Hegemony and the U.S. Health Care Crisis:
Structural Determinants and Obstacles to a National Health Insurance Program

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Abstract

The ensemble of private units which make up the structure of the medical care industry (the insurance industry, the pharmaceutical industry and the American Medical Association -AMA) are guided by the pursuit of profit through the act of exchange in a commodified system. This paper analyzes the systemic contradictions in the U.S. health care crisis. Particular emphasis is on the commodification of health care, the designation of health care as an economic commodity, and the subsequent emphasis on treatment as a mechanism of realizing higher profits. The discussion is guided by Antonio Gramsci's conceptions of hegemony and the "historical bloc."

Relying on Antonio Gramsci's conceptions of "hegemony", "common sense", and "good sense," this paper examines the structural components of the for-profit medical care industry: insurance industry, pharmaceutical industry, and the American Medical Associations (AMA). The hegemonic alliance or what Gramsci calls "the historical bloc" composed of dominant economic forces, political society and the ideological superstructure ("organic intellectuals") has been maintained, strengthened and reproduced through corporate political and economic strategies, inter-organizational; and intra-organizational networks linked by a common interest and control over the political structure. Challenges to the hegemonic structure are always contained through the cooption and or rearrangement of the economic reality, and political posturing. In this regard the state (the political society) has always been the mediating force in the direction of hegemonic reproduction. The inherent contradictions within the system though significant, have not been important in aiding the counter-hegemonic forces precisely because of the dominance of the "common sense" and the absence of credible "good sense." The designation of health care as an economic commodity (the commodification of health care) and its control by the for-profit medical care industry on the one hand and the almost powerless political class subject to immense influence from the powerful lobby on the other, are necessary conditions for the reproduction of the crisis.

A manifestation of the concern over the health care crisis and the degree to which the crisis is understood by the larger society is in the form of periodic and episodic flare ups over the plight of less fortunate citizens who are deprived of a basic access to health care and/or threatened by bankruptcy and untimely death. The clash of interests between those trying to reform the existing health care system and those opposing significant reform particularly the "medical industrial complex" (1) and its component parts now have drawn the political society directly and in support of the uninsured at least in appearance. As publicized by the current debate, shouting, insults and threats, *in spite of the very high U.S. per capita expenditures on health care* millions do not have access to health insurance, millions have inadequate access to health care, an estimated 37000 annual deaths due to lack of health insurance and declining life expectancy and child mortality, over 60% of bankruptcies even among those with private insurance and over 200,000 death in American hospitals due to malpractice and infection and many times that number of death due to iatrogenics. It is obvious that if the general public was informed enough (as a counter-hegemonic mechanism) as to where the tax revenue and the borrowed money by the Federal government is spent, the current opposition to a national health insurance would not have been subject to manipulation as much. Yet, hegemonic strategy demands as one of its basic pillars a successful ideological superstructure capable of promoting the alienating "common sense." Many scholarly and journalistic works on the issue while addressing different dimensions, share a common theme that the U.S. health care is fiscally costly to the nation, financially devastating for individuals with significant medical needs, causes indebtedness, and inadequate in terms of access to basic health care for nearly 50 million citizens. Throughout its long history, the American health care system has been a contentious socio-economic and political issue from the Truman Administration to the present and undoubtedly will remain a political issue so long as the political structure through its laws and regulations remains unable to check the power of the behemoth—the medical industrial complex. The issue is one of structural issues in that serious questions arise regarding the

rights of the citizens in a "free market economy" and a "democratic capitalist society" (both of which are components of an ideological superstructure), where health care is viewed as a commodity, and the annoying social responsibility issue on the one hand and cost of health care on the other. Not having access to health care or having inadequate access with the threats of bankruptcy in the context of capitalism, where the price mechanism decides where commodities go, who purchases them and how much, is understandable. But the designation of all social goods as economic goods within the context of political democracy, and the inequities that follow, raise serious questions about the sustainability of the system, and the environment in which it is located. The designation of health care as a commodity and the emphasis on treatment fly in the face of the requirements of sustainability. Emphasis on treatment leaves the culture of consumption and production (including packaging) intact, thereby increasing the level of environmental degradation of soil, air, water, and food pollution and the illnesses that result from. Counter-hegemonic initiatives must begin with these contentious issues as part of larger sustainability concerns, even if it cannot go beyond the confines of the current political framework.

Historical bloc and counter-hegemony: Political or Economic Democracy

It is widely believed that the ancient Greeks, notably Plato and his peers, initiated a discussion of an ideal form of government which received its authority from the people (Demos) and was responsive to the wishes of the majority –democracy. Whether they intended to limit the discussion to the activities in political arena is subject to debate. But if the history of the practice of democracy and the political philosophy supporting such practice are indications, the notion of democracy beyond political games in pursuit of individual freedom and the limiting of political power as suggested by the current reality does not exist. The limitation of the concept is partly due to the complexities of an evolving social life and partly due to alienated masses and their lack of human capital to fathom such complexities. Political democracy along with society's potential and the ability to maximize social surplus raise expectations and if political democracy which ostensibly must be based on awareness, encourages people to gauge the gap between reality and what they perceive as possible. As economies were monetized and resources of society were gradually concentrated in the hands of a small segment of society, commodification of everyday life was a logical outcome and as commodification progressed, concentration and accumulation of resources intensified. And in this context political democracy took the center stage and has remained the ideal form—an ethos characterized by individualism, individual preferences and, exchange mediating the relationship between people and people and their surroundings. Individuals can participate in the political process as well as in the economic life. The difference however is that participation in the former does not require access to resources, but the latter does. In contrast the absence of economic democracy (democracy in access to resources) at the same time that necessitates the hegemony (a complex web of social, political, intellectual, psychological and economic mechanisms) program as a means of reproduction, it also reinforces hegemony through restrictions. While political democracy may allow for free political participation (as a prerequisite for genuine democratic process), it may not ensure economic democracy -- access to society's resources and opportunities based on needs. Economic democracy provides for access to resources of a society not as a matter of privilege, but as a matter of right. Economic Democracy can exist in a society with or without a large social surplus. Its success can be measured by the gap between the potential (what society is capable of) and the actual (what society is providing).

Economic systems are classified based on the nature of class structure and ownership of the means of production, yet accompanying the professed political philosophy often propagates values and beliefs which may not correspond to the class structure and/or the nature of ownership. In the primitive forms of capitalism, as well as in the era of commercial capital dominance and its sacrosanct principle of exchange, commodities were accorded to those who could afford them rather than to all of those who needed them. The political philosophy of Social Darwinism, manifested in laissez faire philosophy, continued in the era of industrial and finance capital supremacy, until the Great Depression of the 1930s challenged its validity and efficacy. What remained constant and not negotiable was the classification of all commodities as economic goods (commodification of life) which, through the market process, the price and quantity were determined. In this context the idea of public goods, government intervention and regulation were frowned upon, for the market was the solution to all problems big and small. Yet there was no mention of the contradictions resulting from the designation of all commodities as economic goods even in the context of political democracy. Instead the propagation of individual rights and privileges and the freedom to choose within the framework of political democracy was at the same time applied to market and economic sphere.

Individuals were free to choose their leader, they also had the freedom to choose to live their lives as they saw fit. In this world of abundant freedom, commodities also went to those who could afford them rather than to those who needed them. As such were health care and medicine (among others) and the never ending crisis. By the end of the 19th century, the United States accelerated industrialization and with it came the concentration of business and industry—trust. It evolved and big business in pursuit of profit began eliminating competition while at the same time promoting it as social and political values and virtues for the political process and the individual citizen.

The ideology of "individualism" and by extension competition reinforced the philosophy of Social Darwinism. Yet the persistent social problems such as the health care issue, is directly tied to fiscal condition. In the 1960s massive social surplus (hence the notion of "affluent society") allowed for the expansion of government programs such as Medicare and as a response to rising discontents and as a form of social imperialism and the public had no qualms about it. It was part of the mass consumption strategy to encourage both publically and privately. From the late 1960s, capital's strategy of dealing with the rising expectations was austerity programs accompanied by fear –a new version of social imperialism. The struggle for basic rights which are challenged by rising individualism and competition while the culture of not being empathetic to the poor and the disenfranchised was revived and strengthened. Today the culture of not being empathetic to the poor and the disenfranchised along with insecurities and fear are big factors in health care debate and the question of reform. The sense of security on the part of 170 million privately insured people do override any concerns for those not covered at all. The meanness by which this sense of insecurity is displayed is appalling. But people, including the Tea Party folks, are conditioned to display this insecurity in that fashion. They are in their own acting according to the common sense. Here it is important to consider Gramsci's "common sense" as a mechanism for the reproduction of the hegemonic condition. It is within the realm of common sense to oppose all that violates that sense of security and interest. Through the use of common sense, social consensus in conformity with the dominant political philosophy and economic ideology is arrived at. But what are the manifestations of this? First, one has to step outside of this false comfort zone so as to see the social consequences of it. Here is where the search for the "good sense" must begin. Hegemonic programs invariably contain heavy doses of "common sense" since "common sense" is according to Gramsci "disparate", "incoherent" and therefore making all of those operating within that mind set vulnerable to manipulation. Simultaneously for the manipulation to be successful, the "good sense" must be denied entry into the thought and reflection arena. Common sense is a distorted, disparate, scattered and un-unified knowledge of reality which facilitates domination and control. On a different level, the political society opposing the realization of the "good sense" in many ways hides behind the economic ideology of "laissez faire" and natural rights to carry out the program of hegemony. It is in this context that the "free" health clinics resonate much better an appeal to the bearers of "common sense" than the dreaded "socialized" or "national" health care system. And the branding of President Obama with the most pejorative and demeaning labels they can think of and from their perspective as "socialist," "Muslim," and "anti-Christ" – to imply dangerous leadership is part of the hegemonic program. The program of hegemony in the case of medical care industry manifests itself in the form of fear, pharmaceutical marketing, criminalizing various illnesses (particularly mental illness), drug dependency, consumerism in medicine, bankruptcies, budget/fiscal crisis, death and abandonment among others. In addition, the program of hegemony does not stop at opposing health care reform, it includes the free health clinics which although have good intentions, but act as pressure valves reducing the pressure on the "liberal" "do-gooders" who are, and always will, give credence to those opposition that promote the idea that acts of charity can take care of the real need of the poor and the uninsured. All that is necessary is to encourage charitable giving in place of public or government programs. Who should challenge the ethos characterized by "common sense"? Political or civil societies? The civil society has a liberating potential that must be nurtured. To Gramsci, (1971:12), civil society ("the ensemble" of "private organisms") and political society (or the state) are two "major super-structural" components and in the program of hegemony both are equally made active. But the civil society has the potential of countering the repressive political society provided that the "good sense" within the counter-hegemonic groups overwhelms the common sense. Hegemonic structures by virtue of their multi-dimensional control and the internal contradictions at the same produce counter-hegemonic forces. They are all the components of the medical care industry such as insurance industry, pharmaceutical industry, physicians represented by AMA and hospitals, all either, individually or working as a united front attempt to influence first and foremost the political society. Within the context of political democracy, this process must appear legitimate, and that is

where "common sense" must prevail. The quest for legitimacy maintains the line of demarcation between the political society and the economic forces commonly referred to as the market, while at the same time the corporate power and the markets it controls are protected by the State. The political society (whether it is controlled by segments of civil society or has relative autonomy) in the context of Gramsci's analysis of hegemony uses coercive mechanisms or it may attempt to build consensus, reach compromise and facilitate symbiotic relationship between the component parts. Within civil society of the democratic state, various forces compete but they are all in agreement that the condition must be amenable for the reproduction of hegemony. For hegemony to be effective and reproducible, it requires concrete coordination of the "dominant groups with the general interests of the subordinate groups, and the life of the state is conceived of as a continuous process of formation and superseding of unstable equilibria (on the juridical plane) between the interests of the fundamental group and those of the subordinate group—equilibria in which the interests of the dominant group prevail, but only up to a certain point,…" (Gramsci, 1971:182). For Gramsci, an effective hegemony requires the dialectics of material base and the superstructure where both spheres work to guarantee the reproduction of the totality.

INSURANCE INDUSTRY:

All hitherto cultures of the world have in various forms had an understanding of risk and protection against risk. For some the protection against risk was codified and in most cases it became transactional and another business undertaking. For example, the Ancient Chinese, and the Babylonians had maritime insurance. Ancient Persians (Iranians) particularly during the Achamenieds Dynasty were the pioneers of offering protection against variety of concerns. Beginning with the first day of the Persian New Year – Norouz insurance documents were notarized with the seal of the Monarch (Franklin, 2001; http://www.iran-law.com/article.php3?id_article=61.) Around sixth century A.D. the Greeks and Romans offered health and life insurance and coverage for the cost of funeral (Franklin, 2001). With the rise of mercantilism in Europe, particularly during the 17th and 18th centuries, the need for protection against loss had increased the need for this ancient service. During the same time period, fire insurance was issued in the United States and the first of its kind was offered in 1732, and twenty years later Benjamin Franklin popularized fire insurance while at the same time denying those whom he thought were risky. In 1929, the first Blue Cross plan was developed allowing subscribers to pay little just in case they needed hospitalization. Initially, it was the dominant health insurance set up by physicians, hospitals, non-profit organizations and later major insurers such as Aetna, Travelers, New York Life, Prudential among others entered the market which by the early 1950s had surpassed the Blue Cross and Blue Shields. The entry of insurance companies into the existing field altered both the philosophy and the conduct of the insurance industry as whole. The business of insurance began to take hold and grow as the commerce grew, and from the start the main reason for its existence was profit. To ensure the profitability of this segment of the medical care industry, the insurance industry has had to rely heavily on influencing the state apparatus (the political society) on two fronts; first the insurance industry, when convenient, shouts the virtues of "free enterprise system," "laissez faire," and deregulation. However, when there is a dramatic event or there is a plan to change market strategy, the political society is called to action. Thus immediately after 911, the insurance industry asked the Federal government for financial help and that was granted.
Health insurance companies have been very stringent in controlling and managing what they cover. That is in the early 1970s the term Home Maintenance Organizations (HMOs) was coined and what is striking is that they had doctors as employees or partners. HMOs are also involved in the Medicare and Medicaid programs as contractors for the government. Therefore, even in these two government run programs, the private insurers were still very much involved. For-profit HMOs have been increasing and the rate of non-for profit has declined. From 1981 to 1995 the percentage of HMOs organized as non-profit declined from 82% to 29% and has continued to decline since then.

The insurance industry continues to make substantial amounts of profit, which, according to public opinion is unacceptable. Yet in the context of capitalist market economies any criticism of the profit-making ability of a firm, which is considered a sign of efficiency and a reward to the entrepreneur's success, appears groundless. They are expected to make profit while at the same time they are also expected to make irrational decisions. What ought to be of concern is the manner by which powerful industries have used the power of the "political society" to subdue the counter-hegemonic tendencies of the civil society. The insurance industry realizes its profit through business decisions which are in conflict with the interests of the general public. According to the Insurance Information Institute, property-casualty insurers' profits have

increased by an annual average of 46% since 1994 and in absolute terms and just to illustrate the magnitude of the profit consider the fact that the profit increased from $49 billion in 2005 to $73 billion in 2006. Industry analysts cite three main reasons for increase in the profit; increased premium, paying fewer claims and "jumping ship" –abandoning an area deemed too risky or illnesses too expensive and there are many cases. The power of insurance industry within the hegemonic structure relies on the political wing of the "historical bloc" to sustain its imposing presence. With the support of the political society (state apparatus), the industry continues to dishonor its contractual obligations.

Health care expenditures stood at $4000 per capita in the late 1990s and now it is $7000.00 per capita, much more than any other industrialized country's expenditures on health care.
For example, one day's expense for hospital stay in 1997 was $1200.00 but now it is 3200. In 1997, hospital care consumed 34% of the total health expenditures, physicians 20%, nursing homes 7.6% prescription drugs others 31.3% (www.hcfa.gov/status/nhe-oact/tables/chart.htm). In 1997 the US per capita expenditures was $3,925, infant mortality was 7.8%, and female life expectancy at 65 stood at 18.9%; Canada's per capita was $2095 with infant mortality of 6% and female life expectancy at 65 was 20.0% and in Japan which spends $1741 has an infant mortality of 3.8% and female life expectancy at 65 of 21.6% (Anderson and Pollier, 1999). This may be true that not all of the problems in the health care are caused by shortages of funds, but it is true that spending money for the purpose of increasing collective wellbeing in a context where price mediates the distribution of goods and services and profit motive is strong can produce dire consequences.

By 1940s only about 9 percent of the American public had private health insurance, by 1950 half of the population had some private coverage which grew to about 82% of the population in 1975 and then began to decline (Cited in Goddeeris 2001:257). It is estimated that 86.1% of population has had health insurance in 1990, with 73.2% having private coverage and now both shares fallen to 83.7% and 70.2% by 1998 and continues to fall (Campbell, 1998 cited in Goddeeris, 2001:258). Between 1950 and 1997, health care spending per capita increased from $469 (in 1997 dollars) to about $3,613 or an increase of 670% (www.hcfa.gov/status/nhe-oact/tables/chart.htm) yet the benefits to the public from these expenditures as compared to other industrialized countries expenditures have been utterly inefficient. For example in 2004, Japan's per capita spending on health was $2, 250, UK $2,510, Sweden $2, 830, Germany,$3040, France, $3160, Canada, 3,170, and the U.S spent $6,100 (public and private both) (MNM, 2008:38). Sources of funding for national health expenditures in 1997 were private insurance 31.9%, out of pocket 17.2, other public 12.1%, Medicaid 14.6%, Medicare 19.6% and other private sources 4.6% (Health Insurance Administration, National Health expenditures, 1997). The question of reform is essential but what form would the reform take? No matter what direction "reform" takes—"public option" or watered down version to the point of obscurity, the insurance industry will continue to reap the benefit. It will continue to raise the premium and also enjoy "anti-trust" exemptions. The power of the insurance industry must be of paramount import in the analysis of the crisis in the medical care industry. For, it has both economic and political power and consequently the power to block, alter and resist any change which it deems threatening. The industry is the lender of high volume to the big borrower in the private and the public sector and as any creditor, it makes the rules.

Even though the insurance industry is a component of the structure and controls a substantial percentage of United States' economy, it has no problem with reform, provided that the plan does not reduce their profit margins and does not impose restrictions (i.e., coverage for pre existing conditions, and modest premium adjustment). The insurance industry could challenge the rising cost of health care provided by hospitals, laboratories, physicians, surgeons. But it is not an important component of the agenda. And the question is why? Within the structure the component parts do not negotiate and they do not dictate to each other so as to preserve the status quo. Instead the insurance industry simply raises the premium and denies coverage and denies claims as much as it can. If possible, while the insurance industry denies expensive surgeries, it could increase the pressure on doctors to prescribe cheaper generic drugs. But what it has to confront is the power of pharmaceuticals and the AMA member physicians who have an economic interest in prescribing brand-name drugs. The six largest insurance companies (United Health Insurance and subsidiaries, Allpoint, Aetana and subsidiaries, Humana, Cigna, Wellpoint, etc.) provide health coverage for nearly 170 million Americans. The two largest insurers, WellPoint and UnitedHealth Group, each acquired 11 other insurers between 2000 and 2007. They now control a total of 67 million "covered lives."

The entire system is based on treatment rather than prevention and in this regard the insurance industry except in a few cases has been silent but not necessarily out of fear and/or frustration. It has too much power and influence to merely be the recipient of decisions made elsewhere, it makes and implements those decisions deemed vital to the protection of its interests. Price Waterhouse Coopers, in a report for the industry's lobbying group, America's Health Insurance Plans (AHIP), states that "the reforms would raise the cost of premiums, will now be arguing that it's best to drop the whole idea." AHIP has been lobbying to stop any reform including the "public option" arguing that it could "dismantle employer-based coverage and significantly increase costs for those who remain in private coverage" (NYT, 2009). This statement is not a lament, it is a threat and a warning, yet, it even may be supported by data. Once it has accomplished the task of presenting this as a "common sense" approach to the issue, it doe not have to do much except to choreograph the march of the scared public to stop any change in its hegemonic position. If there is any indication that the "historical bloc" is in the process of co-opting the anger and frustration of individuals and institutions adversely affected by its imposing presence, it is to be found within the proposed layers of proposed reform.

As part of the current Democratic Party's reform proposal, the purchase of health insurance by individuals will be mandatory which ultimately puts the individual in a very untenable position. First, if the individual has the means to purchase insurance, does it not benefit the insurance industry? Second, and more importantly, what if the individual does not have the means to purchase it? This is much more problematic in the face of rising premiums and less coverage. In either case, there are more than 32 million new customers who are waiting to be enrolled by the insurance industry once the reform is implemented, and that will be the greatest marketing coup d'etat disguised in humanitarian concern.

Since 2002, the average premium paid to health insurance companies has increased by 87%, the profit of the top ten insurance companies has increased by 428% and 7 out of 10 American bankrupted due to medical bills has health insurance and all done by an average of 70% premium hike. T.R. Reid (2009), and Jonathan Cohn (2007) among others have documented how private insurers decide the extent and the type of coverage one should have. Cohn demonstrates case by case of horrors experienced by people in dealing with the private insurance companies. And how myth shattering is the study by T.R. Reid documenting exactly the opposite in the countries he visited and observed. It is myth shattering because often the American public is told how bad the medical coverage and how ineffective the drugs are in other parts of the world particularly Canada and Europe. Perhaps one of the most ironic aspects of the cross-cultural comparison is the affordability of medicine in countries which import American medicine. Often the cost of the same medicine to the American consumer even when it is re-imported from countries such as Canada is less than the medicine produced by the Pharmaceutical industry.

The Pharmaceutical Industry- Historical and Structural Background:
The contemporary pharmaceutical industry is the product of more than two centuries of growth and diversification. The early phase of industry's rapid growth occurred during World War Two. The discovery of several drugs and the development of vaccine serums, penicillin, and increases in the demand for drugs due to the escalation of the war, revolutionized the industry's research and development (Measday, 1977: 251). As the industry expanded its research and diversified its output, it also began concentrating on brand recognition. The genesis of brand names was crucial for the expansion of industry's output. The increase in the demand for drugs and the existence of a high rate of profit encouraged the chemical companies to engage in drug manufacturing through the acquisition of the already established pharmaceutical firms. The takeover intensified brand name recognition and competition and resulted in further concentration of an industry in search of a high rate of profit. The search for higher profit inevitably had to involve the use of an intermediate group- the physicians who by virtue of their professional authority are located in an important position and capable of increasing drug dispensation.(2) The pharmaceutical industry knowing the vitality and importance of this group, sought its cooperation for a self perpetuating alliance. From the late 1940s, the industry has been spending billions of dollars on drug promotion (or "educational" efforts according to industry), with physicians as the primary target. It begins when physicians are medical students and continues throughout their practice (Garland 1968; Measday, 1977). By the late 1970s the promotional expenditures were $2.5 billion. The marketing programs generally fit into two categories; "shotgun" programs (low cost and indirect) and "rifle" (personalized, specific and direct) (Harell 1981:71). Both are carried out by the industry's sales representatives as important sources of information regarding

the effectiveness of drugs! Moreover, From the 1950s a great number of physicians had been learning about particular drugs by consulting the medical journals, learning from the industry's sales representatives, reading about the drug in print media or the industry supported Physicians' Desk Reference (PDR) for which the industry writes the descriptions of drugs (Garland, 1964:205; Smith and Knapp, 1972:176). In 2008, eighty-four percent of U.S. physicians used the Internet and other technologies to access pharmaceutical, biotech or medical device information – a twenty percent increase from 2004. If the pursuit of information by the prescribing physicians from questionable sources is not enough elevate the level of insecurity and fear in the general public, the fact that "….virtually all physicians in America take cash or gift from the drug companies…" (Multinational Monitor, July/August, 2008:42) should be sufficient to raise serious questions on the part of the public. "A recent survey said 94 percent of physicians took something of value from the drug companies" (Multinational Monitor, July/August, 2008:42). "There has been disaster after disaster caused by aggressively- promoted medicines. Vioxx is a case in point; more than 20 million Americans took Vioxx before it was taken off the market in 2004 because it doubled the risk of heart attack. A government scientist estimated that this single drug might have led to the deaths of 40,000 Americans." (Multinational Monitor, July/August, 2008:44).

The greater the success of the promotional tactics, the greater the brand-name recognition loyalty and therefore more prescription of brand name drugs which often are often more expensive than the chemically equivalent substitute with no greater quality or effectiveness (Linsay 1978:145) Brand name loyalty coupled with their own economic interest significantly increases drug promotion and serious when physicians approve various drugs by fabricating the result of government sponsored field test (Illich, 1976:72). In 2007, number of death in Florida alone caused by illegal drugs was 946 and the number of deaths caused by prescription drugs was 2002 (cited in Harper's Index, Sep. 2008). Nationwide an estimated 100,000 Americans die of prescription drugs recommended by their physician (Multinational Monitor, July/August, 2008:44).

According to a 2003 comprehensive study of medical peer-review journals and government health statistics, there are an additional 199,000 fatal ADR outpatient deaths in the U.S. annually. According to the study, there are approximately 783,936 iatrogenic (medically induced) deaths every year in the U.S. Furthermore, the actual figure is estimated to be much higher, as only a fraction (between 5% and 20%) of iatrogenic acts are ever reported.

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In their attempt to control the political society, US health care companies spent $1,500,000 on congressional lobbying per day in 2009 (as cited in Harper's Index, January 2010). The marketing of prescription drugs is notoriously deceptive. The television ads feature the so-called experts (doctors) and happy consumers. Dr. Jarvick who advertises the Jarvick heart is not a trained or licensed physician and as a rule these companies know "how to put their words in the mouth of someone who appears to be independent, so the public accepts their promotional message as truth" (Multinational Monitor, July/August, 2008:40). For example, for the 700 drugs available in the 1970s in the United States, there were some 20,000 brand names or an average of 30 names for each prescribed drug (Brooke, 1975:19; Gereffi, 1983:207; Harell, 1981:71-2). Therefore, the same drug is prescribed for many different actions and often the physicians are not aware of it or cajoled by the pharmaceutical sales representative to prescribe them. Even official tests in the United States and Britain show that between 60-80 percent of these widely prescribed drugs are ineffective (Lall, 1977:25). These drugs are prescribed by physicians, but the problem lies in their rudimentary knowledge of their effectiveness and/or side effects along with their purported economic interests in the pharmaceuticals industry. By 2008, IMS Health reported that sales for U.S. prescription drugs had reached $291 billion dollars a year. Worldwide sale for prescription drugs was about $400 billion in 2002. Americans spent roughly 200 billion dollars on prescription drugs in 2002, accounting for approximately half of all sales Worldwide. Yet, as of 2006, the U.S. infant mortality rate ranked at 21st in the world (under Greece and South Korea and slightly higher than Poland). U.S. life

expectancy ranked at number 17. This is in spite of the fact that per capital health care expenditures in the United States dwarfs those of all other countries.

The pharmaceutical industry's drive to increase drug consumption ("medicalization" of society), is realized through the "educating" of physicians, direct marketing to consumers via television commercials (including those specifically for children) and the institutional supports of "laissez faire" and toothless commercial laws and regulations. "The drug companies center their efforts on medicines for chronic conditions that affect large portions of the American public. Even inside the labs scientists are told to focus only on drugs that could become billion –dollar sellers." (Multinational Monitor, July/August, 2008:39). Government policies (through its patent trademarks and the new drug policies) have been essential for the concentration of the industry as well as the promotion of unethical conducts in the medical industry at large. "Our medical literature has become so distorted by the industry's influence that some scientists say it is little more than corporate propaganda" (Multinational Monitor, July/August, 2008:42). Before 1997, the pharmaceutical firms were not allowed to advertise on television and gradually all rules with respect of advertising on television, and product information including prices were changed or abandoned and in the process massive abuses of drugs along with deadly consequences increased many fold. When a new drug is developed, it is patented and given it trade mark brand name, thereby impeding the imitation of the drug by other manufacturers by legal sanctions. This creates a major factor in giving one drug so many fancy names. Moreover, government spends a large percentage of its health care funding for research and the development of new drugs only to be monopolized by a pharmaceutical firm and sold at monopoly prices (cancer and AIDS treatment drugs). Pricing strategies include price discrimination on a global scale. Some drugs are sold with close to 400 percent mark-ups in different countries with fewer alternatives and in some others (specifically from Canada), they are cheaper than they are in U.S. market and those are some of the drugs that are re-imported into this country. The National Coalition on Health Care (NCHC) is a non-profit organization which has warned about the rising drug cost and it's impact on the economy, among them are loss of jobs due to high cost to employers, low capital goods due to cost, rising bankruptcies, foreclosures, fiscal crisis and vanishing savings among others. And indeed most of the research and warning come from non-partisan groups rather than the government and the professionals within the system. Interestingly, "the Congressional Budget Office has found that drug prices in other industrialized countries are 35 to 55 percent lower than in the United States" (Baker, 2006:29).

During the past two decades cost cutting measures have been taken to lower the cost of medicine. The generic drugs have become the insurers' choice. The proliferation of generic drugs was due to the expiration of the patented name-brand drug. Once a patent is expired other (usually smaller) manufacturers can copy the drugs. But the major pharmaceutical firms have been working to stop the proliferation of generic drugs which currently make-up about 40 percent of the total prescription drugs. These drugs have had their own problems in terms of causing fatal reaction and being ineffective) and partly due to consumerism and brand name recognition through advertisement by the name-brand pharmaceutical along with physicians level of information and self interest, both the sale and the prices of brand-name drugs have been increasing. Medicare drug benefits provided to the politically viable population—the elderly, have been pouring into the coffers of pharmaceutical industry for many decades. "…the brand- name pharmaceutical industry successfully pressed Congress to prohibit Medicare from bargaining directly with the drug companies to lower prices…." Causing a an added $40 billion to the annual cost (Baker, 2006:26). The Food and Drug Administration (FDA) is the top agency in charge of drug safety. But its requirements for the testing of new drugs goes beyond costs which the small firms in the industry can bear, therefore a handful of large and heavily concentrated firms is able to get FDA approval for their new drugs. While the conduct of the pharmaceutical industries remains largely unregulated, the conduct of physicians is supervised and directed by the self-policing organization – the American Medical Association (AMA), so as to protect "professional dominance" by providing rules of conduct at the micro and macro levels. Obedience to the rules of the organization is both a necessary and a sufficient factor for the strengthening of the structure. These rules stem from the ideological orientation in support of the total structure. Just as the pharmaceutical industry has a symbiotic relationship with physicians, the conduct of AMA and hospital owners/ administrators as well as the physician/ patient relationship must be consistent and within the ideological framework. If the structure of domination is to be successful, without the use of force, the means of legitimation must correspond to the perception of reality based on "common sense" and accordingly in every layer of the organization it is absolutely essential to safeguard the reproduction of the

hegemony by keeping in check the counter-hegemonic tendencies. At the micro level of interaction between physician and patient, the former exercises the monopoly power accorded to him/her through the control of information.

Physicians, the AMA and Hospitals:
The success of every alliance requires internal cohesiveness and unanimity. While the components face one another as a block or entity, their conduct must be coordinated and controlled so as to have the ability to seek their interests. Similarly within the AMA, as a structural component in the medical care industry, the rules unequivocally apply to every member physician. The ideological fabric and the means available to each component part must be consistent and in agreement with the ideology of the hegemonic structure itself. Hence the commodification of the health care and the promotion of "conspicuous consumption" of drugs are ideological elements promoted by the structural components. The treatment of health care as a commodity is calculated and well thought of ideological component necessary to maintaining the dominant relationships between providers and consumers. As parts of this ideological structure, the designation of heath care as a commodity implies that that the production and the distribution of it must be carried out on the basis of the market. The concept of "fee –for-service" corresponds to the hegemonic ideological framework. It reinforces the historical and cultural belief that on this basis, completion and consequently equilibrium and quality are assured. This is based on the classical contention that the market mechanisms are inherently capable of maintaining and restoring equilibrium. This legitimizing contention is maintained even in the face of increasing market distortion. The AMA was formed in 1849 primarily as a response to hostilities of homeopathy (Berlant 1975; Larson' 1977: Twaddle, 1978). Faced with the increasing loss of their professional prestige and dominance, physicians reacted by flexing the organizational muscle of the AMA in "cornering the medical work" (Hauge and Laving, 1983:30) in its approach to public policy, the AMA has worked against any policy which it perceived as a threat to its dominance and interests. Historically, AMA's substantial financial resources have provided the means for an intense engagement in propaganda, political activity and vigorous lobbying. Attempting to eliminate all challenges to its structural dominance, it has opposed federal aid to medical students, opposed philanthropic medical works and has vigorously opposed the formation of a national health insurance (Smith and Knapp, 1972; Klleinback and Grace, 1974; Rayack, 1977; Waitzkin, 1983; Bloom, 1988). Last year (2009) addressing the Senate Finance Committee, the American Medical Association said: "The A.M.A. does not believe that creating a public health insurance option for non-disabled individuals under age 65 is the best way to expand health insurance coverage and lower costs. The introduction of a new public plan threatens to restrict patient choice by driving out private insurers, which currently provide coverage for nearly 70 percent of Americans." (New York Times, 2009).

Initially it opposed Medicare and Medicaid by spending $1 million to break them up. From the late 1950s until early 1960s the AMA campaigned against the Democrats' plans to provide health insurance for the elderly—Medicare through its "Operation Coffee Cup" by which doctors' wives would organize coffee meetings in order to encourage writing letters to Congress opposing the program. But realizing the potential economic gains caused to lower its antagonism to the plans in the mid 1960s when it discovered that there was easy money to be made, without jeopardizing the fee for service it considers to be necessary for maintaining physicians' loyalty and professional dominance (Berlant, 1975:100; Gray, 1986:152; Waitzkin, 1983:120). In the 1970s there was so much money in these programs for the medical care industry that it was dubbed as the "Medicare Mill".

American Medical Association Political Action Committee (AMAPAC) spends a substantial sum of money on lobbying and it is assumed that within a democratic political system and in the spirit of pluralism it has every right as do all others to try to influence medical policies in its own favor. Center for Responsive Politics, utilizing the data made available by the Election Commission shows that AMAPAC "gave over $8,500, on average, to senators facing reelection who helped kill McCain's proposal in June" (New York Times, 2009) (3). AMA has been a big source of congressional campaign money, while denying the "public access to data on doctors. "(Reier, 1990:45). A major source of income has been the pharmaceutical industry drug advertising in its publications and the AMA's stocks ownership in drug companies (Hapgood, 1972:118). In addition to its financial abilities, the concentration of power in the organizational hands of the AMA, "the rise of scientific medicine "and the utilization of state's control over licensing and

registration have been crucial in the creation a monopoly for physicians as well as the control and the expansion of the market by organized medicine (Conrad and Kern, 1981:152; Larson 1977:23).
The presence of AMA as a block and its unconditional support of the status quo is crucial in the structural alliance. Once doctors are members of this organization, they must follow organizational rules which may differ from their professional oath. In return the member physicians receive collegial support according to the rule of "etiquette" (Freidson, 1975) and "gentlemen's agreement" (Millman, 1977) when unethical behavior and or poor performance occur. The AMA has consistently exercised its monopolistic power in controlling the supply of physicians so as to have total control over prices (Berlant, 1975:225). Control over the supply of physicians also included discriminatory practices on the basis of race (among other things). Up until 1968, the AMA had a "color bar" by which black physicians were excluded from most "AMA branches, and thus from most hospitals (Time Magazine, 1968).

In addition to imposing a ceiling on the supply of physicians as dictated by their own self interests, the distribution of physicians is also regulated by the "fee for service" ideology. On this basis the tendency is to avoid low income neighborhood, small towns and poor counties (Mahler, 1980; Reier, 1990:47). The number of physicians in 1996 was 581,000 and the median income was $164,000 which compared to other industrialized countries where it is between 50 to 70 thousand dollars (Reid, 2009). Number of physicians who are members of the AMA is about 250,000. The solidarity and cohesiveness between physicians within the AMA are necessary elements dealing with other components of the medical care industry. Even though physicians are free to relate to other components either as individuals or as a group, they must maintain the guiding ideological principle even if it contradicts the ethical codes. That is, no matter strong his/her ethical codes; the physician has to function based on rules dictated by the dominant structural interests. He has to perform surgery in the hospitals and prescribe drugs.

The pursuit of self interest is accomplished two interrelated mechanisms; first the physicians prescribe those drugs which are produced by the companies in which the physicians are stock holders (Measday 1977:256), and second the overall physicians investment in the health care industry such as becoming the sole investors in a number of medical enterprises, in joint venture with hospitals or other health care organization and serving on the various committees in health care institutions (Morrisey and Brooks, 1985; Alexander, et. al., 1986), or on a franchise basis (Wallace 1984). If physicians are not owners their conducts are monitored by a data system (Gray, 1986; 156). "Doctors ignore and under-report the deaths or adverse reactions to the drugs they prescribe and they are "afraid of being sued, they maintain a culture of denial, and they also profit from their relationships with the big drag companies." This is of course compounded by lack of government's inability or lack of interests in monitoring the behavior. Consequently, the corporate control of the medical care industry (Starr, 1982) has given rise of the " new medical industrial complex" (giant corporations in control of hospitals and in joint venture with physician groups) (Wohl, 1984, among others). The commodification of health care system has brought on a compelling preference for an "efficient" (profitable) medical care system over an "equitable" health care system. Obviously a commodified system seeks commodities (money) in return. In this context as stipulated by the mainstream economic theory, the greater the rate of return the more efficient (i.e., good) the system through which equity is supposedly achieved. The fact that the health care system is primarily a publically controlled enterprise, it requires government expenditures (though it varies according to the business and political cycle). The "dominant structural interests" (Alford, 1975) has had no objection to increases in government expenditures provided that they are not in conflict with the laissez faire principle. The passage of Medicaid and Medicare laws in the 1960s are examples of these expenditures. These expenditures gave the poor an opportunity to utilize more private hospitals thereby reducing the demand for the public hospitals (Waitzkin, 1983:120). The amount of money generated by Medicare in the early 1970s gave hospitals an opportunity to tap into the steady stream of funds available. The problem of patient dumping has been a problem and that has lead to Federal regulations requiring medical facilities to provide follow-up care, "but they don't order hospitals to make sure their discharged patients actually receive it. That's no excuse for dumping patients on the sidewalk in skid row." (Los Angeles Times, April 10,2009) This provides some relief for the hospitals with financial difficulty, but primarily benefited the large hospital chains (Wohl, 1984:8). Hospital mergers in the past two decades have increased dramatically. More than 200 hospitals have merged but the biggest problem is that the non-for-profit have been taken by the for-profit hospitals such as Columbia/HCA (Goddeeris, 2001:286) leading to greater concentration and thereby the ability to drive up costs by eliminating competition. The problem is compounded by the

increasing political influence that a concentrated for-profit hospital chains are exercising. Montana Senator Max Baucus, whose leadership in the reform is deemed essential "receives the most money from private hospitals, insurance companies and doctors" (Halimi, 2009). Given this ideological commitment to the status quo on the part of the political society, renders all public pronouncements regarding "reform" absurd. The commodification of the health care system and the existence of a high rate of profit have transformed the health care into an industry for which efficiency (highest rate of profits) is the ultimate goal without regard for its social consequences. The subordination of the health care system by finance capital must begin with an alliance with the component parts of the structure which control and represent the industry such as physicians, hospitals, and pharmaceutical industry. Logically it follows that every aspect of the structure must be monitored. At the micro level, the interaction traditionally and structurally has been controlled by physicians whose participation in the macro level depends on their success at the micro level of medical interaction. That is for the macro level to be effective in maintaining the system physicians must be effective at controlling the interaction with the patient. Here is when the success of one way flow of information as set in motion by the physician is so critical. Patients must submit to the physician if the physician is to effectively participate in the reproduction of the system. The doctor-patient dialogue is likewise completely infused with power/knowledge relations and highly asymmetrical.

PHYSICIAN- PATIENT INTERACTION:

The precarious position of physicians in the dominant structure and their conduct in the micro level of interaction are crucial components for the perpetuation of the alliance and therefore in the reproduction of the system. Physicians' interaction with the patient embodies a structural imperative and a relationship based on power. In order for the structure to be reproduced, the micro level components must be coordinated and reproduced. Though the patients are important actors in this structure, the physicians by virtue of their position in the alliance have the leading role in interaction. The assumption that patients do (in the context of a democratic society), freely interact and since there is freedom of interaction therefore there is no coercion is not bore by the realty of interaction. Indeed the patients are disengaged in the encounter with physicians since the power is controlled by the physicians. The relationship between doctors and patients has been analyzed from different theoretical perspectives. Weinman (1998, Navarro, 1976), Stewart (1995), Inui (1982, 1985), Power (2002), among others have extensively studied the patient/doctor communication and its impact on the quality of health care and patient relationship.

Physicians –patient interaction is a social relation based on power. Physicians are in a position to dictate the rules of encounter and the patients are expected to submit to the hegemony of the physician and passively and uncritically absorb what has been provided. The reproduction of this part of the hegemonic structure is absolutely essential for the reproduction of the structure itself. The structural determinants of the crisis cannot be resolved without the removal of the micro level interaction based on fear, insecurity and lack of adequate knowledge. Yet the uncritical discipline of sociology particularly the functionalists' view of the micro level interaction began with the concept of "sick role" as a social deviance which upsets the equilibrium and the natural order. While the natural order or equilibrium from a Functionalist perspective is an important and necessary social condition, it certainly goes beyond the mere statement regarding equilibrium and enters the realm of social control mechanism which the Functionalist deem necessary (Parsons, 1951; 1958; 1970). Physicians retain their dominance by controlling information. This includes the practice of using technical terms (Freidson, 1975; Waitzkin, 1989:231). In all encounters, patients provide all of the signs, symptoms and descriptions of how they feel and physicians simply plug those in a readymade model and get the already constructed interpretations. Physicians ability to give meaning to signs and symptoms along with the choice of drugs, "uncertainty" and the conceptions of disease and illness (Twadlle, 1981; Haug and Lavin, 1983:192) and patient's lack of adequate knowledge, place the physicians in control of the situation. The absence of communication may increase the demand for medicine and particularly in a system predicated on treatment and as of late massive pharmaceutical advertisements designed to get patients to ask doctors for specific medication for some real or imagined symptoms. It translates into more revenue for the providers and more cost to the patient. Under this system, the sick role in reality works as a mechanism of social control and domination. The greater the magnitude of the authority the greater the degree of social control and dominance. In the 1960s the concept of "health provider" specifically physicians and "health consumer" (patients) were coined to suggest the rise of consumerism in medicine and the abundance of good choices in care. As the disease of consumerism in medicine began to spread, with it came the marketing of the drugs to feed that disease and with it came the

indispensible role of physicians as pill pushers. This is problematic since medicine is considered to be a commodity and like all other commodities require money and the ability to purchase and does not require professional permission to consume, their consumption may not be a matter of life or death. Illich (1981) popularized the notion that medicinal intervention (iatrogenic) was harmful and that medical treatment ought to be abandoned in favor of preventive measures. A comprehensive study, showed that there are approximately 783,936 iatrogenic (medically induced) deaths every year in the U.S. Furthermore, the actual figure is estimated to be much higher, as only a fraction (between 5% and 20%) of iatrogenic acts are ever reported. (http://www.sourcewatch.org/index.php?title=Pharmaceutical_industry).
Illich's categories of social iatrogenesis, and cultural iatrogenesis are significant in light of the culture of the medical care industry's emphasis on treatment. Social iatrogenesis is the medicalization of everyday life and cultural iatrogenesis refers to the erosion of traditional approach to pain and diseases not based on medicine. Illich's "Sisyphus Syndrome" is the symptom of social iatrogenesis which causes drug dependency and implies a deliberate attempt at increasing the consumption of medicine. Consumption of medicine in light of the expansion of scientific medicine along with complex procedures and equipment require providers, dispensers as well as consumers. Even though the patients are given more choices in the selection of care, this luxury is afforded to the upper and upper middle class and certainly not by the working and non-working poor. Syme and Berkman (1981), have reaffirmed the findings of previous studies and their study corroborated by the current findings which suggest that the high rates of morbidity and mortality as result of various disease and illness for the members of lower classes have not diminished over time –this is what Zola (1981:512) calls the de jure relationship between medicine and the agent of social control. This reflects the contradiction between health as a social good and economic incentives in its provisions as a commodity. Consumerism however has succeeded in increasing the demand for various services with or without the choice. Excessive emphasis on treatment (more fees), have brought the medical care industry under the control of finance capital. The contradiction between health care and profit motive is seen throughout the health care system and has placed the physicians' in a contradictory position. While physicians' Hippocratic Oath demands ethical conduct in the provision of health care, by virtue of their participation in the medical care industry, expected to pursue the organizational interests (profit) which may be contrary to their ethic al codes. No matter how strong their adherence to ethical codes, they have to function within the system and as dictated by the "dominant structural interests". That is, their interest is tied up to the interest of the larger structure. Physicians have to perform surgery in the hospitals and prescribe drugs with no control over either cost or quality. The increasing cost of the current crisis in part is due to this arrangement even if one ignores the increasing cost due to expanding collection departments in hospitals and doctors' offices. In the early 1970s, the US spent $83 billion on health care (Mechanic, 1974:40). By the late 1970s it increased to $215 billion, reaching $320 billion in 1982, $650 billion in 1990 and currently close to one trillion dollars. A large percentage of health care expenditures is wasted as the result of "unnecessary surgery, unneeded diagnostic procedures and puffed up bills" (Reier, 1990:47). Overall the US spends 40% more per capita than other industrialized countries yet it receives by far less in return as measured by various indices such as the mortality and life expectancy. Income from Medicare to doctors increased 31% from 1980 to 1986 (National Health Care).

Part of this increase is realized through excessive prescriptions (some 400 million annually in the 1980s for the elderly alone). Historically Medicaid patients have been hospitalized much more than non-Medicaid patients and that suggests the absence of a countervailing power in this case the government compared to the power of private insurance providers in curbing hospitalization by denying coverage. Before the introduction of the two government sponsored health care, Medicaid and Medicare, "patient dumping" by private hospitals was much more common.. Doctors, hospitals and insurance companies all agree with the public that there is a need for reform in the health care system. The need for reform is also realized on the part of the political appointees of the various Administrations, but powerless when facing the powerful hegemonic medical establishment. Even if the major players arrive at some agreement, that by itself only reduces the conflict within the "dominant structural interests in the short run. In the long run the fractions in the alliance will not resolve structurally induced problems in the health care industry. Consequently, the public must pay the increasing cost of health care, while millions are denied the minimum access to care. In this context it is difficult to envision a long term solution to the problem. Even if the employers are forced to increase their share of employee coverage they will include the health care cost of their employees in the cost of running their operations, therefore inflating the price of commodities (as in the case of auto industry) or force the relocation overseas (as one of the many reasons for job transfer). Given this

arrangement it is easy to blame physicians for all ills of the system, but one must locate their role in the structure itself. No matter how strong their ethical considerations, some must behave according to the dictates from the structure. Since the beginning of the twentieth century, a great majority of physicians come from upper middle class (Kleinback and Grace, 1974; Waitzkin, 1989: 227). Although the physician population has become more inclusive, the fact remains that today's physicians are bureaucratic paper pushers when dealing with insurance companies at the same time that they have to be mindful of lawsuits in every decision they make and in the process becoming anything but a healer. Moreover, the cost of becoming a trained physician has skyrocketed and with massive debt upon graduation the physicians are more likely to be molded by the condition of indebtedness. Even if indebtedness is not a problem for most, the political ideology (ideological superstructure) as members of AMA compels them to go along with the larger "historical bloc" in opposing counter-hegemonic initiatives.

Conclusion:

The structural alliance in the medical care industry has produced a serious crisis for the economic, political, social and psychological spheres and the mechanisms for the reproductions of the hegemonic structure has the potential of undermining the political democratic process in the United States. The components of the structure such as the powerful insurance industry, the pharmaceutical industry, and the powerful professional/political organization such as the AMA have every incentive to keep the structure intact and by virtue of their economic power, they have rendered the political society and a segment of civil society not only powerless, but effectively are employed as a counter-hegemonic force. As one of the largest industries in 2008, healthcare provided 14.3 million jobs for wage and salary workers, the pharmaceutical firms have substantial capital for research and development of drugs and insurance industry controls substantial capital invested in the non-insurance related activities. On the political level, the power of the industry is overpowering and the whole reform agenda is held hostage and or manipulated by the medical care industry's money, and the propagation of hegemonic ideology. Lack of access to health care for a great number of people, inadequate access for many will drive up the cost for everyone. The uninsured is the consumer of the emergency medical services whose cost is passed on to the insured. Of all the uninsured Americans approximately 40,000 die annually and for those who do not the worsening medical condition would make them (as the current insurance industry practices indicates) uninsurable because they have "pre-existing" conditions. But, above all, it would make them unemployable which would add to an already expensive and growing social cost caused by low productivity, job losses, fiscal crisis, bankruptcies, foreclosures and many other social and psychological problems. But perhaps the greatest threat posed by the hegemonic structure is the alienation of people from the political process due to the powerlessness they feel, which in turn, intensifies their political apathy. On the other hand if a "single payer" system replaces the current system (including the reformed components proposed by President Obama) which in light of the hegemonic components of the current system and the support from the political society, it may prevent further deterioration of the fabric of society and worsening financial condition for current and future generations(4). It is estimated that a total of 2, 600,000 jobs would be created if a single-payer health care system in established (cited in Harper's Index, April, 2009), longevity would increase, and preventive measures will be effective enough to lower the need for treatment. The voices of "subaltern" (5) can guide a nation to greatness provided that they are allowed to understand and speak. The author, Dr. Mehdi S. Shariati is a professor of Economics, Sociology and Geography at the KCKCC. mshariati@kckcc.edu. Professor Shariati has published several articles in the areaa of political economy, globalization and social change.

ENDNOTES:

1. The concept of the medical-industrial complex was first introduced by Ehrenreich and Ehrenreich, "The American Health Empire" (1971), and later by Navarro(1976), Relman (1980), Estes and colleagues (1984), Wohl (1984), and McKinlay and Stoeckle (1994).
2. Prior to 1951, almost most drugs were dispensed by pharmacists without prescription. In 1951 United States Congress decided that for public safety consideration, some drugs must be dispensed with prescription by a certified physician and all of them were trusted to be ethical.
3. The defeat of this legislation, which would have increased cigarette taxes and granted the Food and Drug Administration authority to regulate tobacco products, effectively ended tobacco control efforts in the 105th Congress. By comparison, AMAPAC gave less than $2,500, on average, to

senators up for reelection who had tried to move the McCain bill forward. That's more than a 3:1 ratio in favor of pro-tobacco senators and begs the question: Why does a group that represents 250,000 physicians preferentially fund the supporters of an industry that annually kills 400,000 Americans? AMAPAC contributed thousands to help pro-tobacco Senators Kit Bond from Missouri and Sam Brownback from Kansas beat back Democratic challengers. The PAC then went on to give the legal maximum--$10,000--to Ben Nighthorse-Campbell, a Colorado Republican who voted to block the McCain proposal and who faced an anti-tobacco opponent.

4. About half of all U.S. Bankruptcies are due to medical expenses. Thirty U.S. States have laws requiring children to pay for the medical care of "indigent parents" (cited in Harper' Index October, 2009).
5. Gramsci uses the term "subaltern" to describe the masses of powerless people alienated from the socio-economic and political structure.

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