September 1998 (Volume 39, Number 3)

Health Care System of the United States and Its Priorities: History and Countries

Rene I. Jahiel
Department of Community Medicine, University of Connecticut Health Center, Farmington, Conn, USA

The health care system of the United States is examined from the end of the 19th century to the present, using secondary sources on labor and health care. During that period, several actors, each with its own priorities, exercised control over the United States (US) health services: physicians (from the 1900s on), hospitals and not-for-profit insurance (from the 1930s on), governmental regulators (from the 1960s on), and, lastly, for-profit managed care enterprises (from the 1980s on). A class contest between corporations and labor was involved at two critical points. In the 1870s to 1890s (with further steps in the 1920s and, with the Taft-Hartley law, in 1947), it weakened the labor movement that was unable to mount a successful effort for a national health program in 1972 and 1992. In the 1980s and 1990s, as health services developed into a major industry, two contending business groups (health plans and payers) took commanding positions over consumers and employees. Market-oriented, for-profit managed care organizations came to play a dominant role. During that period, access to, and, by some measures, quality of care has declined. The rise in health care costs has been interrupted, but it is not clear how long this will last. European nations that are reforming their health care system, should be wary of such profit-oriented market approaches to bring costs down.

Key words: American Medical Association; health legislation; insurance, health; labor unions; legislation, medical, USA; managed care programs; Medicare; USA

Health care reform is spreading among the European nations (1). In some instances, it is triggered by needs for cost containment. In others, as in Eastern Europe, it involves reconstitution of the health care system in a new capitalist environment. Some American innovations are under consideration, particularly the American form of managed care. However, when such innovations are exported, they often come as packages including not only managed care, but also for-profit industries, changing roles and status of actors, and changing priorities. Therefore, it is important to understand the implications of the various elements in these packages and their relationship to the features of the current United States (US) health care system.

The features of the US health care are well known – high fraction of gross domestic product (GDP) (13.6%); highest per capita spending ($3,708 per year); high development of technology; biomedical research leadership; dominance of private sector, at first by not-for-profit and now for-profit industries; incomplete coverage of the population by health insurance (40 million people are uninsured); and health statistics that is good for elderly people but inferior to the statistics for younger people in many European countries, especially for perinatal events, including an infant mortality of 8.0 per 1,000 live births (2).

In this analysis, I will address two questions, using a historical approach. Firstly, how did the US health care system become the way it is today? To answer this question, I will examine in some details what happened to labor, since the first national health programs were instituted in other industrialized countries in response to labor's growing political power. Secondly, what was the evolution of the US health care system priorities, and what is the significance of its priorities in the current market-oriented phase dominated by managed care organizations (MCOs)? In that section, I will use the concept of priorities in a broad sense, including priorities in the assignment of resources between the health care sector and other sectors of the economy; between population-based public health and personal health services and among different types of providers; among different approaches to personal health care (primary care, specialized care, traditional and lay care; as well as hospital-based, community-based, and home health care); and, among different groups of people with regard to access to and quality of available health care. Finally, I will briefly discuss the implications for other countries adopting features of the US health care system.

Methodological Approach

Facts and Trends

To establish the main facts, this article relies upon the previous studies of the history of US labor (3-8) and of the US health care system (9-12). Data on labor were obtained from the Historical Statistics of the USA (13) and from the more recent Statistical Abstract of the USA (14). Data were obtained from various sources on health insurance (15-16) and managed care (17).

Analytical Framework

Five concepts were used to analyze the development of US labor and the US health care system: class, interest group, social movement, state, and political parties.

Class. Class is not a uniquely defined concept. It has different meanings in different contexts. For instance, social class may refer to distinctions among people with differing social status. I focused here on class in the context of economic productivity. In that context, it is defined, according to Karl Marx, as a relationship between two categories of people who need each other, in which one category dominates and economically exploits the other (18). The importance of this concept derives from the close association of dominant/exploitative classes with the legal and economic power structure of the nation, which, in turn, enforces the relations between classes (19,20). Class action may involve a class struggle to change the social system that sustains class relationships, or negotiations and give-and-take between the two classes. In the latter situation, the two classes may not necessarily act antagonistically.

The definition of class given above refers to the major economic relationship in modern industrial society. However, it requires some qualifications in order to account for the entire population of the country. Firstly, individuals at different levels of vertical organization in a company are likely to have different affiliations; executives and other employees in very high positions tend to align themselves with the dominating capitalist class. At certain points, lower in the hierarchy, there may be some ambivalence regarding affiliation with capital or with labor. Furthermore, workers who have a stake in the company, for instance if they own stocks in the company, or who derive significant benefits from the company, may take them into consideration to varying degrees in defining their relation with the company.

Secondly, some workers are employed by the state, for instance, members of the civil service. However, their salaries are close to those set for other workers in the private-job market.

Thirdly, some people are employed by not-for-profit organizations. These organizations may divert some of their income for excessive internal use. Salary ranges of their workers are close to those of for-profit organizations.

Fourthly, there are individuals (farmers, businessmen, professionals) who own their means of production and do not have employees. They constitute a special category, the petty bourgeoisie of Marx.

Fifthly, there are people who have only a few employees, who might be called petty capitalists. Their interests, and more generally, those of small business do not always coincide with those of the larger corporations.

Sixthly, there are people without legitimate working activities (the lumpenproletariat, or underclass) because of disability, old age, or other reasons of chronic inability or unwillingness to hold a job, who are supported by welfare, their families, and/or an “underground economy”.

Seventhly, there are people who transcend their economic class interests, i.e., they take positions on issues or involve in political actions that favor people in other classes than their own. Some can be related to an intellectual category sometimes referred to as the “intelligentsia”.

Affiliation. Another factor in the analysis of class relationships is affiliation. Class status has additional correlations, such as common ideology, availability of resources, family links and networks of associates, access to government, and extent of accumulated wealth. Because of these class correlations, some people may affiliate themselves with a class other than that specified by their role in the economic production. Class consciousness is the psychological factor that helps to identify one’s position in the economic production process.

Alternatives to the concept of class. In explaining an individual’s position in the social order, alternatives to the concept of class include, among others, occupational categorizations. In the instance of labor, the concept of guild, or specially trained worker, played a role, as discussed later, in dividing workers during the first half of the period under study. In the instance of physicians, the concept of profession plays a major role in the explanation of a physician’s behavior. During most of the study period, physicians fitted better in the various special categories listed above (except for the underclass) than in the two main classes. The concept of profession is a unifying factor for physicians across the various categories.

Physicians did not constitute a unified profession in the USA in the 19th century (9). The attributes of

their profession were sharply defined at the beginning of the 20th century and evolved thereafter, as discussed later in this article.

Ideology. The dominant ideology of a nation influences the behavior of people in various occupational groups. The capitalist ideology became dominant in the USA during the last third of the 19th century. It is associated in the USA with the opposition not only to socialism but also to a strong role of the federal government in economic and occupational affairs.

Interest groups. Interest groups must be sharply differentiated from classes. Interest groups are groups of people with shared interests who negotiate with the power structure for specific objectives without requiring significant changes in that power structure. Their main mode of action is not to engage in a struggle, but, rather, to obtain satisfaction of their needs from an existing system through lobbying or advocacy. They typically compete among one another to satisfy these needs.

Social movements. Social movements may be defined as "collective challenges by people with common purposes and solidarity in sustained interactions with elites, opponents, and authorities" (21). Social movements may merely "blow up steam" in marches, riots, etc., in which instances they are often ephemeral (22). In other instances, they may unleash true social forces, as for instance in the USA, the civil rights, women's liberation, or disability rights movements. In extreme cases, they may trigger revolutions or counter-revolutions. Although the literature has emphasized social movements directed against authority structures, social movements may also be initiated by people or organizations in power to maintain or solidify that power and crush opponents. In both types of movements, collective action is strengthened by at least five factors: cleavage in the opposition (20), an organizational direction (23), grassroots class consciousness (24), incentives to participants (25), and availability and mobilization of resources (26). The success of the movement also depends in part upon the situation of the movement groups in the social system as dominant, emerging, or suppressed groups (27).

The state. The dictionary definition of the state is "a body of people occupying a definite territory and organized under a government, especially a sovereign government" (28). The government's actions are influenced by its citizens, by legal precedents and constraints, and by the decisions of its own bureaucracy. Governmental programs, in sectors such as health, may address the needs of the entire population, of certain interest groups or of a certain class. Core norms of a country in the role of the state in the health sector, as well as in other sectors, address the distinction between social or collective goods versus commodities; the relative strength of the state versus private interests; and accountability to different political, social, and economic constituencies (ref. 1, p. 5-6).

The USA is a federal republic, with a constitution and legal tradition protecting individual freedom, as well as property rights, in a system that specifies separate powers for the executive (President or governors), legislative (Congress or state legislatures) and judicial (federal courts headed by the Supreme Court, and state courts) branches of the federal and state governments, respectively. Its executive heads of government and legislators are elected at stated intervals, while federal judges are appointed by the executive branch subject to approval by the Congress. The President is not elected directly, but through the intermediary of an electoral college.

Political parties. The definition of political parties in an American dictionary is "a group of persons with common political opinions organized for gaining political influence and governmental control and for directing governmental policy" (28). There is much variety among countries in the role and structure of party systems. At one extreme, there is a single party which serves as an upward conduit to transmit views of the citizenry and as a downward conduit to inform the citizens of their role in fulfilling governmental policies. At the other extreme, there is a great number of parties centered on specific issues, sometimes even a single issue. An electoral system of proportional representation favors multiple and small parties. Other countries have a two- or three-party system each with a platform that encompasses several issues. For the period under study, the United States has had a two-party system (Democratic and Republican parties). Its political parties have become increasingly dependent upon financial support, as the cost of electioneering has steadily increased, especially as television has come to play an increasingly important role. In part because of their stability over the years, the two main parties have become a sort of institution in American life, with a large number of people identifying themselves as democrats or as republicans. There is a strong centripetal force which tends to narrow the range of differences among issues in the two parties. There have been numerous attempts to establish a third party during the period under study but none has been sustainable as a significant political force.

Findings: Health Care System and its Context

Governmental Context

Table 1 shows that, since the end of the Civil War (1865), there has been an alternating sequence of

conservative administrations which promoted unimpeded growth of corporations and liberal or moderate administrations which promoted governmental programs for vulnerable populations. Phillips (29) characterizes the former periods (1870s to 1890s, 1920s, and 1980s-1990s) as follows: conservative republicans in power; reduced role of government; difficulties for labor; large scale economic and corporate restructuring, with trusts and mergers; tax reduction; deflation or disinflation; a two-tier economy and a concentration of wealth with increasing socio-economic inequality; increased debt and speculation; and speculative implosions at the end of the period (ref. 29, p. 56-8). A virulent anti-left ideology was promoted, fed by events abroad, such as the Paris Commune of 1871, the Russian Revolution of 1917, and the Cold War from the late 1940s to the 1980s. There was a spill-over against labor which was often depicted in terms of its most radical elements. The moderate Republican government of the 1950s had some of these features in an attenuated way. These periods were associated with a marked concentration of wealth. In the current period, socioeconomic inequality has been markedly increasing, with an increase in the numbers of the very rich and the very poor (30).
The periods of governmental intervention include the “Progressive Period” (1900s-1910s); the New Deal and Fair Deal (1932-1947); and the Great Society and War on Poverty period (1960-1974, with some follow-up till 1980). These periods were characterized by the passage of many health and other social safety network programs aimed at protecting vulnerable or disadvantaged groups. Most of these programs still exist (Table 1).

Table 1: Major social, political, and legislative events relevant to health services in the USA, 1865-1997.
[view this table]

Corporations and Labor
During the 30 years following the end of the Civil War in 1865, a political-economic system based on large industrial and financial corporations developed, which has persisted to this date, with some modifications but without significantly altering the balance of power between corporations and labor, except possibly for a relatively brief period in the years following the New Deal. As a result, the USA has a politically weak labor force as compared to the most European countries (ref. 30, p. 145-7). Some indicators of this weakness are the lack of a labor party in US politics, and low percentage of workers who belong to unions (Table 2). In the last 20 years, this weakness has increased, as shown by the decrease in the percent of unionized workers, and the decrease in the absolute value of wages, especially for most poorly paid workers (Table 2).

Table 2: Selected indicators of labor union strength. [view this table]

This development may be summarized as follows. In the three decades from 1865 to 1893, industrial entrepreneurs had a considerable strategic advantage over their labor force for several reasons. There was a considerable excess supply of workers due to the large immigration from Europe and China (in part due to active recruitment by corporate entrepreneurs). These workers were poor and highly vulnerable if they lost their jobs. The industrial revolution’s technology allowed the employment of relatively unskilled workers. In disputes with labor, government and the courts usually supported the corporations, who were helping to develop the vast US territory into a major world economic power and who, furthermore, provided politicians with a financial support that greatly helped them to be elected. In these conditions, the industrial entrepreneurs were able to employ workers at very low wages and for very long working hours. They opposed labor unions by not recognizing them for collective bargaining, blacklisting their members, or setting up company-dominated unions (yellow dog unions). They repressed strikes violently with the help of their own police or local, state or even federal forces; and, they sought the support of courts for injunctions to stop strikes and jail sentences to labor leaders (3-8).
In these conditions, companies made huge profits which they reinvested by taking over other companies, including those of their competitors, eventually forming large corporations which evolved into huge trusts, oligopolies, and monopolies. By the end of the 19th century, a reaction coming mainly from small business, had set up, and antitrust laws were adopted which slowed the growth of corporations during the Progressive Period and led to the break up of a few monopolies into oligopolies. However, corporation growth resumed during World War I and during the conservative governments of the 1920s, until it was temporarily interrupted by the crash of 1929.

Workers made repeated attempts to organize locally and nationally during the 1865-1932 period, but the concerted power of the corporations, government and the courts defeated them in the majority of the important confrontations, and the economic cycles of prosperity and depression at few years' intervals contributed to the downfall of many unions during recession years. In terms of the social movement variables referred to above (20,23-26), most national worker organizations of that period showed class consciousness and solidarity. However, they were weak in the other four respects: they had united opponents, they usually had weak organizational direction, they were unable to offer material incentives to participants, and they had limited resources.

The one national labor organization from that period which managed to survive and grow was the American Federation of Labor (AFL), founded in 1886. Under the leadership of Samuel Gompers, it had, in terms of social movements, strong administrative direction, material incentives for its members (including sickness benefits programs), and resources contributed by relatively high union dues. To achieve and sustain that strength, participation was limited to unions of more specialized workers ("guild unions") who were in a better bargaining position with employers, each member union had to fight its own battle with employers, and the AFL was to be as free as possible from political ideology or party affiliation. In particular it was to eschew any involvement with a political party. What had been sacrificed for the AFL to survive, was class solidarity, full unity in the labor movement, and the development of a labor party. Although another labor organization, The International Workers of the World or IWW, formed in 1905, developed a marked class solidarity in uniting the industrial unions, it came under strong attack by the courts during the World War I and collapsed.

Other labor groups, both before and after the organization of the AFL, have been involved in political parties. The National Labor Reform Party formed in 1872 with the emphasis on monetary reform was not active for a long time. Attempts to form political coalitions with farmers and other groups in the Greenback Labor Party in the 1870s and the Populist Party in the 1890s were doomed when the Democratic party took over many of their issues. The Socialist Labor Party and the Socialist Party, both of which still exist, developed out of several splits within the First International but they have remained minor parties in part because of lack of resources and in part because the electorate distanced itself from their Marxist program. In the 1900s and early 1912, the Progressive Party received some labor support but not that of the AFL.

The division of labor weakened the first effort to pass a national health insurance program modeled on the basis of the German compulsory sick benefits program between 1912 and 1920. Although that program received support from a part of organized medicine, several economists, and government employees, and the Progressive Party in 1912, it was opposed by a significant part of the labor movement that was suspicious of any governmental program. That effort was suspended during the World War I, and it collapsed in 1920, when a more conservative leadership came to power in the American Medical Association. Also, strong governmental and business campaign, sometimes echoed by labor leaders, painted the program as socialistic, at a time when there was a virulent anticommunist campaign in the nation, following the Russian Revolution.

Industrial-labor relations in the 1920s were marked by severe, often bloody repression of strikes, along with the settlement of relatively good wages in some trades and welfare capitalism (see below). The last major attempt to organize a labor-dominated party, the Conference for Progressive Political Action, achieved its best result at the polls in 1924, when its candidate for President, Robert La Follette, received 5 million votes, but he carried only his own state of Wisconsin, because of the electoral system for electing a president.

Labor's eventual success had to wait for the weakening of the corporate interests following the stock market crash of 1929 and the Great Depression of the 1930s which left 12 million unemployed workers. The liberal government of Franklin D. Roosevelt, who was elected in the midst of the depression, had strong pro-labor policies and legislation (see footnote f of Table 1). The rights of labor unions to collective bargaining were clearly stipulated and protected. Labor became closely allied with the Democratic Party, an association that was to last for over a half-century. However, it never dominated the Democratic Party and the US workers thus have not had a major "labor party" fully committed to their needs.

In the 1930s, the unions of industrial workers which had been neglected by the AFL formed a new national organization, the Committee of Industrial Organization or CIO. The percentage of workers who were unionized was increasing (Table 2). The World War II strengthened both labor and corporations. Immediately after the World War II, a wave of strikes raised solidarity among workers, and the strength of the labor movement became something to be contended with.

There was a swift reaction in Congress which was then dominated by a conservative alliance between Republicans and conservative Southern Democrats. At the same time, a recrudescence of anticommunist, anti-left and anti-labor attitudes, associated with the onset of the Cold War, was

developing in the Congress and in the nation. Congress passed, over the President Truman's veto, the Taft-Hartley Law, which, as pointed out by Navarro (31), prevented labor from acting as a class. It deprived unions from the right to sympathy strikes and boycott (thereby decreasing their ability to mount strong coordinated action); it gave the federal government specific protocols to terminate a strike; it limited the unions' involvement in politics; and it required them to take steps to evict their left-wing unions. Both national labor unions responded by complying. The CIO evicted some of its strongest unions who had leftist leanings. Although the two labor organizations united a few years later into AFL-CIO, the combined organization reached a plateau in political power and percentage of labor force unionized (Table 2).

Some companies began to practice "welfare capitalism", i.e., the provision of amenities to workers in order to keep them allied to the company rather than the union as early as the 1900s. This movement accelerated in the 1920s with the provision of health care benefits through the employer. In a way, the companies were trying to do at the private level what Bismarck had achieved at the public level. In the 1930s, the development of private health insurance became one of the benefits for employees. During the World War II, health benefits were exempt from price controls, and they became an important item in collective bargaining. Since World War 2, employee health benefits have remained a standard item of collective bargaining.

Inequality developed among workers regarding this item. Some unions had excellent health benefits, others had small benefits and many workers, including most of those non-unionized, had no health benefits at all. These benefits usually stopped or decreased upon retirement of the worker. Organized labor made a strong alliance with organizations of elderly people which succeeded in passing Medicare, the Health Insurance for the Aged, in 1967. Following that victory, organized labor united in 1972-74 to mount an effort to pass "Health Security", a national health insurance program. This narrowly failed because of the opposition of hospital, insurance, physician, business, and other organizations. Organized labor was more successful with the Occupational Health and Safety Act to protect the job environment which passed in 1970. By the 1970s, workers were acting more as an interest group than as a class. Many unions had achieved good salaries and benefits. Governmental policies of the Democratic administrations and Congress of the 1960s and early 1970s developed programs for various groups in the Underclass, including Medicaid and other welfare programs for poor, mostly unemployed people, and Supplemental Social Insurance (SSI) for people with disabilities. Workers began to distance themselves politically from these groups. Workers also began to distance themselves politically from the left which had opposed the Vietnam war that many workers in some of the strongest unions supported. The workers with better salaries started to identify with a "middle class" which included small businessmen and low level professionals. Many workers began to vote Republicans. In the meantime, the leadership of the AFL-CIO, flushed with its legislative victories of the 1960s, concentrated on its activities in Washington. There was less activity to organize workers. The percentage of unionized workers began to drop (Table 2).

About the same time, large corporations bonded together as a political class much more closely than ever. They developed networks, a political information system, think tanks, a program of public information, and a concerted lobbying effort in what Edsall calls the "corporate mobilization" (ref. 30, p. 110-40). These activities, which were facilitated by the position of corporations as a dominant interest group (28) and fulfilled the requirements for a successful social movement (20,23-26), were instrumental in bringing about the return of a highly conservative Republican government in the 1980 elections, for the first time since 1932. That government, under President Reagan quickly engaged in well-publicized, strong anti-labor action (e.g., the air controller strike), which gave a signal to the business community to get tough with labor. Furthermore, it precipitated a severe recession in 1981-82, partly to bring inflation under control, and partly to decrease the power of labor.

Organized labor quickly lost ground, as shown by several indicators (Table 2). Over a 20- year period, the percentage of unionized workers markedly decreased, and there was a steady drop in the minimum hourly wage and average wage of workers adjusted for inflation. The former wage, which is that of the most poorly paid workers, dropped even more than the average wage (Table 2), although it has slowly started to increase in 1997.

The third attempt to a national health program originated with the Clinton administration in 1992. The proposal, which was championed by the President's wife, Hillary Rodham Clinton, and was based on a governmentally supervised managed competition program, aimed to gradually provide for the 40 million people without health insurance, and also to gain their political support. It ran into opposition from the same sources which had opposed Health Security twenty years earlier and into vicious disinformation ads in the media. Labor had little influence on this bill, which was turned down in 1994.

Thus, labor failed to bring about the passage of a national health program on three occasions. The first time was in 1912-1920, when a significant portion of labor was opposed to it. The second time

was in 1972-74, when it could not muster enough strength in Congress against the other lobbies to pass the law that it had proposed. The third time was in 1992-94, when it was a minor actor, in part because of its greater weakness, and in part because many of the stronger unions were lukewarm about it since they already had better benefits through their employers than they would have received with the Clinton bill.

Medical Profession and the Health Industry

Returning now to the 1860s, we find that, at that time, public health was a well developed field (32). In the next few decades, it would retain a high priority, losing it only in the 1920s-30s, when organized medicine, which promoted the curative model of health care and opposed the provision of health care in dispensaries by public authorities, began to dominate the health sector.

Although mainstream physicians had formed the American Medical Association (AMA) in 1856, it was not until the AMA was reorganized in 1901 by the medical elite that favored scientific medicine, followed by strong state medical license laws, and, in 1910, by the publication of the Flexner report, that many other medical sects were eliminated, medical training was standardized, a homogenous scientific medical culture was created, the number of physicians (who were in excess earlier) was markedly decreased, and physicians gained control over hospitals, paving the way for the dominance of the health care system by the medical profession from the 1920s to at least the 1980s (9-11).

The biological approach to disease and technological approach to interventions, which have remained to date the approach of American medicine, were promoted at the expense of a Virchowian approach to the social causes of illness and social environment intervention which has remained virtually undeveloped within the medical profession. The Flexner report had another consequence: by increasing the duration and cost of medical education, as well as the prestige of physicians, it helped to select into medicine students coming from higher socio-economic background than before (9). In coming years, the increased income of physicians would contribute to their identification with the other high income groups of society.

Organized medicine, led by the AMA, took steps to enhance the social status of physicians, and, in fact, to change their class affiliation, at a time when many physicians were under contract to companies. It rejected the notion that physicians played the role of employees (and thus lost their surplus value to employers!) and campaigned against “contract medicine”. With the rationale that the physicians’ unique scientific knowledge and personal relation with their patients precluded supervision by non-physicians and allowed only peer review by other physicians, the organized medicine took a strong stand for unsupervised fee-for-service medicine, which has persisted until very recently. Thus, physicians associated themselves with a special category, that of self-employed professionals (9,10). In terms of class, most physicians were petty bourgeois when they had no employees, or more often, petty capitalists when they had one or a few employees.

American hospitals adopted the open staff system in which physicians who practice in the community may send patients to hospitals where they have privileges and continue to care for them there. This has persisted to this day. Technological advances made the hospital the site for the more severe illnesses and complicated surgical procedures. This stimulated a close association of hospitals with teaching centers and the ascendancy of inpatient over outpatient care, and of specialty over primary care, two trends which are only beginning to be reversed in American medicine today.

In the 1920s, several private foundations (some of them financed by the great corporate fortunes realized in the preceding period) became concerned with the increasing costs of medical care. In 1927, they financed the Committee on the Costs of Medical Care (CCMC) which did the first extensive household survey of illness, access to care, medical treatment, and health expenditures in the USA (9-11). After finding numerous unmet medical needs, it presented two sets of recommendations for voluntary medical care plans paid through premiums under the aegis of physicians. The majority report would have medical groups allied with hospital. The minority report would have plans organized by the local medical societies open to all physicians in the area with fee-for-service reimbursement. Both reports opposed administration of plans by private insurance companies and compulsory health insurance.

These two reports reflect a dichotomy in medicine between two concepts of medical care organization. The first, called by Fox (12) a hierarchical regionalism, favors specialists. The more egalitarian second concept favors general practitioners free to establish referral networks with other physicians and hospitals. Though both concepts co-existed, the dominant ideology in the 1920s and until the World War II was the egalitarian concept, and, although hierarchical regionalism steadily gained, it did not become the dominant medical ideology and the main system priority until after the World War II.

While the increasing cost of medical care was a problem for many patients in the 1920s, the 1929 stock market panic and the depression that followed it and that put 12 million people out of a job,

created a much greater medical cost problem, not only for a large part of the population, but also for physicians and hospitals that found it difficult to collect from patients and to fill up their beds, respectively. A local initiative in private health insurance organized by teachers in Texas in 1929 was seized upon as a way to meet the costs by spreading them over the majority of the population that still had an income. Thus were born the “Blues”, first Blue Cross for hospital insurance, in 1929, and then Blue Shield for physician insurance in 1939. Physicians initially resisted private insurance because they wanted no third party. They had dealt with the problem of patients who were unable to pay with widespread use of cross-subsidization (33), i.e., the practice to charge more to richer patients and less or even nothing to poorer patients. However, when the Great Depression began to markedly affect their income, they accepted private health insurance, but only after assurance that the insurance companies were not-for-profit, that physician’s autonomy in practicing and billing was respected, and that physicians were members of insurance companies boards, which also had hospital representatives. The not-for-profit private health insurance industry grew steadily during the 1930s and, after the return of prosperity, in the 1940s, in part because it was popular with consumers of health care and in part because, as discussed earlier, it received a boost from a clause that exempted health benefits from wartime price controls during the World War II. This led to a marked increase in employer-employee subsidized health benefits.

Another development which took place during or just before the World War II was the growth of a few large pre-paid group practice plans, such as GHI, Kaiser, and HIP. These first forms of managed care were developed not to decrease costs as the latter were, but, rather, to better integrate medical practice among various specialties, between hospital and outpatient services, and to provide continuity of care to patients using these various services. World War II had several other effects on the health care system. It stimulated a marked growth in technology. The emerging ideology of the times was the “technological fix”, i.e., societal problems could be solved and society improved by the expansion of technology, in the same way it had helped to win the war. The government, the medical profession, and the health industries shared this approach. The federal government began to enter the field of health care in the years following the World War II with several limited but highly significant programs. It provided financing and a peer review system for medical research, mainly through the National Institutes of Health. It established an administration for a nationwide system of Veterans Hospitals. It provided grants-in-aid to states to construct and renovate hospitals, the Hill-Burton Law. A federal change in patent laws, together with technological advances in medical therapy (antibiotics, corticosteroids), increased pharmaceutical industry activity in research and marketing (34).

Other changes came from the private sector, often helped by permissive governmental policies. Technological advances in rehabilitation, diagnostic medicine, and surgery, led to a marked growth of the medical device industry. For-profit insurance companies, which had entered the private health insurance field during the World War II, at first as an adjunct to life insurance, now entered the health market in a big way, stimulated in part by the increase in employers’ health plans, and in part by state legislation which allowed them to use class or experience rating, rather than community rating. By the end of the 1950s, their membership surpassed that of the not-for-profit blues. The 1950s were dominated by a technological ideology, according to which increases in costs were justified by the continuous progress in the methods of medical science.

The growth of organized medicine and medical sciences in the USA since the beginning of the 20th century had contributed to a professional dominance (35,36), similar to that of physicians in the European continent. This dominance is exerted in the relationship between a physician and a patient; in the role of physician as a provider of diagnosis with all its implications; and, in occupational control of personal health care which was almost entirely vested in physicians or their organizations in matters such as standards of practice, fees, control of entry in the profession and number of physicians, legitimization of alternative approaches to care and control of hospitals, not-for-profit health insurance, and, indirectly (through the physicians’ control of prescriptions), the pharmaceutical industry, among other avenues of control. This dominance was to come under attack from several sides after the 1950s.

A split developed (or perhaps grew) in the American culture and politics in the 1960s and 70s. On one side, there were people, often from a younger generation, and often those opposing the Vietnam war, who were in favor of social change, civil rights, and the support of disadvantaged or vulnerable people, the poor in general, and patients in their relations with physicians. The changing culture of the 1960s challenged many of the old notions. Several of the new programs of the 1960s (such as the Economic Opportunity Act, and the Community Health Planning Act at the institutional level and PL93-641 at the area level) gave new powers to consumers in the oversight of health care, at some expense to physician power. Medicaid passed to provide health care to disadvantaged people (including some people below the poverty line in 1967, and people with disabilities in 1974). Other

progressive legislation included the Occupational Safety and Health Act of 1970 to improve the job environment.

On the other side of the split, justification of for-profit business in health care was becoming an emerging ideology, leading various types of businesses (pharmaceutical and medical device industries, laboratories, for-profit insurance, and hospital-associated business) toward higher priority in the health care system. The new federal legislation of the 1960s, especially Medicare and Medicaid provided boosts to many of these industries and supported the growth of relatively new industries in nursing homes and home health care which flourished in the 1970s. As the cost of medical care continued rising in the 1970s and 1980s, these various industries showed increased profits, and they were joined by others, including the electronic information industry (for computerized billings and other information needs), pharmacological companies specialized in biotechnology, for-profit hospital chains, and various companies formed to exploit new technical devices.

When the federal government proposed Medicare, physicians were initially opposed to it as "socialized medicine", but when there was unmistakable evidence that it would pass, they dropped their opposition, after assurance that they would be able to charge their "usual and reasonable" fee. Medicare became an important source of income for many physicians. After that, the balance of power gradually shifted in favor of at first the government and then the health industry. Physicians had to sacrifice some autonomy in order to participate in the new governmental programs. In some instances, this came in the form of governmental regulations to control quality, utilization, and, especially, cost. For instance, physicians had to accept in the late 1980s a relative value scale for their bills under Medicare. Their ability to control the length of hospital stay of their patients was shared with governmental regulatory agencies.

Organized medicine was initially opposed to group practice, for fear that it would compete with solo practitioners. It gradually changed its attitude as the excess of physicians which had occurred in the 1970s made competition among solo practitioners harder and fee-for-service practice became less fitted to compete in the medical market place. The pre-paid model of group practice, later called health maintenance organizations (HMOs), was still threatening to many physicians, but organized medicine went ahead with the HMO Act in the 1970s, after incorporation of some assurances (37).

By the 1980s, competition among physicians was more intense due to the still increasing number of physicians. Their expenses increased in part because of the rise in the cost of malpractice insurance, and in part because of the increased costs of physician office (in line with the real estate inflation of that decade) and of office personnel and equipment. The marked increase in volume of care in the 1970s and the new federal HMO legislation attracted for-profit managed care organizations (MCOs). Physicians joined MCOs in large numbers in the 1980s because they gave them a competitive advantage.

In the early 1980s, MCOs were participating in the increased costs of medical care. By 1992-93, as pressures were mounting from both payers and government to decrease costs, MCOs imposed more restrictions on medical practice to decrease costs, with some reactions from physicians who resented having an administrator with a business degree tell them what to do.

In the late 1970s, a type of industry that was to become a major player in the 1990s entered the health field. It was hospital management corporations who were initially called in as consultants to help financially distressed hospitals. These corporations came in with business methods to decrease costs, including hospital mergers of services. Others bought hospitals, rehabilitated them, and some of them grew into large hospital chains.

A large managed care industry combining management of physicians and hospitals developed in the 1980s. It grew further in the 1990s, possibly in response to the alternative that the Clinton national health proposal might provide, to the point where it now dominates the health care market in most areas. This industry interacts with insurance companies which provide underwriting and existing patients and physician panels; with large employers as payers; and with physicians, hospitals and other entities as providers of services and goods. These four groups – the MCOs, the insurance companies, the payers, and the providers – constitute the main current structure of personal health care in the USA.

Table 3: Percent changes in some economic indicators. [view this table]

The MCOs have often been able to increase practice size and thereby income by marketing techniques, and to decrease costs by shortening hospital stays (Table 3), hospital outpatient shifts, closure of unprofitable hospitals, decreased use of specialists with increased responsibilities of primary care practitioners, and economies of scale, which translated into greater flexibility to decrease

premiums and therefore a better competitive position. These developments have been associated in the past two years, for the first time in more than two decades, with a marked slowing of the rise of medical care prices in the USA (Table 3), which has received considerable emphasis in the press and the government. It is too early however to fully assess it. Is it a one-time development or the beginning of a trend? It is recalled that when pre-paid group practice was introduced as a choice in employer programs along with fee-for-service systems, there was a one-time drop in the cost of health care in HMOs, and, then, both systems continued to increase in cost at the same rate (38). It remains to be seen whether the shift to MCOs follows the same pattern on the national level or not.
Physicians have participated in the growth of MCOs. When the penetration of the market by HMOs rises above 20%, the physicians in the area find it difficult to maintain their income from their practice, and, they either join the area's MCOs or form a new MCO. In this manner, there has been a very rapid absorption of physicians into MCOs in the 1990s, so that, at present, a majority of physicians provide care in MCOs. In so doing, they have come under some control of (mostly non-physician) administrators regarding such items as the ability to admit patients to hospitals, length of hospital stay, utilization of laboratory procedures, division of work between specialists and primary care practitioners and between physicians and nurses, and, last but not least, the level of their income. This has contributed to a change in the culture of US physicians. Traditional concepts, including the sanctity of the physicians' autonomy and the rejection of profit that is based on the exploitation of physician work have been eroded. In some settings, physicians are becoming more like traditional high level employees. Labor unions of salaried physicians have already formed in the US. The concept of proletarianization has been put forward by McKinlay to describe the process in which an occupational category is divested of control over certain of its prerogatives in subordination to the broader requirements of production under advanced capitalism (39). Seven specific professional prerogatives potentially subject to divestment were identified as: 1. control for entrance in the profession; 2. control of training; 3. autonomy regarding the terms and content of work; 4. the objects of labor (e.g., clients served); 5. the tools of labor (e.g., machinery); 6. the means of labor (e.g., hospitals); and 7. the amount and rate of remuneration for labor (40). However, almost 15 years after McKinlay submitted his first paper for publication, the US physicians still retain many if not most of their prerogatives, albeit, often more indirectly: for instance, physicians may be required by MCO administration to use certain protocols, but these protocols are usually written by physicians.
Another development relates to the concept of "deskilling" put forward by Braverman in the 1970s when many physicians' roles or tasks were being assumed by physician assistants or nurse practitioners to describe the transfer of skills from highly to less highly trained personnel (41). This is the transfer of many tasks from physicians who are specialists to others who are primary care physicians. Still another related development is the partial replacement of individual decision making by protocols or disease management plans providing extensive guidelines for physicians.
Turning now to the consumers of care, the patients, as the size of MCOs has grown, competitive practices have sharpened; the clients with lower health risks who were taken initially were followed by clients more likely to have greater medical needs; payers have become more resistant to high premiums, and providers have made increasing demands. In these conditions, MCOs must react by decreasing their benefits to the extent allowed by insurance laws, increasing their premiums to the extent allowed by the payer and consumer resistance and competition, or by pressuring their providers into greater productivity, such productivity being measured by numbers of encounters per day rather than quality of care, or in making more economies, which might again conflict with quality of care. Despite such efforts, some HMOs have come to the point of bankruptcy (42).

Table 4: Health insurance status of US population. [view this table]

What this means with regard to health care is still under study. Table 4 shows that the period of private health market growth has been associated with a steady increase in the fraction of the population without health insurance, a moderate decrease in the fraction with health insurance, and a marked increase in the fraction on Medicaid. There was an increase in the absolute number of people without health insurance, from 30 million in 1980, to 37 million in 1987, and to nearly 40 million by 1992 (16,43). The number of uninsured people increased by about 1 million between 1995 and 1996 (44). However, during the same period of the 1980s and 1990s, there has been a marked increase in the polarization of the population into very rich and very poor, and a marked decrease in the real value of wages of workers, especially those in the less well paid categories (Table 2). Therefore, it is difficult to assess to what extent each of these two factors – the structural change in the health care system and the change in the societal economy – may contribute to these changes in coverage.

Recent studies concur that the vast majority of uninsured are those from families with at least one wage earner who earns relatively low wages (43-47). The likelihood of low income workers to have employer-sponsored insurance has decreased during the 1980s (45). There was no consistent evidence that that decrease was related to an increase in part-time jobs or in self-employment. There was a slight association with a shift of workers from highly-covered to low-covered employment. However, the fall in coverage rates occurred across all industries (43). Some association was found with decreased real wages and decreased unionization (47). Several studies found that much fewer small firms offered health insurance coverage to their employees than larger firms (44). Furthermore, in the 1990s, though small employers have become more likely to offer coverage, employees have become less likely to enroll (44,46). Thus, while various mechanisms may be at play, it is clear that it is lower wage workers and their families who have been unable to buy health insurance and small employers who have been unable to offer it. It is also clear that for-profit managed care and the health care market have not been able to solve that problem, as it has worsened during the period of growth of for-profit managed care.

Besides the lack of full health insurance coverage demonstrated at the aggregate national level, there is also a considerable variation among states in health insurance coverage, access to care, and health status, clustering in several states (48). The problem of state regulation is complicated by the fact that many of the largest insurers and managed care companies are national, with components in several states, and that the trend toward a national health market place is still increasing (49). Therefore, there has recently been a renewal of interest in federal regulation. The Kassebaum-Kennedy legislation of 1996 provides the first federal regulation of the managed care market (50). The Clinton administration, which has recently introduced the State Children's Health Insurance Program, or CHIP (51), in the Balanced Budget Act of 1997, might be moving in that direction.

The growth of the managed care industry in the 1980s and 1990s has many similarities with that of the industrial corporations of the 1880s and 1890s, particularly the manner in which they increase in size by mergers, acquisitions or forcing competitors out of the market. Antitrust laws are beginning to get invoked in court decisions on HMOs; however, there are still many gaps in the understanding of restraint of trade in the instance of HMOs, which requires further research (52). Concerns over the pitfalls of the market place for purchasers (i.e., employers and secondarily employees) have been augmented by the providers' consolidation and a relative lack of concern of purchasers, as well as consumers, for quality. Provider consolidation is a greater monopolistic threat than health plan consolidation, since in the latter instance purchasers can go directly to providers, bypassing health plans. Current purchasing decisions tend to give a much higher priority to cost rather than quality (53). There is an increasing interest in collective action to regulate health care markets, but this collective action does not necessarily mean government intervention. Enthoven and Singer (54) propose that private purchaser initiatives, such as the Pacific Business Group on Health, play a collective role in regulating pooling of risks, managed competition, and consumer protection, while the governments should subsidize public goods, take antitrust action, create an information infrastructure, enact structural changes, and reform tax laws.

Priorities in the US Health Care System

The preceding historical development shows that there has been several changes in the priorities in the US health system, as well as some invariant features.

Priority Changes

The term priority is used in this section to signify not only priority in the allocation of resources, but also priority in decision-making, recruitment of personnel, prestige, etc. However, these various forms of priorities are ultimately reflected in the distribution of resources.

The priority of the health sector (versus other sectors of the economy) has steadily increased, as shown by the increasing fraction of GNP allocated to the health sector from 1929 to 1990 (Table 1). The excess of the fraction of the US GDP that goes to health, as compared to the European countries (2), is partly due to higher costs of certain items, but also to a larger health industry regarding both personnel and equipment.

The priority of the public health sector decreased during the first third of the 20th century, coincident with the rising priority of the personal health delivery system, and the domination of the health care system by curative medicine and by the private sector, and it has not recovered since.

In the second half of the 19th century, several practitioners of personal health care had relatively equal priority. However, since the beginning of the 20th century, physicians who practice mainstream, scientific medicine have retained the highest priority and still have it. However, some practitioners of alternative forms of health care have received increasing recognition in the past decade.

The priority of different forms of associations of physicians in the practice of medicine has been

evolving. In the first two-thirds of the century, the top priority was held by physicians in solo, fee-for-service practice. During the second half of the century, there has been an increasing recognition of the advantages of, at first, single specialty group practice, and, later, multi-specialty group practice. HMOs and other forms of MCOs, which were initially at the fringes of medical practice, now have a dominant position and a top priority in the US health care system.

There was a shift in the approach of medical care from a priority for general practice throughout most of the first half of the century, to a priority for specialized care in the second half, which still holds, although primary care (a more advanced form of general practice) has been growing in importance during the past two decades.

There was a shift during the first two decades of the century from priority for office or dispensary care to hospital care, which has retained its priority throughout most of the 20th century, although there is now a move away from the hospital, as evidenced by shorter hospital stays, day or outpatient surgery, and increased choice of ambulatory care.

Nursing homes of various types began to have a high priority in the health care system from the 1970s on, but in the last 10-15 years, there has been a shift of resources to home health care and other community-based living. A similar change took place in the second half of the 20th century in the shift of resources from large institutions for people with mental disorders or mental retardation to community living arrangements.

In the relation between consumers and professionals, the professionals had a very dominant role throughout the first two-thirds of the 20th Century. Then, there was a brief period (mid 1960s and 1970s) when consumers were given a significant voice in the management of community health centers through community representation on or even control of their boards, and in area planning in the health systems agencies established by the federal health planning PL-93-641 act. However, the federal health planning act was discontinued in the early 1980s. There was a return to a more professional dominance except for some subtle changes, for example a greater emphasis on the communication skills of physicians and on explanation of alternative treatment choices. Consumer grievances have played a significant role in the marked increase in malpractice suits and premiums since the 1970s.

Physicians were autonomous professionals, mainly in private practice, for much of the 20th century. Since the 1960s, physicians have been subject to increased governmental regulation, and, since the 1980s, most physicians have become subject to management by MCOs. Therefore they share decision-making with both private managers and government regulators, although still retaining a commanding priority in clinical decision making.

Priorities among different groups of users (consumers) of health care have evolved. Throughout the 20th century, the upper socioeconomic groups have had a better access than the lower ones. The enactment of Medicaid in 1967 provided a partial solution by financing care for a part of the poorest population which was variously defined in different states, and usually did not include all the poor. For instance, in most states single men were not eligible, irrespective of their degree of poverty (unless they became homeless, when they could avail themselves of health services under the McKinney Act). The enactment of Supplemental Security Income (SSI) in 1974 changed one of the populations with the lowest priority in the health care system, i.e., people with disabilities, into one that was at least covered through Medicaid, and implementation of the more recently enacted American With Disabilities Act is currently removing other barriers to the care of people with disabilities. On the other end, there has been, as discussed earlier, an increase in the number of working people not covered by health insurance.

Thus, with regard to priority for financing health services, the US population is sharply divided into 5 groups.

1. A large majority, including rich people, most middle class people, the upper strata of the working class, and retired people eligible for Medicare have good health coverage, despite significant co-payments.
2. A significant number of employed workers, in the middle strata of the working class, have relatively poor health coverage because they cannot afford the premiums of better coverage.
3. Another significant part of the population (over 40 millions) in the lower socioeconomic strata does not have any health insurance, as discussed earlier.
4. A large part of the population in the lowest socio-economic level has a relatively good coverage through Medicaid.
5. Finally, in many states poor people who do not qualify for Medicaid, including many undocumented emigrants, have no coverage.

In addition to these five groups, a sixth group consists of people with catastrophic medical illnesses who may start in any group and end up when their benefits expire in the third or fourth group

described above.
Possibly the main change in priority in the 20th century has been that among the for-profit and the not-for-profit private sector and the public sector. In the first half of the century, services were predominantly restricted to the not-for-profit sector (though health goods were always in the for-profit sector). Following the World War II, the federal government took a significant role in the delivery of care in the Veterans Administration Hospitals, and since the 1960s, in financing about 40% of the cost of all health services.
Since the 1980s, the for-profit sector has gained dominance of the private sector. Many MCOs and the associated insurance industries have made enormous profits which have gone to their stockholders through the rise in the value of their shares in the stock market, and to their chief executive officers (CEOs) and other high executives through their stock options and high salaries. Many CEOs have incomes over $1 million a year and, in at least one instance, over $1 billion (inclusive of stock options).
Invariants
The first major invariant is the US type of capitalist system which has remained unchanged despite some fluctuations when acts and regulations were enacted to make the system more equitable in the 1900s, 1930s, and 1960s. It is a system dominated by large corporations that have a considerable power in health care, both as payers of private health insurance and as powerful influence groups in the government. The change brought about by the growth of a for-profit health industry in the second half of the century has reinforced corporate strength in the US health system.
The second invariant is the domination of the constellation of providers, corporate payers, insurers and managers over consumers. Initially, this was primarily the domination of physicians over patients. Now it is that of the above-specified constellation over the users of health care. In either instance, the users (consumers, patients) have a low priority in decision making in the US health care system.
The third invariant is the class system as it relates to socioeconomic inequality in health and health care. Both class and income differential contribute to the steady decrease in health status and access to health care as one goes down these scales.
The fourth invariant is the scientific and technological approach to health care which was established in the late 19th century for environmental health and at the beginning of the 20th century for personal health care, and still persists. Physical and especially psycho-social rehabilitation and other social interventions to improve health are still markedly underutilized, although the recent governmental and judicial interventions to decrease smoking show that there may be signs of change in that respect.

Discussion
With regard to the first question of this article, i.e., what has made the US health care what it is, we can give the following answer. As for the lack of a national health program, the health system of the USA developed within a very competitive and harsh brand of capitalism, in which, during the first 60 years of the period under review, neither corporations, nor labor, nor eventually the physicians were keen on having government intervene in health care, each for a different reason: corporations because they wanted as little interference of government as possible; the main labor organization, the AFL, because it distrusted government; and, physicians because they wanted to maintain their autonomy and professional dominance. After the World War II, labor, which was supported by the Democratic Party in the 1930s and lost its distrust of the federal government, came out strongly in favor of a national health program and supported a large scale effort in 1972 and, less vigorously in 1992. However, by that time, the ability of labor to mount a strong social movement had been eroded. Labor lost its ability to act with class solidarity in two steps. Firstly, in the 1880-1920s, strong corporate repressive measures and hardships during recessions destroyed most labor movements, and under this selection pressure, the one that survived, the AFL had limited its support to workers in only a few trades. Secondly, as labor was recovering from the Great Depression, and unions were growing in many trades, the Taft-Hartley legislation of 1947 prevented labor by law from acting as a class. From then on, labor union acted as interest groups to compete with other groups for governmental resources. The US labor thus did not develop the class solidarity, nor the labor-dominated political parties that were instrumental in gaining national health programs in Germany in the 1890s, in England in the 1910s, and in other countries afterwards. Furthermore, labor considerably weakened in the years following the 1950s, as measured by several indicators (Table 2). In the meantime, various interest groups gained one at a time some governmental or private health programs. Those who have remained without insurance, some 40 million people (15% of the population), belong to a population with relatively little political power.
This does not eliminate the possibility of a national health insurance or other national health program in the USA, if two requirements are met. First, organized labor would have to become much stronger.

It would have to actively recruit workers to the point where the present union membership is at least tripled, focusing on those workers who have no health insurance and who are among the lowest paid or the most part-time. The unions which have satisfactory health programs through their employers would have to develop enough solidarity to campaign for a program that would benefit other unions and that might even leave them with a program inferior to the one they now have. In order to do that, a class identity of labor would have to be developed in contrast to the multiple interest group identities of workers. Finally, labor would have to develop political allies, possibly among retired people again, or small businessmen who presently have considerable difficulty in competing in the health care market, or even among physicians. The second requirement would be that the current for-profit managed care system fails in providing sufficient access or quality of care to its consumers or remuneration to its physicians. A reaction might then develop against the present managed care system strong enough to induce strategically located people to consider whether another managed care system located within a national health program might not be desirable.

With respect to the second question, i.e. what is the significance of the current managed care system and of its priorities for the USA, I have described the cumulative changes in regulation of the US health care system in three phases during the 20th century. At first, a purely professional system, with a large general practice component, provided a direct regulation by physicians to themselves and to the allied, mainly not-for-profit, organizations, until about the World War II. At that time, specialists, hospitals, and academic medicine began to dominate in an expanding system with increasing participation of various for-profit industries, which was regulated by institutions or by the government. Finally, in the 1980s-1990s, a system dominated by managed care organizations arose, interacting in a health care market with various for-profit entities (hospitals, insurance companies, employers, etc.), which is regulated by managers.

During these periods, the nature and objectives of the regulators have changed. The first period's regulators were physicians, intent on maintaining and developing a professional and scientific culture of medicine. The second period added institutional or governmental regulator intent on implementing certain rules and objectives of their organizations and on controlling costs. The third period has added decentralized local private manager-regulators, intent on implementing certain protocols, controlling costs, and achieving a satisfactory profit for their organization.

These changes have various aspects, some of which are more significant than others. The involvement of government officials, and later, of managers has elicited much anguished reactions on the part of physicians, but I think that it is the least significant aspect of the changes. Physicians still retain considerable decision making power regardless of the format under which it takes place. When a manager implements a protocol, it is generally the one that has been written by physicians. Furthermore, physicians have demonstrated a remarkable ability to adapt to various outside influences (insurance, group practice, government programs, etc.) and to retain their autonomy, and there is no reason why they should not continue to do so. Finally, there are many forms of MCOs, some of which provide a much greater regulatory role to physicians, including some in which the physicians are the regulators.

It has also been suggested that increase in regulation and disease management (from the profession, from government programs, and from MCO's management) will stifle the individuality of physicians in clinical practice. Again, I believe that this concern is exaggerated, as physicians retain a considerable degree of freedom in clinical matters, and may often make an exception to certain rules (e.g., in the use of laboratory tests) if a reasonable explanation is given.

What I believe to be a much more serious problem is the new objective of managed care regulation not only to reduce costs, but also to increase profits. The current for-profit HMOs and other MCOs are institutions of a very different type than the HMOs of the 1940s and 1950s. They are a form of private corporate for-profit business. This introduces an entirely different set of values. It also brings in a group of powerful actors who are distant from the health care process and have a primarily monetary interest, namely stockholders and high executives with significant stock options. The need to increase profits while lowering costs has several implications. It may create upward pressure on premiums which would put them out of reach of small business and low income workers. It may discriminate against groups that may be poor risks and, vice versa, select groups that are expected to be low risks. These features mean that access would suffer, and they are consistent with the increased percentage of people without health insurance in the past decade.

Another type of problem has to do with quality or acceptability of care, which might be lowered. An area of concern is the marked downward pressure on length of stay in hospitals (Table 4). The most salient examples (e.g., one-day delivery or one-day mastectomy) provoke a quick reaction in the press and are often reversed. However, there may be other less important instances that may be associated with untoward health consequences or hardship for the patient, which may require special

epidemiological or health services research for documentation.
The third problem refers to pressures to increase physician productivity or decrease cost by downward pressure on the time physicians spend per patient or by replacement of one type of professional by another who might not be as qualified. There is anecdotal evidence of this and it requires further study. Even the shift from a specialist to a primary care physician, which is often desirable, might be overdone and quality of care would decline in those instances.
The fourth problem is related to the effects of downsizing or of mergers, which are quick ways to reduce costs, but which may result in unemployment of health personnel, or in the instance of hospital closures, in depriving a community from a nearby health facility.
The fifth type of problem is related to the economic risks that may be taken by the companies in planning, investing, or going into debt in order to increase future profits. After a honeymoon period for large MCOs, there have been several instances of companies that were deeply in “the red”, some of whom bankrupted, while others had to make harsh structural readjustments. Patients and physicians often suffered in those cases.
Many of these problems might be solved once they are detected, by making necessary adjustments. However, the pressure of the profit motive may often interfere with adjustments or it might create additional problems in the effort to keep profit high. The argument that the profit motive helps to increase efficiency without significantly decreasing effectiveness, quality, and acceptability of health care, has not been supported to date.
Finally, there is an ethical position, shared by many people: simply stated, health care is for people, it should not be for profit. In other terms, the money that goes into profits might be better spent providing health care for the many people who are still uncovered, or decreasing those out-of-pocket payments that prevent utilization of the needed health care, even if a small part of it is wasted by decreased efficiency. Wasting a large part of it through excessively high incomes or luxurious facilities, whether in for-profit, not-for-profit or public organizations is just as reprehensible and should be prevented by strict accountability.
As these needs become more and more salient, a return to consideration of a public form of health care, with the emphasis on preventive, as well as curative care, full access, and efforts to address inequality in health will be in order.
With regard to the European countries, most of them have a national health system which provides universal access. Even though there is still considerable inequality in health care, it is usually not as harsh as in the US, nor is it associated as much with inequality in access. Thus, a move to cut costs which might bring increased reliance on market mechanisms, on the for-profit sector, and on large health care corporations might have very deleterious effects on the most vulnerable populations. This study shows that European nations should value and preserve the solidarity within their population, and their relatively strong labor movements, which have contributed to a better equilibrium among social classes than the USA has. The implication of the answers to the second question discussed in this article is that, since the ability of for-profit managed care (though not necessarily that of other forms of managed care) and of market mechanisms to control costs in the long run remains to be determined, and since they may have negative aspects on equity and quality of care, the European nations should be very cautious in considering the adoption of these approaches to bring costs down. Therefore, the final word of this paper is: Beware!

References

1 Saltman RB, Figueras J. European health care reform. Analysis of current strategies. Copenhagen: World Health Organization Regional Office for Europe; 1997.
2 Anderson GF. In search of value: an international comparison of cost, access, and outcomes. Health Affairs 1997;16:163-71.
3 Commons JR. History of labour in the United States. Volume 2. New York: Augustus M. Kelley; 1966.
4 Lescoyer DD, Brandeis E. History of labor in the United States, 1896-1932. Volume III: Working conditions. Labor legislation. New York: Augustus M. Kelley; 1966.
5 Perlman S, Taft P. History of labor in the United States, 1896-1932. Volume IV: Labor movements. New York: Augustus M. Kelley; 1966.
6 Dulles FR. Labor in America. A history. 3rd ed. New York: Thomas Y. Cromwell; 1967.
7 Sexton PC. The war on labor and the left. Boulder (CO): Westview Press; 1991.
8 Serrin W. Homestead: the glory and tragedy of an American steel town. New York: Random House; 1993.
9 Starr P. The social transformation of American medicine. New York: Basic Books; 1982.
10 Burrow JG. AMA: Voice of American Medicine. Baltimore (MD): The Johns Hopkins Press; 1963.

11 Myers RJ. Medicare. Bryn Mawr (PA): McCahan Foundation; 1970.
12 Fox DM. Health policies, health politics: the British and American experience 1911-1965. Princeton (NJ): Princeton University Press; 1986.
13 U.S. Bureau of the Census. Historical statistics of the United States, Part 1. Washington (DC): Superintendent of Documents; 1975.
14 U.S. Bureau of the Census. Statistical Abstract of the United States: 1997 (117th ed.). Washington (DC): US Department of Commerce; 1997.
15 Field MJ, Shapiro HT, editors. Employment and health benefits: a connection at risk. Washington (DC): National Academy Press; 1993.
16 Chollet DJ. Redefining private insurance in a changing market structure. In: SH Altman, UE Reinhardt, editors. Strategic choices for a changing health care system. Chicago (IL): Health Administration Press; 1996. p. 33-62.
17 Kongstvedt PR, editor. Essentials of managed health care. 2nd ed. Gaithersburg (MD): Aspen; 1997.
18 Wright EO. Class Counts: comparative studies in class analysis. Cambridge (MA): Cambridge University Press; 1997.
19 Mc Quarie D, McGuire P. State and politics. From the king of Prussia to the new world order: marxist theories of state and power. In: McGuyre P, McQuarie D, editors. From the left bank to the main stream: historical debates and contemporary research in Marxist sociology. Dix Hill (NY): General Hall; 1994. p. 129-51.
20 Marx K. Capital. London: Viking Penguin; 1993.
21 Tarrow S. Power in movement: social movements, collective action, and politics. Cambridge (MA): Cambridge University Press; 1994.
22 Zolberg AR. Moments of madness. Politics and Society 1972;2:183-207.
23 Lenin VI. What is to be done? Burning questions of our movement. NewYork: International Publishers; 1929.
24 Gramsci A. Selections from the prison notebooks. Cited by Tarrow S. Power in movement: social movements, collective action, and politics. Cambridge (MA): Cambridge University Press; 1994.
25 Olson M. The logic of collective action. Cambridge (MA): Harvard University Press; 1965.
26 McCarthy JD, Zald MN. The trends of social movements in America: professionalization and resource mobilization. In: Zald MN, McCarthy JD, editors. Social movements in an organizational society. New Brunswick (NJ): Transaction; 1987. p. 337-92.
27 Alford RR. Health care politics: ideological and interest group barriers to reform. Chicago (IL): University of Chicago Press; 1975.
28 Random House Dictionary of the English Language. New York (NY): Random House; 1966.
29 Phillips K. The politics of rich and poor: Wealth and the American electorate in the Reagan aftermath. New York (NY): Random House; 1990.
30 Edsall TB. The new politics of inequality. New York (NY): WW Norton; 1984.
31 Navarro V. The politics of health policy. The US reforms, 1980-1994. Oxford: Blackwell; 1994.
32 Fee E. The origins and development of public health in the United States. In Holland WW, Detels R, Knox G, editors. Oxford testbook of public health. 2nd ed. Oxford: Oxford University Press; 1991. p. 3-22.
33 Ginsberg E. The medical triangle: physicians, politicians, and the public. Cambridge (MA): Harvard University Press; 1990.
34 Ginsberg E, Ostow M. The U.S. pluralistic health care sector. Bull N Y Acad Med 1997;74:156-76.
35 Freidson E. Profession of medicine. New York (NY): Dodd Mead; 1970.
36 Freidson E. Professional dominance. New York (NY): Atherton Press; 1970.
37 Brown LD. Politics and health care organization: HMO as federal policy. Washington (DC): The Brookings Institution; 1983.
38 Luft HS. Trends in medical care. Do HMOs lower the rate of growth? Med Care 1980;18:1-16.
39 McKinlay JB, Stoeckle JD. Corporatization and the social transformation of doctoring. Int J Health Serv 1988;18:191-205.
40 McKinlay JB, Archer J. Towards the proletarianization of physicians. Int J Health Serv 1985;15:161-95.
41 Braverman P. Labor and monopoly capital. New York: Monthy Review Press; 1974.
42 Feldman R, Wholey D, Christianson J. Economic and organizational determinants of HMO mergers and failures. Inquiry 1996;33:118-32.
43 Long SH, Rodgers J. Do shifts toward service industries, part-time work, and self-employment explain the rising uninsured rate? Inquiry 1995;32:111-6.
44 Ginsberg PB, Gabel JR, Hunt KH. Tracking small firm coverage 1989-96. Health Aff 1998;17:167-

71.
45 Kronick R. Health insurance 1979-1989: the frayed connection between employment and insurance. Inquiry 1991;28:318-32.
46 Cooper PF, Shone BS. More offers, fewer takers for employer based health insurance. Health Aff 1997;16:142-62.
47 Fronstein P, Snider JC. An examination of the decline in employment based health insurance between 1988 and 1993. Inquiry 1996;33:317-25.
48 Cantor JC, Long SH, Marquis MS. Challenges of state health reform: Variation in ten states. Health Aff 1998;17:191-200.
49 Corrigan JM, Eden JS, Gold MR, Pickreign JD. Trends toward a national health care marketplace. Inquiry 1997;34:11-28.
50 Moran DW. Federal regulation of managed care: an impulse in search of a theory. Health Aff 1997;16: 7-21.
51 State Children Health Insurance Program, Title XXI, Social Security Act, 1997, sec. 2101(a).
52 Sage WM. Judge Posner's RFP: antitrust law and managed care. Health Aff 1997;16:44-61.
53 Bailit MH. Ominous signs and portents: a purchaser's view of health care market trends. Health Aff 1997;16:85-8.
54 Enthoven AC, Singer SJ. Markets and collective action in regulating managed care. Health Aff 1997; 16:26-32.

Received: March 20, 1998
Accepted: June 9, 1998

Correspondence to:
René I. Jahiel
24 Park Place (#17K)
Hartford CT 06106-5030, USA
jahiel@nso2.uchc.edu