Review Essay

Medical Care and the State

J. Rogers Hollingsworth, Jerald Hage, and Robert Hanneman. *State Intervention in Medical Care: Consequences for Britain, France, Sweden, and the United States, 1890–1970.* Ithaca, NY: Cornell University Press, 1990. 266 pp. $46.50 cloth, $15.95 paper.

David Wilsford. *Doctors and the State.* Durham, NC: Duke University Press, 1991. 355 pp. $49.95 cloth, $19.95 paper.

One of the paradoxes of American health policy is the coexistence of anti-government attitudes and the increasing role of the federal government in medical care. As Lawrence Brown (1991: 40) put it, "For sixteen of the last twenty years the federal executive branch has played the activist *malgré lui*; the Nixon, Ford, Reagan, and Bush administrations have all expanded federal intervention in the health sphere despite ideologies that honor deregulation and reprivatization."

Since the passage of Medicare and Medicaid in 1965, the government's role has evolved beyond its historic function of providing medical care to specific populations, funding public health programs at the federal level and licensing physicians at the state level. It now finances medical care for the elderly, the very poor, and the severely handicapped; regulates hospitals and capital expenditures on new medical technologies; and most recently, launches new initiatives, e.g., hospital and physician payment

reform, quality assurance programs, technology assessment, the publication of risk-adjusted hospital mortality rates, and the financing of research on clinical practice guidelines and the effectiveness of medical procedures.

In contrast to their Canadian and European colleagues, American physicians find their clinical autonomy rapidly eroding as their day-to-day activities are increasingly subject to review and approval by administrative personnel working for government-financed and -mandated peer review organizations, employers, or private insurance carriers. Why, in a country notorious for its suspicion of concentrated power centers and excessive governmental authority, have American physicians become, in the words of Philip Lee and Lynn Etheredge (1989), "the most litigated-against, second-guessed and paperwork-laden physicians in Western industrialized democracies"?

The answer to this question may lie in the importance of centralized private power—large payers and purchaser coalitions—both of which have, in many ways, been more aggressive toward the medical profession than the government, thus making American style state intervention seem relatively unobtrusive. This view of a weak American state, in comparison to other industrialized nations, is widely shared and emerges, once again, in two comparative studies of medical care and the state in the United States and Europe.

State Intervention in Medical Care, by Hollingsworth, Hage, and Hanneman, adopts a broad macrosociological and historical perspective on the consequences of state intervention in medical care from 1890 to 1970 in the United States, Britain, France, and Sweden. *Doctors and the State*, by David Wilsford, adopts a focused political science perspective on the relationship between doctors and the state, mostly since the 1960s, in France and the United States.

Both studies reveal years of meticulous research. They are full of insights and provocative findings. They appear, however, to gloss over the importance and complexity of multiple governments in the United States—fifty state and 82,290 local government units—and the significant variations between these units in the government's role in medical care (Brecher 1990). New York State, for example, is on the high side of the state intervention spectrum. It organizes quality assurance reviews of its hospitals and regulates the number of hours that interns and residents may work.

Both studies also undervalue, or neglect, distinctly American and growing forms of federal intervention in the United States; for example, the government's encouragement of competition, its financing of health services research, the requirement by Medicare and Medicaid that hospitals be accredited by the Joint Commission on Accreditation of Hospitals, and the important role of the state in monitoring health care expenditures and utilization.

Hollingsworth et al. claim to present "a new paradigm of comparative macropolicy analysis and to apply it to the performance of national medical systems" (p. 28). Given the well-known difficulties of measuring the performance of medical systems, few studies have attempted so ambitious a task. Their major findings may be summarized as follows:

1. Medical care costs tend to rise with state subsidies for the financing of medical care, when the price of medical care services and the appointment of personnel are not controlled.
2. Control over the prices of medical care services and the appointment of personnel, as well as the level of medical care expenditures, the number of physicians per capita, and the number of specialists as a proportion of physicians, all have a direct effect in reducing age-standardized mortality rates. Hollingsworth et al. interpret these findings not as a rejection of McKeown's (1975) thesis that improvements in the standard of living have caused a decline in mortality rates, but rather as a refinement, insofar as the effect of improvements in the standard of living on mortality are "mediated" by the delivery system.
3. Increasing levels of professional density and specialization tend to speed both adoption and diffusion of medical innovations, while more state centralization tends to slow adoption but speed their diffusion.
4. Social efficiency, defined as the level of health among the population per unit of expenditure in the medical care system, has tended to fall; however, where the state controls the price of medical services and the appointment of personnel, social efficiency tends to improve when all other factors affecting social efficiency are held constant.
5. State intervention is far more effective in equalizing access to medical care and the distribution of resources than in equalizing health outcomes.

What Hollingsworth et al. tell us is that state intervention in medical care is, for the most part, good. It helps control costs, it improves the population's health, it leads to social efficiency, it leads to faster diffusion of low-cost technologies and slower adoption of high-cost technologies,

and it increases equality of access to medical services and reduces inequality in the geographic distribution of medical resources. Finally, in their concluding reflections on state intervention and privatization, the authors claim to debunk the myth that privatization in the delivery of medical care helps reduce costs and that competition improves efficiency.

In some respects, this study is an empirical tour de force. Its findings are based on an enormous amount of data analyzed with the conventional tools of social science: reviews of relevant literature, elaboration of path models, construction of weighted indices and the use of multiple regression techniques. Although the authors appear to view social science as a kind of social physics replete with hypothesis testing and measurement, they are well aware of the specification problems involved in imposing causal orderings on independent variables. For example, they recognize that health levels are "mediated" by a host of other factors and that the variables they examine are not independent. Moreover, they elaborate on the potential biases that result from models that fail to account for complex feedback effects.

In the appendices, the reader will find many necessary qualifications about the data, the indices, and the findings. The authors note, for example, that "interpretational biases are proportional to the relative magnitudes . . . of the feedback relationships" (p. 225). The problem is that nothing—neither in the data, nor in the relevant theory, nor anywhere else in the book—provides a clue as to what these magnitudes are. As with the specification of their path models, the authors rely on their best judgment which, in my judgment, is sound, albeit with one possible exception—their central concept of state intervention.

Hollingsworth et al. conceive of state intervention as "a form of centralization . . . the degree to which the power to coordinate the activities of society's medical system is concentrated in the state" (p. 9). In operational terms, they focus on the extent of public financing of medical care and on the state's role in setting the prices of medical care services and appointing personnel. The authors believe that a strong state role in the performance of these functions reflects a high degree of state intervention whereas a weak role corresponds to what they call privatization. According to this concept of state intervention, the United States is clearly at the private end of the spectrum. However, the analysis is misleading on two grounds.

First, because the data do not go beyond 1970, Hollingsworth et al. neglect to analyze the growth of state intervention in the United States and the withdrawal of important state functions in Britain. Since 1970 in the United States, there have been major state initiatives in hospital rate regulation. Moreover, Medicare's prospectively and centrally set prices for hospitals and the new physician payment reforms represent a significant increase in the federal government's role. In Britain there has been a significant decrease of state control over prices and appointment of personnel since the implementation of the National Health Service reforms of April 1991, which established hospital trusts and general practitioner budget holders.

Second, Hollingsworth and his coauthors rely on an exceedingly limited concept of state intervention and underplay the importance of several critical state functions. For example, they merely mention, *en passant*, the role of the federal government in designing tax incentives (p. 75); they ignore the role of municipal bonds in hospital capital financing; and they overlook the extent of so-called "voluntary regulation," backed up by government sanctions in cases of noncompliance—e.g., the standards of the Joint Commission on Accreditation of Hospitals and uniform reporting requirements for hospitals. In addition, the authors ignore the role of government—at federal, state, and local levels—in utilization review and quality assurance activities, including the publication and dissemination of risk-adjusted hospital mortality rates for the Medicare population. Only in the United States, where state intervention is presumably weak, is the government strong enough to "get away" with the publication of this sort of information, to provide rhetorical as well as minimal economic support for alternative delivery systems, and (along with Britain since 1991) to promote competition.

In adopting a narrow concept of state intervention and by focusing on the problems of measuring state intervention across nations and over time, Hollingsworth and his coauthors place little emphasis on what Hall (1986: 5) calls the "interaction of interest groups, institutions and ideas." They do argue, in relation to factors affecting health care costs (chap. 2) and in their final chapter, that "physicians are more dominant over ambulatory and hospital care the more the medical system is privatized" (p. 182). However, their aggregative, data-driven approach to the comparison of four countries makes it difficult to expand, let alone explain, such a broad proposition.

David Wilsford's book, *Doctors and the State*, lends some support to Hollingsworth et al.'s argument that physicians are more dominant in more privatized health systems. It also adds much needed contextual clarity and political insight. Through the use of careful case study analysis, Wilsford expands the concept of state intervention by comparing the nature of state

structures, the power of the medical profession, and their interactions in France and the United States.

One important interaction is that between representatives of private fee-for-service medical practice—*la médicine libérale*—and the French state. Paul Cibrie (1954), the first general secretary of the first French physicians' trade union, who anticipated, as early as 1929, in a letter to the minister of labor, what French policymakers did not realize until 1960 and what American policymakers did not realize until the late 1980s—that national health insurance (NHI) and the right of physicians to set their own fees are incompatible:

> We understand administrative procedure well enough to know that the (health insurance) funds will want to impose allowable charges and third-party payment. And we have great difficulty identifying an impartial institution capable of arbitrating between the opposing positions of the medical profession and that of the health insurance funds.

Cibrie's concern was well warranted, for in France, as well as in the rest of Europe and the United States, the institution charged with regulating health insurance has been the state. And its role has expanded from simply regulating reimbursement rates, to collecting data, monitoring physician practice patterns, and more generally, shaping the organization and practice of medicine.

Wilsford notes that the growth of state intervention in all industrialized nations is a response to what he calls the "fiscal imperative." This is his only concession to convergence theory; aside from this general proposition, he emphasizes some significant differences between France and the United States. Wilsford argues that the French state is strong while the American state is weak, and the French medical profession is highly divided while the American medical profession is relatively united. He then goes on to explore how these two "independent variables"—state structures and the cohesion of the medical profession—affect health care policy-making in France and the United States.

The major contribution of *Doctors and the State* is its detailed analysis of the French health care system—an NHI system that deserves considerably more attention than it has received by American policy analysts (Godt 1986; Rodwin 1981). French NHI is organized around three national funds and financed through the social security system on the basis of compulsory employer and employee payroll taxes. Ninety-nine percent of the population is covered with comprehensive health benefits and there are no restrictions on provider choice. In contrast to the United States, most hospitals (two-thirds) are public and the remainder are private, half of which are private-for-profit. But like the United States, ambulatory care is dominated by private fee-for-service practice and relies heavily on co-payments.

Wilsford focuses on French health care politics. His thesis is that American physicians have more successfully resisted government initiatives to contain costs and otherwise intervene in the health care system than their colleagues in France. Wilsford also suggests that "state initiatives in France are more comprehensive, more coherently connected and more sustained than either state or private initiatives in the United States" (p. 264). He concludes that although American physicians have lost some independence and power due to the "fiscal imperative," French physicians have suffered a far more serious setback.

In making these arguments, Wilsford sifts through relevant literature on the centralized and powerful nature of the French state and on what he calls (in chapter 3) the "stateless American state," characterized by "extreme privatism, extreme fragmentation, and extreme decentralization" (p. 82). Moreover, Wilsford presents carefully researched case studies—not always in support of his positions—on key health policy issues in France and the United States. Finally, he examines the consequences of French and American patterns of policy-making on the political activities of organized medicine and suggests a fruitful area in which to pursue his research by examining his hypotheses in Britain, Canada, Japan, and West Germany.

Doctors and the State is an important contribution to understanding the nature of state intervention in medical care. Wilsford has successfully captured some important differences between health care politics in France and the United States. But like so many of us, he has succumbed to the temptation of falling so much in love with his thesis that he has perhaps taken it too far. Three questions, for example, point to evidence contradicting Wilsford's thesis that the French state has more control over health policy and the medical profession than the American state and that French physicians have less independence than their American counterparts.

First, if the policies of the French state are so "comprehensive, more coherently connected and more sustained" than those of the American state, why has its performance in controlling health care costs been ineffective? France's health care expenditures, as a percentage of gross domestic product, are the third highest of all the Organization for Economic Co-operation and Development countries, after the United States and Canada in 1990 (OECD 1991). Their annual rate of increase, in constant prices,

from 1975 to 1990, has averaged 5.3 percent compared to 3.6 percent in the United States (OECD 1991).

Second, if the French state, with all of its "tactical advantages," is so strong, why, as I write this review in Paris, in February of 1992, have the NHI funds and the government so far been unable to impose their position, held since July 1991, that there must be an expenditure target for the services of all physicians in private fee-for-service practice (Durieux 1991)? In this respect, the Omnibus Budget Reconciliation Act of 1989 (OBRA89) establishing "volume performance standards" for all physicians treating Medicare patients has gone beyond the present capacity of the French state to impose expenditure restraints on physicians. Moreover, in contrast to American physicians who do not accept assignment under Medicare, but who are, nevertheless, bound by percentage limits that they may not exceed, French physicians who do not accept assignment may charge whatever they wish.

OBRA89, along with the prospective payment system based on diagnosis-related groups and passed in 1983, are both examples of federal intervention in the payment of health care providers under Medicare and reveal a significant degree of state autonomy overlooked by Wilsford in the United States (Brown 1985; Rodwin 1989). As Brown (1991) argues, Medicare and Medicaid broke the traditional pluralist pattern that made of government a largely passive reflector of the balance of power among interests in society . . . it soon became an 'interest' with an increasingly 'corporate' sense of self and the commanding presence of the proverbial 800-pound gorilla" (p. 40).

Third, if French physicians are so weak compared to their American counterparts, why has the French centralized state been forced to back down on a number of issues dear to organized medicine? It is true, as Wilsford notes, that physician fee levels, as well as their incomes, are far lower in France than in the United States. If income is the relevant indicator of physician independence or autonomy, then Wilsford's argument is infallible. But for those of us who agree with Uwe Reinhardt (1987), as I do, that American physicians have traded off a loss of autonomy in clinical decision making for high incomes, the power of French physicians still appears vast despite what Wilsford rightly calls their "organizational particularism."

French physicians, particularly specialists and professors, are still enormously prestigious citizens—*notables*. Roughly 10 percent of the deputies in the French National Assembly are physicians and they exercise disproportionate power over health policy. In addition, French public hospitals

are still organized around service units with chiefs who retain enormous power (compared to their colleagues in the United States) over the internal organization of their "kingdoms," including admissions, discharges, lengths of stay, and medical records. That is why attempts to reform hospitals, by reorganizing services into departments, failed—a point clearly acknowledged by Wilsford whose explanation is that "paradoxically the strong French state is sometimes weak indeed" (p. 270).

In stark contrast to their American colleagues, French physicians refuse to reveal the procedures they perform and their patients' diagnoses to the NHI funds. As a result, the French state and NHI funds have none of the information and tools available to the American state and private insurers to manage medical care through the use of such widespread American techniques as preadmission hospital reviews, control over hospital lengths of stay, and detailed monitoring of physician practice patterns.

Hollingsworth and his coauthors, as well as Wilsford, have produced important studies on medical care and the state. Both studies, however, tend to exaggerate the half-truth that the American state pales in comparison to its counterparts in Europe. Neither study pays sufficient attention to the growing role of the American state in promoting the management of medical care, financing research on medical care effectiveness and practice guidelines, and disseminating information on hospital outcomes and research findings.

In future comparative research on medical care and the state, it may be helpful to transcend the strong state versus weak state dichotomy and to examine more closely the wide range and changing tools of government action. What tools, for example, are most effective for the implementation of different policy goals? And to what extent does the use of different tools reflect something about differences in institutional structure and culture, and perhaps even in societal preferences and understandings?

Victor G. Rodwin, New York University

References

Brecher, Charles. 1990. The Government's Role in Health Care. In *Health Care Delivery in the United States*, ed. Anthony Kovner. New York: Springer.

Brown, Lawrence. 1985. Technocratic Corporatism and Administrative Reform in Medicare. *Journal of Health Politics, Policy and Law* 10 (3): 579–99.

———. 1991. Health Services Research as a Political Resource. In *Health Services Research: Key to Health Policy*, ed. Eli Ginzberg. Cambridge, MA: Harvard University Press.

Cibrie, Paul. 1954. *Syndicalisme médical*. Paris: Confédération des Syndicats Médicaux Français.

Durieux, Bruno. 1991. Gérer la santé. *Le Monde*, 19 September, p. 1.

Godt, Paul. 1986. Doctors and Deficits: Regulating the Medical Profession in France. *Public Administration* 63 (2): 151–69.

Hall, Peter. 1986. *Governing the Economy: The Politics of State Intervention in Britain and France*. New York: Oxford University Press.

Lee, Philip, and Lynn Etheredge. 1989. Clinical Freedom: Two Lessons for the UK from US Experience with Privatisation of Health Care. *Lancet* 4 (February): 263–65.

McKeown, Thomas. 1975. *Medicine in Modern Society*. London: Allen and Unwin.

OECD (Organization for Economic Cooperation and Development). 1991. *OECD Health Data, 1991*. Paris: OECD.

Reinhardt, Uwe. 1987. Resource Allocation in Health Care: The Allocation of Lifestyles to Providers. *Health and Society* 65:153–76.

Rodwin, Victor. 1981. The Marriage of NHI and *la médicine libérale*: A Costly Union. *Health and Society* 59 (1): 16–43.

———. 1989. Physician Payment Reform: Lessons from Abroad. *Health Affairs* 8:76–86.

Books Received

AIDS

AIDS and the Hospice Community. Madalon O'Rawe Amenta and Claire B. Tehan. Binghamton, NY: Haworth, 1992. 186 pp. $24.95 cloth, $14.95 paper.

AIDS: The Making of a Chronic Disease. Edited by Elizabeth Fee and Daniel M. Fox. Berkeley and Los Angeles: University of California Press, 1992. 436 pp. $45.00 cloth, $15.00 paper.

AIDS, Women, and the Next Generation: Towards a Morally Acceptable Public Policy for HIV Testing of Pregnant Women and Newborns. Edited by Ruth Faden, Gail Geller, and Madison Powers. New York: Oxford University Press, 1991. 374 pp. $39.95 cloth.

A Community Approach to AIDS Intervention: Exploring the Miami Outreach Project for Injecting Drug Users and Other High-Risk Groups. Dale D. Chitwood, James A. Inciardi, Duane C. McBride, Clyde B. McCoy, H. Virginia McCoy, and Edward Trapido. Westport, CT: Greenwood, 1991. 248 pp. $49.95 cloth.

Comparative Health Policy

Comparative Health Policy and the New Right: From Rhetoric to Reality. Edited by Christa Altenstetter and Stuart C. Haywood. New York: St. Martin's, 1991. 332 pp. $59.95 cloth.

The Welfare State in Israel: The Evolution of Social Security Policy and Practice. Abraham Doron and Ralph M. Kramer. Boulder, CO: Westview, 1991. 194 pp. $32.00 paper.

Economics and Finance

The Costs of Poor Health Habits. Willard G. Manning, Emmett B. Keeler, Joseph P. Newhouse, Elizabeth M. Sloss, and Jeffrey Wasserman. Cambridge, MA: Harvard University Press, 1991. 224 pp. $29.95 cloth.

The Economics of Care of the Elderly. Edited by Jozef Pacolet and Celeste Wilderom. Brookfield, VT: Ashgate Publishing, 1991. 233 pp. $52.95 cloth.

The Economics of Child Care. Edited by David M. Blau. New York: Russell Sage Foundation, 1991. 192 pp. $24.95 cloth.

Evaluating Health Maintenance Organizations: A Guide for Employee Benefits Managers. Perry Moore. Westport, CT: Quorum Books, 1991. 208 pp. $45.00 cloth.

Financing Home Care: Improving Protection for Disabled Elderly People. Edited by Diane Rowland and Barbara Lyons. Baltimore, MD: Johns Hopkins University Press, 1991. 256 pp. $47.50 cloth.

Participation in Alternative Health Plans: The Role of Financial Incentives in Medicare Beneficiaries' Decisions. M. Susan Marquis and Jeannette A. Rogowski. Santa Monica, CA: RAND, 1991. 70 pp. $7.50 plus $2.00 handling, paper.

Pharmaceutical Marketing: Strategy and Cases. Mickey C. Smith. Binghamton, NY: Haworth, 1991. 408 pp. $49.95 cloth, $24.95 paper.

Health Services Delivery

The Changing Context for Social-Health Care: Its Implications for Providers and Consumers. Edited by Helen Rehr and Gary Rosenberg. Binghamton, NY: Haworth, 1991. 143 pp. $22.95 cloth, $14.00 paper.

The Ends of Time: Life and Work in a Nursing Home. Joel S. Savishinsky. Westport, CT: Bergin and Garvey, 1991. 304 pp. $49.95 paper.

Health Care Delivery: Current Issues and the Public Policy Debate. Edited by Ronald Kaufman, John Naughton, Marian Osterweis, and Elaine Rubin. Washington, DC: Association of Academic Health Centers, 1991. 169 pp. $19.95 paper.

Improving Access to Health Services for Children and Pregnant Women. Joshua M. Wiener and Jeannie Engel. Washington, DC: Brookings Institution, 1991. 90 pp. $8.95 paper.

Women and Health. Prepared by Patricia Smyke. Atlantic Highlands, NJ: Humanities Press International, 1992. 182 pp. $15.95 paper.

Law and Ethics

Aging and Ethics. Edited by Nancy S. Jecker. Totowa, NJ: Humana, 1991. 408 pp. $32.50 cloth.

Bioethics and the Fetus. Edited by James M. Humber and Robert F. Almeder. Totowa, NJ: Humana, 1991. 200 pp. $39.50 cloth.

Essays in Therapeutic Jurisprudence. David B. Wexler and Bruce J. Winick. Durham, NC: Carolina Academic Press, 1991. 336 pp. $34.95 cloth.

Insuring Medical Malpractice. Frank A. Sloan, Randall R. Bovbjerg, and Penny B. Githens. New York: Oxford University Press, 1991. 241 pp. $35.00 cloth.

Miscellaneous and How-to

The Alexander Technique: A Complete Course in How to Hold and Use Your Body for Maximum Energy. John Gray. New York: St. Martin's, 1991. 176 pp. $10.95 paper.

Cocaine Changes: The Experience of Using and Quitting. Dan Waldorf, Craig Reinarman, and Sheigla Murphy. Philadelphia: Temple University Press, 1991. 326 pp. $34.95 cloth.

The Essential Guide to Psychiatric Drugs. Jack M. Gorman. New York: St. Martin's, 1992. 397 pp. $14.95 paper.

The Injury Fact Book. Susan P. Baker, Brian O'Neill, Marvin J. Ginsburg, and Guohua Li. New York: Oxford University Press, 1991. 344 pp. $31.95 cloth.

Politics and Policy

Balancing Access, Costs, and Politics: The American Context for Health System Reform. John Holahan, Marilyn Moon, W. Pete Welch, and Stephen Zuckerman. Lanham, MD: Urban Institute Press, 1991. 92 pp. $13.25 paper.

From Pragmatism to Vision: Leadership and Values in Academic Health Centers. Edited by Clayton Rich, Anthony Barbato, and John Griffith. Washington, DC: Association of Academic Health Centers, 1991. 103 pp. $14.95 paper.

Hazardous Waste and Human Health. British Medical Association. New York: Oxford University Press, 1991. 242 pp. $35.00 cloth, $12.95 paper.

Health Care Politics, Policy, and Distributive Justice: The Ironic Triumph. Robert P. Rhodes. Albany: State University of New York Press, 1992. 339 pp. $16.95 paper.

A History of Education in Public Health: Health that Mocks the Doctor's Rules. Edited by Elizabeth Fee and Roy M. Acheson. Cary, NC: Oxford University Press, 1991. 349 pp. $49.95 cloth.

Open Season: A Survival Guide for Natural Childbirth and VBAC in the 90s. Nancy Wainer Cohen. Westport, CT: Bergin and Garvey, 1991. 464 pp. $29.95 cloth, $16.95 paper.

Structures of Control in Health Management. Rob Flynn. New York: Routledge, Chapman, and Hall, 1991. 218 pp. $67.50 cloth.

Toxic Politics: Responding to Chemical Disasters. Michael R. Reich. Ithaca, NY: Cornell University Press, 1991. 316 pp. $45.00 cloth, $15.95 paper.

Toxic Work: Women Workers at GTE Lenkurt. Steve Fox. Philadelphia, PA: Temple University Press, 1991. 178 pp. $29.95 cloth, $14.95 paper.

Violence in America: A Public Health Approach. Edited by Mark L. Rosenberg and Mary Ann Fenley. New York: Oxford University Press, 1991. 199 pp. $32.95 cloth.

Journals

North Carolina Insight, Vol. 13, Nos. 3–4, November 1991. Health Care in North Carolina: Prescription for Change, Part I. $12.00 per copy.

Transaction and Studies of the College of Physicians of Philadelphia. Series 5, Vol. 13, No. 3, September 1991. Medicine and History. $10.00 per copy.

World Health Forum: An International Journal of Health Development, Vol. 12, No. 3, 1991. Sw. Fr. 18 per copy.