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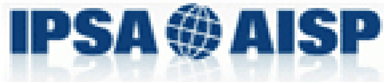

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The choice of healthcare models: How much does politics matter?

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Abstract
This article discusses the main hypotheses generated within the strand of research that focuses on health politics. These hypotheses are subjected to a brief empirical test, presenting data from 15 OECD countries. There seems to be a correspondence between the healthcare models adopted in different national contexts and the ideological orientation of the governments that have instituted them. Most laws instituting a system of social health insurance have been advanced by conservative governments, while those instituting a national health service have been passed – in the majority of cases – by social-democratic governments. The resulting clashes between governments and competing interest groups are largely attributable to the institutional setting. Thus, in the period from 1945 to 2000, most of those countries where political power was more concentrated implemented a national health service. Conversely, those countries where political power was more dispersed tended to maintain a system of voluntary or social health insurance.

Keywords
comparative public policy, health policy, health politics, OECD, welfare state

Introduction

This article concerns health policies viewed through a particular analytical prism, namely, health politics. This perspective assumes that the choices made by different countries in the field of healthcare largely result from clashes involving governments and different competing interest groups. The objective of this article is to present the main hypotheses that can be found within this strand of research, subjecting them to a brief empirical test.

To this end, the initial section presents the three fundamental models of health service organization: voluntary insurance, social health insurance and national health services. As shown in the second section, these three models can be seen as three successive stages of a common developmental path. The third section focuses on the research question that is pivotal to this article: why

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do some countries have a national health service, others a system of social health insurance and the US has neither of the two? Answers from a health politics perspective are the focal point of the following sections. In the fourth section, we will attempt to evaluate whether the choice of a health policy model depends on the ideological leaning of the government promoting it: to put it bluntly, is there a distinctly right-wing healthcare model and one that is typically left-wing? The fifth section discusses the statement that the medical class has traditionally behaved as an influential interest group; if this is the case, are the ways in which doctors have organized themselves to defend their interests relevant? The sixth section arises from a question that takes up and integrates the two preceding questions: to what degree do the institutional rules that characterize each national political system influence the balance of power between competing actors, thus making one healthcare model more likely to be adopted than another? Data from 15 Organisation for Economic Co-operation and Development (OECD) countries are presented with the aim of providing an answer to the foregoing questions.

Three models of healthcare organization

All healthcare systems – at least in industrialized countries – are referable to one of three basic models (Blank and Burau, 2004; Freeman, 2000; OECD, 1987; Rothgang et al., 2010: 1) voluntary insurance; 2) social health insurance; or 3) a national health service. It is worth noting that, for the purposes of this article, these models should be conceived as ideal types. In so doing, their features will inevitably be stereotyped to a certain extent. In their ideal form, these three models differ both as far as funding mechanisms are concerned, and in the way in which healthcare services are provided.

Voluntary insurance

Voluntary insurance (VI) is the model that most closely approximates the free market. Insofar as their income permits it, citizens can freely choose whether to take out a health insurance policy with a private insurance company. It is in the interest of insurance companies to bring to the market a range of policies that users may sign up to. Theoretically, each single citizen – depending on his/her income, health condition and inclination to risk – may design a custom-made insurance policy with his/her insurance company. The provision of healthcare services is usually entrusted to providers who are independent from insurance companies, whereby the latter simply reimburse the former. In the majority of countries, private health insurance policy-holders have great freedom in the choice of the physician or healthcare institute to turn to for treatment (Rothgang et al., 2010).

Social health insurance

The social health insurance (SHI) model is based on the principle whereby the government may require certain occupational groups to take out a health insurance policy. It is not the state that acts directly as insurer, but rather several different sickness funds, that is to say, not-for-profit, non-governmental bodies that collect workers' insurance contributions on a territorial or occupational basis (Busse et al., 2004). The contributions that registered clients must pay to their sickness fund are calculated as a fixed percentage withheld from their net salary and, in the majority of cases, are paid partly by the employee and partly by the employer (Mossialos and Dixon, 2002). Compared with the system of VI, SHI offers – at least in principle – less freedom of choice. The majority of

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citizens cannot choose whether or not to insure themselves (being obliged to do so); and, at least in the classic SHI model, citizens do not even have the freedom to choose the sickness fund to subscribe to, as workers are assigned to funds automatically on the basis of profession or residency. As compared with the previous model, differences involving health service providers are less marked: providers continue to be separate legal entities, among which citizens may choose (Saltman et al., 2004).

National health service

A national health service (NHS) is characteristically different from the two preceding models. First, this model is financed not by payroll contributions or voluntary insurance premiums, but through general taxation. Thus, while the distinguishing feature of the preceding systems is the multiplicity of private entities that act as insurers, in an NHS system, it is instead the state that takes up the task of gathering and managing the resources needed to finance healthcare provision. A second characteristic of an NHS is that it guarantees healthcare to the entire population: all citizens thus have a right to medical treatment that is judged to be essential. While the preceding models permit differences in treatment between those registered with different insurance plans (in terms of both contributions made and services guaranteed), in an NHS system, by contrast, all citizens have a formal right to the same treatment. In the provision of services, most hospitals and other healthcare facilities are publicly owned; most physicians are also public employees.

The differences between the three models

Important differences run through the three models especially in terms of system equity and level of state involvement. As far as fairness of the system is concerned, the model that, at least in theory, guarantees the greatest uniformity of treatment is the NHS: all citizens have coverage and, depending on need, have the right to the same package of treatments. In countries implementing the SHI model, part of the population – that part which is not under the obligation to take out an insurance policy – could be left without healthcare coverage (OECD, 2011; Saltman et al., 2004). Moreover, within the SHI model, there are often inequalities in treatment depending on the sickness fund the individual is registered with (Mossialos and Dixon, 2002). Finally, the model that presents the greatest disparities of treatment is the VI model.

When thinking in terms of a greater or lesser state involvement in the field of healthcare, it is evident how the role of the state varies depending on the model adopted (Frenk and Donabedian, 1987; Moran, 1999; Rothgang et al., 2005; Wendt et al., 2009). In the VI model, both the financing and the provision of healthcare services are the competence of the private sector; the role of the state is limited to the general regulatory aspects of the insurance market and the medical profession. Similarly, in the SHI model, the private sector (especially the non-profit sector) plays a prime role, both in financing and in providing services; however, public regulatory interventions are more pronounced in this second model (Rothgang et al., 2005). The legislator not only lays down the legal context in which the sickness funds must operate, but may also decide which categories of workers are obliged to insure themselves. State involvement is clearly the greatest in the NHS model (Blank and Burau, 2004). In such a system, the state does not limit itself to regulation, but directly takes on both the financing and the provision of services. The private sector is thus relegated to playing a residual role.

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The historical path: Two families and one case apart

The order in which these three healthcare system models have been presented – that is, VI, followed by SHI and finally NHS – holds also for their timing of development. As previously proposed and argued (Immergut, 1992), one may in fact conceive a standard developmental path, structured into three successive stages.

The first stage corresponds to the diffusion, as a supplement to the market, of forms of VI. Such forms generally emerged with social ends in mind, in order to redistribute risk across defined social groups. In different countries, the state intervenes to regulate such forms of VI, offering some sort of economic incentive to those who decide to take part therein.

The second stage coincides with the establishment of the principle of mandatory insurance. The first country to adopt such a system was Germany, starting with the Bismarckian legislation of 1883. In order to understand how such a model has evolved over the course of time, we should emphasize how, in the beginning, this obligation concerned only a limited number of occupational groups, and was later extended: 1) to an ever-greater number of occupational groups; 2) not just to individual subscribers, but also to their families; and 3) not just to workers, but also to pensioners. Following the logic of a progressive extension of insurance coverage, many countries have come to include the vast majority of the population in mandatory insurance schemes (Normand and Busse, 2002).

The third stage corresponds to the establishment of an NHS. The first country to adopt such a model was New Zealand, back in 1938. Notwithstanding New Zealand's claim to primacy, the reference model for all the universalistic systems that subsequently developed has been, from its conception in 1946, the British NHS.

The standard path followed by different national systems is thus marked by two crucial passages: the first, from VI to mandatory insurance; and the second, from SHI to an NHS. Table 1 includes, country by country, the dates on which the first laws establishing mandatory health insurance and national health services, respectively, were passed.

It is not difficult to trace certain common trajectories, based on which one may subdivide the healthcare systems of the 15 countries considered herein into two large families. The first is composed of those countries that adopted an SHI scheme without subsequently reaching an NHS: this path was followed by five countries that we may call 'continental Europe' (Belgium, France, Germany, the Netherlands and Switzerland), plus Japan. By contrast, the second family includes those countries that adopted an NHS, in the majority of cases after having passed through an SHI system. This was the trajectory taken by countries in Northern Europe (Norway, Sweden and the UK), countries in Southern Europe (Greece, Italy, Portugal and Spain) and New Zealand.

Among OECD countries, the US is unique in several respects, having never passed either a scheme of SHI or a tax-funded universal coverage scheme. Not even the Patient Protection and Affordable Care Act, approved in March 2010, formally introduces in the US some sort of SHI. Indeed, the 'play-or-pay' principle contained in Obama's reform package – if fully enacted, but in any event not before 2016 – will not involve the formal obligation to take on any insurance, but will rather be an economic disincentive to refrain from getting insurance coverage (Jacobs and Skocpol, 2010).

Table 1 shows that which – with some emphasis – may be referred to as the 'law of irreversibility'. Some countries (such as New Zealand) may have skipped an intermediate stage, but all have moved in the same direction: first VI, then an SHI system and finally – and only for certain countries – an NHS. There is no one country that has taken even a single step in the opposite direction: in other words, no country that has adopted SHI has ever returned to VI; similarly, no NHS, once set up, has been dismantled and transformed into one of the two preceding models.

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Table 1. Introduction of major healthcare compulsory programmes

	First laws establishing mandatory health insurance (year and groups to which it originally applied)	Laws introducing NHS
Belgium	**1944** (salaried employees)	–
France	**1930** (low-income workers)	–
Germany	**1883** (low-income blue-collar workers)	–
Greece	**1934** (urban salaried employees)	**1983**
Italy	**1943** (salaried employees)	**1978**
Japan	**1922** (low-income blue-collar workers)	–
Netherlands	**1941** (low-income workers)	–
New Zealand	–	**1938**
Norway	**1909** (low-income salaried employees)	**1956**
Portugal	**1946** (blue-collar workers)	**1979**
Spain	**1942** (blue-collar workers)	**1986**
Sweden	**1946** (all workers)	**1969**
Switzerland	**1994** (all workers)	–
UK	**1911** (low-income workers)	**1946**
US	–	–

Source: Based on data in Flora (1986), Immergut (1992) and Cutler and Johnson (2004).

Two clarifications are necessary before proceeding with the analysis. First, by discussing a 'developmental path' structured into three successive stages, we do not wish to make a value judgement. This work does not support the NHS as a model that is superior or in any case preferable to the other two. Second, we do not even want to imply that reaching the third stage of the path is somehow inevitable: in the course of the article, it will be clear that not all countries are meant to eventually implement an NHS.

The questions of health politics

In the light of the considerable differences that run between the different models of healthcare organization, questions instantly arise over why certain countries have adopted an NHS, others systems of SHI, and why the US has adopted neither one nor the other. This is an issue confronted by nearly all health policy scholars. The research question may also be formulated in the following manner: if – as we have seen in the previous section – it is true that health systems may evolve according to a standard sequence, why have some countries stopped at the first stage (VI), others at the second stage (SHI) and others have gone further and reached the third stage (NHS)?

The question has given rise to the most varied answers. Some scholars have identified the cause of the differences between health systems in the prevalent political culture of each nation (Jacobs, 1993). Thus, as Blank and Burau (2004) maintain, those countries characterized by a *communitarian* culture (such as Germany or Japan) find the SHI model congenial; those with an *egalitarian* culture (such as the UK or Sweden) display a tendency towards the NHS; while those countries with an *individualistic* culture (such as the US) display greater affinity with the VI model. Navarro (1989) offers a completely different explanation, reducing the choice of healthcare model to the strength of the working class. In countries where the working class is more organized, the basis for an NHS is present; conversely, where the working class and trade unions are traditionally weaker – as in the US – we find health systems that are more open to the private sector.

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Among the many possible explanations, some conceive the process of formulating health policies as an arena in which actors – such as governments, health professionals, trade unions, employers, political parties and insurance companies – compete. The past outcomes of these clashes were influenced not only by the strength of the actors (and the alliances they were able to build), but also by the rules of the game and the institutional constraints that distinguish each national system. Therefore, if we adopt this perspective, it becomes natural to focus on certain dimensions of an exclusively political nature, and to pose the following questions:

- To what degree is the choice of a particular health model attributable to the ideological orientation of the government that introduces it?
- Do the broad choices of health policy respect more the conviction of the government in charge, or more the interests of organized groups, in particular the medical professionals? Does the form in which doctors organize themselves to defend their own interests have some relevance?
- In what manner do the institutional rules of each national political system structure and condition the balance of power within the health policy arena?

These questions are inspired by research questions and theoretical hypotheses that have been the object of debates for a number of years. In the majority of cases, such hypotheses have been elaborated starting from an interpretation of the US exception, and have subsequently been tested – with rare exceptions (Blake and Adolino, 2001; Blank and Burau, 2004) – on single case studies or in a comparative analysis of two or three national cases. The ambition of the present work is to put some of these hypotheses to the test on a larger scale, namely, 15 OECD countries.

The ideological orientation of governments

The first question to be asked is whether there exists a link between the healthcare models adopted in different national contexts and the ideological orientation of the governments that have instituted them. This theme is already present to a large degree in the debate over the development of the welfare state in Western countries (Castles, 1982; Myles and Quadagno, 2002). The argument made by certain authors – which remains controversial – is that leftist parties have played a decisive role in the development and extension of the welfare state, in contrast with conservative parties, which have more often slowed its expansion (Esping-Andersen, 1985; Huber and Stephens, 2001).

Arguments on the importance of leftist parties have also been used in connection with the choice of healthcare models. Navarro (1989) and Maioni (1997), for example, have taken them up to explain the US anomaly: one of the reasons why the US does not have a national health insurance scheme is the absence, in that country, of a broad-based social-democratic party.

To evaluate the influence of ideological orientation on the choices made in healthcare, it is useful to start from the legislative provisions adopted to establish forms of SHI in the different countries (at least for certain occupational groups). Considering the governments that have adopted such provisions, we find (see Table 2): conservative governments, which were not democratically elected (the Bismarck government of Second Reich Germany); liberal governments (UK and Norway); military governments (Japan); authoritarian regimes (Francoist Spain, Mussolini's Italy and Salazar's Portugal); post-war (Belgium) or post-dictatorship (Greece) governments of national unity, led by a conservative prime minister; and in the Netherlands, the first scheme of compulsory insurance (1941) was imposed by the occupying German forces. Only in one country, namely,

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Table 2. First laws introducing social health insurance

	Year	Government in charge
Belgium	1944	Pierlot (Christian Democrats; government of national unity)
France	1930	Tardieu (Conservatives)
Germany	1883	Bismarck (Conservatives; not elected by Parliament)
Greece	1934	Tsaldaris (Conservatives; government of national unity)
Italy	1943	Mussolini (authoritarian)
Japan	1922	Tomosaburo (military)
Netherlands	1941	German occupying forces
Norway	1909	Knudsen (Liberals)
Portugal	1946	Salazar (authoritarian)
Spain	1942	Franco (authoritarian)
Sweden	1946	Hansson (Social Democrats)
Switzerland	1994	Stich (coalition government led by Liberal Conservatives)
UK	1911	Asquith (Liberals)

Sweden, was SHI introduced by a social-democratic government. In the other cases, it has been predominantly conservative or non-democratic governments that have introduced SHI schemes.

One plausible explanation is that such governments (this holds particularly for countries with executives who are not responsible to the parliament) have used social legislation as a strategy to make up for their legitimacy deficit. As Flora and Alber (1981) explain, national elites often use social security policies as a means of exchange in order to ensure the consensus of the working classes and at the same time defuse some of the principal claims of the workers' movements. The Bismarck government is emblematic: it has been argued that social policy for this government was foremost motivated by the desire to regain political legitimacy and preserve social order after the unpopular anti-socialist laws of 1878 (Cutler and Johnson, 2004).

Turning now to examine the political colour of those governments that have established an NHS (see Table 3), the scenario appears quite different from the previous one. It is social-democratic governments (including socialist and labour governments, namely, all those executives led by parties belonging to the Socialist International) that have, in the majority of cases (six out of eight), been the promoters of an NHS.

Portugal and Italy partly elude this rule. In Portugal, the NHS was introduced during the transition to democracy by a presidential government, which was nevertheless led by a socialist. The Italian 1978 healthcare reform was approved by a government of national solidarity (a single-party Christian Democratic minority government with 'external support' from the Communist Party). The Communists made the health reform a necessary condition for their support.

One should also note that, in certain cases, it was the first socialist government in the history of the country that approved the founding legislation for the NHS. This was the case for the Savane government in New Zealand, for the Gonzalez government in Spain and for the Papandreou government in Greece. The Attlee government in the UK was the first Labour government to enjoy a parliamentary majority. This serves to underline how many governments of the Left have considered the creation of an NHS a rallying call, characteristic of their work.

With no pretensions to stipulating laws of a general nature, there does nonetheless seem to be a correspondence between healthcare models and ideological leaning. A large majority of laws instituting a system of SHI have been taken on by conservative or non-democratic governments; while those instituting an NHS have been – in the majority of cases – the work of social-democratic governments. Logically speaking, this affinity seems entirely plausible: as previously noted, the

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Table 3. Laws introducing a national health service

	Year	Government in charge
Greece	1983	Papandreou (Socialist Party)
Italy	1978	Andreotti (Christian Democratic minority government supported by the Communist Party)
New Zealand	1938	Savage (Labour)
Norway	1956	Gerhardsen (Labour)
Portugal	1979	Pintassilgo (caretaker government led by Socialists)
Spain	1986	Gonzalez (Socialist Party)
Sweden	1969	Erlander (Social Democrats)
UK	1946	Attlee (Labour)

SHI model envisages a reduced public intervention; it seems therefore to be more congenial to parties of the Right (whether conservative or liberal). Conversely, the NHS model envisages a much more extensive intervention on the part of the state, and proposes equality of treatment for all citizens, even at the cost of the individual's freedom to choose. It should not be surprising that a system with these characteristics is more often invoked by leftist parties.

The power of doctors

For many authors, the choices made in the field of healthcare can be traced back to the balance of power between government and interest groups (Alford, 1975; Quadagno, 2004). Among interest groups, the one that has traditionally been the most combative and influential has been the one formed by doctors (Freddi and Björkman, 1989; Moran, 1999; Starr, 1982). At the cost of simplifying the issue, the dispute between medical professionals and the state may be summarized in the following terms: on the one side, the state aims at limiting the autonomy of physicians and restraining their earnings, to this end, governments ought to prefer an NHS, or a highly integrated public system in which healthcare professionals are salaried employees; on the other side, doctors fight for their own professional autonomy and to gain a more favourable method of remuneration. In broad terms, physicians prefer to maintain the status of independent professionals, perceiving any attempt to 'nationalize' the healthcare system as a threat (Hacker, 1998; Immergut, 1992): of the three models, the NHS model is appreciated the least by doctors. Described thus, the preferences of the actors appear perhaps a little simplistic: the fact remains that medical associations have organized large protests in almost all those countries where an NHS has been introduced (Immergut, 1992; Laugesen and Rice, 2003).

Conceiving health politics as a repeated wrestling match between doctors and the state quickly leads to considering how to weigh the strength of the two competitors. Hereunder, we consider the power of doctors, while the strength of governments is discussed in the following section.

Cohesion and fragmentation of the medical class

It has been said that the greater the capacity of the medical professionals to organize themselves in order to speak in unison, the stronger their influence at the political level (Navarro, 1989; Wilsford, 1991). Our hypothesis, therefore, is the following: where doctors organize themselves in a single body, they will likely succeed in limiting the state's intervention in the field of healthcare and retaining their status as independent professionals; where, by contrast, medical organizations are

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divided, and thus unrepresentative of the entire class, governments will have an easy time approving an NHS. This argument seems particularly convincing in the US context: the American Medical Association, considered by many as one of the most influential lobby groups in the country (Campion, 1984; Morone, 1990), has for a long time opposed any attempt to 'socialize medicine', helping to defeat all proposals to introduce a system of mandatory health insurance.

The 15 countries reviewed in this study are therefore separated into two groups: on the one side, those with a cohesive medical organization; and, on the other, those with a more fragmentary organization (Blank and Burau, 2004). The representation of medical professionals is cohesive when there exists a professional association capable of gathering, by itself, more than a majority of the active professionals in its ranks. In contrast, representation is fragmented wherever physicians are organized in rival associations, none of which manages to represent a majority of the professionals. Each country is classified depending on the degree of fragmentation/cohesion of the medical class recorded during most of the period running from 1945 to 2000.

In Table 4, the unitary or fragmented nature of the medical class is cross-tabulated with the healthcare model adopted in the different countries. There does not seem to be any significant relationship between the two variables, nor is the hypothesis described earlier borne out: many countries with a unified medical class have adopted an NHS, while others (Belgium, France and Germany) have a system of SHI, notwithstanding their fragmented medical associations.

The strength of governments and the importance of institutional rules

If it is true that doctors and the state are engaged in a wrestling match, taking into account the strength of the medical class alone obviously means limiting the analysis to just one of the participants. In order to predict the result of this clash, one must therefore compare the power of physicians with that held by their opponent, the government.

But where does the government draw its strength? To respond to this last question, there is a vast literature that may be of use: numerous respected studies have underlined the importance of institutional rules and their impact on policymaking (Steinmo et al., 1992; Weaver and Rockman, 1993). The power that a government wields in its clashes with other actors depends in great part on the institutional context within which it is situated.

Turning to the analysis of healthcare policies, the choice of policy in this sector is often interpreted with reference to the characteristics of the overall political system. We may therefore judge that the result of the clash between medical professionals and the state depends, to some degree, on the rules of the political game (Blake and Adolino, 2001; Giaimo, 2002; Immergut, 1992; Maioni, 1997; Steinmo and Watts, 1995). Steinmo and Watts (1995), for example, maintain that the US does not have a national healthcare insurance scheme not so much

Table 4. Organization of medical professionals and healthcare model

		Organization of medical profession (years 1945–2000)	
		Cohesive	Fragmented
Healthcare model (year 2011)	*SHI*	Japan, Netherlands, Switzerland	Belgium, France, Germany
	NHS	Norway, New Zealand, Sweden, UK	Greece, Italy, Portugal, Spain
	VI	US	

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because successive governments have not wanted it, but rather because US institutions are designed in such a manner as to discourage comprehensive and radical reforms in the social field. The system of checks and balances foreseen by the US constitution confers limited autonomy on the executive class, exposing it to the veto power of pressure groups opposed to reform. Immergut (1992) develops an argument that is similar in many respects, referring to three European countries: Sweden, France and Switzerland.

What the authors just mentioned and others maintain is, in large part, that in those countries where political power is concentrated in the hands of the executive branch, it is more likely that the will of the government will prevail over that of interest groups (translated for the field of healthcare: the government has a better chance of implementing an NHS). Vice versa, in those systems where power is dispersed among multiple actors, the executive is weaker and interest groups find it easier to block its initiatives: in the field of healthcare, this means that doctors have a greater chance of blocking the approval of a system that they disapprove of (and thus no NHS).

In debating the impact that the institutional design of a political system may exercise on the direction of healthcare policy, for each of the countries considered here, it is worth cross-tabulating two variables: the model of healthcare system adopted and the degree of concentration of political power (see Table 5).

For the latter variable, we make use of two noted theories in the field of comparative politics. The first is the distinction between *majoritarian* and *consensual* models proposed by Lijphart (1999), while the second is the veto players theory developed by Tsebelis (1995, 2002).

The hypothesis we wish to verify should naturally take previous arguments into account, that is, that SHI and NHS systems may be considered as the second and third stage, respectively, of a common developmental path. At the end of the Second World War, only one country (New Zealand) implemented an NHS, whereas the other 14 countries either had an SHI or a VI system. The

Table 5. Political institutions, veto players and healthcare model

Country	Lijphart's index of concentration of power (1945–1996)	Tsebelis's veto players (1945–2000)	Healthcare model
New Zealand	−2.78	1.19	NHS
UK	−2.33	1.00	NHS
Greece	−1.48	1.00	NHS
France	−1.39	3.24	SHI
Portugal	−0.34	1.91	NHS
Spain	−0.18	1.00	NHS
Norway	−0.03	1.76	NHS
Sweden	0.15	1.43	NHS
Italy	0.86	3.81	NHS
Japan	0.91	1.85	SHI
Belgium	1.09	3.29	SHI
Netherlands	1.56	3.13	SHI
US	1.82	1.65	VI
Germany	3.19	2.28	SHI
Switzerland	3.29	4.00	SHI

Source: Data from Lijphart (1999), Ha (2008) and Tsebelis's veto players data (available at: http://sitemaker.umich.edu/tsebelis/veto_players_data 0

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hypothesis may thus be formulated in the following manner: from the post-war period to the year 2000, the adoption of an NHS may have been more probable in those countries where political power was largely the prerogative of the executive class. Conversely, in countries where political power was dispersed among multiple veto players, during our period of reference, that is, from 1945 to 2000, the probabilities of maintaining the pre-existing SHI or VI system may have been higher.

Let us start by considering the degree of concentration/dispersion of political power, based on Lijphart's indicators and data (Table 5, second column). Those countries where political power is more concentrated have implemented, in the majority of cases, an NHS. It is perhaps not a coincidence that the two countries that first adopted an NHS (New Zealand in 1938 and the UK in 1946) are precisely those that most closely approximate to the majoritarian model (Lijphart, 1999). Conversely, those countries where political power is more dispersed have generally maintained a system of VI or SHI: among the political systems that are best characterized by the consensual model, we find the US and Switzerland, precisely those countries where the principle of compulsory health insurance encountered the greatest difficulty (Immergut, 1992; Steinmo and Watts, 1995). The principal exception to this rule is France, which has a system of SHI despite the high degree of concentration of its political power.

Somewhat similar conclusions can be drawn if one puts Lijphart's indicators aside and concentrates on the concept of veto players (Tsebelis, 1995). Employing the same data set as Tsebelis, Table 5 (third column) again indicates, on a country-by-country basis, the number of veto players during the period running from 1945 to 2000. As seen before, those countries with fewer veto players (less than two) have established, in the majority of cases, an NHS, while those countries with more than two veto players have generally maintained (or implemented) a system of SHI. The exceptions this time are Italy (which has an NHS despite the high number of veto players), and Japan and the US (which have no NHS despite having 1.85 and 1.65 veto players, respectively).

Despite these few exceptions (which could simply depend on the way in which the different authors define and operationalize the concept of concentration of political power), the choice of healthcare models seems thus to be affected, at least in part, by country-specific institutional settings.

Conclusions

The dimensions analysed in the previous sections – the ideological leaning of governments, the organization of medical professionals and the institutional context – represent just a few of the potential factors responsible for the choices made by different countries in the field of healthcare. Others could equally have been taken into account: for example, culture and national values (to which passing reference was made) or the different interests at play. In this article, health politics has been reduced to a duel between doctors and the state, but the analysis could also have included other actors such as insurance companies, trade unions, the pharmaceutical industry and small and big firms. Forced to make a choice, this contribution has concentrated on general and transnational dynamics, without entering into the specificity of each individual national case. In other words, this article has sought to develop a logic that, to the greatest extent possible, is common to the 15 countries considered here. However, this does not mean that particular or contingent elements, which may emerge from national case studies, are not relevant – quite the opposite (Tuohy, 1999). Equally, it would be of interest to identify, country by country, what the literature refers to as 'critical junctures' (Collier and Collier, 1991; Hacker, 2002; Wilsford, 1994), namely, extraordinary – often unexpected

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– windows of opportunity that in the past have permitted the adoption of innovative provisions that would have been improbable in normal conditions. There are in fact numerous states where the principal reforms in healthcare were undertaken precisely in conjunction with exceptional moments in the political and institutional life of the country. The knowledge that there are more elements to be taken into consideration than are considered in this work suggests using the necessary caution with respect to the conclusions drawn here.

The data presented in the fourth section led to the conclusion that the broad choices in the field of health are – at least in part – influenced by the ideological orientation of those governments who propose such choices. SHI schemes have more commonly been adopted by conservative governments; conversely, the majority of laws instituting an NHS have been passed by social-democratic executives. This obviously does not mean that such services have been instituted in all countries that have had leftist governments: in France and Germany, for example, Socialists and Social Democrats have governed for long periods without ever proposing the creation of an NHS. Nor can one affirm that all parties of the Right have systematically opposed the NHS model: in some countries, the institution of this model was the fruit of bipartisan accord; in others, once introduced, the universal single-payer public system has ended up gaining a vast consensus and conservative governments have refrained from proposing its dismantlement.

Many studies of health politics place great emphasis on the power held by the medical class. In the fifth section, it has been shown how the manner in which medical professionals are organized does not, all things considered, have a great influence on the model of healthcare chosen. By this, we certainly do not wish to suggest that doctors are not a combative pressure group – quite the reverse. The impression is that doctors have, almost everywhere, exercised great influence on policy-making, irrespective of whether they are organized in a unitary structure or divided. The results achieved by doctors seem attributable not so much to the form in which they have lobbied, but rather to the institutional setting in which they operate.

Nor should the effect of institutional rules be overemphasized. The institutional context, however relevant, is not capable of explaining, by itself, the differences between the various healthcare systems. In order to form a more plausible explanatory framework, this factor should be combined with what was argued previously, especially in terms of the historical evolution of different health models. In so doing, underlining the importance of political institutions means simply to affirm that completing all the stages of the standard developmental sequence (from VI to NHS) has been somewhat easier and quicker in those political systems that have fewer veto players. Indeed, in majoritarian systems, the opportunity to give a radical imprint to policies presents itself more frequently than in consensual systems, where occasions for the passage of radical reforms are much rarer, and where changes tend to be subject to collective negotiations and incremental in nature. This statement, which embraces many policy sectors, thus seems to apply also to healthcare policies.

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