Contradictions in the Commodification of Hospital Care[1]

Adam D. Reich
Columbia University

The "moralized markets" school within economic sociology has convincingly demonstrated variation in the relationship between economic activity and moral values. Yet this scholarship has not sufficiently explored either the causes of this variation or the consequences of this variation for organizational practice. By examining different moral-market understandings and practices in the context of a single market-based organizational field, this article highlights the contradictory character of processes of commodification, as different historically institutionalized ideas conflict, in different ways, with the market logic that increasingly organizes the field as a whole. The article examines the contradictory commodification of hospital care in three hospitals within one Northern California community.

The hospital has a paradoxical place in the contemporary U.S. economy and society. While it is central to the U.S. economy, many of us are uncomfortable with what is implied by a market for hospital care. It remains a

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last resort for the poor and desperately sick and is a place to which many turn in moments of greatest physical uncertainty and emotional vulnerability. Perhaps as a result of our ambivalence about the market for hospital care, the vast amount of money that changes hands as a result of this care rarely changes hands within the hospital itself (see Velthuis 2005, p. 6). As historian Rosemary Stevens observes, hospital organizations continue to "carry the burden of unresolved, perhaps unresolvable contradictions" ([1989] 1999, p. 361). At a time when the organization and financing of health care in the United States are in flux, an understanding of these contradictions is all the more important.

This article examines the contradictory nature of the commodification of hospital care by drawing on case studies of three not-for-profit hospitals within the same Northern California community. In so doing it contributes to the existing literature on the relationship between morals and markets. An ascendant "moralized markets" school, reacting against oversimplified accounts of the market in both neoclassical and Marxist theory, has demonstrated the creative ways in which people combine their economic activities with their social values. These scholars have observed that economic activity takes place across a wide variety of social relationships and that we "mark differences between ties with distinctive names, symbols, practices, and media of exchange" (Zelizer 2005, p. 33). For them, the notion of an all-powerful market impinging on our lives is a fiction, a fallacious dichotomy between a market out there and the social values we cherish.

This approach has been enormously influential, yet it has tended to focus on microinteractions at the expense of broader institutional forces—forces that, on the one hand, shape the moral-market orientations of actors and organizations and, on the other hand, constitute the broader environment within which established moral-market orientations flourish or founder. As Fourcade (2012, p. 1060) reminds us, "if people produce meanings through the use of goods and money, they (to paraphrase Karl Marx) do so out of circumstances not of their own choosing." We should be looking not only for "connected lives" (Zelizer 2005, 2012, p. 152) but for contradictory lives, as individuals and organizations work imperfectly to reconcile previously institutionalized values with market pressures that remain out of their control (Friedland and Alford 1991; Sewell 1992).

Within contemporary hospital organizations, I argue, actors try to reconcile their social values with their economic activities, but they do so under conditions of severe constraint. Through their work in hospitals, people participate in the perpetuation of different historical understandings of hospital care, legacies that are themselves in tension with the contemporary market. These are not "good matches" between economic activities and social values (Zelizer 2005) but "bad matches" (Fourcade 2012, p. 1059); yet they are bad in different ways, and with different effects.

The three hospitals on which I focus, PubliCare, HolyCare, and GroupCare, sit within three miles of one another in the same Northern California city of Las Lomas. Together they serve as the only major hospital facilities in the larger 500,000-person county. Each is a part of a different statewide not-for-profit health system, and each considers the other two its primary competitors for the county's pool of insured patients.[2]

Each of the hospitals in this study confronts the same increasingly market-driven institutional environment. Each is under financial pressure to reduce the amount of free (charity) care it provides, to invest heavily in capital, to use staff more efficiently, and to negotiate aggressively with constituencies such as physicians' groups, insurers, and employers (Scott et al. 2000; Light 2004).[3] The local ties that once made these hospitals "community" organizations have also been frayed: all three hospitals are now connected with large state or national hospital systems, derive very little of their revenue from local foundations or charitable giving, and spend much more money on capital investments than on supporting any kind of community program. These local trends are consistent with broader changes in the market for hospital care (Stevens 1999).

Given such an environment, organizational scholarship predicts that these hospitals would become increasingly isomorphic (DiMaggio and Powell 1983; Scott et al. 2000). The literature on moralized markets, in turn, anticipates that market entrepreneurs would work to overcome any lingering cultural discomfort about the commercialism of the hospital (among patients and providers) by articulating and institutionalizing a vision of the market as moral—as assuring high-quality, cost-effective care, for example (Zelizer 1978; Quinn 2008). Existing literature would not necessarily expect the process of moralization to proceed without conflict, but this literature likely would expect the process to proceed evenly—and, ultimately, successfully—across the market for hospital care as a whole (Zelizer 1978, 1985, 2012; Hochschild 1983).[4]

[2] The three hospitals have been competing actively for the same high-end insured patients since 1996. This was the year that Westside Health, a private not-for-profit company, leased PubliCare Hospital from the county. It was also the year, according to interviews, when GroupCare made a strategic decision to focus on high-value, as opposed to low-cost, care.

[3] These negotiations, of course, are structured differently according to the different financial relationships between these various constituencies. These differences are explored in more detail below.

[4] An exception that proves the rule is Turco's (2012) study of the failed moralization of motherhood support goods and services. She observes that much of the literature selects "on successful cases where that conversion has necessarily been accomplished" (p. 385). To the extent that there is variation within a market, existing literature would likely explain this as a result of current contingencies such as differences in actors' (or orga-

Despite the similar market pressures the hospitals of Las Lomas face, what is most striking about them is the persistent variation in their practices and cultures. Within each hospital, the relationship between social values and market forces remains dramatically different. What explains such differences? Each hospital, I will argue, was founded in a different era of American medicine as an answer to a historically specific problem with an emerging market for care. While the three hospitals today confront similar market pressures, they do so carrying the legacy of these different beginnings in both the organizational structures they sustain and the practitioners and patients they attract (Stinchcombe 1965).[5] Within each hospital, actors strive to sustain good matches between their values and economic activities, but in each case they struggle to sustain these values amid a market they cannot control. I conclude by considering the implications of these findings both for economic and organizational sociology and for the future of U.S. health care.

DESTRUCTIVE MARKETS, MORALIZED MARKETS, AND CONTRADICTORY COMMODIFICATION

This section proceeds in three parts. First, I review three separate arguments about the destructive capacity of markets in general and in relationship to hospital care specifically. Second, I demonstrate how the "moralized markets" school has challenged these traditional arguments by illuminating the creative capacity and agency that people have in their economic activities. Yet, I argue, this moralized markets school has failed adequately to explore either the causes of variation in actors' moral-market understandings and practices or the consequences of this variation for organizational practice within an increasingly market-driven organizational field.

Finally, I synthesize and extend these two literatures by drawing on insights from the literature on organizational imprinting (Stinchcombe 1965; Hannan, Burton, and Baron 1996; Emirbayer and Johnson 2008). Each of the three hospitals in my study was founded in a different era of medicine in order to address one of the three destructive tendencies in the market for care. Thus, each hospital's founding moment—viewed in isolation—fits well within the moralized markets school, as actors worked to reconcile

nizations') entrepreneurial capacities or their different positions within jurisdictional struggles (Healy 2006; Chan 2009; Anteby 2010).

[5] It should be noted that GroupCare, as a prepaid group practice organization, differs substantially in its organizational structure from either PubliCare or HolyCare, as it combines insurance provision with health care services and hires its doctors on salary through its own medical foundation. While all three hospitals were a part of larger health systems, GroupCare's level of integration far exceeded the others'.

social values with an emerging market for care.[6] The contemporary period, however, challenges the moralized markets school, as actors and the organizations of which they are a part struggle with contradictions between these founding moral frameworks and deepening market pressures.

Destructive Markets

Scholars from a variety of disciplines have suggested three analytically distinct reasons why the commodification of certain goods and services might be, respectively, unjust, self-defeating, or impossible.

Social rights.—First, scholars have made the normative argument that turning some things into commodities depends on the denial of social protections or social rights. As a result, the argument goes, commodification is unjust or coercive. In different forms, this idea is prevalent throughout economic and moral philosophy. In *Why Some Things Should Not Be for Sale: The Moral Limits of Markets*, for example, the economic philosopher Debra Satz argues that there are "universal features of an adequate and minimally decent human life" (2010, p. 95) and that the commodification of certain things—from child labor to the vote—makes this life impossible (see also Sandel 2012).

The political philosopher Michael Walzer relates this same idea more specifically to medical care: "Doctors and hospitals have become such massively important features of contemporary life that to be cut off from the help they provide is not only dangerous but degrading" (Walzer 1983, p. 89). He continues, "Needed goods are not commodities" (p. 89). In order for hospital care to be turned into a commodity, according to this argument, it must be denied to those people unwilling or unable to pay for it. Yet this denial constitutes an erosion of basic social protections and the denial of basic social rights.

Social values.—A second, separate argument against the commodification of certain things is that it may undermine or debase the very value of these things. Whereas the problem of social rights implies that some things should not be bought and sold, the problem of debasement implies that some things cannot be bought and sold and still retain their integrity. Perhaps most famously, this line of argument has been pursued in relationship to altruism and the blood supply (Titmuss 1971). Titmuss found that a system of blood allocation based on donations was associated with blood of a higher quality than a system in which donations were coupled with financial incentives. The commodification of blood, he argued, eroded

[6] This history quickly becomes more complicated, since HolyCare was founded in order to address a contradiction brought to the foreground by PubliCare, and GroupCare was founded in order to address a contradiction illuminated by HolyCare.

the social values and social institutions through which it was otherwise given and received. To the extent that blood was treated as a commodity, it became degraded. Even Kieran Healy's (2006) compelling critique of Titmuss's findings maintains that market incentives can "crowd out" other sources of motivation.[7] This idea finds support across a broad range of other studies (Frey and Oberholzer-Gee 1997; Gneezy and Rustichini 2000; Healy 2006, p. 89; Satz 2010, pp. 192–93). Even if we did not object to buying access to congressional hearings on the basis of rights, we might object to it on the grounds that it erodes some value essential to democratic governance (Sandel 2012, p. 34).

Just as hospital care might be understood as a social right, it might also be understood as this kind of social and moral good. Hospital care is often a deeply emotional experience for patients and their loved ones, and it depends—at least to an extent—on professionals' and other workers' vocational commitments. Private hospitals are still often classified as "voluntary hospitals," a phrase derived from their origins in philanthropy or religious charity. Well before the hospital was able to provide much in the way of medical cures, those within it were able to offer spiritual guidance and emotional support. To the extent that hospital care is commodified, the hospital might be unable to foster noneconomic values central to care itself.

Uncertainty.—Third, distinct from the denial of social rights or the problem of debasement is the danger of malcoordination and anarchy caused by uncertainty in the value of certain things. If the other two problems concern the potential effects of a market for certain things (on people's rights or on the integrity of the things themselves), this problem concerns the difficulty of establishing a market in the first place. It is well established that doctors often do not know the medical value of the services that they provide (Arrow 1963, p. 951; Fox 1980; Eddy 1984). Indeed, for most of medical history, doctors have been remarkably incompetent in a technical sense (Shorter [1985] 2009). Despite huge investments in recent years in medical research, information technology, and evidence-based medicine, there is still (and will always be) much uncertainty in the diagnosis and treatment of particular conditions (Bursztajn et al. 1990). More profoundly, the value of health, and by association hospital care, is remark-

[7] Healy acknowledges that market incentives can crowd out other sources of motivation but provides the important caveat that different sources of motivation lead to different results in different environmental and organizational contexts. For example, he suggests, Titmuss was writing at a time when blood sellers were more likely to be infected with hepatitis than blood donors. In the 1980s, however, blood donors were more likely to be infected with AIDS than sellers (Healy 2006, pp. 89, 92). Moreover, the nonmarket ties between donor organizations and donors made these organizations less responsive to the AIDS crisis (p. 103).

ably difficult for people to assess in a rational and calculating way, meaning that weighing costs and benefits in relationship to it is fraught. This is not to say that people do not put a price on these things implicitly or explicitly (Zelizer 1994). But it is challenging for people to weigh preferences in relationship to them.

Finally, even when practitioners know the value of a particular intervention, patients often do not. Commodity exchange presumes a market of buyers and sellers with equal amounts of information. But patients are by definition dependent on the authority of doctors to tell them what they need (Arrow 1963, p. 949; Starr 1982, pp. 14–15; Richmond and Fein 2005, p. 137)—what economists call *supplier-driven demand*. Patients' uncertainty makes them unable to discern between different choices. Combined, these sources of uncertainty mean that a market for hospital care can never approach the conditions that economists assume to exist when they discuss "markets" in the abstract.

Moralized Markets

These three separate dangers of the market—the violation of social rights, the debasement of social values, and the anarchy of uncertainty—have, in different contexts, long been recognized in sociological criticisms of the market and may have been given their most famous expression in Karl Polanyi's account of the "grave dangers to society" ([1944] 2001, p. 204) posed by the markets for labor, land, and money. In recent years, however, economic sociologists have emphasized a different dimension of Polanyi's thought—the "embeddedness" of economic life in social relations (Granovetter 1985; Baker 1990; Powell 1990; Uzzi 1996). Fligstein (2002) developed this argument by demonstrating the centrality of institutionalized rules and understandings to the constitution of any market. Indeed, one might argue that the market for hospital care depends on such institutionalized rules and norms that buffer hospital care from some of the effects of the problems elaborated above.[8]

[8] For example, the passage of Medicare and Medicaid in 1965 signaled a right to a degree of care for the elderly and some segments of the poor. Since 1972, those with end-stage renal disease have also been entitled to Medicare coverage. The Emergency Medical Treatment and Active Labor Act (1986) gives patients the (albeit limited) right to be stabilized at an emergency room, though it does not mandate that hospitals treat patients and does not address billing. Professional licensing requirements ensure, at least nominally, that health care practitioners maintain an extraeconomic commitment to their work. Some states have sought to ensure that not-for-profit hospitals earn their special status. With the passage of State Bill 697 in 1994, e.g., not-for-profit hospitals in California have had to document annually the "community benefit" they provide. Regulative oversight by organizations like the Joint Commission and Healthcare Facilities Accreditation Program ensures some degree of measurement and accountability.

Others have deepened the concept of embeddedness further by demonstrating how commodity exchange is itself always shot through with cultural meanings and social values (Zelizer 1989, 1997; Healy 2006; Almeling 2007; Anteby 2010; Turco 2012). Exchange not only may be made possible by social ties or institutionalized rules but may be one of the mechanisms through which ties are maintained and strengthened (Zelizer 2011). Indeed, exchange helps to constitute our "connected lives" (Zelizer 2005) as it is interwoven in our social relationships and used to express our social values. This "moralized markets" school has sought to develop a relational sociology of morality and markets in order to understand why and where people draw the distinctions between moral and immoral economic activity and how people use "different payment systems and exchange tokens to express and define different social relations" (Healy 2006, p. 11).

Within this moralized markets school, the normative claims of critics and defenders of markets are themselves subject to analysis. The important insight is that moral-market understandings and practices—or "relational packages" (Zelizer 2012)—serve to maintain social relationships and distinguish different sorts of relationships from one another. Where Sandel (2012, pp. 144–49) emphasizes how industries such as life insurance threaten to degrade the value of human life, for example, Zelizer (1978, p. 601) documents instead how life insurance came, over time, to be understood as a way of sanctifying death. Where Satz (2010, chap. 6) discusses the ways in which sex work undermines women's right to equal standing, Zelizer (1997, pp. 103–4) points out how the distinction between gifts and payments helps us sustain the distinction between girlfriends and prostitutes. Where Titmuss argues that market incentives debase the altruism necessary for a healthy blood supply, Healy (2006) demonstrates how different economic motivations have different effects within different environments and how all organizations are constrained by the types of economic motivation on which they rely.

By relaxing Polanyi's "claim that money and markets inevitably corrupt and undermine human relationships" (Healy 2006, p. 121), this school has done much to illuminate the creative capacities that people have in drawing distinctions among different kinds of economic activity. It has shown just how deeply intertwined our moral values are with our economic lives. And yet, at the same time, this perspective has been less attentive to the broader institutions—sets of rules, practices, and understandings (Meyer and Rowan 1977; DiMaggio and Powell 1991)—that, on the one hand, constrain individuals' moral-market understandings and practices and, on the

The fact that employers and insurance companies mediate the relationship between most "consumers" and "producers" of hospital care can also be understood to ensure some accountability regarding health care cost and quality.

other, constitute the material and symbolic environments within which moral-market understandings and practices take place.

This shortcoming has led to two oversights within the literature on moralized markets. First, while actors may have a degree of agency and creativity in their moral understandings of market activity, they exist within already-moralized worlds. The moral frameworks they elaborate and maintain do not arise out of thin air and cannot be manipulated by entrepreneurs as easily as some scholars suggest (Zelizer 1978; Quinn 2008); rather, these frameworks have been shaped historically, institutionalized in the organizations in which people participate and the social positions they inhabit.[9]

Organizational sociology has long emphasized the importance of founding moments to contemporary organizational practice (Stinchcombe 1965; Hannan et al. 1996; Emirbayer and Johnson 2008) and has suggested that "core" features of an organization—those that can be changed only if many other features of the organization are also changed—are more enduring over time than "peripheral" features (Baron, Burton, and Hannan 1996; Hannan et al. 1996, pp. 506–7). From this perspective, it seems likely that an organization's founding purpose or mission is likely to be at its very center and therefore be most resistant to change.[10] In his classic study of organizational beginnings, Stinchcombe (1965, p. 142) recognized that in order for an organization to persist after its founding, "men have to be socialized, careers molded, and power allocated to defend the value" central to the organization (p. 167). This process, in turn, requires that actors "infuse the resulting structure with value, to make it an 'institution' rather than a dispensable technical device. 'Interests' become 'vested' because it is possible to defend the interests by appeal to the values the organization was set up to serve" (p. 167). The insight here is that organizations must be imbued with values to survive and that these values then persist both because actors have been inculcated with them through their involvement with the organization and because actors appeal to these values (reaffirming their importance) in pursuit of their interests.

The implication for the literature on moralized markets, in turn, is that organizations have historically rooted moral frameworks that have likely

[9] This point is illustrated, though not argued explicitly, in Turco's (2012) trenchant account of the market for motherhood goods and services. Service providers and other workers at Motherhood, Inc., who joined the company at its founding under one set of premises about the relationship between morals and markets, later resisted the imposition of what was experienced as an encroaching market logic.

[10] This core-periphery distinction has been applied most directly to the study of employment systems in high-tech firms (see Baron et al. 1996; Hannan et al. 1996). Yet it seems likely that an organization's "mission" or defining purpose is even more central than its employment system. It is easier to envision an organization shifting its employment system (see, e.g., Gouldner 1954) than to imagine a gypsum plant becoming a supermarket.

been important to their survival over time—motivating workers' commitments, for example, or securing the ongoing support of different funders—and are likely difficult to dislodge. On the other hand, these moral frameworks are not entirely inflexible, and organizational history should not be understood as a static starting point from which all future events can be read off in path-dependent fashion. Rather, founding values are embedded in the structures of formal organizations, providing the lenses through which organizations and actors make sense of and act in response to contemporary problems (see also DiMaggio and Powell 1991; Emirbayer and Johnson 2008, p. 19; Vaughan 2008).

Second, and as important, actors' efforts to understand and structure their economic activities so as to preserve important social distinctions take place within an evolving institutional environment in which market logics are increasingly powerful. At the level of individual actors, Zelizer is certainly right that an ideal-typical market—anonymous, self-interested, utility-maximizing buyers and sellers making one-time transactions based on full information—is a fiction. Yet at a more macroinstitutional level, this market ideal remains a powerful fiction with real social consequences. As Somers and Block (2005, p. 281) show in their study of 1990s welfare reform, the notion of markets as "self-regulating natural entities" that "must be set free" continues to guide much of social policy in the United States. There is little question that we live in an age in which this ideal-typical vision of markets is particularly powerful, a time—as Fourcade and Healy (2007, p. 293) put it—of "undeniable growth in the commercialization of certain goods and services, notably in the areas of domestic labor, care work services, and human goods."

Contradictory Commodification

Without underestimating actors' creative capacities, then, we must also pay attention to the organizational environments within which these capacities have been shaped and the broader institutional environments within which they continue to be constrained. Our analysis must not be restricted to an examination of how individuals work creatively at a micro-level to reconcile their economic activities with their social values. Rather, we must understand how people participating in already-moralized organizations struggle to reconcile the social values embedded in their roles within these organizations with emergent market pressures.

Zelizer herself recognizes that she has focused more intensively on "interpersonal interaction" than on the relationship between micro and macro processes (Zelizer 2012, p. 165). The important empirical question, then, becomes how individuals' moral-market understandings and practices relate to the broader organizational and institutional contexts within which

they exist. As Fourcade (2012, p. 1060) observes, "the institutional order [people] navigate and negotiate in their everyday transactions comes powerfully structured, by existing patterns of social relations, and by formal organizations."

As Zelizer and others have so powerfully demonstrated, actors work to make sense of and assert control over their economic activity. But where actors are able to do this fluidly (or at least feel that they are doing it fluidly) in some cases, we should also be on the lookout for cases of contradiction—when actors try and fail to engage in such reconciliations (see Turco 2012). Scholars have begun to develop the idea of institutional contradiction to describe the ways in which different institutional orders in modern society—different rules, practices, and understandings—have the potential to conflict with one another (Friedland and Alford 1991; Sewell 1992; Clemens and Cook 1999; Armstrong and Bernstein 2008). Friedland and Alford (1991, p. 256) point out that these "institutional contradictions are the bases of the most important political conflicts in our society. . . . A key task of social analysis is to understand those contradictions and to specify the conditions under which they shape organizational and individual action."

As I argue in what follows, hospitals founded in different periods in the history of U.S. medicine arose from different institutional foundations in order to embed an emerging market for health care in different sets of social relations and different social values—addressing the different destructive tendencies of the market for care outlined above.[11] In one sense, then, this history supports the premise of the moralized markets school, as different actors worked—in different ways—to embed an emerging market in existing social values.

Before the 20th century.—Early hospitals in the United States were indistinguishable from almshouses and guaranteed the poor a basic (if limited) right to care. As the primary source of state relief in many communities, they simultaneously were intended to dissuade a burgeoning working class from reliance on poor relief.

Early 20th century.—By the beginning of the 20th century, the private hospital had emerged as an organization catering to a new clientele of paying patients. In order to distinguish itself from the public hospital and in order to convince a wealthier clientele to leave their homes for medical care, this new kind of hospital emphasized the dignity of the patient and the individualized treatment he or she would receive within it. Thus, at the same time the private voluntary hospital made possible a market for hos-

[11] My periodization builds on the work of historians of the hospital such as Vogel (1980), Rosner (1982), Rosenberg (1987), Stevens (1999), Scott et al. (2000), Nelson (2001), Wall (2005, 2011), and Rodwin (2011).

pital services, it did so by emphasizing how much it was like an upscale home—and downplaying its own commercialism.

Late 20th century.—Finally, in the last decades of the 20th century, medical costs began to spiral and new constituencies—from middle-class patients to the employers who insured them—began to call into question the autonomy and authority of the medical profession. In this environment, a new form of health organization gained prominence that promised to rationalize the provision of medical care, reducing medical uncertainty and reining in medical spending through risk management across established populations.

Today, however, actors in hospitals confront different contradictions between these previously institutionalized values and intensifying market pressures (see fig. 1). I show the following: (1) In a hospital founded to provide care as a right for the poor, actors confront the contradiction between health care as a right and health care as a scarce commodity. (2) In a hospital founded to highlight the emotional and vocational dimensions of care, actors today wrestle with the relationship between the transcendence of the market and the market for transcendence. Administrators pro-

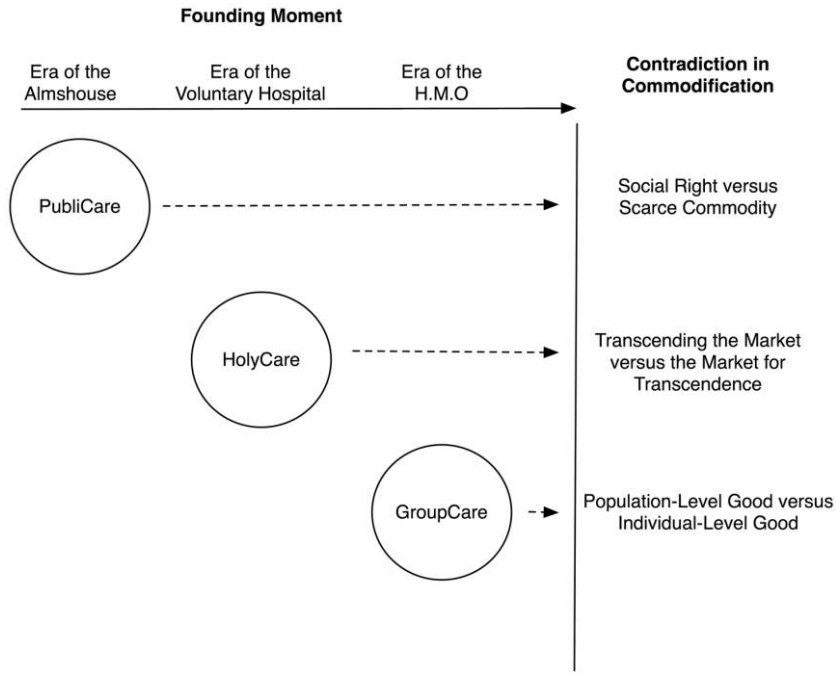

FIG. 1.—Hosital founding moments and contemporary contradictions

mote a patina of spirituality, which threatens to reduce these vocational dimensions of care to little more than marketing rhetoric. (3) In a health care organization founded to rationalize care across a population of patients, actors wrestle with the tension between a population-level good (the well-being of the health system's membership as a whole) and an individual-level good (the well-being of each individual member).

I argue that these contradictions have implications both for the way in which each hospital relates to its patients and for the social relations within the hospital—among actors who relate to moral-market orientations from different standpoints and with different motivations (see Friedland and Alford 1991, p. 255; Healy 2006, p. 118; Emirbayer and Johnson 2008, p. 22).[12] In other words, the contradictions can be seen both in each hospital's efforts to make its mission consistent with its participation in the market for care and also within each hospital as different constituencies relate differently to the moral project elaborated by the organization as a whole.

DATA AND METHODS

The seminal sociological work on the market transformation of U.S. health care is Scott et al.'s *Institutional Change and Healthcare Organizations: From Professional Dominance to Managed Care* (2000). The book demonstrates in exacting detail many ways in which market actors and market logics have come to predominate across the health care field. Yet the framework of the institutional "field," as it is used in their analysis, is much better at explaining organizational similarity at any given moment in time than it is at explaining organizational variation.

Moreover, their analysis of hospital organizations is puzzling. In a section entitled "Trend toward Proprietary Forms," they show that for-profit health care organizations proliferated between 1946 and 1992. Yet hospitals are an anomalous case: the trend among hospital organizations in their study was actually away from the for-profit form. Indeed, across the country today, 70% of hospital beds remain in not-for-profit facilities—a

[12] Healy (2006, p. 118) discusses these sorts of internal organizational tensions in his analysis of the "robustness" of the gift relationship in the market for blood and organs. He asks whether the moral account of giving within procurement organizations is "just a flexible bit of marketing talk or is it more like an institutional logic that has been built into the procurement system?" The answer, he suggests, depends on "whether—and to what degree—the staff of procurement organizations really subscribe to it. If they do, then it will be hard to dislodge it without damaging the procurement system. . . . The actual views of procurement staff in this respect is an open empirical question" (p. 118). Healy acknowledges that actors' investments in organizations' moral-market accounts may vary, with important consequences for the effects of these accounts in organizational practice.

rate that has remained virtually unchanged over the past 40 years (American Hospital Association 2010; see fig. 2).[13]

Scott et al. (2000) explain the persistence of the nonprofit hospital form by arguing that "old forms and practices coexist alongside the new" (p. 1) and that "older organizations and forms of organization exhibit substantial inertia" (p. 113). But the particular ways in which organizational histories differently structure contemporary perceptions and practices are difficult to grasp at such height.

Moreover, reducing organizational history to "inertia" neglects the ways in which past practices and understandings actively provide lenses through which actors and organizations take on the present.[14] Said differently, inertia is not merely passive structural lag; it also indicates the active preservation of important social values. What Scott and his colleagues treat as a kind of historical residual I bring to the forefront of my analysis.

I return to the nine-county San Francisco Bay Region that Scott and his colleagues examined, but I do so with a different theoretical and methodological approach. Rather than explore the dynamics of the field as a whole, I analyze variation in the cultures and structures of practice that have emerged within three different hospitals in the same city. The article examines three hospitals in Las Lomas, California, a medium-sized city with a population of approximately 167,000 in 2010 (U.S. Census Bureau).[15] The city is majority white, with a substantial Latino minority (approximately 30%). The three hospitals in the city, all not-for-profit organizations, serve as the only major hospital organizations in the 500,000-person county and currently compete with one another for the same pool of insured patients (see table 1).

Though the three hospitals compete with one another today, each of these three hospitals began in a different era of American medicine. PubliCare was founded in 1887 as the first "modern" hospital in the city in order to provide care to those unable to afford a private doctor's home visit. In 1996 the hospital was leased to a private nonprofit health system. HolyCare was founded in 1950 by an order of nuns at the urging of private doctors and the local Chamber of Commerce. As the first modern private facility, it was intended to serve those patients capable of paying for their

[13] Scholars have examined the prevalence of not-for-profit hospitals in the United States from a variety of disciplinary perspectives (Scott et al. 2000; Ben-Ner and Gui 2003; Steinberg 2006; Rodwin 2011, p. 13).

[14] As DiMaggio and Powell (1991, p. 26), quoting Bourdieu (1981, p. 309), recognize, "an institution can 'only become enacted and active' if it, 'like a garment or a house, finds someone who finds an interest in it, feels sufficiently at home in it to take it on.'"

[15] In order to protect informants' confidentiality, I have changed place names and hospital names for the purposes of this analysis. I have also removed references to local historical sources, although these references are available on request.

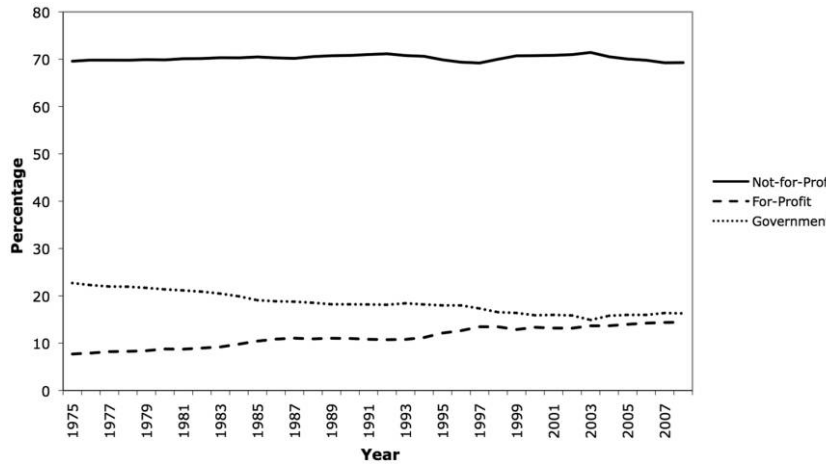

FIG. 2.—Short-term hospital beds in the United States by type of control, 1975–2008. Data are from the American Hospital Association (2010).

care. And while the last nuns left Las Lomas in 2007, the Sisters of St. Francis continue to own it. GroupCare was opened in 1980 as the first prepaid group practice organization in the area in the midst of rising concern about the runaway costs of care in the county. Traditionally it has catered to the working class through its associations with large employers and its historical affinity with labor unions.

These hospitals are not representative of the entirety of the field of contemporary hospital organizations. Missing from this analysis, for instance, are examples of the for-profit hospital, the large academic medical center, and the Veterans Administration hospital. Moreover, while the three organizational forms discussed here are all fairly common in the United States, they are not evenly distributed. Hospitals like PubliCare are on the decline, while "accountable care" organizations like GroupCare are widely praised as heralding a new era of medical care (Fisher and Shortell 2010). HolyCare, with its emphasis on individualized treatment and its premium on professional autonomy, continues in most parts of the country to be the dominant model through which hospital care is delivered. The three types of hospitals I analyze here—and different types of contradiction with which they must grapple—should be treated as ideal types. In other communities, the lines between these different types of hospitals and different contradictions may be more blurred.

The article makes use of 106 interviews I conducted with administrators, physicians, nurses, and ancillary workers who work within (and across) the three hospitals and an additional 15 interviews I conducted

TABLE 1
THE HOSPITALS OF LAS LOMAS

	HolyCare	PubliCare	GroupCare
Type	Not-for-profit	Not-for-profit	Not-for-profit
Founding date	1950	1886, transfer 1996	1980
Net income (2009; $)	5.7 million	(11.9 million)	NA
Rate of indigent or no insurance (GAC 2009; %)	25.4	47.4	7.3
Occupancy rate (GAC 2009; %)	54.8	45.5	75.4
Average length of stay (GAC 2009; days)	4.7	4.1	3.5

NOTE.—Data are from the California Office of Statewide Health Planning and Development. GAC = general acute care.

with community leaders in Las Lomas. These 121 interviews all took place between September of 2009 and December of 2010 and lasted between 45 and 90 minutes. All took place either at interviewees' homes or in private settings at work.

Interviews were transcribed, imported into an electronic database, and coded systematically using the qualitative software ATLAS.Ti. I undertook both open coding and focused coding in order to determine prominent themes among the interviews (Weiss 1994, pp. 154–56; Emerson, Fretz, and Shaw 1995, pp. 142–44). In order to verify the results I obtained from interviews, I triangulated using three other sources of data (Miles and Huberman 1994, pp. 266–67). First, I spent approximately 200 hours conducting participant observation within the three hospitals. Most of this time was spent "shadowing" individual doctors within the emergency rooms and medical wards of the three facilities. I also attended several physician and departmental meetings, as well as meetings with groups representing workers at the three hospitals. Second, I supplemented my qualitative research with quantitative data on the three hospitals collected by California's Office of Statewide Health Planning and Development. Finally, I drew on primary and secondary source material to understand the history of the three hospitals within Las Lomas and these hospitals' relationship to the history of hospital care in the United States more generally.

FINDINGS

While the three hospitals of Las Lomas today all compete for the same pool of insured patients and all provide many of the same services, they do so with different organizational structures and different orientations toward the market for hospital care. Because each hospital was founded in a dif-

ferent era of American medicine and animated by a different conception of care, each confronts an increasingly dominant market environment with different institutionalized values and organizational structures. Each must thus navigate a different contradiction in the commodification of hospital care. Below, I discuss each hospital's history and how that history continues to influence its contemporary practice, both in terms of the hospital's relationship to its patients and, within the hospital, in terms of different actors' relationships with one another (see table 2).

PubliCare: Social Rights versus Scarce Resources

Founded as an almshouse in order to provide a minimal amount of care to the poor, PubliCare was privatized in 1996 and now wrestled with the tension between the provision of care as a right and the market for care as a scarce resource. While administrators had sought to make the hospital a place "for everyone" by attracting paying (insured) patients, the hospital was still understood both by practitioners and by patients primarily as a last resort for the down and out. And so despite the entrepreneurial efforts of administrators, the survival of the hospital was consistently in jeopardy.

Historical foundations.—As was the case throughout the United States, hospital care in Las Lomas emerged from the almshouse, tied deeply to the needs of the dependent poor. Hospital care began at a time when the categories that would come to distinguish different sorts of dependency from one another—physical and mental illness, illness and old age, disability and poverty—had not been firmly established. And it began at a time when the curative capacities of an embryonic medical profession were questionable at best. The fact that most people of all classes were reluctant to turn to the hospital was in some sense deliberate, a strategy by which community leaders could distinguish the truly needy from those able-bodied poor who could turn to the labor market for their subsistence. As the

TABLE 2
CONTRADICTIONS IN CONTEMPORARY HOSPITAL PRACTICE

	PubliCare	HolyCare	GroupCare
Founding conception of care	Social right	Transcendending market	Population-level good
Contemporary market contradiction	Vs. scarce resource	Vs. market for transcendence	Vs. individual-level good
Morals and markets within organization	Insurgency (bottom-up)	Ideology (top-down)	Integration

historian Charles Rosenberg (1987, p. 22) writes, "The hospital's patients were seen as genuinely needy almost by definition and less likely than recipients of free food or fuel to be impostors, for none but the ill and desperate would willingly seek the dubious comforts of a hospital ward." The almshouse and early municipal hospital embodied the "irreconcilable contradictions" (Katz 1996, p. 25) in the early modern welfare state between the provision of basic rights and the fear of generating dependency.

The first hospital in Las Lomas was established in 1859 in the center of town as the second story of the small city jail. According to a local paper, the lower story of the building consisted of "six dark cells, a room for the jailer, and one for petty offenders," while the upper story was "arranged to accommodate, as comfortably as possible, such indigent persons as may need the assistance of the county, in their sickness."[16] Between 1860 and 1867, the years during which records are available, use of the small hospital grew substantially—from only nine admissions in 1860 to 60 by 1867. All told, between 1860 and 1867, 201 admissions and 37 deaths were recorded. Syphilis, a venereal disease suggestive of moral turpitude, was the most common disease recorded among patients, while the most common cause of death recorded was consumption (or tuberculosis).

The county Board of Supervisors soon came to regard the facility as inadequate for medical care and, because of its central location, a risk to a public increasingly concerned with contagion. Between 1866 and 1887, then, the county gradually moved care for the sick further and further away from downtown, until—in 1887—the county erected its first "modern" hospital at the same location on which PubliCare now sits. A newspaper article on May 14 of that year gushed with pride: "If there is any one thing more than another of which [the] county may justly be proud and to which her citizens may point with pardonable pleasure it is her public institutions . . . far from being least, her new County Hospital, which is made the subject of this article." The reporter concluded that the "building is an ornament to the county, a compliment to the Board of Supervisors and a sanitarium most propitious in its location and purpose."

As of 1940, County Hospital—with 178 acute-care beds—was the only hospital in the area to meet the certification requirements of the American College of Surgeons, and it served indigent patients almost exclusively. According to a 1940 report on the facility prepared for the Board of Supervisors, County Hospital provided an annual average of 118,883 patient days to indigent patients compared to an average of 5,204 patient days to those who could afford to pay. A second report written in 1940, this time to

[16] In order to protect the identity of the place I describe, I have not included references for historical material. However, I am able to provide citations on request.

the county's medical society, bemoaned the fact that County Hospital, "in spite of the publicity to the contrary . . . does not accept pay patients other than those who can not pay a part of the cost." And so the hospital, while a testament to the county's commitment to the poor, was always a drain on public resources.

Consistent with a trend toward the privatization of public hospitals nationwide, by the 1990s, the county Board of Supervisors decided that it could no longer bear the financial burden of running the facility. According to a report on the hospital, the county did not have the resources to make the capital expenditures necessary to attract paying patients; the hospital was too small an entity to negotiate with organized insurers and physicians' groups; and the hospital under public governance was at a disadvantage because hospital leaders were "forced to develop and implement long-term competitive strategies in a public forum . . . and their competitors [could] sit in on their planning meetings" (Legini et al. 1999, p. 85).

In its decision to lease the facility to a private corporation, the Board of Supervisors made the argument that the organization could sustain its moral commitment to care as a right only by participating more fully in the market for care. In a study of such public-to-private hospital transfers spearheaded by the Henry J. Kaiser Foundation—a study that included PubliCare among its cases—the foundation wrote, "To preserve the institution for indigent patients, for whom it was the provider of last resort, those responsible for the public hospitals decided it was necessary to operate the institution for *everyone*—that is, to use the market to make the hospital financially viable by attracting not only patients who cannot afford to pay, but also those who can" (Legini et al. 1999, p. 27). County and hospital leaders thus exemplified the flexibility of moral-market orientations suggested by the moralized markets school. Whereas in the past the right to care had necessitated insulation from the market, they suggested, turning to the market now could help the county live out its commitment to the poor more fully.

Indeed, when the county decided to privatize the hospital, the Board of Supervisors sought to be discerning about buyers: it would place limits on the profit motive through the type of organization it would consider as lessee. It refused a proposal from a large for-profit corporation because the "hospital's medical staff was afraid [it] would 'turn the hospital upside down to make a buck'" (Legini et al. 1999, p. 85). And it believed it had found in Westside Health—a large not-for-profit—a corporation that would pay attention to the bottom line while remaining committed to the hospital's public mission. The conditions of the lease were articulated in a health care access agreement, in which Westside Health committed to working "cooperatively and in good faith" to ensure that all residents of the county had

access to a "full range of women's health services (e.g., preventive care, birth control, sterilization, pregnancy termination procedures, labor and delivery) and treatment of HIV/AIDS and other communicable diseases." Importantly, Westside Health also committed not to "seek additional sums from [the county] to subsidize the cost of services" provided to the poor.

An underlying assumption made by both Westside Health and local government officials was that the facility's financial crisis could be remedied without sacrificing the organization's commitment to the right to care. With enough up-front investments and organizational efficiencies, the organization could return to the black. Yet in spite of millions of dollars invested in upgrading the hospital to attract insured patients, PubliCare Hospital had been losing money (even excluding capital expenses) under the management of Westside Health in all but two of the 14 years since the lease had been signed (see fig. 3). Despite the assurances of county leaders and hospital administrators, the facility's moral commitment to care as a right had not been—and perhaps could not be—reconciled with its success in the marketplace.

Contemporary contradiction.—While there are several possible explanations for why PubliCare Hospital continued to lose money despite its new investments and new management, the contradiction between the right to care and care as a scarce commodity—a contradiction manifested in both organizational policy and practitioners' and patients' understandings and practices—is a central element of the story. While hospital administrators prioritized increasing the percentage of insured patients seen at the hospital, practitioners' ongoing commitment to the poor interfered with this goal. As a manager at PubliCare put it, "We're viewed [as an indigent hospital], even though we try not to be." Restating her position later in the

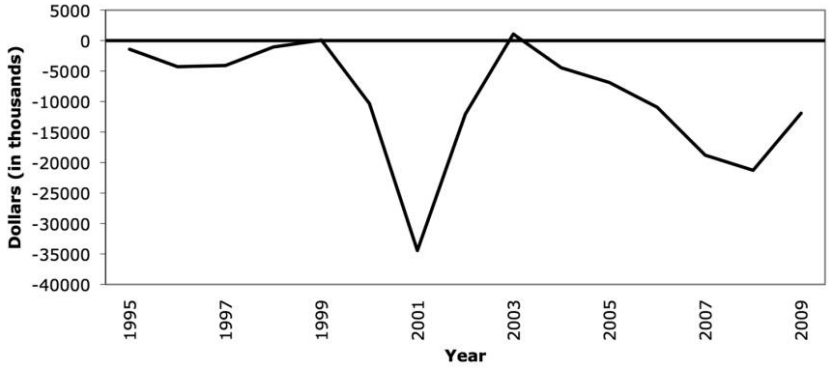

FIG. 3.—Net income at PubliCare, 1995–2009. Data are from the California Office of Statewide Health Planning and Development, Hospital Annual Financial Data.

interview, she said, "Somebody has to take care of [the indigent], and we're proud to do it, but we don't want to only be seen as, 'Oh, that's where all the poor people go.' We want everybody to use us. And we still want to do our part of the indigent." Yet this desire to appeal to "everybody"—both rich and poor—itself dissuaded many paying patients from using the facility. One ER doctor's wealthy neighbors had compared going to PubliCare with "waiting in the Greyhound bus station . . . everyone's speaking Spanish."

Moreover, many doctors and nurses at PubliCare, who had begun working at the hospital when it was still a county facility, took pride in their role as public servants on behalf of the underserved. A charge nurse described how much she enjoyed the "variety of patients [at PubliCare]." She felt that the practitioners at PubliCare shared an esprit de corps tied to the provision of care as a right: "You have an indigent patient on one hand and then you got little grandma . . . on the other side with all her diamond rings. . . . Everybody is treated the same, and that's what makes this place so unique." Caring for the indigent was particularly rewarding. The poor "appreciated [the care] so much," she added, which made the work "very, very gratifying." A social worker at the facility said that the staff at PubliCare "fall under the true motto of health care for everyone. We really try to follow it." While this social worker also worked occasional shifts as a social worker at HolyCare, she found the work quite different. Despite similar job descriptions, at HolyCare, this social worker's role was primarily that of a discharge planner, coordinating care for patients as they left the facility. At PubliCare, "If we really need to advocate [for patients] and they need to be here, we're going to keep 'em here. [At HolyCare we] get 'em out no matter what." Even the hospital administrator at PubliCare responsible for "utilization management"—ensuring that the hospital was not giving excessive amounts of care that could not be reimbursed—expressed a similar commitment to care as a right: "I am an old sixties person and I believe that everybody deserves care. . . . I don't care what your income bracket is. And I believe that everybody deserves the same level of basic care. . . . I believe it's our obligation to pay for that for everybody within our community."

Many of the doctors at PubliCare were similarly committed to the public mission of medicine. The head of internal medicine at the hospital, who also ran the facility's family residency program, had written extensively about his disgust with the market for care: "Our medical heritage, passed on from the professors who taught us . . . was that the practice of medicine, at its purest, is guided by science and driven by compassion. Money matters. But it has distorted the methodology of our science and has distracted us from the motive of our practice." The market, he suggested, was something the medical profession needed to counteract. He considered himself and his colleagues in the family residency program "medically counter-

cultural; some are closet revolutionaries." A second internal medicine doctor said of his practice, "If it's not a calling, if it's not something that you really want to do, you shouldn't be in it." He joked, "I always said I'd do it for nothing, so the government and insurance companies took me seriously." A third doctor said that he had been attracted to PubliCare Hospital because he was "already aligned with" working toward the public good.

Among doctors, this public commitment was facilitated by billing arrangements that separated physicians' work from their patients' insurance status. Most of the doctors who worked full-time at PubliCare either were salaried by Westside Health or were part of a medical group that split revenues among the practicing doctors (with small bonuses for admissions and discharges). As a result, most doctors did not feel that their incomes were directly dependent on treating those who could pay for their care.

This shared commitment to the indigent was evident in the way these practitioners treated the poor who arrived at the facility and meant that the poor arrived at PubliCare much more frequently than they arrived at the other facilities in town. Indeed, despite the formal openness of all three ERs in Las Lomas, the percentage of uninsured or underinsured patients arriving at PubliCare Hospital's ER was consistently higher than the percentage of those arriving at either HolyCare or GroupCare Hospitals (see fig. 4)—a fact made even more surprising by PubliCare's relative distance (compared with the other two hospitals) from the neighborhoods where these patients tended to live. An ER doctor at PubliCare observed that

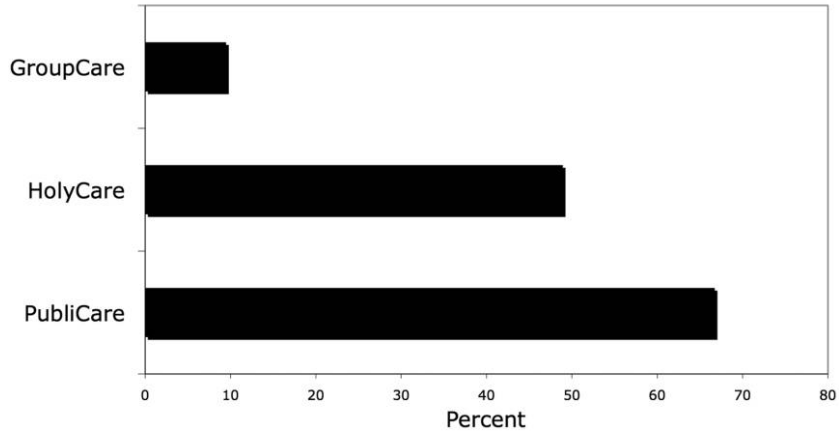

FIG. 4.—Percentage of emergency room visits by patients with no insurance or indigent insurance, 2009. Data are from the California Office of Statewide Health Planning and Development, Hospital Annual Utilization Data.

the unemployed had "been made to feel like the emergency room at [PubliCare] is the place they can come and not be treated poorly." A second ER doctor at PubliCare affirmed that indigent patients "go down [to GroupCare] and don't feel welcome. . . . I think they're treated like second-class citizens."

And while some practitioners at PubliCare grumbled about this uneven allocation of indigent care, they also seemed invested in being the facility capable of managing the down and out. A nurse at PubliCare recalled an incident in which a "fifty-one fifty"—the code used for a patient on involuntary psychiatric hold—had been brought to GroupCare, but "the nurses didn't know how to handle this patient." At the time, PubliCare did not have any beds available. But those at GroupCare "called [PubliCare] every single day to get that patient moved out of there." The PubliCare nurse concluded, with evident pride, "We know how to take care of these people, you know? And they don't. They get all flustered and lost." A nurse-administrator at PubliCare remembered a paraplegic patient who "refused to poop anywhere but in his pants" and would always come to the ER for his care. Despite the county's point-of-entry ambulance plan, designed to equalize indigent utilization of the three ERs, no matter where the ambulance drivers found him, they would always bring him to PubliCare. Those at PubliCare knew what to do.

Caring for the indigent, however, was an enormous fiscal drain. Not only were these patients unlikely to have insurance covering the costs of their medical care; they were also likely to depend on the hospital for social as well as medical needs (Malone 1998).[17] One ER doctor put it bluntly: "The patients who come here are at the bottom of the barrel, they have nowhere else to go. They don't have a primary care doctor. They've burnt their bridges with their family, many of them. The social system has had it up to here with them. The cops drop them off here; they don't even take them to jail anymore."

Because many patients at PubliCare Hospital came from such difficult social situations, it was also a challenge for the hospital to discharge them. Insured patients not only had access to medical resources but also—as a case manager said—were more likely to have "a stable home environment to go home to" and within which to receive follow-up care. As a charge

[17] PubliCare was not the only resource available for the indigent in the county. Several federally qualified health clinics offered primary-care services to the uninsured. Moreover, there were several different sorts of local, state, and national programs for particular classes of patients such as pregnant women, patients with HIV-AIDS, patients with serious mental illness, or children with serious illnesses. As I make clear, despite this range of services, many patients continued to rely on PubliCare for a range of health care needs, and practitioners in the hospital were often unable efficiently to coordinate services with these other resources—particularly with the most difficult patients.

nurse in the ER described, patients were often not sick enough to be admitted to the hospital, so she had to figure out "where are we going to go with this, socially." One unfunded patient came to the ER in kidney failure and needed emergency dialysis. But since outpatient dialysis centers would not accept patients without funding and since the hospital was not licensed as an outpatient dialysis center, the patient had to get treated in the hospital for six weeks while case management worked to secure insurance. As a hospitalist recounted, "He was walking the halls, he was sitting in the patio. I mean, essentially we were room and board."

On occasion, the hospital would take in "social admissions," according to a charge nurse in the ER, in which patients were admitted "until [it] can be sorted out how they can take care of themselves." One patient, who had been in the intensive care unit for a month, could have gone home if only the hospital could find the necessary equipment for her to take home with her. But since the patient had no insurance, and—according to a critical-care doctor—had "stiffed some of the [equipment] companies . . . nobody want[ed] to deal with her. . . . So she sits in the ICU. . . . It's incredible." Another hospitalist was treating a man who had been hospitalized for seven months because no one else could be found to care for him.

From one perspective, these sorts of inefficiencies might be seen as indications of bad management. But many practitioners believed that patients were too desperate and too disorganized to access resources elsewhere. As one indication of this, the hospital's independent ER physicians' group insisted on hiring family practice doctors to help see nonemergency cases in the ER. As one of these family practice doctors explained of a hypothetical case, "This patient really could do those tests as an outpatient, but they may not get there, so I'm going to do them now." Another family practice doctor who worked in the ER said that she treated the "whole person, the whole family situation. . . . I mean, those are the things a family practitioner gets bogged down thinking about and ER doctors, are like, 'Stop using that [drug]—okay, next.'" These sorts of accommodations almost certainly increased the number of nonemergency patients who used the facility, but those at PubliCare did not see a better option.

Practitioners at PubliCare also voluntarily offered resources that included a whole array of social services. As a doctor put it, "Okay, this person has nothing to eat and so why not give them a sandwich, you know? Or they have nowhere comfortable to sleep, so why not keep them a couple more hours?" One nurse-administrator discussed how the ER would sometimes feed and board homeless people "if we're not too busy." The ER also had "a whole closet full of clothes and we give out . . . god knows how many socks and things like that." During the holidays they would "give out toys to kids," and they always had a stash for children to use while their parents got treated. If they had run out of spare clothes, nurses

would often give homeless people whatever they could find: "You know how many blankets we've sent out of this place for homeless people?" Another nurse in the ER acknowledged that the needy had come to expect "this place to be . . . their shelter, their food source." The hospital would sometimes offer taxi vouchers to patients without a ride home or would provide car seats for new mothers without the money to buy them; nurses would bathe patients who had been unable to wash themselves.

Many of those who worked at PubliCare recognized the possibility that they were creating moral hazards, but they prioritized the needs of the poor over the potential for abuse. A social worker noted that the "word was out on the street" that "all you have to do is go [to PubliCare] and they'll give you food vouchers" and that some patients had been arriving for the food. She acknowledged that it was a type of "game-playing," but in her mind it was "also survival. You do what you gotta do to survive out there." Moreover, some practitioners seemed so actively suspicious of financial incentives in medicine that they deliberately eschewed cost considerations. As a charge nurse at the hospital put it, "PubliCare has the heart. [It has] a great heart, and the people that don't care about billing, they just want to take care of patients well. And they will do that. But they will not charge you for it. So it's a little crazy." Another nurse discussed how it would be "taboo" for her or her managers to ask her peers to conserve on costs because they would assume that management "just wanted to save a buck." The same spirit that motivated practitioners to provide health care as a right seemed to stand in the way of basic organizational efficiencies.

Not only did the hospital lose money directly through its care for the poor, but its care for the poor also seemed to dissuade paying patients from using the facility—as if this care tainted the quality of the service provided there. Among the privately insured, the presence of the indigent suggested an inferior quality of care. One nurse said bluntly, "If you had a choice to stay in a room . . . that might be within a foot of some homeless person, or to go stay at HolyCare where everything's shiny and new and looks better, then—as a paying customer—where are you going to go? Are you going to go to McDonald's or are you going to go to somewhere nice, you know?" A nurse-administrator discussed one particular day in which a student from a nearby private high school was brought to the ER after having been hit in the face by a baseball. At the same time, right down the hall from the "very well-insured, wealthy family" was a prisoner who required four police officers with him. The mother was "sitting in the hall with her high school age son hearing this prisoner cuss, swear up and down." The mother filed a "huge complaint" with the hospital.

Morals and markets within the organization.—This commitment to care as a social right was not shared equally among different constituencies at

PubliCare. Rather, practitioners—from ancillary workers to doctors—fought to preserve a right to care against administrative leaders, for whom financial considerations had become paramount. Over several years, administrators at Westside Health had been trying to limit the extent to which practitioners cared for the poor. On one recent occasion, for example, the head of the linen department at the hospital passed by the ER entrance as nurses were putting a blanket around a patient and discharging him. Furious that the department continued to give away hospital materials for free, the administrator said, "I observed this one. . . . You're not going to be able to talk your way out of it." Along similar lines, a department manager had been working without success to encourage doctors to be more rigorous about their billing. Doctors were "still trying to operate in the old ways," she said, "and they are not getting up to what we need to do for 2010 and to move forward progressively."

These tensions had reached a head in February 2007, when administrators from Westside Health announced that they would be closing PubliCare Hospital altogether. As an ER doctor at PubliCare explained, Westside administrators had hoped they could "change [the hospital] around . . . without losing the ability to take care of patients and leaving people out in the street." But this had proven more difficult than the organization had expected. Those who worked at PubliCare—from ancillary workers to physicians—found out about the closure in the local paper. Many felt abandoned by hospital administration. As one ancillary worker put it, "It felt like it was upper Westside management, probably the CEO saying . . . 'This hospital isn't making money, isn't making enough money, so we're gonna close you.'" For her, this felt like abandonment: "You've got an agreement with the County, you knew what you were getting into, you knew how bad it was. You should have seen this if you really looked." Practitioners and patients were united in their outrage. An ancillary worker remembered the feeling of solidarity she had with patients, who were similarly outraged by the news: "We had two ladies that were 87 and 89 and they were knee patients, and they probably knew everybody in the county, [given] the phone calls they were making that day."

Practitioners and community members did not take the news sitting down, however. During one memorable Board of Supervisors meeting in February 2007, a large hall was packed with hundreds of concerned community members, almost all of whom were opposed to PubliCare's closure. And over the summer of 2007, several different coalitions of health care advocates united to put a halt to the closure. In the face of this public outrage, Westside relented and in recent years had been working to fulfill its contractual obligations to the county by constructing a new, smaller state-of-the-art facility. Nevertheless, many at PubliCare were suspicious about a

new facility, which would be far away from town and less accessible to the poor. A nurse-administrator concluded that Westside was building the new facility mainly to change private patients' perceptions of Westside Health: "Having the brand new facilities and be clean, with pretty floors and stuff will really help . . . bring the insured back." In the meantime, Westside seemed to have been divesting from the old facilities in anticipation of its transition to a new location. While practitioners and the public had managed to preserve some degree of right to care at PubliCare, the future of the organization remained insecure.

In sum, since it leased PubliCare in 1996, Westside Health had taken the hospital out of the public sphere, but the company had found it could not take the public sphere out of the hospital. When administrators sought to change physicians' practices in order to increase billing, physicians resisted. When administrators put pressure on nurses to limit the goods and services they offered to the poor, so as to dissuade the poor from relying on the hospital, the nurses went behind the administrators' backs. Even the corporation's effort to close the facility became a site of community struggle over the right to care. Ultimately, Westside decided to open a new hospital rather than renovate the old—as if PubliCare's organizational culture and commitments, so antithetical to success on the market, were baked into the very bricks and mortar of the place.

HolyCare: "Sacred Encounters" versus Luxury Goods

Founded by the Sisters of St. Francis at the urging of the city's private medical establishment, HolyCare had always sought to sacralize the provision of hospital care—highlighting the emotional and spiritual dimensions of care for the paying patient. Yet as the sisters had faded from active roles in service provision or administration and as the hospital faced new financial pressures, the Catholic values on which it was founded had become a patina of spirituality through which the hospital marketed itself to patients and rationalized its corporate decision making. The increasingly transparent "decoupling" of the hospital's espoused spirituality from its market practices created new space in which constituencies could challenge the sisters' traditional monopoly over the hospital's morality (see Turco 2012).

Historical foundations.—By the early decades of the 20th century, the hospital had established itself more certainly as a center of medical authority and medical practice. Because of the new technology available in hospitals and because of physicians' increasing dependence on these facilities for their own practices, the wealthy began to consider these institutions for their own inpatient (and especially surgical) care (Vogel 1980,

pp. 60–62; Starr 1982, p. 159; Rosenberg 1987, pp. 245–46). In turn, in order to attract paying patients, a new breed of "voluntary" hospital consciously worked to dispel the hospital's reputation as an impersonal, dehumanizing place in which the poor and desperate were warehoused or reduced to clinical material. If the almshouse was concerned with the provision of care as a right, then the private hospital of the early 20th century focused energy on the emotional and spiritual meanings of care. Some early voluntary hospitals opened special wards for paying patients so as to better honor the "dignity" of these patients. For these paying patients, "private rooms offered the comfort and convenience of a hotel with the ambience of a home" (Rosenberg 1987, p. 245). Paying patients were spared from the gaze of medical students since "privacy and payment seemed naturally allied" (p. 259).

The emergence of a market for hospital care was thus accompanied by efforts at imbuing this care with practices that reaffirmed the paying patient's humanity and distinguished the hospital from other sorts of business practices. Understood in this light, the Catholic hospital's centrality in the emerging market for hospital services is unsurprising. During the first half of the 20th century, sisters throughout the United States fluidly combined vocational devotion with shrewd political and economic calculations (Nelson 2001; Wall 2005, 2011). As Wall argues, the sisters (and some brothers) who ran these hospitals "conceived of illness . . . within a spiritual framework, and they viewed themselves as spiritual agents of care" (2011, p. 55). Yet these same sisters, according to Nelson, turned "overwhelming social need into opportunities for the development of health care services to the American public" and established themselves as the earliest female entrepreneurs in the United States (2001, p. 55). And while many Catholic health systems could trace their origins to acts of charity and self-sacrifice, by the turn of the 20th century religious hospitals were heavily dependent on patients who could pay (Vogel 1980, p. 101; Rosenberg 1987, p. 240). Income from paying patients made up approximately three-quarters of the revenue of religious hospitals in 1904, compared with approximately half the revenue of nonsectarian hospitals (Stevens 1999, p. 23).[18]

By the 1940s, Las Lomas was forced to confront the problem of the paying patient. Throughout the early decades of the 20th century, County

[18] As the market for hospital care expanded through the 1930s and 1940s, the Catholic Hospital Association (CHA) played a critical role at the national level in putting forward a "voluntary ideal" of hospital care, which could protect patients from crass commercialism, on the one hand, and a dehumanizing state bureaucracy on the other. In opposing the Wagner-Murray-Dingell bill for universal health insurance in 1943, e.g., the CHA argued that, under the bill, patients would become "wards of the state as opposed to wards of society," that the bill would undermine the "dignity of the patient" and destroy the "Catholic attitude toward the patient" (Wall 2011, pp. 111–12).

Hospital (now PubliCare) provided the most state-of-the-art medical care in the area, and yet it served the poor almost exclusively. When the wealthy needed more intensive care, they had to travel almost 60 miles to the nearest hospital. A 1940 report on medical care in Las Lomas concluded, "It is a matter of some irony when we truthfully state that the indigent patient is able to command hospitalization without cost to himself which meets the standards accredited by the American College of Surgeons, while those who have money with which to pay for the service are unable to procure that service within this county."

Private physicians had been making "many . . . attempts to induce sectarian (Catholic) institutions to build and operate a hospital of accredited standards," according to the Board of Supervisors report. In 1946, the town's Chamber of Commerce found a cherry and walnut orchard near downtown Las Lomas on which it proposed to develop such a facility. The fund-raising effort that followed, according to one local history, was "one of the most successful in [the area's] history." The town also succeeded in its pursuit of a Catholic order of nuns, the Sisters of St. Francis, to operate the hospital. HolyCare Hospital opened its doors on January 1, 1950. It quickly became the "ultra-professional" hospital in the area, the hospital that brought the "Age of the Specialist" to Las Lomas.

For many years, the Sisters of St. Francis had given HolyCare Hospital—and the St. Francis Health System as a whole—a sense of common purpose. In a recent internal report put together by a consulting firm for the system, for example, leaders throughout the company—from physicians to managers to system executives—reported that they identified with the "mission of the Sisters" more than they did with their professional groups, with their local hospitals, or even with the health system itself. This sentiment seemed to be shared by ancillary workers as well. A unit manager at HolyCare Hospital told me simply, "To me the Sisters represented the conscience of the hospital."

But the Sisters of St. Francis were aging. In 2012, the average age of an American nun was 74 (Winerip 2012). Where the Sisters of St. Francis had once actively administered and nursed within their hospitals, they now played a more indirect role. An administrator at HolyCare recalled how one sister, in her last years at the facility, had taken it upon herself to walk the halls giving "unconditional positive regard." According to this administrator, the sister was "the visual cue of the mission and the values and she [made] people feel affirmed, and feel part of the legacy." In 2007, however, this sister and her colleague retired and left Las Lomas, meaning that the sisters no longer had any active presence at HolyCare at all. A community leader observed, "The stalwarts were the women religious, and they're getting old and dying. And so these institutions remain and they're being led by people whose culture is largely the business culture."

As the system's ties to the sisters grew more tenuous, the system had sought to inculcate lay leaders and other employees with the Catholic values on which the hospital was founded. A Jewish physician-administrator at HolyCare, for example, recalled going on a "pilgrimage" to the European village where the Sisters of St. Francis were founded in order to "understand this heritage . . . understand what we're responsible for." Many less senior employees had taken part in a "Mission and Mentoring" program, during which they were trained by system leaders in the values and traditions of the sisters. In order to shadow doctors in the facility, even I was required to watch a video about the sisters' history and mission.[19]

Contemporary contradiction.—Among the three hospitals in Las Lomas, HolyCare continued to be the hospital that worked most deliberately to sacralize the market for medical care. Increasingly, however, these spiritual values seemed to have become tools used by economic actors within the hospital to forward their economic interests. If at PubliCare the contradiction was between care as a right and care as a scarce resource, at HolyCare the contradiction was between care as a spiritual good and care as a luxury product. Whereas Catholic values had once provided a robust moral orientation through which multiple constituencies understood their participation in an emergent health care market, in recent years these values had lost much of their legitimacy among those who worked at the hospital and had come to be seen as little more than marketing rhetoric.

Sitting adjacent to HolyCare Hospital was the convent where the sisters had once lived, a building that had since been renovated and turned into administrative offices. Among these offices were the headquarters of HolyCare's extensive Department of Spiritual Care and Mission Integration. As a part of this department, HolyCare had six chaplains on staff. By comparison, PubliCare had no chaplain on staff and GroupCare had only one. The size of the chaplaincy program at HolyCare made it possible for each patient to be visited by a chaplain within three days of the

[19] Although outside the scope of this article, it is worth mentioning that one area in which HolyCare stood firm regarding its ethical foundations was with regard to women's reproductive services—a position that highlighted just how different the moral foundations of the Catholic hospital were from the moral foundations of PubliCare. Those at PubliCare considered services such as abortion and sterilization a right, whereas Catholic hospitals treated them as "medical practices that undermine the biological, psychological, and moral bonds on which the strength of marriage and the family depends," in the words of the U.S. Conference of Catholic Bishops' *Ethical and Religious Directives* (2009*a*, p. 23). When PubliCare Hospital threatened to close in 2007, many in Las Lomas were concerned about losing access to women's reproductive health services. Several practitioners at PubliCare discussed how HolyCare's ethical restrictions violated patients' right to care. According to one physician-administrator at PubliCare, e.g., HolyCare's prohibition on doctors' prescribing the morning-after pill was unjust: "The conflict is in human rights, I think, being violated by a religious belief. It's a strong thing to say, but I believe that."

patient's arrival. And the department's director had sought to place each chaplain in a department that was a good "fit" for the chaplain's emotional disposition. The oncology ward, for example, had a chaplain who was especially skilled at creating and sustaining long-term relationships. The emergency room had a charismatic chaplain who was a bit more of a "glad-hander."

Overall, this department was responsible for looking after the "emotional and spiritual well-being" of patients as well as for preserving the values of the hospital as a whole. In the face of market pressures, one chaplain observed, "it can feel as though the spirit or the heart of the place is getting dried out." But, she continued, "that is always an issue in being in an alive institution." The challenge is to "have heart in our work, even when it feels like there's more pressure from all sides." The department director sought to find ways of highlighting the "spiritual aspects of people's needs" in the hospital. For example, she sent out a daily reflection to all staff by e-mail, she said, "to remind people to get in touch with the sacred in them, so they can be there for patients and their families." She also sought to ensure that all staff meetings in the hospital began with short reflections that "set the context for how you want to be."

Administrators at the hospital focused on helping patients understand their experience in the facility as "sacred," an aspiration that was sometimes difficult to put into practice. As one system leader put it, "We've really struggled with this area in terms of how do you measure it? Because we want to be certain that we're faithfully carrying that out. So we've struggled a lot with the measurement of something like that." As this leader explained, hospital administrators had been working to take "particular moments in the patient experience"—like the birth of a child—and make them more sacred. "We're taking that moment by moment and saying, 'Where are there opportunities?' And we're asking patients to tell us about [it], 'What does that feel like?'"

When I asked a local religious leader involved in Catholic health care why it mattered whether or not a hospital was religious, he responded, "You ever been scared? . . . There isn't any time in the world when religion makes more sense than when you have a problem, especially a health problem, or confronting death." Yet the hospital's attention to the spiritual dimensions of care was entirely consistent with, and actually seemed to make possible, the hospital's success in the marketplace. The same qualities that imbued care with spiritual and emotional significance also attracted wealthier patients. HolyCare Hospital attracted a higher percentage of insured patients than PubliCare Hospital and was more profitable than PubliCare Hospital during every year since PubliCare Hospital turned private in 1996.

Indeed, the "sacred encounters" that hospital leaders emphasized seemed almost indistinguishable from the sorts of customer service practices to

which all hospitals—and indeed all service industries—aspire (Hochschild 1983). A union leader argued that since patients "want to feel that they're more than just a number," there was an economic value to "having the religious brand on your hospital. . . . It's part of the branding, it's part of the identity."[20] Increasingly, it seemed, HolyCare had made spirituality synonymous with luxury and personalized attention. Wealthy people liked to go to HolyCare Hospital because they "had music playing and artwork and nice sofas," according to a doctor at PubliCare. A pianist sometimes played in HolyCare's lobby, and the chairs in the cafeteria were made of heavy oak, compared to the cheap plastic in the cafeterias at PubliCare and GroupCare. According to one medical transporter, the administration had wanted HolyCare to feel "like a hotel" and so had painted the walls brown and carpeted many of the floors. A chapel off the lobby swam with colorful light filtered from the outside through panes of stained glass. And in the central courtyard of HolyCare a "healing garden" had been established. Patients could walk along the curving pathway lined with therapeutic and medicinal herbs, meditate as they navigated a small stone labyrinth, or gaze at a beautiful mosaic wall.

Many different constituencies within the hospital seemed to view the hospital's moral foundation as having lost legitimacy in recent years. This was true even among the founding order of sisters. In the mid-1990s, for example, a group of Sisters associated with HolyCare began advocating that the order sell its hospitals in order to live out their vocation more purely. They asked a retired priest and legal scholar to write a position paper fleshing out the theological argument for abdication. In this paper, the priest wrote that market forces and state regulations had crowded out the spiritual core of the hospital system. These forces had made it "impossible to serve the deeper calling which is to be identified with the ministry of Jesus . . . [and] to respond to the truly deeper spiritual needs of the people." The sisters' entanglement with the contemporary market for medical care meant that "the survival of those [medical hospitals] take[s] precedence over the personal charisms of its members, and in many cases even crushes those charismatic gifts for the sake of institutional survival." The priest, articulating the sentiments of the group of sisters who had approached him, advocated that the order should "divest itself of those institutions" in the medical marketplace "over which it has no control, and re-invest its financial and personnel resources in supporting the various unique charisms of its individual members." Needless to say, the priest's paper was not heeded by the Sisters of St. Francis, but it demonstrated how many persons religous had come to see this "moralized market" as a kind of marketized morality.

[20] Wall (2011, p. 5) makes a similar point when she observes that Catholic hospitals have in recent years been reasserting their values as a way of distinguishing the service they give from that of other hospitals.

Morals and markets within the organization.—System administrators, however, were adamant that the Catholic values on which the hospital was founded were consistent with the hospital's ongoing participation in the marketplace. As one executive put it, "I don't want to speak for the congregation or for the Sisters whose shoulders we stand upon, but they never thought about it as a business practice. It was just the way they work." Another executive in the system said, "The underlying assumption of [mission and market] being opposed to each other is a wrong assumption." She saw the hospital's financial health as a "subtext" and preferred to use the word "stewardship." She continued, "Theologically, we've been given responsibility to steward the resources, so to me it's still part of the ministry. . . . We've been asked to be accountable for resources and how resources are bought and used and that, to me, is what financial management is, it's stewardship of our resources." A sister on the executive team discussed the importance of how they "framed" their discussion about the market for hospital care: "Framing it in the way we're framing it, finances are the supports to doing the ministry, finances and everything else. . . . We've been very disciplined [with] the use of the word 'stewardship.'"

Granted, leaders at HolyCare Hospital had always understood their participation in the market in moral terms. And it might be unsurprising that those at the helm of the organization would elaborate a morality consistent with their participation in the hospital marketplace (see Quinn 2008). Most interesting here, however, were the ways in which this moral legitimacy had faded among those other than the hospital's administration. Where the sisters had once been the "conscience" of the hospital, they were now regarded as empty figureheads. Several workers discussed their feeling that the religious values on which the hospital was founded had lost their meaning in hospital practice. According to one operating room technician, "Everything's push, push, push as far as, you know, making sure you charge the patient, making sure you're not stockpiling, making sure that you've got the minimum you need for the time. They always are watching you and pushing you about that, and they call it 'being a good steward.'" He continued, "There's no spiritualism in it at all. . . . It's just sterile." A kitchen worker asserted that the "values that they're preaching go to garbage" in management's daily practice. And a radiology technician asserted that the "suits are hiding behind these values. . . . They're espousing them all the time and it strikes such a phony chord."

This loss of legitimacy came to a head when, between 2004 and 2012, workers at HolyCare sought to unionize. Despite a long history of Catholic social teaching on the rights of workers to organize (U.S. Conference of Catholic Bishops 1999, 2009*b*), the sisters collaborated with their hired

ethicists to develop an anti-union theology, actively reconstructing their theology to reconcile their moral commitments with their economic interests. They argued that a union would "replace covenants with contracts," reducing the hospital's mission to a set of rules. One oft-repeated story among union supporters was how a nun had approached a pro-union worker and told her she was "greedy" for wanting a union. While rarely so explicit, managers consistently reminded workers of the vocational nature of their work and urged them to mirror the sisters' own selflessness. It was only by way of a four-year campaign among union, community, and religious leaders, examined elsewhere, that the hospital system "discerned" an approach more in keeping with their Catholic principles and refrained from aggressive anti-unionism.

At the level of physician practice, moreover, HolyCare facilitated some of the most brazenly competitive activity within the county. Indeed, the hospital had been founded at the urging of the private medical community, as a physicians' workshop in which doctors could see paying patients. Physicians at HolyCare continued to bill on an individual basis, collecting money only for the patients they saw. When an ER doctor from GroupCare had interviewed at HolyCare, he had been told that doctors there "eat what they kill." A system of individual billing meant that doctors were, in some sense, competing with one another for those patients likely to reimburse at a high rate and—conversely—competing to avoid the uninsured. Several physicians and nurses discussed the problem of "cherry-picking." A new hospitalist at HolyCare, unfamiliar with the individual billing system, was once assigned 12 patients, only two of whom had insurance. "Did that happen by accident?" he asked rhetorically. Over time, he said, he had to "learn how to defend [himself]" against other doctors' attempts to stack the deck.

Here was the contradiction at HolyCare. Of the three hospitals in Las Lomas, HolyCare worked most explicitly to distinguish hospital care from other businesses—to imbue care with emotional and spiritual significance for patients and for employees. Many who worked within the organization were particularly sensitive to these dimensions of hospital care and took pride in the way in which the organization prioritized the "dignity" of each patient. On the other hand, HolyCare was also, in many ways, the most business minded. Its appeal to spiritual values provided a cover of moral legitimacy to entrepreneurial administrators and doctors. These values were enacted in order to attract a wealthy clientele and promoted internally in order to secure a disciplined and subservient workforce. Paradoxically, however, the instrumental use of these spiritual values—whether in the service of an anti-union campaign or in an effort to personalize care—threatened to reduce their impact, to the extent that others understood them as instrumental. Where the sisters once provided deep legitimacy to the

hospital's moral-market position, they now offered a thin veneer of spiritualism atop an increasingly secular organization, allowing new constituencies to claim the hospital's founding values for themselves (Reich 2012; Turco 2012).

GroupCare: Population Health versus Individual Treatment

Established as a prepaid group health organization in order to manage the care for a population of "members," GroupCare sought to tame the market for hospital care through an extensive bureaucracy and an elaborate technological infrastructure. In this way it differed significantly from both PubliCare and HolyCare, each of which was a stand-alone hospital within a separate hospital system.[21] Through organizational integration and evidence-based practice, GroupCare sought to reduce uncertainty in the provision of care. Its moral project was thus in some ways entirely with its market strategy, as it articulated and enacted a vision of efficient medicine, rebuffing what it viewed as the amoral overtreatment in the "real world" outside. Yet GroupCare was not free from contradiction: the reduction of medical uncertainty relied on the use of population-based data and establishment of population-based protocols; yet in a market for hospital care, this care must be presented as an individualized product. The system thus necessarily elided two different goals—the health of the membership as a population and the well-being of each individual member—systematically denying the ways in which these two goals remained in tension with one another.

Historical foundations.—By the early 1970s, across the United States, there were growing calls for restraint and rationalization in what had become—in the minds of many—an unwieldy and unreasonably expensive health system. Patients' rights advocates, business leaders, and political figures on both left and right began to mobilize against the autonomy and excess of the medical profession and the hospital industry. On the advice of Paul Ellwood, in 1971, the Nixon administration advocated for grants and loan guarantees for the establishment of "health maintenance organizations," or HMOs, integrated health systems that would combine health insurance with health provision and so provide medical organizations with incentives to manage the health of patients (or members) in a cost-efficient manner (Starr 1982, p. 395; Light 2004; Mechanic 2004, pp. 76–86).[22] This idea had actually originated in the 1930s and 1940s among industrial

[21] That being said, given the success of GroupCare in the county, each of the other hospitals had begun to form partnerships with physician groups so as to increase their level of integration and capture more of the market for insured patients.

[22] With a similar logic, in 1983, President Reagan signed legislation that incorporated prospective payment into Medicare, meaning that hospitals would get a set amount of

employers and health practitioners as a strategy for efficiently maximizing wellness across a workforce (Somers 1961, pp. 81–92; Greenlick 1972, pp. 100–113; Luft and Greenlick 1996, pp. 445–67). In the 1970s it gained renewed attention, and broader support, as more constituencies began to conceive of health as a technical problem that might be solved through efficient management.

Among many observers, the growth of managed care has been understood as a key indicator of the market transformation of American medicine (Scott et al. 2000). Yet it is, on its face, somewhat paradoxical that we consider these two phenomena so intimately related. Outside of health care, the bureaucratic connotations of "management" seem anathema to a "market" made up of autonomous buyers and sellers. Indeed, many early managed care organizations (like GroupCare) were impugned not for being excessively market driven but rather for being socialistic.

GroupCare arrived in Las Lomas in 1979, when it bought the 23 acres on which its hospital and clinics now stand.[23] The organization began seeing patients in 1980 and opened its own hospital in 1990. A long-time GroupCare physician remembered that the organization's early philosophy in Las Lomas was that it could create a system staffed only by family practitioners "who would be able to do everything." The physicians were all paid the same amount, he recalled, and as late as the 1980s they were "considered commies" by the established medical community. As he put it, "We were the radical fringe of our truly reactionary profession."

As GroupCare grew in Las Lomas and throughout the state, the wider medical community remained wary. Several GroupCare doctors recalled having their colleagues at other health systems tease them for joining the "big box store" of health care. A family medicine doctor at GroupCare paraphrased the critics: "You guys are coming in here and you're going to just give standard[ized] care and poor service and undercut us, because you're

money by type of diagnosis (Stevens 1999, p. 324). As Stevens suggests, this reform meant that Medicare would treat patient care "in terms of standardized 'products,' reinforcing the image of the hospital as a factory. 'Scientific management' was finally to be achieved. The question was, at what cost?" (p. 324).

[23] Given their different organizational arrangements, it must be emphasized that a comparison of PubliCare, HolyCare, and GroupCare is necessarily somewhat imbalanced. Despite the efforts of Westside Health and the St. Francis Health System to integrate their hospitals with primary-care and specialty clinics, PubliCare and HolyCare remained standalone facilities. In contrast, GroupCare's hospital facility sat directly astride its clinics and was deeply integrated with the GroupCare Health System as a whole. Where PubliCare and HolyCare Hospitals saw patients with many different sorts of insurance, GroupCare Hospital primarily saw its own members (more on this below). My analysis of GroupCare is thus necessarily an analysis of the GroupCare system. At PubliCare and HolyCare Hospitals there were no such systems to analyze.

so big and you can give it cheaply." Some referred to GroupCare as the "Darth Vader" of health care in the area. An emergency medicine doctor recalled how she was the only person in her class at medical school to work at GroupCare because "people definitely looked at that as a second-rate place to work." A hospitalist said that GroupCare was considered the "bottom rung of health care"; a nurse-administrator said it was thought of as the "meat market of health care."

That reputation had started to change. As a physician-administrator put it, whereas the outside medical community had once been "openly hostile" to GroupCare, now "it's kind of resignation. . . . There's a lot of recognition that we actually have the best system for delivering care." A rheumatologist at GroupCare said with tongue in cheek, "First we were hated and despised. Now we're hated and feared. That's better." Increasing numbers of private-practice doctors had been signing up with the organization. Whereas doctors used to join GroupCare "because they believed in pre-paid medicine," the rheumatologist continued, they were now joining because "it's the only game in town. . . . There really aren't any viable alternatives in private [practice]."

Contemporary contradiction.—In the late 1990s, according to interviews with several administrators, GroupCare began making a deliberate effort to dispel its reputation as the "big box store" of health care and appeal to high-end health care consumers—those same patients pursued by PubliCare and HolyCare. Leaders and practitioners at GroupCare believed with missionary zeal that they could organize and incentivize the provision of care so as to maximize patient well-being for each individual patient as well as for the membership as a whole—an idea encapsulated by the organization's ubiquitous slogan: Flourish. Many of those within GroupCare viewed with derision the health care market outside—what they called "the real world." In the real world, they argued, the market led to ineffective "overtreatment," malcoordination, and unnecessary uncertainty for both practitioners and their patients. The moral project at GroupCare was to realign organizational incentives and relationships so that the interests of the patient were consistent with the interests of the organization—to create an efficient and coordinated infrastructure. But in working to reduce the uncertainty in medical care, GroupCare inevitably conceived of patient health at the level of its population of members. What went unstated, then, were the ways in which "scientific medicine" and integrated care inevitably involved the rationing of the organization's resources across the population as a whole (Orentlicher 2003).

Across the system, administrators and practitioners at GroupCare expressed pride in the system's bureaucratic efficiencies, which they argued had been able to bring the market into "alignment" with each patient's

well being. Unlike the other two facilities in Las Lomas, GroupCare was organized as a prepaid group practice organization, meaning that patients paid a monthly rate regardless of the amount of care they received. According to a GroupCare executive, health care "is just like every other business in that the people who sell whatever it is they're selling do whatever it is they need to do to get the money. And so, if you can make more money by doing lots of scans, lots of scans happen." He and others cited countless examples of overtreatment in the fee-for-service world. At GroupCare, the implication was, the incentives were aligned so as to maintain members' health without costly and ineffective treatments. An ER physician put the point more bluntly as he compared working in GroupCare to working elsewhere: "As an emergency physician, it's much easier to admit people. . . . So, in some ways, I think [fee-for-service doctors'] job is easier, because their incentives are aligned to utilize resources and to admit people to the hospital and then call in consultants. That's where their incentives are aligned." At GroupCare he had to use more discretion. Another physician-administrator argued that only at GroupCare could members be assured that they were getting the "best care possible" because the "incentives are aligned."

Unlike the two other hospitals in the area, for example, which were compensated on the basis of the number of procedures they performed, GroupCare had the financial incentive to make investments in preventive health care—in keeping members out of the hospital in the first place. The system's electronic medical record (EMR) tracked what percentage of members had their blood pressure and lipids checked during the year. GroupCare also had elaborate programs created to help people manage conditions such as childhood asthma or diabetes and programs to address the social determinants of health such as mental health and diet. During the H1N1 scare of 2009–10, as I was conducting my research, GroupCare was the first area health provider to acquire and distribute vaccines. In recent years the system had also been experimenting with ways of giving members incentives to manage their own health more rigorously. One executive discussed a new initiative in which "if you fill in a health history and then do a couple healthy things . . . you can go to the GroupCare store and buy running shoes or something." Outside the Las Lomas facility, GroupCare held a weekly farmer's market, one of 30 that the system had organized around its entire system. The system also offered discounts for members to sign up for weight-loss programs.

Central to GroupCare's project of "alignment" was the development of what one executive called "the largest electronic medical record in the world," in which the multistate system had invested approximately $4 billion over the course of 10 years. Neither PubliCare nor HolyCare had such

an integrated electronic database. The idea, according to an executive, was not only to make patient information more consistent and reliable but also to develop a common language across heretofore disparate and disconnected practices. Because each medical site within the GroupCare system had previously been so different, "it was relatively difficult to transplant stuff from one site to another." He continued, "You can't re-engineer a system until you have a system to re-engineer. So you first have to engineer a system." The EMR system was initially not intended to standardize practice so much as it was to make differences in practice understandable, so that everyone would have "the same dataflow and the same process and starts from the same set of underlying interactions with the patient and database." This similar structure allowed the system to analyze and make use of existing variation. For this executive, and many at GroupCare, processes of bureaucratization were thus not inconsistent with innovation. The standardization of the organization's information infrastructure would allow effective ideas to percolate upward and spread from one facility to another.

If the EMR made possible a new level of commensurability, it also allowed for a more thorough monitoring of and interaction with each individual member's individuality—both longitudinally, as it tracked each member's care over time, and horizontally, as it tracked each member's care in relationship to other members. The wealth of information accessible through the EMR allowed physicians and GroupCare researchers to compare patients with one another in new ways. According to one specialist, the system had "allowed every physician everywhere in the entire system to have every bit of information everybody else has." A physician-administrator in family medicine explained how the new system allowed him to use the database and "take out one aspect of" care. For example, he continued, he could easily generate a list of his diabetics, analyze how well his doctors were managing their diabetic patients, and "find out whether or not we're accomplishing what we want in terms of goals." Moreover, the system would allow him to analyze, in real time, whether a particular level of diabetes control resulted in an improved outcome—such as whether there was a lower rate of heart attacks among these patients. Historically, medical research has taken place separate from everyday clinical practice. The advent of the EMR thus opened up the possibility of practice and research occurring concurrently.

As a result of the data generated by GroupCare's EMR, the system had been able to study its own practice and generate protocols based on those departments and facilities that were getting the best results. According to one physician who had run the hospital's efforts to improve quality, practitioners were drawn "collectively from all the medical centers and they

centrally come up with what's the best care plan for [a] particular issue." Each protocol was circulated among all physicians "so people can critique it," and then it "becomes part of order sets that are electronically part of our medical record now." A hospitalist described how these regional committees "weigh the studies" out there and "give them a value" as they go about recommending protocol.

In some important ways, GroupCare seemed to have succeeded in taming the market for hospital care by aligning the health of its membership with the economic interests of the organization. In so doing, however, the organization had elided two different goals: that of allocating resources in order to maximize the health of its prepaid membership as a whole and the goal of maximizing the health of each individual member. In their language and practices, many at GroupCare spoke of the former as if it were the latter. One physician-administrator asserted, "Rational care is not rationing care." And yet GroupCare inevitably rationed care, and did so much more deliberately than either of the other two hospitals in Las Lomas. Such collective choices, collective trade-offs, are anathema to a competitive marketplace premised on individual choice. GroupCare was the only health care system in town willing to confront such collective choices in its organizational decision making. But it was, perhaps necessarily, unwilling to embrace doing so openly.

Several physicians and nurses alluded to the ways in which GroupCare weighed financial costs against medical benefits. For example, one ER physician at GroupCare discussed how the ER at the Las Lomas facility did not have its own magnetic resonance imaging (MRI) machine: "When you really look at it carefully, there are very, very few indications for an emergency MRI, and it's extremely expensive." He and his colleagues agreed, "You . . . have to make some economic decisions." Given that there were "very few reasons that you would ever need it emergently," they decided to rely on the radiology department for the "one time a year" when it was necessary—which meant that they did not have access to the machine at night. "It's probably okay," he concluded. Similarly, since the GroupCare facility in Las Lomas did not have a catheterization laboratory for its heart attack patients, cardiologists at GroupCare gave these patients thrombolytics instead of an angioplasty and then transferred them to a facility nearby. One cardiologist estimated that this system probably led to one death per year but implied that the cost savings made it justifiable. There were other more subtle ways that the system saved money as well. For example, family practice doctors could not order certain MRIs or ultrasounds without the approval of a consultant. GroupCare also pushed to discharge patients from the hospital as soon as safely possible. And for nearly every common diagnosis or procedure seen across the three hos-

pitals in Las Lomas, lengths of stay at GroupCare were the shortest (see fig. 5).

Lurking in the background of the GroupCare system, then, were monetary values on life itself—figures that implicitly motivated decisions about resource allocation within the organization. In the fee-for-service world these values were hidden and highly variable, driven by differences in insurance coverage and differences in patients' capacity to pay. In a prepaid system like GroupCare, however, they were structured into the organization more directly. The systemization of patient data described above played an important role in this process: helping to transform the GroupCare member from a "case" or "consumer" to a set of components or variables that could be understood at different levels of analysis. To the extent that patients could be reduced to sets of independent variables (disease histories, demographic characteristics, patient preferences, courses of treatment, prescriptions) and dependent variables (outcomes of treatments or drugs), models could be developed in order to predict the benefits of using resources in particular ways and help prioritize spending over a population of patients. Judgments were sometimes made—implicitly if not explicitly—about what costs were too high to pay. A rational weighing of costs and benefits to any test or procedure, which includes the opportunity costs of spending resources on the particular intervention as opposed to something else, necessarily leads to choices not to intervene in certain cases in which expensive intervention might lead to marginally better outcomes. Evidence-based medicine like that at GroupCare could not answer ethical questions about those treatments that were marginally effective but were also very expensive or might lessen patients' quality of life (Jonsen 1975, 2006).

Morals and markets within the organization.—In the case of PubliCare, practitioners were committed to preserving the right to care in opposition to an administration increasingly concerned with the hospital's bottom line. At HolyCare, in contrast, administrators and some select categories of staff framed the hospital's market participation in spiritual terms, a framing that many practitioners had increasingly come to regard with cynicism. At GroupCare, the organization had managed—in large part—to organize the cooperation of several different constituencies around its project of efficient, evidence-based care. In the same way in which GroupCare had sought to make each individual patient's well-being consistent with the well-being of the organization as a whole, the organization sought to align practitioners' interests with the interests of the organization as well. And in the same way in which the organization systematically denied the inevitable conflict between the individual patient and the well-being of the patient population, it downplayed any divergence between the interests of individual practitioners and the interests of the system.

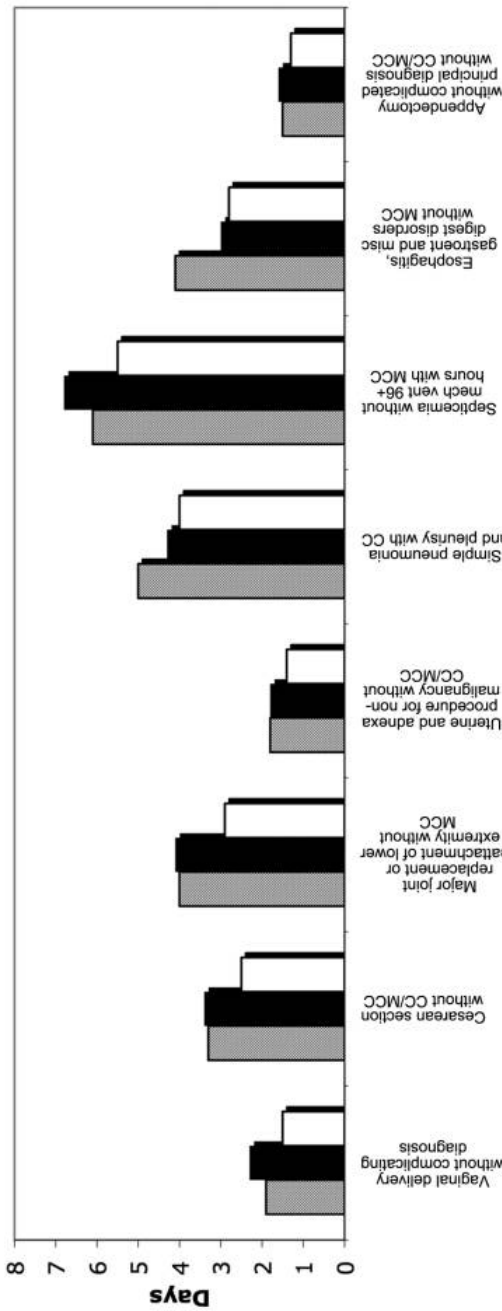

FIG. 5.—Average length of stay by common diagnostic related group at PublicCare (gray bars), HolyCare (black bars), and GroupCare (white bars) 2009. Data are from the California Office of Statewide Health Planning and Development, Hospital Annual Financial Chargemaster Data. (CC = complications or comorbidities; MCC = major complications or comorbidities.)

Just as GroupCare's organizational and technological infrastructure had allowed it to observe and compare its members at the population level, it also allowed for the organization to observe and discipline its paid physician staff, bringing this staff into compliance with the objectives of the organization. Medical uncertainty is inherent in medical practice, and physicians' discretion to address this uncertainty as they see fit is central to the power of the medical profession (Arrow 1963; Freidson 1970; Abbott 1988). Yet the EMR was able subtly to change doctors' relationship to medical knowledge in such a way that doctors' understandings of their professional roles became consistent with their subordination to bureaucratic authority. As one hospitalist said, "Because of the electronics . . . [doctors are] much more connected and know more what each other is doing, but also it's become much more one big group, held to the same sorts of standards." Using the EMR, for example, department directors were able to show physicians how they were performing in relationship to their peers. As one department director explained, "We're very successful here with standardizing the care. . . . And we do it not so much by forcing people, but by bombarding people with the evidence—with their own practices, with where they fit on a curve. Are you ordering 50 carotid ultrasounds when your colleague next to you is ordering 2, and their outcomes are identical? How good is that? Why are you doing that?" One specialist recalled, "Every month now I get a listing in the family medicine service about which doctors are the most successful in seeing their heart disease patients are on the four key drugs, for example." And while originally the physician-administrators listed only the top 10% of doctors, they gradually listed everyone "including the outliers at the bottom." According to this specialist, these public forms of accountability "created tremendous pressure" among those that were measured.

Several doctors in the family medicine and emergency departments discussed how the public exhibition of physician statistics changed physician behavior because of doctors' own inherent competitiveness. One ER physician described how doctors "get feedback on utilization" and continued, "You don't want to be on either end of the scale." One of her colleagues "was ordering way more tests than anyone else" and "made this really big effort to cut back on the latest" interval. Another ER doctor recounted a time, soon after arriving at GroupCare from residency, when he was the outlier, having ordered more computerized tomography scans than anyone else in the department. As he remembered it, he was a new doctor and "didn't want to miss anything." But by being made aware of his own practices, he became "more conscientious" and began ordering fewer tests. While there were some financial incentives tied to doctors' metrics, these incentives were "much more symbolic," according to one ER doctor. Nevertheless, the process of measurement was itself quite effective at standard-

izing practice. According to the chief of the family medicine department, there was always variation in practice, but while "you still get the bell-shaped curve . . . it gets smaller and smaller." Over time, doctors' practices were getting more and more alike.

Just as GroupCare generated compliance among its physician staff, it had established a labor-management "partnership" among its unionized ancillary staff, with the idea that worker participation and advocacy were in the interests of the organization as a whole. The cornerstone of the labor-management partnership was the department team. These teams, made up of representatives from all partnering members of the work unit (physicians, managers, and those workers part of the partnership), were responsible for making decisions about "core operational and environmental issues" using a core set of labor-management partnership principles and practices such as interest-based problem solving and consensus decision making. Another facility-wide team provided coaching for the members of these department teams. As one of several color fliers put out by the labor-management partnership explained, the department teams were intended "to increase involvement and result in improved performance." One labor leader believed that the department team "empowers workers a lot. . . . It's not just following directives; it's really thinking critically about what they can do to help and be more productive. And I shouldn't even say productive; they think creatively about what they can do to help the department."

The premise of the partnership was that productivity and involvement, efficiency and commitment, went hand in hand. More generally, the partnership embodied the idea—widespread throughout the organization—that bureaucratic innovation could tame the hazards of the market and bring stability to health care delivery; that with the right organizational structure, the interests of each part of the organization, and of each individual, could be aligned with the interests of the organization as a whole.

Just as GroupCare had sought to coordinate the interests of each patient and the interests of the organization as a whole, then, it had sought to coordinate the interests of individual practitioners with the system's objectives. To the extent that there was dissent to this moral project among practitioners, it was isolated and dispersed. Some older doctors chafed against what they felt was interference. As one primary-care doctor put it, "Then they start laying the statistics at you. And that's when it just starts to get frustrating, because this is one of your colleagues in there fuckin' with the talent." And some workers and union leaders expressed skepticism that the labor-management partnership was merely a managerial strategy for labor peace. A union representative remembered feeling "slightly frustrated" on occasion because "sometimes management would use the labor-management partnership to blow smoke up our ass." A worker-leader re-

membered thinking that the partnership "was a bunch of bullshit" since it meant that workers were "in bed with management." But over time she had largely come around.

GroupCare tamed the market for care by integrating dimensions of medical practice that remained uncoordinated in the wider marketplace, by investing in technology to reduce uncertainty in medical practice, and by using social technologies along with this technological infrastructure to encourage organizational conformity. Finally, the organization was able to obscure residual medical uncertainty—and concomitant ethical dilemmas and cost-benefit considerations—beneath a rhetoric of scientific medicine and population health. In similar fashion, it was able to coordinate the interests of its practitioners so as to incorporate them into the organization as a whole, successfully submerging the tensions between the interests of individual practitioners and those of the organization.

CONCLUSION

In this article, I have argued that the "moralized markets" school must go beyond its recognition of the flexibility in the boundaries between morals and markets. It must explore the broad institutional forces that, on the one hand, help to establish particular moral-market orientations and, on the other, constitute the environments within which actors struggle to lead connected lives. More specifically, I have shown how three hospitals, founded in different eras of American medicine on the basis of different conceptions of care, conflict—in different ways and with different effects—with the market logics that increasingly have come to constrain all hospitals (Scott et al. 2000). Actors in each of the hospitals try to reconcile these divergent legacies with the contemporary market, but in each case they fail, albeit in different respects. Furthermore, within each organization, different constituencies relate differently to the moral-market orientations on which the hospitals were founded. In this conclusion I discuss briefly the implications of this study for economic and organizational sociology, as well as for health care scholarship and practice in the United States.

Implications for Economic and Organizational Sociology

The most important implication of this article for economic and organizational sociology is that actors and organizations are constrained by their histories as they work to establish connected lives in the face of market pressures they do not control. There are several related implications of this main argument.

First, if the "destructive markets" school has highlighted Polanyi's critiques of commodification and the "moralized markets" school has deep-

ened Polanyi's conception of embeddedness, this article synthesizes these two ideas—as Polanyi himself did. Polanyi writes that, when it comes to processes of commodification, "The rate of change is often of no less importance than the direction of change itself" ([1944] 2001, p. 39). In other words, the market is most destructive when it causes changes in society more quickly than society can re-embed the market in social relations. The implication is that while entrepreneurs may be able to reconfigure the relationships between morals and markets to some extent (Zelizer 1978; Healy 2006; Quinn 2008; Anteby 2010, pp. 608–9), there are institutional and temporal constraints on the success of these projects. While there has been a bias in the literature toward successful moralization efforts (Turco 2012), we must pay more attention to instances of entrepreneurial failure in order to better understand under what conditions, and how, this failure occurs.

A second corollary implication of this article is that the potential contradictions between social values and markets exist along several different dimensions. Current scholarship tends to focus on cases like HolyCare, in which the contradiction or tension examined is between the transcendence of the market and the market for transcendence (e.g., the idea that life is degraded through the purchase of life insurance vs. the notion that the purchase of life insurance dignifies life). Much less has been written within the literature on moralized markets about the tension between social rights and scarce resources or about the tension between population-level goods and individual-level goods. Yet several empirical cases in the literature, from the market for organs and cadavers to the market for various types of insurance, might be enriched by a consideration of the different dimensions along which processes of commodification may be contradictory. For example, the tension between a right and a scarce commodity might usefully be examined in relationship to kidney transplants,[24] and the tension between a population-level good and an individual good might usefully be examined in relationship to life insurance.

A third corollary implication is that "connected lives" are connected within unequal worlds. This article treats the three hospitals of Las Lomas as independent cases, each of which struggles to reconcile previously institutionalized morals with contemporary market pressures. But one might also examine the ways in which the three hospitals of Las Lomas together constitute a field through which the class character of the contemporary hospital is reproduced. PubliCare, founded as an almshouse, continued to attract a disproportionate share of the poor despite the efforts of its administrators to reduce indigent care; HolyCare, founded for the paying

[24] Healy (2006, p. 46) alludes to but does not develop this line of argument in his discussion of the allocation of kidneys.

patient, made spirituality synonymous with luxury and so continued to attract a wealthy clientele; and GroupCare, founded in order to bring health care costs under control for the middle class (and their employers), continued to attract a middle-class membership base. Future research might more explicitly examine the ways in which different types of contradictions are associated with class positions or other sets of social distinctions.

Implications for Health Care in the United States

One way of understanding the analysis above is as a snapshot of a particularly contentious moment in the moral significance of the market for hospital care. One can imagine how, 20 years from now, moral-market entrepreneurs may have succeeded in rationalizing the closing of safety net hospitals like PubliCare, may have transformed HolyCare more unequivocally into a high-end health care spa, or may have made a convincing moral case for the health care rationing that takes place in GroupCare.[25] From this perspective, the contradictions elaborated herein are merely symptomatic of a field in transition. Once the market for hospital care has been more uniformly moralized, it might be argued, the contradictory character of its commodification will fade. Of course, as Steiner (2009, pp. 105–6) points out, this may be a world in which markets drive our morality, "a society in which law and morals are increasingly overwhelmed by the market mentality." An unproblematically moralized market for hospital care may be evidence both of flexibility in the relationship between markets and morals and simultaneously of the power of an expanding market to exploit this flexibility, colonizing domains previously off-limits.

Yet given how long different forms of hospital organization have survived, despite extensive changes in their organizational environment over time, what seems more likely is that the contradictions in the commodification of hospital care will endure. The belief in hospital care as a right will continue to conflict with care as a scarce resource; the vocational, spiritual dimensions of care will be at risk of becoming a patina of luxury; and the best interests of individual patients will continue to be in tension with the best interests of populations of patients.

Even the passage of the Affordable Care Act in 2010 has done little to resolve the market's contradictions. For example, though many more people are covered by insurance under the Affordable Care Act than were before, the tension between hospital care as a scarce resource and hospital care as a social right remains. Most obviously, there still are groups excluded from coverage (such as undocumented immigrants) and still are people

[25] For a good discussion of moral entrepreneurs, see Quinn (2008, p. 747).

unable—for a variety of reasons—to navigate the bureaucracies necessary to obtain care. With easier access to primary and preventive care, fewer people have to rely on emergency room care for primary-care services. But there are certainly still many who appear at the doors of the emergency room burdened by social problems far outside the usual boundaries of medical care. In fact, with more people granted the promise of medical insurance in an age of shrinking budgets and a frayed social safety net, we might expect more people to turn to hospitals (and all medical care) for help with a myriad of social needs. Yet those hospitals that accept this broad social responsibility most willingly will likely continue to be the most "inefficient" in medical terms. And as all hospitals are held accountable even more aggressively for the "value" they produce, those that respond to general social needs are likely to be driven out of the market entirely.

The tensions between the emotional, vocational dimensions of hospital care and its economic value are also likely to persist. In a competitive marketplace, hospitals will always seek to distinguish themselves on the basis of their espoused commitments and values, and the commitments and values of the people who work within them. Yet the relationships between hospitals' economic interests and practitioners' vocational commitments will continue to be fraught. To the extent that insurance providers use measures of patient satisfaction to compare different types of organizations, we might expect hospitals to invest new energy into standardizing the interactions of nurses, doctors, and other practitioners so as to enhance these scores; yet this very standardization will likely make these interactions seem coerced rather than authentic and threaten to undermine or degrade such efforts. Furthermore, one might expect that—in an environment of "accountable care"—government and insurance companies would be reluctant to pay for those aspects of emotional and spiritual care that cannot be quantified or linked directly to better health outcomes. As a result, one might imagine that these aspects of care might move outside the insurance market altogether, becoming even more akin to luxury goods than they are today.

Finally, the tension between individual well-being and group health will almost certainly remain at the forefront of public discussion and debate. One need only recall how images of the "death panel" nearly derailed the passage of health care reform to appreciate how violently the U.S. public recoils from discussion of allocating scarce health care dollars. Somewhat puzzlingly, the legislation establishing the Patient-Centered Outcomes Research Institute in the Affordable Care Act explicitly limits the use of quality-adjusted life years (QALYs) in determining what kind of care is recommended or to compare interventions against one another. The QALY is a metric widely used in the fields of epidemiology, public health, and health policy as a standardized measure by which to understand the average value

of widely varying health care interventions and policies. Yet the new health legislation seeks to avoid any hint of rationing or discrimination against different kinds of patients. As two health policy researchers put it recently, "The antagonism toward cost-per-QALY comparisons . . . suggests a bit of magical thinking—the notion that the country can avoid the difficult tradeoffs that cost-utility analysis helps to illuminate. It pretends that we can avert our eyes from such choices, and it kicks the can of cost-consciousness farther down the road" (Neumann and Weinstein 2010, p. 1496).

Limitations

I will conclude by discussing the limitations of the argument made here. First, one might argue that the differences observed among these three hospitals are merely a result of different organizational structures or financial incentives. I have sought to show that these organizational structures cannot easily be disentangled from their institutional foundations. Rather, the structures and incentives must be seen alongside the understandings and practices as constituting the "relational packages" (Zelizer 2012) through which care is delivered. The differences in these relational packages, in turn, can be understood only by tracing their different historical lineages. Moreover, the organizational structures of these hospitals have changed quite dramatically over time; for example, PubliCare was converted from public to private ownership, and HolyCare had transitioned its executive leadership from a group of sisters to a group of business school graduates. These changes suggest that organizational structures may be more peripheral to hospital organizations than the institutionalized values on which they were founded (see Hannan et al. 1996, pp. 506–7).

This article, of course, raises questions that are beyond the scope of its analysis. For example, the article does not make any causal claim about the relationship between each hospital's historical legacy and the understandings of the practitioners who work within each. While it seems likely that practitioners have elected to work within the hospitals on the basis of the hospitals' reputations, it also seems plausible that different work experiences help to generate different moral-market orientations. Future research should explore more explicitly the ways in which individuals' orientations toward the market are shaped by, and in turn shape, the organizations within which they are a part.

In her review of the rich literature on the relationship between morals and markets, Fourcade (2007, p. 1028) calls for more attention to the "sociological *principles* that may structure different relationships between moral and economic classification." In this article, I have sought to make a small step toward this sort of systematic analysis by demonstrating the different ways in which organizations—and the people within them—

work to reconcile previously institutionalized values with market pressures and the different sorts of contradictions that emerge as a result.

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