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Monopoly and Monopsony Power: A Growing Ethical Challenge in the Care of the Female Patient

Monopoly power is a familiar economic concept: a single seller or a small group of sellers that dominates a market. The seller gains the economic benefit of secure revenue streams and increased profit while shifting to buyers the burden of the resulting higher costs.

Monopsony power is a less familiar economic concept: a single buyer or group of buyers that dominates the market. This results in a disparity of power that is the converse of monopoly, but—like monopoly—there is great potential for exploitation when the power is abused.¹

Monopsonies exploit sellers by setting artificially low prices, not ordering goods or services, and not providing adequate information—all of which injure the interests of sellers. As physicians, we saw this principle at work in the managed care setting in the 1990s.² In recent years, the map of monopoly and monopsony power has become more complex, with some of that power concentrated in payers and some in health care organizations.

The monopsony power of payers is increasing, especially as insurance companies become national

in scope with millions of covered lives. As a consequence, in many parts of the country, some insurance companies dominate market share and therefore are in a position to exercise monopsony power

clinical training for students, and conduct research, it must respond to the teaching hospital's monopsony. A particular service within an ObGyn department may gain monopoly power by creating financial

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over clinicians. Medicare, the major public payer in the United States, has gained monopsony power over hospitals, which affects much of gynecologic practice in women older than 65.

Health care organizations can exercise both monopsony and monopoly power. A teaching hospital can gain monopsony power over a medical school, as when an ObGyn department has highly regarded voluntary faculty who compete with full-time faculty and with whom the hospital has preferential arrangements. Because the medical school needs the teaching hospital to support faculty, provide

and expertise barriers to entry, as with an assisted-reproduction medicine service.

In settings where the medical school controls hospital privileges, it is the sole provider of these services, gaining a monopoly over the hospital. Thus, the medical school's monopoly power is considerable in closed-staff hospitals, in contrast to the weaker power of a medical school affiliated with an open-staff hospital.

The ethical concept of cofiduciary responsibility provides a basis for responding to the ethical challenges of monopoly and monopsony power. This ethical concept

comes to us from British physician-ethicists John Gregory (1724-1773) and Thomas Percival (1740-1804). They identified 3 components of cofiduciary responsibility:

- Physicians and hospitals should be scientifically and clinically competent, basing clinical practice and its continuous improvement on evidence-based medicine
- Physicians and hospitals should act primarily for the benefit of patients, keeping self-interest—including economic interests—systematically secondary
- Medicine and hospitals are public trusts that should be managed for the long-term benefit of patients and society, not primarily for the self-interests of physicians and hospitals—including legitimate and even urgent economic interests.

In the clinical setting, Brody and Wear have argued that clinical transparency obligates the physician to provide clinically reliable information to the patient.^{4,5} The transparency of the informed consent process in which patients are provided information they need protects the patient from the potential for exploitation that results from monopoly and monopsony power.

Transparency is essential for the legitimization of monopoly and monopsony power of both payers and health care organizations. The leadership of payers and health care organizations should routinely provide each other with information about economic self-interests that are necessary for fulfilling their cofiduciary responsibility. For example, improving the quality of patient care is a fundamental responsibility that also costs money.

Business plans should clearly define the true costs of continuous quality enhancement and revenues available to cover them.

To avoid exploitation of monopoly and monopsony power by payers and health care organizations, the assumption of costs by each party should reflect the portion of the benefit claimed by each party. The calculation of costs should be rigorous, comprehensive, and honest.

Meeting this requirement will “level the playing field” between payers and health care organizations and prevent exploitation of power that could be to the detriment of patient care. Failure to achieve transparency results in both parties “gaming” the system by various means, such as strategic procrastination and strategic ambiguity, misdirection, and outright deception, which corrupt the organizational culture.^{6,7}

It is important to distinguish the reality of transparency from its mere appearance. From a desire or need to protect monopoly or monopsony power, payers or health care organizations could simulate transparency by publicly committing themselves to it but then not funding the requisite infrastructure (eg, committing to quality enhancement without paying for data collection, analysis, and dissemination).

The mere appearance of transparency may advance monopoly or monopsony power but should never be mistaken for transparency itself. Clinicians should not hesitate to point out when the mere appearance of transparency is being substituted for the real thing.⁷

An ethical perspective on monopoly and monopsony power is

essential for understanding the complex power relationships between payers and health care organizations. Both must strive for excellence in patient care in this time of major change in the organization and financing of health care, so that this change occurs in an ethically responsible fashion, by protecting and strengthening cofiduciary responsibility.¹

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