Health care and antitrust: current and future issues for the United States

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(Atención sanitaria y políticas antimonopolio: el presente y el futuro en Estados Unidos)

Abstract
The authors discuss the changing role of the antitrust policy in today's health care markets and possible future environments. The antitrust challenges today lie in maintaining competition when hospitals merge or bargain as multi-hospital systems, providing access in areas with high concentration of hospital closures, incorporating quality into the measures of market power. The role of quality competition may become more important in the future scenarios such as single payer system under fixed prices.
Keywords: Hospital competition. Quality. Antitrust.

Resumen
Los autores discuten el papel cambiante de la política antitrust en los mercados sanitarios de hoy y los posibles escenarios del futuro. Los retos actuales se centran en mantener la competencia cuando los hospitales se fusionan o establecen acuerdos de sistemas multihospitalarios, y proveen acceso en áreas con alta concentración de hospitales en proceso de cierre. Es un reto incorporar la calidad en las medidas de poder de mercado. Es posible que el papel de la competición por la calidad pueda adquirir mayor relevancia en determinados escenarios futuros, como el de un sistema de pagador único y precios fijos.
Palabras clave: Competencia hospitalaria. Calidad. Antitrust.

Introduction

As markets are redefined and insurers and providers adapt to new competitive pressures and payer concerns, there is a renewed emphasis on antitrust. During the past decade the health care industry has made profound organizational changes, including the extensive consolidation of hospitals through mergers and the formation of multi-hospital systems. We also witnessed consolidation on the part of the insurers with managed care plans gaining purchasing power to bargain with health care providers. In addition, the rise of specialty hospitals in certain parts of the country may lead to new definitions for hospital product markets in those areas. As response to specialty clinics, such as cardiac and orthopedic centers, the U.S. health care industry experienced a wave of hospital service closures as well as hospital closures per se. Such closures may improve efficiency but create access to care barriers for some populations.

Recent empirical data on hospital market concentration shows that most of the health care markets fit the moderately concentrated or highly concentrated categories[1,2]. The lack of success of the Federal Trade Commission (FTC) in preventing what they deem to be anticompetitive actions in hospital merger cases stands in contrast to its relative success in another health care arena –physician services– as well as in other major industries such as office supplies and telecommunications[3]. This difference in success rate can be attributed to hospitals arguing their exceptionality such as their non-profit mission, administrative nature of the hearings, hospitals' financial resources, and hospitals' ability to secure the testimony of big buyers (e.g. managed care companies)[3].

Although there is empirical evidence that hospital mergers often lead to market concentration and higher prices, the impact of mergers on quality is uncertain.

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Market concentration and health care prices

Economic theory suggests that competition leads to efficient outcomes. Health industry however is dominated by non-profits that have different objectives than for-profit agents. Therefore in health care markets, the impact of competition on social welfare is uncertain. There are many theoretical models that explain non-profit behavior from physician's cooperative at one extreme to identity with consumer cooperatives at the other. Therefore, theoretically, price behavior of non-profit hospitals is ambiguous[4]. Recent empirical assessments of hospital prices and hospital competition show that reduction in competition leads to increase in prices regardless of ownership status[5,6]. Although FTC has been unsuccessful in stopping mergers it began to review completed hospital mergers and acquisitions and to seek to dissolve any transactions that resulted in anticompetitive pricing behavior. On February 10, 2004, the FTC filed a complaint challenging, and seeking the dissolution of the merger of Evanston Hospital and Glenbrook Hospital with Highland Park hospital in Illinois. The complaint alleges that post merger prices rose by 15% to 190%, many managed care plans had to abandon their capitated reimbursement methods and pay fee-for-service, costs increased after the merger and physicians employed by the hospital and those on the hospital medical staff were able to engage in price fixing. The complaint shows that hospitals that merge are not immune from antitrust laws if one can show actual exercise of market power. Although empirical evidence points to higher post-merger prices and costs, the full impact of mergers on social welfare is unknown without its impact on quality.

Incorporating variations in health care quality into the measurement of market power

The importance of quality in market analysis depends on its relationship to the price level. If prices and quality are positively related, then analysis of prices may be sufficient and quality will not merit special consideration by policy-makers. In such cases, higher monopoly prices or post-merger prices may reflect higher quality. However, when competition among health care providers increases, the effect on quality is unknown. Competing providers may increase quality to attract patients. This increase may or may not be desirable since the employers may actually prefer lower quality (which is different from low quality).

The role of health care quality in defining the market power has not been addressed by the literature or the federal agencies. Although health care quality is difficult to observe, the ability to measure quality has improved greatly, and it is being measured more frequently to address antitrust policies. Quality information is becoming more accessible as magazines publish rankings of providers that can be used to help consumers and purchasers make informed choices. From beta-blocker utilization to risk-adjusted mortality rates researchers are using a wide variety of measures to assess and rank health care providers.

One of the first studies to address health care quality by Shortell and Hughes (1988) found no significant association between hospital competition and inpatient mortality rates[7]. This result may be due to the time period the study was conducted. A more recent investigation by Kessler and McClellan (2000) found that competition significantly reduces the adverse health outcomes especially for the time period after 1990[8]. Before 1991 the study found higher quality of care. Sari (2002) shows that both higher hospital market share and market concentration are associated with lower quality of care as measured by in-hospital complications[9]. Empirical evidence shows that it is important to understand how quality fits into market definitions, or into efficiencies associated with mergers of health care providers. Market power gives health care providers the ability to raise prices above competitive levels or lower quality below competitive levels either on a profitable and sustained basis or by precluding expansion and new entry by rivals. This means that quality levels, similarly to price levels and profit levels, relative to competitive benchmarks, are the key diagnostics of the exercise of market power. Therefore, quality should be incorporated into the antitrust analysis and if mergers lead to higher prices and lower quality, thus lower social welfare, the case to challenge mergers is strengthened.

The FTC has not addressed information about quality as a potential factor in measuring the market power. As federal government and researchers study market concentration, output quality should be one of the goals of the antitrust policy. Input quality should be incorporated in market definitions with the low quality providers receiving a smaller market share than the high quality providers.

Future directions and topics within antitrust and health

Future topics in health care will relate to the access to care along two dimensions. First, there will be political pressures for the expansion of the public market to include the non-poor. Second, access to care and availability of hospital services will become greater issues particularly in some markets that experienced an increase in hospital closures. As health care premiums

continue to increase, there will be more pressure to expand Medicare coverage to include the non-poor, thus changing the nature of the public market. At the same time employers and the constituency of the unions want to shift their increasing health care costs to the taxpayers. This will create the pressure to expand Medicare. The fact that many market participants are now willing to consider universal coverage model based on Medicare is echoed by many industry observers even though such model lack incentives for consumers to contain health care spending[1,10]. If Medicare is expanded to cover the entire population, the role of the antitrust will be minimal since prices under such system will be fixed. However, under fixed reimbursement the quality of care may decrease. Such decrease has already occurred in the dialysis industry under similar conditions. However, in the environment of fixed prices the quality competition will become more important.

Access to care will remain an important topic of research due to hospital closures. The problem is especially acute in markets where hospital profit margins are low. Since markets fail to provide access to care in poorly insured areas, the government intervention will be necessary. Government policies to solve the access problem may include building new hospitals or provision of health insurance in poor areas, to relieve existing hospitals and attract new entrants. Also, few attempts have been made to help the financially struggling hospitals to stay open. Such policy will require more research on identification of hospitals that are in distress before they are closed.

Along with hospital consolidation, medical group consolidation has led to a number of highly concentrated physician markets, with some medical groups falling outside of antitrust safety zones. The relationship between the medical group market structure and medical group prices and quality of care is an important topic for future research.

There is enough evidence to suggest that health care markets became more concentrated but the reasons for such consolidation and whether consolidation of health care providers was a response to the increase of managed care plans' purchasing power are not yet investigated. So, since increased competition improves social welfare –and in the case of the health care industry it may lead to improved health outcomes (lower mortality)–, more research is necessary to investigate what factors are responsible for hospital and physician consolidation.

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