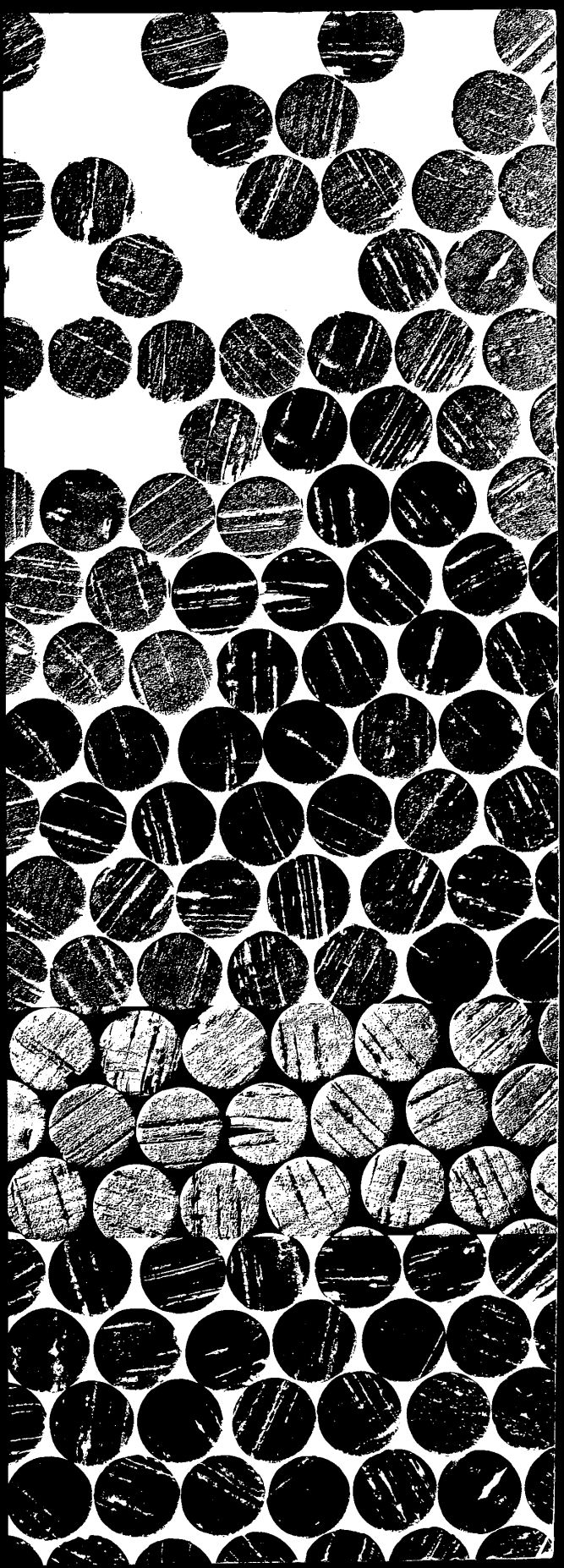
King's Fund

Medical Regulation and Public Trust

An international review

Brian Salter



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Executive Summary

In the UK, the issue of medical regulation and public trust is now highly politicised. Yet the UK is not alone in finding that citizens and doctors are having to redefine their traditional relationship. In all countries, citizens are demanding more and better health care and governments are having to respond. Frequently this response includes attempts to reform the way in which the medical profession is regulated.

As in the UK, governments are finding that it is a complex and difficult arena in which to introduce change. In Europe in particular, the historic interdependence of the state and medical profession renders radical and rapid reform difficult to achieve. Governments have found it necessary first to create distance between themselves and the profession and to limit medicine's role in the policy-making process. Having done so, states can then move to introduce measures to change the behaviour of doctors as they struggle with the universal problem of excess citizen demand for health care over the available supply. It is, after all, doctors who determine the detailed disposal of health care resources through their diagnostic and therapeutic decisions.

Indirect regulation is one option. Here the state may seek to change the context in which doctors work through economic incentives, cost controls or increases in the supply of doctors. However, where the profession has a sizeable influence over the system of payment or has substantial professional autonomy, as is frequently the case in Europe, such measures have had limited success.

More directly, a government may require a change in the system of medical regulation itself in order both to improve the quality of care delivered and to reassure the public that its trust in that quality is justified. Depending on the country, that system will vary along a continuum from entirely government institutions in terms of legal status, procedures and membership, through state-sponsored but professionally controlled bodies, to totally independent professional entities. There is no uniform institutional pattern, though professional self-regulation of one kind or another is the most common arrangement.

Within this, the medical profession of different countries vary in terms of how standards are set and monitored and in terms of how the twin powers of certification and registration are implemented.

For the most part, the profession's response to pressures for regulatory reform has been to focus on the continuing education of the doctor rather than on their performance. Achieving new institutional arrangements to support such reforms and then link them to re-certification and/or re-registration has not been easy. The internal medical politics of all countries is characterised by institutional rivalry, territorial conflicts, elite divisions and a frequent confusion between the certification and registration functions. As a result, the politics of inertia dominate and although medical regulation has been reformed in many countries, the changes made have been essentially cosmetic: the institutional landscape remains the same, as do the values of clinical autonomy on which they rest.
This is least true of the market driven systems of health care such as the USA where commercial pressures have prompted the creation of mechanisms of regulation controlled by the Managed Care Organisation (MCO) rather than the profession – though the latter too has increased its monitoring of its members. Interestingly, here the state and public pressure for reform of medical regulation then focuses on the MCOs.

Under pressure from their citizens, governments face a dilemma. Public trust in the authority of doctors needs to be maintained or restored if the profession is to continue to deal with the demand-supply mismatch in the quantity and quality of health care. Yet to rely on the profession to manage its own process of organisational change to achieve that trust is gambling against history. On the other hand, the introduction of regulatory reform for which the state takes responsibility means that it, rather than the profession, then becomes the target for citizen discontent with the standards of health care. The political advantage of medical self-regulation to the state has always been the distance it places between itself and its citizens.

In conclusion, if the reform of medical regulation is to be politically sustainable and capable of maintaining public trust over time it should exhibit the following characteristics:

Externally

- establish a common discourse
- fulfil the basic requirements of public accountability
- be credible to the public.

Internally

- have a statutory basis
- exhibit logic, coherence and non-duplication
- demonstrate a single line of accountability through the governance functions of standard setting, evaluation and intervention
- ensure mutuality between the twin regulatory powers of certification and registration
- arrange the competing power interests into an explicit hierarchy with the capacity to manage change
- involve the public.

In conclusion, if the reform of medical regulation is to [illegible]
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Foreword

Alison Hill, Director, Effective Practice Programme, King's Fund

The medical profession is almost universally under pressure to reform. There is strong political pressure for doctors to demonstrate their trustworthiness through open accountability to the public. Modernising self-regulation means taking into account not only these current political concerns with the accountability, appropriateness and efficiency of all public services. It also means looking across professional boundaries in the light of technical and social pressure to blur those boundaries and deliver health care in a multidisciplinary model. Put into the picture the decreased deference of clients towards all professionals and citizens' demands for high quality service and ease of redress, and the image is clear of a profession beset by the need to move on. Professions are by nature conservative, so the pressure to reform may be one of self-preservation alone.

Medical self-regulation can be seen as operating at three levels: the personal, the local or corporate, and the national. At the personal level doctors, refer to a moral framework largely developed during their training and socialisation as members of the profession. It is an informal but powerful mechanism through which they are accountable to themselves, their professional colleagues and their patients. It governs the essentially private sphere in which health care is given. At the national level, the regulatory bodies hold formal sway. They provide explicit standards, provide certification, registration and wield their disciplinary procedures. It is at the national level that the profession primarily relates to the state and its legislation. The corporate level is becoming increasingly important with the emphasis in both the public and the private sector on the quality of health care services. Some employers of health care professionals believe that they should be given the power and responsibility for the majority of regulation and to expect the prime accountability of their professional employees to be with them. It is also a formal accountability, but realised through management structures.

In the UK, the Government has in the past two years produced a series of policy and consultation papers aimed at strengthening and formalising corporate accountability beginning with *A First Class Service* in July 1998. Clinical governance has been proposed as a framework that integrates personal self-regulation with education and performance management. The medical profession's leaders were quick to respond with an assertion of the profession's innate trustworthiness, delivered through self-regulation. This response seemed not to have taken into account the concerns of the public and of government alluded to earlier. Subsequent tragic cases of professional shortcomings and wrongdoing by doctors were given high profiles in the media. They seemed to illustrate the problems of ensuring good outcomes for patients through self-regulation alone. The heat was on to modernise self-regulation.

In the ensuing months, power battles have emerged between different regulatory bodies within the profession in the UK, highlighting tensions between the profession, the public and the Government. These struggles will take time to resolve. In understanding these, and in making policy aimed at aiding this process, it is important to take into account the nature of the power relations between the different regulatory institutions within the professions, and between the professions, the public and the state. These power relations are intimately bound up with the economic environment, and historical and cultural drivers.

Brian Salter's review of medical regulation as an international issue, and his elegant political analysis, provides a clear and thought provoking addition to the debate. It helps to raise our view from the confusion of local power struggles by providing both a theoretical framework and an international perspective. It helps to clarify the big questions. Can the practice of health professionals be regulated solely by external or by internal methods? If not, and a mixed model is the way forward, what are the salient features of effective regulatory systems? What model of self-regulation would be sustainable? What will satisfy the state's need to regulate health care as a public welfare system and the public's demand for open accountability and high quality in health care? To what extent will the public find a voice and a role in regulating health care provision in the UK?

Introduction

The regulation of the medical profession in the UK is now fully politicised. At the public level, this politicisation is manifest in the highly visible Inquiry chaired by Professor Ian Kennedy into the events at Bristol Royal Infirmary, the impact of the Shipman case, the Government's introduction of the clinical governance policy in the NHS and the media's vigorous pursuit of stories about incompetent doctors. More privately, but no less significantly, the numerous self-regulatory bodies of medicine are engaging in intense and unprecedented negotiations in an attempt to produce a reformed system of self-regulation which will simultaneously satisfy the demands of state and citizens alike. As the General Medical Council works diligently to produce its final proposals on revalidation, public trust in the profession, some maintain, hangs in the balance.

Because medical regulation in the UK has never before been exposed to the rude winds of political debate, there is no national perspective that can be used to gauge the significance of what is happening. In the absence of context, the construction of policy can all too easily be informed by hasty reactions to emotive pressures. Yet the British experience is, of course, not unique. All states with a welfare system take some responsibility for the health care received by their citizens and therefore have an interest in the quality of the clinical care delivered by doctors. Different states engage with the consequent issue of medical regulation in different ways, their citizens may or may not be exercised by the ability of medicine to achieve particular standards, and the profession itself may shoulder more or less responsibility for its own governance. Variations in the way in which medicine is regulated are therefore the norm.

So what? Of itself, the fact of international variation tells us little that is useful. Rather more helpful is a perspective that provides insights into why these variations exist, identifies the formative political forces at work, and places the British case within a framework that can facilitate international dialogue. In developing that perspective, this report begins with the demands for change in the regulation of the medical profession. Where do these demands originate and what do they tell us about the relationship

between citizens and the state? Secondly, how close is the association between the state, the profession and the health care system and what effect has this had on the interpretation of the demands for change? Thirdly, what of the regulatory organisations of medicine themselves? Do they have the power and the flexibility to respond to demands for change? Finally, where does this leave the relationship between citizens and doctors? Is the present basis of trust sustainable and what is the likely shape of any reformulation?

The approach taken to these questions is that of the political analyst. That is to say, it is concerned with identifying the power relations that determine what happens in the arena of medical regulation, not with the good intentions of policy-makers. The advantage of this approach, if successful, is that it can help ground the debate in political reality. It can enable specific proposals for reform such as revalidation, re-certification, clinical governance and so on to be discussed in terms of their political, as well as their technical, feasibility. To neglect this context is to foster the illusion that policies can be formed and implemented without reference to the power relations with which, necessarily, they must engage.

1. Doctors and citizens

Medical regulation and public trust

The power of the medical profession is based on its unique access to, and regulation of, a body of knowledge that is highly valued by both society and state. Its control of this knowledge resource, what may be termed its clinical or professional autonomy, enables it then to negotiate with its economic and political environment in order to gain certain privileges as an occupational group in terms of pecuniary reward and institutional influence. If successful, these negotiations produce varying degrees of what may be termed economic autonomy (the ability to determine one's own system of economic rewards including market entry and exit) and political autonomy (the ability to determine the most important elements of health policy and its implementation), which constitute a surrounding set of defences against attempts by the state, or in some cases the market, to erode the fundamental professional autonomy (Elston, 1991). The state, for its part, generally prefers to deal with the profession by reshaping its economic and political context rather than making direct attempts to reform the system of medical regulation itself. Some authors have included aspects of the economic and political context in their definitions of 'medical regulation' because, as they rightly point out, these aspects are being used to 'regulate' medicine (Allsop and Mulcahy, 1996; Moran and Wood, 1993). However, the disadvantage of such definitions is that they neglect the essential quality of medical power, the control of knowledge, and thereby diminish their own explanatory strength.

In exploring the politics of medical regulation it is useful to view the control of knowledge as being exercised through the three regulation functions of standards setting, monitoring and evaluation, and intervention, and applied to three arenas of knowledge activity: creation (research), transmission (education) and application (performance) – see Figure 1 (Salter, 1999: 149).

Figure 1: Knowledge control and the politics of regulation

Arena of knowledge activity	***Regulation functions***		
	Standard setting	Monitoring and evaluation	Intervention
Creation (Research)	1	2	3
Transmission (Education)	4	5	6
Application (Performance)	7	8	9

Each cell within the matrix constitutes a political territory over which competition for influence can occur. Historically, an international feature of the profession is that it has demonstrated an ingenious capacity for evolving a plethora of institutions which engage in such competition – though most of this has taken place in the private realm and been resolved through informal means. There is no logical reason why public interest in the various facets of medical regulation should be restricted to one part of the matrix alone. In the UK at present, categories 7, 8 and 9 attract the majority of media attention but regulation failures in any of the other six categories could easily provoke a widening of the political debate. For example, poorly trained and supervised junior doctors or flawed medical research will impact on the public trust in doctors in the same way as will a poorly performing hospital consultant.

Ultimately, any system of medical regulation rests on the twin powers of certification and licensing. In terms of Figure 1, certification is a statement about the success or otherwise of the transmission of medical knowledge through education and, by its removal or limitation, can be used as a form of intervention (cell 6). Similarly, licensing, or registration, is a statement about the appropriate application of that knowledge in professional performance (fitness to practice) and can also be used as a form of intervention (cell 9). Ownership of these two powers is usually divided between several, or many, institutions, which frequently do not integrate their regulatory activities. (In the

UK, for example, a doctor can be removed from the GMC's register yet retain their certification as a member or fellow of a medical Royal College.) In addition, when under pressure to change, different institutions may produce different, and not necessarily compatible, responses couched in terms of one of the two powers without a clear understanding of their interrelationship. This then results in overlapping debates about re-certification, re-registration, and revalidation.

The wider political significance of medical regulation lies in its contribution to the triangular relationship between the citizenry, the state and the medical profession. Analytically, and to varying degrees depending on the national context, that triangle can be seen to constitute a set of political forces based on a mutual exchange of political benefits (Salter, 1999: 144–45). These are as follows:

- as members of a modern welfare state, citizens receive their health care rights from the state delivered to an appropriate standard by medicine
- the welfare duty of the state is thus fulfilled, it gains the respect of its citizens whilst relying on the medical profession to help manage the inevitable tensions between the demand for health care and the available supply
- by fulfilling its obligations to both, the profession receives the trust of the citizenry, in some cases the privilege of self-regulation from the state, and a consequent set of social and economic advantages.

The key contribution of medical regulation to this arrangement is that it assures public trust in medicine by guaranteeing that clinical care is of an appropriate standard. In the case of self-regulation, as the Merrison Report observed, it is 'a contract between the public and the profession, by which the public go to the profession for medical treatment because the profession has made sure it will provide satisfactory treatment' (Merrison Committee, 1975: 3). If the profession does not or cannot fulfil its part of the bargain, then the state is obliged to reform medical regulation in order to restore public confidence. If the state fails to act and as a result does not meet the terms of its contract with its citizens, it must expect to lose their support. It is thus in the very nature of this

ménage à trois that difficulties with one relationship inevitably impact on the other two. Interdependence is a given and is embedded in historic cultural assumptions which render change a complex and difficult process.

From the profession's perspective, the institutional expression of medical regulation is *the* measure of its professional power, or the lack of it, as the case may be. This is because as an exercise in the control of medical knowledge – be this in terms of research, education or performance – whoever dominates the regulatory procedures is in the position to exploit that knowledge territory as a political resource. By commanding those procedures, and assuming their continued efficacy in the public mind, medicine acquires the authority to allocate health care resources and to bargain for economic and political privileges. How far it succeeds is dependent not only on its historic relationship with the state – which with the exception of market dominated systems of health care is the forum for the negotiation of the three types of autonomy – but also on the stability of the triangle of political forces.

The politics of medical regulation are complicated by the fact that the standard of clinical care received by a patient is a product not only of the skills of the doctor but also of the demand-supply relationship in health care (Salter, 1998). If, as is usually the case, demand exceeds supply, then scarce resources can limit the effectiveness of medical skills. In other words, when assessed in terms of outcomes, medical competence is contingent upon the economic and organisational context in which it is exercised as well as upon individual ability. In responding to new health care demands from its citizens, therefore, the state has the option of changing the context in which doctors perform as well as reforming the nature of medical regulation itself. Where economic constraints prevent the injection of more health care resources, that reshaping of the context may include measures to increase the efficiency with which the supply of clinical care is delivered. This again impacts on the issue of standards and medical regulation.

The rise of the active citizen

Like all political arrangements, in order to survive the triangle of forces must be responsive to changes in the political and economic environment. Most obviously, perhaps, it must take account of what the proponents of the 'deprofessionalisation thesis' have argued has been a general cross-national decline in the medical profession's cultural authority and legitimacy (Haug, 1973; Haug, 1998). It has been further argued that the rise of complementary medicine is a clear indication of the erosion of that authority (Ernst, 1998); that technology has increased the accessibility of medical knowledge to non-doctors; that medicine has become reliant upon new areas of knowledge it does not control (Blume, 1992); and that in the UK the preparedness of patients to challenge doctors' decisions is reflected in the steady rise in complaints about medical care and the prominence of patient lobby groups on the national political stage (Allsop and Mulcahy, 1996: chapters 7, 9; Moran, 1995: 30). Public trust in doctors is no longer a cultural given.

As citizens come to see themselves as active consumers of health care, rather than the passive recipients of authoritative clinical decisions, so they are in effect redefining their welfare citizenship, their health care rights, their expectations and the political demands they place upon the polity. States vary in the extent to which their citizens have moved in this direction. At one end of the continuum, consumerism in the socialist welfare systems of Eastern Europe was always (and continues to be) very weak and reflected the restricted health care rights of citizens. Thus in Czechoslovakia, for example, it was accepted that explicit rationing gave the best health care to young workers, hazardous occupations and those in heavy industry while not allowing complicated surgical operations for those past retirement age (Heitlinger, 1995: 214). Given the state sponsored tradition of restricted health care rights, there was, unsurprisingly, no interest group infrastructure to support the articulation of fresh demands once the yoke of communism was lifted. Historically, passive health care consumers, coupled with a weak medical profession, ensured that medical regulation was not an issue.

Contrast this with the situation in Ontario, Canada where a sustained patients' campaign in the 1980s produced a radically reformed system of medical regulation with increased layperson representation on the governing councils of colleges (over 40 per cent) as well as on their registration committees and complaints and disciplinary committees (Coburn, 1993: 847–49). Somewhere in between is the position in France where the principle of 'solidarité' and state dominance in the provision of health care has always restricted the legitimacy of pressure group activity as a vehicle for citizen concerns. In this context Wilsford notes how in France outside groups are seldom consulted at the outset of health policy formation 'but rather at the close of deliberations and negotiations in order to secure their support and to legitimate decisions already made' (Wilsford, 1991: 240).

That the rise of 'the active citizen' is a relatively recent phenomenon is demonstrated by the kinds of assumptions made by earlier analytical approaches. In this context is it useful to recall that Alford's oft-quoted framework of the defining forces in health care politics identified three types of structural interests: the dominant structural interests (organised professional guilds); the challenging structural interests (e.g. managed care organisations (MCOs)) and the repressed structural interests, which he defined as the family, patients, and consumer groups that wish to maximise the responsiveness of health professionals and bureaucratic organisations to their needs, including their need for access to high quality care (Alford, 1975). Rather more dismissive in tone is Björkman's four-part categorisation of the actors in the health sector of contemporary nation states as constituting politicians, bureaucrats, professionals and patients/clients with the latter described as 'residual in the political model of the health sector'. He continues: 'the incidence of organised consumer groups is relatively rare and requires only occasional monitoring' and to all intents and purposes can be excluded from the analysis (Björkman, 1989: 33).

Such analytical certainty is no longer valid. In the USA, consumer, patient and advocate groups are now an established feature of the health care landscape. But, interestingly, in their efforts to improve the quality of clinical care, their target is not the medical profession but the MCOs, which, through their combining of the financing and delivery

functions, have assumed responsibility for providing that quality. As Ross observes of managed care: 'For every documented abuse by a health plan, advocates tend to want a regulatory response [from government]' (Ross, 1999: 607). At the same time, because the medical profession has had its clinical autonomy eroded by the process of managed care, it views alliances with consumer groups to lobby for greater regulation of the MCOs as a means of restoring its traditional clinical privileges. As one might expect, what is meant by 'regulation', and its implications for the governance of the medical profession, has consequently become an area of intense political debate (Ross, 1999: 613–19).

Channelling the demand for reform

Clearly the level of development of patient interest groups is one of the determinants of the scale of the political demand for reform that citizens are able to apply to medicine and the state (Moran and Wood, 1993: 29). But important also is the dominant ideology in a health care sector which may, or may not, encourage the patient voice to appear on the political agenda. In their most traditional form, the hegemonic values of the medical profession remove the need for the patient view to be expressed at all since the doctor is seen as acting purely in the patient's interest uninfluenced by factors other than the purity of their clinical judgement and, on occasions, by peer opinion. Variants of this ideological position occur in most modern health care systems and act as a defence of professional power. Thus in France and Belgium, for example, the dominant concept is that of 'la médecine libérale' which is defined as the patient's free choice of doctor, the physician's freedom of prescription, professional confidentiality, and the direct fee-for-service payment – in effect, a statement of the organisational requirements of clinical autonomy (Dohler, 1989: 190). Meanwhile, in the market oriented USA, doctors claim to value 'consumer protection' and to work solely in 'the public interest'. As Moran and Wood observe, when translated, such phrases mean that doctors are the best people to determine the needs of their patients and colleagues should not interfere – what they term 'a bedside monopoly' is thus created (Moran and Wood, 1993: 47). However, merely because the values are pervasive is no guarantee that they will act to protect the medical profession from state intervention on behalf of its citizens. There is the further issue of

how far the political culture supports those values. In Belgium clearly it does since not only are the principles of the medical charter (as la médecine libérale is termed) incorporated within the insurance system but also medical dominance is legally asserted in the Law on the Practice of Medicine (Schepers, 1989: 166). In France, however, medicine's values are politically much weaker because they are opposed by the political culture of solidarité and state bureaucratic dominance which excludes the profession from the agenda setting arena of policy-making.

It is a universal feature of modern welfare states that citizen demand for health care is increasing in terms of both the quantity and the quality of the service required as the natural expression of an extending range of de facto health care rights. At the same time, the public's trust in the medical profession, and hence the ability of medicine to use the authority of clinical decisions to control that demand (should it choose to do so), is decreasing. It is an interesting characteristic of much of the work on medical regulation that it omits the demand side of the political equation and focuses instead on the supply side. Increased demand is identified in terms of its consequences. Thus terms such as 'a cost-explosion' or the need for 'cost-containment' in the supply of health care predominate with the result that the origins of the fundamental political issue are disguised and understanding diminished. (Ironically, in practice improved efficiency means that the costs per unit of health care may frequently have gone down.) Disguised or not, the effects of this causal chain for the medical profession are clear. As the primary agents for the detailed allocation of most health care resources, doctors are the inevitable target for governments attempting to resolve the demand-supply mismatch in health care. Greater regulation of their activities for one reason or another is deemed to be the answer.

It is, however, not always the state which acts to translate surplus citizen demand over the available supply of health care into forms of intervention designed to change the way in which clinical decisions are made and regulated. Where the insurance market plays the primary role in the financing of a health service, the necessity of maintaining profit margins requires that increased demand is met either through increased prices (through charges and co-payments) or through improved efficiency in the supply. To achieve the

latter goal, either doctors must be persuaded to work within fixed budgets or they must be forced to relinquish some or all of their decision-making power. In the USA, for example, the rise of managed care and the MCOs incorporated bureaucratic systems designed to limit clinical autonomy in the interests of cost-containment. As part of this, utilisation review (UR) by private corporations was introduced to assess medical care in terms of its appropriateness and effectiveness prior to its delivery: a clear example of the private regulation of private provision (Moran and Wood, 1993: 59–61). Similar forces are evident in Spain where since 1990 the state sponsored development of the private health care market has resulted in increasing numbers of doctors employed by large private corporations and subject to pressures on their clinical autonomy in the interest of corporate profits (Rodriguez, 1995: 159).

Once the private sector takes responsibility for the quantity and quality of health care delivered, it is the private sector, rather than the medical profession, that becomes the target of state action in response to any failure to deliver what citizens think they deserve. Hence in the USA, the more that the MCOs have gained control of clinical decision-making through the use of managed health care plans, the more they have become the object of state regulation (Ross, 1999: 607). With consumer groups and the medical lobby also heavily involved, health care regulation in the US has become a highly politicised arena and control of the definition of regulation a significant political issue in its own right.

Summary

As the concept of citizenship changes to incorporate new definitions of health care rights, so the potential demands placed upon the political system correspondingly increase and impact on the triangle of forces between citizens, medicine and the state. Health care rights vary from country to country and so also, therefore, will the initial expression of the demand for change. The translation of that initial demand into real pressure for reform of the ways in which the standard of clinical care is assured and regulated is dependent on several factors. Firstly, consumerism in health care is but weakly developed

in most European countries when compared with the established power of the state bureaucracy and the medical profession's own regulatory bodies. This contrasts vividly with the situation in the USA and Canada where interest groups acting on behalf of consumers are now an established part of the political scene. In the UK, while patient consumer and advocate groups are still in the early stages of development, the combination of media and state interest has facilitated the expression of citizen concerns.

Secondly, the salience of medicine's traditional values can act as a protective screen against demands for reform in the governance of medicine by denying the validity of these demands. All European countries recognise the principle of medical self-regulation to some degree and this is reflected in the pervasiveness of values such as those of la médecine libérale, which are intrinsically opposed to the idea of clinical accountability to non-doctors. However, and thirdly, the extent to which those values can act as an effective defence against demands for reform are dependent on general characteristics of the political culture: for example, the tradition, or not, of central bureaucratic power. Finally, the role played by market mechanisms in a health care system can, in certain circumstances, divert the political demand away from the medical profession and towards the private institutions that finance and deliver health care.

Given the nature of citizenship in the modern welfare state, therefore, it is probable that at some point citizens will exert direct or indirect pressure for the reform of medical regulation. Broadly speaking, the nature of the response to that pressure will depend on (a) the relationship between medicine and the state and (b) the internal organisation of the medical profession.

2. Medicine and state

Varieties of partnership

The relationship between medicine and the state determines the parameters of medical regulation and professional power, either positively (through interventions that help or hinder the profession) or negatively (by giving market forces the primary role in the provision of health care). Frequently also, it influences the nature of the profession's economic and political autonomy. As one crosses national boundaries, the relationship varies from one of incestuous bonding to distant cousins. As it alters, so does its capacity to respond to the pressures for change in medical regulation. In the UK, the state's dependence on medicine for the resolution of the demand-supply conundrum in health care found its original expression in the corporatist agreement between medicine and the state which accompanied the creation of universal health care rights with the foundation of the NHS in 1948 (Moran, 1995: 21–24). That agreement gave the profession power over the disposal of NHS resources, the ability 'to veto policy change by defining the limits of the acceptable and by determining the policy agenda' (Day and Klein, 1992: 486) and confirmation of medicine's right to self-regulation (Klein, 1989: 82). In exchange, the state received covert clinical rationing.

Over the succeeding decades the arrangement consolidated into a form of 'ideological corporatism' which ensured that policy was framed within a set of values acceptable to this particular knowledge elite to produce what some have regarded as an example of 'the professionalised state' (Dunleavy, 1981; Dunleavy and O'Leary, 1987). Then, in a reversal of that position, the 1990s witnessed the erosion of the established 'iron triangle' of the medical profession, officials and ministers (Haywood and Hunter, 1982), the abolition of medicine's policy veto and its exclusion from the inner sanctum of policy-making from the 1988 Review of the NHS onwards, and, as the doctors' wounded surprise turned to anger, a series of acrimonious disputes between the profession's leaders and successive health secretaries (Lee-Potter J, 1997). Most recently, we have the

Labour Government's policy, enshrined in *A first class service: quality in the new NHS*, of a comprehensive, management-led system of clinical governance designed to set and monitor clinical standards (Department of Health, 1998).

Close ties between medicine and the state are by no means confined to the UK, and this is to be expected given the imperatives at work within the triangle of political forces. Historically, both parties have stood to gain from an efficient response to citizen demands and therefore it made sense for their combined interests to be reflected in the profession's presence in the state apparatus. As the welfare state emerged in pre- and post-war Western Europe, the 'medico-bureaucratic complex', as some have termed it (e.g. Larkin, 1995: 47 *et seq.*), became a common feature of government. In most cases, it was the profession that, in the early years, dominated this corporatist arrangement in terms of discourse, structures and policy. An archetypal example is that of Norway where the legendary Dr Karl Evang became head of the Directorate of Health in 1938 and remained so for several decades, ably fusing the distinction between policy matters and those requiring medical competence (Erichsen, 1995a; Erichsen, 1995b). It was not until 1983 that a reorganisation separated the accountability lines of legal and medical expertise in government and not until 1992 that health policy became part of the policy mainstream with the appointment of the minister of health within the Ministry for Social Affairs. Since then the continuing decline of the medical hegemony in Norway and its ability to mould the health policy discourse has been evidenced by the redefinition of 'health policy experts' to mean health economists and social scientists rather than physicians. However, although in recognition of this decline the Norwegian Medical Association has withdrawn from the formal policy-making arena, it continues to exercise considerable influence over policy implementation (Erichsen, 1995a: 731).

While the medicine-state relationship in Sweden and Spain paralleled the Norway model in its immediate post-war form, a different and less vulnerable form of profession-dominated corporatism developed in Germany, Belgium and the Netherlands characterised by the inclusion of the sickness funds in the corporatist arrangement. In health care politics, sickness funds constitute a set of state-sanctioned institutions, which

through their financial power have the potential to facilitate or resist demands for greater medical regulation. They can create or oppose changes in the linkage between finance on the one hand, and the quantity and quality of care on the other, and any regulatory policy is obliged to work through them. In Belgium, therefore, it is of some significance that the Technical Medical Council of the Institut National d'Assurance Maladie-Invalidité is composed entirely of doctors since it is the Council which determines what medical acts with what relative weight should be considered for reimbursement. This is reinforced by the stipulation in the Law on the Practice of Medicine that the control of key issues of medical practice lies with the Order of Physicians (Schepers, 1995: 165).

At first sight the situation in Germany is quite different with the sickness funds (GKV) administered by equal numbers of elected officials from associations of employers and employees. This is deceptive because in practice the funds have no authority to decide when and how the money is spent. That decision is the result of negotiations between the regional associations of sickness funds and the public law regional associations of insurance doctors (Kassenärztliche Vereinigung – KV). Since any physician who wishes to participate in the GKV is required by law to be a member of a KV, which are administered solely by physicians, the grip of the medical profession on the way the sickness funds are used to implement policy is comprehensive (Dohler, 1989: 184–85; Altenstetter, 1989: 160). KVs have a state-granted monopoly over the provision of health care, are legally endowed with the right to self-governance (as are the sickness funds), license their members for insurance practice, and take corrective sanctions against their member doctors if their practice patterns or charges exceed the norm (Giaimo, 1995: 360). And although the KVs are Länder (i.e. local state) based, this does not inhibit their ability to act in concert. As Freddi observes: 'When they [the KVs] negotiate economic transactions with the equally autonomous and corporatist sickness funds, or when they bargain with public authorities over annual increases of health expenditures, they act with one voice'. And their authority is cemented by the great normative power of legal forms typical of the German government tradition (Freddi, 1989: 14).

In countries where the sickness funds formed part of the medical profession's sphere of influence, the state for many years found itself colonised by the profession, rather than vice-versa. Referring to the German case, Giaimo regards the concept of 'private interest government' as useful because it 'highlights the importance of delegated state authority, the crucial enforcement role of the state, and the ways that such a governance arrangement can allow the state to indirectly manage a policy area' such as health (Giaimo, 1995: 356). This is too one-sided a view and unjustifiably assumes a natural pre-eminence of the state in its relationship with medicine. Rather, it is clear that the profession's 'expert' dominance of the policy discourse can determine the state's policy agenda. Thus in the Federal Republic of Germany it has been noted that professional preferences and diagnostic and therapeutic practices were respected by civil service hospital planners who supported medical progress. Bureaucrats and professionals were found to 'share similar values and perceptions about medicine and what is needed to practice it effectively and efficiently to the satisfaction of the public' (Altenstetter, 1989: 176).

An interesting version of state-medicine corporatism occurred in the Italy of the 1950s, where it was the dominant Christian Democrat Party (DC) that strictly controlled the sickness funds, the casse mutue. As the strongest allies of the DC, the doctors both supported and benefited from the funds and, in due course, were to suffer from the funds' decline (Ferrera, 1989: 116–23).

France provides a sharp contrast to this picture of medical hegemony in the relationship between the state, sickness funds and the profession. Eighty per cent of the population are covered by the Caisse Nationale de l'Assurance Maladie des Travailleurs Salaries (CNAMTS), which governs a complex system of 16 caisse régionales and 129 caisses locales. Most health policy is implemented through this national fund which fixes the levels of contribution, reimbursement, charges and fees. From the profession's perspective, the important part of this system is the 'convention': the standard fee schedule for all procedures and consultations (Wilsford, 1991: 125). Given France's political culture of centralised étatisme, it is not surprising to learn that the state uses the

periodic renegotiation of the convention as a means for imposing its will on the doctors – so much so that one commentator has described French medicine as 'administered medicine' (Freddi, 1989: 17). Be that as it may, what is clear is that the ability of medicine to resist the imperatives of the state is diminished by its lack of influence over the sickness funds and, as we shall see shortly, its fragmented internal organisation.

Alternative relationships

In Europe, the professions emerged before the fully-fledged nation state and so were in position to attempt to negotiate a mutually acceptable political bargain to deal with the growth in citizenship welfare rights. However, where the consolidation of the state occurred first, medicine has found itself in a weak and marginal position, unable to penetrate the state apparatus. Thus in Mexico the corporatist arrangement between the state and the ruling political party ensured that social benefits were delivered through the party political organisations to which the medical profession, along with other social groups, was subordinate. With no real power base, the profession was obliged to accept a state-imposed system of medical regulation where, in company with other professions, medicine was subject to the 1944 Law of the Professions. This gave the state the prerogative to establish licensing procedures that explicitly excluded professional groups from the decision-making process. Even within the health delivery system, doctors fared little better. Although they secured the middle managerial positions in the Instituto Mexicano del Seguro Social (IMSS – 70 per cent of whose budget was allocated to health), they remained politically peripheral and, as Nigenda observes, 'could not define the institution's internal policy, influence the recruitment of personnel, or negotiate their own contractual and salary conditions' (Nigenda, 1997: 87).

Corporatism (of whatever kind) is, of course, by no means a universal feature of the medicine-state relationship. To the political culture of the USA, such an arrangement is anathema and an offence against the traditions of institutional pluralism and government by contract. Medicine and its regulatory institutions remain determinedly separate from the state, but as the American Medical Association (AMA) bears witness, no less

powerful for that. For decades it was able to use its lobbying muscle to thwart attempts to introduce a national health insurance scheme and only accepted the introduction of the Medicare/Medicaid bill in 1965 on condition that the profession would continue to charge fees – that is, maintain its economic autonomy. It could be argued that the state licensing boards in the US constitute examples of the medical profession combining with 'the local state' to regulate doctors. However, the extreme variations in the disciplinary activities of different state licensing boards, the differences in state laws, and the lack of co-ordinating machinery between state boards considerably diminish the significance of this particular political union (Moran and Wood, 1993: 76). Of rather more significance are the professional monitoring measures which formed part of the original state-funded Medicare and Medicaid programmes, not because they became an instrument of the state will but because they were eventually to metamorphose into utilisation review used by the market-based Health Maintenance Organisations (HMOs) (Björkman, 1989: 51–54). Not that this was in any sense a development deliberately fostered by an alliance between the state and the health care industry. For just as the anti-corporatist instincts of US political culture militate against a state-medicine union, so also are they opposed to the public joining of state-industry interests.

Summary

The power relations embedded in the medicine-state relationship determine both the nature of medical regulation and the possible responses to the demands for change. Given the variety of forms that relationship can assume in terms of the proximity of the partners, their legal and institutional connections, the degree of ideological overlap in their policy discourse, and the balance of power between them, it is inevitable that the national systems of medical regulation should, as expressions of the relationship, faithfully reflect this diversity. There is, as Moran and Wood observe, what is best described as a continuum of medical regulation rather than a set of distinctive types (Moran and Wood, 1993: 91–93). That continuum ranges from entirely government institutions in terms of legal status, procedures and membership, through state-sponsored but professionally controlled bodies, to totally independent professional entities. Furthermore, it should be

understood that regulation is not necessarily a one-way process. Such has been the interdependence of medicine and state that in some cases it has been the former that has regulated the latter, for example through a decisive influence over health policy, rather than vice-versa. The implication of this analysis is that we can expect the response to the demands for change to be equally diverse. Differences in the juxtapositioning of formative political forces in the medicine-state relationship are bound to produce a differentiated set of responses.

3. Dealing with demand

Redefining the regulatory context

The quantity and quality of the clinical care provided in any system of health care is determined by doctors' decisions. Other factors such as resource availability may constrain or facilitate those decisions, but it is doctors who through their diagnostic and therapeutic judgements determine the pattern of clinical care and it is the structure of medical regulation that most intimately governs their behaviour. When, as appears to be a universal process, citizens demand more and better health care, the state must respond and attempt to readjust the demand-supply mismatch. Almost invariably, and unless the medical profession is able to anticipate the demands of citizens, that response includes seeking to change the behaviour of doctors in order to control the cost implications of the increased demand. This, in turn, frequently means that the regulatory procedures of medicine must be adapted accordingly, as must the state's relationship with the profession.

Where a corporatist arrangement exists, the most radical solution is for the state to abandon its alliance with medicine, seek to impose its own definition of how health care should be supplied and re-shape the context in which doctors work. No longer perceived as politically functional, the profession is then excluded from its privileged position in policy-making. The UK's experience with the emergence of the internal market policy in 1989–90, where the profession found itself comprehensively cold-shouldered, is one example of this. A rather more substantial example of a lasting loss of medical power is that of Italy. Here the sickness funds, the casse mutue, with which the profession was heavily identified, proved unable to cope with rising demand and were duly removed by the 1978 reform which introduced a single unitary scheme covering all citizens, the Servizio Sanitario Nazionale (SSN). At the same time, broad political shifts, including the strengthening of the left (particularly the Communist Party (PCI)) and the establishment of powerful regions, decimated the traditional power of the profession,

severed its links with policy-making and drastically reduced the significance of its remaining rights of self-regulation (Ferrera, 1989: 126). Over-reliance on a corporatism based on an alliance with a single party, the Christian Democrats, had cost the profession dear.

In other parts of Europe, the traditional corporatism has been redefined in a less dramatic fashion as the state has attempted to bring the profession to heel in the interests of costs containment. In so doing, it has used a combination of legal and economic measures to try to alter the context in which medical practice takes place with a consequent impact on the freedoms of self-regulation. In Belgium, the 1993 Law Moureaux on health and disability gave more power to employers, trade unions and government over the finances of the health care system in terms of the setting of both global budgets and those of specific sectors. However, the difficulty the state then faced was enforcing this policy through the complex array of sickness funds where doctors held considerable sway (Schepers, 1995: 171).

A rather more specific legal impact was achieved in Sweden where the 1970 Seven Crowns Reform removed the right of doctors to their own financial transactions with patients and established the machinery for national salary negotiations as a vehicle for the control of doctors' incomes and therefore costs (Lane and Avidson, 1989). In formal terms, medical power was further reduced by the 1982 Health and Sick Care Law which removed the previous legal stipulation that the head of a clinic had to be a physician thus apparently opening the door for the rise of managerial power. This was accompanied by the setting up of a central agency, the Health and Medical Services Disciplinary Board, to deal with patients' complaints against doctors (the procedure was known as the Lex Maria) – seemingly a recognition of patient power. Devolution of the health service to the county councils added further to the sense of an end to the old corporate alliance between medicine and state. But although that alliance has been substantially redefined, clinical autonomy as embodied in the procedures of self-regulation has not been seriously challenged. Managers and patients have not taken over. As Dohler argues, this may be because cost containment was the key issue for the state and 'a reduction of professional

autonomy could be avoided best if physicians were able to restrain, or at least postpone, their economic demands' (Dohler, 1989: 196). If the state can solve the problem of excess citizen demand by restricting supply and cost without confronting the issue of medical regulation, then it will do so.

As the state moves to deal with the cost implications of increased demand, so the profession's involvement with different types of payment systems becomes an increasingly important factor in the political game and a measure of its ability to protect clinical autonomy. In France, the state's dominance of the sickness funds and periodic manipulation of the 'convention', the standard fee schedule, gave it the means to insist that doctors should implement the policy of 'le bon usage des soins' (the wise use of health care services) introduced in 1986. Under the Plan Séguin some illnesses were exonerated from co-payments. To be successful, the Plan required doctors to discriminate clearly between exonerated and non-exonerated illnesses. In return for implementing a policy which reduced patients' rights by eliminating reimbursement or introducing charges, they received a fee increase (Wilsford, 1991: 148). Control of fees was also an initial plank of the Canadian state's strategy to increase its regulation of the profession and, once established, signalled the beginning of a decline in medical power (Coburn, 1993: 844). Even in the USA, that most pluralistic of societies, from 1992 the Medicare payments were based on fee schedules derived from the Resource Based Relative Value Scales (RBRVS).

From the impartial perspective of the economist, it has been argued that 'licensing is sought by doctors because it can be used to reduce supply and thereby lessen competition and enhance income' (Moran and Wood, 1993: 35). Pursuing the same logic, if the state can increase the supply of doctors then greater competition will produce a reduction in income (and health care costs). Part of the French state's strategy was to achieve precisely this. That it was able to increase the supply of doctors from the mid-1960s onwards, was because the state, rather than the profession, regulates French medical education and the number of students admitted (Wilsford, 1991: 128). Similarly, in Canada the state is now directly involved in medical education and the supply of doctors

through its control over university and hospital funding, internships and residency places (Coburn, 1993: 844). Therefore, to achieve the economic and political manipulation of doctor supply, it is more important for the state to regulate education than licensing. In addition, in the French case the absence of a referral system and a GP gatekeeping function reduces the ability of the French medical profession to resist the competitive pressures fostered by the state because patient choice is widened rather than narrowly directed through a series of professionally controlled access points.

In contrast to France and Canada, the capacity of the German state to use the economy of health care to redirect doctor behaviour is limited by the close relationship between the profession and the sickness funds. In the wake of what was widely perceived to be a cost explosion in health care, the 1988 Health Care Reform Act (GRG) and the 1992 Health Care Structural Reform Act (GSG) were introduced with the aim of stabilising insurance contributions by capping medical and prescription budgets. Doctors associations played little part in the formulation of the policy and indeed opposed it at many points: an indication that the corporatism of the past was no more. However, as others have discovered elsewhere, although the state could place the profession on the margins of policy formation, policy implementation is dependent upon the power structures at the local level of the health service, the Länder, where medicine still ruled as it always had done. As a result, despite government threats concerning state intervention in substantive areas of self-regulation in the event of professional non-compliance in policy implementation, the details of its enactment remained a matter for the KVs and the sickness funds. KVs became responsible for cost overruns and the monitoring of their members' practice which merely served to emphasise the state's dependence on the profession (Giaimo, 1995: 363–66). In this important sense nothing had changed despite the rhetoric of the state. Private interest government is alive and well.

As the French case demonstrates, control of the economy of health care removes the need for direct intervention in medical regulation because the redirection of doctor behaviour to deal with rising costs, the object of the exercise, is achieved by economic means. Conversely, in Germany the inability to control that economy without the co-operation of

doctors' associations has revealed the limits of state power: an alternative reason for leaving medical regulation alone. However, a different scenario emerges when the state is concerned to respond to citizen demands for better, as well as more, health care as presently reflected in the debate about clinical governance and revalidation in the UK (Buckley, 1999; Southgate and Pringle, 1999).

Better care and quality control

In the Netherlands, the state used the sickness funds to place pressure on the medical profession to introduce quality assurance procedures. Prompted by government moves in the mid-1970s encouraging the sickness funds to introduce the external audit of doctors, the National Organisation for Quality Assurance (CBO) was established by the National Association of Specialists (LSV) and the Association of Medical Hospital Directors as a professional defence against the potential intrusions of government, health insurers and hospital managers (Schepers and Casparie, 1997: 585). As a tactic this obviously succeeded because it was not until the late 1980s that a resurgent demand from the state for a national quality care policy – culminating in three national conferences – produced agreement that the primary responsibility for the quality of care lay with the providers.

Interestingly, the interpretation of this policy is that the focus of the external review by insurers and patients should be the measures taken to assure the provision of high quality care and not the quality of the care itself. (This move faithfully reflects the situation in the UK under the clinical governance policy where the new legal responsibility for quality given to the chief executives of NHS trusts stops at the level of the quality systems of the organisation.) As Schepers and Casparie observe, what this meant was that 'the leading role of the medical profession in the development of medical quality assurance was acknowledged by other actors in Dutch health care' (Schepers and Casparie, 1997: 587). Medical self-regulation remained intact. As we shall see in the following section on medicine's internal organisation, this dependence posed serious problems for the process of policy implementation. It was not until 1996 that agreement

was reached between the factions of Dutch medicine, enabling the introduction of a law on the re-registration of all medical practitioners every five years.

The course adopted by the Dutch state in responding to citizen demands for better quality clinical care is a common one. Where self-regulation forms part of the corporatist arrangement, the state has first placed pressure on the profession and then waited for its internal politics to produce a solution – with varying degrees of success depending on the extent of professional divisions. In Belgium, the state reconfirmed the therapeutic freedom of doctors in its 1989 Programme law but at the same time introduced the new legal obligation for doctors 'to refrain from prescribing unnecessary, expensive investigations and treatment and from carrying out or having carried out unnecessary treatment at the expense of the obligatory Health Insurance System' (Schepers, 1995: 173). This was symbolically impressive but meaningless in practical terms unless mechanisms could then be developed to implement such good intentions. Since this required the co-operation of the profession, it has taken some time. In 1993 the Belgium Association of Medical Syndicates (BVAS) and the sickness funds reached agreement on the accreditation of medical practitioners at set intervals. This was based on criteria developed by doctors regarding activities such as the keeping of medical records, a stipulated amount of continuing medical education (CME), and participation in quality assurance activities, with the whole process supported by local peer review groups (LOKs).

It is an interesting reflection on medical power, and the state's lack of it, that the approach to re-accreditation adopted in the Belgium case should have consistent international parallels elsewhere. Where the quality of clinical care is at issue, the regulatory methods adopted have in the main followed the contours of medicine's institutions and culture in ways which, firstly, exclude non-professionals from the standard setting, evaluation and intervention activities and, secondly, focus on matters of educational process rather than performance outcomes.

In the Netherlands, the law allows for two methods of re-registration: working in a practice that is evaluated by peers and co-ordinated by the Dutch Association of Medical Specialists, or fulfilling the continuing medical education requirements of the specialist societies (Swinkels, 1999: 1191). Similarly, the maintenance of professional standards programmes run by the Australian and New Zealand medical colleges are based on collecting points for CME and quality assurance activities and most do not have practice-based components (Newble, Paget and Mclaren, 1999: 1185). Nor, unlike the Belgium and Dutch examples, are they mandatory – with the exception of the Royal Australian College of Obstetricians and Gynaecologists, which has a true re-certification procedure in that there is a three-year time limit applied to the award of the fellowship diploma (FRACOG). Whether the programmes will remain a voluntary professional activity outside the purview of the state for much longer is questionable despite their 'being sold to the membership as a pre-emptive strike against revalidation procedures being imposed from outside' (Newble, Paget and Mclaren, 1999: 1186). Most states may accept the inevitability of self-regulation but they are under increasing pressure to make the maintenance of standards through re-registration or re-certification a legal requirement rather than a matter of professional judgement. The question is at what point they do so. Making the requirement a statutory duty before the profession has established the internal procedures for implementation risks policy failure and political exposure to the demands of public opinion. However, not making it a statutory duty risks allowing the profession to continue to engage in expert obfuscation. It is clearly a difficult tension to handle, which is why France, Germany and Switzerland, for example, have yet to take the legal plunge.

For the most part, in countries where there is a tradition of professional self-regulation resulting from a corporate relationship between medicine and the state, the demand from citizens for improvements in the quality of clinical care has been met with procedures which concentrate on the education of the doctor rather than on their performance. In terms of the requirements of individual professional autonomy, this emphasis is understandable because it does not question the doctor's application of medical knowledge (i.e. performance) but measures whether that knowledge base is appropriately

updated, a less intrusive procedure, and so forms part of categories 4,5 and 6 of Figure 1 (*see p.7*) rather than categories 7, 8 and 9. In terms of the requirements of public trust, it will almost certainly prove to be inadequate. In contrast to this, in countries where a medicine-state concordat has never existed, or is very weak, and where the private sector is the dominant player in health care provision, the profession can be forced to accept that its control of its knowledge base is neither unique nor sacrosanct.

In the USA, the introduction by government in 1982 of diagnostic related groups (DRGs) – clinical procedure categories with a fixed price for each – as part of the Medicare programme provided the platform for the development of procedures, external to the profession, for the regulation of performance. This process was facilitated by a state organisation, the Health Care Finance Administration (HFCA), which issued contracts to peer review organisations (PROs) for the conduct of quality control and utilisation review activities based on DRGs. As the commercial pressures of cost-containment increased, hospital administrators and purchasing agencies took advantage of the HFCA's procedures to introduce controls over medical decision-making. Judgements about the use of medical knowledge were no longer the special province of doctors alone and, as Björkman observes, an 'outstanding aspect of the DRG programme [was] the transfer of power by Congress from physician and hospital providers to the federal bureaucracy' (Björkman, 1989: 60). In the market-driven economy of managed health care, the question facing the purchasers is straightforward: 'Should [they] write reimbursement cheques for whatever the doctor orders or does an insurer have the right to evaluate the appropriateness of the treatment before paying for it?' (Ross, 1999: 616).

As in other countries, in the US the medical profession has taken steps to regulate the standard of its members' performance but this has remained a separate exercise from the quality control activities of the health care market and has not restricted the latter's incursions into professional territory. Of the 24 boards that are members of the American Board of Medical Specialties all have limited, or plan to limit, the duration of validity of their certificates to seven to ten years. In the main, their re-certification procedures are

based on CME or examinations (Norcini, 1994; Norcini, 1999; Norcini and Dawson-Saunders, 1994; Norcini and Shea, 1997).

Summary

The manner in which citizen demand for more and better health care is translated into changes in the context and structures of medical regulation is dependent, in the first instance, on the state's willingness and ability to redefine its relationship with the profession and so alter the balance of the triangle of forces between itself, medicine and society. Where there has been corporate relationship, the state has universally moved to create distance between itself and the profession, to diminish medicine's influence over policy-making and to increase its own ability to manage the demand-supply mismatch. Control of the economic context of medical decision-making is a key factor in what happens next. Where the state has that control, as in France, the economic autonomy of the profession, its first line of defence, is reduced and it is obliged to respond to state pressures. Where the profession retains control, as in Germany, it may respond to state pressures but on its own terms. Direct state intervention in the regulatory affairs of the profession is rare, not least because the state is wisely hesitant about assuming responsibility for the quality of care. However, where the state has given the private sector a prominent role in the delivery of health care, as in the USA, commercial considerations have overridden any qualms about such intervention.

For the most part, the changes in the corporatist arrangement can be described as a 'rebalancing' of that arrangement rather than its elimination; not, as Giaimo has argued, as a strategic government act but as a natural consequence of the interdependence of medicine and state (Giaimo, 1995: 368). As Moran and Wood point out, even where a state wishes to exercise more control over the medical profession it cannot always do so: there is 'an implementation gap' between policy goals and their enactment derived from the fact that doctors' 'greatest influence lies less in their overt intervention in politics, and more in the way their everyday influence in regulation shapes outcomes' (Moran and Wood, 1993: 136). Thus, for example, the profession may have accepted the policy goal

that reform of its self-regulation of standards is necessary, but its implementation of that goal has generally been expressed in terms of the monitoring of continuing education (an unconvincing proxy) rather than performance. This, however, is beginning to change, as the need for public reassurance becomes greater.

4. Inside medicine

Regulatory territories

By changing its relationship with the medical profession and reorganising the economy of health, the state can bring pressure to bear on the quantity and quality of medical work in order to deal with the ever-increasing demands from its citizens. How far the profession responds to that pressure, and if it responds how far it is able to do so effectively, is dependent on the nature of its internal organisation. When seen in terms of function, that internal organisation can be analysed in terms of five ideal types, each of which contribute to the maintenance of the professional identity: the learned society (preservation and advancement of the knowledge base), the certifying association (transmission and accreditation of knowledge), the licensing association (fitness to practice – knowledge application), the representative association (lobbying) and the trade union association (economic negotiation) (Burrage, Jarausch and Siegrist, 1990). In practice, of course, these ideal types will overlap and may be complemented by umbrella organisations which combine several functions.

Routine negotiations with the economic and political environments are usually conducted by a trade union or representative association, which may be supported by, or merged with, one or more of the other four types. The tradition in the UK has been for the British Medical Association (BMA) to take the lead with the other organisations remaining discreetly in the background. Not so in other countries. In the Netherlands, for example, the Royal Dutch Society for the Promotion of Medicine (KNMG) is a federation of four medical associations including the National Association of Specialists (LSV) and the National Association of GPs (LHV). It not only acts as a trade union but is also responsible for the register of all qualified doctors, standards of professional conduct and medical ethics (Schepers and Casparie, 1997: 582). Clearly such a concentration of functions increases the profession's bargaining power considerably. The trade union model is also dominant in Belgium though the function is divided between the Belgium

Association of Medical Syndicates (BVAS) and the General Syndicate of Belgium Physicians (ASGB), which have different approaches to the economic and political environments. While the BVAS holds true to the independent ethic of la médecine libérale, the ASGB is quite willing to co-operate with the Health Insurance System and to form alliances with other groups. Thus, in 1975 it created a coalition with two smaller bodies to form the Confederation of Belgium Physicians and, where necessary, it links with the Federation of Belgium Associations of Medical Specialists (VBS).

Probably the most effective form of medical organisation for the negotiation of economic and political rewards exists in Germany where the Associations of Insurance Doctors combine the powers of compulsory membership with the control of market access. In order to treat patients covered by the sickness funds, doctors have to be members of one of the two Associations: the Verband der niederglasen Ärtze (representing doctors in independent local practice) and the Marburger Bund (representing salaried hospital doctors). Since these in turn have exclusive and legally sanctioned rights of negotiation with the sickness funds, the German medical profession's bargaining relationship with its economic environment is inherently favourable to its interests; that is, it has considerable economic autonomy (Moran and Wood, 1993: 61–65).

The extent to which the profession is able to negotiate effectively with economic and political pressures is dependent also on the organisational efficiency with which it regulates itself through the several control of knowledge functions (*see Figure 1, p.7*). In the UK, until recently, across the arenas of research, education and performance the standard setting activity has been undertaken by both learned societies (the specialist associations) and the certifying bodies (the universities and the medical royal colleges); the monitoring largely by the royal colleges; and intervention by the colleges (certification) and the GMC (licensing) (Salter, forthcoming). However, with the move by the GMC towards the introduction of revalidation in 2001 there is a need for these separate institutional contributions to form part of a single system rather than an uncoordinated set of informal arrangements. For the UK this is sensitive and as yet uncharted political territory and international experience shows that even when procedural

agreement is achieved this then has to be maintained. In the Netherlands, the KNMG's inclusion of regulatory, representation and negotiation functions presents an interesting case where, as Schepers and Casparie observe, 'a careful balancing act regarding self-regulation in a broader sense has to be performed with the KNMG and associated professional organisations' (Schepers and Casparie, 1997: 595). In the main the KNMG succeeds in maintaining its hold on the quality policies of the LSV, the LHV and the scientific societies, but this is not always a straightforward process.

Division, rivalry and, on occasions, internecine conflict are more common features of the internal organisation of medicine than are harmony, sweetness and light. Given the breadth and complexity of the political territories summarised in Figure 1 (*see p.7*) and the power inherent in their control, this is inevitable. Politics is, after all, a competitive business. Much of the competition is organised within and between the two arenas of education and performance which, institutionally, can be seen to be subject to the two powers of certification and licensing. As we have seen, the focus on education in the form of CME and re-certification has often given the certifying institutions (mainly medical colleges rather than universities) the lead in the debate over how self-regulation can be improved. However, the certifying institutions are frequently dependent on individual specialist associations (learned societies) for the development of standards and this co-operation may not be forthcoming. For their part, specialist associations may decide that they are the appropriate bodies to regulate their members and view the medical colleges as distant and uninformed. Instances of such rivalry were common in the Netherlands in the 1980s among the organisations of both specialists and GPs as the profession began to respond to state pressure for quality assurance procedures to be introduced (Schepers and Casparie, 1997: 587).

The absence of a natural threshold between the concerns of certifying and licensing bodies means that their negotiating positions can be highly permeable. Those involved in the re-certification field have argued that the requirements of re-certification are more complex and technically demanding that those of certification and should include, as well as basic knowledge and competencies, a focus not only on non-clinical aspects of practice

such as ethical conduct, interpersonal abilities and management skills but also, and more importantly, on job performance, process and outcomes (Norcini, 1994; Southgate, 1994; Southgate and Jolly, 1994). If this is the case, and fitness to practice is proven, the licensing body is left with nothing further to do but to issue the stamp of re-registration approval. In Canada, the national association of licensing authorities, the Federation of Medical Licensing Authorities of Canada, has resisted this implication and is establishing its own model for the maintenance and enhancement of professional performance (MEPP). Quite separately, the certifying bodies are continuing along their chosen route: the College of Family Physicians of Canada is commencing its maintenance of proficiency programme and the Royal College of Physicians and Surgeons of Canada its maintenance of competence programmes (Dauphinee, 1999). When or where the twain will meet is unknown. As the Canadian case illustrates, one political solution is to be guided by the imperative of institutional interest rather than that of functional efficiency, to avoid tedious negotiations and to develop parallel and separate regulatory systems thus preserving territorial integrity. Whether the public will over time regard professional convenience as an appropriate criterion for internal organisational adjustments is another matter.

Elites and tribes

How far the tensions within and between the regulatory territories of education and performance are capable of being resolved is dependent upon the character of medical elites, other divisions within the profession and the values of the individual doctor. The elites of medicine in different countries vary in their homogeneity, their informal linking networks and hence their capacity to manage internal change. In the UK it is doubtful whether much has changed since Rosemary Stevens observed 30 years ago that 'many of the problems besetting the English professional associations of medicine have been not of authority in relation to the government but of their own interrelationships' (Stevens, 1966: 284). Bodies such as the Joint Consultants Committee (JCC) and the Academy of Medical Royal Colleges provide fora for consultation and some loose co-ordination, but not much more. Rather more elite co-operation exists in Germany where many of the key

organisations of the medical profession share the same activists and leaders. This is reinforced by the co-ordinating function of the Artzekammern (doctors' 'chambers') at the Länder level which, as public law bodies governed by their membership, deal with licensing, medical ethics, the organisation of disciplinary tribunals and the continuing education of doctors (Moran and Wood, 1993: 61–63).

Some of the divisions within medical elites are vertical and extend throughout the whole of the professional identity. Specialties attract a fierce loyalty from their members, which can render a common approach to a regulatory issue difficult to achieve. This is particularly true in France where what has been termed 'hyperspecialization' has produced not only inter-specialty disputes but also a continuing tension between generalists and specialists (Wilsford, 1991: 139). In some countries this latter tension is reinforced by a horizontal status stratification. Thus in Mexico specialists constitute an upper social tier with a monopoly of resources, jobs and the highest salaries and generalists the lower tier (Nigenda, 1997: 95). An alternative delineator of hierarchical professional conflict is age. Younger doctors tend to be less enamoured with the traditional medical institutions and more prepared to seek aggressive trade union solutions to their problems. In Italy, the erosion of the casse mutue was followed by the mobilisation of younger doctors and the dissolution of the traditional hospital hierarchy (Ferrera, 1989: 126). Similarly in Spain, the profession is divided between those established in 1975, when the post-Franco reforms began to be introduced, and those not. While the older professionals command a favoured position in the private market, the younger ones are salaried, publicly employed and less privileged (Rodriguez, 1995: 150–53). Underpinning each are different interests and different values.

Summary

At the risk of stating the obvious, it can be concluded that the capacity of the medical profession to respond to pressures for change is highly variable. Although the majority of states accede to the principle of self-regulation, the institutional realisation of that principle takes many and diverse forms and is frequently overlaid with other social

divisions. Only in a few exceptional cases such as the Netherlands and Germany does the profession exhibit a functional and political unity in its regulation of its knowledge base. More commonly, that regulation is conducted by a range of institutions fiercely jealous of their territorial integrity and consequently inhibited from designing and implementing comprehensive reform of their own governance structures.

5. The politics of reform

The political requirements

As the forces at work between the triangle of medicine, society and the state ebb and flow, it is the state that has the primary responsibility for engineering a workable political solution to accommodate the changing pressures. In the few cases where there is no history of medicine-state corporatism, it can attempt to transfer that responsibility to the market though even there, as the example of Medicare and Medicaid demonstrates, it is not immune from citizen demands. Elsewhere, the implacable demand from citizens for more and better health care has forced the state to attempt to redirect the activities of the medical profession. It can do no other, because it is doctors who allocate health care resources. In so doing, the state has universally redefined its relationship with the profession to give itself more freedom of manoeuvre in policy-making. Of itself, this change in the triangle of forces is of much less significance than the issue of who controls the economy of health and, in Europe in particular, the sickness funds and the supply of doctors. For it is in this arena that the shape of policy implementation is determined and the will of the state may, or may not, be realised.

Beyond this outer ring of professional defences lies the heartland of medical power: the regulation of medical knowledge through standard setting, monitoring and intervention. Where the balance of power in the economy of health has been taken from the doctors and these defences removed, as in the USA, doctors have found themselves exposed to direct intrusions on their clinical autonomy not by the state but by the institutions of the market. In Europe, the state has so far been suitably circumspect in its approach to medical regulation. Its first preference has been to attempt to deal with its citizens' ever-rising demand for health care by reshaping the economic context of doctors' work rather than the clinical activity itself. This approach has its limits, not least because the drive for an increased quantity of health care may, given restricted resources, impact on the quality of that care – about which modern citizens are increasingly concerned. In responding to this concern, the state has largely adopted the tactic of placing the profession's machinery

of self-regulation under pressure to reform itself rather than imposing a particular solution. In the past, there have been sound political reasons for this approach, as a brief reflection on the requirements of the successful reform of medical regulation will show.

In an ideal world, a politically sustainable model of medical regulation would exhibit the following characteristics (Salter, forthcoming):

Externally, it would:

- establish a common discourse
- fulfil the basic requirements of public accountability
- be credible to the public.

Internally, the model would:

- have a statutory basis
- exhibit the system characteristics of logic, coherence and non-duplication
- encompass the full range of functions and activities contained in Figure 1 (*see p.7*)
- demonstrate a single line of accountability through the governance functions of standard setting, evaluation and intervention for each activity area
- ensure mutuality between the twin regulatory powers of certification and registration
- arrange the competing power interests into an explicit hierarchy with the capacity to manage change
- involve the public.

Given the findings and analysis of this report, it can be confidently asserted that these characteristics are difficult to achieve. In the main, states have recognised that this is the case and encouraged the medical profession to put its own house in order rather than risk becoming embroiled in lengthy guerilla warfare. However, as a change strategy this

approach has enjoyed limited success and is now running out of time as citizens' expectations expand to encompass the quality as well as the quantity of health care. Although medical regulation has been reformed in many countries the changes made have been essentially cosmetic: the institutional landscape remains the same, as do the values of clinical autonomy on which they rest. For the most part the reforms have been educational in character masquerading as a legitimate substitute for performance measurement. As a consequence, it has been the certifying bodies which have taken the lead, developing a frequently elaborate system of continuing medical education, which may be voluntary or mandatory for their members and which is usually separate from the procedures of registration. Thus re-certification is more common than re-registration. Only in a few cases has the state intervened to insist that re-registration is a statutory requirement for medical practice.

In the light of the many and various divisions within medicine this outcome is, with hindsight, to be expected. There is an inherent resistance in the organisational culture of medicine to proactive, co-operative political effort in pursuit of a common goal. It is characterised rather by a politics of inertia, which when under siege from the state can coalesce into either a unified opposition to change or a consensus that minor adjustments are appropriate. Those adjustments follow the grain of institutional power, may simply embody existing rivalries and so render a clear line of accountability between the regulation functions of standard setting, evaluation and intervention difficult to achieve. In the main the two critical powers of certification and registration remain determinedly separate.

If the triangular relationship between medicine, society and the state is to survive as a central component of the modern welfare state – and at present there is no alternative to this arrangement – then the decline in public trust in the profession has to be halted. Without the authority that derives from that trust, doctors will be unable to carry out their vital political task of dealing with citizen expectations on behalf of the state. From the above it is clear that the profession's own reforms have failed to meet the conditions of a

sustainable political solution. The public has not been reassured and a common discourse has yet to be established.

The state's dilemma

In many countries the state therefore faces, or will face, a dilemma. The interdependence of the forces at work between itself, medicine and society means that whatever solution it generates must incorporate the profession. Yet it now knows that reliance on the profession to manage its own process of internal organisational change is gambling against history. On the other hand, the introduction of reform through simple policy fiat, be this clinical governance or some other initiative, is not going to work while an unsympathetic profession controls the power structures necessary for policy implementation. Something more sophisticated is required. The most convenient solution for the state is the manufacture of a new set of power relations within the profession capable of, and committed to, the introduction of comprehensive reforms in the governance machinery designed to meet the conditions outlined above. Self-regulation remains but in the context of a corporatism that has been significantly rebalanced. To achieve such a realignment within the profession, the state needs not only the artillery of actual, or more probably threatened, legislative intervention in the organisation of medicine but also the massed ranks of public pressure.

The state's historic association with the profession means that it must move carefully in order not to damage its own interests. As Johnson observes: 'Once we recognise the symbiotic form of profession and state formation it also becomes clear that any modern government that pursues policies with the effect of politicizing established areas of expertise and destabilizing existing professional jurisdictions also risks undermining the entrenched conditions that sustain legitimate official action' (Johnson, 1995: 22). What the state does not want to do is to reduce, rather than restore, the public's faith in the profession by adopting an over-aggressive stance towards doctors since this would limit medicine's ability to implement official policy. Nor, if it is wise, does the state wish to assume direct responsibility for the governance of medicine since it, rather than the

profession, would then become the immediate target for citizen discontent with the standards of health care. The advantage of self-regulation to the state is the distance it places between itself and its citizens.

In their turn, citizens may require their own rebalancing of the triangle of forces as a condition of their recruitment to the state's cause and their trust in any new arrangement. Canada and the USA have already had to adjust to the rise of the active citizen in health care and, if the British public's response to events at Bristol and elsewhere is a guide, European countries will be obliged to follow suit. This would entail the opening up to consumer influence of the hitherto closed relationship between medicine and the state and the involvement of citizens in all stages of the regulatory process from standard setting to intervention. However, whether the state and the profession are yet prepared to countenance such a radical exercise in power sharing is doubtful. A more probable outcome in the short term is an attempted accommodation that merely genuflects to citizen participation but does not confront the underlying issue. Such an outcome is unlikely to be sustainable.

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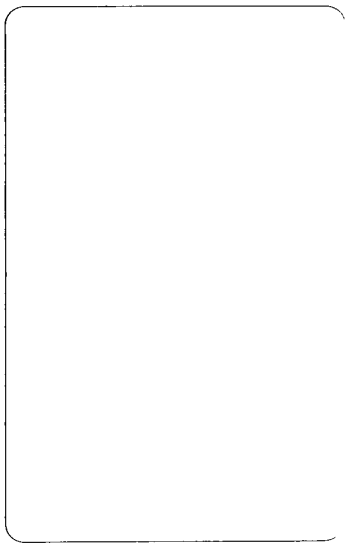

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