I. Medical uncertainty and the importance of trust in medical care.
   A. An important theme in studying doctors as a profession is that their professional work cannot be understood in terms of the economic market model
      1. Medical work is understood to combine
         a. esoteric technical knowledge,
         b. knowledge based on personal experience in practice, and
         c. patient cases that require idiosyncratic problem solving and creativity from the doctor
         d. so that non-doctors cannot evaluate it and people far from the local context cannot evaluate it
      2. Patients as customers cannot make rational market decisions
         a. they cannot evaluate the competence of doctors
         b. nor can they evaluate the interventions doctors recommend
      3. Absent market rationality, patients must evaluate care choices based on trust
         a. based in their individual relationship to their caregiver
         b. in relationship to a medical institution organized to respond to core altruistic values
         c. with the expectations that doctors will put care needs of patients ahead of personal profit choices
   B. The profession of medicine from its beginning around 1915 is organized on a principle that physicians must be trusted by society and cannot be evaluated or regulated by non-physicians
      1. Medical faculty select future doctors and this gives them control over the supply of doctors
      2. Medical quality is evaluated and controlled by doctors and the medical profession
      3. Until the mid-1970s, the medical profession represented by the American Medical Association (AMA) was the dominant force in medical policy making
      4. The dominant model of professional service was the fee-for-service model where individual doctors were autonomous, private businessmen
      5. Client service, physician autonomy, and belief that clinical intuitions and methods of practice had to be centered on physicians’ judgment and their relationships with patients were central values

II. The origins and growth of health insurance
A. Health insurance emerged as a nonprofit service in the form of Blue Cross and Blue Shield and a partnership between hospitals, doctors, and the local businessmen who gave philanthropic support to the system.

B. From the 1930s until 1970 or so health insurance for working people was overpriced to allow for cross-subsidization of hospital expenses and payment for the medically indigent.

C. Insurance is effective to the extent there is a pool of healthy people who can afford coverage that is large so that their payments can easily cover the expenses of the sick and the indigents.

D. Health insurance grew in coverage through World War II and into the 1950s at which point for-profit insurance companies entered the market.

E. For profit companies competed by charging rates that more accurately reflected the true price of patient risk and this gradually eroded cross-subsidization support for indigent medical care.

F. Coupled with rising medical costs, the erosion of cross-subsidization increased the number of people not insured.

III. Medicare, Medicaid and health care cost inflation

A. Medicare and Medicaid which were passed by the federal congress in the mid-1960s are one of the largest and most important policy innovations in U.S. history since they dramatically expanded the pool of people covered by health insurance.

B. However, by expanding the number of people covered they contributed to a sudden and continuing pattern of health care cost inflation simply because many more people were in the system.

C. Expansion of the people insured also opened opportunities for medical fraud and exploitation by doctors and health care companies.

D. Expansion of the need for physicians led to funding of more medical school slots and this had the unintended effect also of expanding and elaborating the number of students trained in medical specialties.

IV. The expansion of medical specialties, regional imbalances, and the disconnection between the amount spent and health care quality

A. The expansion of medical specialties pushed up health care costs because
   1. if specialists exist in a community in large numbers they will order excess care
   2. the excess care often does not result in improvement in health outcomes
   3. it does produce imbalances in health care spending between communities

B. Medical practice, malpractice, and definition of appropriate practices is organized in terms of the medical community that exists in a locality and these communities often are quite geographically restricted.
C. One aspect of local medical communities is that their norms of practice are defined in terms of accidents of local history and in terms of who it is who is the dominant specialist in an area of practice.

D. Research by Fisher and Wennberg showed that there are big differences in preferred medical practices from community to community

E. These differences in norms of practice also lead to large differences in health care costs from community to community

F. But these differences in cost are not reflected in differences in health outcomes

G. Local preferred physician practices also may not conform to the best findings of scientific research.

H. This reality has contributed to the imposition of evidence based medical care by insurance companies, the government, and large HMOs and other health care institutions.

V. The emergence and growth of non-physician health industries

A. Mahar details specific points of policy change through the 1970s and 1980s when medical manufacturing institutions were given greater autonomy so that they were able to grow rapidly

B. A fair assessment would point out that medical technology also grew in sophistication and effectiveness in the period raising costs

C. With the growth of size and profitability of drug companies, medical equipment suppliers, insurance companies, and hospital chains they also became dominant political lobbies pushing for certain policies and types of health care

VI. The emphasis on acute medical care and disinterest in prevention and population health

A. One consequence is that the medical system lavishly reimburses acute medical care interventions where it will not fund preventive care programs

B. One consequence is that we spend huge amounts of money on medical care while we do not provide the kinds of health care that would most improve the overall health of the population