

Antitrust Enforcement in the Medical Services Industry: What Does It All Mean?

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THIS PAPER DESCRIBES AND ATTEMPTS TO EXPLAIN the recent movement to enforce the antitrust laws in the health care sector of the economy. Few would doubt that this movement has important implications, particularly for the medical profession, but not many could be very precise in stating what those implications are. Attempts by physicians, and by the publications they read, to discuss the antitrust effort have been lacking in perception though not in dire predictions (Avellone and Moore, 1978; Paxton, 1979; Relman, 1978). Many nonphysician observers, even though not particularly sympathetic to physicians' views on the various questions that have been raised by antitrust initiatives, have nevertheless been puzzled by the choice of issues and by some of the arguments advanced. They have been particularly struck by certain inconsistencies between the apparent objectives of the antitrust authorities and the premises of the current or emerging health policies administered by the Department of Health, Education, and Welfare. On the whole, outside observers have not yet been impressed by what they have seen in the antitrust effort in the health services industry.

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My thesis in this article is that antitrust enforcement in this industry makes a great deal more sense than is generally appreciated. The public's awareness of enforcement policy necessarily lags behind its development. Investigations are commenced and theories and policies are devised long before they culminate in the issuance of complaints or in other prosecutorial action, and final decisions and remedies are usually delayed further still. It is thus quite probable that the enforcement agencies are far more knowledgeable about the health care industry and its problems than appears from the public record. In addition to arguing that some sophistication has in fact been achieved, I shall show why the agency activities of which the public has been most aware are not indicative of the true directions of current enforcement policy. First, however, it may be helpful to comment briefly on some conflicts that both complicate the application of antitrust principles to the medical care industry and impair public understanding of the enforcement effort.

Bringing Antitrust Perceptions and Values to Bear on Medicine

The effort to enforce antitrust principles in health care began in earnest only after the Supreme Court decided in 1975, in the *Goldfarb* case,¹ that the "learned professions" enjoy no antitrust exemption. That decision, together with the prevalent concern about inflation in general and about health care costs in particular, led the Federal Trade Commission (FTC) to announce a commitment of resources to the industry. This commitment has now been reinforced by three successive chairmen, and seems permanent. The Justice Department's Antitrust Division, though involved less as the result of a conscious policy choice, has nevertheless been an important factor on some issues. Several state attorneys general have also begun significant antitrust activity in the health care field.²

The pre-*Goldfarb* neglect of the health sector by federal antitrust authorities resulted not only from recognition of a possible implied

¹*Goldfarb v. Virginia State Bar*, 421 U.S. 733 (1975).

²*E.g.*, *Arizona v. Maricopa County Medical Soc'y*, No. CIV-78-800-PHX-WPC (D. Ariz., June 5, 1979); *Ohio v. Ohio Medical Indem., Inc.*, Civ. No. C-2-75-473 (S.D. Ohio, filed July 9, 1975). *See also* Weller (1978).

exemption for the medical profession, but also from doubts concerning their jurisdiction,³ a significant judicial setback in the Supreme Court in 1952,⁴ and a lack of expertise about the industry and its competitive shortcomings. The resulting failure to enforce the basic rules of competitive conduct allowed the entrenchment of many anticompetitive practices and institutions, which seemed, without close antitrust scrutiny, to be not only natural but also beneficial because consistently justified in terms of quality assurance, professionalism, and traditional doctor-patient relations. These established practices and institutions are now suddenly threatened by antitrust lawyers who are skeptical of the conventional explanations and justifications offered for the absence of competition in health services.

The new antitrust effort has been met by the medical profession with the kind of displeasure usually reserved for federal regulators (and malpractice lawyers). The profession has not yet seen fit to acknowledge any distinction between antitrust enforcement and government regulation of the direct command-and-control variety, even though the former is based on a preference for free competition over government as a social control mechanism. Thus, although antitrust enforcers, as supporters of free enterprise, would seem to share doctors' preference for viewing medical care as an essentially private business, a considerable gap in understanding has yet to be bridged. It remains to be seen whether physicians will in time come to view antitrust enforcers, if not as allies in the war against regulation, then at least as the lesser of two evils—like the enemy in a two-front war to whom one would prefer to surrender because of the nature of the regime one could expect to live under in the future (Havighurst, 1979; Havighurst and Hackbarth, 1979).

A major reason given by professionals and some others for their concern about the antitrust enforcement effort in this industry is the fear

³The one great antitrust victory in the health sector before 1975, *American Medical Ass'n v. United States*, 317 U.S. 519 (1943), came in a case originating in the District of Columbia, and the interstate commerce issue loomed as a barrier to other initiatives. *E.g.*, *Elizabeth Hosp., Inc. v. Richardson*, 269 F.2d 167 (8th Cir.), *cert. denied*, 381 U.S. 884 (1959). *But see* *Hospital Building Co. v. Trustees of Rex Hosp.*, 425 U.S. 738 (1976). Other jurisdictional problems were presented by the McCarran-Ferguson Act, 15 U.S.C. §§1011–1015 (1976). *E.g.*, *Travelers Ins. Co. v. Blue Cross*, 481 F.2d 80 (3d Cir. 1973). *But see* *Royal Drug Co. v. Group Life & Health Ins. Co.*, 99 S. Ct. 1067 (1979). On the reach of the FTC Act, see note 14 and accompanying text.

⁴*United States v. Oregon State Medical Soc'y*, 343 U.S. 326 (1952). For a discussion of the case, see Goldberg and Greenberg (1977).

that antitrust doctrine and enforcement, being geared to commerce in ordinary goods and services, will prove insensitive to the special features of the medical care enterprise, particularly the quality-of-care problem and the medical profession's self-regulatory responsibilities. Although the Supreme Court has periodically held out the possibility that professional services would be treated differently from other industries, each successive statement of this possibility has been framed more narrowly than the preceding one.⁵ Moreover, the Court has yet to decide a case limiting the reach of antitrust principles into a profession's self-regulatory domain. It remains to be seen, therefore, precisely where substantive law will finally place the professions and whether medical care will be found to be entitled in any way to special treatment.

With legal doctrine an increasingly uncertain protection for professional activities, special attention focuses on the enforcement agencies and their prosecutorial discretion. Although bound in a general sense to enforce the law, the antitrust authorities would be quite free, as a practical matter, to acquiesce in the conventional view that market forces are unreliable in the health services marketplace. Accordingly, they might allocate only limited resources to promoting competition in the field and, without scrutinizing traditional patterns too closely, might bring complaints only against practices so egregiously antisocial that most professionals would themselves find them objectionable—for example, explicit boycotts aimed at suppressing health maintenance organizations (HMOs). Alternatively, the antitrust enforcers could adopt the view that since neither traditional self-regulation nor government's regulatory intervention appears to have prevented severe misallocations of resources, those mechanisms cannot be assumed to protect the public interest. With this perception, an agency might launch extensive inquiries culminating in a major campaign aimed at total reform of the industry along competitive lines. Such a campaign could include not only attacks on cherished professional and other institutions, but also lobbying for legislative and regulatory changes to improve the market's ability to function.

Realistically, the antitrust agencies have probably not had the option of leaving the health care industry entirely to its own devices or of limiting their interventions to the obvious cases. Public dissatisfaction with

⁵See *United States v. Oregon State Medical Soc'y*, 343 U.S. 326, 336 (1952); *Goldfarb v. Virginia State Bar*, 421 U.S. 733, 788 n. 17 (1975); *Bates v. State Bar of Arizona*, 433 U.S. 350, 368–370 (1977); *National Soc'y of Professional Eng'rs v. United States*, 435 U.S. 679, 696 (1978).

the industry's economic performance created a political opportunity that the FTC could not have been expected to resist. Once it was involved in a major way, moreover, the FTC and its staff could not easily ignore the numerous actionable restraints that they discovered. Similarly, the Justice Department, though probably inclined to leave health matters largely to the Department of Health, Education, and Welfare, found it difficult to look the other way when it was directly asked for advice on specific antitrust questions arising in the health care sector (*Antitrust and Trade Regulation Reporter*, 1978; Holcomb, 1978). Moreover, as the industry's favored alternative to increased government regulation increasingly appeared to be expanded voluntary efforts by industry-wide groups, the antitrust agencies were faced with having to accept, not just existing anticompetitive arrangements, but the strengthening of monopolistic institutions, in the name of reform. The clash of policies was simply too great to ignore.

Not only did the public significance and visibility of antitrust issues in health care practically compel the agencies' attention, but also the policy debate began to demand their participation. Strengthened competition in the delivery of health services has seemed to many to offer an attractive middle ground for bringing some stability to health policy and for resolving some of the tension between advocates of existing institutions, on the one hand, and enthusiasts for regulation, on the other. Thus, the trend to regulation in the health sector has itself helped to bring the antitrust agencies, as leading advocates of deregulation in the economy as a whole, into the health care sector by another route. Because antitrust law and its underlying policy of competition contemplate neither the perpetuation of the status quo nor an increase in governmental power, they have current political appeal as vehicles of major reform. This political drama seems likely to cast the antitrust agencies in larger roles than they have sought or, perhaps, can comfortably fill.

In addition to being drawn into health care issues at the "macro" level, the antitrust agencies may find it difficult to be moderate in confronting "micro" issues in specific cases. A factor weighing against their acceptance of broad powers for organized professional interests is the justified skepticism that antitrust enforcers have developed over the years toward the claim that whatever industry they are attacking is a special case. Just as the putative "learned-professions" exemption is now viewed as an elitist anachronism, the claim that profession-sponsored or

industry-sponsored groups can be trusted to face economic trade-offs—between quality and cost, for example⁶—on the consumer's behalf is not likely to be well received. Because antitrust enforcers are convinced of the democratic and economic merits of the competitive model, they will not readily accept as a general proposition the claim that market forces cannot function usefully in this industry. Moreover, the antitrust agencies have by now had the occasion to probe into some of the seamier activities of several professions, and are probably in a better position to judge the validity of at least some of the professions' claims of worthy purposes than are those who advance them.

Although antitrust prosecutors cannot be expected to defer readily to professional opinion, or to revise their abiding faith in market forces, there does exist in the enforcement agencies at the moment some uncertainty about how hard or how far to push the analogy to other industries. As yet, there have been few forays into areas where the quality of care is apt to be directly affected, and, as later discussion suggests, this hesitation is likely to continue at least until self-confidence increases and other items on the enforcement agenda have been disposed of. Moreover, antitrust enforcers will undoubtedly recognize that significant problems exist in phasing competition into a market where it has been absent. In the exercise of their prosecutorial discretion, they might well conclude that weakening certain profession-sponsored controls would be undesirable until competitive institutions are in place and can assume responsibilities on a more decentralized basis. In making such judgments, however, they will also be concerned about the possibility that the existence of such controls may have the effect, directly or indirectly, of foreclosing the desired competitive developments.

Perhaps the main source of the antitrust agencies' lack of enthusiasm for the organized profession's own efforts to police itself is the law itself, which leaves the prosecutors only limited discretion in evaluating collaborative activities among competitors. Now that the "learned-professions" exemption has been laid to rest, most of the legal questions presented by profession-sponsored reforms are relatively straightforward matters under section 1 of the Sherman Act⁷ and its prohibition of concerted trade-restraining action by competitors. Antitrust doctrine, evolved over nearly three generations, requires competition, for better or for worse,

⁶For a discussion of the importance of quality/cost trade-offs in medical care, see Havighurst and Blumstein (1975:9–38).

⁷15 U.S.C. §1 (1976).

and leaves very little room for asking whether competition is desirable in particular circumstances or is outweighed by some asserted worthy motive. That antitrust doctrine is intolerant of claimed justifications for profession-wide restraints on competition was sharply underscored in the *Professional Engineers* case decided by the Supreme Court in 1978.⁸ The Court held that a prohibition of competitive bidding, imposed by the ethical canons of a national professional society, could not be defended by alleging, truthfully or not, that the public safety would be jeopardized if engineering contracts for bridges and other major construction were awarded on the basis of cheapness. The antitrust laws thus embody a virtually conclusive presumption that, unless Congress or a state legislature has otherwise decreed, competition is the only acceptable organizing force in private commercial activity. Although the agencies' discretion allows them to choose their targets on the basis of probable gains to the public welfare, arguments to the effect that competition is undesirable as a social control mechanism in particular circumstances must, as a general rule, be addressed to Congress, which can supply such regulatory substitutes for competition as it deems necessary.

The only substantive issue in an antitrust case involving activities of a dominant professional association is whether those activities have significantly impaired the vigor of competition as a force to discipline the profession with respect to price or output or have appreciably restrained market entry or competitive innovation. By the same token, any attempted justification of self-regulatory activities must be on the basis that the competitive process is strengthened—as it would be, for example, by certification and accreditation programs giving consumers reliable information. Thus, in *Professional Engineers*, the Supreme Court stated that professional self-regulation and “[e]thical norms may serve to regulate and promote . . . competition.”⁹ Professor Philip C. Kissam, borrowing concepts from sociologist Eliot Freidson, has suggested that the courts may distinguish anticompetitive from procompetitive self-regulation on the basis of whether it affects primarily the economic organization of the profession or the technical aspects of the services provided (Kissam, 1979). Although such a line may be difficult to draw in many specific cases, it may prove helpful in identifying serious restraints and in allocating enforcement resources.

⁸National Soc’y of Professional Eng’rs v. United States, 435 U.S. 679 (1978).

⁹435 U.S. at 696.

The medical profession has understandably been frustrated by the antitrust agencies' application of the foregoing principles to its well-intentioned efforts to respond to the pressures and demands increasingly being placed on it by government and consumers. For example, the Antitrust Division refused to issue a business review letter blessing the "voluntary effort," by which the medical profession and the hospital industry proposed to bring increases in hospital costs under control without governmental interference (*Antitrust and Trade Regulation Reporter*, 1978). Similarly, the FTC staff has challenged the legality of certain profession-sponsored "individual practice associations" (IPAs), which purport to impose peer oversight on the economic performance of individual doctors (Federal Trade Commission, 1979:273–307).

Notwithstanding the profession's sense that its most sincere reform efforts are being threatened with frustration, the implications of antitrust doctrine seem clear. The dominant premise of profession-sponsored reforms in the financing and delivery of medical care—that is, in the economic organization of care—has been that the public should look to the profession rather than to individual competitive behavior for solutions to any problems that exist. Traditional antitrust doctrine, however, rejects the premise that industry-wide groups can serve as unbiased arbiters of price, quantity, quality, and other economic matters, and demands instead that decisions on such matters be made on a decentralized competitive basis, by producers whose ability to further their own interests is checked by the need to satisfy consumers. Moreover, this principle applies even when it is unclear that market forces can be immediately or totally effective. To conclude otherwise, perhaps in pursuit of some short-term expedient goal, would perpetuate the displacement of the very market forces that antitrust law presumes will yield outcomes preferable to those changes that industry interests might volunteer. As subsequent discussion shows, many of the factors that make competition an uncertain performer are also under the medical profession's control. To allow it to engage in concerted action to solve problems that are traceable in large measure to other concerted actions it has taken would be to compound the problem rather than to solve it. There thus seems to be no escaping the conclusion, implicit in *Goldfarb's* opening the activities of the organized professions to antitrust scrutiny, that profession-dominated reforms adversely affecting the competitive performance of markets for professional services are unlawful, despite their arguably benign purpose and beneficial impact.

It is apparent that antitrust enforcement represents a major threat to professional prerogatives as they have developed in medical care. The ultimate result of the enforcement effort—though not its goal, which is not yet so well formulated—could well be a major, but privately initiated, overhaul of the entire medical and health services industry, including its hospital and financing components (Havighurst and Hackbarth, 1979). Achievement of this ultimate result requires not only antitrust enforcement, but also redirection of some other public policies.¹⁰ The antitrust agencies, particularly the FTC, are developing a modest advocacy capability that may contribute to a loosening of regulatory and other restraints, and to evolution in various public programs that will make increased room for cost-conscious consumer choice and for responsive competitive developments.

Whatever the outcome, it will certainly be interesting to watch a small band of antitrust enforcers—there are probably no more than fifty full-time-equivalent lawyers in the country working on this side—take on a huge and fragmented industry in which anticompetitive traditions run deep. It will be equally interesting to see whether, how, and where competitive impulses begin to manifest themselves and whether professionalism's many positive features are adversely affected.

The Early Enforcement Initiatives

Antitrust prosecutors and economists, looking at the health services industry carefully for the first time after *Goldfarb*, quickly identified certain practices that seemed worthy of their attention. Several of these were made the subject of enforcement or other actions and are the measures with which the enforcement effort is primarily identified today. My thesis is that, in each of these early instances, the actions taken were in important respects “knee-jerk” moves by the prosecutors and not steps implementing a carefully calculated strategy, based on a full understanding of their target or their mission. This is not to say that any important mistakes were made. Indeed, all of the targets chosen appear

¹⁰See Committee on Ways and Means, et al. (1979) on the need to alter tax treatment of employer-paid health benefits in order to increase competition in the insurance industry. See Committee on Labor and Human Resources (1979:3, 53) and Committee on Interstate and Foreign Commerce (1979:51–56, 106) on the need to encourage competition through the health planning process.

to have been reasonable ones. Frequently, however, the theories employed in choosing or attacking a particular target were lacking in penetration. In other words, as law professors are wont to say of judges with whom they do not differ, the enforcement agencies were right for the wrong reasons.

Restrictions on Advertising

An early initiative was the FTC's complaint against the American Medical Association (AMA) and two Connecticut medical societies, charging unlawful restrictions on competitive advertising. This case, which also involved certain other provisions of the profession's code of ethics, was recently decided in the staff's favor by the administrative law judge,¹¹ and is now on appeal to the commission. It is likely to end up in the courts, following the FTC's final decision.

An agreement among competitors not to advertise is a clear violation of antitrust principles and was an obvious first target. Nevertheless, although the record in the AMA proceeding reveals many clear abuses, the value of the case as a contribution to major reform of the industry may at least be questioned. The issue is not whether the case was useful at all, but whether it was the best use of enforcement resources. It is not likely, for example, that, given the numerous peer pressures to which they are subject, physicians will begin advertising soon, or that, given widespread third-party payment, such advertising will contribute much to the important goal of cost containment. On the other hand, the case should have positive benefits for many alternative delivery systems, such as HMOs and the abortion clinic victimized by practices that have been challenged in a recent Florida case,¹² and for new physicians entering certain types of practice. Perhaps equally significant is the symbolic importance of the AMA case as an attack on the general problem of physicians' withholding of information valuable to consumers, the same problem that has given rise to the legal requirement of "informed consent."¹³

¹¹American Medical Ass'n, No. 9064 (FTC, Nov. 13, 1978) (initial decision).

¹²Feminist Women's Health Center, Inc. v. Mohammad, 586 F.2d 530 (5th Cir. 1978).

¹³For discussions of informed consent, see *Canterbury v. Spence*, 464 F.2d 772 (D.C.Cir. 1972) and *Yale Law Journal* (1970).

An important further question about the case's wisdom was the possible reaction of the public both to the governmental challenge to a respected profession and to the idea of physician advertising itself. Though cartoonists fantasized some distasteful possibilities, editorial comments on the initial decision have been predominantly favorable (e.g., *New York Times*, 1978). Thus, though one could not have been sure of this result, the case may have earned the Federal Trade Commission some political capital, rather than squandering it on a matter of small economic significance.

Note that much of the effort that went into trying the *AMA* case involved, not the ethical code itself, but the FTC's jurisdiction over professional societies, a matter that would have had to be litigated in any case that the FTC brought against organized medicine. The specific problem is that the FTC Act gives the agency jurisdiction over nonprofit organizations only if they are organized for the "profit of their members."¹⁴ The proof needed to establish this fact naturally antagonized the *AMA* and greatly complicated the case.

In any event, the attack on advertising restrictions has appeared to many observers to be the centerpiece of the antitrust enforcement effort in health care. It is in fact quite peripheral, more a warm-up exercise than the main event.

Price Fixing: Relative Value Studies

Antitrust enforcers, new to the health services industry, naturally began immediately to look for price-fixing activities similar to the lawyers' minimum-fee schedules that were the subject of the *Goldfarb* case. Although they found nothing directly comparable, they did identify two price-related practices that have resulted in major enforcement actions. The first of these was professional sponsorship of "relative value studies" (RVSs).¹⁵

RVSs are tables of medical procedures with numerical weights attached to indicate the proportional relation of each procedure to all other items on the list. An RVS is not a fee schedule, but can readily be turned into one simply by multiplying each item by a dollar conversion factor. Antitrust

¹⁴15 U.S.C. §44 (1976).

¹⁵For background on relative value studies, see Committee on Governmental Affairs (1979) and Havighurst and Kissam (1979:50–54).

enforcers, schooled in the use of freight books, basing points, and average cost data by industrial trade associations,¹⁶ were quick to shout “Pricing formula!” A number of RVSs have been enjoined or subjected to FTC orders on the basis of this perception.¹⁷

Investigations have revealed several instances in which the agencies’ antitrust instincts have been vindicated and their fears borne out. The ease of agreeing on a multiplier has apparently facilitated overt price fixing where otherwise it would probably have been impossible because of the large number of professional services and the illegality of explicit fee schedules. Moreover, tacit collusion and the following of price leaders are facilitated by RVSs, as is the identification and chastisement of price cutters. The RVS system, having been adopted by third-party payers, has proved manipulable in several ways that increase physicians’ incomes.

While the case against profession-sponsored RVSs is certainly strong, it is not totally satisfying. RVSs have been useful in administering third-party payment schemes and have some arguable value in cost-containment efforts. More seriously, some economic studies suggest that physicians’ fees are not uniform even where RVSs are in use (Hsiao et al., 1978:17–26). These reservations should not change the outcome, but they do suggest that a deeper analysis might be required.¹⁸ Professor Kissam and I have recently undertaken a more extensive look at RVSs, concluding that the antitrust enforcers were right but for wrong, or at least incomplete, reasons (Havighurst and Kissam, 1979). I will mention RVSs again below, indicating how, when they are viewed in a larger context, their true significance appears.

¹⁶See, e.g., *United States v. Container Corp. of America*, 393 U.S. 333 (1969); *Federal Trade Commission v. Cement Institute*, 333 U.S. 683 (1948); *Triangle Conduit and Cable Co. v. Federal Trade Commission*, 168 F.2d 175 (7th Cir. 1948), *aff’d by an equally divided Court sub nom. Clayton Mark and Co. v. Federal Trade Commission*, 336 U.S. 956 (1949).

¹⁷E.g., *American College of Obstetricians and Gynecologists and American Academy of Orthopaedic Surgeons*, 3 *Trade Reg. Rep.* (CCH) ¶21,171 (consent decree and order entered Dec. 14, 1976); *American College of Radiology*, 3 *Trade Reg. Rep.* (CCH) ¶21,236 (consent decree and order entered Mar. 1, 1977).

¹⁸In a recent case, *United States v. American Soc’y of Anesthesiologists*, *Antitrust & Trade Reg. Rep.* (BNA), July 5, 1979, at F-1 (S.D.N.Y. 1979), a federal judge rejected the government’s argument that a medical-society-sponsored RVS was a per se violation of the Sherman Act. After considering “the unique circumstances surrounding the anesthesiology profession and the adoption of the relative value guide,” the court held that the RVS withstood scrutiny under the “rule of reason.”

Price Fixing: Profession Control of Blue Shield

The antitrust authorities, looking at the medical care market for the first time, also identified another problem that they chose to treat under the heading of price fixing. This is the medical profession's direct participation in the control of most Blue Shield plans, which pay a significant percentage of all medical bills. A public investigation of the relation between organized medicine and Blue Shield was commenced in early 1976 and has only recently reached the point of a recommendation by the staff to the Federal Trade Commission (1979).

The theory underlying this investigation in its early stages was that a Blue Shield plan is a kind of joint selling agency, through which competing doctors indirectly fix prices and determine their own incomes. There was also a stated concern that a conflict of interests was involved that would disqualify physicians from participating in controlling any plan that would control their fees. These ideas have some validity, but the issue is not settled by such simplistic observations. If Blue Shield competes with other prepayment plans in a free market, it should have no market power that it can employ for the benefit of its controllers. Moreover, the conflict-of-interests notion proves too much, because it would preclude any group of doctors from organizing desirable innovations to improve the financing and delivery of medical care; the issue is quite distinct from that presented by physician ownership of pharmacies and clinical laboratories.

The FTC staff, although starting from simple price-fixing notions, has revealed in its forthcoming recommendations to the commission a somewhat greater sophistication concerning the significance of organized medicine's role in Blue Shield. I will return to this topic below.

Educational Accreditation

Another enforcement target chosen early by the FTC was the medical profession's role in the accreditation of medical schools. This issue came quickly to the agency's attention through the writings of economists Milton Friedman (1962:150–152) and Reuben Kessel (1970), who had documented the way in which the AMA gained its control early in the century and used it to limit the number and size of medical schools, thus reducing the supply and increasing the income of physicians. These observations, probably accurate as a historical matter, had become part

of economic folklore, and it was quite natural for the FTC to challenge the AMA's role in the Liaison Committee on Medical Education in a proceeding by the U.S. Office of Education to consider whether to continue that private body's recognition by the federal government as the accreditor of medical schools (Schwartz, 1977).

As it turns out, Friedman's and Kessel's concerns are considerably less relevant today than they once were. The federal government has dramatically expanded the number and size of medical schools, to the extent that the expanded "pipeline" is now widely expected to produce a surfeit of physicians in the near future (U.S. Department of Health, Education, and Welfare, 1978). It seems apparent that federal subsidies have long since deprived the medical profession of the influence it once had over the supply of physicians.¹⁹ In these circumstances, although the FTC's technical arguments, based on the established criteria of the commissioner of education, are quite sound, the staff has been hard pressed to state a very plausible policy basis for its objection to the AMA's role in medical school accreditation (Schwartz, 1977).

Again, it can be said that the FTC's action, while correct, was based on an incomplete analysis. With a colleague, I filed a statement in the Office of Education proceeding, arguing against the joint domination of medical schools by the organized profession and the medical education establishment on some rather speculative but still, I think, persuasive grounds (Havighurst and Cummins, 1977). Although I hesitate to summarize our argument here, the basic concern was over the nature of the product of the educational process—the physician. Drawing on antitrust principles such as the FTC is charged with furthering, we argued the need for greater diversity of products, and for an escape from the particular ideology of medical care that the medical schools, under substantial central control, have propagated. Our statement illustrated its thesis by pointing to the medical schools' strong emphasis on specialization and high-cost acute care, their inattention to cost-effectiveness and efficiency, and their devaluation of primary and preventive care.²⁰ The statement went so far as to suggest—without pressing it—an analogy

¹⁹See Health Professions Educational Assistance Act of 1976, Public Law No. 94-484, 90 Stat. 2243.

²⁰For a study suggesting the importance of primary-care training for a physician's style of practice, see Moore (1979).

between American medical school graduates and the auto industry's "gas guzzlers," and between foreign medical graduates, attracted to our shores in huge numbers, and such other imports as the Volkswagen "beetle." Recent changes in the orientation of medical schools reflect concessions to outside pressures and do not affect the basic conclusion.

Among the many probable consequences we perceived from the enforced sameness of medical education were, on the one hand, the strengthening of professional solidarity and of the profession's commitment to fee-for-service practice and, on the other, a restriction of both the range of consumer choice and the opportunities for the growth of alternative delivery systems. We asked, rhetorically, whether a Kaiser-Permanente medical school, aimed at training physicians for practice in an HMO-type setting, would have been easily accredited by the Liaison Committee on Medical Education. We documented our doubts on this matter by noting that Kaiser hospitals' accredited residency programs must be structured conservatively, and cannot instruct young physicians simply in accordance with the Kaiser ideal (Shearn, 1971:126).

One can understand why the FTC could not advance such sweeping arguments or even endorse them as more than interesting ideas (Schwartz, 1977). One can also sympathize with those who have to defend themselves against such charges. Newton Minow, the AMA's lawyer, responded to our arguments by demanding "facts," although the purpose of the proceeding was not to convict anyone of past abuses but to determine the prospective suitability of the existing accreditation program. Had I been given the opportunity to respond to Minow (once chairman of the Federal Communications Commission and critic of the broadcasting industry), I hope I would have had the inspiration to acknowledge that our allegation was quite a lot like calling commercial TV, as Minow once did, "a vast wasteland." The overriding point—very much involved, though necessarily implicit, in all the antitrust enforcement efforts in the medical care field—is that important values and highly personal consumer preferences are at stake, and that it is not only for economic reasons that professional groups should not be trusted to dictate the way things are or shall be.

Manpower Issues

The early effort to identify antitrust issues in the medical care sector also focused quickly on exclusionary practices in the area of health manpower.

The instinct that led the enforcement agencies into this large field was unerring, but it has proved extraordinarily difficult, given the resources available, to untangle the snarl of restrictions and anticompetitive practices that has been uncovered.

Quality-of-care issues loom large with respect to manpower issues, posing both legal and political problems for the enforcement agencies. The economic significance of such restraints is clear, but the usual antitrust argument, that consumers should be free to select lower-cost substitutes, is less confidently advanced in medical care than in most other fields. The antitrust enforcers often have reason to believe that qualitative differences are negligible, or that they are not great enough to warrant the premium prices that exist, but they would feel rather far out of their element in undertaking proof on such matters. In a few instances, they may discover direct evidence of professional disingenuousness, which supports their belief that a severe conflict of interests compromises professional judgment. Despite the strong sense that the quality-of-care claim has been misused, the agencies find it hard to know where to begin.

Much of the pattern of restrictions on manpower utilization originates in exclusionary licensing by the state, and in self-regulatory activities that have substantial recognition in legislation and in public policies toward the medical care sector. In addition to the substantial legal questions presented by federal interventions in areas traditionally regarded as the province of state law and policy,²¹ political problems are also present. The FTC's Bureau of Consumer Protection has moved to invalidate state laws restricting the advertising of eyeglasses,²² and is looking at other state regulatory programs that infringe on consumers' welfare. Nevertheless, the interest groups in the health services industry have succeeded in getting a great deal of legislative support for the tight divisions of markets and the public-private policing systems that exist, and it would require a major effort to undo that pattern. On the other hand, the FTC is in a position to take some actions in defense of competitors, such as denturists and midwives, of dominant professional groups. Such actions would illustrate the abuses that pervade manpower restrictions, both publicly and privately imposed, and might speed the pace of reform in the states.

²¹*E.g.*, *Parker v. Brown*, 317 U.S. 341 (1943).

²²43 Fed. Reg. 23992 (1978).

Among the areas where private restraints may be looked for is specialty certification of physicians. While antitrust principles support certification as an information service to consumers and others,²³ important problems exist concerning such matters as the objectivity and fairness of standards and their application; the division of markets among certified categories; abuse of the practice of grandfathering when standards are raised; and the freedom of additional certification agencies to enter the market and provide alternative sources of information. Moreover, certification may become more than merely one item of information usable for whatever it is deemed to be worth by independent decision makers. If those independent decision makers are misled or, as in the case of hospitals, dominated in important ways by certified specialists, each with a stake in promoting certification as a prerequisite to hospital use, the certification system is more restrictive than it should be. Obviously, imposing an antitrust regime on specialty certification is a major undertaking. The FTC's ongoing attempt to prevent board-certified plastic surgeons from excluding equally qualified otolaryngologists from the facial plastic-surgery market represents a useful demonstration,²⁴ but it is only one small step toward reconciling the conflicting claims of quality assurance and competition in this important area.

Hospital staff privileges are another realm in which antitrust problems arise. The hospital medical staff provides the best nexus for the control of a professional by his peers, and is thus a primary locus of anticompetitive behavior. Abuses are of course highly localized, so that they are hard to discover and prosecute, and any relief obtained has only limited immediate impact. Again, a few demonstration cases, intended to clarify rules and thus deter violations, are probably the most that can be hoped for. The only cases that have so far been pursued are those involving staff privileges for HMO physicians.²⁵

In addition to the controls exercised by physicians over each other and thus over intraprofessional competition, there is a vast body of restraints

²³*E.g.*, *Marjorie Webster Jr. College, Inc. v. Middle States Ass'n of Colleges & Secondary Schools, Inc.*, 432 F.2d 650 (D.C.Cir.), *cert. denied*, 400 U.S. 965 (1970).

²⁴For an opposing view of the FTC's case against the American Society of Plastic and Reconstructive Surgeons, see Randall (1978).

²⁵*E.g.*, *United States v. Halifax Hosp. Medical Center*, Civil No. 78-554-ORL-CIV-Y (M.D.Fla., filed Nov. 27, 1978); *Forbes Health System Medical Staff*, 3 *Trade Reg. Rep. (CCH)* ¶21,587, at 21,715 (FTC File No. 781 0009, June 27, 1979) (proposed consent order).

exercised by physicians over nonphysicians.²⁶ Here again the magnitude of the enforcement job is staggering, and is greatly complicated by the quality-of-care issues that may be raised.

The enforcement agenda in the manpower area is thus very large. With the resources available, it seems unlikely that the Federal Trade Commission, which has the greater capacity to deal with these matters, will be able to resolve the problems in any definitive way. Perhaps the most that it can do in the exercise of its prosecutorial discretion is to choose several cases as object lessons, and to issue a staff study conceptualizing the issues in these various areas and reporting the findings of its already extensive inquiries. One object should be to lay the groundwork for private litigation, which has considerable deterrent power and may in the long run be the better mechanism for bringing abuses to light.

The Current Enforcement Agenda

The foregoing enforcement initiatives lacked an overall sense of purpose. In the early days of the antitrust effort in the health services industry, the dominant fact was the large number of rather obvious violations, based on analogies to existing precedents. The prosecutors were willing to pursue some of these targets of opportunity, even though they lacked a clear understanding of competition's precise utility and appropriate form in an industry that featured both third-party payment and important quality-of-care concerns—a lack of understanding that prevailed not only in the agencies themselves but also among health economists and other experts.²⁷ Without the means to sort out the more important cases from the less important, the agencies made some debatable decisions in employing their limited enforcement resources, and revealed some minor misconceptions about the industry and its functioning. Moreover, for a long time there was no clear idea of what to do about the nonnegligible fact that providers of health care do not regularly compete on the basis

²⁶For examples of physicians restricting nonphysicians' professional opportunities, see *Levin v. Doctors Hosp., Inc.*, 223 F.Supp. 953 (D.D.C. 1964), *rev'd sub nom. Levin v. Joint Comm'n on Accreditation of Hosps.*, 354 F.2d 515 (D.C.Cir. 1965) (podiatrists' access to hospital privileges); *Higgins v. American Soc'y of Clinical Pathologists*, 51 N.J. 191, 238 A.2d 665 (1965), *appeal after remand*, 53 N.J. 547, 251 A.2d 760 (1969) (clinical laboratories' use of medical technologists); Blackstone (1977).

²⁷For a selection of views on the appropriate role for competition, see Greenberg (1978).

of price, because of the widespread availability of insurance and other third-party payment; in these circumstances, intensifying competition might have the effect of raising costs and reducing consumer welfare.

The thesis here is that sophistication, at the FTC at least, has greatly increased and that a new and substantially more focused enforcement agenda is emerging. The new focus is on improving competitive conditions in which privately initiated change can occur in the health-care financing system. There is new recognition that the traditional forms of private health-care financing are not inevitable but have been adopted, in part, in deference to the power of organized medicine (Goldberg and Greenberg, 1977; Havighurst, 1978b). Although magnitudes are impossible to estimate, it is believed that private incentives to control costs are strong enough to induce significant change in private financing techniques if innovation were not restrained by those provider interests, primarily physicians, who have a stake in keeping things as they are. The new enforcement agenda, some parts of which are being more actively pursued than others, reflects a new appraisal of the history of health-care financing and of the role of organized medicine in shaping the economics of medical practice to the profession's liking. The discussion below attempts to convey both the multifaceted nature of the profession's restraints on the development of the financing system and the consequent interrelatedness of the enforcement efforts needed to make major change possible.

Though it has great promise, the antitrust enforcement effort cannot be assured of ultimate success in reforming the health care system. The Medicare and Medicaid programs are beyond its reach, though advocacy of competition and the lifting of trade restraints inherent in government policy may in time produce changes even there, particularly if a more competitive private sector begins to show signs of outperforming government programs.²⁸ Another possible reason for doubting the success of the antitrust strategy is the questionable competitiveness of the health insurance industry, which may not change appreciably even if existing trade restraints are lifted (Havighurst, 1978b:336–343). Further, the tax laws continue to induce the purchase of excessive insurance coverage and

²⁸S. 1530, 96th Congress, 1st Session (1979), a proposal designed to increase Medicare patient enrollment in health maintenance organizations, is one example of how Congress might take advantage of private sector developments to stem the increase in the federal health budget.

to foster overly liberal claims-payment policies by threatening to tax away much of the saving from effective cost containment (Feldstein and Friedman, 1977; Steuerle and Hoffman, 1979). Moreover, employers and unions, in acting as employees' purchasing agents, have exploited the tax subsidy to cultivate their paternalistic image by giving the workers more liberal benefits and less cost control than was in their true economic interest (Enthoven, 1979). Finally, government regulation has progressed so far—and is threatening to expand even further—that everyone in the private sector has become conditioned to look primarily to government for solutions to the cost problems; regulation has so far done very little about costs (Sloan and Steinwald, 1978), though it has often harmed competition in the name of rationalization and elimination of “duplication” (Havighurst, 1978a:143–147).

Despite all these obstacles, competition still seems a viable idea. HMOs continue to demonstrate a capacity in the private sector to provide good care for less money (Luft, 1978), and an FTC staff study suggests that competition from HMOs also serves to stimulate other elements of the private sector to do more to contain costs (Federal Trade Commission, 1977). Moreover, it is being increasingly recognized that the savings effected by HMOs are not so much intrinsic to any particular form of organization as they are the result of the competition that they themselves face in setting their premiums. More and more markets are beginning to feature meaningful competition (Christianson, 1978), and private-sector change remains the one idea in health policy that has not run its course. On the contrary, it has a certain momentum behind it that antitrust enforcement and advocacy of competition by the FTC are helping to accelerate (Demkovich, 1979; Ullman, 1979).

The following discussion reviews briefly the items on the antitrust enforcement agenda as I see it. For the most part, the FTC appears to have arrived at roughly similar assessments of the importance of these matters and to have shifted its main emphasis to these areas.²⁹ Several of the items discussed below were part of the original set of initiatives, but their true significance and value have appeared only as they have come to be part of a more coherent overall strategy.

²⁹The Antitrust Division, on the other hand, appears to have made only a limited effort to define its role in the health care sector or to focus its energies, still adhering, perhaps inevitably or perhaps in deference to the FTC, to its traditionally prosecutorial, case-by-case orientation. *See generally* Weaver (1977).

Boycotts and Related Restraints

The medical profession's ultimate defensive weapon is the boycott, particularly concerted refusals to deal with financing plans that adopt cost-containment measures threatening to professional interests. Boycotts and other collective sanctions may also be aimed at physicians or other providers who cooperate with HMOs or other innovative programs. Such boycotts are per se violations of the antitrust laws, unless the striking providers are employees of the target enterprise and can claim the benefit of the antitrust exemption granted to labor organizations. Obviously, most physicians are independent entrepreneurs, so that this exemption is not available to them.³⁰

Only recently did the FTC file the first complaints in cases of this kind.³¹ Two Indiana dental associations were charged with encouraging their members not to supply X-rays to dental insurers, who required them in order to assess the appropriateness and cost-effectiveness of treatment and the extent of their liability to the patient. In announcing these complaints, the commission included with its press release a statement by the deputy director of the Bureau of Competition, declaring the staff's intent to file similar cases where cost-containment efforts by third-party payers were being frustrated by comparable professional restraints (Palmer, 1978).

The FTC and the Antitrust Division are currently investigating similar cases involving the medical profession. According to a complaint recently filed by the FTC, the Michigan State Medical Society has aggressively sought to persuade its members to withdraw as participating providers in an independent Blue Shield plan that had undertaken unwanted cost-containment initiatives.³² Once the full implications of this complaint are appreciated, it should discourage retaliatory efforts by providers and give courage to third parties who have hitherto feared to offend the doctors (Havighurst, 1978b). It would be reasonable to expect that future boycotts as egregious as the one in Michigan will be made the subject of criminal prosecutions.

³⁰See, e.g., *Columbia River Packers Ass'n v. Hinton*, 315 U.S. 143 (1942).

³¹Indiana Fed'n of Dentists, No. 9118 (FTC, filed Oct. 18, 1978); *In re Indiana Dental Ass'n, Antitrust & Trade Reg. Rep.* (BNA), Nov. 16, 1978, at A-17 (IDA agrees to FTC consent order).

³²Michigan State Medical Soc'y, No. 9129 (FTC, filed July 27, 1979).

A case recently filed in Florida by the Department of Justice charges a medical society and a hospital with anti-HMO activities.³³ The society's only overt act was a resolution opposing the HMO, and this might be defended as a mere expression of opinion were it not for the multiplicity of anti-HMO actions that followed in its wake. This case should in due course make clear that speech from professional organizations that inspires boycotts and vigilante action is unlawful. It seems extremely important that the medical profession be deprived of this weapon, once and for all. Whereas its right to protest public actions is clear, speech and other professional activities that threaten to restrain private innovation must be subject to sanction if the consumer's right to have his interest served in a competitive market is to be vindicated (Havighurst, 1978b:355–362).

Collective Bargaining

Medical organizations have long maintained the right to deal as a group with third parties and to approve or disapprove cost-containment measures. Third parties have accepted these organizations as doctors' bargaining agents for a variety of reasons, not the least of which is the fear of boycott or other unpleasantness should they refuse to do so. According to the FTC's above-mentioned complaint against the Michigan State Medical Society, the society's boycott gave rise to collective negotiations, which the FTC also seeks to enjoin. Even when negotiations have been institutionalized and friendly, and even when they may have been invited by the third party, collective bargaining by groups of competitors who are not employees entitled to form an exempt labor organization violates the law. Such bargaining stands in the way of independent initiatives that health-care financing plans might take on consumers' behalf (Havighurst, 1978b:381–383), and forecloses efforts by third parties to obtain providers' services on competitively negotiated terms. Comparable collective bargaining by hospitals with Blue Cross plans, over cost-reimbursement formulas and other price-related matters, is a deeply entrenched practice, but it is also an attractive antitrust target. An attack

³³United States v. Halifax Hosp. Medical Center, Civil No. 78-554-ORL-CIV-Y (M.D.Fla., filed Nov. 27, 1978).

on it, perhaps treating the Blue Cross plan as a coconspirator, should be only a matter of time and jurisdiction.³⁴

The enforcement authorities are aware of providers' concern about the sometimes considerable buying power of large insurers, particularly Blue Cross and Blue Shield plans. However, the recent decision by the Supreme Court in the *Royal Drug* case³⁵ assures providers a remedy if they can document a real monopsony problem, which may be difficult in the absence of restrictions on entry. In any event, the appropriate remedy would be neither to permit providers to engage in collective bargaining nor to prohibit the insurer from discriminating among providers on the basis of price. Instead, the opening of the market, particularly large employment groups, to competing plans—perhaps organized by groups of dissatisfied providers—would assure that competition protects providers as well as consumers from exploitation. The law is clear that buying power on one side of the market is no defense for a combination to increase sellers' power.³⁶

Professional Prescription of Reimbursement Methods

Closely related to its use of boycotts and collective bargaining is the medical profession's prescription of the methods by which third parties are expected to pay physicians. As earlier discussion showed, relative value studies sponsored by the profession can be objected to on several grounds, but their ultimate vice, according to the appraisal by Professor Kissam and myself (Havighurst and Kissam, 1979:58–61), is their substitution of the profession's chosen pricing formula for those that third parties might independently devise. Insurers, not eager to compete in the treacherous business of recruiting physicians individually, have been content to accept the profession's dictates. Yet competition among health plans, each seeking to obtain needed inputs at the lowest possible price, is the key to the market's functioning in health care. It will be noted that, whereas the enforcement authorities have feared the direct impact of RVSs on physician pricing, the analysis here focuses on their adverse

³⁴See note 14 *supra* and accompanying text, indicating the limited jurisdiction of the FTC over nonprofit hospitals.

³⁵*Royal Drug Co. v. Group Life & Health Ins. Co.*, 99 S.Ct. 1067 (1979).

³⁶*Cf. Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211, 214 (1951).

impact on insurer competition and on indirect rather than direct effects on price competition among physicians. Identification of these effects would probably have prevented a federal district judge from upholding the RVSs of the American Society of Anesthesiologists in a recent case.³⁷

The medical profession has used other techniques to shift the focus in paying physicians away from market-determined prices to questions of fairness. The profession approves the payment of physicians on the basis of “usual, customary, and reasonable” fees (UCR), a system that allows the physician to set his own fee in the first instance, subject to scrutiny for consistency with his own and his colleagues’ charges for similar services (Federal Trade Commission, 1979:140–143). The unarticulated premise of this approach is that the vast majority of physicians, as ethical professionals, would not charge unreasonable fees, and that, despite the weakness of competition, prevailing fees are a sound guide for third parties to employ. A fee-schedule approach seems much more likely than a UCR system, however, to keep price competition alive in the market for professional services. Not only does an explicit insurer-sponsored fee schedule allow the consumer to discover in advance whether the doctor’s fee will be covered, but it gives him a clearer incentive to shop for a lower price. By the same token, a physician considering a rise in his “usual” fee would more likely be inhibited by the prospect of losing patients under a fee schedule than he would be under a UCR system pegged (as is common) to the 90th percentile. The generally negative impact that a typical UCR system has on the price elasticity of demand for a physician’s services reveals that, despite the possibly greater range of fees under such a system, it is no more, and indeed is probably less, consistent with competition than is a fee schedule (Kallstrom, 1978), and is far from neutral in its effect on price.

The medical profession’s willingness and even desire to have fee disputes referred to peer-review panels of its own creation has also served to establish and maintain a nonmarket, nonregulatory system for setting professional fees. This system has been rather readily accepted by third parties, who have been satisfied not to compete in obtaining physicians’ services for their beneficiaries.³⁸ When one insurer suggested that such fee disputes should be resolved in the courts, professional reaction forced

³⁷United States v. American Soc’y of Anesthesiologists, *Antitrust & Trade Reg. Rep.* (BNA), July 5, 1979, at F-1 (S.D.N.Y. 1979).

³⁸For a case upholding one such peer-review arrangement, see *Pireno v. New York State Chiropractic Ass’n*, 76 Civ. 4309 (S.D.N.Y.) (March 15, 1979).

it to acquiesce in the profession's peer-review program (Goldberg and Greenberg, 1977:62–65). As noted earlier, antitrust principles dictate that decisions on such matters as fees and utilization should be made competitively and not collectively.

Restrictions on Contract Practice

The fostering of “free-choice” insurance plans has long been a key to the medical profession's maintenance of a noncompetitive market for physicians' services. As long as insurers allow patients to choose any physician, subject only to possible limits on the insurer's contribution to the fee, competition among physicians is attenuated. The only bargaining is with patients, whose information and incentives to search for a lower price are limited.

Physicians and other professionals have sought to maintain the advantageous free-choice model by preventing competitively significant distinctions from developing between some providers and others. In the *Michigan State Medical Society* complaint, mentioned earlier (note 32), the FTC staff alleges concerted action by a medical society to curb an independent Blue Shield plan's attempt to reduce payments for treatment provided by “nonparticipating” physicians—that is, those not under contract to the plan. Similarly, in the *Royal Drug* case (note 3), pharmacists who objected to the insurer's fee schedule and its discriminatory treatment of those refusing to accept it brought suit, hoping to have the court declare invalid the insurer's aggressive purchasing practices.

In addition to seeking to curb insurers' efforts to stimulate competition among professionals, the medical profession has directly sought to prevent physicians from marketing their services except under open-panel fee-for-service arrangements. Contract or salaried practice has frequently been declared to be unethical, particularly when the other party to the relation was a lay-controlled organization retailing the professional's services. The invalidation of the AMA's ethical injunctions against contract practice is a little-noticed but potentially important element of the FTC's recent *AMA* case, which also involves the advertising issue.³⁹ Thus, one more piece of the puzzle has been put in place, revealing still more of the big picture of interrelated professional restraints on the bargaining that would normally be expected to occur between

³⁹American Medical Ass'n, No. 9064 (FTC, Nov. 13, 1978) (initial decision), at 207–226.

competing physicians, on the one hand, and competing financing and delivery systems, on the other.

Control of Blue Shield

The one kind of health plan that the medical profession has always been prepared to tolerate is Blue Shield, with which physicians have routinely entered into prospective contracts, or participation agreements. Such plans all originated from professional initiatives, and most are directly or indirectly controlled by organized medicine to this day.

The FTC's investigation of this control relation has been discussed. In the context here, it can be seen that the market for health insurance is not competitive enough to allay concerns about Blue Shield's ability to serve doctors' interests at consumers' expense. Indeed, historical research by two FTC economists has revealed how, in at least one well-documented instance, a profession-sponsored Blue Shield plan served as a "fighting ship" and as a rallying point for a partial but seemingly effective boycott in stamping out aggressive cost-containment efforts by competing health plans (Goldberg and Greenberg, 1977). It seems more than likely, particularly in the light of the Ohio State Medical Society's recent total capitulation on a similar issue,⁴⁰ that the FTC will accept its staff's recommendation that it seek a significant restructuring of relationships (Federal Trade Commission, 1979:308–372). Independent or consumer-controlled Blue Shield plans, having established contractual relations with providers, should be in a position to stimulate important changes. Unlike consumers, whose alternatives to doctor-controlled Blue Shield plans have been limited by professional action, providers who are not satisfied with the terms of a consumer-controlled plan will be free to start alternative plans not under the profession's domination. Such plans would contribute greatly to the development, at long last, of a competitive market.

Other Profession-Sponsored Plans and Reforms

In the recent past, the medical profession has sometimes found it advantageous to start new financing plans of its own as its answer to new

⁴⁰See Settlement Agreement, *Ohio v. Ohio Medical Indem., Inc.*, Civ. No. C-2-75-473 (S.D. Ohio, filed March 22, 1979).

or threatened HMO development or to unacceptable practices of Blue Shield plans that may have become independent of the profession's control, or may be so heavily regulated as to be an inadequate protection of the profession's interests (Breu and Hershberger, 1979; Massachusetts Division of Insurance, 1978:36–41). The medical profession's control of these newly developed plans—"foundations for medical care" or "individual practice associations" (IPAs)—has been called into question by the FTC staff on the same basis that control of Blue Shield has been challenged (Federal Trade Commission, 1979:273–307). The staff has recommended that the commission seek to delineate, in a trade regulation rule, which kinds of plans controlled by competing physicians can be regarded as procompetitive joint ventures and which must be condemned as anticompetitive.

The probable confrontation between antitrust and profession-sponsored prepayment plans, which should include all doctor-run IPAs that enjoy the cooperation and support of local medical societies and function on an open-panel basis, will come as a shock to the medical profession, which often views these new plans as far-sighted reforms. Nevertheless, although the law allows groups of competitors to pursue business purposes by entering into joint ventures lacking market power, industry-wide associations may not normally act as an entity in business matters, particularly when prices are affected (Sullivan, 1977:205–210). Thus, as discussed earlier, the profession's efforts to deal with the economics of medical practice, even when the goal is to lower prices and to increase efficiency, cannot be expected to survive antitrust scrutiny in the long run (Havighurst, 1970:767–777).

The point here, it must be reiterated, is not at all that such profession-sponsored reforms are inspired by greed or are harmful in themselves—indeed, they very often represent sincere efforts by well-motivated professionals to move their colleagues in socially desirable directions. Instead, the antitrust laws prohibit professional sponsorship of changes in the financing of medical care, simply because it is incompatible with competition, and because, insofar as prices are affected, it "tampers with the central nervous system of the economy."⁴¹ Perhaps the key point is that profession-initiated change tends to preempt competitive initiatives by physicians and others. It seems likely that antitrust actions will soon bring to an end the medical profession's historic practice of organizing

⁴¹United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 224–225 n. 59 (1940).

occasional strategic retreats to new defensive positions whenever outside pressures become irresistible.

Summary and Conclusions

Although some temporary setbacks in the courts must be anticipated, most of the medical profession's historic defenses against effective competition should be recognized in due course as unlawful restraints of trade. The most crucial issues are those surrounding the restraints by which organized health-care providers have systematically restricted private financing plans to the passive role of third-party reimbursers of incurred costs, and prevented them from acting as purchasing agents for, or otherwise in the financial interest of, the consumer. If these complex issues are to be confronted successfully, the antitrust enforcers must become fully educated—and must in turn be able to educate the courts—to the overriding importance of vigorous competitive bargaining at the currently placid interface between competing health plans, on the one hand, and competing providers, on the other. In addition to having a possibly favorable impact on prices, such competitive bargaining should also force providers to accept meaningful oversight of their utilization practices.

The antitrust principles needed to reform the medical services industry by breaking up anticompetitive combinations of competitors are as well understood and as well established legally as any we have. However, their effective application requires a clear vision of the industry and its peculiar institutions, of the unusual forms that price competition and consumption decisions must take in the presence of third-party payment, and of the numerous subtle ways in which such competition can be and has been restrained. It remains to be seen whether such clarity of vision can be attained despite quality-of-care smokescreens, assertions of altruistic motives, and the symbolic aspects of medical care itself. The starting point for understanding must be a solid grasp of the economics of medicine, of the trade-offs that medicine involves, and of the historical forces that shaped the industry's growth during the time when antitrust policy was a negligible factor and competitive principles were consequently not enforced. In particular, the enforcement authorities and the courts must learn to view each specific restraint as part of the congeries of restraints on the financing system's development that has been described. Although individual restraints will often appear innocuous, defensible, or sanctioned by long-standing traditions of professionalism

when viewed in isolation, once their cumulative effect is appreciated the probabilistic antitrust calculus of benefits and harms should yield clear conclusions.⁴²

The full import of the antitrust attack on the medical citadel has not yet been appreciated. But, if one concludes that antitrust law can in fact be established as a meaningful check on the medical profession's power to shape its economic environment, major issues of health policy take on a different aspect. It then becomes appropriate to disregard a great deal of past experience in the market for medical services in assessing the prospects for future competitive development, and the entire drift of health policy toward increasingly heavy regulation begins to seem less inevitable. The attention of policy makers could then be more persuasively directed toward the possibility that market forces can prevent unwarranted cost-escalation and toward opportunities for deregulation through measures improving the reliability of consumer choice and private incentives as vehicles of resource allocation.⁴³ Although antitrust law can only affect the climate for privately initiated change and can

⁴²In devising remedies to restore competition in a market, antitrust courts and the FTC are not limited to prohibiting only activities that would be independent violations. This "remedial" approach cannot be adopted, however, until a specific violation has been found, and it is therefore not possible to prohibit specific actions of organized medical groups simply on the basis that such a prohibition is necessary to restore competition—even if it were felt that competition had been suppressed by some larger conspiracy. Nevertheless, the FTC and the courts are not barred from allowing perceptions of the health-care industry's noncompetitive performance and the causes thereof to shape their views of particular alleged restraints. Antitrust analysis permits the industry's overall history, its peculiarities, and its competitive deficiencies to be weighed in a calculus of benefits and harms that incorporates informed speculation, intuitive assessment, and estimated probabilities along with proven, though frequently ambiguous, facts. See, e.g., Areeda (1974:348–349, 380, 409–410). Whether the usual presumptions against private lawmaking by competitive groups should be relaxed in a given case seems to be a question that should surely turn on an appraisal of the risk of larger effects.

⁴³A striking demonstration of the change in the attitude of Congress toward the prospects of competition appears in the legislative history of the 1979 health planning amendments. In restating language from its 1974 report on the original legislation, the Senate Committee on Labor and Human Resources shifted from a statement that "the health care industry *does not respond* to classic marketplace forces" to a statement that it "*has not responded*" to such forces (emphasis added). Compare Committee on Labor and Public Welfare (1974:7878) with Committee on Labor and Human Resources (1979:52). Further, the committee declared its preference for competition as follows: "Despite the fact that the health care industry has not to date responded to classic marketplace forces, the committee believes that the planning process—at the Federal, State, and local level—should encourage competitive forces in the health services industry wherever competition and consumer choice can constructively serve to advance the purposes of quality assurance and cost effectiveness." (Committee on Labor and Human Resources, 1979:53).

neither compel such change nor eliminate all the obstacles to it, the antitrust enforcement effort to eliminate restraints in the financing and provision of medical services opens up many new possibilities. For this reason, it must be regarded as a crucially important venture with broad implications for the ultimate nature and governance of this fundamental industry.

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