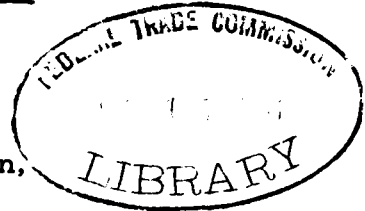


CONTEMPORARY LEGAL PROBLEMS
INVOLVING DRUG DIVERSION
BY INSTITUTIONAL PURCHASERS

Statement of Earl W. Kintner
of
Arent, Fox, Kintner, Plotkin & Kahn,
Washington, D. C.
Special Antitrust Counsel to NARD,
Before the Annual Convention of
the Alabama Pharmaceutical Association,
Birmingham, Alabama
June 16, 1965



It was with a great deal of enthusiasm that I accepted Mrs. Barranco's kind invitation to appear before you on behalf of the National Association of Retail Druggists.

The NARD family sends you its warm greetings. NARD's Executive Secretary, Willard Simmons, asked me to relay his personal expression of gratitude and support for the outstanding work being accomplished by your association on behalf of independent community pharmacists here in Alabama. Your association and NARD share the deep concern over the competitive and economic welfare of independent retail druggists. Our common task is a difficult one, and our inquiry today into the legal problems of drug diversion by institutional purchasers is a timely illustration of an area where

pharmaceutical associations -- national, state, and local -- are in a position to perform a great educational service for all members of the drug industry. As you are doubtless aware from your review of the drug trade press, NARD has been striving to educate and inform all levels of the drug industry as to the responsibility for compliance with the antitrust laws in reference to the pricing of drugs which are sold to institutional purchasers.

Our inquiry today will be into the requirements of our federal anti-price discrimination law, the Robinson-Patman Act, in connection with the sale of drugs to institutional users, notably profit and nonprofit hospitals, clinics, nursing homes and physicians. We will not be concerned with the sale of drugs to such governmental facilities as military and V. A. hospitals, state and municipal institutions, because of the exemption which all of these users probably enjoy from the Robinson-Patman Act.^{1/} Nonprofit hospitals and institutions are exempt from the Robinson-Patman Act only to the extent the drugs purchased are for the institutions' "own use".^{2/}

These exemptions from the Robinson-Patman Act are sharply limited, and do not affect the principal areas of economic concern arising from unlawful drug diversion practices.

^{1/} See, e.g., Rowe, Price Discrimination under the Robinson-Patman Act, pp. 84-85 (1962) and cases cited.

^{2/} Non-Profit Institutions Act of 1938, 15 U.S. C. §13(c).

I.

Appropriately, we may begin our ambitious task with a brief review of the Robinson-Patman Act.^{3/} In general terms, the Robinson-Patman Act recognizes competition where it actually exists, and is aimed at requiring suppliers to treat customers fairly and equally where any difference in price would otherwise adversely affect competition.

Section 2(a) of the Robinson-Patman Act thus prohibits a supplier (satisfying certain jurisdictional requirements) from charging different prices in connection with the contemporaneous sale of the same drugs to its various customers, where adverse competitive effects may arise. Defenses are provided only in those situations where (1) the lower price to one customer is made in good faith to meet the equally lower price of a competitor, or (2) is cost justified, or (3) is a distress merchandise sale. Section 2(f) of the Robinson-Patman Act is the other side of the Section 2(a) coin, and prohibits a customer from knowingly inducing a price concession from a supplier which is in violation of Section 2(a).

The assessment of the adverse competitive effects of a price difference incident to a supplier's sale of the same product to two different purchasers involves the two-fold consideration of geographic trading areas and functional differences.

^{3/} Act of June 19, 1936, c. 592, 49 Stat. 1526.

First, we will consider the requirement of actual competition in the same trading areas between two purchasers.

Suppose Ajax Drug Co. charges California community pharmacists a higher price for Brand X than is charged to community pharmacists here in Alabama. No adverse competitive effects are created among these different purchasers, because these purchasers are reselling in different geographic trading areas, and are not competing with one another in the resale of Brand X. But if Ajax Drug Co. charges one retail druggist here in Birmingham a substantially lower price for Brand X than is charged to another retail druggist across the street, an unlawful price discrimination may exist because these two customers are not separated geographically. That is to say, they are both reselling Brand X to customers in the same geographic trading area, and one customer may be competitively injured where the other favored customer purchased Brand X at a substantially lower price.^{4/} We see that the competitive effects among purchasers is measured in specific trading areas where customers may "shop around". I venture to say that you Alabama pharmacists have little more than an academic interest in Ajax Drug Company selling to hospitals in California at a price lower than charged to you, because you will suffer no adverse

^{4/} Cf. Purex Corp., 51 FTC 100, 174-177 (1954).

competitive effects thereby. We may pause here and conclude that institutional drug diversion in a very real sense is not one national problem but a series of local "trading area" problems, each of which must be considered in its own context.

The second problem of evaluating the existence of functional differences, as would preclude the existence of adverse competitive effects of a price difference, may also be illustrated from the principles of an adjudicated case. Ace Refining Co., a gasoline supplier, sells gasoline to an Ace service station in Birmingham. Across the street from the Ace service station is the Friendly Taxicab Co., which operates a fleet of taxicabs. Ace Refining also sells its gasoline to the Friendly Taxicab Co., but at a price lower than charged to Ace service station. No adverse competitive effects arise from this price difference. This is because Friendly Taxicab Co. and the Ace service station are not in competition with one another in the resale of gasoline to the citizens of Birmingham. Friendly Taxicab consumes the gasoline for its own use, while Ace service station resells it to the public at large.^{5/}

This illustration involving Ace Refining Co. illustrates the lack of functional competition based on an adjudicated case. We may now

5/ Shell Oil Co., 54 FTC 1274, 1279 (1958); Cf. Secatore's, Inc. v. Esso Standard Oil Company, 171 F.Supp. 665 (D. Mass, 1959); Sano Petroleum Corp. v. American Oil Company, 187 F. Supp. 345 (E.D. N. Y. 1960).

reflect on how this practice would be found to exist in the context of drug diversion. Suppose, hypothetically, that Ajax Drug Co. charges Friendly Valley Hospital here in Birmingham a lower price for Brand X than Smith Pharmacy, across the street, pays Ajax Drug for Brand X. This is permissible if Friendly Valley Hospital resells its drugs to hospitalized patients, at whatever price. But if Friendly Valley Hospital resells Brand X to people off the street -- nonpatients, or to private patients of physicians who happen to see their patient at offices maintained at Friendly Valley Hospital, these sales of Brand X could have been made by Smith Pharmacy. In connection with these sales of Brand X to nonpatients, or to private nonhospitalized patients of the physicians, Friendly Valley Hospital ordinarily should pay the same price as Smith Pharmacy, if Smith Pharmacy and other community pharmacists are competitively injured,^{6/} just like our example involving Ace Refining Co.

Thus, where a drug supplier sells the same drugs both to a community pharmacist and to an institutional user such as a profit or nonprofit hospital located in the same trading area, the supplier may lawfully grant the institutional user a special functional discount

^{6/} See E. Edelmann & Co. v. Federal Trade Commission, 239 F. 2d 152 (7th Cir. 1956), certiorari denied, 355 U.S. 941 (1958).

without fear of Robinson-Patman liability, if the institutional user in fact uses or resells the drugs in a manner so as not to compete with the neighboring community pharmacist. But if the institutional user resells the drugs to the public at large, it is in fact competing with the community pharmacist. So far as this latter class of sales is concerned, the institutional user should ordinarily pay the same price as the community pharmacist, thereby competing with the community pharmacist on an equal basis. The Robinson-Patman Act operates, not to prohibit the institutional user from reselling to the public at large, but rather to prevent the adverse effects on competition arising from any preferred price concession granted to a favored purchaser, the institutional user.

A separate point worthy of mention is that nonprofit hospitals and institutions which enjoy exemptions from federal income taxation may be deterred from making indiscriminate drug sales to nonpatients, even if there is compliance with the Robinson-Patman Act, in view of our federal income tax laws.^{7/}

^{7/} §§501(c)(3), 511, 513, I.R.C. 1954; §1.513-1(a)(2), Income Tax Regs. As to whether a nonprofit hospital could lose its exempt status under §501(c)(3) for improper operation of its pharmacy, see, e.g., Better Business Bureau v. United States, 326 U.S. 279 (1945); Robert C. Olney, 17 T.C.M., 982, 991 (1958); Commissioner v. Battle Creek, 126 F.2d 405 (5th Cir. 1942); Rev. Rul. 50-143, 1960-1, Cum. Bull. 192; Rev. Rul. 56-185, 1956-1 Cum. Bull. 202.

The problems arise in determining, factually, when an institutional user is competing with a disfavored community pharmacist. But as I have illustrated, certain outer boundaries are clear. On the one hand, if the profit or nonprofit institution resells the drugs to confined patients in a hospital, clinic, or nursing home, this class of patient-consumers may be in no position to purchase from the neighboring community pharmacist, and no "competition" would probably be found to exist. Contrawise, if a profit or nonprofit hospital, clinic, or nursing home, or a practicing physician resells prescription drugs to the public at large, or to a physician's private patients who are indeed capable of purchasing from the neighboring community pharmacist, "competition" indeed exists between the institutional purchaser and the community pharmacist purchaser. In these circumstances, it would probably be unlawful under the Robinson-Patman Act for a supplier, be it a drug manufacturer or drug wholesaler, to grant the institutional user a preferred functional discount for so much of those drugs which are sold in "competition" with disfavored community pharmacists in the same trading area. The drug supplier in these circumstances is faced with the need to comply with Section 2(a) of the Robinson-Patman Act, and the institutional user, with Section 2(f).

II.

Isolated instances, as yet unverified, are also reported which involve the community pharmacist purchasing drugs through hospital channels. In this connection, a community pharmacy may be opened in leased facilities of a hospital or clinic, or otherwise operated in "close cooperation" with such an institution and/or its chief pharmacist. This relationship may then contemplate the institutional facility as a "straw purchaser" through which the pharmacy secures, indirectly, the institutional preferred discounts perhaps with the cooperation of the drug supplier. The pharmacy then resells to the public at prices well below those prices which other disfavored community pharmacies may resell the same drugs, resulting in lost Rx volume by the disfavored purchasers. What follows next is the serious economic peril of the disfavored community pharmacies -- with dissolution or bankruptcy as the final chapter in the sordid chronology of "competitive effects".

Whether unlawful drug diversion involves the institutional resale to a community pharmacist under the complex "indirect purchaser" doctrine of Robinson-Patman law,^{8/} or resale to the

^{8/} See, e.g., American News Co., FTC Dkt. 7396 (Jan. 10, 1961), modified, 300 F.2d 104 (2nd Cir. 1962), certiorari denied, 371 U.S. 824 (1962); cf. Klein v. Lionel Corp., 237 F.2d 13 (3rd Cir. 1956).

public at large, the adverse competitive effects are manifested by the false image created in the eyes of the public. If the consumer secures a prescription at a lower price as a consequence of unlawful "diversion" practices, the consumer does not realize that the disfavored community pharmacist is in effect forced to subsidize the lower drug price charged through institutional diversion channels. Basic competitive fairness is lacking where competitors are not paying a price for the drugs which is consistent with the law. In the same context, any institution which enjoys an exemption from federal income taxation has the "competitive edge" over taxpaying community pharmacists, when both classes are selling to the public at large in the same trading area.

III.

You will recall that I mentioned physicians as falling within the broad class of institutional purchasers under discussion. The economic impact of resale of drugs by physicians is difficult to ascertain, although we know the practice does exist in varying degrees in different parts of the country.

Last summer, Senator Hart's Subcommittee on Antitrust and Monopoly held hearings on the problem of physician ownership in

pharmacies and drug companies.^{9/} The problems there discussed involved the competitive inequities arising from physicians owning a drug store, or leasing a drug store to a pharmacist with a return based on the volume of sales generated, or physicians owning a drug repackaging house. The obvious inequity is that the physician, by virtue of such affiliations, has an economic and non-medical interest in steering the patient to "his" pharmacy or prescribing drugs distributed by "his" repackaging company.

These hearings did not involve directly the problem of drug diversion, but rather involved a general inquiry into the lawfulness and ethics of these practices just mentioned. However, it is clear that a physician-owned pharmacy must comply with the Robinson-Patman Act to the same extent as neighboring community pharmacists.

During the course of these Senate hearings, the Secretary of the Wisconsin Board of Pharmacy discussed briefly the manner in which some physicians in that state resell prescription drugs to pharmacies in the usual and ordinary course of business. This includes the sale of prescription drugs, some obviously samples, paid for directly by

^{9/} See "Hearings before the Senate Subcommittee on Antitrust and Monopoly of the Committee on the Judiciary pursuant to H. 262," August, 1964, herein ("Physician Hearings").

the patient, ^{10/} using a registered nurse or untrained assistant for dispensing drugs which are sold to patients. This Wisconsin Secretary was perhaps quite accurate when he stated:

"The [Wisconsin state] law permits the physician to dispense to enable him to provide his patient with medication for immediate use. It is not my understanding that the purpose of allowing the physician to dispense medication was to enable the physician to go into competition with the pharmacist. "11/

This observation is accurate, to the extent that, "commerce" being involved, the supplier grants price concessions to physicians not available to disfavored competing pharmacists, who are economically injured as a consequence of such discrimination. Under these circumstances, the drug suppliers must consider a physician "purchaser" as falling within the ambit of the supplier's duty to comply with Section 2(a) of the Robinson-Patman Act.

Unverified information which has come to my attention from one of your sister states in the South reveals the extent to which physicians "compete" with community pharmacists in the dispensing and sale of prescription drugs. There were about 850 pharmacies in this state as of June 30, 1964, with slightly over 4,100 physicians and surgeons licensed to practice in that state at that time.

10/ Physician Hearings, p. 206.

11/ Id. at 207.

Although approximately 24 physicians are licensed to practice pharmacy pursuant to a state law allowing physicians to practice pharmacy in rural communities, it is estimated that a minimum of 200 and possibly 300 physicians are engaged in selling prescription drugs in the usual and ordinary course of business. I am informed that in many instances these physicians compete with community pharmacists. Not only do Robinson-Patman problems arise in the context of these physicians receiving preferred price concessions to the competitive injury of disfavored competing pharmacies, such problems as lack of proper drug controls and labelling, lack of competent dispensing and record keeping, obviously would tend to be rampant, depending, of course, on the controls exerted by particular State Pharmacy Boards. Not only may Robinson-Patman violations occur, there is the obvious danger to the patient's health arising from such practices.

The "side effects" of unlawful drug diversion practices involving physician purchasers of drugs often involve cases of acute disregard of the consumers' welfare.

IV.

So it is that drug diversion is a practice which may involve serious consequences under the Robinson-Patman Act. The economic impact of drug diversion is serious. NARD's investigations show that

in many different areas of the country, community pharmacists are seriously hampered in their efforts to compete because of the resale of prescription drugs by institutional users in the manner I have discussed, where the institutional user purchases the drugs from the same supplier as the neighborhood community pharmacist at preferred discounts.

You are entitled to ask "What is being done to combat this practice of unlawful drug diversion?"

Last September in speaking before the NARD convention in San Francisco, I discussed the legal and economic problems of hospital drug diversion along the lines that I have outlined here. I urged a vigorous program of education for all levels of the drug industry and the hospital service industry.

Where instances of suspected unlawful drug diversion have been called to our attention, we have, in appropriate instances, corresponded with the parties involved, pointing out the possible legal dangers of hospital drug diversion under such circumstances and invited the parties to consult their legal counsel for legal review of their pricing policies.

NARD is presently conducting a nationwide survey of the extent to which hospital drug diversion is suspected to exist. I am confident that as a consequence of NARD's continuing efforts, drug suppliers,

wholesalers and retailers have become increasingly aware of just what hospital drug diversion is -- what is lawful and what is unlawful. I am confident that individual drug manufacturers across the United States have made a quiet reappraisal of this problem as it affects their own distribution practices. I believe it will continue to be more and more the rare situation where a drug manufacturer, out of hand, will let a profit or nonprofit institution's order for Brand X be filled at a preferred functional discount where the manufacturer knows that such institution could never consume such a supply in treating its patients, in the normal course of events.

V.

I believe that education and voluntary compliance will, in the final analysis, form the impetus for eradicating the bulk of these unlawful practices. My experience has been that it is the rule rather than the exception that unlawful pricing practices take place in ignorance of the law rather than in disregard of the law. Once ignorance is replaced by knowledge, the overwhelming majority of unwitting offenders will take active steps to comply with the law.

I thus suggest to you here today and to all other responsible members of the drug industry, whether they be manufacturers, wholesalers, retail pharmacists, hospital administrators, hospital

pharmacists, and physicians, that the whole industry must share responsibility for compliance with the antitrust and trade regulation laws. These laws promote free and fair competition -- equity and fair dealing in the marketplace.

Allow me to add a further word of caution. No national, state, or local pharmaceutical association can or should take it on themselves to be an "extra-judicial enforcer of the law". There can be no group coercion, boycotts, economic pressures, intimidation or harassment by groups of pharmacists or their associations to prevent unlawful hospital drug diversion. Serious antitrust consequences may result from such practices under the prohibitions of the Sherman Act. But within this permissible sphere of freedom to educate, much good has been and will continue to be accomplished.

* * *

It is a pleasure to brief you on this problem which I am hopeful will soon be relegated to the history books of the drug industry -- a vital segment of our American free enterprise system. Much progress has already been made, and I am sure that the Alabama Pharmaceutical Association and the other outstanding state associations across the United States will perform a major role in the task that lies ahead.