The Reconstruction of Legal-Economic Relations: Achieving Workable Competition

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Available at: http://lawecommmons.luc.edu/lclr/vol8/iss2/18

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Health care illustrates one of the fundamental themes of Neil Komesar's recent book, *Imperfect Alternatives*: if one institutional strategy for implementing public policy presents serious problems, then it is highly likely that any other institutional approach is also going to be very imperfect. Basic goals for health care are the subject of substantial public consensus. As a nation, it is important that all citizens have access to good health care regardless of their ability to pay. The problem lies in achieving that goal in a manner consistent with economic efficiency, cost minimization, and the retention of ideological and social aspects of the current system.

At present, health care policy is implemented through a mix of market and political (administrative) institutions. The resulting health care system is economically inefficient and fails to accomplish its fundamental goal of providing all people with adequate health care, despite its obvious capacity to do so. The majority of health care consumers are overcharged for the services they personally receive. The price includes a subsidy for some of those receiving health care who cannot afford to pay for such services or whose agent (state or federal government) refuses to pay. Yet such a subsidy is itself very inefficiently organized and implemented in that it often taxes those of limited means to aid those of substantial means. Moreover, a significant amount of the subsidy fund in fact never actually subsidizes the care of others, but rather is diverted into the hands of participants in health care provision. Thus the dysfunctions of the health care system's methods of paying for care is demonstrated by the amount and pervasiveness of discounts that specific groups of consumers are able to wring from providers.

In these deregulatory times, the general thrust of public policy is to rely more on market institutions to create the appropriate pricing and allocation of health care services. Taking into account the preference for market-based strategies it would be a complete failure to expand the role of health care markets constrained only by general application of antitrust law. Even worse would be the expansion of health care markets that are unconstrained as a result of broad exemptions from antitrust law in order to facilitate agreements and combinations among such providers. Consumers cannot obtain reasonably priced health care services for themselves, nor distribute the cost of supporting health care for those unable to pay in an efficient manner without a more fundamental rethinking and redefini-

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tion of the highly flawed markets and administrative fiefdoms that have evolved in this industry.

This thesis has two elements. First, coherent and productive policy analysis requires an understanding of the recent transformation of personal health care in historical terms. This transformation evolves from a very marginal activity in terms of its social value into a highly valued, but costly, service which has retained a system for payment and an economic organization that maximizes the inherent difficulties in achieving efficient and equitable economic behavior. Second, this historical understanding of the dysfunctional nature of health care payments and organization provides the basis to identify the reforms in the basic legal conditions under which these markets operate. Such reforms will greatly enhance the potential that competitive processes, as governed by active antitrust oversight, and will yield better results for consumers both as recipients of health care and as the ultimate payers for such services.

The transformation of medicine

The nature of health care for individuals has changed dramatically in the last few decades. As recently as the 1930s and early 1940s, doctors were largely diagnosticians who could tell most patients what was going to happen, but could do little to change the outcome in the vast majority of those cases. Hospitals were places people visited to be cared for while natural processes worked themselves out and the patient either lived or died. Due to the patient's uncertainty concerning the outcome, the costs associated with individual health care were very modest. Having a low expectation of success, patients had little incentive to spend more.

Of course, there were exceptions. After the start of the 20th century, people began to spend more on their health care, especially as to certain simple surgical procedures, vaccinations, and other treatments involving limited technological and biological sophistication. During that time medicine presumably offered more useful and valuable responses in the cases of accidental injury. Interestingly, workers compensation laws uniformly imposed the entire cost of health care and a substantial part of the lost wages related to industrial accidents (by far the largest source of injury in those pre-automobile days), on the employer regardless of the unionization of employees or any other indicia of their bargaining power. This allocation of cost and responsibility for treatment of accidents is strongly associated with the rapid decline of injury and death in the workplace and the systematic development of medical science to reduce the harms associated with those injuries that did occur. Still, for most illnesses, medicine could only differentiate the symptoms and predict the outcome. As such, it contributed little of social or economic value and was compensated accordingly.

The transformation of health care over the last five decades is truly profound. Starting in the 1930s and 40s, the discovery of antibiotics, the development of x-rays, and the unraveling of many central biological facts about disease have lead to a genuine revolution in the role of medicine in the lives of people. Technology, pharmacology, diagnostic techniques and medical treatments, including transplants and complex surgery, have made an enormous difference in the role of doctors, hospitals and medical treatment. With greatly increasing frequency, doctors can tell patients not only what...
will happen if a condition is allowed to persist, but also what can be done to ameliorate or cure the condition. Indeed, today medical science often has the capacity to sustain biological life well past the point at which any human or humane interest is served.

The economic implications of this scientific transformation are manifest. Demand for health care has grown exponentially as it now offers substantive improvements in the life and well being of the patient. Such care is often costly and as a result of its changed character the total costs of health care have risen. Whereas prior to 1940, demand for health care was naturally limited by its own ineffectiveness, today no such constraint exists and increased supply at increased cost will ultimately alter the health situation of many individuals. This dynamic has changed, and is still changing, the overall economic context of health care markets.

In terms of human experience, this transformation has occurred at revolutionary speed. Our ideas and social, as well as ethical, responses take generations to adjust to changed scientific realities. Thus, there are enormous problems of how to relate many of the new capacities of medical science to the human condition. For example, the end of life for those terminally ill is increasingly a conscious choice of doctors, patient, and family; yet, our social and ethical norms have not clearly accepted or adapted to this dramatic technological change.

A coherent analysis of the current problems in paying for health care has to start from an appreciation of the technical history briefly summarized in this thesis. Only if people can appreciate that the very nature of the health care being demanded today is radically different from what it was only a few decades ago can we understand how finance and technology have gotten out of step with each other.

The dysfunctional character of health care payments

How the people of the United States pay for their health is the central economic factor in the difficulties currently experienced by the overall health care system. The system has the capacity and the revenue to provide adequate health care for all citizens. Nonetheless costs continue to increase and many people do not, in fact, have access to health care.

Which consumer pays, what they pay, and how they pay, strongly influences the points at which choices occur regarding the services provided and how the resulting funds will be allocated among those providing services. The payments system can facilitate or frustrate general access and equal treatment for consumers. Similarly, the system can encourage or discourage self-seeking, strategic economic behavior by participants.

For reasons of politics and social values, the United States did not develop a system of public, national health care as most other countries have. At the same time, there has been and continues to be a general recognition that all citizens should have access to competent health care services. Consequently, individuals with the financial capacity to do so paid more for their own and their families health care directly or through indemnity insurance (i.e., insurance that reimbursed for specific costs) than the "actual" cost. These individual transactions created a market context in which sellers had a great deal of opportunity to vary prices among buyers. Indeed, in order to finance the provision of health
care for all, it was essential that providers charge prices to some customers substantially above cost in order to have sufficient revenue to cover the costs, especially fixed costs, necessary to provide services to those who were unable to pay the full or even part of the cost. Moreover, in individual transactions, the buyer had little bargaining power and even less knowledge of the value or comparative prices of the services rendered. As a small item in the budget, it was also not worthwhile for individuals to become sophisticated in valuing health care or seeking alternatives.

This privately operated system to subsidize the costs of the medically indigent was a plausible solution for this country where the ideology of individualism and anti-statism was strong and the total costs of individual health care were limited. As a historical matter, it is doubtful that either state or federal government would have had the administrative competency to operate a general health care system until well into the 20th Century, or that the value of individual health care warranted any real concern about the payments system. This strategy of private taxation and subsidization unreviewed and unregulated does, of course, contain great potential for inefficiency and misallocation of resources. In addition, this approach limited the capacity of consumers, each paying a small tax to cover the costs of others, to consider the allocation of or access to services being provided, or to demand more efficient delivery of such services.

In this same period, virtually every state adopted legislation reconstructing the payment for medical and other expenses associated with industrial accidents—an area of medical care in which real progress had already been made. Workers compensation imposed 100% of the costs of health care as well as a substantial part of the resulting lost wages on the employer. Focusing the costs on the employer also meant that the employer stood to gain economically if the number of accidents declined and/or if their costs and long term harmfulness were reduced. Insurers and employers developed a strong interest in industrial safety and industrial medicine both of which reduced the incidence, costs and harms of such accidents. Moreover, the system of payment directly supported the achievement of these goals by defining relationships in which the parties having control and paying the bills also stood to gain from improvements in employee health. The gains were reflected back in a way that created for most employers direct economic incentives to reduce risks and to favor more effective medical treatment. Thus, incentives were aligned and, the gains to be expected from opportunistic behavior were reduced.

In contrast, with respect to general health care, the dispersed payments system denied to any group the capacity to be an effective consumer. Hospitals sponsored insurance systems designed largely to organize payments for their operating expenses without regard to the potential for catastrophic risks that individuals faced. These plans expanded to include routine medical care. Such plans allowed the insured to average out ordinary medical expenses and to have them paid with pre-tax dollars to the extent that such plans were fringe benefits. In addition, especially as the capacity to treat serious diseases and injuries increased, the problems of catastrophically large expenses and the problem of long-term expensive support lead to additional kinds of insurance largely focused on indemnifying patients for expenses. The problem of aged and medically indigent groups lead
to separate schemes—Medicare and Medicaid. Both systems used taxes to fund some or all of the necessary health care. \(^{31}\)

Because these routes to compensate health care costs of different groups arose and developed separately, the problems of transferring costs has been made even greater. \(^{32}\) Each group or the party paying health care costs receives an advantage if they can lower their own direct costs for health care even if the total direct health care costs incurred by the system remain constant. Of course, such cost shifting is likely to inflate the overall administrative costs, but from the standpoint of any particular group the extra administrative costs are worth incurring if they result in a greater offsetting lowering of direct costs. In addition, health care providers have a substantial economic stake in ensuring that their own revenues and profits remain high. Hence, they can and do claim that cost transfers support the system when a primary impact is to protect the income of particular groups or classes of providers. \(^{33}\)

As the costs of health care have increased, the transfers among groups have had to increase substantially. \(^{34}\) Although the public has, through Medicare and Medicaid, undertaken greater direct payment, those systems have employed government power to impose cost transfers to other health care consumers as Congress became reluctant to pay the full cost of the care being demanded from the system. \(^{35}\) This is economically inefficient and counter-productive, but it is politically attractive since the transfers imposed to support public access are imposed in the form of private insurance charges or higher direct payments required of solvent customers, rather than as direct taxes imposed on the general public.

This payment process also disperses power in a way that makes control over costs and service very difficult. \(^{36}\) No one entity is paying for the full cost, and many who pay have no clear idea that they are paying. \(^{37}\) The necessary consequence is that each actor takes an interest in those costs that it can control. Government cuts its contribution to health care costs but insists that all receive care. \(^{38}\) Private actors, especially when organized as group purchasers, insist on special deals. \(^{39}\) Employers limit their contribution. Because the direct costs of providing specific services are often much below the quoted price (i.e., the price needed to generate total revenues sufficient to cover total costs), there is a wide margin for negotiation over price and no generally accepted method of cost accounting provides unambiguous guidance as to reasonable cost assignment.

In the last two decades, group plans of various kinds have emerged as major buyers of and providers of health care. \(^{40}\) Once again, these groups exist within a market system in which buyers negotiate individual prices. The major difference is that groups control large amounts of purchasing power and have the capacity and economic stake to bargain for prices as well as services. \(^{41}\) Thus, once again we observe price differences, often dramatic, between what doctors, hospitals, and drug companies charge for the same service depending on who is paying for that service. \(^{42}\)

**Legal conditions frustrating workable competition**

Assuming market institutions are to be the primary vehicle for reorganizing and reforming health care, it is essential to give serious attention to the basic legal conditions which de-
fine how these markets can and will operate in-cluding how these conditions interact with each other and with the technological and economic conditions that define the markets to create the dysfunctions in their ultimate performance. My suggestion is that some of the legal conditions constituting health care that make socially useful economic competition improbable are amend-able to reform. Others, however, inhere in the basic demand for modern health care and the technical and social constraints within which society provides and expects health care. Only when the socially and legally malleable condi-tions that define health care are reformulated to create a context favorable to workable competition can the market process carry out the social and economic obligations policy makers have assigned to it. After this kind of basic reform has occurred, it is then worth asking what role anti-trust law should play in the reconstituted health care market context. But even then, it is essential that we recognize that the results will be less than perfect.

Two recent cases illustrate important, dysfunctional legal conditions within which health care markets operate. These illustrations also demonstrate that the dysfunctional condi-tions that define relationships in health care operate on both the supply and demand side of the process.

The first illustration is Austin v. Mercy Health Systems, this recent decision of the Wis-consin Court of Appeals involving a hospital that redefined the privileges of doctors on its staff in ways that limited their practice. The hospital’s board decreed that doctors lacking a specific credential could not treat patients in its Intensive Care Unit (“ICU”), a major profit center for the hospital. Not surprisingly, a staff employee of the hospital had such a credential, thus giving the hospital control over and billing rights for all ICU patients because the doctors affiliated with any competing organizations lacked anyone who had such a credential and had privileges in this hospital. The excluded doctors successfully contended that the hospital had violated terms of its contract with them by reducing their rights to treat and bill patients admitted to the hospital (the hospital’s bylaws on privileges constituted the contract). The court concluded that the trial court incorrectly granted the hospital’s motion to dismiss. The court ruled that the doctor’s had come forth with sufficient evidence so that a jury could find the hospital committed a tortious interference with economic advantage which caused the doctors to suffer a loss of position in their community. The court remanded the issue back to the trial court for determination on the merits.

The doctors challenged the hospital’s use of its own, self-created, manpower plan as the basis to determine whether or not new doctors would be granted privileges. Under this “plan” the hospital granted privileges to its own staff physicians but refused to accord access to doctors proposed by the rival HMO. In addressing this issue court upheld the right of the hospital to refuse access to qualified doctors if those doctors did not fit with the hospital’s “plan” for the use of its facilities.

Under Austin, while rights of existing doctors were protected, the court gave doctors no rights to control future grants of privileges in the hospital. Moreover, under this holding the hospital is both a direct economic competitor of a substantial segment of the local medical community and in this case provides the only hospital services in the community. The predictable
consequence of defining the basic rights of the parties in this way is that new entry and new competition is made harder. This occurs because access to the hospital, an essential element of complete medical service, is made more difficult. At the same time established doctors from the competing group have a special position in the existing market. The rights created provide strong incentives for the competing groups to agree on terms that exclude new competition and allocate wealth among the existing practitioners. In sum, the basic rights defined and recognized by the courts will make it very difficult to challenge exclusionary decisions.

Within 11 days of the Wisconsin decision, the United States Antitrust Division commenced proceedings against doctors and hospitals in Danbury, Connecticut and St. Joseph, Missouri, charging them with collaborating to create a price fixing scheme and to exclude new entry at either level.\(^5\) The New York Times, citing unnamed experts, reported that more cases like these will emerge as health-care professionals struggle to defend their fees and control over medical services.\(^5\) The nature of the rights conferred on hospitals to exclude new doctors based on self-defined manpower plans will greatly influence how successful these struggles will be since antitrust law can only reach the most egregious and conspicuous violations.

Similarly, in late April 1995, the United States Supreme Court gave its blessing to large scale, state sponsored price discrimination in hospital services in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*\(^5\) The issue in *Blue Cross* was whether ERISA’s pre-emption of state law relating to employee benefit plans defeated the New York statute which imposed up to 24% price increases on all health insurers and HMOs, including those that administered health care plans for employers.\(^3\) Only Blue Cross plans were exempt, and some of the price increases went to the hospitals while some portion went to the state. The Court correctly held that under ERISA these surcharges did not relate to employee benefit plans within the meaning of the statute.\(^3\) The goal of these charges was to tax one set of health insurance plans for the benefit of the hospitals.\(^5\) The state and federal government were forcing hospitals to take lower payments for patients on Medicare and Medicaid in order to protect the Blues from price competition because the Blues had open enrollment for all individuals. Moreover, the state wanted to reimburse itself for some of its health care costs.\(^6\)

To justify this state interference in employee benefit plans otherwise protected by ERISA, the Court necessarily had to take the position that rate variations among hospital providers are accepted examples of cost variation, since hospitals have traditionally attempted to compensate for their financial shortfalls by adjusting their price schedules for patients with commercial health insurers.\(^6\) For the Court to consider price discrimination (rate variations) examples of cost variation is highly disingenuous, assuming the Court truly understood the meaning of the terms examples of cost variation. The cost of hospital care depends on the physical condition of the patient and not on the identity of the insurer. But to maintain the historic system of subsidy, it is necessary to impose higher prices on some users so that sufficient revenue emerges to cover the total costs of the operation. The Court’s decision in *Blue Cross* operates to validate the “traditional” system of price differences for the same services which in
turn tends to reinforce the discretionary power of the price setter in any market with less than perfect information and transferability.

The foregoing cases illustrate how the way in which health care rights are defined structure the context within which any market activity will occur. The conditions for workable competition require that informed buyers be able to purchase essentially fungible goods or services from multiple sellers. In such a market, price will approximate cost, and all producers will remain under continuous pressure to improve the quality and lower the relative price of the items sold. This occurs because buyers realize they can make informed choices among options and variations in the products being sold. Moreover, if the price differences that emerge are not clearly related to the relative value of different alternatives, buyers will switch from the more costly to the less costly option.

Contemporary American health care markets diverge very substantially from such a model. First, the ultimate consumers, the patients, are generally not well informed, nor are they capable of developing and processing the necessary information, even if it were available. Furthermore, the patients are not likely to pay in an easily and directly discernable way for the choices they have made. The costs and skills needed to do the job would not be worth the potential gains any one consumer might realize, especially in a world in which choices are constrained and frequently subject to major subsidy obligations.

Second, health care is basically a personal service, thus health care is very hard to transfer beyond the initial buyer through any market process. Transferability is very helpful in ensuring relatively equal prices among roughly similar options because a favored buyer can resell to disfavored buyers. The potential for substitution imposes a very significant limit on sellers—essentially they are required to charge roughly similar prices to all buyers. Conversely, lack of transferability greatly aids sellers in varying their prices among buyers because a buyer who gets a low price can not resell the service. Furthermore the inherent non-transferability of basic health care service is made worse because the law imposes limits on transfer of health-related commodities. For example, a retail pharmacy cannot resell prescription drugs that it obtains at a discount to another retail pharmacy. This makes price differentiation among buyers easier and less vulnerable to break down.

Another important factor in health care is that the majority of costs incurred at all levels do not vary directly with the number of patients served. In economic terms, there are very high fixed costs relative to variable costs. Even those items usually thought of as variable such as the number of staff or hours worked are less flexible in the case of health care. Systems exist to serve some expected level of demand. Reducing demand does not change many of the costs involved. Moreover, most systems can handle increases in demand without incurring substantial expenses so long as the increase is insubstantial. The disjuncture between general operating costs and the out-of-pocket costs of particular patient services creates the potential for large scale price discrimination. Particular costs are rarely patient specific. Hence, it is rational to take a more global view from the provider perspective and consider whether total revenues, however derived, are reasonably related to total costs.

Further complicating the pricing system is the wide discretion necessarily given to phy-
sicians to determine the tests and procedures that they will employ. If each item is separately priced, then the party deciding on the array of things to be done to or for the patient has discretion both to select from among alternatives those which have better revenue implications, and to employ more or less tests or procedures, or vary the time or place, if that has income implications.

A closely related problem is that the beneficiary of health care rarely pays directly for such care. When any employer or the government pays, this creates divergent interests. The payer wants to lower costs, but the beneficiary does not get an economic benefit tied directly to cost savings. If all individuals and families purchased health care directly, then choosing lower cost options would translate into visible savings.

A final issue that distinguishes health care is that quality-control concerns are very great and no easy way to police those issues exists. It has not proven feasible to inspect work as is done on production lines to see if a standard of quality is adhered to. Malpractice claims are costly and complex and so do not reach many kinds of quality problems. Similarly, licensure and state regulation has not proven very effective in identifying or removing even very poor quality performance. The traditional solution has been to authorize hospitals to determine which doctors can use the facility. Because access to a hospital is usually important to a physician, staff privileges became a means to police quality of professional services.

However, as hospitals increasingly become parts of integrated organizations that sell comprehensive medical services and provide services to the community at large, this power creates great strategic leverage to force doctors to make choices, even unwillingly and to limit the capacity of new service providers. In fact, vertical integration through the hospital stage creates serious market problems as Mercy Health Systems illustrates.

Reforming legal conditions to achieve more workable competition

Achieving major changes in the legal conditions defining health care will be very difficult politically because of the powerful vested interests in the existing allocation of market positions including legal rights. As Professor Komesar has wisely observed, the failure of one institutional system is likely to parallel that in others. The economic power of vested interests translates into political power in administrative and legislative forums. Hence, the choice between markets and a political-administrative strategy confronts policy makers with the identical problem of minoritarian bias which neither institution can avoid very effectively. This is particularly pointed when it is necessary for the political system to act to reform the legal structure of markets so that the markets can operate more effectively.

The central reforms are in redefining what is sold and to whom it is sold. What is sold needs to be made as standard as possible. Health care needs can be divided into three components. First, the amount of routine care that individuals need fluctuates from year-to-year and exhibits long term trend lines showing high use early and late in lives, but averages out over any period of years for individuals or families. A second component involves catastrophic expenses usually involving a serious illness or accident. This risk is relatively low; thus relatively few people actually experience such very high expenses.
Here, the need is for an indemnity type of insurance policy in which all potential victims pool their risk and agree to pay off the costs of whoever in the group suffers the loss. A related catastrophic expense arises from long term disability requiring substantial maintenance expenses. The risks here probably increase with age, but remain only probable costs rather than certain ones. Once again, one can look at risk pooling and risk sharing as appropriate ways to handle such risks. Whether one product or three are mandated to cover these needs is not important. What is important is that relatively fixed and comprehensive policies to cover these needs be defined as the way in which health care is to be sold. This implies a single price for all customers taking a particular plan from a vendor although it might be rational to vary prices based on broad general characteristics of the population such as age or family status which are related to expected group costs.

All individuals and families would be required to select a comprehensive plan(s) for their health protection, and vendors could not refuse to sell at their established prices based on risk or other adverse characteristics. So long as a vendor achieved a substantial number of sales it would have a relatively random set of the population so that its risks based on individual characteristics of high and low costs should net out. Efficiency and effectiveness in providing for health care itself would be central to profits.

The advantage of a defined package of services to buyers is that buyers now need much less information to evaluate options. By holding substantial elements constant, buyers can focus on price and specific means by which services will be provided, e.g., HMO, PPO, individual selection of physician. Thus, it should be possible to offer consumers real choice within a framework of mandated coverage requirements so that the election is among socially useful alternatives. Meanwhile, vendors who represent large groups of buyers have strong incentives to examine and analyze all relevant data about costs and values. The vendor stands to make increased profits if it can find ways to lower the incidence of illness or accidents among its random set of the population or if it can find ways to reduce the cost of treatment. In a competitive market, the cost savings will ultimately inure to the benefit of the customers because competition will force the passing on of these savings. State or federal government agents charged with providing health care for sub-sets of the population would only have to have them sign up with an appropriate plan and pay the costs.

This can not be a voluntary system because each individual is better off economically if he or she does not share in the costs of the system but only seeks the advantage of the benefit. For this reason, a coercive system of participation with respect to those benefits that all desire is required. By imposing the burden on each individual and family to buy such insurance the gains from efficiency are reallocated to the parties with the greatest stake in their own health care. They get direct cost reduction as a reward for taking less costly options. Even those being subsidized can be given a comparable incentive if they are allowed to retain all or even part of the savings that result from making lower cost selections. A simple withholding requirement on wages and dividends with the funds flowing to a special health care account will make this system enforceable with respect to those who are employed, have income from most kinds of investments or receive public or private pensions.
Creating standard products available to all customers still requires information to make markets work effectively: better information is needed about prices both of inputs (drugs, hospital services, etc.) and of the competing packages. Accumulating information, however, is difficult to accomplish without creating negative side effects. Too much information, too soon from market actors can facilitate price stabilization rather than competition. Still, buyers of health services (inputs) need to know what prices have been. A modest lag to allow the information to lose its immediacy will provide a useful basis for informing future actions.

In addition, rights to inputs need to be made as transferable as is feasible. If a hospital or HMO gets a favorable price on a drug, it should be free to resell that drug to other lawful users. Similarly, if a group such as an HMO or PPO gets favorable terms for hospital access, it should be permitted to resell, at a profit, those rights (sub-license them) to others seeking to place patients in that same hospital. Such transactions make sense economically, when seen on the group level and focused on inputs. Similarly, statutes mandating price discrimination in favor of or against particular users should be eliminated. If transfer payments are required, they should be raised via taxes and paid out as direct subsidy. This is more efficient and provides a clearer picture of what is being spent on the provision of such services.

For such a change in the provision of health care finance to achieve real success requires that some other aspects of market organization change as well. In particular, the hospital must be reformed. The hospital is a bottleneck which can control a great deal of competition in health care. Several solutions might be considered all of which involve limiting the bottleneck power of hospitals. The right to use hospital facilities could be awarded by a third party. Hospitals themselves could be redefined in a common carrier way, i.e., the hospital must lease or provide space to any properly licensed group or individual doctor wanting to use its facilities. A third possibility is to convert hospital ownership into cooperative ventures which own all hospitals in a region. Health care providers in turn would have ownership interests and could collectively shape the “system”. The goal is to create a large system of hospitals with many owners whose only benefit from participation is efficient service. This implies that the right of participation must be open to all existing and new entrants into health care in the area. This also implies that quality control concerns have to be located elsewhere in the health care system. Experience in grain marketing and other agricultural cooperatives as well as electric power transmission suggest that at least if there is a large membership, such cooperative enterprises operate to eliminate the bottleneck effects.

The marginal role of antitrust law in restructuring legal conditions

The analysis presented here is that if workable competition is to be the central basis for producing efficient and effective health care delivery, then the primary focus of attention has to be on the conditions, amendable to legal reform, which currently make competition difficult. Fundamental change in legal conditions that constitute the market must occur. Only after such fundamental change, is it reasonably likely that we can achieve workably competitive markets.

Antitrust law basically polices markets
as they exist. It provides rules to deter and punish misconduct within the market and certain major structures and changes in structure. It can only indirectly alter the conditions under which those markets operate. Moreover, such alteration of basic conditions can only be on a case-by-case basis using antitrust. This process is very slow and very unlikely to be effective in health care markets. Antitrust standing alone is a negative. It forbids certain kinds of structures and conduct. It does not and can not command changes in current legal rights in markets. Experience gained in enforcing antitrust law is quite relevant in guiding and informing the discussion about how to change the basic conditions under which health care markets operate. Also relevant are models of industrial organization and experience gained in the deregulatory process in various industries. Once again, the focus of reform has to be as in other market transforming actions on developing and implementing a strategy that defines the legal conditions and relationships under which the market will operate in ways that maximize the opportunity for competition.

Even in the absence of reform, antitrust law does serve to make the current markets more workably competitive and so more socially useful than they would be in its absence. However, as the two illustrative cases demonstrate, current legal conditions governing important aspects of contemporary health care, ensure that the positive contribution of enforced competition will be seriously blunted. If the nation changes the legal conditions under which health care is financed to improve the prospects for workable competition, then antitrust laws would be more relevant as a means of ensuring that the basic commands were fully and effectively enforced. But real change requires more than active implementation of the Sherman and Clayton Acts.

ENDNOTES

5 Blumstein, supra note 2, at 98-99. The road not taken leads toward more comprehensive publicly administered health care system. The difficulties with that option are also substantial as the experience of various foreign systems demonstrates.
6 Public health issues such as basic sanitation have a much longer, if complex history of success. See generally C. Henrik Hartog, Pigs and Positivism, 1985 Wisc. L. Rev. 899.
7 Burton A. Weisbrod, Economics and Medical Research 34 (1983). Doctors could in most instances only tell a patient what was going to happen; hence, they were not able to demand very high wages. Although generally more useful than fortune tellers, the value added by a scientifically correct diagnosis was not a major enhancement in the economic or psychological status of the patient.
8 Id. at 4.
11 The aggregate data supporting these assertions appears in the accident statistics published by the National Safety

See Victor, supra note 25, at 1, 3-4.

See id. at 7-8.

In the era when health care was not costly, it became a fringe benefit for organized employees. Moreover, as such, to be of value to most workers it had to cover the recurring and ordinary costs of health care. Catastrophic illness and accident is an infrequent event so that individuals get less sense of value when coverage is limited to such events. During World War II when wages were limited, increasing such health care benefits was a way to increase economic wages without violating the controls over direct wage payments. Favorable tax treatment (employer provided health care is not part of the taxable wages of employees and is a deductible expense for the employer) created an indirect subsidy for this strategy. This also screened employees from appreciating the links between the costs of health care or the amount of transfer involved in such charges and their wages. Indeed, so long as health care was a modest and constrained part of the budget for individuals, this system despite its inefficiency and tendency to favor those who could exploit the flow of funds was workable. Improved consumer sophistication would not have been likely to make significant changes in the costs of health care and correcting the transfer system to move the subsidy costs entirely onto the public side would not have greatly altered the net income of taxpayers. Id. at 12.

One consequence of the Medicare and Medicaid systems is that because they involve major sources of revenue to hospitals and doctors, they are manipulated in various ways. See, e.g., Christopher Connell, Hospitals Face Hefty Bills for Medicare Tests: Patients Charged before Admission, Wisc. S. J., Sept. 18, 1995, at 3A. (Under Medicare, hospitals are supposed to receive a single, fixed fee for all services including tests done within three days of admission, but have in fact been billing both the government and the patients for pre-admission services on the grounds that they were "outpatient" services not covered by the single fee.)

See, e.g., Havighurst, supra note 3, at 12, 20-24; Haismaier, supra note 19, at 16-17.

See, e.g., Blumstein, supra note 2, at 108; Havighurst, supra note 3, at 12.

See Feudenhahn, supra note 32, at 1; See also, Havighurst, supra note 3, at 15-16.


Coile, supra note 39, at 8; Havighurst, supra note 3, at 12; Carol J. Simon et al., The Effect of Managed Care on the Income of Primary and Specialty Physicians: A State Level Analysis, Working Paper #41, at 1-2 (June 1995).

Coile, supra note 39, at 9; Havighurst, supra note 3, at 12.

See Lee Hawkins Jr., Study Reveals Discrimination in Drug Prices: Some Prescription Wholesalers Charge Less to Hospitals, Institutions, Wisc. S. J., July 28, 1995, at B8; See also, Feldstein, supra note 4, at 433-434; Blumstein, supra note 2, at 108; See also Blue Cross 115 S. Ct. at 1673.

Komesar, supra note 1, at 271.


Id. at 3-4.
6 Id.
7 Id. at 4.
8 Id. at 6.
9 Id. at 9.
10 Id. at 1.
11 Id. at 6-7.
12 Id. at 7.
13 Id.
14 See id. at 16.
16 Id.
18 Id. at 1672.
19 Id. at 1676-1677.
20 Id. at 1679.
21 Id. at 1678.
22 Id. at 1679 (emphasis added).
23 Id.
24 See Blumstein, supra note 2, at 99-100. See also, David Dranove & William White, Recent Theory and Evidence on Competition in Hospital Markets, 3 J. ECON. & MGMT. STRATEGY 169, 176-177 (1994); WEISBROD, supra note 7, at 33.
25 Dranove, supra note 64, at 176-177; WEISBROD, supra note 7 at 22-23.
26 WEISBROD, supra note 7, at 33.
27 21 U.S.C. § 353(c). See also 21 U.S.C. § 353(c) (absolutely prohibiting resale by hospitals and other health entities of drugs obtained at a discount).
28 ALLAN G. HERKIMER JR., UNDERSTANDING HOSPITAL FINANCIAL MANAGEMENT, 48-61 (1986); MARY LEE INEGAR & LESTER D. TAYLOR, HOSPITAL COSTS IN MASSACHUSETTS 197 (1968); WILLIAM O. CLEVERLY, ESSENTIALS OF HOSPITAL FINANCE 95-104 (1978).
29 See Herkimer, supra note 68, at 48-61; CLEVERLY, supra note 68, at 95-104; INEGAR & TAYLOR, supra note 68, at 117.
30 WEISBROD, supra note 7, at 33.
31 Chatherine S. Meschievitz, Efficacious or Precarious? Comments on the Processing and Resolution of Medical Malpractice Claims in the United States, 3 ANNALS HEALTH L. 123, 127-128; Francis Miller, Illuminating Patient Choice: Releasing Physician Data to the Public, 8 LOY. CONSUMER L. REP. 125.
32 See Timothy Jost et al., Consumers, Complaints, and Professional Discipline: A Look at Medical Licensure Boards, 3 HEALTH MATRIX 309, 314, 335-337; See generally Francis Miller, supra note 71.
34 Austin, 1995 Wisc. App. LEXIS 1071. See also Marshfield, 65 F.3d at 1407.
35 See, e.g., Austin, 1995 Wisc. App. LEXIS 1071; Marshfield, 65 F.3d 1406; Blue Cross, 115 S.Ct. at 1673.
36 KOMESAR, supra note 1, at 271.
37 See Blumstein, supra note 2, at 99-100, 103, 107-108; See also, FELDSTEIN, supra note 4, at 434-438.
39 See Haismaier, supra note 19, at 50. See also Virts & Wilson, supra note 78, at 89-91.
40 See Virts & Wilson, supra note 78, at 89-91.
41 It would be entirely rational for vendors to seek reinsurance to protect themselves from the foreseeable risks of unusual distortions in the costs they experience. Reinsurance allows risk takers to pool excess risk and by sharing it, avoid catastrophic losses.
43 I have elsewhere elaborated in some detail about this aspect of antitrust law. Peter C. Carstensen, Antitrust Law and The Paradigm of Industrial Organization, 16 U.C. DAVIS L. REV. 487 (1983).
44 See Blumstein, supra note 2, at 96. See also Carstensen, supra note 70, at 508.
45 See, e.g., Bates v. State Bar of Arizona, 433 U.S. 350, reh'g denied 434 U.S. 881 (1977); See also Carstensen, supra note 83, at 508.
46 See, e.g., FELDSTEIN, supra note 4; See also, Peter C. Carstensen, Evaluating “Deregulation” of Commercial Air Travel: Dichotomization, Entenable Theories, and Unimplemented Premises, 46 WASH. & LEE L. REV. 109.