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THE ARCHITECTURE OF HEALTH CARE MARKETS: ECONOMIC SOCIOLOGY AND ANTITRUST LAW

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I. INTRODUCTION

Why an economic sociology of health care markets? Surprisingly, while neoclassical economics has well-developed models of competition, it has a fairly impoverished understanding of markets. If economists treat "the firm" as a black box, the same is equally true of "the market." The absence of a theory is not a serious concern in markets that function well. The absence of such a theory in health care, however, is a problem. Health care markets are not well-functioning.[1] Health care is plagued with substantial market failures. Similarly, health care markets defy simple or clear distinctions between what is "public" and what is "private."[2] Without a better theory of health care markets and how public and private elements interact, judges will be constrained in their ability to formulate workable antitrust policy, and legislators will be constrained in their ability to formulate a more rational competition policy.

Much of my past work has sought answers to these questions looking, as an economist and antitrust lawyer, from the inside out.[3] This essay is an effort to examine health care markets from the outside in, through the lens of economic sociology, rather than traditional economic theory. The principal aid in this process will be Neil Fligstein's book, *The Architecture of Markets: An Economic Sociology of Twenty-First-Century Capitalist Societies*.[4] The analysis will pro-

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[1] Peter J. Hammer, *Arrow's Analysis of Social Institutions: Entering the Marketplace with Giving Hands?*, 26 J. HEALTH POL. POL'Y & L. 1081, 1083 (2001).

[2] *Id*. at 1090.

[3] *See, e.g., id.* at 1084.

[4] NEIL FLIGSTEIN, THE ARCHITECTURE OF MARKETS: AN ECONOMIC SOCIOLOGY OF TWENTY-FIRST-CENTURY CAPITALIST SOCIETIES (2001). Fligstein observes that "[m]ost economists ignore, or are unaware of, how noneconomists think about economic processes." *Id*. at 8. This was certainly true of my own graduate training. So what is an economic sociology of

ceed as follows: Drawing upon Fligstein's insights, Part II highlights four general fallacies of neoclassical economic understandings of markets (fallacies, at least, from a sociological perspective). Part III uses the tools of economic sociology to construct an architecture of health care markets. Part IV tentatively considers the implications of the foregoing on three issues that are significant to the future of medical antitrust law: What are the implications for efforts to construct a competition policy in health care? What are the implications for efforts to better cultivate dynamic efficiency? Finally, what are the implications of economic sociology for the antitrust state action immunity doctrine, the principal tool courts use to police the boundary of the public and private sides of economic markets?

II. A SOCIOLOGICAL VIEW OF ECONOMIC MARKETS

It is not surprising that competing academic disciplines will view the same phenomena from different standpoints. Sociologists have a very different understanding than neoclassical economists about how we should think about markets.[5] Four critiques of standard economic theory can be distilled from a sociological perspective. These critiques are characterized as "fallacies" (my label, not Fligstein's) to highlight the tensions between an economic and a sociological approach.

markets? Broadly speaking, Fligstein uses "five theoretical questions to define the terrain of a sociology of markets in modern societies." *Id*. at 10.

1. "What social rules must exist for markets to function, and what types of social structures are necessary to produce stable markets?" *Id*.

2. "What is the relation between states and firms in the production of markets?" *Id*. at 11.

3. "What is the 'social' view of what actors seek to do in markets, as opposed to an 'economic' one?" *Id*. at 13.

4. "What are the dynamics by which markets are created, attain stability and are transformed, and how can we characterize the relations among markets?" *Id*. at 14.

5. "What are the implications of market dynamics for the internal structuring of firms and labor markets more generally?" *Id*.

[5] For an interesting illustration of the different perspectives of economists and sociologists, compare Mark C. Suchman, *Translation Costs: A Comment on Sociology and Economics*, 74 OR. L. REV. 257 (1995) with Lisa Bernstein, *The Silicon Valley Lawyer as Transaction Cost Engineer?*, 74 OR. L. REV. 239 (1995). *See also* Kenneth G. Dau-Schmidt, *Economics and Sociology: The Prospects for an Interdisciplinary Discourse on Law*, 1997 WIS. L. REV. 389 (1997).

A. Economic Fallacy One: Markets are Free-Standing Entities

In neoclassical economic models, markets are undefined meeting places where private buyers transact with private sellers.[6] There is no express role for the state.[7] Indeed, from an economic perspective, the state that governs best, governs least, while staying in the background and assuming at most an implicit traffic cop function.[8] From a sociological perspective, in contrast, the market is a richly textured social institution embedded in other overlapping social institutions.[9] In this setting, there is no clear delineation between "public" and "private." The roles of public and private actors are intertwined and interconnected.[10] The intuition behind a sociological perspective can best be grasped by thinking about the evolution of markets and capitalism. Historically, it is impossible to separate the function of "market building" in modern western countries from the process of "state building."[11] The state played a critical role at the inception of markets.[12] The state continues to define and redefine property rights, governance structures, and the rules of exchange.[13] Moreover, the state referees ongoing disputes between market stakeholders and stands ready to intervene at times of eco-

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[6] FLIGSTEIN, *supra* note 4, at 11–12:

> The model for perfectly competitive markets is a bazaar, a place where individual buyers and sellers meet to trade. The reality is, of course, more complex. Modern production markets require, at the very least, investment in physical plant; the building of organizations; legal, social, and physical infrastructures (i.e., forms of transportation, finance, and communication); complex chains of supply; labor markets and the training of skilled personnel; regulation of fair and unfair competition; and methods to enforce contracts. Neoconservative theorists can do a thought experiment in which private agencies provide all of these services. Historically, however, governments have been involved in providing these market-building services and structures.

(citation omitted).

[7] *Id.* at 12.

[8] *Id.* at 12–13.

[9] Economic sociology has more in common with the new institutional economics than neoclassical economics. For useful surveys of modern institutional economics, see generally DOUGLASS C. NORTH, UNDERSTANDING THE PROCESS OF ECONOMIC CHANGE (2005); THRÁINN EGGERTSSON, ECONOMIC BEHAVIOR AND INSTITUTIONS (1990); and Oliver E. Williamson, *The New Institutional Economics: Taking Stock, Looking Ahead*, 38 J. ECON. LIT. 595 (2000). This article will limit itself to contrasting economic sociology with the neoclassical school of economics.

[10] FLIGSTEIN, *supra* note 4, at 11–14.

[11] *See generally* JERRY Z. MULLER, THE MIND AND THE MARKET: CAPITALISM IN MODERN EUROPEAN THOUGHT (2002); and MICHEL BEAUD, A HISTORY OF CAPITALISM: 1500–2000 (2000).

[12] *See generally* MULLER, *supra* note 11.

[13] *See generally* FLIGSTEIN, *supra* note 4.

nomic and social crisis.[14] In short, there is no market without the state.

Recognizing the state's role in markets is only the starting point of the analysis. Important questions remain. What exactly is a market? What is the role of the state? How are the roles of the market and the state interconnected? While markets vary tremendously, all markets have a basic underlying infrastructure: "[S]ocieties have general rules, both formal and informal, about organizing economic activities. These rules provide the social conditions for economic exchange and allow for the production of new markets. Markets need definitions of property rights, governance structures, and rules of exchange."[15] Sociologists, lawyers, and economists have differing understandings of each of these concepts. For example, for Fligstein, "[p]roperty rights are rules that define who has claims on the profits of firms (akin to what agency theorists call 'residual claims' on the free cash flow of firms)."[16] The delineation of these rights is a political, not an economic or a legal process. "The construction of property rights is a continuous and contestable political process, not the outcome of an efficient process . . . Organized groups from business, labor, government agencies, and political parties try to affect the constitution of property rights."[17] In addition to property rights, markets require a governance structure and rules of exchange. "Governance structures refer to general rules in a society that define relations of competition and cooperation and define how the firms should be organized."[18] "Rules of exchange define who can transact with whom and the conditions under which transactions are carried out."[19]

The state-market interface may change by economic sector and over time. Sometimes the state plays a passive role, simply ratifying or providing legitimacy to rules of private origin. At other times,

[14] *Id*. at 19.

[15] *Id*. at 11.

[16] *Id*. at 33.

[17] *Id.*

[18] FLIGSTEIN, *supra* note 4, at 34.

[19] *Id.*

state intervention may be direct.[20] To understand the relationship between markets and the state, Fligstein invokes "field theory."[21]

> The theory of fields assumes that actors try to produce a "local" stable world where the dominant actors produce meanings that allow them to reproduce their advantage. These actors create status hierarchies that define the positions of incumbents and challengers. Actors face two related problems when constructing these fields: attaining a stable system of power and then maintaining it. The social organization of fields broadly refers to three features: the set of principles that organize thought and are used by actors to make sense of their situations (what might be called cognitive frames or world views), the routines or practices that actors perform in their day-to-day social relations, and the social relations that constitute fields that may or may not be consciously understood by actors.[22]

Both the state and the market can be understood as "fields." In his seminal 1937 article *The Nature of the Firm*, Coase argued that the central planning of the regulatory state was theoretically the same problem faced by individual "firms" in a capitalist economy – allocating scarce resources in the absence of a price mechanism.[23] Though using different tools and perspectives, Fligstein argues for a similar symmetry in understanding the processes generating and sustaining both states and markets. We begin with the state.

> State building can be viewed as the historical process by which groups outside of the state are able to get domains organized by the state to make rules for some set of societal fields. These rules reflect the interests of the most powerful groups in various fields. Politically oriented social movements are, by definition, outside of some established field of a given state. They are oriented toward either creating a new domain where they will have power, or taking over and transforming an existing domain or even the entire state. At any given moment, there are political projects in the fields that make up states (i.e., "normal politics") and social movements oriented toward altering incumbents' ability to set rules.[24]

Markets can also be understood as "fields."

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[20] FLIGSTEIN, *supra* note 4, at 19:

> If producing stability in multiple markets requires rules, then governments are deeply implicated in defining the various social structures that stabilize markets. At the very least, governments have to ratify firms' abilities to use various structures that mediate competition and conflict . . . At the very most, they directly intervene in market processes to produce stability.

[21] "The key insight of the approach is to consider that social action takes place in arenas, what may be called *fields, domains, sectors,* or *organized social spaces* . . . Fields contain collective actors who try to produce a system of domination in that space. To do so requires the production of a local culture that defines local social relations between actors." *Id*. at 15.

[22] *Id.* at 29 (references omitted).

[23] Ronald Coase, *The Nature of the Firm*, 4 ECONOMICA 386, 389 n.3 (1937).

[24] FLIGSTEIN, *supra* note 4, at 16 (citation omitted).

> Using the idea of markets as fields requires one to specify what a market is, who the players are, what it means to be an incumbent and a challenger, and how the social relationships and cultural understandings that come into play create stable fields by solving the main problem of competition and controlling uncertainty.[25]

The sociologist's definition of a market follows from the field analysis. Fligstein writes: "I accept the view that a market is a 'self-reproducing role structure of producers.' A stable 'market as a field' means that the main players in a given market are able to reproduce their firms."[26] Economic reproduction requires the ability to anticipate and strategically respond to the actions of other market participants: "Local market orders refer to a set of firms that take one another into account in their actions and, in so doing, are able to reproduce themselves on a period-to-period basis. All markets, whether organized in a city, a region, or across societies, can be analyzed from this perspective."[27]

The sociological perspective provides a number of insights into the dynamics of state-market relations. To begin with, state-market relations are governed by a dominant template that broadly defines the nature of state-market interaction across sectors.

> Market orders are governed by a general set of rules. These rules are the common understandings and laws that allow capitalist firms to exist. General ideas of market orders are embedded within a particular society and a government and reflect the society's particular history. The dominance of different groups in society means that those rules tend to reflect one set of interests over another.[28]

Neither the market nor the state are static fields. Evolution of state-market relations takes place, but this evolution is highly path dependent. "As forms of fields created by states to intervene in markets respond to and reshape the fields that are markets, state building and market building go hand in hand. Once institutionalized, these rules both enable and constrain subsequent behavior."[29] While general social rules are important, so are local rules and understandings.

> Markets produce local cultures that define who is an incumbent and who is a challenger and why (i.e., they define the social structure). They prescribe how competition will work in a given market. They also provide actors with cognitive frames to interpret the ac-

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[25] *Id*. at 17.

[26] *Id*. (quoting Harrison C. White, *Where do Markets Come From?*, 87 AM. J. OF SOC. 517 (1981)).

[27] *Id*. at 16.

[28] *Id*.

[29] FLIGSTEIN, *supra* note 4, at 19.

> tions of other organizations. I have called these local understandings *conceptions of control*.[30]

Understanding these local conceptions of control is essential to understanding the operations and potential evolution of particular markets. "Conceptions of control reflect market-specific agreements between actors in firms on principles of internal organization (i.e., forms of hierarchy) tactics for competition and cooperation (i.e., strategies) and the hierarchy or status ordering of firms in a given market."[31] Conceptions of control implicitly challenge the economist's view of the rational actor. These conceptions necessarily influence how actors interpret their environment. "A conception of control is simultaneously a worldview that allows actors to interpret the actions of others and a reflection of how the market is structured."[32] These conceptualizations will have important implications for how a market will evolve over time and respond to exogenous changes. "Actors are also cognitively constrained by a conception of control. Their analysis of a crisis is framed by the current conception of control and their attempts to alleviate the crisis by applying 'the conventional wisdom.'"[33] This introduces both an essential conservatism as well as a form of *cognitive path dependence* to the dynamics of market evolution. "Firms in stable markets continue to use the governing conception of control, even when confronted with outside invasion or general economic crisis."[34] Understanding market evolution, therefore, requires not only an understanding of the given market's conception of control, but also how those concepts change over time, i.e., *a theory of market learning*.

B. Economic Fallacy Two: The Firm is the Proper Unit of Analysis

Neoclassical economists focus on the firm as the proper unit of analysis. Firms compete with other firms. Firms engage in serial transactions with consumers. Firms produce, while consumers consume. There is no doubt that firms are important actors and that their conduct is relevant to market analysis. The sociological perspective, however, counsels against viewing firms in isolation and focusing on their actions to the exclusion of others. Markets are

[30] *Id*. at 18 (citing NEIL FLIGSTEIN, THE TRANSFORMATION OF CORPORATE CONTROL (1990)).

[31] *Id*. at 35.

[32] *Id.*

[33] *Id*. at 82.

[34] FLIGSTEIN, *supra* note 4, at 81.

fields. These fields consist of dense and overlapping networks of social interaction. Firm-customer relations constitute only part of the picture. "[T]here are actual relationships among producers, customers, suppliers, and governments in a given market."[35] Stabilizing these multiple, overlapping relations is a significant aspect of market interaction.

> A firm's product mix and marketing strategies, organizational forms, and relationships with competitors, suppliers, customers, and the government are structured by its attempts to mitigate the possible negative effects of competition and internal political conflict. Social structures in markets and within firms emerge to help firms cope with competition and stabilize their various relationships.[36]

These social networks stretch both externally from the firm to other market participants, as well as internally within the firm. "The theory of fields implies that the search for stable interaction with competitors, suppliers, and workers is the main cause of social structures in markets."[37] The theme is interconnectivity. "The imagery," according to Fligstein, is "of markets as fields and of fields as connected to and part of governments."[38] In contrast, economists view firms as both independent and isolated entities.

Networks suggest not only interconnections, but also hierarchies. In these networks, not all firms are equal. There are incumbent firms and challenger firms, and they can be expected to behave differently from each other.

> Incumbent firms are those that dominate a particular market by creating stable relations with other producers, important suppliers, customers, and the government. They exploit their position of domination by reacting to what other dominant firms are doing. Challenger firms fit into the dominant logic of a stable market, either by finding a spot in the market (i.e., niche) or imitating dominant firms.[39]

A focus on markets as fields and on fields as relational networks introduces an unavoidable political aspect to the analysis. "Once in place, the interactions in fields become 'games' where groups in the field who have more power use the acceptable cultural rules to reproduce their power. This process makes action in the field continuously conflictual and inherently political."[40] Exactly

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[35] *Id*. at 10.

[36] *Id*. at 17.

[37] *Id*. at 18.

[38] *Id*. at 90.

[39] FLIGSTEIN, *supra* note 4, at 17.

[40] *Id*. at 15.

what the objectives of these games are is the subject of the next fallacy.

C. Economic Fallacy Three: Firms Maximize Profits and Competition Yields Efficiency

In economic models, the behavioral assumptions are fairly straightforward. Consumers act consistently to maximize utility and firms act consistently to maximize profits. Economic sociology radically redefines the firm's objective function. From the sociological perspective, the firm's primary goal is seeking and maintaining stability. "Much of the market-making project is to find ways to stabilize and routinize competition."[41] As such, firms seek stability and try to avoid sources of instability.

> The sociology of markets that I am developing replaces profit-maximizing actors with people who are trying to promote the survival of their firm. There are four threats to a firm's survival. First, suppliers can control inputs, raise prices, and make firms who require their inputs unprofitable. Second, competitors can engage in price competition, take over market share, and eventually drive the firm out of business. Third, gaining cooperation from managers and workers in the firm presents problems of interpersonal conflict and politics that can jeopardize the ability to produce goods and services as well. Finally, products may become obsolete.[42]

As noted, competition, particularly price competition, is inherently destabilizing.[43] Since competition is a source of instability, it needs to be managed and controlled.

> The goal for dominant firms is to provide a set of understandings for themselves about how to cope with this potential destabilization. Firms frame their behavior, vis-à-vis one another, with the goals of convincing incumbent firms not to directly challenge one another and of ensuring that challenger firms decide not to compete directly over prices.[44]

The resulting stability (equilibrium) is very different from that of the neoclassical economic model. "When successful, actors produce social relationships that have the effect of creating stable markets, that is, situations where incumbent firms who take one another into account in their behavior are able to reproduce themselves on a

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[41] *Id*. at 5.

[42] *Id*. at 17.

[43] *Id*. at 68 ("The basic idea is that the price mechanism in a given market (i.e., the balance of supply and demand) tends to destabilize all firms in a market. This is because it encourages all firms to undercut the prices of other firms, and this threatens the financial stability of firms.").

[44] FLIGSTEIN, *supra* note 4, at 69.

period-to-period basis."[45] "Stable markets can be described as 'self reproducing role structures' in which incumbent and challenger firms reproduce their positions on a period-of-period basis."[46]

If this is true, then the resulting point of stable firm reproduction (equilibrium) will not be one that likely coincides with the competitive equilibrium. This observation necessarily calls into question the normative underpinnings of the economic model.

> A number of normative outcomes are implied by this analysis. First, if firms are effective and not efficient, then the claim that one form of market organization is superior to other forms is probably false. If firms survive by stabilizing their relationships with their competition, then the social relations that are the outcome of this process are not maximizing the efficient allocation of resources for society. Society is prepared to allow individuals to reap profits by finding legal ways to stabilize social relations in markets because there is a general good being served (i.e., the reliable production of goods and services and the offer of employment).[47]

If the equilibrium is not competitive, there is no reason to believe that market competition will yield an efficient allocation of resources.

D. Economic Fallacy Four: Firms are Stable, Unitary Actors

This last fallacy is a corollary of the second. From a sociological perspective, overlapping networks, not firms, are the proper units of analysis. This is true for internal as well as external relations.

> Two related sets of social relations, what can be called "control projects," are implicated in market building. First, a firm's internal power struggle must be resolved. The internal power struggle is about who controls the organization, how it is organized, and how ongoing situations in the product market are analyzed. Second, actors in incumbent and challenger firms must recognize the social stabilizing effects of current relations between firms.[48]

Firms themselves constitute an inherently contestable social and economic space. The continued existence and internal composition of firms cannot be taken for granted. "Issues of internal organization revolve around producing stable (reproducible) social relations. The intra-organizational power struggle is about actors within the organization making claims to solve the 'critical' organi-

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[45] *Id*. at 18.

[46] *Id*. at 31.

[47] *Id*. at 22.

[48] *Id*. at 69 (citing HARRISON C. WHITE, IDENTITY AND CONTROL: A STRUCTURAL THEORY OF SOCIAL ACTION (1992)).

zational problems."[49] The solution to this problem is intertwined with the construction of functional local cultures and conceptions of control discussed earlier.

> The winners of the internal power struggle are those with a compelling vision of how to make the firm work internally and how to interact with the firm's main competitors. I introduced the idea of a "conception of control" to summarize this worldview and the real social relations that exist between firms. In this way, a conception of control is a story about what the organization is and its location vis-à-vis its principal competitors. It is also an interpretive frame used to interpret and justify actions vis-à-vis others.[50]

These insights stand in contrast with the traditional economic view (or non-theory) of the firm as a black box. From a sociological perspective, intra-firm dynamics are significant. Among other things, these dynamics are potential sources of instability. A firm's relationship with and between its managers, and with and between its workers, is critical and changes over time. The firm itself is a shifting composite of these forces. Its internal relations are just as important and potentially contestable as its external relations.

III. THE ARCHITECTURE OF HEALTH CARE MARKETS

What is the relevance of economic sociology to health care? Health care markets illustrate many of the lessons of economic sociology. Moreover, economic sociology can lead to a deeper understanding of health care. This section sketches with broad strokes the architecture of health care markets. From a historical perspective, the story of American health care is a story of physician dominance. A century of physician control in public and private domains has deeply embedded a set of governing templates and conceptions of control for health care relations. But, instability, not stability, has been the central characteristic of health care for the past four decades. The uncertainty that surrounds contemporary health care markets can be modeled as a series of challenges progressively eroding the tradition of physician dominance, in conjunction with the complete failure of physicians and others to establish new conceptions of control that have social and economic legitimacy in a world preoccupied with controlling costs. We begin with the general lessons for health care from economic sociology. We will then examine the tradition of physician dominance and the erosion of that tradition.

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[49] FLIGSTEIN, *supra* note 4, at 71 (citation ommitted).

[50] *Id*. at 69.

A. Health Care and the Lessons of Economic Sociology

Fligstein focuses on economic markets generally, and not the particularities of health care.[51] Still, even a cursory examination of health care markets illustrates many of the above lessons. The state's involvement in medical markets is clearer than most sectors. The state licenses physicians, regulates the sale of health insurance, and constrains the types of corporate forms that are permissible. Medicare, Medicaid, and the State Child Health Insurance Program (SCHIP) account for more than one-third of all national health care spending.[52] Common law courts interpret insurance contracts and police medical malpractice. The FDA regulates the sales of pharmaceuticals and certain medical devices.[53] Public involvement is everywhere. Health care markets are not the private, autonomous, free-standing domains of the neoclassical economic model.

Other lessons of economic sociology are also illustrated. Health care is not characterized by a set of simple firms producing health care services and selling their wares to consumers in discrete, binary transactions. People do not think about their "transactions" with their doctors. They talk about their "relationship" with their doctor. There is very little price shopping or price competition in these relationships. Not even individual consumers can be viewed in isolation. Few consumers are direct purchasers of the health care services they consume. Consumers are either parts of larger (public or private) insurance pools, or stand largely outside the market amongst the ranks of the uninsured. Likewise, physicians and hospitals are members of a range of groups and professional associations, from county and state medical societies, to specialty boards of physicians, to national hospital associations, and the Joint Commission on Accreditation of Health Care Organizations (JCAHO). These groups serve personal, professional, collective economic, self-regulatory, and surrogate public functions. JCAHO certification of hospitals, for example, substitutes for independent Medicare assessments of eligibility.[54]

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[51] *See generally* FLIGSTEIN, *supra* note 4.

[52] CENTER FOR MEDICARE AND MEDICAID SERVICES, PROGRAM INFORMATION ON MEDICARE, MEDICAID, SCHIP AND OTHER PROGRAMS OF THE CENTER FOR MEDICARE AND MEDICAID SERVICES, § 1, 6 (June 2002), http://www.cms.hhs.gov/TheChartSeries/Downloads/Sec1_p.pdf.

[53] FEDERAL FOOD, DRUG, AND COSMETIC ACT, 21 U.S.C. §§ 351 to 360ccc-2 (2004).

[54] American Society for Healthcare Engineering of the American Hospital Association, *JCAHO Federal Deemed Status and State Recognition*, *at* http://www.ashe.org/ashe/codes/jcaho/deemed_status.hmtl (last visited Sept. 20, 2007).

Social networks of professional organizations overlap and work with (and against) each other. In these overlapping networks, individual actors are often called upon to play multiple roles. Physicians, for example, are self-interested sellers of medical services and, at the same time, expected to be faithful agents for their consuming patients. Whether and how these roles conflict often depends on the overriding scheme of reimbursement. Under traditional fee-for-service systems of compensation, physician and patient interests were aligned in the same direction. In contrast, under modern systems of managed care, where a physician may be a partial equity owner of the enterprise, the financial interests of physicians and patients can be in direct opposition. In a different context, physicians may either be individual competitors or colleagues on a hospital's medical staff deciding upon the competence or staff privileges of their economic rivals. Understanding health care markets, therefore, requires understanding these multiple interlocking networks and how these competing and complementary roles interact. A focus on individual actors or isolated "firms" is not sufficient.

Health care markets contain other puzzles. Is the behavior of physicians and hospitals best characterized as profit maximization, or the quest for stability in the form of period-to-period reproduction?[55] Viewed from an empirical perspective, the case for rational profit maximization is not obvious. I have argued elsewhere that business practices in the managed care industry are more consistent with patterns of "herding and cycling" than efficient evolution and rational adaptation.[56] In a turbulent environment, however, it may be difficult to differentiate competing theories of behavior. Resisting change or cooperating to reproduce old power relations in new forms may descriptively be consistent with incumbents either seeking stability or maximizing profits. Survival in an uncertain environment is itself a rational strategy.

In this confused and uncertain environment, the themes of economic sociology have an intuitive appeal. But what does the architecture of contemporary health care markets look like? In the world of social institutions, past is often prologue. To understand the architecture of modern health care markets, one must start with un-

[55] The question of physician profit maximization and the role of non-profit hospitals has long challenged economists and sociologists. *See* Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963).

[56] *See* Peter J. Hammer, *Competition and Quality as Dynamic Processes in the Balkans of American Health Care*, 31 J. HEALTH POL. POL'Y & L. 473, 485–88 (2006). We will return to this puzzle *infra* Part III.C.2.

derstanding the central role traditionally played by physicians. This sets the dominant template for state-market relations. It also establishes the point of departure for the subsequent path-dependent evolution of medical markets. The story of modern American health care is one of progressive change. The analysis must therefore examine the forces that have challenged physician dominance and consider how physicians have responded to these threats. But the architecture of health care markets is not only institutional, it is also cognitive. "Conceptions of control" provide the frames through which actors understand their environment and their relations to others—old and new. New institutions may replace traditional structures, but they will be at best only partially successful unless they also generate workable and persuasive conceptions of control.

B. The Traditional Power and Dominance of Physicians

Historically, one cannot think about the architecture of American health care markets without acknowledging the physician's central role. The "professions" are often extended a special type of "property right" in their labor, one ostensibly born of expertise and protected through state-sanctioned credentialing.[57] Illustrating again the close relationship between the market and the state, the state legitimizes the credential and enforces the license's monopolistic value by making it the exclusive basis of market entry. What the state does less in the professional domain than in other economic realms is engage in substantive control of the trade. This oversight is ceded to the profession itself in the form of self-regulation, further mixing public and private roles.[58]

> Workers can capture domains as well. Groups of workers may, for example, win the right to certify new workers, which in essence gives them the right to decide who has a "property right," who owns a certificate that entitles them to make a profit from their skill. The government may directly intervene in this process or allow certification boards to be selected from members of the worker communities. Professions, such as physicians in the United States,

[57] "The power of workers and professionals has two sources: skill and status differences, and the ability to control the supply of labor and skills." FLIGSTEIN, *supra* note 4, at 103–04.

[58] *Id*. at 106:

> Professional systems that rely on private associations for credentialing tend to have more autonomy from state and corporate actors. Here, boards of experts credential new professionals either through exam systems or by governing training programs. Such systems rely on governments, of course, to legitimate their right for a monopoly over the credentialing process. But they maintain their autonomy by declaring that they are the only ones with sufficient knowledge to certify other professionals.

> have used this tactic successfully for long periods of time to control the supply of doctors.[59]

Here, it is useful to recall two earlier points. First, the template of initial state intervention typically serves as the template for future state interventions. "Initial formation of policy domains and the rules they create affecting property rights, governance structures, and rules of exchange shape the development of new markets because they produce cultural templates that determine how to organize in a given society."[60] This introduces a strong conservative tendency as to how markets evolve and manage change. "The shape of initial regulatory institutions has a profound effect on subsequent capitalist development."[61] Second, state intervention is typically in response to those who have power, the incumbent groups. "The political-cultural approach implies that the historical problems of the instability of markets for market participants, the formation of institutions to deal with these problems, and the configuration of economic and political elites are pivotal to setting up stable markets. Once established, they tend to reproduce entrenched interests and structure the emergence of new markets in that society."[62] These factors seek, although not always successfully, to reinforce the stability of the existing regime, even as state-market relations respond in an evolutionary manner to a changing environment over time.

Policy domains in American health care are numerous, hierarchical, and complex. In addition to noting the strength of traditional physician dominance, it is necessary to realize the relatively circumscribed scope of the domains in which physicians exercised public power. The site of the traditional state-market interface in health care was at the state not the federal level. Moreover, the scope of physician control was relatively narrow, relating to questions that coincided with areas of their professional expertise—issues of licensing, evaluating the quality of care, and overseeing the system of medical education.[63] Within these domains, physician authority was

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[59] *Id*. at 43 (citing PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY (1982)).

[60] *Id*. at 40.

[61] *Id*.

[62] FLIGSTEIN, *supra* note 4, at 20.

[63] Fligstein emphasizes the role that educational systems play in preserving traditional employment status hierarchies. "At crucial points in time, power constellations in society and differentiated patterns in education have crystallized and been 'frozen' into institutions that have continued to shape employment systems even after those initial conditions have changed." *Id*. at 109. This is particularly true in the professional setting. "Professional projects try to use the abstract expertise of a group as a grounds for self-governance. The

and remains quite strong, with state actors typically acquiescing to physician claim of medical and scientific expertise. Significantly, the erosion of physician dominance has less to do with their loss of power in traditional policy domains than with the opening of new policy domains, particularly at the federal level, and the implications that these new policy domains have for state-market relations.

C. Threats to Physician Dominance

While still exercising substantial power, physicians are not the overwhelming political force they once were.[64] Why have old professional systems of domination and conceptions of control broken down? There is no single, or simple, answer to this question. Three factors that are reworking the architecture of health care markets will be examined here. These forces are government actions through the Medicare and Medicaid programs, the changing nature of the health care firm, and the uncertain future of employer-based health care benefits. Understanding changes in health care financing, unrelenting developments in medical technology, and how market and non-market institutions have responded to these forces are essential to explaining the erosion of physician dominance and the resulting sector instability. Two of the overriding policy concerns in health care are (1) Who will pay for care? and (2) How will costs be controlled? The question of cost control can be broken down further into two subcomponents: (2a) rationalizing technology (R&D, adoption, and dissemination) and (2b) rationalizing the utilization of care at the level of the individual clinical episode. These issues are all interconnected. Technology decisions, for example, are strongly but only indirectly influenced by who pays for care, how it is paid for, and how it is expected to be utilized. Together, these forces are reworking health care markets. As all working with the industry know, however, what shape the future architecture will ultimately take remains uncertain.

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new literature on professions also notes that they employ universities in their struggle for governance, focus their control projects on the state, and constantly try to invade other groups' professional territory." *Id*. at 104. Once anchored in, change is difficult to effectuate. "One can see that, once in existence, the organization of labor markets is difficult to change. Workers, employers, governments, and those who run the education system have a stake in the current structure." *Id*. at 102–03. Tellingly, Arrow also stressed the important economic role played by medical education. *See* Arrow, *supra* note 55, at 952–53; *see also* Richard A. Cooper & Linda H. Aiken, *Human Inputs: The Health Care Workforce and Medical Markets*, 26 J. HEALTH POL. POL'Y & L. 925 (2001).

[64] *See generally* Mark A. Peterson, *From Trust to Political Power: Interest Groups, Public Choice, and Health Care*, 26 J. HEALTH POL. POL'Y & L. 1145 (2001).

1. Government Purchasing in Medicare and Medicaid

Initial public involvement in medical markets came in the form of licensing. Paul Starr details how states acted to legitimize the claims of allopathic physicians (M.D.s) and solidified these doctors' positions against their medical and economic rivals.[65] State intervention in an industry creates what Fligstein calls a "policy domain" governing the state-market interface.[66] Traditionally, the health care policy domain was dominated by physicians. The domain, however, was limited primarily to issues of credentialing and defining the scope of practice of rival groups (e.g., property rights). These areas correspond to areas of physician expertise. Physician values of autonomy and independence were also very much part of what Fligstein calls the local culture and conceptions of control in medical markets.

Public-private relations in health care changed dramatically in 1965 with the adoption of the federal Medicare and Medicaid programs. While ushering in substantial change, the initial Medicare and Medicaid programs were surprisingly conservative in their design, retaining the pre-existing template governing relations in the field.[67] Even though public funds would now be expended, the government was not to interfere with the professional decision making authority previously ceded to physicians.[68] Beneficiaries would retain free choice amongst participating providers. Pre-existing economic relations between physicians and hospitals would also be respected and ratified as Medicare Part A (hospitals) and Part B

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[65] *See generally* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY (1982).

[66] FLIGSTEIN, *supra* note 4, at 39:

> I conceive of the modern state as a set of fields that can be defined as policy domains. Policy domains are arenas of political action where bureaucratic agencies and representatives of firms and workers meet to form and implement policy. The purpose of this policymaking is to make rules and governance mechanisms to produce stable patterns of interaction in non-state fields. Modern states also typically develop legal systems with courts that adjudicate and interpret current laws and understandings. These legal fields are domains as well that contain judges, courts, lawyers, and law schools. One way to understand the legal system is to realize that legal systems are alternative ways for challenger groups to engage in political action. By using laws against incumbents, challengers can contest the rights and privileges of dominant groups. *Id*.

[67] The preservation of the existing template, even as radical change is introduced, is consistent with the teachings of economic sociology.

[68] Richard A. Culbertson & Philip R. Lee, *Medicare and Physician Autonomy*, 18 HEALTH CARE FIN. REV. 115, 117 (1996).

(physicians).[69] Even the pre-existing roles of Blue Cross and Blue Shield would be respected and folded into the new program by contracting out public claims administration to the Blues, acting now as Medicare carriers and intermediaries.[70] As a result, the private and professional relations characteristic of 1960s American medical markets would become the defining structural features of publicly financed health care for decades to come, preserved largely to this day.[71]

While preserving the general template of private markets circa 1965, significant changes to the American medical system were surely to follow. To begin with, the introduction of Medicare and Medicaid dramatically expanded the number and scope of policy domains governing state-market relations in health care. While physician licensing was traditionally a state concern, Medicare created important new policy domains at the federal level.[72] Moreover, Medicare politically empowered a new group of beneficiary stakeholders (Medicare recipients), whose political clout would prove to greatly exceed the economic clout they exercised in private pre-Medicare markets. But beneficiaries were not the only new stakeholders. Fights over Medicare eligibility and authorization at the federal level became at least as important as older fights over licensing and scope of practice laws at the state level. Through these numerous and incremental decisions, Medicare began to effectively redefine the scope and composition of modern health care markets.[73] In these new federal battles, physicians proved to be less ca-

[69] *Id*. at 115, 116–17, 122; Nancy E. Lew, *Overview: 40th Anniversary of Medicare and Medicaid*, 27 HEALTH CARE FIN. REV. 5, 7 (2005–2006).

[70] Culbertson & Lee, *supra* note 68, at 115, 116.

[71] Public and private institutions have different dynamic and evolutionary potentials. Private markets are likely to be more flexible and responsive to underlying economic forces. The degree of change in private health care structures and organizations in comparison with the relatively slow rate of change in Medicare is an interesting illustration of this point.

[72] Even at the state level, new domains were opened with the Medicaid program. States were not just passive endorsers of physician operated and controlled certification; they were now also financiers of health care benefits for Medicaid recipients.

[73] The contemporary importance of Medicare and Medicaid has been described by David Hyman as follows: "They influence the nature of competition. They influence the areas in which competition can exist, and the rules under which it has to exist, and the risks and rewards, and the institutional framework within which all those things take place." FED. TRADE COMM'N & DEPT. OF JUST., IMPROVING HEALTH CARE: A DOSE OF COMPETITION 227 (2004) (quoting hearing testimony of David A. Hyman) *available at*: http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf.

pable of excluding challengers from the table than they had been in traditional state forums.[74]

As an aphorism, I teach students that public controls will inevitably follow public dollars. The reality is more complicated. The nature of the policy concerns will dictate the nature and content of the subsequent controls. Medicare and Medicaid debates quickly became preoccupied with controlling costs. Health insurance is associated with strong forms of moral hazard, both static and dynamic. The root cause of moral hazard is the failure of a decision maker to internalize all of the costs of her actions. Medicare's original design, cost-based, fee-for-service compensation with no meaningful checks on the decision making of providers and consumers was a prescription for static moral hazard, the systematic over-consumption of health care services. Dynamic moral hazard is a different concern. Dynamic moral hazard is how Sherry Glied describes the positive feedback loop medical insurance (public and private) creates for investments in R&D and the accelerated pace of adopting new medical technologies.[75] Both forms of moral hazard contributed to escalating health care costs and subsequent demands for cost control. One manifestation of the desire to control costs was a public willingness to renegotiate past public-private divisions of labor defining the state-market interface in health care. In particular, there was a public willingness to encroach further on principles of physician autonomy. Another manifestation of the desire to control costs was a willingness to encourage new ways of doing business. Typically, public intervention is in favor of incumbents. When the political agenda is driven by fiscal concerns, however, public actors may throw their weight behind the efforts of "challengers" to the detriment of market "incumbents." For example, State Medicaid programs began experimenting extensively with various forms of

[74] Aspects of physician markets and professional networks make doctors particularly powerful at the local and state level. Physicians are everywhere. Physicians are organized around a wide range of issues, affording economies of organizational scope. Physician incentives on issues of professional licensing and reimbursement policy are individually intense and collectively homogenous enough to permit concerted political action. It is difficult for other interest groups to duplicate this on a state-by-state basis or throughout the thousands of counties in the country. The dynamics of a single, national lobbying effort, however, are quite different. It is easier for a wider range of interest groups to be players in Medicare politics. Similarly, the newness of the federal forum and the absence of preexisting networks and relationships made the Medicare playing field more level at its inception.

[75] *See* Sherry A. Glied, *Health Insurance and Market Failure Since Arrow*, 26 J. HEALTH POL. POL'Y & L. 957, 961–64 (2001).

managed care.[76] More recently, some states have started to experiment with new types of consumer-driven health care.[77] This public experimentation is made easier by the fact that physicians as a profession have not demonstrated any particular comparative advantage in the private domain for rationalizing the utilization of care or controlling costs.

This section is only suggestive of the many ways that Medicare and Medicaid have had and will continue to have a strong influence over health care markets.[78] Without question, the policy domains occupied by Medicare and Medicaid have become defining features of the architecture of medical markets and will play a substantial role in determining the future shape and direction of market evolution.

2. *Hospitals, Managed Care, and the Changing Structure of the Firm*

The second force eroding traditional physician dominance in health care is the changing structure of the firm itself. Fligstein stresses the inherent contestability of the "firm" in any market and argues that there is an ongoing struggle for internal control.[79] What exactly constitutes the "firm" in health care is an interesting and complicated question. Health care is unusual for the degree to which it has traditionally segregated ownership and control of the physical capital (hospitals), human capital (physician services), and financing (insurance) necessary to provide medical services.[80] Ownership and control of the non-profit hospital is another economic puzzle. Here, groups of otherwise economically independent and often rivalrous physicians come together to form the "medical staff" that exercises significant governing authority over the institution, a facility of which physicians are neither co-owners nor traditional employees.[81] These structures, however, as unusual as they are,

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[76] *See generally* Maren D. Anderson & Peter D. Fox, *Lessons Learned from Medicaid Managed Care Experiments*, HEALTH AFF., Spring 1987, *available at* http://content.healthaffairs.org/cgi/reprint/6/1/71.pdf.

[77] Sidney D. Watson, *Consumer-Directed Medicaid and Cost Shifting to Patients*, 51 ST. LOUIS U. L.J. 403, 403 (2007).

[78] For a more complete discussion of Medicare, see generally Theodore R. Marmor, THE POLITICS OF MEDICARE (2d ed. 2000).

[79] *See* Economic Fallacy Four, *supra* Part II.D.

[80] *See* Peter J. Hammer, *Medical Antitrust Reform: Arrow, Coase and the Changing Structure of the Firm*, in THE PRIVATIZATION OF HEALTH CARE REFORM (Bloche, G.M., ed.) at 113, 117–21 (2003).

[81] *See generally* Clark C. Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 DUKE L.J. 1071, 1074 (1984).

were mainstays of the traditional physician-dominated system of American health care.

Like other aspects of health care markets, the structure of the health care firm is changing. Two important trends can be highlighted. The first involves changes in physician-hospital relations. Driven by changes in technology, the increased specialization of medical services, and market demands that are becoming more competitive, hospitals are evolving in a manner to more closely resemble business firms in other sectors. Pragmatically, this means that they are increasingly organized and operated as unitary, self-interested economic actors. This has challenged the traditionally dominant role of physicians. In contrast to the "physician cooperative" model postulated by Pauly and Redisch in the 1970s,[82] physician-hospital relationships are looking more and more like employer-employee relations, although the exact nature of these relations varies substantially by area of physician specialization.[83] For example, many hospitals now hire certain types of physicians as actual employees. Moreover, exclusive contract arrangements for hospital-based practices are now the industry norm. These changes in physician-hospital relations are taking place at the same time that hospitals are asserting a broader range of independent economic objectives.

Many factors are contributing to these changes. Hospitals are in a better position than individual physicians to pool and manage many types of risk, ranging from malpractice liability to "at risk" contracting with managed care providers. As health care services get more complicated and physician services become more specialized, team production is a more apt metaphor than individual production. Hospitals are in a better position to organize, manage, and supervise these teams. Whether the logic of the multi-specialty community hospital carries forward into the future is a different question. Specialty hospitals, many owned by physician groups, are increasingly prominent.[84] The problems raised by specialty hospitals, however, are just a reminder of how contestable the underlying structure of the health care firm remains in response to changes in technology and reimbursement policy.

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[82] *See generally* Mark V. Pauly & Michael A. Redisch, *The Not-For-Profit Hospital as a Physicians' Cooperative*, 63 AM. ECON. REV. 87 (1973).

[83] *See generally* Peter J. Hammer, *How Doctors Became Distributors: A Fabled Story of Vertical Relations*, 14 LOY. CONS. L. REV. 411 (2002).

[84] *See* Peter J. Hammer & William M. Sage, *Critical Issues in Hospital Antitrust Law*, HEALTH AFF., Nov.–Dec. 2003, at 88, 93–95.

The second major trend in restructuring health care firms has been the closer integration of the financing and delivery of medical services. Managed care can take many forms and operate under many guises. The various organizational structures, however, are largely different attempts to address the moral hazard associated with traditional fee-for-service compensation. This can be done through changing financial incentives (capitation or bonuses), better supervision and monitoring of agents (practice profiling), or rationing access to care (gate-keeping and prior authorizations). While many experiments have been tried, few dominant sets of organizational form, contracting practices, or financial incentives have emerged.[85]

The internal composition of the firm remains a highly contested issue. Fligstein argues that the "intraorganizational power struggle is about actors within the organization making claims to solve the 'critical' organizational problems."[86] The critical organizational problem in health care is how to rationalize the utilization of care at the individual clinical setting in a manner that corresponds to collective needs and resource constraints. If Fligstein is correct, "[t]he winners of the internal power struggle are those with a compelling vision of how to make the firm work internally."[87] Tellingly, no such compelling vision has yet emerged in managed care. The entity that can generate such a workable vision or "conception of control," whether it be within the tradition of physician professionalism or within the tradition of business entrepreneurship, will likely inherit the mantle of market leadership (establish a new status hierarchy). This is not just a business problem, but one that involves local culture and appropriate cognitive frameworks for interpreting managed care policies and practices. Functional conceptions of control in medicine will not be workable unless they can also establish a basis for social trust and afford cultural legitimacy to the new health care firms.

The ongoing foment underscores the internal contestability of firm structure and the fact that relations between stakeholders inside (as well as outside) these firms are continually being challenged and renegotiated. It is fair to ask what role the state plays in this process. Winning in the policy domain can produce advantages in the private realm. At the state level, licensing requirements and

[85] *See* Hammer, *Competition and Quality as Dynamic Processes*, *supra* note 56, at 485–88.

[86] FLIGSTEIN, *supra* note 4, at 71.

[87] *Id*. at 69.

scope of practice limits have long served to restrict market competition. Similarly, state corporate practice of medicine laws were historically intended to privilege physicians and to make the practice of pre-paid medicine (managed care) more difficult. Conversely, the Federal HMO Act of 1973 was expressly designed to encourage new types of business structures (in the name of cost containment). Today, actions in the Medicare and Medicaid policy domain have obvious implications for business structure both by encouraging certain type of businesses by authorizing reimbursement and penalizing other organizational forms in efforts to combat fraud and abuse. The interaction between these public and private realms and their implications for firm structure are manifold and complex. Their significance, however, is often under-appreciated.

More can be said about the historic rise of managed care, the roles played by federal antitrust law, and ERISA preemption. Physicians have never been shy about using their influence on state legislatures to increase physician authority and to restrict the rise of prepaid medicine (managed care). This anti-managed care agenda was often pursued under the guise of professional ethics and self-regulation. Clark Havighurst has persuasively detailed how federal antitrust law, starting in the 1970s, played an important role in helping to transform modern medical markets.[88] The second usage of federal law that contributed to the rise of managed care was the aggressive application of ERISA preemption in the 1980s and early 1990s.[89] Antitrust law was consciously applied to limit the ability of physicians to engage in group boycotts and to employ self-regulation towards anticompetitive ends. ERISA preemption, perhaps less intentionally, limited the ability of physicians to seek comparable private objectives through state legislative (public) processes. The combined result was to create an environment more conducive to the reorganization of the internal structure of the firms providing health care. Federal law (outside the domain of antitrust state action immunity) effectively trumped state law in areas traditionally buttressing systems of physician dominance. This directly challenged the controlling position of physicians, further illustrating how developments in distinct policy domains can have significant consequences in both private markets and other policy domains. That said, it must also be acknowledged that at the same time these changes were tak-

[88] *See generally* Clark C. Havighurst, *Health Care as a (Big) Business: The Antitrust Response*, 26 J. HEALTH POL. POL'Y & L. 939 (2001).

[89] Timothy S. Hall, *Reimagining the Learned Intermediary Rule for the New Pharmaceutical Marketplace*, 35 SETON HALL L. REV. 193, 235 n.218 (2004).

ing place concerns over cost control had already seriously weakened the political influence of physicians, even within their areas of traditional control.

3. Labor v. Capital and the Future of Employee Benefits

The final threat to traditional health care structures comes from the outside. An important theme in Fligstein's book is that in all developed countries, capital and labor strike grand deals that define the relative allocations of power and benefits.[90] The content of these deals vary substantially country-by-country and are heavily influenced by the prevailing national politics at the historic moment of industrialization. Once struck, however, the basic parameters of the deal are long-lasting. In the United States, the post-World War II resolution of labor conflict made health care benefits a staple of union employment. This bargain has been largely respected in subsequent decades. There is much underlying logic to the employer-based system.[91] Sufficiently large employee groups provide workable units of insurance, counteracting problems of adverse selection. Not surprisingly, in light of the teachings of economic sociology, this deal between capital and labor is not entirely private. Employer-based health care gets substantial public support. Benefits are not taxed as income. In addition, ERISA affords employers a great deal of autonomy in defining benefit packages. In the past, ERISA preemption also protected employer plans from state regulation (and continues to do so for those plans that are self-insured). Finally, the federal Medicare and Medicaid programs made the costs of employer-based health care more affordable by removing two of the more costly tails of the population distribution (the elderly and the disabled) from the purview of private insurance.

Despite these subsidies, however, employers still shouldered a substantial part of employee health care costs. Internalizing these costs created predictably strong incentives for employers to control health care expenditures. Not surprisingly, employers were among the first groups in the 1970s and 1980s to demand early forms of utilization review and to experiment with alternative means of financing and delivering care. Today, employer groups like the Leap Frog Group and the Pacific Business Group on Health remain some

[90] *See supra* notes 30–32 and accompanying text.

[91] *See generally* David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23 (2001).

of the most proactive stakeholders seeking ways to control costs and improve the quality of care.[92]

The old capital-labor compromise providing employer-based health care, however, is being called into question by the forces of globalization. Associating health benefits with employment necessarily increases the costs of doing business. These costs are manageable if health care costs are relatively low, and if one's primary competitors have comparable commitments. As American health care costs rise, and as American producers increasingly compete in a global economy where their rivals do not pay health care costs as a part of the cost of doing business, the viability of the old formula is compromised.

If employers get out of the business of providing traditional defined benefit plans, there are only a few places responsibility for the underlying financial risk can go. One can imagine employers joining the ranks of other groups advocating for a greater public role in financing health care. This could substantially change the political formula in favor of universal health coverage. As Fligstein constantly reminds us, however, the overarching template of public-private relations has tremendous staying power and is very difficult to change.[93] Despite the experience of other countries, the American template is one that strongly resists direct government involvement in the provision of health care and holds strongly to the illusion of "private" health care markets.

The second alternative is for the risk currently held by employers to devolve to the individual level. This could be accomplished through a shift from "defined benefit" to "defined contribution" plans, coupled with the greater use of various health savings accounts. This result is more consistent with the American template of public-private relations, meaning that a future of consumer-driven health care may be a safer bet in the United States than the creation of new government-funded programs. Ironically, in a devolved world of consumer-driven health care, individual physicians may regain some of their traditional stature and influence. However these issues are resolved, the fate of privately financed care will have substantial implications for the future architecture of health care markets, as well as for antitrust law and policy.

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[92] For information about the Leap Frog Group see http://www.leapfroggroup.org (last visited Sept. 20, 2007). For information about the Pacific Business Group on Health see http://www.pbgh.org (last visited Sept. 20, 2007).

[93] *See supra* notes 30–37 and accompanying text.

IV. THE IMPLICATIONS OF ECONOMIC SOCIOLOGY FOR MEDICAL ANTITRUST LAW AND POLICY

Contemporary medical antitrust law faces three significant challenges: (1) developing a workable competition policy for health care; (2) appropriately facilitating adaptive forms of dynamic adjustment; and (3) maintaining workable divisions of labor between public actors and private markets. These are difficult challenges, in part, because the neoclassical economic model upon which antitrust courts often rely has little to say about such matters. This section will introduce each challenge and tentatively examine how our understanding of each might be different in light of the lessons of economic sociology.

A. Implications for Developing a Competition Policy

A competition policy in health care seeks (1) to better coordinate actions among distinct public actors that affect health care competition and (2) to better negotiate the interface between market and non-market institutions. Antitrust law is simply one component of a functional competition policy. The approaches of economic sociology fit comfortably within this discussion. A primary insight of economic sociology is that markets are not independent. Rather, markets are institutions nested in other social institutions with strong public participation.[94] If this is the case, then it makes sense to ask how best to mediate public and private participation and to coordinate policy across the various domains. In contrast, there is no need for a competition policy from a neoclassical economic perspective, because the market functions largely independent of the state.

Fligstein's notion of field theory and policy domains can provide some guidance for constructing a competition policy, but this will not be a simple process. The first insight is that each incidence of public-private interface creates its own policy domain. Furthermore, each policy domain is a forum where public and private interests struggle over the creation and preservation of power. The image that emerges, one of multiple and competing fiefdoms, is similar to the Balkans of American health care I have described elsewhere.[95] Fligstein reminds us that the public processes in these domains are biased in the sense that they are designed primarily to

[94] *See supra* notes 9–14 and accompanying text.

[95] *See* Hammer, *Competition and Quality as Dynamic Processes*, *supra* note 56, at 475–78.

respond to and favor the interests of incumbents over challengers.[96] As such, it would be naive to use a simple public interest theory of government action. Moreover, actions within each policy domain are likely to be conservative in a different sense. Policy changes will be reflective of the dominant template governing public-private relations generally, as well as reflective of the local conceptions of control. This does not mean that more global policy changes are impossible, but it does mean that coordinated changes within this setting will be difficult to achieve. Those agitating for a comprehensive competition policy need to be more conscious of the obstacles they will face. This is an important lesson for both lawyers and economists. Economic sociology teaches that the process of social change is more contested and more political than most economists and lawyers are trained or are inclined to believe.

Politics and conflict exist not only between public and private spheres, but between and within public spheres. Policy domains exist at the state level in terms of the licensing of physicians (and the regulation of insurance), at the federal level in terms of Medicare and ERISA, at a cooperative state-federal level in terms of Medicaid, and at the federal (as well as the state and purely private) level in terms of antitrust enforcement. Change is even more complicated because real reform often entails the reallocation of power, threatening the authority and possibly the continued existence of certain public domains. Needless to say, public bureaucracies also seek to reproduce themselves on a period-to-period basis in their own search for order and stability.

In looking at this maze of overlapping and competing policy domains, one can identify some particular institutional virtues of antitrust law as a vehicle for implementing policy change. What are the advantages of antitrust law and antitrust courts as institutions? Antitrust courts are relatively less politicized than state legislatures, self-regulatory forums, and the congressional and regulatory settings where Medicare policy is hammered out. In addition, antitrust law has its own local "conceptions of control" that are different from these other forums. The core of contemporary antitrust law embodies the philosophy of neoclassical economics. Its primary focus is on empowering competitive processes and enabling static efficiency gains. These values are held and propagated by a broad epistemic community of judges, lawyers, and academics. *Where neoclassical competition is the appropriate policy prescription*, these are powerful al-

[96] *See supra* notes 21–27 and accompanying text.

lies in its pursuit. Moreover, the antitrust policy domain is interestingly diffuse, intersecting the health care sector at many different levels. Where other policy domains are relatively discrete, such as licensing, antitrust law bisects the health care sector in an entirely different manner. This gives federal antitrust courts a unique platform from which to work. Finally, antitrust law employs a flexible, adaptive, common law form of decision making. This is a particular advantage when the formation and implementation of a competition policy will itself be an incremental process undertaken against a backdrop of policy uncertainty. By the same token, other institutions and policy domains, such as Medicare and Medicaid, state licensing and self regulation, will have their own roles to play. Ultimately, defining workable and complementary divisions of labor between these domains lies at the heart of constructing an effective competition policy. In this process, specific attention should be paid in fostering adaptive efficiency and effectively policing the public-private boundaries of the state-market interface.

B. Implications for Cultivating Greater Dynamic Efficiency

Health care markets have undergone substantial changes in the past forty years, changes that are ongoing. "Change," as a phenomenon, raises difficult questions for both antitrust law and economic sociology. Economic models of general equilibrium are static models, assuming that technology is held constant. If technology changes, the economy theoretically moves from one equilibrium to another, but the model itself has little to say about how these adjustments take place, and even less to say about what the optimal rate of technological change might be.[97] The challenges to economic sociology are quite different. Markets, from the sociological perspective, seek stability. Change is often a threat to stability and, therefore, is something to be avoided. If change is an unavoidable aspect of the market environment, then actors within this paradigm would seek stable ways to manage change. The motivation, however, is not the same as the economic perspective. Change in economic sociology is managed to produce stability, not in a quest to maximize profits, nor in some distant belief that the change is leading to some new, more efficient point of equilibrium.

[97] The polar positions staked out in *United States v. Microsoft Corp.* suggest the ongoing contestability in antitrust law regarding issues of dynamic efficiency and technological change. 147 F.3d 935 (D.C. Cir. 1998).

If the goal is stability, then health care markets are failing. Change in health care has often produced greater degrees of instability. Why is this the case? Economic sociology offers a number of insights about institutional change and evolution. The first insight is that there is no single right answer. "A sociological approach to market institutions makes us understand that there is not a single set of social and political institutions that produces the most efficient allocation of societal resources."[98] There is a wide range of plausible combinations of market and non-market institutions that can workably co-exist in a stable order. These different combinations are likely to have different efficiency attributes at their inception, and are also likely to have different capacities to respond and adjust to change, i.e., different evolutionary potentials.

Institutions must be adaptive to changes in the external and internal environment. Systems, to encourage adaptive efficiency seek to exploit (1) consciously designed selection mechanisms and (2) systems to facilitate learning, feedback, and adaptation. These concerns are reflected in the sociology literature.

> There are two perspectives at work in the sociology of markets. First, some research suggests that the internal structure is often institutionalized at the founding of the organization. This view implies that an industry converges around a small set of practices because those firms that survive are selected by the characteristics of the environment. The opposite point of view agrees that local environments affect the practices of firms. But, this point of view suggests that adaptation is possible and that organizations make constant internal adjustments to environmental conditions.[99]

These perspectives are not necessarily in conflict. Ideally, systems of selection and learning can coexist. To the extent that environmental aspects relevant to selection can be manipulated, the external environment can be shaped to encourage the selection of desired attributes. To the extent that policy choices, incentives and subsidies can facilitate learning and feedback, these tools are also available in the construction of a competition policy.

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[98] FLIGSTEIN, *supra* note 4, at 23.

[99] *Id*. at 14 (citing Michael T. Hannan & John Freeman, *The Population Ecology of Organizations*, 82 AM. J. SOC. 929 (1977) and Michael T. Hannan & John Freeman, *Structural Inertia and Organizational Change*, 82 AM. SOC. REV. 149 (1984)). Conscious imitation of successful practices is a critical part of learning and moving the entire system to better outcomes. *Id*. at 18. "If conceptions of control are perceived as successful solutions to the problems of competition, actors in nearby markets copy them." *Id*. The same can be said for learning. "Organizational learning oriented toward reducing uncertainty for firms is an important process within and across markets." *Id*. at 18–19.

Unfortunately, contemporary health care markets have demonstrated little adaptive efficiency, either with respect to section mechanisms encouraging more effective sets of organizational forms and contracting practices (market processes),[100] or in learning with respect to the selection and propagation of more clinically effective practices (professional processes).[101] Fligstein's work suggests some of the obstacles that are confronted. Economic sociology predicts certain conservative biases to markets responding to change. First, rather than permitting the factors motivating change to adopt their own logic and momentum, efforts are often made to force these factors to conform, to the greatest extent possible, with the pre-existing social template and conceptions of control. This retards the market capacity for learning and may perpetuate industry misunderstandings about the reasons for recent changes and what such changes might rationally entail about the future. Second, from Fligstein's perspective, market actors seek stability not efficiency. As such, incumbent firms are likely to resist the very processes, like competition, that economists would rely upon to act as selection mechanisms. Finally, incumbents have allies within political structures. Changes within policy domains are more likely to be designed to protect incumbent interests and minimize the adverse effects of change than to facilitate the effective dissemination and adoption of new best practices.

These lessons serve as an important reality check. Adopting more dynamically efficient policies is like swimming upstream. Policy makers and market actors must not only be able to think outside the box (or the parameters of existing conceptions of control), but they must also employ strategies capable of overcoming predictable obstacles in both political and economic realms. All things considered, it is not surprising that most radical policy changes take place at times of crisis or revolution.

Building a normative case for dynamic efficiency is much easier from an economic than a sociological perspective. Innovation, whether in terms of technology or organizational structure (the composition of the firm), lowers the cost of production, increases profits, and triggers a global reallocation of resources through the price mechanism that moves the entire economy to new equilibrium, generating higher levels of social welfare. In this world, antitrust law can be applied to encourage competition, prevent

[100] *See generally* Hammer, *supra* note 56, at 485–88.

[101] *See id*. at 481–85.

collusion, and assist in the dynamic adjustment process. Antitrust law could play an analogous role in economic sociology. Markets and policy domains in economic sociology strive for stability, not efficiency. Conceptions of control protect incumbents to the systematic disadvantage of challengers. One might envision a role of antitrust law that is designed to introduce greater competition (a source of instability) than incumbents would otherwise permit, thereby providing an additional tool to empower challengers in their struggles. But there is a rub. Once we depart from the economic paradigm, there is no guarantee that greater competition is necessarily desirable. Why not favor the pursuit of stability over the pursuit of efficiency, especially if efficiency is not thought to be attainable? In this world, the normative case for competition and antitrust law must be confronted directly.

Health care provides the basis for an interesting thought experiment. In medical markets, antitrust law was consciously applied to breakup a pre-existing, professionally dominant order that likely did systematically favor stability over efficiency.[102] Aggressive application of antitrust principles helped usher in substantial economic and organizational change (favoring challengers over incumbent physicians) that otherwise would not have taken place, or would have taken place at a slower rate and in a different institutional form.[103] A harder question, looking back, is whether we are better off as a result. This question really serves to highlight the indeterminacy of institutional forms and the inability to guarantee that any constellation of market and non-market institutions will necessarily generate the desired policy objectives.

The counterfactual is worth pursuing. While hostile to price competition, advertising, and all forms of pre-paid medicine, professional domination did afford health care a relatively stable infrastructure. The last twenty-five years have witnessed substantial change, but few stable and sustainable solutions. Tellingly, a contemporary reassertion of professional dominance would likely have greater cultural resonance than the continued marketization of health care. Physician control is still more consistent with traditional power structures and conceptions of control. By the same token, the social payoff to greater professional control and less competition is not clear. The old regime demonstrated that professional dominance

[102] *See* Havighurst, *supra* note 94.

[103] Antitrust did not act alone. As discussed, *supra* notes 92–93, it was aided by ERISA preemption and a broader skepticism of dominant physician conceptions of control, given their inability to control health care costs.

coupled with public finance and fee-for-service compensation was unsustainable. Similarly, John Wennberg's *The Dartmouth Atlas of Health Care* documenting the small area clinical variations[104] and growing literature on patient safety,[105] raises serious reservations about the underlying efficacy and adaptive potential of professional systems. The Wennberg variations show relatively weak professional selection mechanisms. The patient safety problems show limited systemic potential for professional learning, adaptation, and the dissemination of best practices.

Counterfactuals aside, the real question is "where do we go now that we are here, given where we came from?" The central policy concern today remains cost control. There are two potentially distinct mechanisms available to rationalize costs: (1) reliance on market forces or (2) reliance on systems of physician deference.[106] Market processes rely on "firm entrepreneurship," the hope that innovative new business organizations, contracting practices, and financial incentives will emerge to better ration care through decentralized competition. Professional processes appeal to physician expertise to rationalize care and control costs at the individual level. Personally, I have greater faith in the ability of market processes to find solutions to our current problems than professional processes. Part of this faith is based on the strength of private incentives, but part is based on certain demonstrated weaknesses of traditional physician conceptions of control. The core of physician expertise, traditionally defined, is medical/scientific – the ability to select the best treatment option available, self-consciously without regard to cost or ability to pay. The appeal to science and the eschewing of financial considerations were both important aspects of the social legitimacy of the medical profession. As such, decisions about how to ration care subject to a budget constraint are both

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[104] *See generally* CTR. FOR THE EVALUATIVE CLINICAL SCI., THE DARTMOUTH ATLAS OF HEALTH CARE 1999, THE QUALITY OF MEDICAL CARE IN THE UNITED STATES: A REPORT ON THE MEDICARE PROGRAM (1999).

[105] *See, e.g.*, INST. OF MED. OF THE NAT'L ACAD., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (1999).

[106] A third option would be cost controls through state-administrative means. I give short attention to state solutions given their disfavor in the American tradition. It should be noted, however, that existing Medicare and Medicaid policies, in particular coverage and authorization decisions, are already acting as de facto administrative-bureaucratic instruments for rationalizing costs, including technology. If one wanted to use formal state mechanisms, there are no doubt better ways to accomplish these tasks than Medicare's current *ad hoc* administration.

outside the domain of physicians' traditional expertise and a threat to their perceived legitimacy.

Now comes the market. Allocating scarce resources in response to diverse consumer preferences is a core competence of well-functioning markets. Moreover, as long as cost control is thought of as an abstract goal, the appeal to market solutions has a certain cultural resonance. But though the market has competence, it lacks legitimacy. The market rhetoric for rationing falls flat when applied at the level of the individual clinical encounter. Markets may be able to achieve greater efficiency, but they cannot provide legitimacy in health care. Professionalism, in contrast, is unlikely to generate efficiency, but is a potential source of social legitimacy.

This is the central paradox of contemporary health care markets. Fligstein's work may suggest how it can be unraveled. No stable market solution will be reached in health care without new conceptions of control governing how the business of medicine can legitimately be conducted in a cost-conscious environment. A modified role of professionalism may be unavoidable in constructing such conceptions of control by affording market solutions social legitimacy. Unfortunately, physicians have been slow to respond to this challenge, while the business structures spawned by the managed care revolution have afforded no real substitute for the individual in the white coat as the cultural repository of patient trust. Any workable competition policy in health care will have to infuse market processes with greater levels of trust and legitimacy, the source of which will likely be rooted in professional rather than economic traditions.

C. Implications for the Antitrust State Action Doctrine

State action immunity is an odd appendage to the rest of antitrust law.[107] The doctrine sits at the public-private interface of state-market relations. The legal rules in this antitrust domain have a strong binary flavor. If the conduct is "private," it is governed by the same antitrust standards as all other private conduct, with no concessional nuance for its public or quasi-public nature. If the conduct is "public," it is completely removed from the antitrust domain and subject to no further scrutiny. As such, if the conduct is of the state government itself, it is clearly immune. The harder case of private conduct undertaken pursuant to state mandate requires further

[107] *See generally* HERBERT HOVENKAMP, FEDERAL ANTITRUST POLICY: THE LAW OF COMPETITION AND ITS PRACTICE (2d Ed.) 721–45 (1999).

proof of (1) a "clearly articulated and affirmatively expressed state policy" to displace competition with regulation and (2) active state supervision.[108] Once the private conduct is sufficiently tinged by the public hand, however, it also enjoys the same complete immunity as the state itself.

Two complementary rationales explain this binary tendency. In the neoclassical model of general competitive equilibrium, there is no role for the state. The economic model lacks a theory of public action. In the absence of a theory of state-market relations, public action in the antitrust domain is viewed as a rare occurrence subject to completely different norms and standards than market conduct. The second rationale has more serious implications for efforts to construct and maintain a competition policy. Antitrust law is ultimately constrained by the courts themselves as an institution. Not surprisingly then, the antitrust rules toggling between "public" and "private" conduct also map onto an institutional division of labor between the legislative and judicial branches, as well as principles of federalism. Under this view, antitrust law, best viewed as a congressionally authorized body of federal common law, must yield to express legislative determinations and processes. As a result, if it is "private," then antitrust law controls. If it is "public," then antitrust law (and private markets) yields to legislative determinations.[109]

One of the principal lessons of economic sociology, however, is that there is no clear distinction between public and private when it comes to economic markets.[110] The public and the private are intimately intertwined and often must be treated as one package. If this is true, then existing antitrust doctrine is seriously misguided. If competition is to be encouraged, it is not sufficient for antitrust law to police private power in private markets. If incumbents can exercise private power in economic markets to their competitive advantage, they are likely able to exercise comparable power in the public arena as well. Policing one and not the other is inconsistent and likely to be ineffectual as a matter of policy and practice. Antitrust errors are two-fold. The first type we have just discussed, anticompetitive conduct that should be condemned can be saved by giving

[108] Cal. Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 105–06 (1980).

[109] This paragraph is a little misleading. The deference afforded state legislative processes is ultimately a deference born of federalism. Parker v. Brown, 371 U.S. 341 (1943). For expositional purposes, however, it is easier to focus on the contrast between "public" and "private", and "judicial" and "legislative" processes without differentiating between federal and state action on the public side.

[110] *See supra* notes 9–14 and accompanying text.

it a sufficiently public cloak. Errors, however, can run in the other direction as well. Existing antitrust law too readily condemns non-market institutions sponsored by private actors that may serve legitimate public purposes. Recognizing this, I have argued elsewhere that antitrust law should be more willing to consider the welfare-enhancing potential of such combinations.[111]

Again, health care illustrates these many possibilities. Antitrust law would clearly condemn as a restraint on trade a prohibition on public bidding by members of a professional organization[112] or the refusal of dentists to share x-rays that would facilitate insurance utilization review,[113] if those actions were carried out under the "private" auspices of professional ethics and self-regulation. The same conduct, however, would receive complete immunity from antitrust scrutiny if it was mandated by the state, or if the state was to authorize a self-regulatory body to make such policy and the state sufficiently supervised that body's conduct. Substantively, the cases are more alike than different. If competition is expected to yield public benefits, then trade is being restrained in all cases. On the basis of economic policy, it is difficult to distinguish between them.

One might claim, however, that important procedural differences provide a basis for distinction. The presence of a deliberative legislative process and/or active supervision by the state itself might provide some substantive assurance that the later cases were unlikely to restrain trade, or that such a restraint would be to the public benefit. This is only persuasive if one can put forward and defend an appropriate public interest theory of public action. This is not necessarily, and often not likely the case, especially in the presence of concentrated producer interests. Again, economic sociology teaches that the state is most likely to intervene at the behest of, and in furtherance of, the interest of incumbent groups. If this is true, then the "public" and "private" cases are likely to have the same adverse impact on social welfare, whether imposed directly by incumbents or under the auspices of state processes.

John Wiley made a similar point some two decades ago.[114] No coherent theory of state action can be outlined without expressly identifying a theory of government action. The absence of a theory

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[111] *See generally* Peter J. Hammer, *Antitrust Beyond Competition: Market Failures, Total Welfare, and the Challenge of Intramarket Second-Best Tradeoffs*, 98 MICH. L. REV. 849 (2000).

[112] *See generally* Nat'l Soc'y of Prof'l Eng'r v. United States, 435 U.S. 679 (1978).

[113] *See generally* Fed. Trade Comm'n v. Ind. Fed'n of Dentists, 476 U.S. 447 (1986).

[114] *See generally* John S. Wiley, Jr., *A Capture Theory of Antitrust Federalism*, 99 HARV. L. REV. 713 (1986).

of the state in economic models of competition and, so far, the unwillingness of antitrust law to assert its own theory of public-private relations at the state-market interface has produced the present no-man's land policed by the state action doctrine. To begin to breathe substantive life into the doctrine, one must start with the premise that there really is a "there" there. Markets do not exist independent of the state. While there are some sectors where state involvement is so minimal that it may safely be ignored, the same is not true for health care. Public-private relations at the state-market interface are critical to the existence and functioning of health care markets. Moreover, power is routinely exercised by the same actors in both realms and it flows across a porous border.

The primary point of a competition policy is to help define and mediate relations at this contested public-private border. Some of this reform can take place within the existing antitrust paradigm and under existing doctrine. Some parts can be accomplished by encouraging the organic development and extension of antitrust doctrine in new directions. Given limits of existing doctrine and the current antitrust mandate, some aspects of competition policy must be legislatively enacted to give courts, antitrust or otherwise, greater powers to police the competitive implications of public conduct. Finally, it may be appropriate to take some of the responsibility antitrust courts have for policing competition and reallocate it to other public (and possibly private) actors. The bottom line is that the existing template governing public-private relations, as defined by the state action doctrine, is inadequate to police the state-market boundary in those sectors where public-private relations are interconnected in complex ways. At such interfaces, a sector-specific competition policy is required. Once constructed, the competition policy would necessarily re-define and possibly even obviate the need for the existing state action doctrine.

The state action doctrine continues to spawn controversy in health care. Clark Havighurst and William Brewbaker take opposing views on the topic in a recent special issue of the Journal of Health Policy, Politics and Law dedicated to the Joint DOJ-FTC Report "Improving Health Care: A Dose of Competition."[115] Havighurst argues that the courts have grown lax in enforcing the existing standards for state action immunity. He calls for stricter interpreta-

[115] *See generally* Clark C. Havighurst, *Contesting Anticompetitive Actions Taken in the Name of the State: State Action Immunity and Health Care Markets*, 31 J. HEALTH POL. POL'Y & L. 587 (2006); William S. Brewbaker, *Learning to Love the State Action Doctrine*, 31 J. HEALTH POL. POL'Y & L. 610 (2006).

tion of the "clear articulation" and "active supervision" prongs of the *Midcal* test, especially as applied to state-sponsored licensing boards.[116] His underlying concern is legitimate. As previously discussed, it is all too easy to disguise private anticompetitive restraints as "state action" and invoke immunity under existing doctrine. In lieu of a new competition policy, I agree with Havighurst that courts should strictly apply the *Midcal* test and subject quasi-public action in this area to greater antitrust scrutiny. Havighurst and I, however, differ on the type of antitrust scrutiny that is appropriate. I favor review under the auspices of a total welfare criteria and not one defined by the conduct's "pro-competitive" conformity with formalistic models of competition.[117] As part of a new competition policy, Bill Sage and I have proposed going even further and subjecting certain conduct of the state itself to antitrust scrutiny, under the same total welfare standard.[118]

Brewbaker takes a different tact. Brewbaker highlights the implicit channeling function played by the state action doctrine. The state action doctrine channels certain categories of disputes to the judiciary to be evaluated under existing antitrust standards. It channels other types of disputes to a legislative forum to be considered under legislative standards and processes. Brewbaker correctly argues that channeling determinations have to be made in light of perceived comparative institutional advantages. Based upon what he perceives as inherent limitations in judicial decision making capacity, he comes down largely on the side of how current channeling is taking place, removing most publicly tinged conduct from judicial antitrust review.[119]

While I agree with Brewbaker's frame, we hold different premises about the underlying comparative institutional advantages and, therefore, come to different conclusions about how the channeling function should take place. I am guilty of being an antitrust optimist. I am optimistic about the ability of courts to handle complex economic questions.[120] While I acknowledge that existing doctrine is inadequately prepared to handle some of the issues raised in the area of hybrid public-private institutions, I have argued for an or-

[116] Havighurst, *supra* note 88, at 596–600.

[117] William M. Sage & Peter J. Hammer, *A Copernican View of Health Care Antitrust*, 65 LAW & CONTEMP. PROBS. 241, 265–67 (2002).

[118] *Id*. at 278–80. Such an outcome would obviously require new legislative authorization, and could not take place under existing antitrust doctrine.

[119] Brewbaker, *supra* note 115, at 618–20.

[120] Hammer, *Antitrust Beyond Competition*, *supra* note 111, at 895–900.

ganic reformation of doctrines to better address these questions under a total welfare standard that can expressly value the welfare-enhancing potential of non-market institutions.[121] Finally, I am optimistic about the institutional advantages of the common law process of decision-making and its adaptive potential. Especially under conditions of uncertainty and in light of a constantly evolving backdrop, a common law system of decision making applying appropriately defined standards is likely to produce better outcomes at the state-market interface than will state legislative decision-making. On this last point, I am more pessimistic than Brewbaker. I do not believe that state legislatures, operating in their own narrow policy domains and under the strong influence of physicians, will necessarily make the best health policy decisions.

V. CONCLUSIONS

In some policy domains, the absence of a theory of markets does not seriously hinder the economic and legal analysis. Public involvement in these areas can legitimately be considered a second order concern. In a sector like health care, however, where public involvement is central, the absence of a theory of state-market relations is a serious handicap. Neoclassical economics provides little guidance. Economic sociology can begin to fill this void. A model is helpful if it provides a useful framework for thinking about problems that leads to new understandings and new lines of inquiry. Fligstein's architecture of markets does both. By introducing these ideas to a broader audience of antitrust and health care lawyers and academics, and by making some tentative suggestions about how economic sociology might be applied to health care, I hope others will be inspired to think harder about the composition and dynamics of health care markets. Economic sociology and Fligstein's architecture can provide a useful foundation and set of tools from which to work.

[121] *Id*. at 921–25.