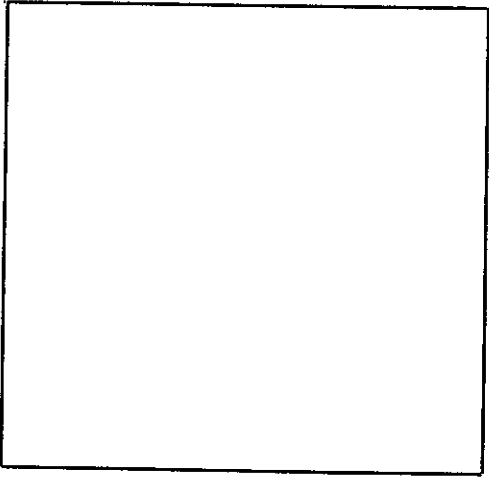
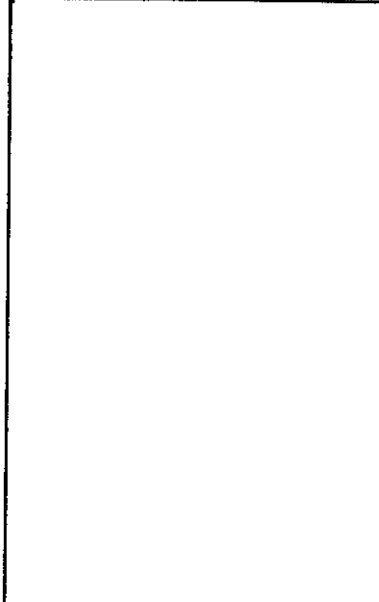




**Antitrust  
Intervention  
in the  
Health Care  
Industry**



*Proceedings of the  
Thirty-second Annual  
George Bugbee  
Symposium  
on Hospital Affairs,  
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The Thirty-second Annual George Bugbee Symposium on Hospital Affairs conducted by the Graduate Program in Health Administration and Center for Health Administration Studies of the Graduate School of Business, Division of Biological Sciences, University of Chicago, was held at the McCormick Center Hotel, Chicago, on May 4, 1990. These symposia are a reflection of strong concern of the Graduate Program in Health Administration with complex current issues in health care management.

The topic for this, the Thirty-second Symposium, was chosen by a committee of the Alumni Association because of its relevance in this period of changing environment for health care institutions. These proceedings are published and distributed in the hope that they will prove useful to both practitioners and students of health care management.

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**PRESYMPOSIUM WORKSHOP:  
IS HOSPITAL COMPETITION WASTEFUL? NO!**

**David Dranove, Mark Shanley and Carol Simon**

**ABSTRACT**

Recent attention has been given to the hypothesis that local hospital competition takes the form of costly duplication of specialized services—the "medical arms race." This contrasts with the hypothesis that the supply of specialized services is determined solely by "the extent of the market." We develop a model predicting the provision of specialized services in local markets. Our analysis of California hospitals provides little support for the medical arms race hypothesis, while suggesting substantial scale economies for many services. Our results emphasize the importance of properly specifying the extent of the market. Failure to do so imparts bias to the analysis of the importance of competition.

**1. Introduction**

Not all hospitals are the same. Some offer only a few basic services such as acute medical and surgical care, deliveries, care for normal newborns, routine diagnostics, etc. Others add to these basic services an array of expensive capital intensive services, such as cancer therapy, heart surgery, neonatology, CAT scans, etc. We refer to these generically as specialized hospital services. The availability of specialized hospital services differs across markets. The typical hospital in a large urban area offers a wider range of specialized services than its counterpart in a small urban or rural area. In this paper we explain intermarket differences in the provision of specialized services. We contrast two hypotheses. The first is that the number of specialized providers in a local market is determined solely by the "extent of the market." The second is that excess quality competition leads to an increase in the number of specialized providers above and beyond those that can be explained by the extent of the market. Hence, competition creates wasteful duplication of capital intensive specialized services. The latter story is known colloquially as the "medical arms race" hypothesis.

Distinguishing between these competing hypotheses—the extent of the market versus wasteful quality competition—has profound implications for hospital antitrust policies. In a recent merger case (*USA versus Carilion Health System and Community Hospital of Roanoke Valley*), the economist for the defendants alluded to the medical arms race (MAR) hypothesis and argued that reducing the number of competitors in the market would increase efficiency. Approving the merger, the district court judge stated, "as a general rule hospital rates are lower, the fewer the number of hospitals in an area." Similar issues have arisen in a related case in Rockford, Illinois (*USA versus Rockford Memorial Corporation and SwedishAmerican Corporation*).

## 2. Literature Review

### *The Extent of the Market*

A primary explanation for intermarket differences in service supply is that there are variations in demand for services, along with non-constant returns to scale in the production of services. To paraphrase Adam Smith, the supply of specialized hospital services is limited by the extent of the market. A simple model of entry suggests that the number of sellers in a market is determined jointly by market demand, the shape of the individual seller's average cost curve, and the nature of competition between sellers. Generally speaking, one expects fewer sellers whenever:

- 1) Demand is smaller;
- 2) The average cost curve demonstrates economies of scale and/or does not demonstrate sharply rising diseconomies of scale; and
- 3) Pricing rapidly approaches perfectly competitive levels as the number of sellers increases.

Bresnahan and Reiss (1989) develop an empirical methodology that enables them to quantify demand, cost and scale factors affecting the supply of professional and quasi-professional services in rural markets. They identify the minimum threshold demand necessary to support different numbers of sellers of each type of service. They find that entry thresholds generally increase as markets expand. These results are consistent with a variety of explanations, including the existence of scale economies, and oligopolistic pricing (i.e., as more sellers enter a market, prices tend to competitive levels and profits are dissipated).

### *The Medical Arms Race*

In general, quality may be over- or underprovided by sellers in competitive markets, depending on such factors as the difference between marginal and average value of quality as perceived by consumers (Spence, 1975), and the observability of quality differences across providers (Dranove and Satterthwaite, 1990). The MAR hypothesis is a special case of quality competition, in which it is assumed that quality is overproduced in competitive markets.

The seminal statement of the MAR hypothesis appears in Robinson and Luft (1985) (henceforth RL), who contend that hospitals in more competitive markets provide duplicative services; i.e., services in excess of that which would be demanded by the market. Although RL focus on service provision, they analyze costs. RL find that hospitals in close proximity to many other hospitals are more costly than hospitals with few surrounding competitors. Similar findings appear in Luft et al. (1986), Robinson (1988), Robinson et al. (1988), Noether (1988), Zwanziger and Melnick (1988), and Health Care Investment Analysts (1990). RL infer that inefficient service duplication occurs in competitive markets.

An alternative explanation that we do not explore is that quality is underprovided in monopoly markets.<sup>1</sup>

The intuition behind the MAR hypothesis is that hospitals compete for physicians, who in turn determine admission patterns. One way to attract physicians is to offer the latest technology, regardless of existing supply and expected utilization.<sup>2</sup>

Although it has a certain intuitive appeal, the MAR hypothesis rests on several questionable assumptions. First, it is assumed that hospitals seek out popular physicians, and not vice-versa.<sup>3</sup> Second, physicians are presumed to value new technology independent of its specific applications for their practice. Third, insurers are assumed to reimburse all costs, so that the costs of technology can be passed through without affecting the demand for services. Not everyone will agree that these assumptions have face validity.

The econometric models used to document the MAR hypothesis are also questionable. In the seminal work of RL, the dependent variable is the cost per admission at each hospital. The key predictor, the degree of competition facing a given hospital, is measured by the number of hospitals within fifteen miles of that hospital, here denoted  $N_i$ .<sup>4</sup> Other predictors include population density, and several measures of the hospital's characteristics.

There are two interrelated problems with this specification: (1) the market boundaries are too small and (2) the predictor of interest,  $N_i$ , is endogenous. The interpretation of the coefficient on  $N_i$  is therefore compromised, since a positive coefficient can represent higher costs due to quality-based competition and/or the effects of correlated but omitted determinants of the extent of the market. Our analysis shows that variables that proxy for "fringe" supply and demand are significant determinants of the extent of the market. Omitting the geographic fringe imparts a serious bias to market structure coefficients. The net effect of these problems has been to exaggerate the empirical evidence in favor of the MAR hypothesis.

Our approach for comparing the MAR hypothesis with the extent of the market hypothesis is based on Bresnahan and Reiss (1989). We estimate entry thresholds for the provision of specialized services in local hospital markets. We test the two hypotheses by measuring the degree to which variation in determinants of the extent of the market and variations in competition accelerate entry.

### 3. Data and Methods

We need three types of information to perform our analyses. First, we need to identify local hospital markets. Second, we need to identify the scope of specialized services provided by hospitals in each market. Third, we need information about the demand for and cost of providing each service, as well as a metric for the degree of competition in each market.

We use 1983 data for the state of California. We chose 1983 because a previous study (Zwanziger and Melnick (1988)) found a substantial and significant "inefficient competition" effect in California up through 1983. Recent legislative changes may have strengthened the bargaining power of insurers, thereby lessening the inefficient competition effect. Our results suggest that there was little evidence for an inefficient competition effect even prior to such changes.

## *Market Identification*

All previous studies of hospital markets use an ad hoc approach to market definition. We will too. We will augment our ad hoc approach, however, by including in the predictive model variables that proxy for potential patient flows between the markets.

We choose as local markets the following:

- (1) All urbanized areas <sup>5</sup>;
- (2) All cities with populations greater than five thousand not in an urbanized area.<sup>6</sup>

We identified a total of 103 local markets, with 445 community hospitals. As our interest is in measuring competitive effects, we restrict our analysis to the 87 local markets in which there is at least one hospital. The hospitals in these markets account for 98% of all of the community hospitals in California, and all but one of the community hospitals with over 100 beds. (Hospitals with fewer than 100 beds are considered small and usually do not offer specialized services.) A complete list of markets, along with some demographic and geographic information, appears in Appendix One.

Economic markets may extend beyond the geographic boundaries of any of the 87 local markets, due to the propensity of patients to travel beyond their local market for health care services. Our methodology accommodates patient flows to and from proximate geographic areas. In particular, for each of the local markets we include variables to proxy for fringe supply and fringe demand. As the impact of fringe supply and fringe demand may vary by service, we estimate different fringe supply and fringe demand effects for each service.

Our approach is in the spirit of Elzinga/Hogarty (E/H) market definitions (Elzinga and Hogarty, 1978). E/H contend that one needs to consider inflows and outflows when defining economic markets. E/H define local markets so that inflows and outflows each account for less than 10% of total patients. We have opted not to use the E/H definition for the following reasons:

- (1) A strict application of E/H would identify only a few distinct markets in California. We believe some of these are unintuitively large, encompassing thousands of square miles. The apparent overaggregation of cities into markets would restrict our ability to analyze the provision of specialized services.
- (2) E/H presume but do not actually demonstrate that fringe supply and demand matter. Our methodology allows us to test the importance of fringe supply and fringe demand, on a service by service basis.
- (3) E/H may be inappropriate when applied to heterogeneous products such as hospital services (cf. Werden (1990), Zwanziger (1990) and Morrisey, et al. (1988)).

Based on patient flow data obtained from the California Office of Statewide Health Planning, we find that our markets are generally smaller than E/H markets. In a few cases, such as Los Angeles, our markets may be larger than E/H markets.

### *Service Identification*

We used data from the California Office of Statewide Health Planning to identify providers of specialized hospitalized services. Each hospital in the state is required to report the presence or absence of 171 specific hospital services. For obvious reasons, we do not individually analyze all 171 services. We take an alternative approach. First, we eliminate 63 services that are either so basic that virtually all hospitals provide them, or are available from non-hospital providers. Second, we aggregate the remaining services into nine groupings that may be defined along clinical or technological lines: Cardiology, Deliveries, Diagnostics, Emergency, Neonatology, Pediatrics, Pharmacy, Surgery, Teaching, and Other "high-tech."<sup>7</sup>

Most hospitals offer some services in most of these groupings. We define specialized providers to be those hospitals offering the most extensive array of services in each group. In general, specialized providers of a given service constitute 30-40 percent of all hospitals. For example, whereas most every hospital has an emergency room, we identify one-third of the hospitals that are "specialized." These hospitals would also have a trauma center or possibly a helicopter service. Appendix Two details our service definitions.

We independently analyze the provision of four specific hospital services: open heart surgery, full body CAT scans, radiation therapy and radioisotope therapy. Each of these has substantial fixed costs, so that unnecessary duplication of any of these services would be economically wasteful.

It is important to point out that our measures indicate the presence or absence of services, rather than the quality of the service or the intensity of its use. We have no quality variables. The intensity variables available in our data are limited to neonatology and open heart surgery. Analysis of these variables yields results consistent with those reported below. In particular, these services are more heavily utilized in more populous markets, on a per hospital basis. Also, market concentration is unrelated to utilization. This is inconsistent with the MAR hypothesis which would predict higher utilization in more concentrated markets.

### *Prediction Model*

We posit that the number of specialized service providers in a market is a function of: (1) Demand—local and fringe; (2) Supply—local costs, scale economies, fringe suppliers; and (3) Competition. For each specialized service,  $i$ , in each market,  $j$ , we can write:

$$(1) \quad N_{ij} = f(\text{Demand Shifters, Supply Shifters, Competition})$$

where  $N_{ij}$  is the number of providers of service  $i$ , in market  $j$ .

The categorical dependent variable  $N_{ij}$  is estimated using an ordered probit model. The probit specification generates an ordinal measure of the level of specialized service availability. The number of providers in each market is treated as a categorical variable with  $M$  response categories,  $m_1, m_2, \dots, m_m$ . For example, if we observe at most 2 providers of a specific service in any market, the categories  $\{m_1, m_2, m_3\}$  naturally correspond to  $N=0, N=1, N=2$ .

The observed response is conditional upon the independent variable set—i.e. upon supply and demand factors. Specifically,

$$\begin{aligned} N_{ij} &= m_1 && \text{if } XB < \mu_1 \\ N_{ij} &= m_2 && \text{if } \mu_1 < XB < \mu_2 \\ N_{ij} &= m_3 && \text{if } \mu_2 < XB \end{aligned}$$

Let the cumulative normal distribution be denoted by  $F(\cdot)$  and let  $\mu_1 = 0$ , then:

$$\Pr[m_k] = F[\mu_k - XB] - F[\mu_{k-1} - XB]$$

Maximum likelihood estimation yields the parameters  $\mu_1, \dots, \mu_{m-1}$  and the coefficient vector  $\beta$ .

Probit analysis offers several distinct benefits over OLS. First, as might be expected when the distribution of the dependent variables is highly skewed, OLS estimates are inherently unreliable and are not robust to model specification. The probit estimates that we obtain appear to be robust. Second, because it fits ordinal categories, probit does not overweight either the abundance of small markets or the few very large markets. These markets are fit extremely well on the basis of population, and variations in other parameter values will not alter their proper categorical placement. Thus, variations in other parameter values will be most important in fitting the markets of greatest economic interest; i.e., those markets with an intermediate number of hospitals. To the extent that we believe the OLS estimates, it is reassuring to note that they are generally consistent with the probit estimates.

### *Dependent and Independent Variables*

It was straightforward to calculate the dependent variables for our analyses. We analyze specialization in each service group separately. For each service group regression, the unit of analysis is the market. The dependent variable  $N_{ij}$  is the number of hospitals in market  $i$  defined to be a specialized provider of service  $j$ . For individual services,  $N_{ij}$  is the number of hospitals in market  $i$  providing service  $j$ .

Our independent variables are intended to measure the extent of the market, and to some extent the cost of providing services. The independent variables specific to local demand are POP, defined to be the natural log of local population, and INCOME, defined to be the mean family income. Both variables are determined from the 1980 census. We used a log transformation of POP both to take account of potential scale economies, and because it affords a better fit for the other variables in the model. The range of INCOME is such that a log transformation is unnecessary. In order to control for differences in variable costs (especially labor costs) across markets we include JANCOST, defined to be the average

expenditure for aides and orderlies per bed in thousands of dollars. This variable was available for all markets, and is probably independent of quality (unlike, for example, nurses wages). Labor inputs may be complements or substitutes to specialized services, so we can not predict the sign on JANCOST. We have no measure of capital costs, but we believe that capital costs probably do not vary much across markets.

The variables instrumenting for fringe supply and demand require special consideration. If fringe supply and demand affect local service supply, then a correctly specified model of local service supply should include measures of nearby population (fringe demand), and nearby service availability (fringe supply). Such a specification involves simultaneously determining service provision for all 87 markets. Empirically, this is not a practical approach.

We simplify the problem by employing instruments for fringe supply and demand. We define our fringe supply measure, DISTANCE, as follows. For urbanized areas this is the log of the distance to the nearest more populous urbanized area. For non-urbanized areas this is the log of the distance to the nearest urbanized area.<sup>8</sup> We define our fringe demand measure, FRINGEPOP as follows. For any given market Y, FRINGEPOP is the log of the total population of all other markets X, such that X has the following characteristics: (1) X is less populous than Y; and (2) of all markets more populous than X, Y is the closest. We predict that for services for which geographic considerations are important, (e.g., not for emergency services), the coefficients on both DISTANCE and FRINGEPOP should be positive. Moreover, to the extent that local service supply responds more to local demand, we predict that the coefficient on FRINGEPOP will be less than the coefficient on POP.

These instruments for fringe supply and demand represent only one of many possible alternatives. Our rationale for the chosen instruments has three components: First, *ceteris paribus*, individuals attempt to minimize transit costs. This is supported by McGuirk and Porell (1984) and Dranove, White and Wu (1989) who find that distance is an important determinant of hospital choice. Second, when patients can not fill their health care needs within their own markets, they will travel to the nearest market that does meet their needs. This will generally be a more populous market. Consistent with this idea, Hogan (1986) shows that rural patients who travel are more severely ill than patients who "stayed at home." Our own data on patient flows tends to substantiate the argument that patients who do travel seek out more populous markets.<sup>9</sup> These flows from smaller to larger markets comprise the fringe demand for services in larger markets.

Third, the provision of specialized services in local markets is determined by a hierarchical ordering largely based on local population. A cursory examination of the data substantiates this assumption. This assumption implies that if a monopoly hospital in a small market is considering offering a service, then competitive suppliers will only be found in larger markets.

Our final predictor is a measure of competition, the Herfindahl index (HERF). We base our computation of the Herfindahl on discharges. This is consistent with Noether (1988) and Zwanziger and Melnick (1988). An alternative measure of the Herfindahl index based on beds was also computed. The two measures were very highly correlated.

We may write our initial regression model as follows:

$$(2) \quad N_{ij} = \beta_0 + \beta_1 \text{POP} + \beta_2 \text{FRINGEPOP} + \beta_3 \text{DISTANCE} + \beta_4 \text{INCOME} + \beta_5 \text{JANCOST} + \beta_6 \text{HERF}.$$

Direct inclusion of the Herfindahl index in the regression model creates two problems. First, there is the possibility of omitted variable bias. In particular, if HERF is determined by

$$(3) \quad \text{HERF} = \gamma_0 + \gamma' \underline{X} + \delta' \underline{Y},$$

where  $X$  denotes one or more of the variables included in equation (2) and  $Y$  denotes any demand or supply shifters omitted from equation (2), then the coefficient  $\beta_6$  will be biased.<sup>10</sup> Lacking a good exogenous instrument for "the degree of competition," we can not avoid this problem. However, by including as many relevant predictors into equation (2)—in this case two geographic indicators of the extent of the market—we can mitigate the omitted variable bias. An estimate of the potential omitted variables bias is reported in section (4).

The second problem is that Herfindahl is highly correlated with the other demand and supply shifters, thereby hindering maximum likelihood estimation of the probit functions and compromising inferences about the effects of the right hand side variables.<sup>11</sup> We address this problem by constructing a residualized value of the Herfindahl index. The Herfindahl index is regressed on our set of demand shifters.<sup>12</sup> The residual from this regression, denoted HERFRES, can be interpreted as that portion of the Herfindahl that is unrelated to the "size" of the market. HERFRES is used in our service prediction equations.

Our decomposition points out that there are two distinct ways that the Herfindahl can change: (1) Holding the extent of the market constant, the Herfindahl can vary for *exogenous* reasons, such as historical factors, regulatory factors, or merger activity; (2) As the extent of the market increases, the number of hospitals increases, causing an *endogenous* decrease in the Herfindahl. Note that the former is of interest for antitrust analysis; the only solution to inefficiencies resulting from the latter change in Herfindahl is to change the extent of the market!

Let  $H_n$  denote the mean value of the Herfindahl for a given market size; i.e., the endogenous Herfindahl. It turns out that market size is almost completely determined by POP, so let us write  $H_n = \delta \text{POP}$ . Let  $H_x$  (=HERFRES) denote the deviation from the mean Herfindahl due to exogenous factors; i.e.,  $\text{HERF} = H_n + H_x = \delta \text{POP} + \text{HERFRES}$ . Recognizing the dual components of HERF, we rewrite equation (2):

$$(4) \quad N_{ij} = \beta_0 + \beta_1 \text{POP} + \beta_2 \text{FRINGEPOP} + \beta_3 \text{DISTANCE} + \beta_4 \text{INCOME} + \beta_5 \text{JANCOST} + \beta_7 H_n + \beta_8 \text{HERFRES}.$$

$\beta_7$  may or may not equal  $\beta_8$ . If they are equal, then they both equal  $\beta_6$ .

We can rewrite the prediction equation one more time to obtain:

$$(5) \quad N_{ij} = \beta_0 + (\beta_1 + \beta_7 \delta) \text{POP} + \beta_2 \text{FRINGEPOP} + \beta_3 \text{DISTANCE} + \beta_4 \text{INCOME} + \beta_5 \text{JANCOST} + \beta_8 \text{HERFRES}.$$



We estimate the reduced form equation (5). The coefficient on HERFRES,  $\beta_8$ , is an estimate of the effect of exogenous changes in the Herfindahl on the availability of services. Note that the coefficient on POP includes both the direct effect of POP on the availability of services ( $\beta_1$ ) and the indirect competitive effect ( $\beta_7\delta$ ). We obtain an unbiased estimate of  $\beta_7\delta$  by comparing estimates from equation (2) with estimates from equation (5). Equation (2) yields estimates of  $\beta_1$ , which we subtract from the POP coefficients in equation (5) to generate our estimate of  $\beta_7\delta$ .<sup>13</sup>

The dual components of HERF are illustrated in Figure 1. The horizontal axis indicates the extent of the market, indicated here solely by POP. The vertical axis measures the number of services available. The solid curve represents the availability of services in the absence of any competitive effects (i.e.,  $\beta_7 = \beta_8 = 0$ ). It is concave to suggest scale economies. In this example as POP increases from  $POP_0$  to  $POP_1$ , the number of services increase from  $S_0$  to  $S_1$ . (i.e., from point X to point Y.)

The steeper dashed curve in figure 2 represents the availability of services if there are competitive effects due to endogenous market growth, but no exogenous competitive effects. As the market grows, more hospitals enter. Competitive interaction of these hospitals leads to the additional provision of services. As the market continues to grow, the Herfindahl continues to decrease, the competitive effects worsen, and therefore the two lines diverge. At the initial population  $POP_0$ , the level of services is  $S_2$  (point M). As population increases to  $POP_1$ , the level of services increases to  $S_3$  (point N). The additional amount of service due to the competitive effect equals  $(S_3 - S_2) - (S_1 - S_0)$ , which is positive. In particular,  $(S_3 - S_2) - (S_1 - S_0) = \beta_7\delta(POP_1 - POP_0)$ , where  $\beta_7\delta$  can be derived from estimates of equations (2) and (5).

Point Q in figure 2 represents the effect of an exogenous decrease in the Herfindahl of exactly  $\delta(POP_1 - POP_0)$  in a market with population  $POP_1$ , combined with endogenous competitive effects. In the example the amount by which services increase,  $S_4 - S_3$ , exactly equals  $(S_3 - S_2) - (S_1 - S_0)$ . Thus, we assume here that  $\beta_7 = \beta_8$ . If instead  $\beta_7 > \beta_8$ , then the effect of the exogenous decrease in the Herfindahl is smaller.

Table 1 presents summary statistics for each of the independent variables, including HERFRES. Unlike RL, Noether (1988), and Zwanziger and Melnick (1988), we do not include measures of hospital characteristics, such as size, case-mix, or ownership type, as these are endogenous. With the exception of the HERFRES our predictors are exogenous.

#### 4. Results

To preview our results, we have plotted in Figures 2a-c the number of specialized providers per capita against the number of hospitals in the market for three representative specialized services: cardiology, diagnostics, and neonatology.<sup>14</sup> If the "inefficient competition" story was dominant, we would expect these plots to show a general upward trend—as more hospitals appear in a market, they add services beyond the level demanded by the population. In fact, the plots show a downward trend. This suggests that as markets grow and more hospitals enter, the dominant effects are either oligopolistic price effects such as those discussed by Bresnahan and Reiss (1989), or scale economies.

The ordered probit analysis more fully controls for the factors that determine resource supply. Table 2 presents, for each service, the estimated coefficients on the

independent variables. The last row indicates, for each independent variable, whether the average coefficient across the thirteen service categories is positive or negative, and whether it is significant under the assumption that the services are independent. Table 3 reports the prediction accuracy of the ordered probit models.<sup>15</sup>

As seen in Table 2, the coefficient on POP is positive and significant for all services. This means that increases in local population lead to increases in the number of services. The coefficient on FRINGEPOP is also positive and generally significant. The coefficient on DISTANCE is usually positive but not significant at  $p < .10$ . The positive coefficients on FRINGEPOP and DISTANCE imply that fringe demand and fringe supply influence resource availability in a manner that is consistent with the theory. Joint tests on both FRINGEPOP and DISTANCE suggest that the pattern of positive coefficients is not due to chance.

Two points about FRINGEPOP are worth noting. First, the effect of FRINGEPOP (as measured by the coefficient and its t-statistic) is smallest for emergency services. This makes sense. When specialized emergency services are needed, travel is prohibitively costly. Second, the coefficients on FRINGEPOP are consistently one-fifth to one-tenth the magnitude of the coefficients on POP. While we acknowledge the imprecision with which FRINGEPOP is measured, we are still led to conclude that local resource supply responds mostly to local demand.

The remaining variables, INCOME, JANCOST and HERFRES, are generally non-significant in individual equations but marginally significant in joint hypothesis tests. In general the signs are in accordance with the theory. Higher incomes result in greater service availability. Higher costs reduce service availability. Greater competition, as measured by lowered values of HERFRES, also increases service availability.

#### *The Bias on HERFRES when FRINGEPOP and DISTANCE are Omitted*

Omitting FRINGEPOP and DISTANCE from probit models imparts a serious bias on HERFRES, consistent with our discussion in section 2. Table 4 reports the estimated coefficients on HERFRES for the full model (i.e., the model presented above) and for the underspecified model that excludes our measures of fringe supply and demand. For every service, underspecifying the extent of the market imparts a negative bias to the coefficient. In several cases, the coefficient on HERFRES becomes statistically significant.

Prior studies have not addressed the geographical extent of local markets; the results of these studies are probably biased. To the extent that we do not fully specify the extent of the market, our results may be biased as well. An implication is that our results reflect an upper bound on the importance of competition.

#### *Economic Importance of the Predictor Variables*

One can use the coefficients of the probit analysis to determine the predicted resource availability in each market, as well as how resource availability changes as the values of the independent variables change. Table 5 examines the effect of a one standard deviation change in the value of each of the independent variables on the predicted number of services in a market.<sup>16</sup> Marginal effects are computed holding all other independent

variables constant at their mean values. The reported figures have been rounded to the nearest one-half provider. Thus, a zero indicates that the change in the number of providers is less than .26.

The results in Table 5 are striking. POP matters a lot. For those services for which FRINGEPOP was statistically significant, it is also economically important. Little else matters. In particular, the estimated magnitude of HERFRES is too small to be an important determinant of resource availability.

Recall that the coefficient on POP may overstate the demand effect because it may incorporate indirect competitive effects. We can decompose the POP coefficient into two parts: the direct population effect and the indirect competitive effect. We estimate the magnitude of the indirect competitive effect by re-estimating the ordered probit equations using Herfindahl instead of HERFRES. The resulting change in the coefficient on POP is an unbiased estimate of the indirect competitive effect. (The indirect competitive effects embodied in the other coefficients were inconsequential.)

Table 6 reports the change in the POP coefficient and the implied indirect effect of competition on the predicted level of service availability, when evaluated at the means of HERFRES and POP. In no case does the indirect effect lead to the existence of even one more provider of services in the market. The last column of Table 6 does suggest that the indirect competitive effect is somewhat more important in larger, more competitive markets.

#### *Evidence on Price Competition and Scale Economies*

We can use the probit results to investigate the pattern of entry in hospital markets as a function of demand. Table 7 reports the minimum population necessary to support various levels of service in a market.<sup>17</sup> It also reports the incremental populations necessary to support additional providers. For example, in the case of cardiology, it takes a local population of 60,000 to support one specialized provider. A second provider enters at a population of 233,000. Additional population increases of 300,000-400,000 lead to the entry of additional providers. A similar pattern appears for most of the remaining services: the population necessary to support one provider is relatively small; the incremental population necessary to support a second provider is somewhat larger; additional providers enter at relatively constant, albeit larger, increments. In two cases (open heart surgery and radiation therapy) the increments stabilize after just one entrant. In two other cases (neonatology and pediatrics), the pattern of entry is contrary to expectations.

The pattern of entry is broadly consistent with that observed by Bresnahan and Reiss (1989) for a variety of personal services. They interpret their results as being consistent with oligopolistic profit effects. In particular, they argue that if the dominant force was scale economies, then the increments would stabilize after just one entrant. We believe that if it is possible to enter by differentiating, and that there is no advantage to the incumbent in offering the differentiated product, then thresholds need not stabilize after one entrant. In the case of auto dealerships, analyzed by Bresnahan and Reiss, a first dealer could sell Fords, a second could sell Chevys, etc. Only after all the major brands are available might individual dealers expand.

We can not rule out the possibility of product differentiation in most of our service categories, so it is premature to conclude that we are only witnessing oligopolistic effects.

Interestingly, the only two services for which entry thresholds are consistent with scale economies in the absence of product differentiation, open heart surgery and radiation therapy are among the four specific services. For these specific services, product differentiation is less likely.

Another possible explanation of the observed pattern of entry is that there are simultaneously scale and scope economies. Thus, as markets grow, hospitals offer additional new services that simultaneously enable them to expand existing services. For example, suppose there are scope economies in the provision of cardiology and diagnostic services. In the absence of specialized diagnostic services, the minimum efficient scale for cardiology services may be relatively small. If, through growth in the extent of the market, a hospital adds specialized diagnostic services, then scope economies may cause the minimum efficient scale for cardiology services to increase.

The arguments in favor of scale and scope economies have great intuitive appeal. First, during the period that we study a substantial percentage of hospital reimbursements were based on accounting estimates of reasonable costs. This reduces the potential impact of oligopolistic pricing. Second, there seems to be little doubt about the presence of scope economies for specialized services—the provision of specialized services across hospitals is highly correlated. The mechanism by which scope economies operate to change the threshold for providing specialized services is an area for further research.

While we can support a variety of interpretations regarding entry thresholds, we can not support the "inefficient competition" hypothesis of RL. If RL were correct, then we would expect that the incremental population necessary to support additional providers would *decline* as the market grew.

## 5. Discussion

Heretofore, discussions of the determinants of hospital service provision have focused on the role of quality competition. The empirical analyses associated with these discussions have devoted little attention to a simpler explanation—that the supply of resources is determined by the extent of the market. The empirical specification of the extent of the market has been taken for granted. Our analysis shows that it should not be taken for granted. Specifically, local population is a powerful predictor, and any specification that does not carefully consider population is lacking. Measures of fringe supply and demand are also important. When these basic measures of the extent of the market are included in the model, the importance of market competition is greatly reduced. Given the omitted variable bias associated with the market competition variable, it is difficult to maintain any role for market competition as a determinant of resource supply.

Our results augment those of Bresnahan and Reiss (1989), who find that the number of sellers does not increase as fast as does local demand. They interpret this as a competitive effect; i.e., profit margins fall as the number of sellers increase. If we offer this interpretation for our results, then the "inefficient competition" story is turned on its head. That is, competition drives down profit margins with the result that fewer services are provided. This reversal of RL highlights the importance of the endogeneity of the degree of competition in local markets. If we instead argue that there is no role for competition in determining hospital resource supply, then our results suggest substantial scale economies.

The public policy ramifications of our analysis are substantial. First, our results undermine those of recent studies that have questioned the application to hospitals of the fundamental tenet of antitrust theory—that competition promotes efficiency. Our results cast doubt on claims that hospital mergers increase efficiency by reducing competition. Second, our results suggest there may be unexploited scale economies in smaller markets—this may be a superior justification for hospital mergers. The potential for economies in services such as deliveries was an important stated rationale for the *Roanoke* merger (which was approved by the district court). Ironically, the hospitals in the *Rockford* case (in which the district court denied the merger) did not emphasize scale economies in either their pre-merger analyses or their pre-trial briefs.

The focus on "inefficient competition" in the recent district court ruling in the *Roanoke* case is troublesome. The presumption that hospital services do not follow the dynamics of supply and demand was too easily accepted. As our analysis shows, one needs to examine alternatives to traditional market models with great scrutiny. The null hypothesis—that the supply of services is determined by the extent of the market—has shown its usefulness for two hundred years.

## ENDNOTES

<sup>1</sup>Noether (1988) does not draw normative inferences from her results. Zwanziger and Melnick (1988) document a strong medical arms race effect through 1983 that diminishes in subsequent years. Health Care Investment Analysts (1990) find that the effect is still strong as of 1988.

<sup>2</sup>There is some consensus that hospitals historically competed on the basis of factors such as quantity and quality (Jacobs, 1974).

<sup>3</sup>Dranove, White and Wu (1989) raise this empirical issue with ambiguous findings.

<sup>4</sup>See Dranove and Shanley (1989) for a detailed critique of the "fifteen mile radius" market definition. Noether (1988) uses the SMSA, and Zwanziger and Melnick (1988) use a narrow definition based on patient flows. Both Noether and Zwanziger and Melnick measure competition with a Herfindahl.

<sup>5</sup>Typically, an urbanized area consists of a central city and all contiguous zip codes with population densities exceeding 1000 per square mile. Generally speaking, SMSAs encompass one or more urbanized areas.

<sup>6</sup>Included in any of these city's markets are any identifiable towns or census designated places within ten miles of the city. Our city definitions are hierarchical in the sense that if a city was within a larger city's urbanized area or ten-mile radius, it was included in the larger city's market and not considered independently. Note that we exclude South Lake Tahoe, both because it is contiguous with a population center in Nevada and because it has an exceptionally high proportion of tourists relative to its population.

<sup>7</sup>An additional 31 services were omitted for a variety of reasons. Some were minor teaching programs, such as "dietetic internships." Others did not readily fall into a category, such as "jail care."

<sup>8</sup>We used the 1989 Rand McNally Road Atlas to determine highway distances between cities. When possible and reasonable, we used interstate highway miles. The value of DISTANCE for Los Angeles was the distance to San Francisco. Our logic was that this was the only market offering an array of services fully competitive with those offered in Los Angeles. As alternative distance measures we tried distance to the nearest market with a teaching hospital, and distance to the closer of San Francisco or Los Angeles. Neither measure proved as powerful a predictor as distance to nearest larger urbanized area.

<sup>9</sup>The main exceptions are Los Angeles, San Diego, and San Francisco, for which outflows tend to be relatively low. These are the "exceptions that prove the rule"—patients in these markets have no reason to travel since no better care can be found elsewhere.

<sup>10</sup>This is conditional on the X's and Y's not being orthogonal.

<sup>11</sup>The simple correlations between the Herfindahl and POP and Herfindahl and FRINGEPOP both exceed .70.

<sup>12</sup>We regress Herfindahl on POP, FRINGEPOP and DISTANCE.

<sup>13</sup>If we had performed OLS, then the coefficients on HERFRES in equation (4) and HERF in equation (2) would necessarily be identical.

<sup>14</sup>For presentation purposes, we have omitted from the figures all markets with no specialized providers, as well as San Francisco and Los Angeles.

<sup>15</sup>Prediction accuracy is defined as the percentage of the time that the predicted XB's are in the correct ordinal category.

<sup>16</sup>Recall that the ordered probit generates a set of  $\mu$ 's that are interpreted as threshold values for ordinal service levels. We define an increase of one provider to occur when the change in XB crosses over a  $\mu$  threshold. If a change in XB does not cross a  $\mu$  threshold, then we interpolated to estimate the fraction of the distance travelled to the nearest threshold.

<sup>17</sup>These estimates are based on the reduced form coefficients on POP from equation (4). Since the "inefficient competition" story appears to be of little economic importance, the estimates largely reflect the direct effect of population on the extent of the market. The estimates are evaluated at the means of the other variables.

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**TABLE 1—DESCRIPTIVE STATISTICS FOR INDEPENDENT VARIABLES**

<b>Variable</b>	<b>Mean</b>	<b>Median</b>	<b>Std. Deviation</b>	<b>Range</b>
Population <sup>a</sup>	2.05	.31	9.4	.01 to 94.8
FringePop <sup>b</sup>	.42	.09	1.2	.005 to 11.6
Distance	47.4	22	38.6	8 to 376
Income (000's)	1.92	1.8	.29	1.4 to 3.0
Janitor Cost <sup>c</sup>	3.17	2.7	1.44	0.6 to 8.7
Herfres	0	-1.3	17.8	-46 to 34

<sup>a</sup>Population in 100,000's. Variables were scaled such that the independent variable set was of approximately the same magnitude. This increases the efficiency of the non-linear ordered probit estimation techniques.

<sup>b</sup>Fringe Population in 100,000's. Markets with no fringe population were coded as 0.01.

<sup>c</sup>Average expenditures on janitors, aides and orderlies per bed. In \$1000's.



**TABLE 2—PROBIT RESULTS: DEMAND COEFFICIENTS**  
(t-statistics in parentheses)

SERVICE	POP	FRINGE-POP	DISTANCE	INCOME	JANCOST	HERFRES
Cardiology	.927 <sup>c</sup> (3.60)	.200 <sup>a</sup> (1.74)	.250 (.86)	.234 (.28)	-.109 <sup>a</sup> (-1.10)	-.009 (-.83)
Deliveries	.766 <sup>c</sup> (3.88)	.191 <sup>a</sup> (1.94)	.264 (1.28)	-.538 <sup>a</sup> (-1.74)	-.134 <sup>a</sup> (-2.07)	-.008 (-.39)
Diagnostics	1.794 <sup>c</sup> (5.46)	.084 <sup>a</sup> (1.68)	.262 (.75)	.469 (.76)	-.112 (-.72)	-.015 (-1.24)
Emergency	.813 <sup>c</sup> (2.93)	.032 (.30)	.086 (.35)	.417 <sup>a</sup> (1.69)	-.052 (-1.37)	-.018 <sup>a</sup> (-1.84)
Neonatology	.914 <sup>c</sup> (4.78)	.163 <sup>a</sup> (1.69)	.151 <sup>a</sup> (1.73)	-.214 (-.61)	-.014 (-.15)	-.009 (-.59)
Pediatrics	.689 <sup>c</sup> (3.85)	.109 <sup>a</sup> (1.83)	.416 <sup>a</sup> (1.65)	.389 (.85)	.057 (.44)	-.016 (-1.04)
Pharmacy	.952 <sup>c</sup> (4.57)	.241 <sup>b</sup> (2.15)	-.046 (-.21)	.402 (1.01)	-.102 <sup>a</sup> (-1.91)	-.016 <sup>a</sup> (-1.83)
Teaching	1.70 <sup>a</sup> (2.08)	-.277 (.66)	.769 (1.15)	.739 (.64)	.337 (.64)	.028 (.81)
Specialized	1.54 <sup>c</sup> (4.50)	.142 (1.19)	-.058 (-.23)	.219 (.61)	-.037 (-.53)	-.003 (-.24)
CAT Scans	1.08 <sup>c</sup> (3.41)	.076 (.56)	-.022 (-.06)	.246 (.73)	-.288 <sup>c</sup> (-2.45)	-.015 (-1.41)
Open Heart Surgery	1.28 <sup>b</sup> (1.99)	.065 (.82)	.281 (.30)	1.05 <sup>a</sup> (1.80)	-.345 (-1.35)	-.026 (-1.15)
Radiation Therapy	.828 <sup>c</sup> (3.37)	.065 (.46)	.521 <sup>a</sup> (1.68)	.209 (.29)	-.040 (-.42)	-.004 (-.40)
Radio-isotope Therapy	1.89 <sup>c</sup> (2.91)	.289 <sup>b</sup> (1.99)	.069 (.20)	.148 (.11)	.179 (.89)	-.009 (-.90)
Joint Test	+ <sup>c</sup>	+ <sup>c</sup>	+ <sup>a</sup>	+ <sup>a</sup>	- <sup>a</sup>	- <sup>a</sup>

<sup>a</sup>Sign. at p \* .10

<sup>b</sup>Sign. at p \* .05

<sup>c</sup>Sign. at p \* .01

**TABLE 3—MODEL PREDICTION ACCURACY: PERCENTAGE OF MARKETS WHERE THE LEVEL OF SERVICES IS CORRECTLY PREDICTED BY THE MODEL**

<b>Service</b>	<b>% Correctly Predicted</b>
Cardiology	77
Deliveries	75
Diagnostics	81
Emergency	61
Neonatology	64
Pediatrics	73
Pharmacy	61
Teaching	93
Specialized	75
CAT Scans	75
Open Heart Surgery	91
Radiation Therapy	89
Radio-isotope Therapy	80

**TABLE 4—Bias in HERFRES When FRINGEPOP and DISTANCE are Omitted**

	<b>Full Model</b>	<b>FRINGEPOP and DISTANCE Omitted</b>	<b>Bias</b>
Cardiology	-0.009	-0.011	-0.002
Deliveries	-0.008	-0.009	-0.001
Diagnostics	-0.015	-0.021 <sup>a</sup>	-0.006
Emergency	-0.018 <sup>a</sup>	-0.022 <sup>b</sup>	-0.004
Neonatology	-0.009	-0.010	-0.001
Pediatrics	-0.016	-0.020	-0.004
Pharmacy	-0.016 <sup>a</sup>	-0.028 <sup>b</sup>	-0.012
Teaching	.028	-0.001	-0.029
Specialized	-0.003	-0.007	-0.004
CAT Scans	-0.015	-0.019 <sup>a</sup>	-0.004
Open Heart Surgery	-0.026	-0.034 <sup>a</sup>	-0.008
Radiation Therapy	-0.004	-0.009	-0.005
Radio-isotope Therapy	-0.009	-0.014 <sup>a</sup>	-0.005

<sup>a</sup> - Sign. at p \* .10      <sup>b</sup> - Sign. at p \* .05      <sup>c</sup> - Sign. at p \* .01

**TABLE 5—EFFECT OF A ONE STANDARD DEVIATION INCREASE IN THE  
INDEPENDENT VARIABLES ON THE NUMBER OF SERVICES IN A MARKET<sup>a</sup>  
(ROUNDED TO NEAREST ONE-HALF SERVICE)**

<b>Service</b>	<b>Mean Providers<sup>b</sup></b>	<b>POP</b>	<b>FRINGE-POP</b>	<b>DISTANCE</b>	<b>INCOME</b>	<b>JAN COST</b>	<b>HERFRES</b>
Cardiology	1.9	1.5	.5	0	0	0	0
Deliveries	2.0	1.5	.5	0	0	0	0
Diagnostics	2.2	2.0	0	0	0	0	0
Emergency	1.6	1.0	0	0	0	0	0
Neonatology	2.1	1.5	.5	0	0	0	0
Pediatrics	.91	1.0	0	.5	0	0	0
Pharmacy	2.3	1.0	.5	0	0	0	0
Teaching	.70	1.0	0	.5	.5	0	.5
Specialized	1.9	1.5	.5	0	0	0	0
CAT Scans	1.8	1.5	0	0	0	-.5	0
Open Heart Surgery	1.4	1.5	0	.5	.5	-.5	-.5
Radiation Therapy	1.2	1.0	0	.5	0	0	0
Radio-isot. Therapy	1.7	1.5	.5	0	0	0	0

<sup>a</sup>Marginal effects computed holding all independent variables at their mean values.

<sup>b</sup>Mean number of specialized providers per service per market.

**TABLE 6—ESTIMATED EFFECT OF COMPETITION ON THE PROVISION OF SERVICES**

Service	Bias in Pop. Coefficient	Additional Services at:	
		Mean $X\beta$	+ 1 Std. Dev $X\beta$
Cardiology	.144	0	0
Deliveries	.121	0	0
Diagnostics	.251	0	.5
Emergency	.279	0	.5
Neonatology	.147	0	0
Pediatrics	.309	.5	.5
Pharmacy	.255	0	.5
Teaching	.330	0	0
Specialized	.041	0	0
CAT Scan	.169	0	0
Open Heart Surgery	.246	.5	.5
Radiation Therapy	.060	0	0
Radio-isotope Therapy	.205	0	.5

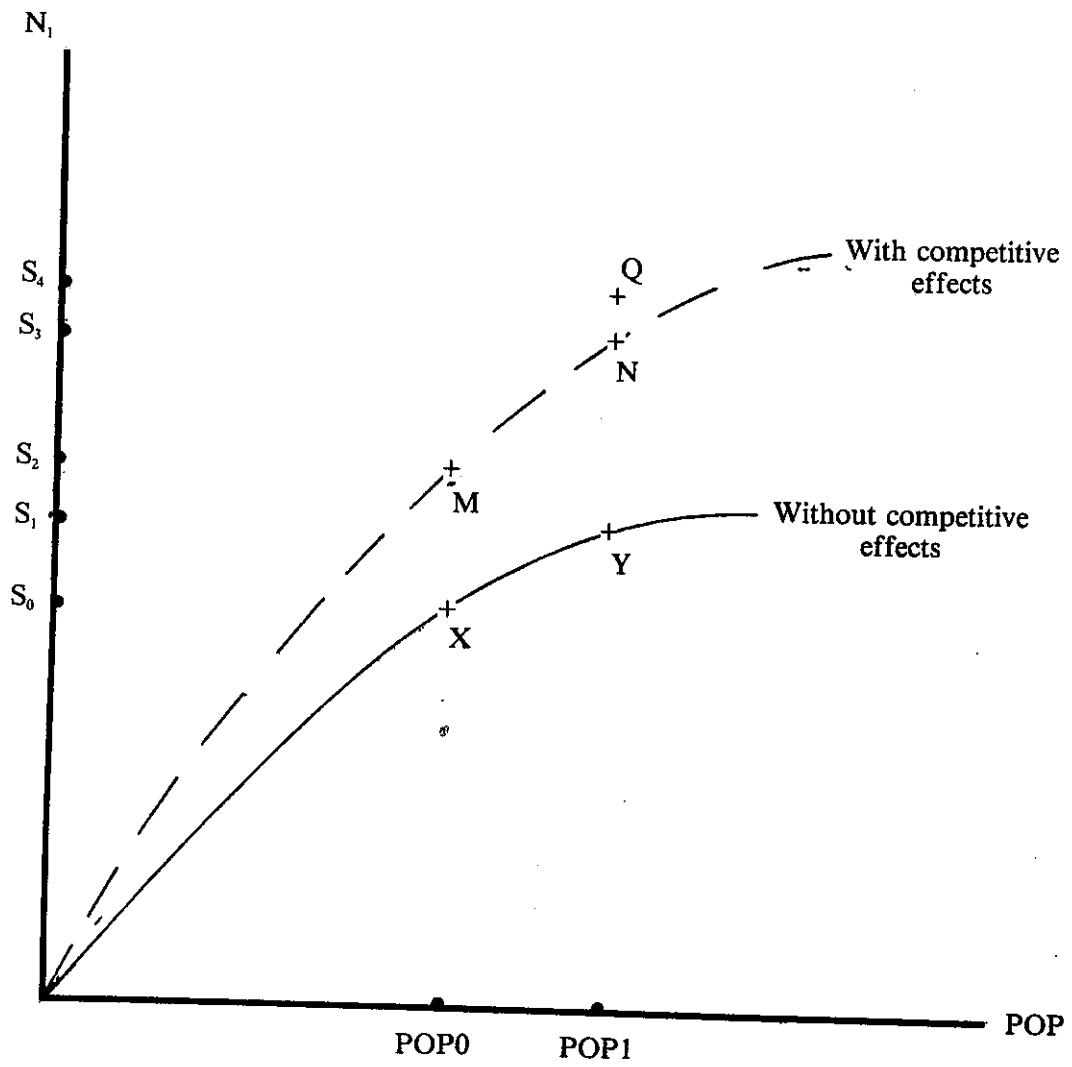
**TABLE 7—POPULATION NECESSARY TO SUPPORT “N” SERVICES  
PER MARKET (IN 1000’s)**

(Differences between successive levels of service are in parentheses. If there is a jump, the difference is divided by two)

SERVICE	NUMBER OF SERVICES					
	1	2	3	4	5	6
Cardiology	60	233 (173)	667 (434)	943 (276)	1310 (367)	*
Deliveries	32	120 (88)	536 (416)	1050 (514)	*	1807 (379)
Diagnostics	47	114 (67)	232 (118)	341 (109)	*	594 (127)
Emergency Room	52	406 (354)	1275 (869)	2011 (736)	*	*
Neonatology	26	145 (119)	984 (839)	*	1481 (249)	*
Pediatrics	106	791 (685)	1281 (490)	*	1941 (330)	2301 (360)
Pharmacy	11	56 (45)	297 (241)	512 (215)	801 (289)	*
Teaching	224	527 (303)	905 (378)	*	*	*
Specialty	62	200 (138)	479 (279)	*	1081 (301)	*
CAT Scan	64	182 (118)	*	643 (231)	841 (198)	*
Open Heart Surgery	175	547 (372)	796 (249)	*	1565 (385)	1905 (340)
Radiation Therapy	100	462 (327)	*	980 (259)	*	*
Radio-isotope Therapy	51	277 (226)	543 (266)	867 (324)	*	1634 (384)

\* - No observations for this service level.

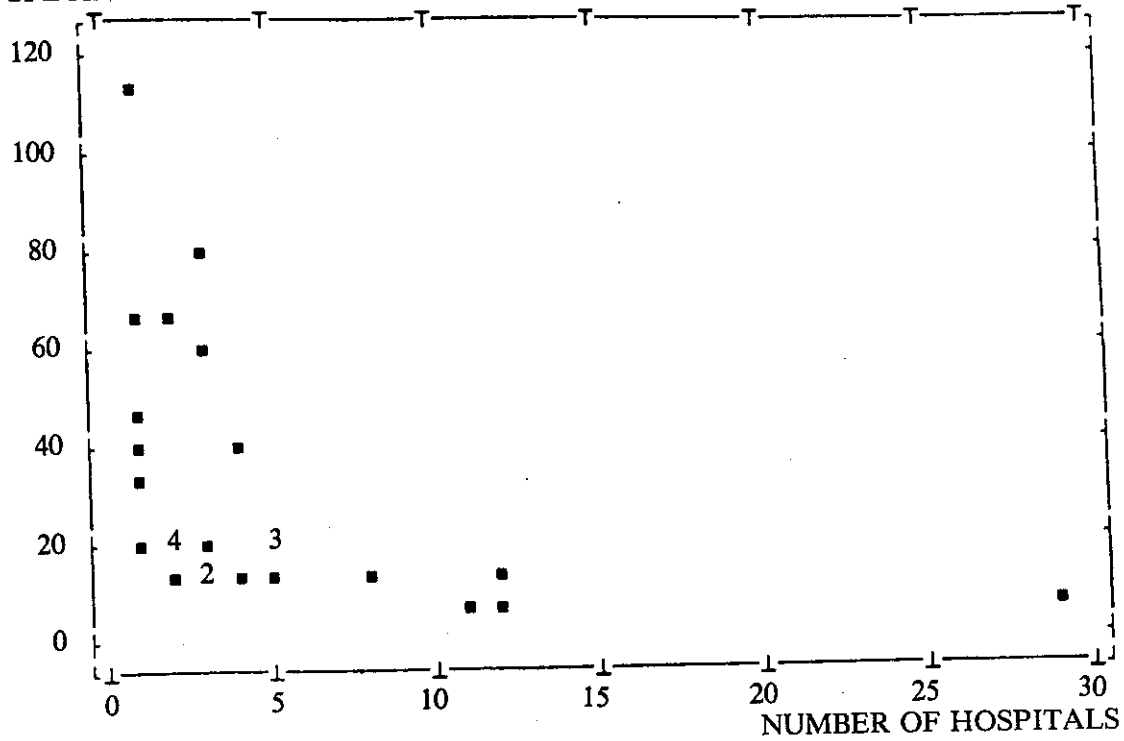
FIGURE 1—COMPETITION AND THE AVAILABILITY OF SERVICES



**FIGURE 2—SPECIALIZED PROVIDERS PER CAPITA BY NUMBER OF HOSPITALS**

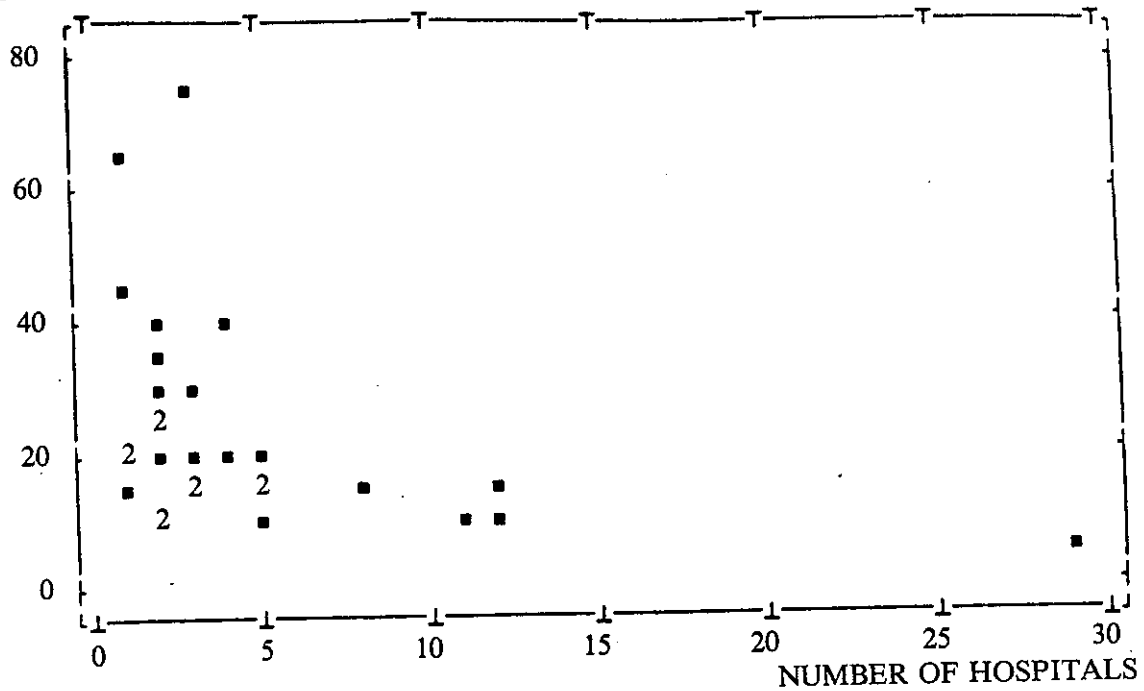
**Figure 2A: Cardiology**

SPECIALIZED PROVIDERS PER CAPITA (in 000,000s)



**Figure 2B: Diagnostics**

SPECIALIZED PROVIDERS PER CAPITA (in 000,000s)

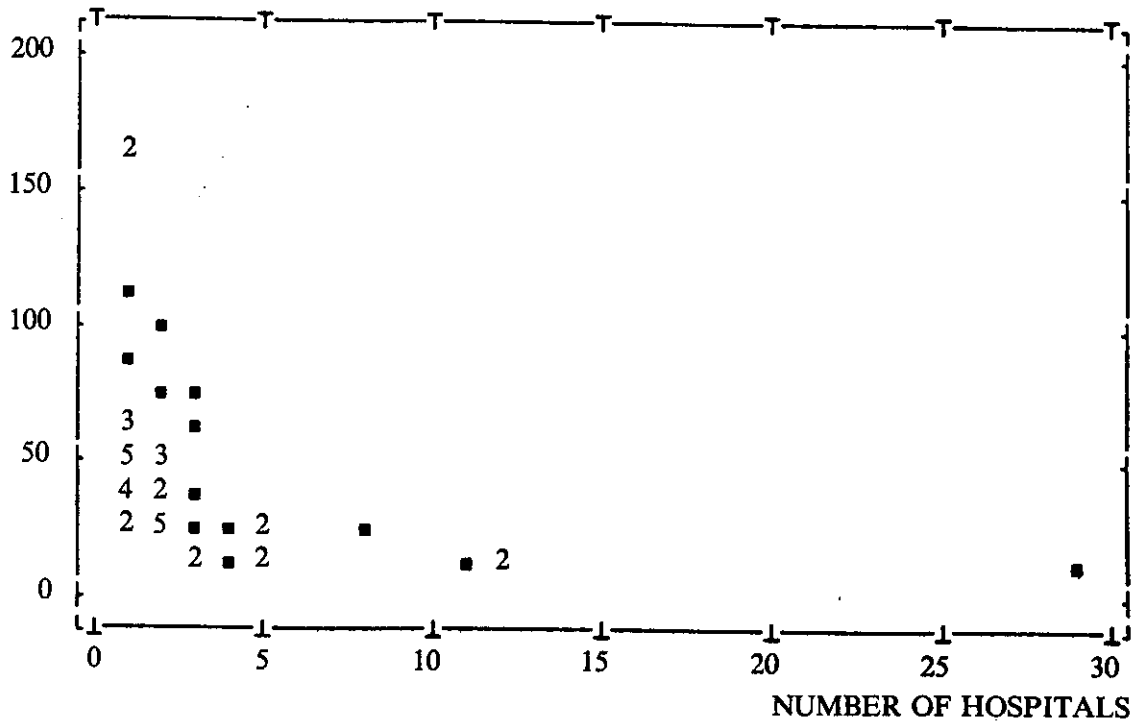


Numbers in figures indicate multiple observations



**Figure 2C: Neonatology**

SPECIALIZED PROVIDERS PER CAPITA (in 000,000s)



## APPENDIX ONE—LOCAL MARKETS

### Urbanized Areas

MARKET	POPULATION (0,000,000)	INCOME <sup>a</sup> (000)	DISTANCE <sup>b</sup>	HOSPITALS	HERFINDAHL
ANTIOCH	0.086	20.540	30	2	51
BAKERSFIELD	0.222	20.475	113	5	26
CHICO	0.052	15.987	77	2	54
FAIRFIELD	0.069	20.530	28	1	100
FRESNO	0.332	19.393	150	5	30
HEMET	0.055	15.086	20	1	100
LANCASTER	0.056	22.232	56	4	38
LOS ANGELES	9.479	23.263	376	181	1
MODESTO	0.160	19.385	79	5	27
NAPA	0.059	21.526	30	1	100
OXNARD-VENTURA	0.378	24.559	30	8	16
PALM SPRINGS	0.066	27.341	50	2	54
REDDING	0.053	18.172	161	2	61
SACRAMENTO	0.796	20.269	85	11	12
SALINAS	0.083	20.059	15	3	51
RIVERSIDE	0.705	19.925	59	12	11
SAN DIEGO	1.704	20.804	120	29	6
SAN FRANCISCO	3.191	23.953	376	56	2
SAN JOSE	1.244	26.540	49	12	11
SANTA BARBARA	0.150	22.568	92	3	49
SANTA CRUZ	0.123	20.200	31	2	59
SANTA MARIA	0.057	20.725	50	2	63
SANTA ROSA	0.137	20.382	55	5	34
SEASIDE-MONTEREY	0.115	20.274	67	2	78
SIMI VALLEY	0.080	27.631	30	2	62
STOCKTON	0.197	18.206	40	4	47
VISALIA	0.059	19.998	41	2	49
YUBA CITY	0.061	16.883	42	3	48

<sup>a</sup>Mean family income

<sup>b</sup>Distance to nearest urbanized area with larger population

**Non-Urbanized Areas**

<b>MARKET</b>	<b>POPULATION (0,000,000)</b>	<b>INCOME (000)</b>	<b>DISTANCE</b>	<b>HOSPITALS</b>	<b>HERFINDAHL</b>
ANDERSON	0.009	14.072	12	0	-
ARCATA	0.021	15.892	10	1	100
ARROYO GRANDE	0.030	19.573	12	1	100
ARVIN	0.018	14.608	15	0	-
ATASCADERO	0.016	20.221	17	1	100
AUBURN	0.016	19.948	34	1	100
BANNING	0.021	15.701	18	1	100
BARSTOW	0.022	20.135	65	1	100
BAYWOOD	0.020	17.782	11	0	-
BIG BEAR	0.011	19.144	42	1	100
BLYTHE	0.008	17.796	106	1	100
BRAWLEY	0.017	19.735	14	1	100
COALINGA	0.007	19.413	63	1	100
CORCORAN	0.006	17.606	28	1	100
DAVIS	0.044	19.446	20	2	65
DELANO	0.028	16.322	18	1	100
DESERT HOT SPR.	0.006	15.964	11	0	-
EL CENTRO	0.049	19.852	150	2	72
EL PASO ROBLES	0.009	17.763	8	0	-
ELK GROVE	0.011	24.125	12	0	-
EUREKA	0.027	17,108	220	2	50
FORT BRAGG	0.005	16.098	36	0	-
FORTUNA	0.009	18.283	20	1	100
GALT	0.006	17.136	23	0	-
GILROY	0.023	21.960	33	1	100
GRASS VALLEY	0.011	13.734	35	2	83
HANFORD	0.024	17.597	35	2	50
HOLLISTER	0.013	17.032	23	1	100
INDIO	0.035	18.181	25	1	100
KING CITY	0.005	19.055	53	1	100
LAKE ARROWHEAD	0.006	30.015	14	1	100
LEMOORE	0.015	18.791	28	0	-
LINDSAY	0.018	16.240	11	2	50
LIVINGSTON	0.008	17.036	15	0	-
LODI	0.037	19.207	11	2	54
LOMPOC	0.026	18.374	25	1	100
LOS BANOS	0.010	17.811	75	1	100
MADERA	0.024	16.703	22	1	100
MANTECA	0.032	19.585	12	1	100
MENDOTA	0.005	13.241	32	0	-
MERCED	0.056	17.829	55	3	46
NIPOMO	0.005	18.316	8	0	-
OAKDALE	0.017	16.980	14	1	100
OJAI	0.021	21.086	10	1	100
OROVILLE	0.023	14.287	17	1	100
PARADISE	0.023	15.728	15	1	100
PERRIS	0.027	14.391	18	2	62
PETALUMA	0.034	22.097	55	1	100
PLACERVILLE	0.019	16.914	42	1	100
PORTERVILLE	0.028	17.111	31	1	100
RED BLUFF	0.009	16.156	32	1	100
REEDLEY	0.032	17.322	25	2	50

MARKET	POPULATION (0,000,000)	INCOME (000)	DISTANCE	HOSPITALS	HERFINDAHL
RIDGECREST	0.020	21.772	88	1	100
SAINT HELENA	0.017	19.045	15	1	100
SANGER	0.013	17.895	30	1	100
SAN LUIS OBISPO	0.034	17.858	32	3	39
SANTA PAULA	0.030	18.561	15	1	100
SEBASTOPOL	0.006	17.198	11	1	100
SELMA	0.021	17.895	15	3	53
SOLANO	0.013	17.370	26	0	-
SONOMA	0.014	19.611	16	1	100
SUSANVILLE	0.007	17.674	85	1	100
TAFT	0.013	22.185	40	1	100
TRACY	0.018	18.506	37	1	100
TULARE	0.027	17.038	41	1	100
TURLOCK	0.035	18.207	12	1	100
TWENTYNINE PALMS	0.015	14.271	56	0	-
UKIAH	0.014	17.529	68	3	41
VACAVILLE	0.043	21.997	10	0	-
VICTORVILLE	0.044	17.697	30	2	52
WASCO	0.017	18.491	21	1	100
WATSONVILLE	0.031	18.340	17	1	100
WOODLAND	0.030	19.446	10	2	78
YREKA	0.007	18.463	95	1	100
YUCCA VALLEY	0.008	14.892	36	0	-

## APPENDIX TWO: IDENTIFYING SPECIALIZED PROVIDERS

A simple approach to measuring service availability is to take one or a few of the 171 different services identified by the state and count the number of hospitals in each market offering each service. We do not believe that this is a good general strategy, however, for four reasons.

First, many service definitions are vague; e.g., "neonatal acute care" and "newborn intensive care." One result is that the actual classification of a service may be at the discretion of the person who filled out the survey instrument. Second, some services are close substitutes, so that the actual activities associated with each service may be substantially the same. Third, we suspect that there are scope economies associated with many services, implying that the list of 171 services may be overly specified.

Fourth, two hospitals may provide different combinations of services as alternative strategies for attracting the same pool of physicians. For example, hospitals seeking to attract cardiologists may offer open heart surgery, a cardiac catheterization lab, or both. In order to maximize the chances of confirming the RL hypothesis, we would like a measure of specialization that permits multiple specialization strategies for attracting physicians.

We deal with the above considerations by aggregating the 171 service offerings into distinct service groupings. We used a conservative approach, which involved excluding a variety of services from further consideration:

- 20 "basic services," such as medical acute care and clinical chemistry services, provided by over 80% of all hospitals;
- 16 psychological services, provided by psychiatric hospitals as well as community hospitals;
- 27 services, including home health services, and non-specialized clinical service, with obvious possibilities for non-hospital competition;<sup>1</sup>
- 13 minor medical education programs, such as medical records technologist;
- 31 services that did not readily fall into a service grouping.

The remaining 64 services were placed into ten service groupings, based on clinical or technological compatibility.<sup>2</sup> These groupings are defined at the end of this appendix. Groups consisted of anywhere from four to eleven services. These service categories were validated by a correlational analysis and hierarchical clustering, which showed that within-group correlations were significantly greater than between-group correlations. Moreover, the correlational analysis was not highly sensitive to small changes in group composition.

In order to identify specialized providers we calculated summative service scores for each category.<sup>3</sup> For each service we examined the upper tail of the distribution of scores across hospitals and identified a natural "break point." Hospitals whose scores equal or exceed the "break point" are considered specialized providers in the category. We could not identify natural break points for one category, surgical services, so we excluded this from further analysis.<sup>4</sup>

<sup>1</sup>During the period studied, there were generally few non-hospital alternatives for the remaining services that we examined.

<sup>2</sup>Hospitals may also offer psychological services. These were not included in our study because virtually identical services are typically provided both in psychiatric hospitals, which are excluded from our study, and non-hospital settings.

<sup>3</sup>For example, consider the summative score for neonatology. Neonatology consists of the following four services: Newborn intensive care; neonatology clinic; premature nursery care; and neonatal acute care. If, say, three of these four services are present in a given hospital, then its summative score would be three. Hospitals classified as specialized providers of neonatology scored three or four on this scale.

<sup>4</sup>We experimented with a number of alternative break points and found few qualitative differences in the results. The exception was when the break points were so low that virtually all providers were defined to be "specialized." Obviously, the number of "specialized" providers would approximate the number of hospitals.

Our aggregation technique has several limitations. First, because we use a summative scale, we implicitly give equal importance to each of the component services in a group. Second, the presence of multiple specialized providers in a market does not necessarily imply there is duplication of services. This is entirely consistent with the RL quality competition model so long as the alternative service mixes represent alternative viable strategies (and not aggregation artifacts). However, it may be more difficult to draw efficiency related conclusions from any observed link between competition and service provision. Finally, there is no across service category compatibility; i.e., one can not readily determine which categories demonstrate greater scale economies than others.

<u>Scale</u>	<u>Services Included (see next page)</u>	<u>Cutoff Point<sup>a</sup></u>	<u>Cutoff %ile<sup>b</sup></u>
Cardiology	1; 3; 25; 38; 41; 85; 143	4	65
Deliveries	2; 5; 8; 36; 49; 62; 64; 104	7	62
Diagnostics	80; 83; 94; 100; 111; 114; 116; 121	6	61
Emergency	140; 152; 155; 164	3	67
Neonatology	16; 30; 55; 61	3	60
Pediatrics	27; 69; 70; 72	2	82
Pharmacy	127; 130; 133; 135; 171; 172	5	50
Specialty	7; 28; 46; 56; 58; 73	5	64
Surgery	10; 13; 14; 17; 23; 26; 35; 44; 47; 50; 88	10	46
Teaching	115; 119; 122; 131; 139; 151	2	87

<sup>a</sup>A hospital is considered a specialized provider if its summative score equals or exceeds this cutoff score.

<sup>b</sup>This indicates the percentage of all hospitals that are not specialized providers.

# SERVICES INVENTORY

Health Care Institution \_\_\_\_\_

Report Period End \_\_\_\_\_

Line No.	HOSPITAL SERVICES	(1) Code	(2) Code	(3) Code
005	<b>DAILY HOSPITAL SERVICES</b>		<b>AMCILIARY SERVICES</b>	<b>CLINIC SERVICES</b>
005	Coronary Intensive Care SERV 1		Delivery Room Services SERV 2	Cardiology SERV 3
010	Pediatric Intensive Care SERV 4		Labour Room Services SERV 5	Chest Medical SERV 6
015	Burn Intensive Care SERV 7		Alternate Birth Center SERV 8	Communicable Disease SERV 9
020	Medical Intensive Care SERV 10		Abortion Services SERV 11	Dermatology SERV 12
025	Surgical Intensive Care SERV 13		Dental Surgery SERV 14	Diabetes SERV 15
030	Neurology Intensive Care SERV 16		Podiatry Surgery SERV 17	Allergy SERV 18
035	Isolation Intensive Care SERV 19		Urologic Surgery SERV 20	Metabolic SERV 21
040	Psychiatric Isolation Intensive Care SERV 22		Otolaryngologic Surgery SERV 23	Neurology SERV 24
045	Pulmonary Intensive Care SERV 25		Plastic Surgery SERV 26	Pediatric SERV 27
050	Communicable Disease Isolation Care SERV 28		Surgical Day Care (One Day) SERV 29	Neonatal SERV 30
055	Protective Isolation Care SERV 31		Gynecologic Surgery SERV 32	Psychiatric SERV 33
060	Defensive Observation Care SERV 34		Kidney Transplant Services SERV 35	Obstetrics SERV 36
065	Drug Abuse Care SERV 37		Open Heart Surgery Services SERV 38	Hypertension SERV 39
070	Alcoholism Care SERV 40		Heart Cath/Sterile Room Service SERV 41	Rheumatic SERV 42
075	Inpatient Care Under Custody (Inl) SERV 43		Cytology Service SERV 44	Renal SERV 45
080	Metabolic Care SERV 46		Neurological Surgery SERV 47	Orthopedic SERV 48
085	Neonatal Nursery Care SERV 49		Ophthalmologic Surgery SERV 49	Trauma Ortho SERV 51
090	Mental Retarded Nursery Care SERV 52		Orthopedic Surgery SERV 53	Ophthalmology SERV 54
095	Premature Nursery Care SERV 55		Renal Dialysis Services SERV 56	Otolaryngology SERV 57
100	Stroke Care SERV 57		Anesthesia Services—Surgical SERV 57	Podiatry SERV 60
105	Neonatal Acute Care SERV 61		Anesthesia Services—Obstetrics SERV 62	Dental SERV 63
110	Post Partum Care SERV 64		Anatomic Pathologic Services SERV 65	Alcoholism SERV 66
115	Psychiatric Acute Care SERV 67		Hematologic Services SERV 68	Child Diagnosis SERV 69
120	Pediatric Acute Care SERV 70		Clinical Chemistry Services SERV 71	Child Treatment SERV 72
125	Geriatric Acute Care SERV 73		Sortoise Services SERV 74	Drug Abuse SERV 75
130	Medical Acute Care SERV 76		Urologic Services SERV 77	Family Therapy SERV 78
135	Surgical Acute Care SERV 79		Microbiologic Services SERV 78	Group Therapy SERV 81
140	Skilled Nursing/Etimated Care SERV 82		Necropsy Services SERV 83	<b>OTHER SERVICES</b>
145	Psychiatric Long Term Care SERV 84		Pathology Lab Services SERV 85	Toxicology/Amidate Info SERV 86
150	Tuberculosis Long Term Care SERV 87		Organ Bank SERV 88	Drug Reaction Info SERV 89
155	Intermediate Care SERV 90		Blood Bank SERV 89	Cancer/Tumor Registry SERV 92
160	Rehabilitation Care SERV 93		Electroencephalography SERV 94	Family Planning SERV 95
165	Residential/Custodial Care SERV 96		Electrocardiography SERV 97	Genetic Counseling SERV 98
170	Mental Retardation Care SERV 99		Electrolyte SERV 100	Dietetic Counseling SERV 101
175	Self Care SERV 102		Eye Examination SERV 103	Parent Training Class SERV 104
180	Respite SERV 105		Eye Therapy SERV 106	Diabetic Training Class SERV 107
185	<b>PARTIAL DAY CARE</b>		Cobalt Therapy SERV 108	Renal Dialysis Training Class SERV 109
190	Psychiatric Night Care SERV 110		Radiant Therapy SERV 111	Public Health Class SERV 112
195	Psychiatric Day Care SERV 113		Diagnostic Radi—x-ray SERV 114	Medical Research SERV 115
200	<b>HOME CARE SERVICES</b>		Therapeutic Radiator SERV 116	<b>MEDICAL EDUCATION PROGRAMS</b>
205	Home Physical Medicine Care SERV 117		Computerized Axial Tomography SERV 118	Approved Residency SERV 119
210	Home Social Services Care SERV 120		Full Body SERV 121	Approved Fellowship SERV 122
215	Home Chiropractic Training SERV 123		Partial SERV 124	Non-Approved Residency SERV 125
220	Self Care SERV 126		Pharmacy W/PT Registered Pharmacist SERV 127	Physician's Assistant SERV 128
225	Psychiatric Foster Home Care SERV 129		Pharmacy W/PT Registered Pharmacist SERV 130	RN SERV 131
230	Home Nursing Care SERV 132		Clinical Pharmacologic Services SERV 133	LVN SERV 134
235	<b>EMERGENCY SERVICES</b>		Psychopharmacological Therapy SERV 135	Nurse Anesthetist SERV 136
240	Emergency Room Service SERV 137		Speech Therapy SERV 138	Medical Technologist SERV 139
245	Ambulance Service SERV 140		Physical Therapy SERV 141	Inhalation Therapist SERV 142
250	Mobile Cardiac Care Service SERV 143		Occupational Therapy SERV 144	Occupational Therapist SERV 145
255	Psychiatric Emergency Service SERV 146		Speech Therapy SERV 147	Pharmacy Intern SERV 148
260	Emergency Observation Service SERV 149		Rehabilitation Therapy SERV 150	Physical Therapist SERV 149
265	Emergency Communication System SERV 152		V Therapy SERV 153	Radiologic Technologist SERV 154
270	Trauma Treatment C. II SERV 155		Psychiatric Therapy SERV 156	Diabetic Intern SERV 157
275	Orthopedic Emergency Services SERV 158		Clinical Psychopharmacology SERV 159	A2— <del>_____</del> SERV 160
280	Respiratory Decontamination Room SERV 161		Vaccination Services SERV 162	Medical Records Technologist SERV 163
285	Emergency Helicopter Service SERV 164		Immunization Therapy SERV 165	Social Worker SERV 166
290			Hyperbaric Chamber Services SERV 167	Paramedic Education SERV 168
295			Blood Collection and Processing SERV 169	
300			Showered Mortuaries SERV 170	
305				



## INTRODUCTION

**RONALD ANDERSEN:** The symposium is sponsored by the Center for Health Administration Studies and the Alumni Association of the Graduate Program in Health Administration at the University of Chicago. It's directed toward alumni and students of the program, as well as a broader audience of health services, practitioners, policy makers and researchers. Each year we try to pick a subject of current interest, which also has longer term relevance to the organization and management of health services. Our intent is to explore that topic from multiple perspectives, including theoretical, empirical and practical. With the help of our symposium participants, representing these various perspectives, we hope to gain a better understanding of the problem, and from a managerial perspective, where solutions might be found. Our subject this year is Antitrust Intervention in the Health Sector. As you can see from the program, we're most fortunate to have a fine, distinguished group of presenters to help us explore this topic.

Before introducing our first speakers, I want to say a few words about George Bugbee. George directed the Center for Health Administration and the program in Health Administration Studies from 1962 to 1970. After his retirement, he continued to teach for some years. This symposium was named in his honor in 1980. George earned a degree in business at the University of Michigan and was a hospital administrator at the University Hospital there from 1926 to 1938. From 1938 to 1943, he was Director of Cleveland Hospital. He became executive director of the American Hospital Association (AHA) in 1943. It was during George's tenure, from 1943 to 1954, that the AHA became an influential national organization, serving the hospital field and developing its relationships with emerging health insurance agencies and various levels of government. During this time, George was instrumental in the development of the Hospital Construction Act of 1946, known as Hill Burton, which resulted in increasing the supply of hospital beds to underserved rural, and subsequently, inner city areas. In 1954 he became president of the Health Information Foundation in New York, a foundation funded by the pharmaceutical, chemical and drug industry for research and health services. The health services research program he promoted, along with Odin Anderson, made a unique contribution to policymaking for American Health Services. Eight years later, George accepted an invitation from the University of Chicago and the Graduate School of Business to become director of the program in health administration, and bring the Health Information Foundation to the university. At Chicago, George pioneered the first full two-year curriculum in graduate education in health administration; was a founder of the Association of University Programs in Health Administration; supported the development of a full-time academic faculty for the program, and worked toward a curriculum structure that included both health services research and health care management applications for the students. George's leadership and contributions in the health care field have been well recognized by numerous awards and commendations. I'll only mention the latest. Earlier this year, he was an initial inductee into the National Healthcare Hall of Fame. I think that puts him right up where he belongs with Babe Ruth and Lou Gehrig. George, thanks for all you've done.

Our first speaker today is Frank Easterbrook, who is Judge of the United States Court of Appeals for the Seventh Circuit, and senior lecturer in the law school at the University of Chicago. He graduated from the University of Chicago Law School in 1973, where he was Topics and Comments editor for the *University of Chicago Law Review*. He served in the United States Department of Justice from 1974 to 1979, as assistant to the Solicitor General, and then as Deputy Solicitor General of the United States. He joined the University of Chicago Law School faculty in 1979, and was Lee and Brena Freeman Professor of Law at the time of his appointment as Circuit Judge in 1985. He is editor of the *Journal of Law & Economics* and a member of the James Madison Memorial Fellowship Foundation, the District of Columbia Bar, American Law Institute, and the American Economics Association. His courses taught include Antitrust Law and Regulated Industries. His many publications include the book *Antitrust: Cases, Economic Notes, and Other Materials*, and *The Economic Structure of Corporate Law*.

Our second speaker for this first session is Terry Calvani, who was appointed Commissioner of the United States Federal Trade Commission by President Reagan and sworn in in 1983. Following his graduation from the Cornell Law School, where he was Articles Editor of the Law Review, he practiced with the San Francisco law firm of Pillsbury, Madison & Sutro. From 1974 through 1983, Mr. Calvani taught courses on antitrust law and trade regulation at the Vanderbilt School of Law. He is the author of numerous articles on antitrust issues. He has served as chairman of the ABA Antitrust Section's Robinson/Patman Committee, Noerr Doctrine and State Action Committee, Special Committee on Antitrust Penalties and Damages, and on its governing council. He is a member of the American Law Institute and the Administrative Conference of the United States, and serves on the Advisory Board of the *Antitrust Bulletin* and the BNA Civil RICO Report. From 1979 through 1983, he was counsel to a Birmingham, Alabama, firm where his practice focused on antitrust and trade regulation.

## COMPETITION AND NOT COMPETITORS: THE DOMAIN OF ANTITRUST

FRANK EASTERBROOK: You will have to ask the organizers why they recruited a judge to make the first presentation—and so early in the morning that my colleagues will scarcely have stirred from bed. Perhaps the organizers think that my time in the classroom will enable me to give you a snappy presentation on the application of antitrust to the hospital industry. They should know better. Academics speak in hourly blocs of time, and I have only 25 minutes—less than I had to argue *Jefferson Parrish Hospital District No. 1 v. Hyde*<sup>1</sup> to the Supreme Court, an antitrust case about exclusive dealing in anesthesiology that is my only claim to practical knowledge.

No, neither theory nor practice explains my being here. I think I was asked to talk, together with Terry Calvani, another sometime academic now with the government, to put the fear of God into you. It is to convey the message, as only people wielding the public sword may do, that antitrust matters—and that the meaning of antitrust rules is shaped by people who believe that the special attributes of the hospital business have little or nothing to do with the application of the basic principles. This is not a perspective popular within the industry, but then the industry is not calling the shots.

### I

Let me start at the beginning: the domain of antitrust, or, as my title has it, "competition and not competitors." The antitrust laws do not embody a vision peculiar to any industry. They embody a vision straight from Adam Smith's *The Wealth of Nations* (1776), the vision of competition.

In this vision firms compete until all profits have been squeezed out. If there is an economic profit—which is to say, if price exceeds long run marginal cost, then a new firm enters and drives the price back down. In competition price equals marginal cost, which is best for society. Consumers purchase until their benefit equals marginal cost. At any higher price, at least one consumer who values the good at more than the cost of producing it turns to something else—which is more costly, less useful, or both. The loss from turning to inferior substitutes is the welfare loss of monopoly. It is the economic objection to price exceeding marginal cost.

Antitrust talks the language of competition rather than the ratio of price to marginal cost because it is competition that induces the two to converge. Competition is valued not as an end but as a means. If we could observe the ratio directly, then cooperation might be fine. Sometimes we can, as in the case of performing rights to music, where it is clear that the blanket license sets price equal to marginal cost, at zero (although, there is an access charge).<sup>2</sup> Sometimes we can be confident that cooperation drives marginal cost down—as the hospital is itself a complex cooperative venture, reducing the total cost of medical care. No one objects to the cooperation underlying the hospital's structure, even though each physician could try to compete with every other in a world without hospitals.

The difficulty in practice is that enforcers usually can't observe the end directly. Then competition becomes a proxy for what the law seeks to achieve. Consider the case of

mergers between hospitals. It may be that the merger is just an extended version of the creation of a single hospital, increasing the span of cooperation, driving down the marginal cost of service and so producing benefits for patients. But a merger could also eliminate the discipline that causes hospitals to contain their own costs.

Faced with this duality, enforcers will use rules of thumb. They suppose that the fewer the competitors, the greater the wedge between price and marginal cost. Because entry into hospital business is slow, elevation of price over marginal cost may last a long time. Enforcers use thresholds to suggest concern. In general, they start taking notice when the market is more concentrated than ten equal-sized firms, and they start worrying when it is more concentrated than five. (An index, the Herfindahl-Hirschmann Index, converts actual shares to the equivalent in equal-sized firms, weighting large firms especially heavily.) Fewer firms may collude easier and find it in their interest to be less vigorous rivals even without express collusion. Movement to fewer than five will be challenged. Data imply that it is a decent though imperfect proxy for price effects.

This is a prediction. No one can be sure what will happen. Perhaps efficiency wins out in a given case. Perhaps firms will be stiff rivals even if few in number. Perhaps they will set price at marginal cost even without rivalry. But enforcers in the Department of Justice, the FTC, and the courts must assume that on average this will not happen. Enforcement goes by the norms, and not by the possible exceptions.

## II

"Wait!" I hear you saying, "medical care is different from highway construction or airframe manufacture or computers or pin making." Indeed it is. Every business is unique. Yet the general principles of antitrust apply across the board. Enforcers always reject the claim that "our business is special." To accept it would be to abandon the antitrust laws.

Moreover, while you are thinking of ways in which the hospital business is kinder and gentler than the normal grasping, rapacious enterprise for which antitrust is designed, the enforcers are thinking just the opposite. They are thinking about ways in which medical care is *less* competitive than the norm, justifying special antitrust attention.

One is the special difficulty of entry. Entrepreneurs can't just start up a new hospital. In many states there are certificate of need requirements. Everywhere you need approval after approval from state and local regulatory officials. Difficulty of entry means reduction in the elasticity of supply, which also means higher prices for any given mix of competitors.

Another is the insensitivity of patients to cost. Many patients are insured, by private plans or public funds. Insured patients want the best possible care, without regard to price—for someone else pays. Reduction in the customers' sensitivity to higher prices (that is, inelastic demand) means that higher prices will prove attractive.

As things turn out, this is an ambiguous fact. When customers are not sensitive to price, then price exceeding marginal cost does not necessarily cause allocative loss. Efficiency loss comes when consumers substitute away from the monopolized product. Customers of health care may fail to substitute. Yet there may be too much care, a different source of loss.

Another reason insurance is ambiguous is that large buyers may organize to move price in the direction of marginal cost. Ability to shift many customers, as through preferred provider organizations, creates pressure on prices.<sup>3</sup> The net effect of customers with weak price sensitivity and insurers with the ability to reallocate demand among providers is very hard to establish.

### III

Two features of the industry, however dear to the hearts of hospitals, enforcers put off limits: ethical rules and non-profit status. Consider the latter first.

Hospitals may say: we aren't like shoemakers because we are non-profit firms. Therefore we do not seek to monopolize, will not take advantage of few-ness to raise prices, and should be left alone. Enforcers do not keel over on hearing this argument. I probably needn't remind you that my court rejected it outright in the recent Rockford Hospital merger case.<sup>4</sup>

Why? Three reasons. First, most enforcers do not believe that the hospital business *is* operated not-for-profit. True, most hospitals do not have formal profits, but that's only because they do not have formal shareholders. An economist wishes to know whether the factors of production earn economic rents—that is, receive incomes greater than necessary to hold the assets in the business. Hospitals may create rents and distribute them to doctors, suppliers, and others, in just the way business corporations distribute profits to managers and investors. "Non-profit" in the tax sense is not necessarily non-profit in the economic sense.

Second, even a true non-profit firm, such as a university, may have reason to set price higher than marginal cost and thus create the injury to consumers antitrust means to stop. A university may overcharge for football—or medical care—in order to create revenues that will enable it to reduce the price of Greek literature. The university does not show a profit and believes that it is doing good, but it does not have the power of taxation. Collecting a monopoly overcharge from consumers in one business in order to subsidize another is not immune from antitrust investigation.

Third, genuine non-profit status may stifle the desire to depress costs even as it stifles the urge to set price above cost. If there is nothing to be gained from driving prices up, there is nothing to be gained from driving costs down. Higher ratios of price to marginal cost and higher marginal cost are equally deadly for consumers.

These three items together led enforcers to disregard non-profit status. In the *Hyde* case, the Court made nothing of it. And in *NCAA v. University of Oklahoma*,<sup>5</sup> which held that the NCAA's arrangements for telecasting college football violated the Sherman Act, the Court squarely held that non-profit status does not matter.

Now for ethics. Most professions have codes of ethics demanding of their practitioners scrupulously moral conduct. No one presents an antitrust objection to these. The difficulty comes when the ethical code also raises prices and increases profits. Ethical practice is also profitable; many mortals come to believe that profitable practices are also ethical.

I start with an example from outside medicine. The National Society of Professional Engineers adopted an ethical rule forbidding competitive bidding for design work. Rationale: If engineers had to bid against one another, they would skimp on safety in order to cut their costs, and the public would die as bridges or skywalks collapsed. The Antitrust Division challenged this because it had another effect: higher prices. To get multiple bids, a customer had to go in sequence from one engineer to another, breaking off the negotiations with the first before opening them with another firm of engineers. Unless the first bid exceeded the expected second bid by the time value of the money involved in the project, customers would not shop. Price could be increased over the competitive level by this time value. The Court unanimously held that the "ethical" rule violated the antitrust laws, *National Society of Professional Engineers v. United States*.<sup>6</sup> The ethical argument attributed stupidity to consumers, the Court thought, because any client could arrange a no-bid environment for his own project. No seller may avoid the antitrust rules by saying that "competition does not work in industry because the consumer does not know his own 'true' preferences."

You can now see, I think, what happened to the American Medical Association in *Wilk v. AMA*,<sup>7</sup> the chiropractor's case. The ethical rule against affiliating with quacks ("unscientific practitioners") or cooperating in their treatments was applied to chiropractors. In other words, MD's boycotted them even though state laws permitted them to practice. My court held the boycott a violation of the antitrust laws, because MD's were suppressing competition from rival suppliers of services and inevitably increasing the price. We distinguished *Schachar v. American Academy of Ophthalmology, Inc.*,<sup>8</sup> in which the Academy stated its views on radial keratotomy for benefit of the public and insurers but did not restrict the choices available to them.

Ethics may do good for consumers, in which case we shall all applaud. There is hardly an antitrust objection to advancing consumers welfare! Ethics also may be a consumption good—it makes practitioners feel better about their work and themselves. When it also enriches practitioners and raises price, antitrust is bound to inquire. Self-delusion, attributing public benefits to self-interested acts, does not gain anything from being phrased in terms of ethics. And no rule based on consumers' supposed ignorance will justify reducing the choices available to them—as opposed to providing information to reduce their ignorance.

#### IV

This has been a tough opener, and deliberately so. Antitrust is an uncompromising field. Applied microeconomics has little room for claims of "we're different," or "we're more ethical," and so on. Speakers who follow me will pursue the details. For now what matters is that although the medical business is very different from the flypaper business, the same antitrust rules apply to both.

## ENDNOTES

<sup>1</sup>466 U.S. 2 (1984).

<sup>2</sup>Broadcast Music, Inc. v. CBS, Inc., 441 U.S. 1 (1979).

<sup>3</sup>See Ball Memorial Hospital, Inc. v. Mutual Hospital Insurance, Inc., 784 F.2d 1325 (7th Cir. 1986).

<sup>4</sup>United States v. Rockford Memorial Corp., 898 F.2d 1278 (7th Cir. 1990).

<sup>5</sup>468 U.S. 85 (1984).

<sup>6</sup>435 U.S. 679 (1978).

<sup>7</sup>895 F.2d 352 (7th Cir. 1990).

<sup>8</sup>870 F.2d 397 (7th Cir. 1989).

## FTC EXPERIENCE IN ANTITRUST HEALTH CARE ENFORCEMENT

TERRY CALVANI: Judge Easterbrook set the stage this morning by giving you the big picture. My task is a more pedestrian one, and that is to describe the current antitrust enforcement agenda at the federal agencies. Some of you will find that we're doing too much. Indeed, in a former life, I at one time characterized my own agency as doing poorly, that which ought not be done at all. But today I wear a different garb. Some of you will find that what we do is too little. Well, let's talk about what is going on.

I have with me in my hands, two recent government complaints. The one in my left hand involves an employee medical insurance plan: so does the one on my right. The one in my left hand is about a dispute over the appropriate measure of payments these plans would make to medical service providers: so is the one in my right. The one in my left hand alleges a combination among those medical service providers to demand higher payments, and so does the one in my right. The one in my left hand involves pharmacists in New York. It was issued by the Federal Trade Commission last March. It is a civil complaint which would subject the respondents to the risk, if found liable, of an order prohibiting them from conspiring in the future. The one in my right is different. It involves dentists in Arizona, and was returned by a federal grand jury in February. It is a felony indictment, which subjects the defendants to the risk, if convicted, of three years in federal prison and fines up to \$100,000.

Now, this morning I cannot and will not comment on the factual details of these particular cases. Each is, at this point, merely a complaint, and I have no idea what the results of the trials and the subsequent appeals will be. But let me assure you that your general impression is correct. While the complaints that were in the left hand and the right hand are almost identical, there is a very important distinction. One will bring you a slap on the wrist and the admonition go and sin no more. The other will bring you a term in the federal pen. That brings with it strip searches, non-consensual sex, loss of the vote, loss of the power to own a rifle and go hunting, loss of your passport; things that are probably more important to individuals and individual liberty than an FTC cease and desist order.

Well, now that maybe I have your attention, let me outline what I propose to do this morning. First, I will briefly explain the basic laws and institutions that we enforce. These subjects are sometimes unfamiliar to audiences such as this one. And then secondly, I'd like to review the last decade's experience in applying these laws in the health care industry. With increasing experience, certain types of cases have become almost standardized. What had once seemed novel is now routine. And finally, I'd like to explore a couple of so-called "hot" topics, and venture a few predictions about the direction the health care antitrust enforcement could take in the next decade. I foresee a substantial increase in the number of indictments for garden variety price fixing, and a substantial shift in enforcement responsibilities toward the Department of Justice. But I also foresee increasingly sophisticated and perhaps even sympathetic analysis of peculiar problems that might face hospitals and other medical service providers, which are simultaneously commanded to lower costs and improve quality, and yet compete for business under what must often seem to be, at least to some of you, an entirely new set of rules.



First, some background. The Federal Trade Commission is responsible for the enforcement of the federal antitrust and consumer protection statutes, and it shares its antitrust jurisdiction with the United States Department of Justice. Although the jurisdiction of the two agencies substantially overlaps, the Justice Department has traditionally focused on price fixing and other criminal practices, while the FTC has focused on non-criminal conduct.

The actions brought by the Commission may take several different forms. In some situations, the Commission issues a complaint and pursues administrative litigation. This ultimately produces a decision by the Commission itself. Such administrative cases have been brought against advertisers who make misleading claims for ineffectual health care products, and against health care providers who have organized to put pressure on insurance companies, or to prevent new forms of competition. In other cases, the Commission staff has obtained injunctions in the federal courts. This judicial process has been used recently to stop allegedly deceptive advertising of health care frauds like spectrographic hair analysis, and is often used to block proposed mergers. In still other situations, the Commission has issued general rules, covering an entire industry, rather than pursue litigation against each individual involved. Of course, there may ultimately be litigation as these rules are enforced in particular cases. Such rules include the Commission's regulations about optometry and its regulations regarding the funeral industry. And finally, in some situations, the Commission has instituted programs of consumer and business education, thinking it best to proceed on an informative, non-adversarial basis.

The FTC's health care program seeks to ensure that health care practitioners and businesses follow the same basic ground rules as other businesses, that is, that they should compete in something resembling a free market, and more importantly, that they not engage in cartel behavior. The correctness of this approach has been clear at least since the Supreme Court's 1975 decision in *Goldfarb v. Virginia State Bar*, which established beyond doubt that antitrust principles apply to the delivery of professional services. The Commission, however, was not waiting for permission from the Supreme Court to begin looking at the health care industry. Even before the *Goldfarb* decision, it was starting to organize a health care enforcement program, and had begun an investigation into physician control over prepaid care organizations. Just a few months after *Goldfarb*, the Commission issued the complaint that led to its first major health care decision in recent times, the *AMA* decision. Although that case is no longer news, it addressed practices that are still the subject of controversy, and announced principles that are still guiding the Commission's law enforcement agenda.

The *AMA* decision challenged a network of formal and informal restraints that limited health care professionals' commercial practices. These restraints may have inhibited practitioners from advertising, practicing under a trade name, opening branch offices, affiliating with non-physicians, or engaging in other novel arrangements that may provide more convenient or perhaps more accessible health care to the public. The Commission challenged, successfully, the AMA's so-called "ethical bans" against most business associations between doctors and non-doctors, and against most forms of physician advertising. Taken together, all of the AMA's restrictions prevented physicians from adopting what may have proved to be more economically efficient business practices, and worked instead to protect the market positions of more traditional service practitioners.

Such practices may often have been, and in many instances clearly were, much broader than was necessary to achieve an optimal level of consumer protection.

The *AMA* case was only the first of a long line of Commission decisions and orders about professional advertising and forms of practice. Although many of the cases have involved private associations, such as local medical societies, the Commission has also taken action increasingly against restraints imposed by state boards, in those cases where the state board's legal authority to act is inadequate to authorize it to prohibit competition. One prime example is the Commission's order after a full trial against the Massachusetts optometry registration board, requiring it to permit truthful advertising.

You should note that the Commission has not adopted special rules that apply only to health care. During the same period that the Commission has obtained more than a dozen orders against advertising and form of practice restraints by health care providers, it has also attacked similar restraints by other professionals. Indeed, the legal principles involved are not that much different, if different at all, from those announced by the Commission recently in orders condemning, for example, agreements among auto dealers to refrain from advertising prices, and to limit their hours of operation.

Now let me move on from the superficially novel notion, now rather well established, that antitrust law addresses advertising, to something that is more traditional, namely, antitrust concern with prices. In the health care area, we routinely deal with boycotts and cartels. I know these are the same harsh words that we usually apply in the context of OPEC or other things that we deem to be conspiracies, but the law is the same because the effects, at least as we perceive them, are the same.

The boycotts of greatest concern to the Commission have generally been those aimed at third party payers, either governments or insurance companies. In the typical case, the health care providers threaten to stop accepting payment unless the payor sweetens its terms, or perhaps stops cost containment efforts. One of the Commission's more important decisions in this area was the *Michigan State Medical Society* case, a boycott of practitioners aimed at the State's proposed Medicaid reimbursement formula. Another was the *Indiana Federation of Dentists* case, which went all the way to the Supreme Court. That Court agreed, unanimously, that it was illegal to boycott an insurance company that wanted to impose a quality control check before reimbursing for some procedures. Including the recent pharmacy cases that I mentioned in my opening, the Commission has brought more than a dozen of these boycott type cases in the health care area. Again, the legal principles applied to the medical profession are the same as those applied to other professions and to other businesses. For example, during the same decade, the Commission challenged a lawyers' boycott aimed at extorting higher fees from a government payer, and as with the *Indiana Dentists* case, again prevailed in the United States Supreme Court. The law is really not that controversial, although it may still be unfamiliar in certain sectors of our economy.

Another slightly different kind of boycott case has now also become routine. This is the medical staff boycott, not aimed at setting a fee level directly so much as at keeping out unwanted new competition. The medical staff boycott cases take two forms. Examples of one form include orthopedists threatening to withdraw from a hospital unless the hospital also agrees to exclude podiatrists, or obstetricians making the same demand with reference to nurse midwives, or anesthesiologists making the same demands with reference to nurse

anesthetists. In each case, different practitioners offer similar services, but at arguably different levels of expertise. Generally, the Commission has tried not to take action in cases like these if there is any possibility that the Commission can be mistaken about quality of care issues beyond its competence. Thus, although the Commission has obtained a few orders in cases like these just mentioned, the Commission is more likely to issue formal complaints where doctors or other providers were aiming their action, not at different levels or types of medical practice, but at different business formats in which to practice the same kind of medicine. Two recent Commission actions were aimed at a threat by all of the obstetricians in a town to boycott a hospital's proposed obstetrical residency program because the new residency program would bring in new, unwanted doctors. In another case, there was a threat by most of the doctors in another town to boycott a proposed new outpatient clinic, to be sponsored by an out-of-town hospital—again, unwanted new competition.

The early health care cartel cases were challenges to fee schedules and relative value guides. Such documents tended to embody the "going rate," meaning the price that everyone charged, reinforced by so-called ethical restraints against charging either too much or, perhaps amazingly, too little. The Supreme Court has agreed that agreements on such price lists are *per se* illegal. The Commission obtained a number of orders against such cartel-like behavior in the late 1970s.

But today, the Commission is paying increasing attention to the phenomenon of doctor cartels masquerading as individual practice associations. One order has been obtained and other investigations are currently underway. Many of these so-called joint ventures are just price fixing devices. The Commission will not hesitate to refer these cases to the Department of Justice for prosecution. And in fact, we've recently referred two to grand juries in the last few months.

A major part of the Commission's work today is mergers, another traditional-sounding antitrust topic not often associated with the health care business. But many of its merger cases have involved health care businesses, including several involving eye care products, a recent case involving vaccines, and perhaps of greatest interest to this audience, several involving hospitals. At one time, and perhaps still, most hospital mergers were really acquisitions, usually the purchase by a large hospital group or chain of another local hospital. Such acquisitions are ones that we, at the agency, would normally call conglomerate, or to be more precise, geographic market extension mergers. They bring under common ownership hospitals located in different cities. Since the Commission does not generally believe that this type of transaction is likely to give hospitals increased power over price, they are not usually of much concern to us.

More troublesome, however, are acquisitions that combine two hospitals in the same market area. Pre-existing competition between them may be lost and the antimerger laws may then apply. Before 1984, the law on this point was quite sketchy. Indeed, I believe, there was only one officially reported judicial decision involving a hospital merger. And then in 1984, the Commission decided the *American Medical International* case, and a year later, the Commission announced its opinion in *Hospital Corporation of America*. These two cases condemned the mergers at issue on the grounds that each significantly increased hospital concentration, and therefore potential market power, within a limited and definable market of a single city. Since then there have been a few more hospital merger decisions,

notably the two District Court decisions in the last year, in cases brought by the Department of Justice. The Justice Department lost one of them in Virginia, and won one in Illinois, the one that Judge Easterbrook made reference to a few moments ago. The Commission recently accepted a consent order in another hospital merger case, and has issued a complaint in yet another. That case is now in administrative litigation at the Commission.

Merger enforcement in the hospital industry encounters some special problems, since most hospital acquisitions are not reported in advance to the federal government. The federal merger reporting program, the so-called Hart-Scott-Rodino program, was drawn up to fit the typical manufacturing or service industry, which markets on a regional or national basis. Hospitals, however, more often compete in local markets, since patients are not willing to travel great distances. As a result, the relevant geographic market for a hospital merger may consist, in appropriate cases, of only a county or perhaps only part of an urban area. A hospital merger may be large enough to confer a considerable market power within this small area, and yet be too small to reach the FTC's national reporting thresholds. Therefore, FTC staff must look to trade publications, newspaper accounts, and consumer or competitor complaints, in order to ferret out potentially anti-competitive hospital mergers.

Commission review of hospital mergers raises specialized jurisdictional issues, stemming from the fact that many hospitals are non-profit, rather than profit-making organizations. This issue is now being contested in three lawsuits. Because of a legal technicality, it is being claimed that all asset acquisitions by non-profit entities are exempt from any merger control, at least by the federal government. And thus, the parties being sued by the Department of Justice are also claiming that the federal merger law does not apply to them either. So far the court decisions are divided on the issue. The most recent, and I think thorough, judicial analysis of the issue, a unanimous opinion by the Court of Appeals for the Seventh Circuit, just last month squarely rejected this argument for an exemption. The Commission's own case is currently in litigation before an administrative law judge. The hospital there being sued has so far failed in its efforts to get the federal courts to throw the case out before the Commission finishes hearing it. A full disclosure compels me to reveal that just last year, I authored an opinion by the Commission in a procedural matter in the preliminary investigation that led to the Commission's now pending complaint, analyzing this jurisdictional issue in some depth. The Commission there stopped short of reaching a final decision on the legal point, saying it was unnecessary at that time, but it did describe in some detail the argument that can be made in favor of federal jurisdiction over acquisitions by non-profit entities.

The hospital merger cases and the recent discussions about them raise another general issue, and that is the treatment of costs and efficiencies. In the two cases the Commission has formally decided, the hospitals contended that the hospital business is fundamentally different from others, so that normal notions about how competitors behave did not apply to them. The hospitals mimicked the arguments that Judge Easterbrook suggested are often made. To tell the truth, in my office, nearly everyone who comes through my doors tells me that, for example, the widget industry is really very different from any other industry, so that the normal rules simply cannot be held to apply to them. You will understand why we treat such arguments with a healthy skepticism. However, contrary to the widespread mythology, we don't completely ignore them. We fully understand that there are facts about the health care industry that make it different from

other industries, and that inescapably affect business incentives. The party getting the service, at least in some contexts in health care, is not the party directly paying the bill. And we also understand that there have been numerous efforts, both public and private, to control hospital costs and regulate hospital facilities, and that these efforts affect how hospitals operate and behave in competitive and non-competitive markets. We are aware of the concept that combining institutions can create efficiencies. And indeed, it is now, although it wasn't always, a fundamental part of modern merger analysis that such efficiencies, if demonstrable and significant, can outweigh threatened anticompetitive effects in the legal analysis.

These are complex questions of degree, dependent on murky matters of fact, to be decided in particular cases. I'm sorry, frankly, that we cannot announce a general rule, such as that all mergers of hospitals in cities smaller than 150,000 people are automatically legal. Some may be legal, others not. The case now in trial before the Commission is attempting to resolve that issue in one particular fact situation. When it is over, I expect that that decision, whatever it may be, will apply only to the particular set of facts at issue there, and will be of limited importance to others.

In closing, I would like to leave you with perhaps a surprising prediction. I think the Federal Trade Commission may be getting out of much of its traditional health care law enforcement business. I don't mean that the law is going to ignore competition problems in this industry. Rather, as recent developments ought make clear, the law applied to these traditional, routine kind of cases will be increasingly the criminal law. Right now that means that agreements dealing with prices are likely not to end up at the Federal Trade Commission, as they have for the past 15 years, but rather at the Department of Justice. It means that complainants and their prayers for relief will no longer ask for a cease and desist order, but rather, the Assistant Attorney General can be expected to appear at sentencing hearings asking for incarcerations in a federal penitentiary. I would expect these cases that have traditionally been grist for our mill at the FTC to return to us only if the courts or the juries consistently fail to return guilty verdicts in the DOJ proceedings, and if the judges are unwilling to send the health care executives to prison.

But history suggests that other kinds of conduct, not just naked price fixing, also may come under even closer criminal scrutiny. Antitrust interest in the health care area dates back at least to the 1930s, when the AMA undertook to obstruct a prepaid health care plan. The AMA coerced its member physicians into not accepting employment with a prepaid health care plan by declaring that it was unethical to work for such an organization. It restrained its member physicians from consulting with HMO affiliated doctors, and induced hospitals to deny them staff privileges. Note that the government did not allege that the AMA tried to fix prices. It is educational, I think, to reread those old decisions. They discussed all of the issues now being debated, about whether the medical profession can be treated like a trade, and about the cost and competition issues raised by novel forms of practice. Indeed, the setting and the issues call to mind many of the same problems the Commission addressed in its own *AMA* decision, more than 40 years later. Most important for present purposes, the old *AMA* case was, I remind you, a criminal indictment, resulting in convictions against the professional societies and against some 21 individuals who organized the effort. That indictment was brought before World War II, and the convictions were sustained by a unanimous Supreme Court.

The recent Tucson indictment perhaps brings us back to full circle. That was a case that was originally investigated by the FTC and then returned to the Department of Justice. Two more referrals have been sent to the Department of Justice for grand jury treatment this past month. Another may be there soon, if settlement discussions don't prove fruitful. My message to you then, is that you and your clients don't want to be before grand juries in the future.

## QUESTIONS FOR MR. EASTERBROOK AND MR. CALVANI

RONALD ANDERSEN: I believe if the intent of our organizers was to have speakers who would wake us up this morning—they succeeded! We do have time for questions.

QUESTION: Does it make a difference for antitrust law if there is a public board for the hospital?

FRANK EASTERBROOK: The answer to that is no. What would make a difference for antitrust purposes is whether state law compels the hospitals to behave in a particular way. The Supreme Court has said that monopolization as a result of state compulsion, with active state supervision of the resulting prices, is not within the scope of the antitrust laws. The Court has been quite insistent on both of those two prongs—both compulsion by state law, and active state supervision of the resulting monopoly. The existence of a public board doesn't satisfy either of those elements. Terry, this is something that you might want to talk on as well, because the FTC has a fairly well developed jurisprudence on the subject.

TERRY CALVANI: I really don't have much to add to what Judge Easterbrook said. Clearly, the Supreme Court has laid out a way, where with the approval of the state legislature or the law-making process of whatever jurisdiction, one can insulate certain kinds of anticompetitive activity from the federal antitrust laws. One can do that in a hospital context too, to the extent that you satisfy the requirements of what lawyers refer to as a state action exemption.

QUESTION: Are states and localities subject to antitrust law?

FRANK EASTERBROOK: I once wrote an article that said essentially, if localities wish to go to Hell, there ought not to be any antitrust objection (Antitrust and the Economics of Federalism, 26 J.L. & Econ. 23-50 (1983).) provided that the injury is borne locally. Municipalities and states can levy taxes and do all manner of things that are expensive to the populace. Although taxes are a form of high prices, nobody thinks of taxes as an antitrust violation. Therefore, my article said, why should we conceive of a local monopoly run by a local government as an antitrust problem? The Supreme Court has not followed that line, so that gets us to the practical level. Is general authority, like the authority to make contracts, going to be viewed as sufficient authorization? Everybody knows that when you authorize people to go out and do these things, monopoly is sure to rear its head. Still, I can't believe the answer will be yes. Not unless the Supreme Court is prepared to adopt my broader proposition that so long as a state or locality is not attempting to export and overcharge to people who can't vote, it can do pretty much what it pleases. Since I don't see the adoption of that in the foreseeable future, it's very hard to see why that form of general authorization would suffice.

QUESTION: To what extent do antitrust laws permit cost containment efforts initiated by insurers or other representatives of purchasers?

FRANK EASTERBROOK: Although neither Commissioner Calvani nor I mentioned the word, there is an equivalent word to monopoly: monopsony, on the buyer's side. If there is market power on the buyer's side, then cost containment efforts can be viewed as an attempt to monopsonize the product, which has welfare losses associated with it. Monopoly and monopsony require similar analysis. Is there market power as viewed on the buyer's side? and so on. There has been a good deal of litigation about this. I will tell you one result in

the Seventh Circuit. When Blue Cross/Blue Shield of Indiana instituted a preferred provider organization, coupled with other forms of cost control, it was sued by some of the hospitals, not only some whose bids were not accepted, because they were too high, but also those who thought they had been subject to a monopsonistic practice. Blue Cross/Blue Shield, by almost any measure, has a high market share. The Seventh Circuit said there was no violation with respect to those efforts, because in the insurance business entry is exceedingly easy. It's very easy for people to write policies. There are no large scale productive assets that take time to duplicate. The big difference between the supply side of this market and the customer side, is that the customer side is essentially financial. An insurance company is a risk pool. Many people can provide pooling and administration services, using assets that aren't specialized to Indiana. The hospital side, on the other hand, requires a great deal of physical capital, other machinery and so on. The Seventh Circuit thought that there was an important line for antitrust purposes between those two sides.

TERRY CALVANI: I'd also like to make a brief comment. I thought maybe your question also addressed whether the courts or the agencies have focused on the possibility of bilateral monopoly problems in the health care industry. I don't want to argue cases for private parties that appear before us, but on a couple of occasions, I've wondered why those arguments haven't been made. I'm not altogether sure that they're legally significant: nonetheless, we seem to see arguments made by counsel assuming that we have organized buyers and sellers within an alleged cartel problem on one side or the other. At least that is the allegation being made by the government, and I've often thought that it would be interesting, if not legally significant, to focus on what significance, if any, the presence of a bilateral monopoly might have. It seems to me that the welfare consequences of a monopsony confronting a monopoly are often indeterminant. Again, the legal consequence of all of that remains unclear, but I think it is an interesting issue. Unfortunately, to my knowledge neither the Federal Trade Commission nor the Department of Justice have, within their economic think tanks, devoted many resources to that question.



## SESSION II: SPECIFIC ANTITRUST ISSUES IN MEDICAL CONTRACTING

RONALD ANDERSEN: Henry Allen is a partner in the law firm of McBride, Baker & Coles, in Chicago. He received his undergraduate degree from Washington University and his law degree from Cornell University. While at Cornell, he was a HUD Fellow at National Center for Health Services Research Trainee, and a teaching assistant. Before joining MBC in 1986, Henry was with Allan and Reed, where he litigated in various jurisdictions, contract, due process and antitrust issues related to hospital credentialing of physicians. He has been primarily involved in antitrust counseling and litigation for the past decade. He has represented both physicians and hospitals in antitrust disputes, and successfully co-represented the petitioner hospital in the recent United States Supreme Court antitrust case of *Jefferson Parrish Hospital, District #2 v. Hyde*. Henry co-authored the current American College of Radiology Monograph, subsequently republished by the American Bar Association, regarding clinical privileges and physician contracts. I might also mention that Henry, together with David Dranove, is primarily responsible for the development of our program today.

William Lynk is Vice President and Senior Economist of Lexecon Inc. of Chicago, where he directs research in industrial organization and analysis of issues in antitrust economics and regulatory policy. Bill received his Ph.D. from the University of Chicago in Business Economics in 1978. Prior to joining Lexecon, he was director of economic analysis for the Blue Cross/Blue Shield Association, from 1977 to 1980, where he did research on the economic position in the Association Antitrust litigation and regulatory issues. Bill's recent research publications include: "The Economic Basis of *Hyde*: Are Market Power and Hospital Exclusive Contracts Related?" in the *Journal of Law and Economics*, and "Establishing Competitive Effects in Markets for Medical Services" in the volume, *Current Developments in Health Care Antitrust Law*.

Steven West has been President and Chief Executive Officer of Galesburg Cottage Hospital in Galesburg, Illinois since 1987. He received his Master of Science in Hospital and Health Services Administration from Ohio State University in 1978. From 1978 to 1987, he has been Vice President for Planning and then Executive Vice President at the Galesburg Hospital. He is a member of the American College of Health Care Executives, American Hospital Association, the Illinois Hospital Association Council and the Society for Health Care and Planning in Marketing.

## HOSPITAL EXCLUSIVE CONTRACTS IN THE FACE OF LOCALIZED AND CONCENTRATED MARKETS

HENRY S. ALLEN, JR.: I will talk, from the plaintiff lawyer's point of view, about antitrust challenges to hospital sole-source physician arrangements. These arrangements are typically implemented by hospitals either by restricting privileging in certain services to only selected practitioners or by exclusively contracting services with a certain physician or firm.

### Hospital Physician Exclusive Service Litigation Typically Involves Multiple Theories for Judicial Intervention

One overriding characteristic of these cases is that antitrust is but one theory of relief available for the excluded physician. There are also numerous state legal theories that may apply to protect an excluded physician's relationship with a hospital. Several months ago a Tennessee appellate court in *Alfredson v. Lewisburg Community Hospital*, Appeal No. 88-311-11, (Tenn. Ap.Ct. Nov. 8, 1989) reviewed a case where a radiologist was denied the use of radiology equipment when the hospital implemented an exclusive contract with someone else. The court was confronted with plaintiff's numerous legal theories prompting the court to write:

"The gravamen of Dr. Alfredson's dispute has been concealed by the numerous legal theories in his complaint. . . . Successful complaint drafting requires a well-aimed rifle shot rather than a shotgun blast."

Perhaps. But the plaintiff's lawyer in an exclusive hospital contract case is likely to find that in areas of the country where he is most likely to have a viable antitrust claim—in sparsely populated states with far-flung hospitals—he is also likely to have recourse to viable state theories—contract, tort, due process, and fiduciary—which protect the physician's hospital relationship. Thus, for example, in Alaska, New Mexico, Hawaii, Montana and so on, there are few hospitals, and any given hospital is likely to have a stranglehold over a physician's ability to earn a living. These states typically have developed a fiduciary theory of judicial intervention whereby a court will require that the excluded practitioner be accorded rudimentary due process. Accordingly, in these settings, a hospital might successfully defend an antitrust challenge to an exclusive contract only to find that it is still liable under state law for excluding a physician unfairly.

### Health Care Quality Improvement Act Does Not Undercut Claim

When evaluating an excluded physician's antitrust claim, you will probably find that it is not undercut by Congress' passage of the Health Care Quality Improvement Act of 1986. That statute confers a limited antitrust immunity on physicians and other persons (including hospitals) who participate in professional review activities by exempting them from treble damages. There is no immunity, however, for credentialing activity unrelated to

physician competence. Thus, if certain neonatologists at a hospital were to review the credentials of an applicant for a service, find the applicant qualified, but recommend that she not be credentialed because to do so would, in their view, conflict with a closed-staff policy of the hospital, there is no immunity. If the hospital agrees with that recommendation, the hospital is also *not* protected by any immunity offered by the Health Care Quality Improvement Act.

### **Hospital Decisions to Close a Service to a Sole-Source Physician Supplier Raises Conspiracy Issue (Third Circuit v. Eleventh Circuit)**

A more interesting question, though, is, when the hospital decides to close, for example, the neonatology service to only certain neonatologists and to refuse to credential other competent neonatologists, whether the hospital has "*conspired*" with the medical staff. As you recall, Section 1 of the Sherman Act does *not* apply to unilateral conduct. (Section 1 does reach alleged tying agreements which do not require proof of a conspiracy. These are discussed below.) Without being able to prove a conspiracy between the hospital and medical staff, you, as plaintiff, would have to prove that the hospital decision is prohibited by Section 2, for threatening actual monopolization—a tougher claim to make. In the Third Circuit, under my hypothetical neonatology exclusive privilege case, there would be no conspiracy between the medical staff and hospital and so no Section 1 claim. The Third Circuit in *Weiss v. York Hospital*, 745 F.2d 786 (3rd Cir., 1984), *cert. denied*, 470 U.S. 1060 (1985), squarely held that "the hospital cannot legally conspire with its medical staff." It explained why not as follows:

The medical staff was empowered to make staff privilege decisions *on behalf* of the hospital. As such, with regard to these decisions, the medical staff operated as an officer of a corporation. Although the members of the medical staff had independent economic interests in competition with each other, the staff as an entity had no interest in competition with the hospital. 745 F.2d at 817.

But, *if* you are in the Eleventh Circuit, the federal antitrust law there is that the medical staff and the hospital *do* have the capacity to conspire. The Eleventh Circuit in *Bolt v. Halifax Hospital Medical Center*, 891 F.2d 810 (11th Cir. 1990) characterized as "faulty" the Third Circuit's decision in *Weiss*. The *Bolt* court concluded that the hospital and medical staff were legally capable of concerted action because they were, in the court's view, "legally separate entities."

The hospital in the *Bolt* case petitioned the Supreme Court for a review of this conspiracy question. This week, the Court denied cert in an order that also indicated that Justice White would have granted cert. The *Bolt* decision will undoubtedly freeze physicians residing in the Eleventh Circuit from playing effective roles in the credentialing process. In my view, *Bolt* was wrongly decided.

On the other hand, there *are exceptional* cases where a physician on a medical staff might properly be found to have conspired with his hospital. I will refer to these exceptional cases as the independent personal-stake type of case: where certain members of

the hospital's medical staff are *not* acting as the hospital's agents, but instead are pursuing their own economic interests.

In such cases, two factors are almost always present. First, the decision-makers on the medical staff are direct competitors of the plaintiff physician, and second, the physicians have the power to effect the exclusion.

In my view, the best example of the "exceptional case" is the Ninth Circuit case of *Oltz v. St. Peter's Community Hospital*, 861 F.2d 1440 (9th Cir. 1988). There, a Montana hospital was liable for exclusively contracting for anesthesia services in violation of Section 1 of the Sherman Act.

In the *Oltz* case, the defendant hospital was one of two hospitals in Helena. It enjoyed the overwhelming majority of the market for general surgery. Mr. Oltz, the plaintiff nurse anesthetist, had been billing for his services under an arrangement with the defendant hospital. The anesthesiologists complained about the independent billing practice and threatened to leave. The medical staff recommended to the Board that Oltz's freelance billing position be continued. However, the hospital responded to the pressure of its anesthesiologists by terminating the independent billing. It ultimately awarded an exclusive contract to the anesthesiologists practicing at the hospital. Oltz moved to Iowa.

Oltz sued the hospital and the anesthesiologists for violation of Section 1 of the Sherman Act. The anesthesiologists settled for \$462,500, and the case proceeded to a jury which found the hospital liable. On appeal, the Ninth Circuit brushed aside the hospital's argument that the hospital and anesthesiologists were legally incapable of conspiring. The Court stated:

*Although the M.D. anesthesiologists may have been the agents of St. Peter's for some purposes, . . . The anesthesiologists were independent contractors pursuing their personal economic interests when they pressured St. Peter's to eliminate Oltz as a direct competitor. Those interests were sufficiently independent so that the collaborated conduct between the anesthesiologists and St. Peter's coalesced economic power previously directed at disparate goals. In short, there was a conspiracy.*

The lesson here is that if, as plaintiff's attorney in an exclusive contract case, you find that the physicians participating in the staffing decision were competitors of the plaintiff and that they used their position to pressure the Board into a decision, you have done much to prove a conspiracy.

### **Oltz Recognizes That the Patient May Be a Relevant Purchaser of Certain Physician Services Under Exclusive Hospital Contracts and that Competitive Effect May Be Properly Evaluated Within a Highly Localized Market**

Your next task as plaintiff's attorney in an exclusive contract case is to define a small geographical relevant market. In these cases, you will be met with a relevant market defense that would have the court focus on the competition *to be* the hospital's chosen physician. The hospital would undoubtedly emphasize that it shops a national market for physicians. Anesthesiologists, the argument goes, are willing to travel across the state, or

even country, to become the hospital's chosen anesthesiologist. The competition is for the franchise, it's ongoing and it's state-wide, if not national. Your job as plaintiff is to characterize the patient as the relevant purchaser. For the patient, medical markets are highly localized. Judge Posner acknowledged this fact in his recent *United States of America v. Rockford Memorial Hospital Corporation et al.*, No. 89-1900 (7th Cir. 1990), decision:

For highly exotic or highly elective hospital treatment, patients will sometimes travel long distances, of course. But for the most part, hospital services are local. People want to be hospitalized near their families and homes, in hospitals in which their own—local—doctors have hospital privileges.

Obviously, your success as plaintiff in characterizing the patient as purchaser will depend on the specialty of your client. If you can show that the patient or his personal physician typically requests your guy's services, then you can show that the patient, and not the hospital, is the relevant purchaser and the market is local, not national. This does *not* work for pathologists. [See *Collins v. Associated Pathologists, Ltd.* 844 F.2d 473 (7th Cir. 1988)]. It does work for anesthesiologists and some other specialties. For example, the Ninth Circuit in *Oltz* acknowledged that an exclusive anesthesia service contract could injure competition in either of two segments of the economy: the broader job market for anesthesia positions *or* the patient market for anesthesia care. In *Oltz*, the Ninth Circuit found injury to competition in the patient market. Physicians who preferred the services of Oltz were hindered from obtaining them. Moreover, the price of anesthesia services and the income of the M.D. anesthesiologists rose dramatically because of the challenged restraint. The Court, therefore, found that the hospital's exclusive contract unreasonably restrained trade and violated Section 1 of the Sherman Act.

To reiterate, I think that the *Oltz* decision is instructive in two areas: (i) it demonstrates the circumstances under which hospital trustees can join a conspiracy; and (ii) it demonstrates that the relevant market for examining the effects of exclusive contracts in services that the patient selects, e.g., anesthesiology, neonatology, cardiology and so on, is the market for patients, and that market is not national, but highly local.

### **Oltz and Rockford Make Life Easier for Plaintiffs and Successful Future Tying Claims Against Exclusive Contracts Are Predicted**

*Oltz* and *Rockford* (though a merger case) have made it easier for plaintiffs in exclusive contract cases involving services that the patient requests (say neonatology). *Rockford* emphasizes that hospital markets are localized. This raises the probability that a given hospital may have a market share exceeding two-thirds—a common threshold of monopoly power. If, by virtue of an exclusive contract and the hospital's market power, the patient is *forced* to take the hospital's chosen neonatologist, a *per se* violation of the antitrust laws is established. Whatever justification the hospital may have for its exclusive deal in neonatology becomes irrelevant.

As you recall, this was the teaching of the Supreme Court in *Jefferson Parish Hospital District No. 2 v. Hyde*. There, the court asserted that the essential characteristics of

a *per se* violation of the antitrust laws "lies in the seller's exploitation of its control over the tying product (hospital services) to force the buyer into the purchase of a tied product (anesthesiology) that the buyer either did not want at all, or might have preferred to purchase elsewhere under different terms." In *Hyde*, the defendant hospital, a hospital in the large metropolitan area of New Orleans, did not have the kind of market power that could force the patient to purchase the hospital's chosen anesthesiology services. The result would surely be different, particularly in the light of *Oltz* and *Rockford*, in smaller communities with few hospitals where there was evidence of actual forcing of a service on patients.

To illustrate a recent application of tying theory in the medical service area, about a month ago, the Federal Trade Commission was successful in obtaining a consent decree in a tying case. The agreement settles charges that Dr. Friedman, a physician in Upland and Pomona, California, engaged in an illegal tying arrangement, requiring physicians who used his out-patient dialysis facilities to use his in-patient dialysis services when their patients were hospitalized. The FTC alleges that Dr. Friedman has had market power in out-patient services (he does 90 percent of out-patient dialysis in the Upland and Pomona area), but could not exploit it because Medicare limits the amount of reimbursement available for out-patient services. Medicare does not, however, regulate reimbursement for in-patient dialysis. Consequently, the FTC alleges Dr. Friedman used the tying arrangement to circumvent Medicare's price regulation and charge higher than competitive prices for the tied in-patient services.

The FTC consent agreement prohibits Dr. Friedman from continuing this tying practice. Gerald S. Friedman, M.D., File No. 8610072, CCH 22,811.

\* \* \*

I am not sure why in the wake of *Hyde* there have not been successful tying cases against hospitals challenging exclusive medical service contracts. CCH, a research service, identifies only two post-*Hyde* medical service cases even addressing the tying theory. One of the cases is *Konik v. Champlain Valley Physicians Hospital Medical Center*, 733 F.2d 1007 (1984), a Second Circuit 1984 case. There, anesthesiologists challenged an alleged exclusive hospital anesthesia services contract. The court found two of the elements of a *per se* tying violation—two products and market power in the tying product. However, there was no "tie." The challenged contract, said the Second Circuit, was non-exclusive. The patient could be treated by non-contracting anesthesiologists with privileges at the hospital.

Perhaps the absence of reported tying violations in this area can be explained by the hospital practice of largely confining exclusive contracts to *pathology* and *diagnostic radiology* where there is no product separate and distinct from hospital services that could be tied. This, for example, explains the plaintiff-pathologist's loss in the 1988 Seventh Circuit case of *Collins v. St. John's Hospital* (decided by a panel which included Judge Easterbrook). There, the Seventh Circuit noted that patients or their doctors at St. John's never requested that Dr. Collins be the patient's pathologist. Without this separate demand, there was only one service—the hospital service—and there could be no tying of two services together.

Perhaps, the absence of antitrust judgments against hospitals for exclusive contracting (outside of *Oltz*) reflects the conservative nature of hospitals and their willingness to settle any real risk of liability and to end litigation fees in these complex cases. Perhaps it reflects past judicial reluctance to intervene in hospital medical staffing decisions. The Tennessee exclusive radiology contract opinion of a few months ago describes that judicial deference, as well as its limit:

"Staffing decisions involve medical as well as business considerations which are best left to the hospital administrator and staff . . . However our deference to the expertise of a hospital's administration and staff does not completely shield their staffing decisions from judicial scrutiny. Like any legal entity, hospitals are capable of breaching contracts, committing torts, or violating others' constitutional rights. When they do, they are no less subject to the court's jurisdiction than anyone else."

I submit that *Oltz* and *Rockford* signal a judicial willingness to enforce antitrust laws against hospitals. After *Oltz*, defendants in exclusive hospital contract cases are no longer able to make the argument that a given court would have to break new ground to find a hospital liable for its exclusive contracting decision.

My prediction is that with the new appreciation in *Oltz* and *Rockford* of highly localized patient care markets, and with the increasing supply—and perhaps over-supply of physicians in specialties, such as neonatology, where patients or their personal physicians have real preferences—efforts to close staffs under exclusive contracts will likely result in more litigation and some successful tying claims.

## ECONOMIC EVIDENCE AND ANTITRUST INJURY

WILLIAM J. LYNK: Assuming Commissioner Calvani and Judge Easterbrook got your attention earlier this morning, it's my intention today to make a few constructive observations on how you might respond if some day you hear the knock on *your* door. Specifically, I want to talk about three alternative approaches that people sometimes use in order to generate economic evidence of antitrust injury, that is to say, economic evidence pertinent to establishing or disputing liability.

Before I get to the specifics though, let me first set the stage. I will assume that you're associated with a health care organization, probably a major hospital. And that you begin your day badly, with a notification that you've just been sued (probably by Henry Allen) on antitrust grounds attacking an exclusive contract that you have for radiology or some other clinical service. And the question you face is: what to do? In particular, how should you go about quickly assessing the facts—the economic facts, the economic evidence—that might be brought to bear in order to assess whether you have a real antitrust risk?

Well, before you start gathering facts, you need to settle on a particular theoretical framework within which to arrange or organize those facts. And let me make my pitch for the following general economic framework, which I will illustrate with two polar opposites. At one pole, you have a characterization which you might call "pure efficiency." In this one, the particular contract at issue has been the best thing that's happened to the hospital since its founding. The quality of care has doubled. Price has been cut in half, costs have fallen even further. The hospital has become tremendously popular, and its patient load has doubled. The hospital's competitors have been grousing about this, of course; they don't like to lose business. But on the other hand their ability to offer the same old product at the same old price has been completely unimpeded.

The characterization at the opposite end of the spectrum goes a little differently. In that case, the contract at issue hasn't done a thing to improve your ability to offer high quality, economical clinical services; it's you who continues to offer only the same old product at the same old price. The contract simply locks you and your preferred contractor together, but it doesn't enable you to do anything differently. Your competitors, on the other hand, have been tied in knots by this particular contract, perhaps because they've been deprived of access to radiologists that they might otherwise have used to their advantage. Because of this, they are barely holding their heads above water. They don't compete so vigorously any more. You, of course, benefit, although this time you benefit simply because the competition that you have to face has become less vigorous because of your contractual arrangement.

So these are two theoretical boundaries within which you might characterize the effects of any actual contract. And the one thing I want to stress about both of these is that, whether they are pro-competitive or anti-competitive, they both have similar net effects on the included and excluded parties. In either characterization, those who are parties to the contract are advantaged, and competitors who are not parties to the contract are disadvantaged.

So we've now got two theoretical pigeonholes, and the appropriate economic evidence task is to determine which of these two abstractions your actual contract looks the



most like. Now, the first of the three potential approaches to economic evidence is really what I consider to be the most common trap, that many people who begin to analyze these questions often fall into. And that trap is to focus on economic facts, data, or statistics that would be appropriate if we were trying to estimate the private damages that were suffered by a non-party to the contract. The plaintiff ordinarily starts this ball rolling, diligently tallying up the appropriate business records and statistics to determine how much business he's lost to you because of the contract, business for which he must be compensated, preferably trebled. Alternatively, he may be able to point to the enormously engrossed profits that you've enjoyed because of the contract, all of which must be disgorged, again preferably trebled. The defendants, for their part, will contribute their own set of calculations, also to determine whether, in this particular case, the hospital was much benefitted or the plaintiff was much inconvenienced.

I think the kindest thing that you can say about this approach to gathering economic statistics or economic evidence on antitrust injury is that it's perfectly understandable. The loss of income and the prospect for a potentially substantial recovery in court are probably the things that motivate many such lawsuits in the first place, so it's not surprising that attention tends to remain focused on this issue. But the worst that you can say about this approach is simply the truth about it: That although the fact of the plaintiff's losses may be relevant in establishing damages if liability is found, its probative value in establishing antitrust injury in the first place is essentially nil. This is because, as we've seen before, whether the contract had beneficial pro-competitive effects or whether it had detrimental anti-competitive effects, the presumption of benefit to included parties and harm to competing excluded parties is common to both.

So if that's a dead-end, then where else might you turn to gather economic evidence that might shed some light on the antitrust injury question? The next stop on that search usually turns out to be a sort of internal examination of the specific effects of the contract on your own business practices. One conventional approach to this is to attempt an empirical determination of what happened to the price of the service. Did it go up, or did it go down, as a consequence of the contract? And because quality of service is so important in most aspects of medical care, related inquiries will attempt to look at whether all sorts of "quality" indicators were affected in any way, shape or form by the contract.

This is not an illogical approach, and therefore to criticize it as one approach to economic evidence is somewhat controversial. But the criticism that I would offer is not based on its theoretical inappropriateness or its logical flaws, because there are none. The criticism is instead that, in more cases than not, you will find that this sort of analysis will turn out to be intractably ambiguous. Defining an operational measure of quality is, to put it mildly, a difficult area. There are several dimensions of quality, and developing some sort of metric in order to get a handle on the concept is no easy task. More fundamentally, too often you will find that price and quality effects move in the same direction. If so, you will have a finding of an adverse effect on the one hand and a beneficial effect on the other, offsetting effects which must be balanced against each other. And that's why this approach, despite its logical appeal, so often fails to produce a clear and unambiguous answer in practice. The third approach, which I would suggest as a potential way out of this ambiguity, is to delegate this "balancing test" to the place where economists have always felt most comfortable leaving it, which is in the lap of the consumer. The test, which many

of us refer to as the "output test," is, in principle, quite simple. It consists of developing the answer to the following straightforward question: Because of the contract, did the output of the affected product in the affected part of the market expand, or conversely did it contract? The reasoning behind that test is, I think, equally straightforward. Before the contract, your organization offered whatever services it offered, at whatever prices it asked. So too did your competitors. And the comparative efficiency of you and your competitors, and the degree of competition between you, determined precisely the overall array of qualities and prices that were offered to the market.

But the consumer (whose welfare is the concern of an antitrust injury inquiry) will be able to detect, at least in principle, the full set of changes resulting from the adoption of a new contractual arrangement. There is a new "choice set," as you might think of it, following the contract. You do things differently, and maybe as a result your competitors do things differently. The consumer reevaluates what is available—what qualities, at what prices, and so on and so forth—thinks it through again, and makes a new decision about how much of the affected service to consume. If the contract had beneficial effects, more of it will be consumed. If the contract had adverse effects, less of it will be consumed.

Now this approach, I should say in all candor, is easy to state in principle, but requires a fair amount of hard thought and diligent empirical analysis in practice. Such seemingly simple questions as what is the affected product, what is the affected part of the market, or, for that matter, in many cases, what exactly is output, can be difficult to answer. Moreover, even if output, properly defined, went up or went down, how do you pin that movement on the contract rather than on two or three dozen other possible causal influences that might have caused output to change?

Now, those questions all have answers, some of which are more satisfying and some which are less satisfying, but I think the details of the actual methodology would keep us here substantially longer than we have. But let me illustrate at least one case in which the output-based approach turns out to resolve the ambiguities that other approaches might retain. This is a case which I will characterize as hypothetical, although it's possible that it may not be. In this case, there are five hospitals in a particular town, and by all of the conventional indicators, one of them is clearly the best or most sophisticated hospital. At the same time, there are numerous anesthesiologists in town. Several of them have organized into a group, which seems, at least by conventional indicators of professional credentials, to be the most qualified anesthesiology group. Initially, everyone operates on an open staff basis. Then the best hospital proposes to the best anesthesiology group that they enter into a mutually exclusive contract, and the group accepts. Now this has the following consequences. It provides a potential improvement, evidently, in the ability of the best hospital to compete even more effectively than it had competed before. At the same time, by the terms of the contract, the anesthesiologists withdrew from some of the hospitals in which they had previously practiced, and those hospitals now rely on apparently less-preferred anesthesia providers. Potentially, these hospitals are absolutely disadvantaged; arguably, they can't compete as efficiently as they did before the contract. The question is, how do you sort all that out? And the answer is, let the consumer tell you. If the total output from all of the affected hospitals, the disadvantaged as well as the advantaged, rose, then we know that on balance the contract had beneficial and procompetitive effects.

To summarize, I want to again reemphasize the obvious. A properly focused antitrust attack on, or a defense of, a contract must focus on antitrust injury. At its simplest, it will show injury to consumers. To develop the economic evidence on that point, I would again stress that the fact of injury to competitors who are not parties to the contract is irrelevant to the idea of antitrust injury. More controversially, don't confine your analysis to the specific characteristics of your operation that might have been affected by the terms of the contract. That's an analysis that *should* be undertaken, if only to get a deeper understanding of what the contract might have done, but in most cases the odds are against that sort of analysis being dispositive. And finally, the potentially sounder approach is to "end run" all of the intervening details and focus directly on the affected party of competitive interest, the consumer. Consumers know how to vote with their feet, and if you can determine an effective way to count up the footsteps, you will be 90 percent of the way to an assessment of the real antitrust injury effect of the contract.

## ANTITRUST ISSUES IN PHYSICIAN/HOSPITAL EXCLUSIVE CONTRACTS: THE REALITY OF ANTITRUST FOR THE HOSPITAL

STEVEN WEST: I'm here to tell you a story about what happened to me in the institution that I'm with. Frank Easterbrook talked about the fear of God. Henry Allen talked about sole source physician arrangements. We heard about theoretical framework and polar opposites. And Terry Calvani talked about cartel behavior. I'm not going to do any of that. I'm just going to tell a story.

I think the sponsors wanted me to get across a message—and the message might have been that if an antitrust lawsuit like ours could happen to me, it could happen to you. For the students in the audience who are going to be health care providers, and for the health care providers who are already out there, I guess that's a legitimate message. For the attorneys in the audience, maybe you'll get an idea of how your clients feel during an escapade like this.

When we went through this process several years ago with our own antitrust lawsuit, I felt like the poster boy for antitrust. What happened to us was a long, expensive, and at times gut-wrenching defense to an antitrust action brought against Cottage Hospital by two anesthesiologists and a handful of other physicians on our medical staff.

You may not be familiar with Galesburg. It's carved out of a cornfield. It's not a tourist mecca, although we do have Carl Sandberg's birthplace, and the inventor of the ferris wheel is a Galesburger. And Knox College is in Galesburg. It's not a medical research center, nor is it even a rising micropolitan area. For a rural community, it's fairly large—30,000 or 35,000. The hospital service area is about 65,000. Some of us affectionately refer to it as Podunk Junction.

Our case really began in the mid-1970s. At that point, Cottage Hospital was about a 250-bed hospital, in the same rural setting. We had an anesthesia department that consisted of four or five nurse anesthetists and two anesthesiologists. At one time or another, each anesthesiologist served as medical director of the department. Sometimes they supervised the nurse anesthetists and sometimes they didn't. Sometimes they scheduled surgical procedures for our department. Sometimes they didn't. Sometimes they evaluated our nurse anesthetists and sometimes they didn't.

The situation was so on again, off again, that the medical staff said something's got to be done about this. We brought in some objective outside observers. We brought in some folks from Rush-Presbyterian, and they took a look at our anesthesia department and said, "You've got to make some changes."

We brought in Peat Marwick. They gave us some advice about physician contracts and recommended changes.

After a lot of analysis and discussion, we decided that the problems we had were not clinical. They were administrative. The main change was appointment of a full time medical director who would have some control, responsibility and accountability for the anesthesia department.

After further review, we opted for an exclusive contract. We even offered it to one of the two anesthesiologists who was there at the time. This was 1978. In 1978 that anesthesiologist turned down an offer of \$175,000 for that contract, saying it wasn't enough

money. Later on the judge thought that maybe that really wasn't enough money, but that's another story.

We began looking for a contractor for the anesthesia position, and in 1980 we found one. We signed an agreement with an individual, who was going to come to Cottage in October of 1980.

When the contract was signed, we got word out to the medical staff. The affected anesthesiologist involved was notified months in advance that a change was coming. The actual exclusive nature of the contract would not go into effect for three or four months after the new anesthesiologist would start. The exclusive part of the contract didn't start until January of 1981.

The anesthesiologists who had been on staff applied for reappointment to the medical staff for calendar year 1981, and our board of trustees denied their reappointment request. They were informed that the only way they could be reappointed would be to become part of this other anesthesiologist firm.

Those anesthesiologists who were excluded hired an attorney. In accordance with the medical staff by-laws and the hospital by-laws, they and their attorney asked for a hearing before the hospital's governing board. They had the hearing and they made their best effort to scare the hell out of everybody.

At this meeting, their attorney stood up and told me point-blank that the board was going to fire me because I signed this contract. He asked me how stupid could I be? Well, I told him I could be a lot stupider than that.

We needed to prepare a response to the attorney and the complaining anesthesiologists. We contacted the Illinois Hospital Association and they referred us to a then young Henry Allen for assistance. Henry was working at the time with Tom Reed, who is also at this Symposium. They had just been working on a similar case in Alaska. I guess their specialty was Podunk Junction.

They agreed to come down and look over our situation and try to work with us. Henry turned the hospital upside down. In the process of doing that, we did prepare our response for the anesthesiologists, gave it to them and waited.

We didn't have to wait very long. On Christmas Eve of 1980, the summons arrived. In the summons we learned that a hearing would be held. The plaintiffs had requested preliminary injunction to prevent us from enforcing the exclusive nature of the contract. The preliminary hearing would be held on New Year's Eve day of 1980.

The hearing was going to be held in Danville, Illinois. Danville is not near Galesburg. It's about 150 miles away.

We began to prepare for the hearing. Depositions were held, discovery was held, and for the next seven days, people were being deposed until well after midnight every single night. It was an interesting period to say the least.

By this time a whole team of attorneys was working with us, including Frank Easterbrook, who was a law professor at the time. It was a very stressful situation. I don't know if I can communicate to you how stressful it was. The only other times in my life that were that stressful probably were my bar mitzvah and the oral defense of my masters thesis.

New Year's Day arrives and we head out to Danville. The fog rolls in. We just barely make it into Danville. The defense attorneys also barely make it. It looks like we're

all going to be stuck in Danville for New Year's Eve. We're all thrilled about that. As the fog thickened, even the judge decided he wasn't too keen about being stuck there. So he suggested a compromise.

He suggested that nobody do anything officially for the next two weeks. That we pretend December 31st would last for 336 hours, at which point he would then reconvene the hearing and make a decision about the request for the preliminary injunction. Knowing that the judge was suggesting this to us in a way that we had no alternative, we eagerly agreed.

Life went on for the next two weeks, as if December 31 were two weeks long. During this period, discovery and depositions continued. It was great fun. At one point during this period, one of our attorneys (not Tom or Henry) and one of the plaintiff's attorneys actually got into a shoving match at a deposition.

The time actually came for the hearing and that again was a very stressful situation. The judge thought he would give us a break. We met in Peoria (which was closer) rather than continuing to go down to Danville. The hearing itself was just a couple of days long.

Amazingly, during this period, there was very little discussion about a settlement. One of the anesthesiologists, who had numerous other opportunities to practice, did suggest a settlement, but our board thought it was for too much money.

After the judge denied the plaintiff's request for preliminary injunction, and the exclusive nature of the contract went into force, that's when the real legal work started. There were all kinds of arguments for summary judgment filed, definitions of the hospital market were developed and definitions of competition were developed. The definition for the market for anesthesiologists was something that we spent a lot of time working on.

We also had to defend why the hospital thought that an exclusive contract was the most reasonable way to deal with our problems. During this period, a number of other similar cases were also being heard around the county. Every time one of those cases was heard, it brought a whole flux of activity from our attorneys. New filings and new briefings. This indeed was the full employment act for attorneys.

Finally in 1985, about five years after all this really started, we began to prepare for a 1986 trial date. However, right about this time, the Jefferson County Parrish case that you heard about earlier this morning was heard by the United States Supreme Court. At that point, the plaintiffs felt that maybe things weren't going to go quite the way they had originally anticipated. There was increased interest on their part in reaching a settlement.

Our board wanted the case to go all the way through to a decision, but we weren't anxious about incurring the cost of the trial, which we knew would be extremely expensive. Our attorneys said, "If you think it's been expensive up to now, you ain't seen nothing yet." We had already spent about \$400,000.

So the case was settled, and that was perhaps the most frustrating thing about all of this. We went through five years of this. We felt we were right. We worked so hard on the case. We spent almost \$500,000. When all was said and done, we never even received a decision. It was no vindication.

Now \$400,000 or \$500,000 for a hospital like ours was a lot of money. We did get some assistance from our insurance carriers. That's an interesting story. We felt that the defense and any settlement costs should be shared or paid by our insurance carrier. Our insurance carrier didn't think so. We thought that this would be covered by one of our

many insurance policies. Our insurance carrier said, "Wait a minute, aren't you self-insured for professional liability?" We said, "Well, yes." They said, "Professional liability should cover your cost." We said, "We don't think it will and are prepared to argue about it." We reached a settlement with our insurance carrier about the amount of money that they would pay toward a settlement or toward the legal fees.

But there was a catch. The catch was that the insurance company's attorneys became involved in the case. Before any briefs were filed, before strategy was planned, before any settlement could be offered, our insurance carrier's attorneys had to have their say.

You may want to go home and consider, if you ever got in this situation, would it or wouldn't it be covered by your insurance carriers?

There are some lessons to be learned from our experience: (1) It was frustrating that we didn't get the vindication we felt we deserved. The cost of being right was extreme. It was expensive in terms of dollars. It was very time consuming. It was emotionally very difficult; (2) There was a medical staff relations problem. There were four or five or six physicians who initially agreed to be co-plaintiffs in the case. They wound up dropping out when they saw that this was going to be a very prolonged process; (3) Board of trustee relations were also taxed. After this thing began to carry on for more than a year, some of our board members said, "Yes, we might be right, but we can't believe you guys got us into this." And it developed a credibility problem after that. The board began to wonder if administration knew what the hell was going on.

Well, second thoughts aside, you know we survived the case. And again, I come back to that same message. If something like this can happen at a rural hospital like Cottage, in an area that some might describe as an unappealing environment, it can certainly happen to you at medical centers, in more attractive, appealing environments. So when your attorneys seem paranoid, and they warn you about these kinds of problems, you may want to take what they are saying with a small grain of salt—but you may want to heed their advice as well. Antitrust cases do not always happen to the other guy. It's already happened to me. I suspect one of you is going to be next.

## QUESTIONS FOR MR. ALLEN, MR. LYNK, AND MR. WEST

QUESTION: Question for Bill Lynk. Are you saying that dramatic price increases because of a contract are not evidence of antitrust violation?

WILLIAM LYNK: No. My point is a somewhat simpler one, and it has not much to do with the insensitivity to price that Frank Easterbrook suggested a little earlier. In fact, I am assuming that there is some sensitivity to price. My only point is that if your local tavern stops serving Blatz, and starts serving Michelob, the price may go up, but if on balance people think that the quality of the product is better, you're going to see output rise as well, if that proves to be a beneficial effect as registered by the consumers in that particular market environment.

QUESTION: Steve, you told us, in retrospect, to beware. Using hindsight, would you have followed a different strategy if you knew the outcome?

STEVEN WEST: In hindsight, our situation was such that we didn't really have any choice. There was enough question about the situation in anesthesia; in the supervision of our nurse anesthetists, scheduling of cases, the problems that were being created for the attending physicians and the patients, and even some questions about billing practices, that I don't know what choice we had. The affected anesthesiologists were not going to leave.

QUESTION: As I understand it, you're saying you had to do something. But was what you did the only possible alternative?

STEVEN WEST: We felt it was. We didn't have any problem with the clinical competence of the individuals. By bringing in another anesthesiologist, someone with an exclusive contract that had responsibility and accountability—if he wanted to hire those anesthesiologists, or make them part of his firm, if he felt he was in a position to control their actions, that was okay with us. But we needed to give control of the day-to-day activities in that department to a different physician—we needed to be sure that person would have the authority to deal with situations that occurred up there—and we didn't know of any way to do that, other than the exclusive contract. Without the exclusive contract, those other physicians would have remained, and he would have had very little or no control over what they did. It had the potential to be a disruptive situation in the department.

QUESTION: Medicare will only pay a certain amount of the cost of anesthesia, and so will the supplemental payer. So the consumer is left with a big gap between what they are insured for and what they have to pay. And no anesthesiologist group accepts assignment, so I don't know how the exclusive contract helps drive the price down, or is competitive.

STEVEN WEST: Well, there are anesthesiology groups who will accept assignment, for one thing. Depends on your environment, I guess. I don't agree with the statement that the consumer can't win in a situation where there is exclusive contract. But based on the scenario you just described, the consumer can't lose either. Because you've already said the rates are high; if you take that as a given, and that the rates are not going to be affected by the contract, then there must be another goal. In our case, what we wanted to do was improve the operation, efficiency and quality of the department. We had nurse anesthetists providing cases unsupervised. Now they have the supervision of an anesthesiologist looking right over their shoulder. So if the billing and other aspects of the way the department runs are unaffected through the contracting, then at least we've been able to impact on the



delivery of service by our nurse anesthetists, and at a hospital like ours, nurse anesthetists provide 80-90 percent of the actual anesthesia.

**COMMENT BY GARY MECKLENBURG:** The contract itself, though, to focus on your assignment question, potentially offers a handy way to get around that. In principle, it wouldn't be unusual to see a hospital suggesting or even imposing assignment to its contracting anesthesiologists as a necessary element of getting the contract at all. But the exclusive contract may be a vehicle to do more efficiently what would have been difficult to do if you had a simple open staff arrangement.

### SESSION III: SPECIFIC ANTITRUST ISSUES IN HOSPITAL MERGERS

RONALD ANDERSEN: Our first speaker is Oscar Voss, who became attorney for the Health Care office of the Bureau of Competition for the Federal Trade Commission in 1981. He received his law degree from Yale University. His specialty at the Commission is antitrust law enforcement against health facilities mergers. He supervises the Health Care office's monitoring in antitrust review of such mergers and serves as lead staff attorney on most of the resulting investigations. He was a member of the trial team in the American Medical International case in 1984, and took part in post trial and appellate proceedings in the Hospital Corporation of America case in 1985. In addition, he participated in some fashion in most other commission health facility merger investigations since 1981. He's a member of the American Bar Association and the State Bar of California.

Diane Wood is Associate Dean and Professor of Law at the University of Chicago Law School. She received her law degree with high honors from the University of Texas School of Law in 1975. She served as law clerk to Justice Harry Blackman of the U.S. Supreme Court in 1976-77, was attorney advisor for the Economic and Business Affairs of the U.S. Department of State in 1977-78, and was an associate with the firm of Covington Burling in Washington, D.C., from 1978-80. She has served on the faculties of Georgetown and Cornell, and was special assistant to the Assistant Attorney General, Antitrust Division, U.S. Department of Justice, from 1985 to 1987. She joined the University of Chicago Law School faculty in 1981. Her courses include antitrust and comparative antitrust seminar. Her recent publications include "The Anti Injunction Act" in the *Brigham Young Law Review*; "International Jurisdiction" in *National Legal Systems*, "The Case of Antitrust" in the *Northwestern Journal of International Law and Business*, and "Unfair Trade Injury" in the *Stanford Law Review*. Her memberships include the American Society of International Law and the American Bar Association, where she co-chairs the International Antitrust Committee in the section of International Law and Practice.

Our third presenter is William Dilts, who is the Vice President of Planning at Rockford Memorial Hospital. He received his masters in public administration from the Sloan Institute of Hospital Administration at Cornell University in 1970. He previously served as assistant administrator for Registrar Services in the U.S. Air Force Regional Hospital in Spokane, Washington, from 1970 to 1972. He was assistant director for the Connecticut Hospital Planning Commission in 1973-74. He has been at Rockford Memorial since 1974. He is a member of the Illinois Hospital Association Council on Health Facilities and Service Planning, the Health Services Administration Regional Board, and the American College of Healthcare Executives.

## APPLYING ANTITRUST ANALYSIS TO THE NON-PROFIT SECTOR

OSCAR M. VOSS: I am pleased to be here today to discuss why the federal and state antitrust agencies, the courts which carry out the antitrust laws, and all the rest of us have reason to be concerned about the possible anticompetitive effects of mergers and other conduct by non-profit hospitals and other health care institutions. As Judge Easterbrook pointed out earlier this morning, the agencies and the courts have been generally skeptical of the notion that the absence of conventional profit motive, or some other characteristic of non-profit firms, means that their conduct is much less likely to injure consumers than similar conduct in the for-profit sector. I'll discuss in detail why I think this skepticism is justified, and in particular why the activities of non-profit entities can endanger consumer welfare despite the best of intentions.

Before proceeding further, I would like to emphasize that the views I express here are solely my own and do not necessarily reflect those of the Federal Trade Commission, any individual Commissioner, or the Commission's Bureau of Competition. In addition, I note, as did Commissioner Calvani, that there is a case pending before one of the Commission's administrative law judges involving allegations that the acquisition by a non-profit firm of a competing for-profit hospital in California violated the antitrust laws. I want to emphasize that my remarks here today are not intended in any way to be a commentary on the facts of that particular case and shouldn't be so construed.

The question of whether non-profit hospitals and other organizations should receive the same kind of antitrust scrutiny as their for-profit counterparts has been raised most prominently in the Justice Department's two most recent hospital merger cases, and more generally in connection with the recent shift of hospital merger and acquisition activity toward the non-profit sector and away from the for-profit chains.

However, the question isn't exactly a new one and it isn't limited to hospital merger cases. Indeed, it was first addressed by the Supreme Court in 1984 in a non-merger case, the *N.C.A.A. v. University of Oklahoma* case.<sup>1</sup> There the court affirmed lower court decisions that the N.C.A.A. violated the antitrust laws by restraining its members' sales of television broadcast rights to college football games. The court gave little weight to the fact that these restraints were imposed by an association limited to public and private non-profit educational institutions. And it refused to either infer in antitrust exemption for non-profit firms, or apply a relaxed standard of antitrust scrutiny. The opinion noted that the N.C.A.A. and its members' athletic programs sought to maximize revenues, and found it unclear that they would be any less likely than for-profit entities to raise prices and revenues above what they could obtain in a competitive market.<sup>2</sup>

A somewhat similar issue arose in connection with the Federal Trade Commission's challenge to hospital acquisitions in the Chattanooga, Tennessee, area by Hospital Corporation of America.<sup>3</sup> Now, HCA and the firms it acquired were all for-profit enterprises. However, HCA argued that its market share of less than 30 percent did not allow it to raise prices above competitive levels without the cooperation of its major competitors, and since most of those competitors were non-profit, including two public hospitals and one large private non-profit hospital, such cooperation was unlikely to be

forthcoming. The Commission and the Seventh Circuit Court of Appeals, which affirmed the Commission's divestiture order against HCA both disagreed with this argument.

The Commission's opinion noted that non-profit hospitals, like their for-profit counterparts, may not be content with the revenues and the net incomes allowed them by a competitive market, and may be similarly inclined to engage in anticompetitive conduct even though their goals don't happen to include lining shareholders' pockets. Additional revenues and income may help them, for example, to maintain and add facilities or equipment, to provide more charity care, to enhance their institutional prestige, to improve the salaries or working conditions of hospital management, or to fulfill other objectives. As the Commission recognized, fulfillment of these objectives might be particularly difficult in a competitive market subject to cost-containment pressures from third-party payers, which would give hospitals of all kinds incentives to use whatever market power they have to resist those pressures. However beneficent the goals of those exercising market power, those goals would be achieved at the expense of health care consumers. The Commission buttressed its general conclusion about the behavior of non-profit firms with evidence that in this particular market the for-profit and non-profit hospitals had in fact engaged in a fair amount of cooperative behavior, including most prominently a market allocation agreement between a for-profit hospital and a non-profit hospital. The Commission also noted that the need of the area's two public hospitals for income to satisfy their legal obligations to care for the indigent, without calling for additional support from taxpayers, made those hospitals particularly unlikely to resist the temptation to band together with competitors to keep hospital prices high.<sup>4</sup>

The Seventh Circuit agreed with the Commission that it was only "conjectural" that the non-profit hospitals in the Chattanooga area would serve as a safeguard against the potential anti-competitive effects of HCA's acquisitions. Judge Richard Posner, writing for the court, pointed out that "the adoption of the non-profit form does not change human nature"—and particularly does not change the common human tendency to dislike competition and the human inclination to do away with competition when it gets in the way of one's goals. The court acknowledged that public hospitals do face political pressures to keep prices down, but they also face countervailing pressures to keep prices up in order to keep taxpayer subsidies down, as well as other political constraints which may limit their practical ability to undermine monopoly pricing by other hospitals.<sup>5</sup>

This issue was revisited in somewhat different form in the two most recent Justice Department hospital merger cases, which involved transactions and markets roughly similar to each other. The Justice Department has so far been successful in its challenge to the proposed merger of two non-profit hospitals in Rockford, Illinois,<sup>6</sup> but lost its challenge to a proposed merger of two non-profit hospitals in Roanoke, Virginia, (which I'll refer to as the *Roanoke* case, although it's sometimes known as the *Carilion* case, after the case name the court gave it).<sup>7</sup> Both the Department's win in the *Rockford* case and its loss in the *Roanoke* case have been affirmed by different appellate courts, although Supreme Court review of the *Rockford* case remains a possibility. And in both cases, the hospitals emphasized, among their many arguments, that the prospect of anticompetitive effects was substantially mitigated not just because they were non-profit hospitals, but also because their boards were controlled by local civic leaders and particularly by business executives whose companies had employee health plans which were significant purchasers of hospital services. As the

hospitals in one case put it, the hospitals are essentially "buyer cooperatives" acting on behalf of purchasers of health care services.

The district court in the *Roanoke* case was persuaded that the non-profit character of the hospitals there was one reason, albeit one reason among many, for finding for the defendants in that case because the proposed merger there would not substantially endanger competition. The court cited economic testimony that non-profit hospitals tend to have lower charges than their for-profit counterparts, as well as some testimony (which was based in part on studies focusing on non-profit hospital markets) that hospital prices are lower in areas with fewer hospitals. The court also expected that the business leaders on defendants' boards of directors would force the hospitals after the merger to pass along to consumers, including particularly their own businesses, the cost savings that the court expected would be achieved as a result of the merger.<sup>8</sup> The Fourth Circuit Court of Appeals declined to overrule these factual determinations by the district court judge because they were not "clearly erroneous," and so upheld the court's general conclusion that the merger would not be anticompetitive. However, the appeals court found no need to address the significance of defendants' non-profit character. It found ample basis for affirming the district court's ruling from that court's findings that the relevant market was not very concentrated.<sup>9</sup>

The district and appellate courts in the *Rockford* case took much less solace from defendants' non-profit character. The district court, in addition to following the Seventh Circuit's general analysis in the *HCA* case, also cited evidence in the case before it to question defendants' commitment to consumer interests. It placed particular emphasis on evidence that the three non-profit hospitals in Rockford had in the early 1980s formed a "united front" to boycott the local Blue Cross plan in a partially successful effort to block proposed reductions in Blue Cross' reimbursement levels. The court cited evidence in particular that in doing so the hospitals appeared to have placed their own institutional interests above those of Blue Cross subscribers. The district court also found that the desire to reduce competition among the three Rockford hospitals was a contributing factor to the defendants' decision to pursue a merger.<sup>10</sup>

The Seventh Circuit's decision last month affirming the district court, this one also written by Judge Posner, emphasized different factors but reached similar conclusions. The appeals court pointed out that people generally prefer not to compete with others if they can avoid it, and that this tendency might be particularly strong in the non-profit sector given its typical philosophical bias in favor of cooperation instead of competition. The court was therefore unwilling to rely on defendants' non-profit character as a reason for rejecting the presumption that anticompetitive effects would flow from a merger giving defendants a very high market share in a market in which entry was difficult. The court at least was unwilling to do so on the basis of defendants' evidence and what the court considered to be "early and inconclusive" economic evidence on the validity of the market share presumption in the hospital industry.<sup>11</sup>

The antitrust case law I've just summarized highlights many of the considerations which support the courts' and enforcement agencies general treatment of non-profit entities like their for-profit counterparts when applying the anti-merger and other antitrust laws. I'd now like to offer some further observations on the subject from my own vantage point, as an antitrust lawyer frequently involved in hospital merger investigations at the Federal Trade Commission, which require me both to follow the hospital industry in general and to take a

very close look at the competitive behavior of hospitals, including non-profit hospitals, in particular local markets. I'd like to focus in particular on how consumers can be injured by the reduction of competition among non-profit hospitals *despite* the good intentions of all concerned.

We should first remember that many non-profit hospitals do not fit the "buyers cooperative" model put forth in the Rockford and Roanoke cases, where hospitals are controlled by boards of directors who are more or less representative of the population using the hospitals and who strive to advance those consumers' interests as best they can. Some non-profit hospital firms do not share that commitment in the first place. For example, a non-profit multihospital system with facilities serving many different markets may trade off the interests of patients in some of its markets in favor of those in other markets, such as by directly or indirectly subsidizing one hospital's construction project with funds from the system's other hospitals. Such trade-offs could result in noncompetitive levels of price and quality for hospital services in the disfavored markets, unless competition in those markets forces the system to keep prices down and quality up.

For some other non-profit hospital firms, meeting the needs of consumers sometimes takes a back seat to other objectives. In particular, some religious hospitals and hospital systems have complained that hospital competition and other financial pressures deny them the funds needed to cross-subsidize their mission to provide hospital care to the poor. Admittedly, it seems somewhat less objectionable for a hospital to charge monopoly prices to its paying patients when the proceeds go to the needy rather than to wealthy shareholders. But that is nevertheless inconsistent with the antitrust laws' condemnation of anticompetitive practices even for benign purposes. Antitrust policy accordingly does not condone the funding of hospital care to indigents through higher-than-competitive prices to paying patients—the burden of which falls in part on the not-*quite*-indigent patients who are not eligible for subsidized care, and also falls disproportionately on those who happen to live in markets where there's not a great deal of hospital competition and on people who are in poor health. Similarly, religious and moral commitments prevent some hospitals from offering particular services for which there is some consumer demand. While such hospitals' unwillingness to compromise deeply-held beliefs is worthy of respect, it becomes a matter of proper antitrust concern if their acquisitions of market power adversely affect those who do not share those beliefs.

Even community-oriented hospitals, like those involved in the Rockford case, may not adequately advance consumer interests in the absence of competitive pressures. First, such hospitals may have, and make take advantage of, opportunities to benefit their own communities at the expense of people in other communities. For instance, in a state like California that uses competitive bidding to purchase hospital care for Medicaid patients, it is hard to imagine a hospital with market power stepping forward to voluntarily offer the state a competitive price, given that most or virtually all of the cost savings would flow to taxpayers in other markets rather than to the people of the community it serves. Similarly, a non-profit hospital which not only offers a full range of hospital services to its own community, but also provides its more sophisticated services to patients from outlying communities whose hospitals don't provide those services, could conceivably yield to the temptation to take higher profit margins on the services used most heavily by outsiders in

order to cross-subsidize services used predominantly by local residents, unless there is substantial competition for the business of those outside the community.

Moreover, the internal politics of a non-profit community hospital may be less effective than external competitive pressures in prompting the hospital to respond to a variety of consumer demands. Consumers preferences, as to what they want from their hospitals, are far from identical. Some prefer austere but economical hospitals; some are willing to pay more for amenities; still others, including particularly Medicare patients, will be interested in getting the hospital to provide the maximum level of service it can in return for the pre-set reimbursement to the hospital. And some patients in all of these categories will also have a variety of specialized concerns, for example, whether the hospital has excellent sports medicine facilities, or whether it will allow their osteopath, or their podiatrist, or nurse midwives to practice at the hospital. A competitive market provides incentives for producers to strike a reasonable balance among competing demands, and to make reasonable efforts to accommodate everybody—for example, people who prefer yellow ties and people who prefer red ties are all accommodated by the market no matter what color is in fashion at the time. Without competition, hospital decision-making could become an essentially "political" process, where majorities can enact their preferences without much concern for accommodating minorities with different preferences, where influential minorities can override majority wishes, and where less influential minorities can get lost in the shuffle.

Moreover, even conscientious efforts to address the needs of all consumers may not be enough for a hospital in a noncompetitive market to respond to those needs as well as it would with the guidance of a competitive market. Market competition happens to provide a rough-and-ready mechanism for patients to tell hospitals what they want—they can simply turn to the hospitals that best meet their needs and avoid the others. That sends a signal to the former that they're doing something right and either should keep doing it or maybe should be doing more of it. And it encourages the other hospitals to change their strategies so that they better serve their patients' needs. Patient freedom of choice among competitors can thus offer clarification to hospitals unsure about how they can best serve consumers.

Hospitals who don't have that kind of guidance may have a harder time determining what really would best serve their customers. The hospital board members could, for example, try relying on their own experiences and intuitions to decide how to best serve patients. One problem with that alternative is that hospital boards tend to be populated with business executives and civic leaders. I wonder whether such persons, even with the best intentions, are in a position to readily identify with the needs and wants of ordinary people. Rather, I suspect that the Joe Six-Packs of this world fare better speaking for themselves through the mechanism of a competitive marketplace. It is also ironic that the everyday businesses of most business executives on hospital boards are in competitive industries, and those executives are used to relying on competitive markets to signal how well they are satisfying consumer needs. When in charge of a non-profit monopoly, they are cut adrift from that measure of effective performance.

Of course, the hospital could arrange for marketing surveys in an attempt to gauge what its customers want. I'm not sure how accurately the often hypothetical responses of survey respondents reflect consumer preferences, compared to the choices *actually made* by consumers among competing hospitals. Moreover, it seems to me that hospitals started

showing more interest in conducting surveys only after competition intensified in the industry, as reimbursement reforms made it more difficult for hospitals to survive without a solid base of customer support. I wonder whether turning off the competitive heat would diminish hospitals' efforts to reach out to find out how consumers want their hospitals to serve them.

A final group of concerns I have go to how relieving a hospital of competitive pressures would affect the efficiency of its operations. As Adam Smith observed, "monopoly... is a great enemy to good management."<sup>12</sup> Economists have elaborated on this notion, that anticompetitive market structures and practices could result in higher prices from sloppy management, yielding higher prices without higher profits. That's something that they call "X-inefficiency."<sup>13</sup> It's really a simple notion. The idea is that running a tight ship at a hospital requires a lot of management time and effort, and all other things being equal, the less vigorous is competition in the hospital's market, the more inefficiency will be tolerated.

The response of the hospital industry to the long-term trend toward less generous reimbursement and more intense competition seems to me to bear out this notion. Those pressures have undoubtedly forced hospital managers to work harder and smarter, and forced hospital trustees and directors and others associated with the hospital to spend more time away from their regular jobs and their families, and certainly have brought on stress and aggravation. But those management efforts have helped hospitals become more efficient by eliminating inefficiencies which had flourished during less competitive times. I wonder whether hospital managements in general would have worked as hard as they have to make their hospitals more efficient had competition not been among the pressures and constraints they faced.

Competition may be even more essential for non-profit hospitals than for their for-profit counterparts in promoting hospital efficiency. Unlike most for-profit firms, most private non-profit institutions are almost completely invulnerable to hostile takeover, since transfers of control of non-profit corporations normally require corporate consent, and there are no shareholders to launch a proxy fight to oust ineffective managements. So we lack that mechanism of the for-profit sector to bring new management to a hospital that's being operated ineffectively. In the non-profit sector, only the threat of bankruptcy or other financial crisis may force the most persistently wrong-headed or ineffective hospital managements to recognize their deficiencies and change their ways. This ultimate remedy for mismanagement would be far less effective if the hospitals can defer crisis by charging higher-than-competitive prices to patients to cover their higher-than-competitive costs.

You see, the problem with anticompetitive mergers and other conduct by non-profit institutions isn't that the people who run them are money-grubbers or scoundrels. It's that they're *human beings*. They're people, like you and I, whose human limitations get in the way when they try to carry out their good intentions, and who can use whatever help market competition can offer in overcoming those limitations. Competition appears to serve a useful role in promoting excellent service to consumers, even from the most well-intentioned institutions. The courts and antitrust enforcers have been, and should be, reluctant to relax their efforts to preserve and promote competition in the non-profit sector.



## ENDNOTES

<sup>1</sup>National Collegiate Athletic Ass'n v. Board of Regents of Univ. of Oklahoma, 468 U.S. 85 (1984).

<sup>2</sup>468 U.S. at 100-01 n.22.

<sup>3</sup>Hospital Corp. of America, 106 F.T.C. 361 (1985), *aff'd*, 807 F.2d 1381 (7th Cir. 1986), *cert. denied*, 481 U.S. 1038 (1987).

<sup>4</sup>106 F.T.C. at 502-06.

<sup>5</sup>807 F.2d at 1390-91.

<sup>6</sup>United States v. Rockford Mem. Corp., 717 F. Supp. 1251 (N.D. Ill. 1989), *aff'd*, 898 F.2d 1278 (7th Cir. 1990).

<sup>7</sup>United States v. Carilion Health System, 707 F. Supp. 840 (W.D. Va.), *aff'd*, 892 F.2d 1042, 1989-2 Trade Cas. (CCH) ¶68,859 (4th Cir. 1989) (opinion not designated for publication).

<sup>8</sup>707 F. Supp. at 846, 849.

<sup>9</sup>1989-2 Trade Cas. (CCH) ¶68,859 at 62,515-16.

<sup>10</sup>717 F. Supp. at 1284-87, 1304-07.

<sup>11</sup>898 F.2d at 1285-86.

<sup>12</sup>A. Smith, *An Inquiry into the Nature and Causes of the Wealth of Nations* (Modern Library ed. 1937) at 147.

<sup>13</sup>See H. Lieberstein, "Allocative Efficiency vs. 'X-Efficiency'," 56 *American Econ. Rev.* 392 (1966).

## MARKET DEFINITION IN HOSPITAL MERGER CASES

DIANE P. WOOD:

### I. Introduction

With respect to at least one point, there is nothing unique about hospital mergers. As Judge Posner put it in the Seventh Circuit's recent decision in *United States v. Rockford Memorial Corporation*,<sup>1</sup> every conclusion he made about the competitive consequences of the merger of Rockford Memorial Hospital and SwedishAmerican Hospital was "provided the district court's market definition is accepted." (By way of full disclosure, I was involved in that litigation on behalf of the hospitals. You are therefore free to credit or discount everything I am about to say accordingly.) The centrality of markets is an antitrust truism: nearly every theory of antitrust liability today depends upon proof of market power, with the exception of the most hardcore *per se* offenses. The most common way to prove market power is to define a relevant market and to examine the effects of the contested practice or arrangement in that market. Alternatively, if actual anticompetitive effects can be and are observed, as in *FTC v. Indiana Federation of Dentists*,<sup>2</sup> the market definition process is superfluous.

My discussion of market definition will proceed along the conventional two lines: first, product market, or in Clayton Act section 7 terms "line of commerce," and second, geographic market, also known as "section of the country." I propose to show that developments in the delivery of medical services, by hospitals and by other providers, require a more precise approach to product market definition than the courts are presently using. Better product markets, in turn, will lead to a different approach to geographic markets. Finally, both these improvements will permit antitrust enforcers to target their efforts at the aspects of hospital consolidations that pose a genuine threat to competition, in lieu of the blunderbuss approach they have been taking up until now.

### II. The Problematic Idea of Cluster Markets

#### A. *The Concept*

Since most hospital merger cases presently define the product market as "acute in-patient hospital services," and since this type of market definition is commonly known as a "cluster market," I begin by taking a closer look at the idea of cluster markets. This notion did not originate with the hospital industry. It arose, instead, in the field of commercial banking, in the Supreme Court's decision in *United States v. Philadelphia National Bank*.<sup>3</sup> In that case, rather than considering each distinct service provided by commercial banks separately (such as various kinds of credit, checking accounts, and trust administration), and considering the sources of competition for each product or service, the Court decided that the overall "cluster" better described the relevant product market. This was so for both economic reasons and practical reasons: the Court believed that the grouping of services conferred a cost advantage on the banks, and it found a "settled consumer preference" for

using commercial banks as opposed to other financial institutions such as savings and loans, finance companies, and credit unions. Different financial products and services in the cluster were not otherwise related to one another.

Since *Philadelphia Bank*, the courts have discovered cluster markets in a variety of areas, including accredited central station protective services,<sup>4</sup> industrial gases,<sup>5</sup> sporting goods products,<sup>6</sup> hair care products,<sup>7</sup> and, of course, acute in-patient hospital services.<sup>8</sup> In the *American Stores* litigation in California, just this week decided by the Supreme Court on a different ground, the Ninth Circuit somewhat reluctantly accepted a cluster market of full-line grocery stores with more than 10,000 square feet.<sup>9</sup> The same court, however, later rejected a market defined as the cluster of goods and services provided by home center stores, which offer a full line of building, plumbing, and electrical supplies along with a trained sales staff.<sup>10</sup>

Almost at the same time it was introducing and developing the idea of cluster markets, the Supreme Court also introduced the concept of a "submarket."<sup>11</sup> More recently, there has been disenchantment with the submarket concept, principally on the ground that it adds little to our basic understanding of market analysis. Judges Posner and Easterbrook, in their Antitrust casebook, regard "submarkets" as simply narrower relevant markets, and they comment that "with proper sensitivity to the market elasticity of demand—a vital qualification—there need be no objection to a submarket approach in which the market is defined narrowly, because the approach will not change the estimate of the firm's market power."<sup>12</sup> In other words, if the antitrust question is whether a merger or other arrangement will lead to an impermissible degree of market power in a "submarket" of a broader market, you will reach the correct answer as long as the responsiveness of consumers to price changes in that submarket is measured accurately.

The cluster market problem is closely related to the submarket concept, both conceptually and in the need for precise economic content. Commentators have tried on several occasions to give clusters a needed boost. Ian Ayres, for example, has suggested that cluster markets are economically reasonable when a "transactional complementarity" exists.<sup>13</sup> He defines goods as transactional complements "if buying them from a single firm significantly reduces consumers' transaction costs." Courts should ask whether consumers typically buy the group of goods from individual firms, and whether manufacturers promote those goods on the basis of joint price. Using these tools, legitimate cluster markets can be distinguished from others in which active competition exists independently for the different products and services in question.

Jonathan Baker, in his well-known article on hospital mergers, disagrees with the proposition that complementarities can be helpful in the market definition process.<sup>14</sup> He argues that the various types of complementarity (supply, demand, and transactional) play a role in facilitating collusion, but they cannot undermine collusion in the same sense that the existence of substitute products can. After being very critical of the use of cluster markets in hospital merger cases, Baker suggests at the end that the term may be good "solely for descriptive and analytic convenience in situations where it will not be misleading." (p. 137-38.) He explains:

[W]hen the same firms sell the same set of products, which do not happen to be substitutes, in the same geographic area with similar market shares, and when each individual product would constitute a product market under the DOJ Guidelines, the antitrust analysis of each would be so similar in practice that no loss of analytic power comes from treating the products as a collection. (p. 138.)

In other cases, aggregate data is used because nothing better exists *and* there is no reason to believe that substitution opportunities, entry conditions, or market shares differ among the constituent products. He concludes by rejecting the use of a cluster market when some firms sell subsets of the clustered goods but not the full line.

At a certain level, the cluster market problem is just another example of the line-drawing exercise that is always necessary in discovering the "product" or "service" that is being offered. Cars, for example, might be considered a cluster of engines, chassis, and tires, or they might be considered as one product. A person who wants coronary by-pass surgery might think of purchasing a room, meals, medications, nursing service, anesthesiology, the use of surgical facilities, and a surgeon's services, or he might think simply of an in-patient hospital visit for the operation. That person, however, (a male in my example), will probably be totally uninterested in the hospital's obstetrical services, only mildly interested in its psychiatric services, and contingently interested in its broader diagnostic services.

The true cluster market problem arises only after the proper "bundle" that is the product or service has been defined, and one looks to the grouping of several different products or services: milk, bread, meat, and maybe even pharmaceutical products in a grocery store; lumber, paints, lighting fixtures, and lawncare supplies in a hardware store; or the sometimes bewildering variety of financial services offered by a bank.

The problem with the cluster concept, as I define it, is that it invites sloppiness in market definitions, which in turn raises risks of improper under- and over-enforcement of the antitrust laws. In the final analysis, Baker's pragmatic approach is not persuasive. In many other ways, antitrust has ceased to be a seat-of-the-pants, pragmatic, intuitive field, striving instead for greater economic understanding and rigor. Although this rigor has come at a price—of uncertainty, of greater complexity of analysis—the net result has been a better antitrust law. The same reform is needed for cluster markets. Unless demonstrable economies of scope justify grouping certain products or services together, or the real question is the delineation of the size of the bundle, I see no justification for continuing to talk about "cluster markets." Furthermore, I suggest that clusters have been particularly pernicious in the area of hospital mergers, for reasons that I will explore now.

### *B. Health Care Services and Hospitals*

Hospitals today offer a wide range of products and services, for which the competitive conditions differ greatly. Most people are familiar with the rough distinction between primary care, secondary care, and tertiary care facilities, and the increasingly sophisticated and specialized care available as one goes "up" the scale. The descriptions of these three categories offered by Philip Proger, a distinguished health care antitrust practitioner, are useful for present purposes:

(1) *Primary Care*, the first level of care. All hospitals provide primary care, and primary care medical services are provided by pediatricians, family care practitioners, and in some instances by internists, obstetricians, and gynecologists. Primary care hospitals and physicians are subject to increasing competition respectively from non-hospital facilities such as surgi-centers, outpatient clinics, birthing centers, and physician offices, and from non-physician providers, such as nurse midwives, podiatrists, and chiropractors.

(2) *Secondary Care*, the second level of care. Most, but not all, hospitals provide secondary care. Physicians who provide secondary care are specialists, such as general surgeons, radiologists, and anesthesiologists. While not subject to as much competition from non-hospital and non-physician providers, secondary care hospitals and physicians are subject to competition from non-hospital facilities, such as surgi-centers, and non-physician providers, such as nurse-anesthetists.

(3) *Tertiary Care*, the highest level of care. It generally is provided by large, urban teaching hospitals and by sub-specialist physicians. Complicated surgery, cancer treatment, and other severe illnesses are grouped within this category. Non-hospitals and non-physicians offer little competition.<sup>15</sup>

As many commentators, including some of the people here today have observed, the nature of competition both among these groups and within them is different in important respects—so different that the idea of lumping all three together and calling them a "cluster" of acute in-patient hospital services is unacceptably rough.<sup>16</sup>

What, then, is the alternative? One possibility would be to analyze each hospital service that is not an economic substitute for another service and not used in a complementary fashion with another service separately (perhaps by DRG's), just as one would do in a merger between two multi-product firms. There are several problems with this approach, however. First, the administrative burden would be great. Second, this might miss another aspect of hospital product configuration, which is most evident in the diagnostic services hospitals provide. Often a patient will not know what is wrong with her, or will be admitted for one problem and then discover another problem. In a manner not unlike the blanket license in the *Broadcast Music* decision, the aggregation of all hospital services may create a completely new product whose inputs are the other services the hospital offers separately. Thus, the market definition adopted must have some way of accommodating the various economic interrelationships between hospital services and the types of competitive pressures each one faces in the outside world.

If the extreme of grouping all hospital services into one general cluster product market of "acute in-patient services" is unacceptable, and the other extreme of evaluating every service individually has equally severe flaws, what should be done? At a minimum, I suggest that the three broad levels of service offerings identified above—primary, secondary, and tertiary—should be regarded as separate product (or service) markets, and competition in each one should be analyzed. At worst, it will appear that the competitive characteristics of each level are more or less the same, in which case a little extra work will have been done. At best, this more finely tuned analysis will reveal important differences in

competitive conditions that can be taken into account in evaluating the merger. It may even appear that these categories are too crude, because particular hospitals have specialized so heavily in certain services—for instance, cancer treatment, or diagnostics—that a more precise market analysis will be preferable.

Before turning to the ultimate consequences of this revised approach to product market analysis for enforcement decisions, it is important to consider briefly the implications it has for geographic market definition.

### III. Geographic Markets, Product By Product

Virtually every form of market analysis, including the 1984 Justice Department Merger Guidelines, Supreme Court cases, and academic commentary, indicates that geographic markets should be defined for the products that have been identified in the first step. In the standard hospital merger decision, exemplified again by the Seventh Circuit's *Rockford* decision, after defining the general acute in-patient hospital product market, the court attempts to decide what geographic limits to place on that market. Putting to one side whether, and to what extent, this inquiry is a question of fact or a question of law,<sup>17</sup> one will look first to see what the hospital's service area is (that is, from what area does the hospital draw its patients), and then one will ask where people living in that area go for their hospital services. Other hospitals in both the first and the second area will be able to provide competition to the hospital in question, and the geographic market should therefore be drawn to include all significant providers from both perspectives.

The problem with this aggregated approach is that it misses too much competition for the hospitals at both ends of the service spectrum. Non-hospital providers are excluded, because one does not go to the general practitioner's office for triple by-pass surgery, and distant tertiary centers are excluded, because their competition overall appears to be faint.

These flaws are substantially eliminated if the more precise product markets are used in lieu of the cluster market. At the primary care level, hospitals will probably face competition from many hospital and non-hospital providers. Thus, the chances of a successful exercise of market power within that product market (or submarket, if one insists), are minimal. At the secondary care level, it is more likely that patients (and their referring doctors) will insist on a hospital rather than an out-patient facility, but many hospitals will fit the bill. Smaller hospitals may actually have a competitive edge over the large urban hospitals, to the extent that patients prefer the more personal atmosphere of the smaller facility and wish to avoid the sometimes impersonal attitude of the teaching hospital. Competition at this level will also be affected by the ways in which health care is delivered in the area. If prepaid plans are common, the plan may negotiate with several smaller hospitals and direct its subscribers to them.

Finally, competition at the tertiary level may look entirely different from that at the primary and secondary level. Only other tertiary hospitals are in a position to compete, but the geographic area to which people will travel may be considerably greater. Indeed, for some highly specialized services it may be as big as the entire nation. At this point, patients are no longer relying on the admitting privileges of their family physician, but are instead relying on the specialists to whom their primary care provider has referred them. Thus,

even if only a small number of tertiary care centers exist in a particular city or region, they may face effective competition from other more distant regions.

With the geographic markets carefully defined to reflect the different kinds of competition faced by different bundles of hospital services, it may appear in the final analysis that a merger whose aggregate concentration statistics appear high is actually not likely to be anticompetitive, because each general area of service is subject to effective competition. If, however, it appears that effective competition exists only at, for example, the primary and the tertiary levels, but market power would reach anticompetitively high levels at the secondary level, the standard antitrust response would be to condemn the entire merger unless some "fix it" mechanism could be devised.

For this purpose, it may be difficult for hospitals to "fix it first," unlike other multi-product firms. It isn't as easy to spin off secondary care services as it is to divest the luggage line of business, or the plants in the Southwest. Without special legislation (perhaps along the lines of the Newspaper Preservation Act), curative measures are practically impossible. However, it is important to remember that this outcome leaves one no worse off than the cluster market approach did: namely, condemning a merger that is neutral from some competitive standpoints, but not all. If, on the other hand, the more precise market analysis reveals that the hospitals do face effective competition throughout the range of their operations, then the abandonment of the cluster approach will have facilitated potentially efficient transactions.

#### **IV. Conclusion**

I have not had time this morning to discuss other aspects of market definition, such as the way in which the well-known imperfections and complexities of hospital markets should be taken into account, or the significance (or not) of the non-profit status of many hospitals. My goal has been to look at market definition in hospital merger cases from a straightforward antitrust perspective, assuming that hospitals neither require nor receive special treatment under the laws. In that light, it seems to me that we don't really need any special rules for hospital markets, but we do need to break away from obfuscating phrases like "cluster markets" and to begin both the empirical work and the legal analysis that more accurately reflects the range of competitive forces that hospitals feel. In fact, I would advocate the same reforms for any other areas presently encumbered with cluster markets, but that is a topic for another conference and another day. Although I am as firmly in favor of a sound and well administered antitrust law as anyone here, imprecise market definitions should not be allowed to inhibit hospitals from entering into useful, potentially cost-saving, and competitively neutral transactions with one another.

## ENDNOTES

<sup>1</sup>1990-1 Trade Cas. (CCH) ¶68,978 (7th Cir. 1990).

<sup>2</sup>476 U.S. 447 (1986).

<sup>3</sup>374 U.S. 321, 356-57 (1963). See also *United States v. Connecticut National Bank*, 418 U.S. 656, 664-66 (1974); *United States v. Phillipsburg National Bank & Trust Co.*, 299 U.S. 350, 360-61 (1970); *United States v. First National State Bancorp.*, 499 F. Supp. 793, 811 (D.N.J. 1980).

<sup>4</sup>*United States v. Grinnell Corp.*, 384 U.S. 563, 572-75 (1966).

<sup>5</sup>*British Oxygen Co.*, 86 F.T.C. 1241, 1345-47 (1975), rev'd on other grounds sub nom. *BOC Int'l Ltd. v. FTC*, 557 F.2d 24 (2d Cir. 1977).

<sup>6</sup>*A.G. Spalding & Bros.*, 56 F.T.C. 1125, 1160 (1960), aff'd, 301 F.2d 585, 603-04 (3d Cir. 1962).

<sup>7</sup>*JBL Enterprises, Inc. v. Jhirmack Enterprises, Inc.*, 698 F.2d 1011, 1016-17 (9th Cir. 1983).

<sup>8</sup>See, e.g., *United States v. Rockford Memorial Corp.*, supra note 1; *Hospital Corp. of America*, 106 F.T.C. 361, 464-66 (1985), aff'd, 807 F.2d 1381 (7th Cir. 1986).

<sup>9</sup>*California v. American Stores Co.*, 872 F.2d 837, 841 (9th Cir. 1989), rev'd on other grounds, No. 89-258, U.S. Supreme Court (decided 4/30/90), 1990 U.S. LEXIS 2214.

<sup>10</sup>*Thurman Industries, Inc. v. Pay 'N Pak Stores, Inc.*, 875 F.2d 1369, 1377 (9th Cir. 1989).

<sup>11</sup>*Brown Shoe Co. v. United States*, 370 U.S. 294 (1962).

<sup>12</sup>R. Posner and F. Easterbrook, *Antitrust: Cases, Economic Notes, and Other Materials* at 367 n.2 (2d ed. 1981).

<sup>13</sup>Note, *Rationalizing Antitrust Cluster Markets*, 95 Yale L. J. 109 (1985).

<sup>14</sup>Jonathan B. Baker, *The Antitrust Analysis of Hospital Mergers and the Transformation of the Hospital Industry*, 51 Law & Contemp. Prob. 93, 136-37 (1988).

<sup>15</sup>Philip Proger, *Relevant Market*, 55 Antitrust L. J. 599, 616 (1987).



<sup>16</sup>See, for example, the opinion of Commissioner Calvani in *Hospital Corporation of America*, 106 F.T.C. 361, 465-66 (1985), criticizing the exclusion of non-hospital providers of outpatient care from the market. Proger commented in "Relevant Markets," *supra*, that "product market definition in the cases has not yet caught up to the changing health care market." 55 *Antitrust L. J.* at 619.

<sup>17</sup>Properly speaking, the methodology adopted by the district court and described in instructions to the jury, or used in a bench trial, presents a question of law. The jury's or court's application of that test to the facts in the case are questions of fact, either protected by the Re-Examination Clause of the Seventh Amendment or by the clearly erroneous rule of Fed. R. Civ. P. 52.

# ONE HOSPITAL'S FRONT LINE PERSPECTIVE

WILLIAM DILTS:

## INTRODUCTION

If any of you still have your programs I'd like to make a change under my section. After listening to the first two speakers this morning I've decided to change my name to Don Quixote.

## WHY CONSOLIDATE?

### Trustee Intent

By this point in the program you are probably wondering why Rockford Memorial Hospital and SwedishAmerican Hospital started on our journey toward consolidation. The answer is a naively simple one. It was the opinion of the seventy or so trustees on the Boards of Directors of Rockford Memorial and SwedishAmerican that it was in the best interest of our community. Not necessarily in the best interest of one or the other of the individual hospitals or of the management teams of either, but that it was in the best interests of the community.

### Rockford Characteristics

Rockford is located approximately seventy miles west of O'Hare on I-90, which places us about seventy miles south of Madison and roughly ninety miles from Milwaukee.

Our community has about 35 percent of its employment in manufacturing, a level that I understand is around twice the national average. Our manufacturing is highly concentrated in parts production for automobile and tractor manufacturing, support of the housing industry, and in machine tool production. As a result of that very unholy trio, in the early 1980s we led the nation for several months in unemployment, in many of those months exceeding twenty percent. We were very slow to recover from the national recession, and long after the rest of the nation was doing well, we were still experiencing a ten percent unemployment rate.

The population of our county, Winnebago, is about 250,000.

### Hospital Services

All three Rockford hospitals consider themselves to be the tertiary care referral center for the northern Illinois and southern Wisconsin area. As a result, we have three open heart surgery programs and three MRIs. We have two Trauma 1 centers, and one Trauma 2 center. We have two helicopters, one at St. Anthony, which is the third hospital in

Rockford, and one shared by Rockford Memorial and SwedishAmerican. We have three medical oncology programs. We have two radiation therapy programs, three neurosurgery programs, two pediatric ICUs, two psychiatric programs, and two substance abuse programs. For the most part, we do not have a duplication of services in our community; we have a triplication of services. Each has developed niches in selected subspecialty care areas. For example, St. Anthony has a burn unit, Rockford Memorial has a neonatal-perinatal center, and SwedishAmerican had the only psychiatric care unit.

The two hospitals that tried to consolidate, SwedishAmerican and Rockford Memorial, are owned and controlled by local boards of directors. Nearly every one of the major corporations in our town is represented on one of these hospital boards. Some of the larger corporations are represented on both. St. Anthony is a Catholic hospital owned and operated by the Sisters of the Third Order of St. Francis of Peoria. They own a large teaching hospital in Peoria and a small hospital in Belvidere, which is about ten miles east of Rockford.

Some of the programs that I mentioned obviously require a much larger service population for support than exists in Winnebago County. Traditionally, the nine counties of northern Illinois have referred almost all of their tertiary care patients to one of the Rockford hospitals. In addition, we also have very special referral ties in McHenry County, in the Elgin area, and down to the I-80 corridor for such programs as open heart surgery and neonatal-perinatal services. For example, in open heart surgery, there were 590 cases done in Rockford in 1988. Only 44 percent of those came from Winnebago County. Another 43 percent came from the "traditional" other eight counties of northern Illinois. The remaining 13 percent came from Iowa, Wisconsin, McHenry, and the LaSalle-Peru area.

## **Rockford Memorial Strategic Plan**

In 1985, Rockford Memorial initiated a major strategic planning effort. As with any strategic planning process, we went through the requisite environmental assessment, competitor analysis, et cetera, et cetera, et cetera. When that process was approximately two-thirds completed, the overall picture we saw for the future of the hospital industry was very depressing. We saw a number of very substantial trends that would dramatically change our industry:

### **1. *Decline in Inpatient Volume***

In the future, we saw the continued decline of inpatient volume, particularly in the routine medical, surgical, obstetrics, and pediatrics services. We felt this would be the results of pressure from all third-party payers to reduce admission rates, reduce hospital stays, and find alternatives to inpatient care. Their desire to accomplish this objective was being supported by substantial advances in technology that were permitting diagnosis and treatments to be performed in alternative settings.

### **2. *Declining Medicare and Medicaid Reimbursement***

In the future, we saw a worsening Medicare and Medicaid situation, in that the federal government and the state government would pay us even less than they

had in 1985 for the services that had been promised by the legislators to their voting constituents.

### 3. *Increased Ambulatory Services Competition*

We also saw increasing competition for ambulatory services. The physicians are starting to go through every aspect of the government cost containment effort that hospitals have been subjected to for many years and, unfortunately for hospitals, physicians have as one of their objectives the maintenance of income. They also have the ability to control access to the system. They are the entry point for patients to the system. They define the care needed. They define the location for care. As the entrepreneurs that they are, we felt they would take advantage of the technological advances in diagnostic and treatment services that I mentioned, and start to do everything they possibly could in their offices.

### 4. *Increased Tertiary Care Competition*

In the future we also saw increasing competition for tertiary care services. We felt that all of the dilemmas Rockford Memorial faced in reimbursement and shrinking inpatient volume were being faced by the major teaching centers and tertiary care referral centers that surround us. They have an additional dilemma and burden. They are supporting major teaching programs and the huge infrastructure which that involves. As a result, we felt they would have to increase their patient volume to support their teaching programs, and one way to do this would be for them to enter Rockford's traditional tertiary care service area. Rockford is surrounded by the University of Wisconsin and Meriter in Madison and by the Medical College of Wisconsin in Milwaukee. Park Ridge is the home of Lutheran General and their affiliated corporation of Parkside. Maywood is the home of Loyola. Aurora is the home of a hospital that has recently become affiliated with Pres-St. Luke's. Peoria is the home of St. Francis, a major teaching facility associated with St. Anthony.

### 5. *The Emergence of Niche Competitors*

Today, in a previous presentation, a comment was made that the barriers of entry for a new hospital in the Rockford market are very high. I have no quarrel with that statement. However, nobody in their right mind would build a new, general service hospital in Rockford. Why would you build a hospital in a community that has a long history of high unemployment, has a relatively high Medicare, Medicaid mix, and has no population growth? You would build your new general hospital in Lake Forest, or Barrington, or Hoffman Estates. While it is true that no new, general hospital would be built, we felt this fact would not protect us in any way from niche competitors; people who might come in and offer a program to compete with one of our product lines. They would obviously pick a product line which for us is successful and for us is profitable, i.e., they would develop programs or facilities to compete in rehabilitation services, in outpatient physical therapy services, in psychiatric services, or in substance abuse services.

Rockford Memorial's trustees and managers consider our hospital to be a substantial community asset. With nearly 2,000 employees, we're the number four employer in Rockford. SwedishAmerican is the number six employer. With consolidation, we would have been the largest single employer in our community. Combined, we bring into our community somewhere between \$70 and \$100 million of revenue from outside of our county.

For the first time in our hospital's history, when we completed our analysis of the healthcare environment and looked to the future, we saw uncertainty and questions regarding our ability, over the long term, to sustain our economic and financial viability. We felt that if we could not sustain our economic and financial viability, the next thing that would suffer would be our quality level and our ability to serve our community. It was the feeling of our trustees, a feeling which was wholly supported by senior management, that we could not allow that to happen. We felt that the future faced by SwedishAmerican was probably very similar to ours. It was for those reasons that we started to talk about the consolidation.

Initially, our discussions centered on our first objective, which was "how to best protect and conserve these very valuable community assets." We wanted to avoid further triplication of services, which to me and to everyone involved, obviously meant future savings to the community. We wanted to control the rate of increase in costs by consolidating services, programs, and facilities as rapidly as possible. We wanted to take these two hospitals and form a larger patient base, because as more and more services move to outpatient settings, we would be left with a smaller number of patients who would be more and more critically ill, i.e., we would be forced to concentrate on tertiary care services. We wanted to take that combined, larger base and build on it and improve our clinical excellence. By doing this, we felt we would then be in a better position to compete with the larger tertiary care referral centers around the periphery of our region.

## **Actual Experience**

When I look at what's happened in the last five years since Rockford Memorial started our strategic planning process, every one of the predictions that we made regarding future developments has come to pass:

### *1. Inpatient Volume*

Between 1982 and 1988, patient volume at the three Rockford hospitals dropped from over 306,000 total days to just over 254,000. That's a 17 percent decline. That's about 52,000 patient days. It's actually worse than it sounds because during that time period our substance abuse program, unfortunately for society, turned into a growth industry and nearly doubled in volume. Our neonatal-perinatal program increased in volume, and SwedishAmerican's psych occupancy increased. So, in actuality, the routine medical services volume declined more substantially than it might appear.

In 1988, St. Anthony had 59,000 patient days. In six years, between 1982 and 1988, we have taken almost that amount of patient days out of the Rockford system. We have, in essence, almost closed one of our hospitals. The problem is that we still have three buildings.

## 2. *Medicare-Medicaid Reimbursement*

In 1986, Rockford Memorial's deductions from revenue for Medicare and Medicaid underfunding were approximately seven million dollars. In our 1990 budget, which has just been approved, those deductions from revenue have gone up to something on the magnitude of \$32 million.

## 3. *Ambulatory Services Competition*

Since our discussions with SwedishAmerican began, the multispecialty clinic adjacent to Rockford Memorial has purchased its own CT Scanner.

Additionally, new for-profit outpatient programs have been established in Rockford in physical therapy and alcohol treatment.

## 4. *Tertiary Competition*

The University of Wisconsin has established referral and outreach ties with Freeport Memorial, 30 miles west of Rockford, and Beloit Memorial, 20 miles to the north of Rockford.

## 5. *Niche Competitors*

Psychiatric Institutes of America has opened a 60-bed, for-profit psychiatric facility. Charter Medical has received a certificate-of-need to open a second 60-bed, for-profit psychiatric facility in Rockford.

# LITIGATION

## Issues

Well, as you are all aware, a funny thing happened to us on the way to the forum. As it turned out, there were three questions debated in our trial.

*First*, whether or not not-for-profit hospitals should get a special exemption from antitrust rules.

*Second*, what was the relevant product market.

*Third*, what was the relevant geographic market.

These same questions were debated in Roanoke, Virginia, where the judge decided all three questions in favor of the hospitals. In Rockford, the judge decided all three questions in favor of the government.

I sat through the entire trial. I listened to countless hours of detached, theoretical testimony on how people might act under a series of very complex, hypothetical assumptions. There were testimonies on the theory of competition. There were testimonies

on product definition. There were testimonies on product market. My feeling at that time was that the theories I heard espoused over those four or five days had almost no relevance to anything that had ever happened in our region or anything I had ever experienced in our region from a motivational or competitive standpoint.

### **Product Definition**

The government contended that the relevant product market was routine medical-surgical, obstetric, and pediatric inpatient volume.

This made no sense from a realistic perspective. Our outpatient services were not considered part of our product even though they represented 20 percent of our revenue. By their exclusion, this meant that we did not compete with physicians' offices or any other ambulatory services provider.

Our neonatal-perinatal program, substance abuse program, and rehabilitation programs, which represent over 25 percent of our revenue, were not considered to be part of the relevant discussion.

Therefore, by the government's selective definition of product, nearly 50 percent of our revenue-generating programs were not considered relevant.

For SwedishAmerican, their psychiatric program was not considered relevant, even though it represented 20 percent of their volume. Therefore, the two psychiatric facilities being built in Rockford were not considered relevant competitors.

### **Geographic Market Definition**

The government contended that the relevant geographic market included the two-county SMSA area (Winnebago and Boone) and a small portion of another rural county.

Earlier, I mentioned that over 50 percent of our open heart volume comes from outside this area. In addition, over 50 percent of our pediatric ICU patients come from outside this area, as do over 60 percent of our neonatal-perinatal patients.

Through use of the narrowly defined geographic market, the major tertiary referral centers around us—the Madison hospitals, St. Francis in Peoria, Lutheran General in Park Ridge—all the Chicago hospitals were eliminated as competitors, even though two of them testified that they compete like hell with us for the very high revenue tertiary patients.

Applying the geographic market and product definition accepted by the court eliminates 60-70 percent of our revenue. You have suddenly turned Rockford Memorial from a 500-bed hospital into a 150-bed hospital, and this does not make sense to me.

### **Not-For-Profit Consideration**

In the period from roughly 1977 to 1985, the average charge per case at Rockford Memorial ranged from a minimum of five percent and sometimes as much as 30 percent below that of either of the other two Rockford hospitals. Under the economic theory espoused by the government, we would have begun to operate inefficiently and/or we would have raised charges to maximize our profit. Well, during that period we led the state, or were one of the leaders, in outpatient surgery, which brings us less revenue. During that

period we had an average income from operations of 3.1 percent. Why? For all the reasons that I discussed regarding the motivation behind the desire to consolidate in the first place. The money from increased charges would have had to come out of our community and it would not have served the best interest of our community.

## **RETROSPECTIVE**

During the past several months I've been asked many times what I think we did wrong, or what we would do differently. I don't know if I can answer what we did wrong. Obviously, I would certainly do things differently because we lost. We were unable to convince the courts that our intentions were pure and that the product and market definitions imposed on us were not valid.

### **Understanding of Antitrust Issues**

In retrospect, I think the first thing I would try to do would be to come to some better comprehension of what antitrust legislation and rulings are all about. It's like so many things in life. People tell you the words, but if you have no personal experience in the matter it's hard for you to understand their true meaning.

Based on the court's ruling, it appears that reduced costs will be the pivotal issues in hospital antitrust litigation. It is apparent that we did not effectively document the potential savings or emphasize them enough in our initial public statements.

For the past 30 years, the leading businesses in Rockford have attempted, approximately every five to seven years, to consolidate Rockford Memorial Hospital and SwedishAmerican Hospital. Our board members made these efforts for one purpose, and that was to realize savings that could be passed on to their businesses. Our hospital board has on it representatives of the manufacturing and business leaders in our community. That's 35 percent of our employer market. They are the most effective control on our costs and our prices that I can imagine. Our community is relatively isolated from Chicago, and our trustees have their factories here. When our board members raise charges, our increased prices have a direct, negative impact on their own companies' profits. In a large metropolitan area trustees may live in one community and be on a hospital board in another community. Therefore, the charges they raise affect corporations other than their own. There is no direct relationship between their decisions and their companies. That is not the case in Rockford.

As to the argument of whether or not we are generally inefficient, I think there are some measures. What is our outpatient surgery rate? How many employees do we have per 1,000 patient days? What is Rockford's rate of patient days per 1,000 population when compared to elsewhere in the state or country? In every one of those measures Rockford Memorial and SwedishAmerican stand close to the top.

With our background of very high unemployment, which at the time we started this process was still very much in the psyche of our community, our initial public statements



emphasized the positive aspects of the consolidation, not the fact there might be layoffs or cutbacks. We emphasized what could be and how it would help the community. We did anticipate an evolutionary transition process involving attrition, cross-training, et cetera, because many of our employees either had been or still were the sole income earner for their family.

At the trial, we were criticized because there were no presentations on savings when the consolidation was discussed. The only defense we have to that is that such a presentation would have been like telling people that water is wet. Because our trustees have been in the community for a long time, they knew the objective was to improve quality, and to do it at a more reasonable or better controlled cost. Consequently, there was no need to make a presentation on cost savings. If we had to do it again, I would bring in outside consultants who could put together a model identifying how the consolidation could be specifically implemented, where the savings would be realized, and objectively estimate the amount of savings that could be expected. We talked in our management groups about how to do it, and we're convinced that over a period of five years we could have saved the community at least \$40 million. I still remain convinced that that savings would have been realized.

## **MARKET AND PRODUCT DEFINITION**

In retrospect, it is also apparent that we did not effectively make our case regarding the changing nature of the healthcare delivery system caused by significantly different approaches to reimbursement for care, and continuous advances in diagnostic, therapeutic, and pharmacological technologies.

If we were to do this again, I would bring in a string of national consultants in an attempt to convince the court that these dynamic forces have changed the nature of healthcare competition, that a multiplicity of "substitutes" for inpatient care will be available during the next 10 years, and that current geographic limits on competition will become meaningless.

## **ROCKFORD MEMORIAL-SWEDISHAMERICAN RELATIONS**

The initial discussions between our boards and senior management groups were kept very secret. When the announcement was made, it hit our employees and medical staffs like a bombshell. The initial euphoria generated by the excitement of the announcement rapidly evaporated. Very quickly, nearly everyone began to ask the question of how the proposed consolidation would affect them personally. Would they have a job? What would happen to their benefits? This reaction was expected given the recent economic history of Rockford. It also explains why our initial announcement emphasized the positive aspects of

the consolidation, rather than what would have been perceived as the negative aspects of cost savings.

When the announcement was made, we expected a positive response from the government within a 3-4 month time frame. Therefore, in an attempt to begin to bring the organizations closer together, we formed several task forces of employees and managers from both hospitals to begin discussing how to consolidate and integrate programs. As the process dragged on, it became impossible for these people to discuss anything meaningful, because we soon reached the point where constructive discussion would have required the sharing of proprietary information, which we could not do. As a result, task force meetings turned into debates on whose program was the best. Whose was more effective. Whose was better liked by the community.

After a period of time, many of these discussions became so personal that we had to disband all of the task forces because their continued existence was becoming destructive.

Our medical staffs were not involved in the discussions regarding the decision to consolidate. This exclusion was a conscious decision made by both hospitals' boards because, as I said earlier, the decision to consolidate was based on what was best for the community, not on what was best for Rockford Memorial or what was best for SwedishAmerican as individual hospitals, nor was it based on what was best for one group or another of physicians. There was every intention that as soon as the consolidation was approved and actual integration of the programs at the two hospitals began, the physicians would be directly involved in how to implement the consolidation of programs.

Because of our failure and SwedishAmerican's to involve our respective medical staffs in the process, we paid a terrible price in medical staff relations. We are still recovering from the problems this approach caused.

Regarding hospital management and employees, in my opinion, I would limit the number of people involved in the consolidation deliberations. I would do anything within my power to make the process as short and expeditious as possible. While the process was underway, I would make it clear to everyone that the hospitals were competing as they had competed in the past. In that way, if the consolidation did not go through, there would be no room for self-doubt, after the fact, about what you might have done or should have done.

## CONCLUSIONS

In my opinion, the government's aggressive antitrust activity in the hospital industry reverses 30 years of national health policy on which federal and state governments have spent hundreds of millions of dollars. In the past 30 years, all government efforts—the regional medical programs, the comprehensive health planning programs, the certificate-of-need programs, the health system agency programs—have had as their objective the concentration of healthcare services and the elimination of competition.

The Health Systems Agency (H.S.A.) in our region spent months trying to close one of the small hospitals in DeKalb County so that the other hospital could have a virtual monopoly of the entire county. At the same time, they tried to get the three Rockford

hospitals to divide the market. One would take obstetrics, one would take cardiology, one would take radiation oncology. To say the least, those kinds of conversations would be suspect today. The ultimate irony to me was that the person who was the head of the H.S.A. at that time and who tried to do those things, testified against the consolidation at our trial as one of the governments's key witnesses.

Discussions on the consolidation began in 1986. It is a considerable understatement to say that this process has been an ordeal. Since that time, however, I have come to some appreciation of the governments's position, and I feel they believe what they are doing is best for the country. To do their job, they must approach these issues in a theoretical and detached manner. They can do nothing else.

It remains to be seen whether or not the Supreme Court will choose to hear the Rockford case. If the lower court's decision is upheld, in my mind, this new policy of competition will rapidly take on a completely financial orientation. If this occurs, I believe it will have a very negative impact on healthcare as we know it, and a potentially devastating impact on care for the poor and indigent. I believe those people will suffer greatly.

I also believe that, if the lower court's position is upheld, the decision will have a very negative impact on my community in both the short and long run.

## RESPONSE TO THE MORNING SESSIONS AND DISCUSSION

**MODERATOR — DAVID DRANOVE:** Duncan Neuhauser is Professor of Epidemiology and Biostatistics, Professor of Medicine, Keck Foundation, Senior Research Scholar and Co-director of the Health Systems Management Center at the School of Medicine, and also adjunct Professor of Organizational Behavior at the Wetherhead School of Management at Case Western Reserve University. He is an adjunct member of the medical staff at the Cleveland Clinic Foundation and Consultant in Medicine at the Cleveland Metropolitan General Hospital, as well as editor of the journals *Medical Care* and *Health Matrix*.

He received his Ph.D. in Business Administration from the University of Chicago in 1971. His research interests include organization and management in health care, and cost effective clinical decision analysis.

Gary Mecklenburg is President and Chief Executive Officer of Northwestern Memorial Hospital and Northwestern Memorial Corporation in Chicago. Prior to assuming this position in 1985, Gary held administrative positions at Franciscan Health Care, Inc. in Milwaukee, St. Joseph's Hospital in Milwaukee, Stanford University Hospital and Clinics in Stanford, California and the University of Wisconsin Hospital in Madison. Gary is a preceptor and guest lecturer at the Kellogg School of Management, Northwestern University in Chicago, and a preceptor and guest lecturer in the graduate program in health administration at the University of Chicago.

In addition to these activities, Gary has been active in both the American Hospital Association and the Illinois Hospital Association, and has served in various capacities with the Catholic Health Association of Wisconsin and the Wisconsin Hospital Association.

Gary received his Masters in Business Administration degree with a concentration in Hospital Administration from the University of Chicago, and his Bachelor of Arts degree from Northwestern University.

**DUNCAN NEUHAUSER:** The monopoly power of sellers harms buyers by raising prices. This is why we have antitrust laws forbidding restraint of trade. Evidence to demonstrate the existence of monopoly power through restraint of trade on the part of hospitals should be easy to obtain. First, the hospitals must be in the same market area. Secondly, payers of care to these hospitals must declare themselves harmed by the behavior in question.

Consider a small city with three hospitals and two large employers who pay for the medical care of their employees and dependents. Two hospitals in the city (market area) merge (the behavior). Are the employers (payers) upset by this behavior? If the answer is "no," then there is no cause for antitrust action. If the answer is "yes," there is cause for antitrust action. It is as simple as that. If the payers are actively involved in promoting the merger, then there is even less cause for concern.

The qualifications to these principles are minor. Perhaps the buyers are stupid, irrational, or ignorant, and cannot see where their best interest lies. The burden of proof in support of this contention lies with the government. In this example, the senior managers of large corporations spend hundreds of millions of dollars on medical care year after year. It is difficult to argue that these buyers are unwise.

Perhaps the buyers say they are harmed which they are not. They see collusion and conspiracy when it is not there. This assumes ignorance or malice on the part of buyers. In this case, the burden of proof might lie with the hospitals to show they have caused no harm.

Employees and employers may perceive the behavior of hospitals differently. Insured employees are not directly affected by their use of medical care and are sheltered from the cost consequences of their use of care. In fact, this is at the center of our medical care cost problem. In contrast, payers such as self-insured employers, HMO managers buying tertiary care, and Blue Cross preferred provider plans *are* directly affected by the price of hospital care. A well managed company and its employees should speak with one voice with respect to hospital costs. Both should work with hospitals in partnership to create value for money in medical care. When employer and employees take opposite sides of a debate on restraint of trade, the voice of the payer should take precedence.

This suggests a very different role for government in hospital antitrust action. Let payers know that the government will investigate, and if necessary, take action if they complain.

In Cleveland, Ohio, over the last fifteen years, about forty independent hospitals have grouped themselves into eight or nine multi-hospital delivery systems which account for 80 percent of admissions and in-patient days. In the process, some hospitals have closed. All this has occurred without complaint from local payers of care, including Blue Cross and self-insured employers. Such market concentration has occurred in other cities. Cleveland payers have repeatedly said that there are too many empty beds and hospitals in the city, and that hospitals should be closed. More recently, the ten largest employers representing about 300,000 employees and dependents have formed the Health Action Council. They plan to pay for care in a few hospitals, letting the others wither, and perhaps, die. They plan to develop long term partnerships with a few hospitals organizing care in a way which gives value for money.

Why would buyers reduce competition by closing hospitals? Why not have forty near empty, starving, independent hospitals desperate for business at lowest cost? Perhaps once this would have been the prevailing logic. Now there is a new kind of management thinking based on ideas often referred to as continuous quality improvement. These ideas started in the United States, went to Japan, and came back to the U.S. in the 1980s. One of the cluster of ideas involved here relates to supplier-user relationships. Instead of offering short term competitive bids to purchase supplies, hire contractors, or pay for medical care, long term "partnerships" with a few suppliers are created. Payer and hospital work closely together to continuously improve care over the long term. In a city like Cleveland, this could result in only three hospitals providing heart surgery as compared with perhaps twenty-five today.

The economic argument for such partnerships might go as follows. Basic economics envisions corporations competing in a marketplace. Corporations exist because the coordination of division of labor is efficiently accomplished by an administrative hierarchy. The boundary of that efficiency is where the corporation ends and marketplace exchange begins. Partnerships can be seen as an intermediary stage between market and corporation. The balance of incentives and the time horizon shifts in such partnerships. In the same way, most employees are not totally driven by the fear of being fired at any moment, but rather are driven by a long term desire to perform well and be rewarded accordingly. Partnerships replace the short run fear of losing the contract with long run desire to perform well in a way that produces gains for both partners.

What are the consequences for antitrust action in the hospital marketplace? One can expect more close working partnerships between payers and hospitals and greater hospital market concentration. This will occur with enthusiastic encouragement on the part of buyers. If you are defending hospitals against antitrust action, you might consider seeking expert witnesses familiar with continuous quality improvement ideas. About 80 years ago, Louis Brandeis successfully called on expert testimony about the then new ideas of scientific management in the Eastern Rate Case. Keeping track of new ideas in management and economics may serve us well today, too.

GARY MECKLENBURG: When Ron first asked me to speak my role wasn't entirely clear. I did note after I received the program that I am the twelfth speaker, after lunch. I immediately follow Duncan Neuhauser, a Ph.D. student when I was a Masters student, whom I consider one of the smartest people I ever had the chance to be with in school. But the real challenge for me today is to be your last speaker before a named professor from Duke Law School gives the Michael Davis Lecture, to provide reactions and synthesize what we've heard today.

If I recall the first symposia that I attended twenty years ago this generally was a hospital administrators symposium. Most of the audience was hospital administrators, and many of the speakers were hospital administrators. My first reaction today is that we've had a lot of lawyers talking to an audience of lawyers, if I read the attendance list correctly. I'm certainly not going to try to comment on the law. Obviously antitrust is a very complicated, sophisticated, technical topic. As I listened I didn't understand many things. We are, however, a nation of law, and all of us must operate within the law. As just one hospital administrator, I believe we do the best we can, in hospitals, as the law and society changes, to work within the structures provided. We all have to realize that the antitrust laws are part of our society, and we have to do the best we can within them.

My reactions really for you are just that—reactions, and will really come from my "gut" as a practicing hospital administrator. Before I do that, however, there's one aspect of my activities currently that David did not comment on, and that is that I am also President and CEO of a new organization called Northwestern Healthcare Network, which is an emerging consolidation of four healthcare organizations in Chicago: Northwestern Memorial Hospital, Evanston Hospital, Children's Memorial Hospital and Highland Park Hospital. We are attempting to do what others have talked about today—to put together a multi-hospital system that will respond to changing market pressures in healthcare, in the best way we know how, to better serve the people of Chicago. We certainly want to keep our hospitals at the forefront of healthcare in the Chicago area. I don't want to give a speech about the Northwestern Healthcare Network, but just to note that it is one example of the need for this symposium today; and also, to do what several speakers have done and place a very clear disclaimer on my comments. My Network has a pending Hart-Scott-Rodino application before the Justice Department. Anything I say is not representative of Northwestern Memorial Hospital or the Northwestern Healthcare Network. These are my personal opinions. I should also note that there are at least four attorneys in the audience that represent me in one of my roles.

So let me give you my reactions. First, in terms of Judge Easterbrook and Mr. Calvani, they both succeeded in their talks—they both scared me! It was very difficult to listen to them speak, as one who is operating in a competitive marketplace and is trying to put together a network of institutions. I was concerned about the messages they were sending while expressing their attitudes towards these antitrust issues. Again, I do not interpret that as in any sense of ill-will, but rather their interpretation of what the law is telling us. We have to work within it, and I was certainly struck by the challenge of trying to manage a hospital and stay within their interpretation of the law. I don't want to go to jail, as was suggested I might, if I'm not careful.

There was a comment from one of the presenters about listening to your "paranoid attorneys." My general counsel is in the audience today and sometimes we do accuse them

of being a little bit conservative. After today I probably will listen to him even more closely.

After listening through the morning, another gut reaction I have is that I now know why I am more stressed than I was a few years ago.

But my major reaction to everything that I've heard today is very similar to what Bill was telling us in the last presentation about Rockford, i.e., the difficulties of trying to work within what we best understand as current public policy in this country towards healthcare. If we look back we find that healthcare policy is changing constantly and difficult to interpret. It is confusing and gives us, at times, a somewhat schizophrenic view of the world.

Before George Bugbee had to leave I was talking to him about the Hill-Burton days when we were told build more hospitals, one or more for every community out there. Today, obviously, we are at the opposite end of the spectrum—we are being told to close hospitals, close hospital beds. "You overbuilt. Shame on you!" The Hill-Burton program has been called one of the most successful federal programs in the history of the government, because it accomplished what it set out to do. And yet today we are being told that hospitals have been irresponsible.

Similarly, I recall when I first entered this field in the late 1960s and early 1970s, that we had a physician shortage. At the University of Wisconsin the only way we could continue to receive federal funds for certain programs was to expand the medical school class size—build a larger medical school. Today we are told that we are training too many physicians, even though we still can't get physicians into small communities. But again, the healthcare system has, on the one hand, been successful in responding to public policy, and on the other hand is now being told of the evils of what we've done.

Thus, I share Bill's frustration with comprehensive health planning, telling us to cooperate and merge services, and then being told it's illegal. Prospective payment told us to compete with a reward of successful hospitals keeping the resulting profits. Today, they are taken away with each successive Medicare budget. We were told in the mid-60s to expand care to the poor and the elderly through Medicare and Medicaid, and we did just that. We made high quality healthcare available to everybody. Today we can't afford it and we're told we're responsible for spending too much money.

There is great inconsistency in public policy. Those of us who are trying to respond find we wind up caught in the middle. I think it is exactly this frustration that you heard today from our two hospital administrator representatives. They are caught within the anti-trust law, while doing things that public policy and other agencies of government are advocating. Again, I cannot criticize the people from Justice and the F.T.C. They are enforcing their segment of the law. But at the same time we have other segments of government telling us exactly different messages. When hospital administrators, boards of directors and physicians do the best they can to respond to one set of public policy, and then are told by another that it is anticompetitive and illegal, this is the source of frustration.

Thus, although Judge Easterbrook scared me, I think Bill Dilts scared me even more. His description of their process is precisely what I would follow today in my own hospital in responding to community needs and planning the future of my organization. If what Bill described is wrong, I'm not sure I know another approach to guide the future of my organization in terms of assessing community need and institutional direction.



Another reaction in this part is a comment on the cost of regulation. We've heard a lot today from the hospital people about the cost of going through one of these processes. There is a great financial expense to society for these antitrust activities. It reinforces the schizophrenia that on one hand we are told that we are too expensive and spend too much money and at the same time we expend hundreds of thousands, if not millions of dollars going through these antitrust processes. These costs are passed on to our patients and our payers. Is it good use of limited resources?

I was very intrigued by Mr. Calvani's issue of monopsony, which I hadn't thought about before. I wonder whether or not one could sue the federal government over Medicare, because, if you think of his description you have the hospitals' single biggest payer setting the price; we have no choice but to participate. The federal government is our biggest purchaser and they set their own regulations. It is certainly a fascinating potential, and delicious really, to consider the possibility of litigation for monopsony.

I also was pleased to hear that the Federal Trade Commission does not support cost shifting, and that it may be anticompetitive. I don't know what I'll do with this, but it's nice to know this unpopular reality might be illegal.

In terms of Mr. Allen's comments on exclusive contracts, I think I heard him say that we ought to be very cautious about joint planning with our medical staff to avoid illegal tie-ins. That is certainly contrary, in a pragmatic sense, to everything I've been taught and everything that I've experienced. The concept that a hospital administrator is going to get in trouble by talking with the medical staff about the future of the hospital flies in the face of common sense. I don't know what to do with his advice.

For Mr. Voss, I'm glad to know that we're not "scoundrels and money grubbers," but that we're human and sometimes unable to comprehend the law. I agree with that, but we're doing the best we can to understand the law and work within it.

I believe Ms. Wood, said that "there's general understanding of the difference between primary, secondary and tertiary care." I don't think that is the case. If we have to justify what we do based on an assumed ability to define primary, secondary and tertiary markets, I'm going to find that difficult. Not only are the definitions unclear, but also it is difficult to gather competitive data among hospitals.

Finally, I would reiterate that I reacted most empathetically to Steve West and Bill Dilts. I think that the passions that you heard from those two speakers reflect what I think is generally true in this industry. Even though I'm sure there are physicians or hospital administrators or board members who act inappropriately, my experience is that the field of hospital management is filled with a bunch of people who are doing the best they can to respond to community need. Regardless of the technicalities of law, there is a great deal of frustration and passion associated with activities to respond to this changing environment.

Just one last comment. I chose the University of Chicago as a place to receive hospital administration training because it was based in a business school. At that time few people described hospitals as businesses. I believed that then, and I believe that today. If you believe that hospitals are businesses then you have to agree that we are subject to the same laws and regulations that other businesses are, and that includes antitrust regulation.

## QUESTIONS FOR MR. NEUHAUSER AND MR. MECKLENBURG

DAVID DRANOVE: Before I open the floor for general questions and comments does anyone have any questions directed towards either of our speakers? ...I guess they were totally convincing—there are no questions at all.

Are there any general questions or comments? This is your opportunity to spread your wisdom.

DAVID DRANOVE: The question is whether the AHA has made any efforts to try to get antitrust exemption for hospitals.

COMMENT: There was some activity a number of years ago. This included lobbying efforts to try to get non-profits or professionals exempt either from the FTC or some of the general antitrust laws. These efforts failed dismally.

DAVID DRANOVE: The comment was that the VHA has attempted to get exemption from Section 7 of the Clayton Act, and that Judge Posner has suggested that even if they were able to get that exemption, it would not mean an exclusion from antitrust consideration.

COMMENT: In the banking industry, one of the areas which they've been exempting some mergers and acquisitions is under the Sherman Act failure theory. Your savings bank may avoid failure by merger and thereby save the federal government expenditures. I wondered if anyone gave any thought to the concept of the failure theory as it applies to hospitals?

DAVID DRANOVE: I know the Department of Justice has certainly given it some thought. In a recent petition for an acquisition of a hospital in the Bay Area, one of the considerations was that the hospital being acquired by a local chain was a failing hospital.

The healthcare quality improvement act encourages consolidation as a way to promote cost savings. How can hospitals reconcile this with antitrust activities against mergers? If one looks at merger results for corporations in general, one finds that the results are mixed. By and large, acquisitions do not generate wealth for the shareholders of the acquiring firm, nor do they generate an overall accumulation of wealth for the firm's concern. The individuals presumably went into the acquisitions with the goal of generating savings for the organizations. There doesn't seem to be much evidence that they succeeded, and these are from massive acquisitions. One of the reasons we find out when we study these acquisitions is that there's been surprising little detailed accounting analysis and financial analysis done prior to the acquisition, at least in light of the dollars at stake. A lot of these deals sound a lot like the Rockford deal. Negotiations continue on and off for an extended period. Then one day, without any further analysis to speak of, it's done. It seems that it is easy to defend deals by saying they will generate savings, yet the numbers belie the defense.

GARY MECKLENBURG: As an organization that did acquire a hospital back when premium prices were being paid for hospitals, we did massive due diligence with accountants, attorneys, outside experts, consultants—the full panel that you would expect. Despite that, and the fact that I come from a large and relatively sophisticated organization with enough resources to do that, we didn't begin to understand the depth and the complications of trying to acquire and turn around an institution. We eventually closed the organization and sold the assets.

It seems to me that non-hospital organizations much larger than we, with more resources, and which are considered some of America's best corporations, make exactly the same mistake after significant due diligence. I wish we didn't make those mistakes, but also I don't think we should forget how complicated organizations are. Despite all the numbers and analysis, there are intangibles that you can't measure and things that numbers don't tell you which may make it look like you didn't do what you were supposed to do.

DAVID DRANOVE: An implication is that it is difficult to identify the savings from a merger but relatively easy to identify the potential for abusive market power. When you take a three-hospital town and make it a two-hospital town it makes it that much harder to justify the merger.

QUESTION: I'd just like to ask a question so that you can clarify my ignorance. If this "monopoly" in Rockford is supposed to be bad for the buyers and is going to raise the prices and perhaps lower the quality, why in Rockford did the buyers, the major corporations in town and their employee groups, decide that the merger was a good thing to do? Now, is this because the buyers are stupid? If they had an economist there they would tell them that clearly they were dumb people and this shouldn't happen. Or, if not, and these are wise buyers, shouldn't that be the absolute definition of the appropriateness of the merger? And if the people in town want it, that's the definitive proof that it should be done.

DAVID DRANOVE: I think that's a very good question.

QUESTION: Why didn't it happen? Will somebody tell me why it didn't happen?

COMMENT: I can partially respond. In our case (Rockford-SwedishAmerican) there was not one objection to it. I shouldn't say that. There was one objection to it. It was St. Anthony's. There was some minor objection from some of the physicians. There was no objection from any business or industry.

DUNCAN NEUHAUSER: I think what you've hit are two conflicting and rather schizophrenic notions that I personally think the courts haven't begun to seriously grapple with. And that is first of all, who is the consumer? If it's the end recipients of the product, i.e., the patient, then you begin to see how some of these philosophies on the mergers and monopolies begin to interplay on the potential abuse. But if the consumer is the one who is paying for the services and directing how those services are provided through their paying status, then you have a whole different set of rules, a whole different set of notions that apply. And I don't think the courts have really begun, while they pay lip service to them, to understand that notion. The other notion is the impact on assessing injury. Justice Stevens would have us believe that with professional engineers, in the case that was discussed earlier, that the marketplace will take care of the safety feature. Because engineers, in their competitive bidding, do not want to be sued on product liability, and doctors or hospitals don't want to be sued in a malpractice context, so in their pricing structures they will reflect that. But by the same token, the court will then turn around and say, Well gee, if a thousand patients die tomorrow because the market did not eliminate that open heart surgery unit that is performing 75 procedures per year and is therefore inefficient and not up to speed and technology, then you have this conflict. I don't think the courts have caught up to where the industry is. In relationship to the dynamics, you do have this third influence, physicians who are in fact consumers. They often direct where the patient goes and what services are consumed.

COMMENT: Maybe we ought to address the question that Duncan Neuhauser cross-raised in this conversation about whether or not Blue Cross could selectively contract for open heart surgery. They said that the antitrust laws would prohibit that, but I think they would not. Maybe somebody else has a different view, but in fact I think Blue Cross hides behind arguments of that kind rather than being sincere in their desire in engaging selective contracting.

GARY MECKLENBURG: In a highly technical symposium like today's, I would like to remind us that despite the complications of our legal and regulatory environment, we must try to keep the health of the public as our top priority. I think that's an important concept to be included someplace in the proceedings of this symposium. Competition is fine. Regulation is fine. Making money can be fine. But the reason that the healthcare system exists, if I remember my medical sociology from Odin, is to provide necessary care and services to the population. Hopefully, behind all of this discussion is the belief that we must do the best we can for the American public in terms of meeting their health care needs.

## INTRODUCTION OF THE MICHAEL M. DAVIS LECTURE

RONALD ANDERSEN: We don't usually introduce the introducer for the Michael M. Davis Lecture, however, this is a special year for Odin Anderson that I do want to acknowledge. Odin served as research director, and later, after George Bugbee's retirement, as director of both CHAS and the Graduate Program in Healthcare Administration, until his formal retirement in 1980. To our benefit for the last ten years, Odin has continued to play an active teaching and research role as Professor Emeritus in CHAS, while at the same time serving as a Professor of Sociology at the University of Wisconsin. With the conclusion of this academic year, Odin is resigning his position in our program in CHAS. Wisconsin is fortunate, as it appears he will continue his work there indefinitely. Odin Anderson's extensive research and writings in the organization and financing of health services, comparative health systems, and health policy have set the standards in our field. He has been responsible for the research agenda of CHAS, and indeed has developed the programs for many of these symposia. He has always been instrumental in the selection of the Michael M. Davis Lecturer. Odin, we hope that your resignation at Chicago will not end your contributions or your presence at CHAS.

ODIN ANDERSON: Well, it's been my privilege to help select the Michael M. Davis Lecturers and to introduce the lecturers, but over the years I've been noticing that there's a higher and higher proportion of people who attend this symposia who don't know who Michael M. Davis was. So I want to tell those who don't know Michael M. Davis, and refresh the memory of those who don't remember. This is my way of perpetuating an institutional memory, which I think we all need in order to have some continuity in our lives and not forget the past and think only of the future—which according to this morning is quite uncertain for everybody.

Michael M. Davis was a very important person in the debate and study of medical care and health insurance, whether voluntary or governmental, particularly from 1916 on. He was born in 1879 and died in 1971 at the age of 92. He was active right up to his death, and he has been one of my models. He was a very bubbling person. When George Bugbee and I came here in 1962, friends and admirers of Michael M. Davis wanted to set up the Michael M. Davis Lecture Fund. Mike established the health service program in 1934. I wish I had the time to tell you about the story behind that within the University of Chicago, but it is of interest to note that he went first to the medical school and wanted to base it there, but he didn't get enough support. Only a couple of mavericks in the medical school were in favor of health service administration and would be willing base it in the medical complex. So he went to the School of Business. He was a very pragmatic person. He didn't give a hoot where it was as long as he had a base to work from. So he got it established in 1934 with about nine students to begin with. Since that time there's been a whole series of directors, including even me, and now Ronald Andersen.

The lecture series was started in 1963. The first lecturer was Michael M. Davis, and he gave a very spirited lecture at the age of 84. It was a very touching experience. He got his Ph.D. in Sociology in 1906 at Columbia University. After 1934 he was working with the Rosenwald Foundation. The Rosenwald Foundation was then liquidated, and Michael

M. Davis was given \$100,000 to do with as he pleased, as long as he was in the health field. This was in the 1930s. And Rufus Rorem got \$100,000 to do with as he pleased, as long as it was in the health field. From the same source of funds Michael Davis set up a Committee on Research and Economics, to promote government health insurance. And Rufus Rorem began to work on the possibility of having voluntary and private insurance as the main vehicle, at least for most people. They had been working together. In fact, Michael hired Rufus, and he wrote one of the classics on hospital capital accounting with Michael Davis which is still worth reading.

Now I will introduce Clark Havighurst, William Neal Reynolds Professor of Law from Duke University with a short biographical sketch, our Michael M. Davis Lecturer for 1990.

Clark C. Havighurst teaches courses in antitrust law, economic regulation, and healthcare law and policy at Duke University School of Law. His scholarly writings include articles on most phases of regulation in the health services industry, the role of competition in the finance and delivery of healthcare, medical malpractice, and a wide range of antitrust issues arising in the healthcare field. His law school casebook entitled *Health Law and Policy: Readings, Notes and Questions*, was published by The Foundation Press in 1988. In 1982, he published a major study of economic regulations and healthcare entitled *Deregulating the Health Care Industry* by Ballinger Publisher. A member of the Institute of Medicine of the National Academy of Sciences, Professor Havighurst is also an adjunct scholar of the American Enterprise Institute and has served as a consultant and advisor on health policy for the Federal Trade Commission. He is currently chairman of the executive and management committees of the Journal of Health Politics, Policy and Law. In 1988 and 1989 he served as the executive director of the Private Adjudication Center, Inc., an affiliate of the Duke Law School, specializing in alternative dispute resolution. While on sabbatical leave from Duke University in 1989 and 1990, he is located at Epstein, Becker and Green in Washington, D.C. Professor Havighurst is known as a leading advocate of policies that would rely less on government and more on competition and consumer choice to guide the healthcare industries' development.

# THE ANTITRUST CHALLENGE TO THE PROFESSIONAL PARADIGM OF MEDICAL CARE

CLARK C. HAVIGHURST:

## INTRODUCTION

The subject of this conference—the enforcement of the antitrust laws against health care providers—has certainly been one of the big stories in the health care industry in the last decade and a half. I hope that I will be forgiven for observing, however, that the institution that is hosting us today bears some indirect responsibility for the extra attention that health care providers have received from antitrust enforcers and plaintiffs' lawyers in recent years. The University of Chicago is, after all, the spiritual home of the revisionist school of antitrust economics that was in the process of narrowing the scope of modern antitrust law just as the health care industry was opening up as a fertile new field for antitrust litigation. Perhaps if the antitrust industry had not been suffering from acute overcapacity brought on by "Chicago School" antitrust analysis when the health care target of opportunity came into view, the antitrust revolution in health care would not have been as sudden or as far-reaching as it turned out to be.

In any event, what I want to explore in this lecture is some of the deeper meaning of the antitrust revolution for the medical profession and its institutions.

### I. The Policy Significance of Bringing Antitrust Law to Bear on Health Services

The sudden application of antitrust law to health care in the late 1970s had far-reaching implications for the course of national health policy. In the early 1970s, health policy makers faced only two basic alternatives: Either the medical profession would retain its customary responsibility for the operation of a mixed public/private health care system, or government would assume primary responsibility for the system—either as a regulator or as the sole payer for medical care. The third broad policy option—reliance on market forces and consumer choice to guide the health care industry—was a nonstarter in the debates of that era. One reason why the market option was neglected was the common belief that competition was unworkable, due in large measure to the tendency of physicians to act in concert and to mount massive collective resistance to any private-sector initiatives they did not like. In the absence of antitrust enforcement against physicians, the strategy of relying on market forces struck nearly everyone as a bit naive.

All that changed when the Supreme Court decided the *Goldfarb* case—*Goldfarb v. Virginia State Bar*—in 1975. Although that case involved directly only the legal profession, the Court's decision that the so-called "learned professions" are not implicitly exempt from antitrust laws had the effect of abruptly altering substantive public policy toward the health care industry. Whereas the implicit premise of previous policy had been that competition could have no place in the health care sector, *Goldfarb* suddenly made competition mandatory, at least in the sense that restraints of trade and monopolization were prohibited.

That overnight change in substantive policy in turn significantly altered the dynamics of the industry with which health policy makers had to contend.

Even more importantly, the new availability of antitrust law to police competition in the health care field broadened the policy debate. Thus, when the Federal Trade Commission (FTC) launched its antitrust initiatives in health care in the late 1970s, it finally became credible to build future policy on the assumption that competition could operate in the industry. In 1979, Congress went rather far toward adopting the neglected third option in health policy by defeating the Carter administration's plan to regulate all hospital revenues, by inserting language favorable to competition in the health planning amendments of that year, and by seriously considering a spate of so-called "procompetition" bills. Intensified antitrust enforcement was an essential prerequisite of the policy shift toward relying primarily on the market to allocate private resources to medical care and concentrating on prudent purchasing by government in the private marketplace to provide for public beneficiaries. The Reagan administration, when it came to power, subscribed wholeheartedly to this policy approach.

In this lecture, I wish to consider whether society has done all that it can do in enforcing the antitrust laws to realize the ideal of a competitive market that allocates resources to health care in accordance with consumer preferences. I will pose the challenge as being broader than just to stop physicians from agreeing not to compete in certain ways and from boycotting payers or others who act in ways they do not like. To my mind, the task of antitrust law is to substitute a whole new way of thinking for the traditional professional model of medical care, which I shall call the professional "paradigm." After describing this paradigm, I will first discuss old business to show how far we have come in challenging it. I will then take up unfinished business, suggesting that there are several areas where the old paradigm of medical care still operates to blur antitrust analysis, with adverse effects on consumer welfare.

## **II. The Traditional Professional Paradigm of Medical Decision Making**

The medical profession has long maintained that medical care is not a commodity, that its content should be determined by science and not economics, and that, because consumers are ignorant of medicine's technical mysteries, decisions should be entrusted exclusively to physicians. One corollary of these nonmarket tenets is that individual physicians and the profession as a whole have heavy ethical obligations; although generally unassailable, this proposition serves to legitimize the assumption of dominant decision making responsibility by the suppliers of medical services. The disenfranchisement of consumers is also facilitated by the paradigm's insistence that medical care should be evaluated and distributed solely on the basis of safety, efficacy, and patient need; in order that cost considerations and ability to pay will not influence treatment, the paradigm dictates arrangements under which patient preferences are consulted only after price tags have, for the most part, been removed. The paradigm also denies a legitimate role in decision making to corporate intermediaries, even though a corporation might employ technically competent professionals as decision makers and might be fully accountable to consumers in the marketplace. Because the professional paradigm of how and on what basis societal choices concerning medical care should be made was so clearly at odds with the market paradigm



underlying antitrust law, it should have been clear that the *Goldfarb* decision, in undercutting the elite status of the "learned professions," exposed physicians to, among other things, a severe culture shock.

The medical profession's paradigm of the medical care enterprise has long enjoyed a high degree of acceptance by the larger society. Although this acceptance was always more *de facto* than *de jure*, the legal system did embrace the paradigm in a number of crucial respects. Professional licensure set physicians apart and gave them—more or less explicitly, depending upon the state—the prime responsibility for collectively regulating their own performance. The regulatory system also accepted organized medicine's assumption of responsibility for determining how physicians should be trained and how medical specialties should be structured. Many courts inferred from licensure laws that only individuals, and not corporations, could sell professional services and determine the scope of services provided. Because consumers were thus prevented from holding physicians accountable through various corporate agents, state regulation and professional controls became the public's main line of defense against bad practice and high costs. Courts administering the law of medical malpractice looked to customary medical practice to ascertain the legal standard of care—not because medical custom was the resultant of efficient market forces, but because physicians, as ethical professionals, were presumed generally to know and to do what was socially appropriate. In all these respects, the medical profession itself provided the benchmarks for the legal system and public policy to use in judging professional conduct. In accord with the professional paradigm, the supply side of the market rather than the demand side—that is, consumer choice—dictated the nature and configuration of the services provided.

Antitrust law itself embraced the professional paradigm of medical care for a long time by generally ignoring the "learned professions" and inviting the inference that they might be exempt. One theory—the currency of which was surprising in light of the lack of legal precedent of it—was that physicians were engaged in something more exalted than "trade or commerce" (the statutory terms) and were therefore beyond the reach of the Sherman Act. There were also hints that, even if the antitrust statutes applied, only special, softer rules would be appropriate for physicians. The most famous such hint was the Supreme Court's dictum in a 1952 case involving the Oregon State Medical Society that "forms of competition usual in the business world may be demoralizing to the ethical standards of a profession."

Not every antitrust authority suffered from illusions about the medical profession, however, as demonstrated by the criminal convictions in the late 1930s of the AMA and the Medical Society of the District of Columbia, for attempting to destroy an early HMO. Thurman Arnold, the iconoclastic head of the Justice Department's Antitrust Division when it brought the case, subsequently opined that "John L. Lewis and Dr Fishbein (the dominant figure in the AMA) are brothers under the skin." Nevertheless, the *AMA* case stood almost alone for many years as an aberration from the conventional view that physicians could be trusted, in the aggregate, to respond to a calling higher than narrow self-interest.

The professional paradigm was manifest even in the *Goldfarb* decision itself—specifically, in the famous footnote 17, which said that "the public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently."

Subsequent history confirms, however, that—as was noted by someone at the time—“footnotes are for losers.” Although the Supreme Court always left open in subsequent opinions the possibility that professionalism might sometime dictate a different antitrust result, its dicta to this effect were increasingly narrow, and the Court has yet to decide a case in favor of a professional group on such a basis. If the professional paradigm still influences antitrust law, as I think it does, it is not simply because the courts have relaxed the law’s clear dictates in favor of some softer rule whenever physicians or other professionals are involved.

### III. Early Antitrust Initiatives in the Health Care Sector

Partly because of the professional paradigm, antitrust enforcers proceeded cautiously in their early encounters with the medical profession. The initial problem was to develop a sophisticated understanding of the medical marketplace itself with its many unusual features, including third-party payment, and a clear sense of how competition could and should operate—or, conversely, might be foreclosed—in such a market. It was also necessary to develop principled and factually supported responses to anticipated antitrust defenses based on the professional paradigm. The public agencies also had to be particularly sure of their political ground before moving against physicians, a powerful interest group. The profession could claim, after all, not only that its members had been unfairly surprised but also that replacing the professional paradigm with the untested, and arguably inappropriate, market paradigm was an unjustified exercise of prosecutorial discretion.

#### A. *Naked Restraints and Per Se Rules*

The earliest antitrust initiatives in the health care sector naturally addressed violations of the more obvious kinds. With respect to these so-called “naked” restraints of trade, traditional antitrust doctrine provided such a clear warrant for proceeding that the professional paradigm engendered few compunctions in the agencies and presented relatively few political problems. Choosing its targets with such thoughts in mind, the FTC directed its initial attention to provisions in the medical profession’s code of ethics that set naked limits on the forms that competition among professionals could take.

Although it would have been hard to argue on narrow consumer welfare grounds that overturning the AMA’s restrictions on professional advertising deserved the highest enforcement priority, those restrictions seemed such a clear and naked agreement in restraint of trade that the FTC deemed them, tactically, a good starting point. Nevertheless, the professional paradigm very nearly operated to frustrate the FTC’s effort, because the Supreme Court affirmed the Commission’s action by only a 4-4 vote. Presumably, four of the justices would have accepted the AMA’s claim that it was a responsible professional organization and that, because it had mended its ways once it learned that it was on shaky legal ground, the FTC’s cease and desist order against it was unnecessary. Ironically, the FTC had itself deferred to the professional paradigm by allowing the AMA and its affiliated societies to retain a role in policing “deceptive” ads. This concession to the tradition of professional self-regulation, even in the face of the respondents’ record of adamant opposition to all but the most innocuous physician advertising, demonstrated the political

difficulty, at the time, of using the free-market paradigm to trump the professional one. In the same case, the FTC also challenged other provisions in medical codes of ethics, including those condemning "contract practice"—that is, a physician's marketing of his professional services through a corporate intermediary, such as an HMO. It seems certain that the FTC's early action against the AMA assisted delivery system reform by making it clear that antitrust law would not tolerate even ethically inspired boycotts aimed at keeping physicians from participating in selective, competitive medical plans or in other innovative arrangements.

Naked restraints of trade by medical professionals, particularly boycotts, have consistently yielded to antitrust attacks, although rarely without a nod in the direction of the professional paradigm. The application of basic antitrust principles to physicians was greatly simplified by the Supreme Court's 1978 decision in *National Society of Professional Engineers*, which forcefully reiterated that antitrust law is concerned only with a practice's effects on competition, and not with whether it serves the overall public interest—which the professional paradigm can plausibly claim to do. In that case, the engineers offered their own paradigm of professionalism—really, it was more of a parody than a paradigm—in claiming that price competition for engineers' services, which they had sought to suppress, would induce customers to neglect quality, with the result that buildings, bridges, and other structures would regularly collapse. The Court ruled rather forthrightly that such defenses are not cognizable in an antitrust case. Indeed, being based as they are on another paradigm, they constitute, as the Court said, "a frontal assault on the basic policy of the Sherman Act."

Perhaps the only serious modern departure from rigorous judicial insistence that competitive effects alone, rather than alleged worthy purposes, govern antitrust cases against professionals is the peculiar rule sketched by the U.S. Court of Appeals for the Seventh Circuit in its first opinion in *Wilk v. AMA*. The court fashioned a narrow exception—too narrow, as it proved, for the AMA to slip through—for professionals' boycotts to suppress competitors if the boycotters' intention is specifically to protect their patients, and not simply to impose their view of the larger public interest. It is most unlikely that lawyers today are counseling physician clients in reliance on the *Wilk* exception—the most prominent modern dictum embracing the paradigm's view that professional organizations can safely be allowed to police the private sector with coercive sanctions as long as their motives remain strictly professional and pure.

One way in which the professional paradigm of medical care has been acknowledged, without affecting antitrust outcomes, is in the apparent reluctance of antitrust enforcers and the courts to treat naked restraints of trade by health professionals as *per se* violations, even when they fall rather easily within the categories of restraints that have been condemned in other contexts without requiring specific evidence of harmful effects. The FTC, no doubt cognizant of the political risks it would run in relying on a seemingly arbitrary legal presumption instead of proving its case in full, elected not to invoke an available *per se* rule in proceeding against the Michigan State Medical Society. The Commission had little difficulty, however, in condemning the society for initiating an egregious physician boycott of a Blue Shield plan in an effort to obtain rescission of certain cost-containment actions to which the society's members objected. The Commission and the Supreme Court both took a similar approach in *Indiana Federation of Dentists*, a case condemning an agreement by

dentists not to accommodate patients' requests that X-rays be submitted to their insurers for cost-containment purposes. Although the Supreme Court noted that "we have been slow to condemn rules adopted by professional associations as unreasonable *per se*," it gave very short shrift to all the dentists' defenses based on the professional paradigm, applying instead the market paradigm with considerable rigor. Indeed, the Court suggested, in response to the dentists' assertion that only they stood between their patients and insurers' disinterest in quality dental care, that competition could reasonably be expected to induce insurers to accommodate appropriately the inevitable trade-off between quality and cost.

The reticence of the courts and the FTC about applying *per se* rules to professional organizations need not be viewed only as a sign of their residual respect for professionalism. During the same years, the Supreme Court was receding generally from its previous willingness to fashion new *per se* rules and to give expansive interpretations to existing ones. Also during this period, the Rule of Reason became generally more flexible, allowing quick resolution of many cases once certain elements are found. Finally, the health care industry has enough unusual characteristics to warrant listening to any defendant's or respondent's claim that the facts of its case are distinguishable in some relevant way from the precedents laying down the *per se* rule. At least until substantial experience with the health care industry was gained, it made some sense for politically accountable prosecutors and careful courts to walk circumspectly.

The case that might be viewed as marking the end of the period of *per se* footing around hard-core antitrust violations by health care professionals is *Arizona v. Maricopa County Medical Society*. In that case, Justice Stevens, writing for only a four-justice majority of the Supreme Court, asserted that "the argument that the *per se* rule must be rejustified for every industry that has not been subject to significant antitrust litigation ignores the rationale for *per se* rules." But even though Justice Stevens said that it was appropriate to apply the *per se* rule against price fixing to the setting of maximum physician fees in the *Maricopa* case, he actually took significant pains in his opinion to satisfy himself that the challenged arrangements were not procompetitive in fact. Despite what he said he was doing, his actual method was to take what is sometimes called a "quick look" under the Rule of Reason. So understood, the *Maricopa* case was not as aberrational as it seems.

In general, it is unlikely that the Rule of Reason, as now administered, will saddle plaintiffs alleging hard-core antitrust violations by health care professionals with any special burdens attributable solely to the elite status of the defendants. On the other hand, the professional paradigm may continue to make criminal prosecutions of physicians for such violations relatively rare. Despite recent declarations by enforcement authorities that they are now willing to seek criminal indictments of physicians whenever they find egregious conduct, it remains to be seen whether physicians will be put in jail as often as long as asphalt contractors for similar offenses. On the other hand, professional status is no longer a certain shield. Although past hesitancy to use criminal remedies was justified by the fact that the rules changed greatly in 1975, by the need to develop bright-line rules through experience, and by the need to allow physicians time to learn what is expected of them in conforming to a new paradigm, there should be no question that criminal penalties are now sometimes appropriate. Such deterrence is needed in part because serious spontaneous restraints continue to appear in local markets, and the victims thereof—such as HMOs or

other payers—often find it difficult to bring private antitrust suits against physicians with whom they hope to continue to do business.

### *B. Physician-Controlled Financing*

Antitrust enforcers faced much more difficult problems, both analytical and political, when they began to scrutinize other forms of collaboration by competing professionals for possible antitrust violations. Under the professional paradigm, the medical profession had assumed important collective responsibilities, and its efforts to perform these affirmative obligations were likely to be seen by the agencies' political overseers in a quite different light than the profession's naked restraints, which by definition were restrictive, coercive, and lacking in any procompetitive merit. The profession's many collective activities ranged from operating plans for financing medical care to the maintenance of programs dedicated to various kinds of quality assurance. The challenge faced by antitrust enforcers was to legitimize the application of antitrust tests and the market paradigm to activities that had theretofore been taken largely for granted as inherent functions of the profession in society.

Among the FTC's first major objects of study in the health care industry were Blue Shield and similar plans for financing medical care that operated under the control of the organized medical profession. One reason why this area especially invited the agency's scrutiny was that physician domination of these plans—and hospital domination of Blue Cross plans—had frequently been questioned on nonantitrust grounds. In addition to not being entirely sacred cows, some Blue Shield plans had very large market shares, making antitrust scrutiny logical. Moreover, because any insurance plan necessarily sets the terms of compensation of providers of insured services, provider control of the plans created an element of price fixing that further legitimized the FTC's interest. The FTC's published study and enforcement policy in this area, although they never produced much litigation, hastened a trend that diminished professional dominance in health care financing.

The professional paradigm did not present much of a problem to the FTC in pursuing Blue Shield plans, confirming that price questions do not implicate the paradigm to the same degree as quality-of-care issues. On the other hand, the FTC's analysis did run into trouble with the professional paradigm when it began to call into question the legality of certain physician-controlled HMOs of the individual-practice-association variety. Some of these plans had been created—and even subsidized by the Department of Health, Education and Welfare—under the federal HMO Act of 1973. Believing that these creatures of local professionals were useful in advancing the causes of both cost containment and HMO development whether or not they were consistent with antitrust principles, some observers attempted to get the FTC to rethink its position and not to deter powerful physician groups from undertaking reforms of the approved types. The impulse to make extra room for physicians to act collectively to reform the health care system and control costs was vintage paradigm. Another manifestation of the professional paradigm that occurred at about the same time was the so-called Voluntary Effort, which the medical profession offered as its alternative to regulation but on which antitrust enforcers, to their credit, did not sign off.

In time, the antitrust enforcers evolved rough analytical tools for identifying procompetitive joint ventures in financing and delivery—especially IPAs and PPOs—and for distinguishing them from anticompetitive collaboration. Their analysis was aided by the

Supreme Court's drawing of similar distinctions in cases under section 1 of the Sherman Act during this same period. In particular, the Court's ruling in the *Maricopa County Medical Society* case was helpful in identifying those plans in which price agreements would be permitted as ancillary to an undertaking that was primarily procompetitive in its impact. The Court condemned the foundations for medical care in that case precisely because their physician members had not integrated their practices, shared no financial risks, and could demonstrate no significant efficiencies that could not be achieved through less anticompetitive arrangements.

Justice Stevens, writing for the majority in the *Maricopa County* case, substantially undercut an important feature of the professional paradigm in refusing to be impressed that the defendant physician organizations fixed only maximum fees, not minimum ones, and could therefore claim to be lowering prices rather than raising them. Although the dissenting justices took a contrary view, the Court's decision deprived organized medicine of its ultimate paradigm-based worthy-purpose defense—the claim that, although a professional group's practice might restrain competition, it advanced the larger public interest in cost containment. Those who still question the *Maricopa* holding should consider that the defendants probably sought to lower the cost of lucrative, inefficient fee-for-service insurance only in order to discourage entry by more efficient HMOs and other plans that engaged in selective contracting for physicians' services. The entry barriers facing such plans are great enough that concerted efforts by dominant fee-for-service physicians to maintain entry-limiting prices through traditional insurance can be fairly penalized as being neither in the long-run public interest nor ultimately procompetitive.

#### **IV. Unfinished Antitrust Business With Respect to Medical Care**

Once one gets beyond physician collaborations impacting directly on the price of physician services, the professional paradigm begins to loom somewhat larger as an obstacle to antitrust enforcement. The difficulties are not attributable exclusively to the professional status of the potential defendants but also reflect some failings in general antitrust analysis. I will devote the remainder of this lecture to some comments on two problem areas where I would like to see some clearer antitrust thinking about the precise role of physicians in the larger competitive system. In both areas the professional paradigm is in part to blame for the analytical failings I observe.

##### **A. *Ensuring Competition in the Production of Information***

Many activities of the organized medical profession are appropriately viewed for antitrust purposes as the collective production of information and opinion on matters important to consumers and industry participants. Accreditation of medical schools, of graduate specialty training, and of training programs for the many allied health occupations all fit this characterization. So do profession-sponsored programs for certifying medical specialists and allied health personnel and for accrediting institutional providers, such as hospitals. So also do efforts by professional organizations to assess new medical technologies, or to develop practice guidelines or "parameters" to assist physicians in treating particular medical conditions and payers in making judgments concerning what to

pay for. Finally, various peer-review activities of broad-based medical organizations may be seen in the same essential light, as the issuance of informative labels on which other, independent decision makers may or may not choose to rely.

Because of the influence of the professional paradigm, it is common to describe many of the activities I have mentioned as instances of professional "self-regulation." That terminology is misleading, however. Regulation involves not only the setting of standards but also the enforcement of those standards by coercive sanctions. In each of the areas of professional activity I have cited, the professional organization ordinarily does not impose any affirmative sanction—other than publishing in some form the fact of compliance or noncompliance—on those who do not comply with its standards. Indeed, if an organization were to organize a true boycott of those practitioners or institutions of which it did not approve, antitrust law would step in to penalize the naked restraint. But as long as the only direct consequence of noncompliance with professional standards is the publication of information to that effect, there is no obvious antitrust problem. Indeed, far from being anti-competitive, collaboration for the production of information and opinion is highly procompetitive. This is particularly true in health care markets, which are especially information-poor because of the free-rider problems associated with public goods. Under modern antitrust analysis, the law should leave competitor groups free to express their views on important issues while conceding to them no power actively to enforce those views.

When a professional group is sued for publishing information or an opinion harmful to a competitor, the professional paradigm might make things worse, not better, for the physician defendants, exposing them to greater litigation costs and liability risks than they would face under modern, Chicago School antitrust doctrine. Because the paradigm purports to assign professional organizations quasi-governmental responsibilities, their actions may seem to call for close judicial scrutiny under public-interest standards similar to those employed in reviewing actions of public agencies. In addition, because the paradigm's influence may give a professional body's pronouncement decisive weight in the marketplace or with public authorities, antitrust courts might overlook the essential difference between a result that flows solely from independent decisions—in the marketplace or in the political process—and the same result achieved by short-circuiting the market process of independent decision making. In these ways, the professional paradigm may easily cause an antitrust court to revert to the pre-Chicago School view that its task in such cases is to verify the "reasonableness" of the standards or opinions promulgated. Moreover, some professional organizations might freely accept the burden of proving reasonableness, preferring to be defended in terms of the professional paradigm rather than the market one. Thus, a professional body might wish to be portrayed in court as a responsible public servant even though it might stand a better chance of getting the case dismissed quickly by asserting that "there can be no restraint of trade without a restraint." (Judge Frank Easterbrook, formerly of the University of Chicago and now of the Seventh Circuit Court of Appeals, recently relied upon this "truism" in upholding the publication by the American Academy of Ophthalmology of its skepticism regarding radial keratotomy, a new surgical procedure.)

Although a professional organization would have greater freedom to express itself under the market paradigm than under the professional one, modern doctrine might expose it to a new and hitherto unrecognized antitrust risk. Specifically, once the professional paradigm is set aside, a professional body might face antitrust scrutiny in cooperating with

other professional organizations in efforts to arrive at common positions on debatable issues. Not only does the professional paradigm legitimize the medical profession's monopoly of information and opinion, but it invites concerted efforts to ensure that the profession speaks with one voice on important matters. Under the market paradigm, however, there is cause for concern when combinations or agreements between independent actors deny consumers the chance to hear a variety of competing views, giving them instead only a single authoritative opinion on a given subject. The professional paradigm notwithstanding, there are many reasons why the medical profession might hide elements of the truth from consumers and their agents, thus denying them the ability to make informed choices concerning the services they buy. Concerted efforts to keep consumers in ignorance can create market power and should be subject to antitrust challenge.

In my view, the antitrust laws should be used to discourage joint ventures in the production of information by professional bodies that are each capable of acting independently in the affected field. Although there are good efficiency reasons for encouraging competing physicians to collaborate in accrediting, credentialing, certification, and scientific activities, there is much less justification for allowing independent professional organizations, which may have very different views on many of the questions in issue, to combine to ensure that only one view is finally issued to the public. I see no good reason why antitrust law should not seek to preserve attainable competition in the production of commercial information and opinion just as it does in the production of more private goods. Unless one is prepared to argue that the production of such information and opinion, despite being bought and paid for by a combination of application fees, membership dues, grants, and contracts, does not constitute "trade or commerce," there is no legal justification for not subjecting agreements to suppress competition in such production to some antitrust scrutiny.

Admittedly, it would not be easy to devise antitrust standards for appraising joint ventures in accrediting, certification, credentialing, technology assessment, and the development of practice guidelines. Usually, antitrust liability turns on whether the challenged conduct creates "market power," which is typically defined as the ability to raise price profitably by reducing output in the relevant market. But, because information and opinion of the kind in question are not bought and sold for profit, such price effects would probably not be detectable and are, in any event, not the central reason for wanting to preserve competition among producers. In addition, because information and opinion are public goods that, by definition, are published only once and not consumed in use, there is no way to calculate producers' market shares—usually a crucial indicium of market power. Although there are many other sources of information to which consumers might turn, the influence of a professional organization may still be dominant, even if that dominance cannot be precisely measured.

Despite the difficulty of analyzing markets for public goods, a joint venture between two professional bodies, both of which are capable of expressing independent views and of credibly criticizing the views of others, represents an agreement to limit the diversity and output of information and opinion. Such combinations should not be permitted in the absence of either an efficiency justification—e.g., economies of scale or complementarity of inputs—or evidence that other equally reliable sources of information and opinion exist or will emerge if a vacuum is created. Even though there is no precedent for an antitrust campaign to preserve competition in the production of public goods, I believe that such a



campaign should be mounted. Consumers lose a great deal in being denied access to a full range of professional opinions on crucial matters.

Assuming that the antitrust laws apply to agreements between professional organizations that reduce competition in the production of information and opinion affecting consumer decisions concerning medical care, there are numerous potential targets for attack. The Joint Commission on Accreditation of Healthcare Organizations is the most prominent of these, but there are many others, including the American Board of Medical Specialties and the various educational accreditors. Each of these joint ventures represents an agreement to resolve any controversies that may arise by negotiation and compromise in order that consumers (and governmental purchasers of medical care) will not hear the competing viewpoints and have an opportunity to choose between them. As a result of such collaborations, there is only one authoritative manual on what constitutes a good hospital, only one set of standards for each type of educational program, and a carefully worked out set of territorial arrangements among the medical specialty boards under which each concerns itself only with its own precisely defined field of medical practice. As an example of the medical profession's desire to suppress competition in the marketplace of technical ideas, the Council of Medical Specialty Societies recently held a national conference for the sole purpose of finding ways to resolve differences between professional organizations concerning the content of practice guidelines. It was noted with evident concern in floor discussions that if inconsistent guidelines coexisted—that is, if competition were allowed—a payer might choose to be guided by the standards that promised cheaper treatment.

Obviously, the resistance to enforcing the antitrust laws in this area springs in large measure from the professional paradigm of medical decision making, under which the organized profession, rather than informed consumers and their sophisticated agents, are expected to make all the important choices. In my view, the medical profession's current monopoly over crucial information and opinion deprives consumers of important opportunities to economize in purchasing health care. If antitrust law confines itself to addressing only restraints directly affecting price and organizational matters, it is neglecting a crucial source of professional power that undermines the efficiency of the health care marketplace.

### *B. Eradicating the Paradigm in Hospitals*

The professional paradigm has also adversely affected antitrust reasoning with respect to hospital/physician relationships. Courts have generally handled cases involving hospital admitting privileges with the Joint Commission's model of the hospital exclusively in mind. Because that model was developed by a physician-dominated joint venture, it is not surprising that it embodies the paradigmatic view that all decisions relating to medical care in hospitals should be made by or in co-equal collaboration with the self-governing medical staff. There are several specific respects in which legal analysis of decision making in hospitals has been distorted by the professional paradigm, and has consequently failed to carry out the implications of the market model on which antitrust law is exclusively based.

Consider first how the so-called state-action exemption has been applied in staff privileges cases. In *Patrick v. Burget*, the Supreme Court held that the exemption was inapplicable because the State of Oregon had not provided for "active supervision" of

hospitals' actions on staff privileges, thus failing to satisfy the second prong of the two-part *Midcal Aluminum* test for implied antitrust immunity. The question I want to raise, however, has to do with the first prong of that test—the requirement that the state legislature must have "clearly articulated" an affirmative policy setting competition aside, in which event federal antitrust policy will give way to state policy as a matter of comity. In every staff-privileges case in which the state-action issue has arisen, it has been pretty much assumed that this requirement is satisfied if the state statute mandates hospital-based peer review of physicians and their practices. But I find nothing in such statutes that mandates or even expressly contemplates anything that is inconsistent with competition or federal antitrust principles. The Oregon statute, for example—which, incidentally, the Supreme Court did not construe in *Patrick* because the second-prong test was so obviously not satisfied—required merely that hospital governing bodies "be responsible for the operation of the facility, the selection of the medical staff and the quality of care rendered in the facility." In addition, it required that physicians be "organized into a medical staff in such a manner as to effectively review the professional practices of the facility. . . ."

Does such a statute compel or even contemplate anything that would violate federal antitrust law? The Eleventh Circuit, in its recent *Bolt* decision, concluded that the Florida legislature, in passing a similar statute, "could foresee that [the hospital] would rely on recommendations made by a physician's peers and refuse to deal with (i.e., boycott) that physician." Only someone thoroughly blinded by the professional paradigm would automatically equate a hospital's decision to terminate a physician's staff privileges with an anticompetitive boycott engineered by his competitors. That equation reflects a conclusive presumption that hospitals could never be expected to act independently on their own responsibility in such matters. The Eleventh Circuit's construction of the statute also reflects the view that taking a recommendation from a medical staff necessarily implies a conspiracy with the staff rather than independent action by the hospital. Not even the Joint Commission, which has always acknowledged the governing board's ultimate legal responsibility for operating the hospital, would go so far as to deny the hospital's freedom or ability to act on its own with information obtained not only from its medical staff but from the sources as well.

A sufficient predicate for state-action immunity would exist only if a state legislature took away all authority from hospital governing boards and required that physicians alone be allowed to control their competitors' access to hospital facilities. No state has done anything so radically anticompetitive, however. Indeed, all any state has done is to nudge hospitals to take more responsibility for the quality of care provided on their premises—something the legal system has encouraged since even before the *Darling* case. Only the professional paradigm has kept judges from appreciating (a) that physician domination of hospital actions affecting other physicians is not inevitable and (b) that making hospitals more responsible for overseeing staff physicians would strengthen competition, not restrain it.

Another issue relating to the internal affairs of hospitals also rewards discussion in light of the professional paradigm and its presumption that doctors, not lay persons or corporations, should be in charge of medical matters. In the *Bolt* case, the court held that the *Copperweld* principle regarding intra-enterprise conspiracies does not preclude finding a conspiracy between a hospital and its medical staff in withholding staff privileges. The

contrary argument, which finds support in the earlier case of *Weiss v. York Hospital*, is that the medical staff is merely an administrative arm of the hospital, not an independent entity capable of conspiring with it. The only strength that this latter argument has derives directly from the professional paradigm's tenet that a hospital's organized medical staff should control everything having to do with patient care in the institution.

Under the market paradigm, a typical medical staff would be regarded as an independent entity fully capable of entering into anticompetitive agreements with the hospital. Far from being an integral part of the hospital, a medical staff comprises physicians who are independent contractors, not hospital employees, and is highly insulated from accountability to the governing board. Moreover, under the Joint Commission's paradigmatic accreditation standards, medical staffs enjoy the extraordinary privilege of being self-governing. There is therefore no basis in antitrust theory for courts to insulate a medical staff's exercise of powers delegated to it by the hospital from antitrust attack.

A Chicago School antitrust analysis would view a hospital and its medical staff as engaged in a classic, highly procompetitive joint venture. Analysis should not stop with recognition of the efficiencies gained by combining the collaborators' complementary resources, however. Because such a collaboration can threaten competition by limiting the opportunities of competing physicians, the joint venture's internal operations must be subject to antitrust scrutiny to ensure that the venture's anticompetitive potential is minimized. Under the less-restrictive-alternative requirement of the antitrust Rule of Reason, a hospital's internal decision-making should be structured so that the governing board, rather than the medical staff, is truly—not just on paper—in charge. Thus, if a hospital could demonstrate that it acted independently, consulting only its own commercial interests, in making a decision to terminate an individual's staff privileges, summary judgment terminating that individual's antitrust case would be appropriate. On the other hand, if the medical staff seemed to be a co-equal party to the decision, the staff/hospital conspiracy theory would be appropriately invoked, and the hospital's action would have to be defended on its business merits—at great legal expense.

There is an excellent opportunity here for the law finally to overcome one of the last bastions of the professional paradigm. A legal regime that gave close scrutiny to physician-dominated decisions and only very limited scrutiny to hospitals' unilateral decisions would yield a market in which an aspirant for hospital privileges would have to deal, not with his horizontal competitors, but with an entity standing in a vertical market relationship to him. That kind of market relationship, while not the one contemplated in the professional paradigm, is what antitrust law should foster.

## V. Conclusion

The application of the antitrust laws to the health care industry has contributed significantly to the changes that have occurred in recent years in the way Americans regard medical care and its providers. But the professional paradigm of medical decision making has not yet been finally replaced by the market paradigm, under which the industry is driven and shaped by consumer choice rather than professional fiat. If antitrust law is to complete the intellectual revolution it has helped to begin, antitrust enforcers must think more deeply about the enterprise in which they are engaged on society's behalf. In particular, they

should recognize that the proper role of organizations of competing physicians is to advocate, but not to impose, their views and to leave to the marketplace the resolution of the many disputes and trade-offs that abound in the provision of medical services.

Perhaps we need to be more explicit about the goals of antitrust law in the health care industry. I see antitrust law as driving a peaceful revolution that is similar in many revealing respects to the revolutions that have recently occurred in central and eastern Europe. The law's immediate object in the health care industry, like the object of reform in those previously oppressed nations, should be to put an end to one-party rule by a powerful, self-appointed elite. The way to achieve this democratizing goal is by widening consumer choice, by encouraging market-driven *perestroika*, and by substituting *glasnost* for the current professional monopoly of information. Antitrust law has long embodied a paradigm of an unfettered, democratic marketplace—of ideas as well as goods and services—that could serve Americans better than the professional paradigm has done. It still remains, however, for antitrust enforcers and courts finally to discover, articulate, and give full effect to the law's implications as a charter of freedom in the health care sector of the economy.

## QUESTIONS FOR MR. HAVIGHURST

ODIN ANDERSON: It's customary to entertain a couple of questions. But I wish to make an observation that this paper should hold us for a while in thinking about this particular problem. Any questions?

QUESTION: I'm wondering, in listening to all of this that has been presented here, if there is any merit at all to the professional paradigm. If there isn't, why not simply abolish medical logic here? It seems to be that we've heard that issue completely.

CLARK HAVIGHURST: Well, this is not an attack on professionalism. The paradigm is a little bit of a distortion. I mean, it's the extrapolation of some notions that I think spring mostly from professional self-interest. Professionalism is very valuable in this society. I think that it's used to remind people that they have ethical obligations, and I think society needs some means of overseeing, of checking up on individuals. I never really thought it was very productive to attack professional licensure as such, I can imagine a world where we didn't have it, but that seems so unrealistic that I've never taken it on as a challenge. This paradigm is based on a conception about where decisions ought to be made, and who ought to dominate them, and on keeping as much of that decision making power in the hands of the profession as possible. I think one can understand a lot about this industry if you think of it in those terms. That's what I'm attempting to do here, and I think antitrust provides a fairly useful antidote, but it takes a little bit more courage of our convictions than we've yet shown to get us there.

QUESTION: Professional licensure, basically I assume most states are the same, provides that a physician can do anything for which he was trained and licensed to do. Therefore, the obstetrician can cut brains open, the pediatrician can deliver babies. You come to a certain point, whether it be through board certification standard setting and sanctioning capabilities, or hospital medical staff certification and credentialing, which is a sense of standard setting. How can you correlate the "fox-watch" and the "hen-house" concept to the need to go far beyond our traditional concepts of government licensing?

CLARK HAVIGHURST: Well, nothing I said opposes the existence of any of these programs you're talking about. I think that the staff privilege system—the careful evaluation of physicians in hospitals—is probably the greatest protection the consumer has. So far superior to licensure that it hardly bears any comparison. In other words, you have a private system. Licensure seems a really modest factor in the total equation. Specialty certification is the same way a very valuable service. I think it would be more valuable if there were more systems of certification out there, and not just one. It turns out that just about everybody now in medicine gets certified in one specialty or another. There is some move toward recertification, in an attempt to keep peoples' skills up to date, but that hasn't progressed very far, and the history is quite the opposite. The specialist certification did not really help consumers make qualitative judgments. All they knew was who had training in a field, but not who had distinguished himself in that field. I think it would be nice if we had more systems of certification. The problem there is that we have a monopoly in each area. Maybe that's too stilted in a way of stating the problem, but I think it is a helpful way, particularly in an anti-trust context of looking at it. All of these professional activities are extremely useful, but they ought not be the exclusive method of solving these problems.

Consumers ought to have more chances to hear competing points of view on all of these questions. I don't think the world would change all that dramatically all that fast. But I do think that the change would be in the right direction.

QUESTION: But let's say I am a consumer and I want my pediatrician to cut my brain open. Should I have the right to subject that hospital to forcing a decision to let my pediatrician, who does not have brain surgery capability, cut my brain open?

CLARK HAVIGHURST: I don't think I've said anything that would require the hospital to allow that type of action to occur. The hospital is quite free not to let that happen on its premises.

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