

INTRODUCTION

Ironies of Success:

A New History of the American Health Care “System”*

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The context for contemporary research and policy is set through a theoretically informed history of the modern American health care system that draws on the concept of countervailing powers and Fligstein’s theory of control. In this context, the papers of this special issue are then introduced.

Having watched “ruinous competition” undermine both the achievements and potential of historic scientific breakthroughs, James Peter Warbasse wrote the following words in 1912, already with a certain sense of despair just twelve years into the 20th century:

The matter with the medical profession is that the doctor is a private tradesman engaged in a competitive business for profit . . . It is difficult, nay, impossible for him to do otherwise. He is surrounded by the competitive system, and unless he conforms to the methods of warfare about him, he must go down. . . . The science of medicine has made wonderful progress in the past fifty years . . . The whole history of medicine . . . is a glorious refutation of the sophistry that competition for profit is important to human progress. The competitive system, which surrounds and harnesses medical advancement, hindered it from the beginning and retards it still . . . (Warbasse 1912:274).

A distinguished surgeon and author of a major text on the subject, a bench scientist and author of numerous scientific articles and books, Warbasse had also published three years earlier the first book entitled, *Medical Sociology*

(1909). He provides an apt starting point for undertaking an institutional, political, and cultural assessment of how the medical profession reorganized into a political powerhouse and used the state to deconstruct early health care markets, stop “ruinous competition,” and develop closed guild markets that produced the “golden era of medicine” after World War II. However, the professional ideal of good medicine produced its own lapses and excesses that have led to strong buyers returning with a force that is transforming the medical profession. As an introduction to new research on contemporary health care, this essay will help readers understand the dilemmas and ironies that seem to have the American health care system in their grip today. This essay also contributes to the research on how specific markets form (for overviews, see Fligstein 2001; Swedberg 2003). Much (but not all) of this literature overlooks the predatory ways in which major stakeholders get legislators and governmental agencies to disadvantage or even eliminate others and to make large sums of taxpayers’ money available to them. Preemptive actions commonly known to actors get little attention from researchers. One could say that the dominant actor tried to “stabilize its market,” but that would reflect only the actor’s point of view, rather than a critical, societal perspective.

Two great strengths that sociology brings to the policy table, or to any effort at understanding how some aspect of society works, are its analysis of how past structural or organizational forces influence life and of how people or

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organizations construct their own reality. Most economics and much of journalism focus on the individual and on psychological explanations. They leave out the institutional and organizational forces that shape how people perceive their reality and the options from which they make choices. For example, nearly half of all employers in the American employer-based, voluntary health insurance system do not offer health insurance, in part because they see how terribly expensive it is and want to avoid getting involved. What most do not realize is the degree to which key stakeholders—the medical and hospital associations, insurance companies, employers unions, and more recently health care corporations and a raft of secondary industries that have grown up to support the medical-industrial complex—have designed the American health care system to minimize any party's ability to provide integrated, cost-effective care in a system that could manage the major sources of inefficiency, fragmentation, and escalating costs. American employers cannot choose, as Dutch or Finnish or British employers can, to participate in a system that controls costs, waste, and inefficiency and puts primary and secondary prevention at the center of health care.

Besides attending to institutional and organizational forces, sociology also differs from most of economics and psychology in documenting how deeply culture and history shape present organizations, institutions, and individual behavior. The past becomes embedded in the organizations, rules, and habits of the present. Sociology thus provides the substance and analytic tools that policy makers and citizens need to understand the world around them. This collection of specially commissioned and peer reviewed essays by talented sociological analysts makes manifest what the discipline can offer.

Why is the American "health care system" in such organizational, financial, and clinical disarray?¹ Even the orthodox, elite Institute of Medicine has issued a stream of reports showing that the system is deeply unjust; discriminates against the vulnerable and disadvantaged; causes plane-loads of avoidable deaths, injuries, and treatment-induced illnesses; wastes far more than any other comparable system in administration, marketing, and other non-clinical costs; and has a weak public health foundation (Institute of Medicine 2001, 2003). Why does "the best health care system

in the world" rank below health care in every other affluent country and below several others as well (World Health Organization 2000)? Even if we put aside the one-sixth of the nation that has no insurance (but why should we?), and another one-fifth that have limited health insurance that continues to be diluted (most accurately called "unsurance," not insurance), the patients with coverage get patchy care.

The quality of clinical medicine that patients receive is also patchy and overall falls far short of the self-congratulatory claim that we have "the best health care system in the world." A few years ago, the Institute of Medicine (1999) discovered the large number of preventable deaths, injuries, and illnesses that patients in American hospitals suffer each month, a pattern that has existed for decades (McCleery et al. 1971; Illich 1976). A recent systematic review found that clinicians provide the services to patients their own professional bodies recommend only 54.9 percent of the time (McGlynn et al. 2003). Consistency of quality ranged from 78.7 percent for cataracts to 10.5 percent for alcohol dependence. A carefully designed survey of sicker patients in five nations found that U.S. patients were more likely to claim a medical mistake had been made in their care than patients in the United Kingdom, Canada, New Zealand, or Australia (Davis et al. 2004). The United States ranked lowest in both efficiency and effectiveness measures, as experienced by patients. Equity was also lowest in the United States among patients with above-average incomes, and the equity gap is substantially wider among patients with below-average incomes.

Why does the simple goal to add coverage for prescription drugs for the elderly to Medicare result in a bizarre piece of legislation with quite poor coverage except for the most seriously ill and with over 90 percent of its cost going to large, additional profits for drug companies; to insurers, pharmaceutical benefit management corporations, and other intermediaries; and to rural hospitals? (Sager and Socolar 2003; Shearer 2003; Goldstein 2003 (24 November)). The week-by-week developments of the bill centered around the many corporate sectors that have grown up over the past 40 years using their profits for lobbying to be sure they would receive millions for themselves, so that the new coverage became a vehicle for taxing employers and individuals in order to increase corporate profits on a no-risk

basis. Such behavior is rare in other countries because they do not have a fragmented, for-profit corporate structure (Roemer 1991; White 1995; Giarelli 2004). No wonder they are so much more efficient and cost-effective. They can cover essentially everyone for what are considered medically necessary services for about one-third less. This essay provides a historical and sociological framework for understanding how mainstream American health care acquired its contemporary problems.

EARLY MARKETS AND COMPETITION

The most formative period of the modern American health care system occurred between about 1880 and 1920. In the last quarter of the 19th century mainstream physicians faced several competitive forces:

1. Price competition among the surplus of doctors, due to scores of loosely assembled “medical schools” by physicians trying to make extra money by collecting lecture fees;
2. Competition for fees from a raft of alternative healers, often popular for their more naturalistic, gentle forms of therapy, and aided by weak licensure laws;
3. Free care at dispensaries as part of the revolutionary success of public health based on germ theory and the new science of medicine;
4. A proliferation of nostrums, cure-alls, and other medicines widely advertised in newspapers and magazines that substituted for seeing the doctor and competed with doctors’ own concoctions made up in their offices; and
5. The rapid proliferation of wholesale contracts and services that threatened the autonomy and income of physicians (Starr 1982).

A Surplus of Competing Providers

The census of 1870 found 64,414 medical practitioners; by 1900 there were about 132,000, and this did not include a large number of “irregular” practitioners using alternative methods that were popular in many areas (Stern 1945). By the 1890s, a serious surplus was widely discussed, though this might have had more to do with sharp recessions in the general economy than with the growth in num-

bers. The period also witnessed a rapid proliferation of “medical schools,” so that by 1900 there were 126 “regular” schools and perhaps 40 homeopathic, osteopathic, and eclectic schools. Altogether, these schools graduated up to 5,700 new physicians a year (Rothstein 1972).

Initially, regular or orthodox physicians had no clear technical or therapeutic advantage, and many of their therapies were as likely to do harm as good. However, advances in scientific medicine came rapidly so that by World War I, the orthodox school of what came to be called scientific medicine had distinct advantages which were largely enjoyed by the medical elite among their ranks who had attended the leading schools of scientific medicine in Europe. Thus, while the number of herbalists, bone setters, and healers proliferated, normal market dynamics were rewarding those with new, effective skills.

Public Health and Dispensaries

Originally created in the 18th century as a humanitarian gesture towards the sick poor, dispensaries took on a new meaning and posed a competitive threat to the rank and file profession at the end of the 19th century. That fact has profound implications for today. As scientific medicine rapidly advanced, dispensaries proliferated as the place where new specialty techniques were first tried out on “clinical material.” Since the leading specialists worked and trained at dispensaries, the affluent came in disguise: “There was also the millionaire in poor clothes, the lawyer, the broker . . . fully fifty percent of ‘charity’ patients are persons whose financial position puts them wholly beyond the scope of charity” (DeVeaux 1904). Dispensaries proliferated in response to the millions of new immigrants. In New York City, for example, the number of dispensaries increased from 100 in 1900 to 574 in 1910 and exceeded 700 by 1915 (Goldwater 1915). They were considered superior to ordinary doctors because they offered a skilled team of specialists at the leading edges of scientific medicine, and the famous Boston Dispensary (affiliated with Harvard Medical School) integrated social work and a home health care plan as well as a service for detecting occupational health problems.

Goldwater and other leaders of major public

health departments, where the greatest gains in reducing morbidity and mortality were taking place, found it natural to extend their successes in applying scientific advances to improve the health of whole cities to the clinical diagnosis and treatment of individual patients. One could say they were achieving David Kindig's (1997) vision at the end of the 20th century of what the American health care system should look like if it wanted to raise the health status of the nation and improve productivity in a cost-effective way. Nothing could more threaten the leaders of autonomous private practice at county medical societies.

A Proliferation of Cure-Alls

As if backbiting within the ranks, aspersions between sects, and the proliferation of dispensaries were not enough, everyone had a cure for everything. Physicians made up their own cures and advertised them on their calling cards. Pharmacists made new compounds and stole the compounds of others whose prescriptions they filled. Companies sprang up with thousands of medicines. Most threatening of all was Lydia Pinkham's compound, because she in effect said, "Why go see a doctor? Write me and I will personally advise you about your health problem." Her compound cured all female ills, she claimed, and she further guaranteed that no man's eyes would see the letters of her clients (Caplan 1981; Starr 1982). Lydia Pinkham became one of the most successful businesswomen in the industry, and every letter was one less visit and one less fee for a local doctor. Patent medicines were sold at grocery, dry-goods, and hardware stores. Sales nearly doubled in five years, from \$74.5 million in 1904 to \$141.9 million in 1909. As one essay in the *Journal of the American Medical Association* put it, "... as the proprietary manufacturer becomes richer, the physician becomes poorer" (AMA Council on Pharmacy and Chemistry 1905). The manufacturers produced a plethora of prepackaged, ready-made drugs to make medical practice easy. G. Frank Lydston (1900), a prominent critic and professor at the University of Illinois School of Medicine, called such manufacturers "fakirs" and wrote a scathing commentary on the effects:

How gently flows the current of Doctor

Readymade's professional life. No more incurable cases. No more midnight oil. No more worry. . . . All the doctor has to do now-a-days is to read the labels on the bottles and boxes of samples the fakir brings him. Does the patient complain of stomach disturbance? He is given "Stomachine" . . . Give him one of these pretty little tablets with a hieroglyph on it, which nobody knows the composition of . . . (p. 1403).

Contract Medicine

Besides the relevance of Dr. Readymade to the billions spent today on commercializing prescription decisions (Wazana 2000; anonymous 2003; Goodman 2004), the other most relevant form of competition that frames our current era was wholesale contracts to provide services to groups of employees or people belonging to an association, or union, or working for a company or a branch of government. The corporate practice of medicine began during the 19th century in the railroad, mining, and lumber industries, where remote locations, high accident rates, and the growth of lawsuits by injured workers called for companies to organize medical services (Williams 1932; Starr 1982). They contracted for services on a retainer basis or on salary; some even owned hospitals and dispensaries for their workers. Some textile industries also established comprehensive medical services in mill towns. Thousands of doctors were involved in these contracts or worked on salary.

By the end of the 19th century, however, more and more businesses with none of these special needs also began to contract on a competitive basis for the health care of their employees. For example, the Michigan State Medical Society reported in 1907 that many companies of various sizes were contracting for the health care of their employees (Langford et al. 1907). The Plate Glass Factory contracted with physicians and hospitals for all medical and surgical care needed by its employees and their families for \$1.00 a month apiece. The Michigan Alkali Company did the same but did not include family members. Several other companies had contracts for the treatment of accidents and injuries. Commercial insurance companies of the day also got involved, putting together packages of services for a flat amount per person per year

(capitation) or for a discounted fee schedule. Their profits must have been enormous and the doctors' pay low, since several reports allude to the "usual" 10 percent of premiums that physicians received.

More widespread than early corporate health care plans were comprehensive health care medical services offered for a flat subscription price per year to members of the fraternal orders that had proliferated rapidly during the same period. The national and regional orders of the Eagles, the Foresters, the Moose, the Orioles as well as other fraternal associations, offered medical care at deeply discounted prices through their local lodges (Gist 1937). Various reports from Louisiana, Rhode Island, California, and New York attest to the prevalence of such plans and of "contract practice," as competitive health care was then called. A 1909 report on Rhode Island stated, "The English, Irish, Scotch, Germans, French-Canadians, and Jews have clubs employing the contract doctor. The Manchester Unity, Foresters, Sons of St. George, Eagles, Owls and others are in this number" (Mathews 1909).

The government also became heavily involved in organized buying at the turn of the 20th century. Most of the more comprehensive reports on contract practice describe municipal, county, and state agencies putting out for bid service contracts for the poor, for prisoners, and for government employees. At the federal level, the armed services and Coast Guard had long contracted for medical services at wholesale prices (Richardson 1945; Burrow 1977). The rates for the physician varied from \$1.00 to \$2.50 per member per annum. A committee of physicians in 1916 reported, "[T]he growth of contract practice has been so amazingly great during the last twenty-five years as almost to preclude belief. . . . Practically all of the large cities are fairly *honeycombed* with lodges, steadily increasing in number, with a constantly growing membership" (Woodruff 1916:508).

Hospitals also designed prepaid insurance plans, a little-known fact that reframes the commonly held view that this did not happen before the origins of Blue Cross at Baylor Hospital (Richardson 1945). "Hospital service associations" were also formed and organized prepaid contract services. For example, the Hospital Service Association of Rockford,

Illinois offered in 1912 hospitalization up to six weeks a year and surgery, with defined benefit ceilings, for an entrance fee of \$10, an annual fee of \$1 and a weekly contribution of 10 cents. A report from Chicago stated that by 1910, over 25 percent of hospitals in Chicago had some form of contract practice (in Burrow 1977:Ch 8).

Contract practice was considered the most dangerous threat to medicine as a profession. A typically scathing report claimed that "A certain institution which advertises as a hospital engages in wholesale contracts for an infinitesimal amount to care for its policy-holders . . . for any illness of any nature whatsoever. This institution has a dispensary where colored solutions under alphabetical labels are dispensed by an undergraduate" (Haley 1911: 395). Through contract practice, critics claimed, employers obtained the records of each worker's physical and mental condition and used it if there was litigation: "This clearly invalidates the pre-established idea that the first duty of the physician is toward his patient" (Woodruff 1916: 509). Despite these criticisms, there seemed to be considerable evidence that a wholesale market of volume discount plans and capitated medical services with selected willing providers were being established on several fronts and growing, long before Sidney Garfield and Henry Kaiser put together the first Kaiser plan.

A Profession in Crisis

These five sources of competition were said to contribute to the historically low income of physicians—about \$1,200 a year, the same as skilled craft workers (Burrow 1977:15). State medical societies reported that fierce competition had fostered backbiting, fee splitting, and open criticism between members. From their point of view, no one was in control and matters were deteriorating rapidly. However, it was a favorable situation for consumers and institutional buyers, who felt they were exercising the control they wanted to secure adequate services at reasonable prices. No one had good market information about quality, so patients and payers did not know what they were getting for their money. (Fortunately, we no longer have this problem!) In a rough and ready way, however, based on hearsay and testimonials,

competition was steadily favoring the new scientific medicine, and winnowing out ineffective therapies, poorly trained doctors, and inferior medical schools. The average income of poorly trained physicians was being driven down, but specialists were earning three to ten times as much, even with only the skeleton of modern licensing and with no specialty boards (Stevens 1971; Burrow 1977; Rosen 1983). Their growing stature complemented the efforts by hospitals to attract middle and upper-class patients. The proprietary medical schools, established by physicians who used lecture fees to supplement their income from private practice, were beginning to face competition from the serious, university-based schools, whose graduates were earning the respect of the marketplace (Billings 1903; Flexner 1911). Thus, quality and value were being recognized by "the market" on several fronts. Nevertheless, the organized profession campaigned hard for regulations, arguing that the public must be protected from inferior medicine.

SUPPRESSING COMPETITION

The ability of organized medicine to address the sources of "ruinous competition" both within its ranks and from outside remained weak until, in 1901, new leadership revised the American Medical Association's constitution so that medical societies became a pyramid of coherent power. The new AMA was a confederation of state medical societies, which in turn became a confederation of county societies, with delegates elected at each level to make up the committees and House of Delegates at the next level. A physician could not be a member in good standing at the national or state levels without being in good standing at the county level, which was made the basis for hospital privileges, group malpractice insurance, and other benefits (Starr 1982: Ch. 3). This ingenious design transformed the AMA into a pyramid of power and control. Medical societies reorganized and membership shot up from 8,000 in 1900 to 70,000 in 1910. The whole structure formed a hierarchy of networks, coordinated by small groups of influential physicians at the center of each. These networks were used to mount campaigns against competition and contract medicine and universal health insurance (Quadagno 2004). A key

tool was the *Journal of the American Medical Association*, whose circulation rose with membership as it became the authoritative voice of AMA leadership against "unscientific sects."

Leading this transformation of the AMA from a weak association to the uniting center of "organized medicine" was the legendary Joseph McCormick. This charismatic president traveled tirelessly across the country to attack the bitter fruits of competition and oversupply: rivalry, advertising, contract medicine, price competition, unethical behavior, and a surplus of badly trained doctors. He held out a uniting alternative: higher standards, good schools, fewer doctors, and fees set at reasonable levels (Burrow 1963; 1977).

Eliminating Sects and Reducing Supply

One campaign aimed to eliminate competing sects and reduce the supply of physicians by gaining control of licensure and setting high standards based on the new scientific medicine. In the early 1900s, medical societies launched a campaign to eliminate dual licensing boards and to give themselves more influence on who was selected to the boards. The boards, in turn, supervised state licensing examinations, and through these the educational leaders of the societies constantly raised the standards in terms of scientific medicine, thus forcing other sects to train their students allopathically or fail the licensing exams. This reflected "the Davis strategy," formulated by N. S. Davis, a founder of the AMA and its first president. The way to control the profession but avoid charges of monopoly, Davis wrote, was to establish state licensing boards outside the profession, but whose members would be chosen by the profession, and to make graduating from a certified medical school a prerequisite for licensure (Davis 1851). Licensure had suffered a national setback in the 1830s as part of populism and suspicion of privilege, but it returned in the 1870s as part of a cultural celebration of science and professionalism of everything: undertakers, librarians, social workers, pharmacists, dentists, accountants, and others (Bledstein 1976). By 1877, the first Davis-style medical practice act was passed. "Irregular" practitioners objected that open competition based on patient choice was being replaced by one sect using state power to create a professional monopoly. They took the

new laws to court, but the laws were upheld. By 1898, every state had an act and licensing board (Shyrock 1967).

A related tactic was to broaden the legal definition of medicine so that all sects would be subject to the medical practice laws and then define “unprofessional behavior” in those laws by allopathic standards. By 1904, the AMA’s Committee on National Legislation had lobbying organizations in every state except Nevada and Virginia, staffed by 1,940 members. In many states this political machine succeeded in obtaining single boards or increasing power over composite boards (Burrow 1963; Burrow 1977).

Frank Billings, president of the American Medical Association in 1903, displayed a demographic understanding and nicely summarized the profession’s campaign. There was one physician to every 600 people in the population, and there was a net surplus of 2,000 new graduates a year “thrown on the profession, overcrowding it, and steadily reducing the opportunities of those already in the profession to acquire a livelihood” (Billings 1903: 1272). Billings recommended that about three-fourths of the 156 medical schools be closed and the rest upgraded. He also sketched out the concept of special, regional hospitals, devoted to research and teaching. At the same time that Billings advocated the elimination of “unfit and irregular” doctors by training small cohorts in scientific medicine, he conceded that diagnosis amounted to little more than naming the disease and that “in the vast majority of the infectious diseases we are helpless to apply a specific cure.” This is important, because today we commonly assume that mainstream medicine’s therapeutic superiority justified its strong actions in the early years to eliminate competing sects and monopolize services.

In the same spirit, the profession captured or professionalized other markets. It attacked midwives, who attended one-half of all births in 1910, as the cause of high infant mortality and sought legislation outlawing them. This campaign largely succeeded, even though midwives surpassed physicians in all measures of safe birth across the country, such as puerperal fever and infant and maternal morbidity and mortality (Wertz and Wertz 1989). In Washington, D.C., infant mortality rose as the percent of physicians delivering increased. Moreover, few medical schools had a strong

curriculum in obstetrics with which to prepare physicians for the responsibilities they had insisted on assuming (Burrow 1977).

This massive lobbying effort to squeeze out competing sects by mobilizing the power of the state was joined by the second prong of the campaign, to drive inferior medical schools out of business and reduce the supply of physicians. As Abraham Flexner noted, “The state boards are the instruments through which reconstruction of medical education will be largely effected” (Flexner 1911).

The *Journal of the American Medical Association (JAMA)* began collecting and publishing data on the quality of every medical school in 1901, and in 1904 the AMA created the Council of Medical Education. Composed of a distinguished group of academic physicians trained at the leading centers of medicine in Europe, the Council quickly became the voice of the profession on educational matters, and that voice advocated high admission standards, long and expensive training, training in laboratories and hospitals, and tough examinations for licensure. Working closely with *JAMA*, the Council started to publish the failure rates by school of graduates taking licensing examinations. The Council established committees on medical education in the states and territories to carry out its work, and it held national conferences on medical education where it propagated its ideas about model curricula based on the new medical sciences. These efforts constituted market information on quality, and enrollments at proprietary schools with low pass rates declined. What went beyond marketing was the incorporation of the Council’s model into the requirements for state board licensing examinations.

The elite members of the Council on Medical Education developed a detailed framework for quality education and began to visit every medical school in the land. It recruited state medical societies and governments along the way, and in 1907 it launched its first attack on medical schools that could not meet its high standards: a four-year curriculum of 3,600 hours. The Council launched a second inspection by Abraham Flexner at the Carnegie Foundation that led to his famously scathing report of 1910. He charged most commercial medical schools to be little more than money machines for their faculty, and he recommended that all but 31 medical schools be shut down. The Flexner report is widely

regarded as single-handedly ushering in scientific medical education. In fact, however, the report was part of a systematic campaign started some years earlier by the new elite at the AMA to reduce physician supply and raise quality. The Flexner report played another important role—that of recruiting the great fortunes of Andrew Carnegie and John D. Rockefeller to the AMA's cause (Fox 1980; Light 1983). Between 1911 and 1938, they together gave the staggering amount of \$154 million to a small circle of medical schools that agreed to install the new, costly curriculum. To this amount was added \$600 million in other grants and matching funds from the fortunes of other industrialists. Historical research shows that Flexner and the foundation staff systematically disguised the degree to which they insisted that medical schools receiving their millions adhere to their model of medical education. By these means, a very small group of socially and professionally elite physicians were able to recast the entire profession in their image (Fox 1980; Light 1983).

This two-pronged campaign of building the new curriculum and standards into state licensure exams and giving large sums only to schools that would implement it worked. The number of graduates plummeted, from 5,440 in 1910 to 2,529 in 1922. Medical schools, which were already closing from competitive pressures before 1910, could not keep up with the rising expense of teaching the new curriculum that was increasingly reflected in state licensing exams. By 1924 there were only 80 schools left. Six of the eight "Negro" medical schools were forced to close, and quotas on ethnic groups could be found in many places (Burrow 1977). Women's medical schools were closed, on the false expectation that women would be admitted to the new medical mainstream. This might be regarded as a by-product of scientific medicine, but that would ignore how few effective scientific techniques the orthodox practitioners had and how central to the campaign was the leaders' goals of reducing supply and raising incomes. Between 1900 and 1928, physicians' incomes more than doubled, even after accounting for inflation (Starr 1982).

What the Council had done with the help of Flexner and the two great foundations was to redefine professional education so that all the small, marginal, and for-profit medical schools had to close, and medical schools could only

survive if they towed the line and thus received philanthropy from foundations dedicated to implementing the Council's new vision of professionalism. This might be regarded as monopoly capitalism shaping modern medicine after its own image (Navarro 1976; McKinlay and Arches 1985), but the evidence supports the obverse: Leaders of professionalism mobilized monopoly capital to their goal of creating a professional monopoly. Only decades later did investors exploit the protected markets that the organized profession had constructed.

Eliminating Price Competition and Free Care

A third campaign which contributed to the doubling of incomes focused on minimizing the growth of free care at dispensaries, price competition among physicians, and external price competition by sponsors of contract medicine. To battle contract medicine, county and state medical societies took a number of actions (Burrow 1977). They conducted studies and reported on the allegedly terrible conditions under which contract physicians worked. Strangely enough, the few times that remarks were published by physicians doing contract work, they said they liked the guaranteed income rather than having to deal with the large number of unpaid bills, often from patients who could barely make a living. County medical societies were also forced to acknowledge that a sizable proportion of their own members actively bid for contracts and did contract work (Langford et al. 1907; Haley 1911; Woodruff 1916).

To those leading this campaign, however, complicity was reason to redouble their efforts and save their colleagues from their own bad judgment. Some medical societies drew up lists of physicians known to practice contract medicine in order to embarrass them. Others drew up "honor rolls" of members who promised to swear off competitive contracts. Committee members would ferret out every recalcitrant colleague and make group visits to pressure him to abandon contract practice. Some societies threatened to expel or censure members who did not cooperate in stamping out price-competitive medicine. On other fronts, state and county medical societies pressured departments of public health, legislators, and their members who worked at dispensaries

to have public health stop where clinical medicine begins and to turn over patients with diseases of concern to public health to private practitioners.

They also transformed hospitals from charitable institutions, where the local poor could receive rest and nursing, to centers of surgery and the latest scientific techniques, wooing the paying middle-class patient. Trustees of charitable hospitals reluctantly began to woo physicians in private practice, needing their well-to-do patients, yet fearing that the doctors would demand too much control in return (Vogel 1980; Rosner 1982). The pursuit of paying patients changed the character of hospitals, just as trustees had feared. Historian David Rosner (1982) writes, "By 1915, doctors at many institutions had essentially wrested control from the trustees and had gained the power to make the decisions that were in their best interests, regardless of the traditional charity goals of the hospital" (121). In changing from wards to semi-private or private rooms and to specialized departments, the architecture and organization of hospitals reflected the new power relations and the new social composition of patients. Commercialism, Rosner points out, was also evident in the national movement to transform "the old rich charity hospitals into a 'scientifically' managed medical enterprise" (Rosner 1982:121). By 1912, there was enough of an organized audience for a magazine called *Hospital Management* to start, featuring techniques to attract well-heeled customers out of the comfort of their homes and into the "superior" accommodations of the hospital for serious medical problems. Towns, counties, states, governmental departments, religious sects, labor unions, and fraternal orders built hospitals at the turn of the century, and in places where no one built hospitals, doctors converted a large home to a small "hospital." By 1928, 38.9 percent of the 4,367 of the nongovernmental general hospitals were proprietary—a much higher percentage than in the 1980s when hospital chains proliferated. They had only 16 percent of the beds, however, and often lost money, so that doctors were only too happy when a growing town or voluntary association supplanted them with a larger community hospital (Light 1986).

Although organized medicine never eliminated competitive contracts entirely, it greatly reduced their numbers and shifted them from service to cash contracts. Fraternal orders did

not want to cause a row with county and state medical societies, and they shifted benefits to partial payments for wages lost and reimbursement for medical bills rather than for prepaid contracted services. Reimbursement allowed doctors to set their own fees and eliminated any intermediaries setting the terms of service. Several court decisions supported the profession's opposition to the corporate practice of medicine, even though its legal basis was weak. In a number of states, societies persuaded state legislators to pass laws prohibiting the corporate practice of medicine or the practice of medicine by organizations run by non-physicians. They got other laws passed against the organized practice of medicine for profit. Medical societies meanwhile dusted off their old fee schedules and raised their prices to a professionally respectable level (Schwartz 1965). Historian James Burrow (1977) observed, "Hardly had the United States Steel Corporation succeeded in its consolidation effects that raised prices of basic steel products in 1901 from 200 to 300 percent above the most competitive level of 1898, when the medical profession began its income uplift and price maintenance program" (p. 106).

The goal of these and other efforts to gain control over the practice of medicine has not been to eliminate competition entirely but rather to keep outsiders (i.e., consumers and buyers) from setting terms, especially price. As Max Weber (1968) understood, guilds secured a monopoly over a domain and then let members compete freely within it. By the 1920s, the medical profession had confined contract medicine to a few industries with special needs, to group purchasing of services for the poor and the military, and to a few maverick experiments on the periphery of medicine (Williams 1932).

"No Middlemen" was a call to arms by the Propaganda Department of the AMA in the 1920s and 30s; for they were the ones who had created contract medicine and commercialized medicine by pitting one doctor against another for the lowest bid. Having patients pay doctors directly was the only way to keep the profession free of commercial agents. It also directly links professional services to the pocketbook. The drive for national health insurance between 1910 and 1915 posed a threat, especially since the reformers advocated paying doctors by capitation. While initially attracted to the idea of universal coverage, the rank and

file of medical societies made clear they would have none of it.

Reining in the Nostrums Industry

As part of the assault on competing sects, dispensaries, public health clinics, midwives, and other forms of treatment that reduced the demand for professional medical care, the AMA mounted an intense campaign against patent medicines. Many basic professional issues spurred this action. First doctors faced relentless competition from drug salespeople, peddling their wares directly to customers and through massive advertising. Second, this \$100 million industry (in 1905) promoted self care and home remedies instead of going to the expense and trouble of seeing a doctor. Patent pharmaceutical companies not only sold drugs which they widely advertised, but they published guides for laypeople and set up advisory services such as the popular "Write Mrs. Pinkham." Third, many doctors made up their own secret remedies and promoted them as superior to others, thus tacitly undermining their colleagues. Fourth, druggists competed with the doctors by refilling prescriptions without a return visit and by stealing doctors' remedies and offering them independently. Scientifically, none of these patent medicines or doctors' remedies were tested. Starr (1982) observed, "The nostrum makers were the nemesis of the physicians. They mimicked, distorted, derided, and undercut the authority of the profession" (p. 127). One article estimated that the money spent on nostrums was enough in 1905 to more than double physicians' incomes (cited in Caplan 1981:320). Yet the medical journals were implicated, and only a few were immune from manufacturers' demands that promotions appear disguised as articles or editorials (Young 1961:207).

In 1900, the AMA published an eight-part series of unsigned articles which provided an overview of issues and policies towards relations with pharmaceutical firms (anonymous 1900). The series called for drugs to have names that reflected their composition rather than their allegedly healing qualities. It discussed the problem of substitution and warned against the widespread use of "polypharmacy," the combination of more than one drug in a pill or dose. It identified the pernicious pattern of

companies donating drugs to hospitals and dispensaries where medical students learn, "with the result that the average medical student's ideas and experience concerning medicines are largely confined to the proprietary articles, which his 'professors' used in their demonstrations" (p. 1115). It described the problem of secret proprietary drugs.

In concert with its other actions to promote scientifically based medicine, the newly reorganized AMA created in 1905 the Council on Pharmacy and Chemistry to professionalize drugs by providing the public and its doctors with an AMA-approved list of drugs. It required a drug manufacturer to reveal the ingredients and formula of any drug submitted for the Council's review, and it set itself up as the arbiter of advertising copy in professional journals. The overall goal was to have a list of drugs that were known only to doctors and prescribed by them. It established professional rules of acceptability which included a prohibition against advertising to the public or stating on the label the diseases for which the drug was indicated. Doctors would decide that, as they often do today for disorders for which drugs have not been tested.

The AMA wished to professionalize the large and growing market of self-administered medicines. Without advertising or indications, the profession hoped that patent medicines would disappear. At the same time, the power to prescribe the more effective, AMA-tested medicines would add to the profession's powers to certify sick leaves from work and admit patients to hospitals. The AMA also established what it called the Propaganda Department to publish books and articles warning the public against patent medicines and self-diagnosis. These articles repeatedly told the public that medicine was now a complex scientific field that required years of training, and the articles reported deaths, injuries, and disabilities which patent medicines had purportedly caused. Of great assistance was an exposé by Samuel Hopkins Adams (1905), detailing the dangers and deceptions of patent medicine manufacturers. The Propaganda Department of the AMA also put pressure on lay publications to refuse ads for prescription drugs and even for patent drugs. All these efforts met with partial success, particularly in reducing the number of doctors who developed their own remedies and

in stopping druggists from competing directly with them.

Consolidating Professional Control

By 1920, the organized profession had largely succeeded in transforming medical care from an open marketplace where providers and therapeutic schools competed on price and claims of effectiveness to a professional monopoly that claimed to end “ruinous competition,” guarantee quality, and establish true patient choice. Freedom and choice were central values. But as Charles Weller (1983) has pointed out, professional “free choice” is a restraint on trade. It is *guild* free choice rather than *market* free choice, that is to say free choice within the profession’s terms of training, licensure, fees, and the structure of services. Market free choice would mean competing on price as well as different kinds of services offered by competing kinds of providers. The profession had in effect created a trust during the era of trust-busting, because professions were regarded then as benevolent forms of social control as developed by E.A. Ross ([1901]1969). His best seller, *Social Control* helped shape efforts by community leaders to clean up corrupt political machines, monopoly trusts, and companies that would sell contaminated meat or dangerous drugs to an unsuspecting public. However, Ross noted that social control could become class control when done by a closely knit elite. They would pass laws and regulations that appeared to treat all parties equally, yet most benefited their own class. Leaders of the medical profession did much to clean up the medical profession in ways that brought civilizing order to modern communities, and they were exempted from anti-trust law. They did so, however, in ways that resembled class control more than community-based social control, especially by creating professionally controlled monopoly markets.

Later, Parsons (1975; [1939] 1954) admired the professions as viable alternatives to business but did not see the degree to which the tactics of the organized profession echoed those of business monopolies (compare them with those in Jones 1921). Weber (1968) understood better the nature of guilds, which pursue quality, prestige, and profits for their members by forming an interest group and

then pursuing a legal monopoly. What the profession did not anticipate was the degree to which the very success of their harnessing the nostrum manufacturers would commercialize it. Many of the practices which the AMA attacked returned, but now within the professional fold.

The prevailing sociological theory of modern medicine has been that of professional dominance (Freidson 1970b; 1970a; Starr 1982). The proletarianization of the medical profession by capitalists also has its followers (Navarro 1976; McKinlay and Arches 1985). Both theories identify part of the whole but do not provide a comparative, historical framework (Light and Levine 1988). One emphasizes the rise to dominance and the other the decline to subordination, but neither can explain both. The concept of countervailing powers offers a more fruitful framework, one which invites researchers to consider the changing dynamics over time among key stakeholders and across countries (Light 1995a; 2000b).

Larson (1977) has provided a cogent theoretical and historical account of how the medical profession turned expertise into market power, by creating a new kind of monopoly market (p. 56). The key is to define and defend a unique service, or commodity; to standardize it and the training of professionals in it; to get the backing of the state in the name of safety; and thereby to exclude all other claimants. One creates, then, a professional caste centered on autonomy and control. Ironically, the profession is “allowed to define the very standards by which its superior competence is judged . . . professionals live within ideologies of their own creation, which they present to the outside as the most valid definitions of specific spheres of social reality” (p. xiii). This collective monopolistic project takes place within a specific economic and institutional context which shapes the structure of professional markets. This provides a framework for understanding both the ferocious campaigns to eliminate or contain other countervailing powers and the unanticipated consequences that have led to the pathologies of the health care system today.

From a comparative perspective, however, we need to realize that accounts of the rise of professionalism by Larson, Starr, and others that are focused on the American case overlook fundamental differences in professionalism

orchestrated top-down by the state in a number of other countries or bilaterally between professional associations and the state in other countries. All share the rise to dominance of medicine, especially hospital-based specialty medicine, but in the other cases professional dominance is framed by societal needs and state power to determine the number and distribution of specialists, what they charge, and how they fit into a national system of health care (Burrage and Torstendahl 1990; Immergut 1992; Light 1994; Giarelli 2004). As this history shows, the “accidental logics” of the contemporary system and its lack of universal health coverage were hardly accidental (Touhy 1999).

This institutional history provides a quite different but complementary example to economic sociology of the rise of large corporations (Roy 1997; Perrow 2002). Roy’s emphasis on power rather than on efficiency as the more accurate way to explain the rise of large corporations fits the rise of professional medicine as well. Markets, in this view, are constructed by the participants with the cooperation of government. Control over training and licensure gave the profession property rights over medical knowledge. Although in retrospect the promotion of scientific medicine seems enlightened and correct, evidence indicates it was winning converts rapidly on its own merits, and one must remember that at the time, the strong medicines and aggressive therapies did as much harm as good.

THE PROFESSIONALLY DRIVEN HEALTH CARE SYSTEM

The health care system that evolved from the campaigns of organized medicine fulfilled the professional vision of what a good system should look like, a system that strives to provide the best clinical care for every sick patient who could pay, to develop scientific medicine to its highest degree, to preserve the autonomy of the physician, and to increase the dominance of the medical profession (for comparative visions, see Light 1997). Power centers on the profession, and the organization of work centers on physicians’ choices of specialty, location, and clinical judgment. The result is a loosely linked network of autonomous offices, clinics, hospitals and related facilities. The image of the individual is of a private person

who lives as he or she sees fit and comes in for help as she or he chooses. Financing in this ideal type centers on the fees that doctors choose to charge.

This vision has several flaws from a societal point of view. Organized medicine destroyed medical schools for women and “Negroes,” crushed midwifery and alternative sects, used scare tactics to discredit national health insurance, and cared little about patients in low income and rural areas. Its almost exclusive focus on clinical care for sick patients who can pay began the historic separation of medicine from public health, even though public health achieved more spectacular successes using the same scientific foundation and discoveries, and a disinterest in prevention and primary care as low-status work of little interest. The organizational profession’s vision of good medicine also lacked a sense of responsibility for communities or community health, because doing so would require forms of financing and governance that compromised professional autonomy. Concepts of interprofessional teams were resisted as threats to professional authority.

The organized profession, however, rarely behaves as a servant of humanity or public good. For that to happen, it needs a strong societal framework, precisely what other countries provided where the state constructed the modern profession or where the state and profession worked in harness together as equally strong partners (Roemer 1991; White 1995; Giarelli 2004). This is shown in column three of Table 1. This point is put more broadly in a reinterpretation of Parsons: one cannot expect a profession to be much different from the economic, organizational, and political framework of the society in which it operates (Light 2000a). If that society sanctions a for-profit, financial system that does not reward disease prevention and care of poorer patients, one cannot expect the medical profession alone to make up the difference. Emanuel (1991) likewise showed the limitations of professional ethics and the need for a societal ethic to set the larger context. This fundamental point is illustrated by contrasting the professional ideal health care system with the societal ideal that is manifested in a strong state. The societal system seeks to promote a healthy, vigorous population and to minimize illness. Medical services are therefore universal, equitably distributed, and focused on primary care and pre-

TABLE 1. Contrasting Visions and Values of a Good Health Care System

Corporate Providers, Suppliers, and Middlemen	The Organized Profession	Governments or other larger payers
Key Values & Goals:		
To maximize market share and profits. To maximize the size, range and expenditures of markets.	To provide the best possible clinical care to every sick patient (who can pay and who lives near a doctor's practice).	To have a healthy, vigorous workforce.
To increase demand and form new markets.	To develop scientific medicine to its highest level.	To minimize illness and maximize self-care.
To minimize, neutralize or circumvent regulations by government or payers.	To protect the autonomy of physicians and services.	To minimize the cost of medical services
	To increase the power and wealth of the profession.	Perhaps to provide good, accessible care to all
Image of the Individual:		
An object of marketing to maximize expenditures.	A private person who chooses how to live and when to use the medical system.	An employee, and somewhat the responsibility of the employer.
Power:		
Centers on corporate headquarters. State and profession relatively weak.	Centers on the medical profession, and uses state powers to enhance its own	Centers on key governmental officials, politicians, sometimes unions.
Key Institutions:		
Health care and supplier corporations. Governments and employers as sources of revenues and managers of competition.	Professional associations. Autonomous physicians and hospitals.	Departments of health, social security, and related departments.

vention. The number and distribution of specialists, hospitals, and costly technology, as well as costs, are subject to institutional rules and regulations within which the profession works. For-profit services have been rare, and for-profit suppliers are held in check. By contrast, the American case illustrates the professional health care system unleashed and unfettered.

Creating Provider-friendly Insurance

This sociological interpretation of American medical services offers a different perspective on subsequent events than most accounts. It explains the extreme reluctance of the organized profession to allow any form of insurance and the absence of a state that would direct the skills of the profession to the needs of society, even when evidence showed that millions of poor and elderly people were being impoverished and not getting needed care. When unpaid hospital bills became so great that the American Hospital Association broke ranks with the AMA, it began the search for a non-profit, passive form of hospital insurance that would become Blue Cross. Great care was taken to avoid comprehensive prepaid plans

and consumer-based plans, and to endorse only private, voluntary, no-profit insurance that covered just the hospital part of the bill (Rorem 1940; Richardson 1945; Reed 1947). The AMA's Bureau of Medical Economics remained steadfastly opposed. Insurance, its reports had maintained, depends on compensating for defined liabilities (like fires or thefts), which are impossible in medicine (Bureau of Medical Economics 1935). Service-based coverage, like Blue Cross, leads to standardized, cookie-cutter care for the wide variations among individual patients. This degrading of professional medicine was what contract medicine had brought 30 year earlier, the AMA's Bureau pointed out, and it must not be allowed again. But open rebellion among physicians during the Depression and their development of various insurance schemes led the AMA reluctantly to develop Blue Shield several years after the AHA launched Blue Cross. Great care was taken to be sure it was pass-through reimbursement of what doctors charged, largely focused on hospital-based specialists, rather than based on a fee schedule (Rayack 1967). Passive intermediaries and physician autonomy were the key goals, not any collective sense of access or managing costs. Thus the organized profession laid the

institutional and cultural foundations for private, voluntary, and pass-through approaches to covering medical bills that would ironically become their nemesis.

Both of the Blues required a majority of directors to be hospital trustees, administrators, or specialists, hardly an auspicious group to restrain costs but considered the natural and obvious choices at the time. The Blues were professionally controlled insurance organizations that covered only those who could afford to pay, and laid the institutional foundation for commercial insurance companies to cover lower-risk groups (Bodenheimer, Cummings, and Harding 1974). The authoritative Louis Reed envisioned in 1947 that although most hospitals were not for profit,

... under a situation in which a large proportion of the population was enrolled and hospitals were paid on a cost basis, hospital administrators would wish in general to provide a more and more perfect or elaborate service, and to make this possible would ask for higher and higher rates of payment. (Reed 1947: 89).

This is precisely what happened over the next 30 years. With the enemies of professionalism vanquished and the victories won before 1920 anchored in institutional reforms, the professionally driven health care system roared ahead, magnifying its successes as well as its pathologies. Professionally designed passive insurance led to ever-higher charges for ever-more procedures and bed-days.

Professionally Crafted Public Funding

World War II had many effects on society and medicine, including great advances in surgery and medical science. After the war, the Public Health Service was transposed into the National Institutes of Health. Further federal support for research and academic medicine came from a realignment and expansion of the Veteran's Administration hospital system around medical schools. Hospital reconstruction received central attention through the Hill-Burton program, guided by a national commission through which the American Hospital Association outlined a huge, 40 percent expansion in beds. Hill-Burton regulations favored poorer and Southern states but required that community hospitals raise two-thirds of the funds for construction and be financially

viable, thus favoring middle-class communities. In a carefully constructed argument, Starr (1982) demonstrates that these major infusions of public money were designed to reinforce professional sovereignty and local institutions. Requirements that recipient hospitals treat those unable to pay remained ignored for decades.

Federal funds also greatly influenced the growth and shape of academic medicine. The incomes of medical schools tripled during the 1940s, more than doubled in the 1950s, and nearly tripled again during the 1960s, but largely from federal funds concentrated on research. This focus enhanced the technical prowess of American medicine, but diverted attention from organizing medical schools, the recruitment of students, and the distribution of specialists to meet the health needs of the population. It led to building academic health care "empires" that exploited the poor more than serving their considerable health care needs (Ehrenreich and Ehrenreich 1976; Waitzkin 1983).

In the private sector, commercial health insurance grew rapidly. These for-profit giants had no relation to the non-profit, community-based ethos of Blue Cross and proceeded to draw away the lower-risk groups with lower premiums. Risk-rated private insurance left the Blues with an ever higher-risk profile of patients left in their community-rated pools. Eventually they had to cave in and risk-rate too (Somers and Somers 1961). Focused on quarterly returns to investors, corporate insurers eventually turned on professional autonomy itself in order to contain costs for their true clients, the employers who hired them. Through the 1950s and 1960s, however, health insurance covered just about anything doctors wanted to order. This exacerbated the super-professionalism of academic health complexes (Ludmerer 1999: Part II).

PATHOLOGIES OF PROFESSIONALISM

Most accounts of American health care since the 1970s describe its fragmentation, inefficiencies, run-away costs, impersonal care, uneven distribution, variable quality, and over-specialization, but without acknowledging how these emanated from a professionally driven health care system operating in its own professionally constructed markets. In time, corporations realized that protected profes-

sional markets were a capitalist's dream of a market with virtually no downside risk. After 1920, the drive to develop the best clinical medicine based on physician autonomy led quite naturally to more and more specialization. Specialists charged higher fees, and subspecialists charged even more. Since doctors were to be free to choose their specialty and where they practiced, rural and poor areas were underserved, as was primary care; so that by the 1970s a double crisis of uneven distribution became a central policy concern. Impersonal care was also an unanticipated consequence of specialization leading to highly bureaucratic care divided into compartments of expertise. This problem can be overcome, but it takes a shared vision of specialty-based care that is not common.

Specialization, when combined with professional autonomy, produces fragmented care. Around the need for coordination arose secondary industries of intermediaries—just what the profession wanted to avoid at all costs and yet an ironic consequence of its ideal system. Another pathology resulted from presuming that quality was whatever a licensed physician did. This led to great variation in actual skills, preferences, and practices without any evidence that more costly care produces better results (Wennberg and Gittelsohn 1982; Wennberg 1984). The whole system, as well as its hierarchy of values and prestige, centered on hospital care for the seriously ill. As hospitals grew and became elaborated, costs not only rose faster, but they became large institutions in their own right, and this led to a new profession to run them: professionally trained administrators. Thus, by the 1970s, the professionally ideal health care system had led to widespread complaints about impersonal, over-specialized, fragmented care; run-away costs; widely varying and uneven quality; and a neglect of public health, prevention, and primary care (Cray 1970; Kennedy 1972; Ehrenreich and Ehrenreich 1976; Illich 1976).

One pathology of professionalism was to make medical care and charity less and less affordable to the poor and elderly who did not have pass-through commercial insurance. Despite these untenable gaps, the AMA fought long and hard against all efforts to provide coverage and relief, though Medicaid and Medicare finally passed in a form that explicitly extended the profession's ideal of autonomous physicians in private practice

charging what they liked. While the medical profession insisted that charges be reimbursed, community hospitals insisted that their debt service be built into the bed-day rate, including Hill-Burton assets funded by taxpayers. This meant that "community hospitals" would no longer have to appeal to their communities to raise funds, though they did anyway. All costs for medical equipment were rolled into the bed rate too, so even mistakes were fully paid for. Fledgling corporate chains hired lobbyists to insert phrasing that enabled them to use taxpayers' money to develop large corporate chains (Feder 1977). In short, the values, mind-set, and regulations built into major new public funding reflected the professional model on a binge. Physicians exercised their uncontrolled autonomy by raising their fees almost three-fold between 1965 and 1980. Hospital bed-day charges quadrupled (U.S. Department of Health and Human Services 1982).

Leaders and advocates of professional medicine now look back at the postwar period as "the Golden Age of Medicine" (McKinlay and Marceau 2002); however, while there were legendary individuals, the period looks more like an Age of Gold. Physicians incorporated themselves and became increasingly commercial in their approach to patient care. As early as the mid-1950s, physicians led the movement to establish for-profit hospitals and made many times more than they could in their practices. An early detailed report noted that these doctors' hospitals did not provide any community services that did not make money and elaborately used legal strategies to create interlocking sets of corporations (O'Neil 1956 (Dec)). Leaders of the profession rarely admit that the corporatization of direct services was a natural outgrowth of the system the profession put in place. They do not admit that physicians commercialized themselves and related services before corporations commercialized them. When combined with insurance that passively reimbursed charges, the professionally driven health care system was a capitalist's dream. Soon, outside investors began to realize the low-risk, high-profit character of medical services, and the corporatization of medicine moved into full swing.

Investor-owned health care corporations grew rapidly, a logical extension, I would argue, of the monopoly markets that the organized profession set up for itself in the absence

of a national health care system. When O'Neil reported in 1956 that some doctors had discovered that building a private hospital pumped out more profit than having an oil well, investors were not far behind. By 1964, the early chains had lobbyists insert into Medicare legislation extraordinarily profitable phrases, and the floodgates opened. Relman's (1980) famous essay about the "new medical-industrial complex" missed the point: It was a natural extension of the old medical-industrial complex centered on the medical profession which Relman excused as not the point. Two years later, Starr (1982) concluded his much-celebrated history by discerning that "Medical care in America now appears to be in the early stages of a major transformation in its institutional structure, comparable to the rise of professional sovereignty at the opening of the twentieth century" (p. 428). He predicted a shift in ownership to for-profit corporations and a concentration of ownership into conglomerates that would integrate hospitals, clinics, and physicians both horizontally and vertically. Several articles in this volume, and the more recent studies on which they build, provide a more differentiated analysis of this prediction (Wholey et al. Casalino 2004; Rundall, Alexander, and Shortell 2004).

A famous chapter of Waitzkin's (1983) important book described how a high-tech fad (coronary care units) proliferated without any evidence that it was effective, based on campaigns of academic and corporate entrepreneurs who profited from the costly, un-evidenced fad. And when the U.S. market reached saturation, the major corporations involved turn to exporting their costly, latest product lines to countries in Latin America and Asia that have fixed, much smaller budgets, where they persuaded by various means the ministers to give their people "the latest" and "the best" from the global center of academic-medical capitalism (Jasso-Aguilar, Waitzkin, and Landwehr 2004). A modified version of Waitzkin's figure appears in Figure 1.

In sum, the financial, political, organizational and clinical pathologies of professionalism (Table 1) were built into Medicare and Medicaid and accelerated after them. It is for these reasons that I do not think the second era of American health care began with this legislation (Scott et al. 2000), but rather a few years later when all the payers began to revolt as a countervailing power and launched a series of

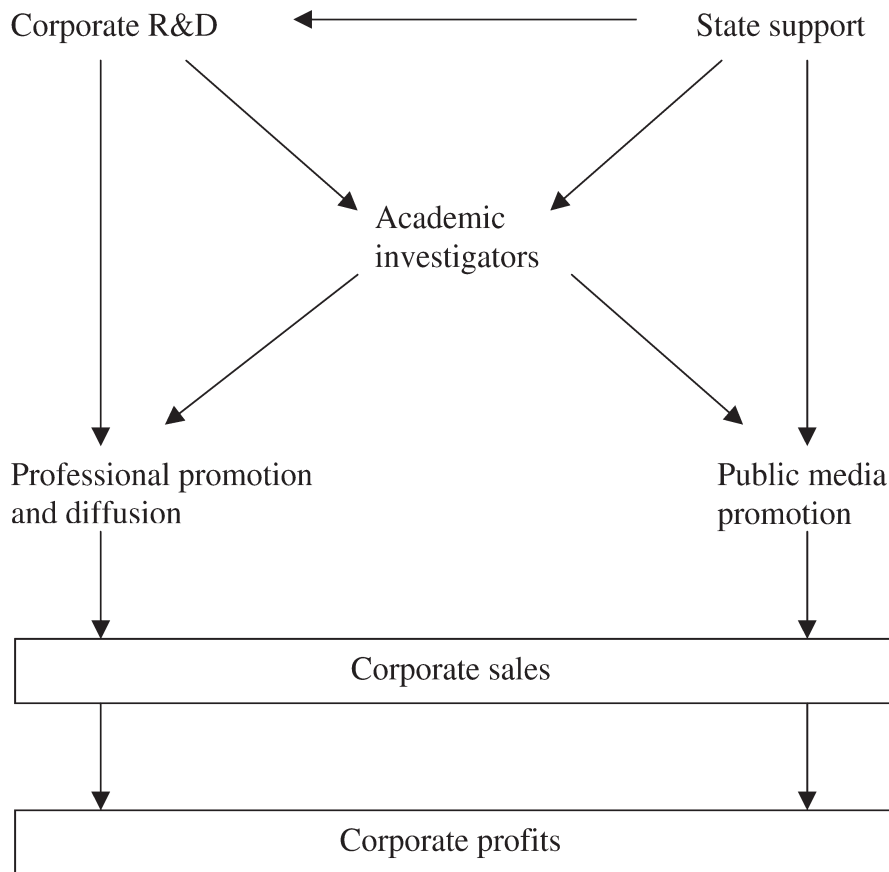
efforts to rein in costs and rationalize medicine.

THE REVOLT OF COUNTERVAILING POWERS

Unrestrained growth in utilization, variation, and charges in this age of gold for doctors and hospitals generated an intense feeling from the right to the left that professionally driven health care had led to greed, waste, inequities, and dubious quality. In the 1960s, the thalidomide affair documented how medical hubris could wreak havoc on the lives of trusting patients and how professional arrogance led to abuses (Hilts 2003). Friedson's (1970a, 1970b) studies of the "golden age of medicine" described in detail the structural dominance of the profession in the United States and the resulting pathologies. He concluded that an organized profession could not discipline itself effectively. Dr. Robert McCleery (1971) produced a graphic report, now forgotten, that detailed the low quality of clinical work and injury to patients by ordinary physicians (in contrast to those celebrated in the press at the great medial centers) and the very limited ability of medical societies and state boards to do much about it. In 1972, Senator Abraham Ribicoff, who had been Secretary of Health, Education and Welfare, published *The American Medical Machine* and described the machine's relentless ability to generate bills. In Tulsa, Oklahoma, he found, medical debts accounted for 60 percent of all personal bankruptcies (Ribicoff and Dandaceau 1972). In the same year, Senator Ted Kennedy (1972) published his critique, *In Critical Condition*, based on vivid testimony from citizens at hearings his committee held across the country.

These books were read and discussed widely and set the stage for the most radical critique of all, *Medical Nemesis: The Expropriation of Health*, by the Jesuit priest, Ivan Illich (1976). Drawing on research reports in the leading medical journals, Illich held up a mirror that both shocked and fascinated the public as well as the medical world, a world of medicine gone mad, of error and iatrogenesis. Yet as Navarro (1976) and Waitzkin (1983) pointed out, underlying Illich's critique was a radically conservative individualism—each person should take responsibility for his or her health and treat himself or herself—when many causes of

FIGURE 1. The Medical-industrial Complex of Corporations, Universities, and the State in the 1980s



Note: Adapted from Waitzkin (1983)

illness as well as pathologies of the medical-industrial complex that had grown up around the profession's vision of an ideal system stemmed from a sharply inequitable class structure and a capitalist economy with fewer compensatory programs than any other advanced capitalist society (Moller et al. 2003).

Weak Regulatory Reforms

The countervailing powers of payers, including Congress and state legislators as the new dominant payers, had had enough. Moreover, the state as regulator had become worried about lapses in quality; the unshakable trust in the profession to safeguard standards of care began to crumble. During the 1970s, Congress and the states developed

large-scale programs to rationalize physician referrals and hospitalization, to plan more equitable capital expenditures, to develop a comprehensive cost base for reasonable charges, to establish hospital rate-setting systems, to establish quality review, and to transform American health care into a network of self-regulatory health care systems that rewarded prevention and primary care called "HMOs." These national and state systems and proposals were all undermined in various ways by hospitals and doctors (Starr 1982: Bk. 2, Ch 4).

Meantime, Paul Ellwood realized that prepaid group health plans—those "hotbeds of socialism" so adamantly opposed by the medical profession—could be recast as private, self-regulating health care systems in which incentives were aligned with keeping people healthy and keeping costs down (Brown 1983).

These “health maintenance organizations” (HMOs) were just what the newly elected President Nixon needed: a private alternative to socialized medicine. In 1970 he gave the first speech on health care to the joint houses of Congress and proposed universal health care delivered by 1,700 HMOs. The corporate lobbies of all the suppliers, providers, and insurers opposed it. Watergate discredited Nixon, and a severe recession sealed its fate (Starr 1982:Bk 2, Ch 4). What came out the other end was the HMO Act of 1973, which lobbyists tried to block and then weighed down with so many requirements that federally qualified HMOs would collapse under their weight (Starr 1982; Brown 1983). The nation’s leaders concluded that “regulation does not work,” despite its working reasonably well in every other advanced medical system. A signal event occurred when the U.S. Supreme Court reversed in 1975 the long-standing exemption of professions from anti-trust regulations, on the grounds that professions were, after all, businesses. These events, despite their limitations and failures, signaled a transformation in values and vision and a new balance between countervailing powers.

Strong Corporate Reforms

With the “failure” of regulation, the stage was set for the Reagan era of market-based solutions to social problems. Employers, who had increasingly self-insured to avoid a thicket of regulations that had developed over the years, turned from years of complaining to staging what I have called a Buyers’ Revolt (Light 1988). Table 2 outlines the basic cultural, economic, organizational, political, and technological changes wrought by a re-balance of countervailing powers. As employers aggressively sought ways to rein in costs, insurance companies took on a new role of developing techniques to monitor, gatekeep, and select providers. Secondary industries developed to select providers into “preferred provider organizations” (PPOs), to deliver services within a fixed budget (network HMOs), to screen and monitor physicians’ clinical decisions for costly procedures, and to redesign health benefit plans. These various techniques and new organizational forms came to be known collectively as “managed care,” and the macro theory and policy for getting them to

drive better value for less cost was called “managed competition.” The rise of managed competition and managed care centered on the medical profession’s refusal to take responsibility for the highly variable quality and rapidly rising costs that resulted from physician autonomy.

As originally conceived by Enthoven (1988), managed competition was aggressively promoted as the solution to the extensive problems of market failure in health care. The many commentators on managed competition fail to note that deep sources of market failure remain, only hidden behind the walls of the managed care organizations as they compete for contracts and market share (Light 1995b). Using a rhetoric of “choice,” they restrict choice of provider and procedures by design. Competing managed care organizations are usually oligopolies in most markets, and oligopolies usually do not compete on price. Yet price competition is supposed to be the key goal of managed competition. Managed competition also leaves no one responsible for common issues of public health. Managed competition, ironically, is based on a distrust of doctors but a trust of managers. Investor-run network HMOs are in this way profoundly different from the original, non-profit, physician-run HMOs such as Kaiser. Based on the distrust of doctors, they require a great deal of regulation, and they commercialize clinical decision-making by relying on payments and penalties. Evidence of greater “efficiency” usually turns out to be the surreptitious result of enrolling fewer sick or disabled patients. In these ways, managed care corporations of various forms undermined the moral foundations on which successful markets depend (Etzioni 1988). The health economist, Uwe Reinhardt, is said to have asked, if managed care companies require another 15 percent more overhead than Medicare and Medicaid and want to make at least 10 percent return, can they really reduce costs by 25 percent without cutting into needed care? The chief result, in Medicare and in the general markets, has been cost shifting and cost avoidance through risk selection, and these remain the more common ways to “contain costs” in a system that lacks universal coverage. Patients (as well as doctors) rebelled (Mechanic 2004).

Managed care profoundly altered the balance among countervailing powers. The imbalances of professional dominance first led to a

TABLE 2. The Buyer's Revolt: Axes of Change

Dimensions	From Provider-driven	To Buyer-driven
Ideological	Sacred trust in doctors	Distrust of doctors' values, decisions, even competence
Clinical	Exclusive control of clinical decision-making	Close monitoring of clinical decisions, their cost and their efficacy
Economic	<i>Carte blanche</i> to do what seems best: power to set fees; incentives to specialize; Emphasis on state-of-the-art specialized interventions; Lack of interest in prevention, primary care, and chronic care; Informal array of cross subsidizations for teaching, research, charity care, community services	Fixed prepayment or contract with accountability for decisions and their efficacy Emphasis on prevention, primary care, and functioning Minimize high-tech and specialized interventions Elimination of "cost shifting" pay only for services contracted
Organizational	Cottage industry	Corporate industry
Political	Extensive legal and administrative power to define and carry out professional work without competition, and to shape the organization and economics of medicine	Reduced legal and administrative power over professional work and also the organization and economics of services
Technical	Political and economic incentives to develop new technologies in protected markets	Political and economic disincentives to develop new technologies
Potential disruptions and dislocations	<ul style="list-style-type: none"> • Overtreatment • Iatrogenesis • High cost • Unnecessary treatment • Fragmentation • Depersonalization 	<ul style="list-style-type: none"> • Undertreatment • Cuts in services • Obstructed access • Reduced quality • Swamped in paperwork

powerful alliance with the rapidly expanding medical-industrial complex. Corporate employers and public legislators developed what might be called a *managed-care-industrial complex*, replete with large new secondary industries that designed benefits, select providers, manage services, define outcomes, and establish systems of quality, performance, and value—precisely the functions that the profession promised to perform. Clinicians “. . . face an increasing set of organized stakeholders who question the content, quality, and cost of professional work, increasingly ‘shop around’ for the professional services they want, and otherwise act to control professional activity in ways that were unheard of as late as 20 years ago” (Leicht and Fennell 2001; 226). In sum, the consequences of a professionally designed health care system and the efforts to deal with its social and clinical pathologies has led to the most costly, inefficient, wasteful, and inequitable health care system in the industrialized world, and to a complex of secondary industries that thrive on these four characteristics. Inefficiency, waste, and risk selection are good business, and the multi-billion dollar beneficiaries lobby hard against efforts to reduce them.

This transformation of corporate control extends Fligstein's (1990) seminal research

and theory on that subject. He posits that major corporations develop a “conception of control” that is collectively held and enables them to solve core problems in their organizational field so that they can re-establish stability and control over their economic environment. When an industry faces an historic crisis, the conception of control changes. Of particular note is the corporate definition of efficiency as “the conception of control that produces the relatively higher likelihood of growth and profits for [leading] firms, given the existing set of social, political and economic circumstances” (p. 295). Fligstein applies this theoretical characterization of historical changes to corporations as sellers, but it can apply, as outlined here, to corporate buyers as well.

Managed competition and the rise of managed care organizations arose because corporate and government buyers faced a crisis of excess created by the stakeholders of professionalized markets and needed a new concept of how to control rising costs. They sought to rein in the excesses, replace professional autonomy with accountable performance measures, and reorganize the center of care from hospital-based acute intervention to community-based prevention and primary care. As Fligstein notes, such concepts are loosely applied, as suits different stakeholders. A deep

TABLE 3. Tragic Flaws of Managed Competition/Care

The model of having self-contained HMOs (such as Kaiser) compete for quality, service, and value seems to overcome most of the serious dangers of market failure in medicine that can harm patients and exploit buyers. Yet the model has several inherent flaws:

- | | |
|--|---|
| 1. Creates oligopolies, which usually minimize price competition. | 6. Assumes efficiency gains will exceed sharp rise in administrative and marketing costs that markets require when compared to non-competitive systems. |
| 2. Competitive systems require much more regulation (not less) than non-competitive systems. | 7. Reduces provider choice by design, to choosing between plans and then providers within plans. |
| 3. The major competitors become the regulators of the market. | 8. Encourages discrimination against higher risk patients. |
| 4. Based on a distrust of doctors but a trust of managers. (Are managers a different breed?) | 9. Undermines a public health or community-wide agenda, because based on plans competing for market share. |
| 5. Assumes patients will maximize value, but usually they do not. | 10. The uncertain, emergent, contingent nature of clinical work that makes medicine so ill-suited to competition remains, only hidden within the walls of each managed care organization. |

distrust and distaste for government and a belief in markets as the way to solve social problems has precluded the alternatives that employers in every other capitalist economy support. The result, not considered in *The Architecture of Markets* (Fligstein 2001), are socially destructive markets “designed” by legislative architects who take contributions from all the major sellers as well as the corporations that are supposed to manage the market. Managed care corporations, as agents for corporate employers, have designed markets in a society with few of the social protections deemed essential in other countries; so that “consumers” get harmed as insurers and providers de-select costly, sick patients or shift the costs of care back to the households of sick patients. Prevention and wellness get attention to the extent that one can charge for them. In short, power and interests need to be given full attention in sociological theory and research.

CONTRIBUTIONS TO FOLLOW

The original contributions that follow were commissioned to provide long-term sociological perspectives on the American health care system as it enters a troubled new century. Quadagno (2004) provides original archival research on how “interests” stymied universal health care legislation. Caronna (2004) offers an insightful historical analysis of mis-alignments and inconsistencies between the institutional pillars that hold up the health care system. Casalino (2004) provides original explanations of how managed care evolved and health care markets formed as jurisdictional arenas. Meantime, the legitimacy of the entire

enterprise suffered a massive consumer backlash, and David Mechanic (2004) assesses why it happened. Kitchener and Harrington (2004) provide a detailed history of how for-profit chains co-opted the government’s power to regulate and tax to enrich themselves and disadvantage non-profit services. Two distinguished teams of sociologists, led by Tom Rundall (2004) and Doug Wholey (2004), draw together organizational and economic concepts to explain the dynamics of physician-hospital relations and the dynamics of national firms in local markets, both central aspects of the managed care revolution.

The final trio of original papers goes beyond managed corporate care as an American conception of control to more global matters. The team headed by Rebeca Jasso-Aquilar (2004) draws on their original, in-depth research to describe how managed care corporations took their profits here and then went abroad to profit from corporatizing the public health care systems of other countries. Exporting corporate managed care is still thriving, and several European countries are weakening the equity and efficiency of their universal systems by implementing “modern” ideas of management. Beyond and surrounding managed care is the commercialization of illness, and now risk, as “health” needing medical attention (Conrad and Leiter 2004). Professional knowledge itself has been changed in the process, and Stefan Timmermans and Emily Kolker (2004) show how this has changed the nature of the medical profession. A disturbing tension is created between these last two essays. If clinicians are held to “evidence-based” guidelines, how will this be reconciled with the care of “health” expanding as far as corporate mar-

keters can stretch it without increasing forms of inequality and health disparities? As a whole, these papers vindicate the JHSB editorial board's decision more than two years ago to commission a special issue of this distinguished, highly cited journal that would feature original contributions providing sociological insights into the development and deeper nature of the American health care system over the past decades.

NOTES

1. As has become the custom, "health care system" refers to the organization, financing and delivery of medical services.

REFERENCES

- Adams, Samuel Hopkins. 1905. *The Great American Fraud*. New York: Collier & Son.
- AMA Council on Pharmacy and Chemistry. 1905. "The Secret Nostrum Vs the Ethical Proprietary Preparation." *Journal of the American Medical Association* 44:718–19.
- Anonymous. 1900. "Relations of Pharmacy to the Medical Profession." *Journal of the American Medical Association* 34: 986–68, 1049–51, 1114–47, 1178–79, 1327–29, 1405–47 and 35:27–29, 89–91.
- . 2003. "U.S. Promotional Spending on Prescription Drugs, 2002 (\$21 Billion)." *Canadian Medical Association Journal* 169:699.
- Billings, Frank. 1903. "Medical Education in the United States." *Journal of the American Medical Association* 40:1271–76.
- Bledstein, Burton. 1976. *The Culture of Professionalism*. New York: W.W. Norton.
- Bodenheimer, Thomas, Steve Cummings, and Elizabeth Harding. 1974. "Capitalizing in Illness: The Health Insurance Industry." *International Journal of Health Service* 4:583–98.
- Brown, Lawrence D. 1983. *Politics and Health Care Organization: HMOs as Federal Policy*. Washington, DC: Brookings Institution.
- Bureau of Medical Economics. 1935. *An Introduction to Medical Economics*. Rev. ed. American Medical Association, Chicago, IL.
- Burrage, M. and R. Torstendahl. 1990. *Professions in Theory and History*. London: Sage.
- Burrow, James G. 1963. *The AMA: Voice of American Medicine*. Baltimore, MD: Johns Hopkins University Press.
- . 1977. *Organized Medicine in the Progressive Era: The Move toward Monopoly*. Baltimore, MD: Johns Hopkins University Press.
- Caplan, Ronald L. 1981. "Pasteurized Patients and Profits: The Changing Notion of Self-care in American Medicine." PhD Thesis, Department of Economics, University of Massachusetts, Amherst, MA.
- Caronna, Carol. 2004. "The Alignment of Institutional 'Pillars': Consequences for the U.S. Health Care Field of Normative, Cognitive and Regulative (in)Consistency." *Journal of Health and Social Behavior* 45(Extra Issue): 45–58.
- Casalino, Larry. 2004. "Unfamiliar Tasks, Unsettled Jurisdictions: Describing the U.S. Health Care Market." *Journal of Health and Social Behavior* 45(Extra Issue):59–75.
- Conrad, Peter and Valerie Leiter. 2004. "Medicalization, Markets and Consumers." *Journal of Health and Social Behavior* 45(Extra Issue):158–76.
- Cray, Ed. 1970. *In Failing Health: The Medical Crisis and the AMA*. New York: Bobbs-Merrill.
- Davis, Karen, Cathy Schoen, Stephen C. Schoenbaum, Anne-Marie J. Audet, Michelle M. Doty, and Katie Tenny. 2004. *Mirror, Mirror on the Wall: Looking at the Quality of American Health Care through the Patient's Lens*. New York City: The Commonwealth Fund.
- Davis, N.S. 1851. *History of Medical Education and Institutions in the United States*. Chicago, IL: S.C. Griggs & Co.
- DeVeaux, Edith P. 1904. "Free Dispensaries and Their Abuse." *Northwest Medicine* 2:151.
- Ehrenreich, Barbara and John Ehrenreich. 1976. *The American Health Empire: Power, Profits and Politics*. New York: Vintage.
- Emanuel, Ezekiel J. 1991. *The Ends of Human Life*. Cambridge, MA: Harvard University Press.
- Enthoven, A.C. 1988. *Theory and Practice of Managed Competition in Health Care Finance*. Amsterdam, Netherlands: North-Holland.
- Etzioni, Amitai. 1988. *The Moral Dimension*. New York: Free Press.
- Feder, Judith M. 1977. "Medicare: The Politics of Federal Hospital Insurance." Lexington, MA: Lexington Books.
- Flexner, Abraham. 1911. "Medical Colleges." *The World's Work* 21:1438–42.
- Fligstein, Neil. 1990. *The Transformation of Corporate Control*. Cambridge, MA: Harvard University Press.
- . 2001. *The Architecture of Markets*. Princeton, NJ: Princeton University Press.
- Fox, Daniel M. 1980. "Abraham Flexner's Unpublished Report: Foundations and Medical Education, 1909–28." *Bulletin of the History of Medicine* 54:475–96.
- Freidson, Eliot. 1970a. *Profession of Medicine*. New York: Dodd, Mead.
- . 1970b. *Professional Dominance*. New York: Atherton.
- Giarelli, Guido. 2004. "Convergence or

- Divergence? A Multi-Dimensional Approach to Health Care Reforms." *International Review of Sociology* 14:171–203.
- Gist, Noel. 1937. "Secret Societies: A Cultural Study of Fraternalism in the United States." *University of Missouri Studies* 15:(entire issue).
- Goldstein, Amy. 2003 (24 November). "Medicare Bill Would Enrich Companies." Pp. A1 in *Washington Post*.
- Goldwater, S. S. 1915. "Dispensaries: A Growing Factor in Curative and Preventive Medicine." *The Boston Medical and Surgical Journal* 17:613–17.
- Goodman, Robert. 2004. "No Free Lunch." vol. 2004: Goodman, Robert.
- Haley, Edward E. 1911. "The Evils of the Contract System." *New York State Journal of Medicine* 11:394–96.
- Hilts, Philip J. 2003. *Protecting America's Health*. New York: Alfred A. Knopf.
- Illich, Ivan. 1976. *Medical Nemesis: The Expropriation of Health*. New York: Pantheon.
- Immergut, Ellen M. 1992. *Health Politics: Interests and Institutions in Western Europe*. New York: Cambridge University Press.
- Institute of Medicine. 1999. *To Err Is Human*. Washington, DC: National Academy Press.
- . 2001. *Coverage Matters: Insurance and Health Care*. Washington, DC: The National Academy Press.
- . 2003. *Hidden Costs, Value Lost: Uninsurance in America*. Washington, DC: The National Academy Press.
- Jasso-Aguilar, Rebecca, Howard Waitzkin, and Angela Landwehr. 2004. "Multinational Corporations and Health Care in the United States and Latin America." *Journal of Health and Social Behavior* 45(Extra Issue):136–57.
- Jones, Eliot. 1921. *The Trust Problem in the United States*. New York: Macmillan.
- Kennedy, Edward M. 1972. *In Critical Condition: The Crisis in America's Health Care*. New York: Simon & Schuster.
- Kindig, David. 1997. *Purchasing Population Health*. Madison, WI: University of Wisconsin Press.
- Kitchener, Martin and Charlene Harrington. 2004. "The U.S. Long-Term Care Sector: A Dialectic Analysis in Institutional Dynamics." *Journal of Health and Social Behavior* 45(Extra Issue): 87–101.
- Langford, T.S., A.S. Kimball, H.B. Garner, E.H. Flynn, and T.E. DeGurse. 1907. "Report of the Committee on Contract Practice." *Journal of the Michigan State Medical Society* 6:377–80.
- Larson, Magali Sarfatti. 1977. *The Rise of Professionalism: A Sociological Analysis*. Berkeley: University of California Press.
- Leicht, Kevin and Mary L. Fennell. 2001. *Professional Work: A Sociological Approach*. Malden, MA: Blackwell Publishers.
- Light, Donald W. 1983. "The Development of Professional Schools in America." Pp. 345–65 in *The Transformation of Higher Learning: 1860–1930*, edited by K. Jarausch. Stuttgart, Germany: Klett-Cotta.
- . 1986. "Corporate Medicine for Profit." *Scientific American* 225(6):38–45.
- . 1988. "Towards a New Sociology of Medical Education." *Journal of Health and Social Behavior* 29:307–22.
- . 1994. "Comparative Models of 'Health Care' Systems, with Application to Germany." Pp. 455–70 in *The Sociology of Health and Illness*, edited by P. Conrad and R. Kern. New York: St. Martin's Press.
- . 1995a. "Countervailing Powers: A Framework for Professions in Transition." Pp. 25–41 in *Health Professions and the State in Europe*, edited by T. Johnson, G. Larkin, and M. Saks. London: Routledge.
- . 1995b. "Homo Economicus: Escaping the Traps of Managed Competition." *European Journal of Public Health* 5:145–54.
- . 1997. "The Rhetorics and Realities of Community Health Care: Limits of Countervailing Powers to Meet the Health Care Needs of the 21st Century." *Journal of Health Politics, Policy and Law* 22:105–45.
- . 2000a. "The Medical Profession and Organizational Change: From Professional Dominance to Countervailing Power." Pp. 201–216 in *Handbook of Medical Sociology*, edited by C. Bird, P. Conrad, and A. Fremont. Englewood Cliffs, NJ: Prentice-Hall.
- . 2000b. "The Sociological Character of Markets in Health Care." Pp. 394–408 in *Handbook of Social Studies in Health and Medicine*, edited by G. L. Albrecht, R. Fitzpatrick, and S. C. Scrimshaw. London: Sage.
- Light, Donald W. and Sol Levine. 1988. "The Changing Character of the Medical Profession: A Theoretical Overview." *Milbank Quarterly* 66 (Supplement 2):10–32.
- Ludmerer, Kenneth M. 1999. *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*. New York: Oxford University Press.
- Lydston, G. Frank. 1900. "Medicine as a Business Proposition." *Journal of the American Medical Association* 35:1403.
- Mathews, George S. 1909. "Contract Practice in Rhode Island." *Bulletin of the American Academy of Medicine* 10:599–603.
- McCleery, R.S., L.T. Keilty, M. Lam, R.E. Phillips, and T.M. Quinn. 1971. *One Life-One Physician: An Inquiry into the Medical Profession's Performance in Self-Regulation*. Washington DC: Public Affairs Press.
- McGlynn, Elizabeth A., Steven M. Asch, John Adams, and Joan Keesey. 2003. "The Quality of Health Care Delivered to Adults in the United

- States." *New England Journal of Medicine* 348:2635–45.
- McKinlay, John and Joan Arches. 1985. "Toward the Proletarianization of Physicians." *International Journal of Health Services* 15:161–95.
- McKinlay, John and L. Marcceau. 2002. "The End of the Golden Age of Doctoring." *International Journal of Health Services* 32:379–416.
- Mechanic, David. 2004. "The Rise and Fall of Managed Care." *Journal of Health and Social Behavior* 45(Extra Issue):76–86.
- Moller, Stephanie, Evelyn Huber, John D. Stephens, David Bradley, and Francois Nielsen. 2003. "Determinants of Relative Poverty in Advanced Capitalist Democracies." *American Sociological Review* 68:22–51.
- Navarro, Vicente. 1976. *Medicine under Capitalism*. New York: Prodist.
- O'Neil, Will 1956 (Dec). "How to Get Rich: Own a Hospital?" *Modern Hospital*, pp. 51–55, 134, 138, 140, 142.
- Parsons, Talcott. 1975. "The Sick Role and the Role of the Physician Reconsidered." Pp. 66–81 in *Action Theory and the Human Condition*, edited by Talcott Parsons. New York: The Free Press.
- . [1939] 1954. "The Professions and Social Structure." Pp. 34–49 in *Essays in Sociological Theory*, edited by Talcott Parsons. Glencoe, IL: The Free Press.
- Perrow, Charles. 2002. *Organizing America: Wealth, Power and the Origin of Corporate Capitalism*. Princeton, NJ: Princeton University Press.
- Quadagno, Jill. 2004. "Why the United States Has No National Health Insurance: Stakeholder Mobilization against the Welfare State, 1945–1996." *Journal of Health and Social Behavior* 45(Extra Issue):25–44.
- Rayack, Elton. 1967. *Professional Power and American Medicine: The Economics of the American Medical Association*. Cleveland, OH: World Publication Co.
- Reed, Louis. 1947. *Blue Cross and Medical Service Plans*. Washington D.C.: Federal Security Agency.
- Relman, Arnold S. 1980. "The New Medical-Industrial Complex." *New England Journal of Medicine* 303:963–70.
- Ribicoff, A. and P. Dandaceau. 1972. *The American Medical Machine*. New York: Saturday Review Press.
- Richardson, J.T. 1945. "The Origins and Development of Group Hospitalization in the United States." *University of Missouri Studies* 20:9–102.
- Roemer, Milton I. 1991. *National Health Systems of the World*. New York: Oxford University Press.
- Rorem, C. Rufus. 1940. *Non-Profit Hospital Service Plans*. Chicago, IL: Commission on Hospital Services.
- Rosen, George. 1983. *The Structure of American Medical Practice, 1875–1941*. Philadelphia, PA: University of Pennsylvania Press.
- Rosner, David. 1982. *A Once Charitable Enterprise: Hospitals and Health Care in Brooklyn and New York: 1885–1915*. New York: Cambridge University Press.
- Ross, E.A. [1901]1969. *Social Control: A Survey of the Foundations of Order*. Cleveland, OH: The Press of Case Western Reserve University.
- Rothstein, William G. 1972. *American Physicians in the Nineteenth Century: From Sects to Science*. Baltimore, MD: Johns Hopkins University Press.
- Roy, William G. 1997. *Socializing Capital: The Rise of the Large Industrial Corporation in America*. Princeton, NJ: Princeton University Press.
- Rundall, Thomas G, Jeffrey A. Alexander, and Stephen M. Shortell. 2004. "A Theory of Physician-Hospital Integration." *Journal of Health and Social Behavior* 45(Extra Issue): 102–17.
- Sager, Alan and Deborah Socolar. 2003. "61 Percent of Medicare's New Prescription Drug Subsidy Is Windfall Profit to Drug Makers." Boston, MA: Boston University School of Public Health, Health Reform Program.
- Schwartz, Jerome I. 1965. "Early History of Prepaid Medical Care Plans." *Bulletin of the History of Medicine* 39:450–75.
- Scott, W. Richard, Martin Ruef, Peter J. Mendel, and Carol Caronna. 2000. *Institutional Change and Healthcare Organizations: From Professional Dominance to Managed Care*. Chicago, IL: University of Chicago Press.
- Shearer, Gail. 2003. *Medicare Prescription Drugs*. Washington D.C.: Consumers Union.
- Shyrock, Richard H. 1967. *Medical Licensing in America: 1650–1965*. Baltimore: Johns Hopkins University Press.
- Somers, Herman M. and Anne H. Somers. 1961. *Doctors, Patients, and Health Insurance*. Washington DC: The Brookings Institution.
- Starr, Paul. 1982. *The Social Transformation of American Medicine*. New York: Basic.
- Stern, Bernhard J. 1945. *American Medical Practice in the Perspective of a Century*. New York: The Commonwealth Fund.
- Stevens, Rosemary. 1971. *American Medicine and the Public Interest*. New Haven, CT: Yale University Press.
- Swedberg, Richard. 2003. *Principles of Economic Sociology*. Princeton, NJ: Princeton University Press.
- Timmermans, Stefan and Emily Kolker. 2004. "Clinical Practice Guidelines and the Implications of Shifts in Knowledge for Sociological Accounts of Professional Power." *Journal of Health and Social Behavior* 45(Extra Issue):177–93.
- Touhy, Carolyn Hughes. 1999. *Accidental Logics*. New York: Oxford University Press.

- U.S. Department of Health and Human Services. 1982. "Health United States, 1982." U.S. Department of Health and Human Services, Washington DC.
- Vogel, Morris. 1980. *The Invention of the Modern Hospital*. Chicago, IL: University of Chicago Press.
- Waitzkin, Howard. 1983. *The Second Sickness: Contradictions of Capitalist Health Care*. New York: The Free Press.
- Warbasse, James P. 1909. *Medical Sociology*. New York: D. Appleton and Company.
- . 1912. "What Is the Matter with the Medical Profession?" *Long Island Journal of Medicine* 6:271–75.
- Wazana, Ashley. 2000. "Physicians and the Pharmaceutical Industry." *Journal of the American Medical Association* 283:373–80.
- Weber, Max. 1968. *Economy and Society*. New York: Bedminster Press.
- Weller, Charles. 1983. "'Free Choice' as a Restraint of Trade, and the Counterintuitive Contours of Competition." *Health Matrix* 3 (2):3–23.
- Wennberg, J. 1984. "Dealing with Medical Practice Variations: A Proposal for Action." *Health Affairs* 3:6–32.
- Wennberg, J. and A. Gittelsohn. 1982. "Variations in Medical Care among Small Areas." *Scientific American* 246:120–35.
- Wertz, Richard W. and Dorothy C. Wertz. 1989. *Lying-in: A History of Childbirth in America (Expanded Ed.)*. New Haven, CT: Yale University Press.
- White, Joseph. 1995. *Competing Solutions: American Health Care Proposals and International Experience*. Washington DC: Brookings Institution.
- Wholey, Douglas R., Jon B. Christianson, Debra A. Draper, Cara S. Lesser, and Lawton R. Burns. 2004. "The Response of Local Communities to Entry by National Healthcare Firms." *Journal of Health and Social Behavior* 45(Extra Issue): 118–35.
- Williams, Pierce. 1932. *The Purchase of Medical Care through Fixed Periodic Payments*. New York: National Bureau of Economic Research.
- Woodruff, John V. 1916. "Contract Practice." *New York State Journal of Medicine* 16:507–11.
- World Health Organization. 2000. *The World Health Report 2000*. Geneva, Switzerland: World Health Organization.
- Young, James Harvey. 1961. *The Toadstool Millionaires: A Social History of Patent Medicines in American before Federal Regulation*. Princeton, NJ: Princeton University Press.

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