countries. Also, while the inclusion of efficiency or cost containment as a goal appears universal, there remain wide disparities among the countries as to the degree of access and equity in their respective health care systems. Similarly, although all countries have integrated some aspects of the market into their systems through recent reforms, the wide variation in both form and degree argues against the conclusion that they are converging to a market-driven health system. Far from it! Unlike the USA, other countries continue to maintain relatively robust regulatory controls over market forces.

Regarding the allocation and rationing of health care resources, about the only perceivable convergence is that it is increasingly clear in all countries that medicine must be rationed because, in the light of endless technological possibilities, no country can serve all the health needs of their population to the fullest. Countries with global budgets or other supply-side controls are likely to depend on non-price rationing mechanisms and make harder choices at the macro-allocation level. In contrast, countries that rely more heavily on price rationing forgo setting broad limits, thus losing any semblance of equity or systematic rationing policy. The result is that rationing in national health systems differs greatly from that in social insurance systems and, especially, market-dominated systems.

It should also be noted that health policy is not static and that movement in one direction is often followed by a move in the opposite direction as political fortunes change or the public responds negatively to a change. Any discussion of convergence risks underestimating the political dynamics inherent in health policy. For instance, New Zealand was widely cited as an example of convergence towards a market system in the early 1990s when it initiated strong market reforms, but most of these were withdrawn by succeeding governments.

In the end though, all countries must face the issue of rationing of health resources for the high users of medicine, including the elderly and individuals who engage in multiple high-risk behaviours. Evidence suggests that there is little consensus in these countries as to whether or how to do this. Finally, because the diffusion of new medical technologies is such a critical factor in cost containment and central to any debate over rationing since it is generally expensive technologies or drugs being rationed, the preliminary efforts at technology assessment outlined here must be strengthened. The process must be made more transparent to the explicit tradeoffs required when a decision is made to fund expensive new technologies: where specifically will the money come from, and what other programmes might be cut? This leads us back to medical professionals who, as we shall see in the next chapter, continue to wield considerable power and have a substantial stake and interest in cost containment, rationing and health policy in general.

Chapter 5

The Medical Profession

The power of the medical profession stems from the fact that health care is largely defined as medical care. Doctors are responsible for diagnosis and as such define patients' health care needs. Doctors also provide treatment, but more often than not this involves (either directly or by referral) other health practitioners, such as medical specialists, nurses, physiotherapists, laboratory technicians or dieticians. This puts doctors in a key position regarding the allocation of health care resources. Health systems, health policy and politics cannot be understood without doctors and vice versa. Doctors often enjoy considerable power and are seen as the archetypal example of a profession. Autonomy and dominance are at the heart of medical power and refer to the ability of doctors to make autonomous decisions concerning the contents and the conditions of medical work (see also Box 5.1).

Inasmuch as doctors are embedded in specific sub-systems of funding, provision and governance, professional autonomy will always be contingent and relative, and this also points to the complex relationship between doctors and the state. Significantly, professional autonomy and power are part of the implicit contract between doctors and the state. The state grants professional autonomy in return for doctors providing services that are central to the legitimacy of modern states. Medical practice, by virtue of the specialized knowledge on which it is based, also gives legitimacy to the (potentially problematic) allocation of health care resources. However, inherent in this interdependent relationship between doctors and the state is conflict, such as that between medically defined need and the finitude of financial resources. For the medical profession, the challenge is 'to manage the relationship with the state so as simultaneously to appropriate public authority without surrendering to public control' (Moran, 1999: 99).

What are the implications for understanding doctors in the context of health systems and policy? Power emerges as a central theme, as does the complex nature of medical power. Far from being absolute, the power of doctors is relative and varies between different specialties, points in time and countries. This comparative analysis highlights how medical power is contingent upon the specific sub-systems of funding, provision and governance. At the same time, the power of doctors is intrinsically changeable as it is linked with states and their agendas. Analysing how

Box 5.1 Understanding professions

The understanding of professions has changed over time. Early approaches defined professions by specific traits (such as formal knowledge, long training and high social status) and by a positive role in society. However, these approaches have been criticized for taking the self-image of professions at face value and for remaining largely uncritical. Instead, later approaches focus on the social organization of power. Freidson (1994) for example defines professions as being primarily concerned with attaining and maintaining control. Control consists of autonomy (that is, control over the professions' own work) and dominance (that is, control over the work of others). Medical power is highlycomplex and has both an individual and a collective dimension, comprising the freedom of individual doctors to practise as they see fit as well as the activities of doctors' professional organizations. Here, Light (1995) further distinguishes among clinical and fiscal autonomy, practice and organizational autonomy, and organizational and institutional control. Elston (1991) adds cultural authority to her understanding of medical power. Cultural authority refers to the dominance of medical definitions of health and illness. At the same time, analysing professions across different countries has become an important concern for recent studies on the organization of expertise (Burau *et al.*, 2004). This builds on earlier historical analyses that emphasized the diversity of the phenomenon called 'professionalism' and exposed the Anglo-American centredness of many ideas about professions. For example, Johnson (1995) suggests that professions and the state have tended to be perceived as separate entities, which then relate to each other as autonomous professions and interventionist state. This makes it difficult to understand professions in Continental and Nordic countries, which have traditionally been 'state interventionist'.

health care reform affects doctors and their power is key. Equally, as much as doctors are entangled with health systems, changes in the regulation of medical work also give an indication of wider changes in health systems (Moran, 1999).

This chapter explores the issues of embeddedness, power and change. The first section provides an overview of the medical profession using OECD statistics. The second section locates the practice of doctors in the context of the health system, while the third directs attention to recent reforms and how they have affected doctors. The fourth section examines how doctors are paid and what this says about the relative power of doctors. This is followed by an analysis of the political organization of doctors and the role of doctors in the policy process. The concluding section summarizes relations between doctors, health policy and the state.

Who doctors are

Doctors are often thought of as a homogeneous group. The notion of profession suggests a cohesion that allows for dominance and autonomy. This corresponds to the idea that medical professionalism is a universal phenomenon (see Box 5.1). However, even a cursory look at statistics reveals considerable diversity among doctors across and within countries, for example in terms of the number of specialists or the percentage of female doctors. The analysis of statistics naturally remains on the surface, but as an overview it provides a useful starting point for comparison. Through highlighting similarities and differences, statistics raise 'why' questions which demand more detailed analysis. The number of doctors presented in Table 5.1 provides a first indication of the diversity that exists across countries.

In many countries, the trend in the number of doctors per 1,000 inhabitants since the early 1960s tells the familiar story of welfare state expansion, together with a shift towards curative, specialized medicine. In the majority of countries, the number of doctors has more or less doubled. Beyond the commonality of growth over time, the current number of doctors ranges from 1.5 doctors per 1,000 inhabitants in Singapore to 4.2 in Italy. However, Italy is a clear outlier. The remaining countries fall into roughly three groups: Britain, Japan and New Zealand with about 2 doctors per 1,000 inhabitants; Australia and the USA with

Table 5.1 *Number of practising doctors per 1,000 inhabitants*

	1979	*1984*	*1989*	*1994*	*1999*	*2004*[a]
Australia	n/a	1.8	2.1	2.4	2.4	2.6
France	1.8	2.5	3.0	3.2	3.3	3.4
Germany	n/a	n/a	n/a	3.0	3.2	3.4
Italy	n/a	n/a	n/a	3.7	4.2	4.2
Japan	1.2	1.4	n/a	1.8	n/a	2.0
Netherlands	1.8	2.2	2.4	n/a	3.1	3.6
New Zealand	1.5	1.7	1.9	2.0	2.2	2.2
Singapore	n/a	n/a	n/a	n/a	n/a	1.5
Sweden	2.0	2.5	2.8	2.8	3.0	3.3
UK	1.3	1.4	1.6	1.7	1.9	2.3
USA	n/a	n/a	n/a	2.1	2.2	2.4

[a] The figures for Australia, New Zealand and Sweden are from 2003.
n/a = not available

Sources: Data from OECD (2006) and Singapore Ministry of Health (2006).

about 2.5 doctors per 1,000 inhabitants; and France, Germany, the Netherlands and Sweden with about 3.5 doctors per 1,000 inhabitants. The variation is significant and, while there is no ready explanation for it, it may reflect differences in the levels of health care expenditure. It might also reflect government restrictions on the number doctors in the form of limits on the number of medical students or the number of doctors allowed to set up practice outside hospitals.

The disparity in the number of doctors also disguises regional variations in the distribution of doctors. This is particularly pertinent in large, unevenly populated countries. Australia is a case in point. There are no legal restrictions on the ability of doctors to establish a practice wherever they wish in Australia. This has resulted in a geographical maldistribution of doctor–patient ratios, which are much higher in the capital cities than in the remainder of each state, especially among specialists in the most rural areas (Palmer and Short, 2000: 196). Successive Commonwealth governments have attempted to address the shortage of doctors in the bush, but the imbalance in their distribution has proven persistent, in part reflecting lifestyle choices of doctors (Davies *et al.*, 2006; Hamilton, 2001). For example, there is one GP for every 1,000 residents of Australian capital cities, while small communities have a ratio of 1:1,700 (Birrell, 2002). Day *et al.* (2005) found the recent changes in bulk billing have done little to ameliorate geographical inequities. Hamilton (2001) argues that even though most doctors receive much of their income in the form of Medicare payments, the government has little control over where they practise. In 1996, the government did require graduating doctors without their full qualifications to take part in programmes designed to address this imbalance. As a result, the number of doctors practising in rural and remote areas increased from around 5,400 in 1996 to 6,200 in 2000, although rural areas remain underserved (Wooldridge, 2001).

The situation is similar in the USA. Rural areas tend to have physician shortages while urban areas have high concentrations of doctors, especially specialists. Despite incentive programmes through Medicare's massive subsidy for hospital-centred residency training of doctors, isolated areas find it difficult to retain doctors (Medicare and Graduate Medical Education, 1995). The fact that the USA is heavily skewed towards specialists compounds this problem because specialists are least likely to practise in rural areas (Medicare and Graduate Medical Education, 1995). In recent years, rural communities have come to depend heavily on foreign-trained doctors to fill the void (C. Busse, 1998).

Countries differ not only in terms of the number of doctors but also the diversity of the medical profession itself. One feature of this diversity is the fact that doctors are increasingly female and, as Table 5.2 shows, in

Table 5.2 *Female practising doctors, as a percentage of practising doctors, 2004*[a]

Australia	32.0
France	37.7
Germany	37.6
Italy	35.3
Japan	16.4
New Zealand	34.5
Sweden	41.2
UK	37.7
USA	28.1

[a] The figures for Australia, New Zealand and Sweden are from 2003.

Source: Data from OECD (2006).

the majority of countries about a third of doctors are women. This can be attributed to cultural and economic developments which have changed the position of women in society and also to more specific state-initiated measures which have strengthened the position of women doctors (Riska and Wegar, 1995). For example, the end to discriminatory practices has helped to increase the number of female medical students, as has the establishment of new medical schools with their emphasis on community and primary care medicine. Only in Japan with 16.4 per cent women doctors do they account for less than a quarter of all doctors. The traditional dominance of males in medicine in Japan has been resistant to change, although an increasing number of young women have entered medicine in recent years. The reason for the smaller proportion of female doctors in the USA (28.1 per cent) is less clear, but it might be linked to the fact that medical education in the USA tends to be considerably longer than in other countries (4 years of medical school after 4 years of university). Also, the strong emphasis on medical specialties instead of general practice might be less attractive to potential women candidates.

Another indication of the diversity of the medical profession is the division between generalist and specialist doctors. As Table 5.3 illustrates, in half the countries there are about twice as many specialists as generalists. One possible explanation is that in specialist practice and in relation to acute care the medical model of health and illness can excel. The ratio is even higher in Sweden, where the number of specialists per 1,000 inhabitants is three times that of generalists. This reflects the fact that hospitals have long been dominant in the provision of health care, with patients having direct access to specialists in outpatient hospital

Table 5.3 *Numbers of generalist and specialist doctors per 1,000 inhabitants*

	Generalist doctors	*Specialist doctors*[a]
Australia	1.4	1.2
France	1.7	1.7
Germany	1.0	2.4
Italy	0.9	n/a
Japan	n/a	n/a
Netherlands	0.5	0.9
New Zealand	0.7	0.7
Singapore	n/a	n/a
Sweden	0.6	1.8
UK	0.7	1.6
USA	1.0	1.4

[a] The figures for Australia, the Netherlands and Sweden are from 2003.

Source: Data from OECD (2006).

departments. In contrast, the provision of ambulatory care has been patchy. The other exception is France, where the numbers of generalists and specialists per 1,000 inhabitants are the same. Data for Japan are unavailable in part because, unlike Western countries, in Japan the generalist–specialist distinction is almost meaningless. Medical practitioners are all doctors of medical science, which includes some specialty. Significantly, there is no nationally recognized or formal system of specialty training or registration, and instead numerous academic societies have established their own training systems.

Types and settings of medical practice

In many ways medical practice goes to the heart of what doctors are about. It is here that doctors relate to patients and make decisions about the allocation of health care resources. This occurs at the micro-level of individual clinics, doctors' surgeries and ward rounds but it is also embedded in the respective health system. The sub-systems of funding, provision and governance frame the practice of doctors. The settings of medical practice describe the institutions in which medicine is organized and relate to what Moran and Wood (1993) call the 'regulation of market structures'. This section focuses on the settings where different

Table 5.4 *Types and settings of medical practice*

	Ambulatory settings (in either solo or group practice)	*Hospital settings*
Generalist/ specialist practitioners[a]	*Generalists only* Australia, Britain, Netherlands, New Zealand, Sweden, Singapore	*Mostly specialists* Australia, Britain, Germany, Netherlands, Sweden, Singapore, USA
Private/public practitioners	*Mostly public* Sweden	*Mostly public* Australia, Britain, New Zealand, Sweden, Singapore
	Mostly private Australia, Britain, Germany, Japan, Netherlands, New Zealand, Singapore, USA	*Mostly private* Japan, Netherlands,
		Public and private Germany, USA

[a] It is difficult to include Japan in this category as there is no clear distinction between generalist and specialist practitioners.

types of doctors work and the implications this has for the power of the medical profession.

As Table 5.4 illustrates, hospitals and ambulatory practices are the typical settings for doctors. Ambulatory settings can be further distinguished into solo and group practices. Different settings are closely associated with different types of medical practice (ambulatory settings with general practitioners and hospitals with specialists), although there are exceptions. As discussed in Chapter 3, in the majority of countries, patients have direct access to GPs, but need a medical referral to see specialists. In contrast, there is more diversity in terms of the public/private distinction, reflecting the public/private mix of the health systems in which medical practice is embedded.

Hospital doctors are either public or private practitioners, depending on the ownership of the hospital. As providers of specialist care, hospitals are complex organizations that rely on the division of labour across

a wide range of health practitioners. This means that specialists depend to a great extent on the work of others when they practise in hospital settings. As complex organizations, hospitals also need management structures that coordinate the different parts of the labour process. In addition to being an organizing force, hospital managers personify the rationality of economics, which has come to the fore over concerns about cost pressures and containment. Not surprisingly, potential and real conflicts between managers and doctors have become a prominent issue, and highlight the contingency of medical power.

The introduction of market mechanisms and corresponding managerialist reforms are the key here. In Britain, an important juncture in the rise of hospital managers in the NHS was the introduction of 'general management' in 1987, replacing professionally based consensus management structures. The underlying idea was that health service management required first and foremost generic skills, particularly those to be found in the private sector, rather than professional judgements by doctors. This, together with the introduction of an internal market in the NHS in 1992, inevitably led to conflicts about the relative power of hospital managers and doctors (Harrison and Pollitt, 1994).

Similarly, in New Zealand before the health reforms of the 1980s and 1990s hospital boards were run by triumvirates composed of medical staff, nursing staff and administrators, with medical staff predominant on most boards. In large part, the reforms were an effort to wrest control from these boards, which critics felt were self-serving, inefficient and unconcerned with cost control. Beginning in 1983 with the government's setting of hospital budgets and culminating in the replacement of hospital boards with Area Health Boards in 1989, a series of steps was taken to create a structure for hospitals that would enable them to 'avoid capture by the medical community' (Blank, 1994). The continual erosion of the influence of the medical community over decision making and the shift in authority to managers and outside consultants has been a contentious issue that at times has resulted in near open warfare between the parties.

Conflicts between doctors and managers are less prominent in Japan where a majority of hospitals (though not usually the high-tech medical centres which are in the public sector) are owned and operated by individual doctors, most being expansions of private ambulatory practices. These hospitals rely on outpatient primary care for a large proportion of their revenues. Furthermore, in Japan the chief executive of all hospitals must be a physician (Nakahara, 1997).

The situation is different in smaller ambulatory settings where doctors tend to work as independent, private practitioners. Solo practice, the traditional way in which doctors have worked, provides the greatest independence, while group practices are more likely to circumscribe

independence. In Germany and Japan the majority of doctors work in solo practices. The independence associated with solo practice is especially pronounced in Japan where doctors operate out of so-called 'clinics', about 40 per cent of which have some inpatient accommodation (Nakahara, 1997). Clinics can keep a patient for up to 48 hours and are legally defined as having fewer than 20 beds. Doctors working in ambulatory settings do not have access to hospital facilities, although most doctors have some degree of specialization.

In contrast, in the USA, Australia, Britain and Sweden, most primary care doctors work in group practices. The significance of group settings is particularly apparent in Sweden where they work in multi-disciplinary health centres where their role is not necessarily paramount. This reflects the fact that the provision of health care has long been dominated by hospitals (Harrison, 2004) and that the initiative to set up health centres came from political-administrative circles (including the Ministry for Health and Social Affairs) not the medical profession (Garpenby, 2001). Likewise, group practices are the norm in Australia with solo practitioners accounting for less than 15 per cent of total practices. Recently there has been a trend towards corporatization of practices with companies taking on the administration under contract to the practitioners.

However, operating in a group setting can also strengthen the position of doctors as demonstrated by the emergence of regional independent practice associations (IPAs) of ambulatory care doctors in New Zealand and Australia. The IPAs act as collective negotiators, contract and fund holders for doctors who are overwhelmingly generalists. In New Zealand, for example, IPAs were originally established to provide GPs with a critical mass for negotiating with the Regional Health Authorities (Finlayson, 2001). IPAs act as umbrella organizations for GPs in negotiations with purchasers and manage any resulting fund-holding relationships (Crampton, 2001). The increasing membership in IPAs has strengthened their negotiating power and protected their professional status (Malcolm and Powell, 1996). Currently over 75 per cent of New Zealand GPs are members of over 30 IPAs. Although developments in contracting and alternative methods of funding and managing services were initially either resisted or treated with caution by the majority of GPs, early successes in contracting, in budget holding for pharmaceutical and laboratory services and in establishing new services led to a progressive recruitment of IPA membership (Ashton, 2005).

Regardless of the relative size of the practice settings, the status of independent contractors is likely to give doctors in ambulatory settings considerable autonomy. Nevertheless, it is in specialist practice that the medical model with its emphasis on acute illness and specialist knowledge can excel, making hospitals the most prestigious setting within which doctors work. A notable exception is Japan, which places heavy

emphasis on preventive medicine and primary care in ambulatory settings. As a result, the hospital admission rate is about one-third and the surgical procedure rate is only one-quarter of the USA (Ikegami and Campbell, 1999).

In the majority of countries, hospitals are the only places in which specialist doctors practise. Germany and the USA are unusual in this respect. In Germany, hospital work is seen as transitional and is used as a springboard to set up a specialist practice in ambulatory care. In the USA, many specialists practice in ambulatory settings. However, as a result of managed care, demand for GPs is growing because of their increased use as gatekeepers and to encourage the use of primary care doctors in lieu of more expensive specialists. These moves have generated vehement opposition by a US public which is used to being able to consult a specialist directly rather than having to be referred by a GP (Lamm and Blank, forthcoming).

The practice of doctors is embedded in the specific context of hospitals and ambulatory care and their relative position in the sub-systems of funding, provision and governance. This is a truism but nevertheless highly relevant to understanding medical practice. In the case of Germany, for example, hospitals have traditionally been less well integrated in health governance, reflecting not only the mix of public and private non-profit providers, typical of social insurance systems such as those found in Japan and the Netherlands, but also the absence of a system of self-administration. Instead, health governance has been fragmented into contracts between individual hospitals and insurance funds, and into coexisting competencies between the federal and state governments. The fragmentation of health governance (also typical of other federalist countries such as Australia and the USA) strengthened the position of the provider side and left hospitals and hospital doctors relatively untouched by health reforms in the 1980s (Schwartz and Busse, 1997). However, this has been changing and the practice of hospital doctors is now much more strongly integrated in and controlled by joint self-administration (see Burau, 2005). The funding of hospitals has moved away from prospective payments to payments based on DRGs, also flanked by extensive measures of quality assurance (see Luzio, 2004). The Joint Committee as the key body of the joint self-administration now has a separate sub-committee on hospital care. The sub-committee consists of the representatives from the hospital association, doctors and insurance funds, and is responsible for maintaining and extending the benefits catalogue for hospital care and for deciding on measures of quality assurance.

The situation is different in national health services such as those in Britain, New Zealand and Sweden, which have traditionally been characterized by a greater degree of public integration. Britain is a typical

example of a system where the degree of integration of ambulatory care has actually increased since the early 1990s. As part of the introduction of the internal market, many GPs chose to become 'fund holders' and were given budgets to purchase diagnostic procedures and elective surgery for their patients. GPs thereby extended their managerial responsibilities beyond their own practice and moved closer to the mainstream of NHS management. The reforms under the New Labour government in 1998 took this development a step further. General practices became part of Primary Care Trusts, which are responsible not only for the provision of primary care but also for the commissioning of all other health services within a certain area (Peckham and Exworthy, 2003). GPs now work within an organization that is directly funded by and accountable to government. The Minister for Health appoints the chief executives of Primary Care Trusts and the Trust is subject to government guidance in the same way as hospital trusts. For example, the Primary Care Trusts have to follow the National Service Framework that includes guidelines about appropriate care for individual patients and preferred service models (Checkland, 2004). In short, government control over medical work in primary care has increased, pointing to the contingency of medical authority (Harrison and Lim, 2000).

Reforming medical practice

Positioning doctors in the context of health systems provides a sense of the type of settings where doctors work. More importantly, this also gives an insight into the relative permeability of medical practice when it comes to reform. Considering the centrality of doctors in the allocation of health care resources, any reform will, directly or indirectly, affect the practice of doctors. Measures to control expenditure at the macro-level are increasingly complemented by measures to control the allocation of health care resources at the micro-level, and it is these measures that can be expected to affect doctors most directly. Reforms directed at the micro-level have included changes to how doctors are paid (discussed in the next section), restrictions on available treatment and measures of quality management such as medical audit, clinical standards and, more recently, evidence-based medicine.

In any publicly funded health system, available treatment is naturally restricted in terms of both the range and the volume of services. By virtue of being contract based, social insurance systems such as those in Japan, Germany and the Netherlands have traditionally spelled out more explicitly what services are covered while the commitment to comprehensive coverage has remained more vague in national health services. In Germany, for example, the Social Code Book Five defines the scope of

social insurance, which is complemented by the more specific provisions of self-administration. In contrast, the national health services in Britain, New Zealand and Sweden are based on the duty of government to provide services as opposed on the right of patients to receive them. As Harrison (2001: 279) observes in relation to the British NHS, '[t]his enables governments to "cash limit" (that is, cap) increasing proportions of the annual NHS budget'.

Concerns about cost pressures and containment, together with the move to a public contract model in national health services, however, have put the issue of restricting treatment high on the political agenda. This is well illustrated by New Zealand's attempts to define core services discussed in Chapter 4 (p. 117). Similarly, in the case of Britain, resources became tighter and health authorities were encouraged to manage their budgets by setting priorities. At the same time, rationing received considerable media and academic attention and as a result probably lost its innocence (Harrison *et al.*, 2002). A recent example is the National Institute for Clinical Excellence. The use of scientific and evidence-based criteria is supposed to give the Institute legitimacy, yet its work is often associated with explicit, national rationing (Syrett, 2003). In contrast, market-based systems like those in the USA and Singapore are unlikely to set limits on particular treatments or on routes to those treatments that a patient might need if they have the resources or insurance to cover the costs.

Even in national health services the explicit exclusion of treatment is notoriously controversial among patients and doctors because such measures directly constrain medical practice. In contrast, doctors (by exercising clinical freedom) have traditionally been secret accomplices in the rationing of health services (Harrison, 1998). By providing a medical rationale for the necessity of treatment in individual cases, doctors have given legitimacy to implicit rationing. Nevertheless, the alliance between doctors and the state has become fragile, reflecting more assertive and demanding patients, government challenges to medical autonomy as well more general cost concerns. In the case of Britain, for example, the national contract previously stated only that GPs had to provide their patients with 'all necessary and appropriate care'. In contrast, the latest contract from 2003 is more specific and lists the type of services GPs have to provide (Baggott, 2004).

The emergence and prominence of quality management in recent years has to be seen against the background of the controversies surrounding the explicit restrictions of available treatment and potentially challenges existing mechanisms for regulating medical work (see Box 5.2). Quality management promises to square the circle between restricting treatment, while at the same time ensuring the quality of health care and allowing for (and even using) medical judgement (Harrison, 1998). This solution is

Box 5.2 Professional self-regulation of medical work

Professional self-regulation has been the traditional approach to setting and ensuring standards of medical practice, and involves licensing and (by implication) education and training. Further, self regulation is a key indication of the 'professionalism' of doctors and is at the centre of the regulation of competitive practice in medicine (Moran and Wood, 1993). A typical example of professional self-regulation is the General Medical Council in Britain, which is responsible for keeping a register of doctors and for regulating their education, training and professional standards. The regulatory ideology underpinning the GMC has traditionally been rather narrow and isolationist and the Council has tended to focus on protecting doctors from market competition on the one hand and from interference from the state on the other (Moran, 1999: 103). Similar arrangements exist in Australia, Germany and the USA. However, as recent scandals in Britain have demonstrated, these arrangements are not necessarily successful at securing the quality of medical work and have led to policy reform. In Sweden and Japan, by contrast, professional self-regulation is less prominent. The bodies regulating medical work are government agencies that include doctors, but not exclusively so. In Sweden, for example, the Medical Responsibility Board, a government agency that assesses and decides on complaints and instances of malpractice, consists of members drawn from different stakeholders in the health service, including county councils, municipalities, the unions of health professionals and the public, all of whom are appointed by the government.

politically attractive because it diffuses blame for potentially unpopular decisions away from government while safeguarding the autonomy of doctors over clinical decision making. In Britain and New Zealand the prominence of quality management has coincided with a move away from purely market-based reforms. The reforms of the late 1980s and early 1990s were built on the belief in the superiority of the market and business style management. In contrast, quality management redirects the attention to medical practice, though one that is expected to adhere to explicitly defined standards. At the same time, the introduction of market mechanisms itself has stimulated the development of mechanisms of quality management. As Herk *et al.* argue in the case of the Netherlands '[t]he increasing importance of health insurers as negotiating partners of the providers put[s] increasing weight on measurable quality, on quality indicators, which could be objectified and specified in contracts' (2001: 1726). Initial legislation on quality goes back to the mid 1990s, but following limited implementation the government put renewed emphasis on quality and in 2004 introduced new, compulsory measures supervised by the Inspectorate of Health Care (Exter *et al.*, 2004).

The medical audit has been a long-standing measure of quality management. As an instrument to systematically evaluate clinical care and increase the accountability of doctors, it has been promoted heavily by governments. However, as Herk *et al.* demonstrate in their comparative study of the Netherlands and Britain, medical audit demonstrates 'the capability of the [medical] profession to maintain autonomy through re-negotiated mechanisms for self-control' (2001: 1721). As part of this process, professional controls have become more formalized and the freedom of individual doctors is circumscribed by collegial regulation through peer review.

The case of the Netherlands is indicative here. The professional organizations of doctors took the lead in developing medical audit in the late 1970s and this helped the medical profession maintain control. Doctors are well represented on the board of trustees of the Institute for Quality Assurance in Hospitals, and while medical audit has become compulsory, doctors have remained responsible for its organization. The system of site visits as the predominant form of medical audit emerged in the late 1980s (Lombarts and Klazinga, 2001). This was a time of increasing public concerns over health care expenditure and related questions about the (economic) autonomy and accountability of hospital doctors. Here, doctors 'traded' peer-controlled quality assurance in exchange for the government not interfering with the income of specialists. External peers, under the auspices of the specialist scientific societies, conduct the site visits. Being doctor-led and owned the results of individual reviews remain confidential and the implementation of recommendations is left to the group of specialists itself. As Dent (2003) suggests, the development of clinical guidelines tells a similar story. The Netherlands was one of the first countries to adapt and widely implement clinical guidelines, although importantly clinical guidelines mostly have taken the form of consensus guidelines combined with peer review.

Developments in New Zealand have been similar, although the medical audit takes a more individualized form. Doctors on general registration must work under the general oversight of a doctor who holds vocational registration in the same branch of medicine. An overseer is similar to a mentor and assists a doctor in his or her continuing education and audit. Doctors report to the Medical Council, the professional self-regulatory body, every year as part of their annual practising certificate application and each year some will be audited to ensure they are meeting requirements. This enhanced rigour of regulation, combined with the removal of the disciplinary function from the Council to a separate tribunal, were major innovations of the Medical Practitioners Act 1995.

However, in other countries, such as the USA and Australia, doctors have been less successful in exclusively controlling medical audit. The expanding role of Medicare and Medicaid in the USA has increased

federal government activity through regulations and audits for hospitals that have Medicare/Medicaid patients (which means virtually all of them). The states, however, remain the key players in setting and enforcing quality assurance standards for doctors, hospitals and nursing homes. Although the rigour of such programmes varies by state, as noted above, concerns over cost containment have put great emphasis on quality and efficiency. The implementation of quality programmes is in the hands of State Medical Boards, which are government agencies dominated by doctors. This means that doctors have considerable influence over quality programmes, but enjoy less autonomy compared to doctors in the Netherlands and New Zealand.

In Australia, medical acts in each state also provide the principal control over the practice of medicine and conduct of medical audit, and are administered by state medical boards that are similar to the boards in the USA. Furthermore, in the early 1990s legislative action was taken to facilitate the monitoring of doctors in specified areas by the Health Insurance Commission under the Medicare programme. Doctors suspected of excessive ordering are referred to the Medical Services Committees of Inquiry, although the test of whether a particular treatment is acceptable practice falls on local medical community standards, which vary considerably across states (Palmer and Short, 2000: 195ff.). Nevertheless, this is an example of a quality programme that is clearly controlled by the payers of services rather than by doctors as the providers of services (see Box 5.3).

Box 5.3 Australian Primary Care Collaborative Program (APCCP)

The national APCCP is a large-scale coordinated programme of rapid change management to improve service delivery in general practices across the 4,300 general practices in Australia. The Divisions of General Practice are designated as the local organizers of the collaboratives. The Programme's initial objective is to involve 600 general practices, representing 20 percent of the practices in each geographical location. It is being funded under the Primary Care Providers Working Together component of the Focus on Prevention funding package and is managed or commissioned by the Primary Care Quality and Prevention Branch of the Australian Department of Health and Ageing. The National Primary Care Collaboratives aim to improve care in national priority disease areas, provide greater integration among providers in the primary care sector, and focus on prevention through better chronic disease management and accessible primary health care.

Source: Bertelsmann Foundation (2004e).

In some ways, clinical guidelines are the natural extension of medical audits because audits assume the existence of standards of good practice against which performance can be judged. Significantly, guidelines have become increasingly evidence-based, and '[t]he emphasis shifted from professional consensus to systematic evidence or from professional endorsement to authority derived from science' (Herk *et al.*, 2001: 1728). From the perspective of doctors, evidence-based medicine is ambivalent (Berg *et al.*, 2000). Evidence-based medicine promises to strengthen the scientific nature of medicine by reducing unwarranted variation in diagnostic and therapeutic practice. At the same time, guidelines encourage a standardized approach to practice and as such limit the leeway for professional judgement. Reflecting this ambivalence, Harrison (2002) suggests that clinical guidelines are part of a 'scientific-bureaucratic' model of medicine that gives primacy to knowledge derived from research and distilled into guidelines of best practice. Developments in Britain and Sweden illustrate the move to clinical guidelines, although initial rationales for introducing guidelines differed.

In Britain, setting, measuring and improving quality standards has been one of the priorities of the Labour Government. At the centre is a system of 'clinical governance' designed to set and monitor clinical standards (Salter, 2005). NHS managers are responsible for clinical quality, putting particular emphasis on cost-effectiveness. This builds on systems of medical technology assessment developed throughout the 1990s but, in contrast to its predecessors, the Labour Government established a set of institutions that supposedly ensures professional compliance (Harrison, 2002; Harrison *et al.*, 2002: 13). The National Institute for Clinical Excellence plays a central role in this and is responsible for evaluating new technologies and care guidelines with regard to their clinical and cost-effectiveness. As such, conflicts between medical and economic rationality are embedded in the Institute's work (Butler, 2002; Syrett, 2003). The Institute can rule against treatment that is proven clinically effective on the basis that the costs to the NHS are disproportionate to the long-term benefits. Technically, doctors can choose not to follow NICE guidance, although in practice this will be difficult. The establishment of NICE in 1999 must be seen in conjunction with the development of the National Service Framework which sets out patterns of care for specific diseases, disabilities and patient groups, and the establishment of the Commission for Health Improvement which is responsible for monitoring and improving standards at local level (Salter, 2005; also Dent, 2003).

In Sweden, by contrast, the development of quality standards was initially underpinned by the intention to counterbalance the increasing decentralization of the health system. The debate on quality assurance was initiated in the mid 1980s by a government agency, and the National

Board for Health and Welfare emerged as one of the key actors in quality management. The Board became responsible for collecting data on health outcomes and good practice and intensified its monitoring of health care personnel and health care providers. For the government, quality management became a 'new means of influencing and monitoring health care' (Garpenby, 1999: 409). Significantly, and in line with the emphasis on consensus building, national agencies only provide general guidelines, leaving considerable space for doctors to develop strategies independently at the local level (Garpenby, 1997: 197). At the same time, although doctors do not have any formal representation on the relevant government agencies and consultation committees, the Medical Quality Council, a body set up by doctors, serves as a pool for recruiting individual doctors into these agencies and committees.

Medical care is at the centre of health reform, reflecting the centrality of doctors in the definition, provision and allocation of health care resources. Macro-level reforms have increasingly been complemented by micro-level reforms which affect the practice of doctors more directly. However, the picture that emerges here is ambivalent. Doctors are certainly under greater pressure to account for their practice, but the turn to quality provides an opportunity for doctors to appropriate measures of control. In many ways, quality management marks the rebirth of medical practice, although under different, more closely defined terms.

Paying for medical care

How doctors are paid is not merely a technical issue; in fact, systems of remuneration are important pointers to power and are at the centre of the regulation of doctors (Moran and Wood, 1993). Power here refers to the privilege of doctors to be rewarded according to the medical treatment they provide. Systems of remuneration can either sustain or constrain this privilege (for an overview, see Jegers *et al.*, 2002). The fee-for-service system, under which doctors are paid for the individual services rendered to patients, supports this type of medical privilege most extensively. In contrast, with payment by salary there is little connection between the services rendered and the payment received by doctors. Between these two extremes is payment based on capitation, whereby doctors are paid according to the number of patients registered with their practice. Typically, hospital doctors receive a salary, whereas office-based doctors are paid on either a fee-for-service or a capitation basis. In addition to systems of payment, another indication of medical power is the role of doctors in the determination of fee schedules and payment structures.

Table 5.5 *Types of payment for different types of doctor*

	Predominantly salaried	*Predominantly capitation payments*	*Predominantly fee-for-service payments*
Ambulatory care doctors	Singapore (public) Sweden	Britain Netherlands New Zealand	Australia Germany Japan Singapore (private) USA[a]
Hospital doctors	Australia Britain Germany New Zealand Singapore (public) Sweden	Netherlands (lump sums)	Japan Singapore (private) USA

[a] The USA is undergoing a shift due to HMO movement but is still free-for-service based.

As Table 5.5 illustrates, the payment of doctors is characterized by variation and includes unexpected cases, such as salaried office-based doctors (in Sweden and in public health centres in Singapore) and hospital doctors paid on a fee-for-service basis (in Japan, the USA and in private hospitals in Singapore). Significantly, however, in most cases pay is not directly related to the volume of services, and even where this is the case, there are limitations on payments. If power refers to the privilege of doctors to be rewarded according to the medical treatment they provide, medical power is restricted.

Concerns for cost containment are likely to direct the attention to systems of remuneration, especially in countries (including Australia, Germany, Japan and the USA) where doctors are paid according to the volume of services provided. Germany and the USA are classical examples of the fee-for-service system and also illustrate its problems. In Germany, the Uniform Value Scale (*Einheitlicher Bewertungsmasstab*) lists the services that are reimbursed by health insurance funds, together with their relative weights for reimbursement, which are measured in points. The monetary value of each point varies and depends on the total reimbursement agreed by self-administration at state level on the one hand, and the total volume of services provided by doctors on the other. This constrains the total expenditure on ambulatory care, although not necessarily the incentive to maximize the volume of services at the level of the individual practice.

Nevertheless, the fee-for-service system in Germany remains problematic from the perspective of cost containment and has undergone several changes in recent years. Fee negotiations take place within legally set limits and there is a maximum ceiling for the number of points that can be reimbursed per doctor. In addition, doctors may be subject to utilization review, either randomly or if their levels of service provision are significantly higher than those of their colleagues. This has been accompanied by measures to change the system of payment itself including rewards for particular specialties (GPs in particular) and specific services (e.g. counselling rather than medical testing), together with blanket payments for certain sets of services.

Contraints also exist in the fee-for-service system in Australia. With the introduction of Medicare in 1984/85, Australia adopted a bulk billing system of payment under which a GP can choose to bill the government directly and receives 85 per cent of the scheduled fee thereby avoiding administrative costs and delay. This also ensures that services are effectively free to the patient at the point of service. However, if the GP chooses not to bulk bill or chooses to charge patients a co-payment, the patient pays the bill and is reimbursed by Medicare for 85 per cent of the scheduled fee. Although the proportion of bulk billing increased steadily until the mid 1990s, it declined significantly after 2000 (Swerissen, 2004). In response to concerns about the fall in the bulk billing rate, the Commonwealth Government proposed a Fairer Medicare later implemented as Medicare Plus. This package introduced a participating practice scheme under which GP practices that agreed to charge a no-gap fee to concessional patients were eligible for increased Medicare rebates for these patients.

In the USA, controlling doctors' pay is even more difficult. Ambulatory-care doctors are paid through a combination of methods, reflecting the fragmentation of health care funding. Fee-for-service payments include charges, discounted fees paid by private health plans, capitation rate contracts with private plans, public programmes and direct patient fees. However, the growth of Health Maintenance Organizations and other managed-care schemes has resulted in changes in the methods of payment away from fee-for-service reimbursement. HMO doctors may be salaried, paid a fee for service, or a paid a capitation fee for each person on their list. However, often there are financial incentives to the doctor to reduce services to their patients. A variation of the HMO is the Preferred Provider Organization (PPO) in which a limited number of providers – doctors, hospitals and others – agree to provide services to a specific group of people at a negotiated fee-for-service rate that is lower than the normal charge.

By contrast, in Britain, the Netherlands and increasingly also New Zealand ambulatory-care doctors are paid predominantly on a capitation

basis, allowing for much more direct control of doctors' remuneration. Britain is typical here, and fixed sums per patient are complemented by allowances for providing enhanced services and for quality improvements.

In New Zealand, the capitation payments coexist with considerable co-payments, but this is changing. New Zealand's Primary Health Care Strategy (PHCS) was introduced in 2002 to reduce health disparities in access to general practice services and transformed publicly funded primary health care payments from targeted welfare benefits to universal, risk-rated insurance premium subsidies (Howell, 2005). Under PHCS, GPs are grouped under umbrella groups called Primary Health Organisations (PHOs) which are not-for-profit organizations funded on a capitation basis which contract with DHBs to provide a comprehensive set of preventive and treatment services for their enrolled populations. Government subsidies historically were paid on a fee-for-service basis targeted to low-income and high-risk people, but because the subsidy levels were not sufficiently tied to inflation and because GPs retained the right to set their own levels of co-payments, it resulted in a significant cost barrier to GP services for some people. In an effort to remove or reduce this cost barrier, the move to PHOs was also accompanied by the phased introduction of higher government subsidies for GP services and pharmaceuticals (Ashton, 2005).

Sweden is the only country where the majority of ambulatory-care doctors are public employees and paid a salary. This manifests the high degree of public integration of the health system, and doctors are firmly positioned in what is a very politically controlled health system (Garpenby, 2001: 263). In this respect Dent (2003: 53) suggests that the medical profession in Sweden appears more like civil servants than autonomous professionals. However, private providers of ambulatory care do exist, particularly in major cities, and their numbers increased after the introduction of patient choice for family doctor in the early 1990s (Harrison, 2004; Harrison and Calltorp, 2000). However, that scheme was abolished after a few years, reflecting the return of the Social Democratic Government and the fact that the emerging competition among doctors for funds threatened existing health centres. The providers are private in that their facilities are privately run, although the majority have contracts with the county councils. In 2003, a third of health centres and practitioners worked in privately run facilities (Glenngård *et al.*, 2005).

Unlike ambulatory-care doctors, hospital doctors tend to be salaried employees, although in many countries they have the right to treat private patients who represent an attractive source of additional income since services are often paid for on a fee-for-service basis and remuneration tends to be high. In Britain, for example, the right to practise privately was the condition on which hospital doctors agreed to become

part of the NHS when it was set up in 1948. Hospital doctors were initially opposed to a tax-funded health service instead advocating the extension of the existing health insurance system, but they were won over by a number of concessions. Besides private practice and pay beds, they received large increases in salaries for those receiving distinction awards. This led the then Minister of Health to remark that he had 'stuffed their [the hospital doctors'] mouths with gold' (Abel-Smith, 1984: 480, quoted in Ham, 1999: 11). Senior hospital specialists are allowed to earn up to 10 per cent of their income from private practice, while there is no limit for specialists on part-time contracts.

Notable exceptions are the Netherlands and Japan, where hospital doctors are paid on a fee-for-service basis. In the Netherlands, medical specialists have traditionally been independent practitioners who have 'bought' the right to practise in a hospital and who practise in partnerships. As such, they contracted directly with patients and insurance funds and are reimbursed on a fee-for-service basis separately from the hospitals. However, this changed in 2000 and now doctors receive a lump sum directly from the hospital in which they practise. As a result, specialist medical services are now an integral part of the hospital contract and budget (Harrison, 2004), thus potentially providing a leverage for hospital managers to exercise greater control over the practice of medical specialists (Trappenburg and Groot, 2001). In Japan, hospital doctors are paid by a national fee schedule, not surprisingly since many doctors work as private entrepreneurs running their own hospitals.

A case on its own is Singapore, where the form of payment depends not on the practice setting, but rather on whether doctors work in public or private health care facilities. Doctors in government-owned facilities receive a civil service pay scale plus a clinical supplement. Those with very heavy clinical loads may opt for an incentive based on their total billings in place of the fixed supplement. Private doctors are generally paid on a fee-for-service basis. The Singapore Medical Association publishes guidelines on fees for billing in the private sector.

The involvement of doctors in the process of determining pay is another indication of medical power. As Table 5.6 illustrates, there is some variation here. However, in large part salaries and capitation/fee-for-service payments are negotiated between doctors and the payers of health services, although there may be some restrictions as in the Netherlands. Even where the government alone decides, the decision may be based on a broad range of evidence as in Britain or be limited in scope as in Singapore. Significantly, doctors enjoy considerable power relative to pay determination, although they can rarely act alone.

In the case of salaries, the process of pay bargaining involves the pay negotiations where medical power depends on the relative strength of unions and employer organizations, together with the overall economic

Table 5.6 *The involvement of doctors in systems of pay determinations*[a]

	Salaries	*Capitation/fee-for-service payments*
Set by government	Britain (with review body as intermediary); Singapore (for doctors in public health facilities)	Australia (de facto); Britain (with review body as intermediary); New Zealand (de facto)
Negotiated between doctors and payers of health services	Australia Germany New Zealand Sweden	Germany Japan Netherlands (government approval required)
Set by doctors		Singapore (for doctors in private health facilities)

[a] The USA has been omitted from this table as the system of pay bargaining is too fragmented.

climate. An interesting exception is Singapore, where doctors working in public health facilities are paid on the basis of the civil service pay scale, which is set by government with little input from the medical association.

The situation is more complicated in the case of capitation and fee payments, as they are the basis for many rounds of future remuneration. Negotiations of this type generally require extensive bargaining to reach an agreement. Countries operate different kinds of decision systems, ranging from payments set by government and negotiated with doctors to payments set by doctors themselves. Britain provides an interesting example of the first variant where the government determines capitation payments and allowances for GPs and salary scales for hospital specialists though the Minister for Health normally takes into account the recommendations of the Review Body on Doctors' and Dentists' Remuneration. The Review Body is an independent agency that is financed by government. The government also appoints the members of the Review Body, usually with the approval of the British Medical Association. The recommendations of the review body are based on demands submitted by the professional organizations and the government as well as other input,

such as the budget plan and the evaluation of statistical material (see, e.g. Department of Health, 2006b).

By contrast, in Germany, Japan and the Netherlands doctors' organizations have more direct influence and negotiate directly with insurance funds as the payers of health services. However, in some cases the negotiation process has become curtailed in recent years. In Germany, for example, the autonomy of negotiations between doctors and insurance funds has been more constrained as control over funding has become more centralized (Rosenbrock and Gerlinger, 2004). This began with the introduction of legally fixed regional budgets for ambulatory medical care which replaced negotiated budgets after 1992. The regional budgets have now been substituted with a maximum ceiling for fees per doctor.

Turning to Japan, we have an example of a country where the influence of doctors on fee negotiations remains relatively unchallenged. The Japanese Medical Association (JMA) nominates all five doctors who sit on the fee-scheduling body and negotiates the fees with the Health Ministry's Health Insurance Bureau. The influence of doctors is further strengthened by the fact that '[i]n effect, those on the provider side must work through the JMA' since 'hospitals, pharmaceutical companies, and other important actors are not directly represented on the council' (Ikegami and Campbell, 1999: 63).

The organization of doctors' interests and access to the policy process

Issues around the practice and payment of doctors often concern medical practitioners as individuals. In contrast, the political organization of doctors' interests directs attention to doctors as a group and how doctors relate to policy process. The interests of doctors can be organized in different ways, through specialist scientific societies, professional associations and trade unions. An important indicator of power is the degree of cohesion (or fragmentation), that is, the extent to which a group of doctors speak with one voice, or at least with different voices complementing each other. This has become increasingly difficult as distributional struggles between diverse groups of doctors have intensified under pressures of cost containment. At the same time, countries offer dissimilar points of access to organized interests, reflecting the specific characteristics of the respective political and health systems. The power of doctors to a great extent depends on how states are organized and also on how powerful states are.

As Figure 5.1 suggests, in most countries the political organization of doctors is relatively cohesive with one organization acting as the main representative of doctors' interests. This normally goes hand-in-hand

		Access to policy process	
		As outsiders through lobbying	*As insiders through corporatism*
Organization of doctors' interests	*Cohesive*	Australia, Britain, Japan, New Zealand, Singapore, Sweden	
	Fragmented	USA	Germany, Netherlands

Figure 5.1 *The organization of doctors' interests and access to the policy process*

with a high membership among doctors. However, as Germany, the Netherlands and the USA show, divisions between different types of doctors have led to the fragmentation of the political organization of doctors. These divisions affect the distribution of financial resources and intensify under policies designed to contain costs. The relative collective strength of doctors coexists with varying degrees of access to the policy process, which as seen in Chapter 2 embody one indicator of how the power of the state is organized.

In most countries, doctors have to rely on lobbying the government from the outside. As Britain and Australia demonstrate, the extent of influence varies over time and the cohesion of interest organizations is only one factor. At the same time, lack of cohesion is not necessarily a bar to influence as the USA, Germany and the Netherlands demonstrate. The considerable influence of doctors in the USA reflects not only the economic power of the medical sectors, but also the weakness of the state in health governance. Germany and the Netherlands, to a lesser extent, are unusual in that doctors are an integral part of health governance and as such often have privileged access to the policy process. Being insiders gives doctors considerable influence, although this may come at the price of becoming agents of cost containment.

In the majority of countries the political organization of doctors shows a considerable degree of cohesion. This reflects a number of country-specific factors, including the type of political system and the size of the country. Cohesion can be expected to be most likely in small unitary countries such as New Zealand and Singapore. New Zealand, for example, has one primary medical association that has a high level of membership among doctors. The New Zealand Medical Association (NZMA) is a voluntary organization which claims membership of about 65 per cent of the country's doctors. As such, the Association has a broader-based

membership than many national medical associations, maintains formal links with affiliates including the Royal Colleges and specialty organizations, and acts as the primary representative of the profession in dealings with the government. The New Zealand GP Association (NZGPA) is an offshoot of the NZMA and mainly represents the interests of GPs, although it has remained closely linked to its parent body (Crampton, 2001).

Even in larger unitary countries the organization of doctors' interests can be cohesive. Britain is a case in point. The British Medical Association (BMA) is at the centre of the political organization of doctors' interests and more than 80 per cent of doctors are members (European Observatory on Health Care Systems, 1999: 22). The BMA acts in a dual role as a professional organization and as a trade union. As a professional organization, it promotes medical education and professional development, whereas as a trade union it represents doctors' economic interests. This de facto monopoly puts the BMA in a strong position in principle, but also requires the BMA to cater for a diverse range of constituencies within the medical profession. Here, conflicts between GPs and hospital consultants have been particularly prominent (Giamo, 2002).

Likewise, as Sweden and Australia demonstrate, a more decentralized political system is no bar to a cohesive organization of doctors' interests. In Sweden, more than 90 per cent of doctors are members of the Swedish Medical Association (Garpenby, 2001: 261). The Association acts as a type of umbrella organization and the specific interests of its membership are channelled through seven professional organizations and 28 local bodies. The Swedish Medical Association coexists with a range of scientific societies and while the Swedish Society of Medicine is the largest with over 60 per cent of doctors being members, the smaller specialist societies are the more influential actors (Garpenby, 2001: 264). The Medical Association and the Society of Medicine have different responsibilities, although in relation to some issues the two organizations compete with each other (Garpenby, 1999). In Australia, the Divisions of General Practice are local area-based representative bodies for GPs and their national body, the Australian Divisions of General Practice (ADGP), which has a growing policy presense.

In comparison to the countries discussed so far, the political organization of doctors in Germany, the Netherlands and the USA is more fragmented. The USA represents a case of fragmentation between generalists and specialists, which is exacerbated by federalism and the sheer size of the profession. Although less than half of all practising doctors are members of the American Medical Association (AMA), it remains a very powerful political lobby group with significant influence in Washington, DC, and the state capitals. Many specialty medical groups have been established which concentrate on their own interests, often in conflict with the AMA.

There are literally hundreds, if not thousands, of medical associations at the local, state and national level in the USA, and although the AMA is the single most influential, the voice of the medical community is considerably more diverse than in other countries.

Germany provides another example where the organization of doctors' interests is divided, not only between different types of doctors, but also between different types of organization. The *Marburger Bund* is the main professional organization and trade union for hospital doctors, but the situation surrounding ambulatory care doctors is more complicated. The vast majority of these doctors cannot exclusively rely on private practice and instead have to provide services under the social health insurance. However, this requires joining one of the regional associations of insurance fund doctors (*Kassenärztliche Vereinigungen*) which assume an intermediate position between doctors and the state (Rosenbrock and Gerlinger, 2004). As public law bodies, the associations have the statutory responsibility of ensuring the provision of ambulatory care and organizing the remuneration of doctors, including control functions such as assessing the economic efficiency of the performance of individual doctors. At the same time, they represent the interests of doctors when the associations negotiate contracts and fees with insurance funds. The tensions inherent in this dual role have become more prominent; and intensifying distributional struggles have made it more difficult for the associations to integrate the conflicting interests of their membership (Burau, 2001). The distributional struggles result from a combination of the increasing number of doctors, falling income and more extensive government control. The heightened conflicts have also negatively affected the division of labour between the associations of insurance fund doctors and the two lobbying organizations for ambulatory-care doctors.

The relative cohesion of the political organization of doctors is only one measure of collective power of the medical profession. Another, complementary, measure of power is the role of doctors in the policy process, and different health and political systems provide different degrees and types of access. This demonstrates how the power of doctors is tied to the power of the state. In most countries, doctors' organizations have access to the policy process as outsiders, mostly through lobbying and some informal consultation.

Britain and Australia, countries with tax-funded health services embedded in a centralist and a federalist political system respectively, illustrate the ups and downs of the influence of doctors. In both countries, the relationship between the medical profession and the state has traditionally been close. However, access to the policy process has largely consisted of lobbying and informal consultation. In Britain, the fragility of this type of access became apparent in the late 1980s. Reform efforts in part were aimed at weakening the role of the profession in the governance of health

care and this affected the influence of doctors in health policy, resulting in a widening rift between the parties. Significantly, the medical profession was practically excluded from the policy review that lead to a major reform in the early 1990s (Harrison, 2001). Similarly, Kay (2001) sees the conception, implementation and abolition of the GP fund holding scheme as an indication of the weaker influence of the medical profession. This stands in sharp contrast to the earlier corporatist settlement that was characterized by a strong insider role of doctors in government (Giamo, 2002). Similarly, in Australia, the Medical Association regressed from a comfortable corporate-style partnership to an awkward pressure group when the political struggles over national health insurance legislation erupted in 1972 (De Voe and Short, 2003). Government leaders faced strong opposition from key players in the health arena and created fractures in the medical establishment. This resulted in a realignment of the power structures in health policy.

In the USA, by contrast, the medical profession seems to have been more successful at maintaining its traditionally compelling influence over health policy. The medical sector is consistently ranked among the best organized and financed sectors in influencing politicians at the national and state levels by the Congressional Quarterly Service. This reflects the strength of the 'health care industry', which coincides with a policy process that is typically driven by lobbying and one where winning is largely manifested in blocking change.

In Germany, and to a lesser extent in the Netherlands, corporatism means that doctors are an integral part of health governance and this often gives them access to the policy process as insiders (see Giamo, 2002; Kuhlmann, 2006). However, as the example of Germany shows, even as insiders the influence of doctors is variable. Together with the insurance funds, doctors form a self-administration, which is responsible, not only for negotiating contracts, but also for implementing health care legislation. Here, the Joint Committee is key and responsibilities include defining the benefits catalogue, clinical guidelines and measures of quality assurance (see Busse and Riesberg, 2004). The role of doctors in the health system is highly institutionalized and codified in the relevant Social Code Book Five. In addition, the federal structure of health governance offers doctors multiple points of access. Significantly, however, doctors are involved in a public role granted to them by the state, and are not first and foremost involved as representatives of private interests. This can lead to the kinds of conflict of interest discussed above and can also constrain the collective power of doctors.

Over the last decade the federal government has expanded the scope of self-administration while at the same time circumscribing its activities. For example, the joint committee is now also responsible for evaluating the medical efficacy and economic efficiency of existing treatments.

Issuing such guidance may be subject to a timetable with the possibility of a unilateral decision by the ministry. The pendulum has swung from autonomous negotiations towards hierarchical decisions by the state (Burau, 2005; Luzio, 2004; Wendt *et al.*, 2005). The government has defined more precisely the substantive issues to be decided and has set deadlines by which agreement has to be reached. Doctors have become key agents of cost containment through self-administration precisely because the system of self-administration is adaptable and depoliticizes the implementation of potentially problematic policies (Giamo and Manow, 1999: 978). Yet, recent years have been characterized by a greater scepticism about the capacity of the Associations of Insurance Fund Doctors. Since it is now possible to complete contracts with specific groups of doctors rather than the Associations, there has been open discussion about abolishing the Associations (see Greß *et al.*, 2004).

Doctors, the state and health policy

Doctors are deeply embedded in health systems, and since the state looms large in health systems and policy, doctors inevitably have a close relationship with the state. This means two things: medical power will always be contingent on the state, but states cannot do without doctors. Light's (1995) notion of 'countervailing powers' offers one way of understanding the close, but above all changeable, relationship between doctors and the state. Here, medical power is seen to oscillate between highs and lows. Highs of medical power (dominance) produce imbalances and provoke countervailing powers originating from the state, third-party payers and patients. This in turn and over time weakens medical dominance and strengthens the power of the state.

In his discussion of the Foucauldian notion of 'governmentality' Johnson (1995) goes one step further and suggests that doctors and the state are inextricably linked through the process of governing. Johnson (1995: 9) observes that '[e]xpertise, as it became increasingly institutionalized in its professional form, became part of the process of governing'. It is impossible to distinguish clearly between doctors and the state: the state depends on the independence of doctors to secure its capacity to govern, a process through which doctors become agents of governing. However, acknowledging independence does not mean denying shifts in relations between the doctors and the state. Over the last two decades, states have become more interventionist, reflecting the need of states to assert their agency in times of concerns about costs. This has noticeably changed the institutional context in which doctors work, but, importantly, has not necessarily reduced their power (Moran, 1999).

Chapter 6

Beyond the Hospital: Health Care in the Home

Care outside hospitals has traditionally been the poor relation of health systems. Health systems are concerned first and foremost with the provision of medical care and focus on acute illness. Doctors are the key professionals shaping the delivery of health care and hospitals are the primary location. The emphasis is on *curing* as opposed long-term *caring*. Less acute, more long-term health care is typically characterized by considerable diversity in terms of the range of services, the user groups, the localities of service provision and the professionals involved.

Care outside hospitals includes basic care to help with daily living, mobility and self-care; medical and nursing care to help with physical and mental health problems; therapy, counselling and emotional support to promote well-being; and other social, educational and leisure activities (Tester, 1996). User groups are equally diverse and reflect the support required at different stages of the life span, ranging from severally ill infants to people at the end of life. Other beneficiaries include people with mental illness and handicap, physical disability, drug-related disorders and progressive illness (Means *et al.*, 2003). Care outside hospitals is also located in different settings, such as residential care and nursing homes, day hospitals and sheltered housing, as well as people's own homes. The professionals involved are equally diverse and include nurses, mental health nurses, care assistants, home helps, counsellors and physiotherapists.

The diversity of care outside hospitals reflects the varied yet interlocking needs of people who require long-term care. Diversity makes care outside hospitals interesting, but also difficult to define, analyse and compare. At the same time, care services are often locally specific and even tailored to particular individuals and it is difficult to identify the typical, let alone to generalize. For example, in their comparative analysis of community care policies in Finland and Britain, Burau and Kröger (2004) highlight the distinct local nature of policies together with the importance of local politics. Antonnen *et al.* (2003b) go even further and suggest that because of the interchangeability with informal care, the use of formal care services is highly individualized and does not follow any methodical patterns. Furthermore, although care services outside hospitals are central