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ORIGINAL ARTICLE

# Power abuse & Monopoly Risk in Healthcare System: Heterodox Analysis & Empiric Illustration

## Abuso de poder y riesgo de monopolio en el Sistema de Salud: análisis heterodoxo e ilustración empírica

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**Abstract**

It is generally accepted that the potential for the abuse of power is inherent in medicine, especially under a monopolistic system. The case of doctors in Nazi Germany provides a frightening example of such power abuse. History provides additional examples of grave power abuse by government-run healthcare entities. In this paper, we first analyze the historical and institutional context of doctors' behavior in Nazi Germany and then proceed to analyze instances of medical power abuse in other totalitarian countries. Subsequently, we examine some dangerous trends in modern democracies. While state-run medicine has the capability to provide effective solutions in certain cases, we should not overlook the potential dangers of power abuse and the degradation of service quality resulting from the state's domination in healthcare. It is questionable whether ethical guidelines and proper education alone can substitute institutional means to safeguard patients' rights. These dangers need to be carefully analyzed when determining medical policy. For example, the well-known problem of information asymmetry between doctors and patients can be effectively mitigated in a free society with a competitive market for healthcare.

***Keywords:*** Public Healthcare, Medical Policy, Power Abuse, Competition, Charity, NGO.

***JEL Classification:****I13, I18, D73, D82*

***Resumen***

Generalmente se acepta que el potencial de abuso de poder es inherente a la medicina, especialmente bajo un sistema monopolístico. El caso de los médicos en la Alemania nazi proporciona un ejemplo aterrador de dicho abuso de poder. La historia ofrece ejemplos adicionales de graves abusos de poder por parte de entidades de salud gestionadas por el gobierno. En este artículo, primero analizamos el contexto histórico e institucional del comportamiento de los médicos en la Alemania nazi y luego procedemos a examinar casos de abuso de poder médico en otros países totalitarios. Posteriormente, analizamos algunas tendencias peligrosas en las democracias modernas. Si bien la medicina estatal tiene la capacidad de ofrecer soluciones efectivas en ciertos casos, no debemos pasar por alto los peligros potenciales del abuso de poder y la degradación de la calidad del servicio resultante del dominio estatal en la atención médica. Es cuestionable si las pautas éticas y la educación adecuada por sí solas pueden sustituir los medios institucionales para salvaguardar los derechos de los pacientes. Estos peligros deben analizarse cuidadosamente al determinar la política médica. Por ejemplo, el conocido problema de la asimetría de información entre médicos y pacientes puede mitigarse efectivamente en una

sociedad libre con un mercado competitivo de atención médica.

***Palabras clave:*** *Salud pública, política médica, abuso de poder, competencia, caridad, ONG.*

***Clasificación JEL:*** *I13, I18, D73, D82.*

## 1. Introduction

It is generally accepted that the potential for abuse of power is inherent to medicine (Reis & Wald, 2019). The case of doctors in Nazi Germany provides a frightening example of such power abuse. We should stress the amazing popularity of the Nazi party (NSDAP) among German physicians: 40% of physicians joined NSDAP (Kater, 1987), as compared to 10% on average (Kater, 1983) and to 22% among teachers (Jaraush & Arminger, 1989). Two means to mitigate the threat of abuse are usually discussed. One is due ethical guidelines and proper doctors' education (Gallin et al., 2020); another is proper government regulation and control, as well as legal liability of the medical professionals. However, we hypothesized that under certain circumstances both means may miss their target or even promote abuse of power instead of protecting the patients. In this paper we elaborate on the following research questions:

- Can one point on an institutional background of medical power abuse in pre-Nazi Germany?
- If yes, does such a background exist in other countries, including democracies?
- Do we see dangerous trends in modern democracies?
- If yes, what can be done?

## 2. Theoretical and methodological frameworks

This review applies the heterodox analysis from Austrian Economics (i.e., Menger, Mises, Hayek, Rothbard, et al., Huerta de Soto, 2000; Zanotti, 2012), New-Institutional Economics (i.e., Coase, Buchanan, Tullock, Fogel, et al., Buchanan & Tullock, 1962; Brennan & Buchanan, 1985), and its mixture (Sánchez-Bayón, 2022a, 2023a, and 2024a-b). This heterodox synthesis (Sánchez-Bayón, 2022b-c and 2023b-c) is based on a mainline foundation (Boettke et al, 2016) , and common tools and approaches: methodological individualism (included the State, which includes other economic agents: bureaucrats, politicians and lobbies; Buchanan & Tullock, 1962; Anderson, 1986), principle of realism (realistic and positive study and not normative and econometric biases, i.e., F-twist, mathiness, Romer, 2015; Sánchez-Bayón et al., 2023), etc.

According to this heterodox analysis, this review realizes 3 kinds or levels of analysis:

- Comparative analysis of healthcare systems in the 19th-20th centuries.
- Institutional analysis of public health systems in different countries—totalitarian and democratic.
- Narrative review of alarming trends in modern democracies.

## 3. Results

### *3.1 State-dominated healthcare in Germany and the Holocaust*

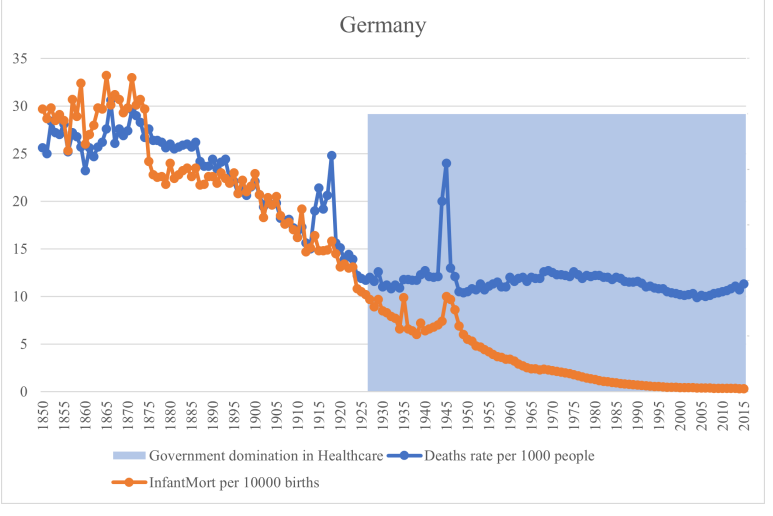
Decades before Hitler came to power, Germany had a tradition of government intervention in healthcare. State-run health insurance GKV (Gesetzliche Krankenversicherung) was established by Bismark in 1890 (IQEHC, 2015); noncommercial health insurance run by the oppositional Social-Democratic party was dissolved on political grounds (WHO HiT, 2000). In other countries like Britain, France, and Belgium, state-run health programs were created only after the Second World War; meanwhile, non-commercial health programs for the needy developed successfully (Green, 1993; Rodwin, 2003; WHO, 2004). In Germany, however, governmental policies promoted expansion of the state-run healthcare. The presence of free healthcare (at taxpayers' expense) influenced the competition in

providing medical services. Clearly, a provider like GKV—whose service is free—was able to suggest even a low standard of care and still enjoy a significant market share. This share was growing, supported by the state budget. And in the private sector, physicians and hospitals were more and more busy searching for alternative means to maintain or increase market share—namely, the alliance with regulatory authorities. Ultimately, GKV covered most of the population by 1927.

The long-term decision to adopt state-run healthcare in Germany was not prompted by a crisis in private healthcare. We propose that this choice was driven by two intertwined bureaucratic incentives: the desire to expand discretionary power and gain electoral support for this expansion (Jasay, 1985) and the aim to maximize public spending while maintaining control over resources (Tullock, 1965; Niskanen, 1971). Also, deep in this kind of interventionism there are unwanted effects and failures (Sánchez-Bayón, 2023c-d & 2024b-c), and the risk of omnipotent government (Mises, 1944) and the road to serfdom (Hayek, 1944).

Additionally, as depicted in Figure 1, the state's assumption of healthcare responsibilities did not lead to noticeable improvements. This same trend is evident in other countries—refer to the cases of the USA, UK, and Belgium in the Supplementary Materials (Data Set[1]). In all instances following the implementation of state control, healthcare costs experienced a more rapid increase than the rate of economic growth. The extension of healthcare bureaucracy's authority has become a prevalent phenomenon in Western countries.

**Figure 1. The extension of healthcare bureaucracy's authority in Western countries**




Source: Mitchell (2007) & World Bank (2023).

This historical development may explain the phenomenon of the amazing popularity of the NSDAP among German physicians mentioned above. Namely, under free society and limited government, the free market causes tough competition between service providers, and therefore the client (here, patient) is a king. Under lack of freedom (numerous restrictions on competition), doctors escape competition and enjoy de facto exemption from liability. Even the best doctors' benefit from such circumstances. Membership in the party solidifies the abovementioned advantages.

There is another extremely important point: change in doctors' perception of the patient. Absence of liability developed a habit to decide for an unenlightened patient—in the best interest of the patient himself, of course. Thus, they turned open to accept totalitarian ideology, which also legitimized their power and, eventually, their irresponsibility (Reis et al., 2019). The habit is hard to break, so the

1. http://dx.doi.org/10.13140/RG.2.2.27312.33285

doctors began to make their decisions in the best interests of the nation (and of the party) as well—and to perform euthanasia on the mentally ill, etc., as well as medical experiments on prisoners, causing suffering, permanent disability, and death (Wiendling et al, 2016).

One may suggest an alternative explanation of the NSDAP's popularity among German physicians: Jewish doctors enjoyed a pretty significant share of the healthcare services market before 1933. The percentage of Jewish physicians was about 10%, with higher representation in big cities, probably up to 40% in Berlin (Kater, 1987). Therefore, one may suggest that Aryan doctors could wish to join the Party to crash Jewish competitors. However, this explanation is rather weak in our opinion. The huge majority of doctors joined NSDAP only after Hitler came to power (Kater, 1983), when their influence on policy was zero. In addition, people (including physicians) are generally not interested in politics and tend not to see political involvement as a reasonable means to promote their personal interests; there is substantial literature where authors work hard to explain even minor participation in politics, like voting (Downs, 1957). Therefore, we conclude that the latter factor—willingness to get rid of Jewish competitors—cannot explain the doctors' mass membership in the Nazi party.

### *3.2 Medical power abuse in the USSR: total monopoly and oppression of dissidents*

We should mention here that neglect of patients' rights and interests is not unique to Nazi Germany (i.e., the USSR legislation never mentioned patients' rights). The right to free healthcare was proclaimed merely symbolically, taking into consideration the poor quality of medical service for the huge majority of Soviet citizens (Troshkina, 2014). Mental health clinics were routinely used to repress dissidents; some of those dissidents acquired real and irreversible mental health problems because of the abovementioned "mental care" (Van Voren, 2010; Bonnie, 2022). The most comprehensive overview is probably the Moscow Helsinki Group's review (MHG, 2004)—unfortunately, in Russian only (for health problems caused by the 'treatment'). Even in modern Russia, where people enjoy incomparably more freedom than in the USSR but the healthcare is still state-dominated, the problem of medical power abuse is of great concern (ibid.).

The American government's extensive intervention in funding psychiatric health services was initially driven by altruistic considerations in the 1870s. The goal was to swiftly move mentally ill persons from poorhouses to specialized psychiatric clinics (asylums).

As state governments became the principal providers of psychiatric health services, psychiatrists naturally inherited and adopted incentives inherent in bureaucratic operations, such as lobbying for more funds with limited liability and accountability. This development caused a massive expansion in the number of patients in government-run facilities, beyond the initial increase caused by the influx from poorhouses (Paserman, 2002). The pace of this increase even accelerated after the initial transfer of patients (Geloso & March, 2021, Fig. 1). Geloso and March attribute this development to efficient lobbying efforts. The number grew at the cost of the share of patients cared for by families and privately (charitably) funded almshouses. Governmental facility physicians and superintendents lobbied and made noticeable PR efforts to impress public opinion and mobilize more support for funding extension, acting under an obvious conflict of interest. The sharp increase in patient numbers could be at least partly explained by the rent-seeking motivation of government-run asylum physicians and superintendents (ibid.).

The extensive use of lobotomy treatment, even after professionals understood its medical inefficiency, could also be traced back to rent-seeking behavior within the framework of the government-run system of psychiatric care facilities (March & Geloso, 2020). Thus, despite the absence of politically motivated malicious intentions, the American experience with government-run psychiatric healthcare facilities teaches us to be very cautious about large-scale government intervention in health services. Such intervention could easily result in the reproduction of perverse incentives, conflicts of interest, and consequently, moral hazard."

### *3.3 Organ harvesting from prisoners in China (PRC)*

Another dangerous example of medical power abuse we find in the organ harvesting from condemned prisoners in China (PRC). The officially admitted practice of harvesting organs from executed prisoners has been lasting for decades (Hillman & Nathanson, 2001; Stevens, 2017). There have been allegations that, besides other ethical issues, not only the process of execution may be modified with donation in mind, but even that executions might be organized specifically to obtain organs for transplantation (Cameron, Hoffenberg, 1999). The PRC officials repeatedly promised to stop the practice of the above-mentioned organ harvesting (NBC, 2012; Dai, Xu, 2015). However, significant changes occurred in the PRC political system during the last decade. The system of informal checks and balances crafted by Deng Xiaoping had collapsed and was substituted by the unlimited personal rule by Xi Jinping in 2017 (Georguiev, 2018; Shirk, 2018; Gore, 2019). These changes made improvements less probable. While the PRC government denies the allegations of the forced organ harvesting, lack of transparency in the PRC makes the denial not trustworthy; there is also some direct evidence of medical power abuse (Nice et al., 2020).

### *3.4 State-dominated healthcare in UK: conflict of interest and less competence*

The conflict-of-interest problem is probably immanent to any state-dominated healthcare, even in established democracies. As mentioned above, the state's assumption of healthcare responsibilities did not result in significant improvements in any country; instead, healthcare costs consistently experienced a more rapid increase than the rate of economic growth. What is even more noteworthy is that the expansion of healthcare bureaucracy's authority has become a widespread phenomenon in Western countries.

The case in the UK where parents were deprived of efforts to save their child by flying him abroad for medical treatment (Hammond-Browning, 2017; Wilkinson, Savulescu, 2018) is an important warning. The details of the case can be found in the documents of the UK Supreme Court (UK Supreme Court, 2017a; UK Supreme Court, 2017b). In this case, the natural desire of the National Health Service (NHS) to prevent competition caused a grave conflict of interest. That conflict of interest was ignored by the court and aggravated by the court's use of its power to decide in the best interest of the child. Even if we assume that the NHS position was perfectly founded professionally (though there are many reasons to challenge this assumption (Wilkinson, Savulescu, 2018), the court's reliance on expert opinion to use extremely strong power 'to permit the child to die with dignity' in his best interests creates a very dangerous precedent. European court of Human Rights endorsed domestic court's approach[2]. A similar recent case (UK Supreme Court, 2021) underlines the danger.

Back in the UK, with its state-run healthcare (NHS), there is a practice (still secretive but occasionally revealed) that certain government servants are provided with special healthcare. (Sparrow, 2003; Tonkin, 2015) In other words, some proponents of state-dominated healthcare admit openly that in a democratic state "some animals are more equal." (There is a revival of this interpretation with the current socialist government of Spain and its public law of animal welfare and well-being of 2023). In the USSR, such special healthcare was an official policy: the corresponding agency was called the 4th Main Medical Department (Voslensky, 1984; DPRF, 2021).

## 4. Discussion

Though there is effective consensus that governmental healthcare has many problems, most authors express deep concern about the threat of big business to personal rights if we remove the government from healthcare—see, for example, Glaeser and Shleifer (2003). In the context of this research, medical commercial insurance companies and especially Big Pharma are often named as potential sources of

2. In its decision in the case of Gard and Others v. the United Kingdom (application no. 39793/17) today, the European Court of Human Rights has, by a majority, endorsed in substance the approach by the domestic courts and thus declared the application inadmissible. The decision is final. (June 27, 2017)

the threat to our freedom, both directly and through the capture of governmental institutions. This concern is widespread among colleagues, and we cannot ignore it.

Addressing this concern, we should note the lack of evidence and absence of proof of big business' threat. History provides proof of governmental assaults on big business, not the other way around (Yanovskiy and Socol, 2023).

The existence of Big Pharma was caused and continues to be reproduced by the heavy burden imposed by the government, with the Food and Drug Administration being the primary culprit (Philipson and Sun, 2008). Small and medium-sized firms cannot bear this burden. The government's unique ability to cause and perpetuate market monopolization is a well-studied phenomenon (Armentano, 1986; De Soto, 1989; Huerta de Soto, 1992; Rothbard, 2002).

Historically, before the coercive establishment of governmental control, the pharmaceutical industry was much more competitive than after government conquest. Healthcare services were provided in a competitive environment by nonprofit insurers, commercial insurers, and charitable organizations. A significant share of consumers preferred to receive and pay for private doctors' services without intermediaries or agents for better control over crucial decision-making (Green, 1993).

It should be mentioned that when the share of state-controlled medical services is on the rise, every next round of competition takes place in worse conditions. While opportunities to win competition by better serving the patient are shrinking, the alliance with regulatory authorities looks more and more attractive (if not the only) option for both business and charity. When service providers compare different options to increase (or just to maintain) their market share, political and administrative opportunities may 'outperform' efforts to maintain and increase the quality and efficiency of service.

The main dangerous side effect of government expansion (ultimately ending in the establishment of full control and 'one payer' financing of medical services) is turning doctors into de facto parts of bureaucratic machinery. At the same time, they become authorized to represent the government in their interaction with the patients. Thus, they escape the patients' and civil society's control. Both the information asymmetry (discussed below) and the discretion to provide or decline specific treatment empower doctors over patients. It is at least questionable that due ethical guidelines and proper doctors' education can substitute institutional means of safeguarding patients' rights.

Terrifying results of medical power abuse in Nazi Germany are felt even today all over the world: Actually, the entire institute of Helsinki clearance assumes that researchers bear the burden of proof that their experimental studies have nothing in common with the Nazi experimental practice (Schneider, 2015) and are conducted according to the Nuremberg code, including informed consent of patients.

One of the main arguments in favor of government regulation of healthcare is the problem of information asymmetry (Arrow, 1963; Buck, 2016; Dulleck & Kerschbamer, 2006). However, this problem has been discussed for many years, both particularly in medicine (Leonard et al, 2013) and generally in economics (Axelrod, 1970). It has been shown that strong interests of various stakeholders (commercial and noncommercial private insurers, charities, private clinics) to save money and to prevent reputational damage mitigate risks of informational power abuse by physicians. In a free society with a strong tradition of civic initiatives (Tocqueville, 1835; Olasky, 1994) and flourishing private business, there arise independent expert bodies possessing sufficient expertise, which is shared with the client or patient (Sullivan, 2006). Such bodies may be commercial—independent medical experts like the American Board of Independent Medical Examiners (https://www.abime.org), insurance, and legal firms. There are also non-commercial medical associations like Physicians for Patient Protection (PhysiciansForPatientProtection.org) and charities like Ezra Lemarpe (https://www.ezra-lemarpe.org/en). All the above-mentioned organizations are likely to effectively address the problem of information asymmetry without governmental control.

Another frequently used argument is the assumption of restricted rationality (or even restricted legal capacity) of an average person (Howard, 1994; Leoni, 1991). Actually, this is the reasoning for compulsory health insurance or compulsory pension programs: "There are people who are unable to care for themselves". However, this assumption is not compatible with the basic principles of a free

society. Moreover, in the context of public health, the 'limited capacity' argument is challenged, e.g., by the history of British non-commercial healthcare insurance (Green, 1993).

When healthcare is strictly regulated, more and more sophisticated legislation protecting the rights of patients is promoted. The legislation and the assumption of limited patient capability provide lawyers and patients with strong incentives to extract money from medical practitioners and institutions. Not only doctors and hospitals suffer from such practices: in such circumstances, responsibility insurance often proves to be a better option than investment in healthcare quality—not to the benefit of patients. Lawyers clearly benefit from the legislation expansion (Leoni, 1991). Not accidentally, US lawyers' political donations are clearly biased to the most 'liberal' wing of the Democratic party (Bonica, 2014).

Somewhat paradoxically, in the absence of competition, even educating doctors for responsibility may have an opposite effect. While authority without responsibility is clearly regarded as immoral, responsibility without authority is understood as unfeasible (Plant, 2011). Therefore, demand for responsibility may be translated—both psychologically and institutionally—to expanding authority with corresponding potential for power abuse.

Among the obvious advantages of a market, decentralized organization of the economy, one should note its enormous informational advantage over a command, centralized one (Kirzner, 1973, pp. 66, 151-169; Mises, 1949). The robust motivation of entrepreneurs and consumers, despite their limited knowledge, more frequently leads to the successful fulfillment of a rapidly expanding spectrum of personal needs and demands. At the same time, the command-centralized economy has routinely failed even when satisfying the most basic needs - food and clothing. For example, food rationing and the fight against "profiteering" in the Russian Empire on the eve of the 1917 revolution caused interruptions in the food supply of the largest cities, ultimately resulting in March 1917 mass unrest. It happened in one of the largest agricultural economies in the world at that time (Yanovskiy, Zhavoronkov, 2016). The economic collapse of the USSR (1991) further emphasizes this point (Gaidar, 2007). The decision-making centers of bureaucrats and politicians in a command economy are not only in practice but even in theory powerless against the market (Hayek, 1988). Progress in medicine is largely associated now with the individualization of treatment (Rajpurkar et al., 2022; Bajwa et al., 2021; Schork, 2019). Personalized treatment can only be done effectively by being provided in a decentralized manner, based on the strong incentives of the patient and the private physician. Such progress is in principle incompatible with centrally imposed treatment protocols broadly practiced, particularly during the COVID-19 pandemic. Thus, centrally imposed decisions in medicine not only violate individual rights and are morally problematic but also grossly counterproductive.

Summarizing, state domination in healthcare poses several dangers. Alternatively, there are multiple state-independent institutional frameworks safeguarding patients' rights and interests through both free market and non-profit initiatives. Such institutions proved their efficiency in various countries (Green, 1993), including in solving the problem of information asymmetry; they also protect doctors from lawyers. Dissolving these frameworks for the sake of a perfect governmental solution is an extremely dangerous experiment that may well jeopardize both patients' interests and physicians' capacity to succeed in their mission.

## 5. Conclusion

Even in the absence of criminal intent of totalitarian government, even without deliberate abuse, centralized medicine aggravates information asymmetry, threatens personal rights, and is dangerously inefficient: that is a public monopoly without competence.

Free decentralized choice of medical services, made in a highly competitive environment, mitigates risks of information asymmetry abuse, fosters opportunities for the collection and utilization of best practices, and incentivizes the establishment of reputations. Conversely, centralized decision-making, exemplified by treatment protocols imposed by government coercion, stifles the realization of these opportunities.

Thus, the capability of state-run medicine to provide effective solutions in some cases should

not mask potential dangers of power abuse and service quality degradation as a result of the state's domination in healthcare. It is at least questionable that due ethical guidelines and proper education can substitute institutional means to safeguard patients' rights. These dangers should be carefully analyzed in determining medical policy.

## Author Contributions

Moshe Yanovskiy: Conceptualization, investigation, project administration, validation, visualization , writing—original draft.

Yehoshua Socol: Investigation, methodology, visualization , writing - original draft, writing—original draft.

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