

Why Competition Law Matters To Health Care Quality

Competition law is a bellwether for changes in the way health care quality has been understood over the years.

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ABSTRACT: Competition law (encompassing both antitrust and consumer protection) is the forgotten stepchild of health care quality. This paper introduces readers to competition law and policy, describes its institutional features and analytic framework, surveys the ways in which competition law has influenced quality-based competition, and outlines some areas in need of further development. Competition law protects the competitive process—not individual competitors. It guides the structural features of the health care system and the conduct of providers as they navigate it. Competition law does not privilege quality over other competitive goals but honors consumers' preferences with respect to trade-offs among quality, price, and other attributes of goods and services.

THE FEDERAL HMO ACT IN 1973 introduced the principle of competition to the national health policy debate. Two years later the U.S. Supreme Court ruled in *Goldfarb v. Virginia State Bar* that the professions were subject to the same rules of competition—the federal antitrust laws—as were other trades and businesses.¹ Health policy has not followed a linear path since those watershed events. Nonetheless, competition has become the dominant U.S. paradigm for financing and delivering health care, and medical markets have been protected at each step of their advance by the laws governing competition.

Yet competition law has long been the forgotten stepchild of health care quality. Two recent reports from the Institute of Medicine (IOM) emphasize the point. Quality of care, framed dramatically as patient safety, burst onto the national health policy agenda in 1999 with the publication of *To Err Is Human*.² The IOM's subsequent report, *Crossing the Quality Chasm*, emphasized the importance of economic incentives and market forces in preventing errors and improving quality.³ Both reports analyzed the impact of law on quality of care, focusing mainly on the relationship between malpractice liability and providers' ability and willingness to report errors and engage in quality improvement activities.

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The IOM reports did not even mention competition law (commonly but incompletely known as antitrust law), but the success or failure of the ambitious goals set forth in these reports is likely to depend on how thoughtfully and thoroughly competition law is designed and enforced. Competition law affects quality of care by influencing the conduct of providers and the institutional and structural arrangements through which health care is financed and delivered.

This paper introduces competition law and policy, outlines its institutional features and analytic framework, surveys the ways in which it has affected quality-based competition in health care, and suggests areas for further development.

What Is Competition Law?

Competition law and policy encompass two discrete bodies of doctrine: anti-trust and consumer protection. Economic analysis lies at the heart of competition law. Its core assumption is that competitive markets are efficient. In an efficient market, sellers produce the goods and services that buyers desire in the least costly manner, prices approximate marginal costs, and resources are allocated to their most valued ends. Competition is primarily price-driven in some markets; in others it occurs along both price and nonprice dimensions (such as quality). When health care markets operate properly, competition will determine the appropriate prices for medical services, the appropriate organizational forms for health care financing and delivery, and the appropriate range and availability of cost/quality/service trade-offs.

■ **Protection of consumers.** Private markets do not always operate properly. Supposed competitors have been known to collude on price, divide customers and markets, and refuse to deal except on specified terms. Monopolists have an incentive to restrict output and charge higher prices than would otherwise be the case. Dishonest sellers misrepresent the quality of their goods and services. Competition law protects consumers from conduct that is anticompetitive, deceptive, or unfair. It differentiates between flatly improper conduct for which no defense is acceptable (*per se* violations) and conduct that is lawful if the evidence shows that it actually improves competition (*rule-of-reason* analysis).

■ **Protection of competition.** Importantly, competition law and policy focus on protecting competition and the competitive process—not competitors. Thus, a provider who is put out of business through the ordinary operation of market forces does not have a cause of action under the antitrust laws, no matter how sincerely he believes that his goods and services were superior to those available elsewhere or that his customers were misguided in purchasing from his more successful competitors. Such matters are left to the impersonal workings of the marketplace and not the second-guessing of judges and juries.

Policy analysts who dislike the role of market forces in health care frequently argue that some or all of these consequences are socially undesirable. Competition law and policy proceed from a different premise: not whether the outcomes that

result from the operation of an efficient market accord with a particular definition of optimal social policy, but whether the competitive process has been interfered with. This determination is made based on quantitative economic analysis of consumer welfare in the specific product and geographic market at issue. Indeed, the argument that competitive markets result in “undesirable” results is routinely rejected out of hand by courts deciding competition cases.

■ **Courts’ interpretations.** Competition law is cast in expansive terms, and the judiciary has had considerable freedom to elaborate its own understanding of the broad statutory language enacted by Congress. For example, Section 1 of the Sherman Act declares unlawful “every contract, combination...or conspiracy, in restraint of trade.”⁴ This sweeping language technically invalidates every contract for goods and services in the United States, since all contracts restrain trade. Not surprisingly, the Supreme Court has interpreted Section 1 to prohibit only unreasonable restraints of trade. The other antitrust statutes are similarly broad. Section 2 of the Sherman Act prohibits “monopolization” and “attempted monopolization.”⁵ Section 7 of the Clayton Act condemns mergers and acquisitions where the effect “may be substantially to lessen competition, or to tend to create a monopoly.”⁶ Section 5 of the Federal Trade Commission Act prohibits “unfair methods of competition” and “unfair or deceptive acts or practices in commerce.”⁷

■ **Antitrust enforcement.** The U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC) are the primary antitrust enforcement authorities, although state attorneys general can also bring suit. The criminal provisions of the Sherman Act, like all federal criminal laws, are enforced solely by the DOJ. The civil provisions of the Sherman and Clayton Acts also authorize suits by private parties, who can receive treble damages if successful. The FTC Act is enforced by the FTC, both administratively and through the courts. The FTC can also pursue violations of the Sherman and Clayton Acts, either directly or by declaring the conduct an “unfair method of competition.” Similar patterns prevail on the consumer protection side.

Since the early 1990s the DOJ and FTC have issued joint statements of antitrust enforcement policy for health care. The statements specify various “safety zones” (circumstances that will not provoke enforcement actions) for hospital mergers, hospital and physician joint ventures, physicians’ provision of information to purchasers, multiprovider networks, and providers’ joint purchasing arrangements.

■ **Flexibility.** Reflecting its development through selective enforcement and adjudication rather than legislation and regulatory rule making, competition law is quite flexible. Different factors are relevant depending on the geographic area, product, and type of conduct at issue. In all antitrust cases, however, the touchstone is whether “market power” is being (or likely to be) exercised. If so, prices are likely to be maintained above competitive levels, and competition along other relevant dimensions (such as quality, service, and innovation) is likely to be lessened. Similarly, in consumer protection cases, the question is whether “unfair” or “deceptive” methods of competition are being used. If they are, there is reason to believe that prices do

not reflect the quality of the goods and services being purchased.

■ **Limits and state immunity.** Competition law does have limits. Congress can exempt entire industries from the ambit of the antitrust laws, as it did with important aspects of insurance in the McCarran-Ferguson Act.⁸ Congress can also immunize particular activities, as it did with peer review conducted pursuant to the Health Care Quality Improvement Act of 1986.⁹ Similarly, the state action doctrine allows state governments to regulate the marketplace without running afoul of federal antitrust law. To qualify for state action immunity, the state must clearly articulate its purpose to supplant competition and must actively supervise the resulting regime.¹⁰ State action immunity also extends to private parties acting pursuant to the state mandate. In recent years more than twenty states have enacted laws to protect hospitals, providers, and other health-related entities from antitrust liability.¹¹

■ **Competition law and health care quality.** Competition law is a bellwether for changes in the way quality has been understood in health care. Conceptually, one can identify three phases in its development. In the first phase, which *Goldfarb* both heralded and consummated, antitrust law helped break down collective control by the medical profession over the terms of service.¹² Quality (and its price) would no longer be defined and assessed exclusively by physicians. In the second phase, courts aggressively defended price competition as a legitimate attribute of the health care system, notwithstanding quality-related arguments to the contrary. Courts also cautiously asserted a beneficial effect of competition on quality. As health care became a “big business,” these two phases were necessary to overcome physicians’ resistance to price discounting and corporate control.¹³ We are now entering a third phase, in which competition law must devise a rational framework that assesses trade-offs between price and quality, fosters innovation, and accommodates concerns (for example, access and trust) that have not historically been given much weight by antitrust enforcers.¹⁴

How Competition Law Got Involved In Quality

Throughout much of the twentieth century, health care was marked by physicians’ prerogatives, patients’ deference to physicians, and price-insensitive insurance payments. Each of these elements was explained on the grounds that health care was “special”—that the ordinary rules of market exchange simply would not work. Quality was central to this paradigm. Preemption of market forces was justified with the claim that competition would erode physicians’ ethical integrity and result in lower-quality care. Around 1980 this pattern of professional dominance broke down, and competitive forces firmly took root in health care markets. Competition continues to reshape the manner in which medicine is practiced and purchased in America, and law can take considerable credit for this transformation. Indeed, it is only a slight exaggeration to view antitrust law as the engine that powered the emergence of a competitive market in health care.¹⁵

■ **Opening the door to alternative practitioners and forms of practice.** The

initial salvos in the legal battle for health care competition focused on supply-side competition. After consolidating its political power during the early twentieth century, organized medicine waged no-holds-barred campaigns to ward off outside challenges to the autonomy of physicians and their monopoly on licensure.¹⁶ One target was prepaid group practice, an early version of the modern health maintenance organization (HMO). During World War II the DOJ brought an important criminal antitrust case against the American Medical Association (AMA) for interfering with prepaid care in Washington, D.C.¹⁷ Organized medicine also sought to destroy chiropractic treatment, through a group boycott on referrals and affiliation between chiropractors and physicians. A private antitrust case against the AMA resulted in an injunction prohibiting the AMA and state medical societies from engaging in concerted antichiropractic behavior.¹⁸ These cases were competition law's first forays into health care quality, notifying physicians that the right of professionals to practice the healing arts was to be determined through legitimate political or regulatory processes, not economic vigilantism disguised as patient protection.

■ **Overcoming quality as a trump card.** Before the mid-1970s physicians invoked quality with impunity to excuse blatant forms of anticompetitive conduct. Physicians asserted that the lay public could not reliably distinguish appropriate from substandard services, and many commentators believed that there was a “learned professions” exception to the antitrust laws. The Supreme Court dispelled this impression in *Goldfarb v. Virginia State Bar*, a case involving “ethical” prohibitions on discounted attorneys’ fees for title searches. The Supreme Court made it clear that professional conduct that interfered with normal market processes would face a heavy burden of justification and might even be unlawful per se.

Other cases confirmed and extended the reasoning of *Goldfarb*. In *Professional Engineers*, members of a professional society collectively refused to negotiate the price of construction projects until after a single firm had been selected, arguing that competitive bidding would lead buyers of engineering services to pay insufficient attention to quality and safety. In *Indiana Federation of Dentists*, the defendants collectively refused to provide dental x-rays to insurers who sought to verify the need for treatment, arguing that patients’ welfare was improved when treatment decisions were left to professional discretion.¹⁹ The Supreme Court flatly rejected both quality-based claims, reasoning that they amounted to “nothing less than a frontal assault on the basic policy of the Sherman Act.”²⁰

■ **Improving access and quality by generating price competition.** Competition law also engaged quality by addressing price. Policy analysts are used to thinking of a “three-legged stool” of health care resting on separate and distinct components: cost, quality, and access.²¹ But these legs are interconnected, and lower cost can itself enhance quality. When costs are high, people who cannot afford something find substitutes or do without. The higher the cost of health insurance, the more people are uninsured. The higher the cost of pharmaceuticals, the more people skip doses or do not fill their prescriptions. Competition law prevents providers

from collectively increasing prices above their competitive level or blocking the development of cheaper forms of health care delivery. For example, competition law has helped to ensure that generic drugs are brought to market without improper interference from branded pharmaceutical companies, and that alternative forms of health care delivery are not “frozen out” of the market by incumbent providers.²²

What Competition Law Has Accomplished

In the twenty-eight years since *Goldfarb*, thousands of antitrust suits involving the professions have been filed, most initiated by private parties. Federal and state antitrust agencies were involved in a modest number of litigated cases, but they also exerted influence through formal administrative decisions, consent orders and decrees, and business review letters and advisory opinions. The actual and deterrent effects of these efforts helped to disrupt long-standing patterns of professional dominance and moved health care closer to a competitive model. Even unsuccessful cases had an impact, because market participants could be confident that such conduct would pass antitrust muster in the future.

Litigation during this period frequently touched on quality, but quality was seldom a central concern of the parties or the courts. Four themes emerge from close analysis of the case law.²³ First, courts failed to develop specific theories of quality competition in health care, but instead followed standard economic assumptions that quality would improve in tandem with price as the medical profession's competitive stranglehold was broken. Second, courts began to identify quality with consumers' preferences as well as professional standards. Because competition law is explicitly based on a model of consumer sovereignty, it encourages consumers to treat health care like any other market, in which they insist on value for money and on the information necessary to make buying decisions. Third, courts started to look beyond physicians to other components of the health care system with the power to define and influence quality through competitive interactions. Fourth, courts began to reassess their attitudes toward quality-oriented self-regulation by the medical profession. While maintaining the position developed in *Goldfarb* and *Indiana Federation* that consumer welfare must ultimately be defined by consumers, competition law is becoming more open to collective action by health professionals so long as it is designed to remedy specific market failures.

■ **Empowering hospitals to define quality.** Perhaps the clearest effect of competition law on quality was to allow the hospital to escape its image as a “doctors' workshop” and to establish itself as an independent clinical and economic actor. Impelled primarily by Medicare cost containment in the 1980s, hospitals began to assert control over clinician staffing of certain departments (such as radiology, anesthesiology, pathology, and emergency medicine) through exclusive contracts with physician groups. Physicians who lost their affiliations often sued, claiming competitive injury. For the most part, courts were unsympathetic to physicians' complaints, holding that the hospital's competitive interest in reducing costs and assuring qual-

ity entitled it to limit physicians' access.

In other words, antitrust courts effectively analogized hospitals to producers and physicians to retailers of hospitals' services.²⁴ Drawing on experience in other industries where distributors challenged restrictions imposed by manufacturers, competition law concluded that, in part for quality reasons, interbrand competition between hospitals for patients was more beneficial to consumers than was intrabrand competition between doctors working in a single hospital.

■ **Preserving professional peer review.** Antitrust courts were similarly inhospitable to the large number of claims brought by physicians whose hospital privileges were restricted after peer review, although occasional cases with clear evidence of bad faith by rival physicians on the hospital's medical staff resulted in large damage awards. Congress immunized bona fide peer review activities from antitrust attack by passing the Health Care Quality Improvement Act of 1986, but even without the statute, judges had little difficulty distinguishing physicians' economic interests from their professional commitments to quality.

In one respect, however, staff privileges cases have had problematic effects on the legal analysis of quality-based competition. Although traditional peer review was protected, courts began using quality to remove conduct from the purview of competition law, rather than factoring quality into an overall competitive mix.

■ **Asserting choice as a competitive consideration.** Competition law also enhanced quality by maximizing choice in the marketplace.²⁵ The FTC successfully challenged professional opposition to new forms of health care delivery and financing, such as HMOs, nonphysician practitioners, hospital-sponsored clinics, and out-of-town brand-name providers.²⁶ Among the few victories won by private plaintiffs in staff-privileges litigation were cases involving demonstrably different styles of medical practice that would otherwise be unavailable to patients.²⁷

Overall, courts have been much quicker to grasp the competitive importance of assuring consumers a range of health care products and services than they have been to examine the direct effects of providers' conduct on clinical processes or outcomes.²⁸ Courts may have felt more comfortable judging dimensions of quality that did not require technical knowledge. But the recognition that consumers' definitions of quality are broader than those of professionals was itself a critical insight and ensured that consumers would have a fuller range of options than they would have had professional conceptions of quality prevailed.

■ **Limiting choice to its competitive meaning.** The flip side of addressing choice in competitive terms is rejecting it as an absolute constraint on marketplace behavior. Courts hearing health care disputes never wavered from the view that antitrust law protects the competitive process, not individual competitors. Two observations flow from this approach. First, competition law helped the health care system distance itself from physicians' traditional argument that "free choice" by physician of patient and by patient of physician was essential to quality. Instead, courts embraced the idea that choice matters to quality only insofar as consumers

value it. This approach is evident in a series of antitrust cases challenging health insurers that contracted selectively with providers. Limiting choice of physicians to enable choice among forms of insurance was considered quality enhancing and thus procompetitive. Second, by assessing limits on choice as they affect entire markets, rather than individual patients and doctors, competition law stepped away from the dyadic notion of quality that had been the centerpiece of the professional paradigm. This transformation raises the possibility of defining quality in population-based terms in future cases.

■ **Empowering purchasers to define quality.** A consequence of competition law's commitment to consumers has been its willingness to accommodate the preferences of health insurers (acting as purchasers of health care services) rather than those of physicians and hospitals (acting as sellers of health care services). In health care, the historical overhang of guild-protective behavior by physicians led courts to look elsewhere for patients' economic agents, indirectly empowering insurers and employers to articulate competitive preferences for price and quality. Although competition law imposes some restrictions on very large purchasers (monopsonists), the fact that consumer welfare is the touchstone for competitive analysis implies that buyer-initiated changes to the marketplace are generally encouraged. Courts therefore routinely excused major insurers from competitive scrutiny when they contracted selectively with health professionals or imposed onerous contractual requirements on network providers.

■ **Encouraging disclosure and preventing deception.** Information occupies a special place in the evolution of health care competition law. Long before mandatory disclosure requirements and consumer report cards became common features on the regulatory landscape, courts struck down efforts by professional associations to limit the collection and dissemination of such information. An important early case was brought by the FTC against the AMA and resulted in the AMA's being enjoined from enforcing "ethical" restrictions on advertising.²⁹ Subsequent cases followed a similar pattern, and plaintiffs alleging informational harm enjoy a much higher success rate than do those bringing any other type of health care antitrust claim.

Courts regard abundant information as an important element of quality-based competition because it enables consumers to define and exercise their preferences along many dimensions of quality. The biggest challenge for courts has been to balance the procompetitive effects of accurate information against the anti-competitive effects of false or misleading information. This tension is one way to distinguish *Indiana Federation*, which held that self-regulatory restrictions on information are unlawful, from the Supreme Court's most recent foray in medical competition, *FTC v. California Dental Association*, which upheld such restrictions. In the former case, consumers were being represented by sophisticated insurers specifically requesting evidence of medical necessity, while in the latter case, unsolicited advertising was being directed at individual patients who might be misled.

Several commentators view *California Dental* as the misguided resurrection of a

footnote to *Goldfarb* preserving anticompetitive prerogatives for the learned professions.³⁰ *California Dental* can also be interpreted simply as requiring lower courts to carefully evaluate professional self-regulation based on its actual effects in the marketplace. The Supreme Court treated the permissibility of the dental association's restrictions on advertising as an empirical question of how well the market would function with limited information, and not as a theoretical debate over whether markets or professional judgment should be controlling.³¹

What Competition Law Should Do Next

Competition law has successfully defended price competition in health care, and courts have made some progress incorporating quality as a competitive dimension. However, the recent rapid conversion of the health care system to market governance places greater demands on competition law. For market processes to result in the appropriate mix of cost, quality, and output, competition law must be proactive. In other words, quality must be fully factored into the competitive mix, allowing consumers to weigh both price and nonprice characteristics of health care. Courts have had few guideposts for this endeavor, and health care antitrust cases involving plausible assertions of quality-motivated conduct are accordingly dealt with at a high level of generality.

Developing an effective analytical framework requires reconciling opposite notions of quality. Competition law treats quality as one attribute of a good or service, which must be traded off against price and other attributes, while the medical profession has historically regarded quality as an irreducible minimum standard, to be determined by physicians without reference to cost. As one of us has previously observed, “these conflicting orientations toward quality lead in fundamentally different directions. The medical professional wants to impose professionally predetermined restrictions on market processes, while the anti-trust lawyer strives to free the market from such restrictions, with both groups asserting their positions in the name of quality.”³²

The rise and subsequent decline of managed care has not eliminated this conflict, but it has changed the landscape in important ways. First, managed care has sensitized judges to trade-offs between price and quality. *Indiana Federation* was written as if the primary reason for utilization review was the elimination of waste. A judge familiar with managed care would be more likely to perceive the review procedures as enforcing a price-quality trade-off. Second, the battle between managed care and pharmaceutical companies, played out in the market through pharmacy benefit management and direct-to-consumer drug advertising, has highlighted the importance of nonphysicians in the health care system. Third, managed care has increased judicial skepticism regarding the motives of insurance companies that claim to be agents of consumers. Courts may well have become more willing to accept the medical profession (and nonprofit hospitals) as patient representatives. Fourth, the bottom-line orientation of some managed care plans

has forced the question of whether a market model is compatible with traditional social objectives in medicine, such as compassion, charity, and trust.

■ **Treat all quality claims as empirical issues.** Courts have historically relied on presumptions and burdens of proof to handle health care antitrust cases. As noted previously, *California Dental* requires judges to decide quality cases based on objective empirical evidence. Unfortunately, statistical analysis of quality is, as yet, virtually invisible in antitrust litigation. For example, the well-established relationship between hospital volume and quality has yet to be reflected in legal analysis.

One promising sign in this regard is that the FTC recently closed an investigation in which physician collaboration resulted in a substantial degree of market concentration because the parties demonstrated dramatic objective improvements in quality of care.³³ Hospital merger cases involving quality-related scale economies represent a logical extension of this approach. Consolidation that would be problematic applying general antitrust principles might well be defensible based on verifiable improvements in clinical outcomes for patients undergoing particular procedures.

■ **Preserve technological innovation at the patent-antitrust interface.** Legal protection of innovation depends on a complex interaction between patent and antitrust law, the former granting a conditional monopoly as an incentive to future inventors, the latter attempting to confine the monopoly narrowly to benefit current consumers. Strategic behavior by patent holders can improperly enlarge the scope of patent protection. Private plaintiffs rarely pursue technology-related antitrust claims because they usually do not meet strict legal requirements regarding standing to sue and antitrust injury. Furthermore, defendants routinely argue that their conduct is shielded by the *Noerr-Pennington* doctrine, which protects “political action” such as lobbying the patent office or FDA, even if it is engaged in collectively by competitors, and even if it produces anticompetitive effects. Incentives for strategic manipulation of public processes involving patents are particularly intense because the stakes are structured in zero-sum fashion: A government decision strengthening one competitor simultaneously weakens all others. These factors make it particularly important for the DOJ and FTC to make such cases an enforcement priority, as they have done in recent years.³⁴

■ **Foster organizational and informational improvement.** The IOM’s two reports repeatedly emphasize the adverse quality implications of a fragmented health care delivery system. Competition law can help to address this problem because it encourages providers to integrate clinically and economically—at least as long as they do not monopolize a market. Section 1 of the Sherman Act prohibits agreements in restraint of trade, but intrafirm agreements do not violate this provision.³⁵ By forming a single firm, providers can simultaneously enhance quality and insulate themselves from antitrust liability.

More generally, direct economic incentives for providers to improve clinical processes are insufficient.³⁷ This “public goods” aspect of health care production

suggests that competition policy should look favorably on collective strategies for knowledge generation (figuring out the right thing to do) and dissemination (getting people to do it). The FTC and DOJ have taken a step in this direction by concluding that providers who integrate clinically by developing clinical guidelines or shared information systems may qualify for antitrust protection even though they remain economically independent.³⁸

■ **Address risk selection and insurance issues.** Insurers have historically received only modest scrutiny from antitrust enforcers, because they were generally perceived as buyers' agents, and product markets for insurance were considered so broad—encompassing all forms of health care financing rather than single categories such as HMOs—that virtually no defendant could acquire market power. Managed care has altered both perceptions, and organized medicine has lobbied hard for statutory antitrust immunity when negotiating with health insurers.

A more detailed examination of insurance risk may be necessary if competition policy is to promote clinical quality and efficient price-quality trade-offs. As a general matter, competition policy is agnostic to the axis along which competition occurs and simply defers to market preferences. But health insurance bears an uneasy relationship to both competition and quality. Insured patients may be insensitive to the price of health care services, leading them to select services of high apparent quality but low cost-effectiveness. On the other hand, competition in insurance markets may be more vigorous in attracting people at low risk than promoting efficiency in health care delivery. Some forms of quality, such as affiliating with providers skilled at treating serious diseases, may even run counter to insurers' business strategies because those services appeal primarily to the very sick.

■ **Protect consumers directly.** Health care competition policy has emphasized antitrust, leaving consumer protection enforcers to focus on out-and-out frauds such as cancer cures, miracle weight-loss products, and the like. Although the FTC has been a strong advocate for direct-to-consumer drug advertising, consumer protection in health care remains an unexplored frontier. Informed consent, end-of-life treatment decisions, proxy decision making, and provider report cards present obvious (albeit challenging) targets for a robust consumer protection agenda.

■ **Assimilate public purchasing.** Public dollars make up about 45 percent of the \$1.3 trillion that the United States spends annually on health care.³⁹ Public purchasing distorts prices, overbuilds capacity (both physicians and facilities), and skews the development and dissemination of technology. Competition law has largely ignored this reality and indulged the belief that U.S. health care is a private system governed by private competition. In the future, close attention should be paid to the government as both a source of and a remedy for private market failure. For example, competition policy could influence the use of government purchasing power to develop and implement market-oriented solutions to quality problems, such as standardized consumer information.

■ **Acknowledge tensions with access and trust.** Congress, the enforcement

agencies, and the courts must also decide whether and how considerations such as charity, access for the uninsured, and therapeutic trust between patients and providers—atypical subjects for economic analysis—should be incorporated into competition policy. These issues have surfaced primarily in challenges to nonprofit hospital mergers, perhaps explaining some unexpected results in these cases.⁴⁰

In *FTC v. Butterworth Health Corp.*, the district court allowed the two largest hospitals in Grand Rapids, Michigan, to merge.⁴¹ The court dismissed the concerns of paying customers—managed care organizations—because they purchased care selectively for their own enrollees. Instead, the court looked to the interests of hypothetical consumers, including people who could not afford medical care but nonetheless needed it. Had the case not involved entities in the health care sector, it is inconceivable that the merger would have been approved.

In addition, courts may misperceive antitrust claims involving hospital mergers as extending beyond economic analysis and calling into question the overall trustworthiness of major community institutions. The goal of a hospital merger case is to prevent the acquisition of market power that will be exploited economically. However, nonprofit health facilities are widely presumed to be acting in the public interest, and this expectation is an important part of the reason for according them nonprofit status in the first instance. Judges also tend to be receptive to the suggestion that nonprofit hospital mergers can help solve the “medical arms race” that seemingly afflicts many communities.⁴² From this perspective, competition based on technology is social perversion rather than quality enhancement, and hospitals that reduce such duplication by merging are eliminating waste rather than compromising care.

Competition policy must grapple more explicitly with these beliefs and effects, if only to avoid leaving them to the ad hoc impulses of federal district court judges. For example, the court’s order in *Butterworth* reflected a decidedly nonmarket approach.⁴³ The court imposed a “Commitment to the Underserved”—a laudable goal, but one fundamentally at odds with the economic underpinnings of traditional antitrust law. At the same time, the court dismissed the importance of price discounts for managed care, blithely assuming that increased revenue to the merged hospital would be spent by the board of trustees on improving quality. Similar instincts may come into play in the recently filed antitrust challenge to the National Residents’ Matching Program, which confronts the court with the possibility that overturning collective restrictions on salaries for medical trainees will increase operating costs and reduce access to services at teaching hospitals.

BY ENSURING A COMPETITIVE MARKETPLACE, competition law and policy prevents a group of providers from preempting “the working of the market by deciding for itself that customers do not need that which they demand.”⁴⁴ Needless to say, the medical profession applies a very different set of assumptions where quality is concerned.

In an efficient market, consumers' preferences specify the targets at which providers aim. Some customers are likely to prefer higher-quality care than that currently provided, while other customers are likely to demand lower-quality care, at least as *quality* is defined by the medical profession. The challenge for competition policy in the twenty-first century is to move beyond its traditional focus on price competition and explicitly address the complexities raised by nonprice competition in all its various manifestations. Health services researchers and health policy analysts have important roles to play in this endeavor.

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NOTES

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24. P.J. Hammer, "How Doctors Became Distributors: A Fabled Story of Vertical Relations," *Loyola Consumer Law Reporter* 14, no. 4 (2002): 411–438.
25. N.W. Averitt and R.H. Lande, "Consumer Choice: The Practical Reason for Antitrust and Consumer Protection Law," *Loyola Consumer Law Reporter* 10, no. 1 (1998): 44–63.
26. Health Care Services and Products Division, "FTC Antitrust Actions."
27. See, for example, *Boczar v. Manatee Hosps. and Health Sys., Inc.*, 993 F.2d 1514, 1517, 1519 (11th Cir. 1993) (reinstating jury verdict for plaintiff obstetrician based on evidence that she provided different style of medicine, consisting of lower-cost services and fewer cesarean sections).
28. From 1985 to 1999 the only antitrust opinion to assess clinical outcomes was a staff-privileges case, *Angelico v. Lehigh Valley Hosp., Inc.* 984 F. Supp. 308, 313–314 (E.D. Pa. 1997), *rev'd* by 184 F.3d 268 (3d Cir. 1999). The court credited testimony by the plaintiff's expert with respect to physician-specific data on mortality, but even so did not address its competitive implications.
29. *American Medical Ass'n*, 94 F.T.C. 701 (1979), *aff'd as modified*, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided court*, 455 U.S. 676 (1982).
30. The footnote reads: "More generally, the fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions as interchangeable with other business activities, and automatically to apply to the professions antitrust concepts which originated in other areas. 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." *Goldfarb*, 421 U.S. at 788–789, n. 17.
31. This interpretation of *California Dental* is undercut by the refusal of the 9th Circuit Court of Appeals, to which the case was remanded by the Supreme Court for further proceedings, to allow additional fact finding on the effects of the restrictions in question. "FTC Dismisses Case against California Dental Association," Press Release, 5 February 2001, www.ftc.gov/opa/2001/02/cdadismisspr.htm (15 November 2002).
32. Hammer and Sage, "Quality and the Courts," 557. Similarly, as a former assistant attorney general for antitrust noted, from a competition law perspective, "there is in most cases a fundamental contradiction in the argument that quality can be enhanced through restraints among producers (providers) that significantly restrain the competitive process and result in adverse price and output effects." T.E. Kauper, "The Role of Quality of Health Care Considerations in Antitrust Analysis," *Law and Contemporary Problems* 51, no. 2 (1988): 273–340. From a provider perspective, by contrast, it is inconceivable that quality can be improved without self-regulation and self-imposed restraints.
33. T.J. Muris, "Everything Old Is New Again: Health Care and Competition in the Twenty-first Century," www.ftc.gov/speeches/muris/murishhealthcarespeech0211.pdf (15 November 2002).
34. Health Care Services and Products Division, "FTC Antitrust Actions."
35. *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752 (1984).
36. Staff Advisory Opinion Re MedSouth, Inc. reflected in letter from Jeffrey W. Brennan, assistant director, Bureau of Competition, to John J. Miles, Ober, Kaler, Grimes, and Shriver, 19 February 2002, www.ftc.gov/bc/adops/medsouth.htm (15 November 2002).
37. D.A. Hyman and C. Silver, "You Get What You Pay For: Result-Based Compensation for Health Care," *Washington and Lee Law Review* 58, no. 4 (2001): 1427–1490.
38. Staff Advisory Opinion Re MedSouth, Inc.
39. Centers for Medicare and Medicaid Services, "U.S. Healthcare System: The Nation's Health Dollar CY 2000," www.cms.gov/charts/series (15 November 2002).
40. Muris, "Everything Old Is New Again."
41. 946 F. Supp. 1285 (W.D. Mich. 1996), *aff'd without opinion*, 121 F.3d 708 (6th Cir.), *reported in full*, 1997-2 Trade Cas. (CCH) P 71,863 (6th Cir. 1997).
42. Remarkably enough, in several of these cases, courts suggested that competition increases price and decreases quality, rather than the converse.
43. Muris, "Everything Old Is New Again."
44. *Indiana Federation*, 476 U.S. at 462.