

# Changing the Balance of Power in American Medicine

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**P**OPULAR REPRESENTATION AND MARKET COMPETITION are usually thought to be opposite strategies in public policy. But although often sponsored by ideologically opposed groups, they are not necessarily contradictory. In health care, the two approaches share a common purpose. What greater representation and greater competition both seek to achieve is a change in the balance of power in American medicine: a weakening of the traditional dominance of the medical profession in dictating financial arrangements and public policy decisions.

That the goals of representation and competition in medical care have until now been poorly understood and ineffectively pursued is the point of departure both for Theodore Marmor and James Morone, who write on representation, and for Clark Havighurst, who writes on antitrust policy. These two papers are efforts to reconceptualize the democratic and market strategies—to give them sharper intellectual definition and to turn policy in more effective directions. Neither strategy, it can be fairly said, has yet produced any significant improvement in medical care; so far, they have done a little good and a little mischief but, on the whole, have been of small consequence. The reasons are evident from these essays. The efforts in health planning to improve representation failed to include any mechanism of accountability, and the efforts by the Federal Trade Commission

(FTC) to improve competition lacked any coherent conception or plan and failed to comprehend the peculiar economics of medical practice.

One of the virtues of the Marmor-Morone paper is its careful distinctions among the related concepts of accountability, participation, and representation. *Accountability*, they point out, means "answering to," and it requires that the persons to whom officials are accountable have some resource—votes, money, legal authority—by which they can control or sanction those officials. In health planning, consumers have no such resource to make their ostensible representatives answer to them. They are entitled, however, to *participation*, as at public meetings of planning agencies. But participation favors those whose interests are concentrated rather than dispersed, since they are likely to have greater incentive to bear the costs of organization. Provisions for participation, theoretically meant to favor consumers, in practice are used by "aroused providers." Finally, the *representation* offered by health planning agencies is of a particularly weak sort—what has been called "socially descriptive representation." Consumer representatives are deemed to represent particular constituencies, merely on the grounds of sharing some demographic characteristic (sex, race, socioeconomic status, residence, etc.). The law specifies no method by which such representatives are to be selected or held accountable by their constituents. It seems not to contemplate the possibility that individuals may become representatives precisely because they are atypical of the groups whose nominal characteristics they share. As Klein and Lewis (1976) remark in their book on consumer representation in England, the laborer who is a member of a Conservative Party committee is there not because he is representative of workers, but because he is unrepresentative of them. There is nothing that binds the "socially descriptive" representative to his constituency's preferences or to its substantive interests. Effective substantive representation is the goal of democratic policies, but health planning, as constituted at present, does not remotely achieve it.

As one possible reform, Marmor and Morone suggest that consumer representatives be selected by consumer organizations, to whom they would then be accountable. Organizational selection is undoubtedly superior to socially descriptive representation, although

it raises the problem of which organizations are to be given the function of representing consumers. It also destroys, perhaps usefully, the myth of a common interest of all consumers. It provides accountability, but of a partial kind.

The one example of a functioning system that provides general accountability to consumers is, it seems to me, the membership-controlled prepaid health plan, such as the Group Health Cooperative of Puget Sound. In the cooperative, a governing board is selected by the plan's members in periodic elections; there are also annual meetings that provide a forum for direct participation. The Group Health Cooperative has a genuine political life, with contested elections and caucuses of different factions (such as a women's caucus that several years ago formed to fight for distribution of contraceptives and access to abortions through the cooperative).

In general, members of a prepaid plan or health maintenance organization (HMO) have a much more direct interest in its planning decisions than citizens have in the planning decisions of a health systems agency (HSA), since the members of an HMO will have to pay for the decisions, whereas the health costs in a geographic region will be spread over a larger population as a result of health insurance and government programs. In addition, consumer representation has a particularly necessary function in HMOs because of the potential of HMOs to underservice their members—a less likely danger if the members themselves elect the ultimate governing body.

Representation in HMOs, however, is likely to encounter some of the same problems that representation always faces in medical institutions. Since people are little concerned with medical care when they are well, they are usually little motivated to participate. The problems often seem technical, or can be made to seem technical, and so laymen easily defer to professional judgment. However, the capacity of elected consumer representatives to make general organizational and planning policies ought to be no less than that of unelected lay trustees of hospitals and other nonprofit institutions. Representation is probably most useful as a check on administrators and professionals, typically held in reserve, but still important as a source of power when the organization fails to respond to other pressures.

Besides electing representatives to the governing board, members of cooperatively run HMOs also have available a second mechanism for making known their felt interests—the process of collective bargaining on behalf of employee groups that enroll in the plan. The groups' representatives can bargain for more favorable benefits or rates, giving their members additional leverage with the organization. Of course, this creates a certain inequality between HMO subscribers who are members of large and powerful subscriber groups and those who are not.

Thus some fundamental differences separate membership representation in an HMO from consumer representation in an HSA. The membership's stake in an HMO is more concentrated than consumers' interest in an HSA, and they have available two resources to ensure the accountability of the plan to them—their votes for the governing board and their fees for enrollment, which they can withdraw either individually or collectively as part of a dissatisfied subscriber group. To use the language of Albert O. Hirschman (1970), this structure gives them a particularly strong combination of "voice" and "exit" mechanisms for exerting control over the organization. They can use "voice" at times of elections and negotiations, and "exit" at times of re-enrollment.

In Hirschman's model, "exit" and "voice" are two means of resisting the tendency toward slack and decay in social life. "Exit" is really no more than a shorthand for use of the market mechanism; "voice," a shorthand for use of the political process. In health care, the medical profession has traditionally insisted that the patient's right of exit—"free choice of physician"—was adequate protection against abuse. But the patient's ability to exit from the care of a particular doctor did not include the ability to exit from a system of professional dominance and fee-for-service payment. The medical profession insisted that it had the right to define the limits of free choice, and it is remarkable how easily public policy and the law accepted that claim, until recent years. If we can view the attempts to improve consumer representation as attempts to improve voice, then we can view the recent antitrust measures as attempts to improve exit. Both constitute checks on professional power and slack performance.

Havighurst points out that the first antitrust moves were conceived by lawyers, who were reasoning from their experience with other industries and on the basis of out-of-date information about medical care. Hence they were led to take up questions such as the professional ban on advertising and the American Medical Association's (AMA) control of medical education, although doctors are not likely to advertise even in the absence of a ban and the AMA is no longer effectively restricting the physician supply. The early antitrust efforts were not grounded in any overall understanding of the way the medical market worked or what effect increased competition could be expected to have. Now, Havighurst argues, the FTC is moving toward a more coherent and sophisticated strategy that will help break down the profession's defenses against effective private cost-containment. While the public continues to identify antitrust with the issue of advertising, the FTC is now looking more at such things as physicians' control of Blue Shield and price-setting arrangements, and professional boycotts of new forms of health service like HMOs. Havighurst believes the medical profession ought to distinguish these efforts to improve the market from regulation of the "command-and-control" variety. I particularly like his image of the profession surrendering to free-market advocates rather than to government regulators, just as a country losing a two-front war might choose to surrender to the enemy whose values it preferred. Actually, however, I think a genuinely free market would be worse for the doctors' material interests than government regulation, which they could almost certainly expect to manipulate in their own favor.

How far are the competitive and democratic strategies likely to take us? My own opinion is that it depends on the institutional structure within which representation and competition take place. In a medical market with a large number of membership-controlled prepaid health plans, I believe representation and competition would take care of most of our problems, and there would be little need of government regulation. Under the present system, it seems unlikely that either competition or representation will take us very far. The competitive measures are handicapped by the structure of third-party insurance; when most of the bills are paid by a third party, there simply is not

much incentive for price competition among doctors and hospitals. The attempts to increase representation, at least in health planning, are handicapped by the dispersed interests of consumers and the weakness of planning agencies. The structure envisioned in the current Kennedy-Waxman national health insurance plan, on the other hand, might provide the context within which exit and voice could begin to have the effects we expect of them. It would create an entirely new environment for competition among insurers and HMOs; by returning to consumers the savings from more efficient plans, it would encourage price competition and cost containment.<sup>1</sup> In the long run, such a measure would probably favor the expansion of HMOs, and eventually one could expect demands for consumer representation in those HMOs that originally did not provide for it. Thus one can imagine a distinctive system slowly emerging in America that would provide for both more competition and more representation, a system in which exit and voice could function to control costs and maintain quality without extensive government regulation.

I suggest this development, not as a likely scenario, but as a plausible ideal for medical services in America. The regulatory approach now seems to dominate policy making, but its effects are often perverse. As Feder and Scanlon point out in their analysis of the nursing home industry, regulation is creating monopoly power where it previously did not exist. Their analysis belongs to a budding genre that goes under the rubric "the ironies of regulation." While the government is trying to break down monopoly power with one hand, it is creating it with the other.

Health care policy is replete with such ironies because there has never been any overall plan or conception that united the disparate elements. In their various ways, these papers show how disastrous incoherent formulations of policy can be, and they offer models of the kind of critical intelligence that policy making in medical care so desperately needs.

<sup>1</sup> See my discussion, "Kennedy's Conservative Health Plan," in the *New Republic*, Vol. 180, No. 23, pp. 18-21, 1979.

## References

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