

The Corporate Compromise: A Marxist View of Health Maintenance Organizations and Prospective Payment

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Recent developments in health care are strikingly congruent with a Marxist paradigm. For many years small scale owner producers (physicians) dominated medicine, and the corporate class supported the expansion of services. As health care expanded, corporate involvement in the direct provision of services emerged. This involvement is reflected not only in the rise of for-profit providers, but also in the influence of hospital administrators, utilization review organizations, insurance bureaucrats, and other functionaries unfamiliar with the clinical encounter, but well versed on the bottom line. Corporate providers' quest for increasing revenues has brought them into conflict with corporate purchasers of care, whose employee benefit costs have skyrocketed. This intercorporate conflict powerfully shapes health policy and has caused the rapid proliferation of health maintenance organizations and other forms of prospective payment. Corporate purchasers of care favor the incentives under prospective payment for providers to curtail care and its costs. For corporate providers, prospective payment has allowed increased profits even in the face of constrained revenues, because reimbursement is disconnected from resource use. Unfortunately, this corporate compromise serves patients and physicians poorly. Alternative policy options that challenge corporate interests could save money while improving care.

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Over the past century medical care has evolved from a small cottage industry, through a period of rapid expansion as a charitable public service, to an enormously profitable and increasingly private business. Medicine has become one of the largest industries in the United States, and economics now competes with science and humanitarian concerns in shaping the future of medical care. The dominance of economic imperatives and the corporate transformation of American medicine is strikingly congruent with Karl Marx's century-old description of the development of a capitalist industry.

We present a Marxist view of current U.S. health policy. We argue that the growth of prospective pay-

ment can be traced to an implicit compromise between cost-conscious corporate purchasers of care and corporate health care providers struggling to expand profitability and assert control of medicine.

Marx emphasized that technological progress in the 18th and 19th centuries changed not only the processes of production, but also power relations in industry. As the cost of the tools of manufacture (capital) rose to exceed the means of individual producers, the owners of capital gained power, because producers without modern equipment could not compete. The dominance of the owners allowed them to depress wages and command profits, which in turn paid for the ever larger investments needed to remain competitive—investments increasingly unthinkable for ordinary workers. Thus owners of capital came to control production (often from afar), as well as the profits that became new capital. Through these powerful levers they shaped much of society.

The history of health care's emergence as a capitalist industry reads like a modern textbook of Marxist economics. Small scale owner producers (physicians) initially came together in workshops (hospitals). Technical development made access to large concentrations of capital (buildings and machines) indispensable for medical practice and increased the power of those who controlled health care capital. At the same time that accumulation of capital was increasing, control of health care institutions shifted from public to private hands. Today the power of those who control capital is reflected in the rising influence of hospital administrators, corporate executives, insurance bureaucrats, and other functionaries unfamiliar with the clinical encounter, but well versed on the bottom line.

The recent conversion of health care from public service to private industry has brought those who profit from providing health care into conflict with industries for whom health care (namely, employee health benefits) is a cost of production. This intercorporate conflict powerfully shapes health policy. It has caused the rapid proliferation of health maintenance organizations (HMOs) and other forms of prospective payment that establish incentives for cost containment but allow health institutions to remain profitable, and has hastened the decline of physician dominance in both health policy and clinical decision making.

Health Care and the Profitability of Industry

Marxists view medical care as an industry analogous to other industries. Medicine is not an autonomous

discipline guided solely by scientific discoveries or idealistic concerns; rather, health care is one sector of economic production that responds to the economic and political needs of the capitalist system as a whole. Marxists hold that the drive for profit and expansion is the main determinant of the development of any capitalist industry. However, some industries that would not be viable in a purely market-driven economy are necessary for the profitability of other industries, or the stability of the system as a whole. In such cases the government, which Marx referred to as "a committee for managing the common affairs of the whole [corporate class]" (1), may step in to assure that needed functions are carried out. The provision of roads, water and sewage systems, public education, and other public services are examples. Similarly, the impetus for government programs to improve medical care for the poor is not primarily humanitarian, but mainly a response to fears of popular unrest, an effort to increase the productivity of current and future workers, and a means of channeling money to the profitable drug, medical supply, and hospital construction industries. Thus, an analysis of health care must encompass its impact on the profitability of other industries as well as the growth of production for profit within medicine.

Health care facilitates profit-making in three ways. First, many illnesses that sap the productivity of workers can be cured or managed. To quote Charles Eliot, a 19th century president of Harvard University: "The objective of research in medicine is to prevent industrial losses due to sickness and untimely death among men and domestic animals" (2). Second, medicine is an important psychological tool for the maintenance of the domestic tranquility and social stability needed for production and profit; in Marxist terms this is the ideological role of medicine. Since Bismarck's introduction of health insurance for German workers in 1883, governments have used health care to ameliorate the conditions of working class life, responding to popular demands and forestalling more radical ones (3). Third, the medical care industry has itself become an important field for investment and profit.

While the first two of these roles for health care (often perceived as public service and charity) have a long history, the last (pecuniary interest) has only recently emerged as a driving force for health care expansion. Within the past few decades medicine has become not only a service for the rest of industry and society but a major profit-producing industry in its own right. Health care, initially an adjunct to production in other sectors, has itself come into the age of capitalist production. Previously, the corporate class was most concerned with the products of health care—biological and ideological. The transformation of the past few decades is making profit, rather than health or ideology, the major objective of production in this field. Ultimately, to paraphrase Marx's *Das Kapital*, in health as in other industries, capitalist production is indifferent to the particular product produced. Increasingly, the sole purpose of production is to secure profits (4).

From Public Service to Profitable Industry

At the turn of the century public health and sanitation measures dramatically increased life expectancy (5). In contrast, most curative medical therapies were useless or worse (5). A physician could serve as a comfort in time of suffering but could offer patients little else besides sympathy and morphine. Individual (physician) producers who required few tools to ply their trade dominated medical care. For less than a dollar a day hospitals provided room, board, and quarantine, but little specialized equipment or personnel (6, 7). Some cities had established public hospitals for the poor. Most "private" hospitals were small, charitable enterprises aided by state and local governments. The distinction between private and public hospitals was blurred and relatively unimportant because the total amount of money spent on hospitals was small (\$29 million in 1903, 0.08% of the gross national product [GNP]) (6, 7).

In the first half of this century there was a gradual and accelerating growth in medical knowledge and technology, and an increase in the capital needed to practice medicine. By 1950 the nation's hospital bill had climbed to \$3.7 billion (1% of the GNP) (8), and items such as radiology departments, laboratories, and surgical suites were considered necessities for every hospital. With the further accumulation and increasing importance of hospital capital (net fixed hospital assets grew from \$2.8 billion in 1950 to \$48 billion in 1980 [9]), hospital boards and administrators who controlled capital came to command greater power. The need for ever-expanding investment to maintain state-of-the-art facilities gradually eroded the former charity and service orientation of hospital managers, and fostered an entrepreneurial mentality even in many nominally nonprofit institutions (10). Philanthropy and local government grants accounted for more than 90% of hospital investment capital in the 1920s (9), and philanthropy remained the largest single source of hospital capital until the mid-1960s (11). However, by 1973 charitable donations accounted for only 10% of construction funds, while debt financing contributed 58% of the total (9). In 1983 philanthropy and debt financed 4% and 70%, of hospital capital, respectively (9).

The corporate class as a whole supported the expansion of health care by providing health insurance for employees of large firms. Government encouraged these employer-paid health benefits by exempting them from taxes and, during World War II, by freezing wages but not benefits. Employers welcomed this development for several reasons. Health insurance was popular with workers, improved their productivity, and gave corporations additional leverage over workers by tying health care to employment, while maintaining a lower standard of care for the unemployed, retired, and disabled. Whereas the labor movement in the rest of the developed world demanded and won universal health insurance, organized labor in the United States abandoned this demand and accepted health benefits negotiated on a contract-by-contract basis.

Blue Cross, founded in 1929 by hospitals, became the model for all subsequent employee health plans. Blue Cross paid hospitals for whatever services and equipment the hospitals deemed necessary and specifically included payment to cover all capital costs (12). Thus any hospital that could raise the down payment for new acquisitions was given a blank check to cover the mortgage, with patients footing the bill for the accumulation of hospital capital under private control. In 1946 the federal government intervened to solve the problem of raising down payments with the passage of the Hill-Burton program, which gave billions of dollars in grants to hospitals for capital projects (13).

These financial encouragements assured the post-war expansion of the medical industry. Hospitals added over 40% of today's total inpatient capacity during the 1950s and 1960s. The United States went from a shortage to a surplus of hospital beds (reflected in a sharp drop in occupancy rates) (14, 15). Expensive new equipment and medical techniques were widely adopted, often without proof of efficacy (16). However, the large number of uninsured poor and retired persons who could not afford to purchase the increasingly costly services limited the further growth of the industry.

The movements for civil rights and social justice of the 1960s provided additional impetus to remove this barrier to the growth of the medical industry. Responding in classic "Bismarckian" fashion to the threat of social unrest, Congress established the Medicare and Medicaid programs. These programs were a cornerstone of the expansion of the social welfare system and constituted a real victory for the health of the poor and elderly (17). However, both programs helped not only the poor and elderly but also the health care industry, by dramatically increasing and radically reorienting government spending on health care. Spending that had previously been concentrated in direct grants to public health programs and public hospitals skyrocketed and was devoted to the purchase of care in the private sector (18-20). The programs were closely modeled after (and often administered by) Blue Cross, and included virtually unlimited payments to hospitals for capital expenditures. While noisily proclaiming the benefits of Medicaid and Medicare for the poor and elderly, government quietly signed the blank check for private hospital expansion.

Public Money, Private Control

After the passage of Medicare and Medicaid, private hospitals moved to capture the newly insured patients from public hospitals (19, 21), while often refusing to care for the millions of nonelderly poor who were not eligible for either program (10, 21-24). Because insurance paid for almost any service provided, insured patients received an increasing number of tests and interventions, many of uncertain value (25). Public hospitals remained the low-tech institutions of last resort for the uninsured (26, 27).

The nonprofit status of most private hospitals proved small hindrance to profit making. While non-

profit hospitals could not themselves reap profits, the cost-plus payments provided by government and private insurance made them ideal conduits for the profits of drug companies, equipment manufacturers, construction and real estate firms, banks, and insurance companies (10, 28, 29). The situation is somewhat analogous to the defense sector in which suppliers are paid on a cost-plus basis and reap profits, while the military itself is operated as a nonprofit "public service." Health-related industries have been extraordinarily profitable. For example, the profit rate of pharmaceutical firms has for decades ranked first or second among the 47 U.S. industry groups (30, 31). Incentives to raise the cost of hospital care and thereby expand the market for medical products led to the seemingly bizarre result that during the 1970s the lowest cost hospitals were the most likely to be driven out of the market (32).

Since 1965 government subsidies to private hospitals have become the financial backbone of the industry. For example, in 1985 the Medicaid and Medicare programs contributed 38% (\$63 billion) of hospital revenues (33). Tax exemptions for health insurance and nonprofit hospitals indirectly contribute tens of billions more (34-37). Finally, tax-exempt bonds have financed much recent hospital expansion. In 1981 alone hospitals sold over \$5 billion in tax-exempt bonds, (17% of all tax-exempt bonds issued; 7% of the total bond market) representing a loss in taxes to the federal treasury of \$1.5 billion (11). Overall, the proportion of hospital capital funding supported by federal subsidies (direct or indirect) increased from less than 20% in 1968 to more than 80% in 1976 (9). Private hospitals now receive more than 60% of revenues from government sources, a government subsidy that far exceeds the budgets of public hospitals ([18], and Woolhandler S. Unpublished data).

By the early 1980s private health insurance and government support had fostered the emergence of health care as one of the United States' largest industries (38). Between 1950 and 1983 national health expenditures increased more than 25-fold, reaching \$357 billion per year, and the proportion of the GNP accounted for by the health sector increased from 4.4% to 10.8% (33). During the 1970s health care employment increased from 4.2 to 7.2 million workers (8), accounting for one seventh of all new jobs. Hospitals expanded so rapidly that by 1980 the average age of hospital capital assets stood at an all time low of 7 years, compared to 15 years for the service sector as a whole and 23 years for capital in manufacturing industries (39). Whereas between 1946 and 1950 public hospitals accounted for 32% of new hospital capital, between 1970 and 1974 this figure had fallen to 16% (40).

While private hospitals vied to purchase the latest technology and provide the greatest number of profitable services, public hospitals were left as pitiful remnants of their former selves, housed in aging buildings, equipped with outdated machines, and serving mostly uninsured patients (27, 41, 42). The average age of public hospital capital assets exceeds 12 years, almost

twice the average for private hospitals (27). Since 1965, 6 of New York City's 19 public hospitals have closed, as have 29 of California's 66 county hospitals (43). The only public hospitals that served Detroit and Philadelphia have also closed (41, 44). Further cuts in New York's public hospitals, including those in medically underserved areas, are being considered. Meanwhile, private hospitals in bed-rich Manhattan neighborhoods have embarked on extensive new construction projects.

The Rise of Profit-Making Providers

The copious flow of funds for private health services eventually convinced entrepreneurs that hospitals and HMOs need not be mere nonprofit conduits for the profits of other industries, but could themselves be operated as profit-making (proprietary) entities. While proprietary hospitals and HMOs are not eligible for tax exemptions, they can tap capital markets (by issuing stock) unavailable to nonprofit hospitals. Both government and private insurance programs virtually guaranteed the profitability of proprietary hospitals by including profit as an allowable (and reimbursed) cost. Proprietary hospitals and HMOs able to "market" services to the well-insured were assured rapid expansion.

Between the founding of the first for-profit hospital company in 1960 and the reorientation of hospital payment heralded by the passage of the Medicare diagnosis-related group (DRG) program, the number of corporate-owned proprietary hospitals grew to more than 1000. By 1982, Hospital Corporation of America, the largest proprietary chain, owned 351 hospitals with 50 200 beds, producing revenues of \$3.5 billion (45). Among HMOs, U.S. HealthCare Systems was the first, in 1983, to convert to for-profit status, go public, and offer stock (46). Today, 431 of the 650 HMOs are proprietary (47). Interestingly, in 1983 even the enormous profits of proprietary hospitals (\$1.2 billion) (48) were still dwarfed by those of suppliers of drugs (\$5.6 billion) (31) and medical equipment (\$2.8 billion) (29).

The Intercorporate Conflict

In the past, the corporate class was virtually unanimous in its support for the expansion of health care. However, divisions emerged as employee health benefit spending became a major cost of production. By 1983 U.S. corporations were spending more than \$89 billion a year for employee health benefits (49). Health care costs were not only eating into profits, but also compromising the international competitiveness of U.S. industry. For example, in 1983 Chrysler Motors spent \$5300 per employee for health care, while Mitsubishi spent only \$815 (50). As nonmedical corporations have come to view soaring health care costs as a major concern, they have moved to curtail the assured profits and rapid expansion of the health sector (51-53). In the Marxist analytic framework, this process is viewed as a result of the tendency toward

equalization of profit rates across different sectors of industry (4).

By 1970, *Fortune* magazine had sounded the corporate alarm, editorializing, "The management of medical care has become too important to leave to doctors. . . . The majority of physicians constitute an army of pushcart vendors in an age of supermarkets" (54). In 1981 the Business Roundtable, an organization of the most powerful corporate executives, declared the control of health care costs a top priority and formed a health task force headed by Citibank President Walter Wriston. As a reporter for the *Boston Globe* remarked, "The Business Roundtable's decision to get serious about hospital cost control marked the turning point in the debate. Until then, the issue had been the province of insiders [who] had more of a stake in the status quo [the continuing expansion of the health care industry] than in cost containment" (55). The number of business-sponsored coalitions devoted to health care costs grew from 25 in 1982 to over 200 in 1986 (53), and coalitions now operate in at least 43 states. Eighty percent of the members represent business, and one third of the coalitions allow only corporate members (53). Many corporations have restructured health insurance benefits to force providers to lower prices and shift costs to employees through co-payments and deductibles (56-59). In Massachusetts in 1982, representatives of the hospital industry, insurance firms, and the Business Roundtable rewrote the state's hospital reimbursement laws with no input from patients, physicians, or even politicians (60). By 1984 corporations in Arizona were engaged in open warfare with the hospital industry, placing a stringent cost-control measure on the ballot and spending millions of dollars campaigning for the measure.

Government has moved to end the privileged position enjoyed by the health care industry. In 1971 the Nixon administration made support for HMOs (previously reviled as incipient socialized medicine) the centerpiece of its health policy, pressaging a major shift in the structure of the health industry (61, 62). Phase-out of Hill-Burton grants for hospital capital projects began in 1975 (13). In 1983 the passage of the Medicare DRG program and widespread corporate advocacy of HMOs firmly entrenched "prospective payment" as both government and corporate policy (53, 63).

Prospective Payment as Corporate Compromise

The growing conflict between corporate providers and purchasers of care has given rise to prospective payment schemes that are acceptable to both groups but exact a toll from patients and physicians. Two principal variants of prospective payment have emerged. Capitation schemes pay the HMO (or other provider) a fixed annual fee per enrollee to cover all care. In contrast, per case schemes, such as DRGs, pay the provider a fixed fee to care for a single episode of illness (for example, a hospital stay). Both HMOs and DRGs untether payment from actual resource use and allow health institutions to retain any surplus for ex-

pansion, profit, or both.

Prospective payment radically reorients both the financial imperatives and the internal power relations of health institutions (64, 65). Previously, profitability depended on recruiting well-insured patients and maximizing the services provided to them. Prospective payment preserves the incentive to serve only the well-insured but rewards minimization of services or their cost. This latter feature may bring the financial interests of physicians and health institutions into conflict. Under DRGs, reduced use of resources lowers physician income but benefits hospitals. In HMOs, physicians' incomes are subtracted directly from the bottom line. With both HMOs and DRGs, institutional profitability, expansion, and even survival hinge on administrative control of physician behavior. The result has been an enormous expansion of the administrative apparatus of health care, which now consumes about 22% of all health expenditures (29, 66). The premium on administrative control has hastened the shift of power from physicians to those who manage and own the massive concentrations of capital now needed to practice medicine.

Corporate purchasers favor the incentives under prospective payment for providers to curtail care and its costs. In addition, because HMOs provide virtually no care to the uninsured, they eliminate the cross subsidy for free care incorporated into Blue Cross and commercial insurance rates.

For corporate providers, prospective payment allows increased profits even in the face of constrained revenues because reimbursement is disconnected from resource use (67-70). While this incentive rewards efficiency, it also rewards less desirable behaviors. Thus, many HMOs selectively enroll the healthy—marketing to employee groups with low health care utilization rates, and on occasion even going so far as to place enrollment offices on the upper floors of buildings without elevators (71-73). The HMOs may also profit by discouraging enrollees from seeking care or curtailing physicians' ordering of needed tests, hospitalizations, and so on (71, 72). Indeed, the Rand Health Insurance Experiment found that HMOs decrease appropriate medical admissions as much as inappropriate ones, although they do selectively discourage unnecessary surgery (74).

Under DRGs, hospitals can prosper by encouraging the admission of patients likely to require little care (75); discharging patients prematurely (68, 76, 77); avoiding admitting patients whose DRG payment is likely to be less than the cost of care, for example, the seriously ill, patients admitted on an emergency basis or cared for by more experienced surgeons, the poor, or patients with inadequate home supports who may require longer lengths of stay (78-81); or "gaming" the system by miscoding patient diagnoses into a higher-paying DRG (82). Conversely, institutions unwilling or unable to alter patient mix, physician behavior, or diagnostic coding face financial ruin. Thus, under the DRG program, average hospital profits on Medicare patients have soared (70), doubling in the first year of prospective payment to \$5.5 billion (68, 69).

Meanwhile, the financial situation of many rural and inner city hospitals has deteriorated (27, 79, 83, 84). Indeed, the gap in profit margins between hospitals that are doing well (the top 5%) and those that are doing poorly (the bottom 5%) has increased by 37% under DRGs (84).

While other health policies might be acceptable (or even preferable) to corporate providers and purchasers separately, prospective payment is uniquely acceptable to both. Unfortunately, this policy option poorly serves many patients and individual providers. By curtailing cost-shifting, prospective payment even more rigidly excludes the 37 million uninsured from the medical mainstream. The HMO enrollees, particularly if low income, may be unable to obtain needed care due to the "gatekeeping" essential for HMO profitability (71, 85). In extreme cases, such as International Medical Centers, the largest Medicare HMO, the drive for profitability has caused fraud and outright patient abuse (86). Even in high quality HMOs, patients routinely suffer disruptions of doctor-patient relationships if they change jobs or retire, or if their employer decides to change health plans. At one Boston-based HMO, 35% of members disenroll annually, and annual disenrollment figures as high as 42% have been reported (87). The doctor-patient relationship is often further compromised by patients' fears that their doctor may be rewarded for skimping on care (88, 89). A spate of anecdotal reports as well as a few careful studies raise concern that DRGs have compromised the quality of care (68, 76, 77).

As prospective payment increasingly dominates the policy landscape, physicians find many satisfying aspects of their traditional role challenged—their position transformed from independent small producer to highly paid foreman in a medical factory. Long-term relationships with patients are arbitrarily disrupted; doctor-patient confidentiality is routinely violated by financial reviewers; productivity standards constrain human interactions; decisions on new programs and equipment become the prerogative of a management increasingly divorced from clinical care; and even the right to waive fees for the needy is usurped. Physicians are losing their former control of medical production; they are being "proletarianized" (90), a process vividly described by Marx: "The [corporate class] has stripped of its halo every occupation hitherto honored and looked up to with reverent awe. It has converted the physician, the lawyer, the priest, the poet, the man of science, into its paid wage-laborers" (1).

More than a century later, Paul Ellwood coined the term HMO and sold the concept to President Nixon as a policy alternative to blunt the drive for national health insurance (62). Ellwood's prediction of the effects of the policy is striking both for its accuracy and its congruence with a Marxist formulation. Health Maintenance Organizations "could stimulate a course of change in the health industry that would have some of the classical aspects of the industrial revolution—conversion to larger units of production, technological innovation, division of labor, substitution of capital for labor, vigorous competition, and profitability as the

mandatory condition of survival" (91).

Prospective Payment and the Dissolution of Health Planning

While prospective payment imposes tight regulation on clinical practice, it undermines broader health planning. The increasing economic rationality of each production unit (that is, the individual HMO or hospital) fosters the irrationality of the system as a whole—a phenomenon Marx labeled "the anarchy of capitalist production" (4).

Rational health planning should allocate new capital based on health needs. However, prospective payment makes profitability rather than need the implicit basis for allocating new capital. Profitable hospitals and HMOs not only can reinvest their own profits but can also attract additional money from outside banks and investors. Resource allocation decisions are made in the board rooms of profitable firms or of nonprofit institutions with a revenue surplus. These decisions must be bent toward the narrow institutional goal of profitability, because future modernization, expansion, and even survival depend on a continuing surplus. Hospitals lacking a surplus (because of poor management, spendthrift physicians, or uninsured or unprofitably sick patients) are likely to be those most in need of new investments. Unable to modernize, such hospitals often enter a downward spiral toward closure (27, 92-94). Meanwhile, hospitals in highly competitive markets vie to provide profitable services, causing wasteful, and sometimes dangerous, duplication of lucrative "product lines" such as coronary angioplasty and bypass surgery (95). The net result is increasing irrationality in the distribution of health resources—a surfeit of expensive facilities in some areas and continuing shortages in areas of greatest need.

In contrast, in Canada, where corporate dominance of health services is limited, a public insurance fund in each province pays hospitals "prospectively" but effectively prohibits them from making a profit or retaining any surplus. Capital expenditures are not folded into operating budgets but appropriated separately. Hospital expansion and modernization are explicit public policy decisions (96). In the United States, capital funds also come largely from public sources but are implicitly appropriated for the expansion of profitable institutions regardless of health needs. The explicit public control of capital funds in Canada has facilitated rational resource allocation, avoiding costly overbedding and redundancy of high-technology services (96).

Conclusions

In the past thirty years there has been an enormous accumulation of capital in health care institutions, the emergence of medical production for profit, and the rapid rise of administrative dominance of clinical practice. The explosive growth of the health sector in the past, encouraged by the entire corporate class and fueled by government funds, now threatens the profits

of other capitalist industries. Prospective payment with providers permitted to retain any surplus is an intercorporate compromise that maintains profitability, reinforces private control of health care capital, and accelerates the trend toward bureaucratic and corporate dominance of medical care. This is not the only, or the best, possible direction for health policy. The Canadian National Health Program has assured access to care, preserved clinical freedom, and contained costs by constraining corporate dominance and rationalizing health resource (capital) allocation.

Health policy in the United States has been shaped largely by the interests of the corporate class, a process that threatens many valuable traditions in medicine. The enormous sums spent on health care are sufficient to provide high quality services to all, improve prevention of disease, nurture research, and assure providers adequate income. However, the imperatives of corporate profitability now foster massive irrationality and waste: \$50 billion devoured annually by the insurance industry and armies of administrators (66, 97), and billions more squandered on profits and advertising for health care corporations (29, 30). Finally, allocating new capital on the basis of profitability to private providers pursuing narrow institutional goals assures massive duplication and maldistribution of facilities.

A reorientation of policy will require an alternative coalition of forces capable of resisting the imperatives of pecuniary interests. Physicians together with other health care workers and our patients may provide such a force.

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