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Some twenty-five years ago, when I was still a young health services researcher, I went to England to study the National Health Service (NHS). My expectations were that a system of care dedicated to equity of access and based on need rather than the ability to pay a fee would encourage appropriate dedication and a high level of responsiveness. After all, common sense suggested that if physicians’ work depended little on what patients paid and more on discretion on how best to use clinical efforts, everyone would benefit.

The experience was impressively disillusioning. There were many things to admire in the NHS, particularly the guarantee of ready access to anyone who felt need. But in comparison to their American counterparts, British physicians did not work particularly hard, processed patients in a fairly perfunctory manner, were commonly unresponsive to patients, and characterized many of their patients’ concerns as trivial. Diagnostic assessment was often limited, facilities were antiquated, and my preconceived notion that physicians in a nationalized system would be sensitive to broad social factors affecting illness and socioemotional considerations was off the mark. In a comparative study with American physicians performing similar roles, I was surprised to find that American office-based, fee-for-service doctors were more responsive and accommodating to patients’ perceived needs and had a broader social perspective than their British counterparts. So much for preconceptions.

The growth of corporate medicine, like the NHS, could almost serve as a projective test allowing observers to impute their preconceptions, ideologies, and fears. Considering how much is written on the topic, we have an amazingly poor grasp of the consequences of corporatization, the heterogeneity within types of organizational structures, and the extent to which corporatization serves or violates the public good. The Corporate Transformation of Health Care, mostly consisting of revised papers that appeared in the International Journal of Health Services, a Marxist-oriented publication edited by Vicente Navarro, won’t help a great deal in closing the knowledge gap, but it presents some forceful polemics and several thoughtful and provocative essays. There is a clear inverse relationship between the higher-quality essays and efforts to elucidate what the editor calls “the macroanalytic dynamics of the overall society.” This observation will probably assign me to that class of persons “silencing all positions that clearly threaten the ideological reproduction of established class relations.”

Evolution of a system. The volume is apparently the first in a series on Policy, Politics, Health, and Medicine. Navarro, the series editor and Marxist polemicist, views American life as governed by vigorous class struggle in which corporate America dominates by its control over the means of production, consumption, and change. He sees the structures and ideologies of medi-
cine as an outgrowth of capitalist domination and a reproduction of the dominant class ideology. He judges the unwillingness or inability of society to intervene in the conditions "of work, consumption, environment, and residence" as a reflection of "dominant capitalist relations," which more often than not repress interventions conducive to health.

In one essay, Navarro accounts for the success of Paul Starr's *The Social Transformation of American Medicine* as due to the legitimation function and the rationalization of the power of the establishment. This characterization of the 1980s is not atypical of his style. He writes: "The government social and health expenditure cuts and the weakening of government occupational and environmental regulations were an outcome of a most brutal repression from the most aggressive sectors of the U.S. capitalist class who saw those advances by the working population as threats to their privileges and interests." Had Navarro simply said that social and tax policies in the 1980s reflected selfishness and greed of powerful interest groups that increased poverty in America, it would not be difficult to agree. But it is the style of Navarro's writings, and much of Marxist scholarship, to attribute social policy developments to structural class relations and the dominance and repressiveness of the capitalists.

Navarro's version of the debate over national health insurance in the early 1970s suggests the ways in which his analytic framework distorts history. He reviews the debate over the Kennedy-Griffith proposal and the opposition of the insurance industry. Edward Kennedy and Wilbur Mills then joined in a proposal that brought us as close as we have been to national health insurance, but the unions, particularly the auto workers' union, and various liberal groups such as the Committee for National Health Insurance refused to compromise. But, as Navarro saw it, "Even with these changes, the combined resistance of the dominant sectors of corporate America, side by side with the opposition of the major medical and hospital interest groups, defeated and silenced that alternative."

**Corporate growth in medicine.** Stripped of its theoretical superstructure, the book provides a decent summary of some of the existing information on corporate growth in medicine. Two essays, one by Howard Berliner and Rob Burlage on the relationships between hospital chains and academic medical centers and a second by Berliner and Carol Regan on multinational operations of for-profit hospital chains, bring together useful information, although somewhat dated, in a careful and fair-minded way. With respect to the first issue, the authors conclude that there is no "clear national or even inter-regional institutional systems pattern," and that findings could be "best explained as uneven, short-run opportunism among financially healthy teaching hospitals seeking expansion and consolidation."

As to multinational chains, an area where much less is known, the authors conclude that "the American chain hospitals do not constitute a significant challenge to the health systems of the countries in which they operate."

John McKinlay and John Stoeckle present perhaps the most stimulating essay in the book, in which they review various forces transforming the work of physicians, such as the growth of regulation, more aggressive physician administration, the increasing influence of other health workers, the oversupply of physicians, and the emergence of physician unions. Using a Marxist perspective, they critically examine Eliot Freidson's concept of physician professional dominance, maintaining that this concept no longer applies. Alternatively, they argue, physicians are experiencing increasing proletarianization, which they define as a "process by which an occupational category is divested of control over certain prerogatives relating to the location, content, and essentiality of its task activities, thereby subordinating it to the broader requirements of production under advanced capitalism."

While their analysis is not convincing, they make a credible case, and, unlike some of the other essayists, they represent opposing viewpoints fairly and engage them on a serious intellectual level. As a final caveat, they argue that the evidence is less clear
than it might be because proletarianization is “a useful explanation of a process under development, not a state that has been or is just about to be achieved.”

Throughout the volume, the concept of corporatization is used in the sense of “an organizational restructuring in the direction of an organizational form typically found in industrial corporations, characterized by clearly articulated corporate objectives and a division between corporate and operational levels.” As such, it encompasses adaptations of profit and not-for-profit chains and religious as well as secular organizations. In this sense, it would be difficult to disagree that corporatization is occurring quite rapidly, but many of the essays imply that the process is evil.

As several of the authors recognize, the corporatization of medicine has not been quite the boom that many predicted. With prospective payment of hospitals and other efforts to constrain reimbursement, the institutional health sector has lost some of its profitability, and the major health corporations are consolidating rather than achieving dominance over the marketplace as many predicted just a few years ago. Profitable niches still remain, such as alcohol, drug abuse, and mental health services not under diagnosis-related groups (DRGs). These are being exploited, but this is likely to be a short window of opportunity.

Although a great deal has been written about the threat of profit-oriented hospital chains, the evidence suggests no massive differences between profit and nonprofit hospitals, although both show less public responsibility than would be desirable. Overall, the for-profit hospitals are not as efficient as advocates suggested, and they charge more, particularly for ancillary services. They also provide less uncompensated care than nonprofit institutions, but neither type of institution is particularly benevolent. The heavy burdens of providing uncompensated care fall on a relatively small proportion of nonprofit and public hospitals.

The most damaging consequences of the competitive strategy in health have been the destruction of community rating, a development that has been evolving for some years but that accelerated in the 1980s, and the vigorous risk selection that now characterizes the marketplace. Ironically, the idea of health insurance was to share risk, since relatively few in any year incur large medical expenses. Instead, current incentives have made it difficult for those who need insurance the most to get it, and the ranks of the uninsured keep growing. Our health system may stagger along for some years before this issue is resolved, but it seems apparent that national health insurance will rise again as a major public policy issue.

Health and society. One need not be a Marxist to recognize that much of ill health arises from the material bases of society and that those at the lower end of the class system face higher risks of illness, disability, and premature mortality than the affluent. Similarly, one need not explain the narrowness of the medical perspective relative to the challenges of chronic disease, long-term care, or possibilities for prevention as an ideological manipulation in the service of corporate America. The historical reality is more complex than Navarro and some of his colleagues would have us believe.

The past year has witnessed extraordinary events with the crumbling of Marxist economies throughout eastern Europe and the embrace of capitalist strategies and market solutions. Similarly, the Soviets are scrambling to find a politically acceptable route to a market economy. The health care systems of these countries are in a shambles, and health indicators are on a downward trajectory. Perhaps none of these systems offers a test of Marxist utopia, but which models do?

If we look anywhere for alternative models of countries that deal with health issues more sensibly than we do—whether Canada, Germany, or Scandinavia—the fact is that they are all capitalist societies. In each case, the social contract between the citizen and the state guarantees a more adequate minimum welfare base than we do. The road to reform requires an informed citizenry, active political participation, and the development of coalitions. Marxist rhetoric takes us no place at all.