Special Challenges for Antitrust in Health Care

BY THOMAS B. LEARY

ANTITRUST POLICY IS A fascinating field of study because it so often involves hard choices. Even those who agree on the broad economic objectives of antitrust can disagree in particular situations. It may be difficult to balance beneficial and harmful effects, and predictions about both are always uncertain. When we talk about health care, these problems are magnified because the usual concerns about competition and efficiency themselves compete with emotionally compelling concerns about the life and health of individual human beings.

The health care sector is regarded in our political system as something "special," subject to special disciplines and granted special dispensations. Whether we agree with this special status or not, we in the antitrust community need to understand the factors that contribute to it and to take account of them as we analyze problems. This article will highlight the special factors that I think are most significant.

The issues are immensely important. Recent numbers indicate that expenditures on health care amount to about $1.5 trillion a year, well over 10 percent of the nation's gross domestic product, and expenditures are again rising rapidly after a period of relative stability. Moreover, even though the United States leads the world in some areas of health care—like the introduction of new drugs and innovative medical procedures—we also are deficient in other respects. Large segments of the population are under served; there are substantial differences in quality of care, depending on geographical location; and there is an unacceptably large incidence of so-called "medical errors."[1] So, quality is an issue along with cost and availability.

Health care issues are a major priority for the Federal Trade Commission. Wholly apart from the expanded law enforcement activities of our Bureaus of Competition and Consumer Protection, we have held joint hearings with the Department of Justice on Health Care and Competition Law and Policy.[2] A detailed report will be issued, but the hearings have already enriched our understanding of issues in health care.

Much of this article is based on information presented at the hearings. Since the audience for an ultimate report and for this article primarily consists of lawyers, I will also occasionally compare and contrast competition issues as they affect the medical profession and the legal profession. When we look at the medical profession, we also need to take a hard look at ourselves. The article is deliberately provocative because the purpose is to stimulate discussion not to conclude it.

The following are what I believe are the most significant factors that distinguish competition in the health care sector from competition in many other sectors of the economy.

1. Third-Party Payors and Health Care as an Entitlement

Perhaps the most serious and pervasive problem, with which readers are undoubtedly familiar, is the fact that the consumers of medical services and products normally do not pay the full incremental costs of their care. They may pay collectively and indirectly through insurance premiums and taxes, but these costs are relatively fixed. Accordingly, there is a tendency to "over-consume." The overall tendency to over-consume may be mitigated in this area—as in other areas characterized by third-party payments—by provisions for larger co-payments or deductibles. There is sometimes strong resistence to these measures, however, when it comes to health care.

Health care providers (like doctors) have a corresponding incentive to "oversupply," to the extent that they are paid for inputs like tests and procedures. Their patient-customers have neither the incentive nor the requisite knowledge to discipline this tendency. The mutually reinforcing incentives of providers and consumers means that supply and demand cannot reach an equilibrium. Some rationing or gatekeeping system is required in order to temper the inevitable upward pressures on prices.

The political will to devise an acceptable rationing system that will contain collective costs is compromised by the fact that any individually identifiable human life is popularly considered to have an almost infinite value. This immense and widespread solicitude for the individual is one of the glories of our society, but it makes it hard to apply the rational

Thomas B. Leary is a Commissioner, Federal Trade Commission. This is a written version of a speech given at a forum on Antitrust and Health care jointly sponsored by the Health Lawyers Association and the ABA Sections of Antitrust Law and Health Law (May 15, 2003). As always, the views are the author's own and not necessarily shared by any other Commissioner.

economic models with which antitrust lawyers are familiar. This solicitude is even harder to accommodate when elected officials are almost compelled to say that everyone, regardless of means, is entitled not only to medical care but the "best possible" medical care. This is, of course, literally impossible, just as it is impossible for all the children in the mythical town of Lake Wobegon to be "above average." But, we have to pretend that we believe it.

As a result, the keepers of the gates will never be popular. If they are health maintenance organizations (HMOs) or insurance companies, they are broadly excoriated in the press and on the floors of Congress. If the gatekeeper is the State, like our neighbor to the North, people not only complain but also pour across the border to bypass the system.[3] (In fact, we can assume that the relatively affluent or well-connected will find a way to jump the line in any seemingly objective and egalitarian rationing regime—whether we are talking about health care or education or anything else where the perceived stakes are high.)

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Most lawyers are not familiar with this kind of environment. Payment by third parties is relatively rare. Companies may pay for the legal expenses of employees in situations where the company may be vicariously liable for employees' conduct, but payment for purely personal legal expenses is not part of an ordinary compensation package, even when medical expenses are subsidized in some way. The government will pay for the legal defense of indigents accused of serious crimes but, notwithstanding persistent concerns about the quality of this representation, no elected official is likely to proclaim that these defendants are entitled to the "best possible" defense, even when their lives are on the line.

Perhaps the most common example of third-party payment for legal services occurs when insurance companies undertake the defense of negligence claims against their policy holders. These insurance companies want to manage the process in the same way that health-care payors do, and their priorities may similarly differ from those of their clients who pay the premiums. However, this situation does not seem to stimulate the same level of "over-consumption." People may well drive more aggressively when they know they are covered by insurance, but there are other factors (like physical fear) that help to constrain their "over-consumption" of accidents.

Moreover, anomalies in the market for legal services do not seem to stimulate the same political passion. The fundamental reason for treating medical care as a moral entitlement, but not legal care, is probably a popular perception that even "good" people or "careful" people can get sick by random chance but lawyers are only necessary for people who skate close to the edge. This generalization, of course, does not always hold true but, like many generalizations, it may have some rational basis in the aggregate.

2. The Myth of the Competent and Disinterested Professional

Most providers of goods and services have long been regarded as no better or worse than the common run of humanity—capable of some true altruism and fidelity to the truth but also inevitably driven by self interest. The intellectual defense of capitalism is premised on the assumption that individual self interest is transmuted by an "invisible hand" into collective virtue. However, people who work as professionals—like doctors and lawyers—were traditionally thought to operate in a rarified environment, untainted by crass commercialism.[4] (Government employees like me were also assumed to be motivated purely by the "public interest." We have, in fact, just survived a century of utopian experiments predicated on the assumption that entire economies could be managed by presumably omniscient and selfless bureaucrats.)

We are no longer so naive about these matters. The credibility of lawyers and public employees—perhaps particularly those who are both—has fallen dramatically, but doctors still seem to rank high. This is not surprising since so many of us owe our continued health, indeed our lives, to the skillful intervention of medical professionals. Perhaps we are unwilling to entertain the idea that these people are anything less than selfless and competent because what they do is so important.

The aura of disinterested competence that still surrounds the medical profession contributes to the unrealistic notion that high-quality health care can be made universally available, just as it can fuel support for proposals to exempt doctors from certain strictures of the antitrust laws.[5] Perhaps an even more significant downside consequence of the myth, however, is the fact that the myth makes it even more difficult than it would otherwise be for consumers to make intelligent choices about medical care. The nexus will be explained in more detail below.

Before elaborating, it is important to emphasize that the purpose for calling a myth a myth is not to denigrate any profession. The purpose is simply to highlight one more obstacle to the introduction of competitive discipline in the health care sector.

3. The Inability to Make Cost/Quality Tradeoffs

In most sectors of the economy, consumers can readily make tradeoffs between cost and quality, to suit their individual needs. Consider a simple tool, like a hammer.[6] A consumer who only uses a hammer to hang the occasional picture will not want (and should not be forced by regulation) to spend

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a lot of money on a hammer of a quality suitable for use by a master carpenter. Similarly, a dollar-conscious but unostentatious consumer who wants a quality automobile can save a lot, with very little compromise of quality, by purchasing last-year's model. However, it is hard to imagine a consumer consciously seeking low-quality medical care or "last-year's model."[7] But, consumers may get it all the time without knowing it.

There is some exaggeration in that statement. Medical insurance plans can discourage consumers from seeking the most costly (and perhaps highest quality) medical care, and many consumers probably sense that this is the price that they pay for lower premiums. Presumably, other consumers sense that there is a cost/quality tradeoff when they visit a low-priced clinic or, indeed, when they forgo conventional medical treatment altogether and take a chance on some home-grown remedy recommended by a friend.

Nevertheless, there is a vast discrepancy between the amount of consumer information available in the health care sector and the amount available in other sectors. Cost-quality tradeoffs are harder to make. Statistical information may be available on outcomes for specific procedures, but broader indicia of "quality" are harder to come by.[8] The same information gap also applies to the legal profession, by the way. The ratings in legal directories are not really useful for consumers of legal services. As a lawyer, I instinctively resist the idea that the quality of legal services could be adequately captured in a consumer-friendly format, anyhow, and therefore have some sympathy for doctors who are similarly resistant. However, I also know from experience that there are vast variations in the quality of legal services and have no reason to believe that medical services are any different in this respect.

The recent Supreme Court opinion in the *California Dental*[9] case recognizes that it may be particularly difficult to convey accurate information about the quality of professional services. However, the opinion does not stand for the proposition that it is preferable to convey no information at all to consumers. Factual support of quality claims is particularly important in a professional setting, but more truthful information, rather than less, is still the preferred outcome.[10]

It is therefore worthwhile to consider the implications of a system that would provide more information on objective measures of the quality of medical care. If this were possible, it would facilitate cost-benefit tradeoffs by payors and ultimate consumers of medical products and services. It could also encourage compensation based more overtly on outcomes rather than on inputs, and perhaps lead to a more rational allocation of resources.

In medicine, as in law, there are likely to be formidable measurement problems. A simple tally of "wins" and "losses" does not mean much in the context of complex litigation, and the "success" or "failure" of medical treatments may be similarly difficult to capture. Even if the measurement issues could be addressed, some might also object on the ground that a system that rated medical professionals by outcomes could discourage the most high-risk treatments. Cold blooded as it seems at first glance, this is not necessarily a perverse result in an environment where medical care has to be rationed somehow. Triage is still something that is hard for people to contemplate outside a battlefield because of the innate reluctance to acknowledge any limits on the "value of a human life," but a market system that tends to give priority to cases where the treatments are most likely to succeed may be better than the alternatives. In fact, for certain special medical procedures, like organ transplants, this seems to be the way treatment is rationed today.

The legal profession is less reluctant to ration services overtly. Lawyers can and do refuse to take on difficult cases (unless they are assigned counsel in a criminal trial), and contingent fees can be a mechanism for differentiating between high-risk and low-risk matters. Lawyers are routinely paid for inputs in many situations (billable hours), but they may also accept a contingent fee, in whole or in part. Most typical are contingent fees in lawsuits brought for people of modest means but, increasingly, even substantial companies are willing to pay a performance bonus or a share of the monetary recovery. When courts are called in to decide the reasonableness of a contingent fee (in a class action, for example), they are supposed to weigh not only the size of a recovery but also the difficulty and complexity of the matter. If courts do their job conscientiously, the system should pro-

vide incentives for lawyers to provide high quality services and to tackle the hard cases.

As a general matter, there does not seem to be any broad movement toward output or result based compensation for medical services.[11] At first, it seems hard to understand this reluctance. Results are difficult to predict in any individual case, of course, but it should be possible for an individual provider or group to charge for results, based on statistical data for a large enough patient population. Once again, however, we have to recognize the general squeamishness about any overt connection between money and human life or health. For example, most people are probably not particularly upset if a lawyer charges a contingent fee in the millions for recovery of a particularly large sum in a particularly difficult case. Imagine the adverse reaction if a doctor were to charge millions for a particularly delicate operation against long odds—even if the operation saved a life or perhaps saved immense future medical costs.

We confront this powerful taboo[12] against the commercialization of health care as we attempt to apply competitive principles to the market for medical services. There are other factors at work here that may also inhibit contingent payments to doctors. People are more likely to begrudge large payments for services that contain losses than for services that yield gains. (This factor also inhibits contingent payments to lawyers who practice "defensive" rather than "offensive" law.) To the extent that medical services mitigate adverse consequences rather than make "well" people feel even better,[13] it may be hard for the public at large to think about favorable medical outcomes in the same way as they think about monetary recoveries. In addition, of course, medical benefits are harder to quantify—they are sometimes literally "priceless."

4. Other Incentives for Efficiency

Apart from result-based compensation, there are other incentive systems that might lead to greater efficiencies in the delivery of medical services. One concept that was once considered the wave of the future was a so-called "capitation" contract, under which the groups of providers would agree to supply needed services to a group of covered patients for a fixed fee per head. This really is similar to a contingent fee because the providers were relying on experience with large numbers to set a per-capita fee, and themselves undertaking the actuarial risk. The providers do not "bet" on the outcome for any individual patient but rather on their ability to predict the cost of providing an overall package of diverse medical services needed for a large number of people. This kind of "financial integration" should supply a powerful incentive for efficiency, and the Health Care Statements of the antitrust agencies have made it clear that this integration could justify collective negotiation of fees with payors.[14] The growth of capitated contracts has stalled, however, because many providers have found them unprofitable and because the patient population has become increasingly interested in plans that gave them greater choices.[15]

In my view, there could be substantial benefits if doctors could find a way to achieve greater financial and clinical integration.

Another recognized method for achieving efficiencies and justifying collective negotiations is so-called "clinical integration." A practice association is clinically integrated if carefully selected practitioner members share clinical information, coordinate treatment, develop practice protocols, and monitor compliance of individuals in the group.[16] Arguably, efficiencies are even more predictable in this situation because the association is promising specific management oversight rather than relying on the general financial incentives provided by capitated contracts. In fact, it may be that capitated contracts are ultimately doomed to fail in the absence of some clinical integration.

Despite the promise of efficiencies and the advantages of collective negotiations with payors, we have not thus far seen many examples of large physician associations with genuine clinical integration.[17] There seems to be a marked difference between the legal profession and the medical profession in this respect. Lawyers practice together in immense firms, with varying degrees of financial and "clinical" integration, and they collectively set rates with virtually no fear of antitrust consequences. It remains to be seen whether large numbers of medical providers—under increasing pressure from payors and antitrust litigation—will choose to go this route and do it the right way.

Because we have encountered so few examples of genuine efforts to achieve clinical integration, and there are no litigated cases, it is not yet possible to provide a blueprint for antitrust counselors. However, a general observation may be helpful. We have, in non-public proceedings, considered and summarily rejected a number of clinical integration claims. In these situations, it was apparent that the initial and principal objective of the target associations was to increase physician bargaining power simply by the weight of numbers, and that claims of clinical integration were afterthoughts.

Contrast this with an association that seeks to increase its bargaining power by improving the quality of its services. Membership of an impressive scale and scope may be essential for achieving these quality improvements, but it is not enough by itself. The difference is reflected not just in isolated documents that may reflect "intent" but in the organizing principles of the association and in its communications to payors and to its own members. We think we can distinguish between a pretextual justification and an effort to achieve the real thing,[18] and we trust that antitrust counselors can do so, as well.

In my view, there could be substantial benefits if doctors could find a way to achieve greater financial and clinical

integration. Integration should improve outcomes and also enhance the autonomy of the profession as a whole. The unusual economics of the health-care market, described above, make it likely that there will always be pressures for overconsumption and oversupply, with a corresponding need for one or more gatekeepers to "ration" medical care. If provider associations were better integrated, they could theoretically assume a greater role in gatekeeping themselves. I am not optimistic that this will happen any time soon, however, because of the profound cultural barriers outlined above.

Conclusion

The suggestion that we at least consider ways to introduce more competitive discipline into the health-care sector has not and will not be met with universal warm applause. The concept is antithetical to the way that the public thinks about doctors and the way that doctors think about themselves.

Lawyers should be understanding about this because we have had similar "image" issues. About twenty-five years ago—when I was on a corporate legal staff, and therefore a "client" part of the time—I spoke at an ABA function and told the outside lawyers present that they had better get used to the ideas of price competition, litigation budgets, and greater client oversight. The audience reaction was generally confined to the spectrum between hostility and horror. But, these things have come to pass, and the profession has survived. The process has not always been pleasant, and none of us would deny that a more competitive, market-oriented profession does have some downside consequences. Overall, however, I think most would agree that more active client oversight has resulted in better quality service at lower prices.[19]

The fundamental premise of our free-market system is that overall welfare is best served by open competition and consumer sovereignty—even when complex products and services are involved. The FTC has a particular responsibility for advocating competitive market solutions. We recognize that there may be other compelling state interests, which sometimes trump or at least limit open competition. (For example, entry into both the medical and the legal professions is limited by license requirements.) However, it is part of our job to make policy makers more aware of the costs associated with various impediments to competition and to invite consideration of more procompetitive alternatives—even as we recognize that there are no easy answers. ■

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[1] *See* Commission on Quality of Health Care in Am., Inst. of Med., *Crossing the Quality Chasm: A New Health System for the 21st Century* 193 (2001); Mark A. Schuster et al., *How Good Is the Quality of Health Care in the United States?* 76 MILBANK Q. 517 (1998); David Hyman, *Does Quality of Care Matter to Medicare?* 46 PERSP. BIO. & MED. 55 (Winter 2003).

[2] *See* http://www.ftc.gov/ogr/healthcarehearings/index.htm.

[3] There is, of course, a reverse flow of people, or simply money, to get U.S. pharmaceutical products that are subject to Canadian price controls. It is likely that these controls will have some deleterious effects on supply like price controls have had throughout history, but the adverse consequences have probably been diluted by the relatively small volumes of commerce involved up to now.

[4] In fact, in the pre-*Goldfarb* era, they were assumed to be immune from the antitrust laws. *See* Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975).

[5] There are two physician collective-bargaining bills currently pending in Congress: the Health Care Antitrust Improvements Act of 2003, H.R. 1120, 108th Cong., and the Quality Health Care Coalition Act of 2003, H.R. 1247, 108 Cong.

[6] Jim Miller used to cite this example when he chaired the FTC twenty years ago.

[7] Professor Mark Pauly, Wharton School of Business, Leonard Davis Institute, once asked, "[w]hy doesn't anyone offer last year's medicine at last year's prices?"

[8] *See* David Hyman & Charles Silver, *You Get What You Pay for: Result-Based Compensation for Health Care*, 58 WASH. & LEE L. REV. 1427 (2001).

[9] California Dental Ass'n v. FTC, 526 U.S. 756 (1999).

[10] *Accord* Nat'l Soc'y of Prof'l Eng'rs v. United States, 435 U.S. 679 (1978); FTC v. Indiana Fed'n of Dentists, 476 U.S. 447 (1986).

[11] Anthem Inc. and WellPoint Health Networks Inc., two large managed-care firms, are reportedly considering "pay for performance," whereby doctors and hospitals are measured and paid based on the quality of the medical care they give. *See* Bruce Japsen, *Anthem to Buy Wellpoint; $15 Billion Combination to Form Largest U.S. Health Plan*, CHI. TRIB., Oct. 28, 2003, at C1. At the moment, I do not know anything about this development—or, indeed, about the proposed merger—beyond what I read in the press.

[12] Another illustration of the taboo against commerce in health care is the fact that some body parts (e.g., a kidney) can legally be donated but not sold.

[13] It is probably no coincidence that contingent fees in health care seem to be confined to those elective procedures that make well people feel better, like laser correction of vision problems. *See* Hyman & Silver, *supra* note 8.

[14] *See* U.S. Dep't of Justice & Federal Trade Comm'n, Statements of Antitrust Enforcement Policy in Health Care (1996), *reprinted in* 4 Trade Reg. Rep. (CCH) ¶ 13,153, at § (8)4 [hereinafter Health Care Statements].

[15] *See* The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2002 Annual Survey* 10, *available at* http://www.kaisernetwork.org/health_cast/uploaded_files/ACF4D93.pdf.

[16] *See* Health Care Statements, *supra* note 14, §§ (8)(B)–(C); *see also* Thomas B. Leary, *The Antitrust Implications of "Clinical Integration": An Analysis of FTC Staff's Advisory Opinion to MedSouth*, 47 ST. LOUIS U. L.J. 217 (2003); Letter from Jeffrey W. Brennan, Assistant Director Health Care Services & Products, FTC, to John J. Miles, Ober, Kaler, Grimes & Shriver (Feb. 19, 2002), *available at* http://www.ftc.gov/bcadops/medsouth.htm.

[17] In addition to the advisory opinion cited *supra* note 16, there is only one additional staff advisory opinion relating to a proposed physician network. *See* Letter from Jeffrey W. Brennan, Assistant Director Health Care Services & Products, FTC, to Martin J. Thompson, Manatt, Phelps & Phillips, LLP (Sept. 23, 2003), *available at* http://www.ftc.gov/bc/adops/bapp030923.htm.

[18] Again, a comparison with law firms may be helpful. There are many law firms that can command premium rates, based on the perceived value of their services. Size and diversified expertise can be a selling point if the services require a massive commitment of legal resources, as in a major corporate transaction or complex litigation. But, it is the consequent impact on quality that is important, not the sheer weight of numbers (or "market share").

[19] Over-compensation of lawyers can still be a problem in class actions where there are no "clients" in control. *See* Thomas B. Leary, Commissioner, FTC, Remarks Before the Class Action Litigation Summit (June 26, 2003), *available at* http://www.ftc.gov/speeches/leary/classactionsummit.htm.