The Corporate Transformation of American Health Care:
A Study in Institution Building*

Laura Anne Schmidt, Ph. D.

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In the last three decades, the American health care system has undergone revolutionary change. What was for much of the 20th century a cottage industry dominated by a monopolizing medical profession is now a sprawling, price-competitive market dominated by large, integrated health care firms. Medicine's traditional ethos of community service and fiduciary ethic seem to have given way to the unbridled spirit of corporate capitalism. And the organizations that now populate the landscape of the health care system seem radically unfamiliar. Gone are the autonomous community hospitals and solo medical practices that most Americans grew up with. Entrepreneurs and venture capitalists have replaced them with a whole menagerie of integrated delivery systems, managed care plans, provider networks and national health care chains.

Perhaps the most striking changes are in the medical profession. For much of the 20th century, medicine was an heroic exception to the otherwise waning tradition of independent professionalism in America. But in recent decades, much of the profession has succumbed to the iron rule of the large corporation and bureaucracy. The majority of young physicians today work in jobs as the employees of organizations. And most practicing physicians, young and old, work under contracts with firms that actively monitor and control what they do by making them accountable to outside standards of cost-effectiveness. Today, medical trade journals debate if and how physicians could "take back" medicine.

Depending on one's perspective, the changes in health care may seem worthy applause or derision. Some praise market-oriented solutions as the only rational way to control rampant inflation and inefficiency in medicine. Price competition promises to lower costs without dampening the drive for innovation and without resorting to one-size-fits-all government rationing

schemes. Others scorn market-driven health care for imposing corporate interference on the private relationships between doctors and patients, and as a source of growing inequality in America. The health care market, it seems, has led to a paradox of excess and deprivation: Well-insured people receive ever more technology-intensive and costly care, while the uninsured get little or no care at all.

Whatever their opinions on whether competitive health care is good or bad for America, most people today take it for granted that health care is an aggressively price-competitive business. This study is about how and why Americans came to agree that health care could be subjected to the same economic and business strategies that drive other sectors of the economy. Why did America turn to the competitive market for solutions to the problems of allocating and financing medical care? And why did it not turn to some other solution?

The central thrust of my argument is that the early 1970s produced a major turning point in American medicine, when the way people talked about the system and its problems fundamentally changed. Around this time, the core concerns in health care came to revolve around costs, budget deficits, economic incentives and inflation, and this definition of the problem suggested the competitive marketplace as the obvious solution. The turn towards the market was not driven by the proven benefits of competition and business solutions in controlling inflation or reducing overall costs. The appeal of the market conception is its consistency with fundamental currents in American political culture, and its ability to serve the varying interests of key stakeholders in the system, including physicians, hospital administrators, insurers and big business.

The market conception has succeeded in America because it offers a politically viable and culturally meaningful approach to collective problem-solving in the health care field. In the early

70s, when the idea of building a market emerged in political debates, it seemed new and untried, and this allowed its advocates to work around longstanding political divisions in the contentious politics of health reform. Competing options, such as creating a national health insurance system similar to the ones in most other countries, have repeatedly fallen prey to interest group stalemates and political gridlock. Of the options on the table at a key turning point in the 70s, the market approach was the only politically viable solution available to a situation of prolonged gridlock and institutional crisis. Malleable enough to allow all of the key stakeholders in health care to see their interests as being served, market principles have also appealed to longstanding shared values, such as free choice, personal responsibility, innovation, and individual freedom from government oppression.

Market solutions have also succeeded in America because they have helped to solve a narrow range of problems for powerful stakeholders in the system. Market innovations both legitimate change in the organization of health care and facilitate that change by providing actors with practical tools for solving their dilemmas. Consider, for example, the situation of large employers in America, who have been saddled with increasing costs for employee health coverage, but still rely on health care as a key benefit in bargaining with labor. The market approach preserves employment-based health coverage while giving management a legitimate rationale and effective tools for cutting costs. It legitimates private cost containment by assumin that much of the health care delivered in America is unnecessary, overly invasive and potentially harmful to consumers; employers have a right and duty to scrutinize the “medical necessity” of the services they pay for on behalf of employees. At the same time, the market conception facilitates change by encouraging employers to view health care services like any other input to the firm.

This leads them to apply to health care purchasing the same kind of practical strategies for monitoring and bargaining over costs that they would use with any supplier.

My approach to understanding change in the health system differs substantially from those that have dominated debates in the scholarly literature and trade press. These include economic explanations that view change in terms of the managerial drive to increase efficiency, and social change theories that emphasize broad environmental forces leading to the industrialization of medicine. Economic perspectives stress that price competition and the restructuring of economic incentives have been rational solutions to a health care crisis of rising medical inflation and costs. The integrated health care corporations and new strategies of health care reimbursement we see today are vehicles for overcoming the inefficiencies and economic perversities inherent in traditional fee-for-service approaches to reimbursement. The prime movers in this story are large employers, along with a new breed of health care managers and entrepreneurs, who took logical steps in the 1970s and 80s to control their increasing medical bills by applying standard economic and business solutions to the problems in health care.

This perspective has several limitations. The most obvious problem is the reality that American health care has continued to struggle with high inflation rates and high aggregate spending both during and after the transition to a market-oriented system. Throughout the 1970s and 80s as procompetitive solutions spread, there was very little convincing evidence that they actually could achieve sustained savings. And while market strategies may work for some groups today, they fail to serve the economic interests of the society as a whole. The health industry today consumes almost 14 percent of the American gross domestic product — about twice that spent by many other industrialized countries with national health systems that do not have large

numbers of uninsured people.

By depicting organizational change as a rational response to economic pressures, economic explanations also create an heroic account of what managers have achieved under conditions of uncertainty. Throughout the 1970s and 80s, managers faced rapidly changing federal policies, unpredictably expanding and contracting markets, and shifting alliances among key players in the state and private sector. Such vast changes made it extremely difficult for any of the stakeholders in health care to know what their interests were, much less to pursue their interests in a rational way. As I will argue, it has been precisely this situation of uncertainty and free-floating interests among key stakeholders in the industry that has made it possible to forge a new consensus for change based the appeal of market solutions.

In the scholarly literature, there is a second image of the health care transformation, which views it as a long historical process in which broad social forces gradually undermined the professional sovereignty of American medicine. Arguments of this sort point to the progressive penetration of the welfare state into a domain that had traditionally been controlled by the medical profession. As the welfare state grew, it produced a steady expansion of administrative capacity and bureaucracy that undercut professional sources of power. A related argument points to the declining authority of professionals of all stripes during recent decades, attributable to the rise of consumerism and to the growing education and sophistication of the American population, which have made the public more willing to question professional authority. This trend towards "deprofessionalization," along with the medical profession's growing fragmentation due to

specialization, have undercut its authority and control over medicine.[1]

It is undoubtedly the case that these broad social pressures — not to mention spiraling inflation — have helped precipitate change in American medicine. But both the economic and social change accounts fail to explain the particular outcomes that came about in America. While virtually every advanced industrialized country on the globe has faced increasing medical inflation, welfare-state expansion and deprofessionalization, only America has witnessed such a widespread restructuring of health care as a competitive market. Moreover, by suggesting that change has been a natural consequence of powerful economic or social pressures, both accounts are prone to reading history backwards from the perspective of the present. In doing so, they gloss over important questions about precisely *how* norms of efficiency and market competition could have become routine assumptions in a health system that was, for most of this century, dominated by a monopolizing profession oriented around suppressing price competition and bureaucratic control. And both accounts fail to explain why viable alternatives to market reform were rejected in the United States. To explain what happened in America, one needs to not only show why

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[1] A range of arguments have been made about the declien of the medical profession in America. These include arguments about the changing basis of managerial control (Scott 1982), corporatization (Alexander and D'Aunno 1990; Light and Levine 1988; McKinlay and Stoeckle 1988; Pollitt 1982; Salmon 1985; Salmon 1987), proletarianization (McKinlay 1977; McKinlay and Arches 1985; Stoeckle 1988), and consumerism (Haug 1983). Freidson's is a minority voice in the debate. He maintains that the changes in medicine have not really undermined professional dominance, but have merely rearranged power relations within the profession (Freidson 1984; Freidson 1985).

competitive market approaches succeeded, but also why viable alternatives to the market, like national health insurance, have failed.

The current system has come about through the combination of a unique set of social circumstances and strategic action by groups seeking change. The changes have not simply been about managers and entrepreneurs responding rationally to economic problems. Nor are they just consequences of slow, gradual social pressures that undercut professional control. The discrediting of elites in organized medicine did help pave the way for change, and the social skill and strategy of groups promoting the market mattered. But they only mattered because a key turning point had arrived in the early 70s, when change became possible, although not inevitable. At that historical moment, it was up to strategic actors to use what the situation offered to forge new agreements around meaningful alternatives for the health care industry. The health system we have today is the product of their success at doing precisely that.

Stability and Change in Organizational Fields

In my history of the rise of corporate medicine in America between 1965 and 1990, I draw on a sociological framework for understanding how industries remain stable and undergo change. The starting place is a perspective on the health sector as an organizational field in which interdependent actors are oriented towards survival, and engage in action based on common understandings, shared goals and an established role structure (DiMaggio 1983; DiMaggio and Powell 1983; Scott 1995, ch 5). Fields have an established hierarchy of central and peripheral players among whom power and resources are distributed unevenly. Action in stable organizational fields is coordinated around common understandings about the “right way” to do

business — around a dominant "conception of control" or "logic of organizing" (Fligstein 1990; Friedland and Alford 1991). This central logic defines collective goals, promotes cohesion by appealing to shared values, establishes basic ground rules for action, and justifies an uneven distribution of power and resources among groups.

Once in place, these common understandings are extremely difficult to change. Powerful groups, who are heavily invested in maintaining the status quo, will resist change by appealing to the field's central logic. In doing so, they actively engage in reproducing the existing framework of institutions. Moreover, states play pivotal roles in maintaining the stability of fields by establishing and enforcing rules around property rights, governance and economic exchange that work to the advantage of central players (Fligstein 1995). As institutional structures themselves, states help to define markets and to assure their stable governance (Campbell, Hollingsworth, and Lindberg 1991; Campbell and Lindberg 1990). For example, the decentralized American state can potentially govern the health economy from the local, state and national levels. Depending on which level of government that makes most of the rules, the state may reinforce a regional or national conception of the market.

Organization theory provides a good starting place for understanding how the traditional fee-for-service medical system remained a stable field throughout the first half of the 20th century. At the center of the field were fee-for-service medical practitioners who comprised the rank-and-file of the American Medical Association (AMA), and who justified the status quo by drawing on common understandings about the profession's scientific authority and the importance of insulating the doctor-patient relationship from bureaucratic interference. The state reinforced that authority and helped to keep the field stable through a framework of laws that supported the

profession's control over defining who could and could not practice medicine, that backed up the profession's control over hospitals through the accreditation process, and that insulated the profession from managerial control with laws that rendered for-profit medical corporations illegal.[2]

While organization theory makes a compelling case for how the traditional fee-for-service system worked, it has far less to say about how this vast industry underwent a radical transformation in the 1970s and 80s. Organizational sociology does not offer a very clear picture of how the existing frameworks of institutions that maintain fields fall apart (Powell 1991) — of how even the remarkably longstanding institutions of fee-for-service medicine became vulnerable to fundamental change. Nor does it offer a theory of agency to explain the roles of actors in constructing, maintaining and transforming institutions (DiMaggio 1988). Moreover, what is truly puzzling about the health care transformation is that this industry underwent a profound restructuring in the absence of comprehensive reform legislation or any national health strategy orchestrated by the state. This particular case raises some fascinating questions about the state's role in industry transformations, and as I believe, about the capacities of actors in organizations to

[2] For further applications of the neoinstitutional approach in organization theory, see: Alexander and D'Aunno 1990; Arnold 1991; Light 1991; Mohr 1992; Ruef, Mendel, and Scott 1998; Scott and Backman 1990; Scott, Mendel, and Pollack forthcoming; Westphal, Gulati, and Shortell 1997.

mold and shape the institutional environments around themselves.

In this study, I pursue the hypothesis that, if *stability* in organizational fields is achieved by environments pressuring organizations to conform, then significant *change* in institutional environments must be achieved in the opposite way: through mobilization and strategic action by groups acting from within fields to change the environments in which they operate.[3] Working with this hypothesis means dealing with the fundamental problem of explaining how actors are able to operate rationally and strategically under conditions of uncertainty. The best opportunities to bring about institutional change arise during periods of crisis within organizational fields, such as periods of political and economic upheaval (Stinchcombe 1968).

Crises are high-opportunity times because the regular process of institutional reproduction becomes disrupted. In the actor's perspective, existing rules of the game are brought into question, and identities and interests become more ambiguous. In unstructured situations, actors face opportunities to forge new alliances, to develop new courses of action, and to alter their structural positions and identities within fields. However, it is precisely during a crisis that the preconditions for rational choice and instrumental action by groups seeking change are the least likely to be satisfied. In the actor's perspective, strategic action is more difficult because one

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[3] There is the alternative possibility that institutional change occurs because there is slippage in the regular process of institutional reproduction. For instance, Lynn Zucker (1987) suggests that institutions erode over time under forces of "social entropy," when they are not actively maintained by human actors. However, presuming that institutions require regular, active maintenance seems to go against the general conception of them as deeply embedded, "taken-for-granted" blueprints for social action. More important for my purposes, this type of argument doesn't go very far in explaining how new institutions are generated to replace those that have eroded away.

My views on change owe much to work on institutional genesis and transformation in organizational fields by Neil Fligstein (Fligstein and Mara-Drita 1996; Fligstein and McAdam 1995) and Paul DiMaggio (DiMaggio 1983; DiMaggio 1991). In addition, S.N. Eisenstadt's work on institution building provides a broader backdrop for this work.

cannot accurately read the environment. It becomes difficult to determine what one's interests are, who one's allies are, and what will happen if one takes a particular course of action.

Actors may be able to solve this strategic action problem by constructing a new cultural frame that allows them to better interpret and map a changing organizational environment, and to adapt and orient their behavior to it in new ways. The skills required to construct a new frame, or logic of organizing, are similar to those involved in creating an ideology and achieving "frame alignment" within a social movement (McAdam 1994; Snow, Jr., Worden, and Benford 1986). On the one hand, the frame needs to be worked out and coherent enough to organize collective action in new ways, to identify who the relevant actors are and what their interests are, and to steer a course of action through a chaotic environment. On the other hand, it must be flexible enough to encompass widely different perspectives on the situation, to progressively win over a widening circle of participants from the field, and to incorporate new information as the situation evolves. The challenge is to speak to all sides of the debate at once, and to bring along all of the key stakeholders in the field by making them feel that their interests are being served.

However, unlike social movement ideologies that open up avenues for striving toward new social ideals, the cultural frames around which successful movements for organizational change become mobilized bring forth new technical competencies. They suggest new "rationalized myths," organizing tools and impersonal prescriptions for achieving technical ideals, such as efficiency and control (Meyer and Rowan 1977). They legitimate new kinds of organizational action by appealing to shared values and goals. They also facilitate new forms of action by providing people with tools for developing new strategies and structures of organization that allow them to solve the practical problems they face.

New frameworks of institutions, in other words, emerge through the work of strategic actors operating as "institutional entrepreneurs" in situations of uncertainty (DiMaggio 1988; Eisenstadt 1971, 1978). In a crisis, competing groups of entrepreneurs are likely to emerge with alternative frames that define the situation, and will try to forge agreements among actors around new collective definitions. In S. N. Eisenstadt's words,

> The concrete institutional framework which emerges in any given situation is...the outcome not only of some general appropriateness of a given solution proposed by [entrepreneurs] to the groups acting in the situation but also of the relative success of different competing groups of such leaders and entrepreneurs who attempt to impose, through a mixture of coercive, manipulative, and persuasive techniques, their own particular solution on a given situation. (Eisenstadt 1968, p. xl)

The goal of institutional projects is to build consensus around new definitions and agreed upon rules. In order to work together in a stable arrangement, everybody in the field must acknowledge that the rules are binding, and at a minimum, this means instilling a sense that the rules are legitimate — that they somehow serve the general interest.

Once a particular set of principles becomes generally appreciated as the "right way" to organize, it will become built into the institutional environment. Success here usually requires that actors in the state become willing to sign on to enforcing new rules for organizations in the field. Once embedded and elaborated in the rules and structures of the state, a strategic frame will hold the power to stabilize the field on a new basis, and along new lines of authority.

Agents in the state have at least two mechanisms at their disposal for enforcing a new way

of doing things within a given industry. Through regulation, governments formalize and enforce new definitions of legitimate and legal ways for organizations in the field to cooperate and compete (Campbell, Hollingsworth and Lindberg 1991; Fligstein 1990). In recent decades, for example, the state has had a growing influence over health care organizations through the application of generic antitrust laws to the field. The state can also act as a "developmental state" by investing public dollars in new organizing approaches and by modeling new forms in government-run organizations (Block 1993). This has been a common role for the state in health care, where government agencies have variously operated like venture capitalists investing in new forms of organizations, as well as owning and operating health care organizations, as in the cases of Medicare and the federal hospital system.

The state is essential to successful institutional projects for one final reason. Institution building is inherently about evolving a common view of the field among a critical mass of actors operating within it. To cultivate consensus, organizational movements need central, influential, non-partisan brokers who can actively bring along a variety of groups in the project. They need someone "above the fray" who can, by working on multiple different fronts at once, build consensus among actors who do not necessarily communicate with one another directly or see things in the same way. Organizations in the state are likely candidates for this role because they often hold central, influential brokering positions within inter-organizational networks, have ties to many groups within different industries, and often maintain an appearance of impartiality in the decisions they broker.[4] As I will show throughout this study, bureaucratic agencies within the

[4] Fernandez and Gould (1994) have shown empirically that certain federal agencies in the health field, such as the Department of Health and Human Services, occupy network positions that span structural holes between other, non-communicating actors, and that, to remain influential in their brokering roles, state

federal government have played important roles in fostering organizational change in the health industry. Officials in the Department of Health, Education and Welfare (DHEW) and in the Federal Trade Commission (FTC) have been responsible for changes in the economic rules fostering health care competition, and have used their network positions to build alliances among groups promoting competitive health care.

To conclude, projects of institution building instigated by groups from inside organizational fields are not simply about floating new ideas. They are also about allowing the competing perspectives to be winnowed down to the point where groups become willing to fundamentally rethink their interests and goals. Getting to this point may mean allowing the competing alternatives to be disclosed while keeping one's own options open. Actors that narrow their fields of vision and define their interests too early in the game can become locked into roles, thus curtailing their strategic options in the future. As I have suggested, some cultural frames for interpreting and acting are better suited to this task than others. Those that are flexible allow actors to better read a changing environment, and can allow more different groups to think that their interests are being served, thus making it possible to bring many constituencies along in the project at once.

Crisis situations offer unique opportunities for highly skilled institutional entrepreneurs to engage in this sort of "robust action" (Padgett and Ansell 1993). In a crisis, interests and

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agencies must generally maintain an appearance of neutrality on substantive policy issues.

identities are in flux, and there are likely to be multiple avenues open along which actors can pursue a range of interests simultaneously. Unstructured situations offer an unfolding sequence of new opportunities that can be used to one's advantage, so long as the changing scene can be monitored and incorporated into a continuously revisable world view. Historical openings such as this are rare, and it is perhaps even more rare that they will happen to come along at a time when entrepreneurs with the right skills are available and ready. However, when institutional projects are able to succeed in such situations, their effects can be profound. An organizational field can be reconstructed from the ground up in a process that unleashes new technical capacities for organizing, carves out new channels of authority, and that redefines the identity of the field and the actors within it.

Change in the American Health Care IndustryChange in the American Health Care Industry

Opportunities to fundamentally restructure industries are historically rare. There have, in fact, only been two such transitions throughout the 20th-century history of American medicine. For change to occur, there must be a crisis that undermines existing assumptions and principles, and that encourages institutional entrepreneurs to propose alternative ways of seeing things. In addition, actors in the state must agree that there is a crisis and must sign on to a new logic for organizing the field.

The first period of health care industry structuration was during the progressive era. This period gave rise to the fee-for-service system and to the long tradition of professional sovereignty in American medicine, or what has variously been called “professional monopoly,” “unregulated professionalism” and “professional dominance” (Alford 1975; Freidson 1970; Robinson 1999a, ch

2). The fee-for-service system revolved around a logic of organizing that viewed local professional monopolies as the best mechanism for delivering health care. This logic defines medical care as a personal service that should be delivered in the intimacy of the one-to-one, doctor-patient relationship. The central organizing problem it raises is how to create a neutral social space inside organizations that allows the doctor-patient exchange to take place free from interference. Only an organizationally neutral sphere can allow the physician to act as the patient's fiduciary and as an impartial scientist by insulating him from socioeconomic pressures, and from conflicts between serving the competing interests of patients and organizations. In the broadest sense, professional monopoly defines the boundaries of the whole health field as outside both the state and corporate sector, and thus free from interference by government bureaucrats and enterprising laymen.

Solo fee-for-service physicians in the AMA were both the main architects and primary beneficiaries of this approach to organizing the health sector. They were at center of the fee-for-service system while traditional forms, such as nonprofit hospitals and private insurers, were responsive to physicians' interests. The medical profession's rise to power is a paradigmatic case of successful institution building, a story that is perhaps nowhere better told than in Paul Starr's *The Social Transformation of American Medicine* (1982). The fee-for-service system was born out of a situation of crisis at the turn of the century. At the time, medical practitioners faced declining incomes, uncontrolled growth and fiercely competitive medical sects operating in crowded, unregulated markets. Hospitals were in the midst of an economic crisis and closures were common.

During the first two decades of the 20th century, institutional entrepreneurs in the AMA

responded to this situation by promoting professional monopolies as the solution to problems in the field. They did so by lobbying for new laws at the state level that would promote the interests of private fee-for-service practitioners and secure professional control over health care organizations. AMA medical societies moved to establish sole jurisdiction over medicine by coopting their main competitors, alternative sects of medical practitioners. They established new property rights rules through state laws that gave medical societies control over who could and could not obtain a license to practice medicine. The AMA secured control over the accreditation of hospitals by arguing that this was necessary for high-quality medical education. Legal precedents were set up that defined alternatives to the private fee-for-service practice — such as HMOs and other forms corporate medicine — as illegal. By 1919, when the medical profession first opposed national health insurance as posing bureaucratic interference in the doctor-patient relationship, most of the central institutions of fee-for-service medicine had been put into place.

The fee-for-service medical system proved to be a remarkably stable order, one that survived until 1965. Professional monopolies concentrated professional power and appealed to American values of free choice and personal privacy, which seemed beyond question. Over decades, the fee-for-service system successfully weathered repeated political challenges by advocates for national health insurance and for the corporate control of medicine, as well as surviving the economic tumult of the Great Depression. State laws and antitrust protections automatically reinforced professional control of the field, and institutional entrepreneurs in the AMA proved remarkably adept at coopting outsiders, and at proposing incremental changes that could solve problems while working within principles of the status quo. By 1965, the fee-for-service system had become so stable and taken-for-granted that when economic problems and

political attacks began to undermine professional control, it took AMA leaders a long time to accept that a real crisis was unfolding around them.

The second major transition in American health care took place between 1965 and 1990, and gave rise to the current framework of medical institutions. The current order revolves around a market conception that defines health care as a basic commodity like food. The pursuit of health is seen as a responsibility of the individual, and markets are valued for their ability to decentralize decision-making and maximize consumer choice pertaining to health. Thus the market conception resonates with the American cultural emphasis on individualism and free choice. Health care seen as a basic economic good that can be bought and sold in a range of packages, of widely varying price and quality, to satisfy everything from essential needs to luxury tastes. The goal for markets is to make a wide range of choices available to consumers with known cost-quality trade offs.

The central organizing problem for managers in today's market is one of making organizations, and the physicians within them, accountable for what they produce by showing evidence of a "value for the dollar." Health care organizations compete in the market by locking in groups of insured patients, by marketing bundles of services that allow for comparison-shopping by purchasers. Since doctors make most of the decisions affecting price and quality, organizing strategies revolve around making them accountable for what they produce. These strategies include computer profiling of physician practice patterns, selective contracting with physicians shown to produce low-cost, high-quality services, and risk-sharing schemes that realign the economic incentives of the physician with those of the organization.

At the center of today's health care system are the institutional purchasers of health

services — large employers and agencies within the state, such as the Medicare bureaucracy. Their role is to act as "prudent buyers" in purchasing health coverage for groups of consumers. Prudent buyers use their market power to demand favorable arrangements, to bargain for the best price and quality, and they employ insurers or managed care organizations as active bargaining agents on their behalf. The central logic of health care today is built upon a critique of traditional fee-for-service medicine as excessively costly and wasteful, and this reflects the world view of large buyers. It argues that many of the health care services typically available to consumers are inappropriate, over-valued and unnecessary. Indeed, by being non-preventative, not standardized and overly invasive, unmanaged health care can actually be dangerous to one's health. Large purchasers have not only a right but a responsibility to demand evidence of the "medical necessity" of the services that they buy on behalf of consumers.

A precondition for the transition to today's market system was an institutional crisis in fee-for-service medicine that began in the late 60s and continued to unfold throughout the decade of the 70s. The health care crisis was a *rolling crisis* that progressively unraveled as a sequence of inter-related events that spread unpredictably across densely tied elements of the health care system. Economic and political problems, such as rising inflation, uncontrolled growth, and unmet consumer medical need served as preconditions for change. But what triggered the crisis was the unintended consequences of federal policy that came about through the passage of the Medicare legislation in 1965. While the goal of this legislation was to address problems in ways that preserved existing fee-for-service arrangements, Medicare's impact on the market was to create multiple dynamics of destabilization that could not seem to be stopped through conventional approaches to problem-solving.

On the one hand, by suddenly introducing vast numbers of new consumers into the market, Medicare and Medicaid dramatically increased demand relative to supply, triggering an uncontrolled inflation spiral. *Economic* instability then generated *institutional* instability by undercutting longstanding alliances and undermining faith in existing knowledge and principles of organizing. By creating new markets in health care capital, Medicare attracted an invasion of the field by entrepreneurs from outside industries, who introduced new organizing principles that radically undermined existing ones. By putting government in the role of a health care purchaser, Medicare gave the state a direct interest in rising medical costs. As government officials looked to the private sector for answers to their economic problems, groups at the center of the fee-for-service system, such as the AMA, kept on trying their usual solutions and resisting change. As the crisis rolled along throughout the 1970s, it gradually undermined the credibility of fee-for-service principles and of the central groups most attached to them.

There were three main alternatives proposed for resolving the health care crisis during the 1970s, and competing projects of institution building became mobilized by entrepreneurs around each (for relevant discussions of the policy options, see: Marmor, Wittman, and Heagy 1976b; McClure 1976; Rodwin 1984). One option was for the state to simply take over the industry by effectively nationalizing it, thus following the path taken by practically every other industrialized country. A second possibility was to transform the industry into a public utility along the model of the electrical utilities, thus allowing it to directly control prices, quality, patterns of investment, and entry into markets. The third possibility was to create a competitive market in health care that resembled efficient markets in other sectors of the economy.

In the early 70s, most knowledgeable observers believed that some form of national

health insurance was virtually inevitable in America, while the idea of creating competitive markets seemed new and untried. By the end of the decade, however, consensus was already emerging around the unlikely alternative the idea of building a competitive market. By this time, most groups in the field — even the old guard of fee-for-service medicine — had come around to seeing markets as the best solution to the situation, or at least as better than any of the alternatives being proposed.

There were several reasons for the success of the competitive market approach. In the highly polarized health reform debates of the 1970s, the fact that market solutions seemed new and untried turned out to be an advantage rather than a liability. Market ideas were more saleable to a variety of groups within the field because, in the contentious politics of health reform, they could be made to speak to the collective interest broadly, rather than seeming tied to particular interests. Entrepreneurs promoting market principles proved to be highly skilled in helping actors rethink their interests, and were able to forge agreements around a new conception of collective interest based on the appeal of the market.

The contentious politics of health reform in the 1970s also helped to winnow away alternatives to the market on their own. Competing proposals for national health insurance and public utility regulation emerged out of the narrow interests of particular groups. They had existing legacies from earlier periods of debate over health reform that sometimes blind-sighted groups and dictated their strategies. The movement for national health insurance, which entered the 1970s with the advantages of a large grass roots coalition, political influence and a coherent strategy, failed due to polarized opposition between labor and organized medicine. Similarly, major proposals for federal public utility regulation suffered bitter defeat in head-to-head combat

with industry trade groups. During the final years of the decade, as these alternatives failed, no major proposals for procompetitive reforms were debated in Congress. While the legislative debate did away with the alternatives, entrepreneurs promoting market solutions pursued avenues for reform outside the arena of legislative politics.

Entrepreneurs channeled consensus building around market solutions in two alternative directions. First, they mobilized local private-sector initiatives to work for voluntary reforms by getting business and labor to form coalitions with local doctors, hospitals and insurers that would allow them to work out mutually agreeable solutions to problems. Second, entrepreneurs cultivated allies in bureaucratic agencies within the state who facilitated changes in the laws governing the industry. High level actors in the federal bureaucracy were able to make fundamental changes in the groundrules for action in the field, but did so largely from behind the scenes, in ways that worked around the gridlocked legislature.

The FTC and Office of the Secretary of DHEW proved to be crucial bureaucratic players in the process of building a health care market. In the late 70s, the FTC undertook a major program of antitrust analysis and investigation in health care that redefined traditional professional monopolization strategies as illegal restraints on trade, and that promoted active price competition and the spread of HMOs. In the process, the FTC introduced a deeper conceptual shift in the collective identity of physicians: throughout the investigations, it dealt with medicine not as a profession, but as a trade. In the late 70s, DHEW, the bureaucratic agency responsible for managing Medicare, began promoting competitive HMOs and partnerships between governmental and private-sector buyers, and took major steps to reorganize the federal health financing bureaucracy to act as a “prudent buyer”on behalf of the elderly and poor of America. During the

late 70s, both the FTC and DHEW were able to make important, but narrowly-targeted, changes in the rules governing the health economy by working through bureaucratic channels within the state.

The final three years of the 1970s were the crucial ones for the market-building project. With the failures of national health insurance and public utility proposals, groups that had been tied to those agendas became more free-floating and open to considering alternative ideas. Politically, things had reached an impasse in the legislature. While economic problems were still growing, no political solution seemed possible. In the words of the DHEW Secretary, things were "coming apart" (Califano 1981). It was at this point that entrepreneurs promoting market solutions were able bring groups around to seeing the situation in new ways, and to forge alliances around new identities and conceptions of collective interest based on procompetition ideas. Ultimately, even longstanding opponents of corporate medicine and price competition in health care, such as the AMA and hospital trade groups, came out in formal support of the competitive market approach.

The 1970s produced a consensus that the main problems in health care revolved around perverse economic incentives in traditional fee-for-service reimbursement, and that competition and standard business strategies were the answers to the industry's problems. By the time Ronald Reagan entered the President's office in 1981 on a procompetitive platform, virtually all of the important groundwork had already been laid for rebuilding the health care field around the vision of a competitive market. In the 1980s, actors in private industry and the state participated in a profound restructuring of the health care field from the ground up. Markets were built up in a piecemeal way, by individuals using procompetition ideas to strategize about the practical

situations that they faced. Strategies that seemed to produce desirable results for some were copied by others facing similar situations, and were thus spread throughout the field.

By the end of the 80s, this piecemeal restructuring process had produced the basic contours of the health care system today. As actors facing different situations adapted market-oriented ideas, there was an explosion of new forms of health care delivery. When competition intensified in the late 80s, the industry went through a period of consolidation, resulting in larger, integrated health care firms. By the end of the decade, the medical profession had undergone a reorganization. Standards of payment, service use and quality were increasingly shaped by forces outside the profession. Many physicians now found that their only options for survival were to embrace price competition, even though such entrepreneurial behavior continually undercut traditional sources of professional authority.

The dramatic changes that took place during the 1970s and 80s left all of the major players in health care in fundamentally new roles. At least in the eyes of the law, medicine was no longer a learned profession but a trade, and groups like the AMA increasingly acted like trade associations that pursued the economic interests of their members. Insurance companies no longer passively underwrote insurance and managed risk, but they "managed care" and aggressively monitored physicians' work. The central organization in the health care system was no longer the community hospital but an integrated "healthcare" corporation marketing bundles of services to institutional purchasers. The health care field, it seemed, had been transformed from a cottage industry into a competitive market that now operated according to the same immutable economic laws that drive other sectors of the American economy.

Methodological ApproachMethodological Approach

The key problems of this study revolve around how and why America turned to the competitive market for solutions to its problems with medical care, as opposed to some other logic of organizing. By framing the problem in this way, I assume a comparative perspective on change that guards against teleological reasoning. Alternative explanations, such as economic and social change approaches, have failed to explain the particular outcomes that came about in America. By making the changes in health care seem like natural or inevitable consequences of powerful economic or social pressures, they run the risk of reading history backwards from the perspective of the present. As I argue, the changes in health care were not inevitable, historically necessary or even easily predicted. They grew out of a social context of instability that created the possibility, but not the certainty, of fundamental change.

My theory is that, once an organizational field has become destabilized, groups within it are likely to become engaged in a competitive search for a new framework to regulate action. Competing approaches must be winnowed down to a single one, which will ultimately become enforceable by rule of law. However, for any given historical case, the outcomes will be highly dependent upon the strategic capacities of the actors involved, and on the particular structural positions in which they are situated, which shape their world views, as well as the resources and alliances that they can draw upon to promote change. Understanding why one logic of organizing rather than some other one triumphs calls for analyzing the particular historical circumstances by which projects of institution-building arise and prosper, and systematically comparing these to the alternatives that don't.

In this study, I trace back and compare the development of four alternative approaches to

health care organizing in America, including the professional monopoly and market conceptions, as well as alternative ways of seeing the field as a public utility and national health system. The four cases of collective action that grew up around these frames during the institutional crisis of the late 1970s are shown in Table 1.1, which summarizes their core ideas, organizational strategies and supporters. My comparative approach assumes that at the beginning of an institutional crisis, there are always multiple developmental paths that an organizational field can take, and that the key analytic task is to explain what social conditions and processes of collective mobilization best predict particular historical outcomes. In this way, it guards against teleological and efficiency-oriented interpretations that try to explain the rise of organizing innovations as historically necessary, or as rational adaptation to changing competitive demands and

Table 1.1 Four Projects of Institution-Building In the Late 1970s

Cultural Frame	Dominant Conception of Health Care Crisis	Organizing Strategies	Key Private-Sector Actors	Key Actors in the State
National health system	problem of unmet medical need; goal to achieve access and equity	expanding Medicare for all	labor advocacy/consumer groups	Democrats in Congress
Public utility	problem of unregulated growth; goal to achieve coordination	local planning rate regulation price controls	commericial insurers	Democratic White House
Self-regulating professional monopoly	problem of protecting doctor-patient bond; goal to maintain autonomy and choice	PSROs "Voluntary Effort"	AMA AHA The Blues	Rostenkowski coalition
Competitive market	problem of inflation in reimburse-ment systems; goal to achieve efficiency and known value	HMOs competitive contracts	large employers	DHEW/DHHS FTC

environmental pressures within fields.

To explain why some projects of institution building succeed and others fail, one also needs a theory of action — a theory of how actors gain leverage within organizational fields while operating under conditions of uncertainty. In stable social situations, the capacity to mobilize resources toward definable ends is likely to be rewarded. In unstructured situations, the capacities to reduce uncertainty and to negotiate politically are more likely to be rewarded. The theory I have laid out above suggests that three elements played decisive roles in determining the success or failure of institutional projects in health care during the 1970s.

The first element is the project's *cultural frame*. Successful frames need to be able to legitimate and facilitate change at the same time. They must provide a rationale for why a particular set of goals serve everybody's interests, and imply a clear set of organizational strategies and structures to achieve those goals. Frames that are flexible will be the most useful. For example, depending on one's perspective, the market conception could be read as a populist assertion of consumer rights in health care, as a free-market alternative to government bureaucracy, or as involving new modes of government-administered pricing. In contrast, the political interests served by some of the alternatives, such as national health insurance, were less ambiguous. The symbols and assumptions of frames define the limits of the coalitions that can coalesce around them.

The second factor in outcomes is *strategy*. What is strategic depends on the situation. In a fluid social situation like the institutional crisis of the 1970s, we would expect that the capacity to maintain flexibility, to pursue multiple avenues of opportunity at once, and to retain role ambiguity were especially likely to pay off. "Political learning" can result from a flexible strategy.

This is evident when actors change strategies mid-course based on experience, thus taking account of what the situation has to teach them. Working with and around political obstacles is another aspect of strategy. Uncertainty and political opposition may have posed constraints on institutional entrepreneurs in the 1970s, but those who could see how constraints also opened up new avenues for change were operating strategically. Conversely, a weak strategy for navigating uncertainty should be a factor in the failure of groups to sustain control. To the extent that actors benefit from the existing system, we would expect them to be less flexible and to have evolved fewer skills at devising novel political strategies — a problem that political scientists refer to as the "competency trap" (March and Olsen 1989).

The third element of successful institutional projects relates to the *structural position* of the actors involved. Actors' capacities to create new ideas and strategies are always mediated by the constraints and opportunities afforded by their structural positions within fields. In a stable, institutionalized system, power flows to those in central positions in the social structure. In a crisis, power is more free-floating and having a peripheral position in the field can have its advantages. Being peripheral allows one to see all sides of the debate, and to forge cultural frames that speak to varying interests. Peripheral players may be more able to keep their identities and interests ambiguous, which can increase flexibility and enhance coalition-building by allowing actors to maintain an appearance of impartiality. Brokering positions may also be advantageous. A role as "middleman" in the network allows the actor to work on multiple fronts at once and to build broader consensus through ties to multiple groups within the field (Heclo 1974).

Chapter-by-Chapter OverviewChapter-by-Chapter Overview

This study unfolds in a narrative time-line that follows the rise and fall of fee-for-service medicine and the process of rebuilding institutions around a new conception of the market. The next chapter, Chapter 2, examines how the fee-for-service medical system remained a stable order up until 1965. It illustrates the ongoing dynamics of stable fields during the postwar period by examining the roles of the medical profession and the state in shoring up the system against attacks by advocates for national health insurance and corporate medicine. By showing how the fee-for-service stayed stable for so long, this discussion sets the stage for understanding how things fell apart in the institutional crisis of the 1970s.

Chapter 3 proposes an institutional theory for understanding the health care crisis, and explores piece by piece, the social and economic forces and political events that undermined the stability of the fee-for-service medical system. Economic and structural problems, such as rising inflation, uncontrolled growth, and increasing consumer demands for more and better services, served as preconditions for change. But Medicare triggered the crisis by presenting actors in the field's central coalition and the state with new uncertainties in their ongoing attempts to reproduce existing arrangements, and by creating a context in which continuing adherence to traditional views became a strategic liability. Two dynamics of destablization characterized the crisis, both occurring along the margins of the field, in its relations with other fields in the economy and the state. By creating new markets in health care capital, Medicare attracted an invasion of outside entrepreneurs into the market seeking new growth opportunities within it. At the same time, Medicare led actors in the state to see their interests in health care differently, and to begin tampering with laws and bureaucratic rules that had historically protected the fee-for-service market.

Chapter 4 goes back over the decade of the 1970s, to follow the parallel process of institution building that occurred alongside the dynamics of destabilization. It traces back the development of alternative projects to nationalize the industry, to restructure it as public utility and to build competitive markets, as they emerged during the late 60s and early 70s in response to the crisis. Groups had access to different models for framing their understandings of the problems and solutions in health care, and drew on different resources, skills and strategies to build momentum behind them. During the health reform debates in the final three years of the decade, some potential paths out of the crisis, such as nationalizing the industry, became closed down. It is at this point that one starts to see the consensus emerging around more market-oriented solutions to the problems in health care which, ultimately, would provide the groundwork for institutionalizing a new framework in health care.

In Chapters 5 and 6, I examine the institutionalization of the market during the 1980s. Chapter 5 follows the emergence of a new dominant coalition of large employers and government payers within the field. It examines the perceptions that drove buyers to attempt to make changes in the way they purchased health care and in doing so, provides some insights into the ongoing relations between business and the state with respects to health care. Chapter 6 follows the spread of market strategies, the rise of integrated health corporations and the decline of professional control in the emerging market of the 1980s. I argue that the spread of market strategies had two stages: an explosion of new organizational forms in the early 80s and a period of consolidation and integration of firms in the late 80s that solidified the new order.

In the final chapter, I examine sources of stability and instability in the new order through the window of the health reform debates in the early 1990s. Those debates not only cast a spotlight on the current system's problems and the assumptions driving health care today, but also

gave us a glimpse of the institutional constraints on further change. Institution building during the 1970s and 80s had brought players in the field into agreement that health care was best organized through private-sector initiatives and the free play of competition. This left very limited options for making further changes in the system despite the ambitions of the new President. American health care today remains troubled by the rising numbers of uninsured people and continuing problems with high costs. But the market serves the interests of powerful stakeholders who are now in the business actively shoring up the new order against further change.