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Antitrust Policy And Real Health Care Reform

by Dick Davidson

Hospital leaders agree with Sen. Howard Metzenbaum on one thing: Health care reform is long overdue. But the senator’s notions about reform seem to be based on the outmoded competitive models of the past.

Antitrust law reflects the legislative judgment that competition will produce not only lower prices but also better goods and services. But any observer of the health care scene in the 1980s knows differently. To the contrary: We have competition to thank for the medical arms race, with a magnetic resonance imaging (MRI) device on every corner, and for the most rapid escalation in health care costs this nation has ever seen.

Although competition may tend to keep prices low and quality high if you’re selling persimmons or personal computers, the rules are somewhat different when you’re trying to save lives and keep people healthy. There is a better way to gain control over health care costs while providing access to care for all Americans and keeping quality high: collaboration.

We need to give hospitals, doctors, and other providers incentives to work together more closely than ever for the good of their communities. And that means adapting antitrust policy to allow providers to eliminate excess capacity as well as wasteful and costly duplication of equipment and services.

Collaboration does not have to raise prices. More likely, the opposite will be true. In December 1992 an administrative law judge dismissed a suit by the Federal Trade Commission (FTC) against the merger of two hospitals in Ukiah, California. The FTC had challenged the arrangement, charging that it violated antitrust laws and would be harmful to the interests of consumers. After reviewing the merger’s effects on patients and the community, Judge Lewis Parker noted that “the facts belie [the claim that] competition among health care providers will give consumers the same benefits as competition in other industries. . . . Competition did exist [before the merger] . . . but it appears to have increased the costs of hospital care in the Ukiah area through duplication of services.”

Access, too, is likely to improve under collaboration, as providers come together motivated by a desire to maintain important but unprofitable services needed by their communities.

Given this conflict between competing public policies, I propose that where antitrust policy and health policy goals collide, health policy goals must take precedence. The government needs to clear the way for collaboration as a step toward real health care reform by adopting a more flexible approach to antitrust, one that puts the public interest at the top of the agenda.

Senator Metzenbaum implies that antitrust is a toothless tiger that health care leaders have no reason to fear. There is little empirical evidence, he says, that collaboration is being stifled by antitrust enforcement. Hospital leaders say otherwise. More than 44 percent of top hospital executives responding to a recent Hospitals and Health Networks poll agreed that antitrust concerns had slowed down or inhibited their collaborative efforts. Regrettably, perception, when it impedes collaboration, is reality.

Dick Davidson is president of the American Hospital Association in Chicago.
There is good news and bad news here: A lot of hospital collaboration is going on, but a whole lot more could be and should be happening now if the United States is going to restructure its health care system to meet patient and community needs. And while the collaboration that is going on gets publicized—and rightly so—what is not happening because of hospital leaders’ fears is harder to pin down.

In seeking a more flexible antitrust policy, hospital leaders by no means propose to abandon consumers to the predatory pricing practices of 3 handful of monopolistic providers. Hospitals in Colorado, Florida, Maine, Montana, Ohio, Oregon, Tennessee, Washington, and Wisconsin have sought and won relief from antitrust constraints by agreeing to let the state actively supervise certain of their collaborative activities for the consumer’s protection. Hospital leaders are not proposing that hospitals be allowed to make decisions based on their own best financial interests, as Senator Metzenbaum charges; to the contrary, we simply want hospitals to be free to act in the best interests of the communities they serve.

Federal lawmakers, too, are increasingly recognizing the need for more flexible antitrust policy. We in the hospital community applaud Senator Metzenbaum’s pledge to encourage the US. Department of Justice and the FTC to give hospitals clear guidelines up front on antitrust enforcement. More accessible information early on in the process is likely to ease the chilling effect of unpredictable enforcement on collaboration. Over the past two years several of Senator Metzenbaum’s colleagues in Congress have introduced legislation to exempt certain forms of hospital collaboration from antitrust enforcement. Health care leaders welcome these initiatives.

Not long ago, a public figure who has thought long and hard about reforming our nation’s health care system was quoted as saying that there should be antitrust law changes to shield hospitals from regulations that make it difficult for them to collectively purchase expensive medical equipment. Hillary Rodham Clinton understands why hospital collaboration is crucial to health care reform. We have every hope that Senator Metzenbaum and his colleagues will hear the message.

NOTES
1. In Re: Adventist Health System/West, Docket no. 9234 at 44 (9 December 1992).
2. Legislation is awaiting the governor’s signature in Iowa, Minnesota, and Texas, while similar bills have been introduced in Georgia, Illinois, Indiana, Kansas, Massachusetts, Nebraska, North Carolina, and North Dakota. In other states, such as Maryland, hospitals are protected under state programs.

Physicians As Professionals, Not Pawns
by James S. Todd

It is amazing how old labels and impressions never seem to fade away. Sen. Howard Metzenbaum recounts ancient history relating to the presumed transgressions of the antitrust laws by the American Medical Association (AMA). He indicts the AMA’s previous objections to health maintenance organizations (HMOs) as a reason not to acknowledge any current need for antitrust relief for the medical profession. It is true that for some time the AMA had real concerns over managed care, and with good reason, as demonstrated by nefarious activities and significant early failures. Since 1977, however, the AMA has declared that physicians may be employed contractually but should not be subjected to lay interference on professional matters, and that physicians’ primary responsibility should be to their patients. Any contemporary violations of the antitrust laws have been not by the AMA but by physicians who, because of the ambiguity of these laws, have inadvertently found themselves in violation.

We are about to enter into a new era in

James Todd is executive vice-president of the American Medical Association in Chicago.