

FOREWORD

This symposium helps document the law's contribution to the current revolution in the health care industry. It also indicates some of the challenges that the law faces in adapting to the rapidly emerging view that the health care sector is a competitive industry in which market forces, rather than professional self-regulation or government controls, are the primary determinants of how resources are allocated. The symposium's theme, "Public and Private Barriers to Competitive Reform of Health Care Services Delivery," is broad, and the articles herein cannot fully encompass it. But the symposium presents a valuable new focal point for thinking about law and health care. This focus departs fundamentally from the traditional bifurcation of the field between, on the one hand, "law and medicine," which is mostly concerned with forensic matters, liability for personal injuries, and medical-ethical problems, and, on the other hand, "health law," which largely focuses on providers' and patients' rights under public financing and regulatory programs.

Philip Kissam explores antitrust doctrine relating to boycotts, using the health care industry as an abundant source of illustration. As one who has recently tried to clarify terminology and doctrine in the area,¹ I admire his courageous attempt to sort out these badly muddled issues. His courage is also manifest in his position that antitrust law should be generally available to contest on fairness grounds every action by a powerful but lawful joint venture of competitors that has the effect of disadvantaging a competitor. Because I am already on record as being in strong disagreement with this view, I will say only that Professor Kissam has written a provocative challenge to the view that antitrust law is intended to protect competition, not competitors.

James Blumstein's contribution takes us into the political world and away from the free market. Recapitulating the long and successful struggle to convert an innocuous provision in the Hill-Burton Act into an enforceable "right to health care" for indigent patients, Professor Blumstein offers useful insights into the political process and the courts' policymaking role. The story that Professor Blumstein tells is instructive on many levels. The overriding issue, however, is the failure of our political system to come to grips with the severe hardships facing citizens needing health care for which they are unable to pay. At the moment, a regrettable side effect of intensifying competition in health care is the erosion of the monopoly revenues upon which hospitals have previously drawn to cross-subsidize "free care" for such citizens. As Professor Blumstein reminds us, there is no such thing as a free hospital stay.

1. Havighurst & King, *Private Credentialing of Health Care Personnel: An Antitrust Perspective* (pt. 1), 9 AM. J.L. & MED. 131, 173-84 (1983).

The tension between equity and efficiency that begins to appear in Professor Blumstein's article is even more evident in Josephine Gittler's article on the debate over cost containment in Iowa. Many other states are also currently examining their policy options regarding the provision of health care, and this article will help them. My impression during a brief visit to Iowa, to attend the conference at which these papers were presented, was that Iowa is an exciting testing ground for competition. I hope that Iowa will find ways, short of re-regulating the industry in order to preserve some institutions' ability to cross-subsidize essential services, to protect the state's needy citizens against the hardships that competition might inadvertently bring in its wake. The state is fortunate to have the benefit of Professor Gittler's analysis.

Charles Weller, an experienced enforcer of antitrust laws against health care providers, offers a dramatic view of the health care revolution. His research, which draws on documents of an earlier era when medical interests' motives were more explicit, reveals our beginnings. His review of the contemporary scene shows how far we have come. By pointing out how, paradoxically, the cry of "free choice" was long used to limit consumer options, Mr. Weller has illuminated the significance of the rapidly occurring power shift from providers to consumers in health care markets.

Mitchell Raup's contribution to this symposium addresses the applicability of the antitrust laws to boycotts in the health care area. Some analysts reject the automatic classification of naked boycotts as unlawful restraints, preferring, instead, to analyze whether their purposes or effects are anticompetitive. But it seems to me that virtually the only defense for a naked boycott is that its social or political objectives remove it from the economic arena that the Sherman Act was intended to police. Mr. Raup advances the novel claim that an economically motivated provider boycott—for example, a doctor strike—aimed at increasing the level of state payments for services covered by the Medicaid program, should be deemed beyond the Sherman Act's reach. This controversial conclusion will surprise many antitrust experts. It also will require them to rethink some basic doctrine. Like Professor Kissam's article, Mr. Raup's contribution implicates legal doctrine well beyond the confines of the health care field.

By publishing the articles in this symposium, the *Iowa Law Review* has contributed to clearer thinking about a variety of legal issues in health care. I only regret that my own article scheduled for publication in this issue had not measured up to my standards of publishability by the symposium's deadline.

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