The Misalignment of Institutional "Pillars": Consequences for the U.S. Health Care Field

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This paper uses an institutional perspective (Scott, 1994; 2001; DiMaggio and Powell, 1991) to analyze the history and current state of the American health care field in terms of the alignment of its normative, cognitive, and regulatory elements. I depict the relation between institutional elements in each of three historical eras of the health care field (Scott et al. 2000): the era of professional dominance (1945–1965), the era of federal involvement (1966–1982), and the era of managerial control and market mechanisms (after 1983 to the present). I argue that a weakening of alignment between these elements, beginning in the 1970s and increasing in the 1980s, led to consumer and provider dissatisfaction with managed care, and that the state of the field in the beginning of the 21st century suggests that a new era is emerging with renewed alignment between normative beliefs and values, cognitive models, and regulation. Implications for the future of health care and institutional theory are discussed.

The history of American health care has been told many times and in many ways, and yet the lessons of history remain elusive. If we knew how to use our knowledge of the past, we would be less apt to face yet another health care crisis in the present. With rapid and complex changes in technology, financing, and medical research, though, lessons of history necessarily reflect simpler times. In this paper, I use an institutional perspective (Scott 1994; 2001; DiMaggio and Powell 1991) to analyze the history and current state of the American health care field in terms of the alignment of its normative, cognitive, and regulatory elements. These three elements, or "pillars," constitute the system of meanings, norms, values, beliefs, and rules in which all organizations are embedded. The content of these pillars may change over time, but the presence of each is consistent in both simple and complex times. Thus an analysis of institutional pillars can help shed light on how to use history to lead American health care into the future.

To frame this analysis, I borrow the three historical eras of the health care field outlined by Scott and colleagues (Scott et al. 2000): the era of professional dominance (1945–1965), the era of federal involvement (1966–1982), and the era of managerial control and market mechanisms (after 1983 to the present). I argue that all three pillars of the institutional environment, in which the health care field was and is embedded, were in alignment prior to the 1970s. A weakening of alignment, beginning in the 1970s and increasing in the 1980s, pitted the cognitive and regulative pillars against the normative, which led to consumer and provider dissatisfaction with managed care. The tension of unaligned institutional elements has enabled a new era of the health care field, in which a renewed alignment is emerging. The ramifications of the schisms in the 1980s and early 1990s, however, have yet to fully play out. This analysis provides future directions for both the health care field and the institutional perspective.

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INSTITUTIONAL THEORIES, INSTITUTIONS AND FIELDS

Within the broad framework of institutional theories (Scott, 2001), this paper uses concepts from both "old" institutional theory, with its emphasis on the normative value of institutions, and "new" institutional theory, with its emphasis on cultural-cognitive models of organizing and meaning (see Scott, 1987; 2001; Selznick, 1996). In Selznick's original conception (1949; 1957), an institution was an organization that had become infused with value beyond the technical and instrumental aspects of its day-to-day operations (Selznick, 1957; 1996). This value took the form of a special mission, long history, or quality of uniqueness (Selznick, 1952). In today's parlance, an institution exists at a higher level of analysis than the organization: "institutions are composed of cultured-cognitive, normative, and regulative elements that, together with associated activities and resources, provide stability and meaning to social life" (Scott 2001:48).

This web of *normative*, *cognitive*, and *regulative* elements (or "pillars") makes up the "common meaning system" in which is embedded "a community of organizations whose participants interact more frequently and fatefully with one another than with actors outside" the community (Scott, 1994: 207–208). This community of organizations is the *organizational field:* "those organizations that, in the aggregate, constitute a recognized area of institutional life: key suppliers, resource and product consumers, regulatory agencies, and other organizations that produce similar services or products" (DiMaggio and Powell 1983:148). The institution (or institutional environment) constrains and enables the organizational field, providing culture, structure, and meaning, while at the same time, the field influences the institutional environment, through conformity and transformation (Hirsch and Lounsbury 1997).

The normative pillar of the institutional environment consists of values and beliefs, as well as the informal and diffuse rule systems that structure expectations and enforce mutual obligations between actors in an organizational field. Normative elements are "prescriptive, evaluative, and obligatory" (Scott 2001:54). The cognitive pillar of the institutional environment consists of "the shared conceptions that constitute the nature of social reality and the frames through which meaning is made" (Scott 2001:57). Conceptions, frames, and meaning systems include models of organizing and institutional logics. Models of organizing are sets of expectations for how organizations that provide certain functions or services should be structured. Institutional logics are sets of "material practices and symbolic constructions which constitute [a field's] organizing principles and which are available to organizations and individuals to elaborate" (Friedland and Alford 1991:248). To the neo-institutional theorist, these templates and scripts have more influence over organizational behavior than the social obligations of the normative pillar (Scott 2001; Selznick 1996; DiMaggio and Powell 1991).

The regulatory pillar of the institutional environment recognizes the authority of certain organizations and governments to formally constrain and enable organizational behavior. In contrast to the informal obligations of the normative pillar, "regulatory processes involve the capacity to establish rules, inspect others' conformity to them, and, as necessary, manipulate sanctions" (Scott 2001:52). Sanctions might include threat, coercion, or inducement. Although researchers often emphasize one pillar over the others (Scott 2001), all three exist at the same time within an institutional environment, with varying degrees of influence (Scott et al. 2000).

Health Care Field and the Institutional Environment

Based on the definition of an organizational field (DiMaggio and Powell, 1983), Scott and colleagues included four types of actors in their depiction of the organizational field of American health care: (1) organizations with governing authority, such as professional associations, public agencies, and corporate systems; (2) purchasers, including individuals, employers, and government programs; (3) providers, including physicians and other medical professionals, hospitals, and health care systems; and (4) intermediaries, such as insurance companies and health plans (Scott et al. 2000:34). Each of these organizations exists within a broad institutional environment, which contains normative, cultural-cognitive, and regulative elements. The normative aspects of the health care field include profes-

sional standards of training and care; expected relationships between physicians and other types of providers; and the value of providing high quality care that is accessible. Cultural-cognitive elements establish accepted models of organizing for hospitals, health care systems, and insurance plans, as well as beliefs that Western science should be the basis for medicine. The regulatory pillar consists of both professional associations that monitor their members (e.g., the American Medical Association) and local, state, and federal governments.

These three elements of the institutional environment translate into three predominant *logics*[1] at the forefront of the health care field at different times (Scott et al. 2000): (1) professional dominance (pre-1965), which defined physicians as the ultimate authorities, agenda-setters, and coordinators of the field; (2) federal involvement (1966–82), which legitimated the federal government's active involvement in the field in the realms of insurance (e.g. Medicare) and health planning; and (3) managerial control and market mechanisms, which introduced the belief in the power of market competition to solve problems of health care access, cost, and quality. These institutional logics influenced what perceptions and strategies were acceptable in each era, providing different justifications for behavior. The involvement of administrators in medical decision-making, for example, was more acceptable in the era of market mechanisms than the era of professional dominance.

In the Scott et al. configuration, one pillar of the institutional environment predominated in each era, but all three elements existed in each (Scott et al. 2000:316). The logic of professional dominance and the normative pillar had the most influence through the mid-1960s, but the logics of federal involvement and market mechanisms competed for influence with professional dominance during and after the 1970s. In the 1970s and early 1980s, federal involvement and the regulative pillar had more influence than market mechanisms and professional dominance; after the early 1980s, market mechanisms and managerial orientations and the cognitive pillar pulled into the forefront of defining meaning for the health care field. However, "all three logics retain considerable salience" in the 1990s, which makes the field more fragmented than when physicians' interests dominated the institutional environment (Scott et al. 2000:316).

This characterization simplifies the relations between logics over time and the consistency of their meanings across eras.[2] Specifically, in the two latter eras, it neglects to address how the two less dominant pillars were aligned, both with each other and with the dominant pillar, and what the consequences of these alignments were for the behavior of organizations and the overall meaning system of the field. An exploration of these alignments yields an improved understanding of how we arrived at our current state of the health care field and if and how we have moved into a new historical era.

HISTORICAL ALIGNMENTS IN THE HEALTH CARE FIELD

The Era of Professional Dominance, 1945–1965

American health care during the 1940s and 1950s reflected the height of Marcus Welby medicine (Dranove, 2000), with physician control over their patients locally and medical concerns and policies nationally. While it is unquestionable that physicians' interests dominated the health care field prior to the mid-1960s, there were hints of the cognitive and regulative changes to come during this era. Importantly, the presence of federal involvement and managed care was filtered through the normative pillar. Physicians not only controlled the norms and values of the field, but how government regulation was deployed and how meaning systems were created. This alignment allowed the unification of pillars and the dominance of one institutionalized belief system.

It is useful to remember that contention and competition among different forms of medical practice and philosophies of care led to the eventual dominance of orthodox Western medicine (Starr 1982). When orthodox physicians finally captured control of the health care field, they used their newfound legitimacy to continue a process of shaping the norms, beliefs, and values of the field. As they imposed their agenda on the field, they were building the institutional environment with foundational beliefs in the connection between science and medicine, the ability of the community of physicians to

be self-monitoring and self-policing, and the dedication to the highest quality of care. This agenda reached far beyond the individual physician and (almost always) his practice, to define the roles of other providers (e.g. nurses), the behavior and expectations of patients, the structure and culture of hospitals, the authority of governments, and the interpretation of deviant providers and organizations. In this sense, the era of professional dominance came at the tail-end of a narrowing of the health care field, and in hindsight, this narrow, highly structured field was short-lived.

An examination of deviance during this era brings the alignment of the institutional environment's pillars into focus. Precursors to the modern HMO, such as Kaiser Permanente and the Group Health Cooperative of Puget Sound, had existed since the 1940s (Luft 1981). These prepaid group practices (PGPs) generally were founded by physicians for the purposes of innovation instead of profit, and served local consumers and cooperative groups using prepayment financing and preventive health care (Dranove 2000). Because of their deviance from the accepted model of fee-for-service insurance and the potential for administrators to interfere with physician autonomy, early PGPs were actively opposed and persecuted by organized medicine (Starr 1982). At the local level, physicians involved in group practice were denied hospital privileges, membership in medical societies, and board certification (Smillie 1991; Hendricks 1993). At the national level, in the 1950s the American Medical Association (AMA) debated resolutions that would condemn group practice as a violation of patients' freedom of choice (*Time* 1954). In terms of the cognitive pillar of the health care field's environment, physicians made it clear that there was no room for alternative models of organizing.

The advantages of the PGP model, however, were beginning to make inroads in the eyes of the public and federal government. In the 1950s, Kaiser Permanente's innovations were profiled in *Time* and *The Saturday Evening Post* (*Time* 1953; Velie 1953). In 1951, The President's Commission on the Health Needs of the Nation recommended PGPs (Velie 1953), and the Federal Employees Health Benefits Act of 1959 mandated that federal employees have the option of a prepaid group practice if one was available to them. Even organized medicine began to back off—in 1959, the Larson report commissioned by the AMA found no evidence of lay interference in medical decisions in prepaid group practices and no differences in the quality of care given by physicians in PGPs compared with other doctors (Starr 1982). By the early 1960s, faced with no evidence of deficient care provided by physicians in group practice, the AMA became more supportive of PGPs but made no movement to encourage their growth (Stevens 1989).

These acts of legitimacy for PGPs should not be over-emphasized, however. Both federal legislation and AMA endorsement were not aimed at doctors currently following the norms of the field, but as an acknowledgement that a small minority of physicians could be allowed to make an alternate choice, because this choice (although deviant from standard practice configurations) was not deviant in terms of the delivery of actual medical care. After years of battling the establishment, the few doctors already in PGPs finally, grudgingly, were accepted into the club, but this acceptance did not redefine PGPs as a legitimate way for all doctors to practice. The physicians in PGPs won a war of attrition, but not a war of influence over the normative, cognitive, and regulative pillars of the institutional environment.

The Era of Federal Involvement, 1966–1983

The marker of the beginning of the era of federal involvement was the introduction of Medicare and Medicaid in 1965 (Scott et al. 2000), not just because of the new programs' provision of federal health insurance to the poor and the elderly, but because of their considerable contribution to the rapid cost inflation of medical expenditures in the late 1960s and early 1970s (Starr 1982; Robinson 1999). These new federal insurance programs for the elderly and poor brought increased federal involvement to insurance and issues of access to care, but were not intended to chip away at professional dominance. In this way, the normative pillar of the institutional environment (doctors' interests) and the regulative pillar (government rules and authority) were aligned, even though the regulatory elements of the environment changed significantly. Medicare and Medicaid also were consistent with the cognitive pillar (as defined by physicians), as

the new programs did not deviate from the normative value of improving access to care (Scott et al., 2000).

The disjoint in elements of the institutional environment began in the early 1970s, as the Nixon Administration looked to Health Maintenance Organizations as solutions to cost-escalation following Medicare and Medicaid's implementation. Amidst strategies to contain costs through health planning and regulation, policy makers sought "a strategy of indirection, an attempt to induce change in the larger system by building new, exemplary organizational forms" (Brown 1983:24). In 1970, Minnesota physician Paul M. Ellwood, Jr. coined the term "health maintenance organization" to broadly label prepaid group practices and other comprehensive health plans "whose common defining feature would be contractual acceptance of responsibility to provide a comprehensive range of service to members in exchange for prepaid premiums" (Brown 1983:207). At the time, three million persons, or just two percent of those with health insurance, were enrolled in health maintenance organizations (Miller and Luft 1994). Given the track record of Kaiser Permanente and other PGPs of reducing hospital costs through lower utilization (Starr 1982; Dranove 2000), Nixon committed to encouraging the growth of HMOs (Somers 1971; Starr 1982), both through including HMO enrollments and contracting in the 1972 amendments to the Social Security Act and in the HMO Act of 1973 (Zarabozo 2000).

After three years of Congressional consideration, the Health Maintenance Organization Act of 1973 introduced several programs to fulfill Nixon's strategy, including a federal subsidy for the development of new HMOs and a requirement that employers with twenty-five or more employees offer a federally qualified HMO as a health insurance option (Health Maintenance Organization Act of 1973, 1974). The Act's initial objective was to have 1700 HMOs established to serve 40 million Americans by 1976 (Starr 1982; Morrison and Luft 1990; Inglehart 1994), but it was riddled with fatal flaws: it was too complex yet too vague, with low subsidies but high requirements (Starr, 1982; Brown 1983; Robinson 1999). The actual number of HMOs established in the 1970s fell so short of the Act's goals that the "HMO program was . . . branded a government failure, an allegedly unworkable program embodied in a badly drafted law poorly administered by the federal bureaucracy" (Brown 1983:22). The Act is considered so dismal and ineffective that some prominent histories of the development of managed care do not even mention it by name (see Dranove 2000). By 1980, there were only about 200 HMOs nationwide with 9 million enrollees, of whom about 50 percent were members of Kaiser Permanente and several other large HMOs (Gruber, Shadle, and Polich 1988; Miller and Luft 1994). Federal efforts to promote HMOs had accomplished very little (Brown 1983:401).

Importantly, the HMO Act defined two types of HMOs: the prepaid group practice, and the individual practice association (IPA). The two types differed in their organization of physicians, particularly the connections of individual physicians to and the amount of their involvement with specific HMOs. HMOs would either employ physicians or contract with multispecialty groups to provide care for their members. IPAs would have a more traditional physician/insurer relationship, with solo practitioners and small groups of physicians contracting independently with HMOs to provide care (Christianson, Sanchez, Wholey, and Shadle 1991).

These two alternatives defined two cognitive realities, or in different words, a widening of cognitive scripts. The inclusion of the IPA as a type of HMO represented a political compromise: organized medicine supported IPAs because physicians could maintain their own offices and see fee-for-service patients from other health plans (Inglehart 1994). In this way, the IPA was a bow to the existing normative order and represented an alignment of cognitive, regulative, and normative pillars. The definition of the HMO, however, legitimized a model of organizing that, until this point, had been on the fringes of cognitive reality (Morrison and Luft 1990). This legitimation in its short-term consequences was not unlike earlier acknowledgements from the federal government (the Federal Employees' Health Benefits Act discussed above) and the AMA. The HMO Act confirmed that it was acceptable for physicians to join an HMO, but the endorsement of the IPA model demonstrated that the "old way" was the "natural" way of practicing medicine, entrenched in the normative order of the institutional environment. For

the maverick physician, it was no longer career-suicide to join an HMO, but there was no real incentive for the average physician to join. The average physician would not take on a new model of organizing if (now) he or she did not have to.

It should be noted that along with the newfound legitimacy for PGPs, the HMO Act did not delegitimize anything. The traditional ways of organizing medical care were not forced out of cognitive space, and in fact were re-legitimated by the HMO Act. The cognitive pillar expanded and the degree of field structuration decreased, in theory if not in practice. The ideal typical HMO was codified in constitutive legislation (Edelman and Suchman 1997), but the implications of this legislation did not materialize until a decade later. In 1965 Medicare and Medicaid created a watershed in the health care field by increasing federal involvement. The HMO Act, though often overlooked, marked a transition of its own: the planting of seeds that could weaken the alignment between the cognitive, regulative, and normative elements of the institutional environment, which led to a schism in the decades to follow.

The Era of Managerial Control and Market Mechanisms, 1984–1995?

In the early 1980s, a diversity of legitimate cognitive models of organizing medical care existed, at least in the eyes of the federal government. The Prospective Payment System (PPS) for Medicare, introduced by Congress in 1983 Social Security bailout legislation, transformed this simple plurality of acceptable models into a hierarchy. PPS established a general, standardized rate schedule for the majority of hospital procedures and services. Under PPS, if a hospital was able to treat a patient for less than the standard rate, it kept the excess, but if it incurred more costs than the rate allotted, it absorbed the loss. When federal budgetary deficits emerged in the 1980s, Congress repeatedly reduced Medicare's reimbursement rates. Hospitals responded by turning to privately insured patients to make up their losses (Morrisey 1994). This cost-shifting contributed to sharp increases in private indemnity insurance premiums (up to 30 percent a year in the mid-1980s [Miller and Luft 1994]).

Cost control in the public sector fueled medical inflation in the private sector, which triggered a massive switch to managed care insurance (Miller and Luft 1994; Drake 1997; Mayes 2001). In the mid-1980s, there was a "profound surge" in HMO development (Christianson, Sanchez, Wholey, and Shadle 1991): the number of HMOs tripled, from about 200 in 1984 to over 600 in 1987 (InterStudy 1998), and enrollment doubled from about 15 million to 30 million (InterStudy 1989). During the same time period, there was a proliferation of hybrid forms of HMOs and development of the preferred provider organization (PPO) (Morrison and Luft 1990). There were fewer than five PPOs in 1982 (Miller and Luft 1994), but over 330 by 1985 with 3.4 million enrollees (*Directory of Preferred Provider Organizations* 1985), and almost 800 by 1990 with 48 million enrollees (Jenkins, 1996). By the late 1980s, the "managed care continuum" (e.g. Hale 1988) contained a group of insurance plans and medical organizations with varying degrees of capitation and risk borne by providers, and a diversity of relationships between intermediaries and providers (Miller and Luft 1994).

The growth of HMOs coincided with, and even helped fuel, a change in the meaning systems of the health care field. In terms of the cognitive pillar of the institutional environment, in the 1980s the prevailing logic of the health care field had changed: in the place of normative control and professional dominance, market forces, price competition, and deregulation governed the field (Starr 1982; Dranove 2000; Scott et al. 2000). In the years that followed, the broad business models of utilization review, total quality management, and standardized treatment protocols were imported into the field (Dranove 2000). The growth of managed care itself supported market mechanisms—for-profit HMOs were driving force behind the surge of HMO development (Robinson 1999). These cognitive changes connected with regulative changes in ways that contrasted with the taken-for-granted normative values and beliefs that had held sway in the field for decades. The intention of Medicare PPS was not a wholesale shift in private insurance, but the ramifications of the pricing system made the HMO form "real." What was once a codified ideal type in the institutional ether hit the ground as a moving target, subject to adaptation and selective adoption of man-

aged care principles. As new forms of HMOs were developed, though, they were all subject to the new criteria for legitimacy in the health care field: efficiency and effectiveness.

Given these changes in the health care field, in the abstract, the normative pillar faced pressure to comply with the alliance of the new cognitive and new regulatory agenda. Physicians would either have to reinterpret the normative foundations of medicine in terms of efficiency instead of access and cost-effectiveness instead of quality, or they would exist in tension with the reigning meaning system. Because "the goal of HMOs is to reduce health care costs by monitoring physician practice and restructuring the role of the physician in service delivery" (Wholey, Christianson, and Sanchez 1993), physicians viewed managed care as anathema and thus were set up against health care administrators, legislators, corporations, and large insurance companies as a countervailing power (Light 1991; 2004). Countless aspects of physicians' professional socialization were undermined by business logics and regulatory constraints. Managed care fragmented the physician domain, letting non-physician practitioners and even administrators make medical decisions. It challenged their monopoly on scientific knowledge and their control over training, certification, and credentialing of medical practitioners. It undermined the very autonomy that characterized their profession in the first place (Freidson 1970).[3] It weakened their professional boundaries and weakened their professional claims. Professional dominance, in the world of managed care, was a fractured logic, knocked out of alignment with the prevailing pillars of the institutional environment.

Physicians were not bereft of influence over the field, however, and in this way the normative pillar managed to stay in business. The influence of physicians, and their unhappiness with the employment relations of traditional HMOs, is evident in the growth of IPAs and the development of network HMOs and PPOs in the mid-1980s. Within the HMO population, network HMOs and IPAs offered more freedom and flexibility for members and preserved traditional arrangements between patients and doctors, while still controlling costs. PPOs became a popular alternative to HMOs because they paid contracted physicians fee-for-service rates, at a discount or according to a fee schedule (Miller and Luft 1994). These innovations appeased physicians, who could maintain their own practices and treat patients from many different health plans, and patients, who could avoid "losing" their personal physicians due to HMO limitations. In a sense, these variants of the HMO eased the shock of managed care for doctors and patients who were used to fee-for-service medicine. Although historical indicators of normative strength (AMA membership, degree of specialization) in the 1980s and 1990s depicted an unstable normative order (Scott et al., 2000), a decline of core beliefs was not concomitant. Instead, core beliefs strengthened as the normative voice became one of resistance (Light 1991).

A NEW ERA OF REALIGNMENT?

At the turn of the twenty-first century, the dominance of managed care organizations in insurance indicated that they had "won the market test" (Dranove 2000:3). After 1998, traditional indemnity insurance made up less than ten percent of employer-sponsored health insurance enrollment, falling to about four percent in 2003 (AHA 2003). HMOs accounted for less than 25% of insurance enrollments, with the bulk of managed care insurance made up of PPOs and point of sale plans (AHA 2003). Medicare and Medicaid recipients were less likely than the general public to be enrolled in HMOs (AHA 2001), thus enrollments in all forms of managed care organizations reached about 70 percent of the total ensured population in 2000 (InterStudy 2000).

But at the same time, "managed care ha(d) utterly failed to win the trust of American patients" (Dranove 2000:3): "the chorus of opposition from physicians and other professionals, negative media coverage, repeated atrocity-type anecdotes, and bashing by politicians all contribute to the public's discomfort with new arrangements" (Mechanic 2001:37; see also Mechanic 2004). In the mid-1990s, a strong economy and tight labor market allowed provider and consumer dissatisfaction a voice, resulting in more types of managed care products and a relaxing of controls on physicians (AHA 2001). In 1999, the second largest insurer in the U.S., United Healthcare, ended most of its prior authorization requirements for enrollees (AHA 2001). Managed care organizations continued to dominate the insurance

market, but the meanings of managed care were in flux.

Reflecting on these trends, an American Hospital Association publication in 2001 asked "Is the managed care backlash permanent? Will strict utilization controls remain anathema in the market? Will restrictions on choice and access as a way to manage costs be replaced with better approaches to prevention and disease management?" (AHA 2001:6).

Examining changes in the health care field over the last decade in terms of the alignment of the pillars of the institutional environment, a variety of indicators do point to the possibility of a new era for American health care. Three main indicators are federal and state regulation, trends in utilization and managed care, and the strategic behavior of hospitals and other health care organizations. Changes in these areas point to a growing re-alignment of regulative, cognitive, and normative elements of the institutional environment of health care.

In terms of federal legislation, the 1997 Balanced Budget Act (BBA), although creating the "most drastic and dramatic changes to [Medicare] since its inception more than 30 years ago" (Silversmith 2000), was consistent with earlier Medicare legislation in the era of managerial control. In the 1990s, Medicare expenses grew more than 8 percent a year, home health care grew around 30 percent a year, and Medicare consumed 11.3% of the federal budget in 1995 (Silversmith 2000). Intended to save Medicare up to $115 billion between 1998 and 2002, the BBA created a prospective payment system for home health care and a per diem rate for skilled nursing facilities. It also introduced Medicare + Choice (Zarabozo 2000) and allowed states the authority to require Medicaid beneficiaries to join managed care organizations (Silversmith 2000). Not surprisingly, with new payment rates and prospective payment, the number of Medicare home health agencies decreased 32 percent from 1997 to 2000, Medicare home health spending dropped 48 percent, and skilled nursing utilization days decreased (Silversmith 2000). Facing losses of over $100 billion, hospitals successfully lobbied for the 1999 Balanced Budget Refinement Act, which restored $18 billion to Medicare (*Hospital Outlook*, 1999).

Although the BBA and amendments broadened the use of prospective payment for Medicare, in line with earlier cost-containment and efficiency concerns, other legislation at both the federal and state level confronted certain aspects of managed care head on. The 1996 Newborns' and Mothers' Health Protection Act mandated a minimum hospital stay of 48 hours for vaginal births and 96 hours for Cesarean births. The 1996 Mental Health Parity Act made illegal lower lifetime limits for mental health coverage than medical and surgical coverage. The 1996 Health Insurance Portability and Accountability Act placed limits on the preexisting conditions insurance providers could evaluate, and created ways to help people maintain continuous health coverage when changing or losing jobs. The 1997 BBA broadened federal insurance coverage of children through the State Child Health Insurance Program (SCHIP), which allows states to insure children up to age 19 who do not have health insurance, and who may not qualify for Medicaid. All of these laws sought to protect consumers and widen the health insurance safety net, in direct contrast to deregulation efforts of the 1980s.

State consumer protection legislation aimed at the market failures and most egregious aspects of managed care erupted in the mid-1990s. In 1995 and 1996, eight states enacted "patient bill of rights" or "patient protection act" legislation, and by 2002, all but three states (Alabama, Utah, and Wyoming) had such legislation in place (AHA 2001; Sloan and Hall 2002). The first wave of laws focused on physicians, as "organized medicine, a very effective political force, harnessed consumer dissatisfaction" (Sloan and Hall 2002:169) to push for any-willing-provider laws and inclusion of certain specialists in managed care networks. The next wave of laws focused on issues of access and quality of care: "liability and appeal provisions . . .; provisions affecting choice of and access to providers . . .; protecting providers from undue influence . . .; provisions governing general coverage standards (medical necessity and emergency care) and specific coverage mandates, such as minimum maternity stays" (Sloan and Hall 2002: 169–170). Although enforcement of these laws vary, consumer protection at the state level represents a new approach to the relationship between the insurers, physicians, and patients. Normative concerns of access, quality, patients' and physicians' rights regained a legislative agenda and voice.

In addition to changes in the regulatory pillar of the institutional environment, the mid-1990s saw a reversal of trends in several aspects of insurance and utilization. The annual change in health insurance premiums decreased to 0.8 percent in 1996 after an alarming 12 percent in 1988, but started to rise again in 1998, growing to 12.7 percent in 2002 (AHA 2003). The median operating margin of HMO plans hovered around 2 percent in the early 1990s, falling to 1.2 percent in 1995, becoming negative through the late 1990s, from –0.9% in 1996 to –3.5% in 1997 and 1998, back up to 0.2% in 2001 (AHA 2003). The percentage of Medicaid beneficiaries enrolled in Medicaid managed care leveled off in 1998 at about 56 percent, and the percentage of Medicare beneficiaries enrolled in Medicare managed care hits its peak in 1999 (17 percent), decreasing to 13 percent in 2002 (AHA 2003). Whatever impact managed care, and HMOs in particular, had made in controlling cost escalation in the health care field was short-lived.[4]

One of the main ways HMOs control costs is through reducing hospital utilization, but in the mid-1990s, the need for hospital services rose (AHA 2001). Inpatient admissions in community hospitals declined from peak in early 1980s of over 36 million, to a low through the late 1980s and early 1990s of around 31 million, then started increasing again in the mid 1990s, back up to 34 million in 2001. Since the U.S. population was growing at the same time, the rate of inpatient admissions per 1000 persons in the 1990s was lower than in the early 1980s, although not significantly lower than the rates in 1988 (AHA 2003). Total inpatient days fell during most of the 1990s, but began to increase in 1999 (AHA 2003). Overall, "the downward trend in inpatient use rates and volume began moderating in the mid-nineties as managed care backlash reduced payer pressures" (AHA 2001:1).

Accompanying these trends in increased hospitalization, outpatient services rose sharply in the 1990s and early 2000s. Compared to 1980, when there were about 200 million outpatient visits in community hospitals in the U.S., and 1990, where there were about 270 million, there were over 500 million outpatient visits in 2000 (AHA 2003). The number of hospital outpatient visits per 1000 persons has steadily increased since the late 1980s, from less than 1000 in 1980 to close to 1800 in 2000 (AHA 2003). Outpatient surgeries in freestanding facilities doubled between 1989 (15 percent) and 1999 (31 percent), and the percentage share of inpatient vs. outpatient surgeries in community hospitals increased from under 20 percent of surgeries as outpatient in 1980 to over 50 percent in 1993 (AHA 2003). Outpatient revenues as a percentage of total revenues for community hospitals increased from 13 percent in 1980, to 21 percent in 1988, 30 percent in 1995, and 35 percent in 2001 (AHA 2003).

Reacting to and in part creating these trends in utilization, hospitals and other health care organizations have exhibited a number of changed emphases in their strategic behavior. The number of freestanding ambulatory care facilities has increased dramatically, from 2425 in 1996 to 3570 in 2002, a increase of 46 percent (AHA 2003). Unlike the 1980s and early 1990s, when the number of hospitals owned by, managed by, or affiliated with integrated health care or multi-hospital systems increased steadily, the number has remained fairly constant since 1997 at around 2200 (the percentage continues to increase due to the shrinking of the hospital population overall, from 5732 in 1985 to 4927 in 2002).

Although the 1980s brought for-profit interests to the forefront of the health care field's meaning systems (Scott et al. 2000), most hospitals in the U.S. remain non-profit.[5] In 2002, the American Hospital Association annual survey identified 4927 community hospitals, of which only 766 were investor-owned (AHA 2003–4). Private, non-for-profit hospitals made up 62 percent of the total. Health care systems also are mostly non-profit. Of the 321 systems listed by the AHA in 2002, 43 were Catholic, 13 were owned by non-Catholic religious groups, 209 were non-profit, 51 were investor owned, and 5 were federal. Investor owned systems owned more hospitals than non-profit systems (an average of 21 versus 7 per system), but the overall number of hospitals in systems were primarily non-profit.

A number of corporate strategies geared toward increasing profits were less evident in hospitals after the mid-1990s. The volume of merger and acquisition activity declined 30 percent between 2001 and 2002; in 1998, 139 deals involved 287 hospitals, dropping to 110 deals involving 175 hospitals in 1999, then 58 deals involving 101 hospitals in 2002 (AHA 2003).[6] Hospitals also reduced their involve-

ment with physician relationships and insurance products. The number of hospitals with physician hospital organizations, IPAs, management service organizations, and group practices without walls peaked around 1996 (AHA 2003). The percentage of hospitals offering HMO insurance products hovered around 20 percent from 1994 to 2000, then dropped to 15 percent in 2001 (AHA 2003). The percentage of hospitals offering PPOs steadily declined from a high of 31 percent in 1997, to 18 percent in 2001; indemnity fee-for-service offerings declined from 10 percent in 1997 to 5 percent in 2001. These trends indicate that in the late 1990s, most hospitals went back to the business of being hospitals, as opposed to hospitals plus insurance providers and physician coordinators.

In light of these changes in regulation, utilization, and organizational behavior, did American health care enter a new era in the late 1990s? If so, have the regulatory, cognitive, and normative pillars of the institutional environment realigned? In other words, has the normative been brought back 'in'? Based on the indicators discussed above, the potential new era is characterized by a continued federal concern about cost-containment but a new legislative focus on consumer protection laws; a massive increase of outpatient activity, from surgeries to hospital visits, and a growing demand for inpatient care; and a peaking or decrease of the strategic behavior of the for-profit world. Consumer protection resonates with normative concerns of the past, including freedom of choice for patients and physicians. The decrease of corporate strategies may indicate less faith in the appropriateness of business models for the health care field. The increase in outpatient care and inpatient needs may demonstrate a reduced constraint of insurers on patient visits and treatment. Overall, the alignment of regulatory, cognitive, and normative interests may be on the path toward renewal.

IMPLICATIONS OF A NEW ERA AND CONCLUSIONS

If the health care field has entered a new era, what does that era imply for the state of the field and its future? In other words, what does this realignment "get" us as consumers of health care? Some researchers and observers argue the answer is: stagnation. Health policy specialists Sloan and Hall (2002) fault consumer protection laws for "their tendency to suppress the innovation and variation in medical care delivery that managed competition was meant to foster . . . the "backlash" mentality would like to rid the country of HMOs, or force them back into a traditional indemnity mold. Recent market trends indicate a move in this direction, with distinctions among different types of insurance becoming increasingly obscure" (Sloan and Hall 2002:205). In addition, they observe that "the market has not generated integrated delivery systems that offer fundamentally different styles of practice and care management, analogous to the choice in transportation markets among bicycles, motorcycles, Neons, and BMWs" (Sloan and Hall 2002:204).

In a more interest-based interpretation, Harvard business professor Christensen and physicians Bohmen and Kenagy argue that "health care may be the most entrenched, change-averse industry in the United States" (Christensen et al. 2000:102) because "regulators, litigators, insurers, physicians, hospitals, and medical schools have such powerful interlocking interests in the status quo" (Christensen et al. 2000:110). A host of problems result from this stagnation, some of which date back to the beginnings of modern medicine. Despite the growing use of quality measures, defining and assessing quality remains elusive (Dranove 2000). Patients also are still limited in their ability to acquire information about available options and find the best providers. There is great faith in the market, but the imperfections of the health care market have not changed significantly since economist Kenneth Arrow's treatise on the economics of health care (Arrow 1963; see also Light 1997). There may be pressures on health care organizations to be of high quality, but if quality cannot be measured accurately and consumers lack full information, innovations to differentiate organizations based on quality will not be the norm. In addition, costs continue to rise unabated.

Unlike in years past, in the new era "health care delivery is convoluted, expensive, and often deeply dissatisfying to consumers" (Christensen et al. 2000:104). The introduction of new types of practitioners, such as nurse practitioners and physician assistants, brings new competition to physicians, especially

those who practice primary care. Because professionals mobilize to resist new technology that would enable lower-status competitors to take over their jobs, in a kind of reverse Peter Principle, the industry forces specialists to practice at their lowest level of expertise (Christensen et al. 2000). At the same time, highly specialized diseases and injuries are given the lion's share of research funding and attention, while simpler disorders that make up the majority of medical cases are given short shrift. A field that has benefited for so long from technical innovations is in a position of rejecting innovations that would cause disruptions in staffing, organization, and professional identity (Christensen et al. 2000).

Where do solutions lie, if the health care field is in such a state? How do we move forward to create a field that provides better quality care efficiently and cost-effectively, accessible to most, if not all, consumers? From an institutional perspective, the most important steps to improve health care are abstract: in any change or innovation, work to coordinate and align the regulatory, cognitive, and normative elements of the health care field. This suggestion does not mean a return to the organizational structures and values of the era of professional dominance, which is infeasible (Robinson 1999; Dranove 2000). Instead, it means recognizing and incorporating the priorities of the normative pillar that have never left the American culture of health care: physician and patient choice; trust in providers, systems, and policy; physician autonomy over aspects of their professional organization and delivery of medical care; reasonably priced, high-quality treatment; and the provision of care to as many Americans (insured and uninsured) as possible.

In order to carry this suggestion forward, we need some new developments in institutional theory. Finer distinctions of the interplay between the three pillars of the institutional environment would help health care reform. What prevents or facilitates the influence of one element on another? How are norms and cognitive models used, intentionally and unintentionally, in regulation? How and when do cognitive elements of the field change norms? In addition, when and how does an organizational form become "real"? When the form materializes in some form in the field? When or if it is codified in legislation? Or when it is adopted by a critical number of organizations?

The arguments over the usefulness of "old" and "new" institutional theory are less relevant as scholars take a more integrated approach (Hirsch and Lounsbury 1997; Scott et al. 2000), but we still need a better understanding of how and why "values matter in the context at hand; how to build them into the organization's culture and social structure; and in what ways they are weakened and subverted" (Selznick 1996:271). This last point about subversion presages Hinings and Greenwood's recent point (2002) that organizational theory in general needs to bring back power as a central concept. If the health care field is stagnant because people in power are protecting their power, then we need a better understanding of how logics get created, supported, and maintained, while competing logics are blocked.

The future of health care in America thus seems to hinge on the acknowledgement that some vestiges of the era of professional dominance have not been lost, while at the same time the field is moving away from the era of managerial orientations and market control. The transitions to new eras over time do not mean that the components of the normative pillar of the institutional environment—our norms, beliefs, and values—have changed. It means that the playing field in which norms are interpreted and enforced (or not enforced) has different underlying structures, mechanisms, and goals. Economics prevent us from returning to the field of the past, but that does not mean managed care or what new models evolve in this time of transition should dismiss professional dominance outright. No matter how cognitively legitimate a model of organizing becomes, or how supportive regulation is, if the normative structures of a field do not evolve with new logics, changes in the field will never be fully accepted. When new forms contradict or ignore old values, doctors and patients are often the ones that get caught in the middle.

NOTES

1. Technically, a logic is part of the cognitive pillar of the institutional environment and not part of the normative or regulative elements. In this regard, I am taking liberties in my interpretation of logics and pillars as interchangeable. However, in the case of the Scott et al. eras, each particular logic relates

to and highlights the most influential pillar of the institutional environment at that time, as well as defines the primary meaning system. In practice, logics and pillars are intertwined.

2. Given the scope of Scott and colleagues' project, this observation is not intended to be a criticism.
3. Perceptions of the evils of managed care may not match reality. There is very little evidence, for example, that the amount of time physicians spend with patients has changed since the advent of managed care—in fact, the average amount of time for an office visit increased by a minute or two between 1989 and 1998 (Mechanic 2001).
4. Although health care premiums are currently rising, it is entirely possible that managed care will control costs again in the future.
5. Given the cost containment pressures nonprofit hospitals face from health plans and insurance companies (many for-profit), non-profit hospitals may be forced to behave more like investor owned hospitals. As one Catholic hospital CEO stated, "no margin, no mission." This development raises questions for institutional theory: if a non-profit hospital behaves like a for-profit hospital, should it be considered non-profit or for-profit? Are tax statuses and missions, or behaviors, more important for defining an organizational form and differentiating it from others?
6. This decline could be due to a number of factors, such as a changed belief in mergers and acquisitions as a viable strategy, or that the population of hospitals willing or in a position to deal has been depleted.

REFERENCES

AHA (American Hospital Association). 2001. "Forces Driving Inpatient Utilization." *TrendWatch*. 3 (3):November.

AHA (American Hospital Association). 2003. "Trends Affecting Hospitals and Health Systems." *TrendWatch Chartbook 2003*. Washington, DC: American Hospital Association.

AHA (American Hospital Association). 2003–4. *Guide to the Health Care Field*. Washington, DC: American Hospital Association.

Arrow, Kenneth. 1963. "Uncertainty and the Welfare Economics of Medical Care." *American Economic Review*, 53:941–973.

Brown, Lawrence D. 1983. *Politics and Health Care Organization: HMOs as Federal Policy*. Washington D.C.: The Brookings Institution.

Christensen, Clayton M., Richard Bohmer and John Kenagy. 2000. "Will Disruptive Innovations Cure Health Care?" *Harvard Business Review* September-October:102–112.

Christianson, Jon B., Susan M. Sanchez, Douglas R. Wholey, and Maureen Shadle. 1991. "The HMO Industry: Evolution in Population Demographics and Market Structures." *Medical Care Review* 48(1):3–46.

DiMaggio, Paul J. and Walter W. Powell. 1983. "The Iron Cage Revisited: Institutional Isomorphism and Collective Rationality in Organizational Fields." *American Sociological Review* 48:147–160.

DiMaggio, Paul J. and Walter W. Powell (eds.). 1991. *The New Institutionalism in Organizational Analysis*. Chicago: University of Chicago Press.

Directory of Preferred Provider Organizations and the Industry Report on PPO Development. 1985. Institute for International Health Initiatives.

Drake, David F. 1997. "Managed Care: A Product of Market Dynamics." *Journal of the American Medical Association* 277(7):560–564.

Dranove, David. 2000. *The Economic Evolution of American Health Care: From Marcus Welby to Managed Care*. Princeton, NJ: Princeton University Press.

Edelman, Lauren B. and Suchman, Mark C. 1997. "The Legal Environments of Organizations." *Annual Review of Sociology* 23:479–515.

Freidson, Eliot. 1970. *Professional Dominance: The Social Structure of Medical Care*. Chicago: Aldine.

Friedland, Roger and Robert R. Alford. 1991. "Bringing Society Back In: Symbols, Practices, and Institutional Contradictions." Pp. 232–263 in *The New Institutionalism in Organizational Analysis* edited by Walter W. Powell and Paul J. DiMaggio. Chicago: University of Chicago Press.

Gruber, Lynn R., Shadle, Maureen, and Polich, Cynthia L. 1988. "From Movement to Industry: The Growth of HMOs." *Health Affairs* Summer:197–208.

Hale, Judith A. 1988. *From HMO Movement to Managed Care Industry: The Future of HMOs in a Volatile Healthcare Market*. Minneapolis, MN: InterStudy.

Health Maintenance Organization Act of 1973. 1974. Explanation of Act and Text of Public Law 93–222. Prepared for the Subcommittee on Health of the Committee on Labor and Public Welfare, United States Senate. Washington, D.C.: U.S. Government Printing Office.

Hendricks, Rickey. 1993. *A Model for National*

Health Care: The History of Kaiser Permanente. New Brunswick, NJ: Rutgers University Press.

Hinings, C. R. and Royston Greenwood. 2002. "Disconnects and Consequences in Organization Theory?" *Administrative Science Quarterly* 47:411–421.

Hirsch, Paul M. and Michael Lounsbury. 1997. "Ending the Family Quarrel: Toward a Reconciliation of 'Old' and 'New' Institutionalisms." *American Behavioral Scientist* 40(4):406–418.

Hospital Outlook. 1999. "1997 Balanced Budget Act Gets Some Needed Refinement." 2(9):1–2.

Inglehart, John K. 1994. "The American Health Care System: Managed Care." Pp. 231–237 in Philip R. Lee and Carroll L. Estes (Eds.), *The Nation's Health* (4th edition). Boston: Jones and Bartlett.

InterStudy. 1989. *The InterStudy Edge.* Vol 1. Excelsior, MN: Interstudy.

InterStudy. 1998. *The InterStudy Competitive Edge 8.2. Part I: HMO Directory.* Bloomington, MN: InterStudy.

InterStudy. 2000. *The InterStudy Competitive Edge: HMO Industry Report 10.2.* St. Paul, MN: InterStudy.

Jenkins, Melanie A. (Ed.). 1996. *The Managed Care Yearbook.* Wall Township, NJ: Managed Care Information Center.

Light, Donald W. 1991. "Commentary: Professionalism as a Countervailing Power." *Journal of Health Policy, Politics, and Law* 16:499–506.

Light, Donald W. 1997. "The Restructuring of the American Health Care System." Pp. 46–63 in Theodor J. Litman and Leonard S. Robins, eds., *Health Politics and Policy*, 3rd ed. Clifton Park, NY: Delmar Learning.

Light, Donald W. 2004. "Introduction to the Special Issue" *Journal of Health and Social Behavior* 45(Extra Issue):1–24.

Luft, Harold S. 1981. *Health Maintenance Organizations: Dimensions of Performance.* New York: John Wiley and Sons.

Mayes, Rick. 2001. *Universal Coverage: The Elusive Quest for National Health Insurance.* Lanham, MD: Lexington Books.

Mechanic, David. 2001. "The Managed Care Backlash: Perceptions and Rhetoric in Health Care Policy and the Potential for Health Care Reform." *The Millbank Quarterly*, 79(1):35–54.

Mechanic, David. 2004. "The Rise and Fall of Managed Care." *Journal of Health and Social Behavior* 45(Extra Issue):76–86

Miller, Robert H. and Luft, Harold S. 1994. "Managed Care Plans: Characteristics, Growth, and Premium Performance." *Annual Review of Public Health* 15:437–459.

Morrisey, Michael. 1994. *Cost Shifting in Health Care.* Washington, DC: AEI Press.

Morrison, Ellen M. and Luft, Harold S. 1990. "Health Maintenance Organization Environments in the 1980s and Beyond." *Health Care Financing Review* 12(1):81–90.

Robinson, James C. 1999. *The Corporate Practice of Medicine: Competition and Innovation in Health Care.* Berkeley: University of California Press.

Scott, W. Richard. 1987. "The Adolescence of Institutional Theory." *Administrative Science Quarterly* 32:493–511.

Scott, W. Richard. 1994. "Conceptualizing Organizational Fields: Linking Organizations and Societal Systems. Pp. 203–221 in *Systemrationalitat und Partialinteresse*, edited by Hans-Ulrich Derlien, Uta Gerhardt, and Fritz W. Scharpf. Baden Baden, Germany: Nomos Verlagsgesellschaft.

Scott, W. Richard. 2001. *Institutions and Organizations*, 2nd ed. Thousand Oaks, CA: Sage.

Scott, W. Richard, Martin Ruef, Peter J. Mendel, and Carol A. Caronna. 2000. *Institutional Change and Healthcare Organizations: From Professional Dominance to Managed Care.* Chicago: University of Chicago Press.

Selznick, Philip. 1952. *The Organizational Weapon: A Study of Bolshevik Strategy and Tactics.* New York: McGraw-Hill.

Selznick, Philip. 1957. *Leadership in Administration: A Sociological Interpretation.* New York: Harper and Row.

Selznick, Philip. 1966 [1949]. *TVA and the Grass Roots: A Study in the Sociology of Formal Organization.* New York: Harper and Row.

Selznick, Philip. 1996. "Institutionalism 'Old' and 'New'." *Administrative Science Quarterly* 41:270–277.

Silversmith, Janet. 2000. "The Impact of the 1997 Balanced Budget Amendment on Medicare." *Minnesota Medicine*, 83 (December).

Sloan, Frank A. and Mark A. Hall. 2002. "Market Failures and the Evolution of State Regulation of Managed Care." *Law and Contemporary Problems* 65:169–208.

Smillie, John G. 1991. *Can Physicians Manage the Quality and Costs of Care?: The Story of the Permanente Medical Group.* New York: McGraw-Hill.

Somers, Anne R. (Ed.) 1971. *The Kaiser-Permanente Medical Care Program: One Valid Solution to the Problem of Health Care Delivery in the United States.* New York: The Commonwealth Fund.

Starr, Paul. 1982. *The Social Transformation of American Medicine.* New York: Basic Books.

Stevens, Rosemary. 1989. *In Sickness and In Wealth: American Hospitals in the Twentieth Century.* New York: Basic Books.

Wholey Douglas R., Jon B. Christianson, and Susan M. Sanchez. 1993. "The Effects of Physician and Corporate Interests in the Formation of Health

Maintenance Organizations." *American Journal of Sociology* 99(1):164–200.
Time Magazine. 1953. "Push-Button Hospital." June 29, pp. 55–56.
Time Magazine. 1954. "What is Free Choice?" July 5, p. 37.
Velie, Lester. 1953. "Supermarket Medicine." *Saturday Evening Post* 225(51):22–23, 44, 49–50.
Zarabozo, Carlos. 2000. "Milestones in Medicare Managed Care." *Health Care Financing Review* 22(1):61–67.

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