

The Problem of Monopoly Power in Federal Health Policy

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FEDERAL REGULATORY PROGRAMS IN THE HEALTH area appear to have contradictory objectives. In one direction, the government is attacking the alleged monopoly power of health care providers. The Federal Trade Commission (FTC) and the Antitrust Division of the Justice Department are actively pursuing these professions on such issues as price fixing and advertising restrictions. At the same time, in an apparent effort to gain better control of the medical profession, government enacts legislation for programs that explicitly create new arenas of provider dominance. Professional standards review organizations and health systems agencies are examples. One wonders whether there is any rationality behind these contradictory efforts, or whether health regulatory initiatives are simply a series of random occurrences that might just as likely move in one direction as the other. How can we account for this seemingly schizophrenic behavior on the part of policy makers?

The contradictory stance of government toward health care professionals reflects a certain ambivalent attitude toward group power in American political philosophy more generally. The founding fathers, we are told in all our textbooks, were concerned with the problem of preventing excessive strength in either large or small groups. This theme is eloquently expressed in "The Problem of Faction in a Republic," which first appeared in 1787, the tenth paper James Madison

wrote for *The Federalist*. But whatever careful inventions of constitutional engineering were devised for the purpose of controlling the tyranny of a small group, they were not applied to the medical profession—and not, many would argue, to the wealthy elite, either. Why not?

Along with the concern about excessive power, American political ideology holds a profound belief in the relative harmlessness of private associations. As Grant McConnell (1966) argues, private associations, because they are voluntary and because they are associations of like-minded people sharing a common interest, are not thought to be either coercive or dangerous, and therefore do not require any checks and balances. Moreover, the medical profession in particular has benefited from a widespread cultural acceptance of its own self-description as a group of people who serve the public interest. This self-description is so widely accepted that the founding father of medical sociology, Talcott Parsons (1951), declared serving the public interest (or in his words, “collectivity orientation”) to be one of the definitional elements of a profession.

Thus, with what amounted to an exemption from traditional public concern with checks and balances, the medical profession has been allowed to acquire considerable power—a power only magnified when first the commercial insurers and then the government began to finance their services. The concern with excessive power is always in the background, however, and it is not surprising that when Americans are dissatisfied with their health services, whether for reasons of quality, cost, or accessibility, they look to an imbalance of power as an explanation. The traditional weaponry for combatting excessive power—antitrust policy and constitutional engineering—is dusted off and pressed into service.

The articles that follow grew out of a panel sponsored by the Committee on Health Politics, at the 1979 meetings of the American Political Science Association, on the theme, “Monopoly and Antimonopoly Strategies in Federal Health Policy.” Each paper examines a facet of federal health policy in light of the tension between monopoly-creating and monopoly-destroying strategies.

The paper by Feder and Scanlon describes a program—certificate-of-need legislation to control the number of beds in nursing homes—

that effectively created monopoly-like power for the operators of nursing homes. The Feder-Scanlon analysis of the case of nursing homes is suggestive of another reason why government actually creates monopoly power when it is ostensibly trying to curb group power. In the face of strong pressure from a concentrated group of providers with an intense interest in health services, and diffuse public pressure from citizens with a sporadic or only potential interest in health services, it is easy for the government to respond with material benefits for the providers and symbolic benefits for the consumers. Consumers were given liberal criteria of eligibility so that, in theory, many people were given access to nursing home care. But, at the same time, in order to set limits on spending for nursing home care without antagonizing nursing home operators, government allowed—even required—the industry to restrict its supply of services. The result, as Feder and Scanlon argue, was to give providers the ability to select the most profitable patients. Such “cream-skimming” is, of course, anathema to antitrust enforcers.

The papers by Havighurst and by Marmor and Morone deal with two very different antimonopoly strategies. Havighurst describes some current efforts of the FTC to apply antitrust legislation to the health professions, and he argues the case that the medical profession can and does behave like a monopoly, and should be regulated like one. Marmor and Morone analyze the strategy of citizen participation, with specific reference to the National Health Planning and Resources Development Act. As an answer to the problem of controlling professional power, citizen participation falls in the tradition of constitutional engineering. The authors argue that by manipulating the rules governing the composition of decision-making bodies (“concepts of representation”), the balance of power between providers and consumers can be changed.

The integration of professional power into a democratic political system is a central theme—if not the core issue—in federal health policy. Society wants the benefits of professional expertise, and is quite willing to finance publicly many of the services of health professionals. But, somehow, the professions must be made to serve democratically determined social purposes, rather than society’s being made to serve (or at least finance) professionally determined goals. The

papers that follow attest to the continuing importance of this dilemma in American health policy.

References

- McConnell, G. 1966. *Private Power and American Democracy*, chapter 4. New York: Alfred Knopf.
- Parsons, T. 1951. *The Social System*, esp. pp. 434–435. Glencoe, Ill.: Free Press.

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