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CASE STUDIES OF SOCIAL CHANGE IN HEALTH CARE

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Barrie Thorne
Major professor

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By

Claire Hoffenberg Kohrman

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ABSTRACT

CONSUMER-SPONSORED HMOS:
CASE STUDIES OF SOCIAL CHANGE IN HEALTH CARE

By

Claire Hoffenberg Kohrman

In the early 1970s, social activists gathered at playgrounds and kitchen tables to develop consumer-controlled health plans--now called health maintenance organizations (HMOs)--which would diminish the power of the medical profession. This dissertation studies this social movement begun by consumers, encouraged and then coopted by the federal government, and finally, corporatized by major insurers and health care institutions. The shift from consumer activism to corporate control is examined with case studies of two HMOs in Illinois and Michigan and analyzed in the context of the changing patterns of medical practice and shifting political economic conditions from 1965 to 1986.

The methodology integrates extensive interviews, bureaucratic documents, and media reports to explain how the activists' interests converged with those of government and corporations to form an ironic alliance with unintended consequences.

In spite of the differences in local community circumstances, the two HMOs followed similar trajectories: first animated by the ideology and energy of the consumer-founders, they then gained extensive publicity and membership in their communities, but finally fell into financial crises that forced them to sell out to corporate insurers. The work explores both the intended and unintended consequences of the HMO movement for the consumer activists, for the medical profession they intended to change, and for the health care system.

The consumer founders were all from a particular cohort experienced with the social activism of the 60s; their first goals were equitable access and consumer control in health care. But as they sought legitimacy and funding for their HMOs they reluctantly relinquished their goal of equity, and were themselves professionalized. By 1986, most were administrators in health care insitutions or government agencies.

Physicians in communities where HMOs now dominate report declining sovereignty and altered relationships with hospitals, colleagues, and patients. Health care delivery itself is in transition nationwide, as control shifts from providers to managers who respond to corporate and government payers.

To explain these unforseen shifts, this study highlights the intersections of ideology, technology and the economy, reflecting both the symbolic and substantive importance of the early consumer-sponsored HMOs.

Dedicated, with gratitude, to the universities which, because of their commitment to public education, have made this work possible.

ACKNOWLEDGEMENTS

My graduate education began officially in 1972, and this dissertation has developed over many years, as I, like the activists I write about, began to explore the territory beyond the focus of home and family, and was drawn into the world of professions.

The path through graduate school to the completion of this work has been long. So it pleases me to thank the many who have so substantially helped me along the way. Family and friends, teachers and colleagues first helped me to recognize my own deep wish to be a social scientist, and then offered the respect and support that made it possible. In addition, there are those who specifically helped me to accomplish this study.

It seems right to start with my children--Deborah, Ben, Ellen, and Rachel--with whom I have grown up. It has been with and from them that I have learned the most telling lessons about the social world, and those things I most wanted to know about myself. Furthermore, they have been my sidekicks on field trips; searched libraries for references; provided coffee, custard and cookies when my energy lagged; and talked with me long into the night about ideas.

Friends and other relations, too--more than I can name here--have encouraged me with their expectations, their support, and their own examples of excellence. I thank them all and mention here an important few who prodded me at the beginning (David Klein), supported me throughout the years (Elaine and Mike Bailie, Donna Edison, Shelli and

Arthur Elstein, David Kohrman, Judy and Lee Shulman, Sherry Van Amburg, V and Bill Weil), or sustained me at the end (Carol and Larry Gartner.)

One of the consumer activists whom I interviewed, musing about the consumers' history, introduced an applicable phrase. She said: "we were dogged with serendipity." And indeed, serendipity visited my graduate education often. My first "trial" class, when I began to explore the possibility of graduate school in 1972, was by chance with Barrie Thorne, who would become, years later, the chair of my dissertation committee. She won my respect in the first lectures and my commitment to graduate school by the end of the social psychology class. I, like so many of Barrie Thorne's students, found her weave of the theoretical with the concrete enticing, and her mentoring unmatched. I respect her perspectives, employ "her" methodology, and cherish her friendship.

My dissertation committee as a group, and each member of it, has had a lasting effect on this process and on me. I thank Rick Hill for my rigorous first course in conflict and change, and for the frame that that has continued to provide my work. And Gitte Jordan has for years believed in my efforts, expanded my perspective, and modeled for me the use of social science not only as a tool to understand medicine but as a way to help the medical profession understand itself.

When, in 1980, I tentatively ventured away from the shelter of Michigan State University, I, again serendipitously, found Odin Anderson just beginning a project on HMOs at the University of Chicago. He willingly added me to his decades-long list of those he has "shown the ropes" of health care research, and thus significantly expanded my understanding and this dissertation. I am very grateful. Most

recently Harry Perlstadt has added his thought and experience in sociology and health care research; his support and his meticulous and insightful reading of this dissertation have been invaluable.

Others, also, at MSU have had a crucial, though less specific role in my decision and ability to continue and complete this work. In 1974, I was offered the opportunity to teach writing at James Madison College. At Madison, I taught with, thought with, and learned from scholarly, committed, and often compelling teachers; I began to want to count myself among them. I especially thank Ron Dorr (whose convictions about writing find their way into most pages of this dissertation), Richard Evans, Patricia Hummer, Peter Lyman, Jack Paynter, and Katherine O'Sullivan See. And Mary McCormack, my colleague at Madison as well as in graduate school, has for a decade shared with me her thoughts, her books, her wit, her car and her priceless capacity to remember what I forget--be it a quote from Nietzsche or where I left my keys.

There are also important specific thanks for contributions directly to this study and its completion: above all, it is the founders of Health Central and NorthCare, and the early staff and board members named and described in this study, whom I thank for the content of this work. They have searched their garages, their attics and their memories for the stuff this study is built on. In learning about them I have learned from them. I thank them and hope that in this discussion of their efforts they see my deep respect and admiration, as well as my gratitude.

I owe thanks to all who gave their time and thought in the many interviews, and particularly Dr. Bonta Hisco for his earliest and

ongoing encouragement to study Health Central, as well as Karen Weller who provided her complete Health Central records and correspondence. Also thanks to Millicent Lane, of the Lansing State Journal, who lent me her files and her insightful observations.

I am grateful, too, to the Center for Health Administration Studies at the University of Chicago which, at the gracious behest of its director, Ronald Andersen, offered me a fellowship and thus the company of good colleagues, a space to perch, and xerox priveleges, for the final months of the writing.

And the writing would not have come to this reading had it not been for Joyce Van Grondelle and Shirley Rhyne whose skill as typists and cool heads when confronting the technology of wordprocessing, production, and reproduction were indispensible.

Finally, I turn to that unique combination of colleague and critic, friend and family, AFK. Since we met when he was 17 and applying to medical school, he has made it possible for me to be a participant observer in his profession and a participant in his life. This finished work is in largest part a consequence of the life, both intellectual and personal, which we began together 35 years ago.

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PART I. THE STUDY

CHAPTER 1

CONSUMERS CHALLENGE TRADITIONAL MEDICAL PRACTICE PATTERNS AND FORM AN IRONIC ALLIANCE

INTRODUCTION

Health care in the United States in the mid-1980s is in a period of significant cultural and economic change--some say in chaos (Starr 1982; Freidson 1985; Mechanic 1985; Fuchs 1985; Ginsberg 1984). This work focuses on a particular aspect of that change: the development, the growth, and the significance of health maintenance organizations (HMOs), particularly those sponsored by consumers in the early 1970s.

In 1986, HMOs represented a significant encroachment on traditional health care and on the professional occupation of medicine. While as recently as 1980 only eight million Americans were enrolled in HMOs--and those were concentrated in a few geographic areas--by 1984 enrollment had grown to 15 million. In 1986, 21 million Americans throughout the United States had chosen to enroll in HMOs--instead of continuing to be patients of their physicians who are in the traditional private practice of medicine. In some communities, as many as 50 percent of the population have chosen HMOs. Clearly, something important is happening in the organization of medicine and is reflected in the professional occupation of physicians.

Everett Hughes noted that ". . . investigation about occupations becomes investigation about the nature of society itself" (1958:87) and that "most occupations rest on some explicit or implicit bargain between the practitioner and the individuals with whom he works and between the occupation as a whole and the society at large. . . ."

In the early 1970s, that "explicit or implicit bargain" with physicians was challenged by consumer activists as they asked questions in medicine, as well as in other domains, about "the nature of society." Consumer activists "sought (particularly) to reduce . . . power in the hands of professionals" (Ruzek 1978). These activists sought schools that did not depend on professional teachers, food that did not depend on grocers, divorce that did not depend on lawyers, churches that did not depend on priests, as well as health care that did not depend on doctors.

It was the effort of local activists in Lansing, Michigan, to control the delivery of their health care by developing a community-based, consumer-controlled health maintenance organization that first drew my attention. In my research I was to find that the Lansing case was one of a number of such efforts throughout the United States in the early 1970s in which certain consumers--most already experienced with the social activism of the 1960s--became interested in health care. Strengthened by earlier successes in confronting bureaucracy and professional authority, such as the military, the school system, and the church, these consumers examined the health care available in their community and defined it as a social problem. Working from their living rooms and kitchen tables, the lay people planned to wrest power from the medical profession.

The medical care system they confronted was then, as it is now, deep and complex, including layers of health care institutions and professionals developed through distinct historic periods. The adult consumers of the 1970s had been born and raised to adulthood in the period between 1930 and 1965 which, for health care, is best

characterized as the "Era of the Third Party," a period of enormous growth in the technology and distribution of health services as well as of the "discovery... that hospital costs and surgery were insureable" (Anderson 1985). As a consequence, in a period when consumers became increasingly dependent on expanding medical technology and professional services (Hughes 1984:123), they were also insulated by the third-party payment system and became increasingly distanced from the workings and costs of the complex system.[1] The visible part of the system was the medical profession and the consumers saw it as symbol and center of health care.

In an effort to gain some consumer control over medical care, activists of the 1970s confronted the medical system on a number of fronts. They developed free clinics, drug education and treatment centers, and a powerful women's health movement which included women-care clinics, self-help groups, the home birthing movement, and so on (Freeman 1975; Ruzek, 1978; Kohrman 1985). They built their plan on a model of health care that had been present, although minimally, in the United States, since the early 1900s. And as in the Lansing area, consumers also sought models, elicited support, developed networks, and confronted widespread antagonism to develop small, marginal, and unconventional prepaid medical groups.

Prepaid Plans

The medical profession long resisted prepaid plans, like the best known Kaiser Permanente Foundation on the west coast and the Group Health Cooperatives in Washington state, in Minnesota, and in Washington, DC. Such organizations--in 1970 named health maintenance

organizations (HMOs)--provide, most simply, a comprehensive package of services to a voluntarily enrolled membership for a fixed prepaid fee. Thus HMOs combine in an organized system both health care delivery and financing. Consumer activists sponsored them because they perceived them as radical organizations in which, theoretically, consumers would play a critical role in the development and management of their own health care organization. Initially, and in an ironic way central to this study, they financed their efforts with federal grants offered by a politically conservative Nixon administration (Starr 1982).

The growth of HMOs was slow. In the ten years from 1970 to 1980, only 207 HMOs were developed throughout the United States (from 33 in 1970 to 240 in 1980, in contrast to the 1,700 predicted for 1980 by Elliot Richardson of the Nixon administration in 1972) and for every two that opened, one closed (InterStudy 1980). And it was not until 1982 and 1983 that the dramatic accelerated growth noted earlier began. In Illinois, for example, where until 1982 HMOs had found little acceptance (Anderson et al. 1985), 1983/84 saw an increased enrollment of 49 percent, and Chicago which had 6 HMOs throughout the 1970s, in 1986 had over 20. Experts now predict that 40 million Americans will be in HMOs by 1990; already several metropolitan areas have enrollments of 25 to 30 percent, and some even 50 percent of their population (Minnesota Medicine 1986).

This seemingly dramatic success is not, however, the outcome the consumers sought or foresaw. Although the medical profession now has less power (Starr 1982; Kohrman 1986), that power has not been transferred to the consumers. In fact, most activists who founded and served on the boards of consumer sponsored HMOs have left. They have

become professionals themselves and pursue careers of their own while the organizations that they founded grow, multiply, diversify, often sell stock, and operate (usually with no consumers on their boards) under conservative leadership (often of large insurers), the capital of major corporations and the encouragement of the federal government.

Lansing, Michigan 1970s

However, in the late 1970s in Lansing, Michigan, all of this was not yet clear. At that time, when I became aware of the community consumer project, it promised to become a Lansing health care institution and seemed of considerable interest to local area residents and the media. As I interviewed participants, I found that the group had the vitality, commitment, and leadership associated with a social movement (Mauss 1975; Killian 1964; Blumer 1971; Weber 1947; Michels 1962), and, indeed, it was challenging the accepted normative way of practicing medicine in the area and was perceived as radical by the medical profession.

At that point, I began to study the organization and its short history through the media, interviews, and participant observation. I would soon find that consumer activists had introduced the idea of a health maintenance organization to the area in early 1973. The HMO, to be known as Health Central, had had an exciting period of development, opened on schedule, rocketed to success with exceptionally high enrollments, and then plummeted into financial crisis. In May of 1979, the new HMO could not pay its bills. As a result of the financial instability, and amidst great controversy and publicity, the consumer-founded Health Central had been sold to Blue Cross/Blue Shield of

Michigan. In the bargain, the activists' central goal--consumer control--had been lost. While the organization had survived, the founders' dream had died; they hoped that my study would help them to understand "how things could have gotten so untracked"--where "they went wrong" (field notes 1980). I, too, immersing myself in the data, hoped I would understand where, while they had appeared to do everything right, they had "gone wrong."

My early intention was to examine the HMO in three ways: first, to follow Blumer's (1971:299) mandate and by examining the movement from the activists' point of view, "study how society comes to recognize its social problems"; second, to develop the natural history of the movement from its earliest discernible moments. (I was alert to Jo Freeman's [1975:81] warning that "most studies [are] of the decline or institutionalization of a social movement and virtually none of their origins and early development," and began at the beginning; and third, to describe and analyze a movement that set out to change an institution and, as Weber predicted, found "unintended consequences" (Weber, in Gerth and Mills, 1979).

I gathered all the information I could on the brief history and dynamic present of the newly emerged institution and felt, as the founders themselves believed, that it was in the details of their many and complex actions that one would find the explanation of the outcomes. I was, like many sociologists, as Blumer (1971:299) wryly notes, taking my "cue from the focus of public concern." And certainly, early examination found a variety of ideological, historical, economic, bureaucratic, and personal tensions within the organization

that seemed to promise a possible explanation of the unintended and unforeseen events.

As I continued to document the founding and development of Health Central, I moved to Chicago (just 240 miles from Lansing), which gave me the opportunity to participate in additional research. At the Center for Health Administration Studies of the University of Chicago, we examined the development of HMOs and the medical profession from a broader perspective.

The additional research and the time it took to complete it (until 1985) had a significant effect on the course of this dissertation, because it offered a number of opportunities. First, I gained the comparative perspective of the development of HMOs in different community contexts (Anderson et al 1985); and, second, it presented the opportunity to study another consumer-sponsored HMO--Northcare in Evanston--which was, in fact, the model that the Health Central founders had turned to. Furthermore, I had a longer period in which to observe changes in HMOs and health care.

While the first two additional opportunities expanded and deepened my understanding of the consumer movement, of the medical profession it was confronting, and of the development of the individual HMOs as I had originally intended to study them, the extended period of time imposed a larger context and an unexpected additional perspective that demanded attention.

One should pause here to recall that the consumer founders of Health Central blamed themselves for the "failure"--i.e., the ideological failure--of the now, paradoxically, thriving institution. I found that in Evanston also, the founders of Northcare had "failed"

to create the consumer-navigated institution they planned for. They, too, searched into their actions and the internal workings of the HMO to explain their "failure" and their vulnerability to a "takeover"--in their case by Prudential Insurance. Furthermore, I found other consumer movements in health that had made similar efforts with similar outcomes.

For example, analyzing the Women's Health Movement, Ruzek (1978) outlines the goals and strategies of such activist groups. She says that they sought to deinstitutionalize medical authority by . . .

> (1) reducing the knowledge differential between patient and practitioner.
> (2) challenging the license and mandate of physicians to provide certain services.
> (3) reducing professionals control and monopoly over related necessary goods and services.
> (4) altering the size of the profession relative to potential clientele.
> (5) transforming the clientele from an aggregate to a powerful and effective collectivity (p. 144).

This quote is evidence of the social movement to reduce medical authority; however, it brings to attention not only what activists succeeded in doing, but also what they failed to do.

The late 1970s and early 1980s have revealed that consumer health care movements have played an important role in accomplishing the <u>first four</u> of the above goals, but not the fifth. The clientele--the consumers and patients--did NOT gain the collective power by accomplishing the first four. During the activism of the social movement itself, the clientele did form and act as a collectivity, and defined themselves in opposition to the medical profession, but they were not able to turn their collectivism to power. Rather, as they

tried to deinstitutionalize medical authority, their own efforts were institutionalized.

In retrospect, one can see that consumers were not the only group interested in weakening the perceived hegemonic professional grasp of traditional medical practitioners; the consumer/patients and the physicians were not the lone inhabitants of a closed system in which power lost by one would pass to the other. Rather, larger economic interests, both public and private, have reached in, benefited from the efforts of consumer activists to weaken the authority of the medical profession, and have intercepted, and now wield, the shifting power for themselves.

In 1986, in geographic areas where a significant proportion of the health care is delivered in HMOs (and/or in their expanded forms of "managed care systems"), physicians are now required to be accountable. However, they are not accountable to their patients; rather they are now accountable to those powerful government and corporate forces--payers of health benefits--and to the bureaucratic managers who run the medical systems. In such systems, which are designed to respond to the market demands of those payers, patients--as well as physicians--become "pawns" moved around in the health game by the "kings" who have the health care dollars (Kohrman 1986). And so it has become clearer that health care dollars and the large payers who spend them must be given an important place in this analysis of the consumer movement to sponsor and develop HMOs.

Contrary to interpretations which "revise" history-- such as Mayer & Mayer in the New England Journal of Medicine 1985, cost was NOT the principal concern of consumers sponsoring HMOs in the early

1970s. Rather, the ideology of the activists was consistent with the social movements from which they had just emerged; for example, with the civil rights and anti-war movements.[2] Access, equity, and control repeatedly emerge as central themes when founders recall "the early days" in interviews. In the early 1970s the efforts of the consumers, which were based on these values and ideology, were to converge ironically, however, with those of the federal government and the major corporations who were crucially interested in costs.

Thus, while I began this study from the perspective of the consumer activists in the social movement (a micro perspective), I found that the consumers' unanswered questions about their "failure," as well as my own academic questions, led me to search beyond the case studies for an explanation of their development. I found it necessary to also consider the larger context of the social movement (a macro perspective), that is, to examine not only the consumer activists and the medical profession whose power they sought to reduce (Ruzek 1978), but also to examine the consumers' unanticipated allies--"powerful forces arraying themselves against health providers . . . the insurance industry, the employers, and the government itself" (Starr 1982). It was with these new allies that the consumers' interests converged, and under their influence that the HMOs developed. I sought to understand the common interests and conflicts of this unanticipated alliance.

The Allies' Interest: The Cost of Health Care

Economist Victor Fuchs offers a relevant analysis of the forces and economic changes that have affected health care since World War II (Fuchs 1985). "The health sector which in 1950 had used only 4.4

percent of the nation's output, had grown to 6.1 percent in 1965, to 9.4 percent in 1980, and 10.8 percent in 1983." Fuchs (see Figures 1.1 and 1.2) gives clear evidence of ways that rising health care costs pressure the economy. Figure 1 shows the changes in expenditure on health compared with the gross national product, adjusted for inflation and population growth between 1951-1981.

Changes in Expenditures on Health and Gross National Product, Adjusted for Inflation and Population Growth, 1951–1981 (Five-Year Moving Average)

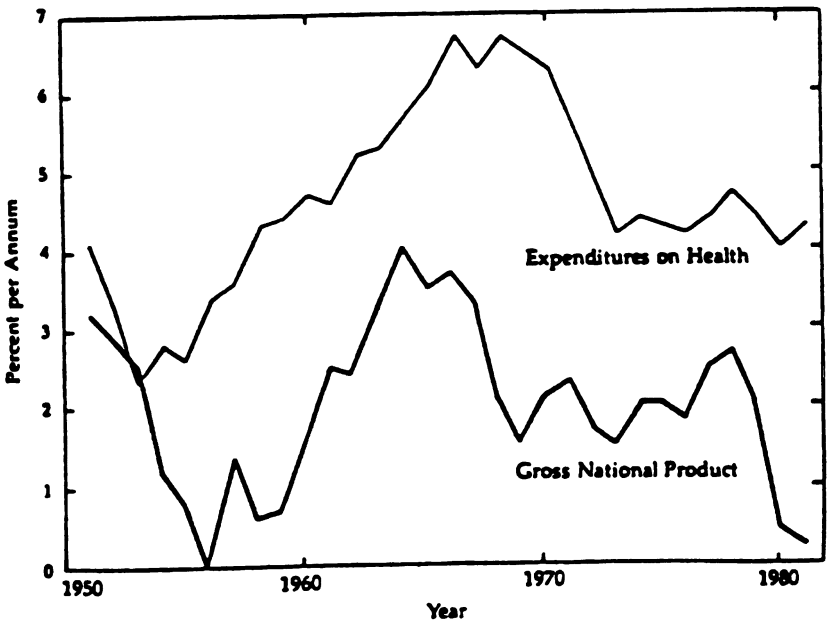

Figure 1.1

Figure 1.2 shows the pressures on the economy more sharply by demonstrating the difference between changes in expenditures on health and the gross national product. Fuchs explains that "this gap is the measure of the rate at which labor and capital flow to the health sector away from the rest of the economy." The now apocryphal anecdote that illustrates that problem is that in 1975 "General Motors . . . spent more with Blue Cross/Blue Shield (for workers' health care) . . . than with U.S. Steel, its principal supplier of steel" (Crawford 1977).

Private corporations have felt an increasing squeeze as a result of the rising costs of health benefits. "In 1950, health insurance premiums were less than 6 percent of profits but by 1980 they were 40 percent. In the long run," Fuchs continues, "these payments come out of real compensation for employees (in the form of lower wages or higher prices). But unions resisted lower wages, and in the economic recession of the early 1970s, business could NOT raise prices and continue to compete." One should note that while during this recession American corporations went abroad for lower priced materials and workers, they could not look overseas for less costly health care; they suddenly became acutely aware of the rising costs of health benefits.[3] A president of a UAW local in Michigan said that "in the old days the auto industry was making so much it didn't matter what health care cost . . . but in 1974, the UAW saw the handwriting on the wall . . . after the gas prices everyone realized that the auto industry was never going to be the same again."

fference Between Changes in Expenditures on Health and
oss National Product, 1951–1981
ve-Year Moving Average)

Figure 1.2

sure of increased health care costs was not limited to the
r. The federal government, which had been burdened since
with its commitment to Medicare and Medicaid, was
nerable to the high costs. At the same time it had
o the spiraling costs with a broad and not well supervised
nechanism for payment. Fuchs writes, "The macroeconomic
s have a special force within the federal government and
ted to a sense of panic." This "cause for panic" is

illustrated in Table 1.1) By July of 1969 signs of this panic were evident in President Richard Nixon's public statements. At a press conference on health care he asserted:" . . . the problem is much greater than we realized. We face a massive crisis in this area unless action is taken both administratively and legislatively to meet the crisis within the next two years . . . (Anderson 1985:203). And indeed it was "within the next two years" that the Nixon administration discovered and supported the concept of health maintenance organizations, as it scrambled for a politically acceptable way to confront both health care costs and the liberal Democrats, led by Senator Edward Kennedy, in their campaign for National Health Insurance.

The idea of prepaid health care plans as an effective way of distributing health care in the 1970s is attributed to Paul Ellwood, a young Minnesota physician who directed the American Rehabilitation Foundation in Minnesota in the late 1960s. He explained to me that, particularly because he had worked with the chronically ill, he had become convinced that fee-for-service health care was unmanageably costly and that it perversely penalized the physicians who helped their patients to become independent of them. A Nixon staff member heard Ellwood speak about the possibility of prepaid comprehensive care, which would reverse the incentives to provide more care than necessary and reduce costs. Ellwood was summoned to Washington, and at a meeting, February 5, 1970 with Nixon staff, Ellwood proposed his strategy. This strategy, which he named "health maintenance organizations," suggested a way to reduce the costs of health care by stimulating private sector initiatives rather than expanding government

bureaucracy. It appealed to the Republicans (Starr 1982). Ellwood's political insight and energy, combined with his credibility as a physician, armed him to be an important officer in the administration's battle for HMOs and the reduction of health care costs.

Table 1.1

Federal and National Expenditures on Health, Total Federal Outlays, and Gross National Product

	1950	1955	1960	1965	1970	1975	1980
	(5-Year averages centered on selected years)						
	(Billions of 1983 dollars)						
(1) Federal expenditures on health	6	7	9	16	42	63	87
(2) National expenditures on health	52	63	84	119	176	228	302
(3) Total federal outlays	170	248	295	359	463	547	695
(4) Gross national product	1,175	1,404	1,589	2,015	2,369	2,686	3,224
(2) as percent of (4)	4.4	4.5	5.3	5.9	7.4	8.5	9.4
(1) as percent of (2)	12.5	11.2	11.2	13.4	24.2	27.6	28.7
(1) as percent of (3)	3.8	2.9	3.2	4.4	9.2	11.5	12.5

Sources: Council of Economic Advisors, *Economic Report of the President* (Washington, D.C.: Government Printing Office, 1984), tables B-1, B-73. Robert M. Gibson, Daniel R. Waldo, and Katharine R. Levit, "National Health Expenditures, 1982," *Health Care Financing Review* 5 (Fall 1983), table 1.

Fuchs asserts that this effort to control the costs of health care in the United states is the third of three revolutions in the financing of health care since World War II. The first he identifies as "the extraordinarily rapid diffusion of private health insurance between 1945 and 1960" which increased the number of Americans with hospital insurance from 32 million to 122 million, and with insurance for (certain) physicians' services from fewer than 5 million to 83 million all in 15 years. The second, he says, was the 1965 legislation that

created Medicare and Medicaid. And, indeed, these earlier two created the perceived need for the third.

But the third--the control of costs--is a generically different revolution. The first two movements "increased demand for medical care, regularized payment, and made it more secure, and increased equality of access." Neither movement was intended to threaten the traditional system of organization and delivery of medical care. The Medicaid and Medicare legislation stated specifically that there was to be no interference with traditional practice.

But in the most recent revolution the intention has changed. Now, says Fuchs (1985:1), "the third parties (government and business) who have been paying the piper have decided to call the tune. Far from promising NOT to change the system, they frequently have change as their major objective." And it is with a series of alternative programs including HMOs that they intend to bring about change.

Unexpected Allies; Unintended Consequences

The consumer-activists, too, wanted change. They began a social movement to bring about change in the traditional health care system by gaining more control for consumers, but they encountered what Weber described as "the paradox of unintended consequences." Weber predicted that the course of a social movement would not depend so much "on the subjective intentions of the followers or the leaders (as) on the institutional framework of the movement and especially the economic order." (Gerth and Mills 1979:54) This research found clear evidence of the influence of the "institutional framework" and of the power of the "economic order."

Both Weber's classical analysis of social movement participants and Fuchs' contemporary analysis of the changing health care environment emphasize the importance of the structural and economic framework in which change--in this case, change in health care--takes place. These analyses provide a crucial portion of this study, but they are, by themselves, insufficient. They do not explain the significance nor the impact of the consumer activists and their social movement to confront the traditional institution and culture of medicine.

Fuchs, for instance, does not distinguish between HMOs with their deep ideological roots and other alternative competitive forms of health care delivery sprouting in the 1980s. This research, however, demonstrates that HMOs <u>are</u> generically different; they are based on, and have disseminated the idea, that medical care is <u>not</u> a mysterious "black box" understood only by physicians. The activist sponsors of HMOs asserted that physicians can be confronted and held accountable and health care can be managed bureaucratically, not mysteriously.

I noted at the beginning of this chapter that Everett Hughes had observed that most occupations rest upon "some explicit or implicit bargain" between practitioner and individuals, and between the occupation or profession as a whole and society at large. He continued that this "bargain" is "about receiving, keeping and the <u>giving out of information</u> (emphasis CK) gathered in the course of one's work." The license to keep this bargain is of the essence of many occupations. It is also a fundamental feature of all social and moral division of labor, thus of the social and moral order itself (Hughes 1958:81).

With this understanding, it is not surprising that in this contemporary transformation of American medicine (Starr 1982), "accountability," that is, "the giving out of information" about the workings of the profession and about the patients the profession serves, has become a central issue.

I found that parallel and interwoven with the ideologically and economically stimulated demand for information (which had its origins in the HMO movement), there is also a powerful technological development of complex and sophisticated computerized information systems. This synergistic development between the demand and technological capability is crucial to contemporary changes that are increasingly evident in health care delivery in the United States. (See discussion in Chapter 8.)

REVIEW OF THE LITERATURE

To understand the emergence and significance of consumer sponsored HMOs, this study traces and describes the intersections of three dynamic and institutional themes. I will describe the literature that informs this research in categories that parallel the themes: i.e., literature about 1) consumers and consumers' activism, as part of a social movement, 2) the history and patterns of practice in American medicine, and 3) the interest and influence of the state and corporations in health care. (In the language of health economics these are: consumers, providers, and payers.) (Additional literature relevant to specific topics is included throughout this work.)

While categories 2 and 3 conceptually overlap, the practice of American medicine and the political economics of health care have,

until recently, been studied by different disciplines and therefore, with a few notable exceptions, have been considered in separate literatures. This historical disciplinary dichotomy, which I believe to be unnecessary and detrimental to the best study of health care, is discussed in the second chapter.

Consumers and Consumer Activism as Part of a Social Movement

Social movement analyst Lewis Killian (1964:452) believes that "The significance of social movements, of course, lies not in their careers but in their consequences for the larger society and the culture". However, participation in the career of the movement had important consequences for the activists who participated, regardless of, and in addition to the impact of the movement on the "larger society and culture." Here I include literature about social movements that analyses the consumers' actions as a group, as well as literature that considers the effects on the consumers themselves, of their activism.

Social Movement Literature

Consumer activism in health care is a clear and interesting example of the social construction of reality (Berger and Luckman 1967). In Social Problems as Social Movements (1975) Mauss describes a social movement as a "voluntary collectivity who perceived a social problem. The social problem was defined by the opinion, not the problem." This describes well the emerging consciousness reported by HMO activists. A founder of one HMO in a comfortable college town described a meeting at which a collectivity who, she said, "had this community-action-peace-activist-bond" decided that there was "a lack of

health care." ". . . that there was no care there for students--they would have a terrible time, just terrible." Later in the interview she added "We knew we were looking for health care but we didn't know what kind." This is in some way consistent with Mauss' treatment of social problems . . .which . . . reverses the causal connection of social problems and social movements. He claims that "social movements generate social problems" (1975 p. xvi). Noting that conditions, are not themselves sufficient, Blumer (1971) asserts that social problems are "collective behavior, not objective conditions." Furthermore, and with notable relevance to the complex interests in the HMO movement, he notes:

> A social problem is always a focal point for the operation of divergent and conflicting interests, intentions, and objectives. It is the interplay of these interests, and objectives that constitutes the way in which society deals with any one of its social problems.

Blumer posits five stages in the development of social problem/movements: (1) emergence, (2) legitimation--through the media, etc., (3) mobilization (some succeed and others fail), (4) formation of an official plan of action, (5) implementation of the official plan. His framework is a useful heuristic to guide my examination. This analysis may help discriminate strengths and weaknesses of consumers as activists. It provides a systematic way to see "new social values and collective arrangements made and unmade" and to see which are "not-yets and didn't-quite-make-its..." (Hughes 1971:53). Hughes also notes the importance of the environments of social movements--the clientele, personnel, political environment, etc.

Spector and Kitsuse (1977:73-75) discuss the importance of accounting for "the emergence, nature, and maintenance of claimsmaking

and responding activities," as well as examining activities of individuals or groups making assertions or claims with respect to some putative condition. Particularly predictive for this work was their assertion that the movement will not emerge unless and until activists see the possibility of a solution to conditions that concern them.

To understand the development of these HMOs it is necessary to understand not only the emergence of the problem and the movement, but the career that it follows. As noted above, Weber (1921) anticipated that a social movement would move from a period of zeal through a phase of bureaucratization in which a hierarchy of authority would be developed, tasks would be distributed and the charisma of the leaders would be routinized.

The issue of charismatic leadership and its routinization is of particular interest in the social movement to develop consumer controlled health care because not only did the movement begin with a sense of its own charismatic members, but it was consciously confronting what it considered the misuse of charismatic authority among physicians. It was that which they wished to routinize.

Michels' (1962) view, often paired with Weber's, also illuminates the consumers' behavior. He asserts that in such social movements the original commitment to democratic decision making--characteristic of the consumers' grass roots organizations in this study--would move inevitably (by "iron law") to a form of oligarchy in which a minority of the movement would enforce their perspective.

This classical analysis finds interesting elaboration and abundant verification in a contemporary analysis by James Morone (1983). He analyzed the role of consumers on the boards of Health Systems Agencies

(HSAs) which operated in the same 1970s period. Morone carefully describes the HSA boards and demonstrates the power of the bureaucracy and the cooptation of the consumers. (His work will be discussed in Chapters 7 and 8.)

These theories are revealing and in some ways predictive; for example, goals often may be replaced in favor of organizational maintenance. However, these theorists do not deal specifically with the environments external to a social movement nor with the ways that branches of social movements may interact. These issues are discussed elaborately by Zald and Ash (1965); for instance they describe a cooperation between arms of a social movement: an example is found in NorthCare's advice and council to Health Central. Furthermore, Zald and Ash examine the traffic of members between social movements, also exemplified by the activists discussed in this dissertation.

Review of the literature on specific social movements of the early 1970s offers interesting comparisons. As noted earlier consumers' sponsorship of HMOs parallels other social activism of that time (Freeman 1975; Ruzek 1978; Mandle 1979). For example, it was not only the founders of HMOs who "sought to reduce. . . power in the hands of professionals" (Ruzek 1978) and to return power to the people.

Writing about the politics of the women's liberation movement, (Freeman 1975) notes that through public policy, government stimulates, responds to, and/or curtails social change. Her analysis is helpful in considering how, unanticipated by the consumer HMO activists, the government, as well as the corporate sector, influenced the consumers' HMO movement with an agenda ironically similar to that of the consumers. Thus, unlike the government policy response to other social

movements, the federal HMO policy at first supported, then regulated, and finally engulfed or coopted this social movement. Now in 1986 it is necessary to explore what role those activists of the 1970s HMO movement did have, or now have, in ameliorating the social problem they helped to define. What role did the ideology of those who were so early to publicly identify the now widely acknowledged problem play in developing or affecting health policy?

The HMO movement had many parallel concerns as well as some overlapping membership with the women's health movement. Yet there is another ironic contrast of the consumers' HMO movement and the women's health movement. Ruzek (1978:233) notes that "it is unlikely that the academic and professional women and agency insiders can be successful change agents without the existence of a broad based--and generally more radical--social movement" because in most movements "the radical flank of the movement is essential...to press for change...." However, in the HMO movement it was the conservative flank--corporate and government power-- which pressed for change and altered the movement. The conservative administration at first supported the consumers movement but then increasingly brought direct pressure for change on the medical profession.

Paul Starr (1982), whose book The Social Transformation of American Medicine offers important information and analysis in all three areas of this literature review, notes that the radical consumers and the conservative government formed an "ironic alliance" (1982), to develop HMOs. But because the two groups had very different purposes, the changes wished by the consumers and pressed by the larger powers were seldom the same.

Drawing further on her comprehensive study of the women's health movement until 1977, Ruzek (1978) draws attention to what in the long run may have been the most far-reaching effort of the consumer group. She optimistically asserts that "as powerful professions become more like private governments...their governing power should be acknowledged and balanced by organized consumer participation. Organized health groups' willingness and ability to establish quality criteria and to evaluate professional practice suggests that outside accountability structures are both feasible and beneficial."

In 1986, there is no doubt that outside accountability structures for medicine are being put in place, and that was, indeed, a goal of the HMO movement. It is important, however, throughout this study to consider that this social movement is enmeshed in a complex social and economic context, and to ask: In what ways can it be seen to have caused specific change, in what ways did it mediate change, and to what extent did it largely reflect a broader change?

The social movement literature is enhanced by the work of Alice Rossi (1980) and of Tamara Hareven (1978) who demonstrate that attention to the life course and to cohort historical context can be revealing for any group that shares age and historical experience. Their perspective illuminates not only the choices and actions of the consumer activists, but also of the physicians, administrators, and patients whose attitudes and responses to the HMO movement were found to vary with their age group, i.e., to be "cohort specific."

Daniels and Ruzek (1972) also considered relevant cohorts as they analyzed the role of volunteerism, noting its place in the life cycle and emphasizing "organizational structures" and "networks" in

volunteerism that often served as "stepping stones to a salaried career."

The History and Patterns of Practice of American Medicine

In American Health Services--A Growth Enterprise for a Hundred Years, Odin Anderson (1985) reviews the development of health services, designating the period from 1930 to 1965 as The Era of the Third Party and describing the enormous growth of health services in that period. The period after 1965 he designates as the Era of Management and Control. This analysis sets the context for the emerging HMOs which in fact are mechanisms for managing and controlling health care delivery and its associated costs. Anderson's analysis also calls attention to the tension discussed by Bellah et al. (1985) which is manifest in conflicting health care policies between personal autonomy and group responsibility -- personal health or public health. This theme is central to the widespread ambivalence about HMOs among policy makers and providers who echo the issues of the consumers discussed above.

The broadest and most synthetic understanding of health care comes from Rosemary Stevens (1972) and Paul Starr (1982) who make major contributions to our historical understanding of health care and the profession of medicine. They trace the health, health professions, and health policies of the United States. Starr's analysis is the most recent and thus most inclusive of HMOs and this turbulent period. He first describes the rise of medical power in this century, particularly since World War II, and then he documents the profession's resistance to regulation and public programs -- in fact, to any avoidable change-- and then its diminishing power. "The great irony," he says, "is that

the opposition of doctors and hospitals to public controls of public programs, set in motion entrepreneurial forces that may end up depriving both private doctors and voluntary hospitals of their traditional autonomy" (p. 445).

Starr and Stevens discuss not only the political behaviors of physicians, but the professional behaviors as well. An extensive literature on the professional behavior of physicians and their socialization to the profession includes classics on professional dominance (Freidson 1973), professional training (Becker et al. 1969; Fox 1977), professional mistakes (Hughes, 1971; Bosk, 1981), professional practice (Mechanic 1985), and others including Hughes (1971) and Crawford (1977). For example, Crawford describes the cultural complexity of medicine. Although committed himself to economic interpretations and "radical" perspectives, he states "medicalization of society is based in cultural roots which extend far and beyond professional imperialism." His particular understanding of the socially constructed role of physician and is particularly relevant to the dissertation analysis. Crawford joins two important perspectives--a cultural understanding of the profession and an acute economic analysis. "Medicine," he observes, echoing C.W. Mills, "is increasingly unable to perform the traditional role of resolving societal tensions which emerge when people identify the social causes ("public issues") of their individual pathologies ("personal troubles"). (Crawford's work will be discussed further in the section below.)

HMOs

Until recently, there has been scant literature specifically focused on HMOs. In 1980, when I began reviewing the subject, discussion of HMOs in medical sociology texts was either absent (as in Albrecht and Higgens, 1979) or brief, (one or two paragraphs e.g., Cockerham, 1978: Jaco, 1979; Rosengren, 1980). The brief discussion in Jaco's (1979:367) text by Riska and Taylor noted that in their survey of consumers in a midwestern area, seventy percent were unaware of HMOs. Since 1980, however, there has been a notable growth in interest which parallels the growth of HMOs themselves (Falkson, 1980, Luft 1981, Brown, 1983, Anderson et al. 1985).

The term "health maintenance organization" was not coined until 1970 by Paul Ellwood, but others in health care studies had been considering the concept (Donabedian 1969, Berki and Ashcroft 1977; etc.) including, for example a careful "Evaluation of Unnamed Prepaid Group Practice" (Donabedian 1969). In 1970 Ellwood, who is considered important in the growth of HMOs began to promote his growing interest in prepaid health care (Ellwood March 1971, May/June 1971) and was courted eagerly by the Nixon administration in need of a health care policy. Although, the idea of prepaid groups had had a long history, (discussed in Chapter 3) it had never had a substantial following.

A number of discussions in the literature now provide the history of HMOs, and the increased number of articles in the professional and popular press both parallel and promote the growing interest among the public. (In 1985 the internationally respected New England Journal of Medicine [Mayer & Mayer 1985] as well as popular and local publications

like Chicago Magazine [Star, 1985] included several page histories of the development of HMOs.)

The structure and performance of generic HMOs is best discussed by Luft (1981) and an extensive literature in academic journals on HMOs, explores their characteristics and performance (Berki et al. 1977, Fleming et al. 1978, Ellwood 1971, Goldsmith 1979, etc.). However, in a period when the generic concept is being shaped by the competitive market place, HMOs and their successors are likely to be followed in a literature more fluid and responsive than books. Trade journals, such as Hospitals and Modern Health Care, are more immediate and timely sources of information than are academic journals.

Falkson writing in 1980 seemed optimistic, predicting 19 million members in 440 HMOs by 1988. At the time he was writing there were only 7.9 million in 217 plans (Falkson, 1980); however, after a plateau, HMOs have grown at a rate of 20 to 49% per year. The 1986 enrollment of 21 million in over 400 HMOs has even exceeded Falkson's prediction of growth (see discussion in Chapters 5 and 8). His prediction however, that the HMOs would "yield over $20 billion in cost savings" is still only a "promise." The financial consequences of the changing structure of U.S. health care is a matter of vast interest and little understanding. It will be discussed in Chapter 8.

Brown (1983) was less optimistic about the financial consequences of HMOs or even their growth, but emphasized their crucial political importance in mediating between the demands of rising costs and a "nation...not ready, or at any rate not thought ready, to address these problems by means of regulatory controls " (p. 488) and national health insurance.

Anderson et al. (1985) in a three year study in which I participated, consider the development of HMOs in two metropolitan areas with different histories of regulation and social organization. The study demonstrates the importance of a community's history, economy, social networks and professional practice patterns in the development of HMOs. We discuss the community interaction with HMOs analyzing it in seven sectors--consumers, employers, unions, hospitals, physicians, regulators, and insurers--and thus provide an understanding of the Chicago metropolitan area where Northcare/Prucare developed, and a framework for analyzing the Lansing Metropolitan area of Health Central (See Chapters 2 and 7).

Interest and Influence of Corporations and the State in Health Care

There is, of course, an extensive theoretical literature concerning the workings and influence of both corporations and the state. Some, although not themselves written in relation to health care, offer potentially useful approaches to the analysis of the increased influence of employers and the federal government on the practice of medicine and the delivery of health care.

O'Connor (1973) notes " the tendency for government expenditures to outrace revenues" and calls it "the fiscal crisis of the state." His analysis of the sectors of the economy suggests ways of thinking about the fluidity of the workforce in health care and about the powerful influence of the state sector in determining health care policies. (Such policies and their implications, e.g., reimbursement plans for medicare patients, are discussed in Chapter 8.)

Navarro's (1976) largely Marxist analysis of health care issues (which, in part, builds on O'Connor's analysis of the U.S. economy into the monopolist, the competitive, and the state sectors), has focused attention on the real and potential power of employers in the health care of their employees. This is a prominent issue now as employers seek to control costs of employee benefits often through HMOs. His analysis, however, clusters the professionals, including physicians, as the upper middle class--the monopolistic sector--and does not predict the confrontation between corporate power and the medical establishment.

It is also interesting here to consider C. Wright Mills' perspective on the power elite. For example, while until recently health care has not been of great interest to the government, the military, or the major corporations of the United States, the dramatically increased costs of health care have raised it to a matter of interest to that elite. The government and military do not want to pay the high prices of health care. Furthermore, corporations not only do not want to spend so much for health care, but now that health care has become such a "high ticket item" (and over 11% of the GNP passes through health care), corporations--particularly major insurers --themselves getting into the business.

Fuchs (1985), an economist with a different perspective, offers an explanation of employer behavior particularly related to employee health benefits. Among other things he analyzes the increased economic pressures on the government and corporations.

Crawford, (1977) too, identifies the growing concern of the corporate sector and the federal government as health care costs

ballooned in the early 1970s. From 1969 to 1975 the Federal budget expended for health increased from 8.9% to 11.3%, Crawford notes, and Standard Oil announced that its employee health expenditures tripled in the same years.

While private employers were deeply affected by rising health care costs, the federal government, which passed Medicare and Medicaid legislation in 1965, also became increasingly focused on the distribution and cost of health care. Falkson (1980) and Brown (1983) have extensively analyzed HMO development as reflections of national politics and changing Federal health care policy.

Finally, and in the most comprehensive way, it is Starr (1982) who synthesizes the data on the changing political and economic pressures on health care. He traces the general corporatization of American medicine. The case studies of this report offer telling examples of his more theoretical discussion. The HMOs are the product of an "ironic alliance" between the conservative federal administration the consumer-activists' social movement. They clearly exemplify what Starr calls "the conservative assimilation of reform" (p. 396) and finally the "coming of the corporation."

QUESTIONS AND PLAN OF ANALYSIS

The questions and analysis of this dissertation will examine 1) the emergence of the social movement to develop consumer sponsored and controlled prepaid health care, and 2) the convergence of diverse interests and the environment that shaped and changed the movement, as well as the intended and unintended consequences for consumers, physicians, and the health care system.

More specifically, the social movement questions include: How did the social problem (the consumers' concern with access to and control of health care) emerge? become defined? What was the course and impact of the social movement? What was the relationship of the movement to other movements of the same period , e.g., to home-birth, hospice, or self-help groups? What was the effect on the consumer sponsors? That is, what place and impact did the social movement have in the life course of these activists? In what ways might the experience be generalizable and in what ways was it specific to their cohort?

Questions about the nature of the interests and the effects of the environment in which the activists were establishing the HMOs include: What was the history, nature and response of the medical profession, particularly regarding forms of practice, which the activists set out to confront? What were the perceptions and roles of those community members whom the HMOs actually or potentially affected, i.e., consumers, employers, unions, insurers, hospitals, and regulators? What were the nature and influence of other powerful interests in the national environment--that is, the economic interests of the state and corporate sector, affected by and affecting health care delivery?

These questions will be explored with both historical and contemporary analyses, as well as case studies of two HMOs and the examination of a third medical community. More precisely: Part I includes this first chapter of introduction and Chapter 2 which will describe the methods used to gather the data. I will explain the way I have integrated multiple methods in this study and argue that qualitative methods can provide excellent data about organizations. Part II, the third chapter, will present a history and analysis of the

American medical profession and its patterns of practice from the early 1900s until the early 1970s.

Part III includes chapters 4, 5, and 6; the Consumers Movement in HMOs including the two case studies and a summary of Alternative Health Care Delivery in 1986. Chapter 4 will examine the communities--Chicago, Illinois and Lansing, Michigan-- which provided the context in which the HMOs were founded and developed. I will describe the sectors of each community relevant to the HMO: the regulatory environment, the providers--physicians and hospitals, the insurers, the employers, the unions and the consumers. Chapter 5 will trace the historical and development of the case study HMOs--their emergence, legitimation, mobilization, formalization, and implementation, as well as the story of their "sell out" to well-capitalized insurers. Chapter 6 will update the case studies as well as the national health care delivery context in 1986.

Part IV includes Chapters 7 and 8 and discusses the intended and unintended consequences for the consumers, the physicians, and the health care delivery system of the consumers' HMO movement. Chapter 7 recounts the experience of the social activists--the founders of the HMOs--and the effects of their participation on their own lives as individuals and as a cohort. Chapter 8 will first discuss the consequences for physicians of a competitive HMO environment where managed care dominates. Finally, I will reflect on the changes found in the health care delivery system in 1986, and consider the role of the consumer-activists, of their "ironic alliance with powerful forces arraying themselves against health care providers"(Starr 1982), and of the HMOs nurtured by that alliance.

END NOTES

1. Those interviewed often gave evidence of the consumer/ patients' isolation from the realities of health care costs and the consequent overutilization. A labor leader in Lansing, Michigan, reported: "The members didn't care (about the cost); they weren't paying. They would go quick to the ER like they were buying shoes."

2. The implications of this ideology are reflected both in the selection and decisions of the board of directors of Health Central and NorthCare and are directly related to the outcomes of these HMOs specifically and the consumer-sponsored HMOs in general. This will be discussed in Chapter 5.

3. Thanks to Rick Hill for noting that particular aspect of the constraints.

CHAPTER 2

FROM MULTIPLE METHODS AN INTEGRATED METHODOLOGY

INTRODUCTION

Research by "medical sociologists," grounded with field experience, has given us memorable and instructive views of healers and curers, the healed and the cured, and sometimes the incurables (Fox 1979; Bosk 1981). Less often, however, has such research been applied to the systems in which the healing and curing is given, received . . . and paid for.

On the other hand, research by those in traditional health service research has provided extensive information about these systems--usually broad understandings of certain groups' access to health care systems, the quality of the health care systems, and most recently, the cost of health care systems. This essential information is usually based on quantitative information gathered in broad, often national, surveys and evaluation studies (Aday and Andersen 1975; Aday et al. 1980).

While health care research has become increasingly important throughout this century, in the mid-1980s cooperative and comprehensive research linking varied traditions seems critical, as health care has become the repository--or at least the pass-through--of 11 1/2% of the United States' gross national product.

In the previous chapter, I have referred to the history of this dissertation and to the different sources of data that have contributed to it. In this chapter, I will first describe the multiple methods

with which I gathered data as well as the levels of analysis, and then I will argue that more than one methodological approach is necessary for understanding health care and complex health care systems.

As noted above, I began this research by studying the development of a consumer-sponsored HMO at the micro level; that is, by close analysis of the perspective of the founding activists and the community in which it was founded. Although that level of analysis was and is crucial, it is also insufficient. Further research revealed the influence of the larger context--the metropolitan areas and the national political economy.

In the course of my research, I have made four general observations about traditional sociological methods and the subject of medicine and health care: 1) sociological theorists have paid little attention to the institution of health care; 2) medical sociologists in general have demonstrated narrow interests; 3) health care research has demonstrated a limited methodological range; and 4) medical sociologists with their methods, and health care researchers with theirs, have maintained a sharp disciplinary boundary and have rarely collaborated. About the first, I can only offer an example; about the others, I will offer examples and discuss ways in which my own research strays from the traditional methodological path.

First, sociological theorists, even those who have made systematic and effective efforts to demonstrate the complex ties of the American economic system to all phases of American life, have neglected to include health and medical care. For example, Edwards, Reich and Weisskopf, writing in the 1970s described their 540 page book, The Capitalist System, as a "radical course in the American Political

Economy" or a "radical analysis of American society," but did not mention or include the American health care system as one of the fundamental institutions of American society. This in spite of the fact that already, at that time, over 8% of the gross national product and almost 10% of the federal budget were being spent on health.

Second, medical sociologists have traditionally studied health care in the U.S. as an endless series of dyadic relationships. As members of their culture, they seem to reflect, their American subjects' predominant perception that good health care is realized and understood in the doctor-patient relationship and that the health care system is peripheral. Ignoring Blumer's (1971:299) caution not to take their "cue (exclusively) from the focus of public concern," well known medical sociologists have focused on patients and doctors. Parsons (1951) studied patients, defining "the sick role" for generations of sociologists. Freidson (1973; 1975), Mechanic (1985), Fox (1979), and Bosk (1981) have examined doctors and the doctor-patient relationship, but have largely neglected the political and economic context in which medical care is given. For example, as recently as 1979, Freidson discussed extensively the roles and imperatives of health care without ever mentioning the costs or administration of the hospital.

While medical sociologists have focused on health care very narrowly, those in "health care research," who study the systems broadly, have narrowed their choice of methodology. In fact, qualitative field methods, which have been so effectively used to understand all micro settings and professional and patient interactions, are rarely used by those studying systems.[1] But,

qualitative methods can make an important contribution to understanding the administration, the management, the finance, and the influence of local communities on health care. The tendency of those in health care research to study organizations and systems without attention to their internal and cultural aspects--those aspects most accessible with qualitative methodology--limits the usefulness of health systems research. Although not all research projects can or should include multiple methods as I have tried to here, all health care research should, I would argue, proceed in the context of both.

Navarro, a Marxist sociologist, who does discuss the political economics of health care, also notes the dearth of contextual health care studies.

> In trying to understand the present composition, nature, and functions of the health sector in the United States, one is hampered by a great scarcity of literature, both in the sociological and medical care fields, that would explain how the shape and form of the health sector--the tree--is determined by the same economic and political forces shaping the political and economic system of the United States--the forest. In fact, health services literature reveals . . . a predominance of empiricism, leading to dominance of experts on trees who neither analyze nor question the forest but accept it as a given (Navarro 1976:136).

The paucity of methodologically-integrated studies reflects the dichotomy in sociology between macro and micro analysis. Anthony Giddens, in The Constitution of Society (1984), discusses this dichotomy as "relations between social and system integration." He resists, he says, the familiar terms micro and macro sociological study because:

> . . . these two are not infrequently set off against one another, with the implication that we have to choose between them, regarding one as in some way more fundamental than the other.

He notes, with what I observe to be regrettable truth, that with those who study microsociology, such as Goffman, "there seems to lurk the idea that in what he sometimes calls microsociology is to be found the essential reality of social life." On the other hand, advocates of the macrosociological approaches are prone to regard studies of day-to-day social activity as concerned with trivia--the most significant issues are those of a broader scope. But, Giddens concludes, "this sort of confrontation is surely a phoney war if ever there was one." He says that others also are concerned with the relation between the two perspectives but he cautions against a reductionist perception like Collins' (1981) "that 'macroprocesses' are the 'results' of interactions in 'microsituations' . . . that the 'macrolevel' consists only of 'aggregations of microexperiences'." He insists that the macrolevel has more than a "sham existence." Giddens perceives, as I do, the importance of the complementary and interactive existence of the two perspectives, i.e., ". . . institutionalized patterns of behavior are deeply implicated in even the most fleeting and limited of 'microsituations'."

Avoiding "Phoney Wars"

In this research, the case studies are important and necessary for understanding health care at the micro level--i.e., the experience of the providers (physicians and other health care professionals) and of the consumer activists (patients), as well as of the planners, the managers, and the payers. I ask, for example, what is the interaction among these actors? What and where is the resistance to change? And how does it vary, by actors and specific conditions? The complex and rich qualitative data generated by such questions gain power and

implication when we know, quantitatively, how frequently and how widely these observations occur and the impact of that frequency. More specifically, to consider HMOs effectively, one needs to examine the circumstances of their individual development in order to understand the implications for other such groups and efforts in other communities. However, in order to understand HMOs' significance, this understanding must be linked to and informed by information about the larger context--the national, political, and economic conditions--that facilitates or inhibits these health care delivery organizations.

OVERVIEW OF THE RESEARCH METHODOLOGY

The research began in 1978 as a narrowly focused qualitative study of an HMO and its consumer-founders. It developed over time and through space to include another HMO, three metropolitan areas, and aspects of the political economy of the nation. The qualitative observation and interview study expanded to integrate documents, news and journal articles, federal and state regulations, legislation, and survey data and statistical abstracts reflecting the health care changes across the nation. Table 2-1, "An Integrated Methodology," summarizes the sources of data and the levels of analysis. In the most general terms, the research may be described as progressing chronologically from the upper left corner to the lower right corner. The density of data collection of a given kind is reflected in each cell. It should be noted that almost all methods yielded valuable information for all levels of analysis. That is, federal and state documents offered some information about the individual HMOs and an unstructured phone interview with a federal official at the U.S. Office of Health Maintenance Organizations

(OHMO), offered valuable insights on national HMO policy over time. One can see that in this study newspapers and other media provided the most consistent source of information across all levels of analysis and different locations.

The data gathered for this research are both longitudinal and comparative. In order to analyze the initiation, development, and corporatization of the HMOs, I have examined the history of group and prepaid group practice from secondary sources, and the history of the HMOs which are the subject of these case studies from institutional documents, media coverage, and especially from interviews and observation at different points in time beginning in 1978 and continuing through 1986. (Although the final writing is in 1987, all references are to data gathered through 1986.)

I compare the development of two HMOs, not so much to compare the HMOs per se, but to evoke and explore as fully as possible different ways of examining this phenomenon. For example, NorthCare's affiliation with and support from a hospital in Evanston suggested that I examine an additional element in the development of Health Central in Lansing. On the other hand, Health Central's affiliation with and support from organized labor in Michigan suggested questions to ask in Chicago. Furthermore, the contrasts between the two HMOs make all the more striking their self-perception that they are very alike--one modeled on the other. And so these similarities and differences, both externally observable and internally perceived, fill out a picture of consumer-sponsored HMOs, their development, and their impact.

The sources of data, the levels of analysis, and their interactions are displayed in Table 2.1.

Table 2.1.

AN INTEGRATED METHODOLOGY
(from multiple methods)

LEVELS OF ANALYSIS

DATA SOURCES	HMOs		Communities			National Political Economy
	HC	NC	Lnsng	Chcgo	MSP	
Observations	**	*	*	*	*	---
Unstructured Interviews	****	****	*	*	*	*
Semi-structured Interviews	***	***	****	****	****	*
Institutional Archives pub/private	****	***	*	*	*	**
Newspapers/ Media	***	***	***	****	****	****
Professional Journals/ Magazines	*	*	**	**	****	****
Fed/State Documents/ Regulations	*	*	**	**	**	****
Survey Data/ Statistical Abstracts	---	---	**	**	**	***

--- = Not a source of data
* = Occasionally, though rarely, a source of data
** = Regular but not frequent source of data
*** = Important source of data
**** = Principle and very important source of data

OBSERVATION

A certain amount of observation was important in the initial phase of my work with the HMOs, especially at Health Central in Lansing. I visited and observed at a number of their sites and offices as they were becoming established and expanding. At first, I observed regularly over a three-month period in the spring of 1980 for a total of thirty-six hours. Then, I returned to interview and observe once or twice a year through 1986. These observations made it possible to see the image that HMOs were trying to develop--an image distinct from "clinics." I wrote in my field notes about Health Central x-ray and lab waiting area:

> . . . although (the room) was large there was an overall tranquillity that was unexpected to me. It had the general feeling of a small waiting room, like a dentist's office. . . the furniture was practical but not institutional looking--large brown upholstered cushions on blond wood . . . the cushions gave the impression of being one-per-sitter, and so, although if there had been no separations more people could have sat on a bench (for instance), they did not. So in general there was a sense of space instead of crowding (Field notes 4/7/80).

Although considerable attention was given to the waiting rooms, the children's playroom, and even the washrooms, the offices in which I interviewed administrators were very simple and unpretentious. The director's office was small and poorly soundproofed. Those environmental differences in 1980 (which again are sources of comparison for 1986) established the impression that the patients or "enrollees" as they are called, were the most important part of Health Central. Observations were also particularly helpful in stimulating and validating interview responses. In addition, I could observe the value and status of different procedures and personnel by the assignment of space. Observation was also indispensable in comparing

the communities as I visited companies and observed the role and status of benefits personnel and the resources devoted to health benefit management. For example, in Minnesota the status and resources of the corporate health benefits departments were at a notably higher level than in Chicago and Lansing. And in Chicago, observation at one particular luncheon for labor leaders and invited guests provided major findings about the difference in the written attitudes of national leaders and the informal attitudes acted out by local leaders.

INTERVIEWS

At the center of this work are the case studies of the initiation, development, and corporatization of NorthCare/Prucare in suburban Chicago, and Health Central in Lansing, Michigan. I gathered much of the data on the ideology, founding, and development of Northcare and Health Central through intensive, "unstructured" interviews--i.e., interviews which have an underlying structure to the interviewer but which permit the understanding of the activities and goals and life course to emerge from the language of the participants (Whyte 19). With such a method, for instance, I learned from an early interview how the ever present issues of the delivery of health care emerged in the early 1970s as a social problem. A founder of Health Central reminisced:

> . . . We all had this "Community-action-Peace-Activist-bond,"and so we agreed there was a lack of health care. One of the people had been related to "the Dec" (Drug Education Center), and knew that "there was no care there for students . . . they would have a terrible time, just terrible". The founder then became animated about the "terrible" health situation. Later she added about their group, "We knew we were looking for health care but we didn't know what kind. We didn't know the needs of the people" (Interview notes May 1, 1980).

Intensive Interviews

In Lansing, I conducted intensive unstructured audio-taped interviews with key informants, the founders, certain early staff and administrators, and those identified in early interviews as important to the initiation of the HMOs. In Lansing, nine of the twenty-two important interviews were unstructured.

I was granted permission to interview and observe at Health Central and later I successfully "made contacts" through the University of Chicago HMO research to conduct interviews at NorthCare/Prucare. The following is an excerpt from my letter of agreement with Health Central:

> I am sensitive to the ethical issues in such a study and I will explain my research and obtain signed consent forms from those I interview. I will ask for permission before observing in any specific setting. In any spoken or written public presentation of my work I will change names to guard confidentiality. I welcome suggestions and observations from those with whom I am working and will provide to Health Central copies of anything I write for public distribution including a copy of my dissertation.

Because it was the earliest part of the research, I emphasized unstructured interviewing so that the issues important to the founders and to the beginning of the HMO could emerge.

In Chicago, three years later, the overarching issues were becoming clear, and I conducted unstructured interviews only with the founders and medical director who had the most complete recall of the organizational development. Through these unstructured interviews, the issues that were similar as well as those that were different for NorthCare than for Health Central emerged. In Chicago, five of the thirty most relevant interviews were unstructured. The unstructured

interviews lasted from two to four and one-half hours and were often in two or three sessions. I tape recorded and transcribed and/or summarized the extended interviews, and then analyzed them by "constant comparison" (Glazer and Strauss 1967). It is from these approximately forty-five hours of tapes that the initial and persistent themes emerged.

It should be recalled that much of the data gathered in Chicago, including the thirty interviews, were part of the larger University of Chicago study of HMO development in the Chicago metropolitan area which included over 180 taped interviews. All of the data served as context for my understanding, but for comparison in this study, I selected the thirty interviews which were most relevant to the development of Northcare/Prucare.

In the larger study, five staff members each did some interviewing. My primary responsibility was to design the interviews and later, to do the interviewing and analysis of the interview data. I interviewed over one hundred subjects, including all those directly related to the development of NorthCare.

Semistructured Interviews

I designed the semistructured interviews to elicit an understanding of the context in which the HMOs developed. In each of the HMOs' metropolitan areas, we interviewed key informants from the seven sectors

of the community proposed by Anderson and Kravitz (1968) to be most relevant to health care:

Physicians
Hospitals
Employers
Labor
Insurers
Regulators
Consumers

The semistructured interviews included directed but open-ended questions about community issues that had emerged in the unstructured interviews and a set of general questions about the following topics:

1. Patterns of power, communication, and leadership in each of the sectors.
2. Previous knowledge of HMOs and the prepaid concept.
3. Support and opposition to the local consumer-sponsored HMO.
4. Interaction with the HMO.

The interviews were from one to two hours long, audio-taped and selectively transcribed for analysis, again according to the methods described by Glazer and Strauss (1967). The interaction of the different sectors and their differential influence in the communities in this study became clear from this analysis.

For the 1982 studies, we had selected respondents for the community interviews on a number of criteria: their position in a relevant sector; reputation among those knowledgeable in their field; the attention of the news media to them as decision makers; and the recommendation of others whom we interviewed.

The selection and number of interviewed were grounded in the field and the differences in the communities were reflected by the numbers of interviews we found necessary. We began with a list of about ten

potential interviewees in each sector (physicians, hospitals, employers, labor, insurers, regulators and consumers); other respondents were added and interviews were continued until the interviewers--consulting with each other and other HMO staff members--found that the information gathered was no longer new; at that point the interviewers found they could predict the response; together the staff could readily agree that they had completed interviewing in that sector. Consistent with these findings, in the Twin Cities we found we needed many fewer interviews in most sectors than in Chicago.[2]

The fewer interviews in Minneapolis-St. Paul reflect clearly the more centralized and institutionalized community-wide networks of communication; the greater homogeneity of response, and the tendency toward consensus within all sectors. Conversely, the greater number of interviews conducted in Chicago reflect fewer institutionalized community-wide communication networks, greater heterogeneity of response, and greater numbers of isolated and diverse activities and responses. In Minneapolis-St. Paul, 141 interviews covered the range of information; in Chicago, 184 were required. Based on the information gathered in that exhaustive set of grounded interviews I conducted a small set of semistructured interviews (thirteen interviews) with representatives of the appropriate sectors in Lansing, Michigan, focusing on community issues that had emerged as relevant in the larger study.

I selectively transcribed and analyzed the Lansing interviews (Glazer and Strauss 1967). I compared the interviews with the data from the earlier study as well as watching for new themes that might emerge

in Lansing. For example, it became clear that labor had a much greater role in Lansing than in either of the other two communities.

Other examples of relevant and interesting data emerged among the physician interviews in Chicago and Minneapolis-St. Paul. The physicians themselves, who were chosen for interviews from a variety of clinical, administrative, and academic settings--in solo, group, and HMO practice--were revealing in their office interviews. Although appearing to be very busy, they often extended their interviews to discuss topics that apparently were very important to them. As project staff analyzed those interviews, theory could sometimes be "discovered" (Glazer and Strauss 1968) clearly enunciated in the words of such informants. For example, it was an assertion by a physician in private practice that suggested an important theoretical element for comparing and analyzing the three communities. He noted casually that it was not the HMOs but rather the multispecialty group practices that had introduced the competitive environment.

In his and subsequent interviews it became clear that before present day HMO development, multispecialty group practices had already altered the referral patterns in the Twin Cities; for many there, prepayment seemed just a refinement and thus not the threat it appeared to be in Chicago and Lansing. Armed with this insight, in Chicago we found that multispecialty group practices were almost unknown. This significant contrast was confirmed by the survey data and other quantitative measures. This insight was again relevant in Lansing where, as in Chicago, solo practice has predominated and physicians strongly resisted new forms of practice they saw as threats to their referral patterns.

Another important area of physician concern was clarified by the complementary and productive interaction between the quantitative and qualitative data in the Chicago/Minnesota study. Our initial interviews with the Twin Cities physicians demonstrated physicians' considerable interest in HMOs and in their ability to contain costs. Cost was the only health care problem that was spontaneously discussed by the Minnesota physicians. Physicians in Chicago, however, seemed to have little interest in HMOs and did not spontaneously mention cost as a problem. What, then, were they concerned about? That question raised the subject that all Chicago providers and consumers became animated about--the "two-tiered system" of health care--i.e., the problem of providing health care to the poor. This problem, we will see, perplexed the founders of NorthCare as they opened its doors.

The research team considered the communities' contrasting responses to this question. Our overview of the economic conditions and physician/patient ratio in the two metropolitan areas had seemed to show remarkably similar conditions:

	Chicago	Minneapolis-St. Paul
Physicians/100,000	192	192
Income per capita	$ 8,568	$ 8,666
Median family income	$24,539	$24,646

But the interviews clearly stated that the respondents in the two metropolitan areas were not experiencing similar conditions. We dug further into the data and found quantitative validation and explanation for the residents' qualitative experience:

	Chicago	Minneapolis-St. Paul
Families AFDC/1000	22	14
Families below poverty level	8.8%	4.9%
Infant mortality	16.9	11.9

And in the largest urban counties, an even starker contrast:

	Cook County	Hennepin County
Families AFDC/1000	28	15
Infant mortality	18.4	11.8
Physicians/100,000	210	283

This interaction of field experience with quantitative data revealed the divergent conditions in the two metropolitan areas: social and economic homogeneity in the Twin Cities in contrast to the social heterogeneity and economic polarity in Chicago. In light of this discrepant distribution of resources and health problems, Chicago physicians' persistent concern about two-tiered health care and their inability to see the relevance of HMOs (which in 1983 served only the young and employed) takes on a new logic.

Supplementary Physician Interview Data

The rich data on physicians from the 1982 study provided an excellent base for considering the effects in 1986 of the changes in health care management on the medical profession (which the consumer activists had intended to change). In order to understand the effects of the changes on physicians in a medical community dominated by HMOs, I decided to interview physicians again in the Twin Cities in Spring of 1986. I reviewed the earlier interviews of 26 Minnesota physicians, and selected six physicians whom I thought, with the benefit of retrospect, had been the most observant, responsive and informative. Again I chose representatives of public and private institutions, of fee-for-service and prepaid care, of Minneapolis and St. Paul; furthermore, they included clinicians and administrators in both individual and organizational settings, including the university and

the state and local medical societies, and those who opposed as well as those who supported--even founded--HMOs.

In addition, I interviewed six other professionals in the Minneapolis-St. Paul area who work with, administer programs for, and write about physicians. These included academics and consultants as well as staff at the state and local medical societies. All of the interviews with these informants, with the exception of some short phone calls, were audio taped. (I also examined newspaper, magazine, and journal articles on health care delivery in the Twin Cities at that time to understand physicians'attitudes toward HMOs in 1986.)

DOCUMENTATION

Institutional Archives, Public and Private

In addition to the live words of informants in interviews I have used extensive documents to gain insight into the development of the HMOs. Some are specific to the HMOs themselves--institutional archives that had been kept as a public record or in the personal files of the participants. Particularly for Health Central, these were plentiful and illuminating. In addition to all the publications and newsletters of the Health Action League (HALE, the activist group that parented Health Central) and of Health Central itself, there are complete records of board meetings (to the extent that they were kept) and correspondence with government agencies, providers, contractors, and so on. Furthermore, I was given access to the personal files of a founder, of an early board member and of the first executive director. For NorthCare publications include newsletters, board and committee

meeting minutes and annual reports--a substantial record though not as deep as the data from Health Central.

Newspapers/Media

Fieldwork has its analogues in library research (Glaser and Strauss 1967). Indeed newspapers, largely on microfilm, provided a dense and unforgetting layer of data, sometimes about the HMOs themselves when they "made news," but always about the community and national issues that formed the baseline for the new organizations. For example, while unstructured interviews discussing the development of HMOs in the early 1970s seem to focus on the things that were accomplished, the newspapers offer evidence that much was left undone. The newspapers of 1971 predict confidently that there will be national health insurance and describe the factional disputes concerning which kind to institute. Such information is an important part of the national context in which one must build an analysis of the consumers movement to develop HMOs.

Professional Journals and Magazines

Professional journals and the more timely magazines provide important access to the attitudes, politics, and leadership of professional groups concerning HMOs or general changes in health care delivery. The following journals were important sources of historical and contemporary information regarding the development of HMOs: Journal of the American Hospital Association, journals of the American Medical Association, the journals of the state medical societies in Michigan, Illinois, and Minnesota, Group Health Association News and newsletters, Modern Healthcare, Hospitals, and Business and Health. They only

occasionally had information about an HMO in this study but they give the best sense of the dynamic nature of what is now the "health care industry" and the changing actors nationwide.

Federal and State Regulations and Legislation

Less dynamic, but indicative of the efforts of government to manage health care without nationalizing it are the changing rules and regulations at the state and national level. A comparison of the importance of state versus federal regulations for each state studied was very illuminating. The focus of the government's effort to control is always interesting and shifting. From regulations about access and quality the government moved almost exclusively to regulations about cost. In 1986 the focus is about to shift again as there are heightened concerns about quality.

The National Survey Data and Statistical Abstracts

The national survey data and statistical abstracts set the context of the communities in which the HMOs developed--their size, their workforce, their health care utilization patterns. Juxtaposition of such data with the interview data highlights important social patterns such as the skewed economic patterns and health care distribution of the Chicago metropolitan area.

The following are sources from which the data are drawn:

1. American Hospital Association, Guide to the Health Care Field, the 1976 and 1981 Editions, Chicago A.H.A. 1976 and 1981.
2. American Medical Association, Distribution of Physicians, Chicago, AMA 1970, 1975, 1980.
3. U.S. Bureau of the Census, Census of the Population: 1970 Vol.1, Washington D.C.. U.S.G.P.O.,1973.

4. U.S. Bureau of the Census, Census of the Population:1980 Vol 1 USGPO 1983.

5. U.S. Bureau of the Census, County and City Data Book, 1967. Washington D.C., U.S.G.P.O., 1967

6. U.S. Bureau of the Census, County and City Data Book, 1967. Washington D.C.: U.S.G.P.O., 1967

7. U.S. Bureau of the Census, State and Metropolitan Area Data Book, 1982. Washington D.C.: U.S.G.P.O., 1982.

8. U.S. Department of Health and Human Services, Bureau of Health Professions, DHPA Area Resource File, December 1980.

With these multiple methods, I approached the complex issue of consumer activism to change health care. The next chapter discusses the traditional medical system they set out to change.

END NOTES

1. Rosabeth Kantor's (1977) work on organizations and mobility within organizations is an exception that draws attention to the fact.

2. Exceptions in Minnesota are discussed in HMO Development: Patterns and Prospects, (Anderson, et al. 1985).

PART II. TWENTIETH CENTURY AMERICAN MEDICAL PRACTICE

CHAPTER 3

HEALTH CARE IN THE UNITED STATES, 1910 TO EARLY 1970s: THE TRADITIONAL DOMINANCE OF THE MEDICAL PROFESSION

To understand the efforts of consumers and others to introduce alternative forms of health care delivery, it is important to consider the nature and history of the complex social, economic, and scientific institution they set out to change.

It is in this century that the status of the medical profession, tied to that of science and technology, has risen dramatically. The profession, which at the turn of the 20th century was composed of physicians who depended largely on arts and crafts of comfort and condolence, is now composed of physicians wielding the tools of science--techniques and potions which seem often to halt once certain death at the doorway. In this, the last quarter of the century, we witness individuals saved by surgical procedures that replace defective vital organs and whole populations protected by inoculations that stop epidemics.

While this lofty level of health care is clearly the accomplishment of many different professionals, scholars, and workers, it is the medical profession which culturally has been most closely identified with this progress. And it is physicians who, as individuals, are most highly regarded among the general population (Hollingshead 1958).

In the early 1970s the terms "medicine" or "medical care" were most generally or synonymously used for "health care," and generally medicine was equated with physicians. When in the early 1970s the

consumer activists in Chicago and Lansing, Michigan began to explore the possibility of introducing prepaid health care, it was their intention to broaden the understanding of health care and remove it from the hegemony of physicians. For example, as the consumers in Michigan began to publish statements about the Health Action League (HALE, Health Central's predecessor) and its mission, they avoided the words "medicine," "physicians," and patients, and emphasized the more generic terms, "health care," "providers," and "consumers."[1]

One of their earliest publications asked:

> Why do we need HALE?
> Health Care is becoming more technologically sophisticated, and providers of health care more specialized. Decisions have to be made. . . . The consumer, directly affected by all these decisions, should constructively participate in the decision-making process. . . . HALE is working to educate consumers and to increase communication between providers and consumers (from Lansing community circular, "Introducing HALE," 1974).

Activism concerning health, of course, was not the only activism in the late 1960s and early 1970s, a time well known for notable ferment in the United States. There was important disagreement and activism concerning both domestic and international issues. Writers of different times and interests--e.g., James Madison, Alexis de Touqueville, and Tom Wolfe--have noted that Americans are not homogeneous, but, rather, factional, and this period of social activism illuminated the national heterogeneity. This heterogeneity is as true of doctors as of any other segment of Americans and, in the early 1970s, there was a wide range of practice patterns throughout the United States. Nonetheless, the health consumer activists approached the profession of medicine as it seemed to them--homogeneous and monolithic.

The analysis which follows discusses elements of medicine's heterogeneity by recounting certain historical influences that shaped the complex institution the activists wished to change.

The history of the American medical profession has over time had multiple influences, including the far-flung geography of the United States; the differing interests of private citizens, of business and industry, and of government; as well as by the needs of rural, small city, and dense metropolitan populations.

In spite of these diverse influences, dominant themes have emerged. Physicians in general have, throughout this century, demonstrated certain central unifying attitudes and values which characterize their professional community--described by Goode (1957) as "community within community." These qualities are associated with their selection to and training in medicine (Becker 1969, Mechanic 1985, Freidson 1975, Fox 1979, Bosk 1981). But although their attitudes and values are remarkably similar--reflecting their homogeneous socialization to the medical community--their behavior is diverse and is strongly associated with the nature of their geographic community. In other words, one finds remarkably similar cautions, commitments and concerns among American physicians nationwide, but their behavior and practice patterns may vary according to the social, political, and economic patterns of their geographic community (Anderson 1985).

In this chapter, I will briefly trace the development of the medical profession in the United States from 1900 until the early 1970s with particular attention to the attitudes of physicians, their patterns of practice, and their professional convictions. It is these

elements which consumers sought to confront, and it is these elements that physicians have sought to protect. I will trace the main themes as well as the counterpoint, considering the history and implications of solo versus group practice, and fee-for-service versus contractual payment for medical care.

Although until recently American medicine has seemed dominated by--almost synonymous with--solo fee-for-service practice, close attention to the history of the medical profession demonstrates that tensions regarding group practice as well as prepayment have been persistently present throughout the century.

During the first three-quarters of the century, prepaid group practice (PGP) and its accompanying ideology born largely of the American Cooperative Movement (Tompkins 1982), has been a counterpoint to the dominant theme and mode of American medicine. PGP, as well as group practice, has both intensified and moderated in response to political, social, economic, and scientific issues. Now, as noted in Chapter 1, that countertheme seems to resonate with certain broader public perceptions and demands.[2] Also as noted earlier, prepayment and its implications have become, since the early 1970s, increasingly visible in health care. The consumers' contribution to this development are discussed throughout this work. Here I will discuss first the predominant norms, values, and patterns of practice of physicians through the century; second, group practice and its place in American medicine; third, the alternative themes of prepayment and the response of organized medicine; and fourth, professional issues of historic and perpetual concern to the medical profession.

NORMS, VALUES, AND PATTERNS OF PRACTICE OF PHYSICIANS

In the 1980s, when the 360,000 physicians in America enjoy a relatively secure and autonomous role, "competition"--so closely associated with HMOs as either cause or effect--is seen as a new mode for, and a challenge to, the profession. Before the 20th century, however, the predecessors of modern medicine were required to compete with naturopaths, homeopaths, and assorted patent medicine men and faith healers, as well as with each other for the privilege of healing late 19th century ills.

Starr (1982:7-8), considering simultaneously both the history and structure of medicine, notes that "in the nineteenth century the medical profession was generally weak, divided, insecure in its status and income, unable to control entry into practice or to raise the standards of medical education. In the 20th century, not only did physicians become a powerful, prestigious, and wealthy profession, but they succeeded in shaping the basic organization and financial structure of American medicine." The structure of health care cross-culturally is examined by Odin Anderson who notes that in other countries also, physicians constitute a powerful and prestigious profession. However, he asserts that in America the profession has had notable freedom, not only in the "art and science of medicine," but also "in the methods of organization, delivery and payment for their services . . ." (Anderson 1968). Official professional organizations, representing the medical community, throughout this century have developed an increasingly specific set of policies and official

statements to reflect but also to shape, the norms of practicing physicians.

Physicians of the early 20th century faced dramatic challenges as well as important opportunities as they saw an unprecedented rise in both technology and bureaucracy. They embraced the elements that could strengthen the profession and rejected those that might inhibit it. Thus, in the name of professionalism, physicians allied themselves ideologically with technology but fought doggedly against both corporate and government bureaucracy.

American physicians began the century in disarray. Paul Starr (1982:198), summarizes the condition of their profession:

> . . . beleaguered by unscientific sectarians and quacks who preyed on the credulous sick; by druggists who plagiarized their prescriptions and gave free medical advice to customers; by too many of their own profession, turned out in profusion by medical schools; by hospitals that stole patients from them and denied them admitting privileges; and by public dispensaries and health departments that offered medical services to many people who doctors believed could afford to pay.

But in the 1900s the AMA, in concert with university medical centers, began purposeful efforts to standardize medical education and licensure. Thus they improved the credibility of, as well as limited the competition within, the profession. This effort was both galvanized and symbolized by the Flexner Report of 1910, which called for tightened standards, led to the closing of many marginal institutions, and thus, formalized medical education. By the 1920s, the freshly and rigorously educated, credentialed, and self-righteous physicians had secured their position. "They claimed specialized technical knowledge validated by communities of their peers" (Starr 1982:199). As will be elaborated below, physicians as a group had

resisted the pressures of corporations to employ them and permitted the repugnant touch of government only to license them. But the security was not deeply felt nor permanent; the costs and complexity of their dramatically growing artful science placed them on a shifting foundation, and echoes of the century's early insecurities would be heard as the medical profession continued (and continues) to defend its position regarding patterns of practice and forms of payment.

Throughout the century the vast majority of physicians have been solo practitioners reimbursed fee-for-service. They practiced their science independently and they wanted no mediators interfering with the way their practice was organized or the way that they were paid. They interpreted any intrusion as a threat to their autonomy and to their role with their patients.

Rosemary Stevens (1971) explains that when physicians were able to design their own practices, the practices were almost never cooperative. As a consequence, although by 1923 there were twenty-three recognized specialty fields, "there was very little coordination and cross reference of (physicians) skills." Stevens (1971:140), in support of this contention notes that in the course of a year a patient (trying to arrange for his/her own care might need to) call on . . . five specialists . . . with little coordination of treatment. . . ."

THE POSSIBILITY OF GROUP PRACTICE

In addition to a bevy of physicians in solo practice, there was another form of medical practice which could provide better coordinated care. Private group practice by specialists was developed early in the century before the first World War. The prototype was the Mayo Clinic

of Rochester, Minnesota, seventy miles southeast of Minneapolis-St. Paul. Begun in the 1880s by three physicians, two Mayo brothers and their father, by 1914 the clinic had opened its own building with seventeen doctors and eleven clinical assistants (Starr 1982). The Mayo clinic was, however, exceptional in its development; such group practices were few and far between before the first World War. It was not until WWI that "such patterns of cooperative practice were experienced by many physicians" (Stevens 1971), but after the war, 1918-1920, there was an intense growth of private group practice. Stevens (1971:141) reports that in 1919 both the acting chairman of the Council on Medical Education, and the president of the AMA saw the logic of group practice once physicians had "experienced the accurate scientific work possible in the wartime group practices of specialists."[3]

By 1930, there were 1,500 to 2,000 physicians involved in 150 physicians owned and managed group practices. "In Minnesota, it was claimed there were few towns of 10,000 or more inhabitants without one or more private group clinics" (Stevens 1971:141; Starr 1982).

However, this surge was temporary, and although it is true that a number of those group practices survived, as a movement specialist group practice was strongly resisted by the profession because it represented potent competition to other physicians. It alarmed both generalists and specialists by threatening the viability and legitimacy of general practice . . . . and by competing with specialists in solo practice. As a result, by the mid-1920s the "initial enthusiasm (for specialty group practice) within organized medicine was replaced by a spirit of caution, followed by hostility" (Stevens 1971:142). This

tension and change in the attitudes about group practice was occurring within a period of even greater change for organized medicine. The group practice conflict reflected a divisiveness in the AMA of the 1920s which was just becoming evident. For example, although the AMA editorial board wrote against group practice, another arm of the AMA, the Council on Medical Education and Hospitals, concluded that concerns about group practice were unfounded and that such practice had positive values. And yet a third element, the House of Delegates, could not agree. During 1922, this tussle reflected a divergence in interests of the medical educators and the medical practitioners. As Stevens (1971:142) summarizes it, "AMA leadership was passing from medical school faculty to the practitioners, and from progressivism to conservatism."

Since that time, mode of practice has continued to be one of the AMA's major political issues, and it has strongly supported solo, fee-for-service, practice. Freidson notes "the term 'solo practice' is as often ideological as it is descriptive" (Freeman et al. 1979:299). The practitioners' ideology is strongly guarded by the physicians at the local county medical society level who, until the early 1950s, controlled National AMA membership. Admission was at the county society's discretion (Freidson 1970:29); thus, county medical societies were able to deny membership locally and (thus) nationally to physicians "who worked on an economic base repugnant to local members." [Examples of such denial and restraint of untraditional physicians is described below. They include those who practiced in the Elk City Cooperatives and Puget Sound Cooperatives as well as the Health

Insurance Plan of Greater New York who were at one time denied membership (Freidson 1970:29)]. The form of practice and delivery of care in a time of changing economy and technology drew the attention of a number of influential thinkers. In 1928, several philanthropic organizations funded a study group of fifty prominent figures both in and outside of medicine (Anderson 1985). This "Committee on the Costs of Medical Care"[4] studied "the economic aspects of the prevention and care of sickness, including the adequacy, availability and compensation of the persons and agencies concerned." They discovered widespread problems with the quality and financing of medical care and in 1932 issued a twenty-eight volume report recommending in part:

> that medical service, both preventive and therapeutic, should be furnished largely by organized groups of physicians . . . nurses, pharmacists, and other associated personnel. Such groups should be organized, preferably around a hospital, for rendering complete home, office, and hospital care. The form of organization should encourage the maintenance of high standards and the development of personal relationship between patient and physician. . .
>
> The Committee recommends that the costs of medical care be placed on a group payment basis, through the use of insurance . . . taxation, or . . . both of these methods. This is not meant to preclude the continuation of medical service provided on an individual fee basis for those who prefer the present method. . . .

The AMA "preferred the present method" and, as Stevens notes, "under the watchful eye of the AMA Judicial Council, multispecialist group practice has remained . . . in the background rather than in the vanguard of health services, a possibility rather than the model for organizational reform" (p. 142).

The AMA at that time was also resisting, although it would eventually come to accept, a different approach to health care

financing reform which was to have great influence on the distribution of American health care. It was in 1929 that Baylor University in Dallas, Texas developed the first Blue Cross third-party health insurance plan--the form of health care reimbursement which was to expand and dominate health care payment for the next fifty years.

The AMA's efforts to control the form of medical practice have been reflected in many ways, ranging from peer pressure to extended anti-trust law suits (Goldberg and Greenberg 1977). The goal of the AMA policy has been to prevent as much change as possible.

In 1970, Charles Bornemeier, M.D., president elect of the AMA, speaking at the Chicago Medical Society summarized the policy:

> The physician has been trained in medical school and in his practice to accept change slowly. Until material and methods have been proved to be safe and effective, we consider it dangerous to move too rapidly. If we as doctors grasped each new suggestion before adequate study, we would kill more people than we cure. We have earned the label of conservative and we must continue to wear it wisely and well. (Chicago Medicine 1970).

Furthermore, as Freidson (1970) emphasizes, this policy "is rationalized more on 'ethical' than technical grounds" (p. 31). Notably, while these are descriptive and organizational matters of practice, they are discussed normatively in "The Principles of Medical Ethics" (AMA 1981). Furthermore, although organized medicine officially accepts the general principle of group practice and the use of the insurance principle in financing medical care, its "Principles of Medical Ethics" are predicated on a model of individual rather than cooperative forms of practice, financed on a fee-for-service rather than a prepaid basis (Freidson 1970). In fact, not only in documents but in conversations and interviews with physicians, political issues

of power and resources, i.e., who treats which patients and how are they paid, are considered and discussed as moral issues--issues of good and bad (Anderson et al 1985). Freidson writes: "Much of what has been called 'ethics' and certainly the common rules of etiquette [right and wrong] is designed to prevent 'unfair' internal competition and preserve comparative equality of opportunity in the medical marketplace at the same time as it preserves an impeccable front of silence to the outside world" (Freidson 1975:245).[5]

But physicians have not been the only ones concerned with the form of their practice throughout the century; others have had an important interest in the distribution of medical care also.

Particularly, early in the 1900s, in areas where medical care was not available such as the Northwest, or where large portions of the population could not afford traditional medical care as in eastern cities, alternative forms of practice were sponsored.

ALTERNATIVE FORMS OF MEDICAL PRACTICE

Early in the century companies with many employees particularly in remote areas had an interest in providing medical care to their employees and in controlling the providers. Contracts for industrial practice were developed particularly in the mining and lumbering industries as well as in the railroads. Perhaps the first such medical practice recorded was that of Drs. Thomas Curran and James Yocum in Tacoma, Washington in 1910. They had opened their Western Clinic in 1906 to provide standard fee-for-service care, but four years later, in response to the efforts of mill owners and mill employees, they contracted with the lumber industry to provide medical care for a set

fee of fifty cents per member every month. Prepaid practice was so well received by employers and employees in the Northwest that a Dr. Bridge developed the Bridge Company, a chain of twenty such clinics in Washington and Oregon (Mayer and Mayer 1985). Another historic fee-for-service partnership, which switched to prepayment and served a large employed population, was that of Dr. Donald Ross and H. Clifford Loos. Their Ross-Loos Clinic, in 1929, was asked to serve the Los Angeles Department of Water and Power and, because of the success of that venture, it began to serve other companies in the late 1920s as well.

The economic depression of the late 1920s and early 1930s brought serious financial stress to many families and communities, but it also created a number of cooperative efforts. Certain farmer and consumer cooperatives sponsored prepaid medical plans themselves and then became models for others. Of historic importance was one begun two years before the Ross Loos Clinic, in 1927 in Elk City, Oklahoma. Dr. Michael Shadid, in an effort to build a much needed hospital for the farm community, sold shares in the hospital for $50 each. In 1929, he established the Farmers' Union Cooperative Hospital Association, which became the model for a cooperative movement in medicine" (Kaiser 1978). By 1930, such programs covered over a million employees and an undetermined number of dependents in the West and Northwest. (The resistance to the untraditional efforts of these physicians is a crucial element in this development and will be discussed below.)

It was not only on the frontiers and plains of America that innovative efforts to provide access to health care were developing. In the more densely-populated industrial cities of the East, many

immigrant groups, in an effort to reform the community, developed lodges, mutual aid societies, and fraternal orders, which contracted for medical care for their members. In the first decade of the century, on the Lower East Side of New York City, there were 1,500 to 2,000 societies and benevolent associations (Kaiser 1978:9). In North Adams, Massachusetts, 8,000 of the 22,000 citizens received their care from lodge doctors (Kaiser 1978:9) and, in 1911, a Buffalo, New York medical committee estimated that lodge practice covered 150,000 people (Starr 1982:207).

Other important prepaid groups were begun through urban and rural cooperative societies "as ideological outgrowths of the cooperative health care movement" begun by the Farmers Cooperative Association begun in 1927. Group Health Association of Washington, D.C. began in the East in 1937, and Group Health of Puget Sound began in the Northwest in 1947. By 1949, there were more than 100 health cooperatives in twenty-one states (Kaiser 1978:13).

The most influential employer-sponsored prepaid plans began in 1933 when Dr. Sidney Garfield provided prepaid care for aqueduct workers in the California desert. There he came to the attention of Edgar F. Kaiser who, in 1937, asked Garfield to provide contract care to construction workers and their families at the Grand Coulee Dam. After success there, Kaiser convinced Garfield to provide care for 90,000 workers at the Kaiser shipbuilding yards in the San Francisco Bay area. These were the beginnings of the Kaiser-Permanente Health Care Program, the largest HMO, which in 1986 served over 4.7 million members.

And, on the opposite coast in the mid-1940s, another innovative and dynamic individual was concerned about health care in New York City. Mayor Fiorello LaGuardia initiated a study that resulted in the formation of the Health Insurance Plan of Greater New York--HIP--which now has over 900,000 members. Unions were also responsible for developing prepaid groups, e.g., in 1960 the UAW began Community Health Association in Detroit.

But these prepaid groups, as suggested above, did not develop without conflict or consequence. Many physicians felt threatened and, represented by organized medicine, objected. Discussion of their opposition follows.

OPPOSITION FROM ORGANIZED MEDICINE

In both the West and the East, in urban and in rural settings, organized medicine has consistently opposed contract medical practice throughout this century. Although early in the century medical societies recognized the necessity of the contract practices to remote areas, in other areas they considered it a form of exploitation because it enabled companies to get doctors to bid against each other and drive down the price of their labor" (Starr 1982:203). They fought it. For example, in 1908, the physician who had been the company doctor for Sears Roebuck felt obliged to resign from the company because the Chicago Medical Society had excluded him from membership on the grounds that his service to employees' families constituted "an unethical invasion of private practice" (Starr 1983:203).

The subject evoked considerable controversy and turmoil; only a year earlier a committee of the same Chicago Medical Society had looked

into contract practice and reported that "many of the men working under these contracts are desirous of improving the conditions of things, that they are not wanton violators of ethical codes and that they are willing to cooperate on any amicable solution of the question." Here again one sees that often departures from the norm of private fee-for-service medicine are defined by organized medicine as "unethical."[6]

In addition to censuring these disapproved forms of practice, medical societies in areas like the Pacific Northwest, where contract medicine was especially prevalent, competed by forming their own prepaid plan. Known as medical bureaus, these plans offered care by a member of a local medical society in exchange for a fixed prepayment to the bureau. However, in these plans, individual physicians were paid on a fee-for-service basis and patients were free to choose their own doctor. Thus, organized medicine found a way to perpetuate its ethics and protect its professional interests (Fitzmaurice 1959). (These bureaus were to serve as models and precursors to the contemporary Independent Practice Associations.)

In a case characteristic of this effort to control the medical marketplace, the King County Medical Society of Washington State attempted to both compete with and censure physicians who did not cooperate. Jonathan Tompkins describes these actions in his organizational study of Group Health of Puget Sound (GHPS). In Washington state in 1933, as the County Medical Society recognized the inevitable growth of prepaid medical care, it created a "bureau," the King County Medical Service Corporation. With the open-panel prepaid plan, "the Medical Society retained the usual structure of private

practice, including free choice of physicians, professional control, and fee-for-service reimbursement" (Tompkins 1981).

Tompkins further notes that competition with the closed-panel plans was not the aim of the medical society; rather they intended to eliminate competition. Simultaneous with the creation of the Medical Service Corporation, the medical society changed its bylaws in order to make the "Service Corporation the only health care plan recognized as legitimate by the medical profession." For example, an amended bylaw relating to disciplining of members read:

> A member . . . who shall engage in contract practice unless the same shall previously have been authorized by the Board of Trustees of this Society, or who as physicians or surgeon shall serve on the staff of or perform work for the patients of, or shall perform work in, any institution or group or organization unless such services or work shall previously have been authorized by the Board of Trustees of this Society shall be liable to censure, suspension or expulsion. (Tompkins 1981:49).

This and actions like it led to court cases throughout the country at local, state, and federal levels.

When Group Health of Puget Sound found itself unable to negotiate an end to the blacklisting of its physicians with the King County Medical Society, in 1949 they finally pursued the matter in court. They asked injunctive relief against restraint of trade as the King County Medical Society "acted to discourage prepaid practice to bolster its own monopoly. They lost the suit locally but the state supreme court overturned the lower court ruling" (Tompkins 1982).

GHPS was trying at the State level a case that already had been laboriously won at the national level by the Group Health Association of Washington, D.C. in 1938. In that struggle, Group Health Association (GHAA) battled at first the insurance commissioner of the

District of Columbia, but most importantly the District of Columbia Medical Society, which impeded recruitment of physicians for GHAA staff, limited access to hospitals for physicians in GHAA, and threatened those who already had hospital privileges with expulsion from the medical society (Mayer and Mayer 1985). In one of the "bitterest battles in the history of modern American medicine, the U.S. Supreme Court decided in favor of Group Health." Furthermore, the medical society was indicted for restraint of trade and "once again, organized medicine was facing charges of antitrust violations" (Mayer and Mayer 1985).

However, physicians often claimed that it was not only they who opposed contract practice at some level. For example, the unions, generally favorable toward plans which guarantee comprehensive benefits to workers, mostly distrusted prepaid plans as well as physicians who were directly employed by their companies. They preferred to see private practitioners, particularly in cases of industrial injury and workmen's compensation which had been passed into law in 1908. Union leaders, embroiled in their early battles with industry for the loyalty of the workers, opposed company medical care. For example, "the American Federation of Labor opposed as 'paternalistic' all forms of compulsory medical care through employers" (Starr 1983:203). However, some unions were satisfied to bring prepaid plans under their own control, for example, Union Health Services in Chicago and the UAW's Community Health Association in Detroit.

All in all, the strong views of physicians and the ambivalence of the consumers continued to protect the traditional forms of American

medical practice. In spite of considerable efforts to establish contract practices and medical bureaus, alternative forms of practice were isolated, had little impact and set no precedent for mainstream medicine.

PROFESSIONAL ISSUES OF HISTORIC AND PERPETUAL POLITICAL CONCERN TO THE MEDICAL PROFESSION CONVERGE IN HMOS

Here I want to note that for organized medicine the explicit concerns about group practice and prepaid plans are historically interwoven with a recurring set of political issues that are perceived as issues of medical ethics. These are particularly interesting when considered in the context of HMOs, because although they have been historically problematic in the absence of HMOs, HMOs do raise and aggravate each of these concerns. The issues to be discussed in this section are not only found throughout the historical and sociological literature on the medical profession, but are consistently found in the conversations of physicians who discuss their profession (Anderson et al. 1985). The concerns fall into two categories: 1) issues regarding interactions with those associated with but outside of the profession, and 2) issues with others within the profession. (See Table 3.1.)

Table 3.1

PROFESSIONAL/POLITICAL CONCERNS OF THE MEDICAL PROFESSION

A. EXTERNAL: "ETHICAL" RELATIONSHIPS WITH THIRD PARTIES

1. Physicians should not be employed by:

   a. Lay persons
   b. Hospitals

2. Physicians should not be regulated by government

3. Physicians should supervise all paraprofessionals

B. INTERNAL: AREAS OF "ETHICAL" CONCERNS AMONG PEERS

1. Relationship between primary care physicians and specialty care physicians

2. Appropriate referral patterns

3. Peer review

4. Form of payment

5. Advertising

Regarding the first set of concerns--those outside of the profession--there are a number of areas in which physicians have worked to establish what Starr (1978) calls professional authority or sovereignty. Organized medicine has stated clearly as a first principle that no third party should come between doctor and patient, i.e., that physicians' professional roles cannot be under the authority of others. Thus they oppose interference of three types: (1) they are opposed to physicians working for (a) lay persons or (b) hospitals; and (2) they are also opposed to government regulation of medical practice; or (3) they are opposed to the independent operation or practice of

paraprofessionals, i.e., they must be under the authorization of a physician (AMA 1981).

In the first argument, the medical profession (as represented by organized medicine) asserts that it is unethical for physicians to work for lay persons; only physicians can supervise physicians. This has created a continuing argument against salaried physicians and is to this day an unresolved problem in HMOs with lay board members. Study of consumer-sponsored HMOs suggest that the "interference" of lay persons continues to be considered a problem by physicians. Anderson et al. (1985) report that both physicians and administrators comment without hesitation that only a group made up exclusively of physicians may deal with any professional issues of medical colleagues.

Secondly, there has been an historic if tenuous balance of power between medical staff and hospital administration. The interviews (Anderson et al 1985) suggest that actions by both physicians and hospitals regarding HMOs have been in reaction to real or anticipated behavior on the part of the other. Even in Minnesota, where physicians and hospitals appear to have a history of some cooperation, discussion with physicians regarding their decisions to become participants in HMOs reveals that they felt that, if they did not develop HMOs and participate actively in them, the hospitals would develop HMOs and physicians would be at the mercy of the hospitals.

The second focal point of opposition concerns the historic attitudes of organized medicine toward government regulation of medical care. This has included the AMA's major and successful campaign against national health insurance, as well as opposition to federal grants to HMOS, which I will discuss later. Much of both the explicit

as well as the subtle opposition to HMOs was based on the perception that HMOs were "like socialized medicine" or "a step toward socialized medicine." Freidson (1970:24) summarizes medicine's understanding: "to the extent that medicine is dependent on the state for its position of preeminence it is vulnerable to non-professional or lay controls which are anathema."

Third, physicians have worked since the 1930s to carve out a position vis-a-vis paraprofessionals in which physicians are secure from their potential competition. In the 1930s "non-physician specialists were subordinated to the doctor's authority" (Starr 1982:223) and "their work (now) is given legitimacy (only) in relation to physicians' work" (Freidson 1970). But, here again, in the early 1970s HMOs were raising the spectre of paraprofessionals gaining more status. In 1974, Fuchs wrote optimistically and anticipated that there would be an increased use of "physician extenders" (1974:75). But, in fact, as the perception of a "physician glut" develops in the mid-1980s, paraprofessionals are less needed and the 1981 AMA Conference Guide to Policy and Official Statements (1981:60-62) includes two full pages of cautions, caveats, and instructions regarding physicians' assistants. The present response of physicians to these and other elements of change in health care will be discussed later.

In the early 1970s, the interest of both certain consumers and government in HMOs provoked physicians to think again about protecting their boundaries against external assault. Furthermore, the spectre of HMOs aggravated old problems internal to the profession (see Table 1): 1) competition between primary care physicians and specialty care physicians, 2) appropriate referral patterns, 3) peer review, 4) form

of payment, and 5) advertising. The issues of specialization and the differing--sometimes conflicting--interests of specialists and primary care practitioners are closely connected with the historically volatile issue of referral patterns. The development of HMOs brought out old arguments of "closed panels," "contract medicine," and "fee splitting." It also intensified another aspect of the tension between the specialists and primary care physicians: the differing interests in teaching and nonteaching hospitals (Starr 1982:425). In addition, there had been a longstanding interdiction against advertising--since the AMA decisions of the early 1920s--which has served as another way of controlling competition within the medical profession by prohibiting direct appeals to the public.

It is not difficult to see that in the early 1970s the insertion of HMOs into the health care system would reawaken or keep alive these earlier issues and offend values of the organized medical profession. These historic issues of professional controversy, in fact, converged in HMOs.

With this selective history as background, it is appropriate to consider the case studies including the impact of the medical profession of the Evanston/Chicago community and the Lansing/East Lansing community on the development of the consumer-sponsored HMOs.

END NOTES

1. They were reflecting and repeating an earlier important linguistic policy decision discussed in Chapter 8.

2. The origins of such altered perceptions and ideologies and their role in change is discussed by Morone and by Crawford. They will be discussed further in Chapter 7.

3. Throughout this research and other studies of physician practice and attitudes the importance of wartime for physicians is underscored. The pressures of war have brought about dramatic changes in both the types of medical treatment and the social organization of that treatment. Because American physicians after graduation from medical school have traditionally been largely independent and thus isolated from each other, (except within academic training centers), service in the military has provided them the first opportunity to work collaboratively as mature practitioners learning from each other and optimizing their results (Starr and Stevens). Not only medical and war historians have described this phenomenon, in interviews that I conducted in 1982 and 1983 with physicians about their professional development, they themselves spontaneously harkened back to their war experiences as pivotal in their ideas about ways to practice. However, it is interesting that their decisions about practice as a result has not been uniform; some who found the cooperation practice supportive have chosen group practice; others who found the bureaucracy stifling have become intensely committed to practicing independently (Anderson et al. 1985).

4. The discussion of this committee and quotes of proceedings are based on the report of the Kaiser Foundation 1978: 11.

5. For a provocative and illuminating analogy, see Freidson's discussion of physicians' group protection of their individual independence and autonomy, and similar behavior among delinquent groups of French school children (Crozier and Pitts 1956:242-246).

6. "Economics and the Ethics of Medicine," published by the AMA in 1935, provides another excellent example of the intertwining of the two (Starr 1983:473).

PART III. CONSUMER MOVEMENT IN HMOs, 1970s TO MID-1980s: TWO CASE STUDIES

PART III

CONSUMERS MOVEMENT IN HMOS--1970S TO MID 1980S
TWO CASE STUDIES

INTRODUCTION

> No social study that does not come back to the problems of biography, of history, and of their intersections within a society has completed its intellectual journey.
>
> C.W. Mills

This social study of consumer sponsored HMOs of the early 1970s is best understood as complex intersections of biography and history. The two case studies of HMOs developing in their communities exemplify two such intersections. The biographies are of the founders of the HMOs--NorthCare and Health Central--who were committed to changing health care delivery, and of those in the communities who supported and opposed HMO development. The history is of both national and community concern about health care, and of the medical profession which has traditionally provided it. Both the consumer/founders and the traditional practice of medicine have been changed as they have met at and passed through this historical intersection.

Chapters 4 and 5 together present case studies of NorthCare and Health Central: Chapter 4 discusses the communities--the individuals and institutions that formed the context; and chapter 5 discusses the development of the HMOs themselves--intersections of historical contexts and individual actions. In Chapter 6 I give an "update" to 1986, describing first NorthCare and Health Central, and then the national context of the changing health care system. Part IV, (chapters 7 and 8,) will describe the other side of the intersection-- changes

observed in the consumer/founders and in the traditional practice of medicine and its institutions as a consequence of the participation in and the development of HMOs (or their sequel, "managed care.")

While together Chapters 4 and 5 present the case studies of the HMOs developing as "social movement organizations" (Zald and Ash, 1966), Chapter 4 focuses on the environments, or the community context, in which each of the HMOs developed. Zald and Ash (1966) emphasize the importance of the environment of a developing organization and consider the environment in two segments: 1) the broader group of potential supporters, and 2) the "society in which the social movements exist--the target structure or norms which the social movement wishes to change." Everett Hughes (1957), discussing social movements, also emphasized the importance of environment--particularly those environments from which social movements or other going concerns could get clientele, personnel, financial support, as well as the political environments. Furthermore, in what seems like a clairvoyant remark for this study, Hughes (1957:64) wrote, "Another way of saying environment, I suppose, is to call it a market.... we need more study of this sort of thing, which will, incidentally, be more historical than sociologists are generally inclined to be."

In this study of a social movement in health care, both "market" and history are fundamental. Chapter 4 discusses the community environments--or "market areas for health care--in Evanston, Illinois (within the Chicago metropolitan area) and Lansing, Michigan, as they developed and responded over time. I

consider the environment in seven sectors which interact with health care: consumers (formerly called patients) who use health care; physicians and hospitals, who provide health care; and employers and unions, insurers and government agencies, which pay for and regulate health care (Anderson and Kravitz, 1968; Anderson et al. 1985).

CHAPTER 4

THE COMMUNITY CONTEXT: EARLY 1970s IN CHICAGO, ILLINOIS AND LANSING, MICHIGAN

INTRODUCTION

Chicago, Illinois and Lansing, Michigan provided very different environments for consumers to initiate and develop HMOs. Discussing the environment for such movements Zald and Ash (1966) note the importance of a "strong sentiment base" and "low hostility" toward the movement. In this chapter I will present an overview of the environmental "sentiment", i.e., the support for and opposition to the two developing HMOs in their communities.

Between 1981 and 1983 at the University of Chicago, in a study directed by Professor Odin Anderson, we compared HMO development in two communities, Minneapolis-St. Paul and Chicago (Anderson, et al. 1985). The study demonstrated the importance of the seven sectors of the local community environment, noted above, in the development of HMOs: the consumers, physicians, hospitals, local employers, unions, insurers, and, finally, the regulators of health care.

While Zald and Ash (1966) state that the environment of a social movement divides into supporters, on one hand, and the larger part of the community which is the "target" of the movement, on the other hand, we found that that distinction is not sufficient to predict the support and opposition of HMOs across communities. In one community a sector (e.g., hospitals) may be the source of opposition, while in another a source of support; and in fact, as the reader will see, the most explicit "target" of the social activism, the medical profession,

offered very little response. I will briefly describe each of the communities and then each of the sectors. This will develop a comparative overview for the purpose of answering two general questions: 1) Which elements of their communities supported and opposed NorthCare and Health Central? and 2) What were the consequences of that support or opposition?

This descriptive analysis will reflect some aspects of the social and economic nature of the communities in the mid-1970s and will serve as a base for the discussion of the emergence and the development of NorthCare and Health Central in the next chapter. I also include here appropriate references to Minneapolis-St Paul for the purposes of further comparison with a community which has been a leader and national model for the development of HMOs and presents something of an ideal type. Table 4-1 includes selected comparative social and economic data as background for the discussion that follows.

In Minneapolis-St. Paul, for example, we found that in the population of 2 million people there was relative racial, ethnic, and economic homogeneity. All but 2% of the population was white and mostly of similar Scandinavian or German heritage. The work force is largely white-collar and there is relatively little unemployment, a very small percentage of the population on public aid, and historically plentiful resources. This mixture served as a fertile seedbed for the growth of HMOs in the 1970s.

In contrast, the population of the Chicago metropolitan area of over 7 million people was notably heterogeneous. There was racial, ethnic and economic diversity. Immigrants from other countries as well as other parts of the United states have established boundaried ethnic

communities, often non-English speaking, throughout the city. Almost half of the urban area is non-white and there is a very large blue-collar and unemployed population. While the per capita income is slightly higher than the national average--similar to the Twin Cities metropolitan area-- the numbers of Chicagoans below the poverty level and an even greater number on public assistance (over twice the percentage in the Twin Cities) draws attention to the skewed distribution of resources in the Chicago area.

The Lansing-East Lansing metropolitan area, usually considered a "tri-county area" of three contiguous counties, had a total population of under 400,000 persons. The non-white population had been growing; it doubled between 1960 and 1970 to 4 percent. Two percent of the permanent population was Spanish speaking, and summers brought many migrant workers, largely Spanish speaking, to the area. Per capita income in Lansing was lower than in the urban areas the Twin Cities or Chicago. The numbers below the poverty level and on public assistance were considerably higher than in Minneapolis St. Paul, but distinctly lower than Chicago's. (See Table 4.1 for comparisons of the three communities in the early 1970s.)

Table 4.1

Selected Characteristics of the Three Communities (Early 1970's): Minneapolis-St. Paul, Chicago, Lansing.

Categories	Minneapolis-St. Paul	Chicago	Lansing
Total Population (SMSA), 1970	1,813,647	6,978,947	378,423
% Black (SMSA), 1970	1.8%	17.6%	3.9%
% Black (Urban County),1970	2.4%	21.9%	5.5%
Per Capita Income (Metro Counties), 1974	$5,511	$5,433	$4,321
Families Below Poverty, (SMSA), 1970	4.6%	6.8%	6.1%
% of Individuals on A.F.D.C., (Urban County), 1970	5.0%	11.0%	8.0%
Physician Per 10,000 Population, (SMSA), 1970	152	159	133
Counties Include:	Ramsey Hennepin	Cook Du Page Kane Lake	Ingham Clinton Eaton

Source: U.S. Bureau of the Census, County and City Data Book, 1977. U.S. Government Printing Office, Washington, D.C. 20402;1978.

CONSUMERS

There is general agreement that consumers (called patients until the consumer activism of the early 1970s) are a central part of the health care system in all communities, but there is little agreement about the definition of a health care consumer. For the employer, the employee is the consumer of health care, but for those marketing health care, the employer is the consumer. Others may variously define consumers from their roles as rank and file union members, clients, patients, voters or enrollees. As Luft (1981) notes, "the definition of the consumer is open to various interpretations. Health plans may (even) solicit individuals whom they desire to have serve on their board of directors and offer them health plan memberships, thus classifying them as consumers." In addition to such instrumental perceptions there are distinctions in the ways that consumers behave and define themselves.

Some consumers in Chicago and Lansing, as well as in Minneapolis-St. Paul, are proactive: they have an ideological perspective which is often associated with collectivism--such collectivism emerged in the American farmlands in the early 1900s and spawned grain and dairy cooperatives for both producers and consumers. Such consumer-activists act out of a commitment to certain beliefs and actions. It is from this group that the social activists who founded NorthCare and Health Central came. One Chicago consumer-activist asserted her belief about health, "Health care is NOT like buying a refrigerator." But for other consumers, buying good health care may not seem so different than buying a refrigerator. Their approach to health care is not ideological but simply pragmatic. It may arise out of a specific health care issue

and/or a wish to correct a specific problem, e.g., high cost, poor quality, or inaccessibility. They may not think of themselves as health care consumers until asked to serve on a health care committee. Such a social construction, for example, was established by the federal law that requires 1/3 of an HMO board to be composed of "consumers". This legislation created a new role or reality for those who took such "consumer slots"-- slots in which they would be empowered or coopted. (In Chapter 8 I will discuss the transition from the social activism of the 1960s to consumer activism of the 1970s.)

As a result of my interviews with consumers in the comparative study of Chicago and the Twin Cities, I recognized that consumers can be considered to have two types of roles in facilitating or impeding the development of HMOs: as citizens they both create and reflect the nature and decision-making style of their community; as potential patients they accept or reject the emerging HMO.

Consumers, we found, were in some ways the most, and in others, the least influential of the sectors that we interviewed. That is, the nature of the community--its social history and decision making style helped explain the emergence and development of HMOs in the Twin Cities. The homogeneity, corporate leadership, and commitment to consensual decision-making supported the exceptional early development of HMOs. In Chicago, the heterogeneity, absence of centralized civic leadership, and history of political contention and confrontation inhibited the early spread of the health care innovation in the city as a whole.

In the 1982 study, both communities of consumers seemed strongly influenced by the attitudes of their physicians and of their employers.

The Twin Cities respondents reflected the paternalism of the corporate and largely white-collar employers, and accepted, with confidence, their employers' positive view of HMOs. In Chicago, employees reflected and shared their employers lack of interest in HMOs.

In the Lansing-East Lansing area, the consumers, as employees, were not so much affected by their employers' views as by the views of labor unions. In the highly unionized work force, the support of the UAW, the AFL-CIO and the Michigan State University Employees' Association had a major effect on the exceptionally high early enrollment at Health Central.

PHYSICIANS

American physicians' historic resistance to changes in their own practice and to competition from other health care providers has been discussed earlier. The consequences for medical practice in communities where HMOs, or associated managed care systems have, in fact, changed practice patterns are discussed in Chapter 8. That is, in Minneapolis-St. Paul, although physicians shared the norms and values of the medical profession throughout the United States, they also responded to the norms of their progressive community. There, homogeneity reinforced trust and communication networks in an environment already predisposed to collectivism. Furthermore, HMOs were seen as relevant to their predominant health care problem--escalating costs. (In the affluent and homogeneous community, with an abundance of physicians, access and quality of care were not considered a problem.) The interviews showed also the importance and the predominance of group practice, especially multispecialty group

practice. Where physicians and patients were already accustomed to group practice, HMOs seemed only a change in the payment mechanism. Where group practice was unknown or only associated with "clinics" for the indigent, HMOs met great resistance from physicians and patients alike.

In Chicago, the qualities of cautiousness and traditionalism which are characteristic of the medical profession were intensified by the conservative, fragmented and adversarial nature of the metropolitan area. Despite localized medical resistance or support, the overall result was a virtual absence of impact on HMOs. While some physicians reported "frank reprisals" from physicians against "wayward HMO colleagues" who interrupted the general flow of referrals within the medical community, most physicians interviewed in Chicago in 1982 knew little about HMOs. Furthermore, neither they nor their patients had experience with multispecialty group practice except for those associated with the six competing university medical centers that further fragmented (and continue to fragment) the Chicago medical community. Finally, Chicago physicians, who were concerned about access and quality of care for the large poor inner city population, did not see the relevance of health care plans they associated with the young, the healthy, and the employed. (See number of physicians in the metropolitan area. More recent studies have demonstrated the paucity of physicians in the inner city and the density in the suburbs.)

In the mid to late 1970s most Chicago physicians' general lack of interest in HMOs extended into Evanston. The founders of NorthCare reported no direct opposition or support with the crucial exception of Dr. Arnold Widen whose early and lasting interest has been a critical

factor in NorthCare's development. (In 1986 he was still medical director.) Although Widen does not reflect physicians' attitudes toward HMOs in general, he had a positive effect on physicians' attitudes toward NorthCare. It is interesting to note that in spite of the fact that traditional medical practice was the explicit target of the social movement, there was little friction between the movement founders and physicians themselves. [This is in contrast to other health activism of the time, e.g., the home birth movement, which evoked vehement opposition from physicians (Ruzek 1978)]. The NorthCare founders believe that physicians simply thought they were "crazy ladies'" and did not take them "seriously."

In Lansing, as in Evanston, practicing physicians were slow to take the HMO movement seriously; multispecialty group practice was unknown and physicians practiced alone or in small single specialty groups. Although the two new Michigan State University medical schools, one allopathic and one osteopathic, were reported to have introduced new ideas to the conservative medical community, many practicing physicians had found them threatening. And although the medical schools added numbers to the physicians' census, they provided more teaching than practice and the community ratio of practicing physicians to population remained low. (See Table 4.1; note that the ratio is comparatively low even with university physicians included.)

The medical schools, however, were supportive of the emerging HMO, offering advice and some practical support services on the campus in East Lansing. Furthermore, the dean of the College of Human Medicine assured the HMO founders that the school would provide

specialty medical services when the HMO became operational. The medical schools had a less than naive interest in HMOs; they had considered developing a university HMO but the idea never materialized. Some interested physicians from the two medical schools served on Health Central's board.

The medical schools' response to Health Central was not typical of the physician community. The practicing physicians' attitudes are quintessentially represented by the county medical societies' written responses to Health Central's early request for a statement of support for their feasibility study. The response of the Secretary of the Clinton County Medical Society is so concise that I quote it fully:

> October 1, 1974
>
> Dear Miss Abramson:
>
> The Clinton County Medical Society has received your letter and it was read and discussed by the Clinton County Medical Society.
>
> We find that we have no need for an H.M.O. in this area.
>
> I hope this will answer your request.

Clearly the physicians of Clinton County, located just north of Lansing, had no "felt need" to change their patterns of practice. The president of the Eaton County Medical Society was less terse and more candid. His words represent well those of many physicians whom I interviewed. He speaks not only the conservative view of physicians but of "heartland" Republicans, as well. I excerpt from his letter:

> ....The whole concept of H.M.O. at the present time, I feel, is unwise and unwarranted. The federal government is now spending more money than they are taking in, and thus are contributing immensely to our rate of inflation. H.M.O.s

> across the country, even though guaranteed by the federal government, are in no way breaking even. The government is having to bail them out with tax dollars....I don't think it is right that the federal government should undertake to subsidize this type of private enterprize.
>
> The Eaton County Medical Society would be interested in H.M.O.s on a paying basis, self sustaining. This possibly could be done; and in the future if we find there is an organization which is self-sufficient and standing on its own two feet without the taxpayer's dollar, we would be glad to provide you with any assistance necessary.

The private practitioners whom I interviewed in both Lansing and Chicago often expressed resentment--even hurt--that the federal government would subsidize a competitor. (It seems ironic that both the government and the physicians carried the banner of free enterprise, both claiming the appropriateness of fair competition--but defining it differently.)

The president of the Ingham County Medical Society, representing the most urban of the tri-county physician groups, sent a formal but not unfriendly letter. Representatives of the Ingham County Medical Society, he said, had met about the HMO in March of 1974. They offered to "continue to meet with representatives of HALE at times mutually acceptable." He concluded, "We know you have a long difficult task before you and hope that your problems may be solved speedily."

Just as I observed about the NorthCare founders, in spite of the Health Central consumers' avowed interest in diminishing the power of physicians, their relations with the physicians were not problematic. Both the Ingham County and the Michigan State Medical Societies were basically supportive; their medical journals also discussed the HMO in non-hostile articles.

An early Health Central staff member gave her explanation which mirrored the words of the founder in Evanston:

> There was always rumored hostility from the local medical society but it never materialized. I think because they never took us seriously. They thought we were just flailing at this windmill. If we had been a group of men the project would have been in greater jeopardy. I think they got a lot of giggles...

HOSPITALS

Zald and Ash (1966), writing a decade before the development of NorthCare and Health Central note that such social movement organizations exist "in an environment with other organizations aimed at rather similar goals (which) causes an uneasy alliance but also creates the conditions for inter-organizational competition." With these words they perfectly anticipated the relationship of hospitals and HMOs. Though challenged and changed by HMOs, hospitals cannot fill their beds without them. Although some hospitals at first tried to ignore, then to resist HMOs, others have developed competing HMOs either with their own administrative structure or in a joint-venture with their medical staff. The following descriptions of the community environments will demonstrate the wide range of roles hospitals have played in the development of the consumer sponsored HMOs.

In the model community of the Twin Cities, the hospitals reflect the homogeneity and cooperative history of the community. Until the increased competition of the 1980s, hospital administrators--most trained in the same Minnesota institutions--met together regularly as an association of friends. This environment nurtured HMOs. Furthermore, the early support of the HMO concept by business leaders, legislators, and community groups would have made rejection by hospitals politically

and financially unwise. Therefore, many Minneapolis-St. Paul hospitals gave active or passive support to HMOs including start-up financial and technical support as well as discount and risk-sharing arrangements (Morrison, in Anderson et al. 1985).

In Chicago, hospitals have played a different and dichotomous role in HMO development generally. In the city of neighborhoods and enclaves, hospitals, like churches, have sprouted everywhere. There is little communication or unity among them; in the late 1970s and early 1980s this resulted in a wide range of understandings about HMOs. In fact, interviews with hospital administrators revealed rampant rumors about HMOs. In contrast, however, to the general hospital ignorance of HMOs, two of Chicago's major hospitals have sponsored and developed two of the city's most successful HMOs; ANCHOR, and the Michael Reese Health Plan. Furthermore, and most relevant, Evanston hospital gave advice, support, and credibility to the emerging NorthCare in ways which will be described in the following chapter. Despite the fact that the hospital acted out of self-interest and, in fact, refused to contract with the HMO for a discount, the association with a respected hospital--and implicitly its highly credentialed medical staff--were essential to the development of NorthCare.

In Lansing in the 1970s, the four hospitals--one Catholic, one private osteopathic, one private allopathic, and one county hospital--were amiable competitors. One hospital director told me that the hospital administrators met regularly as colleagues--much like those in the Twin Cities--until the late 1970s, when under the pressure of competition and "strategic plans," a "new guardedness" discontinued their collegial meetings. At first these hospitals paid little

attention to the emerging Health Central. Then, as a community service, the Catholic hospital provided office space for the founders, staff, and volunteers to meet and prepare their federal grant applications. All of the Lansing area hospitals were unfamiliar with HMOs; however, they were willing to sign contracts, but without discounts. The one hospital director recounted his relationship with Health Central:

> They were all delightful people and our working relationship was very good....but then the receivables began to build up to substantial amounts....

Health Central's ultimate financial crisis caused the hospitals to join together as a group to demand and retain a "watch dog" seat on the board of Health Central when it was newly constituted under Blue Cross.

In 1980, in reaction to the competitive pressures, one of the private hospitals in conjunction with a medical staff group began developing a competing IPA, Physicians' Health Plan. (The details and consequences are discussed in Chapter 6.)

EMPLOYERS

United States employers' interest in employee health benefits has been increasing since the early 1940s when federal government policies exempted fringe benefits from wartime wage and price control which provided strong incentives to expand health benefits. Subsequently a post World War II interpretation of the Wagner Act of 1935 encouraged the proliferation of union health insurance plans. Employers have varied in their attention to these benefit plans. However, during the economic recession of the early 1970s, employers throughout the United States became alarmed at the increasing costs of health benefits.

Employers' interest in health benefits is crucial to HMOs because employers are, in fact, the first consumers to whom HMOs must market their plan. Employers act as gatekeepers, and unless they offer a plan to their employees, the employees cannot enroll. Furthermore, as I interviewed employers, benefits managers, and HMO marketing representatives, it became clear that employers are in an excellent position to "sell" a given HMO, a competing health insurance plan, or the company's own self-insurance plan.

In the Twin Cities, the employer community, with leaders from the headquarters of Pillsbury, 3 M, General Mills, Honeywell, and other companies, acted cooperatively and decisively. Employers say that in the early 1970s they became interested in HMOs "more to improve the health care system" than to "get involved in reducing benefit expenditure." (Anderson, et al. 1985). They actively participated in the development of HMOs and encouraged their employees (as noted above) to join them.

In contrast, in Chicago, the large, fragmented, and diffuse business community showed little knowledge of or interest in HMOs until the early 1980s. They adopted a passive role as HMO consumers, responded if they were mandated (under the federal 1973 HMO legislation) to offer an HMO, but did not encourage their employees to enroll. The predominance of many small and medium size businesses scattered over 3724 square miles made it difficult for Chicago HMOs including NorthCare to enroll employees.

In the Lansing area, however, employment is heavily concentrated in three major groups of employers: the auto industry, including General Motors, Oldsmobile, Fisher Body, and Motor Wheel; the State of

Michigan, with nearly 17,000 civil servants and Michigan State University. Nonetheless, the employers themselves did not take an interest in HMOs in the 1970s. Like Chicago, Lansing has little centralized civic leadership. (For example, one community resident complained that when the new Lansing-East Lansing cultural center was built, donors included Ford and Chrysler [from other parts of the state] but not General Motors, the largest employer in the community.)

In spite of employer apathy in Lansing, employees have strong leadership; it comes from organized labor which has had various effects on HMOs in the three communities.

LABOR UNIONS

Health insurance benefits have been an important part of collective bargaining since World War II and organized labor has shown considerable interest in HMOs. The influence of organized labor is found in each of the communities studied.

In Minnesota, trade unions offered ideological and financial support to Group Health Plan in the early 1950s. Actual union enrollment occurred later. Union representatives support and serve on the boards of several Twin Cities HMOs. The unions also gave political support for the 1973 Minnesota HMO legislation.

Labor largely expressed interest in expanded benefits, first dollar coverage, and <u>choice</u>, that is the opportunity to go to a physician of choice in her or his private office, i.e., middle class coverage. Union representatives referred to anything else as a "roll back." Union workers with this viewpoint favor Independent Practice Associations, (IPAs) and Preferred Provider Organizations,

(PPOs) rather than staff model HMOs. This I found strongly expressed when I interviewed labor representatives at union locals.

National labor leaders were early advocates and strong supporters of staff and group model HMOs. Unions have developed their own prepaid plans throughout the United States, and in Detroit the Unions alone and together with Ford Motor Company facilitated the development of HMOs. The Union Health Plan was the first lasting HMO in Chicago, and it was labor that brought pressure on the Illinois legislature to pass the HMO enabling act.

But there are conflicting themes in organized labor's interaction with HMOs and disagreement among different elements of the movement. That is, while labor representatives want to control the costs of medical benefits, they insist on services and products of unionized workers. I witnessed a very angry public confrontation at a labor union luncheon in Chicago at which a speaker talked of using a competitive hospital supplier and a member of the audience raged that the supplier used non-union workers. And, in East Lansing, a union official who is a long-time member of the Health Central board said that there was considerable tension when board members from the unions insisted on installing union-made telephones in the HMO facilities.

In Lansing, unlike Chicago or the Twin Cities, labor was a central, if not the primary source of the consumer-activists' support for their HMO. Although no union representative was among the first initiators of the HMO, the first founders quickly turned to labor (with which most founders shared a Democratic party connection) and found early and lasting support. The union representatives on the first board of Health Central were still on the board in 1986. And organized

labor in Lansing was not only instrumental in the development of Health Central but also in gaining access to employers and encouraging enrollments. The founders were interested to find, however, that local labor support was not sufficient; for permission to enter the plants to recruit members they had to "end up going through the state hierarchy" of the United Auto Workers starting at Solidarity House in Detroit.

INSURERS

Insurers had a mixed, but generally quiet response to the introduction of HMOs in the early 1970s. One industry sponsored public relations agency explained that the insurance industry did not want to present a confrontational image to the public, preferring, rather, to meet potential threats through "negotiation, compromise, and adjustment of its own position." Instead of competing aggressively with HMOs, they maintained the strategy suggested by the following recommendation of the insurance association's Subcommittee on Health Care Delivery of the Committee on Medical Economics in 1969:

> That insurance companies (should) continue to remain abreast of developments in the prepaid group practice field and be prepared to conduct experiments, the purpose of which would be to determine the proper relationship of the industry to this concept....It is important that insurance companies do not place themselves in the position of impeding any such sound developments (Health insurance Association of America, 1969) (Anderson, et al. 1985:213)

Indeed, in the early 1970s the insurance industry made small arrangements--administrative and financial services, including stop-loss insurance and claims processing, and in some cases offered modest amounts of venture capital-- while they proceded to "determine the proper relationship of the industry to this concept...." As Chapters 6 and 8 will demonstrate, their stance in 1986 was very different.

Furthermore, it was with the consumer sponsored HMOs like those of these case studies that they have been "prepared to conduct experiments."

In Chicago three insurance companies helped or negotiated with NorthCare as it developed. Blue Cross of Illinois, headquartered in Chicago, was the most threatened by the changing health insurance market; it offered advice and an alliance but was rebuffed by the consumers who wanted to maintain control. Washington National Insurance Company lent some financial support, and finally Blue Cross of Rockford provided extensive capital in order to have a foothold for competing with Blue Cross of Illinois. They demanded certain controls that would later weaken NorthCare's financial position and make the HMO more vulnerable to the ultimate takeover of Prudential Insurance which was beginning to "experiment" with HMOs throughout the country.

In Lansing, insurers showed no interest in the emerging Health Central. Insurance in the state of Michigan was dominated (and still is) by eight separate licensed Blue Cross corporations; one insurer explained that Michigan regulation is "unfriendly to national companies." Blue Cross had earlier been associated with the early "medicaid HMOs" in Detroit. When in 1979 Health Central needed to be "bailed out" of its financial calamity, Blue Cross resisted. Nonetheless, the executive who was the "key person" to finally accept the responsibility for the Health Central takeover has been rewarded with an executive vice presidency in Blue Cross as Health Central has flourished, expanded, and further secured the giant corporation's position in the state.

REGULATORS

The regulatory sector at both the state and federal level was very involved in the development of the HMOs, first through legislation and then through grant programs. In Chapter 1, I described the Nixon administration's political interest in presenting a viable health program and the federal government's need to contain the costs of the ballooning Medicare and Medicaid programs. In 1973, the federal Health Maintenance Organization Act was passed to make it possible to provide needed assistance to HMOs in the early stages of development. It reduced the many legal, financial, and enrollment barriers that had limited organizations like HMOs in the past. The legislation provided specific supports: those HMOs which were "federally qualified" could "mandate" employers, i.e., any employer with over 25 employees in the HMO's geographical area could be required to offer HMOs as an option to his/her employees. Furthermore, a developing HMO could apply to the federal government for funding for several levels of health plan development. The legislation was innovative in two ways: it was the first federal act with the explicit goal of changing the medical care system in the United States, and it presented a way in which the change was to be accomplished--through competition (Herold, in Anderson et al. 1985).

The legislation, while innovative at the federal level, was in fact, preceded by state legislation for the same purpose in Minnesota. In Minnesota, as a consequence of the distinctive corporate leadership and civic decision-making patterns already described, it was the private sector that initiated the proposal preferential to HMOs, and the public sector that codified and implemented it. Minnesotans

perceive and are proud that they are often ahead of the federal government. Furthermore, two opposing proposals, one for a proprietary HMO bill and another limiting HMOs to non-profit plans were presented to the Minnesota legislature. Supported by Group Health Plan and also by farm, labor and cooperative organizations, the non-profit bill passed, including provisions for consumer representation on the HMO board of directors and primary regulatory authority to the Minnesota Department of Health.

In contrast, in Illinois, where there was little private sector interest in HMOs it was the public sector, the Department of Public Health, that obtained sponsorship for state legislation from the chairman of the Senate Committee on Public Health, Welfare and Safety. The state legislation passed in 1974 following the federal legislation. The sponsor of the bill commented, "since no one in the Senate understood HMOs there was no opposition." In Illinois, separate regulation drafted by the Departments of Insurance and of Public health split the responsibility for HMOs between the two agencies.

In Chicago, where so little was known of HMOs, federal HMO regulations were used by HMOs to bring HMOs to the attention of employers. However, it was not the policy of NorthCare to "mandate" employers to gain enrollees. While NorthCare did not choose to use the clout of government agencies (which often had negative political side-effects), the developing consumers' group did apply for funds to both state and federal agencies; first the Illinois Regional Medical Programs (IRMP) and then the Office of HMOs (OHMO) in The U.S. Department of Health Education and Welfare (HEW). As I will recount in the following chapter, funds granted from IRMP were discontinued when

the Nixon Administration cancelled the program. It was one of many ways in which government agencies proved to be incompetent or unreliable in their relationships with the emerging HMOs. NorthCare, however, served frequently as a model for both state and federal governments of the health care plans they were trying to promote.

In Michigan, too, the state and federal government proudly hailed the development of Health Central. The founders of Health Central had extensive interaction with regulators at many levels. As I will explain in more detail in Chapter 5, Health Central founders' testimony was important in the development of the Michigan HMO Law, which was also meant to facilitate and regulate HMOs. In Michigan, also, the responsibility was divided between the Department of Public Health and the Department of Insurance. The state of Michigan had an early interest in developing prepaid plans and picked up the newly coined name immediately. The Governor of Michigan in his Special Message to the Legislature on Health Care (May 8, 1971) said:

> to hasten the establishment of HMOs in Michigan, I am asking the Office of Comprehensive Health Planning and the Director of the Department of Public Health to develop a state program for health care. The purpose of this program will include the design and encouragement of a health maintenance strategy and action plan.

A Technical Work Group was established pursuant to this message and the announcement attributes the name HMO to the Department of Health Education and Welfare (HEW) in March of 1970." (The new acronym had barely been spoken when it was published by HEW.) A 1971 state document, which I read from the Health Central files, attributes the program to the "health care crisis in America"--1) rising health care costs and 2) maldistribution of health care resources, e.g., manpower

and facilities." I found it interesting that the former executive director had penciled in the margin of the document a supplement to the government's perspective. She wrote, "lack of comprehensive system of health care delivery."

Both the state and federal government applauded, advised, and counseled, with Health Central at regular intervals, but there is clear evidence that their advice (for example about board members and staffing) was illfounded and misleading. Furthermore, they were so eager to see the success that neither the state nor federal regulators saw nor warned of the financial difficulties that were undermining the HMO and about to overwhelm it. Regulators whom I interviewed assured me that the state and federal government had "learned a lot" from the problems of Health Central and that "they do things differently now." (Details of the events are in the following chapter, and analysis of the interaction of government and the consumers' HMO movement is found in the conclusion.)

In sum, the comparison of the seven sectors in the two communities demonstrates certain similarities as well as significant differences in the "sentiment base" (Zald and Ash 1967) i.e., the context of support and opposition for the development of NorthCare and Health Central.

Consumers as a group, with the important exceptions of the activists themselves and their followers, responded to, rather than initiating change in both the Chicago and Lansing areas. In Lansing, however, many participants and much expertise came from Michigan State University in East Lansing, while Northwestern University in Evanston played only a minor role. In both the communities most physicians, it

appears, did not take the consumer movement "seriously." It is interesting and ironic to note that although their profession was the "target" of the consumers' efforts, as individuals they offered no resistance and some, in both communities, offered support.

The hospital context, in contrast, was significantly different in the two communities. Evanston Hospital was the central source of support and legitimation for the NorthCare founders. In Lansing, the hospitals were mostly neutral observers of the Health Central consumers' early efforts. And in neither Chicago or Lansing did employers themselves have an important effect. (This was particularly noteable in comparison to their central role in the Twin Cities.)

Unions, on the other hand, while of little influence on NorthCare, had the most powerful community influence on Health Central. Finally, in both communities, regulators and regulation were integral to the development of the HMOs. The complexities of their role, and the roles of the other sectors will unfold in the next chapter.

CHAPTER FIVE

THE HISTORY AND DEVELOPMENT OF THE HMOs: NORTHCARE AND HEALTH CENTRAL

INTRODUCTION

In this chapter, I trace the development of the two HMOs as social movement organizations. I draw from a range of social movement literature, synthesizing certain elements of the analyses to clarify the largely parallel careers of the two social movement organizations, NorthCare in Chicago, Illinois, and Health Central in Lansing, Michigan.

The development of the HMOs is most clearly and completely described as a combination of 1) social movement stages and interactions which dominated their early years (Spector and Kitsuse 1977; Zald and Ash 1966; Blumer 1971; and Hughes 1957), and 2) the bureaucratic stages of funding and regulatory agencies, which the founders accepted as they institutionalized reform. They first sought personnel and resources to establish their consumer-sponsored health care organization, but once it was created and institutionalized, they focused on organizational maintenance (Zald and Ash 1966, after Michels/Weber model).

The two distinct social movement and bureaucratic periods are manifest in similar ways in the parallel histories of the two HMOs. In both Evanston and in Lansing the founders created consumer groups--Evanston Medical Consumers (EMC) and Health Action League (HALE)--based on, and as a vehicle to foster, their ideological commitment; in both communities consumers sought equitable access to health care, consumer

control in health care, and preventive medical services in a prepaid health plan. These groups "captured the spirit of their time " that health care was a right (Starr 1983:389) and they sought to diminish the power of the medical profession (Ruzek 1978) and create a consumer-physician partnership in place of physician sovereignty.

In both Illinois and Michigan the consumer/founders discovered that to receive government funds to develop their goal the consumer group would have to separate itself organizationally from the HMO they had been working to develop. This separation--the consequence of a federal regulation--marked both in fact and in symbol the change from an ideological movement organization to a bureaucratic and instrumental organization. Thus, ironically, as the social movement organizations began to succeed in establishing their objectives, their goals were institutionalized and bureaucratized in an infant organization which then competed with its own parent organization for attention and resources. EMC spawned North Communities Health Plan (NCHP or "NorthCare") and HALE spawned Health Central. The newly born HMOs became less influenced by the parent organization's ideology and increasingly influenced by the demands of bureaucracy; the original consumer groups exemplified Zald and Ash's description of social movement organizations when their goals have been reached:

> But what happens when the goals of the MO (movement organization) are actually reached; what happens when a law is enacted, a disease is eradicated....or social conditions change thus eliminating the ostensible purpose of the organization? Two major outcomes are possible: New goals are established maintaining the organization or the MO can go out of existence. (p. 333, 1966)

In fact both EMC and HALE did both. First they developed new consumer health goals but soon found that their principle energy had come from the interest in developing the HMO and after some time, each discontinued.

There are a number of important differences in the development of the two HMOs in part because of the different contexts (urban metropolitan Chicago and middle-sized mid-Michigan town) their different sources of support, and the symbolically different historical moments when each emerged--1970 in comparison to 1973. These differences and others will be discussed more extensively later. However, the overriding impression when comparing the histories of the two social movement organizations is of similarity, and in this discussion, similarities dominate.

Both social movement organizations emerged as a result of what Spector and Kitsuse (1977:75) describe as "the activities of individuals or groups making assertions and claims with respect to some putative condition" which they defined as a social problem. They go on to say that the sociologist's task is "to account for the emergence, nature, and maintenance of claims-making and responding activites."

This chapter will describe first the emergence of the movement, the nature of the activists (the early "personnel" drawn from other social activism [Hughes 1957]), and of their claims, as well as their goals, activities, and interactions with individuals and interest groups through which they were legitimated and supported. Blumer (1971) has suggested a series of five stages through which a social problem is defined and a social movement may develop. These provide the useful heuristic which guides the description of the early period of the

consumers' social movement organizations--their stages of 1) emergence, 2) legitimation, 3) mobilization, 4) development of an official plan of action, and 5) implementation of an official plan. These stages are interwoven with important themes of social movement development including the nature of claims made by activists, the recruitment and turnover of personnel and clientele, the sources of financial support, and the influence of the political environment (Hughes 1957).

As the organizations began to develop an official plan they needed increased resources (beyond those that the consumers' best bake sale could provide). Seeking support, the founders (the claimants) were very cautious of professional power (the power of those against whom they made claims [Spector and Kitsuse]) and avoided cooptation by the medical establishment which they wanted to reform. However, in spite of their earlier activist experience, they seemed unaware of the possibility of government and corporate cooptation. To make themselves acceptable to state, federal and private granting agencies, they modified their goals; later, with the funds subsequently awarded to them, they hired staff for the previously all-volunteer social movement organization.

While at first salaried staff shared the ideology of the social movement organization and worked hand-in-hand with the volunteer consumers, over time the staff became increasingly committed to organizational maintenance and bureaucratized the organization in the name of perpetuating it. Furthermore, all of the founders were to some degree professionalized (or coopted) as they worked with the new HMO, and some left the board to serve on the staff. (Others would later serve on the staffs of health care and government organizations

throughout the state and nation institutionalizing and disseminating the reform.)

The two consumer sponsored HMOs appeared to be very successful, but as they became increasingly large and complex organizations, their success brought unintended consequences (Weber 1947). The staffs became larger and more professional and gained increased control of the financial reins of the HMO. Although the consumer boards continued to espouse the original values of the social movement organization, they were increasingly isolated from essential information and control. Finally, in both NorthCare and Health Central (although with different scenarios) an urgent, unescapable need for capital to pay creditors and continue services to members led the consumer sponsored HMOs to vote to sell themselves to major corporations.

The remainder of this chapter describes the individual ways in which the two HMOs followed this pattern from consumer social movement to corporate bureaucracy.

NORTHCARE

NorthCare, a health maintenance organization in the Chicago metropolitan area, began, its founders say, on the swings of a local playground in Evanston, Illinois. This story of the consumer sponsored HMO is based on extensive interviews with its founders, community and health care observers and participants;[1] and documents, including media coverage, that reflected the development of the HMO. The founders' words show that they saw the development of a prepaid group practice as "a solution to certain conditions that they asserted existed" in health

care, and which they defined as a social problem (Spector and Kitsuse 1977:73).

In the case of NorthCare, its founders became active before HMOs were a well known entity, or prepayment an explicit interest of the federal or state governent. Thus, NorthCare developed in its earliest stages, without the bureaucratic and regulatory influence, that affected other HMOs. Health Central, for example, was aware of itself in relation to bureaucratic and regulatory interests at its earliest stages of development.

THE EMERGENCE OF A SOCIAL MOVEMENT:THE ORIGINS AND CLAIMS OF ACTIVISTS

At the Playground

Newspaper accounts and conventional wisdom would describe the beginnings of NorthCare at a kitchen table in Evanston, and indeed much of Northcare developed at kitchen tables. But Carron Maxwell, one of the founders of Northcare recalls:

> I remember the day this came up. We were all at the playground. We had all the kids, and we were sitting around in swings. I was sitting in a swing. The reason I remember is because it seemed to me so astounding that we did it so matter of factly....

The founders were four women in their early thirties with twelve children who lived within two blocks of each other in houses near Northwestern University. Three of their husbands were on the faculty, and they all had college degrees. Three of them had been friends since the early 60's and one, Kate Carey, though originally a Chicagoan, had been living in California with her family and had recently moved back to Evanston.

It was late summer 1970; they all report they were "sitting around talking about life" and their families. Kate said she "could not find a reasonable doctor" and they all said that they hadn't seen a physician recently. "They didn't feel a real need" Kate says, but "knew at some intellectual level that that wasn't smart." In California, for ten years, Kate had been used to being a member of Kaiser (a large prepaid plan then only on the west coast)[2] and she asked "why the hell isn't there anything like that!" Mary Bruglierra describes Kate's frustration: "After Kaiser she came out here and was finding nothing, zero, zip, in Chicago."

Although the others--Carron, Mary Bruglierra, and Patty Crosby--were not yet familiar with prepaid health care, and had not been active in health care issues earlier, they were primarily responsible for their families' health care and they had had extensive experience working together for their families' good.

The most powerful memory for all of them, was their earlier work together in St. Nicolas parish. Patty, Mary, and Carron, and their families had been part of PEG, the Parents Education Group, which for four years in the mid 60's ran programs for parish high school kids who attended public schools. Mary Bruglierra had been the director. Carron explains:

> We became a unit, a group. We began to realize that we were doing all this for high school kids and we had a bunch of babies at home and we weren't doing anything for them. So we started a church. An underground church... Patty Crosby was trained in theology. She was the thought leader.... Everybody in that group (about 25 families) will date things in their life before and after that.

She goes on to make the connection:

> (We) use it as a reference point. THAT was really the backdrop of Northcare. It's hard to make that leap, but it was. Let me tell you what it did. It taught us that you can stand up against a very powerful organization and create an alternative that is meaningful to human beings individually, and that you can take power back from a big organization.

Kate explains that in "making God real to our children, in a non institutional way, (we had learned) to take burdens on to ourselves, not to put them off on others." But, she says, "it was beginning to wane because...the children were growing up. That was beginning to taper off."

They also reported having had a deep commitment of spirit and effort to other social activism of the 1960s: "We marched, sent mailings, gave money, participated in demonstrations locally, though (some of the 25 families) did go to Washington or Selma." Together they developed a food coop and some were active in the Dewey Conference (a group committed to racial integration).

It was with that as "backdrop" that they sat on the swings. Mary Bruglierra told them about an article in the January 1970 Fortune Magazine on "Our Ailing Medical System," which discussed the Kaiser plan, and Kate talked about a book review in the Chicago Sun Times by a local Dr. Mendelson, on comprehensive care. They wondered aloud "why don't we do something like that for us.!"

They all tell with nostalgic amazement how easily they decided:

> "We just decided it was a good thing to do and we would do it."

> "OK, fine, we said, you read this, you read this, then we'll call up this Mendelson person and go down and talk to him. And we did."

Dr. Robert Mendelson invited them to one of his weekly staff meetings which they went to in the winter, and though he himself showed no further interest in the group the meeting began an important series of connections. In Mary Bruglierra's words, "We were dogged by serendipity!" Dr. Judy Benzinger, who had recently finished her residency at Evanston Hospital was there. She said that the group should talk to John McClaren, a vice president at Evanston hospital. She called him and he called Pat Carey with an invitation to the group to meet with him. They would later find out that Evanston Hospital had been "under sharp criticism about not responding to the community, and we were a group of women they could put down in their report."

Networks and Intersecting Interests

Also during the same late summer and fall the consumers came in contact with national models for HMOs as well as local interests under pressure to change. Mary Bruglierra had attended an annual consumer education conference at The University of Chicago's Center for Continuing Education. It was sponsored with a grant from HEW, characteristic of the early 1970's political support for consumer participation. At a panel on prepaid care, Mary, vocal and enthusiastic, met Helen Nelson. Nelson, who was an activist on the boards of the Consumer Union and the Consumer Federation of America, and also the director of the consumer affairs department at the University of Wisconsin invited Mary to a conference in Wisconsin. The brochure for that meeting listed the speakers for that conference, which included Maurice McKay, an honored founder of Group Health of

Minnesota--one of the most successful cooperatives begun in the 1950s--and others successful in prepaid health care. Mary explains :

> With that little green brochure we sat down to call (all the places listed) and we parcelled it out so no one would have too big a phone bill. We said we'll call these people up and ask them what we should do next!

At this point in her description Mary laughed heartily. Carron too was laughing in retrospect as she told about standing in Mary's kitchen and calling the long-time director of Group Health of Puget Sound, in Seattle, Washington with the questionnaire they had "whomped up," They say they asked questions about the size, payment mechanisms, exclusions and coverage (particularly obstetrics), how the plan got started, where the original money had come from and what role consumers played in the plans. Although Kaiser's HMO had been important in their early thoughts, they say that they never called Kaiser because they "focused on consumer model groups."

When I asked them to reflect on what it was during those early months that they wanted to change, they consistently listed what Spector and Kitsuse (1977) would term "putative conditions": 1) insufficient access to primary health care, 2) no way to evaluate or make judgments about the quality of health care, 3) no way to budget for health care, 4) no consumer involvement in health care.

Early in 1971 they had completed their "survey" and accepted the invitation to visit Evanston Hospital where they met with administrators Joseph Turenzio, who had been president of the hospital for six months; Ernest Libman, director of planning; and John McClaren a vice-president of the hospital who had called to invite them. In spring of 1971, all three were very interested in this group. The

hospital had been feeling pressure from the outside community to involve consumers, and within the hospital there was considerable tension between the hospital adminstration and the staff physicians over the consolidation of programs that brought together "poor people and private paying patients."

There were a number of problems. One founder asserted, "Joe Turenzio really only liked New York and he didn't think much of doctors." Libman was described as "a sort of 'new type' who cultivated the image of an acceptable maverick," had not long before run a sensitivity session with the hospital employees where he had "raised a few peoples' consciousness (about racism) and made <u>everyone</u> mad." Another founder offered her explanation for their welcome at the hospital:

> (while there was a lot of pressure to respond to consumers,) it was unusual at that time (in Evanston) to have middle class consumers. We were verbal and we weren't mau maus.

Another founder said that McClaren, a physician who had taken the administrative job after recuperating from a serious illness, was helpful because "he was bored and we were an interesting group--if you had to choose between us and drug salesmen." Libman was particularly helpful. He offered them space, a secretary to type letters, a phone and access to the library.

The administrators perhaps relieved that there were activists whom they found it comfortable to work with asked the four women to write a position paper and to meet with a committee of the Evanston Hospital physicians.

LEGITIMATION: AN ARENA FOR CLAIMS AND GOALS

The Evanston Hospital and its physicians offered two important elements to the budding social movement organization: 1) an arena in which the activists could make their "claims" against physicians,(the "recipients of the claim" [Spector and Kitsuse 1977:79-85] and 2) "social legitimacy"--"the necessary degree of respectibility which entitle(d) (the social movement organization) to consideration in the recognized arenas of public discussion" (Blumer 1971:303).

Everyone involved would remember this meeting as pivotal for three reasons: 1) they confronted the skeptical medical establishment; 2)they set down in writing for the first time their Philosophies and Principles; and 3) they met Dr. Arnold Widen, who would become their partner in the development of their dream as well as the launching and managing of the HMO.

McClaren had arranged the meeting with physicians from a number of specialties including obstetrics, surgery, and internal medicine. Mary remembers that the women "walked in and were met by awful faces--suspicion." It was not until later that they would hear about the more general problems and physicians' distrust of consumer groups, but the physicians were not pleased with the women's presentation. Carron recalled

> When we sat down with the doctors and told them we wanted some control over our health care they were absolutely beside themselves; we have the best health system in the world, they said. They were affronted.

In part the physicians were affronted by the written statement of their "Philosophies and Principles" that the consumers brought with them. Although these founders now all laugh at the naivete reflected in the

statement, it provides an excellent summary of their ideology and understanding at the time, including evidence of their commitment to challenge professional dominance (Freidson 1975; Starr 1983).

Philosophies and Principles

1. Quality health care is a human right. No human being is to be penalized for his ill-health.

2. Medical consumers are partners with the physician member in their own health care and maintenance. The partnership is one of equality and cooperation.

3. Physician members of this cooperative shall be freed to practice and deliver the best possible medical care. They shall not perform non-medical tasks.

4. Paramedical personnel will be trained and employed for all appropriate tasks, and clerical and/or volunteer help be made available for record keeping, report forms and similar routine functions.

5. A family health cooperative is concerned with the well-being of the whole person. Accordingly, health team members will be responsible for follow-up contact with all patients and for house calls where necessary and desireable.

Dr. Arnold Widen, the internist at the meeting recalls the meeting as as "disaster." "The women had written up a manifesto!" But he was not affronted; rather, he was interested in their ideas. Carron recalls:

> He was provoked and he followed us out of the meeting meeting,"now don't get mad; don't get mad. You people use all the wrong words."

Not only was Widen interested, he was eager to help. So Carron and Widen "spent four hours the next Sunday night rewriting that thing--fighting over every line."

Widen would prove to be another of the "personnel" important to NorthCare, who had been strongly affected by the social activism of the 60's. One founder described this upper middle class Jewish physician as

a "man with a strong social sense" who had "been looking for a cause all of his life" and was "slightly embarrassed by his own success."

It is important to note that although the consumers were making claims against physicians, they were challenging not the principles of medicine nor any individual physicians, but rather the power of the profession to control the delivery of health care. They were not a group demanding alternative therapies (e.g. natureopathy or homeopathy) and they needed some aspect of the medical profession to legimate their efforts. They recognized that Arnold Widen's interest in them was "critical."

> We would have needed a medical physician to do anything and not only was he a physician, he was a peer among peers--very well thought of ... That which we had thought would be the most difficult came to us the most readily.

With Widen's help they modified their written statement to develop a "workable" proposal. They were already changing the language of their claims.

MOBILIZATION: DEVELOPING A MEMBERSHIP (CLIENTELE) AND BEGINNING THE SEARCH FOR FINANCIAL SUPPORT

In the spring and summer of 1971 things seemed to happen quickly. With the sense that they were legitimate, the four began to develop a consumer group i.e., to reach out to a new clientele (Hughes, 1957, 1984:63):

> We were having ten to twelve meetings a week.--the Association of University Women, the PTA, the health department people, others from the union, a book discussion group, agroup of teachers... Each one of us would take turns. There were 25 families (from the earlier church group) so (there was always someone) you could drop your kids off with.

They would later summarize that period in a grant application:

> NCHP took its idea into the Evanston community. Representatives spoke at nearly 100 meetings of neighborhood, fraternal and civic associations, and through this process more than 600 dues-paying members were recruited to the organization.
>
> [...the application for an Initial Development grant]

Near that same time the hospital paid for the four consumers, McClaren, and Libman, to attend the Group Health of America Asssociation (GHAA) annual meeting in June of 1971. There, Mary remembers, in the lobby of the Shoreham hotel in Washington, they met Morton Creditor, the director of the ILLinois Regional Medical Program (IRMP). At that expansive time, when there was considerable support for consumerism, IRMP was "taking their mandate broadly" and funding a number of alternative delivery mechanisms. They had not had any applications however, from HMOs (which were only just becoming heard of nationally), and Creditor encouraged the women to apply for a grant. (IRMP would later respond to the application with $47,800 to study the feasibility of an HMO over a two-year period beginning September 1972.)

In order to be able to receive funds, the activists incorporated as Evanston Medical Consumers, and applied for tax-exempt 501(c)(3) status from the Internal Revenue Service. They then selected an advisory board --"like minded people"--from among their own friends and associates. (About half were from the network of 25 families who had earlier created the alternative Catholic church group.) They also asked Arnie Widen to be on the board. Although his peers "gave him a tough time," they say he responded: "thought you would never ask." At this point the organization began to professionalize but carefully

maintained and emphasised the cooperative, volunteer, family, and community ideology. They say they realized that they needed space "other than our homes, though we brought the kids with us." The Democratic party in Evanston lent them a corner of their large loft space. It was next to a dance studio and they all recall the thumping and shaking from the ballet and jazz classes. Still holding a very local, volunteer, perception of themselves, they charged $3 dues for the growing membership and with that paid for printed stationery and a telephone. They bought a desk for $10 and took turns staffing the office, watching each other's kids, and talking in the community.

During this period, the founders had increasing numbers of professional encounters. They were invited to attend Illinois Hospital Association Meetings, which, along with their office, made them more visible. The Chicago Tribune published an extensive article on "the housewives" complete with pictures of their husbands moving furniture into the new office.

At their office they were visited by health care administrators and entrepreneurs inviting their support or affiliation, but they adamently protected their ideology:

> Merv Shallowitz came to our office to offer us the chance to join Intergroup (a group being formed under the control of physicians)...(He wondered why we were getting all the publicity) We could have what we wanted, he said, a prepaid group plan. We said NO; we wanted a consumer owned prepaid health plan. It was different. Basically different; we never talked to him again....

Blue Cross and Washington National Insurance Company also visited them.

> That was a dance with those two. They couldn't understand those zany ladies in the board rooms. Blue Cross saw the prestigious group from the Northshore as a future Co-care (a satellite health center for Blue Cross.)

By then the founders, now including Dr. "Arnie" Widen, were recruiting both board members (personnel) and consumer members (clientele) wherever they could. They held board meetings in alternative spots throughout the community, increasing visibility and affiliations. They got support from the community's "Black hospital" but found that St. Francis, the Catholic hospital, was not interested in their activities. A St. Francis hospital administrator advised the founders that "their doctors saw the plan to put up a professional building as close to a communist plot, so it (the plan for an HMO) would fall on deaf ears."

Arnie Widen "buttonholed" physicians, some of whom were his own patients, to support the HMO and commit to being staff physicians when it opened. Some, he says questioned his sanity. "They didn't think it was going to fly." He did, however, and accepted the role of Medical Director for the planned-for HMO. The founders all spoke with great admiration of his "courage" and willingness to stand up against "a lot of (negative) reaction from his peers...a lot of pressure."

FORMATION OF AN OFFICIAL PLAN OF ACTION

Issues of Ideology and the Press of Practical Matters

Although the founders had accepted certain compromises from the start without particularly noting them, in 1973 they were confronted with practical problems that explicitly tested their ideology. Funding their goal was becoming a problem. The Regional Medical Programs had been discontinued by the Nixon administration and their funding from IRMP was cut off $7000 short of the grant they had been promised. Kate Carey heard of, and wrote a grant for, the Robert Wood Johnson foundation, which would supply much needed funds at the end of the

year, but every other solution, with other insurance companies, threatened compromise of their ideology. CNA insurance company had an independent practice association (IPA) operating, but the consumers were "wary of giving up the staff and group models." They also negotiated with Washington National Insurance Company and Blue Cross to possibly develop "cooperative marketing and a joint benefit package." But although Washington National did give them some financial support and Blue Cross offered important advice, they explain:

> We felt we couldn't go with Blue Cross because we would be giving away the consumer element. Washington National ...disappeared from the picture and we had to explore other possibilities. We had no collateral. We even thought of getting money from the members like Puget Sound (an early cooperative health plan in Washington state). But things had become too expensive. It was no longer like the early days of the Puget Sound Coop.

It is important to note here that while Puget Sound and other cooperative prepaid health plans were the ideological models for the consumers, the political and health economy had changed dramatically since the 1950s when the earlier plans had been established, and there were no models or mechanisms for consumers to begin a plan independently.

They began to realize that in spite of their efforts to be known in the community, they had not established ties among employers. (This association was commonly "neglected" or "avoided" in ideological consumer groups at that time, including Health Central.) "On the board we didn't have ANY busines poeple, zip, zero." In an effort to be more practical and to move on with the feasibility study, in the summer of 1973 they added an important new dimension -- "the second wave of founders."

Four new "housewives" were recruited at $25 a week to do a marketing analysis--calling employers to ask about their understanding of and interest in HMOs. They also surveyed other communities. Two important issues of ideology are reflected in this period. In a commitment to cooperation and to avoiding hierarchy, the four were all hired as "associate marketing directors" with no individual in charge. In their interviews, each of the four commented on that decision and all felt that they were effective as a "team" and had had a very productive summer.

Some of the information they gathered in their surveys raised another important issue for the consumers. They found that in the employers' minds, the group was too exclusively identified with Evanston. They would have to change their name.

> It was a real loss,...we had a terrible time...an hour discussion at the board level, and then we changed the name.

This name change, to North Communities Health Plan (NCHP), was an early (and painful) sign of a changing identity. Fall of 1973 brought more changes, and another loss. Patty Crosby, one of the original four, moved out of the state. At about the same time there was a sigificant financial gain. The Robert Wood Johnson Foundation provided $88,000 for community education and planning and promised another $100,000 in matching funds.[3]

IMPLEMENTATION OF THE OFFICIAL PLAN: THE TENSION BETWEEN IDEOLOGY AND BUREACRACY

Now with ample funding--further contributions from the Chicago Community Trust and an anonymous donor had brought them close to $100,000 matching funds--they did not want to lose momentum. They felt

they needed to be more professional. They moved to a new office and looked for a director with the right "credentials:"

> We thought we should look for a man...you know, because of the reception of "the housewives"...Carron didn't have her MBA then, and we didn't have much place to go for help.

The man they found stayed only three months ("It was not what he thought") and Kate Carey and Mary Brugglierra took on the responsibilities and shared the salary of executive director. The summer "module of housewives" became a "marketing staff"

> "retained on a permanent basis to assume responsibility for developing an enrollment strategy and for maintaining and expanding employer and community contacts.

The Language of Bureaucracy and Business

The quote which describes the four women hired as associate directors of marketing, is useful not only for its content but for its form. It indicates the changes that were occuring in the consumers group. It is an exerpt from an application to HEW for grant support of initial development cost. As soon as the Federal HMO Assistance Act was signed at the end of 1973, The consumers submitted the grant for NCHP. Their application is evidence of Blumer's (1971) observation that "outsiders...begin to influence the framing of the problem". The language is an abrupt change from earlier written material and the consumers' spoken language. It is characteristic of the passive voice and marketing jargon ("enrollment strategy") throughout the application and indicates the pressures internalized by the consumers to professionalize.

Mixed Commitments and Interests

Nonetheless, the consumer/founders maintained their excitement and commitment to a consumer controlled non-hierarchical partnership in health care. The administrative staff of the health plan was selected from committed activists in their fields. In an effort to avoid hierarchy and emphasize the power of the consumer board, in place of one executive director, the founders appointed three administrators as a triumvirate. Bernie Libman, "bright, innovative and zany, willing to try anything", formerly at Evanston hospital was appointed executive director; Arnie Widen, medical director; and to emphasize the equal role of nurse practitioners and other health professionals, Lynn Sinclair as Health Associates Director. Each reported to the board. A founder recalled, "We liked the idea of a troika; no one wanted to be head honcho; it was a team effort."

In 1974, professionals were hired for legal counsel and for a number of "consultative services," but the consumers' original ideals were strongly evident. Even in the bureaucratic and jargon-filled application to the federal government they reiterated their concerns about community needs "...the special problems of the poor and the elderly, as well as the middle class resident also burdened ...by inaccessibility." The line was hard to hold however; they began the same Narrative Statement by including, in a revisionist form, the government's contemporary concerns as if they had been their own from the start:

> "NCHP was initiated in 1971 by a group of Evanston residents concerned with the unbudgetable high cost and inaccessibility of personal health care.

Although the activists in 1974 were being pulled between the interests of the funders and their original commitments, they remained very active as a board. They developed several strong productive volunteer committees: Medical Services, Physician Recruitment, Benefits, Personnel, and Member Satisfaction.

In June of 1974 Widen became full time with NCHP and soon after they received a $270,000 Initial development loan from the federal government to support them through the ten months prior to "start-up." They needed additional support and arrangements with an insurer. Again their interests intersected the interests of other groups. Libman began to talk with Rockford Blue Cross which was "interested in going to war" with Chicago Blue Cross and saw Northcare as a means to break into the Chicago market. "They were `up front' that they intended to make it on the tails of NorthCare." Rockford Blue Cross loaned NorthCare $1.3 million which enabled them to become operational. November 14, 1974 Northcare was chartered by the State of Illinois and shortly after it received federal qualification. It was the second HMO in the US to be federally qualified, and the first in the Chicago area. (By 1975, there were five other HMOs in the area, two sponsored by hospitals in response to the demand of their unions, another sponsored by a union, one by Blue Cross and another by a physicians' group.)

ENROLLMENT AND START-UP: THE TEST AND CONSEQUENCE OF IDEOLOGY

Federal regulations had important structuring effects on the developing HMOs. They required that the health plan, when operational, and the sponsoring consumers group have separate boards. This had important symbolic and practical effects. The health plan was able to

provide service but could not receive educational funds. The reverse was true for the consumers' group--then called a foundation. It would later sell its name to the health plan for a symbolic dollar and change its name to Consumers Health Group (CHP)--another identity change.

Some of the founders I interviewed saw the different functions as a reason for the two groups to work together closely; others saw it as a crucial rift between ideology and practice. Some consumers held positions on both boards; ten board positions overall overlapped. Others remained on the board of CHP which sought new arenas for its commitments, such as school health programs, education, senior citizens health, but "went out of business" in 1982.

It is characteristic of social movements that personnel change as the movement is institutionalized. Some are innovators; others are implementors; some begin as innovators and become implementors. For example, Mary Brugliera was the board member assigned to recruit Northcare's "member representative" who would be responsible for complaints and grievances. In 1975 when she still had not found an appropriate candidate, "Libman said `you do it'" and she accepted the position, resigning from the board and joining the staff in October 1975.

The new board of Northcare was different: "New people had been added, powerful employer groups, VPs, etc, " and three seats belonged to Rockford Blue Cross. But the consumers who remained on the board say "...the dominant strain was still the ideological bent of the original group." And indeed the enrollment process for the opening HMO supports that claim.

By March of 1975, members were waiting for enrollment. One founder summarized everyone's recollection and the board's view:

> We had a collection of 700 or 800 members who wanted to join; now there were new (federal) provisions by which HMOs could get a waiver of open enrollment[4], but we were committed to those who had been faithful to our cause.

That commitment would be costly. After the open enrollment in March, when the doors opened May 1, 1975 1200 people were waiting for appointments, "many of them sick as hell." Of the over 2000 enrollees 1200 were open enrollees who had come in under no medical exclusions. Some of them were the medical director, Dr. Widen's, patients who were very sick. In fact, the board had determined that the enrollment site should be accessible to those in wheel chairs and some patients enrolled while on passes from the hospital! This very sick population--an "adverse selection" of patients--was said to be the beginning of persistent financial problems for the new HMO.[5] I will discuss this commitment found in both NorthCare and Health Central in Chapter 7.

In thirteen months, the HMO had used up the Rockford money budgeted for three years; they had been obliged to raise the premiums and to limit the psychiatric benefits. And while they held an open enrollment in 1976, this time they required a "health statement" from new enrollees. An early consumer, now professionalized (note choice of language), looked back:

> As we looked at the financial statement we were a disaster. We had borrowed heavily into Rockford Blue Cross and federal loans. There was poor control of utilization in those days, part time doctors...they had an excellent reputation. We were caught between a rock and a hard place.
>
> We needed the credibility of Evanston hospital and the private docs to enroll people, but they were used to practicing in their own traditional (costly) way...

The consumers, at that time, did not recognize the seriousness of the financial difficulty, but it is important and interesting to note that while the HMO would soon prove to be seriously unstable in 1977, outside examining agencies did not recognize the problems either. In 1976 the Illinois Dept of Public Health certified that Northcare satisfied their requirements, and an independent study done for the Teamsters by InterStudy, a health policy think tank, gave a very positive report, concluding, "InterStudy highly recommends the North Communities Health Plan, Inc. to potential consumers." The same difficulty in predicting problems occurred in the case of Health Central; it seems to have been a systematic problem early in the development of HMOs, and a way in which regulatory and advisory agencies failed to serve the HMOs well.

FINANCIAL CRISIS: RESTRUCTURING FOR ORGANIZATIONAL MAINTENANCE

In Spring of 1977, in spite of appearances, the HMO was in serious financial distress. Those I interviewed attributed it to a combination of costly part-time physicians, inexperienced financial management, growth in membership, and high referral and hospital costs, (Evanston hospital never gave the HMO a discount). The second executive director in two years was terminated and Arnold Widen, the medical director--the only staff member who had continuity with the organization and strong leadership within it-- was named the Acting Executive Director. The Executive Director was able to obtain $10,000 from an officer of Blue Cross to hire a consultant to make recommendations to the board.

The resulting "Getty's Report' recommended changes in the health center and the board of trustees which were both substantial and powerfully symbolic. Many of the changes were implemented, including the discontinuation of open enrollment. The incumbent trustees of the board were asked to submit resignations as a sign of good faith to the regulatory agencies that were now concerned about the HMO's stability.

The majority submitted their resignations and the board was reconfigured. In place of those with the early ideological commitments the board consisted of vice presidents and other senior figures in Chicago businesses. Three members from the old board "remained for continuity." Although the organization maintained its name and major staff, interviews suggest that this restructuring alienated those who had been principally identified with the early consumer goals and was for them the significant step toward what would become the approaching corporatization of the HMO.

Although the Getty's report had emphasised that an infusion of capital would not be sufficient itself, capital was still essential. In 1978 the HMO sought federal loans but for an extended time Rockford Blue Cross exercised its right to veto outside loans to the HMO.

During 1979 and 1980, the new executive director (Ron Lodder) attempted to arrange an affiliation that would provide more capital for the marginal organization. He negotiated with Kaiser Permanente for 1 1/2 years. But Kaiser Permanente, they said, was under retrenchment and although NorthCare had "understood that the vote was a shoo-in," the acquisition lost on a split vote. The executive director was stressed not only by the need to find additional capital but also by tensions with the medical group. Characteristic of physician groups,

they resisted the executive director's efforts to centralize management and impose performance requirements on the medical group. In the summer the executive director resigned.

THE COMING OF THE CORPORATION

Late in 1980, Arnold Widen attended a meeting of HMO medical directors and the board of GHAA where he met and talked with the president of Prucare, who was interested in "getting into a northern Industrial city". Widen says he suggested that Prucare talk with the NorthCare board. In January, Prudential executives visited NorthCare and in April proposed acquisition. This created a powerful ideological split, still discussed, although with less heat, six years later. Some founders and board members felt that too much of the "deal" had been arranged among the physicians before it was brought to the board. Others, the consumers especially, strongly distrusted for-profit health care organizations. One founder later wrote a summary of one last argument to protect consumer ideology:

> Three consumer members protested, citing conflict with the history and original goals of the HMO, particularly its long commitment to consumer governance and member control of the grievance process. A proposal was made by these members to require that within any agreement with Prudential, a member controlled local advisory group be set up empowered to adjudicate local member grievances. This motion was defeated by a majority of the Board...claiming the membership could adequately express their will through the voting process.

On April 6, a letter was sent to the 20,000 members telling of the proposed acquisition and announcing three open meetings for discussion at the end of April. The disagreement was bitter and the media covered it extensively while proxies were sent for a membership vote. Those who opposed the acquisition complained that NorthCare staff encouraged

patients to vote for the acquisition. Those in favor of the acquisition said it was the only way to save the HMO and serve the membership.

The staff (who predictably would be invested in organizational maintenance) were not, however, the only participants who favored the acquisition. On May 11, 1981 over one-third of those eligible voted overwhelmingly in favor of acquisition. As one opponent of acquisition ruefully wrote: "It represented the promise of unlimited expansion, as well as an association with one of the most stable sources of capital in the world." And as Starr (1982) suggests, it represented the "coming of the corporation" to American medicine in the 1980's.

HEALTH CENTRAL

It was a rumor about the old East Lansing Post Office that would lead a group of Lansing and East Lansing social activists to define a social problem and create a social movement organization to solve it. This story of the development of Health Central in Lansing, Michigan is well documented in newsletters, committee meeting minutes, grant applications, legislative documents, contracts, and newspaper accounts, but the emergence and the earliest development of the idea, and of the "claims making activities" (Spector and Kitsuse 1977) are best discovered in the recollections of the earliest actors.

The interviews show that the idea emerged from the interests, earlier experience, and convictions of the activists. But for the founders of Health Central in 1973, unlike for the founders of NorthCare in 1970, there was a ready stream of information formulated about prepaid plans, already called HMOs. Although the Health Central

founders sought models like NorthCare, Group Health of Puget Sound, and other ideologically founded, consumer-controlled plans, the historical moment placed them more quickly into the arenas of bureaucracy and regulation. Thus the recounting of the development of Health Central will move methodically from kitchen tables and borrowed offices through the chambers of the state legislature and more quickly--albeit reluctantly-- to the corporate board rooms.

COLLECTIVE DEFINITION OF A SOCIAL PROBLEM AND THE EMERGENCE OF A SOCIAL MOVEMENT: A RUMOR AND CLAIMS

Late in 1972 the rumor developed that the old East Lansing Post office was available for a symbolic dollar a year to a worthy community group. It is Barbara Green who remembers the beginning of the story. She had moved to East Lansing in 1970 from Detroit where she had been part of the community of social activists opposing the war in Viet Nam. In East Lansing she became part of the Lansing Area Peace Group, and it was a member of that group who called her with the "news" of the post office. They called a meeting and a group of five people gathered at Eleanor Holbrook's house to discuss the opportunity: Eleanor Holbrook, an active local Democrat, nurse, and realtor; George Griffiths, a city council member; Richard Conlin who was about to run for Public office; Sally Schlegel from the Women's International for Peace and Freedom, and Barbara Green.

I quote here fully from Barbara's description of the meeting because it includes important elements of the movement about to develop: 1) it indicates the importance of the activists' past relationships, 2) it exemplifies "claims" emerging about "putative conditions", and 3) it clearly identifies the activists' original

"value oriented interests in others -- the people" (Spector and Kitsuse 1977), and 4) one also sees the selection of physicians as the "target" (Zald and Ash 1966). The activists' values are comparable to those just discussed among NorthCare founders, and they undergo similar pressures and revisions in the course of the HMO development. The founder said:

> We all had this "community-action-peace-activist bond; we asked ourselves: "what does this community need." We all concluded that there were a lot of people who didn't have access to health care, ...students who stayed on (after graduating from the university), thousands of kids of students,. (She spoke with increasing animation.) One of the group worked at the DEC (Drug Education Center in East Lansing) and knew there was no care for those students. They would have a terrible time--just terrible. At the same time, it seems to me, there was a big push by the local medical society to get doctors not to accept Medicaid patients so there was a sense that the poor were lacking resources; it was not just East Lansing Hippies that were imperiled. We knew we were looking for health care but we didn't know what kind. (Here BG shifts in her chair and looks very intense.) We didn't know the needs of the people, but we knew it wasn't for just more of the same. We knew we didn't want just more docs.

Shortly after, a slightly larger meeting was held at Barbara Green's house to decide what to do with the old Post office. Jim Ward, also a community activist who had been on the health Economics committee of the area's Health Planning Agency (CACHPA), was invited and described the participants:

> Bob Carr (a congressman) was there, Lynn Johndahl (a state legislator) was there, George Griffiths who was soon to be mayor was there; (all Democratic party politicians) I didn't know any of them then...(perhaps) union people. Certainly university people...

And he restated the early ideology:

> Being a community group they wanted to make it into a sort of clinic for people who couldn't afford it, for students and that sort....regardless of age or ability to pay. To a lot of people in that group it was an important issue.

In sum, he said they were

> .... just an odds-lot collection of people, mostly Democrats; ... at Barbara Green's house convinced that medical care in the community was lacking.

Here Jim Ward, who became a central founder, identified a conviction that was emerging in the community about insufficient access to care. Unlike NorthCare's community, in fact in Lansing there was a low density of practicing physicians (see Table 4.1).

He continued:

> There were not enough providers. That was an intuitive thing that seemed to be known by a lot of people. You couldn't get an obstetrician; it was tough to get a pediatrician; you had to... everybody had to use the emergency room at that time. You just couldn't get access.

He reflected for a moment about his perspective and continued insightfully:

> But that was more of an undercurrent at that time. It wasn't an explicit thing; it became a more and more explicit as we went on.

And just as soon as the group defined health care as a problem in the area, they discovered that the availability of the post office had been a rumor. But as Green would write five years later, "by the time we discovered the dollar-a-year rumor was false, we were on our way!" (Hale Newsletter June, 1977). But of the "original group" of five, Barbara Green was the only one who could continue. The others remained supportive but their activities (and life stages) took them to other responsibilities or other countries. Jim Ward, however, and others drawn to the cause in the summer of 1973, would , with Barbara,

develop their idea and gather promises to support it. That summer, on the Michigan State University campus, Barbara "researched the possibilities, and tapped into a network of support and information. She explained:

> a friend and neighbor said we could use the PIRGIM (Public Interest Research Group in Michigan) office on the MSU campus--the telephone, the typewriter, xerox, paper and everything else, and Bill Given's name was given to me at OSHER (The Office of Health Service Education Research). He had drawers full of information on HMOs from all over--Interstudy; the one in Columbia, Maryland; Kaiser Permanente; a plan in Rochester; and a think-tank in Minneapolis, led by a guy named Walt McClure.

Networks and Models

Like the founders of NorthCare, the activists were excited to find that the idea had a history and a growing literature, including the influential early and excellent review of the concept in the Harvard Law Review (1971).

In the university community, the word spread. For example, the chairperson of the Visiting Nurses Association became active, and she interested her husband who was a state representative also concerned with health services. The two leaders described the building momentum and their personal motivation:

Barbara: What is so wonderful; there are always like-minded people. It's incredible--really marvelous...and Jim Ward was one...

Jim: It was a new concept; it was a frontier concept,and I'm always interested in working on that frontier of organizations.

It is important to observe here that with different motivations and in an environment in which the actual access to health care, though deficient, had not significantly changed, the social movement

gathered momentum as they saw "the availability if not the promise of.... reforms and solutions..." (Spector and Kitsuse 1977:84).

Although the sources of support of the Michigan founders were different than those of the NorthCare founders, their tactics were similar; from the PIRGIM office Barbara called "every known office of HMOs." They connected to important sources in their own community, also. Nancy Koert, then with the State of Michigan in the Department of Social Service, was important because she brought expertise from Minneapolis where she had important experience with Group Health, one of the best known consumer sponsored HMOs established in the early 1950s.[6]

In spite of a warm interest in the consumer group and her advocacy of health maintenance organizations as an alternative health care delivery system, Nancy chose to maintain only a professional relationship with Health Central; she was not a "member" of that group and thus adds a different perspective.

CK: Did you ever participate directly with Health Central?

NK: Well, yes, I used to meet with the Health Action League, usually evenings. Little--six, seven, or eight people to discuss strategies or how we're going to do this or that kind of thing.

CK: Did you consider yourself as participating from your role in the state government or as a consumer?

NK: I think merely as an HMO person providing technical assistance.

In Minnesota she had worked on the development of a neighborhood health center and was then hired by Group Health Plan as an HMO technical specialist. When she moved to Michigan "the only thing that had anything to do with HMOs was in state government" and she took the

position in the state Medicaid agency which "contracted with various HMOs for the delivery of health care for medicaid recipients."

Nancy Koert knew the complex history of prepaid plans in Michigan--their early association with Labor, with Medicaid recipients, even with Blue Cross. Furthermore she knew informed and interested "HMO people." John O'Connell, who had worked with Nancy in Minnesota and had been associated with a legendary consumer sponsored HMO in Twin Harbors, Minnesota, and Calvin Lippitt, an HMO founder in Detroit. All became sources of information and support to the growing group. By the end of the summer they were "rolling," wanted more "hard information," and "got this idea for a conference."

LEGITIMATION: October 26 AND 27, 1973

The conference was held on a Friday evening and Saturday at a local community center, Cristo Rey, and the Ingham County Health Department. The founders gathered national and local leaders and supporters of HMOs to lecture and give workshops. They included representatives from the Group Health Association of American in Washington D.C., Group Health Association of Northeast Minnesota, and health Plans in Detroit. In addition, Nancy Koert, State representative Lynn Johndahl, and Joseph Tuchinsky from PIRGIM gave workshops with the national speakers.

While the meeting and its agenda was simple, it had an important symbolic impact. It is to this conference that everyone who knew of the movement in "the early days" refers. In Blumer's (1971) terms, the conference became the reference point in the history of the organization--the point at which it attained "social legitimacy." The

conference signified that the social problem defined by the small group described above had "acquired the necessary degree of respectability which entitle(d) it to consideration in the recognized arenas of public discussion" (Blumer 1971:303). Blumer's perspective offers an explanation for the recurring references to this conference in the interviews, their newsletters, and self-descriptive data. In all written material the conference is the first identifying (legitimizing) characteristic mentioned. And five years later, in 1978, in the Grand Opening Program for Health Central the conference is again referred to as the first moment of history in the development of Health Central. But this reference to the early days also reflects the cooptation of the consumer efforts:

> in the summer of 1973, HALE,...a group of consumers in the Lansing area concerned about the lack of accessibility to providers, fragmentation of the Health care system, and the rising cost of health care, held a conference on alternative health care delivery systems. The conference, which emphasised health maintenance organizations, attracted approximately 200 people.

There are a number of minor inaccuracies in the statement but the most significant revision relates to the goals of the founders. The goals stated at the time of the development DID NOT include reducing the cost of medical care, and direct questions to founders, when asked in the context of the time the idea emerged confirms that cost was not one of the concerns. The insertion of cost containment reflects the later internalization of bureaucratic and professional norms. The same phenomenon developed in NorthCare; it will be discussed further in the next section.

The conference and the active summer drew new people to join the cause. Jim Ward's wife, Sheila, a public health nurse who worked at MSU

interviewed Fred Matthies, a pediatrician, for a television program on health and learned that his wife was interested in health care. Susan Matthies, an economist from Stanford, had recently come with her family from Northern California. Fueled with her knowledge of Kaiser HMO plans, and her talent as an economist, Susan became a central actor in the early years.[7] Others from Michigan State University with talents in health, nutrition, demography, and industrial and labor relations became involved.

Having legitimized their definition of the problem and having gathered enthusiastic and competent participants, the group was ready to mobilize their efforts to pursue the possibility of developing an HMO.

Goals

Blumer (1971) notes that when a group reaches the stage where they mobilize for action the problem "becomes the object of discussion, of controversy, of differing depictions... and "outsiders, less involved, bring their sentiments to bear on the framing of the problem."

Because the founders were about to subject their idea to such public pressures and "framing" it is important to understand their purpose and goals at that time. Barbara Green wrote in 1977:

> (By the end of the conference) it suddenly seemed possible to create an HMO in our community....We were committed to improving access to care for all citizens; to addressing the problem of quality of care; to facilitating continuity of care; and to altering the incentives which were the mainstay of the present system. (Health Central Newsletter June 1977:2)

Jim noted that they wanted "access regardless of age or ability to pay...." They DID NOT want "more of the same." They wanted "consumer

control." Most interestingly, none of those interviewed when recalling the early days and the early dreams EVER mentioned the cost of health care as a point of concern. I asked Nancy Koert if the consumers had been concerned about cost and she asserted that the consumers were unlike those who began HMOs in the mid 70's for financial reasons. Rather they were like those who "in earlier years, in the fifties, with the Group Health Plan in Minnesota. (It was) developed with the same kind of community involvement...as the small HMO in Twin Harbors, Minnesota."

In the next section, I will trace the goals as they were elaborated and modified as the founders shaped their dreams for presentation in the public arena.

MOBILIZATION: LOOKING FOR MONEY AND MODELS

With the momentum of the October conference and additional volunteers, HALE founders began to mobilize in two principle areas of activity to develop their own HMO and to develop legislative support for HMOs. These efforts are well documented in the history of Health Central and the State of Michigan. Barbara Green writes about that period:

> In January of 1974 six months after the first meeting of the group which was to become HALE, we set ourselves two tasks: 1) to build an effective grass roots organization, and 2) to gather the information necessary to write a feasibility study grant application for HEW funding. A third task was thrust upon us by events--that of participation in developing Michigan's HMO law which was then in the drafting stages. (HC Newsletter July 1977)

Through their connections with Group Health Association and with Bob Carr, U.S. Congressman from their district who had attended early

meetings, they found that money was available from the federal government to study the feasibility of developing an HMO. But as Barbara Green explained they would have to do a feasibility study to get money to do a feasibility study. They were introduced early to the bureaucracy, as they found there were elaborate requirements for applying for the initial federal HMO grant.

First, Barbara went on, they "complied with the formalities required by state law for incorporation as a non-profit charitable scientific or educational organization." They formalized the name Health Action League of of Greater Lansing, or HALE, and wrote by-laws. Fifteen people signed the articles of incorporation on the 25th of February 1974.

A smaller group worked intensely on the feasibility proposal. Susan Matthies said, "the feds gave us a recipe." She recalls that she and Barbara, Signe Nelson, and Jim "sat around our dining room table--maybe ten times. Sometimes we went to the Wards' house, Barbara's was a very busy household at that time--lots of kids."

Weaving their family responsibilities with the new challenges, together they worked out the proposal. In March, 1974 they held their first annual meeting, elected officers (Jim and Barbara were co-chairpeople the first year), and invited Eleanor Brand, a board member from Group Health Cooperative of Puget Sound, in Washington state to speak about start-up requirements.

More Volunteers and Supporters

The annual meeting reflected the dynamics of the group. They were drawing on the knowledge of those who were successful before them and

on the resources about them. The founders had important ties to representatives of organized labor through their particiption in the Democratic Party and Jim and Barbara recruited Joe Finkbeiner, active in the UAW and then president of the Ingham County Democratic Party, to join HALE. He became an important and committed member. In addition, Barbara had enlisted the interest and help of her neighbor Dr. Andrew Hunt, Dean of the College of Human Medicine, at Michigan State University. He later wrote a letter of support for the feasibility application saying that "the Professional Services of the College of Human Medicine would be willing to contract with the community based health maintenance organization developed and sponsored by the Health Action League to provide referral and consultative service." In an interview Barbara laughed and reflected that that hope also, had turned out to be something of a "rumor." But the dean's good intentions along with the "consultation and collaboration" of James Lyon, assistant to the dean in OHSER (Office of Health Service Evaluation and Research) gave the founders momentum when they needed it. In fact, the medical school had sponsored the trip of Eleanor Brand to the annual meeting.

In the Lansing area Brand spoke to both the university and the State Legislature, and the visit from such a "significant other" consumer activist intensified the activists' interest in the consumer sponsored HMO and also connected them more closely to the legislative process and the bill's sponsor, Republican Senator Bill Ballenger. This was important for Barbara who would later work for Senator Ballenger. At the same time, wearing the recognition as "experts" that the conference bestowed on them, Barbara Green and Susan Matthies, and

occasionally other HALE members, began testifying at the legislative hearings on Senate Bill 1000, the HMO Act in Michigan. It was clear from Nancy Koert (who was herself involved as discussed elsewhere) that the consumers had been well prepared and had considerable influence on the final legislation. When Barbara summarized their participation, her pride in their competence as well as their growing ability to meet the bureaucratic demands and standards was evident:

> As the only free-standing group with a stated interest in health care and a strong consumer orientation, our advice was sought on the various aspects of the proposed legislation. We formed a coalition with the UAW and AFL-CIO spoklespeople and with the other developing HMOs in the state, with strong advocacy for proconsumer measures.

During this same period the consumers were preparing the feasibility study application.

> Writing the feasibility study aplication was an infinitely more difficult task. (Six of us) met weekly to report on our individual efforts. Much of the data required by HEW was very hard to come by, yet somehow we managed to produce a document which detailed the local demography, the availability of medical care in the area, and the kind of HMO we intended to establish. (Barbara Green)

Barbara took the application by train to the Region V office in Chicago. The federal project officer initially made mistaken demands which, Barbara now says, should have forewarned her about their "relationship with the feds."

The application, 82 pages, plus an almost equal number of pages of supporting letters from community groups and individuals, demonstrates the broad support the founders were gaining in the community. But it is also clear that as the founders presented their ideas for public support they were also subtly changing them.

Reshaping Definitions and the Search for Resources

An excellent example of the reshaping of a definition is found in the application to the federal governement for the funds to support a feasibility study. As noted above, through the early months of activism the founders' goals had been improved access and quality of care, particularly for certain groups with limited care, and with special attention to consumer participation. And, in fact, pages 1 and 2 of the application list the goals of the Health Action League (HALE) as contained in their by-laws:

> Improvement of the availability, accessibility, continuity and quality of health care in the health service area of Ingham, Clinton and Eaton Counties by:
>
> 1) developing and supporting programs to achieve these goals
>
> 2) educating consumers to better health care practices
>
> 3) increasing consumer awareness of problems in the health care delivery system and encouraging consumer participation in the solution of these problems.

The document continues with a request for funding "to study the feasibility of creating a prepaid group practice HMO in the Tri-County area of Mid-Michigan." Eight objectives of the HMO are then listed and elaborated: (Portions of the list below are paraphrased.)

> 1) To involve, insofar as possible, the residents of the Tri-County area in the planning and development of a non-profit, prepaid group practice plan.
>
> 2) To achieve an enrollment broadly representative of the population serve including the medically underserved, Medicaid recipients, and within three years persons with Medicare coverage.
>
> 3) To facilitate access to care through 24-hour service at central and satellite clinics.
>
> 4) To execute provider contracts with full time salaried primary care providers (NOTE the use of "provider" in place

> of physicians in response to application directions) with quality control mechanisms and allied health professionals encouraged.
>
> 5) To offer a comprehensive benefit package that reflects the total patient perspective with basic health and psychological, environmental, and sociological health considered.
>
> 6) To contain the rapidly increasing costs of health care through incentive structures for both provider and enrollees, health education, allied health professionals, generic drugs, prevention and early detection.
>
> 7) To promote quality care through emphasis on health outcomes, problem-oriented records, formal peer review, continuing professional education for providers, grievance procedures for subscribers.
>
> 8) To serve as a health model for health professionals training in the Tri-county area.

In this their first official document, the social goals reflected in the interviews predominate and are clearly stated. Not until #6 is there any mention of cost containment, and even there cost is woven with other social goals. However, in an early indication of the shifting definition of this "radical" proposal and, to gain allies, the same authors of the document assert that their "reasons coincide fundamentally" with those given in (the following excerpt from) the New England Journal of Medicine:

> Public pressure to control medical-care costs better, to allocate resources rationally, to expand benefit coverage and ambulatory care and to guarantee access to round-the-clock primary and backup specialty services is conducive to the development of a PPGP(prepaid group practice) in urban settings."

It is evident in this journal statement, with which the founders say they agree, that the emphasis and priorities ARE CLEARLY REVERSED. Nonetheless, the founders do not comment on the differences but rather go on for a concluding four paragraphs to simply restate their earlier

commitment to developing a "community based HMO" with extensive consumer involvement after the model of Group Health of Puget Sound. They conclude:

> Our commitment to voluntary consumer involvement is substantiated by the preparation of this proposal, completed entirely on a voluntary basis by HALE members and by our willingness to donate a great deal more time to complete the proposed study.

Accompanying the proposal for a $50,000 grant was a Statement of Income, and Sources and Uses of Funds as well as a statement of Financial Position from 3/1/74 through 10/31/74 audited by the State of Michigan Department of Management and Budget. Member dues brought in $142.50; expenses totaled $141.40; net income totaled $1.16; and net worth totaled $1.16.

Consistent with Blumer's model, this ideologically committed, still fully volunteer group, operating on liberal goals and a "shoestring" budget, was already verbally "buying into" the restructured language (or jargon) and goals of the federal government and the Republican administration which was seeking to create a conservative, competitive, cost containing, private sector, health care system.

FORMATION OF AN OFFICIAL PLAN OF ACTION: SEEKING SUPPORT

In this stage, Blumer (1971) asserts, one finds "the decision of a society as to how it will act with regard to the given problem... including hammering together an official plan of action, such as takes place in the legislative committees, legislative chambers, and executive boards." Indeed, founders were specifically invited to give their opinions to legislative committees, and they were deeply

influenced by the bureaucratic process. In the interaction with the "diverse views and interests" there were compromises...and judgements of "what [could] be workable" (Blumer 1971:301).

After the founders had worked through the summer in the office of PIRGIM, (the Public Interest Research Group in Michigan), other institutions with interests of their own offered their support. The Lansing Labor News offered HALE free office space while they awaited news of their grant, and St. Lawrence Hospital promised space for use during the feasibility and planning phases.

On March 10, 1975, just before HALE'S second annual meeting, Michigan Congressman Bob Carr announced that HALE had been awarded $50,000 "to study the feasibility of developing a non-profit, consumer sponsored Health Maintenance Organization in the Tri-county area...for a one-year period." After a full and successful year of operation in which as a consumers group they operated on dreams and the generosity of the community, they had earned the chance to develop a health maintenance organization, i.e., to, in Blumer's words, to "implement the official plan" (Blumer 1971).

IMPLEMENTATION OF THE OFFICIAL PLAN: $50,000

At the beginning of HALE's second year they moved not only from PIRGIM and The Labor News offices to St. Lawrence Hospital, but also from an organization with $1.16 in assets to an organization with $50,001.16. With the grant came the requirement to hire an executive director and implement the feasibility study they had painstakingly described in the grant application. Also with this new role and organization would come "unforseen and unintended restructuring of the

area of (the) social problem that arises from the implementation of an official plan of treatment." Heeding Blumer's lament that this is a process that is often ignored by sociologists, I have observed and describe here that continuing process, including the unexpected consequences. As the consumers won the federal grant to support their social movement they at the same time began to institutionalize the social movement. As they implemented their own plan they were drawn into the plan of the federal government.

Nonetheless, the founders at that time, as well as the newly recruited staff and volunteers felt that they were working for "a cause" and they did so with the conviction, commitment and comaraderie still more characteristic of a social movement than of a bureaucracy.

Introducing Salaried Staff and the Search for a Project Director

As the founders waited for news of their grant and worked with the legislature, they met Joan Hunault, then working for Bill Ballenger, chair of the senate committee on Debate Bill 1000, the HMO act. An English teacher interested in Public administration, Joan shared the interests of the consumer activists and recalls that even before HALE got the grant or hired a project director, the consumers had asked her to work for HALE when they were funded. Funding required a project director in place and an urgent search for that director began. Notices inviting applications for the position were posted, one of them at the OHSER office where Karen Weller-Fahy, an anthropology graduate student worked. She had become interested in the idea of the HMO after hearing Eleanor Brand from Puget Sound speak at the medical school. A friend who knew of Karen's interests and abilities talked Karen into applying.

The board, a founder remembers, was very methodical in choosing a director. The committee included board members and Community representatives including representatives from the Ingham County Medical Society, the two medical schools, and Labor Relations at Oldsmobile.

They sought experts to make up for the boards' "naivetè". But in the interviews one experienced administrator punched holes in the records of all the candidates but Karen, who had no record to punch holes in. Those involved said she was "very bright," "had a debate background," and "was very handy." It is important to note that Karen's "freshness" and lack of credentials was compatible with the sense of the organization at that time and with its budget and its need for a director quickly. Karen was offered and accepted the position, and was satisfied to accept the board members' recommendation of Joan as the second staff person. The two of them "set up shop" at St. Lawrence hospital in 2 small un-air-conditioned offices in May. They hired a 1/2 time secretary, Toby Salzman, "a part-time student and full-time Mom."

They began work without money. Although Karen began officially May 1, and HEW's Region V Project director made her first monthly visit to Lansing, the Region V office "kept sending the check to Flint!"

The addition of a salaried staff was one of the distinctive elements that characterized the powerfully dynamic year for this consumer organization. Others included a notable esprit de corps within the organization, effective networking outside of the organization, and developing signs of tension.

Esprit de Corps

Interviews with both Joan Hunault and Karen Weller-Fahy like those of the "second wave" of founders at NorthCare who became the four "associate marketing directors," demonstrate the excitement and close working relationship of that period. Although "the project director" and her "associate director" both report significant differences in their own work and life-styles, they emphasize that they shared the goals of the founders and and both held strong egalitarian and feminist positions. (A binding, though more superficial comaraderie was based on their role as staff sometimes "at odds" with that same board of directors. This is a not uncommon dynamic experienced and reported in non-profit organizations guided by boards although it was remarkably absent at NorthCare until the later operational stages.)

Karen and Joan both tell with relish and "insider humor," stories of trying to furnish their empty offices at St. Lawrence hospital with office equipment from a government warehouse and of tedious board meetings in which "the board discussed for one hour and forty-five minutes which kind of used typewriter to get." But they speak seriously and respectfully of the work they were all able to do together and with the 56 volunteers whom they organized into six HMO development task forces. These task forces included: physicians, other providers, marketing, finance, legal issues, and problems. They explain that the task force categories were a direct response to the federal guide to writing the feasibility grant.

The summer of 1975 was filled with intense work, with the task forces preparing the feasibility grant. Each of the six task forces met in both July and August from two to four times. The newsletters

demonstrate constant activity: open houses, meetings, speaking engagements, workshops, and so on. In the office Karen reports that she felt a very strong bond with the other staff members, which in part she attributes to a shared feminist perspective. (I often saw the energy of other contemporary social movements fueling this one.)

Through this period there were other strong ideological themes, also. Both staff and volunteers told me that it was very important that they were developing not just a prepaid medical group but one that was non-profit and consumer controlled. Their commitment caused them often to work very long hours, ordering pizza in the middle of the night, and once, when Karen's 2-year-old son, David, was hospitalized, they went on meeting in his hospital room. Reflecting on that period Nancy Koert commented: "It was a movement and it was a cause. It was not merely a new health program." This prominent commitment, or esprit de corps, was an important factor in the quality and speed with which the grant was prepared and other HALE goals accomplished at this stage.

Networking

Another factor in the success of HALE at this stage was the networking they accomplished both in and out of the community. Within the community they held meetings all over town--at community centers; hospitals, both osteopathic and allopathic; at the university; the Ingham county health department; the community college and labor unions. They widely distributed clear, professional, attractive literature about the Health Action League and about HMOs in general. They built bridges to other health interest groups i.e., HALE members participated in CACHPA's Physical Health Committee and HALE arranged to

be represented on the Tri-county regional Planning Commission. HALE, like NorthCare developed a Speaker's Bureau which responded to invitations to speak .PA about health care delivery issues and health maintenance organizations. May 13 board meeting notes announce the first of many:

> ...HALE's first speakers' engagement. It will be on May 23 at 3:30 at Westminster Presbyterian Church...Those attending will be members of Tri-county family Planning Commission, Model Cities Health Project, and League of Women Voters. Susan Matthies and Elliot Wickes (a board member and economist) will speak.

In addition to the professional networking, members were also visible in more traditional volunteer events like a Bake Sale at a shopping center central to Lansing and East Lansing. Finally, within the community HALE developed a community Advisory Board "composed of community members representing labor, business, the clergy, and local governmental units" (Newsletter, July 1975) which met every other month and became an important source of communication and support. Joan Hunault called it "premarketing." It was important " because we were precluded from doing any marketing of HMOs until we had something to sell. (The power of this premarketing would be evident when they opened.)

Activities outside of the community during 1975 were equally energetic and wove them into the network with groups they admired. Not only were speakers invited from other HMOs--Group Health of Puget Sound, NorthCare, and Metro Health Plan-- but members and staff attended Group Health Association Conferences and visited HMOs throughout Michigan as well as the Harvard Community Health Plan in Cambridge Massachusetts, and NorthCare.

Developing Signs of Tension: Original Values Lose Ground

While 1975 had been a very successful year for HALE, particularly the months in which the staff worked with the volunteers, this organization was developing problems out of its own success. The director's column in the November 1975 HALE newsletter suggests some of the problems brewing. I quote it in its entirety because it has within it a number of elements: 1) the energy and success of the consumer-activists; 2) the dependency on HEW, 3) concern about the symbolic separation from and disaffection of the consumers, and 4) the director's hopes for herself and for the HMO.

> The Feasibility Study is approaching completion! The Legal, Providers, Problems and Physicians Task Forces have all completed their primary tasks and are compiling the results into final reports. The Task Forces on Marketing and Finance are in the midst of their tasks. Every indication is that a prepaid group practice in this area is indeed feasible! The next step is to convince the Department of Health, Education and Welfare, since it is DHEW that administers the funds legislated in the federal HMO law (93-222).
>
> Our feasibility analysis becomes the basis of the application for Planning funds. We will be applying for these monies in December. DHEW Region V estimates that 12 to 14 weeks is needed to review and process an HMO grant. During Planning, all of the estimates and contacts of Feasibility are concretized.
>
> Also during December, the HMO will become an entity separate from HALE. HALE is incorporated to educate consumers and work for the improvement of health care but not to deliver medical services. Thus an HMO corporation is required, by DHEW to file the application for Planning. The formation of the separate corporation does not negate the need for your participation. A consumer directed, community oriented HMO requires even more input that a Feasibility Study! Special problems and rewards result from any cooperative effort. We have had our share of both and are completing our study five months early with a good product.
>
> By the way, the funding stage after Planning is termed Initial Development. During this stage we open our doors!

In this period, just as HALE seemed remarkably successful, both structural and personal tensions began to build. The structural tension involved a dichotomy between ideology and viability. As with NorthCare, the practical offspring (the HMO) was explicitly separated from its nurturant ideological parent (the consumers' group) by the federal requirements. The separate board became not only a instrumental structure but also a symbol of the separation of the consumers' ideology from the task. From this historical point, the task pulled the ideas rather than, as before, the ideas creating the task.

Karen's words acknowledge the importance of the task as well as their dependence on HEW; she tries to assure the consumers that their participation is even more needed as she tries to assure herself that the ideals of consumer direction and community orientation will be protected.

Another important tension emerged in all the interviews about that period. Although it is presented in interviews as a personal issue, in fact it appears to be another of the consequences of the bureaucratization and professionalization of that period. Simply, the project director was not specialized in administration, nor was she a very formal person, but everyone I interviewed said that she had done an excellent job of directing the organization through the early and successful stages. Furthermore, the federal staff she worked with in the Office of Health Maintenance Organizations assured her that her work was excellent and that they supported her. Proud of her accomplishments, and reassured by the apparent support from the federal HMO staff, Karen wanted to (and perhaps assumed she would be able to) continue as executive director of the HMO.

It is clear from interviews with board members, on the other hand, that they were very influenced by the federal advisors' increased insistence on credentials. In spite of all the board members' admiration for Karen's competence, and the outright advocacy by a number of board members, as a group the board voted to begin a formal search for a "professional" director; they would even hire a professional high-status consulting firm to help them.[8]

PLANNING

But, before that, as Joan Hunault was fond of putting it, there were "more hoops to jump through." Having won the planning money, $111,000, consumers and staff had to meet a new set of requirements. Karen Weller-Fahy's first words in the January HALE newsletter were "Health Central Exists. As of December, an organization whose sole purpose is to plan, establish, and run an HMO in Lansing was formed." She said that the 259 page Planning application/feasibility report had been submitted before Christmas and thanked everyone for their help. A contest was held to name the HMO birthed by HALE, and "Health Central" was chosen. In the early months of 1976 the task forces continued to be very active.

On March 9, HALE held its 3rd annual meeting; a new board was elected and HALE received assurances that they would get the $121,000 applied for in December. While HALE had been primarily occupied with getting the HMO off the ground (which meant orienting always toward sources of funds), now at this meeting members discussed the many health issues they were interested in in addition to the HMO. (Just as the consumers group did in Evanston.)

Health Central had its first board meeting April 20, 1976; board member Bill Carr was elected president, and the 23 member board constituted a search committee for a new executive director and heard Dr. Arnold Widen from NorthCare discuss "NorthCare's Origins and Function."

A Founder Leaves and the Feds Give Ill-Founded Advice

In May the $121,000 arrived and earnest work began on eleven areas of concern designated by HEW. In their May newsletter HALE and Health Central bid a regretful farewell to Susan Matthies and her family. (Just as at NorthCare, a founder who had been central to the initiation of the HMO, was able to leave with only regret once the movement had gathered momentum.) In June several members and staff attended a GHAA conference. There they were cautioned not to overestimate their membership (Marketing report June 22, 1976).

By the end of the summer, the Health Central (HC) board and staff were actively planning the initial development. Now, parallel to HALE, HC had its own board, published fact sheets, and newsletters. Health Central's publications and board minutes suggest that the second half of 1986 was dominated by an awkward and ill-fated search for a new executive director. Health Central"s newsletter, "Vital Signs" in November offers telling examples of the problems in store: Karen, still executive director, announced a building had been found but the location could not be announced until the Federal initial development funding was received. In addition two articles were published announcing new directors--one executive director and one medical director--including detailed biographies and welcoming them. However,

neither really became established in the positions. HEW rejected the board's choice for Executive director and the medical director, beset with family health problems, decided not to come.

The final Health Central Board Meeting of the year, December 21,1976, demonstrates a number of important dynamic issues for the fledgling organization at the time:

1) Budget and Finance Committee: While the organization then had the responsibility for managing one million dollars in grant money, the federal regulations require that they match 10% and that presents a challenge. To that date fund raising by HALE had included curry dinners, bake sales, and a A&P Donation day--all of which had netted under $100.

2) Grant Committee. It is reported that the budget had to be cut because "personnel was cut by $93,000 because HEW felt that we had too many on staff for phase 1 resulting in too heavy overhead." (This is consistent with HEWs continued rejection of Health Central's enrollment projections and it is important because Health Central's acceptance of HEWs opinion (they had no choice) caused them to be unprepared for the large opening enrollment which precipitated the slide into catastrophic financial insolvency two years later.)

3) Executive Director Search: After discussing HEWs rejection of the boards' choice for executive director, ("Board members were told by HEW that this was not an unusual action.")

> "The Board then met in executive session. Motion was made to keep the present Executive Director, Karen Weller-Fahy as Executive Director until such time as another Executive Director is chosen and approved by HEW. MOTION CARRIED. UNANIMOUS. Meeting adjourned at 11:05 pm." (Board of Directors Meeting Minutes Dec. 21, 1976.)

1977 began for Health Central as 1976 had ended--searching for an executive director. The search reflected increased tension between early ideological commitments to consumer control and the external (as well as internal) pressures to professionalize. Many executive Committee meetings and two board meetings paid considerable attention to the problem and after much research and discussion the board decided to spend thousands of dollars to hire the Arthur Young professional consulting firm to train and professionalize the board and help with the search.[9] Some board members I interviewed found the training fascinating; they were shown how to simulate work situations that the executive director would encounter, including situations with considerable pressure, and then to evaluate the performance. Other board members, however, objected to bringing outsiders into the process saying that the responsibility in a consumer-directed organization should be handled by the board themselves. Nonetheless, a number of candidates were interviewed and in March a professional candidate, John Hennan, was chosen for his excellent credentials. (Mr. Hennan had a BA from the University of North Dakota, an MA from the University of Minnesota, an MPH from Harvard and a Ph.D from Brown University. He had had extensive experience in health care statistics, programming and management in Providence, Rhode Island and Boston.)

While new staff and members were being added, others were leaving. Bill Carr, president of the board of Health Central resigned in February to take a position with HEW in the Region V office in Chicago. (This pattern of movement from volunteer to professional positions is discussed in Chapter 7.) Joe Finkbeiner, vice-president of the board,

acted as presiding officer and then went on to fill his own term in March.

And in March Karen Weller-Fahy announced that she would be leaving for Albequerque with her family in June. She continued to work until April 29, when she was sincerely and formally thanked by the board.

FACILITY CONSTRUCTION AND STAFFING: EFFICIENT AND PROFESSIONAL

It is worth noting that Health Central's April newsletter began with the explanation by Hugh Hufnagel, Marketing Director, that the publication's name had been changed from "Vital Signs" to "Newsletter" and, he said, "although it is not a hallmark of creativity...it presents information in an efficient, professional way."

Health Central was now marketing not only health care but also an image, and the image would not be folksy, but rather efficient and professional.

The professional new executive director, John Hennan, was at work in May and board and executive committee minutes reflect considerable discussion about the role of the "professionals" and the role of the board. The board of trustees felt it should have access to the same information that was available to the executive committee. The dispute or discussion would continue for the next two years.

In July, a "wall breaking ceremony" symbolizing the preparation of a building for the new HMO drew considerable media attention to Health Central but funds were still needed for the necessary capital improvements. HALE applied for a grant from Kaiser to help the HMO since the Health Central's tax status did not permit it to receive such

a loan. By August, the staff had submitted the hundreds of pages of State licensure application and they were eager to open. HEW, however, behind schedule, delayed their site visit but finally provided "full federal qualification for full operation" on December 19, 1977 and the doors opened in January of 1978.

THE START-UP PERIOD: THE PROBLEM OF SUCCESS

In this last period of the consumer-sponsored HMO the pace quickened. In January, the director of Public Health in Michigan opened the HMO and emphasized traditional consumer concerns of disease prevention and health maintenance. But as soon as the door opened, there were other issues. Enrollment was much higher than expected. Dr. James Hughes, the newly recruited medical director, wrote in his report that he needed more physicians and other health staff. He also recommended setting up an urgent care service because already Health Central was referring too many patients out.

While high enrollment was the goal and the public mark of success, the HMO, under the insistance of the federal advisors, had not hired a sufficiently large staff or facility for the population to whom they had been marketing so vigorously.

By March, Health Central was 1200 members ahead of projections, and in July they celebrated an early "birthday" because they hit their year goal of 4000 in 6 months. Health Central was the pride of the Office of HMOs in Washington and the state, but within the HMO there was a strong sense of overload. In June, Hufnagel wanted to hold back on marketing because they already had more enrolled than they could handle. The Executive committee, however, decided to go ahead. [Two

possible explanations are offered--the sense of obligation to offer the plan when and where they said they would, and the egos of those invested in its growth.]

While their federal advisors had told them to expect 5% enrollment from the employer groups they were getting 15-20%, and the success was forcing speeded up remodeling and increased staff. In August the medical director reported growing medical staff but concern with the upcoming visit of OHMO as grievances began to come in. In Fall General Motors, Fisher Body and Oldsmobile were also offered the Health Central option and the enrollment exploded to 16,000. There was not enough parking, phone equipment, or staff. Although staff was being hired at a dazzling rate they needed time to be trained.[10] In October, Dr. Hughes recommended exploring connections with the MSU medical school to see if they could help his hard working staff. He wrote, "I hope the purple hearts don't come posthumously."

In late fall, the State Department of Health worried that such a jump in enrollment could reduce quality of care. But when the federal office HMO visited, they discovered "nothing they thought was of interest". By the end of December--one year after opening--Health Central had 21,000 enrollees. Their success was widely publicized and applauded by state and federal officials.

During this period members of the board, including Barbara Green who was now on the executive committee, asked to see the budget and to get more information. However, the executive director did not make it available. It is clear that the balance of control on the board had shifted from the founders and consumer representative to the executive director and staff, which held the information and perpetuated its own

bureaucratic control. (Note: it was not that there was not expertise among the consumers, rather that their role prevented them from using it.)

At the end of the year, with 21,000 enrollees, and the system about to come down around them, board minutes show that the board, isolated from full information, mostly discussed the kind of chairs and table to get for the board room. 1979 would be different.

FINANCIAL CRISIS: Tension Between Growth and Management

January 1979 found continued expansion and growth. An urgent care service was opened to handle 160-170 calls a day. More staff, both physicians and nurse practitioners were added. While patient complaints about long waits and service continued to pour in and worry the board, John Hennan expanded the program, adding satellite offices and services.

The board minutes of February 13 show that Barbara Green expressed concern about unpaid bills, and questioned the service and budget projections. The minutes note that her questions were referred to the Health Services Committee. Discussion continued regarding affiliation with MSU and it was announced repeated that a local practicing physician would join Health Central and bring his practice with him--some on a fee-for-service basis.

As the problems became increasingly complex, Dr. Hughes, the medical director, tendered his resignation in frustration with the inability to get enough support to provide service; the executive director recruited Dr. Bonta Hisco, a respected community surgeon to be the new medical director. Dr. Hisco, a man with a reputation as

"something of a maverick" (not unlike Arnie Widen), was interested in innovative medical services and ideas, and was excited by the opportunity to direct the medical program which was known to be growing so quickly. He began March 1, and on March 12 submitted a report discussing the importance of health maintenance and preventive care that had been the concerns of the founders. But by the March 13 board meeting the minutes allude to concerns about telephone, financing, physician recruitment and possible medicaid contracts, and it would not be long before he, too, was drawn into the practical problems of organizational maintenance.

In April, the state placed the HMO under a marketing moratorium because of the excessive pressures of enrollment, but the staff were concerned and frustrated because they feared losing marketing opportunities; on April 12 a special board meeting heard the request of Hisco and Hufnagel to reopen marketing. (Hisco explained in an interview that at that point he had no idea that the HMO was in serious financial trouble.) On April 16, another visit from a regulatory agency failed to find a problem. The Michigan Department of Public Health conducted a site visit of the HMO and was "very supportive of the HMO" mentioning only that it should expand its medical records personnel. Barbara Green again expressed worry about offering a new enrollment to state employees, but was not supported.

Two weeks later the OHMO in Washington, after receiving warning calls from creditors in the Lansing area, sent a letter of noncompliance to John Hennan and arranged a federal site visit to discuss areas of concern. At about the same time Bonta Hisco reports that he began to

get troubling calls from colleagues in the medical community saying their bills to Health Central had not been paid.

The warning signs were beginning to overshadow the impression of dramatic success. On May 11, the executive director, the financial director, two board members and legal counsel were summoned to Washington where they were told that the OHMO would help Health Central out of its deep financial troubles only if the director and treasurer resigned. John Hennan and Joe Brown resigned May 12, and were out of their offices Sunday, May 13.

THE COMING OF THE CORPORATION

The press and government officials were "shocked" by the dramatic financial collapse of the "successful" organization. But the founding board members were less surprised. The labor representatives on the board, for example, said they "saw it coming." One said that John Hennan was spending a lot of money, and "we were not getting sound financial reports." Furthermore, he said,

> (the administrators) acted as if the Feds came to the front door every day with a wheelbarrow of money and all we had to do was spend it....

Others on the board, like Barbara Green, had for months been asking for an explanation of the finances.

After "the Feds blew the whistle" there remained no full explanation of why the HMO was in such deep trouble. A state regulator told me that the government money was not used in the way it was intended (e.g., Hennan bought land for expansion out of operating funds) --but no one I interviewed ever said they believed that there

was any criminal intent. Neither the state nor the board had demanded an interim audit and there was no prosecution.

There were many personal speculations about the director's individual behavior, but none explained the problems of the organization; they seemed, rather, an effort to find an explanation. John Hennan had been chosen because his professional credentials seemed perfect. Since he had been chosen to fit the structural specifications, his failings, some seemed to think, must be personal ones. Apparently, as management worsened and the debts mounted, and the problems seemed insoluble, Health Central had stopped paying its bills. The tales of where they had been hidden and stored were apochryphal--not only in desk drawers but in the trunk of his car, and so on. A state regulator summed it up: "He was very, very bright, but he just couldn't handle this situation."

It was the state that would handle the situation. At first Bill Bramen, the chairman of the board, was made acting executive director and then Robert Rowe, a former chief deputy commisioner from the Insurance Bureau, was appointed interim executive director under an order giving the state supervision over the troubled plan. I was told "he carved away a third of the staff with surgical precision."

Many were involved in trying to raise funds. Arrangements were tried with labor, and with industry. Governor Milliken (who had recently been speaking with pride of Health Central in his speeches) wrote a personal letter to Tom Murphy at General Motors "trying to get capital to link up with money from the Michigan Hospital Association."

Several insurers "came to take a look" including Blue Cross Blue Shield. " Then it got down to just the Blues, and they said they

weren't interested. (They had been "burned" earlier when the state barred their ownership of a prepaid plan in Detroit.) But this time the state was a party to the negotiations.

"Finally, there was a weekend marathon of telephoning," a labor leader told me,

> We were trying to make things happen. Finally we told the politicians that they were about to have 18,000 people shitting on their doorstep...and then things began to fall together.

It is clear from the descriptions of the participants that because of the structure of the situation--labor's responsibility to its members, the promises the consumers had made to the 22,000 enrollees, and the enormous need for capital--many of the participants came to believe (just as many had in Evanston) that selling to the insurance corporation would be the best alternative. The Lansing State Journal summarized it:

"Blues Called only Lifeline for HMO".

Finally Blue Cross agreed to meet with the state, federal and HMO representatives. When the Blue Cross representative arrived, he had a check for $1,000,000.

The decision to sell Health Central to Blue Cross was put to a vote of the membership at a general meeting for all members August 16, 1979. One founder said:

> The meeting was a very bittersweet experience. We saw the effects of the grass roots. They called a meeting and set up folding chairs inside. And people kept coming and finally there were about 650 people and we met out in the parking lot.

A news columnist attending described the event.

> The change was overwhelmingly approved. Many cheered and clapped when the final action was taken...after three hours of debate, questions and explanations. Some said they were "being taken to the cleaners..." but the vote was 4 to 1.

Health Central was saved, but with the coming of the corporation, consumer control was lost.

END NOTES

1. For the purpose of this dissertation and the reading of the committee I have used the actual names of places and participants. The social activists considered the development of the HMO and the activities associated with it to be public; most are eager to see it described. However, where an informant has asked that something remain confidential, or if the matter is sensitive and could be thought to be confidential, I have presented the data in a way that does not identify it with a specific individual. For example, "a founder told me," or even--in classic passive voice--"it became clear in interviews that..."

2. It is important to note that for the founders of NorthCare as well as for Health Central the presence of someone who had had experience with Kaiser in California was crucial, i.e., someone among them who knew that health care could be different. "People do not define as problems those conditions they feel are immutable....Every experience of displeasure and dissatisfaction has its origins in the availability, if not promise of remedies, cures, reforms, and solutions for such troubles" (Spector and Kitsuse, 1977:84).

3. Another example of the way Mary Bruglierra says they were "dogged with serendipity": Between NCHP's first and second letters of application General Robert Wood Johnson died making the foundation the second wealthiest in the nation.

4. Enrollment without restrictions based on age, medical history, or history of illness, etc.

5. One founder disagreed strongly saying she believed the problem was, rather, the employees of the city of Evanston (49% of whom enrolled) and that it was fashionable to blame the open enrollment group. Such blame was prevalent; the first amendment of the HMO legislation was to eliminate open enrollment.

6. Koert was not only important to the activists; she was a very important informant for this study of Health Central. She had had extensive experience with both health care bureaucracies and with community organization in Minnesota and had a keen personal and professional interest in the development of Health Central as well as a view from within Michigan state government. By 1986 she was chief of the HMO division with the Michigan Health Department; her views as a regulator are discussed in Chapter 4.

7. Susan, like Kate Carey, brought knowledge of Kaiser's working "solution" to the "putative conditions." (Spector and Kitsuse 1979)

8. It is interesting to note that the changes in the organzation reflected and were reenforced by the changes in the culture about them. Early in the 1970s, when they gathered as a group of post 60s social activists, they associated with the informality and antimaterialism prevalent in the 1960s, particularly at universities. While they were developing the HMO, the culture around was also accepting bureaucracy and emphasising professionalism. For many around them materialism was regaining its respectability; students came to the campus looking for "careers."

9. Note how this anticipated health care management in the 1980s. See Chapters 6 and 8.

10. Joe Finkbeiner reported that enrollees who worked for with him at Oldsmobile came by and shouted at him because they could not get through on the telephone. And Joe said, once the ground froze they simply couldn't lay in more phone lines. "Now who could have predicted that!" he wailed.

CHAPTER 6

1986: CASE STUDIES AND THE NATIONAL CONTEXT

INTRODUCTION

The last chapter documented the accomplishments in the 1970s that made possible the development of NorthCare and Health Central, as well as the compromises that led to their purchase by two major insurers, Prudential and Blue Cross. In the 1980s, changes which the HMOs consumer-founders tried to resist have accelerated, and HMOs are one important part of a significantly changing Americian health care delivery system. HMOs had a distinct, in fact catalytic, role in the changing system, but now they are decreasingly distinct within that system. Shifts in the organizational types within the minimum HMO definition (a prepaid health plan with comprehensive in and outpatient care, for a defined population) reflect the direction of change.

In the early 1970s, when the consumers began to think about sponsoring consumer-controlled, community-based HMOs, themselves, there were only 30 prepaid plans in the United States; almost all were salaried staff or group models. In 1986, there were 595 HMOs, but only 40 percent were staff or group models and 60 percent were independent practice (IPA) models. The modifications are not just within the HMO definition. Permutations and combinations abound, both as elaborations of the already existing plans, and in competitive reaction to the existing plans. As I will describe more fully in the following chapters, the federal government has purposefully promoted the

competitive marketing of health care, and health care itself now has taken on many of the characteristics of other "products" in a competitive economy.

For example, organized medicine has traditionally considered advertising to be unethical for physicians (AMA 1981). However, advertising now accounts for $500 million spent by competitive health care plans and hospitals. Furthermore, to increase competitive strength--and sometimes simply to survive--plans are merging and acquiring each other. They increasingly develop hybrid (or "triple option") managed care organizations that promise to serve employers' needs for economical management, and employees' need for good health services often as part of major insurers.

With the clarity of retrospect, it is evident that the purchases of NorthCare by Prudential and of Health Central by Blue Cross, which the consumer-activists felt to be the failed end of their goals, were in fact early signs of this developing trend. In this chapter I will describe some details of the trend as it appeared in 1986: first, with an update of NorthCare/Prucare and Health Central in their communities, and then with an overview of the national health care delivery environment.

The reader will note that portions of this chapter will have a different tone than other parts of this analysis. To provide an "update" I must present these organizations in the present, that is in their corporate form; corporations have a language of the "market place" very different from the language with which the consumer founders first formed their ideal HMOs. I have noted in Chapter 5 the way in which the the consumers were coopted by the language of the

regulatory and corporate environment; here it will be evident that in order to discuss health care as it is today, I, too, often use the language of the market place and the corporation.

NORTHCARE/PRUCARE UPDATE

The Chicago "Market Area"

In 1981, when Prudential bought NorthCare, 252,123 Chicagoans were enrolled in eight HMOs, that is, 3.5% of the Chicago SMSA. In 1986 1,160,000 were enrolled in 22 HMOs, or 15% of the population. This growth was somewhat faster than the national average and there are other ways in which the Chicago area is distinctive in its acceptance of HMOs.

My research with others in the early 1980s (Anderson et al. 1985) showed that Chicagoans are loyal to local, even neighborhood, institutions; that characteristic is evident in the HMO distribution in 1986. While Chicagoans' enrollment in HMOs has been growing rapidly--between 25% to 38% a year -- Chicago HMOs have not consolidated in the way that is typical nationally. (See next section). Rather, in Chicago many new HMOs continue to spring up (and some close), bringing the total number to approximately 22. Ten of the 22 listed in June of 1986 had been operating a year or less. Furthermore, because of strong localism, Chicago has not been an excellent market for national companies. Of the five largest HMOs in Chicago all have been in the community for ten years or more; two are staff models associated with well-known local hospitals. Although some of the best established HMOs in Chicago are of the staff/group model favored by consumers and early HMO advocates, the percentage of enrollment in staff/group models

continues to fall, as it does nationally, because the new plans are the preferred IPAs or networks which permit more autonomy for physicians and choice for patients. (See implications in concluding section.) While in 1981, when NorthCare became Prucare, 55% of Chicago's HMO enrollment was in staff/group models, in 1986 that has fallen to 23%.

NorthCare/Prucare: "One of the Insurance Products"

NorthCare/Prucare has itself contributed to the fall in percentage of enrollees in staff/group models. In January of 1986, in order to be more competitive, Prucare added an IPA component to the HMO group model and became a "network", or "mixed model" by affiliating with 25 other formerly independent practice groups. This change was implemented simultaneously with the offering of Prucare Plus, a "triple option," combining conventional insurance and prepaid care.

Since 1981, when NorthCare had 30,500 members and was acquired by Prudential and became one of its Prucare HMOs, its enrollment has almost tripled. Prucare has a reputation in the city for quality, in part beacuse of its selective hospital affiliations (which however, are costly for the plan), and because of the high regard for the medical director, Arnold Widen, who has remained with the plan since its founding. However, growth was very slow until the middle of 1985, when there was considerable growth. At the end of 1986 there were 80,000 enrollees. Nonetheless, in the exploding Chicago area market, which I described above, Prucare remains sixth (not among the "top five" of the 22 HMOs in the Chicago area). That is not what Prudential, the parent company, had in mind. Although Prudential officials told me in 1981 that they knew it would be necessary to subsidize the beginning HMOs

for some years, and they have subsidized expansion to nine health care delivery sites, it appears that they are not now satisfied with the financial results in the Chicago area.

One of the staff people who has been with NorthCare and then Prucare from its earliest days offered her interpretations. She feels that the marketing representatives who present Prucare and the additional plans, like the triple option, do not understand or support the HMO concept. They present Prucare and its triple option "as if it's major medical (traditional health insurance) with an HMO option instead of the other way around." Therefore, members do not understand the concept and "go outside the plan at three times the predicted rate, rather than staying in the network." This adds to the costly spiral and to Prudential's dissatisfaction with the HMO.

As a result Prudential is centralizing its operations, and pulling resources back to its Minnesota and other Illinois offices. Unlike the individuality expected by NorthCare when it was purchased by Prucare, Prucare/NorthCare is now "only an entity on paper." In place of a vice president of its own to work with in Illinois, Prucare/Northcare now answers to the Group Department of the Prudential Insurance Regional Office. Furthermore, the Regional Office has withdrawn the NorthCare medical group subsidies and many of the medical group have had to be terminated. The staff member concluded, "It's demoralizing; we are now one of the `insurance products'"[1]

HEALTH CENTRAL AND THE LANSING AREA UPDATE

Lansing Area[2]

In 1979, when Blue Cross bought Health Central, Health Central was the only HMO in the Lansing area and its enrollment was 21,900 members. It was one of nine prepaid plans in the state of Michigan with a state enrollment of 200,792. In 1986 there are two HMOs in Lansing : Health Central with 55,000 members and Physicians Health Plan (PHP) with over 70,000 members.[3] The growth in HMO membership--five fold in seven years-- is even greater than for the same period nationally. (See national data below). Much of the enrollment is with PHP, a plan that was not yet an idea in 1979. PHP, which was first proposed publicly at a physicians' meeting at Sparrow hospital, June 3, 1980 and licensed in 1981, is a classic example of the plans formed by physicians, sometimes in cooperation with a hospital, in reaction to the "threat" of an early HMO in the community. It is an independent practice association (IPA) of physicians practicing from their own offices, partly with HMO patients from PHP and partly their own fee-for-service patients. PHP is now (also typically) affiliated with (or part of) a large parent corporation, United HealthCare Corporation, which has thirty plans nationally with 1,160,000 enrollees, and is headquartered in Minneapolis. An HMO administrator in the Michigan Public Health Department told me that "virtually every doc in Lansing except those on staff at Health Central" has signed up with PHP.

In 1979, IPAs enrolled only 17 percent of the 201,000 HMO members in Michigan; 83 percent were in group or staff models. In 1986, only 25 percent of Michigan's 1.6 million HMO enrollees are in group or staff models; 75 percent are in IPAs or in network models which mix

and match some groups with some independent practitioners in prepaid contracts.

To understand consumers' recent (mid 1980s) attitudes about HMOs in Michigan I interviewed an administrator of the HMO office of the state Public Health Department, which licenses and receives questions and complaints about HMOs. In 1986 there is a marked increase in misunderstanding of the nature of HMOs. "People don't understand HMOs anymore," she said, and doctors don't understand what is expected of them when they join an HMO. This seems to be evidence of the new population who are joining and affiliating with HMOs. They participate not because they want to change to an alternative form of care or care-giving, but because they are pressured by their employer or their competitors to change from their traditional ways. They do not realize the implications of the different form of health care delivery; they still have a "fee-for-service mentality."

In addition to the IPAs, which are providing significant competition in Michigan, an official at the Michigan Department of Public health reports, there are nine preferred provider organizations (PPOs) in Michigan. However, less is known about them because they are not regulated by the state and their enrollment is difficult to count. In most cases they are marketed as part of a package of health care insurance options.

Health Central

Since 1979 Health Central has changed its shape but certain important elements have remained the same. There are 35,000 more enrollees and several different sites in the Lansing area for

treatment. Originally a group model--consistent with the founders' conviction that physicians should work together as a committed group, preferably salaried--Health Central, like Prucare, is now a network model. In order "to remain competitive" it has added seven affiliated small groups (which account for 10,000 of the enrollees) in communities not far from Lansing. The medical director who came to Health Central in 1979 just months before its critical troubles became evident, has remained, developing and maintaining a largely stable core of physicians and other health care professionals. He reports that he struggles with the Blue Cross organization ("the Blues") for more autonomy and for more information. He and others I interviewed say that the Blue Cross information system, "Diversitek," although highly touted, has important inadequacies. (Information systems have become crucial to the success of managed care systems, as I will discuss in the conclusion.) To this observer it seems that the medical director and the Blue Cross management are in a detente--needing and respecting each other but each fearful of losing ground to the other.

In the first years after the Blues purchase, Health Central operated in the black, putting over $2 million/year in surplus in 1982, 1983 and 1984. But by 1985 "competition was heavy and things got tight;" they had to cut prices and in 1986 they have a significant deficit of over $1 million which Health Central blames on delayed bill handling by Blue Cross in Detroit. It is interesting that staff in Health Central, as in Northcare/Prucare, see their insurance companies not only as separate, but as a source of difficulty rather than support. This complaint is particularly notable in certain professionals who, when I interviewed them four years earlier, had been

optimistic. Now, caught in the bureaucratization, they say at Health Central, as they did at NorthCare, that their parent insurer is centralizing operations, limiting their autonomy and erasing their identity.

One of the original founders of Health Central told me that she has recently been asked to come back on the board which she left in 1978 since,

> they need people to help them maintain a certain mind set that some feel is being lost....someone devoted to consumers....to help keep the Blues on the straight and narrow. Apparently they are trying to standardize all the Blues HMOs in Michigan....that flies in the face of everything they have done. In the face of success they are trying to impose a model.

Although Michigan law still requires that every HMO have a board with one third consumer representatives one state official observed:

> But with the big boys from the Blues (also) on the board, if they want anything to fly, it's going to fly.

NATIONAL ALTERNATIVE HEALTH CARE DELIVERY PATTERNS IN 1986

Types of HMOs and Sponsorship

I have noted that at the end of 1986 both NorthCare and Health Central have strong competition from the growing IPAs in their respective areas. To remain competitive, they say, they have modified their own model type. They reflect the strong national trend away from the group and staff models which the consumer/founders considered central to their plan. I quote here InterStudy's description of this trend from their 1986 June Update of the National HMO Census for both the content and the manner in which they choose to present the data:

> Over the past decade there has been a shift in the predominant model type of HMOs. In 1976, group models represented 75% amd IPAs comprised the remaining 25% of all HMOs By June 1986, 58% of all HMOs wereIPAs and 42% were group models. The number of group model HMOs increased by over 100% between June 1976 and June 1986 (from 123 to 250). The most dramatic increase, however, was seen in the rise in the number of IPAs. A 741% increase occurred over the decade, as the number of IPA model HMOs increased from 41 to 345.
>
> The majority of HMO members (64%) are currently enrolled in group model HMOs as opposed to IPA models (36%). Group models, however, are no longer the dominant force they were in June 1973 when 93% of all members participated in group models... Over the last ten years enrollment in IPA models grew at the phenomenal rate of 2,070 percent (from 390,000 to 8.5 million members), while enrollment in group models rose by 172% (from 5.6 to 15.2 million members.)

A number of issues in this quote deserve attention. First, of course, the significant numbers. In ten years there has been significant growth in HMO enrollment, and that enrollment trend is moving from the group practice models to the independent practitioner models in which physicians treat a mix of HMO and fee-for-service patients in their own offices.[4]

Second, the dramatized way in which the "phenomenal rate" of IPA growth and HMO growth in general is described draws attention to the institution responsible for the census. InterStudy is the independent private "think tank" founded by Paul Ellwood, who as I have noted earlier, suggested the concept of HMOs to the Nixon administration and has been the strongest advocate in the Twin Cities and the nation for HMOs as a competitive free enterprise solution to the rising costs of health care. Throughout the 1970's, the Office of Health Maintenance Organizations (OHMO) in the US Department of Health Education and Welfare gathered HMO data. In the Reagan administration's commitment to privatizing and decentralizing responsibilities of the federal

government (Starr 1983) the OHMO was closed and InterStudy became the official data gatherer on HMOs.

Third, the "phenomenal" nature of the 2000% growth rate is not so much a function of the many IPAs now as of the few IPAs earlier. Unlike the staff/group models like NorthCare and Health Central and the consumer cooperatives that were their models, IPAs were not born out of an ideological commitment to restucturing health care. Rather, IPAs are a reaction to the perceived competition of the group models, and an effort to protect the traditional model of medical practice.

Independent practitioners in Chicago and Minnesota explained that they developed or joined IPAs because they feared losing their patients to HMOs run by consumers or hospitals. I found that these physicians are most often those ideologically opposed to salaried physicians or group practice. It is therefore ironic that their successful reactive efforts to oppose the original HMO concept are listed as evidence of the success of HMOs. IPAs have, in fact, coopted the symbols of the early HMOs for their own competitive individual practices.

Fourth, the large percentage of HMO members who are still found in group plans is explained not by the number or vitality of group plans in general, but by the powerful national dominance of Kaiser Permanente, which accounts for nearly 5 million enrollees in their massive group practices largely on the west coast.

Census 1986, Growth and Distribution

The InterStudy Census reports that in June 1986, 23,663,626 Americans were enrolled in 595 HMOs. This reflects a steady 24% annual rate of enrollment growth. (The growth in number of plans is less

meaningful because there is remarkable inconsistency in reporting of plans or the multiple offices of plans (See Table 6.1). In 1986 forty-six states headquartered HMOs. Five states reported enrollments exceeding a million HMO members, including the three states in this study and California and New York, as well.

Table 6.1

GROWTH OF HMOS SINCE 1970

(InterStudy, National HMO Census through June 1986)

1970		33	plans	3.0 million enrollees
1972		72	"	4.4 " "
1974		142	"	5.2 " "
1976		175	"	6.0 " "
1978		203	"	7.5 " "
1980		236	"	9.1 " "
1982	(June)	280	"	12.0 " "
1983	"	290	"	13.6 " "
1984	"	306	"	15.1 " "
1985	"	393	"	18.9 " "
1986	"	595	"	23.7 " "

Changing Plans: Multiple Options

PPOS

It is necessary to emphasize that "HMO" is no longer a sufficient term to describe the contemporary health care delivery alternatives that began with HMO development. In addition to HMOs, rather, in response to HMOs, PPOs (preferred provider organizations) are sprouting. While in the early 1980s there were only 7 PPOs, in 1986 there were 500 distributed throughout the 50 states.

Whereas HMOs have the ideological roots and history noted throughout this discussion, PPOs are a recent competitive response to

HMOs and other cost containment pressures--particularly those pressures from the federal government to reduce costs of Medicare and Medicaid patients. PPOs are contractual liaison mechanisms by which the services of a specific panel of providers--physicians, hospitals, or both--are marketed with certain cost or efficiency incentives to enrollees. PPOs are often sponsored by providers, but they are also sponsored by multi-hospital networks, and entrepreneurs, such as third party administrators and insurance brokers.

For patients, PPOs are more flexible than HMOs (including IPAs) because patients are not limited to specific providers as they are with HMOs; by paying part of the cost, they may choose a provider who is not "preferred," i.e., the provider panel is preferred but not exclusive. For physicians, PPOs make it possible to continue to practice in their own offices, to continue to see non-PPO patients, and to avoid sharing the risk of prepayment. In PPOs, physicians are paid fee-for-service, but at an agreed-upon discount. In other words, PPOs are an effort to duplicate the traditional health care delivery system but claim to contain costs. While they are being established at a rapid rate, it is very difficult to measure their growth because there is a marked difference between the number of potential participants and the actual enrollees. While patients are <u>encouraged</u> to use physicians, hospitals, specialized clinics, etc. which are "preferred" by the plan, they are not "locked in" to a fixed group of providers. Therefore data on PPOs are difficult to interpret because participation in a PPO is not an exclusive commitment; therefore one physician or provider organization can appear on many lists of PPOs.

Although it is difficult to measure the extent of the PPO competition in response to the HMO movement, certain PPOs, built on the experience of HMOs, are drawing very large enrollments. I include here an example, AWARE GOLD, a PPO in Minnesota, because it demonstrates the potential for competitive response elicited by the HMOs, and it demonstrates the capacity and characteristics of a new generation of sophisticated corporate health care systems. Furthermore, it is an important force in (as well as a result of) the competitive health environment in Minnesota which will be described more fully in Chapter 8.

AWARE GOLD an Exemplary PPO

Aware Gold, the 1 1/2-year-old PPO of Blue Cross Blue Shield of Minnesota (BCBSM) illustrates the potential commercial success of PPOs. Until recently BCBSM was a weak competitor among the managed care systems in Minnesota, and had suffered a number of years of contract losses in the Twin Cities. But with their new product, Aware Gold, they have not only underbid other Twin Cities HMOs in closed bidding for state employee contracts (causing many state employees to choose to shift plans), but are also competing aggressively and successfully for other HMO enrollees. The Public Relations and Marketing office of Aware Gold reports an enrollment of 200,000 persons in 80,000 contracts during its first year and a half of operation. In the mature Minnesota market area, already familiar with both the benefits and limitations of HMOs, this PPO presents several attractions:

For patients, it covers their care, including preventive services, with any provider they choose and without the requirement

that they go first to a primary care physician/ gatekeeper. (Services by "preferred providers"--those on the Aware Gold panel, which now constitute over 75 percent of the physicians and 100 percent of the hospitals--are fully covered. But if the patient chooses to seek care or consultation elsewhere, even out of the state, Aware Gold will cover all but a copayment.)

While physicians and hospitals must accept a negotiated discounted rate, the plan reimburses them for each service they provide for patients, fee-for-service.

For employers, the premium rates are very competitive (some speculate unprofitably low to gain a place in the market) and furthermore, Aware Gold, because it is a PPO, can "experience rate," i.e., the premium rate for the employer group can be based on the actuarial characteristics of the employee group-- age, sex, and use of medical and hospital services. (This is in contrast to the less favorable premium rates under "community rating" which requires HMOs [by law] to provide the same rate to all persons and groups regardless of their age, sex or likely use of services.)

Aware Gold is a "product" carefully conceived and marketed by a company that has networks ready to carry it throughout Minnesota, and affiliates to imitate it throughout the nation. Already the midwestern states, as well as Ohio, Pennsylvania, Florida, and Arizona are "expressing interest in Aware Gold cooperative ventures that would further enhance [its] acceptance and recognition." (Public relations material from Blue Cross)

To capitalize on and expand their success, BCBSM has recently introduced HMO Gold, a product which, coupled with Aware Gold, will

provide employers with a complete range of prepaid and fee-for-service alternatives with efficiency and limited paperwork. Health care management analysts note that this efficiency and effective competitiveness are directly related to BCBSM's highly sophisticated computerized management information system developed to review and coordinate the medical, administrative, and financial aspects of the system.

Managed Care Systems: Hybrids and Triple Options

The plan just described in Minnesota, in which Blue cross provides Aware Gold and HMO Gold together, is characteristic of the new hybrid systems in which major corporate insurers offer to an employer a complete set of "managed health care" options in one package. These include both health insurance and health care options. These systems require the most sophisticated (and costly) Management Information systems which provide the essential foundation for management of care, cost and utilization in a large system.

Furthermore, the oldest HMOs built on the cooperative and consumer movement ideology are not immune to this trend. Group Health Plan of Minnesota (one of the founders' primary models) announced a joint venture with Prudential Insurance Company to create a "hybrid health plan, Choice Plus--one company which will be able to meet indemnity needs, hybrid needs, ahd the HMO needs of every employer." The arrangement provides the Group Health Plan access to indemnity insurance, and for GH members, Prudential's nationwide PruCare coverage.

Insurers Invest

Nationwide coverage is most readily offered by the large traditional insurance corporation. In the early 1970s these companies did not make any major commitment. Rather they were hanging back and observing while the HMOs made their mistakes, and finally became increasingly accepted. Now that conditions are stabilized, insurers are taking a major role in the health care market. For example, three insurers, John Hancock Mutual Life Insurance Co., Hartford Insurance Group, and Northwestern National Life Insurance Co. have decided to "joint venture"[5] to establish, first, a national network of PPOs, to be followed by HMOs, in about 50 locations. Each company will contribute a third to the $100 million deal. And Metropolitan Life Insurance company has planned $105 million for 1986 HMO startups for a total investment of $210,000,000 through its triple option Metlife Healthcare Plans.

In 1986, of the 23 million HMO subscribers in over 595 plans more than half (53%) are enrolled in the large corporate multistate companies, and seven companies provide 44% of the care: Kaiser, Cigna, Maxicare, Health America, US Health Care Systems, Prudential, and United Health Care Corporation. Not-for-profit companies still account for 61.5 percent of the HMO enrollment.

HMOs and most health care have traditionally been provided through not-for-profit corporations; furthermore, not-for-profit health care was an important principle of the HMO consumer-founders, but that too is changing. For profit companies are taking an increasingly large role in financing and organizing health care. In 1986, of the 595 HMOs 308 are incorporated for profit.

In sum, the alternative health care delivery market is increasingly complex, for providers, patients, and investors. It is no longer clearly possible to designate types, sponsorships, membership, or profit-making status. The plan types are often mixed, and sponsorship in 1986 includes significant small and large joint ventures between competitive doctors, hospitals, insurers, and employers, as well as groups that have not been in health care before. Membership is more difficult to designate, particularly as large insurers begin to offer a choice of HMO, PPO, and indemnity insurance to employees under one umbrella as one risk group. Finally, in alternative health care, for-profit and not-for-profit HMOs seem very much alike. For-profits often have not-for-profit components, and traditional not-for-profits have for-profit affiliations; e.g. Blue Cross/Blue Shield is also developing a for-profit IPA in Washington D.C.--Capitol Care--a wholly owned subsidiary. The Minnesota Medical Association now has a for-profit management consulting component, as does the Harvard Community Health Plan. Symbolically, a significant number of plans are changing their names, making it even more difficult to designate which are new plans, and which are components, affiliates, or subsidiaries of old plans.

The consumer-founders' role in the many changes, as well as the consequences for the consumers themselves, will be the subjects of the next chapter.

ENDNOTES

1. Note the increasingly frequent use of the word "product" to describe what have previously been considered professional interactions or services.

2. Data from this section, unless otherwise noted are from the HMO Census, OHMO, HEW, and InterStudy.

3. PHP enrolls over 100,000; members but the members are not only associated with the home office in Lansing but also in other small cities throughout the state.

4. It is clear from interviews with physicians, that remaining in their own offices is an important symbol of autonomy. However--as will become clear in Chapter 8--while there physicians maintain their internal micro world of assistants and patients, much of their practice is controlled by external plan managers.

5. Now a verb in the health care "market place," meaning to join together in a business venture.

PART IV. CONSEQUENCES FOR CONSUMERS, PHYSICIANS, AND THE HEALTH CARE SYSTEM

CHAPTER 7

CONSUMER-ACTIVISTS: CAREERS AND CONSEQUENCES

"A successful movement is the intersection
between personal and social change."
Jo Freeman 1975

INTRODUCTION

Earlier chapters have documented the importance of the personal efforts of individual consumers and the nature of the social change they sought to bring about. In this Chapter I will discuss the consumers themselves--particularly the founders. I will examine their ideology, goals, and the groups they sought to model themselves after, as well as the consequences in their own lives of their participation in the social movement organizations. In addition, expanding on these specific data, I consider what impact consumers have had, and can be expected to have on the changing health care system.

Chapter 4 described consumers as an integral part of the communities in which they live, and, in this case, in the communities in which these HMOs emerged and developed. As noted, consumers reflect the dynamics of their community and affect it in different ways, depending on the nature of the community and its history and patterns of decision making. (Anderson et al. 1985)

Our research in Minneapolis-St. Paul demonstrated that consumers as citizens accepted and supported centralized leadership which, in the homogeneous Twin Cities, has traditionally come largely from the major midwestern corporations headquartered there, such as General Mills, 3M, and Honeywell. In the 1950s Minnesota consumers active in the cooperative movement (strong because of the grain and dairy cooperatives

of the midwestern plains states) established Group Health of Minnesota, a model of radical consumer participation in a medical cooperative. However, by the 1970s there was little consumer activism; instead centralized community leadership (e.g., in the Citizen's League and Metropolitan Council) explored the possibility of health care delivery based on the addition of prepayment to the prevalent group practice model.

In neither Chicago, Illinois nor Lansing, Michigan, was there such a tradition of centralized community leadership. In those communities in the 1970s it was local consumer activists who initiated the idea of consumer controlled prepaid health plans and effectively recruited personnel and clientele to their cause.

In Chicago, we found this consistent with considerable "grass roots" consumer activism scattered throughout the heterogenous metropolitan area. In an environment of community activism in Evanston, on the edge of Chicago within the larger metropolitan area, local consumer activists sowed the seeds of change in health care.

Lansing is a community dominated by three institutions--Michigan State government, the United Auto Workers (UAW) (Oldsmobile is headquartered there) and Michigan State University--but it has little coordinated civic leadership. In the 1970s consumer activists initiated the idea of a prepaid consumer sponsored health plan and they drew on resources from these three major institutions. (In Lansing the dominant activist leadership has traditionally come from labor, which, in fact, the consumer-founders quickly recruited to their movement.)

CHARACTERISTICS AND EARLIER ACTIVISM OF THE FOUNDERS

The founding members of the two HMOs, like their communities, are in some ways different. These differences have been detailed in the case studies of the last chapter. It is the purpose of the analysis of this chapter to highlight the patterns of similarity.

The founders of the HMOs in both Evanston and lansing were in their early 30s, white, college-educated (all had a BA, some an MA), and married. Most were women (all in NorthCare), and, in interviews both the men and women regularly mentioned the supportive attitude of their spouses, though no spouse became a primary member of the HMO movement. None among the "first wave" of founders was employed. The women lived with their professional or academic husbands in (the then normative) one-career families and had primary responsibility for their usually three or four children who had been born to them in their early, mid and late twenties. In Lansing, the man among the founders of Health Central was a graduate student (in agricultural economics) whose wife was a professional and academic. He, too, had children for whom he shared responsibility.

When the founders described themselves, they stressed the importance of their earlier social activism. For some it was their earlier activities that brought them to the attention of the HMO group. To summarize data from the case studies, those in NorthCare had already developed food and child care coops and, most important to them, had created an "underground" Catholic church organization of twenty-five families that confronted the hierarchical tradition of the Catholic church, and took religion as a personal responsibility, "not something that should be put off on others." Furthermore, they had been

associated with, though less active in, the civil rights and anti-war activism prevalent on their college campus and among the students they knew.

In Lansing, the earliest idea leading to Health Central emerged in a group that, like those in Chicago, already had a "community-action-peace-activist bond." They also shared an activist history in the Democratic Party, which, in the Lansing area, is strongly influenced by labor union activism. Though many of that earliest group were too fully employed to become primary movers in the HMO movement, they recruited an activist graduate student who had become visible in his battle against poor television for children, "the great TV caper," and had recently returned from the Peace Corps, where he had fought against hunger in India. They had all more recently been allies in the anti-war movement that animated the college town as well as the nation. As Ruzek notes (1978:62) activists are often "trained" in other social movements, and membership overlaps.

NorthCare founders generally referred to the twenty-five families in their Catholic activist group as a reliable source of both support ("We had 25 families we could drop our kids off with") and recruitment of personnel and clientele (their first advisors and board were drawn largely from that group.) A similar network of personnel, clientele, and support in the Lansing area came from the Democratic party activists, particularly those associated with labor.[1] (The Lansing Labor News donated early office space and other support.)

Having honed their commitments in earlier activism, the founders had already developed a strong ideology which they brought to their determination to change health care delivery.

Ideology and Goals

To understand these founders, I will examine those relevant perceptions and convictions with which they explain their beliefs and behavior in my interviews with them. A discussion of their views should show that while they held the views strongly, there were often dichotomies or conflicting threads within their convictions.

In the 1960s and early 1970s across the country, consumers concerned with health care reflected the then-prevalent national consumer ideology. Starr (1982) summarizes this ideology and notes:

> "Health care as a matter of right, not privilege: No other single idea so captures the spirit of the time.
> (Starr:389)

He convincingly ties this belief to other movements which I have already traced in the founders' histories. Starr notes:

> The civil rights struggle lost its momentum as a protest movement in the seventies, but it set the example for dozens of other movements of similar purpose.

The language of rights in health was notable in Michigan agencies that were sponsored by HEW. A Consumer Support Group Project funded by HEW to help "establish a mechanism for partnership between health consumers and providers," exemplifies this theme. The introduction to their consumer handbook notes: "Recent years have brought heightened social awareness of equal rights under the law. Along with this awareness has come a recognition that health care is a right of all people and not a privilege of the fortunate."

But the health rights groups were not developed simply to help the less fortunate. In fact two distinctive themes developed along with two corresponding types of groups (although the rhetoric was sometimes mixed). First there was the right claimed TO medical care; secondly

there were rights claimed IN medical care "such as the right to informed consent, the right to refuse treatment, the right to see ones own medical records, the right to participate in therapeutic decisions..." and so on (Starr 1982:389).

Spector and Kitsuse (1977) suggest two other dimensions that illuminate the tension slightly differently. They describe one category of "humanitarian reformers...and garden variety `do gooders' engaging in disinterested, principled activity for disadvantaged others," and another "who claim to be victims of the conditions; (these) we call...an interest group."

The convictions may also be described as two different ways to be concerned about equity: 1) one concern is with an equitable distribution of good care among the population--the poor and minority groups as well as the more secure majority groups; and 2) another concern is with a more equitable distribution of power between the providers of health care, mostly perceived as doctors, and the consumers of health care, patients. Outgrowths of these latter sets of interests are the self-help movement, the home birth movement, the women's health movement, and so on.

I dwell on the distinctions between these two concerns (and the groups that voice them) because: first, the possible solutions to the two perceived problems are often different i.e., they may require different distribution of resources, and may make different assumptions about personnel; and second the founders of NorthCare <u>and</u> of Health Central voiced <u>both</u> concerns simultaneously. This tension offers insight into the consumers themselves, as well as into the organizational and financial problems they would have.

Equity: Equal Access

In the earliest documents (some quoted in Chapter 5) of the Evanston Medical Consumers and the Health Action League, concerns about equal access for all are prominent. Furthermore, as discussed earlier, the consumers' commitment to "community rating," that is, open access for all enrollees without a health exam, was a concrete effort to act on their belief in equal access. And in Michigan, an important decision, the location of the health center, was based on the wish to be accessible to more than the privileged university community. It should be noted that for both HMOs their commitment to open enrollment led to heavy utilization which was eventually blamed for many of the financial difficulties that would plague consumer HMOs.

Interviews revealed another important belief of some of the founders. In the early 1970s, they had favored or accepted some form of the national health insurance which had been expected to become law, Many in the national HMO movement, and one founder in particular whom I interviewed, explained that he had not been convinced of the importance of HMOs until (while attending a meeting at Group Health in Minnesota) he came to understand that HMOs were a way to demonstrate that costs could be controlled. He saw this as a crucial step toward National Health Insurance, which, he anticipated, would provide universal access to health care in the United States.

Relationship to Physicians: Ambivalence

While guaranteeing access to medical care was one primary goal, changing the relationship with physicians <u>within</u> medical care was also central to the founders' plans. For the founders of NorthCare one of

their first "Philosophies and Principles" reads: "Medical consumers are partners with the physician member in their own health care and maintenance. The partnership is one of equality and cooperation." And, characteristically, HALE's board minutes of May, 1976 read:

> A draft of "Patient Rights" on how the patient should interface with the physician was handed out to the board...by the health education committee....there is a book out now on how to diagnose and treat yourself...

In the same period HALE sponsored a workshop called "From Patient's Rights to Patient Power."

These are examples of efforts to deprofessionalize physicians, (Freidson 1985) "proletarianize" medicine (McKinlay 1982), or reduce "professional sovereignty" (Starr 1983). Indeed, the HMO founders wanted more power in the doctor-patient relationship; they wanted to be "partners."

However, consumer-activist attitudes toward physicians were complex. As noted in Chapter 5, they did not wish to go outside the mainstream of medicine, and they knew that they needed physicians to validate their efforts. Furthermore, as Mechanic (1985:11) notes, "attitudes and behavior are quite different things...Despite growing consumerism and skepticism about authority in the culture as a whole, it is remarkable how pliant and deferential most patients continue to be."

Perhaps because traditionally in America the consumers' connection to understanding issues of health has been through the physician, the health consumer/patient is very strongly influenced by the viewpoint of the health provider/doctor. The doctor-patient relationship seems, unlike other provider-consumer relationships, to include elements that

cannot be completely explained by direct logic or reasoning. For example, survey data show that people believe that there is a health care crisis in America; however, the same people report that they are satisfied with their own medical care (Andersen et al. 1981). In fact, high levels of satisfaction with their own providers are reported in almost all studies (Luft 1981:253). Furthermore, I found when I interviewed consumers, regulators, hospital administrators, insurers, employers, and union leaders in Minneapolis-St. Paul and Chicago, it was consumers' views that most closely paralleled the views of physicians in the same community.

My interviews, and those of my colleagues, suggest that even the most skilled and adversarial consumer health advocates avoid conflicts with physicians. I asked the principal spokesperson for an influential health consumers' group in Chicago how they had brought their concerns about cost to the attention of physicians. He responded:

> (We) have stayed away from doctors...for political reasons. They have the most powerful lobby both in Springfield and in Washington. We've tried to be very realistic about what we can do. And we have found as long as we don't antagonize the doctors we can have a field day with the hospitals and insurance companies--just as long as we leave the doctors alone.

I asked if there was any change anticipated in that policy, and the spokesperson responded that it would eventually be necessary, but then, he said, we "need a complete reorganization of the system...I don't see it in my lifetime."

One can see that this pervasive reluctance, in the general population, to confront the power of doctors, coupled with admiration and close affective ties with one's own doctor has important implications for the ability of consumers to advocate innovations in

health care, HMOs or any other policy that physicians oppose or even do not actively support. Given this documented attitude, it is interesting that the consumer founders were so effective in recruiting personnel and clientele to their movement. Individual conditions in the communities, as noted in Chapter 4 (as well as the consumers' marketing to exploit the conditions), offer explanations for this effectiveness.

In NorthCare, from an early point, the founders associated themselves with a well-respected hospital and they accepted the advice and benefited from the reputation of an esteemed--slightly "maverick"--physician. In Lansing, physicians were not associated early with the HMO movement in a visible way, and consumers who had good relations with physicians were reluctant to leave them. However, in Lansing in general, access to primary care physicians was insufficient for the population; therefore an HMO promised a better association with a regular physician for the many patients who otherwise had inconsistent care received largely in emergency rooms.

Although the founders and other sophisticated consumers were not awed by the medical profession, one noted:

> There is a mystique that the health field is "highly technical and too hard to understand" and that the "doctor is well intentioned and knows best."

Although this person interviewed disagreed with that common perception, she continued her understanding:

> If you go to the doctor not well, you're not going to fight with your doctor, particularly if you think he is a wonderful person... patients don't see through to the system of health care."

But the consumer founders DID see through to the system of health care and they wanted to control it. While usually acknowledging the important medical role of physicians, they wanted a partnership in which they would manage the care. Most wanted a staff model in which the physicians are salaried directly by the health plan. One founder in Michigan summed up why they "want(ed) to hire the docs:"

> Yeah, I know they lose some independence, but frankly that's what I want to do. But I always voted to pay them well, just not let them run it."

The effort not to let physicians "run" health care was waged with only slight success by consumer-founders of HMOs. While consumers dominated the early boards of trustees, physicians dominated the health care itself. Both of these two HMOs under study have medical directors who are unconventional in comparison to the normative physicians in private practice; however, those physician-directors protect the rights of physicians to control the clinical environment. Even at a premier model of consumer-controlled HMOs, Group Health Plan of Minnesota, the salaried physicians demanded that they be allowed to form a physicians' group that would be responsible for the review of clinical practice because they would not accept the evaluation of a board of lay persons over physicians.

Distaste for Business and Profit

In addition to the central issues of ideology that motivated the founders, two less important but notable related issues protected their social movement roots and values but hobbled their ability to make their way in the increasingly competitive health care market. The founders unanimously distrusted business and anything in health care designated "for profit."

Although "...non-profit status often reflects legal technicality rather than actual organizational goals" (NCHSR, 1981), most consumer activists, even those who have been observing the health care system for many years, have a strong aversion to "for profit" health care. The Minnesota legislature, no doubt in some part responding to such consumer sentiment, passed legislation requiring HMOs to be non-profit. Illinois and Michigan, however, allow for-profit HMOs but consumers in Michigan and Illinois continue to express distrust of for-profit organizations in spite of the evidence that non-profit organizations behave similarly to those explicitly for profit (Taylor and Kagay 1986). (For example, not-for-profit health care institutions can funnel off profits to affiliated entities such as holding companies.) Nonetheless, consumer founders of both NorthCare and Health Central were adamant about the rightness of non-profit status and in Michigan, at least, labor saw the HMO in a favorable light because it was non-profit.

More important to the development of the HMOs than the philosophical distinction between "for and not-for-profit" was the consumer-activists' apparent aversion to the business community. Although in early publications they acknowledged the importance of a board of trustees fully representative of the community, neither of the early boards had business community representatives. In one interview a founder described the development of their early boards:

> At first there was friendship; later there was expertise...lawyers were important"
> I asked:
> "What about business people?"
> She responded immediately:
> "We didn't have any business people; zip, zero."

It appears that because the founders' personal networks, largely built on their earlier social activism, did not include business leaders--who were also employers--in either community, the organizations developed without those dimensions of expertise and connection which they would later find they needed.

Models For Action

Just as the founders' ideology had an important impact on their choice of goals and allies, so it also had an important effect on the models of health plans they chose to emulate. My interviews with founders revealed a patterned selectivity in the models they discussed. I noted earlier that for both NorthCare and Health Central a founder who had belonged to Kaiser Permanente in California had been the catalyst to action. That is to say, in each community of activists one among them had an example of a way in which their perceived problem of access to care could be solved. ["Only the (knowledge of) the prior existence of institutional arrangements and putative solutions make problems possible, perceptible, nameable, and actionable" (Spector and Kitsuse:85)]. Thus, Kaiser was the first and indispensable model for their action.

However, the successful model of Kaiser was explicitly avoided when the consumers began to gather information for developing their own HMO. In Chicago, they said, "we never called Kaiser, we focused on the consumer model groups"; "we knew we wanted consumer control."

And in Michigan, the founders of Health Central who spoke of a strong commitment to providing universal access to health care did not look to the prepaid plan in Michigan which had developed in the late

1950s outside of Detroit and, with the support of the UAW, was in the early 1970s already providing care to medicaid patients. (The founders later had cooperative discussions with HMO leaders in Detroit, but the Detroit model was not what the founders planned to create.) Nor did they look to Kaiser.[2] Rather, they and the NorthCare founders used as their models the consumer cooperatives founded twenty years earlier. "We called Puget Sound; we thought it was the gospel."

Group Health Cooperative of Puget Sound and Group Health Plan in Minnesota were founded in the 1950s by credit union and cooperative leaders "profoundly influenced by the philosophy of the Cooperative League of the USA" (Uphoff and Uphoff 1980:31-32). These plans were extensions of the theme of the consumer and producer cooperatives of the thirties which had developed in a period of economic recession. (For example, that Michael Shadid successfully began the Elk City Oklahoma Medical Cooperative in 1929 with a $50 contribution from members.)

In interviews the founders often referred to visits back and forth with members of those consumer cooperatives that had been begun in a different historical moment. (Eleanor Brand, the "pioneer woman" from Puget Sound was the first invited speaker to HALE, and Maurice McKay, the classic representative of Group Health Plan in Minnesota at an early conference motivated the NorthCare founders.) But the economics of highly technological medical care, inflated over years by an unmonitored third-party payment system, were dramatically different than those in which the consumer coops were founded. A NorthCare founder wryly recalled that when they first realized the challenge of financing a health care institution in the 1970's they "even thought of

getting money from members, like Puget Sound, but things had gotten too expensive. It was no longer like the early days of the Puget Sound Coop."

Thus, the models which the consumer founders found compatible with their ideology did not, in fact, provide examples for establishing a viable prepaid plan in the 1970's.

THE CONSUMER/FOUNDERS AND THE HMO MOVEMENT

Overview Of An "Ironic Alliance"

I have described the ideology, goals, networks, and models of these consumer activists in the context of social movements and literature about social movements. However, the influence of the HMO founders as social activists and the impact of their actions deviate in interesting ways from those described for other social movements. These differences are particularly telling as they highlight the irony and unintended consequences of the consumer/founders' efforts.

Freeman (1975) and Ruzek (1978) also describe social movements in the early 1970s--movements which, as noted earlier,in some ways intersected with the HMO efforts. In the Women's Health Movement (Ruzek 1978) describes the important and characteristic role of the "radical flank" in paving the way for change; but for the HMOs it was the conservative flank that smoothed the way for the HMO founders. The interests of a conservative government administration caused a very different response to the HMO movement than the one which confronted the women's health movement. Furthermore, Jo Freeman (1975) notes that the women's liberation movement was characteristically slow to have an impact on policy and society. In contrast, the founders of the HMO

movement were invited and encouraged to testify at legislative hearings as states tried to develop policy and regulations. This experience, as I will show shortly, had a profound effect on those who participated. (Zald and Ash [1966] note that sometimes a social movement is altered because the society moves in the direction of the change sought.) In the HMO movement of the early 1970s the consumers' efforts and the actions of the federal and state governments were very dense and synergistic.

While on one hand the consumers' views were incorporated into law and their developing consumer-sponsored and-controlled health maintenance organizations were held up as models by both state and federal agencies, on the other hand, the consumers were being coopted. As they sought approval and support from government agencies they began to modify their own language to fit that conservative structure. Other social movements, such as the women's movement, first confronted government agencies, and in response, the agencies slowly began to acknowledge the demands of the movement and <u>then</u> began the process of cooptation (Freeman 1975). For the HMO movement, this usual bureaucratization or conservative assimilation of reform was <u>accelerated</u> by the government's already present interest in the health care delivery reform.

Because the consumers perceived that it was the medical profession which held the power they were seeking to share, they readily accepted the government as an ally. For example, they accepted the bureaucratic reconstruction characterized by the new language regarding "consumers and providers" in place of "patients and doctors."[3] The consumers welcomed it as the language of partnership and at the same time won

essential financial support from government agencies. One founder noted that the federal applications were time-consuming but "not difficult--they gave us a recipe."

In the two segments that follow, The Consequences for the Consumer/Founders, and The Impact of the Consumers on the Development of HMOs, I describe the effects of the HMO movement on the consumers, as well as on alternative health care delivery system, including important interactions with government. The final section, Part IV will consider the nature of their group as a specific cohort and the potential influence of such groups.

Consequences For Consumers

> "Rarely does a social movement leave unchanged the structure of the group in which it arises."
> Killian (1964:454)

In 1970 in Chicago, the eight women of the first two waves of NorthCare founders were "housewives" primarily raising children. None had educational background or family members associated with health professions. In 1986, all eight are professionals, seven earn a living in health care administration or consulting, and one is a professional educator still associated with a neighborhood health clinic.

In Michigan in 1972, the "first wave" of founders were housewives and graduate students; the second wave added young academics and a labor leader. In 1986 all but two of these are (or have recently been) in health care administration, regulation, or consulting.

The dominance and similarity of outcomes demonstrates the power of the processes of professionalization and bureaucration experienced by the activists (Weber 1945; Blumer 1971; Hughes 1957; Ruzek 1978;

Freeman 1975; etc.) In an analysis of the "reorganization of the medical profession" Freidson (1985:18) considers the consumer health movements and asserts:

> The consumer movement in any case has no broad grass roots base in the population. It is less a function of organized activities on the part of numerous consumers than it is of organized political actions by "program professionals."

While in the mid-1980s the numbers of consumer activists <u>is</u> limited, it is a revision of history to assert that the activists involved in the consumer movements of the 1970s--certainly as exemplified by the consumer HMO movement--were always professional. Their recent professional status is a product of their early commitments as naive but educated social activists intersecting with a complex political and economic health delivery system. While this study has shown that they did not begin as professionals, they certainly did become professionals. The process is described in their interviews and the evidence is seen in their careers.

One "second wave" NorthCare founder summarized her experience:

> I wasn't working at the time. I was on the City Council. My kids were growing older and (the job) sounded interesting--$25 a week to do community assessment....We grew with it; we proposed the grant; we got the money; we did the federal feasibility . One thing led to another and by the time we finished it was four years. By that time I felt committed to the health care field... an experience that probably can't be repeated.

As I have already discussed, enthusiastic commitment to creating a successful organization in conjuction with the need for support and financial resources drew the consumers toward compromise from the start. I add here some evidence of that experience from their own words. A founder told me:

> Gradual substantive changes were being made by each of us. A gradual lessening of idealism, a giving up of the principles that influenced us. For example, we couldn't serve everybody. That we couldn't get enough money together to serve the poor...and that medicaid wasn't going to pay for them...and we weren't allowed to cross-subsidize by the regulators... That was a really terrible realization, because it was one of the principles.

The requirements of the regulators and funders structured much of the consumers' professionalization. As noted earlier, when the HMO was prepared to provide service federal regulations required that they develop a board of directors separate from the original (and ideological) board that founded it. That split required those who went on the new organizational board to make a symbolic commitment to the plan and a practical commitment to making the plan viable. A NorthCare founder who made that shift explains:

> Ten people (from the original board) moved over to the plan. New people were added--powerful employers, VP's, etc. The character of the board changed but the dominant strain was still the ideological bent of the original group. But it had been diluted. Practicality made a certain amount of compromise necessary.

In Michigan the invitation to the consumers to testify before the legislature socialized them to different expectations of themselves. They prepared extensively and felt the importance of the testimony; they knew it would influence the state's health legislation. Furthermore, in both communities, preparing the voluminous 500 and 600 page applications for feasibility, planning and start-up funds taught the consumers about the complexity of their community as well as the delivery of health care, and the effort committed them to making the plan work.

At the state capitol the consumer activists were given not only the experience, but also the contacts and networking that

professionalized them and finally led them to professional opportunities and careers. One Lansing founder pinpointed a specific time that began her professional career:

> We brought Eleanor Brand (from GHPS) in to speak as an expert (for twenty years!) for the state legislative hearings. I picked her up at the airport and took her directly to Bill Ballenger's house. (The senator who chaired the committee conducting the hearings.) That's how I ended up working in licensing and regulation. Years later, after I had been to law school Bill Ballenger was the director of the Department of Licensing and Regulation and even though he was an eminent Republican and I'm a card carrying Democrat... he remembered me...it was a direct result of my being a consumer lobbyist for HMOs.

Other founders in both NorthCare and Health Central were recruited from their board position to a place on the staff; they have continued careers as professional HMO administrators. Others, three in Lansing (the state capitol) and one in Chicago, have served in state and federal health regulatory agencies. (Movement of these professionals between the public and private sector is discussed in Chapter 8.) (Freeman [1975] also notes the recruitment of activists in the Women's Liberation Movement into government positions.)

It should be further noted that while all the principal activists in these movement organizations did "professionalize," they ended up in a wide range of professional activity. At one end of the spectrum is professional activism i.e., roles in which professionals are paid to administer institutionalized social movement programs, such as hospice, fair housing, home nursing, or anti-nuclear organizations (all of these are among the subsequent interests of the HMO founders). At the other end of the spectrum, some former activists chose business organizations that are essentially separate from their earlier ideology

but incorporate skills learned in the activist process. In such cases they administer business organizations whose policies explicitly contrast with those they supported as activists. In fact, one founder, once committed to equal access for the poor as well as staff model HMOs, now directs an IPA that refuses contracts with Medicaid because Medicaid does not pay the IPA's costs.

Influence Of Consumers On the Development of HMOs

The powerful impact of the HMO movement on the consumers who founded it is evident in concrete ways. The reciprocal influence of the consumers' movement on the development of HMOs as a whole is both concrete and symbolic. While in 1986 less than a fifth of the HMOs in the United States were sponsored by consumers, the influence of their ideas, and certainly their rhetoric, is present in all HMOs. Conceptually, the consumer sponsored HMO is the archetype of HMOs. The major principles embodied by those "pure" HMOs have become the rhetorical ideals--that is the issues referred to in marketing materials-- of all HMOs: They say that HMO care provides continuity, comprehensiveness, accessibility, prevention, and responsiveness to (or "partnership" with) patients, i.e., enrollees.[4]

The consumer activists also concretely influenced HMO legislation and regulations, both willingly, and unwillingly. As noted before, much of the consumers' testimony before the state legislature was reflected in the law. Not only their testimony, but also the problems and failures of consumer groups had an important impact on legislation and regulation. For example, the troubling statistics from NorthCare's open enrollment were taken before a Congressional committee to amend

the open enrollment requirement. As a result, the elimination of open enrollment was among the first amendments to the HMO legislation. Other regulations were built on lessons learned from the financial failures of other HMOs.

Furthermore, and most telling perhaps, the problems were not always unanticipated by the federal agencies. The government had a more complex agenda than to simply begin HMOs. A onetime federal administrator explained;

> Feasibility grants were not necessarily votes of confidence in a group but rather an effort to get competition into a community. I think we always knew that consumers groups were not going to be successful in starting an HMO. But by supporting (consumer HMOs) we might get something like the Mayo Clinic to do a feasibility study.

In addition to the lessons learned intentionally or by chance, the government also gleaned from consumer sponsored HMOs a rich source of personnel for state and federal health agencies. The government recruited some of the early founders: for example, one of the early board members at Health Central was recruited for the federal Region V office in Chicago. And the first recruits, in turn, scavenged among their network of colleagues for more regulators and administrators for government offices. Although their earlier views have been modified, these professionals continue the influence of the consumer movement.

IMPLICATIONS: POTENTIAL INFLUENCE OF CONSUMERS AS ACTIVISTS

These cases suggest that the potential for consumers to be influential as activists depend on 1) their own characteristics--particularly their availability and their interest, and 2) the structural definition and role available to those defined as "consumers."

In this chapter I have discussed the consumers' social movement as intersections of personal and social change (Freeman 1975) and of history and biography (Mills 1954). Tamara Hareven and Alice Rossi also provide useful perspectives on intersections of biography and history.

Rossi (1982) and Hareven (1978) argue that biography and history intersect differently for every cohort, and individuals and actions must be considered in their historical context. Hareven emphasizes the interactions between life course transitions and historical change. (Consider, for example, that the Evanston founders moved to a new activism as their interest in early childhood education in the church "began to wane because the children were growing up;" this occurred at the same time the college town echoed with social activism.) Hareven (1978) says the:

> "task is to identify the interaction among demographic, social, and economic conditions with specific historic periods as it affects the patterns of timing in the life course transitions. It is the intersection between the conditions and the historic period that define a cohort's particularity."

Chapter 4 has described the effects of the conditions in the different communities in a specific historical period, and the founders' story is of a specific cohort of social activists of the early 1970s who have bridged the historic period of <u>activism</u> to <u>professionalism</u> in their own middle years and thus demonstrate and define a <u>particular</u> intersection of biography and history.

Rossi (1982:32) cautions that we not "burden the future with research findings and political ideas relevant to one cohort of adults but irrelevant to an understanding of their successors." This caution is particularly relevant to this study of social activism in health

care. While for the founders, children and their volunteer work were the center of many of their activities, women of the same social class and education but ten years younger do not, and will not typically in this generation, follow the same life course. Rather, data suggest they are likely to bear children later in their lives, continue some career and possibly have little or no time or energy for volunteer activities no matter how challenging and important.

Volunteerism is changing markedly; health care organizations will not have young well-educated "housewives" to initiate them any more. And there are suggestions that there will not be older housewives for this task either; my interviews (among other growing data) demonstrate that now it has become characteristic of the founders' cohort for a significant number of its members to return to a career or professional education when in their late 30's and early 40's. The women who eight or ten years ago would have worked on or been members of a board as consumers, are likely now to take professional positions in the health organization itself or, if on the board, then not as "consumers" but rather as lawyers, real estate agents, or congresswomen. They have become a different kind of community resource.[6]

In addition to the implications of different cohorts on potential volunteers and activists, it is important to consider information about the roles available to consumers and their potential effectiveness on boards. While in these case studies we have seen effective social activists (particularly in the early phases of the consumer groups), as the organizations became more complex and the boards more professionalized, the consumer' role became less sure. Both the literature (Morone 1983) and interviews suggest that when consumers are

mixed on boards with professionals and/or others with highly technical knowledge, their effectiveness is altered. One sophisticated consumer advocate with more than ten years of experience on health committees and boards told me that although she was once committed to consumers on such boards as the Health System Agency, she now thinks it would be "better if they had their own organization." She says that they "come in cold" with no experience in bureaucracies and try to work with providers and bureaucrats who have political agendas and staff to back them up. "The biggest problem with a voluntary agency is paperwork; that's how they kill volunteers." The staff, she explained, develops more paperwork to prove that they are needed (and that their organization is very important--organizational maintenance is their primary goal [Morone 1983]). The volunteers (consumers) have limited time; so, she says, if the staff wants to run the organization they "flood the volunteers with paperwork." Most consumers, though hopeful when they volunteer, begin to feel incompetent and withdraw.

Some volunteers, on the other hand, as in these case studies, are professionalized by the experience and begin to lose their consumer viewpoint.[7] There is, then, a paradoxical effect: Consumers who persist in their original, naive, or idealistic perceptions have little impact, and those who are effective often change their original consumer perceptions. Thus, consumer representation continues to be a problem (Luft, 1983).

Health planners whom I interviewed in Chicago and Lansing in the mid-1980s all remembered their hopes and enthusiasm for consumer participation in the early 1970s. But they feel that consumers were

not able to have the influence on health care that was expected or intended.

While the consumers have not gained the control they hoped for over the last fifteen years, there has been considerable change in the medical profession, which the consumers set out to change; and in the delivery of health care, which the consumers sought to influence. These will be the subject of of the following chapter, along with final considerations of the implications now and in the future of the converging interests and intersecting themes that have affected health care in the mid 1980s.

END NOTES

1. The labor movement itself is an institutionalized form of social activism (Killian 1964).

2. Note again: the successful Kaiser plan WAS the model examined by Minnesota physicians beginning St. Louis Park MedCenter, in Minneapolis--NOT Group Health in Minneapolis OR Puget Sound.

3. Paul Ellwood is attributed with the recommendation in the early 1970s to replace the words "physician and patient" with "Provider and Consumer."

4. Note, however, that such rhetoric is not always backed up with action or resources. Prevention ("health maintenance") the early theme of these prepaid plans is included in some way in most HMOs but rarely given substantial resources and the personnel associated with the program have low status in the organization. (Graduate student study by Mary Draper, University of Chicago, 1985).

5. See Daniels and Ruzek's (1972) study of volunteerism, in which they also emphasize the importance of the stage of the life cycle, the different structural contexts, organizational structures and networks.

6. One notes also that these patterns, as well as the professionalization and continued career activity of the founders is consistent with Rossi's observation, and the work of Neugarten and Guttman, that women's behavior becomes more agentic as they pass through middle years and they are "more tolerant of their own aggressive and egocentric impulses (Rossi:20). Also, this datum can be seen as the outcome of the womens's movement as well as the HMO movement--again intersecting movements and themes.

7. This is consistent with the findings of Ruzek and Daniels' (1971) study of volunteers.

CHAPTER 8

THE CHANGING HEALTH CARE ENVIRONMENT: THE ASCENDANCE OF MANAGERS, THE IMPACT OF PAYERS

It is not possible to write a conclusion about HMOs: one cannot say where they began, nor where they will end. As there were many beginnings--in lumber camps, farm towns, ship yards, and urban neighborhoods- so there will be a variety of endings. The term "HMO" has accumulated many clinical and political connotations unintended by the consumer founders.

I have shown in Chapter 7 that in spite of their personal professionalization and growth, the consumers were not able to form the "powerful and effective collectivity" (Ruzek 1978) or "partnership" with physicians that they intended. What, then, have been and will be the consequences for the physicians whom they hoped to change? And what have been the consequences for the alternative health care delivery system as a whole--for its accessibility, its quality, and its cost? To answer these questions, I will first turn to data I gathered in a case study of a medical community where HMOs dominate; this study suggests the potential impact of HMOs on the lives and practice patterns of physicians. Second, I will summarize my observations, as well as contemporary reports in the literature, of the impact of HMOs on the delivery of health care in 1986. Finally, I will ponder the implications for consumers now and in the future reflecting on interweaving themes and forces that have brought health care to this point.

CONSEQUENCES FOR PHYSICIANS

In 1986 the 23 million people enrolled in HMOs are barely 12 percent of the population, but the rate of growth is now very rapid (25 percent a year) and physicians nationwide are, or soon will be, affected. A national survey of physicians by Louis Harris (Harris et al. 1984) suggests that in 1984, as compared to 1980, physicians were already practicing in prepaid health plans in increased numbers. While only 10 percent of U.S. physicians described themselves as prepaid group or capitation physicians, over 50 percent of U.S. physicians said that part of their practice was with an HMO or other contractual reimbursement mechanism. Four out of ten said that more than 10 percent of their practice was prepaid. Furthermore, of those with HMO affiliations 86 percent said they plan to continue those affiliations, and of those NOT affiliated 46 percent were planning to affiliate (up from 27 percent in 1981.)

Physicians in the same national survey also reported other consequences of increased pressures on their practices between 1981 and 1984. Twelve percent reported having reduced their fees (up from 2 percent in 1981), 14 percent reported reduced hospital days for their patients, and 18 percent reported reduced income (up from 8 percent in 1981). Sixty percent of the physicians believed HMOs would affect their practices over the next 10 years.

The changes and anticipated changes noted here earlier are dispersed more or less densely throughout the country. To examine and possibly anticipate the consequences of HMOs for physicians, I chose to interview in Minneapolis-St. Paul, where 50 percent of the two million citizens are now enrolled in HMOs or in preferred provider organizations

(PPOs), and where four years earlier I had had the opportunity to interview these Minnesota physicians during the rapid growth of HMOs in their community.

Minneapolis-St. Paul is a metropolitan area of particular interest to those who study HMOs, as it was to the consumers who founded HMOs in the 1970s. While the relative homogeneity and prosperity of Minneapolis St. Paul makes it demographically unlike Chicago and Lansing, those same characteristics make it a good community to study because it is easier to see the issues related to HMOs relatively less tangled in the economics and politics of a complex urban area. St. Paul is the home of Group Health Plan (GHP), conceived in 1937 and operational in 1957; it is one of the early staff models for pre-paid health plans which survived the resistance of mainstream medicine and served as a model for HMO sponsors in the 1970s. Founders and board members of both Health Central and NorthCare often spoke of the importance to them of visits to and from colleagues at GHP.

The 1982 interviews were part of a research project[1] designed to explore why HMOs were developing and spreading more rapidly in some communities than in others (Anderson et al. 1985). At that time 25 percent of the Twin Cities community was already enrolled in HMOs. For the purposes of that research, we contrasted the heavily enrolled Twin Cities metropolitan area with the Chicago metropolitan area where only 3 percent of the population was then enrolled in HMOs.

On this return to the Twin Cities, I selected six of the original 26 physicians to interview again, as well as six other professionals, observers, and administrators closely tied to the medical community. By comparing their interviews in 1986 with those in 1982, I was able to see

certain changes in their experience over time as well as to explore their perspectives on the changes they had observed as HMOs came to dominate in their community.

All the physicians I interviewed were gracious and cooperative. Their responses, however, were complex, reflecting a time of considerable change and controversy.

Medical Community of Minneapolis-St. Paul

Physicians in Minneapolis-St. Paul, as everywhere, are a diverse group. Furthermore, the Twin Cities themselves are not identical twins. Minneapolis physicians, associated with the Hennepin County Medical Society, have generally different patterns of practice and often different attitudes than in St. Paul physicians, who are associated with the Ramsey County Medical Society.

In contrast to Chicago and Lansing, in Minneapolis, historically, group practice has predominated and large multi-specialty group practices have flourished. Even in 1982, one physician explained: "Here it's hard to find a solo practitioner,... [group practice] has been the pattern for ever and ever." But in St. Paul, much like in Chicago and Lansing, most physicians have practiced in solo practices, or in small, single-specialty group practices. However, as a whole, the Twin Cities have an exceptional and important history of medical practice for others to observe and learn from.

In 1982, our research group found physicians in the Twin Cities to be distinctive in that their attitudes about the medical profession itself were remarkably similar to those in their profession throughout the country, i.e., they expressed similar values, commitments, cautions

and concerns. However, the delivery of health care and the actions of physicians in the Twin Cities were dissimilar because the environment--historically, socially, and economically--was unlike that throughout the rest of the country (Anderson et al. 1985).

History and Demography

Some brief historic and demographic information is important background to contemporary changes and attitudes. The physicians in the Twin Cities, like the community in which they practice, are very homogeneous. Most have had similar training; 93 percent graduated from United States medical schools and in fact most Minneapolis-St. Paul physicians have had some part of their training at one of three nearby institutions: the Mayo Clinic, the University of Minnesota, or the local Veterans Administration hospital. Over 90 percent are male and (as in the community they serve) there is little racial or ethnic diversity among Twin Cities physicians; there are only 14 foreign medical graduates (FMG) per 100/000 population (in contrast, for example, to 61 FMG/100,000 in Chicago.) And Twin Cities physicians are numerous--about 250/100,000 population in contrast to 185/100,000 average for other US metropolitan areas (US Bureau of the Census, 1982).

Further, their community has a strong history of consumer cooperatives and corporate responsibility. These are reflected in both the early beginnings and the very high incidence of group practice (The Mayo clinic, the prototype of multispecialty group practice, began 70 milies from the Twin Cities in 1895) and in the active participation of community leaders from all corporate and professional sectors in community affairs. Thus there is both a Metropolitan Council and a

Citizens League in which community problems and possibilities are addressed and consensus is sought and usually achieved.

Because of the network of leadership and the well integrated community decisionmaking, we found that unlike physicians nationally, Twin Cities physicians were at the forefront of the 1970's surge of interest in HMOs. Physician leaders were serving together with Minnesota corporate leaders on the Citizens League when they expressed an interest in, and plans were developed for, physician-sponsored prepaid plans.

In addition, the community is a center for several policy research organizations including Interstudy, the influential think-tank founded by Dr. Paul Ellwood, which spawned important HMO leaders and became a leading center for research and advocacy of competitive and prepaid health care.

In 1982

In 1982, while in many parts of the United States physicians associated HMOs with mediocrity, bureaucracy, and a loss of autonomy, that was NOT the interpretation of most Minnesota medical leaders. In interviews Minnesota physicians expressed unwaivering pride in, and commitment to, the excellence, as well as the independence, of their health care; their active participation in civic affairs, including their public leadership in the development of HMOs, they said, was meant to preserve those commitments. As a group they strongly opposed externally imposed regulation and saw their role as innovative national leaders in health care. A physician in 1982 characterized that understanding:

> When the government came with their regulation we were usually way ahead in terms of understanding...I think that we feel a sense of responsibility as far as the Feds are concerned, realizing that they're a bunch of people who are as human as we are, and looking for leadership in these areas, so we've always had a sense of providing leadership--that sounds arrogant, I guess, but that really is the sense in our private practice community in the Twin Cities... (and when federal regulation comes)...we've anticipated it and have our own system in place so it causes little ripple...the practices of utilization review and supervision have taken place by our own private efforts, so government regulations are not so odious when all things are being done by peers.

In 1982, with 25 percent of the population enrolled in 7 HMOs, some physicians voiced articulate and persistent objections to HMOs--particularly certain solo practitioners in St. Paul and specialists, e.g. surgeons and dermatologists, who resented the gatekeeping role given to primary care physicians. But, in general, Minneapolis-St. Paul physicians at least accepted, often embraced, and over 90 percent affiliated with, HMOs. Most of the then 7 HMOs of the Twin Cities had had central physician leadership in their development, and by 1982 Physicians Health Plan (PHP), the IPA sponsored by the Hennepin County Medical Society, was the fastest growing.[2] Indeed, the reluctant Ramsey County physicians, in the competitive environment, were also developing affiliations with HMOs.

It is precisely because Twin Cities physicians had been informed and articulate participants in the earlier stages of HMO development and expressed a sense of accomplishment at having minimized government regulation, and a sense of leadership in developing competitive alternatives, that I thought it appropriate to interview them about this recent stage of dramatic growth.

In 1986

In May of 1986, the physicians I interviewed discussed their perceptions of their professional lives particularly as they had changed since 1982. In 1982 when physicians had described their practices, they had especially emphasised the central importance in their professional lives of both the doctor/patient relationship, and of their independence and autonomy. (Those physicians in HMOs emphasized the independence and autonomy of clinical judgments and interaction with the patient, while those in fee-for-service practices often felt that that essential clinical autonomy was also linked to the independent management of their own practices.) Additionally, relationships with other physicians and with hospitals were discussed as integral parts of their professional lives.

Here I will summarize their 1986 perceptions of these issues--the physician/ patient relationship, relationships with colleagues and with hospitals, and the form and management of their practices--as well as certain new or modified perceptions which they spontaneously raised and emphasized in the open-ended interviews.

Physicians and Patients: What About Loyalty and Quality?

As I re-encountered these physicians after four years, I first asked what they found had changed the most since 1982. Most physicians' first response concerned the doctor-patient relationship. In 1982 physicians in staff and group model HMOs expressed considerable satisfaction with the doctor/patient relationship they had been able to establish and the care they were able to give. Some in IPAs who were capitated (contracted for a set fee per patient per year regardless of

the health care needs of the patient) had felt pressured by the new system and already were reporting the need to accept financial losses for some patients in order to remain affiliated with the HMO. But, as a whole, in 1982 physicians associated with HMOs reported that their doctor/patient relationships had been enhanced because: 1) physicians had less worry about expense to the patients, 2) they could concentrate more on the patients themselves while the plan took care of the management, and 3) awareness of cost had brought to their attention certain unnecessary procedures that both they and their patients were content to forego. For example, one physician explained:

> it was once routine to watch the progress of pneumonia cases using x-rays. The plan said that was too expensive, so now the physicians watch the patients clinically (by physical exam), with an x-ray at diagnosis and one at follow-up....all those x-rays weren't necessary, and, in fact, it is better for the patient not to have all that radiation (Anderson et al. 1985:201).

However, in 1986, this same thoughtful physician--an HMO advocate, a founder, and a longtime provider in a prestigious HMO-- discussed changes in the doctor/patient relationship in the first minutes of the interview:

> First, the physician/patient; that's where the primary interaction is. (But) what is happening now is patients are aligning with health plans that do not allow free choice of provider--hospital or physician...That is the basic principle of an HMO--that you limit choice. You give incentives to reduce resource ...use.... So what has happened is that the doctor/patient relationship-- that primary principle of American medicine is...uh...going away--going by the boards. That is what is necessary to change the system and it is changing--very dramatically, and it's affecting all physicians (in the Twin Cities) now. The doctor-patient relationship is no longer a mystical, theoretical, philosophical, or human interaction; it is now a business interaction--and the patients are choosing health plan above physician.

He went on to explain that matching patients with physicians over time is more complicated than people anticipated. When the employed family member chooses a physician and enrolls with a plan, it limits other family members' choices of primary care physician and everyone's choice of consultants. He continued:

> Doctors have felt that if I am a good doctor, patients will have loyalty to me--as their good physician; that's gone. That loyalty is still part of the milieu and the decision but (a member may choose initially) a physician he knows but in five years--let's say an individual is moving through middle age--he might have contact with four or five different doctors. They used to have one here (at the group practice) and four somewhere else; now they have five here. So that's what happened to the physician/patient relationship. It was a real test and an eye opener for people who weren't aware of what that financing mechanism was going to do to their doctor/patient relationship.

On a yet more concrete level, a family practitioner who was already cautious about HMOs when we spoke to him four years ago explained why he thinks "patients are no longer your patients, but rather HMO enrollees:"

> Enrollees can be moved around from office to office at the will of the HMOs. HMO Minnesota (HMOM) dropped us, so our patients had to follow the plan...also when we (the family practice group) joined SHARE (another HMO) HMOM was afraid we would switch the patients--this way they forced us to! We eventually got most of them back but not all of them. My relationship is no longer one-to-one with the patient; I am the agent of the HMO management company and they can take that patient out of this office at a moment's notice...

In a recent and extremely controversial action, with symbolic overtones for physicians, Physicians Health Plan (PHP), with 300,000 enrollees the largest in the Twin Cities, in February 1986, offered a selected group of their enrollees--those in Medicare Plus--new options. They could save premium dollars by selecting an option that limited their choice of hospitals. That is, Plan 1 includes only 9 hospitals;

Plan 2, fifteen hospitals, and Plan 3--the most costly--all 59 PHP affiliated hospitals. Thus PHP "arbitrarily" excluded many Twin Cities hospitals from two of their three Medicare Plus options. Not only, then, were the hospitals excluded from the plan, but physicians affiliated exclusively with those hospitals were, as a consequence, excluded from the plan.

Although this alternative hospital plan option was available to only a small percentage of Twin Cities residents (the 10% of medicare patients who were also enrolled in PHP), and chosen by only a small percentage of those, the seemingly "high-handed" action of the plan was seen as betrayal by Twin Cities physicians who had been the founders and developers of Physicians Health Plan through the Hennepin County Medical Society in 1975. In the Twin Cities where consensus has been characteristic, (Anderson et al 1985) tempers are raw and there has been fervent talk of impeaching the physicians on the board of PHP as well as counterthreats to bring suit against physicians making "unfounded charges".

Dr. Richard Reece, long time editor of Minnesota Medicine (Journal of the Minnesota Medical Association) and health care consultant, explains in a now regular publication that was precipitated by the event:

> What worries physicians...is that their own managers, or the managers that they made possible, make decisions that change physicians' lives and those of their patients without consulting those affected by the decision. Doctors are angry because they feel manipulated and deceived by an organization of their own making. (Reece Report, "Information for Physicians in Control" Vol. 1, No. 1, March 1986 [9]).

It is not only physicians whose practices are affected who observe this shift. A Minnesota colleague in health care research noted that:

> The health plans do marvelously well because most of the time they negotiate a percentage of the premium as their fee--the manager--the insurance brokers just don't lose because as long as they continue to increase the membership, which they do quite well, their take continues to go up and what happens is that all the new members need to be taken care of by the physicians, the clinics; (the physicians) are the ones who eat the difference; they are the ones who lose. (The managers) are in an incredibly good position . . . because the tie with the patient is now with that broker as against with the physician, and the patient may feel some loyalty to the physician but only in really dire cases is it my experience that the financial incentives involved with going with the broker is going to be overcome by the loyalty to the physician. So people sadly will leave, but <u>will</u> leave . . . .

Another health care writer in Minneapolis-St. Paul noted "there's very little loyalty; loyalty is 'The Myth of Medical Care.'" However, the increased sensitivity of physicians to the loyalty of their patients may have certain benefits for the patients. One beleaguered Group Health physician said that the stresses felt by the staff...

> on the one to one have no effect on the patients; in fact,in a sense I feel that I must sell myself a little more--put myself out for the patients to keep them in the plan.

Quality

While a nationwide survey indicates that physicians continue to believe that "HMOs offer inferior quality care" (Lou Harris 1985), that is not the view among Minnesota physicians. (See further discussion of quality in HMOs in next section.) The Minnesota physicians I interviewed were painstakingly precise on the subject of quality. ALL of them expressed fear that the developing competitive system based on prepayment COULD impair quality of health care, and most predicted that

if the competition continued to intensify, it WOULD impair the quality of health care, but none said that he or she had seen an incident of poor quality care. As noted above they now report inconvenience, discomfort, frustration, loss of autonomy, and an impaired sense of control--but still no specific examples of poor medical practice.

The physician from the University of Minnesota with whom I spoke had just attended the April meeting of the bioethics committee of the Minnesota Academy of Medicine. Reporting the committee's discussion among six physicians from the community and four from the university, he said:

> the highest priority, if I might say so, is really the ability to provide patients the highest quality care in the light of medicine being part of a corporate activity. In other words, the priorities of the corporation which...manages health care,is profit and the priority of the individual physician dealing with the individual patient is the individual patient's best interest. How do you combine those two priorities? That managed to generate a wonderful discussion for some time.

Others are more heated on the subject. There is an increasingly vocal contingent of physicians, largely from St. Paul and the Ramsey County Medical Society, who believe that the rapid growth and consequent intensive competition among health plans will "depress the quality of care in the quest for profits." Physicians like Dr. Robert Geist believe that there is a clear "conflict of interest" created by capitation. He notes that the "HMOs are insurance brokerages taking 15 percent off the top," forcing physicians to become "the local corner insurance companies" as they contract out the care for their patients rather than providing it themselves. One family practitioner told me that such capitation was a very real and difficult problem in his group.

> "With our capitation we didn't pay only our doctors but for the druggist and the surgeon, etc...we came too close. If we had been 10% off we would have lost money. It felt like a conflict of interest. (We changed our contract and) now we're capitated only for our own work. It's much more comfortable."

However, Dr. Geist's proposed resolution to outlaw payment to physicians for any care but the care they themselves give was defeated at the annual meeting of the Minnesota Medical Association (MMA); the delegates did vote to "study the effects of the competitive health-care system on physicians, patients, healthcare institutions and purchasers of care." They further resolved to urge the MMA to "work on development of ways to measure quality of care which could then be used by the public to compare various health plans."(MMA 1986; MMA 1986B; Berenson 1986.)

Physicians/Physicians: "Competition with Colleagues Is Culture Shock"

Physicians are worried not only about the barriers developing between them and their patients; most report that their customary relations with colleagues have also been altered.

> We can't go on referring to people we're used to...to who you think is "the best," or the most convenient, or your friend, or someone you're confident in. It's more problematic--we have to learn what plan the patient is in.

A senior specialist at MedCenter noted:

> As a consultant I had a lot of referring doctors. Even last year 2/3 of my business was from outside but that is being cut off. Other plans grow...gain their own expertise... restrict their patients. The doctors used to referring to me just can't do it. Traditional referral relationships are impacted day to day, every day, several times a day... and then new patterns are developed, not necessarily by tradition or quality of service and access, but by the payment mechanism.

Dr. Reece says physicians are experiencing "culture shock":

> Doctors care more about what other doctors think of them than anything else ... and it's an earthquake in their feelings when they find out they're going to have to compete with their friends--(with whom) they've been through the same educational experiences.

He said there is an expression he hears so often among physicians that it would make a good title for a paper:

"It isn't any fun any more."

"Paul (Ellwood)'s idea of medical plans competing with one another fit our culture at large," Reece observed,"but it did not fit our medical culture."

Another Minneapolis physician:

> Your colleagues you've worked with for decades end up aligning with other health plans and you lose the contact with them; patients aren't referred back and forth, and you lose some of the professional interaction. The colleagiality between physicians and physicians is not as it was before.

It is the physicians who have worked "for decades" who some observers believe are having particular trouble with the "culture shock." A Minnesota professor, Theodore Fredrickson says that younger physicians "are a different strain." They "have been watching and adapting" and believe that without a 70-80 hour work week they can have a better "quality of life." Nonetheless, the MMA does not recommend that young physicians will be able to start their own practices in the Twin Cities any longer and some physicians worry about their younger colleagues.[3] Many I interviewed felt that their own way of practicing was sufficiently established so that they would be able to complete their careers in a way that was comfortable for them. But they thought

that young people coming into the profession would have a difficult time.

Medical Education

Already, they noted, one of the consequences of "cost effective medicine" was having a powerful impact on students and residents training in hospitals. In Minneapolis-St. Paul hospitalization of HMO patients has been dramatically reduced--both admissions and length of stay have dropped the average number of days to a startling 385 days per thousand HMO patients compared to an average of 1,087/1000 for non-HMO patients (AHA 1986). This, the physician explained, means that" patients are not hospitalized AT ALL except for acute needs . . . . There seems to be a real shift now as the hospital becomes an intensive institution rather than an institution involved with preparation for surgery or recovery from childbearing." He further discussed the serious consequences for the students and residents in training because the experience has been both educationally narrowed and emotionally intensified. Some trainees, he said, have thought of leaving medicine, and certainly applications to medical school are down. Furthermore, "based on the perception of a surplus of physicians" since 1982, the size of the class admitted "has been reduced from about 250 to 205."

This academic physician reported other changes seemed to him more curious and less troubling, but contain an important acknowledgement that some changes were worth making:

> It's probably only been in the last three years in my rounding with the residents and medical students I talk of always questioning "Now is that procedure necessary?" Do you really think that we have to get that chest x-ray? Do we really have to have the vital signs? Now the residents are thinking about that all

> the time, but (he adds with satisfaction and righteousness) it has been rare that I have found that the residents did not have a good reason for the procedure. The change is that we are asking differently--tons more questions than I had before; in the best of all worlds I should have had the same questions before, but I didn't. And most of my colleagues didn't because the cost didn't come into our heads.

Physicians and Hospitals

In 1982, one of the notable themes in Minneapolis-St. Paul health care was the competition between physicians and hospitals. While physicians acknowledged the competence and quality of the Twin City hospitals, they were competitive with hospital administrators and feared losing ground to hospitals. In fact, the origin of PHP, the Hennepin County Medical Society's plan, was explained to me, in 1982, as follows:

> The greatest impetus [toward Physicians Health Plan] was the fact that the hospitals were really looking seriously at starting their own hospital-based HMOs in our community. I think that was the most scary thing to the rank and file physicians who at that time felt really no threat at all from Group Health or [any other plan that was just getting started]... But the physicians do have a great deal of respect for how hospitals can get things done. [Physicians] also have a fear that hospital administrators, when they do something, don't really include physicians in their thinking process. So...(there was a fear the hospitals would start something); that was a great big unknown. We certainly weren't afraid of the other HMOs which were so young, but today (1982) is certainly different.

In 1986, the "plans" have become undoubtably the principal competitors and warhorses, and it is the plan managers that ride them. In most cases physicians and hospital administrators are learning to cooperate. Dr. Reece, joking ironically, said that perhaps as the HMO enrollment rises above 50 percent in a community, the hospital census inevitably dips below 50 percent. It is an uncomfortable teeter-totter

for hospitals, and they are seeking joint-ventures with physicians to gain stability. Reece again explained: "Physicians supply the clinical skills and visibility; and hospitals supply the capital and marketing." This takes various forms, e.g., together they exploit "niches in the market" and create "boutiques"--specialty services like foot clinics or headache clinics. A larger version is an institute like the Phillips Eye Institute, a joint-venture between physicians and a hospital. These have marketing and bargaining power.

A specific form of this cooperation is the MeSH concept: Medical Staff and Hospital. MeSH is a vehicle for joint-ventures "on an equal footing" between physicians, who themselves form a corporation, and a hospital. The hospital and the physicians' corporation become partners with equal governance and together they are able to contract with HMOs. MeSH characterizes both the competition and the cooperation found throughout the medical community of the Twin Cities in 1986.

Medical Practice In Minneapolis-St. Paul 1986: Changing Practice Patterns and Income

Although physicians are actively learning new ways to adapt to the competitive environment, there continues to be an overall and immediate concern about the future of their practices and, most likely, the stability of their incomes--although these subjects are not spontaneously raised in conversation. Aware primarily of their own experience, physicians do not know if, or how, their practices fit into a larger pattern. However, the county and state medical societies have gathered some systematic and much anecdotal data from their constituents which reflect their experience. The most recent data were collected in an unpublished November 1983 survey of the MMA. Although

no question was asked about income specifically, of those physicians who responded throughout the state, 1/3 reported that their patient visits had declined while 1/3 reported visits remaining stable and 1/3 reported increases.

Observers at the county and state societies note that since 1983 they have been receiving increased reports of declines in the number of patient visits. Furthermore, these patient visits are often reimbursed at a lower rate because physicians have accepted discounted rates in order to be included in the growing plans like the Blue Cross preferred provider organization, Aware Gold (see discussion in Chapter 6). Group model HMOs have, it is reported, "put downward pressure" on the incomes of some of their physicians, but Group Health Plan, the one staff model remaining in the Twin Cities, says it has not lowered salaries because they can manage to reduce costs by "changing their staffing patterns."

To better manage their practices under the pressures of competition, fee-for-service practitioners are forming or joining groups at an accelerated rate, and groups themselves are banding together. As is true throughout the United States, physicians joining groups and affiliating with pre-paid or capitated systems are mostly affiliating with IPA and PPOs--by far the fastest growing segments of the managed care systems.

Some young physicians out of residency <u>do</u> choose a salaried staff model position; however, in Minnesota, again as it is throughout the nation, a <u>decreasing</u> proportion of HMO physicians are salaried and working in clinic settings. In fact, physicians in the remaining staff model who are committed ideologically to it now say they may be forced

to form a physicians' group so they can be more flexible in the competitive environment.

As the multispecialty groups join to become larger, they are able, first, to contract for better consultation rates; and finally, to hire subspecialists into the group--thus protecting their economic base but further disrupting the traditional referral patterns discussed above. This, of course, is not an avenue available to physicians in Chicago and Lansing where multi-specialty group practices are rare.

Private physicians in specialty practices are also joining together to protect their interests. For example, in St. Paul about 30 specialty groups have formed "Vista", with a hired manager to negotiate contracts for them. The group, however, has not included all specialists, which, members say with regret, has further undermined the sense of collegiality.

And, consistent with the trend noted in Chapter 6 on a broader scale, the Minnesota Medical Association (MMA), which has a remarkably high membership rate of practicing physicians--90 percent of the community physicians, compared to the national average of 45 percent--has also responded to the competitive environment by forming a for-profit subsidiary consulting group, Medical Management Services, to help physicians and physician groups with marketing, legal issues, and practice management.

Throughout the Twin Cities and indeed the state, Minnesota physicians are changing their patterns of practice and learning new ways. After the shock, a new culture.

When we finished interviewing in 1982, Twin Cities physicians in fee-for-service practice, as well as hospitals and insurers, were

worried about the competition of HMOs. But today that is no longer a worry. Now, physicians tell me, fee-for-service medical practice and third party health insurance "are virtually dead." In their traditional forms they are no longer competitors.

Although in healthy and homogeneous Minneapolis/St. Paul physicians still report that they are mostly satisfied with the quality of their medical practice, they recognize that they are no longer autonomous or independent. Although they have mostly avoided government regulation and consumer partnership they are now, instead, "agents of a plan" or of several plans. It is the plans that compete with each other, and the competition is fierce and costly (See data in next segment). Physicians and hospitals are important actors, but they can do no more than jockey for position and affiliations with the increasingly complex contractual systems. The term "HMO", though ubiquitous in the Twin Cities, is in fact no longer descriptive, but rather symbolic. It is being abandoned for the more futuristic and realistic "managed care systems."

Physicians in the Twin Cities seem resigned. Proud of their medical community and its history, they actively protect the quality of the care they give, but they have less and less to say about what it costs or to whom they give it.

This case study exemplifies Starr's understanding of the declining sovereignty of the medical profession. While in a prosperous community which prides itself in its rational civic problem solving, most physicians are adapting to the change, it will be more difficult for competitive medical communities in more contentious communities like Chicago to incorporate change without suspicion and hostility. This is

intensified since in the Twin Cities physicians themselves have participated in the development of the managed care system, whereas in Chicago, physicians feel new systems have been thrust upon them.

And new systems ARE being thrust upon physicians not only in the management, and not only in the Minnesota area, but also in the treatment of patients in Michigan. For example in October 1986 all physicians licensed in Michigan received the following memo from the Bureau of Health Services, Department of Licensing and Regulation of the State of Michigan regarding Public Act 195 of 1986:

> On November 5, 1986 physicians who are administering the primary treatment for breast cancer must begin informing their patients about alternative forms of treatment.
>
> P.A. 195 of 1986 mandates that a brochure be developed by the Department of Public Health for distribution by physicians....Please note that the brochure contains a form which must be signed by the patient indicating that the patient has been given a copy of the brochure. The law requires that this form should be included in the patient's medical record.

This Michigan regulation steps directly between the physician and the patient NOT in a matter of organization or finance but in a matter of treatment. As Starr (1982) observes:

> Indeed, few other developments so well illustrate the decline of professional sovereignty in the 1970s as the increased tendency (of the law) to view the doctor-patient relationship as a partnership in decision making rather than a doctors' monopoly.

These changes are the consequence of the efforts begun by consumer activists in the early 1970s in their effort to challenge the autonomy of physicians and participate more actively in decisions about and treatment of their <u>own</u> health care.

CONSEQUENCES FOR THE DELIVERY OF HEALTH CARE

In 1986 it was clear that consumers' activism had left its mark on both the cultural and the economic dimensions of health care. Although it is not always possible to assign specific consequences to given actions, the consumer-founders of HMOs were part of an important transition in both beliefs and behaviors about health care. The results of their activism is evident, both symbolically and concretely, in the alternative forms of health care delivery--or managed health care--now growing so rapidly as an extension of the HMO movement. In this section I will consider briefly certain salient points about managed health care in each of the three areas of traditional health care delivery analysis: access, quality, and cost (Aday and Andersen, 1975).

Access

As I have shown earlier, it was the HMO founders' original intention to provide equitable care to all who wished to enroll. The financial losses that NorthCare and Health Central suffered from their commitment to open enrollment were important steps in their march toward corporatization. The stability of HMOs depends on the balance of their group of members--their risk pool. Some attributed the early success of many HMOs to selective enrollment i.e., enrollment drawn from young and healthy employed groups (Luft 1981). HMOs do not market to individuals and only in rare cases permit individual subscribers.

Populations that do not have a normal distribution of health problems--the elderly and the poor--cannot be managed by an HMO unless they are subsidized or pay a higher premium than other members. The federal government has been very interested in HMOs as a way to control

costs with prospective payments for those groups. They have established over 100 Medicare (TEFRA) risk contracts with HMOs. Some plans have subsequently tried to cancel the contracts because they could not cover the costs of care with the contracted amount. The rate is based on 95 percent of the adjusted average per capita cost (AAPCC); Group Health News (Feb/Mar 1986) notes that "HCFA refuses to release the 'black box' or basic formula used to derive numbers that determine the AAPCC." Some plans are satisfied with the reimbursement and others have taken the government to court to break the contract or recover losses.

The government also seeks contracts with HMOs for Medicaid recipients. There is evidence that the poor can get good care in prepaid plans (Health Care Finance Review 1985). A state survey conducted in Ohio shows that residents from Cuyahoga County AFDC families who are in an HMO program are considerably more satisfied[4] with their health care than those using private physicians. Eighty-five percent are satisfied with their health care and 75 percent report excellent or good health in their family (compared to 53 percent using private physicians.)

However, the results were different in a limited group of Medicaid enrollees that the Rand Health Insurance Experiment studied at Group Health Puget Sound (GHPS) (Lancet May 5, 1986). For low income enrollees in the HMO, health outcomes appeared to be poorer than for those in fee-for-service. Although certain methods of the study limit generalizability, officials at GHPS acknowledge that the study alerts them, as well as researchers and policy makers, to the difficulty of applying complex bureaucratic systems without modification or

supplement for the poor, who often have more health problems and fewer skills for overcoming obstacles to access.

Health professionals whom I interviewed noted that while the continuity that HMOs provide could improve the care of the poor, HMOs are presently managed with services and patterns that have been developed to attract middle class members. HMOs need additional services to serve the poor, just as they do for the elderly. It was interesting to find in my interviews that HMOs, in order to be competitive, do in fact pay particular attention to appearing middle-class. They say this is because, in many regions of the country, especially near University medical centers, there is considerable suspicion of "clinics." My interviews confirm that impression: A UAW labor leader told me that he had learned a lot about his workers when the UAW contracted with Health Central. While the labor leader himself was interested in the quality of care and keeping the costs down, he heard grumbling "on the line" because wives would complain "if it wasn't like the (private) doctors' office."[5]

In 1986, another needy group troubles policy makers: the uninsured. It should be noted that in spite of their ideological beginnings, HMOs are the <u>least</u> suited to provide free care because of the careful accounting demanded of them by payers-- employers and government--who have switched to HMOs to contain costs.

<u>Quality</u>

The 1984 National Harris poll about HMOs (Harris et al. 1985) notes that patients in HMOs are more satisfied with their care than fee-for-service patients, and that health care research indicates that fee-for-

service and HMOs have similar treatment practices and quality (Manning et al. 1984; Yelin et al. 1985). Nonetheless, in a nationwide sample "the feeling that HMOs offer inferior quality care, while not shared by either HMO members or employers, continues to be the view held by most physicians" (Harris et al. 1985).

I noted above that the MMA passed a resolution to "work on development of ways to measure quality of care which could then be used by the public to compare various health plans." Now that business and government pressure health care plans and institutions to be competitive, many policy makers as well as physicians see as their first priority the assessment and assurance of equitable and excellent health care.

The National Committee for Quality Assurance (NCQA), formed in 1979 by Group Health Association of America (GHAA) and American Medical Care Review Association (AMCRA), reports intensified activity which reflects the increased attention to monitoring quality in the growing managed care systems throughout the United States. Representatives of Arizona's Health Care Cost Containment System (AHCCCS) visited provider settings throughout the state and carried out an "exhaustive investigation" of 1,836 medical records in HMOs with Medicaid contracts which has brought "assurance review systems to the brink of measuring service quality" (GHAA News Feb/Mar 1986:7).

Ohio, in response to federal pressure, will also strengthen its quality assurance program for HMOs. The state admits that while preoccupied with developing HMOs, it had "been lax in pulling together a quality assurance program." (GHAA Newss Feb/Mar 1986:16).

In Washington state the $78 million ongoing Rand Health Insurance Experiment continued its comparative study of health care. In 1986 the research team reported on care for patients who had been studied for five years in the Seattle area (Lancet 1986). The study concluded that "Group Health Cooperative (GHC) tended to produce better health habits than fee-for-service.... (And) for most people, and particularly for those with higher incomes, GHC care saved money and may have been better for health."

Interview data relating to quality have an interesting pattern. Several of those whom I interviewed, like Dr. Geist in St. Paul, are articulate and well reasoned about the potential for poor quality or underservice; nonetheless there are few, even anecdotal, reports of poor medical care. While reports of inconvenience and bureaucratic irritation abound, members and providers seem satisfied with the medical care. For example, the administrator at the department of Public Health in Michigan who is responsible for complaints reports (as noted above) an increase in calls from both new HMO members and newly affiliated physicians complaining that they do not understand the requirements or coverage of the plans that they joined. The administrator groaned as she said it was a "morass of complications." However, she added in a somewhat lighter tone, "I guess they could be calling about the quality of the care." "Don't they?" I asked, "Nope, not really." she replied.

Cost

While the consumer-founders developed HMOs to improve access and give consumers a controlling partnership in health care, payers now

drive the system, and cost containment, their first concern, is now the major stimulant to changing forms of health care delivery. And, in fact, certain aspects of costly health care are reduced by HMOs and PPOs for those enrolled in the plans--particularly as a result of decreased hospital days. However, there has continued to be dissatisfaction among payers, predominantly employers and the federal government, because they find that in spite of reduced HMO hospitalization, HMO premiums are not significantly lower than premiums for traditional health insurance coverage. My interviews with market representatives suggest that plans intentionally market themselves at similar premiums to avoid drawing selected or "adverse" selections of enrollees. Market representatives explain that instead they compete by "differentiating their product." That is, they may seek a distinctive identity with certain hospitals or staff, certain products (eyeglasses) or services (classes, house calls, etc.)

A report in the New England Journal of Medicine (Himmelstein and Woolhandler 1986) offers information that may help to explain the persistent rise in the cost of health care when, in fact, at the same time physicians and hospitals generally report level or decreased revenues. While total costs of health care are composed of many elements, the NEJM reports that a growing portion of health care dollars is going to administrative activities. In 1983, 22 percent of U.S. medical bills or $77.7 billion were spent on administration including accounting and billing. Thus, while changing patterns of health care delivery may reduce expenditures for direct care to the patient, they are accompanied by increasing costs for internal administration, including accounting, billing, marketing, and external

consultants.[6] In 1985, hospitals spent $313 million in advertising and $700 million for marketing consultants,[7] (a single health care system reported an $8 million account for advertising alone) and in 1986, (while health care costs generally rose 7.7%) advertising and marketing expenses again rose over 57% to $500 million and $1.1 billion. (SRI Gallup Marketers Survey 1987).

These dollars provide jobs for a new cadre of business competitors, and profits for advertising and accounting corporations. They are also further evidence of the ironic and unintended consequences of the HMO movement.

END NOTES

1. The research staff included the Principal Investigator, Odin Anderson, a project director and three research project analysts.While all project staff did some interviewing, I was principally involved in interviewing and conducted over 100 interviews. The project was conducted at the Center for Health Administration Studies, University of Chicago, and funded by the Kaiser Family Foundation and the Chicago Community Trust.

2. Note that this pattern anticipated the pattern in Lansing--the two IPAs are now affiliated with the same umbrella organization, United HealthCare Corporation.

3. Here again is the important theme of cohorts. Cohorts of physicians and medical students separated by very few years may have very different practice demands, opportunities and expectations.

4. Correlation of satisfaction with quality has not been systematically established. It is a current research effort of the Academy of Internal Medicine. (personal communication, Gerald Levy, M.D.)

5. Visitors from the British Health Service visiting HMOs in 1986 remarked and later wrote me that they were surprised (they looked shocked) at the investment made in comfort and furnishings for the facilities as well as for the administration offices.

6. These findings are from 1983, when the insurance overhead was already increasing at a rate of 1 1/2 times the rate of increase for the health care itself. Certainly the last two years have seen even more dramatic increases in non-care related spending.

7. Many of the marketing consultants are symbols, themselves, of the privatization of health care. Many professionals, formerly in public service or non-profit health organizations, have changed to jobs in the private sector. Examples include Carolyne Davis, the former head of the federal Health Care Financing Administration (HCFA) who now offers her publicly gained expertise to corporate clients as a special consultant for Ernst and Whinney, a private consulting firm. In addition, HMO authority Paul Ellwood, until recently associated only with his non-profit think-tank, Interstudy, in 1985 formed his own for-profit consulting firm. And at least three long-time health policy analysts for the State of Michigan have joined Price Waterhouse, a private accounting firm that is developing a strong health consulting section.

CONCLUSION

RECAPITULATION AND REFLECTIONS

To recapitulate and then reflect on the development of this social movement, now bureaucratized and corporatized, I return to Starr's statement that early in this work provided an important structure for the case studies and their analysis.

> "in the seventies ...a variety of new social movements demanding reform...formed an ironic temporary alliance" with "powerful forces arraying themselves against health care providers...the insurance industry, the employers, and the government itself." (Starr 1982:337)

This quote of Starr's provides the generalization for which these case studies give evidence. It is descriptive and it is visual. There are three clear groups of actors: 1) the activists; 2) their targets--the physicians; and 3) the "powerful forces" or payers whose interests allied them with the activists. Against such an alliance the physicians lose their sovereignty and American medicine is becoming corporatized, as the activists are coopted by their ironic and powerful allies.

While this analysis is descriptive, interesting, and even true, it is insufficiently complex to explain the source or meaning of the changes. The scenario presents one-dimensional competitors: the consumer soldiers for HMOs, the physician soldiers against HMOs, and the mercenaries who come in for the spoils when the battle is all over. But the changes and interactions in this study are more complex. Though not as easy to stage dramaturgically, I find it provocative to consider, in addition to the three actors, three dimensions or themes of that historical period which recur, interact with, and explain more

fully all of the actors; these are 1) the economy, 2) ideology, and 3) technology. All, of course, are changing and not necessarily in parallel movement.

In conclusion, I will recapitulate and reconsider the consumers' movement to develop HMOs by examining these three elements, their intersections, and their synergy. Together these illuminate the emergence and the development of contemporary HMOs and suggest foci and avenues for continued sociological study of the changing health care environment.

ECONOMY

It is not new to look to economic conditions and pressures to understand a social movement. Weber asserted that the course a movement would take did not depend " on the subjective intentions of the followers or the leaders (but rather) on the institutional framework of the movement and <u>especially on the economic order.</u>" (Gerth and Mills 1979, p. 54 underline CK). But it is of particular interest that in the social movement described here the economic forces were not only the underlying framework or order, but were explicit, though unanticipated, actors--the insurance industry, the employers, and the government itself-- which shaped the movement.

In Chapter 1 I noted health economist Victor Fuchs' (1985) explanation for the increased attention to health care by government and the corporate sector. He juxtaposed the nation's general economic trends since World War II and the economic trends in health care and thus demonstrated that the decline in the GNP just as the costs of health care were escalating set the economic stage for

resistance of employers to the costs of health care benefits in the early 1970s. Furthermore, only a few years earlier in 1965 Congress passed both the Medicaid and Medicare legislation which made the federal government a principal purchaser of private health care benefits. Also noted earlier, the surge of interest in health care exemplified Mills' (1959:246) observations about the interests of the "power elite." Health care, which has until now been an interest only in the middle levels of power now comprises over 11% of the GNP and has drawn the attention of that power elite.[8] Throughout this dissertation I have offered evidence of the increased interest and involvement of both corporations and government in health care. Furthermore, the corporate sector not only seeks to reduce their costs in health care but also to participate in the (now evidently) profitable market of health care.

Note that Starr mentions the triumvirate of insurers, employers, and government. The insurers and employers together reflect the private sector interests. Most simply the employers are concerned with reducing the costs of health benefits while the insurers profit from the management of health costs. But these distinctions also become clouded when the insurers are pressed by a more competitive market place and the employers develop "self insurance" plans (insure their own employees). These are fruitful areas for continued observation and analysis. Future work would also benefit from O'Connor's (1973) further division of the private sector into a competitive sector and a monopoly sector. I anticipate that as the changes in health care distribution are pushed further, the competitive sector of small manufacturers and services employing roughly one third of the U.S.

labor force (O'Connor 1973:13) will have less choice or control of the health care benefits affordable and available to them. The monopoly sector employers will begin, themselves, to market health care, or at the least manage it for their own work force--again giving less choice to the worker, but in this sector, more control to the employer.

IDEOLOGY

For this research I have observed health care in a period when it has been strongly influenced by economic pressures and constraints. Some, like Fuchs (1985), emphasize, even extol, the economic explanation of Americans' health care behavior. However, the United States is the only remaining industrialized nation, except South Africa, that does not cover as a right of citizenship, the medical expenses of anyone who becomes seriously ill (Light 1986). This distinctive national condition is both a consequence of and a problem for the ideology of U.S. citizens. Anderson (1963:3) notes that Americans have a dilemma; they do not know to what extent health care is "part of the free market economy..." and to what extent ""...part of traditional social relations" (Anderson 1963). Elsewhere he notes (Anderson 1987) "although there are attempts to mold the health services delivery system into a technocratic model....health service systems are essentially social systems."

Issues of "traditional social relations" and "free market economy" as well as of social responsibility remain in tension, unresolved in the American health care system. When in the early 1970s the nation expected, but failed to adopt, some form of national health insurance, the HMO movement became heir to these unresolved tensions.

As I have noted in Chapter 7 the consumer-activists were deeply committed to ideologies of their historical moment and cohort. These included ideological issues outside of health care, such as the strong feminist bond that many of the consumer-founders reported was woven into the HMO development, as well as to ideologies directly related to health care. They believed in equitable distribution of health care to others, and in altering the power relationship with physicians, that is creating a partnership in which the patient (consumer) would take a personal responsibility for her or his own health care. This paralleled convictions in other self-help movements at the time.

I earlier noted, and am now convinced by, Crawford's (1977) argument that such an ideology channels demands on the social and political environment back to demands on the self (Crawford associates this with a pattern of "blaming the victim "[Ryan 1971]). This patterns, he asserts, reduces the demands for care on government and corporate providers by funnelling them back to the partnership of patient and provider. The ideology focusses on issues of individual distribution of power in the dyad of doctor and patient--middle class issues--thus drawing attention away from the larger social responsibility to pay for health care for those outside of the middle class (This also coopts the activists to that less costly and inflamatory interest [Crawford, 1977]).

This deserves attention because it highlights a change in the ideology and pattern of social activism in the late 1960s and early 1970s. I have noted in chapter 6 the important distinction made by Kitsuse and Spector (1977) between activists whose activities are for disadvantaged others and activists in interest groups who are active in

their own interests. Starr draws a parallel distinction in medical activism between those who claim rights TO medical care (i.e., access for all), and those who claim rights IN medical care (i.e., the right to participate in therapeutic decisions, to see one's own medical records etc.) I have given examples of both themes in the consumers' HMO movement and noted the activists' reluctant but complete relinquishing of the broader themes of access and equity as they shifted to emphasize rights of consumers within medicine.

This shift exemplifies a larger ideological shift that was taking place between the 1960s and the 1980s. While Starr asserts that the civil rights struggle "set the example for dozens of other movements of similar purpose" (p. 389) I highlight the shift in purpose. Most interestingly, in the HMO movement these activists did not simply shift from one movement to another, for example from the civil rights movement to the home birth movement, but rather shifted within the movement itself. In Chapters 5 and 6 I have documented the activists' relinquishing of the broader social goals and acceptance of the goals modified by the structure imposed by their funders. This exemplifies not only the conservative assimilation of the reform but also the conservative assimilation or cooptation, of the activism. That is, not only the goal of the activists was coopted but also their ideology and directed energy.

In the 1970s, other government programs of a liberal administration also recruited consumers--for example, the Consumer Support Group Project funded by HEW--and thereby weakened the costly power of the professionals. Although it is less evident, it is important to see that at the same time, these programs coopted and

redirected the energies of the activists. A careful study of the Health Systems Agencies of that same period, by political scientist James Morone (1982) documents the same pattern. He shows that the putative goal of the HSA boards was to reduce costs, which they were unable to do. Morone (1982:249) concluded that the HSAs of that same period "are not important for their cost control achievements or potential, but rather (because they)... delineate the present imperatives and future directions of the American health care system and its politics." This they did, in large part, by coopting the consumers to their cause. In place of activism against government programs, consumers were allied with them. It is worth noting that in interviews the consumers reported that they had been anti-war and civil rights activists for a number of years, but did not show any reluctance to become allied with government to develop consumer controlled HMOs.

Morone (1982:258) concluded that "federal agencies seek to balance the interests of powerful producer groups by injecting competing consumer interests into local political frays."

Paul-Shaheen and Perlstadt (1982), in a study of class action suits, observes similar dynamics--"the Hill-Burton Class action suits provide both organized structure and process for (re)channeling discontent...." Furthermore, also similar to consumer programs, the class action suit program provided "grass roots leadership training for local activist."

TECHNOLOGY

While it is clear that economy, ideology and technology are all closely interrelated, technology might be expected to be the most

clearly seen-- to have the clearer boundaries. But, in fact, in this social movement to change health care, technology is tightly interlaced with ideology.

Although the issue is large and complexly woven, I will draw out two simplified threads to tie to the HMO movement. 1) In large part the challenges mounted against medicine result from its declining credibility--not only because of its inflated costs, I argue, but because of inflated expectations. 2) Without specifically stating it, or perhaps without yet recognizing the process, decision makers are shifting their expectations to computerized information technology. The growth of computer technology is seen in almost every sector of society-- finance, education, commerce-- but the SHIFT of expectations from one technology to another is seen within health care.

Throughout their lives, those in the founders' cohort, still children at the end of World War II, have been awed, healed, and protected by "wonder drugs": penicillin, polio vacine, widely available insulin. Hips, kidneys, and even hearts have been replaced. When they were young, the promise seemed unending. But as they age, the scourges are still waiting--cancer and heart disease, unyielding and outrageous. I am suggesting that the steep curve of scientific success after the Second World War created expectations that even a remarkable medical science cannot satisfy. (The rising anger recalls that of the underclass which revolts when conditions improve and they experience relative deprivation [Merton 1957]). The explosive growth and succcess were tightly woven to the economy--research largely funded by the National Institutes of Health, and care "invisibly" paid for by the third party payment system discussed earlier.

Now to control this disappointing and costly institution there is another technology, younger and on a steeply rising curve of accomplishments--still creating expectations, not yet disappointing them. Computerized information system technology is now at the heart of ALL government programs related to health care delivery research and reimbursemnt for care. An early stage was the foundation for diagonosis related groups (DRGs) which now control hospital utilization across the nation under the euphemism "severity index" (Horn, 1987).

The attempt to measure the quality of care may in the long run be one of the most far-reaching consequences associated with HMOs and competition in health care. It is difficult to see whether HMOs created or responded to the demands of payors (insurers, employers, and the government as both), but the idea that physicians, as well as hospitals, should and could break down into items or elements the care they give and the decisions they make is a significantly different cultural understanding of medicine. Medical training emphasis the fact that every patient is unique and that to care and treat each case most effectively each physician must synthesise his or her facts and experience in a way that is responsive to the uniqueness of the patient and the experience and judgement of the physician (Fox 1979; Bosk 1981; Freidson 1981). This process and cultural understanding of medicine resists the formulations and the imperatives of bureaucracy or business.

Parallel and interwoven with the ideologically and economically stimulated demand for medical information (which was seen very early in the HMO movement and was strongly re-enforced by it) is the technological development of complex and sophisticated computerized

information systems. This synergistic development between demand and capability is crucial to contemporary changes in health care delivery.

As large employers began to examine their health care costs they were at first perplexed and then angry to find that the health care system did not have the same capacity to store and disseminate information that they were accustomed to in industry. Their demands for information and their expectations regarding information system capacity had an important impact (Anderson et al. 1985). In the mid 1980s, the spread of medical information systems in health care has been dramatic and has become essential for health care plans to remain competitive. Several examples emerged in my interviews:

1) The conceptualization and the operation of the powerful regulatory idea of Diagnosis Related Groups (DRGs) and other prospective payment systems (PPS) now used extensively by the federal government and seeping into the private sector is a product of such technology. And the example of HMOs is often cited as justification for changed expectations.

2) In Minneapolis St. Paul where competition is fierce and the market was considered already "mature" Blue Cross introduced the new "product" discussed above, Aware Gold--a complex, widespread, competitive, and tightly-managed preferred provider network which in its first one and one half years of operation has an enrollment of 200,000 persons in 80,000 contracts. In interviews in Minnesota in April of 1986, health care management analysts insisted that this efficiency and effective competitiveness is directly related to BCBSM's highly sophisticated computerized management information system

developed to review and coordinate the medical, the administrative, and the financial aspects of the system (Kohrman, 1986).

3) In 1981 and 1982, corporate employers I interviewed in the Twin Cities, e.g., at General Mills and Control Data, were accustomed to their own complex computer systems, and insisted that it was possible to set up medical information systems so that they could know their own employees' health experience and costs. They were disquieted and dissatisfied to find that medical providers, neither hospitals nor physicians, were prepared to provide those data. These were early signs of the now frequently heard demand that physicians and hospitals document their patients' health conditions and account for their treatment decisions and the costs.)

4) Consistent with the changing expectations, in Lansing, a professional electronics specialist who was also a labor leader at General Motors noted that the explosive growth of their computer system now makes it possible for General Motors to manage all their own information and self-insure their workers. They merged with a major information systems company and incorporated their expertise into the plant operation. The labor representative said, "we went from not a computer to be seen to having one at every work station." This informant anticipated that with these capabilities, soon major companies will be managing their own medical programs.

Furthermore, as I watch the health care literature and health management mailings, I see dramatically increasing announcements of conferences on complex information systems. Academic research for over seven years at John Hopkins University by Susan Horn and others has developed "severity indices" with thousands of medical condition

variable combinations and the private sector is beginning to market elements of high tech computerized their work under names like "Medisgroups."

The now prevalent demand that the medical care system be accountable--even measureable--is a major cultural and economic effect of the HMO movement.

The sociological analysis of the growth of information technology in health--its uses, its costs, its power, and its control--is an important study that would contribute not only to our understanding of changes in health care but to other altering patterns in the economic and social fabric of the late twentieth century.

REFLECTIONS

I like to think that I have followed C.W. Mills approach to using history in sociology. It invites, he said, "grubbing for detail, but also encourages a widening of one's view to embrace epochal pivotal events in the development of social structure" (Mills 1959:143).

I have noted the playground swings, the kitchen tables, the boardroom tables, the midnight pizzas, and the many thousands of pages of grant applications that served as "props" for the actors in this social movement. These details, and the individuals who used them, have in the course of their activism intersected with significant national--and sometimes global--events powers and conditions. The intersections of individuals' lives and the historical moments define their cohort and the possibilities of what they might do. I have been asked by the activists, as well as by my colleagues, if, in retrospect, the activists might have done things differently. I conclude, that acting

with the information and resources available to them, confronted by regulatory power both direct and indirect, and bound by their historical moment, they did all that was possible. And, as I have noted elsewhere, they made substantive as well as symbolic contributions to health care delivery as it is in 1986.

I have described both differences and similarities in the these case studies of social activism. I will conclude with some incomplete, but for me provacative thoughts about the strongest and most striking similarity of the consumers experience--their interaction with the state and federal government.

My examination of the consumers' local communities showed that the consumers worked wisely and successfully within their communities, coopting or coming to terms with all the elements that might have sabatoged their efforts. For example, while it was problematic that they did not, at first, include local business, they learned and compensated.

They knew that their efforts were also inextricably tied to the legislation, regulation, and funds of the state and federal regulators. And knowing this, the consumer-activists in both NorthCare and Health Central lobbied, testified, and nurtured political contacts with energy, competence, and success. And the individual regulators whom I interviewed, as well as those who were described to me in interviews, were (usually) competent, well meaning and invested in the success of the HMOs in their domain. I conclude that they themselves did not understand the context in which they and the consumer-activists were enmeshed. I quote a highly respected and experienced Michigan

regulator's conclusion regarding the financial troubles of Health Central. She said there were several factors:

> First, the consumer orientation of the board. They probably placed too much trust and reliance on the executive director who did not know what he was doing, and there were probably people on the board who did not view Health Central as a business but viewed their participation on the board as just part of community service.

This study of the activists, their efforts, and the institution they developed strongly demonstrates that this regulator's perception is not true. The consumer activists did NOT trust the executive director, but the structure provided him control to which the consumers did not have access. The "consumers" themselves were labor negotiators, legislators and other professionals, but the ROLE of "consumer" hogtied them. Although they began the movement as a "community service" they were quick to learn. For example, it was their effectiveness at marketing that brought the overwhelming enrollment.

Furthermore, the government agencies, once binding the consumers to government funds, bound them to agency information. And very often the information was wrong, and the regulators, I have shown, less competent than the consumers. Thus it seems that the institutionalized role of "consumer" is a trivializing one. It identifies otherwise productive individuals by their "consumption" and inherently weakens their position. The government programs of the early 1970s encouraging consumer activism to "empower" consumers, actually defined them into a powerless role. It created a synergy for failure.

However, the consumers' HMO movement did not fail the government. Rather, it served an important role. In the mid-1970s, the HMOs showed themselves to be crucial sources of information and leverage for the

federal government as it tried to crack the armour of the medical establishment (which held the key to health care costs). Lawrence Brown (1983) observes, that because of the complexity of medical questions and the political need for medicine's "expertise and legitimacy..."the medical profession (had historically) easily intimidated government generalists." However, "...health maintenance organizations were a valuable ally of the generalists and a standing reproach and challenge to the professional mainstream. HMOs gave the federal "government officials a rationale for federal endorsement of a revisionist model of medical care that had been gaining adherents among academicians and other observers in the private sector for some time. By endorsing and articulating (as well as funding) the new perspectives, they helped publicize and legitimate them." (Brown, 1983:494)

In 1976, another writer observed (Starr 1976:96) that "the primary function of HMOs may turn out to be as a yardstick for social policy, indicating what kinds of advantages are possible from more systematic organization of medical care." Brown offers a number of examples of the "yardstick effect"; for instance, Undersecretary of HEW Hale Champion acknowledged that a hospital cost-containment bill had been predicated (erroneously, CK) on HMO data. In 1977, a state health planning official in Rhode Island explained:

> We're utilizing HMO experience to a large extent. They provide us with standards for hospital utilization, ambulatory visits rates, etc.--guidelines, in short. We face a paucity of decent empirical and normative standards with which to measure the system.....We'd be at a great loss without these HMO statistics....We gather them up as fast as they can produce them." (Brown, 1983, footnote p. 494)

Thus at both the state and national level, federal regulators were getting significant returns for their efforts to keep the HMO experiment alive. The federal interest was not in individual HMOs, but in the overall cost-saving and system-changing effect. Thus, they cheered and publicized when individual plans succeeded, and "cut their losses" when plans failed. .

Finally, I have shown that the consumer-sponsored HMOs in the early 1970s served as an excellent camouflage for the developing arsenal of the government and corporate payers intent on controlling costs of health care. The consumers' movement served as a Trojan horse left in the medical midst. The consumers looked innocent and the medical profession "did not take them seriously." But within the camouflaged exterior of the consumers' HMO movement were the ideas and challenges that changed, and will continue to change, health care delivery in the United States.

GLOSSARY

AAPCC	adjusted average per capita cost
AMCRA	American Medical Care Review Organization
BCBS	Blue Cross Blue Shield
CACHPA	Capital Area Health Planning Agency
CHP	Consumers' Health Plan
EMC	Evanston Medical Consumers
GHAA	Group Health Association of America
GHPC	Group Health Cooperative of Puget Sound
GHP	Group Health Plan (Minnesota)
HALE	Health Action League
HCFA	Health Care Finance Agency
HMO	Health Maintenance Organization
IPA	Independent Practice Association
IRMP	Illinois Regional Medical Program
MCS	Managed Care Systems
MIS	Management Information Systems
MSGP	Multispecialty group practice
NCHP	North Communities Health Plan
NCQA	National Committee on Quality Assessment
OHMO	Office of Health Maintenance Organizations
PHP	Physicians Health Plan
PPO	Preferred Provider Organizations
PIRGIM	Public Interest Research Group in Michigan
UAW	United Auto Workers

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