LAW AND CONTEMPORARY PROBLEMS

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FOREWORD

Proposals to alter the health care system abound at the present moment. According to the disposition and self-interest of their proponents, they tend to feature either monopoly or a high degree of governmental control (or both) as a solution to existing problems, and it is a common assumption that the forthcoming policy choice must be between the lesser or some combination of these evils. Indeed, the trends to monopoly and comprehensive government control are already well advanced, although the culmination of neither has yet become inevitable.

The threat of monopoly in health services is difficult both to detect and to resist because present circumstances make concentration and reduced competition seem both logical and desirable. For one thing, competition has long been thought to be largely incompatible with the rendering of medical services. Recent recognition of the need to increase efficiency in health care now argues strongly for larger providers and for bringing the diverse components of the system under central control. Moreover, there is already in motion a potent vehicle of monopoly which is more threatening because it has hitched itself to the widely accepted notion of "comprehensive health planning." Such planning is clearly needed for the purpose of supervising and coordinating the health investments of the public and eleemosynary sectors to prevent redundant, extravagant, or even corrupt expenditures. Nevertheless, this purpose does not justify the current tendency to extend planning to include private-sector investments and to give the planning agencies the power to prevent market entry wherever a "need" is not demonstrated to their satisfaction.[1] Unfortunately, "planning" is being silently metamorphosed into protectionist regulation for the benefit of incumbent providers.

Of course, as things now stand, community hospitals are indeed excessively vulnerable to competition, in part because their rate structures do not reflect the costs of their various services but more fundamentally because they bear a considerable financial burden in serving the poor, much of which must be covered by monopolistic charges to paying patients. Health insurance helps to spread these latter charges and prevents the monopolistic-charity model from being a totally irrational and in-

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[1] *E.g.*, 1971 N.C. Sess. Laws, ch. 1164. *See also* Havighurst, *Health Maintenance Organizations and the Market for Health Services*, in this symposium, p. 716, 785-86 n.217.

equitable way for society to absorb the cost of caring for the poor, but reliance on this model requires protective legislation and forfeits the substantial benefits obtainable from competition.

Provision of medical care for the poor is not fundamentally incompatible with a more competitive health care marketplace. Some of the pending legislative proposals would pursue the more attractive route of providing the poor with adequate insurance coverage rather than subsidizing the providers of care by direct public grants or through award of monopolistic privileges. Of course, proposals for improving citizens' ability to pay for care may still reflect compassion for hard-pressed providers more than concern for the deprived poor themselves, but at least that compassion should not be carried to the extent of relieving providers of both the need to treat some nonpaying patients *and* the threat of competition. There is a real danger that the process of legislating protectionism will be completed at just about the time that the chief justification for it is largely removed.

Exclusionary licensing or franchising is, of course, borrowed from public utility regulation. But the utility model, with its guarantee of monopoly, needs to be analyzed since it has troublesome implications for both efficiency and the quality of care. Furthermore, limitations imposed on consumer choice may be more portentous in the health care field than elsewhere because of patients' sensitivity to insensitive treatment and the recognized therapeutic benefits of patient confidence in and rapport with the provider. Finally, even though most monopolistic hospitals are technically nonprofit enterprises, their frequent slighting of patients' interests, their capacity for inefficiency, and their propensity to operate for the convenience and benefit of their managers and medical staff[2] are sufficient reasons that planning agencies ought not to be given the authority to award or strengthen monopoly power. Moreover, the health planning bodies may already have reached the status, which all regulatory agencies may be fated to attain, of being the captive of the establishment they are expected to regulate.

Since the proper course for achieving better performance from the health care system is still being mapped, there is some reason to hope that the mistakes attending past regulatory endeavors will be avoided. Explicit recognition of the market as the primary instrument of social control, with supplemental regulation to improve its functioning and avoid its shortcomings and with an adequate insurance scheme covering lower-income persons, remains an available option. Even if Congressional faith in the market's capacity is weak, perhaps the sheer complexity of devising a tenable comprehensive regulatory and financing scheme will dictate a trial of an explicitly market-oriented system.

August 1, 1971 CLARK C. HAVIGHURST.

[2] Latter-day radicals object to monopoly less for its mere profitability than for its dehumanizing aspect and the power it accumulates, suggesting that nonprofit status, if it could be established, would be no defense. *See* HEALTH POLICY ADVISORY CENTER, THE AMERICAN HEALTH EMPIRE (1970); Halberstam, *Liberal Thought, Radical Theory and Medical Practice*, 284 N. ENG. J. MED. 1180 (1971). Health policy must recognize the legitimacy of these concerns, perhaps by making the consumer rather than the provider sovereign. *Cf.* A. BLACK, A RADICAL'S GUIDE TO ECONOMIC REALITY (1970).