

ANTITRUST ENFORCEMENT IN THE HEALTH CARE INDUSTRY:
A BATTLEGROUND OF COMPETING PARADIGMS

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In response to Barak D. Richman, *Antitrust and Nonprofit Hospital Mergers: A Return to Basics*, 156 U. PA. L. REV. 121 (2007).

The application of the antitrust laws to the health care industry reflects a challenge—a *Kulturkampf*—to a traditional culture that often has resisted the incorporation of economic considerations¹ into its process of making decisions.²

“[H]ow one thinks about an issue and the way an issue is framed shape the way one analyzes it.”³ In the health care arena, there are two different ways of thinking about the product and the industry—the traditional professional/scientific model and the market-oriented model.⁴

The traditional professional/scientific model “reflects a response to perceived market failure”—an asymmetry of information between professional provider-experts and uninformed (and uninformable) patient-consumers.⁵ The response to this perceived market failure is that “professional providers, such as physicians, serve as substitute de-

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¹ For a skeptical discussion of the effect of financial incentives in clinical decision making, see David M. Frankford, *Managing Medical Clinicians' Work Through the Use of Financial Incentives*, 29 WAKE FOREST L. REV. 71, 79-83 (1994), discussing the belief structure that underlies physicians' ways of thinking about medical care, and Jonathan J. Frankel, Note, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 YALE L.J. 1297, 1315-18 (1994), discussing the problem of cost containment from the perspective of a hostile physician culture.

² For a general discussion of these issues, see James F. Blumstein, *Health Care Reform and Competing Visions of Medical Care: Antitrust and State Provider Cooperation Legislation*, 79 CORNELL L. REV. 1459, 1463-86 (1994) [hereinafter Blumstein, *Competing Visions*].

³ James F. Blumstein, *Regulatory Review by the Executive Office of the President: An Overview and Policy Analysis of Current Issues*, 51 DUKE L.J. 851, 880 (2001).

⁴ James F. Blumstein, *Of Doctors and Hospitals: Setting the Analytical Framework for Managing and Regulating the Relationship*, 4 IND. HEALTH L. REV. 211, 219-21 (2007) [hereinafter Blumstein, *Of Doctors and Hospitals*].

⁵ *Id.* at 220.

cision makers, displacing consumers.”⁶ In theory, decisions in this paradigm are based on science and are not influenced by economic considerations or financial incentives.⁷ Under this model, “economics and trade offs become marginalized in the policy debate,” as “[m]edical care . . . becomes an exclusively technical-scientific enterprise.”⁸

The response of the market-oriented model to the lack of consumer information is not to substitute decision making by experts, but “to provide information and education,” with the “objective of public policy” being to empower consumers by “improv[ing] the flow of comprehensible information to consumers so that they can function better as consumers.”⁹ Experts such as physicians become expert-advisers in this paradigm, instead of autonomous substituted decision makers. The recent embrace of so-called consumer-directed health care is a market-based strategy that depends on better-informed consumers with better-aligned financial incentives.

In the battle of the paradigms, the mere use of the term “industry” (above) as opposed to “system” is an empirically and normatively loaded descriptor. “Use of the term ‘system’ suggests a social services delivery model,”¹⁰ which is consistent with the traditional professional/scientific paradigm. In order for the antitrust laws to apply to health care services, those services must constitute “trade or commerce.”¹¹ The application of the antitrust laws to the health care “industry,” suggests that health care will “be policed through antitrust enforcement against anticompetitive conduct as are other economic sectors”¹²—a position consistent with the market-oriented paradigm.

Over thirty years ago, the Supreme Court applied the antitrust laws to the professions, holding that the “nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act,” thereby rejecting a “learned profession” or public-service-categorical

⁶ *Id.*

⁷ *Id.*

⁸ Blumstein, *Competing Visions*, *supra* note 2, at 1466.

⁹ Blumstein, *Of Doctors and Hospitals*, *supra* note 4, at 221.

¹⁰ James F. Blumstein, *The Application of Antitrust Doctrine to the Healthcare Industry: The Interweaving of Empirical and Normative Issues*, 31 IND. L. REV. 91, 94 (1998) [hereinafter Blumstein, *Application of Antitrust Doctrine*].

¹¹ Sherman Act, 15 U.S.C. § 1 (2000); *see also* Goldfarb v. Va. State Bar, 421 U.S. 773, 787-88 (1975) (holding that the legal profession was “trade or commerce” subject to coverage under the antitrust laws).

¹² Blumstein, *Application of Antitrust Doctrine*, *supra* note 10, at 95.

exemption from Sherman Act coverage.¹³ Shortly thereafter, the Court more broadly noted that the health care industry was subject to antitrust scrutiny, rejecting a claim that health planning and antitrust enforcement were incompatible.¹⁴

While the “empirical effects of collective conduct in the context of the professions (such as medicine) might differ from that in other economic sectors,”¹⁵ the core value and policy of the antitrust laws—the promotion of competition—has been applied to the professional context.¹⁶ The Supreme Court has, thus, confined its antitrust analysis to “balanc[ing] procompetitive against anticompetitive aspects of a restraint or a set of restraints,” expressing “reluctance to weigh procompetitive virtues against other competing policy objectives.”¹⁷ In short, as a general matter, the Supreme Court has rejected “challenges to antitrust enforcement actions based on the asserted worthiness of the pursuit of other, noncompetitive objectives—the ‘worthy purpose’ defense,” labeling “such purported defense theories a ‘frontal assault’ on the core values and policies of the antitrust laws themselves.”¹⁸

In this context, I have argued that “[a]ntitrust law is the virtual engine of the market paradigm,”¹⁹ because it “focuses on the promotion of competition and evaluates conduct according to considerations of economic efficiency and consumer welfare”²⁰—objectives consistent with the market-oriented model. By “eliminat[ing] non-efficiency-based criteria from consideration in deciding the legality of collective conduct,” the antitrust laws “come[] into conflict with traditional professional norms, which recognize values other than competition as justifications for collective conduct.”²¹ Antitrust enforcement leads to “more attention” on the part of “professionals and providers” to “traditional economic considerations of balancing quality and cost”

¹³ *Goldfarb*, 421 U.S. at 787-88.

¹⁴ See *Nat'l Gerimedical Hosp. & Gerontology Ctr. v. Blue Cross of Kansas City*, 452 U.S. 378, 389-91 (1981).

¹⁵ Blumstein, *Application of Antitrust Doctrine*, *supra* note 10, at 99; see also *Goldfarb*, 421 U.S. at 788-89 n.17 (recognizing the importance of context in applying the procompetitive mandate of the antitrust laws).

¹⁶ See, e.g., *Nat'l Soc'y of Prof'l Eng'rs v. United States*, 435 U.S. 679 (1978) (applying antitrust law to engineers); *FTC v. Ind. Fed'n of Dentists*, 476 U.S. 447 (1986) (applying antitrust law to dentists).

¹⁷ Blumstein, *Application of Antitrust Doctrine*, *supra* note 10, at 97.

¹⁸ *Id.* (citing *Nat'l Soc'y of Prof'l Eng'rs*, 435 U.S. at 680).

¹⁹ Blumstein, *Competing Visions*, *supra* note 2, at 1482.

²⁰ Blumstein, *Application of Antitrust Doctrine*, *supra* note 10, at 93.

²¹ *Id.* at 97.

and “has helped change the way that policymakers and market participants think about medical care.”²²

Application of the antitrust laws to the health care marketplace has, therefore, contributed toward a greater emphasis on the market-oriented paradigm. At the same time, “[s]erious analysts do not call for the elimination of the professional paradigm,” calling instead for “an accommodation between elements of both models.”²³ That is, the question for public policy is where to strike the balance along a continuum between the competing ways of thinking about health care issues. The antitrust law and its application tug in one direction, but counterforces exist and have pushed back in some cases in the application of antitrust doctrine to the health industry context.²⁴

This push back in antitrust doctrine has manifested itself in the context of judicial hostility to applying traditional antitrust orthodoxy to some components of health care—most notably the context of mergers by nonprofit hospitals.²⁵ This is where the article by Professor Barak Richman²⁶ enters the conversation.

In his article, Professor Richman observes that, in refusing to enjoin “proposed mergers of nonprofit hospitals,” courts have “abandoned the bedrock principles of antitrust law.”²⁷ That is, Richman criticizes courts in their review of nonprofit hospital mergers for being soft on antitrust enforcement and for diluting antitrust doctrine to something that one might call “antitrust light.”

The relaxation of conventional antitrust standards in this context has been criticized before, often on the grounds that the hospital merger cases reflect an infidelity to core antitrust principles of exclu-

²² *Id.* at 98.

²³ *Id.* at 93; see also Randall R. Bovbjerg, *Competition Versus Regulation in Medical Care: An Overdrawn Dichotomy*, 34 VAND. L. REV. 965, 1001 (1981) (arguing that the regulatory and competitive models will coexist in a “rather lengthy” transition period to a completely procompetitive regime, and speculating that this transition period may well “last forever”).

²⁴ See Thomas L. Greaney, *Whither Antitrust? The Uncertain Future of Competition Law in Health Care*, HEALTH AFF., Mar.–Apr. 2002, at 185 (noting courts’ apparent bending of antitrust doctrine to accommodate mergers of nonprofit hospitals).

²⁵ See Peter J. Hammer & William M. Sage, *Antitrust, Health Care Quality, and the Courts*, 102 COLUM. L. REV. 545, 614–15 (2002) (“In [hospital merger] cases, antitrust courts occasionally veer toward heresy, explicitly questioning the desirability of competition . . .”).

²⁶ Barak D. Richman, *Antitrust and Nonprofit Hospital Mergers: A Return to Basics*, 156 U. PA. L. REV. 121 (2007).

²⁷ *Id.* at 121.

sive reliance on procompetitive objectives and a rejection of “worthy purposes” as an antitrust defense.²⁸ Richman notes that other commentators, more sympathetic to the professional/scientific paradigm, defend the hospital merger cases precisely on the ground that antitrust doctrine and the health care industry constitute something of an odd couple.²⁹ These commentators laud what may be described as the lack of consummation of the marriage between antitrust and the health care arena—at least with respect to mergers of nonprofit hospitals. Richman’s undertaking is to explain, in essence, why the marriage should be consummated and certainly not annulled—i.e., to defend a robust application of antitrust to the nonprofit hospital merger context. Richman contends that it is the “failure to understand the structural details of the American health care market”³⁰ that has led the courts astray in their watering-down of the application of the antitrust laws to the merger of nonprofit hospitals.

Richman focuses on a number of features of the American health care industry (he uses the term “system,” actually, in a somewhat surprising use of nomenclature³¹):

- (i) the prevalence of third-party insurance to pay for care;
- (ii) a tax preference that encourages comprehensive coverage (sometimes called “first-day, first-dollar” coverage) in contrast to coverage of financially catastrophic outlays for medical care;³²
- (iii) “a legal and regulatory system that tends to require all ‘medically necessary’ care”³³; and

²⁸ See, e.g., Blumstein, *Application of Antitrust Doctrine*, *supra* note 10, at 111 (noting that reliance on “noblesse oblige” considerations, such as the altruistic motives of community leaders serving on the boards of nonprofit hospitals, to justify hospital mergers “abandons reliance on the structural guarantees of a competitive marketplace in favor of reliance on alternative mechanisms of assuring accountability”).

²⁹ Richman, *supra* note 26, at 123-24 & nn. 8-10.

³⁰ *Id.* at 121.

³¹ *Id.* at 124, 137, 144.

³² For a discussion of catastrophic coverage issues, see Clark C. Havighurst, James F. Blumstein & Randall R. Bovbjerg, *Strategies in Underwriting the Costs of Catastrophic Disease*, *LAW & CONTEMP. PROBS.*, Autumn 1976, at 122.

³³ Richman, *supra* note 26, at 124. The term “medical necessity” has been described as “ubiquitous as a criterion governing the obligation of [a health] plan to pay for . . . services.” CLARK C. HAVIGHURST, *HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM* 125 (1995); see also Timothy Stoltzfus Jost, *The American Difference in Health Care Costs: Is There a Problem? Is Medical Necessity the Solution?*, 43 *ST. LOUIS U. L.J.* 1, 1 (1999) (noting that medical necessity has played a “dominant role” in defining the scope of health coverage “[f]or the past half century”). Professor Mark Hall has pointed out that the typical issue under the “medical

(iv) the prevalence of nonprofit institutions “to provide care to the indigent, technological innovation, and other public goods.”³⁴

Richman contends that “[t]hese features are critical in understanding the market for health care, and they accordingly shape a proper anti-trust analysis.”³⁵

Many of the specialized characteristics of the health care industry identified by Richman arose, properly or improperly,³⁶ in response to an adherence to the professional/scientific paradigm. For example, comprehensive third-party insurance would typically be expected to increase levels of consumption, since neither consumers nor providers are absorbing the bulk of the expenses for actual utilization decisions.³⁷ Adoption of such widespread comprehensive coverage could

necessity” standard has been “whether, on balance, the procedure’s medical benefits outweigh its medical risks,” not “whether a beneficial result might be obtained more cheaply, let alone whether a marginally increased benefit is simply too expensive to be worth the cost.” MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING MECHANISMS 67 (1997). That is, the “medical necessity” criterion conventionally requires “only that some medical benefit be demonstrated, however slight” *Id.* For a critique of the medical necessity issue, see William M. Sage, *Managed Care’s Crime: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance*, 53 DUKE L.J. 597 (2003). In 2004, Tennessee adopted a statutory definition of medical necessity in its TennCare program (a Medicaid demonstration) that expressly incorporates economic considerations into the medical necessity determination. To qualify as medically necessary, a diagnosis or treatment must meet several standards, including a requirement that it be the “least costly alternative course of diagnosis or treatment that is adequate for the medical condition of the enrollee.” TENN. CODE ANN. § 71-5-144(b)(3) (2004).

³⁴ Richman, *supra* note 26, at 124.

³⁵ *Id.*

³⁶ For a discussion of the causal relationships that have resulted in the specialized institutional structure of the health care industry, see CLARK C. HAVIGHURST, JAMES F. BLUMSTEIN & TROYEN A. BRENNAN, HEALTH CARE LAW AND POLICY: READINGS, NOTES, AND QUESTIONS 303-06 (2d ed. 1998). Havighurst et al. note that Nobel Prize-winning economist Kenneth Arrow concluded that the specialized institutions of the health care industry arose in response to certain market failures, whereas prize-winning sociologist Paul Starr argued that the medical profession organized and lobbied for protectionist legislation out of fear of the effects of robust market forces. *Id.*

³⁷ This point has been captured as follows:

There is for all practical purposes no one in the system of insured-fee-for-service health care who has and can consistently act on an incentive to conserve resources; neither patient, nor physician, nor institution, nor insurer, nor regulator, nor government faces in any true sense the cost of each procedure at a point where it can be effectively weighed against its benefit.

only gain its primacy in the face of a claim under the professional/scientific paradigm that science exclusively drives medical care decision making and that economic incentives have no role—a claim once advanced as an empirical assertion but now more likely asserted as a normative preference.³⁸ Similarly, the prevalence of nonprofit institutions is consistent with the longstanding hostility to commercial enterprise in the health care marketplace, which is also a product of adherence to the professional/scientific paradigm.

Together, these characteristics of the health care marketplace, consistent with the traditional professional/scientific paradigm, largely insulate decision makers from facing the economic consequences of their decisions, with the result that accountability mechanisms for cost consciousness in medical care spending are weak.³⁹ In short, the health care industry is an economic sector that has been constructed on a foundation—the professional/scientific paradigm—that assumed (initially) the irrelevance of economic incentives and (later) their questionable normative legitimacy. In such an ideological environment, it is predictable that attention to designing accountability mechanisms for cost consciousness would be attenuated. This has spawned the evolution of high style care that relies on expensive technology that often enhances costs without hard-nosed consideration of the value of the incremental benefits.⁴⁰ “This has been labeled the ‘too much of a good thing’ problem.”⁴¹ Failure to understand the significance of these institutional/structural characteristics of the health care marketplace—particularly the lack of accountability mechanisms and the resultant incentives for “overconsumption”⁴²—has led some courts “inappropriately” to “relax[] the standards of antitrust law.”⁴³

Clark C. Havighurst & James F. Blumstein, *Coping with Quality/Cost Trade-Offs in Medical Care: The Role of PSROs*, 70 NW. U. L. REV. 6, 19 (1975). For a graphical depiction of this expected distortion, see *id.* at 18 fig.1b.

³⁸ See Blumstein, *Of Doctors and Hospitals*, *supra* note 4, at 220 (“At one time, the claim that financial incentives do not matter was an empirical one. . . . The claim that financial incentives do not matter now rings more of a normative than an empirical bell; that is, consideration of economics is, or runs the risk of being, corrosive to medical practice and therefore is inappropriate.”).

³⁹ For a discussion of these matters, see *id.* at 214-19.

⁴⁰ See *supra* note 33.

⁴¹ Richman, *supra* note 26, at 141 (quoting Clark C. Havighurst & Barak D. Richman, *Distributive Injustice(s) in American Health Care*, LAW & CONTEMP. PROBS., Autumn 2006, at 7, 24).

⁴² *Id.* at 142 (noting the “harms of overconsumption”).

⁴³ *Id.* at 124.

Any evaluation of the proper application of antitrust doctrine to the context of mergers of nonprofit hospitals must take into consideration the realities of the specific structures and institutions of the health care marketplace, even if many of those institutions were developed out of (at least nominal) adherence to a very different way of thinking about medical care (the professional/scientific paradigm) than is reflected in the antitrust laws (the market-oriented paradigm). In any policy arena where there are contesting visions, an accommodation must be made that recognizes the coexistence of policies and practices that are founded upon and animated by very different premises. It is Richman's contention that robust antitrust enforcement is desirable precisely as an antidote to the structural realities that have arisen in the health care marketplace.

The tensions that arise from the battle of the paradigms are perhaps nowhere more dramatically played out than in the area of cross-subsidization—what then-Professor Richard Posner once characterized as “taxation by regulation.”⁴⁴ In concluding this Response, I want to examine (as does Richman) the problem of antitrust enforcement in the context of the traditions in the health care field of cost shifting⁴⁵ and cross-subsidization.⁴⁶

The culture of the professional/scientific paradigm—supported by the prevalence of tax-advantaged nonprofit institutions and tax-advantaged forms of insurance design—has resulted in an expectation of cross-subsidization by hospitals.⁴⁷ Surplus revenues generated in some areas are used to offset revenue shortfalls in others. In the absence of sufficient charitable donations, hospital cross-subsidization can only occur when hospitals are able to earn supra-competitive returns in some areas that can be used to subsidize preferred areas of activity.

An important goal of competition is to compete away those supra-competitive returns. Because competitive pressures chip away at an

⁴⁴ Richard A. Posner, *Taxation By Regulation*, 2 BELL J. ECON. & MGMT. SCI. 22 (1971).

⁴⁵ For a discussion of cost shifting, see Charles E. Phelps, *Cross-Subsidies and Charge-Shifting in American Hospitals*, in UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES 108 (Frank A. Sloan et al. eds., 1986).

⁴⁶ For a discussion of hospital cross-subsidization, concluding that hospitals charge insured patients as much as they can, see MICHAEL A. MORRISEY, COST SHIFTING IN HEALTH CARE: SEPARATING EVIDENCE FROM RHETORIC 85-89 (1994).

⁴⁷ Richman, *supra* note 26, at 143-48.

institution's ability to price so as to earn supra-competitive returns, these pressures also place constraints on an institution's ability to engage in cross-subsidization. The ability to earn supra-competitive returns depends upon an institution's ability to set prices above competitive levels, typically through use of market power; if competition reduces those extra margins, then the result is likely to be a restraint on cross-subsidization and, in the view of hospital managers, a threat to their ability to perform an important part of their mission.

Hospital managers cross-subsidize activities they deem "worthy," but pursuit of such worthy purposes is not an accepted defense to an antitrust enforcement action.⁴⁸ Proponents of cross-subsidies are understandably concerned that the erosion of hospital margins can place at risk a hospital's ability to provide community services.⁴⁹ Richman responds, appropriately, on grounds of allocative efficiency—a cornerstone of antitrust doctrine.

Thus, Richman observes that cross-subsidization supports "activities that are not demanded by the market, are unsustainable absent generous subsidies, and are therefore not efficient market-driven uses for valuable resources."⁵⁰ He further notes that the case for support of these subsidized services must be based on grounds of public policy (often on the basis of distributive justice considerations). But, as he notes:

If any of these activities are deemed socially desirable public goods and worthy of public support—and many undoubtedly are—then they should be supported by public institutions following a transparent and accountable public debate, not through carved-out exceptions to the antitrust laws that entrust paternalistic power to a few private actors.⁵¹

And that is the point from the broader policy perspective. Traditional antitrust doctrine, applied to the context of mergers of non-profit hospitals, can build accountability into an economic sector that has inadequate accountability mechanisms—at least when it comes to cost-conscious decision making. This is a constructive role for traditional antitrust doctrine. It may be that hospital managers who have been empowered to transfer funds to support projects or programs

⁴⁸ See *supra* note 18 and accompanying text.

⁴⁹ See Bruce C. Vladeck, *Paying for Hospitals' Community Service*, HEALTH AFF., Jan.–Feb. 2006, at 34, 41-42 (noting that, without a viable solution to the problem of subsidizing community services, hospitals might find themselves incapable of maintaining current levels of community service activity).

⁵⁰ Richman, *supra* note 26, at 145.

⁵¹ *Id.* at 145-46.

they deem worthy will be unhappy with the loss of authority. It may also be the case that some programs or projects that hospital managers currently fund and deem worthy will not be deemed of sufficient priority to receive public subsidy. But that criticism is nothing more than a claim for insulation from accountability; alternatives might be reductions in medical care spending or redirection of subsidized activity. The existing world of cross-subsidization is not accountable, and, with the lack of agreed upon accounting principles to set baselines, it is likely that hospital managers are not even able to determine with precision or clarity the nature of the cross-subsidies that exist or the trade-offs that are or are not being made.⁵²

There is a long tradition in antitrust law that private organizations cannot justify an anticompetitive restraint even to achieve valuable public policy objectives unrelated to the promotion of competition. For example, an organization cannot engage in anticompetitive collective conduct to prevent or punish unlawful conduct.⁵³ Private actors are not deputized to act in anticompetitive ways to achieve worthy purposes absent “state action”⁵⁴—the existence of a “clearly articulated” state policy to substitute regulation for competition and “active[] supervis[ion]” of that policy by responsible government officials.⁵⁵ Adherence to that traditional antitrust principle in the context of mergers of nonprofit hospitals promotes accountability; if supra-competitive returns through the exercise of market power are to accrue and to be used to pay for other worthy purposes, then use of state action immunity allows for political oversight to assure that public purposes and priorities are being served. In short, antitrust law provides a vehicle for modifying the effect of antitrust laws, and, in the 1990s, a number of states sought to make use of that provision.⁵⁶

Many of the institutional structures that have arisen in the health care industry have evolved in obeisance to the professional/scientific paradigm, which looks askance at the consideration of economics in

⁵² Enforcement of traditional antitrust doctrine could well have the salutary effect of encouraging the development of accounting norms that would allow for a better understanding of the nature and scope of patterns of cross-subsidization.

⁵³ See *Fashion Originators' Guild of Am., Inc. v. FTC*, 312 U.S. 457, 467-68 (1941).

⁵⁴ See *Parker v. Brown*, 317 U.S. 341, 350-52 (1943).

⁵⁵ See *FTC v. Ticor Title Ins. Co.*, 504 U.S. 621, 633 (1992) (quoting *California Liquor Retail Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980)).

⁵⁶ See Blumstein, *Competing Visions*, *supra* note 2, at 1486-1506 (discussing the competition exemption for hospitals in a number of states).

medical care decision making. A result has been that the disincentives for service utilization that exist in a normal market have been diluted in the health care industry. These institutional structures and characteristics of the health care marketplace call out for a counterbalance; the antitrust laws provide that balance, by forcefully bringing economic values of competition, allocative efficiency, and ultimately economic accountability to bear on the calculus of decision.

Antitrust doctrine does not necessarily stand in the way of non-profit hospitals that seek to merge, but it imposes an analytical metric that focuses on competition and efficiency and has the result of promoting accountability for expenditures. To the extent that hospitals resist “develop[ing] less costly ways of delivering services, or marginally . . . reduc[ing] quality to contain costs,”⁵⁷ enforcement of traditional antitrust norms and doctrine present a counterweight—one that promotes cost-consciousness and economically accountable decision making. I conclude where Professor Richman does: “A proper application of antitrust law would . . . understand that extensive cross-subsidies are reasons to subject nonprofits to *additional* scrutiny,”⁵⁸ not to water down the application of antitrust doctrine and principles.

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⁵⁷ *Id.* at 1480.

⁵⁸ Richman, *supra* note 26, at 148.