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DOCTORS, POLITICS, AND PAY DISPUTES IN ADVANCED INDUSTRIAL COUNTRIES: AN ESSAY REVIEW AND A RESEARCH NOTE

Theodore R. Marmor

and

David Thomas

UNIVERSITY OF WISCONSIN - MADISON

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ABSTRACT

This paper comprises an essay review of Eckstein's classic work and a research report on investigations of payment disputes which the authors conducted in England, Sweden, and the United States, 1965-68. The first section discusses difficulties in Eckstein's research, particularly methodological problems that arise from the failure to use comparative data to test his hypotheses about the influence of the BMA on health policy. Secondly, this paper seeks to account for why governments pay doctors as they do. It evaluates the hypothesis that, among western industrial countries, widely known physician preferences on method of pay determine subsequent policy, whatever the bargaining arrangements and distinctive national political setting. Two bodies of data are used: primary studies of payment method decision in Sweden, England, and the United States, and secondary information on methods of payment employed throughout Western Europe compiled by Glaser. Both bodies of data proved consistent with our factual hypothesis. The explanation offered stresses the structural imbalance between the political resources of physicians and governments on questions of payment method. This account has policy implications quite different from those stressing the impact of bargaining forms and settings in payment method decisions; it implies that governments should not concentrate on changing methods of pay to reform health policy, but should use other policy instruments to accomplish reform goals.

Doctors, Politics, and Pay Disputes in Advanced Industrial Countries: An Essay Review and a Research Note

Studies of medical politics usually emphasize one of the following types of inquiries: a) analyzing the internal politics of medical organizations, as with Oliver Garceau's classic study of the American Medical Association;[1] b) describing and explaining the roles individual physicians play in the political life of the community as voters, officials, or citizen participants in civic life;[2] or, c) assessing the impact of medical groups and organizations on public policy, particularly health policy.[3] Harry Eckstein's widely known study of the BMA is primarily a study of the third type, a discussion of the channels of influence, the tactics, and the effectiveness of the British Medical Association in shaping public policy to their ends.

This paper comprises an essay review of the Eckstein work and a research report on medical payment disputes which the authors conducted in England, Sweden, and the United States, 1965-68. The research report tentatively suggests ways to correct the difficulties we identify in the Eckstein research, particularly problems that arise from Eckstein's failure to use comparative data to test his hypotheses explaining the influence of the BMA on health policy. Our larger concern, of which this study is a part, is an investigation of the outcomes of conflicts over the methods by which doctors ought to be paid in western industrial countries. England, Sweden, and the United States provide the primary comparative data, but we fortunately have extensive secondary evidence on other countries from the recently published work by William Glaser, Doctors Pay, (Baltimore: Johns Hopkins Press, 1970). The first section discusses the Eckstein

book; the second presents our preferred research alternative. Interspersed are responses to the criticisms Professor Eckstein has made in reaction to our paper.

I.

In pursuing the comparative politics of medical remuneration we turned naturally to Eckstein's pioneering study; for our purposes that work proved to be both unclear and incorrect. We here will concentrate on only one part of the Eckstein analysis: his attempt to theorize about the effectiveness of the BMA in influencing public policies that affect the interests of English physicians. Eckstein is concerned about other matters as well, in describing and accounting for the form, intensity and scope of the BMA's pressure group politics, and in purportedly broader generalizations about groups of which this is a case. We shall comment on the latter issue as well but the former questions will be considered here only insofar as they pertain to the issue of BMA effectiveness. Our objections to Eckstein's work are both methodological and substantive.

Eckstein is interested both in why, in general, pressure groups are effective and why, in particular, the BMA appears to have been extremely successful in influencing the nature and scope of governmental health policies. He uses two case studies of past medical conflicts to "illustrate" his general theory. He states, quite emphatically and correctly, that "case studies never 'prove' anything; their purpose is to illustrate generalizations which are established otherwise, or to direct attention towards such generalizations."[4] But there is more to the relation of case studies and generalizations than that. This paper first considers the general theory of effectiveness offered in the

opening section of Pressure Group Politics, and then assesses the account of BMA effectiveness by considering both Eckstein's own illustrations and evidence beyond his study on the general practitioner crisis, 1965-66.

Eckstein, despite his broad interest in pressure group influence, is not clear about what it would mean for a pressure group to be "effective" at all. Rather, he catalogues the "factors" which are determinants of whether such a group warrants such a description. It is uncertain whether Eckstein considers the satisfaction of group goals as the criterion of effectiveness, or whether the ability to triumph over the conflicting goals of other actors is the chief standard. This conceptual vagueness about effectiveness is a considerable handicap in evaluating Eckstein's work, though one could assess his theory for these two of the possible meanings of effectiveness: satisfaction of goals, and satisfaction of goals over opposition from the government or other groups. Despite this conceptual difficulty, Eckstein is convinced, he is presenting an hypothesis about the effectiveness of all pressure groups, a set of general statements connecting various features of the political environment with the policy outcomes that measure the effectiveness of the pressure group.*

What is the character of this theory? This question should be examined before looking at the case study application. "Factors determining the effectiveness of pressure groups," we are told, "may be classified under three headings: (a) attributes of the pressure groups themselves; (b) attributes of the activities of government; (c) attributes of the governmental decision-making structure."[5] Now it is not clear what kind of statement this is intended to be. Eckstein likely intends it to be an

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hypothesis.[6] Language such as "factors determining the effectiveness" would seem to so indicate. Such language conjures up the prevailing hypothetical-deductive model of scientific explanation, which Eckstein surely accepts. Yet on its canons this is scarcely an hypothesis at all. Is it falsifiable? What would it mean to say that the "attributes of the pressure groups themselves," plus the other two "factors" did not affect the effectiveness of given pressure group? These factors encompass virtually the range of plausible causal possibilities, but they are not marshalled in a significant, determinate relation.

In fact, this is a pre-theoretical rather than a theoretical formulation.[7] It is a very general set of categories in terms of which data may be set and hypotheses cast. The categories may or may not be useful; that can be decided only by using them determinately. To this end we need, for instance, an assertion about a specificable relationship between the structure of government and the activities of pressure groups that in principle is falsifiable, that is, for which one could imagine contrary evidence.

The attributes of the pressure group itself constitutes Eckstein's first class of factors. Rich or poor, large or small, centralized or decentralized--such group features may be important, but to list them is not to make an hypothesis about pressure group effectiveness. Eckstein states, "certain characteristics of groups are likely to determine decisively their effectiveness under almost any pattern of policies or structure of government (popular government, of course): for example, physical resources, size, organization, cohesiveness, and political skills."[8]

One can imagine hypotheses which employ some of these features as independent variables and make testable claims about their relationship to dependent variables like "effectiveness." But stated in this way, Eckstein's formulation does not constitute an hypothesis at all; it is only a catalogue of possibly relevant phenomena. The same criticism applies to the two other classes of "factors" determining pressure group effectiveness, but it is redundant to repeat the above analysis for them.*

Eckstein does indeed make a number of very specific observations under these headings, but in their ad hoc character they do no more than marginally increase the plausible utility of the categories. The movement in Pressure Group Politics from the very general to the very concrete neglects the vital need for mediating, determinate connectives. In a later work, Eckstein complains about those social scientists who "save" their hypotheses by redefining them in the face of unexpected factual findings.[9] One might say that Eckstein himself has not so much saved his hypotheses in the BMA study as innoculated them against the test of proof or disproof.[10] In short, no body of data could be appropriately manipulated to prove or disprove Eckstein's claims at this general level.

Thus far, we have discussed one of the major difficulties in Eckstein's study: the lack of a usable theory of pressure group effectiveness. We will now turn to the relationship between hypothesis and evidence in the case studies Eckstein presents. Discussion will focus on the implicit hypotheses which Eckstein actually employs instead of the above "theory." We will then show how the failure to use comparative data accounts for those problems in Eckstein's case studies which are not attributable to the general scheme.

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II.

Two chapters, each containing a detailed and fascinating history of a prolonged negotiation between the BMA and the Ministry of Health, are devoted to illustrating Eckstein's general comments about the effectiveness of the BMA. The general characterization of BMA-Ministry relations is that they are "intimate," ("on the whole, strikingly close and friendly")[11] and that this feature of intimacy is causally important. The BMA, while not always getting its way, exerts a substantial influence on medical policy, and this indisputable finding is accounted for in large part by what Eckstein describes as the continuing, close relations between the pressured and the pressurers.

What has this intimacy of relations to do with particular failures and successes of the BMA? The bitter, intense dispute over remuneration 1950-51 is offered as an illustration of a BMA "failure." Now here Eckstein is either stipulating a highly idiosyncratic meaning of failure or using the word incorrectly. For, measured by the demands the BMA made for payment, the Dankwerts award was an extraordinary success, giving the doctors more than their negotiators had demanded, though the basis of the grant was the same: the Spens Report and the government's original promise of large raises over prewar incomes and changes in the scheme of distribution.[12] How can this success be considered a failure? Only by positing a goal which the process of bargaining frustrated: the goal, in this instance, of keeping negotiations over remuneration a matter of BMA-Ministry bilateral relations without the use of arbitration. The pay dispute negotiations were terminated and Justice Dankwerts arbitrated; the BMA was not opposed in principle to arbitration, making the Eckstein characterization of the case all the more problematical. The lesson, which our interviewees in the Ministry of Health

learned, was that it is extraordinarily expensive to have medical payment disputes arbitrated, the significance of which lesson was again to be evident to the Review Body award of 1966.

This case study of "failure" might have been more relevant to the isssue of BMA effectiveness if Eckstein had heeded the logical requirements of testing an hypothesis. This problem is particularly evident in the Eckstein discussion of the remuneration issue. If influence--or effectiveness--is defined as the capacity to get opposed others to do one's bidding, the analyst must be clear about the conflict of goals and the degree to which a given outcome can be attributed to the activities of the influencer. Otherwise, influence and satisfaction become synonymous. Prescribing for political scientists, of course, is considerably easier than performing these tasks. It nonetheless remains the case that an illustration of effectiveness will not emerge from an empirical study that neglects these logical requirements.

It is important here to explicate the relationship between attributions of influence and explanations of policy outcomes. The latter is a necessary requirement for the former. Unless one can account for why it was that an event or set of events did or did not take place, it is impossible to attribute "influence" at all. But beyond the causal account one must also have evidence about the intentions of the actors whose effectiveness or influence is being assessed. Because policy outcomes are involved in assessments of pressure group influence, one must therefore be clear about how one accounts for a policy outcome.

The first requirement is that one not look exclusively at final decisions. Decisions are about matters of dispute or uncertainty, and the

timing and breadth of considerations is a crucial element in the range of possible outcomes. Pressure groups may be thought to be engaged in influencing the policy-making process at three different stages:

a) the timing of disputes over relevant issues.

b) the range of matters at issue.

c) the decisions about those disputed matters.

Pressure group influence can be evaluated at any of these stages. Eckstein's view is that the intimate relations between the BMA and the Ministry best account for BMA successes, although he does not explicitly outline a scheme of the policy-making process. In any event, one cannot assess a pressure group's influence over public policy without accounting for outcomes at each of these three stages in the policy-making process. Having said that, and having shown that Eckstein's general formulation is untestable and his specific account of a BMA failure paradoxical, we will turn to the main hypothesis implicit in Eckstein's account of BMA activities.

In his introductory remarks, Eckstein pays equal attention to the attributes of the pressure group, the policy area, and the relevant decision-making structure as "determinants" of influence. In practice, however, he places special stress on the latter in explaining why the BMA does or does not get its way. Two features of the decision-making structure are, in Eckstein's view, crucial for the outcome: whether the dispute is carried out in <u>public view</u>, with other departments, large blocs of doctors, and the mass media anxious about and interested in the result, and whether BMA-Ministry negotiations are carried out in a <u>cooperative or disputatious manner</u>.[13] When BMA-Ministry negotiations are subject to "external pressures," both sets of officials lose their "normal freedom of accomodation," a

situation particularly the case in, as Eckstein puts it, that "touchiest of all areas of policy: remuneration."[14]

"Remuneration has remained the chief area of tension between the Ministry and the Association" he reaffirms.[15] What has this to do with the achievements of the BMA? We are told that the same "four basic factors which account for the BMA's failures also account for its achievements." This is a logical absurdity (X's account for both Y and non-Y); one cannot explain a variable by a constant.[16] Eckstein in practice does choose factors which operate selectively to promote success or failure. The degree to which negotiations are private and restricted to the BMA and the Ministry constitutes a resource for the BMA. The less constrained the Ministry is by the Treasury and various external publics, the more likely the BMA is to get its way. This is a testable hypothesis. In accounting for why the BMA got the Ministry to change its policy on redundant registrars in the early 1950's (his "successful negotiation" example), Eckstein specifically emphasizes the importance of the unpublicized private atmosphere of negotiations. The issue was "treated as a matter between the Ministry and the profession, even by the Treasury, for which the financial stakes were picayune. . .Under these circumstances, the powers of the profession were at their maximum, those of the Ministry at their minimum, and the final result. . .just what might have been expected (a BMA victory)."[17] How useful is this hypothesis in explaining policy decisions in the area of remuneration?

For the case Eckstein cites as a failure, his hypothesis does not hold. As he himself states, "Clearly, the BMA had the better of the argument in the end. Not only did it obtain the increase in pay it had

demanded for three years--indeed, slightly more than it had demanded--but it had forced the government to adhere to the Spens proposal, it had obtained arbitration, and it had gained the abolition of the much disliked basic salary."[18] So, "in the end," Eckstein concludes of the remuneration fight of 1950-51, the doctors "got what they wanted," and qualifications about their failure to keep negotiations "closed" do not change that signal measure of success.

On Eckstein's own evidence it was precisely this remuneration dispute that least conformed to the model of closed, intimate negotiations. According to Eckstein, "disputes over general practitioner remuneration which cannot be resolved by easy accommodation among the principal parties seem to be inherent in the National Health Service."[19] BMA members cannot be controlled by their leadership on remuneration issues and it is the one issue "on which the Ministry's freedom of action is sure to be restricted by powerful extra-departmental pressures."[20] With this characterization we agree. We disagree that the negotiations were a failure and therefore that intimacy of negotiation was a key differentiating explanatory factor.

III.

This section of this paper presents a research report on the doctors' pay crisis in Britain (1965-66) as well as commentary on both when and why the BMA is successful in getting its way on the methods and amount of its remuneration. We want to know--through the use of remuneration disputes in England--why it is that Eckstein's local, national explanation of BMA influence is faulty (the "closest imaginable relationship" between the BMA

and the Ministry). And we want to suggest, through the use of comparative data in Part IV, a more promising account of the unquestionable success doctors in Western Europe and America have in controlling the form and amount of their remuneration by the state.

Neither internal nor external evidence supports Eckstein's view that bargaining structures determine much of the British Medical Association's effectiveness. The internal evidence--remuneration disputes over time within England--already has suggested that intimacy of negotiations is not a crucial factor in accounting for BMA success on pay. External evidence is another check on this causal scheme. We have taken three countries for study--Great Britain, Sweden, and the U. S.--and analyzed three policy decisions about how doctors are to be paid by the state: (a) the changes in methods of remuneration following the general practitioner crisis (1965-66) in Great Britain; (b) the fee-for-service policy of the National Health Insurance Act in Sweden (1955); and (c) the Medicare "reasonable charge policy" in the U. S. Two features of this type of comparative study should be made clear at the outset. First, the countries differ markedly in the setting and atmosphere of negotiations about medical remuneration.[21] Secondly, the policy decisions in each case are strikingly similar, when measured by the intentions of the medical organizations. That is to say, methods known to be preferred by the respective medical organizations were, broadly speaking, what the government policy became in each of the three episodes. Here we have a common burden on a political system--the requirement of settling methods of remunerating physicians in public programs--and three different decision-making structures which cope with this burden.

The existence of a common outcome suggests that the causal factor lies in the first of Eckstein's three categories--the nature of the pressure group and the resources which doctors, as opposed to other producer groups in the society, share. The question of why it is that doctors in different national settings prefer different methods is a separate issue in the history and sociology of professions.* For present purposes, it is enough to know that knowledge of their preferences is the single best predictor of policy decisions in this area.

The politics of medical remuneration methods involves three separate areas of argument not all of which are equally at issue in remuneration disputes in the three countries. Method may refer to the unit of payment: whether by person, by item of service, by time, etc. The source of payment may be the method feature at issue, either in the sense of whether the patient should transfer funds to the doctor and be reimbursed by the public program, or whether the doctor should be paid by the state directly or by agencies mediating between the profession and the government. Finally, the bases of differentiating doctors for payment may be the issue; the dispute may involve whether age, training, setting of work, etc. should count in the amounts paid physicians. The political influence of medical organizations in remuneration policy may be understood as the ability of physician groups to raise issues, suppress issues, delimit alternatives, and produce desirable policy outcomes in these three types of conflict.

What does the British case of 1965-66 tell one about the influence of the BMA, when influence is understood in the terms suggested above? The very creation of a dispute was the work of the BMA, its answer to the Review

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* This is an issue which some sociologists have explored, particularly Mark Field and Talcott Parsons.

Body's decision in 1965 to give doctors a net 10% increase and to leave the methods of remuneration substantially unchanged.[22] No changes in unit, source, bases of differentiation were made in the 5th report of the Review Body on Doctors' and Dentists' Remuneration. Interviews with government actors suggest the conclusion that hesistancy about changing the methods of remuneration grew out of the unwillingness to pay the doctors in ways they themselves had not suggested. The response to the 5th Review Body Report was unexpectedly heated; the BMA asked for signed but undated letters of resignation from the National Health Service, and demanded that a complete review of methods and amount of remuneration take place. Approximately 16,500 of Britain's 22,000 general practitioners sent in these letters by March 17, 1965,[23] and the stage was set for raising a wide variety of issues about method and amount of state payment to general practitioners.

How did the BMA fare in delimiting the range of issues considered and getting its way on those which were at issue? On the question of the unit of payment, the BMA was able to get a consideration of all three of the typical possibilities: capitation, item-for-service, and salary. The outcome was, first, the continuation of capitation and, second, the expression of the Ministry's willingness to pay doctors in health centers by salary (subject to later negotiation). Finally, the government rejected the BMA demand that item-for-service payment be permitted. The latter result superficially suggests a BMA defeat. But it should be added that no widespread enthusiasm for item-for-service payment was evident in the profession, except among the numerically insignificant Fellowship for Freedom in Medicine. In the course of BMA-Ministry negotiations on units

of payment during the summer of 1965 it became clear that item-for-service recommended itself to the BMA only insofar as it involved lifting any ceiling on the income of doctors who used it. When the Ministry cited the case of dentists to suggest it would be unwilling to let amounts of remuneration expand without control, the BMA leadership quickly gave up. BMA leaders then asked the Ministry to write up its argument so that they could explain how unappealing the necessary control would be, and how irrelevant this means was to their general aim to reduce workloads, an aim unlikely to be satisfied if doctors' pay varied largely with respect to the incidence of their consultations. In this case, the issue of payment amount was dominant, both in the sense of the global increases attributable to this unit of payment, and in the sense of the uneven distribution of income which item-for-service payment would entail if it were not limited by an income ceiling.[24]

The source of payment was not raised as an issue during the course of negotiations, except for occasional laments that patients had no financial incentives to avoid excessive medical consultations. The profession was not interested in patients actually paying physicians. In England, payment by the patient was not so much an issue of remunerating doctors as controlling the distribution of medical services. The decisive argument raised against patient payment was that such pecuniary arrangements always present a dilemma. If costly enough to dissuade hypochondriacs, payment would also dissuade those who really needed medical attention. If inexpensive enough to avoid that latter problem, direct payment would not prevent nasty or casual consumers from pestering doctors. From a comparative standpoint, the

striking fact is that source of payment was not a controversial matter. Doctors raise this issue in both the U.S. and the Swedish context; in both cases the patient is involved in the actual transfer of money to doctors, a practice at the insistence of the medical organizations, and done against the original intentions of the government health reformers. In Great Britain, the source of payment is not a political issue in that there is no conflict over what source ought to be used.

But if there is consensus on the source of payment, there is disagreement between the BMA and the Ministry on what sorts of doctors ought to be differentially rewarded. This disagreement is evident on all three of the most common ways of discriminating one general practitioner from another: the nature of his output (health measure, quality), the nature of his practice setting, (shoddy, underdoctored, group) and the characteristics of the doctor himself (age, training, etc.). Since the Royal Commisssion (1957-60) there have been persistent attempts to reward something called superior general practitioners. Both the Ministry and the Review Body have encouraged this form of differentiation, using tactics from persuasion to ear-marked funds, as in 1966. The recent outcome-a rejection of ear-marked merit awards to general practitioners (by a BMA vote of 16,000 to 4,000) illustrates the capacity of the BMA and its membership to shape public policy. But note that merit awards represent a small expected expenditure, and as such fall under the conditions whereby the government is not constrained financially from conceding medical wishes on the methods of their payment.[25]

The use of merit awards is but one of the controversial ways by which physicians may be differentiated for payment purposes. Another attribute of the physician that the BMA has made relevant to general practitioner remuneration is age. Seniority payments have never been a Ministry of Health preference, and because such payments would have financial implications for a very large proportion of the participating physicians, they are worrisome from a budgetary standpoint. The fate of seniority payments during 1965-66 is an excellent illustration of the limited ability of the government to resist medical preferences on methods when the profession is acknowledged to be angry, militant, and prepared to create difficulties for the continuation of normal health services. The precise timing of the demand for seniority payments is difficult to establish, but it is absolutely clear that the BMA took the initiative in pressing for this type of differentiation during negotiations with Minister of Health, Robinson, in the summer of 1965. The Ministry, on the other hand, was anxious that differentiation by type of doctor should reflect differences in quality. Either subjective judgments of physicians or objective measures of training (to become better doctors presumably) were the preferred methods. In the end, the subjective judgment approach (merit awards) was rejected by a vote of the profession and the training criterion was incorporated into seniority payments. After a short delay, seniority payments would only be paid to those physicians who took a prescribed number of refresher courses. Here was a case in which the Ministry was able to add a quality consideration to a method of remuneration which only very indirectly measured ability (through experience) and were unable to get more direct measures of quality practice.

The same pattern is evident in the other methods of payment which the Ministry and the BMA agreed upon during the summer and fall of 1965.[26] Either the BMA was able to satisfy its charter demands fully, or the government, while agreeing in principle, placed constraints on the amount or scope of special payments. The BMA demanded full reimbursement for practice expenses, but the Ministry was unable to recommend this to the Review Body, arguing for some proportion below 100% to avoid the necessity of direct supervision of the expenditures and reimbursement. The BMA insistence on special payment for work outside the hours of a normal working day met with substantial, but not unlimited success. The government reluctantly agreed to pay physicians both for being responsible for patient cases between 8:00 p.m. and 8:00 a.m. and for actually going out on home visits between midnight and 7:00 a.m. The BMA had requested actual payment for any night call during the whole period outside the normal working day.

The evident pattern is that of the government intermittently qualifying or slightly adjusting the requests that the BMA makes on method. These requests may well be those which the government at an earlier date has suggested. But the timing of their serious consideration is determined by the BMA. In short, the BMA exercises both positive and negative influence, determing what is done through suggestion and veto. Typically, the government manages to get its way only when a preferred method of payment is known to be favored by only a small proportion of the physicians, as was the case in item-for-service remuneration. Only a small proportion favored salary, but the Ministry itself approved of this unit, and the lack of sharp disagreement produced the expected outcome. Until the profession had given up its crusade against salary, the Ministry avoided serious suggestion of it.

As with the old issue of salary, the very use of a pool in establishing a desirable average physician income was sacrosanct until the profession itself recommended its abolition. As early as 1960, discussions took place within the Treasury and the Ministry of Health on the anomalies of the pool. But the government refrained from suggesting to the Royal Commission that the pool either be done away with or substantially changed. Instead, discussions took place with BMA leaders on whether the pool would be changed so that practice expenses could be reimbursed more directly. Those discussions proceeded in the early 1960's, and there was substantial agreement by 1965 that this change should take place. When the profession took the view, after the crisis over the 5th Report, that the pool should be abolished, the government acceded to their wishes. Here was another illustration of the veto and initiating power of the professional organization. Since 1948 they had been able to foreclose the suggestion of doing away with the pool. In 1965, they were able to go beyond the limited Ministry suggestion of extracting practice expenses from the pool payments.

It is idle to provide further illustrations of BMA influence during the 1965-66 period. What should be clear is the basis for their successes. None of the variables mentioned by Eckstein changed between 1964 and 1966, except the constituency resources of the BMA. The style of negotiations leading up to the 1965 crisis was the same, regular consultations at the top floor of the Ministry of Health that took place in the summer of 1965. The Review Body was the authoritative decision-maker on the amount of payment both in 1965 and 1966. What had changed was the mobilization of professional

opinion. The threat to strike had intervened. The Ministry at no time was worried about the resignation of 17,000 doctors, and the BMA was never confident that more than a third of that number would actually go out of the NHS.[27] But the fear was that substantial sections of the country would be faced with a crisis of medical supply, that a government with only a bare majority would face a crisis of confidence. Even after the election of 1966 the government was not willing to face such a NHS catastrophe, although it is clear that some members of the Cabinet were willing to consider a rejection of the Review Body recommendations on amount, and hence the negotiated methods that had proceeded the determination of amount. But these pressures were, it appears, rejected almost as soon as they were brought forward.

The 1965-66 crisis represents an almost unbroken string of BMA victories. These victories support the hypothesis that doctors get their way on methods of payment when two conditions are satisfied: when intense and widespread doctors' preferences are known by the actors in the decision-making process, and when large additional public funding is not entailed. We would offer this hypothesis as one covering all medical-political systems in the democratic and developed world except Israel, where the relative oversupply of physicians reduces the threat of a breakdown in the public provision of medical care. In fact, large Exchequer contributions were also conceded in the 1965-66 crisis, but the victory on amount is <u>analytically and temporally distinct</u> from the policy changes on method. The granting of a 35% payment increases in the time of a general wage squeeze can only be interpreted as an extraordinary concession to medical demands. This is doubly evident when one considers that the

profession was given a 10% increase just a year earlier, and no criteria used to establish the 10% figure had changed to promote an upward revision; rather, pressure had arisen for lower payments to all government employees.

The comparative study of the U.S. and Swedish cases offers support for both the positive hypothesis and the rejection of the Eckstein emphasis on the "style" of bargaining in explaining medical policy decisions. In the United States, any method other than item-for-service payment was foreclosed by what might be termed tacit bargaining. The medical profession did not in fact take part in the detailed drafting of the Medicare law, and only consultation took place at the administrative stage in 1965-67. But the outcome was precisely what the AMA would have demanded had they been asked, and these implicit preferences were recognized by all the legislative and administrative actors concerned: a clear case of anticipated reaction. Interviews show that although many of the executive officials would have preferred other methods (a limited fee schedule), they were unwilling to precipitate an open dispute with the profession. And they recognized that members of the profession were not simply income maximizers (at least in the short-run) when they insisted that patients be permitted to be the source of payment under the Medicare program. A reimbursement plan (direct billing option) involved the possibility that some patients would not pay their doctors, while billing the insurance companies (assignment option) would have insured 100% payment, but up to the reasonable charge standard. The AMA contended the patient payment would keep the doctor further removed from the state. It also meant that some of the aged would be faced with either borrowing

the money to pay the physician directly or signing promissory notes to the physician. In either case, the doctor was trading off income certainty for a preferred source of payment and risking money losses for the gain of distance from the federal government program. However odd such insistence may appear by international comparison, this demand illustrates the goals of status and independence which doctors seek to maximize in payment method disputes. What they prefer for these ends varies with the cultural definition of status and independence. But that they seek non-income ends, and are successful in securing them against the insistence of the state holds for all three of the countries studied.[28]

The Swedish case testifies as well to the influence of medical organizations on payment policy. Without going into detail, it is apparent that the Swedish experience parallels that of England and the United States. The Swedish medical profession, a small and disciplined group, has obligingly accepted both a national health insurance scheme and expansion of its numbers, but has retained most of what it values in high status and remuneration. The SL has been successful at its attempts to retain a mixed system of employment and compensation methods. Options are kept open by retaining a sector of private practice not rigidly bound to a fee schedule. Thus, doctors both in the private and public sector, are able to retain an important bargaining lever, a lever that has been used by the SL to resist government sponsored schemes to increase ambulatory medical care in the hospital polyclinics.[29]

The very presence of similar successes of medical organization involved in very dissimilar political settings is evidence against the local explanation of Eckstein and support for the hypothesis we have put

forward. Decisive support would come from a comparison of effectiveness of those pressure groups which can withhold vital services (through limited substitutability or supply) and those (like teachers) who share national styles and methods of bargaining, but do not have the resources of a producer group like physicians.

It should be clear that the most promising tests of pressure group theory are not single country studies, but those which use the comparative data which, at a theoretical level, are the only type of data that could confirm hypotheses like those Eckstein has put forward. When one reviewer commented that the Eckstein book is an "excellent example of how to conduct a case study if it is to have analytic value,"[30] he was surely unclear about the logical requirements of a study of pressure group effectiveness. What Eckstein provides is a conceptual introduction which is little more than the substitution of words like "all" and "every" for singular pronouns referring to the British case. The book provides a case illustration of the use of a would-be universalistic theory which proceeds to individual cases without the intervention of comparative data and determinate hypotheses. As such, it is a book with a crippling methodological flaw. And since it is widely read as a description of medical politics, its assumptions and conclusion are legitimate objects of analysis for those interested in explaining public health policy decisions in Western Europe and America.

IV.

The Determinants of Government Payment Methods for Physicians: England, Sweden, and the United States

This section sets forth more formally our findings about medical remuneration disputes in the above three countries and assesses the implications

of these findings for scholarly analyses of health politics and future policy decisions about how doctors ought to and will be paid.

The method of paying physicians in government programs is an important political issue in every society in which there are substantial public programs of personal medical care services. The issue of method is important first because there are substantial conflicts over the appropriate ways of paying physicians, conflicts both between the state and medical organizations and within the medical organizations. Secondly, it is important because the preferences for particular payment methods are intensely held, particularly by physicians. Hence disagreement over how to pay doctors usually becomes not only a public issue, but a strikingly bitter type of issue. Finally, decisions about payment methods are important because they have significant financial implications for both the governments and physicians involved. Western industrial nations typically spend more than 5 percent of the gross national product on medical care services.[31] Health is thus a substantial industry within these nations; it is an industry with expensive component services, and the costs of those services are almost certainly going to continue to rise rapidly in the foreseeable future. As a result controversies over medical payment method are likely to continue to be deeply divisive and important. Increasing prices and their fiscal impact on public programs insure that much.

THE PROBLEM

This discussion focuses upon controversies concerning method of pay and does not concentrate on disputes over the amount of income doctors

should receive from the state. Both issues are important, and the decision to exclude the question of total payments in no way reflects the judgment that the latter topic is unimportant. The chief reason for excluding the amounts of payment as the object of investigation is that public decisions on methods of pay, while obviously affecting total expenditures, are not always about the amounts of pay that doctors receive. That is to say, governments make explicit decisions about the total income of physicians in some societies, or the total income physicians can expect to receive from the state. But this is not the case in all western industrial societies with substantial medical care programs. In some societies, notably the United States, decisions are in fact made about methods of pay (e.g., Medicare, 1965) and no explicit recognition is given to the likely implications of such methods for the total income American physicians will enjoy. The latter issue becomes important after use of payment methods generates unexpectedly high program costs, as for example took place in the United States after 1966.[32] Hence if one is interested in illustrating the workings of various political systems by taking into account the way they cope with a common burden, the common burden most easily discussed in the medical remuneration area is the public method of paying doctors, not the amounts paid.

All governments must make decisions about how doctors are to be paid, whether those decisions are negative ones to exclude alternatives or positive ones to select among logical possibilities one method rather than another. By method of payment we mean the unit of payment (by person, by item of service, by salary units), the source of payment (patient, intermediary, government), and the bases of differentiating doctors for

payment purposes (by type of practice, type of doctor, or type of result).[33]

Public medical care programs must answer, even though tacit acceptance, the question of which unit, which source, and which basis of differentiation are to be used in state payment of doctors. One way of framing the issue for comparative politics is to say: there are a finite number of logically possible units, sources, and bases of differentiation to be chosen among by governments. Among these options, governments must and do choose; hence the outcome of the decision process can be seen as the way by which a given political system copes with a burden common to a large class of political systems. Such studies offer the bases for estimating both the dterminants of payment method decisions, and, through comparative analysis, the constraints on what is not possible for western industrial countries to do in this controversial area of public policy.

CENTRAL ISSUES

The central research interest was in the following hypothesis: "Whatever the political and medical structure of a western industrial country, physician preferences determine the governmental methods of payments." This outcome takes place except when medical preferences expressed represent views known by both doctors and government bargainers to represent only a minority of physicians within the relevant physician group.*

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*A striking example was the demand for item of service payments made in the course of the general practitioners' crisis in England in 1965.[34] The British government knew that this demand did not represent a widely held physician preference; so did the British Medical Association. In the end, the British Medical Association, to deal with its militant members, asked the government privately to set forth in writing the reasons why such a unit of payment could not be granted.[35]

As producers of a crucial service in industrial countries, and a service for which governments can seldom provide short-run substitutions, physicians have the overwhelming political resources to influence decisions regarding payment methods quite apart from the form of bargaining their organizations employ. The hypothesis thus links directly the economic and political attributes of physicians to public policy outcomes, and asserts that the intervening bargaining variables are not central to explaining public policy decisions in this area. This hypothesis challenges the assumption that bargaining conditions are key factors in medical policy outcomes, an assumption set forth explicitly in Eckstein's Pressure Group Politics* [36].

The evidence gathered in the testing of this hypothesis is of two sorts. First, we have investigated the pattern of payment method decisions since World War II in three western industrial countries--Sweden, Great Britain, and the United States. Data from these countries include broad patterns of medical payment methods over time in the postwar period, reported in the secondary literature, and our own analysis of three extraordinarily controversial instances of payment method decisions in each of the three societies: the Medicare payment method decisions in the United States in 1965, the payment policy changes following the general practitioner strike crisis in Great Britain in 1965-1966, and the payment methods introduced at the outset of the Swedish national

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*Eckstein asserts that negotiations between the British Medical Association are typically "intimate," that the issues are "treated as a matter between the Ministry and the profession . . .the powers of the profession [are] at their maximum, those of the Ministry at their minimum" (8, p. 125). The two case studies Eckstein presents to illustrate this generalization provide ambiguous support. More important, varying the bargaining tactics and atmosphere across the three countries does not coincide with differences in medical influence on the salient question of payment methods.

health insurance program in 1955. The second major type of data collected was secondary analysis of payment methods used in other industrial countries, notably the Netherlands, West Germany, France, Switzerland, Spain, Italy, Canada, Greece, Poland, the Soviet Union and Israel.[37] We have considered our hypothesis in light of both the extensive secondary evidence and our fuller data on Swedish, English, and American decision patterns. We have analyzed the decisions on the basis of a model of payment method decisions, and tried to estimate the conditions under which the premises of the model are true--and hence the conclusion (our hypothesis) entailed. The model may be described as follows.

THE MODEL OF EXPLANATION

Premise 1. Doctors in western industrial countries prefer payment methods in public programs with which they were familiar before the onset of the public program in question.

Premise 2. Doctors are presumed* to be willing to strike over government efforts to change these familiar payment methods or to prevent changes which the overwhelming majority of the profession is thought to want and has expressed the desire for in programs outside the public sector.

Premise 3. Western industrial states will never risk a medical strike because of the high political costs associated with the interruption of personal health services, irrespective of government views on the merits of physician demands concerning payment methods.

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*The actors whose views are referred to here are government officials responsible for payment decisions concerning doctors. References to the government are broader, meaning the whole range of actors involved in the fiscal decisions of a modern industrial state.

Premise 4. Such governments, while often disagreeing with physicians and their organizations about desirable methods of payment, prefer gaining medical concessions on the amount of expenditures in exchange for concessions on methods of payment.

Premise 5. The failure to satisfy widely understood medical preferences on payment methods is presumed in western industrial countries to be the sufficient condition for a physician's strike.

Premise 6. In general, government medical officials prefer salary method of payment.

Conclusion: Hence, whatever the political and medical structure of the western industrial country, medical preferences determine the methods of payment used in public medical care programs (subject to the constraint cited above). Worldwide, the methods for paying physicians are extraordinarily diverse. What they share, however, is a remarkably close resemblance to what physicians were used to before programs began.[38]

The application of this model to the three national settings we have investigated highlights our disagreement with two prominent types of political science analysis:

A. Individual country studies cannot logically test the explanatory power of hypotheses which emphasize distinctive features of the individual political systems. On the basis of our model, the relevant structural attributes are the central elements in an explanation of payment method decisions by western industrial governments. If factors common to these countries account for common patterns of decision making, it is impossible to find this out by studying decisions of individual nations.

In addition, there is no way of testing the superfluity or centrality of one or another attribute of a political system in explaining the pattern of decisions within a nation in the absence of comparison.

B. Studies which focus on political culture as a causal variable are called into question by our model, or more precisely, by the data used in testing our model. Political culture may well be an important variable in the explanation of some public policies, but our findings suggest that the economic power of physicians is an overriding political resource which washes away the effects of both the bargaining styles employed by physician organizations and the attributes of the political culture such as mass and elite conceptions of the nature and legitimacy of physician demands.

THE EXPLICATION OF THE MODEL

We now want to turn to an explication of both the premises and conclusion of the model. First, in the most general terms, the argument is simply that doctors get their way on the methods of their pay. This generalization has very wide scope: the Western European industrial countries, North America, and the countries of the British Commonwealth at comparable levels of industrialization. The reason for this can be deduced from an analysis of the economic producer position of physicians (what it is they can produce, withhold, and whether or not their services are substitutable in the short run) and the ranking of goals on the part of bargaining antagonists, represented in the model abstractly as doctors and governments (see Figure 1). Generally put,

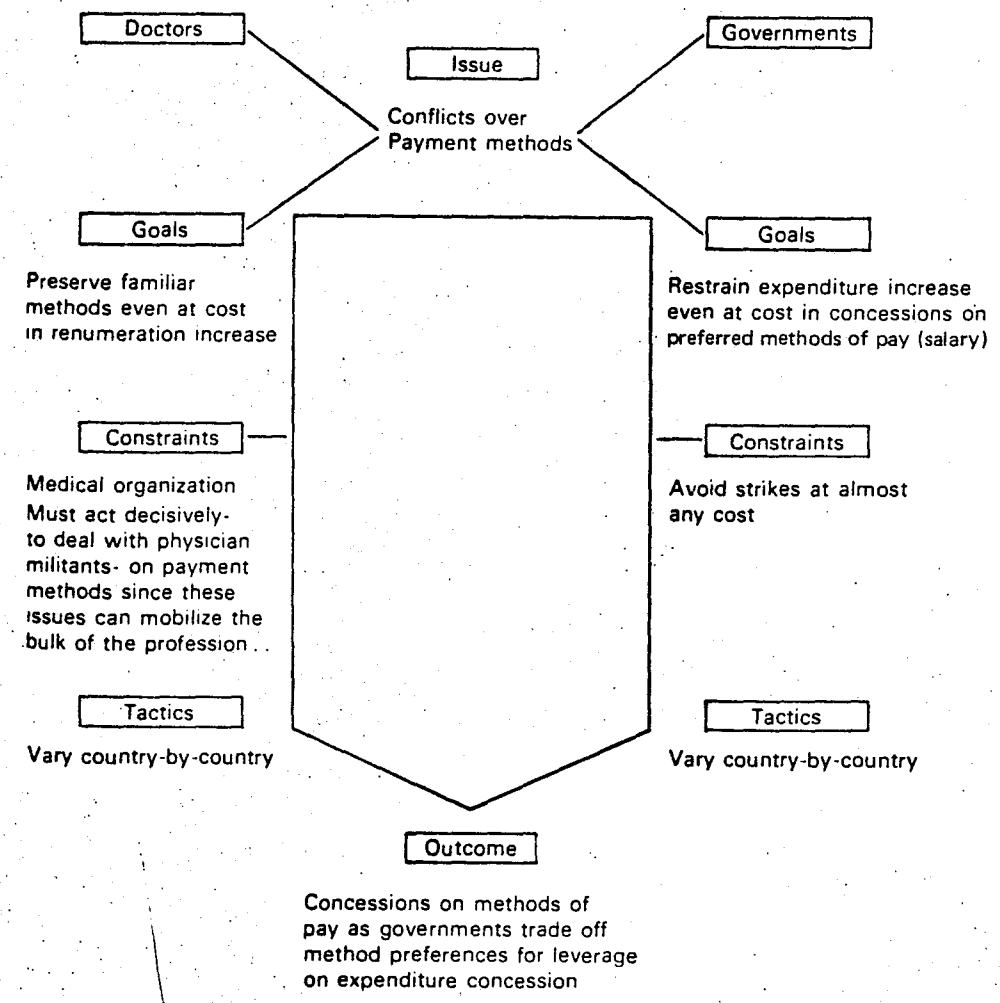
Doctors
Issue
Governments
Conflicts over
Payment methods
Goals
Goals
Preserve familiar
methods even at cost
in renumeration increase
Restrain expenditure increase
even at cost in concessions on
preferred methods of pay (salary)
Constraints
Constraints
Medical organization
Must act decisively-
to deal with physician
militants- on payment
methods since these
issues can mobilize the
bulk of the profession . .
Avoid strikes at almost
any cost
Tactics
Tactics
Vary country-by-country
Vary country-by-country
Outcome
Concessions on methods of
pay as governments trade off
method preferences for leverage
on expenditure concession

Figure 1.

we argue that the political resources of physicians in western industrial countries are so overwhelming that institutional differences among the countries are rendered unimportant in accounting for public policies regulating the payment of physicians.

These comments on the geographic and economic limits of the application of the model should be extended to discussions of the limits of the model related to timing. The conditions under which the hypothesis is most likely to be true are twofold: (1) the initiation of a public medical care program in which the political costs of noncompliance by doctors are at their highest, given the expectations aroused by the statutory enactment of such a program and the increased likelihood that opposing doctors could be mobilized in preventing the initiation of a program; and (2) circumstances in which mass physician protest is expressed, thus making salient again the possibility of a medical strike, a possibility that always exists on payment disputes, but neither is nor is perceived to be equally probable under all circumstances. A premise of the model is that a strike threat is a credible possibility. We argue that such a strike threat is always credible when traditional medical demands are violated or initiatives blocked, but that this constraint on government behavior is most evident at the time of mass protest or the initiation of a new public program.

Under what conditions are the other premises of the model true? Since the conclusion of the model follows logically from the premises, the description of the conditions under which the premises are true permits predicting the outcome we have described. Our factual premises

concerning the preferences of physicians and governments do not arise from either polling data concerning mass publics or structured interviews with a random sample of involved bureaucrats in the countries studied. Rather this distribution of preferences is inferred from secondary country studies[39] and interviews with key officials in England, Sweden, and the United States. We take confidence in these findings because only preferences widely understood are relevant to the model we have used. Typically, medical organizations and their government counterparts articulate the issues that shape medical care disputes. Our presumption about preferences is not restricted to these subgroups, but extends to widely held presumptions concerning the preferences of governments and doctors. Secondly, the description of preferences concerning methods of pay applies not to all features of the transmission of income from states to doctors, but rather to the three above-mentioned types of method issues. That is to say, preferences are relevant if and only if they deal with the unit, source, or basis of differentiation in the payment of doctors. Disputes about which unit to use whether, in England, for example, to pay general practitioners by salary or by capitation in the 1940s, exemplify the type of payment of issue for which the model is relevant. Disputes about whether or not physicians paid by salary ought to be compensated every week or every two weeks are not relevant to the model. In short, mechanisms used in the administration of the type of unit, source, and basis of differentiation are not subject to the constraints that the selection of the unit, source, or differentiation basis themselves are subject. We should add that why it is that doctors prefer the method they're used to is an issue in the sociology of the

profession separable from the question of whether or not their preferences predict public policy results. It is worth adding, perhaps, that fee-for-service preferences have a logical relationship to market ideologies and may well be more extensive in societies where the social distance between physicians and patients is less marked, and where the imposition of market relationships is part of the subordination of patient by doctor, and doctor by patient. Likewise, the source of payment may well be more at issue in market-oriented societies because of the obligations generally entailed by the transfer of cash from consumers to producers (patients to doctors). Finally, differentiation of doctors for payment purposes may well reflect the degree to which there is wide acceptance of formal training accomplishment as an accurate indicator of medical ability, beliefs more typical in societies with marked class differences and aristocratic legacies.

The proposition that doctors prefer concessions on methods over concessions on amounts when they are forced to choose and are thought willing to strike over method disputes is true for all the cases investigated. But the political costs of an interruption of medical care services are reduced in societies like the U.S.S.R., where the supply of physicians has been expanded enormously through the revolutionary takeover of the medical profession. Israel is another exception. There the per capita supply of doctors is comparatively high, and hence the bargaining position of governments is comparatively stronger. By stronger, we mean that the government has a larger pool of physicians to call upon for emergency purposes. The ability of medical organizations to cripple health programs is thus diminished; the political costs of strike efforts are, as a result, lower for the state.

The third type of limit on the political costs of medical strikes is the degree to which politically relevant consumer groups take medical care to be a vital public service, one whose interruption counts as an extraordinary failure of the government in power. Non-modern societies, with major population groups outside the market economy, are what we have in mind. Public medical programs in such societies usually focus on environmental health problems (sanitation, epidemic control, and so forth) and the relevant elite groups are usually not dependent upon the public health service for their personal health care. This means that the interruption of public medical care programs is a burden for those sectors of the population least powerful politically and less likely (than urban, middle class groups) to consider the restriction of public health services decisive grounds for militant political protest.

Finally, we ought to make clear that in describing bargaining agents as governments and physicians, we are well aware of the lack of descriptive realism. We have made use of the simplifying abstractions for purposes of clarifying the main line of argument. We have specified the model in such terms while recognizing that qualifications could be made throughout. We are saying, however, that the bargaining process can be represented as if the relevant agents were in a dyadic relationship (doctors and government), and the test of the model is not the realism of the premises, but whether the model accurately predicts public policies governing medical pay method.

RESEARCH PROCEDURES

Our research design specified the analysis of instances of medical payment conflict in three dissimilar institutional settings. Our purpose

was to vary the political setting so as to test for the impact of what we took to be the comparable economic power of physicians in the three societies studied. Our second strategy was to use secondary information on the patterns of medical payment policy for a wider range of countries. Here our aim was to provide secondary confirmation (or disconfirmation) of the scope of the hypothesis we applied to the English, Swedish, and American experiences. Finally, our concern was to give case analyses of the initiation of issues, the limitation of what became at issue, and the policy outcomes in the three settings. Our design involved detailed analysis for three national arenas of medical payment policy and more summary evidence from the rest of the western industrial countries.

RESEARCH FINDINGS

The most important research finding was that the conclusion of the model accurately described public policy outcomes in the three countries studied. This was the case not only for the three instances studied in depth, but also for medical care payment conflicts over time in these countries. Moreover, the secondary evidence supported the extension of the hypothesis to the larger class of western industrial nations. (See Table 1.)

The major implications of these findings, first, is that national explanations of public policy in this controversial area are invalid, that explanations must use structural and economic variables rather than political and cultural ones in accounting for why it is that doctors get their way on how they ought to be paid. Second, there are methodological implications, the primary one being that cross-national research is essential for the adequate explanation of public policy outcomes. Finally, the policy implications are extraordinarily important.

TABLE 1

		Present Payment Methods				Past Payment Methods Changed by Public Programs	
		Specialists		General Practitioners		Specialists	G.P's
	Type of Public Medical System	Unit*	Source**	Unit	Source	Unit	Source
FRANCE	Insurance	Fee	Reimbursement	Fee	Reimbursement		
GERMANY (Federal Republic)	Insurance	Fee	Direct	Fee	Direct		
GREAT BRITAIN	Health Service	Salary	Direct	Capitation	Direct	Fee	
ISRAEL	Insurance	Salary	Direct	Salary	Direct	Fee	Fee
THE NETHERLANDS	Insurance	Salary, Fee, Case	Direct	Capitation	Direct		
SWEDEN	Insurance	Salary, Fee	Reimbursement	Fee	Reimbursement		
SWITZERLAND	Insurance	Fee	Direct, Reimbursement	Fee	Direct, Reimbursement		
U.S.S.R.	Service	Salary	Direct	Salary	Direct	Fee	Fee
U.S.A.	Insurance	Fee	Direct, Reimbursement	Fee	Direct, Reimbursement		
CANADA	Insurance	Fee	Reimbursement	Fee	Direct, Reimbursement		

Source: Adapted from Paying the Doctor, William A. Glaser, (Baltimore and London: The Johns Hopkins Press, 1970) p. 24.

*Unit of payment: salary, capitation, fee for service, case payments.

**Source of physician remuneration: direct government payment, on patient payment and government reimbursement.

POLICY IMPLICATIONS

First, the most important thing for governments to understand is both the nature of medical power and the limits on that medical power. We conclude that certain features of payment method controversies are, in fact, not negotiable however much these disputes are raised in the course of medical-government confrontations. That is the negative case we want to claim, the limits on what governments are able to do. Why governments are not able to control medical payment methods is accounted for in terms of the different priorities and economic power of the bargaining antagonists.

Knowing what governments cannot do, and what outcomes will take place, is of obvious importance to government officials involved in controversial negotiations. In health policy, such knowledge may permit concentrating on alternative means to the goals which traditional government payment preferences express. There are two alternatives to continually disputing the choice of payment methods. One is to concede the choice of method to physicians and concentrate on administrative techniques to make undesirable methods less so. The other is to seek alternative ways to accomplish the goals which payment methods were to serve: reward of quality education, limits on excessive services, and so on. The application of this perspective in individual cases is best left out of this article. We want to suggest here only the direction such applications should take, based on our findings.

NOTES

[1]This paper is an adaptation of the authors' presentation to the American Political Science Association panel on pressure group, "Pressure Group Politics Revisited," Los Angeles, 1970. A different version of the concluding section "The Politics of Paying Physicians: U.S., U.K., Sweden" was published in the International Journal of Health Services, Vol. 1, No. 1, 1971, 71-78.

[2]Oliver Garceau, The Political Life of the American Medical Association (Cambridge, Mass.: Harvard University Press, 1941).

[3]See, for example, William Glaser, Paying the Doctor (Baltimore: Johns Hopkins Press, 1970).

[4]A number of books exemplify or include this type of investigation: James Gordon Burrow, AMA: Voice of American Medicine (Baltimore: Johns Hopkins Press, 1963); Robin F. Badgley and Samuel Wolfe, Doctor's Strike; Medical Care and Conflict in Saskatchewan (New York: Atherton Press, 1967); William Glaser, Doctor's Pay (Baltimore: Johns Hopkins Press, 1970); Rosemary Stevens, American Medicine and the Public Interest (New Haven: Yale University Press, 1971).

[5]Harry Eckstein, Pressure Group Politics: The Case of the British Medical Association (Stanford, California: Stanford University Press, 1960), p. 15.

[6]Ibid., pp. 33-4.

[7]In the Preface he refers to "the hypotheses in Chapter 1," (Ibid., p. 7) of which this presumably is one.

[8]As Eckstein perhaps suspects by once refering to his own 'theorectical framework' in half-quotes, ibid., p. 7. See Eckstein's rejoinder.

[9]Ibid., p. 34.

[10]Harry Eckstein, Internal War (New York: The Free Press of Glencoe, 1964), pp. 5-6.

[11]"To sum up the argument in very general terms, pressure group politics in its various aspects is a function of three main variables: the pattern of policy, the structure of decision-making both in government and voluntary associations. And the attitudes--broadly speaking, the 'political culture'--of the society concerned each affects the form, the intensity and scope, and the effectiveness of pressure group politics, although in each case the significance of the variables differs--structure, for example, being especially important in determining the form of pressure group politics, policy especially important in determining its scope and intensity. I will sketch broadly, in light of these major variables, the conditions under which the Association acts as a pressure group." Eckstein, Pressure Group Politics, p. 39.

[12]Ibid., p. 88.

[13]The Spens report recommended that general practitioners as a group should recieve raises and specified the net amounts to be earned by various proportions of them (in 1939 values): three-fourths were to earn at least 1,000 net a year, one-half over 1,300, one fourth over 1,600, and about 10 percent over 2,000. Judge Dankwerts' decision of March, 1952 applied a betterment factor of 100 percent for 1952 and of 85 percent for 1948, and used a percentage of 38.7 percent for practice expenses, both higher than the BMA's original claims. In addition, maximum lists were reduced from 4,000 to 3,500 patients; a special 'loadings payment' of 10 shillings per patient would be paid for patients in the range 501 to 1,500 on doctors' lists; and the 'basic salary' was abolished and replaced by an 'initial practice allowance' of 600 pounds, 450 pounds, and 200 pounds payable only in the first, second, and third years of practice. Ibid., pp. 127, 148.

[14]Ibid., pp. 84-91.

[15]Ibid., p. 89.

[16]Ibid., p. 95. That this particular issue on which we focus is not idiosyncratically chosen is acknowledged by Eckstein when he refers to "the most important trade-union activity of the Association, pressure for greater remuneration." Ibid., p. 96.

[17]Ibid., p. 109.

[18]Ibid., p. 125 (our italics).

[19]Ibid., p. 148 (our italics).

[20]Ibid., p. 126.

[21]Ibid., p. 126.

[22]Highly structured and regular, in Great Britain and Sweden; diffuse and irregular in the United States, where consultation may take place in congressional hearings or through ad hoc meetings with executive officials responsible for public medical care programs.

[23]Interview with Sir Donald Fraser, formerly Permanent Secretary of the Ministry of Health (April 1967).

[24]David Mechanic and Ronald Faich, "Doctors in Revolt: The Crisis in the British Nationalized Health Service," Medical Care Vol. VIII, No. 6, p. 444.

[25]Interviews with both BMA and governmental officials in 1967 provided the basis for this account. These officials, understandably, prefer to remain anonymous. See Mechanic and Faich, op. cit., for a similar interpretation.

[26]For information on this episode, see Mechanic and Faich, op. cit.

[27]Interviews with BMA Secretary and National Health Service officials, Spring, 1967.

[28]See Glaser, op. cit. and Section IV of this paper.

[29]David J. Thomas, Postwar Swedish Medical Politics, unpublished research report for U.S. Public Health Service, 1968.

[30]American Political Science Review, LX, No. 1 (March 1961), p. 141, Review of Harry Eckstein, Pressure Group Politics, by Ralph M. Goldman.

[31]Abel-Smith, B., Health expenditure in seven countries. The Times Review of Industry and Technology, p. VI, March 1963.

[32]Department of Health, Education, and Welfare. "A Report to the President on Medical Care Prices," Government Printing Office, February 1967, published by the Ways and Means Committee, July 1971, for evidence of interest in physician incomes and the impact of public programs on those incomes.

[33]Horowitz, L. H., "Medical Care Price Changes During the First Year of Medicare," Research and Statistics Note No. 18, pp. 3-4. Social Security Administration, October 31, 1967; Chase, E. T., "The Doctors' Bonanza," The New Republic, No. XV (April 1967):15-16; Marmor, T. R., "Why Medicare Helped Raise Doctors' Fees," Trans-action, September 1968.

[34]British Medical Association. A Charter for the Family Doctor Service, p. 1. March 9, 1965.

[35]Confidential interviews with British Medical Association officers and Ministry of Health officials, Spring 1967.

[36]Eckstein, Harry, Pressure Group Politics: The Case of the British Medical Association. London: G. Allen and Unwin, Ltd., 1960.

[37]Abel-Smith, B., "Paying the Family Doctor," Medical Care 1 (1):27-35, 1963; Abel-Smith, B., "The Major Pattern of Financing and Organization of Medical Services that have Emerged in other Countries," Medical Care 3 (1): 33-40, 1965; Glaser, W. A., Paying the Doctor: Systems of Rumuneration and Their Effects, Baltimore: Johns Hopkins Press, 1970; Schnur, J. A., and Hollenberg, R. D., "The Saskatchewan Medical Care Crisis in Retrospect," Medical Care 4 (2):111-119, 1966; Badgley, R. F., and Wolfe, S., Doctors' Strike: Medical Care and Conflict in Saskatchewan. Toronto: Macmillan Company of Canada Limited, 1967.

[38]Marmor, T. R., op. cit., p. 25; Abel-Smith, B., op. cit., p. 26.

[39]Abel-Smith, B., op. cit., p. 26; Abel-Smith, B., op. cit., p. 26; Glaser, W. A., op. cit., p. 26.