



SOME CURRENT LEGAL PROBLEMS
OF THE INDEPENDENT RETAIL PHARMACIST

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before the Annual Convention of the
Nebraska Pharmaceutical Association,
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Ladies and gentlemen of pharmacy, I was delighted to accept Miss Cora Mae Briggs' kind invitation to speak here today on behalf of NARD and to share with you a brief review of recent developments in the antitrust field affecting retail pharmacy.

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 Nebraska. 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 antitrust laws 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 in the forefront of striving to educate and inform all levels of the drug industry as to the responsibility for compliance with the antitrust laws.

The federal antitrust laws indeed constitute the backbone of our free enterprise economy. Your competitive well-being as vital cogs in the wheels of the drug industry depends in no small measure on a general understanding of the Sherman Act,^{1/} the Clayton Act,^{2/} the Robinson-Patman Act,^{3/} and the Federal Trade Commission Act.^{4/} In short, the federal antitrust laws are basic ground rules of competition. To know these ground rules well is to know important outer limits of competitive freedom beyond which serious legal

^{1/} Act of July 2, 1890, c. 647, 26 Stat. 209, as amended.

^{2/} Act of October 15, 1914, c. 323, 38 Stat. 730, as amended.

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

^{4/} Act of September 26, 1914, c. 311, 38 Stat. 717, as amended.

consequences may lie. To know these ground rules well is also to arm yourself more effectively in asserting your competitive rights.

I.

I should like to begin by discussing an issue of perennial importance to drug and pharmaceutical associations, local, state, and national across the United States. This is the question of what activities are lawful by an association under our federal antitrust laws and what activities cross the outer boundaries of unlawful conduct. It is appropriate to recall one "absolute" ground rule of competition. This is the Sherman Antitrust Act's prohibition against agreements, combinations, conspiracies, or tacit understandings between competitors to fix prices. Neither manufacturers, nor wholesalers, nor retailers, nor their associations can avoid this sweeping prohibition imposed by an unbroken line of judicial decisions involving members of the drug industry engaged in commerce. Another absolute prohibition embraced by the Sherman Act deals with group acts involving boycotts, refusals to deal, coercion, and related group practices aimed at restricting the freedom of competitors or potential competitors to exercise their unilateral right to compete in the market place.

Back in 1965, a private antitrust suit affecting retail druggists was settled before any adjudication on the merits took place. The allegations in this case serve as a timely illustration of the kind of antitrust dilemma which drug associations should take scrupulous care to avoid. Let us review the facts which were alleged in the complaint as a basis for seeking treble damage recovery for violation of the Sherman Act.

Plaintiff in this proceeding was a discount drug store which was opened in a medium-sized community which we will refer to as Anytown, U.S.A. The defendants were other independent retail druggists in the Anytown area, along with a national drug chain store, the local retail pharmaceutical association and two Anytown drug wholesalers. Anytown is located in a Fair Trade State, but we shall see shortly that this factor was not of controlling significance to the case. The plaintiff charged: that the defendants combined and conspired to maintain Fair Trade prices even though such prices were not enforced by the manufacturers; that they sought to maintain and enforce manufacturers' suggested retail list prices on non fair-traded products; that they fixed and maintained prescription prices through code systems -- all for the purpose of maintaining "a general and artificially high retail price level . . . in the market area." Departures, it was alleged, were allowed for so-called

leader advertising, for special classes of customers, for delivery service, trading stamps and the like. It was alleged that the defendants sought to keep discount drug stores out of the Anytown trading area by number of practices including threats of litigation under State Fair Trade laws; by discouraging registered pharmacists from working in discount drug stores; by inducing local drug wholesalers to discourage retailer customers from carrying on a general discount retail drug business.

As a consequence of the above group conduct, the complaint goes on to allege that a local pharmacist could not be hired by plaintiff.

Moreover:

"In making purchases to complete its inventory, plaintiff found it impossible to obtain credit from local drug wholesalers, and plaintiff had to purchase its merchandise from those wholesalers with cash. The wholesalers insisted that plaintiff's president talk to representatives of the [retail pharmaceutical association] concerning the difficulties of one who would attempt to carry on a discount retail drug business in Anytown. "

The local pharmaceutical association's efforts to secure plaintiff's adherence to its plan was charged by plaintiff, along with plaintiff's unwillingness to cooperate. Shortly after the plaintiff's discount store was opened, a group action was brought by some of the defendants against plaintiff in the state courts to enforce Fair Trade Agreements, with its attendant adverse publicity. Plaintiff, it was alleged, was finally driven out of business.

The truth of these allegations was never adjudicated because the case was settled before trial commenced.

If this plaintiff alleged no more than the fact that the local pharmaceutical association brought a group action in the state courts to enforce valid fair trade agreements, plaintiff's right to recovery under the Sherman Act would be in a grey area, if the state court action was brought in good faith, for one New York case ^{5/} ruled that the mere fact that plaintiffs have joined together in litigation is not a restraint of trade in violation of the Sherman Act. In United States v. Hawaiian Retail Druggists Ass'n., ^{6/} the Association voluntarily accepted a consent decree which prohibited the Association from:

"v. . . (b) Advocating, suggesting, urging, inducing, compelling or in any other manner influencing or attempting to influence any manufacturer or supplier to enter into fair trade contracts or to increase or enforce fair trade prices;"

In United States v. Frankfort Distilleries, Inc., ^{7/} the Supreme Court admonished that "whatever may be the rights of an individual producer . . . to make price maintenance contracts . . . a combination

^{5/} Dior v. Milton, 155 N.Y.S. 2d 443 (Sup. Ct. 1956), affirmed 156 N.Y.S. 2d 996 (App. Div. 1956).

^{6/} Civ. 2064 (D. Hawaii).

^{7/} 234 U.S. 293, 296-97 (1945).

to compel price maintenance in commerce among the states violates the Sherman Act. "^{8/} The Anytown case involved broad allegations of price fixing and group boycott which swept beyond any exemptions from Sherman Act liability allowed under our permissive federal laws dealing with Fair Trade. This case in effect alleged a concerted effort to inhibit the freedom of a discounter to compete in the market place. Pertinent to observe is the allegation that the drug wholesalers became implicated through their participation in social activities and the like with their pharmacist-customers.

The lessons are clear: Scrupulous care should be taken to avoid any conduct which might be construed as group coercive or boycott activity. Avoid any conduct which affects your unilateral freedom in dealing with customers and suppliers. Resist any invitation or coercion to cooperate with competitors or suppliers to fix or maintain prices or to regulate competition, or otherwise to impinge on the right of any retail druggist to compete in the market place.

If probable violations of the law exist, a drug association has completed its duty if the matter is referred to law enforcement authorities, federal or state. In addition to the powerful tool of education,

^{8/} See also McGuire Act of 1952, 15 U.S.C.A. §5(a)(5); United States v. McKesson & Robbins, Inc., 351 U.S. 305 (1956); Hudson Distributors, Inc. v. The Upjohn Co., 377 U.S. 386 (1964).

pharmaceutical association efforts to combat anticompetitive conduct are usefully -- and legally -- channeled to vigorous action aimed at enacting stronger trade regulation laws by the state or federal legislature.^{9/}

II.

The Robinson-Patman Price Discrimination Act constitutes another area of federal legislation which directly affects the pricing activity of pharmacists here in Kearney, Nebraska, and in comparable communities, rural and urban, throughout the United States. Section 2(a) of the Robinson-Patman Act operates to prohibit your suppliers from engaging in price discrimination.

What does price discrimination mean? Technically, there are nine elements which must be proven to establish a violation of Section 2(a). There must be sales -- by the same seller -- of commodities -- of like grade and quality -- in commerce -- to two different purchasers. These sales must be reasonably close in point of time. They must be at a price difference; and finally, they must give rise to adverse competitive effects. As you can see, this is a complicated statute, but once these elements are proven, there exists a violation of the law subject only to

^{9/} Eastern R. R. Presidents Conference v. Noerr Motor Freight, Inc., 365 U.S. 127 (1961).

the limited and equally intricate defenses or exemptions of cost justification, meeting competition, distress merchandise sales, or sales to governmental institutions and sales to nonprofit institutions for their "own use". Section 2(f) of the Act prohibits a purchaser from "knowingly inducing" a price concession from his supplier which is a violation of Section 2(a).

It is precisely in this area of Robinson-Patman law that one of the major issues of the day exists. This is the issue of institutional drug diversion, an inquiry into the requirements of the Robinson-Patman Act, in connection with the sale of drugs to institutional customers, notably profit and nonprofit hospitals, clinics, nursing homes, and indeed, dispensing 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 these users probably enjoy from the Robinson-Patman Act.^{10/}

As just mentioned, nonprofit hospitals and institutions are exempt from the Robinson-Patman Act only to the extent the drugs purchased are

^{10/} See, e. g., Rowe, Price Discrimination under the Robinson-Patman Act, pp. 84-85 (1962) and cases cited.

for the institution's "own use", under the provisions of the Nonprofit Institutions Act of 1938.^{11/} These exemptions from the Robinson-Patman Act are limited ones, which do not affect the principal areas of economic impact. Diversion is meant to be really a shorthand term involving profit and nonprofit institutional resales to nonpatients of that institution.

In order to assess, under the Robinson-Patman Act, the adverse competitive effects of a price difference incident to a supplier's sale of the same product to two different purchasers, we properly turn to the two-fold considerations of geographic trading areas and functional differences.

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

Suppose Ajax Drug Co. charges California community pharmacists a higher price for Brand X than is charged to community pharmacists here in Kearney. No adverse competitive effects are created among these different purchasers, because these purchasers are reselling in different geographic trading areas, and are not competing

^{11/} 15 U.S.C. Sec. 13(c); See Students Book Co. v. Washington Law Book Co., 232 F. 2d 49 (D. C. Cir. 1955), certiorari denied, 350 U.S. 988 (1956).

with one another in the resale of Brand X. But if Ajax Drug Co. charges one retail druggist here in Kearney a substantially lower price for Brand X than is charged to other retail druggists "across the street", we know that an unlawful price discrimination may exist because these two customer classes are not separated geographically. That is to say, they are both reselling Brand X to customers in the same geographic trading area, and one retailer class may be competitively injured where the other favored retailer purchased Brand X at a substantially lower price. ^{12/} 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 Ace service stations in Kearney. In the same trading area as the Ace service stations is the Friendly Taxicab Co., which operates

^{12/} Cf. Purex Corp., 51 FTC 100, 174-177 (1954).

a fleet of taxicabs. Ace Refining also sells its gasoline to the Friendly Taxicab Co., but at a price lower than charged to the Ace service stations. No adverse competitive effects arise from this price difference. This is because Friendly Taxicab Co. and the Ace service stations are not in competition with one another in the resale of gasoline to the citizens of Kearney. Friendly Taxicab consumes the gasoline for its own use, while the Ace service stations resell it to the public at large.^{13/}

This illustration involving Ace Refining Co. shows the lack of functional competition based on an adjudicated case. We may now 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 Kearney a lower price for Brand X than Smith Pharmacy across the street and others similarly situated pay Ajax Drug for Brand X. This is permissive 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 patients at offices maintained at Friendly Valley Hospital, these sales of Brand X

^{13/} 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).

could have been made by the Smith Pharmacy class of retailers. 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 the Smith Pharmacy class of retailers, if Smith Pharmacy and other Kearney pharmacists otherwise may be competitively injured.^{14/}

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 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 pharmacists. But if the institutional user resells the drugs to the public at large, it is in fact competing with the community pharmacists. So far as this latter class of sales is concerned, the institutional user should ordinarily pay the same price as the community pharmacists, thereby competing with the community pharmacists on an equal basis. The Robinson-Patman Act operates, of

^{14/} See E. Edelmann & Co. v. Federal Trade Commission, 239 F. 2d 152 (7th Cir. 1956), certiorari denied, 335 U.S. 941 (1958).

course, 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 reseller.

Problems arise for drug suppliers in determining, factually, when an institutional user is competing with disfavored community pharmacists. But 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 pharmacists, and no "competition" would probably be found to exist. Contrawise, if a profit or nonprofit hospital, clinic, or nursing home 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 pharmacists, "competition" indeed exists between the institutional purchaser and the community pharmacist purchasers. In these circumstances, it may 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.^{15/} 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 purchaser-reseller with Section 2(f).

NARD has been in the forefront in efforts to bring the problem of institutional drug diversion to the attention of drug suppliers and hospital administrators throughout the United States. On behalf of NARD, I personally have made a number of speeches across the United States to pharmaceutical associations such as yours, alerting everyone to the legal problems, in the public interest. Indeed, in retrospect NARD was initially a voice "crying in the wilderness", for there was a reluctance on the part of some national leaders in the pharmacy community even to acknowledge the seriousness of the problem. It is, however, gratifying to see an increasing awareness of this problem by all national leaders of community pharmacy. Our efforts have not been in vain. As a result of NARD's efforts, I am confident that drug suppliers as a whole have become increasingly aware of the pricing problems involved in granting preferred price concessions to institutional resellers.

^{15/} The drug supplier, of course, still has the benefit of the affirmative defenses to a Section 2(a) violation as discussed, supra 8-9.

The point is, of course, that whatever be the extent of unlawful institutional drug diversion practices today, the potential for anticompetitive injury of a greater magnitude is likely to exist as a consequence of Medicare. For Medicare is certain to bring about an expansion of health-care institutions with out-patient dispensing facilities.

I am sure that many responsible drug suppliers have made a quiet reappraisal of their pricing practices with a view to complying with the letter and spirit of the Robinson-Patman Price Discrimination Act. I am also sure that in overwhelming measure the drug suppliers of the United States will remedy this problem through the admirable route of self-regulation and voluntary compliance with the law of the land. Statesmanship will be necessary on the part of drug suppliers to accomplish this result, and I for one have the utmost confidence in the sense of responsibility drug suppliers will exert in this sensitive area of pricing which involves public image of the disfavored community pharmacist -- helpless in explaining to his customer why his prices must be higher than those of the institutional reseller. The general public is not concerned with the Robinson-Patman Act -- community pharmacy is.

What can you as individuals do to combat suspected instances of unlawful institutional drug diversion in your community? You as individuals can call the matter to the attention of the drug supplier and to the

hospital administrator involved, pointing out the facts and urge them to familiarize themselves with the requirements of the Robinson-Patman Act. I think you will find that most organizations indeed are eager and willing to comply with the law of the land and that many times they simply are not informed as to what the law requires.

III.

Ladies and gentlemen, we could spend days and days on trade regulation matters affecting pharmacy. There is Senator Hart's pending bill which is aimed at prohibiting physicians from earning a profit on dispensing drugs. There is prepaid prescription with its many different faces. There is the question of Medicare being expanded to include out-of-hospital prescription drug benefits under the Supplementary Medicare Benefit Provisions. There is the wide range of regulatory activity by the Food and Drug Administration.

In this mid-twentieth century, pharmacy and the drug industry stand in the forefront of the public interest. Each of you carries the heavy responsibilities of service to the sick and needy, and preservation of the eminently successful segment of our free enterprise system, the drug industry. I wish you and your fine association every success in the many challenges which lie ahead for us all, challenges which NARD shares with each of you.