

## Solidarity Forever? The Possibilities and Perils of Physicians Unionizing

By John R. Graham

### Key Points

- Many physicians view winning collective bargaining rights as key to achieving negotiating leverage over “oligopolistic” health plans.
- Other professions, such as airline pilots or screenwriters, collectively bargain; yet they have not achieved the legal “turf protection” that physicians have.
- In the absence of organizational arrangements that many physicians shun, it is difficult to imagine what the unionized practice of American medicine would look like.
- Innovative organization of physicians’ practices can avert federal antitrust issues. Nevertheless, most physician groups are local. Federal law should abandon the field and let states alone make antitrust laws in these cases.
- Historically, American patients, not third-party payers, directed physicians’ incomes. Restoring that relationship is a better solution to physicians’ concerns than is unionization.

Anyone who talks frequently to physicians will quickly learn what the single biggest problem in American health care is today: health insurers are *oligopolies*. Federal law *forbids* physicians from collectively bargaining a standard fee-schedule with third-party payers.

That sounds fair enough when you think of the humble country doctor, his stethoscope stuffed in his black bag, calling on widows in their homes and having to send his claims to a Fortune 500 insurance company with a multi-millionaire CEO. Regrettably, things are not so simple. Certainly, physicians used to have more power than they do today. Physicians *founded* Blue Shield and hospitals founded Blue Cross in the 1930s, when hospitals were closely allied with physicians. In the 1960s, however, physicians lost control of the Blues, when representatives of the public joined the boards of many

plans. In addition, commercial insurers, who had no collegial relationship with physicians, expanded steadily into health insurance.<sup>1</sup>

As relationships between physicians and payers frayed, a number of legal decisions lessened physicians’ ability to resist health insurers’ efforts to contain costs. The final word belonged to the U.S. Supreme Court in *Arizona v. Maricopa County Medical Society* (457 U.S. 332). In this 1982 case, the Supremes decided that the physicians involved had united to fix their fees in violation of the Sherman Antitrust Act. At about the same time, the Federal Trade Commission (FTC) ordered the Michigan State Medical Society to “cease and desist” its group boycott of Blue Shield.<sup>2</sup> These and other cases from the second half of the twentieth century resulted in “ample legal authority for prosecuting health care professionals who act collectively to coerce insurer behavior.”<sup>3</sup>

Since then, physicians have formed Independent Practice Associations (IPAs). An IPA that exists solely for the purpose of administrative efficiency, instead of delivering “integrated” care, can only act as a “messenger” between its individual members and health plans. On the other hand, physicians can organize “physician network joint ventures” to provide “integrated” care, and this entity *can* negotiate as a unit with health plans, subject to usual tests of market power.<sup>4</sup> Nevertheless, IPAs that claim to be only “messengers” find ways to facilitate their members’ collusion. The FTC’s files bulge with cases of “messenger IPAs” that actually fixed prices or threatened boycotts.<sup>5</sup>

Why is the federal government so hostile to doctors organizing? After all, airline pilots and screenwriters organize. At the time of writing, the Writers’ Guild of America, West, is on strike against the Alliance of Motion Picture and Television Producers over failed negotiations to update its Minimum Basic Agreement. What is the difference between these professionals and doctors?

For a pilot, the difference is immediately apparent: he is an employee of an airline and, having signed a collective agreement, is bound to show up on schedule, fly planes as the airline demands, and (importantly) not fly planes for competitors. A physician is emphatically *not* an employee of a health insurer!

For screenwriters, the difference is harder to see: they are often self-employed, pitch scripts to a number of studios, and generally manage their own benefits, such as insurance or pensions. However, there are two important differences between screenwriters and physicians. First, screenwriters are not *licensed* professionals. If all the screenwriters boycott a studio, the studio can engage whomever it sees fit to write screenplays. We cannot simply replace *licensed* physicians if they all go on strike. Secondly, the screenwriter's duty is to the studio that engages him. There is no sacred trust for movies, no ethical "screenwriter-audience" relationship that is remotely similar to the physician-patient relationship.

The first two differences are privileges that the state accords medicine; the last is the moral basis for those privileges. An American Medical Association white paper summarizes this:

Although weak in some states, in others State Boards of Medical Examiners have upheld or re-affirmed their prohibitions on the corporate practice of medicine.... Consequently, in a corporate practice of medicine state, such as Pennsylvania, by law physicians are not permitted to be employed by an entity other than a professional corporation controlled by other licensed professionals. Since the hallmark of a relationship is that the employer directs and controls the manner in which the employee fulfills the duties of the relationship, even today corporate practice of medicine states have reasserted the need for the essential independence of medical judgment."<sup>6</sup>

This raises major issues with respect to general unionization of the medical profession. First, it is very difficult to see what a collectively bargained agreement with its independent practitioners would *look* like in practice. Imagine an airline negotiating

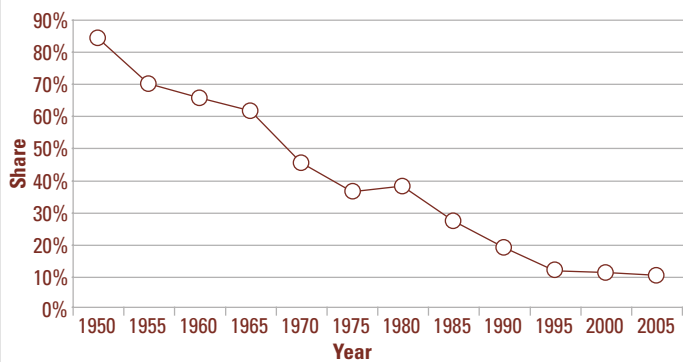
with pilots who claimed the right to fly passengers wherever and whenever the pilots' professional judgment demanded, instead of according to the airline's schedule! Imagine a movie studio bargaining with screenwriters who demanded the right to write dramas, comedies, musicals, or animated features according to *their* judgment of the audience's needs!

Second, physicians *can* unionize when they "look" like employees. The Committee of Interns and Residents, part of the Service Employees International Union, represents 12,000 residents in hospitals in five states, Washington, D.C., and Puerto Rico.<sup>7</sup> The Union of American Physicians and Dentists collectively bargains for physicians serving in the public sector, such as prisons.

Third, there are a number of successful models of physician organization to provide "integrated" care. The classical model is the staff-model HMO. HMOs have long lost market share, largely because most doctors hated them.<sup>8</sup> Nevertheless, Kaiser Permanente and its allied Permanente Medical Group continue to thrive. Also, there is at least one example of physicians organizing *their own health plan*: the very successful Capital District Physicians' Health Plan in Albany, NY, that defines itself as a "not-for-profit IPA model health maintenance organization."<sup>9</sup> Also in New York, the Greater Rochester Independent Practice Association has just secured an FTC "safe harbor" opinion that its network, while not exclusive, is satisfactorily "integrated" to avoid antitrust action.<sup>10</sup> The Pediatrix Medical Group is a physician-led group practice of 900 physicians specializing in high-risk pediatric care and is *listed on the New York Stock Exchange*.<sup>11</sup> Finally, of course, doctors who simply cannot bring themselves to organize can drop out of contracts with third parties and work for cash only.

Nevertheless, although physicians are able to organize *around* the Sherman Antitrust Act, it does not follow that they should have to waste resources soliciting "comfort letters" from Leviathan. The FTC itself notes that "relevant geographic markets for the delivery of physician services are local."<sup>12</sup> There is really no reason for the FTC to be involved: Congress should amend antitrust law to abandon this field to the states, which would result in keener observation of the consequences of different antitrust regimes.

**Graph 1: Share of Physicians' Costs Paid Directly by Patients (Out of Pocket)**



Source: Frech 1988, CMS 2007.<sup>13</sup>

However, even this does not address the “root cause” of physicians’ concern about corporate control of the physician–patient relationship. Graph 1 shows that in the middle of the twentieth century, of every five dollars American doctors earned for their services, patients paid four dollars directly. Around 1980, when the Supreme Court was about to lay down the law on physician collusion, patients still controlled about two dollars of every five dollars physicians earned. However, the share of physicians’ incomes directed by patients rapidly shrank in the 1980s. Today, a patient controls fifty cents of each five dollars a physician earns. As long as third-party payers control ninety percent of doctors’ incomes, it is hard to see how doctors can restore either their historical status or the physician–patient relationship. It’s time to get the money out of the hands of the third-party payers and back in the hands of the patients who need it. Consumer-driven health care is a far better solution than unionization.

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## Endnotes

- <sup>1</sup> Clark C. Havighurst, “Questionable Cost-Containment Record of Commercial Health Insurers,” in *Health Care in America: The Political Economy of Hospitals and Health Insurance*, ed. H.E. Frech III (San Francisco, CA: Pacific Research Institute, 1984), 245–246.
- <sup>2</sup> Ibid.
- <sup>3</sup> Mark V. Pauly and Michael Redisch, “The Not-for-Profit Hospital as a Physicians’ Cooperative,” *American Economic Review* 63, no. 1 (1973): 87–99; Sol S. Shalit, “A Doctor–Hospital Cartel Theory,” *Journal of Business* 50, no. 1 (1977): 1–20; Clark C. Havighurst, “Questionable Cost-Containment Record,” 248–251.
- <sup>4</sup> U.S. Department of Justice and Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care* (Washington, D.C.: U.S. Department of Justice; Washington, D.C.: Federal Trade Commission, August 1996), 43–48, 61–105.
- <sup>5</sup> David R. Pender and Markus H. Meier, *Overview of FTC Antitrust Actions in Health Care Services and Products* (Washington, D.C.: Federal Trade Commission, October 2005), 8–29.
- <sup>6</sup> Alice G. Gosfield, *Quality and Clinical Culture: The Critical Role of Physicians in Accountable Health Organizations* (Chicago, IL: American Medical Association, 1998), 4.
- <sup>7</sup> Committee of Interns & Residents, *Who We Are*, online at <http://www.cirseiu.org/ourlocal/> (New York: SEIU Local 1957, accessed December 4, 2007).
- <sup>8</sup> J.D. Kleinke, *Oxymorons: The Myth of a U.S. Health Care System* (San Francisco, CA: Jossey-Bass, 2001), 56.
- <sup>9</sup> Capital District Physicians’ Health Plan (CDPHP), *History of CDPHP*, online at <http://www.cdphp.com/aboutCDPHP/about.aspx> (Albany, NY: CDPHP, accessed December 4, 2007).
- <sup>10</sup> Markus H. Meier, Greater Rochester Independent Practice Association, Inc.: Advisory Opinion, letter to Christi J. Braun and John J. Miles of Ober, Kaler, Grimes, & Shriver, 1401 H St., Ste. 500, Washington, D.C. (Washington, D.C.: Federal Trade Commission, September 17, 2007).
- <sup>11</sup> Pediatrix Medical Group, *UBS Annual Healthcare Conference Presentation* (Fort Lauderdale, FL: Pediatrix Medical Group, February 12, 2007).
- <sup>12</sup> U.S. Department of Justice and Federal Trade Commission, *Statements of Antitrust*, 65 fn 26.
- <sup>13</sup> H.E. Frech III, “Monopoly in Health Insurance: The Economics of *Kartell v. Blue Shield of Massachusetts*,” in *Health Care in America: The Political Economy of Hospitals and Health Insurance*, ed. H.E. Frech III (San Francisco, CA: Pacific Research Institute, 1984), 313 and sources; Centers for Medicare & Medicaid Services, *National Health Expenditures by type of service and source of funds, CY 1960–2005*, ZIP file online at [http://www.cms.hhs.gov/NationalHealthExpendData/02\\_NationalHealthAccountsHistorical.asp#TopOfPage](http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage) (Baltimore, MD: Centers for Medicare & Medicaid Services, accessed November 30, 2007).