10)

Bochel and Denver attempted an advance by employing a behavioural approach to the study of selection, but their effort was still limited to one party in one country and was without an explicit analytical framework.

It is unlikely in present circumstances that adequate resources will become available to conduct a large-scale comparative study of selection, but a good second best is to attempt to settle a framework that individual researchers could utilise for single-country studies, whilst having some comparative relevance. The present paper arises from reflections on the Bochel and Denver study and outlines very tentatively a possible framework.

An approach through functions

One possible approach is to study selection through functions. For present purposes the word function is used in a fairly straightforward way. The sociological definition of the word is hardly appropriate because it is used here with reference to a restricted part of the social system, political parties. I have considered using other words, for example, purpose, but I accept Emmet's view that 'the notion of purpose...may well be eyed with suspicion as imprecise and indeed subjective. Belief in purpose rests

on our intuitive conviction that we act from intentions, and our readiness to accept the testimony of other people that they do so too'.(11) The advantage of function is that it can be used to consider unintended consequences 'of something which people think they are doing for some quite different reason, or may have no clear idea of the reason for which they are doing it'.(12) We may, then, distinguish between manifest and latent function, an important feature, as I see it, of selection. There are obvious limitations in this perspective because it seems reasonable on the face of it to assert that the functions of selection will vary with the constitutional arrangements in any given political system, with political culture, the nature of the parties (e.g. cadre v mass, centralised v decentralised, left v right, ideological v non-ideological and so on), with the detailed rules of the parties, the nature of party membership and bases of electoral support, (e.g. the SDP rule that at least one of those on the short list be a woman), with the electoral system (e.g. list, STV or first past the post, simple plurality), levels of competitiveness and many other variables. Despite this it also seems likely that there will be some common functions. The interest in, and value of this approach may lie in identifying the functions in various political systems, in evaluating the priorities given to them by selectors, in explaining differences and assessing the consequences for parties and the larger political systems.

This paper utilises some empirical data from the Bochel and Denver survey of selectors of Labour candidates in Scotland and the North of England. In this survey 487 selectors in 18 constituencies were interviewed. The data relate to eight Labour-held (one

marginal), six safely non-Labour and four marginally non-Labour constituencies.

The analytical framework is based on the proposition that the selection of candidates may be seen as performing functions for various parts of the polity. These parts are labelled, for analysis 1. The Party. 2. The Constituency. 3. The Participants and 4. The System. For the present I wish to concentrate only on the first of these.

The Party

For analytical purposes it is advantageous to distinguish different aspects of the parts. For illustration, the party must not be seen (in the British context at least) as a monolithic, centralised institution. It can be perceived as having at least four aspects. (i) The local party. (ii) The parliamentary party. (iii) The party as government and (iv) the national party. It is, of course, possible to distinguish other aspects, but for present purposes these four seem adequate.

The local party. By this is meant the collectivity of members and especially of activists who sustain, through their presence and activities, the party at local level. (Party membership in the main British parties is by affiliation and local level). This analytical definition implies that the collectivity that we call the local party has an autonomous interest that may coincide with, but is separable from, the interests of other levels of the party.

The suggestion here is that it is justifiable to view the local party as analytically separable from other levels of the party and to hypothesise that what may be seen as a function of selection for it may be different from that which is seen as a function for the parliamentary party. These functions will not necessarily be in conflict, but they may be.

The parliamentary party is defined simply as the delegation of party members who have been elected to the legislature. In Britain, members of the Parliamentary Labour Party have no role in the selection process except as supplicants or victims. The PLP has, however, needs that may or may not be supplied by the process.

As this workshop is concerned with the selection of candidates for election to national legislatures it may be appropriate to deal in the first place with the functions of selection for the parliamentary party, whilst bearing in mind that the process may have both latent and manifest functions for other parts of the political system.

One of the problems associated with the use of the word function is illustrated by my very first point. Is electoral success a function of selection? At the very least I would claim that electoral prospects are an important consideration in any system of selection. In another context it has been said that 'The post-1968 presidential nominating process...undermines the election-fighting capacities of the political parties'(13), that is, it is dysfunctional.

It is not going too far to assert that the selection process in any democratic political system has some effect on the election-fighting capacities of all parties.

So, for the present I wish to say that any objective assessment of the functions of selection would include electoral success. This is likely to apply no matter which electoral system is in operation, whether it is a nationwide list multi-member STV or one member per constituency typical of simple plurality systems. It is also likely to be the case no matter what the organizational structure of the party, whether, for example, candidates are selected by some national or central body, by some intermediate level, or by relatively autonomous constituency (or local) parties, caucus or convention. In any of these cases one would expect that the electoral attractiveness of candidates would be very high on the list of attributes sought by the selectors in any party aspiring to win a majority of seats in a legislature, to enter a coalition or to have significant influence in a legislature. Minority parties, especially those with no hope of forming a government or sharing in government might have different priorities. But it is hardly likely that any party will deliberately field candidates with little electoral attractiveness.

Although it is suggested that electoral considerations are likely to be of great importance in all electoral systems and competitive party systems the extent to which this is so may vary. Where list systems exist, for example, it may be that it is the electoral attractiveness of the party leaders or those near the top of the list that is most important, or it may be the perceived popularity of the party. If this is the case, the selection process can be used to recruit candidates with other attributes of value to the parliamentary party or the party outside the legislative. On the other hand, in single member systems like Britain's, despite the absence of evidence

about the electoral importance of candidates, one would expect local parties to take no chances and to focus much of their effort on acquiring candidates who are "good vote winners". Evidence presented later shows that the overwhelming concern of British selectors is with electoral success.(14)

A second function of selection for a parliamentary party hoping to enter government might be to achieve a slate of candidates amongst whom there would be an adequate pool of potential ministerial material or effective opposition spokesmen. On the face of it a centralised system of selection has more chance of successfully recruiting such candidates than a highly devolved system. If the right kind of material is available it can be placed high on a party list with a good chance of eventual election. In systems in which local parties are largely autonomous in the selection process the chances of achieving an appropriate balance of abilities would seem to be much more random, even though the central agencies may exercise indirect influence. The British Conservative Party does have an 'approved list' of aspirants and it can be assumed that Central Office attempts to influence the character of this pool, but in which respects we do not know. The Labour Party merely has lists (A and B - nominees from unions, constituency parties and other affiliated organisations) of aspirants, but these are in no sense 'approved'; they are simply, at this stage, not disapproved of. Furthermore, constituency parties are not obliged to make their selections from these lists, and there are cases in both parties where candidates have been selected who do not appear on any list. The role of party headquarters in selection is essentially negative. They may refuse to endorse a local party choice

of candidate, although this is very rare. The NEC of the Labour Party does have to give permission to CLPs to begin the selection process; the idea seems to be to allow Labour-held constituencies who are seeking a new candidate an early choice of aspirants. Thus there is no certainty in systems such as the British, that potential ministerial material will be retained in, or added to, the parliamentary party. Indeed, with the operation of reselection in the Labour Party former and so prospective ministers, even existing ministers, can be dismissed by their local parties and, unless some constitutional irregularity is uncovered, there is nothing that party headquarters can do. Although reselection is not a feature of the Conservative Party's selection process, an analogous situation arises when there is large scale redrawing of constituency boundaries and say, a minister's or a shadow minister's seat is abolished, combined with another or otherwise made unsafe. Local Conservative parties are perhaps somewhat more deferential to position and central authority than are local Labour parties, but there are on record numerous examples of ministers or ex-ministers having to hawk their talents around in search of safe seats - sometimes unsuccessfully. And there is some truth in the assertion, heard in both parties, that interference by national party officers in an attempt to influence a nomination is like "the kiss of death".

Not only are the chances of producing ministerial material more random when local parties do the selecting, but this function may well conflict with other functions perceived to be important by local selectors. If, for example, they give high priority to finding a vote winner, or someone who will be active in the constituency, or who will

'get on with the constituency party', and they place little emphasis on finding ministerial material, then the distribution of talent may be totally random at best and may well be biased. Ministers and shadow ministers do not have, for obvious reasons, the best of records in Britain for constituency work, for attention to local party activities or even for their presence in their constituencies. In addition, local parties are frequently disapproving of even their own party in government and resentment can be focussed on an MP who is a minister. It is not inconceivable then, that some local parties might deliberately avoid selecting 'ministerial potential'. It could be argued too that national selecting bodies are likely to have more experience than local selectors. (In the Bochel and Denver study 57.5% of selectors were attending their first selection conference), and they are more likely to know more about aspiring candidates and to be able to investigate, and make meaning of, their backgrounds. (More than half - 51.4% of Bochel and Denver's respondents said that they would have found more knowledge about aspirants helpful. Given the minimal amount of information usually available this is not surprising).

If indeed, identifying and selecting ministerial potential is a function of selection, then centralised selection is, on the face of it more likely to be efficient than local selection.

A third function of selection for the parliamentary party could be to produce a team in the legislature that was somehow representative of the party at large in terms of ideological orientations, social composition, geographical origins, subject expertise and interests and various groupings in the party (e.g.

unions in the British Labour Party). Despite this apparent diversity of factors, they could, taken together, be labelled cohesion. Cohesion need not imply uniformity, it is an altogether more complex and healthier phenomenon. A cohesive parliamentary delegation is obviously advantageous for a party of government or an effective opposition. It could again be argued that a centralised system of selection is more likely to perform this function well than local selection, but there are dangers inherent in this, there must inevitably be a temptation to see a cohesive parliamentary party as one in which there is, to a large extent, ideological homogeneity and to pay less regard to the other factors. And, whilst ideological homogeneity must have strong appeal to party managers, if it does not reflect orientations of the party at large or if it results in any degree of disaffection then its imposition could be extremely damaging. On the other hand, local selection holds its own perils. Local selection will almost certainly produce mavericks and non-conformists, even extremist factions that could be a thorn in the flesh for the leadership and, in the long run, electorally damaging. The degree to which selectors at any level attempt to achieve ideological or other homogeneity is difficult to estimate, but some data for the British Labour Party are presented later. A preliminary conclusion is that real cohesion, interpreting the word very liberally, is more likely to be achieved through local rather than central selection.

Local Parties

Despite differences in constitutional arrangements, electoral systems and party structures, most serious political parties depend

for their existence and operation on a network of local branches, and it is usually at the local level that party membership is held. These local branches will vary in organisation, powers, level of activity, composition and so on. In Britain the major parties organise on electoral units. Thus the lowest level is usually the local government ward, the next is the constituency and, for local election purposes, there are now District and in Scotland, Regional parties. The last two are largely ad hoc in the sense that they are concerned almost exclusively with local government affairs and meet infrequently. It is the constituency party that is concerned with the selection of parliamentary candidates, and this job is done, in the case of the Labour Party by the General Management Committee (GMC) meeting in special session. The GMC consists of delegates from ward parties, unions and other affiliated organisations. But before the selection conference, nominations of aspirants are made by ward parties and other affiliated organisations (e.g. trade unions) and a short list is drawn up by the executive committee of the CLP. Little attention has been paid to this crucial stage in the process, and unfortunately there is no time to discuss it here.

It can stand repetition at this stage that constituency parties in Britain are very largely autonomous in the selection process. Certainly party rules in the Labour Party are very strict indeed about procedures, and selections are supervised by a representative of the National Executive Committee, but the choice of candidate is very much a matter for the constituency parties.

It was suggested earlier that local selectors might view the functions of selection as somewhat different from those objectively

hypothesised for the parliamentary party, and this section is concerned with the ways in which selectors perceive selection. Local party branches are usually concerned with pretty routine party matters like raising money, recruiting members and generally maintaining the branch. Elections see an increase in activity but even here the activities are of a pretty routine nature - canvassing, the distribution of literature and the organising of the odd public meeting. It is not surprising, then, to find in the Bochel and Denver study that getting on for half (46.0%) of their respondents saw selection as the most important, or almost the most important, activity in which they participated. Only 8.0% saw it as not very important or of no importance. When asked why they responded in the way they did a very small proportion gave what might be described as negative responses. Selectors clearly got a good deal of personal satisfaction out of the process. Only about a quarter (26.4%) said that they got no special satisfaction or negative satisfaction from the process. It is possible to use the word 'only' because for many who voted for a losing candidate, the result would not have been very satisfying. It is not unrealistic to view selection as performing the latent function of giving some kind of psychic satisfaction to party activists, and it is difficult to see how a centralised system of selection could do so, although there may well be intermediate stages in the process in which they are involved.

It was suggested earlier that an objective assessment of the functions of selection would place a high priority on electoral success. This was done in the context of the requirements of the parliamentary party. It can hardly be doubted that electoral success

is likely to give considerably psychic satisfaction to selectors. The question is whether they see this as the most important function of selection. Its importance can be expected to vary with, amongst other things, the electoral status of the constituency, and for the present the focus is on this one variable. For some local parties the selection of a candidate is tantamount to the selection of an MP, though since the rise of the Alliance this is less true than in the past. The nature of the British electoral system and the distribution of socio-economic characteristics amongst the electorate has meant that, until recently, most seats were 'safe' for one party or another. There are of course long term changes in the status of individual constituencies and, even in the short term, in an age of electoral volatility, formerly safe seats may become, statistically at least, safe for another party as the success of the SNP in the seventies demonstrates.

As a simple preliminary, an attempt was made to examine selectors' perceptions of the functions of selection, and the importance they attach to them. We used two questions for this purpose - one open-ended, the other closed. Responses are given in Table 1. The majority of selectors in Labour constituencies saw selection as serving the straightforward instrumental function of finding an MP or electing a Labour government, and not surprisingly, the proportions giving this response declined as we move from Safe Labour to hopeless seats. The closed question put to selectors a list of the reasons for having a Labour candidate in their constituencies and they were asked to say how important this reason was, very important, quite important, not very important, or not at all

important. The reasons were rated on a scale from 1 (not at all important) to 4 (very important). It must be said that this was not a very successful sequence of questions. Respondents were not very discriminating in their use of the alternatives. The results should be seen therefore as reflecting tendencies rather than as absolute quantative statistics. Table 2 shows the mean scores for each reason in each category of seat. Despite the inadequacies of our method there is a pattern here. Again selectors in Labour-held and marginal Labour seats are most concerned with straightforward electoral considerations. Those in hopeless seats see the selection of candidates in what might be called propagandist terms, i.e. putting forward Labour policies, in maintaining Labour voting habits amongst their minority support and in boosting party morale.

So, in relation, to at least one function of selection, maximising the size of the Labour delegation to parliament, selectors, in the seats that matter, have perceptions congruent with the needs of the Parliamentary party. But equally, it should be noted, selectors in different categories of seat have different priorities. The primacy of electoral considerations overall is confirmed by an analysis of the attributes selectors look for in candidates - ability to win votes scores highest. (Table 3).

On the other hand selectors are less likely to perceive a function of selection as to provide a pool of potential ministerial material for the parliamentary party. We asked selectors to rank in order of importance 5 factors that they might consider when choosing a candidate. A score of 5 was given for the first choice, 4 for the second and so on. Table 3 shows the relative importance attached to

each factor. Good potential as a minister comes a poor last overall and in every category of seat. If we examine respondents' views on the importance of certain qualities for candidates we find that the most important are understanding local problems, ability to get on with working class people, potential to make a good constituency MP and ability to get on with the CLP. It is not so much the absolute values recorded in Table 4 that are important as the relative priorities. Probably only the last item, an understanding of large and economic and political problems, has relevance to the requirements of the PLP and it is given relatively low priority by selectors. When we asked which particular characteristics were an advantage or disadvantage for a Labour candidate experience as a councillor came second only to a local person. And local councillors are not usually the stuff from which ministers are made. Clearly selectors do not, on the whole, see it as their job to find ministerial material.

It was suggested that a third function of selection for the parliamentary party might be to produce a balanced representatioon of various ideological, social and geographical tendencies in the party, with a view to a cohesive parliamentary group. The absence of any great interest in the ideological position of candidates (and therefore it must be assumed in the ideological composition of the PLP) has been noted by other writers.(15) This is an important question for other reasons (e.g. the struggle for control of the party). The idea of a balanced or indeed ideologically left parliamentary party does not seem to have been much in the minds of our selectors - or at least were not articulated to us. Table 3 shows that the ideological position of the candidate was not accorded a very

high priority by selectors. Electoral considerations seem to neutralise any great concern with ideology. Nearly two-thirds of our selectors said that the fact that their choice of candidate might affect the composition of the PLP on a left-right basis did not influence their choice. On the whole selectors favoured moderate left positions. When asked the ideal political position for a Labour candidate in their constituencies (using a 5 p oint left-right scale of 3 for centre, 2 for centre left and 1 for left) selectors in Labour seats scored a mean of 2.40, those in marginal seats 2.63, and those in hopeless seats 3.28, that is slightly to the right of centre. It may well be then that local selection does result in relative ideological homogeneity in the PLP, but the important point is that it is not imposed from above. Left with the initiative local and on the whole, left-wing activists choose, generally, moderates as candidates. The election of 1983 was commonly said to have produced the most left-wing PLP for generations, but when elections to the Shadow Cabinet were held in 1984 left wingers Tony Benn and Eric Heffer failed to gain election and the centre-left and centre remained firmly in control. There is a paradox here; there is no doubt that the left is in a majority in CLPs - witness the results of elections to the NEC, but the concern of selectors with winning elections has priority over ideology.

It is well known that the PLP is now overwhelmingly middle-class and university educated. Do selectors approve of this? If they do not approve, why and what do they do about it? We found little spontaneous expressions of view about this. When we asked selectors whether they thought the increasing number of middle-class university

educated candidates was a good thing a majority (53.5%) disapproved of the trend. On the other hand being working-class scored 2.67 on our five point scale of advantages and disadvantages whilst being middle-class scored only slightly higher at 2.79. As might be expected working-class candidates were seen as more acceptable in safe Labour than in marginal or hopeless seats.Although theoretically favouring more working class representation, when given the chance, selectors usually select middle-class people.

We have no conclusive evidence that selectors had any conscious preferences about other social or other characteristics that might be important in attaining balance in the PLP. Over 60.0% agreed that women were under-represented amongst candidates, but only 16.4% approved of positive discrimination to redress the balance. Similarly with another sector of Labour supporters, half (50.6%) agreed that more coloured people should be Labour candidates, but again there was little sign of the approval of positive discrimination. The electoral risks seemed too great.

There is little evidence then, that local selectors give much thought to the functions of selection for the PLP. Some of the priorities of local selectors are, on the face of it, dysfunctional for the PLP. Yet, it could be claimed that some of the needs of the PLP, if satisfied, could be dysfunctional for CLPs, or at least could be seen by selectors to be so.

The needs of local parties cannot, however, be ignored. Important though parliamentary parties are, our political system could not long survive without the activities of local parties. We have

already discussed some of the functions of selection for local parties in the context of the needs of the PLP, but there are others which could be seen to be necessary for the maintenance of local parties. The psychic rewards for selectors has been remarked upon and need emphasis.

Of all the powers in the hands of local parties in Britain, the selection of candidates is perhaps the most significant. In this process they are virtually autonomous. Selection is one of the few political as opposed to organisational activities in which local parties engage. It is true that they can and do participate in policy-making, but for success they must rely on others. The selection conference is an 'event', formally convened and solemnly, not to say ceremoniously conducted, with a much larger than normal turnout of members. It is small wonder therefore that selectors see this as one of their most important activities and that they derive satisfaction from it. Selection can be seen as serving the function of stimulating and reinforcing the commitment of local party activists. There are no hard data to confirm this, but experience shows that it is the case. A new candidate has the effect of renewing the sense of purpose amongst local activists. This is particularly the case for parties in hopeless seats. The chances are that they will have a new candidate for each election, and that the candidate will have ambitions to become an MP. Obviously a good showing will benefit him or her in later attempts to reach parliament. Selectors in hopeless seats derive a good deal of satisfaction from giving a candidate experience and many CLPs have considerable pride in seeing a one-time 'rookie' candidate's subsequent election to parliament for

another constituency. My own CLP (a hopeless seat) has, over the last decade or so, selected two candidates who subsequently became ministers, one who became the Scottish Secretary of the Labour Party and it was the first (and so far only) to select a coloured candidate in Scotland.

Paradoxically, selectors in hopeless seats have far more experience in selection than those in safe Labour seats, and although it is difficult to measure, the former are probably better at the job than the latter.

The campaign for the reselection of MPs was based on the desire of local party activists to have more control over their own MPs, and so over the PLP (16) and the institution of the procedure did, on the face of it, seem to have this potential. That reselection has resulted in very few deselections of sitting MPs is probably not a true reflection of the importance of this change. Table 4 shows that 'ability to get on with the CLP' is one of the important qualities sought in candidates. Reselection was not a crucial issue when we did our research so we did not pursue what this meant. But it seems likely that for many this would now mean 'agreeing with our policy demands', or 'working to have the party manifesto (which we approve of) implemented'. There is no doubt at all that Labour MPs have had to make adjustments to their stands on many aspects of policy and to make greater efforts 'to get on with the CLP' than hitherto. This function of selection for local parties - to have greater control over MPs and thus over the PLP - requires more study. Again this could be dysfunctional for the PLP which would claim to require a large measure of discretion over policy in government as well as in opposition.

Even in safe Labour seats the selection of a new candidate is stimulating and rewarding. By the time an MP retires a local party has usually "had enough of him". A new man is usually younger, more energetic and will take no chances in his efforts to retain the seat. In such a seat too, selection is likely, at least in the short-term, to aid cohesion in the local party. A long-serving MP nearly always has a group of loyalists as well as one of critics in his CLP, the latter usually in a majority. A new man has, by definition, a majority on his side. Of the minority of our selectors who preferred another candidate almost half said that they would work as hard for the winner as for their first preference.

It is not possible, on the data available, to say whether selectors see stimulation and increased local party cohesion as functions of selection; these may only be latent, but they are undoubtedly present. Their impact on the PLP are likely to be entirely neutral.

Local parties have, in the normal course of their activities, perhaps more concern with local than with national problems. It is natural therefore that they should want their MPs and/or candidates to be able to deal with these, because quite apart from a desire to obtain the best for their constituencies, their credibility with the electorate might be at stake. It surprised us, but on reflection it is understandable, that the single most important quality that selectors sought in a candidate was an understanding of (and by implication) an ability and willingness to deal with local problems (Table 4). If a function of selection for local parties is to find such a candidate then this might well be dysfunctional for the PLP.

Of course the whips will see to it that MPs go through the lobbies when required, but the obligation to pay a great deal of attention to local problems could well detract from the need for MPs to spend time and energy in participating in debates and in acquiring subject expertise. Too much commitment to constituency interests could also detract from the cohesion of the PLP. Voting for a constituency interest and against the whips is one of the few acts of disobedience tolerated in the PLP, but obviously there is a limit to the extent to which it can be tolerated. Pressures on MPs by CLPs to promote the interests of the constituency could have damaging effects at local level too, if the MP cannot comply.

One could go on ennumerating possible functions of selection for local parties. The problem for the political scientist, as well as for selectors is firstly how to reconcile functions that need to be performed for the PLP and for the local parties, and secondly how the (sometimes) conflicting functions for the CLPs can be accommodated.

It could be claimed that somehow the system in Britain works. Electoral success is a prerequisite of all else and there is no doubt that selectors give this priority. Labour has not been noticeably short of ministerial material despite fears to the contrary and the apparent randomness of the ways in which it has been recruited, ideological homogeneity, 'representativeness' and the accommodation of diverse interests is an endemic problem for left wing and progressive parties and it is a matter for debate whether the British Labour Party is worse in this respect than many others.

There have been calls for a further reform of Labour's selection procedures, most notably involving the party membership at large (16), but what seems more immediately important is that the parties themselves doa job of education. We were struck by the number of selectors who said to us, 'Why did you not come to ask us these questions before?' What they were saying, in effect, was that they had not given much, if any, thought to the functions of selection, and it is clear that the national parties give no guidance on the matter. The larger question with which we are left is, does anyone give any thought to the matter? and is it a meaningful question anyway? For political scientists the question is whether an approach through functions contributes to comparative research. I now have many doubts.

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16. See Alison Young, The Reselection of MPs for a very good account of this.

Table 1

Reason for Having a Labour Candidate
by Electoral Status of Constituency*

	Labour %	Marginally Labour %	Never Labour %
Keep/win seat	54.2	44.5	18.4
Represent views/needs of Working Class/ Labour area	35.8	36.7	39.8
Promote Socialist Ideas/fly flag	5.6	0.0	16.5
To occupy Opposition	0.8	3.1	9.7
Give candidate experience	0.0	0.0	1.8
Give Labour supporters a chance to vote	0.0	5.5	5.8
Other	2.4	12.7	8.8

*What would you say is the main reason for having a Labour candidate in this constituency?

Table 2

The Importance of Reasons for Putting Forward a Labour Candidate by Electoral Status of Constituency

		Labour %	Marginally Labour %	Never Labour %	All Seats %
1.	To put forward Labour policies	3.7	3.7	3.8	3.8
2.	To get a Labour candidate elected	4.0	3.9	3.0	3.7
3.	To help elect a Labour government	4.0	3.9	3.0	3.7
4.	To give Labour voters a chance to vote for their party	3.6	2.9	3.8	3.4
5.	To boost morale of local party and encourage it to carry on	3.1	2.5	3.7	3.0
6.	To add to total votes Labour obtains nationally	3.1	2.3	3.3	3.0
7.	To occupy the Opposition	2.7	2.1	3.4	2.7
8.	To show the flag	2.2	1.7	3.3	2.3
9.	To give a candidate experience	2.1	1.7	3.1	2.2
10.	Because Labour HQ insists on fighting every seat	2.4	1.7	2.3	2.2

Table 3

Selectors Rankings of Five Attributes for Candidates
By Electoral Status of Seats*

	Labour %	Marginally Labour %	Never Labour %	Total %
1. Ability to win votes	74	87	82	78
2. Good potential as MP	78	72	72	76
3. Ability to get on with CLP	61	53	61	56
4. Political position on Left-Right scale	51	62	56	54
5. Good potential as minister	36	22	27	33

*Percentage of maximum possible scores for each attribute.

Table 4

Importance of Some Qualities in Candidates

	%
Understanding local problems	95.0
Ability to get on with working class people	94.5
Likely to make a good constituency MP	92.3
Ability to get on with CLP	87.5
Ability to get on with middle class people	84.5
Willingness to work hard on the doorstep	81.4
Understanding large economic and political problems	75.5

Trade Unions and the Selection of Parliamentary Candidates in the Labour Party

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The selection of parliamentary candidates in the Labour party, as in other major British parties, takes place at local constituency level. Aspiring candidates are nominated by branches of the Constituency Labour Party (CLP) or by local branches of trade unions and other affiliated organisations. A special meeting of the general management committee of the CLP is held, known as the 'selection conference' and comprising delegates from party branches and branches of affiliated organisations, at which nominees make a speech and are questioned. The meeting then votes by exhaustive ballot (1) to select one of the nominees as the constituency's prospective parliamentary candidate. The role of the party's regional and national organisations is restricted to determining the rules relating to selection, providing lists of persons willing to be considered for candidature, overseeing the procedures, considering appeals and (usually) rubber-stamping the decisions of the local constituencies. (For a fuller description and assessment of these procedures see Ranney, 1965 and Rush, 1969).

In recent years candidate selection in the Labour party has become an area of considerable conflict and dissension. Conflict between Left and Centre/Right factions as they struggled for control of the party during the 1970s was increasingly expressed in battles over candidate selection and the rules relating to it (see Kogan and Kogan, 1982). CLPs were increasingly choosing left-wing candidates (Berrington, 1982); 'moderate' MPs were alleged to be threatened with removal by left-wing activists. In 1980 the Left succeeded in getting the rules altered so that all incumbent MPs would have to face a full selection process before each election rather than being (almost) automatically renominated. The Centre/Right responded by seeking to extend the right to vote in selections and reselections to all party members but so far this has not been successful and even a modest proposal for change, relating to reselections only, was voted down at the 1984 party conference. Selection continues to be the prerogative of relatively small selection conferences.(2)

In order to provide some much-needed data on the characteristics, attitudes and perceptions of these local selectors, a colleague and I carried out a survey of selection conference delegates in 18 constituencies in the period 1976-79. A total of 487 respondents were successfully interviewed. (For a fuller description of this survey and a report on some of the major findings, see Bochel and Denver, 1983). The bulk of the present paper is also based on data obtained from the survey but in this case the analysis is more narrowly focussed on the role of trade unions in the selection process.

At national level, the unions' position in the party enables them to affect selection in two main ways. Firstly, by their votes at annual conferences they can decisively affect the rules governing candidate selection. In the series of conference

debates on mandatory re-selection, for example, union votes were crucial in that a switch of votes by only one or two unions would have altered the outcome. Secondly, unions' representation on Labour's National Executive Committee (NEC) also enables them to influence selection to the extent that the NEC can do so - by endorsing candidates, investigating complaints of malpractice and so on.

These are rather general powers, however, and their impact is difficult to assess. A more direct impact on the kinds of persons selected as candidates can be made at local level. Firstly, unions may 'sponsor' candidates. One of the lists of available candidates maintained by the national party organisation, the 'A' list, contains the names of persons whom unions are willing to sponsor. That is, if a candidate is selected from this list then the union concerned will pay most of his or her election expenses and make a grant towards the local party's running costs, thus considerably easing the perennial financial problems of CLP's. Secondly, even without sponsorship union influence can be powerful in that local union branches affiliated to the local CLP are entitled to make nominations for candidature and to send delegates to the selection conference.

Although decisions about which candidates will be sponsored are usually made by unions at national level this can be described as a means of local influence because it is ultimately local CLP's which decide whether or not to select a sponsored candidate. Increasing numbers of local parties have chosen to do so. As Table 1 shows, the percentage of Labour candidates sponsored by unions was very stable throughout the 1950s and 1960s. In February 1974, however, there was an increase to one quarter of all candidates and, since then the proportion has remained slightly higher than it was before 1970.

Unions are selective about sponsorship however. For obvious financial reasons they are usually only willing to sponsor in safe or at least winnable seats. The effect is that sponsored candidates have much higher success rates than Labour candidates in general. The figures in Table 1 show very clearly that in every election since 1950 very much greater proportions of union-sponsored candidates were elected than were other Labour candidates.

From the point of view of a local party the attraction of sponsorship is, of course, financial, even though party rules forbid the raising of the question of financial sponsorship in selection conferences. Most CLP's struggle to make ends meet and the prospect of having election expenses covered as well as receiving an annual grant is a tempting one. Despite the formal absence of discussion of such matters, it is clear that selection conference delegates are aware of the possibility of sponsorship and there are frequently allegations that some constituencies pass

over 'good' but unsponsored candidates and that unions sometimes seek to 'buy' seats. According to Ranney, in the 1930's 'contests for adoptions increasingly resembled auctions in which CLP's bid for the support of wealthy unions' (Ranney, 1965, p. 223).

Table 1: Union Sponsorship of Labour Candidates, 1950-83

	Sponsored Candidates N	Sponsored as % of All Lab. Candidates %	% of Sponsored Candidates Elected %	% of Other Lab. Candidates Elected %
1950	140	23	79	43
1951	137	22	76	40
1955	129	21	74	37
1959	129	21	72	34
1964	138	22	87	40
1966	138	22	96	48
1970	137	22	83	36
Feb.1974	155	25	82	37
Oct.1974	141	23	90	40
1979	165	27	81	30
1983	154	24	75	20

Sources: 1950-79 figures are derived from Craig, 1981, pp. 100-1; 1983 figures are from Butler and Kavanagh, The British General Election of 1983, p.240.

In the nature of things it is difficult to know the extent to which this sort of thing happens today. One careful discussion of the role of union money in candidate selection in the 1950's concluded that Labour 'has not yet matched the Conservatives' success in banishing financial considerations from selection conferences...but...the importance of finance in swinging nominations has declined and seems likely to decline still further'. (Harrison, 1960, p. 278).

In our survey of selectors, respondents were asked whether they thought that in general financial sponsorship by a union was an advantage or disadvantage to someone seeking nomination and also, more pointedly, whether unions use the attraction of their money in order to get their candidates selected. The answers to these questions are shown in Table 2. Clearly there is a widespread belief that financial sponsorship is an advantage to a potential candidate. There was less agreement in answers to our rather loaded question about union activity, but over half of all respondents accepted the implicit criticism of this aspect of selection. Even amongst those who accepted this, however, not all regarded unions' use of money to get candidates chosen as

illegitimate. Of those who agreed that this happened, 24 per cent positively approved of it (29 per cent among union delegates, 22 per cent among other delegates) while a further 11 per cent suggested qualified approval, or no positive disapproval.

These data suggest, then, that while selectors recognise that union sponsorship advantages candidates for selection there is no widespread criticism of union activities in this respect. In total only 35 per cent of all respondents agreed that unions use their money to get their candidates chosen and disapproved of this. There is nothing surprising in this. A nominee who is known to bear a gift of election expenses plus other financial benefits is bound to be at an advantage. But as reported in a previous article (Bochel and Denver, 1983), this is only one factor which may influence selectors (others including the personal qualities and political position of candidates) and most selectors claim that they have no preference between sponsored and unsponsored candidates (see Table 3 below). The relatively small proportion of delegates who recognise and disapprove of the unions' use of money to obtain seats is a reflection of the fact that sponsorship is a long-standing and rarely challenged feature of Labour politics.

Table 2: Selectors' Beliefs About Union Sponsorship

	Union Delegates	Other Delegates	All
To a potential candidate sponsorship is:	%	%	%
Advantage	68	70	70
Disadvantage	5	9	8
Neither	27	20	21
(N)	(129)	(267)	(396)
Do unions use money as attraction?			
Yes	51	56	54
No	47	33	37
Don't Know	3	11	8
(N)	(165)	(319)	(484)

Note: The question on sponsorship was not asked in all constituencies.

The above data refer to questions about the practice and effect of sponsorship in general. Selectors were asked further questions about their own preferences and their own constituency. Table 3 shows for each category of seat and for union as opposed to non-union delegates how selectors responded when asked whether they would prefer a sponsored or unsponsored candidate and whether it would be a 'good thing' for their constituency to have a union sponsored candidate.

Table 3: Union Sponsorship in Selectors' Constituencies

	Labour Seats	Marginal Seats	Hopeless Seats	Union Dels.	Other Dels.	All
Selectors' personal preference:	%	%	%	%	%	%
Sponsored	23	18	30	33	18	23
Unsponsored	12	25	17	10	20	16
No preference	65	57	53	58	62	60
(N)	(252)	(123)	(100)	(163)	(311)	(475)
Sponsorship in local constituency:						
Advantage	53	55	46	51	52	51
Disadvantage	8	21	31	11	18	16
Neither	38	24	24	38	31	33
(N)	(250)	(42)	(101)	(128)	(265)	(393)

Note: On the basis of the result in the October 1974 election, eight of the constituencies studied were Labour-held (256 respondents), four were marginal not held by Labour (128 respondents) and six were hopeless from Labour's point of view (103 respondents). The question on sponsorship in the local constituency was not asked in all marginal seats.

The first part of the table shows that most selectors claim not to be influenced by the attractions of sponsorship in that substantial majorities in each category, and 60 per cent of all, said that they had no preference between sponsored and unsponsored candidates - they simply wanted the best candidate irrespective of sponsorship. Ironically, the largest proportion favouring a sponsored candidate is in hopeless seats - precisely the ones in which unions are unlikely to be interested. No doubt party activists in these seats would welcome an injection of union finance. Selectors representing local branches of trade unions were much more likely to favour sponsorship than other selectors -

indeed the majority of the latter who had a preference opted for an unsponsored candidate.

Those respondents who expressed a preference were asked their reasons for it. Not unexpectedly, of those who favoured a sponsored candidate the largest proportion (62 per cent) gave as their reason the financial benefits that would accrue to the CLP from sponsorship. What might be termed more ideological answers were given by 15 per cent who believed that there simply should be more union-sponsored Labour M.P.'s. The remainder of those favouring sponsored candidates gave a variety of reasons for doing so. The answers of respondents who preferred an unsponsored candidate indicate a fear of union domination. Almost half of them (46 per cent) believed that unsponsored candidates were more independent and could represent all constituents, not just their union. A further 25 per cent of these respondents explicitly expressed a fear that unions (rather than the party itself) might control candidates and M.P.'s while 12 per cent would go no further than stating, rather gnomically, that 'sponsorship can be misused.'

At first sight it might appear that the second part of Table 3 contradicts the first part. Whereas the proportion of respondents favouring a sponsored candidate is relatively small, a majority think that having a sponsored candidate locally would be advantageous. The contradiction is more apparent than real, however, since in the first case selectors were asked for their personal preference while in the second they were asked whether a sponsored candidate would be an advantage, disregarding their own preference.

As can be seen, only in hopeless seats, did less than a majority of selectors think it would be advantageous to have a sponsored candidate and there was no difference in view on this matter between union and non-union delegates. Overwhelmingly those who believed sponsorship to be an advantage locally once again gave as their reason for this the financial benefit to the C.L.P.. This was mentioned by 75 per cent of them. The only other significant reason given was that in a working-class area union sponsorship would be appealing to the electorate (18 per cent). In contrast, 69 per cent of those who thought sponsorship a disadvantage did so because they believed that voters were not well disposed towards unions, while 20 per cent thought that candidates should have appeal for the whole electorate and not just a section of it.

These data suggest, then, that at local level sponsorship by a union is widely recognised to be advantageous to a potential candidate and also to a local party. The attraction of sponsorship is clearly financial but for a significant minority of selectors this is outweighed by the unpopularity of trade unions among the electorate and an unwillingness to have candidate

selection dominated by unions.

The question of union sponsorship, at national level at least, has received a good deal of attention, from students of British politics, (see Harrison, 1960, ch.6). Much less is known of the part union members play in the selection of candidates at local level, though this is of great potential importance. Members of the Labour party by union affiliation greatly outnumber individual members.(3) At local level, union branches may affiliate to a CLP and thus be entitled to nominate candidates and to send delegates to selection conferences.

Very little is known about how union branches consider nomination and decide upon a name. Some branches seem simply to refer to their national body and nominate someone from its parliamentary panel - sometimes without even seeing him.(4) In other cases potential candidates seek out nominations and branches hold interviews. In the constituencies surveyed here unions were not very active as nominators. Only 45 per cent of union delegates represented branches which had made a nomination in the selection in question whereas 66 per cent of other delegates represented organisations which had made a nomination. Union interest clearly varies with the electoral status of the seat since only 5 per cent of union delegates in hopeless seats represented branches which had nominated compared with 48 per cent in marginal seats and 53 per cent in Labour seats. Of those union selectors representing nominating branches, 43 per cent claimed that the nomineee had been interviewed or invited to speak by the branch, 27 per cent relied upon the recommendation of one or more branch members and 12 per cent said that the nominee was a well-known figure on the local scene. (Comparable figures for non-union delegates from nominating organisations were, 50 per cent, 12 per cent, and 33 per cent). Nine per cent of union delegates said that their branch had simply taken a name from their union's parliamentary panel.

There appears, then, to be no obvious scramble by union branches - even in Labour seats - to nominate candidates. It is likely that in some cases initiatives over nominations are taken at a higher level and that union branches act as agents. When branches do nominate, the process can be rather haphazard and the examination of potential candidates less rigorous than that undertaken by party branches. Union branches do not, on the whole, indulge in formal meetings at which candidates compete for their nomination - as happens frequently in ward and local party branches. Rather, they either invite some likely person to their meeting or accept the suggestion of branch members. Less frequently they simply put forward the name of a local activist or someone who will be sponsored by the union. Union delegates at selection conferences were, however, no more likely to vote for their union's nominee than other delegates were to vote for a nominee put forward by their organisations. In both cases

three-quarters voted in the first ballot for the nominee of their organisation.

Even if unions are not very active as nominators they can still profoundly influence candidate selection by sending delegates to selection meetings. Individual CLP's determine their own formulae for representation so that it is difficult to estimate the number of union delegates entitled to attend CLP meetings, but there is little doubt that, if they wished, local union branches could swamp most selection conferences. More frequently, however, one hears of complaints about union branches failing to affiliate or being unable to find the full number of delegates to which they are entitled and of poor attendence by union delegates at party meetings.(5) Table 4 shows the various organisations represented at selection conferences by respondents in the survey.

Table 4: Organisations Represented by Respondents

	Labour Seats %	Marginal Seats %	Hopeless Seats %	All %
Local/ward party	53	58	75	59
Trade Union	40	33	20	34
Socialist Society	1	-	3	1
Women's Section	3	3	1	3
Young Socialists/ Labour Club	1	6	-	2
Co-op	2	-	1	1
(N)	(255)	(127)	(103)	(485)

Union delegates accounted for about one third of the total but this varied with the electoral status of the seat. It seems likely that this can be explained in part by the fact that union organisation is more comprehensive and therefore affiliations higher in urban, industrial seats than in suburban, small town and rural areas. It is, however, also a reflection of union interest. Union people are simply more interested in selections where there is a strong probability that the candidate chosen will eventually be elected. This is not just a matter of more union branches affiliating to the party in more winnable seats but also of union delegates being more willing to attend meetings. In the selections studied, the 'turnout' of eligible union delegates at the selection conferences was a mere 22 per cent in hopeless seats, rising to 50 per cent in marginal seats and 80 per cent in Labour seats. (The turnout of 'other' delegates was 57 per cent, 85 per cent and 90 per cent respectively).

In only a few constituencies does a single union have sufficient voting power to have a decisive influence, on its own, on the choice of candidate; but if union selectors as a whole constitute a distinctive group and have distinctive preferences about candidates, then their influence may be considerable. Table 5 presents data comparing union delegates with others in terms of social and political characteristics. Certainly the union representatives are distinctive in terms of sex and class. They are overwhelmingly male and two-thirds of them are manual workers. By contrast the imbalance between men and women is less marked among other delegates and a clear majority of them are non-manual workers. The data on education and house tenure reflect the occupational differences in that union delegates are more likely to have had minimum education and to be council tenants than are other delegates. In the absence of union representation at selection conferences, then, Labour selectors would be more balanced in terms of sex but would be more heavily middle-class.

There are not, however, very great differences between the two categories of delegate in terms of political characteristics. The slightly larger proportion of union selectors who had not previously participated in a selection conference is to be explained by their concentration in Labour-held seats while the lower proportion of union office-holders in the party is probably a function of their commitment to union activity. Union delegates have somewhat less of a family tradition of party membership and place themselves slightly to the Left of other delegates. In this respect the most left-wing group of delegates were, unsurprisingly, from Young Socialists and Student Labour Clubs (mean score 1.20) and the furthest to the right were delegates from the Co-operative Party (mean score 2.67). But the former accounted for only ten respondents and the latter for six.

It was implied above that union delegates can have a large effect on local selections simply by turning up to the selection conference and voting for 'their' candidate. One frequently hears allegations that union delegations turn out in large numbers for selection conferences - unlike normal party meetings - and by voting en bloc for a candidate, force him, as it were, upon the regular party workers. The miners' ability to obtain seats for their candidates, for example, is said to be less a result of financial inducement than of the number of delegates they send and their disciplined voting. (See Harrison, 1960, p.114).

Respondents to the survey were asked directly whether it was their view that in their constituencies union delegates did indeed turn out for selection conferences in greater numbers than at ordinary party meetings. They were also asked more generally an open question as to whether there were any groups with particular influence over the selection of candidates in the respondents' constituencies. Table 6 shows the proportion of respondents who

Table 5: Social and Political Characteristics of Union and 'Other' Delegates

	Union Delegates %	Other Delegates %
Sex		
Men	93	70
Women	7	30
Age		
Up to 44	44	48
45 and over	57	53
Occupation		
Non-manual	34	57
Manual	66	43
Age Completed Education		
15 or less	79	54
16/17	18	19
18/19	2	7
20+	1	15
Education continuing	1	6
House Tenure		
Owner occ.	31	51
Council Ten.	61	40
Other	5	9
Length of Party Membership		
Up to 5 years	21	27
5-14 years	40	34
15 years +	38	40
Previous selections attended		
None	63	55
1	12	12
2-4	20	23
5 or more	5	10
Party Offices Held		
Now office-holder	36	54
Past office-holder	20	20
Never office-holder	45	26
Family Tradition of Party Membership		
Parents	20	28
Other family	7	12
No tradition	73	60
Elected Councillor now or past	24	18
Score on Left-Right Scale	1.93	2.14
(N)	(165)	(320)

Note: Left-Right score is based on respondents' self-location on a five-point scale of 'positions in the party'. Left scored 1, centre-left 2, centre 3, centre-right 4 and right 5.

agreed in the case of our first question and who mentioned trade unions in response to our second. Just half of all selectors agreed that union delegates turned out in greater force at selections than at ordinary party meetings. Not surprisingly, this seems to have been much less true in hopeless seats than in marginal or safe seats. Almost a quarter of delegates spontaneously mentioned a union or unions when asked whether there was any group with particular influence over selection in their constituencies. Again this was closely related to the electoral status of the seat. More than a third of delegates in safe seats thought unions were influential compared with only 5 per cent in hopeless seats.

Table 6: Selectors' Perceptions of Union Turnout and Union Influence

	Labour Seats %	Marginal Seats %	Hopeless Seats %	Union Delegates %	Other Delegates %	All %
Agree that union delegates turn out more at selections	51	69	23	49	50	50
(N)	(254)	(123)	(103)	(164)	(315)	(479)
Mention unions as influential	32	13	5	31	19	23
(N)	(256)	(40)	(103)	(129)	(270)	(399)

Note: The question about groups woth influence was not asked in all marginal seats.

When those who mentioned unions in this context were asked what the source of union influence was, more than two-thirds (68 per cent) ascribed it to sheer weight of numbers. Clearly there is a recognition that union delegations can swamp other delegates. A further 13 per cent thought that the unity and discipline of union delegations gave them influence while 9 per cent believed that unions canvassed support for favoured candidates. Only 3 per cent believed that financial considerations gave unions influence. These are, of course, only the perceptions of selectors. The questions remain: does the weight of numbers of union delegates actually give them influence? Do they actually exhibit disciplined and united voting patterns in selections?

Any exploration of these questions can only be rather crude even though each of our repondents was asked detailed questions relating to his or her voting at the selection conference. One reason for this is the exhaustive ballot system used in

selections. Ultimately, however, delegates must support the winner or a loser and an analysis of voting patterns can begin there.

In only one of the 18 constituencies studies did a majority of union delegates ultimately vote for a losing candidate and that was in a marginal constitutency in which there were only three union delegates. In contrast, there were five constituencies (2 Labour-held, 1 marginal and 2 hopeless) in which a majority of non-union delegates supported the losing candidate. In these, union delegations clearly carried the day. Overall, 75 per cent of union delegates finally voted for the winning candidate while only 59 per cent of other delegtes did so.

Cohesiveness in voting can be analysed in more detail if delegates' voting pattern is assigned to one of four categories. A delegate may have voted for the winning candidate in all ballots, voted for a specific losing candidate on all ballots, switched to the winner when his first choice(s) were eliminated or switched from an eliminated candidate to the ultimate loser. By analysing the proportions of delegates in each category we can measure the cohesiveness of different group by using D. W. Rae's index of vote fractionalisation, (Rae, 1971, pp.53-8). Overall, union delegates were more cohesive or less fractionalised than other delegates. The index is .47 for union delegates and .60 for others. The index can be calculated for individual constituencies and the results of this are shown in Table 7. The cells in this table refer to the number of constituencies concerned. Thus in 4 constituencies the fractionalisation of union delegations was low while this was true of other delegates in 3 constituencies. Clearly, union delegations in individual seats were on the whole rather less fractionalised than other delegates.

Table 7: The Fractionalisation of Selectors' Votes in Individual Constituencies

	Fractionalisation				
	Low		Ave.		High
	1	2	3	4	5
Union Delegates	4	6	2	1	0
Other Delegates	3	4	4	3	3

Note: One constituency is excluded from both rows of the table because there was only one candidate. In 4 other seats there were too few union delegates for meaningful analysis.

Analysis of voting behaviour at selection conferences can only be rather superficial. One indicator of this is the fact that in this analysis all union delegates have been treated as a

single group. More detailed analysis of delegates from individual unions might be revealing, but this is inhibited by the small numbers that would be involved. It is worth noting too that although union delegates are more cohesive in their choice of candidates this does not necessarily indicate some sort of union plot or that unions instruct their delegates about whom to support. It has already been seen that union representatives are in some respects social distinctive and it could simply be that because of this they prefer one kind of candidate to another. There is some slight evidence from the survey that union delegates are indeed a little more favourably disposed towards working-class candidates than are other delegates but the general conclusion to be drawn from the data is that there is no single 'union view' about what kind of candidates should be selected. Union representatives display the same mixture of motivations, attitudes and perceptions as regular party workers.

Trade unions have then, very great potential for influencing the selection of Labour candidates at local level by sponsoring and/or nominating candidates and by sending delegates to selection conferences. It would appear, however, that this potential is not always maximised. There are, of course, cases in which union influence is decisive. (Indeed in one of the selections studied the successful candidate was sponsored and nominated by a union and supported by a large turnout of delegates from the same union). But this is the exception. Unions do influence selections - especially in Labour seats - but this influence is not generally seen as illegitimate by selectors and it does not take the form of attempting to have particular kinds of candidates chosen. Union delegates are frequently regular party activists in any case and usually the fact of being a union delegate is not the paramount influence upon them when making decisions about candidates. Rather, like other delegates, they take into account a variety of considerations such as the nature of the constituency, the electoral appeal and personal qualities of the candidates and the consequences their choices may have for the ideological composition of the Labour party in parliament. Unions do not 'control' many selections; their influence, though pervasive, is partial, subtle and only one of the factors that determine who gets selected as parliamentary candidates in the Labour party.

FOOTNOTES

1. That is, there is a series of ballots in which the lowest placed candidate is eliminated until one candidate obtains an absolute majority of votes.

2. In the 18 selections on which this paper is based, attendance ranged from 11 to 92 delegates. The median attendance was 36

people.

3. Labour Party membership statistics show 750,000 individual members in 1978 compared with 6.25 million trade union affiliated members (Labour Party Conference Report, 1979). Even this exaggerates the number of individual members.

4. In a description of a selection in the Birmingham Stechford constituency it is reported that five branches of the Post Office Engineering Union nominated one of their parliamentary panel without seeing him (Guardian 29/11/76).

5. Thus in the selection in Birmingham Stechford noted above there were 274 union branches affiliated to the CLP, which could have swamped the activists from party branches. In fact there were only 13 union delegates. (Guardian, 29/11/76).

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THE SELECTION OF PARLIAMENTARY CANDIDATES IN BELGIUM

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1. Introduction

The intraparty selection of parliamentary candidates in Belgium is viewed by most authors as an apparent exception to Michels' observations on decison making in voluntary organizations. Since nearly all authors have focused on the selection methods used in the sixties, ignoring the dramatic changes which occured in the seventies, the Belgian case would seem to constitue an anomaly (1). The predominant method used in this period was the so-called poll system, which was a sort of intraparty primary in which dues paying members could vote and select their parliamentary candidates. Although the nature of candidate selection in the seventies changed drastically, no systematic research had been conducted on this period until recently (2). So even in comparative studies, published within the last five years, the poll system erroniously emerges as the dominant selection procedure in Belgian parties (3).
This paper will focus on:

1. the institutional selection procedures within each Belgian party
2. the de facto selection process and its evolution during the 1958 - 1978 period
3. the causes and consequences of the above and of their changing nature

2. Some General Remarks on Candidate Selection in Belgian Political Parties

The procedures by which Belgian political parties select their parliamentary candidates are not governed by public laws.
Rather, they are governed by rules made, amended, interpreted and enforced entirily by party agencies. These rules are contained in the constituency charters, and often in the national charter, of each party. The intraparty selection processes are adapted to procedures governing general elections. Since the 212 members of the Chamber of Representatives are elected through a proportional representation system from thirty multi-member constituencies,

parties in each constituency normally compose lists which include a number of candidates equal to the number of Representatives to be elected.

In Belgium the ordening of candidates on the lists is of particular importance because the voters only decide on the number of seats a party will receive, not on who will fill the seats. Due to electoral laws the candidates of a party are nearly always elected in the same order as they are presented on the candidate lists.

Article 170 of the Electoral Code stipulates how seats are distributed among candidates on each party's list. The candidate who first reaches the eligibility figure (calculated by dividing the party's total vote with the number of seats it won, plus one) is seated. If the head of the list has received fewer preference votes than this figure, list votes are added until the figure is reached (5). This procedure is repeated for the candidate situated in the second place on the list and so forth until all the party's seats have been allocated. If the list votes are depleted before all the seats have been assigned, the next seat is accorded to the candidate with the most preference votes. So, if no list votes are cast, the personal preference indicated by the number of preference votes will determine who among the candidates offered by a party is elected. As the proportion of list votes increases, the likelyhood that candidates will be elected in their order of appearance on the list rises.

This procedure makes the internal selection of candidates by the parties crucial in the election process. Belgian voters have rarely managed to alter the ordered lists.

Following the establishment of general male suffrage in 1919 and until the last election of 1981, only 26 of the 4.083 parliamentary seats (0.64 %) were accorded to candidates who had been elected out of order. This is usually the result of a national party leader receiving a high number of preference votes in a big constituency such as Brussels -Halle-Vilvoorde, Antwerp and Ghent. Thus the general number of list votes is decreased and the preference votes of other candidates become more important, since they can no longer appeal to list votes to reach the eligiblilty figure.

Although the proportion of preference votes in the total vote has

increased steadily (from 16.36 % in 1919 to 47.39 % in 1981, with a maximum of 51.86 % in 1978) , the number of candidates elected out of order hasn't increased at all. There is no upward trend. On the contrary, in the peak years of 1977 and 1978 with more then half of the votes being preference votes, nobody got elected out of order (4).

So the Belgian voters only decide on the number of seats a party gets, the parties themselves decide who will receive them.

Since article 170 of the Electoral Code prevents voters from altering the order of the candidates, party officials have come to think in terms of safe, combative and hopeless list positions. In choosing candidates , they are naturally most concerned about who occupies the safe and combative positions and they often fill the hopeless spots with well-known personalities who may attract voters but who have no seribus intention of pursuing a parliamentary career.

3. General Features of the Poll System

The poll system was first used by the Liberal Party in the late 1840s. The Catholics starting organizing polls in the late 1860s and by the 1920s they were held in most constituencies. The Socialists started as soon as universal male suffrage was implemented.

By the end of the 1940s the poll system had become an accepted tradition in party life.

Although procedures regulating the primary varied considerably according to constituency and party, all polls were organized along the following lines:

1. All parties set eligibility requirements for candidacy. In some parties they were extremely demanding, in others very easy to meet. Personal exceptions under certain circumstances were allowed, which had to be approved by constituency and /or national party agencies
2. All persons who had been members of the party for more than a specified period prior to the poll were enfranchised. Some parties only required membership at the moment of the candidate selection itself, while other parties demanded a more long term

commitment. This restriction was designed to discourage factions from recruiting new members into the party for the sole purpose of supporting their candidates in selection competitions.

3. The poll was a contested election. In practice the number of aspirants usually exceeded the number of safe and combative places to be filled.
4. Most commonly voting members marked their preferences for one or more of the aspirants. The candidate who attracted the most votes was placed at the head of the list, and so on according to the mumber of votes received .

The above procedures are still contained today in the charters of most parties.

4. Methodological remarks

1. Since the Belgian Senate, contrary to similar bodies in many other parliamentary democracies, has exactly the same powers and functions as the Chamber of Representatives, has the same distribution of seats among the parties as in the Chamber, and is composed of members who for the most part are directly elected, we should not neglect the selection of senatorial candidates. But data on the selection of the Senators is much more scarce than that available regarding the selection of the Representatives. It is therefore difficult to give an accurate and detailed description of the selection of this kind of parliamentary candidate.

   In general the selection of senatorial candidates is more oligarchic than of Representatives. Since for the election of the directly elected Senators some constituencies are merged, the poll system is often abandonned as agreements have to be made between the party committees of different constituencies in order to secure a regionally balanced candidate list.

   The decision as to which candidates shall be co-opted as Provincial Senators is made by the provincial and national party leadership. The National Co-opted Senators are selected by the national party leadership alone. Many of the provincially and

nationally co-opted Senators were unsuccessful candidates for the House or for the Senate.

2. In describing the use of the different processes of candidate selection in each party, two methods can be applied. One focuses on the constituencies, and counts the number of constituencies in which a certain selection procedure is used. In practice, this is hardly feasible, since the data is incomplete, especially for the small constitutencies.

   A more important reason is that this method won't give an accurate image of the way the 212 members of the House of Representatives are selected. As J. Obler has pointed out: "In those associations which have no hope for electing even one deputy, the designation of candidates engenders little interest among party members and enven less competition among prospective nominiees. Often association leaders must search for party members willing to have their name placed on the list. Given the general indifference among party members and aspirants about who will occupy the hopeless places on the list, party leaders are understandably not eager to expend the time , money and energy to poll the members preferences. When candidates have no chance for electoral succes, a primary becomes superflous. The reluctance of Belgian parties to hold primaries under such circumstances in roughly equivalent to the unconstested primaries among minority parties in the United States. It is only when an association expects to elect at least several deputies that there is sufficient competition among aspirants and concern among the rank-and-file to warrant the expense and time required to hold a primary" (6).

   So, since many constituency parties have no representatives in the House, the question of the level of internal democracy concerning candidate selection in these constituencies is of little relevance.

   It is therefore more valuable to focus on the procedures through which the successful candidates were selected. So we will not use the constituencies as counting units, but rather the number of actually elected candidates.

3. In dealing with the the evolution of application of the different procedures in the 1958-1978 period, the Representatives of the Flemish and French-speaking Christian-Democratic parties have been dealt with as a single group . The Socialist and Liberal parties have also been treated as a single category. This choice of treatment is methodologically acceptable within the confines of this study for the following reasons. First, the three major parties (Christian-Democratic, Liberal and Socialist) only split along linguistic lines in 1968, 1972 and 1978 respectively. Second, their present charters concerning candidate selection are still based on the ones which were effective before the party fractures.
   In analysing the the present selection procedures, however, parties will be treated with seperately.
4. In dealing with the different arrangements governing candidate-selection, the focus will be on the present rules, as approved by the most recent Administrative Congress in each party.
   Although the implementation of the rules changed a great deal, the rules themselves varied but slightly during the 1958-1978 period . In this study only major changes during the period will be mentioned.

5. Candidate Selection in the Christian-Democratic Parties

5.1. Candidate selection according to the party charters

The national charter of the Flemish Christelijke Volkspartij (CVP, Christian Popular Party) explicitely calls for the use of the poll system. But the constituency parties must work out for themselves the practical arrangements for implementation of this system.
The charters of most CVP constitutency parties stipulate the use of the particular type of poll system - one based on a "model list". The Constituency Committee establishes an alphabetical list of all aspirants and a list of candidates of its own preference. The latter is the so called "model list", and usually consists of the number of incumbents plus one. Each voter may cast his or her

ballot for either the entire model list or for particular candidates on the alphabetical list. In the latter case the voter must order the candidates according to preference. If a majority of votes are cast for the model list, it will become the final electoral list. If it is rejected, the votes cast for aspirants on the alphabetical list will be considered in order to rank the candidates. The total vote for each aspirant is calculated by adding the votes received on the aphabetical list to the total number of votes cast for the model list (if the candidate appears on the latter). The aspirant with the highest number of votes is placed at the head of the list, the one with the second highest number in the second place, and so on, until all places have been allocated. Some constituency parties apply a variation of this counting method. Candidates' personal votes are combined with a proportion of the model list votes depending on the candidates' position on the latter list. As a result of both tabulating procedures voters in the CVP have rarely managed to alter the model lists.
Finally, some constituency parties apply the "pure" poll system, in which no model list is used. Under this system the number of preference poll votes alone determines the selection and order of the candidates for the final list.
In 1965 it became obligatory that final lists drawn up by each constituency party be approved by the National Party Bureau. The Bureau has the power to alter the order of the list, and to add or remove candidates.

The national charter of the French-speaking Parti Social Chrétien (PSC) stipulates that a poll must be organized for every general election, except in the case of premature elections, into which category most of the elections in Belgium fall. (7)
As in the CVP, the PSC constituency committees (comités directeur) establish both alphabetical and model lists. Three voting methods are allowed: by mail, in the general assembly of the constituency, or through several voting bureaus.
If the model list obtains 50 % of the vote, it will become the final list. If not, a third counting method is used. For each vote on the model list a candidate will receive the numerical figure

equivalent to his or her position on the list. For votes cast on the alphabetical list for a particular candidate, a figure corresponding to his rank under the voters' preference is accorded. The numbers obtained according to both lists are then added. The candidate who obtains the most number one votes is placed at the head of the list. The second position is accorded to the candidate who obtains the most number one and number two votes, and so on.
If as a result of premature elections there is not sufficient time to organize a poll, the Constituency Committee establishes the final list, which must be approved it by a 4/5 majority. If the list receives between 1/2 and 4/5 of the vote, a Constituency Congress consisting of delegates of the local sections will be organised. Should the Congress reject the list, the national "Comité Directeur" will formulate it.
The eligibility requirements within the Christian-Democratic parties are not very stringent. There is an age limit of 65, and a prohibition against holding a seat in Parliament while serving as the mayor or deputy of a city of more than 30.000 inhabitants. Candidates in the PSC must have been member of the party for at least two years.

5.2 The evolution of the election procedures in the Christian-Democratic parties

In TABLE I CVP-PSC Representatives are classified in four categories, according to the method by which they were selected for the final list. The four methods are:

1. a pure poll, without a model list
2. a poll with a model list, which has been rejected by the poll voters
3. a poll with a model list, which has been approved by the poll voters
4. any other procedure (a congress of delegates of local sections, a decision by the constituency party leaders, an intervention of national party leadership, etc.)

TABLE 1 GOES ABOUT HERE

TABLE I shows that the use of the poll system dropped dramatically in the 1958-1978 period (8). In 1958, 97 % of all Christian-Democratic Representatives were placed on the electoral lists through some kind of poll system. Following 1968 the figure is no more than 10 % . Throughout the entire period, about two-thirds of the CVP-PSC Representatives were selected without a poll.

Of the Representatives who were selected through the poll system, 18.7 % gained their place on the list through the pure poll method, 12.6 % through a modified model list, and 68.7 % through an approved model list.

These proportions call into question the significance of the high number of Representatives selected under the poll system in the 1958, 1961, and 1965 elections in regard to the democratic nature of the selection procedures. Model lists, established by constituency party leaders, are very difficult for party members to modify . In most cases the party officials decide which candidate will get which place on the list, not the members.

Although data on the rate of participation of party members is scarce, and the use of the poll system dropped dramatically after 1965, the data for the 1958, 1961 and 1965 elections suggests a declining participation rate. In 1958 51 % of the members of constituencies using the system actually voted. In 1961 and 1965 the figures were 40 % and 38 % respectively (9) . This decline may indicate a growing dissatisfaction among party members with the oligarchic model list procedure. The growing tendency to reject the model lists in the 1958-1965 period can be interpreted in the same way.

In constituencies applying the poll system, poll participants constitute approximately 5 % of the entire electorate of the constituency party.

5.3 Causes of change in the selection process

Undoubtedly, the most important reason for the decline in use of the poll system and the decreasing influence of rank-and-file party members has been the growing influence of the three main interest groups wihtin the parties. The CVP is a Catholic catch-all party

which appeals to workers, the middle class and farmers. These three socio-economic categories are highly organized . The "Algemeen Christelijk Werkersverbond" (ACW) represents the workers, the "Nationaal Christelijk Middenstandverbond" (NCMW) the middle class, and the "Boerenbond" (BB) the farmers . All three have active sections at the constituency level. All consider the CVP to be the sole political representative of their interests. As a result each tries to achieve as much power within the party as possible. Control over the selection of political personnel at all levels - local, provincial, and national- is of major concern in their strategies of power achievement. During the recent decades the alliance of these groups within the party has become increasingly uneasy. In the forties and the fifties, they presented a united front concerning the two major issues of the political agenda, namely the return of King Leopold, and the dispute between Church and State on the school issue. In 1958 a general compromise , the "School Pact", on the financing of Catholic and state schools removed this topic from the political agenda. The "King Issue" was resolved as well, by putting King Leopold's son on the throne in 1950.

Thus, the other two main cleavages in the Belgian polity, the economic and linguistic conflicts, came to dominate the political agenda . The three interest groups were, and continue to be, divided over socio-economic matters in particular (10). Control over selection of the CVP's political personnel became crucial as a means of realizing the divergent policy interests of different factions. On the eve of elections (especially in the case of general elections) all groups tried to secure as many safe places on the electoral lists as possible. The designation of candidates thus has become the focal point of factional conflict.

Party leaders strive to compose electoral lists that will not alienate these interest groups and their followers. Party members voting in a pure poll are not likely to produce such balanced lists, because they are not usually representative of those who vote for the party in the general election. Political participation is unequally spread amongst different social categories, and so is party membership. In Belgium party membership ranks high on the

political participation scale (11) But even in the absence of bias, the poll method could fail to result in a balanced list if one faction, supported by a majority of the members as well as of the poll voters, managed to win all or most of the safe places.

Finally, the control of candidate selection by leaders of the interest groups, secures them an important tool for the enforcement of conformist political behavior on the part of their Representatives, both inside and outside of Parliament.

So, the uneasy alliance between interest groups explains many features of the candidate selection system within the CVP: the predominance of the model list system over the pure poll, the growing tendency in the sixties to reject the model lists, and the near total abolishment of any form of poll system in the seventies. The present control of pressure group leaders over the selection of candidates and their political behavior is often highly institutionalized.

In the CVP delegates of the three interest groups in the constituency party committee come to an agreement regarding safe places which they can reserve for their own candidates. In most consituencies a longlasting agreement (one that is valid for many elections) has been reached. Of the 56 CVP - Representatives of 1978-1981 legislative term, thirty-four(60.7 %) were elected on fixed places which have been reserved for a particular group over a period of time. Seventeen (30.4 %) were elected in constituencies where the interest group leaders negociated an agreement valid for only one election on the eve of the composition of the lists. Only in one constituency were there neither agreements nor consultations, because the ACW group was so strong that it dominated the constituency party and did not have to bargain at all.

So nearly all CVP -Representatives obtained their seat because one of the interest groups offered them a safe place on an electoral list. In 1978, 46 % of the CVP-Representatives belonged to the ACW group, 16 % to the BB, 26 % to NCMV, and 7 % were backed both by the BB and the NCMV (13). Only a few were not backed by any of the groups. These "sans familles" CVP- parliamentarians are usually national party leaders or Cabinet members, with a strong electoral appeal. They cannot be neglected in the bargaining process between

the groups. In 1978 there were only three "sans familles" CVP-Representatives: the present prime minister, the present national party leader, and the present minister of economic affairs.

In the French-speaking PSC, interest groups are less well organized. Many changes occured in the institutionalized representation of the three social classes within the party framework.
The French-speaking Catholic workers are organized in the "Mouvement Ouvrier Chrétien" (MOC). Until 1972 the MOC recognized the PSC as its sole political representative. Since then it has opted for a more pluralistic political representation which includes two federalist parties, the "Rassemblement Wallon" (RW), and the "Front Démocratic des Francophones" (FDF). The MOC factions which remained loyal to political representation by the PSC regrouped in 1973 in the "Démocratie Chrétienne" (DC). DC committees at the constiteuncy level can recognize PSC parliamentary candidates as their political representatives in the PSC and support their selection and election. The national party has offically recognized the DC as the representative of the worker's interest in the party.
In 1955 the Catholic middle class organized itself within the PSC in the "Mouvement Chrétien des Indépendants et des Cadres" (MIC). To counter the growing influence of the workers' organizations in the PSC, the MIC was reorganized in 1972 into the "Centre Politique des Indépendants et Cadres Chrétiens" (CEPIC). The CEPIC was officially recognized by the party as representing the Catholic middle classes, liberal professions and cadres.
The French-speaking Catholic farmers organization, the "Alliance Agricole Belge" (AAB), is not officially recognized, but does have individual Representatives defending agricultural interests.
Finally, there also exists an unstructured group of "sans familles" PSC politicians, related to neither the DC or the CEPIC.
Longlasting institutionalised agreements between the socio-economic interest groups within the PSC are less common than in the CVP. In some constituencies there is no tradition of bargaining or seat-sharing. Consequently, conflicts between the DC and the CEPIC on the eve of elections are more frequent, and usually more bitter. Since the PSC is also smaller than the CVP, it can count only on

one safe seat in many constituencies. So, often there is no package of seats to share between the tendencies. This usually results in the selection of a neutral, "sans familles", candidate, acceptable for all groups. Of the 25 PSC Representatives in 1978, ten were "sans familles", ten belonged to the DC and five to the CEPIC.

5.4 Consequences of the selection processes

Consequences of interest group control over candidate selection in the CVP-PSC are manifold.

Most candidates need to procure group sponsorship in order to get selected and, finally, elected. Interest groups tend to support candidates who will most effectively defend their interests on all policy levels (in Parliament, in the Cabinet, and within their constituency).

Candidates gain interest group sponsorship in many ways (13). Many new candidates have been active within one of the groups long before their first candidacy. Nearly all workers' Representatives previously held leadership positions in one of the organizations of the Catholic workers movement (trade unions, cultural organizations, health insurance organizations, policy study committees, women's organization, youth organizations, etc.). Their proven record makes them more reliable as future parliamentary representatives.

The groups tend to choose candidates coming from families which belonged to the same social category represented by the interest group. Similarly, the NCMW favors aspirants who themselves exercise middle class professions.

Some candidates are chosen because of their close relationship to a interest group leader, being a member of his or her personal staff, family, etc.

Candidates are sometimes sponsored by an interest group only after their first election. Although their initial success was achieved as an independent candidate, recognition offers many advantages for the incumbent; groups recommend candidates to their followers in membership periodicals and the national press, offer financial and organisational campaign support, and provide various speaking op-

portunities . Once elected, policy study committees supply parliamentarians with information necessary for legislative work. Sometimes these committees even prepare ready-made legal proposals.

But serving as representative of a pressure group within the CVP-PSC involves obligations as well as benefits. The role expectations held by interest groups vis à vis their Representatives are many-sided. They differ between national and constituency group leaders and, additionally, between the constituencies themselves.
In Parliament as well as in the party MP's are expected to defend the policy interests of their group. On the other hand, they must respect compromises reached between divergent factions . Usually these compromises are not worked out by the Representatives themselves in their "parliamentary group", but rather by group spokespersons seated in the national party bureau and, sometimes, on an even higher level -in the neo-corporatist decision-making institutions (14).
In order to insure responsive representation, top leaders of interest groups meet regularly with their sponsored MP's. The Permanent Contact Commission of the ACW meets monthly and consists of all members of the Daily Executive of the ACW, an ACW member of the House and the Senate for each province, a representative of each provincial ACW organisation, the ACW ministers, and the political secretary (a senator) of the Commission. The General Contact Assembly meets two or three times a year and includes all members of the ACW National Bureau, and the ACW parliamentarians and ministers. ACW parliamentarians are also members of ACW policy study committees covering various policy domains. ACW Contact commissions function ,as well,on the constituency level, in order to insure regular contact between parliamentarians and the ACW leaders of each constituency.
Parliamentarians backed by the Boerenbond are members of the "Centraal Comité voor Land- en Tuinbouwbelangen" (CCLT, Central Committee for Agricultural Interests). On the national level, the CCLT consists of three delegates of BB's National Executive Committee, the dean of the BB, delegates of the constituency BB organizations, BB women's organizations and youth and cultural organizations, as

well all BB parliamentarians and provincial deputies. Normally, the national CCLT meets three times a year. BB parliamentarians meet monthly in order to prepare initiatives and positions to be taken in Parliament. CCLT committees also function on the provincial level to insure contacts between parliamentarians, provincial and local politicians and leaders of the Boerenbond.

Contacts between national NCMV leaders and their MP's are institutionalized in the Political Committee of the NCMV. NCMV parliamentarians attend the General Assembly of the NCMV and participate in NCMV policy study groups. NCMV Political Committees also function on the constituency level.

The Political Committee of the DC includes the members of the Executive Bureau of the DC, all DC ministers and parliamentarians, the DC members of the Comité Directeur of the PSC, and the national leaders of the MOC. The committee holds monthly meetings.

The CEPIC parliamentarians keep contact with their organization through the national "Comité Directeur" of the CEPIC.

These institutionalised contacts serve to inform the CVP-PSC parliamentarians on the policy preferences of their respective sponsors (15).

The constituency interest groups' role expectations vis à vis their Representatives cover a wide range of activities. These expectations relate to normal parliamentary activities (issue stands, dedication to parliamentary duties, and promotion of general constituency interests) as well as external activities, particularly within the constituency pressure group. These external activities include an informing role regarding their own activities and the political scene in general , service as a local leader in the constituency pressure group, personal contacts with rank and file members, and clientelist case work.

As a representative of a Catholic interest group an MP is also expected to lead an exemplary personal and family life. Divorce ,for instance, usually means the end of a political career.

Not living up to these role expectations can lead to removal from the candidate list, or placement in an unsafe or hopeless position at the next election. Very few parliamentarians have been reelected after betraying the confidence of the pressure group that previous-

ly backed them. The few that have succeeded have done so as the result of a powerful political base built up during their career , usually as a national party leader or cabinet member, which insured them a safe place on the list even without sponsorship of a group.

So the main representational focus of CVP-PSC parliamentarians is undoubtedly on the interest group that backs them during the candidate selection process. Since these groups have enormous power to sanction non-conformist role behavior by controlling the candidate selection process, their expectations define the political behavior of Representatives in a much stronger way than those of other relevant groups , such as voters, party members, constituency officials, parliamentary colleages, etc.

The experience of the Christian-Democratic parties regarding candidate selection can be summarized along the following lines:

1. With the heterogeneity of its electorate, the strong integration of each socio-economic category into its own organization, and the increasing domination of socio-economic issues within the political agenda, the CVP-PSC has been very anxious to compose parliamentary lists which will accurately reflect the social diversity of its electoral base in order to minimize intraparty conflicts.
2. A socio-economically biased poll electorate has proved unable to produce such lists.
3. As a result members' direct influence has been restricted in two steps. The first was the replacement of the pure poll with the model list. This proved not to be a sufficient restriction, so at the end of the sixties the poll system was abolished completely.
4. Since the beginning of the seventies constituency leaders of intraparty socio-economic interest groups have divided the safe places on the lists and decided to whom they will offer them, consequently exercising extensive control over the role behavior of Representatives .

6. Candidate Selection in the Socialist Parties

6.1 Candidate selection according to the party charters

The national party charter of the French-speaking "Parti Socialiste" (PS) contains no stipulations regarding candidate selection. Therefore constituency parties may choose the methods they wish to apply.

Most constituency charters call for use of the pure poll system. The constituency party committee draws up a list of all candidates, ordered alphabetically, in a circle, or at random, in order to prevent the committee from showing its preference for certain candidates by putting them at the top of the list. Party members can cast votes on one or more candidates. The candidates are ordered on the final electoral list according to the number of votes they have obtained in the poll.

The national party agencies have no right to interfere with constituency party arrangements concerning candidate selection.

In some constituencies the party committee can decide to place a candidate "hors poll". This means that it reserves to the candidate a safe place, usually at the top of the final candidate list. In this case, the poll only determines the selection of candidates for the lower places. This procedure is usually applied to protect candidates who are of great value to the national party leadership such as the party president, former ministers or valuable legislators who lack sufficient local popularity to insure their placement at the top of the list.

In the Socialist party the eligibilty requirements are generally stringent though they differ widely among constituencies. Most charters require a minimum party membership of five years, membership in the Socialist trade union and Socialist health insurance fund of five years minimum, membership in the Socialist co-operative, and subscription to the party newspaper. In addition, some constituencies require annual minimum purchases from the Socialist co-operatives, the holding of some party office, the enrolment of children in state rather than private schools (i.e. Catholic schools), party militancy, that private insurance be held

through the Socialist insurance company, membership of wife or husband in the party, the trade union and the medical insurance fund, and membership of children in party youth organizations (16). Under the national charter candidates may not be over 65, be seated on the board of directors of private enterprises, or hold more then one public offices.

These stringent eligibility conditions are not always strictly enforced. Today some are completely unenforcable due, for instance, to the disappearance of party newspapers and of many co-operatives. Also, in order to attract new voters, the national party leadership has recently tried to open Socialist lists to famous left wing personalities with few organizational ties to party structures. However, many constituency parties have succesfully resisted enlargement of the party's candidate lists by strictly applying the constituency charter.

The national party charter of the Flemish "Socialistische Partij" (SP) also contains no rules concerning the composition of candidate lists. As in the PS, most constituency party charters prescribe the use of the pure poll system.

6.2 The evolution of selection procedures in the Socialist parties

For the purpose of this paper Socialist Representatives will be divided into two categories: those who were selected through a pure poll procedure and those who were not. The non-poll procedures include selection through a "hors poll" placement, or through a congress of delegates of local party sections, who approve a list proposal compiled by the constituency committee.

TABLE II GOES ABOUT HERE

TABLE II reflects a steady decline of the use of the poll system, but a less dramatic one than in case of the CVP-PSC. In the seventies approximately half of the Socialist Representatives were still selected by poll (not counting 1978) (17). The low number of 1978 can be explained by a rule, applied in most constituencies, which stipulated that in case an election is held less than 18 months

after the previous election, the previous list is used again.
In constituencies where a poll was organized about half of the members participated. About ten procent of the Socialist voters were actual party members.
In cases where no poll method was used, the constituency committee drew up a list, which was then presented for approval at a constituency congress of delegates of the local party sections.Approval was usually not problematic because leaders of local sections were also members of the committee which drew up the list.
Although data for the 1981 election is incomplete, it appears that the use of the poll system was approximately the same as in 1977.

6.3 Causes and consequences of the different selection procedures

The causes of decline in the use of the poll system in the Socialist parties are not as clear as in the case of the Christian-Democrats. The socio-economic compostion of the Socialist electorate is fairly homogeneous. Candidate selection is thus not a focal point of factional conflict.
The main cause of decline is probably the fact that a general member poll does not generate the most attractive electoral list. The poll method tends to favor types of candidates who do not have optimal electoral appeal (18).
The poll system favors candidates who are backed by one or more organizations of the Socialist movement. Socialist trade unions and health insurance organizations often support particular candidates. Leaders of the trade union and health care organizations can mobilize their rank-and-file members, and even their personnel (for which party membership is often required), to vote for them in the poll elections. The support of trade union and health care organizations also offers financial advantages. Since these organizations are the financial backbone of the Socialist movement , they pay for most of the general electoral party propaganda. Sometimes they also contribute substantially to the personal campaign funds of the candidates they support.
Candidates are usually eager to gain the support the aged, who constitute about one-third of the party members. Thus many candi-

dates are active in, or at least pay attention to, Socialist organizations for older citizens. Young candidates often rely backing of the party youth movement. All female Socialist parliamentarians held leadership positions in Socialist womens' organizations before their election to Parliament.
Membership in a strong local party section is also important because local party members tend to support candidates of their own community.
Holders of local public office, such as mayors, are favored too, due to the local visibility and service nature of their positions.
Finally, incumbents who concentrate on constituency service can appeal to the many party members in their clientele (19).
So, in general, candidates raise the necessary support for their selection through devotion to their constituency. Political performance on the national level is a much less effective means of assuring selection in the poll process . Only those politicians with a highly visible position in national politics, such as party leaders and ministers, do not have to rely solely on their local popularity. The use of the "hors poll" system proves that in many cases even these national positions are not sufficient to secure party leaders the first place on the final electoral list under normal poll procedures.

The wide use of the poll system is reflected in the background characteristics and legislative role behavior of Socialist parliamentarians. Most of them held leadership positions in one or more Socialist organizations or held local public office, usually as a mayor. Socialist MP's tended to display constituency oriented legislative role behavior. They were less active in Parliament than other MP's, and usually concentrated only on matters relevant to their constituency or the Socialist organization(s) that supported them. They spent most of their time in their constituency organizations and local offices. It was necessary to secure a strong local power base before concentrating on national politics. They were generally older then the average MP when they entered Parliament, but once seated, they tended to stay for a long time.

As can be seen, the poll system resulted in preservation of the status quo. It disadvantaged new candidates, young candidates, parliamentary technocrats, and candidates coming from outside the Socialist world.

Since the end of the seventies, national leaders of the SP have tried to gain votes among Catholic workers. The presentation of well known left-wing catholic personalities facilitated this, but they had to cope with strong anti-clerical sentiments of rank-and-file members. The abolishment of the poll system in many constituencies has consequently made the recruitment of these new types of candidates easier.

The Flemish Socialist constituency parties were the first to drop the poll system. The abolishment was favored by several factors. In many small constituencies with but one Socialist Representative polls were never held. The tradition of the poll was never strong in the political culture of Flemish Socialists.

In 1976 Karel Van Miert, a new young party leader, was elected. His organizational ties to the Socialist world were limited and his political career had been rather technocratic . His main goal was to infuse new blood into the party, by recruiting young and left wing candidates from outside traditional Socialist structures.

The break up of the Belgian Socialist Party in 1978 also favored the abolishment of the poll system in the Flemish Socialist Party. Since most of the Socialist party machinery at the national level (the political secretariat, parliamentary staff, etc.) was formerly controlled by French speakers, the Flemish Socialists had to create their own national structures. The group of "young turks" around the new president had little difficulty dropping their people into these new positions. Their aim was to increase the power of the national party leadership over the constituency leadership. One way of doing this was to further the recruitment of political personnel who supported the party renewal.

Up until now they have been most succesfull in smaller constituencies. Most parliamentarians of the new type represent these constituencies, and were elected without the use of the poll system. In these constituencies Socialist organizations are usually less well organised and the party apparatus is smaller, less bureaucra-

tized and thus easier to take over. In large constituencies with an older Socialist tradition there is more resistance to the new national party leadership. In these traditionalist strongholds Socialist organizations and local sections are better organized, party leadership is more bureaucratized, and membership is proportionally larger. They continue to use the poll system and send the more traditional types of Representatives to Parliament (20).

The above factors explain why the poll system is more widely used in French speaking constituencies and why the role characteristics of French speaking Socialist Representatives have not changed as much as those of the Flemish. The average age of the present Flemish Socialist Representative is lower today than twenty years ago. The SP group is the most active in Parliament, and is praised even by its opponents for the technical knowledge SP Representatives and their devotion to their work. Their representational focus is less constituency oriented than in the past.

One can summarize the selection process experiences in the Socialist parties as follows :

1. the pure poll allocated substantial power to rank-and-file members in the selection process
2. the pure poll combined with the stringent eligibility requirements lead to inbreeding and reduced the attractiveness of the lists to potential new voters less integrated into the Socialist world
3. In order to widen the electoral appeal of Flemish Socialist lists and improve the quality of the Socialist parliamentary group, national party leaders have to a great extent abolished the poll procedure.

7. Candidate Selection in the Liberal Parties

7.1 Candidate selection according to the party charters

The national charter of the Flemish Liberal party, the "Party voor Vrijheid and Vooruitgang" (PVV, Party for Liberty and Progres) recommends the use of a general member poll, but allows other procedures as well. Constituency parties must establish their own rules and act accordingly.
The national Party Bureau and the Party Council can give recommendations concerning candidates and their order of appearance on the list of a given constituency. These must be communicated to all participants in the poll, or whatever other selection procedure is used. The recommendations are not binding. If no internal agreement on candidate selection is reached within a constituency party the national Party Bureau can arbitarily intervene.
Traditionally, eligibility requirements are not demanding in the PVV. Today only the age limit of 65 exists. The national Party Bureau can allow exceptions even as to this rule.

The present national charter of the "Parti Reformateur Libéral" (PRL, the former "Parti de la Liberté et du Progrès") gives the constituency party organizations full freedom to establish their candidate selection procedures.
Candidates can not be older than 65. This age limit can be overruled through the results of a poll, or by a two-thirds majority vote in the constituency selection committee. These exceptions must be approved by the national Party Bureau. The national "Commission de Conciliation et d'Arbritrage" can intervene in the selection process in case of conflict within the constituency selection committees.
In the sixties, when the party was still linguistically united, the national charter explicitly prescribed the use of the poll system, but left the elaboration of the practical arrangements to the constituency parties.