

Editorial

COMMUNICATION BETWEEN THE ANTITRUST AND THE HEALTH LAW BARS: APPEALS FOR MORE EFFECTIVE DIALOGUE AND A NEW RULE OF REASON

Many observers, looking for the key to more cost-effective health care, now view deregulation of America's hospital industry—particularly when combined with the development of regionally or nationally competitive health care delivery systems—as the most viable solution to the widely perceived inefficiencies in our health care system. Deregulation, however, is not synonymous with the general elimination of legal restraints on the conduct of health care providers; it does mean, among other things, the replacement of “command-control” regulation, such as rate setting and certificate-of-need laws, with “procompetitive” regulation, such as antitrust and fair trade laws.

Such a shift in the type and thrust of regulatory mechanisms will require major intellectual and professional adjustments both by health lawyers (particularly those who are advising health care providers) and by antitrust lawyers (particularly those who are advising government officials charged with enforcing the antitrust and fair trade laws). Health care providers and their health law counsel, on the one hand, must be made aware of the potential anticompetitive consequences of provider activities. Antitrust enforcers and their antitrust counsel, on the other hand, must become knowledgeable about the special needs and problems of the health care industry and must adapt traditional antitrust theories to the unique economics of the health care delivery system, even as government strives to change the economics of that system.

I. LATENT SOURCES OF ANTITRUST LIABILITY IN THE HEALTH CARE INDUSTRY

Health lawyers who lack exposure to antitrust law may fail to see that many common professional and institutional practices, once accepted by a less competition-oriented government as methods of promoting quality health care, may now be viewed by a procompetitive government as methods of stifling the adoption of new, more competitive ways of delivering health services. Responsibility for review of the quality of health services,

for example, although theoretically shared by laypersons, often is delegated to nongovernmental review systems composed entirely of physicians, because of the difficulty laypersons have in judging the quality of health services. Such peer review, as presently structured, however, may have serious anti-competitive consequences.

Self-serving control by prominent members of a hospital's medical staff over the awarding of hospital staff privileges (both initial appointments and reappointments) provides a prominent example of peer review's anticompetitive consequences. Past legal challenges to restrictive staffing practices were based almost universally on federal or state constitutional or state common-law theories. Where these constitutional and common-law theories have failed, antitrust law, especially in regard to boycotts, has provided powerful new weapons for attacking inappropriately restrictive staffing practices.

Careful examination of other long-standing health care industry practices will disclose many more examples of inappropriate artificial restrictions on, or barriers to, provider access to health care facilities and markets. Eventually, these must fall. The Federal Trade Commission's sweeping (and successful) attack on organized medicine's right to regulate advertising by physicians is a good example of how strongly accepted "ethical" restrictions may run afoul of antitrust laws. The Federal Trade Commission's success in eliminating absolute bans on advertising by physicians indicates that medicine must accept competition, so long as it is not unfair or deceptive. Thus, long accepted views of what is ethical must be scrutinized carefully for anti-competitive consequences.

The classical model of collegial physician control over health care delivery is being replaced rapidly by a view of health care providers (institutional as well as individual) as intense competitors for a limited health care dollar. As trade regulators apply the competitive model with greater vigor, they are tending to view "ethical rules" as anticompetitive restrictions; as a result, the possibility of antitrust liability is growing exponentially.

II. DANGERS OF THE ANTITRUST "EXPLOSION"

The potential antitrust enforcement "explosion" could produce not only stress for antitrust lawyers who face exposure to health law, but also a large number of undesirable and even a few dangerous results. One such danger is that if the health and antitrust law bars fail to take timely notice of this explosion and fail to assist health care providers in reforming their anticompetitive practices, antitrust entanglements will become not only more and more common but also more and more deadly—leading, perhaps, to a paralysis of the health care delivery system and of nongovernmental health care quality review efforts.

A second danger flowing from increased antitrust enforcement in the health care arena is the increased possibility for inappropriate or overzealous application of conventional antitrust "rules" to the health care industry by antitrust attorneys and regulatory agencies unfamiliar with the unique characteristics of the health care industry. Every appropriate application of conventional antitrust principles to the health care industry must account for great dissimilarities between the present day health care sector and the traditional commercial context in which classical antitrust doctrines developed. Because of the professional, social, and economic complexities of health care delivery, physicians and hospitals cannot be held to the same procompetitive rules as the makers of cellophane and aluminum; our society is willing to tolerate the large-scale production and consumption of cut-rate aluminum and cellophane, but is unwilling to tolerate the large-scale production and consumption of substandard health care services. Additionally, application of the "rules of the marketplace" assumes that consumers can balance quality against cost, a dubious assumption in the context of health care. More to the point, no one knows whether a more competitive health care industry would better allocate health resources than the status quo; and, after all, improved resource allocation is the primary theoretical justification for antitrust enforcement. Before the courts attempt to coerce health care providers into more competitive modes of behavior, they should be reasonably certain that more competitive behavior not only is possible, but is desirable as well. Unfortunately, the majority of antitrust attorneys do not now appear to be (and probably are not) familiar enough with the unique characteristics of the health care industry to provide truly helpful advice on such complex questions to regulatory agencies or, indeed, even to health care providers themselves.

A lack of understanding of health care economics by antitrust attorneys and their clients could result, in turn, in the fragmentation and stagnation of the health planning process, a third danger. Because of long-standing financial difficulties, federally mandated appropriateness review by Health Systems Agencies (HSAs) already relies heavily upon peer evaluation of hospital services. Hampered by recent budget reductions, however, HSAs cannot even begin to review hospital services comprehensively unless the hospitals themselves assist in the implementation of review, planning, and consolidation processes. Thus, health planning cannot proceed in an orderly manner unless hospital groups can take an active leadership role in the planning process. But any attempt by hospitals to do more than merely cooperate with health planners, such as jointly planning to eliminate excess beds through voluntary consolidation of services, might expose them to antitrust suits for price-fixing or market division. The Department of Justice, for example, has expressed its concern over the anticompetitive aspects of appropriateness review-related activities carried out by some

hospitals, despite the fact that even the mere threat of federal antitrust action could irreversibly chill those hospitals' desires to cooperate voluntarily with and participate in health planning activities. In this case, it seems that the Department of Justice's antitrust lawyers may not have given due weight to the special problems of health care providers and planners.

Under a more antitrust-law-oriented health care industry regulation model, multihospital and other multiinstitutional systems and shared services organizations also will likely come under more intense scrutiny than in the past. As a result, a fourth danger of the emerging emphasis on antitrust law in health care regulation is the discouragement both of the horizontal integration of duplicative hospital services (which could help to eliminate excess bed capacity) and of the vertical integration of providers at different levels of care (which could allow hospitals to reduce unnecessary acute-care days by more efficient coordination of care with active rehabilitation facilities, nursing homes, and homes for the aged). Although the integration of potential competitors will almost always raise legitimate antitrust questions, uncritical adherence to antitrust principles—developed in other industries and in other eras—could serve merely to balkanize the hospital industry and to thwart providers' attempts to take advantage of economies of scale or of new management techniques. Such a result would breed continued economic inefficiency in this industry, in direct opposition to the overriding policy mandate behind antitrust law.

Health care industry trade associations (specialized forms of shared services organizations), too, will be under even more intense scrutiny under an antitrust-oriented model. The AMA, for example, has already lost one round in its battles with the Federal Trade Commission, and it seems likely that there will be more such battles in the years to come. It won't be long before health care industry trade associations of all types will likely be forced to justify their activities either in terms of economic efficiency or of quality assurance in order to avoid the sting of antitrust enforcement. The fifth danger of increased antitrust regulation in the health care industry is that these trade associations will cease to perform their many valuable activities because of their fear of antitrust liability.

III. HEALTH-RELATED ANTITRUST LAW AND THE COURTS

A sixth danger of increased reliance upon health care industry antitrust regulation is that increased health-care-related antitrust suits might get the courts in over their heads by leading them into a vast and unknown territory without providing them with maps either to return from that wilderness or to avoid the dangers of misapplied and inappropriate antitrust regulation. Antitrust law, it should be remembered, is a form of economic regulation carried out by the courts. Until some fundamental questions of

policy and economics have been answered by the executive and the legislative branches of government, however, the courts should be quite reluctant to take any firm steps toward restructuring the health care industry along more traditional competitive lines. We cannot expect the courts to become experts in health care regulation through the infrequent and irregular medium of antitrust suits.

This sixth danger is particularly strong because the key antitrust statutes insufficiently specify prohibited forms of trade restraint. Instead, they specify only general mandates to the courts to ban “restraints of trade” and “unfair trade practices.” Enforcement of these statutes is, in many ways, similar to the application of provisions of the Constitution—both require the courts to grapple with major social policy issues and vague questions of legislative fact. Given the inherent open-endedness of antitrust analysis, courts applying antitrust law will, in almost every instance, be faced with crucial questions of policy and fact, the resolution of which could change the face of America’s health care delivery system for years to come. A current prominent example of how far-reaching nearly every health-related antitrust suit is likely to be is the case of *Arizona v. Maricopa County Medical Society*, for which the United States Supreme Court recently granted a writ of certiorari.¹ The *Maricopa* case probably will result in a ruling by the Court on the applicability of strict “per se” rules of antitrust liability to physician fee schedules utilized by foundations for medical care, a form of prepaid medical practice. This case undoubtedly will result in a landmark ruling in health and antitrust law, as it will provide the first opportunity for the Court to rule on the merits of a health-related antitrust claim in some time. The unique economic structure of the health care industry may require the Supreme Court to fashion a special “rule of reason” for use in resolving such health-related antitrust law problems—a rule that accounts not only for the often counterintuitive economic aspects of health care delivery, but also for the strong societal needs for high levels of quality and of availability of vital health services. In handling such cases, the courts ultimately will be compelled to rely on members of the antitrust and health law bars to marshal the facts and the legal analysis necessary to illuminate this area for them.

IV. THE NEED FOR A NATIONAL HEALTH CARE REGULATORY POLICY REVIEW

In order to reduce or to avoid the six antitrust-related dangers outlined above (and such other relevant dangers that undoubtedly will arise), we call upon the health and antitrust bars to begin now a long-term dialogue

¹ [1980-1] TRADE CASES (CCH) ¶ 63,239 (Mar. 20, 1980), as corrected, ¶ 63,573 (9th Cir. Apr. 26, 1980), cert. granted, 48 U.S.L.W. 2665 (Mar. 9, 1981).

with us and with one another in order to create a more constructive exchange of ideas on the appropriate role of antitrust law in regulating the health care industry. More specifically, we propose that a thorough discussion of the proper role of antitrust regulation is a vital component of a long-needed, serious national health care regulatory policy review. Full discussion of this matter will help us to determine the appropriate consumers' role in a more competitive health care system, the real value of interhospital competition, as opposed to cooperation, and the appropriate role of third- and fourth-party financing mechanisms in structuring a more competitive health care environment. Accordingly, we ask for your written responses to these issues, as well as to the following more general economic questions, in the hope that a national health care regulatory policy review might begin, albeit modestly, on these pages:

1. What is the effect of competition, or the lack of competition, on the accessibility of health care services, especially for the poor?

2. What is the effect of competition, or the lack of competition, on the quality of health care services?

3. What is the effect of competition, or the lack of competition, on the total cost of health care services, and on the distribution of the cost of health care services?

These issues and questions illustrate but a few of the concerns that must be addressed if comprehensive procompetitive trade regulation is to be applied sensibly to health care providers. We hope that Professor Kissam's excellent Article in this edition of the *Journal* on the antitrust aspects of medical credentialing will set an example encouraging the antitrust and health law bars to begin a more effective dialogue—to help answer these and other relevant questions. This attempt to create a foundation for a new antitrust policy—a policy based upon a new rule of reason keyed to more rational regulation of the American health care system—will be well worth the effort.

John A. Norris, J.D., M.B.A.
Editor-in-Chief

David S. Szabo, J.D.
Health lawyer practicing with Norris & Norris, P.C., Boston, Massachusetts