The Social Control of Organizations in the Health Care Area

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Available data suggest that the influence and autonomy of health care professionals have been declining. Of course, professional impact remains higher in health care than perhaps any other economic sphere, but the locus of much health care decision making has been shifting from independent professionals to employed personnel of large-scale governmental, hospital, insurance, and research organizations. The question therefore arises as to what shall replace this previous reliance upon individual professional ethics to assure the society that its newly powerful health care organizations are functioning in a desirable manner. In other words, what are to be the preferred mechanisms for socially controlling health care organizations.

This paper traces three dominant belief patterns about how the characteristics of health care organizations and their environments produce desired control. It proposes that belief patterns have emphasized (1) the non-profit motives of many health care organizations; (2) the system of interrelationships that surround health care organizations; and (3) the vast differences among health care consumers. Choices from among these models continue to depend less upon knowledge of organizational functioning than upon political dispositions and social fancy.

In 1928-29, expenditures for physicians' services were the largest category of medical cost in the United States, accounting for 28 percent of all health expenditures. Hospitals, which were second with 18 percent of total expenditures, were workshops of physicians and were dominated by them. Following expenditures for hospitals were expenditures for drugs (17 percent), dental services (13 percent), and "other professional services" (7 percent) (Cooper and Worthington, 1973:12). The bulk of care thus was dispensed in settings controlled by professionals, and the cost and quality of care were in large measure determined by the decisions of these individuals. Much has changed since then.

By 1971-72, expenditures for hospitals had grown to be the largest category of medical cost, more than doubling in relative share to 39 percent of total health expenditures. The relative share of physicians meanwhile had declined to 19 percent, after which came drugs (9 percent), research (7 percent), and dental services (6 percent). Organizations thus had increased their importance in the arrangements by which Americans received medical care, with three organizationally dominated areas (hospitals, drugs, and

research) accounting for more than one-half of all expenditures. Furthermore, the immense power of physicians and other professionals in these organizations had been somewhat weakened while the power of administration had increased, particularly in hospitals (Perrow, 1961; White, 1971). Health care organizations and their administrative structures were becoming the focus of planning, decision making, sanctioning, and much else in health care.

Because of this ongoing shift, there developed a need to change assumptions about motivations and controls in the health care field. The tradition of professional motivation to serve clients could less and less be relied upon as a way to assure laymen that medical institutions function "properly." Patient-oriented professionals do not control medical organizations; organizationally oriented employees do. Unfortunately, however, little is understood about circumstances that would encourage the elites of health care organizations to provide quality care at reasonable prices.

Social Control of Medical Organizations

The health care field is not unique in its failure to understand the control of organizational activities. Public inability to control corporate political contributions and CIA domestic spying, as well as the nearly universal failure of federal regulatory agencies, are just a few illustrations that available technology for external control of organizational actions is weak in many areas. Little is known about how organizations can be controlled. In a controversial area such as health care, this lack of knowledge leaves a costly vacuum where strategies for control reflect little more than the political and social predispositions of their advocates (see Reinhardt, 1973). But, as illustrated by experiences with Blue Cross, Medicare, and Comprehensive Health Planning, the usefulness of these predispositions has not been affirmed by experience. Control has been difficult to obtain, and health care organizations have proven more complicated and intractable than expected, with narrow organizational interests regularly undermining outsider preferences. For instance, while it may be rational for a hospital to abandon an emergency room or purchase open-heart surgery facilities, this may not be desired by concerned outsiders. Hospitals nevertheless continue to

buy unneeded technology and companies continue to sell it.

These behaviors are sociologically defined as deviant; they are contrary to the standards and expectations defined by important groups in society. However, incomplete knowledge about the relationship between these deviant organizational behaviors and the societal responses to them results in fostering behaviors that are neither intended nor immediately obvious (Ermann and Lundman, 1975). This tendency prompted Somers (1969:ix) in her excellent book on hospital regulation, to observe succinctly that hospitals so far have "defied conventional public regulation"; despite past failures, or perhaps because of them, the search for organizational knowledge and regulatory technology has continued.

Models of Behavior and Control of Medical Organizations

This paper analyzes changing models of organizational behavior and control in the health care field. It argues that these models, in their times, have been used by the public and by elites (1) to describe the internal dynamics of medical organizations, and (2) to prescribe the conditions that should exist to encourage medical organizations to perform in socially desired ways. Though the models are not mutually exclusive in theory, an emphasis on one has tended to be accompanied by relegation of the others. The models, like the conceptual scheme used here to describe them, are of necessity crude because of the recent importance of large medical organizations and the resulting newness of the need to control them. When applied, these models have enjoyed little success—partly as a result of problems of their unstated and therefore untested nature which we will here try to remedy.

Available data suggest three partly overlapping stages of American beliefs about how medical organizations operate. The first model stressed that the non-profit status of most hospitals and some other medical care organizations makes them substantially immune from corruption of their health care goals. Conversely, it assumed that the profit motive in medicine has a powerful corrupting influence. The second model emphasized systemic ties of hospitals to a wide range of organizations in their environments. It implied that connections, exchanges, and coordination involving health organizations are the most important constraints on their

performance. The third and most recent model, just now emerging, emphasizes the impact of the immediate environment of medical organizations. It proposes that the idiosyncratic differences among health care recipients are or should be the major determinants of the performance of medical care organizations.

These three models have remarkably different implications for choices regarding how hospitals and other medical organizations are to be controlled. Each will be analyzed in detail in the following sections.

The Non-Profit Motivation Model

The non-profit motivation model, which has had the longest history and probably the most influence of any model, emphasized distinctions between profit-making and non-profit organizations. It placed great emphasis on the altruistic goals of formally non-profit organizations (Lentz, 1956) and on the parallel unworthiness of those that seek "to make profit from the suffering of others." Because this model accepted the official service goals of non-profit organizations, and because it has been influential, attempts to control non-profit medical organizations until recently have been minimal. Why, it was asked, should we regulate organizations whose only goals are public service? The description below shows that the answer to this question in the case of voluntary hospitals and Blue Cross often was that they need not be regulated.

Voluntary hospitals for a long time escaped common law and legislated controls, such as a financial penalty for poor performance, applied to most other organizations. For example, malpractice suits, despite their notoriety, are a recent and incomplete phenomenon for hospitals. Beginning with a case in 1876 (Somers, 1969:29) voluntary hospitals have been protected from liability under a doctrine of "charitable immunity." (In that 1876 case the court ruled that a patient whose fractured thighbone allegedly was incompetently treated by an intern could not receive damages from the non-profit Massachusetts General Hospital, even if he proved his allegations, because hospital funds were held in trust solely to maintain the hospital.) Despite a trend in the past thirty years toward reduction in hospital immunity, Zald and Hair (1972:62) characterize 1967 rulings in seven states as still conveying

"full immunity" and in eight as "qualified immunity" for voluntary hospitals.[1]

Voluntary hospitals continue to be exempted from control in other areas as well. They have been exempted from most labor legislation, including legislation controlling working conditions and minimum wages until recently. They are specifically excluded from six of the 14 state laws patterned on the federal government's National Labor Relations Act (Metzger, 1970:83), and were until mid-1974 excluded from the federal law as well. The origins of this federal exclusion vividly illustrate the non-profit model as applied to hospitals. In 1947, the Taft-Hartley Amendments to the Wagner Act excluded employees of non-profit hospitals from NLRB protection as a result of the efforts of Senator Tydings, who, in making his proposal (U.S. House of Representatives, 1973:2), explained that the exclusion was:

> designed merely to help a great number of hospitals which are having very difficult times. They are eleemosynary institutions, *no profit is involved in their operations;* and I understand from the Hospital Association that this amendment would be very helpful in their efforts to serve those who have not the means to pay for hospital service. [Emphasis added.]

There was little opposition voiced to this exclusion of protection of workers solely because a hospital was non-profit.

Non-profit status as a basis for regulation has not been limited to hospitals. The American Hospital Association, shortly after creating Blue Cross as a non-profit insurance organization, sought and received for Blue Cross special regulatory treatment despite its basic similarity to profit-making insurance programs. Among the items sought were exemption from state insurance laws and from reserve requirements applied to commercial insurers. Law (1974:9) found that all states but three now have "special enabling legislation for hospital service organizations, and in 20 states such corporations are exempt from taxation." She also found (Law, 1974:17) that most states do not even require Blue Cross to file proposed increases with their insurance departments. Here again

[1] For 1967-68, Somers (1969:29-31) characterized two states (Massachusetts and South Carolina) still offering total immunity and 20 with "liability limited in one way or another."

medically related organizations were given special treatment—and subjected to relatively loose control—because they were deemed to be non-profit.

By comparison, the level of control of proprietary hospitals and commercial insurance companies has been high, partly because of low legitimacy of commercialism in these areas. Proprietary hospitals always have been subject to malpractice suits, labor legislation, and regular taxation. Commercial insurance companies have been regulated by state insurance commissioners for more than 100 years (Kulp and Hall, 1968:958-959). They were not given special treatment for their involvements in health care.

The level of regulation of these medical businesses appears to change in concert with regulatory trends in the society. When the regulatory movement in the general economy is in a laissez-faire direction and controls on businesses are being loosened, health-related businesses also have their controls lessened. At other times medical businesses join non-medical businesses in being closely regulated.

American public opinion appears to be in a period of increasing distrust of commercial organizations, growing desires to control them, and decreasing support for laissez-faire economics—and these attitudes are carrying over into the medical field. Recent studies of nursing care facilities and their failures, for example, have focused on the need to control the medical practices, as well as the high profits, of commercial nursing homes. A Senate report (U.S. Senate, 1974:225) on "Profits and the Nursing Home: Incentives in Favor of Poor Care" quoted a Dr. Butler expressing this focus quite clearly:

> After 15 years of research and practice, I come now to believe that the profit motive must be eliminated from our care systems including medicine and institutional care and its alternatives. There are many fine and well-intentioned nursing home owners. They are not all miscreants...But the conflict between profit and service is too great to overcome.
>
> Only in the United States and Canada (to my knowledge) is there "commercialization..."

The report itself, as well as its title, placed its authors with Dr. Butler among the critics of profit-making nursing homes.

The non-profit motivation model, in sum, presumes differential need to control health care organizations based on a single

criterion—whether they officially seek a profit. Those organizations holding official non-profit goals tend to be less controlled than profit-making organizations engaged in similar activity. In health care sectors where non-profit organizations account for much activity (e.g., hospitals and insurance), emphasizing this dimension has resulted in low levels of societal control.

The Systemic Model

The systemic model has been replacing the profit motivation model in American regulatory imagery. Unlike its predecessor, the systemic model as applied to health and other fields does not focus on internal (profit-related) motives; rather, it focuses on external relations with other organizations.

This systemic approach when applied to health problems emphasizes that all hospitals (whether voluntary or proprietary) buy from commercial pharmaceutical firms, that non-profit Blue Cross is disbursing agent for the government's Medicare program to proprietary hospitals, and that university-based research centers rely on federal funding. The systemic approach is unconcerned with adjectives like "profit-making," "voluntary," or "governmental." It emphasizes instead how organizations interconnect (Levine and White, 1961). Its current popularity is evident in the widely used phrases like "health care delivery systems" and the "chaos" of the "health care non-system." The word "system" in particular is emphasized.

Fortune magazine, in an issue ushering in the present decade devoted primarily to "Our Ailing Medical System," made this model as uncomplicated and explicit as possible. Its editorial (Fortune, 1970:79) explained that "most Americans are badly served by the obsolete, overstrained Medical system that has grown around them helter-skelter." Its first article offered (Fortune, 1970:2) prescriptions based on the systemic model:

> ...What is needed is a drastic restructuring of the medical system. The federal government, which is paying a sizable share of present medical costs, should encourage the establishment of more efficient systems of medical care, particularly group-practice plans....Also private insurance companies should begin challenging high medical costs more firmly...

Letters to the editor, even critical ones, published in subsequent months all accepted the underlying systemic assumptions.

A more thought-provoking article in *Modern Hospital* (1970), summarizing a five-day "off the record" meeting of 23 hospital-related leaders, used the systemic model with greater sophistication. It predicted a future with three power coalitions in the medical care field, each vying with the others. The coalitions would be (1) physicians, allied professionals, and medical managers, (2) consumers and their agents, Blue Cross, Blue Shield, and other third-party purchasers, and (3) government. The creation and interaction of these three groups, the article concluded, would determine the future course of American health care.

The popularity of the systemic model for understanding and controlling health organizations goes beyond these descriptions and predictions—it is reflected in current regulatory activities. Hospitals are being required to buy generically from pharmaceutical manufacturers, and Blue Cross is being pressured by Medicare to contain hospital costs. Use of the model is evident in some aspects of all national health insurance proposals, and in recent legislation such as the National Health Planning and Resources Development Act of 1974 (P.L. 93-641).

Three of the six most important national health insurance bills introduced into the recent Ninety-third Congress share wholeheartedly the assumptions of the systemic model. They postulate that health care is a system of interrelated parts, and that the parts' relations with one another should be altered. They differ about what relationships should be altered, which is not surprising given their divergent support, but they agree on the need for alterations. The Senate sponsor of the strongest and best known of them, the Kennedy-Griffiths bill supported by organized labor, made these assumptions perfectly clear in his introduction to the bill (Kennedy, 1973:1)

> ...The history of medicare and medicaid has taught us that attempts to offer health insurance on a piecemeal basis to segments of our population—without major efforts to expand and reform our health care system—result in increased inflation which robs Americans of much of the benefit of the new insurance....The answer to this problem is not to cut back on benefits, to raise insurance premiums even more, or to simply offer more insurance to more Americans. The answer is to reform our health care system and bring these costs under control.

Control of medical organizations under Kennedy-Griffiths rests with a unitary, inclusive program administered and coordinated by

the federal government, with special boards and councils to make policies and administer them within the Department of Health, Education, and Welfare. Medicare, Medicaid, Maternal and Child Health, and other programs would terminate as separate programs. In sum, the "system" of health care "delivery" would have the relation of its parts reordered and rationalized.

One of the earliest and clearest examples of the systemic model is the Comprehensive Health Planning (CHP) Act, passed (O'Connor, 1974:391) in 1966 amid "great hopes for a rationalization of what has recently come to be called the American medical care 'non-system' [through the] application of sophisticated planning technology." The act created local and state agencies to plan for and coordinate activities in their (O'Connor, 1974:393) "medical catchment areas." As its title implied, it was to be comprehensive, including all segments of the health care industry, and (O'Connor, 1974:394) "looking at the system as an operating unit." However, achievement of desired coordination has been more difficult than its conceptualization. CHP is widely considered a failure. Its planning agencies have had little influence on the coordination of health care activities, apparently spinning their wheels and accomplishing little, and influencing few behaviors of other organizations in the health field.

The failure of CHP may be due more to the accuracy of the systemic model and its assumptions than to their inadequacy. The model correctly avoids superficial assumptions that non-profit organizations which fail to serve the public will change their behaviors readily in order to serve, and that profit-making organizations will change to protect or enhance profits. It emphasizes instead that organizations tend toward stability and autonomy because of the constraints of other organizations with which they interact. As a result, medical organizations often resist external forces trying to disrupt their existing patterns—to the immense frustration of critics. The following criticism of reforms (Alford, 1972:128) vividly summarizes the frustrations (and the assumptions) of the systemic model:

> ...The overwhelming fact about the various reforms of the health system that have been implemented or proposed—more money, more subsidy of insurance, more manpower, more demonstration projects, more clinics—is that they are absorbed into a system which is enormously resistant to change. The reforms which are suggested are sponsored by different elements in the health system and ad-

> vantage one or another element, but they do not seriously damage any interest. This pluralistic balancing of costs and benefits successfully shields the funding, powers, and resources of the producing institutions from any basic structural change.

This disillusionment with the systemic approach is understandable when one considers American health-planning experiences to date, and basic American attitudes toward planning. American distrust of planning runs deep and strong. George Wallace had little difficulty finding audiences sympathetic to his attacks on pointy-headed bureaucrats who plan other people's lives; calls for reduced governmental planning gain support at all points of the political continuum on all types of issues.

Despite these misgivings (engendered by recent experiences and anti-planning biases), the systemic model has enjoyed popularity among health care professionals because it is consistent with many of the growing technical and scientific subcultures within American society. Management information systems, operations research, and inventory control are just a few instances of this approach in business. In the social sciences, econometric modeling and interorganization studies have gained popularity more recently. As can be seen by the statements from *Fortune* and Senator Kennedy, use of the systemic approach in other areas has provided powerful imagery for the systemic models of health care.

In sum, the systemic model's emphasis on interconnections is being challenged because it creates frustration and distrust. Frustration results from the accuracy of the model's emphasis on interconnections that inhibit change, as well as from the failure of legislation based on systemic approaches. Distrust by a large segment of American society results from the model's implication of large-scale government planning.

The Idiosyncratic Needs Model

More consonant with current American beliefs than the systemic model is a model that emphasizes the peculiar, idiosyncratic nature of the geographic, racial, class, age, and other categories of health care recipients. Focusing on differences between categories, this model deemphasizes the interconnections among (and profit-making traits of) health care providers. Instead, it implies that the differences between black urban ghettos, rural backwaters, and

suburban sprawls are more important than similarities—so their health care organizations must be different and locally controlled. Preferably these organizations would be controlled by those being served, because centralized planning and controlling agencies, even when they attempt to be flexible, are seen as incapable of serving such a wide divergence of health care needs. With its emphasis on diversity and decentralization, this model, not surprisingly, is useful to a number of groups.

First, as used by those on the political left, differences in needs require local "community control" of health care so that the special interests of consumers, particularly the downtrodden, can be asserted and protected. *The American Health Empire* (Ehrenreich and Ehrenreich, 1971), a well-received critique of American health care, makes essentially this case when it argues that health care presently is controlled by and serves profitable commerical ventures and uncaring hospital leaderships. But health care could be consumer-controlled, the book suggests. The final chapter is entitled, "The Community Revolt: Rising Up Angry," and expresses belief in a community's ability to deal with a neighborhood health center it so far had been unable to control. "With literally a century of struggle behind it, the lower east side community is too old and too experienced to be discouraged by one short skirmish" (Ehrenreich and Ehrenreich, 1971: 279). The book illustrates that the idiosyncratic needs model, as implemented by the political left, assumes communities have relatively homogeneous needs which (1) differ from the needs of other communities, and (2) should and can be served.

In the same vein is the Office of Economic Opportunity (OEO) program of Neighborhood Health Centers begun in the mid-1960s. OEO's policy was to encourage "maximum feasible participation" by local poverty groups. According to the positive evaluation of one physician (Sheps, 1972:69), this use of the idiosyncratic needs model advocated "a much greater role, in fact a controlling role, for the consumer [as] an essential condition for future success in our *pluralistic* health system" [emphasis added].

Second, as used by the political right, the model directs more attention to individual differences and less to group differences. Consistent with classical economics, this use of the idiosyncratic model would permit each individual to purchase the services that his own peculiar configuration of needs dictates. The American

Medical Association's national health insurance proposal, "Medicredit," is in this category. It implies that the nation's most significant health care problem is paying health insurance premiums, and proposes little more than federally subsidized optional private insurance so that individual citizens can buy the particular configurations of health care they desire.

Finally, as used by health care administrators, the idiosyncratic model discards the bad old days when local differences were ignored in favor of formulas applicable to a wide range of cases (e.g., Hill-Burton had a small number of population-to-hospital ratios applied over a broad array of circumstances). Somers (1969:217) supports this trend in seeking "a practical, achievable, federal-state system, encompassing the essential aspects of regulation, and *flexible* enough to permit a *creative* mix of controls and incentives" [emphasis added]. This goal of a flexible system based on rational incentives underlies recent interest in using prospective reimbursement to encourage hospital administrators to make cost-conscious decisions reflecting local needs. It also is part of what Ellwood (1974:85) calls the "competitive HMO model" under which federal planners adopt "certain positive programs to aid in the development of HMOs and to further a competitive health market." It has been criticized (Navarro, 1973:228-237) because planner responsiveness to consumers would be undermined by the tendency toward monopoly that characterizes health care providers.

In sum, although no version of the idiosyncratic-needs model has been widely accepted, the model nonetheless is attractive to a diversity of political and professional groups because it has components they share. It advocates a decentralized control system, consumer choices, and the avoidance of "big brother," all of which makes it appealing in American culture. Consequently, it appears to be gaining attractiveness in the general society as "think small" becomes desirable, and as sentiment among citizens and leaders grows against bigness in government and commerce. (Even pornography is now legally definable by community idiosyncrasies.) In health, once the controversy over national health insurance is resolved, this "back to the roots" movement may enter with full force. This model may be attractive enough to dominate future health care control decisions.

The Sociological Imagination and the Social Control of Medical Organizations

This paper has attempted to clarify the alternative ways Americans have gone about modeling the increasingly apparent problems of controlling their powerful health care organizations. It has argued that American thought gradually has been abandoning profit as a prime explanatory variable in many areas and moving toward the idea of a system. Now, as nostalgia for simpler days is gaining strength, as large institutions generally are falling into disfavor, and as sexual, age, and ethnic groups are asserting their distinguishing traits, health beliefs and preferences are discouraging bureaucratic impersonality and efficiency in favor of the charms of group differences.

The changing health attitudes described here parallel Charles Reich's (1970) interesting but overstated description of the sequence of "world views" held by Americans. Reich's categories can be seen as the larger context for the sequence of views on controlling medical care organizations described here. "Consciousness I," the earliest of the world views, belonged to the small businessmen, farmers, and pioneers whose life experiences taught them that man's natural condition is to struggle. "One worked for oneself, not for society. But enough individual work made the wheels turn" (Reich, 1970:22). Some people were profit-motivated, others were not.

"Consciousness II," the replacement for "Consciousness I," belongs to those whose most compelling experiences were with the interdependences and interconnections of large organizations, and who came to believe that organized rationality is man's most necessary state. And, finally, Reich's "Consciousness III" is held by an emerging group who seek a stronger respect for people. "In place of the world seen as a jungle, with every man for himself (Consciousness I), or the world seen as a meritocracy leading to a great corporate hierarchy of rigidly drawn relations...(Consciousness II), the world [of Consciousness III] is community" (Reich, 1970:227).

Beliefs of health care leaders, like those of laymen, are influenced by societal trends and fancies. These changing social attitudes in general could have unfortunate consequences for health

care organizations if applied indiscriminately in the health field. This writer believes that there may be unfortunate consequences if social trends lead to wholesale acceptance of the idiosyncratic model. While many of the most noticeable American medical care problems are visible at the community level, their roots lie deeper in the social structure. Attracting health personnel from affluent suburbs to urban ghettos and poor rural regions, for example, cannot be accomplished by the poor communities; a mechanism encompassing the relative surplus and shortage communities is needed. Medical care requires resources that are spread throughout the society, resources that cannot be mobilized locally but must be organized regionally or nationally.

Similarly, hospitals are in a national nexus of government programs, commercial manufacturers, insurance organizations, and professional associations. The growth of this system has outstripped Americans' understanding of necessary circumstances for health care organizations to provide reasonably priced high-quality care. As Mills (1959:3) noted, "the more aware [people] become, however vaguely, of ambitions and of the threats which transcend their immediate locales, the more trapped they seem to feel." The idiosyncratic model in health care may turn out to offer a false road to losing the sensation of being trapped and powerless.

It would be unfortunate to end this paper defending the systemic model, however, because the goal of this paper has not been to boost one model and disparage others. Convincing data for doing this are unavailable in any case. The goal, rather, has been to draw attention to the need to understand and make explicit the models proposed for controlling increasingly dominant organizations in American health care. Professional responsibility will not work because professionals, even when they happen to be client-oriented, do not control medical organizations. What is needed in the health care area is organizational control *knowledge* as the basis for developing organizational control technologies. Current technology, in the absence of knowledge, has become an offshoot of idiology and popular culture.

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References

Alford, Robert R.
1972 "The political economy of health care: dynamics without change." Politics and Society 3 (Winter): 127-164.

Cooper, Barbara S., and Nancy L. Worthington
1973 "Health care expenditures, 1929-1972." Social Security Bulletin 36(January): 3-19.

Ehrenreich, Barbara, and John Ehrenrich
1971 The American Health Empire. New York: Vintage Books.

Ellwood, Paul M., Jr.
1974 "Models for organizing health services and implications of legislative proposals." Pp. 67-95 in Zola, Irving K., and John B. McKinlay (eds.), Organizational Issues in the Delivery of Health Services. New York: PRODIST.

Ermann, M. David, and Richard J. Lundman
1975 "Organizational control of organizational deviance." Paper presented at the 70th Annual Meeting of the American Sociological Association, San Francisco (August).

Fortune
1970 "Our ailing medical system." Fortune 81(January).

Glaser, William A.
1966 "'Socialized medicine' in practice." The Public Interest 1 (Spring): 90-106.

Kennedy, Edward
1973 Pp. 1-4 in Congressional Record, Vol. 119, No. 17, January 31.

Kulp, C.A., and John W. Hall
1968 Casualty Insurance (4th edition). New York: Ronald Press.

Law, Sylvia A.
1974 Blue Cross: What Went Wrong? New Haven and London: Yale University Press.

Lentz, Edith

1956 "The American voluntary hospital as an example of institutional change." Unpublished Ph.D. Dissertation. Cornell University, Ithaca, New York.

Levine, Sol, and Paul E. White

1961 "Exchange as a conceptual framework for the study of interorganizational relationships." Administrative Science Quarterly 5(March):583-601.

Metzger, Norman

1970 "Labor relations." Hospitals 44(March):80-84.

Mills, C. Wright

1959 The Sociological Imagination. New York: Grove Press.

Modern Hospital

1970 "Experts see new balance of health care forces." Modern Hospital 14(April): 39-40d.

Navarro, Vicente

1973 "National health insurance and the strategy for change." Milbank Memorial Fund Quarterly/Health and Society 51 (Spring): 223-251.

O'Connor, John T.

1974 "Comprehensive health planning: dreams and realities." Milbank Memorial Fund Quarterly/Health and Society 51(Spring): 223-251.

Perrow, Charles

1961 "The analysis of goals in complex organizations." American Sociological Review 26(December):854-866.

Reich, Charles A.

1970 The Greening of America. New York: Random House

Reinhardt, Uwe E.

1973 "Proposed changes in the organization of health-care delivery: an overview and critique." Milbank Memorial Fund Quarterly/Health and Society 51(Spring): 169-222.

Sheps, Cecil G.

1972 "The influence of consumer sponsorship on medical services." Milbank Memorial Fund Quarterly (October, Part 2): 41-69.

Somers, Anne R.

1969 Hospital Regulation: The Dilemma of Public Policy. Princeton, New Jersey: Industrial Relations Section, Princeton University.

U.S. House of Representatives

1973 Extension of NLRA to Non-Profit Hospital Employees. Hearings before the Special Subcommittee on Labor of the Committee on Education and Labor. 93rd Congress, 1st Session (April 12 and 19).

U.S. Senate

1974 Nursing Home Care in the United States: Failure in Public Policy. (Supporting Paper No. 1: The Litany of Nursing Home Abuses and an Examination of the Roots of Controversy.) Prepared by the Subcommittee on Long-Term Care of the Special Committee on Aging. 93rd Congress, 2nd Session (December).

White, Rodney F.

1971 "The hospital administrator's emerging professional role." Pp. 51-69 in Arnold, Mary F., L. Vaughn Blankenship, and John M. Hess (eds.), Administering Health Systems: Issues and Perspectives. Chicago: Aldine-Atherton.

Zald, Mayer, and Feather Davis Hair

1972 "The social control of general hospitals." Pp. 51-82 in Georgopoulos, Basil S. (ed.), Organizational Research on Health Institutions. Ann Arbor, Michigan: Institute for Social Research, University of Michigan.