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Nuno Garoupa
Universidade Nova de Lisboa

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REGULATION OF PROFESSIONS IN THE US AND EUROPE: A COMPARATIVE ANALYSIS*

Nuno GAROUPA**

Universidade Nova de Lisboa

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**Faculdade de Economia, Universidade Nova de Lisboa, Campus de Campolide, P-1099-032 Lisbon, Portugal. Phone: 351-21-3801600. Fax: 351-21-3870933. Email: ngaroupa@fe.unl.pt

Abstract

In this paper it is analyzed the regulation of access to and activity of certain professions, namely lawyers and physicians. A quick review of the economic theory of regulation of professions, namely (a) Why regulate, (b) How to regulate, and (c) What to regulate is presented. We suggest a set of indicators to measure the quality of regulatory restrictions (hence exposing comparative inefficiencies) in professional activities. We conclude that generally speaking the US followed by Norway, the UK [England and Wales] and Belgium perform better in terms of efficient regulation, whereas Germany, Austria and Portugal perform badly for both legal and medical professionals. Other countries (including the Netherlands, Spain, France) vary. Our results are somehow consistent with previous reports.

Keywords: Regulation, Rent-Seeking, Lawyers, Physicians, Numerical Comparative Law

JEL classification: I18, J44, K29, L43, L51, L84.

1. INTRODUCTION

A profession can be defined as an occupation with the following characteristics: specialized skills, that skill is partially or fully acquired by intellectual training, the service calls for a high degree of integrity, and it involves direct or fiduciary relations with clients (Ogus, 1994, page 216).

In this paper it is analyzed the regulation of access to and activity of certain professions, namely lawyers and physicians. The legal and medical professions (also notaries, pharmacists, and accountancy, less so architects and engineers, and even less economists and journalists) appear to be relatively highly regulated according to the European Commission. However, there are important disparities in levels of regulation across European countries. Austria, Germany, Greece, Italy, Luxembourg, and Portugal appear to be quite rigid whereas France, Spain, and Belgium have a relatively less strict approach to regulation of a significant number of professions. By contrast, Denmark, Finland, Sweden, Ireland, the Netherlands, and the United Kingdom have developed a more flexible regulatory framework for the professions (Stocktaking Exercise on Regulation of Professional Services, Overview of Regulation in the EU Member States, 2003). The United States could be included in this last group of countries if the analysis were to be extended to outside of the European Union, though there are important differences at state level.

Even though many economists think that professional regulatory activities are mostly explained by rent-seeking motivation, we find very different institutional arrangements across countries. Whilst ultimately governed by law and oversighted by some public official (judge, bureaucrat or legislator), these regulations are somehow delimited and enforced by the profession itself. Thus, it is of importance to assess which arrangements are more prone to private capture and suggest ways of reforming regulatory institutions.

One obvious motivation is the fact that professional regulatory activities have been included in the current public policy agenda. The European Commission, in particular the Directorate-General for Competition, has shown interest in promoting competition in the market for professional services, thus opening a general discussion concerning regulatory frameworks (Stocktaking Exercise on Regulation of Professional Services, Overview of Regulation in the EU Member States, 2003). The British Government has started a review process of the regulatory setup of legal services in order to foster competition, innovation, as well as consumer protection and accountable regulatory enforcers (Review of the Regulatory

Framework for Legal Services in England and Wales, Consultation Paper by Sir David Clementi, 2004).

The present paper has two major parts. In the first part, we present a quick review of the economic theory of regulation of professions, namely (a) Why regulate, (b) How to regulate, and (c) What to regulate. In the second part, an application to the regulation of professions in the United States and Europe is developed. We suggest a set of indicators to measure the quality of regulatory restrictions (hence exposing comparative inefficiencies) in legal and medical activities. The choice of countries to be included in the analysis has been determined by available information.

2. THEORIES OF REGULATION OF PROFESSIONS -- WHY

We can categorize the different theories in three groups:

- 2.1. Market Failure (Asymmetry of Information)
- 2.2. Public Interest (Apart from Market Failure)
- 2.3. Private Interest (Rent-Seeking)

2.1 MARKET FAILURE

The view that regulation pursues public interest in correcting for market failure (Posner, 1975; Noll, 1989) relies on the inefficiency of the market equilibrium. The main market failure that applies to professional markets is information asymmetry (Stephen and Love, 1999). For most clients and consumers, professional services are credence goods (Darby and Karni, 1973). The consumer is less informed about the nature and quality of the service, and often relies on the expertise of the professional in order to assess (agency function) and implement the adequate strategy (service function). There is a potentially severe problem encompassing some kind of supplier-induced demand. Under these conditions the market usually fails to produce the socially optimal quantity and quality of the professional service. Some protection for the consumer of professional services is necessary to guarantee quality and mitigate inefficiencies. Protection of consumers frequently takes the form of regulation of the profession and its markets.

Nevertheless we should have in mind that the costs generated by asymmetry of information must be balanced against the benefits of labor specialization. A reduction in information asymmetry might not be efficient if it also implies a substantial loss of benefits from labor specialization. For example, it is important to emphasize that the information asymmetry does not apply to all consumers. Repeat purchasers in the market for professional services are able

to acquire experience and knowledge of the market which reduces the asymmetry of information (e.g., corporate clients in the market for legal services). Professionals must also take note of reputational effects which may arise from social networks even when most consumers are not repeat purchasers. Furthermore, when the service function is provided separately from the agency function, there is scope for revelation of information that limits opportunism (e.g., medical diagnosis and treatment by different medical doctors) (Emons, 1997).

Besides the moral hazard problem we have so far described, there is of course adverse selection since consumers cannot judge the quality of professionals. The "lemons problem" may arise, thus the need for some kind of licensing or an equivalent mechanism (Leland, 1979). Competition among professionals does not solve the problem due to the fact that good professionals may be driven out of the market by bad professionals given the inability of the market to pay for quality.

Another information problem may occur in the market for professional services, namely bounded rationality or rational ignorance. Consumers use simplified rules to process information rather than complex rational analysis. They also usually lack the education level, or even the intellectual ability, to be able to understand all available information on services in a correct way. Regulation is justified if the regulatory body has more information and expertise at its disposal than average consumers (Maks and Philipsen, 2002).

Legal professionals usually stress the need for self-regulation, arguing that severe losses would occur if poorly trained lawyers were allowed to perform services. This loss is particularly significant in the health sector, where injuries to the body and life represent substantial and eventually under-compensated damages. The consequences of medical maltreatment and legal misrepresentation go beyond the direct customer and generate serious negative externalities for the general public. Good health standards and the quality of the legal system are positively related to the quality of physicians and lawyers (Rubin and Bailey, 1994; Grajzl and Murrell, 2004).

Finally a fifth form of market failure that justifies regulation is the existence of public goods. Information concerning the quality of professional services satisfies the conditions of non-rivalry and non-exclusivity in consumption. Therefore, there is the possibility that private provision (by professionals) of information is not efficient. This may well justify mandatory information disclosure with respect to professional quality (Maks and Philipsen, 2002).

Regulation of the professional services can improve the market equilibrium. Asymmetric information causes moral hazard and adverse selection and eventually negative externalities for the general public thus precluding an efficient level of health and legal safety from being achieved by the market. The benefits of regulation include a decrease of search costs, improvements in service quality and more adequate supply of information concerning quality of professional services. Also, and very important, a reduction in risk is to be expected. In fact, due to the asymmetry of information, regulation could be the most adequate substitute for insurance (Zerbe and Urban, 1988).

Notice that the case for regulation in a public interest perspective is not controversial among economists, however it remains unclear which form of regulation should take place. If severe limitations to entry, prohibitions of advertising and regulation of fees are justified under a theory of public interest, it is still much of an open question. What seems clear is that in a market for professional services, where quality is uncertain, confidence and trust in the professionals is important for efficiency. After a couple of visits to a doctor a patient whose health problems have been solved may start trusting the doctor. An attorney who handles cases with care and arranges affairs with success may create a trust relationship with his clients. The problem is of course that most customers are not repeat purchasers, and even if they were, the costs of mistakes in the initial rounds could be very high.

Regulation and legal rules should aim at enhancing the trust relationship by economizing on information costs. There are three reasons why regulation should create a confidence premium (thus rewarding professionals above marginal productivity): (a) The cost of obtaining information is lower for the professional than for the client, (b) The information involved is productive, (c) The provision of true information must be rewarded in order to avoid strategic behavior or opportunism. At a first observation, these reasons explain the need for minimum quality standards and even some regulation of fees, but severe restrictions on entry and on advertising do not seem justified (Van den Bergh, 1993).

2.2 OTHER GOALS OF PUBLIC NATURE

Regulation of professionals may also pursue other goals of public nature that are not necessarily economic efficiency (i.e., correcting for information asymmetries and externalities). These goals may be explained by some kind of patronizing view of the government or community values, and usually are related to redistribution (Ogus, 1994, pages 218-219).

Confidence, honesty and trust might be values pursued by the government which in turn may actually promote greater social welfare and foster growth. The social willingness to pay for

these values may be above its market or economic value, thus justifying government's intervention. A doctor or a lawyer in a small town may have a socially valuable role or function that goes beyond the professional service s/he provides. Redistribution in favor of the professional against the consumer is just a form of paying for these social services.

The problem with this explanation is that it can hardly apply to all professionals. If a doctor or a lawyer enjoys local monopoly power in a small town, then we expect s/he to earn extra profits (marginal revenue above marginal cost) that could be in some ways justified by these other social services s/he provides. However, why a lawyer in a big city where s/he surely does not provide such social services should enjoy the same extra profits (due to regulation of fees) is hardly justified under a theory of public interest. Furthermore, why consumers of professional services should abstain from revealing their willingness to pay for those social services in a competitive market seems odd and could in fact conflict with an adequate welfare analysis (Kaplow and Shavell, 2002).

2.3 PRIVATE INTEREST

The last theory of regulation relates to private interest and relies on capture and collusion (Posner, 1974). From this perspective the regulation of markets for professional services is seen to arise and be sustained because it is in the interests of the members of the profession. It essentially allows for their cartel-like behavior (Benham and Benham, 1975). As a result, the capture theory predicts that professional licensure should decrease the supply of professionals below social optimum, increase the prices charged by professionals, and increase existing professionals' incomes beyond marginal productivity, thus generating rents and quasi-rents (Stigler, 1971; McChesney, 1987; Olsen, 1999; Hadfield, 2000; Kleiner and Kudrle, 2000).

The most successful groups in obtaining wealth transfers are likely to be small, usually single issue oriented and extremely well organized. On the other side, those who bear the cost of paying rents are large fractions of the population, difficult to organize and with information problems. When these conditions are met, wealth transfers are expected to take place from the public as a whole to the very well-organized interest groups.

The government should protect the public from these interest groups but incentives to provide public interest legislation can be overcome by pressure by those benefiting from wealth transfers. Moreover, wealth transfers may not be recognized by the public in general and comparisons with other jobs and occupations can be difficult (Van den Bergh, 1993). Just take the case of confidence premium. Comparing figures about the income situation of professionals and other occupations may provide some evidence about how better paid they are, but we can

hardly distinguish the confidence premium from pure rents. Unemployment within the profession below average unemployment could be an indication of rent-seeking but could just be that the population requires more professional services than other goods and services on average. Less regional variance with respect to payments could help to identify rent-seeking (payments less subject to local market and business conditions indicate some degree of market power), but at the same time it could be that the willingness to pay for health and legal professional services varies less across regions than for other goods and services. Market concentration indices for professional services can be constructed but are of course subject to the appropriate delimitation of the market (e.g., most large law firms are specialized in certain areas of the law) and the distortions of the public sector (e.g., the national health service is the major provider of medical services in many European countries).

The fact that rent-seeking behavior is intrinsically difficult to identify, specially when there are sound public interest arguments for regulation to be made, makes rent-seeking and regulatory capture to be more likely. Nevertheless, it is possible to develop legal and political instruments to limit it. Promoting competition, in particular by making use of the internal European market (which should promote a free flow of professional services), auditing professional bodies (including comparative institutional analysis) or forcing the separation of the service function from the agency function (e.g., medical diagnosis and treatment by different medical doctors) certainly helps to mitigate the problem.

2.4 A COMPROMISE BETWEEN THEORIES

In contrast to both pure private and public interest theories, the public and the professionals have an impact on the existent forms and contents of professional regulation. Thus, professionals will sometimes, but not always, be able to use regulations to limit supply and generate rents. On the other hand, public interest will be pursued sometimes, but not always (Peltzman, 1976). In fact, public and private interest theories mirror two distinct historical phases on economic research, emphasizing the corrective and the redistributive roles of regulation. The distinction between these two theories has lost validity even in economic theory due to game theory and institutional research (Hägg, 1997) that combine both.

Different institutional arrangements and regulations are consistent with both theories. In particular, self-regulation is not necessarily a sign of rent-seeking. Professional regulatory bodies are consistent with public interest theory. Identifying rent-seeking requires a more detailed analysis of the legal substance than just the legal form.

3. INSTITUTIONAL ARRANGEMENTS -- HOW

There are several possible institutional arrangements to correct for market failure in the market for professionals as well as avoid private capture. We categorize these solutions in three groups:

3.1 Regulation by the Government

3.2 Self-Regulation

3.3 Regulation by Third Parties

3.1 REGULATION BY THE GOVERNMENT

Regulation by the government usually includes quality regulation, certification and licensing. The government could subsidize high quality suppliers to ensure that they remain in the market even if adverse selection persists. Unfortunately it does not guarantee that the higher quality service will actually be supplied due to moral hazard. Second, penalties can be imposed on low quality suppliers and entry to the market could be restricted to some adequate standard (Dingwall and Fenn, 1987). These regulations however require a regulatory agency that must avoid capture and be able to do what consumers cannot: assess quality and signal it to potential clients (Stephen and Love, 1999). Apart from simple mandatory disclosure measures (e.g., professional specialty, professional education) and prohibiting what seems obvious misleading advertising (e.g., saying one is a lawyer or a doctor when one is not), effective quality regulation by the government seems difficult to imagine.

Under certification or licensing, a document (certificate or license) is awarded to an individual who satisfies certain conditions. These conditions may be education or training. The government as well as a private agency may certificate or license professionals, and regulate professional education, compulsory periods of training, and performance requirements.

The difference between licensing and self-regulation is that while rules are issued by public authorities in both settings (since the professional body is entrusted with public authority), entry and performance are regulated by the state in the first case (eventually delegated to a private agency independent from the profession) and by the profession in the second case. The consequence is that self-regulation promotes strong professional association (as we know with lawyers and doctors) whereas licensing does not. A profession becomes only a real profession if it has the decisive power to fix remuneration; otherwise it is just a form of licensing (just like economists in Portugal and journalists almost everywhere).

The two arguments against licensing and thus making the case for self-regulation are the following: (a) It still does not solve the problem of asymmetric information because neither the government nor a private agency independent from the profession have better knowledge of the quality of the service the profession provides than the profession itself (though they might have better knowledge than the average consumer), (b) It is less flexible (in dynamic markets where innovation is important agencies should be able to change quickly) and generates costs to be borne by the government rather than by the profession itself (Miller, 1985). The second argument nevertheless has serious limitations. First, the profession can regulate fees to cover these costs (hence they will be borne by taxpayers or consumers in both cases). Second, rents created by the exercise of regulatory powers by the professional body can undermine flexibility. For example, rents may be used to successfully resist competition from other regulatory bodies offering more efficient rules (Curran, 1993).

3.2 SELF-REGULATION

Professional regulators have the necessary information to extract signals in markets for credence goods (the well-known specific knowledge argument by Miller, 1985) but can hardly avoid the ultimate form of regulatory capture. Yet this type of bodies persists in most jurisdictions. One view is that there is a social contract between the profession and the community in order to reduce moral hazard. Naturally safeguards are required in order to ensure the profession does not operate a cartel. Also various watchdogs are necessary (Dingwall and Fenn, 1987). Another view is that the reduction in costs of extracting information by professionals more than compensates for potential losses due to cartel-like behavior (Ogus, 1995). These potential losses can be mitigated if there is more than one professional body in competition with each other (nevertheless in most jurisdictions professional bodies have a national or local monopoly), a large heterogeneous profession (Shaked and Sutton, 1982), and adequate legal instruments (e.g., efficient tort law) (Danzon, 1985 and 1991; Gravelle, 1990).

Though self-regulation solves the information problem we have discussed before, it is difficult not to expect that professional bodies use their regulatory powers to restrict competition somehow. Such rent-seeking behavior, alongside other significant costs of administering the regulatory system, causes a significant deadweight loss.

In order to tackle this problem, we should have in mind four specific dilemmas: (a) It will be easier for professionals not to pass their better information and expertise to the users unless of course they have an interest in doing so (this will increase search costs for the consumers since asymmetric information will not be reduced), (b) Professionals will induce demand of services that clients, if fully informed, would not require (inefficient allocation of resources), (c)

Control and enforcement of quality standards will not be very effective due to collusion (hence we should investigate for sanctions for malpractice), (d) Fees will be set above confidence premium.

3.3 REGULATION BY PRIVATE PARTIES

Alternatives to professional regulation have been proposed, most of them never implemented. One solution could be independent rating agencies designed by repeat purchasers to perform the agency function on behalf of infrequent consumers (Stephen and Love, 1996). Others suggest deregulation via competition that will generate quality signals with adequate liability rules and removal of informational barriers (Leffler 1978; Klein and Leffler, 1981; Carr and Mathewson, 1988; Van den Bergh and Faure, 1991; Miller and Macey, 1995).

There has been a recent trend to relate effective regulation of professional services with litigation. The large scale of litigation in the US allows litigants to use their financial leverage to force changes of a regulatory nature and professionals to limit opportunism. If appropriate regulation does not exist for professional services, litigation can provide an effective substitute when it generates a transfer of wealth from the profession (the injurers) to the consumers (the injured) (Viscusi, 2002). Even so, there are important objections to the use of litigation as a way to stimulate effective regulation: (a) Consumers do not have the appropriate information to make a comprehensive analysis whether or not negligent behavior, reckless attitudes, or professional malpractices were exercised (thus, litigation will usually be an inferior substitute for regulation), (b) Consumers may be opportunistic when making decisions with respect to filing lawsuits and settling out of court (e.g., nuisance litigation), thus generating too much litigation, (c) Litigation may not create the adequate incentives for efficient levels of professional services since it usually aims at providing compensation, (d) Litigation may fail in achieving efficient risk-sharing (restoring pre-accident levels of utility may not be possible, specially in the context of health effects).

In the context of medical malpractice there is some further controversy concerning the effectiveness and efficiency of litigation. Kessler and McClellan (1996, 1997, 2002a, 2002c) have shown that malpractice liability provides important incentives for medical care. Doctors in areas with greater malpractice pressure tend to use more defensive medicine, better treatment and medical high productivity seems to be positively related to the willing of patients to litigate (Olsen, 1997). However, once the incentives for hospitals and managed care organizations are explicitly taken into account, the empirical results are less striking. In fact, there is some debate among economists over optimal liability rules for physicians and health organizations, though most agree that tort reform and managed care function are substitutes in achieving incentives

for adequate performance (Danzon, 1997; Kessler and McClellan, 2002b; Agrawal and Hall, 2003; Arlen and MacLeod, 2003).

4. REGULATORY INSTRUMENTS -- WHAT

Currently, the literature has been focusing on controlling regulatory instruments and reflecting the private interest nature of their use. These instruments are:

4.1 Entry Restrictions with Consequent Professional Monopoly Rights

4.2 Restrictions on Advertising and Other Means of Promoting Competition within the Profession

4.3 Restrictions on Fees and on Fee Contracts

4.4 Restrictions on Organizational Forms

4.5 Restrictions on Conduct and Procedures

4.1 ENTRY RESTRICTIONS

Entry restrictions are justified in order to assure quality of professional services but on the other hand they undermine competition by creating professional monopoly rights (Shaked and Sutton, 1981; Van den Bergh, 1999). These restrictions require candidates to have specialized skills acquired by intellectual education at university (in Europe, after obtaining a university degree; in the US, after completing studies in a professional graduate school) and by training (for a mandatory period). These requirements of education (a specific diploma) and traineeship may be determined both by the government and the professional body.

Controls over these requirements can be exercised at three levels: (a) By defining the content of intellectual and training requirements, (b) By exercising influence over the organizations that educate and perform training of professionals (Shepherd, 2000), (c) By evaluating candidates after education and training at an exam or other type of screening device (eventually subjecting admission to some kind of *numerus clausus*). From a public interest perspective, we would expect some control over entry requirements but no strong influence over organizations that educate and perform training as well as a strict examination of candidates. Some level of education and training is indeed positive since the relationship between human capital and high quality services is expected to be positive. Moreover, reliance on self-regulation may increase the specificity of human capital investment and individual commitment to the profession (Donabedian, 1995).

Educational requirements do vary for lawyers. A law degree is enough for practicing law in Spain and in the United States, but not in most countries. Quite extensive mandatory training

periods exist followed up by examination. Making licenses dependent on requirements of continuing education is not practiced, but professional associations run courses and seminars in joint ventures with law schools and law firms to help updating knowledge. It should be noted, nevertheless, than in Sweden and Finland there are no restrictions on who can provide legal advice and representation.

Entry regulations are not very different across our sample of countries with respect to the medical profession, with the exception of the Netherlands where registration is not required. As a consequence, a complex insurance system has been developed in the Netherlands to protect consumers. One of the consequences is that now it is actually easier for a doctor registered in a professional body in another country of the European Union to practice medicine there than a Dutch doctor (because the insurance premium is much lower for the former).

Entry restrictions can also apply to para-professionals (e.g., para-medicals or other legal professionals) under the argument they supply an inferior quality service. However, they also do it at lower prices. It turns out that the entry of low quality para-professionals could be welfare improving (Shaked and Sutton, 1981). In other words, restrictions on para-professionals are expected to be undesirable unless the profits of the profession are given a sufficiently high weight in the social welfare (Gehring and Jost, 1995).

From our discussion it is clear that entry restrictions should be more similar to certification rather than a very comprehensive and strict examination of candidates before, during, and after education and training takes place. Notwithstanding, the absence of severe restrictions on entry does not necessarily imply competition. Professional markets tend to be spatially localized (Stephen and Love, 1999). Hence mobility might be seriously undercut and thus promote local monopolies (Pashigian, 1979). For example, in many jurisdictions lawyers may only appear before courts in the local area corresponding to the bar they have been admitted. In general in Europe lawyers can plead before any court. There are however limitations in United Kingdom, Germany and the United States.

In Europe, many of the entry restrictions are in the process of being removed. The implementation of the Establishment Directive means that it is possible for lawyers and doctors qualified in one member state to become full members of the profession in another member state without further examinations, though for example it does not apply to mobility for the legal profession between United Kingdom jurisdictions (Stephen, 2003). In the United States, the lack of reciprocity between state bar associations seems to lead to lower number of practicing lawyers and higher incomes, though not to higher prices of legal services (Lueck et al., 1995).

European directives (namely Directive 77/249, Directive 89/48, and Directive 98/5) have been implemented in most countries for the legal profession. Entry restrictions can collide with competition law in Europe and anti-trust in the United States. For many years, entry regulations issued by professional bodies were not subject to competition authorities. In Europe, the European Court of Justice (ECJ) explicitly recognizes that professionals may be subject to higher standards of conduct, and therefore accepts some restrictions. However, whether or not competition rules apply will depend on whether the professional body could reasonably have considered the restriction adequate for the proper functioning of the profession. Hence simply showing that the restriction itself is not necessary for proper functioning does not suffice for enforcing competition law (Andrews, 2002). As follows from the Wouters case (309/99), the ECJ precludes two ways to regulate professions. Either the government has empowered the professional body to regulate the profession without the government being fully involved, or the government retains the power to adopt professional rules. Regarding the latter, these professional rules will be considered state measures and excluded from the scope of EU competition law. The United States case law however seems to point out in a different and more competitive direction by not tolerating outright collusion, for instance on prices, simply because it is the market for a professional service.

European directives (namely Directive 93/16) have been growingly implemented for the medical profession. The medical diplomas and certificates obtained in any state of the European Union are recognized by each member state (Directive 93/16 complemented in details by Directive 97/50, Directive 98/21, Directive 98/63 and Directive 99/46). After registration in the professional body, a physician can practice under the rules of the country (given the recognition by the ECJ of the so-called principle of double deontology). For example, given the shortage of physicians in Portugal and the high number of doctors in Spain, many Spanish doctors have made use of this European legislation to establish themselves in Portugal.

Even though entry restrictions are important and significant, entry to legal and medical professions has continued to grow in most jurisdictions. Obviously what is important is the growth in supply relative to demand (Stephen, 2003). Nevertheless, we should notice that some empirical evidence points out that economic growth is negatively affected by more lawyers, the explanation being that their professional services do more redistribution than production (Murphy et. al., 1991).

A quick overview of statistical data concerning professions confirms substantial differences across countries. The evolution of the legal profession can be observed in Table one, where we

show the number of lawyers per 100,000 in several countries. One can see immediately that jurisdictions with less restrictive entry rules (Spain as well as the United States and the United Kingdom) have a substantially higher number of lawyers per capita, Greece being an exception (severe entry restrictions but high number). France, Austria and the Netherlands have a low figure, Japan having the lowest.

According to international databases (Table two), Italy, Spain, Greece, and Belgium have the highest relative number of physicians. The United States and Norway, Switzerland and Japan have a low figure, the United Kingdom has the lowest. From Table three, it is clear that there has been a steady increase in the number of physicians in most countries, though the United Kingdom, the United States, Denmark and Japan below average. A more accurate statistics to measure the dynamics of entry is the number of doctors entering the workforce in the period 1992-2000. It is the lowest in Portugal (European Observatory on Health Care Systems, 2000) and in the United States, see Table three.

In Figure one, we offer a comparison of number of lawyers and physicians per 100,000. A positive correlation between the two measures is clear, most countries having more physicians than lawyers. There are however three notable exceptions. On one hand, Italy clearly has a much higher proportion of physicians than lawyers than every other country, whereas the United States and the United Kingdom come out on the opposite side, having a very number for lawyers and relatively low figure for physicians.

4.2 RESTRICTIONS ON ADVERTISING

Restrictions on advertising can be justified under a public interest perspective inasmuch as they apply to other markets of goods and services. Advertising is a common method to provide information and, from a social welfare perspective, advertising should be allowed when it is productive, that is, it conveys important and relevant information to consumers concerning professional services. There is no reason to suppose that advertising of professional services should be subject to different regulations than those applied generally to other experience and credence goods and services. This argument conflicts with the claim used by professional bodies that advertising should be prohibited because it threatens the integrity and ethical responsibility of the profession by commercializing it. According to most professional associations, competition would be contrary to the dignity of the profession. However, as we observe in Europe, lawyers seem to be increasingly aware that dignity has a price. When Belgian lawyers seemed to lose business to Dutch and British law firms, the professional association decided to relax constraints on advertising (Faure, 1993).

Two kinds of advertising can be distinguished, price advertising being more controversial than quality advertising. When information about price is easier to obtain than information about quality (which is true for experience and credence goods but not for search goods), increasing the availability of price advertising might discourage quality competition and encourage price competition, leading to a degradation of the average quality in the market (Cave, 1985). This argument may support some restrictions on price advertising, but not necessarily banning it.

The general conclusions of empirical evidence seem to be that restrictions on advertising increase the price of professional services and that the more advertising exists the lower the price is. However, there are several articles that contradict these findings (Rizo and Zeckhauser, 1992; Love and Stephen, 1996). There is no systematic evidence that distinguished between the effects of the two forms of advertising (Stephen, 2003). Nevertheless, quality advertising is much more common than price advertising (Stephen, Love and Peterson, 1994).

Medical advertising is regulated in most jurisdictions, the United States and the United Kingdom being less restrictive and Portugal and Germany being the most restrictives. With the exception of announcement of opening or closing practice, listing in the phonebook and the nameplate (and even this one is clearly regulated in dimension and content), advertising is banned. Competitive pressure and publicity in the internet have led the professional bodies to issue new documents on publicity, clarifying the strictness of the rules justified by the so-called principle of non-commercialization of medical services and alleged protection of consumers. Advertising is allowed in Spain or Belgium as long as it does not convey false information or bad publicity to the medical profession. More difficult to understand is why in some countries physicians are not allowed advertising, but managed care organizations can do it. They operate in the same market for professional services and there is no economic reason to justify why physicians cannot advertise in price and quality but managed care organizations can.

For legal professionals, price advertising is banned in most jurisdictions, except the United States (though regulated by each state bar), under the cover that comparative advertising is strictly prohibited. Quality advertising is usually allowed for partnership but not for sole practitioners. Competition within the European Union has pushed bars to relax somehow the constraints. Overall, the regulation of publicity for legal services is still more restrictive in Portugal, Spain and France and much less restrictive in the United Kingdom and the Netherlands, Germany and Belgium being intermediate cases with a trend for deregulation.

The arguments against deregulation of publicity for legal services used by the professional bodies include: (a) publicity misleads the public and it has a negative effect on the quality of the profession (untrue of quality advertising and probably true in price advertising), (b) it is very expensive (we do not know since the current market is most likely very thin due to strict regulations), (c) it generates unfair competition because only the large law firms can benefit from advertising (the US experience shows otherwise), and (d) it is against professional ethics by violating the so-called principle of non-commercialization of legal services (Guedes da Costa, 2003).

4.3 RESTRICTIONS ON FEES

Restrictions on fees can be seen as way of assuring the confidence premium to professionals. Fees can be subject to control by the profession itself, by the courts or by the government by use of mandatory fee schedules. Over time, in most jurisdictions, mandatory scales have been transformed into recommendations. However, in Germany legal fees are still determined by the government. For a long time, in Belgium and the Netherlands a recommended legal fee schedule was produced by the professional body and in Belgium there was a recommended minimum, until competition pushed for the abolishment of such rules. Medical fees are set by the government in most public health services (e.g., NHS in the United Kingdom) or by managed healthcare organizations.

Price fixing is very restrictive and not very common. Moreover, it is unclear if it enforces high quality production (it seems it would if quality were either high or low and with homogeneous consumer preferences, Maks and Philipsen, 2002). Recommended fees suggest a more sophisticated approach to cartel-like behavior. Though we would expect recommended fees to be seen as mandatory by the profession, the evidence provided by Shinnik and Stephen (2000) for conveyancing markets in Scotland and Ireland goes on the opposite direction. The authors nevertheless recognize that these markets satisfy the necessary conditions for successful deviations from collusive agreements. Another possibility is that recommended fees provide a focal point against which professionals discount thus colluding at a lower level (Stephen, 2003).

Limitations on fee contracts (e.g., contingent fee contracts in the market for lawyers is forbidden in Europe) are more difficult to justify on the basis of quality assurance. Moreover, the enforcement of limitations on fee contracts is costly and generates incentives for bargaining on the shadow of the law (e.g., informal contingent fees in Europe). In fact contingent fees for both legal and medical professional services would solve the moral hazard problem. The fundamental argument put against contingent fee contracts in the legal profession is that they conflict with the principle that lawyers should not have a vested interest in the cases they take.

There could be a conflict of interest between client and lawyer over if and when to settle. The determination of an appropriate fee if settlement takes place would of course solve the problem. Also, we would expect well-informed clients to prefer an hourly fee contract (and avoid conflict over settlement) whereas less experienced litigants would prefer contingent fee contracts.

With respect to legal fees, in most countries prices can be freely negotiated and usually more competent lawyers charge higher fees, except in Germany. Recommended fees existed at some point in Belgium, the Netherlands, and Portugal. Fees are usually based on hours worked, litigation value (except in Belgium), and complexity of the case. Contingent fees are allowed in the United States but not in Europe. Usually legal fees take the form of hourly fees or flat fees. A first exception was developed in the United Kingdom where a lawyer receives an up-rating on the normal fee if the case is won which is not related to the value of damages (conditional fees). Similar arrangements are now being allowed in many countries. The introduction of contingent fees is under consideration in the Netherlands.

As to medical fees, Germany alongside with Portugal and the Netherlands have the least competitive market (in the Dutch case, it could just be the consequence of no registration and expensive insurance schemes). Nevertheless, European countries have a powerful national health service that effectively restrains fee competition. The same does not happen in the United States, where fees can be freely negotiated.

Professional bodies can also manage the subsidies the government supplies to consumers of professional services, usually the national health service for health services and legal aid for legal services. The costs of legal aid and national health services have been growing rapidly. Usually it is caused by the increasing number of cases, rather than by fees paid to lawyers or physicians. Though these fees are usually much lower than normal fees, the profession can use them as a way of attracting consumers. Professionals have no clear incentive to avoid using government subsidies to generate oversupply of services.

Legal aid in particular is usually run by independent government funded bodies (e.g., the Netherlands and the United States), legal aid boards (e.g., Scotland and Spain) or courts (e.g., Germany), the exceptions being Belgium and the new system in Portugal where legal aid is funded by the Government but run by the professional body.

4.4 RESTRICTIONS ON ORGANIZATIONAL FORMS

Special regulations apply to law and medical firms. Restrictions on organizational forms are difficult to justify by public interest. If some aspects of professional services may favor partnerships rather than incorporation, we should expect the market to solve that, not the professional body.

Common organizational restrictions exclude incorporation (even where incorporation is permitted usually unlimited liability is maintained and the directors of the firm must be professionals) and multidisciplinary partnerships (i.e., involving members of more than one profession) from possible organizational forms. The usual justification for these restrictions is agency costs. Effort in production and quality are difficult to measure by others outside of the profession, thus making sole practitioners or professional partnerships the most likely form of organization where adequate incentives will be less costly to be designed (Carr and Mathewson, 1990; Matthews, 1991). The problem of course is that by banning other organizational forms, specialization of professionals beyond particular aspects of their service (thus lowering the cost of providing services) and economies of scope (by providing a "one stop shopping" including lawyers, accountants, surveyors or medical doctors, dentists, and beauty consultants) are lost. For example, in the European countries where multidisciplinary partnerships are permitted, commercial law is increasingly dominated by the legal branch of the major international accounting firms (Stephen, 2002).

A second type of restrictions on organizational form concern the separation between the service function (assess or diagnosis the problem) and the agency function (implement the correct solution). This separation limits opportunism and creates incentives for reveal of information (Emons, 1997). However, it can be seen as prohibition on vertical integration between different stages in production, thus generating costs in terms of technology (economies of scale) and agency costs (hold-up problem). The issue then is whether or not the benefits from formally separating the roles outweigh the costs (Stephen, 2003).

In the United Kingdom, as well as in Ireland and most of Australia, the legal profession has two branches: solicitors and barristers. Solicitors provide legal advice to the public and have rights of audience in the lower courts. Barristers have the rights of audience in higher courts and can be commissioned to advise solicitors, and they provide the majority of judges in the higher courts in later stages of their career. A member of one profession cannot become a member of the other. The debate over the efficiency of separating the legal profession in the United Kingdom is inconclusive (Bishop, 1989; Ogus, 1993; Bowles, 1994).

The structure of legal firms in Europe has been changing since the 90s. Sole practitioners or small professional partnerships have been growingly replaced by large professional partnership, corporations (where they are allowed) and multidisciplinary organizations. The entry of foreigner law firms or partnerships in the market for legal services is not helped by current regulations in some countries where the use of original denomination as well as original organizational form are allowed under certain limited conditions.

4.5 RESTRICTIONS ON CONDUCT

The introduction of professional standards and ethics generates a number of costs, including administrative costs (defining, monitoring, and enforcing quality), compliance costs (from fulfilling professional obligations), and opportunity costs (since opportunistic behavior is restricted) (Ogus, 1994).

Professionals are expected to pursue an agenda to minimize these costs. They will lobby for their own quality level and standards (Hau and Thum, 2000). A standard can be an effective mechanism to protect insiders from competitors by imposing their own quality standard thus reducing to zero compliance costs. On the other hand, a conflict between the government and the professions with respect to accepting and formally observing conduct rules is not likely, because professionals are usually involved in the actual formation of these rules (Maks and Philipsen, 2002).

Administrative costs will depend on how the professional body regulates the conduct of professionals. Many forms of conduct regulation can be found in the professional rules. A code usually describes the tasks and duties of the profession and is often called professional ethics. The professional body also establishes disciplinary procedures in case the restrictions on conduct are violated. These rules usually define under which conditions professionals might be sanctioned and eventually expelled from the profession.

There are two reasons why the enforcement of restrictions on conduct is not expected to be high. First, it is not a problem of controlling entry, but rather of controlling exit. There are clear incentives to avoid conflicts within the profession and make exit too easy. Second, the alternative mechanisms (litigation in court) still rely too much on the profession. By controlling the production of expert witnesses (directly, by providing and managing expert witnesses; indirectly, by training them), the professional body may block any attempt to force physicians and lawyers to leave the profession for violating professional conduct or gross malpractice. Naturally, in most countries, professionals are subject to contractual and extra-contractual

liability, however it is difficult for judges to make a decision on medical malpractice or negligence in preparing a lawsuit if expert witnesses are not available.

Some limitations to the discretion professional bodies have in dealing with restrictions on conduct have been emerging out of international professional federations (though these are mostly recommendations) and to some extent by EU directives on professional services (not surprisingly usually perceived by professionals as intrusions into national legal and medical culture). However, evidence points out that most disciplinary actions are taken for lack of dignity or improper behavior towards other professionals rather than professional malpractice (Faure, 1993; Hellingman, 1993).

In the United States, lawsuits for medical negligence are quite too frequent nowadays (some people talk about a medical malpractice crisis), but were very infrequent 50 years ago. Physician liability existing prior to 1960s might actually have been too low, resulting from capture and the consequent use of self-regulation to deny expert witnesses testimony in malpractice cases. However, after the 1960s, it became much easier to obtain expert witnesses due to the erosion of local medical societies in disciplining unethical practices and local rules (Olsen, 1997). The consequence was a blow up of litigation over medical malpractice and thus the current need for tort reform in medical negligence (Miller, 1997; Dauer and Marcus, 1997; Sloan and Hall, 2002; Fine, 2003). Liability for medical malpractice is also of growing importance in European tort litigation. Contrary to the United States experience, the medical malpractice explosion does not seem to have come to an end yet (Faure and Koziol, 2001).

Liability for medical negligence is extremely complex in many European countries. First, it can be contractual (breach of contract in the private sector) or extra-contractual liability (negligence for doctors in the national health system). Whereas for contractual liability, the patient has a longer period to sue the physician after the wrongdoing, for extra-contractual liability, the same period is typically much shorter. Such liability dichotomy exists in England and Wales, but the development of expert witnessing and the structure of the legal system has not produced the chilling effect that is observed in other countries such as Portugal. The problem in some continental European countries is that whereas for doctors in the private sector, law enforcement is exercised by regular courts, doctors in the national health service are under the jurisdiction of administrative courts. Given that many physicians work for the national health service but practice privately in part-time, conflicts and questions of court jurisdiction usually take place when patients want to sue doctors. Not surprisingly, lawsuits for medical negligence are occasional and unlikely to succeed.

4.6 A GUIDELINE FOR RESEARCH ON RENT-SEEKING

Table four summarizes most of the discussion we have presented. It also suggests some guidelines to identify rent-seeking behavior from the profession. We will use these results while presenting the methodology developed for comparative analysis of professions.

5. COMPARATIVE INSTITUTIONAL ANALYSIS

Given the very distinct institutional details, ranking the different institutional frameworks is a difficult and controversial task. Some comparative law scholars seem to be opposed to the idea of building indicators for law and legal institutions (Siems, 2004). Obviously, some institutional details are lost and legal complexity is reduced by providing comparable indicators. Nevertheless, a comparative institutional analysis cannot be reasonably influential without providing testable results.

Following the methodology proposed by Faure et. al. (1993), we construct a comparative institutional ranking of the regulations of professional services. The interpretations of the indicators should be very careful having in mind that it depends crucially on the questions surveyed (which do not cover all institutional details) and the relative importance we give to each set of questions (we try to correct somehow for this problem by presenting different weighted averages).

The process by which we construct a market failure approach index is the following: A country gets a point if the answer to the question complies with the market failure approach and zero otherwise. Complying with the market failure approach means that the answer to the question is consistent with improving market performance (as summarized in Table four). Our index is based on a set of questions (Tables nine and ten). They are a modified version of Faure et. al. (1993) where questions concerning professional schools, management of legal aid in the case of lawyers, and malpractice litigation have been included. We also eliminated some questions that in our view were duplications.

Details on the United States, the United Kingdom [England and Wales], the Netherlands, Belgium and Germany regulatory framework for the legal and medical professions can be found at Faure et. al. (1993). For legal services, a detailed report for Denmark, Italy, France, the United Kingdom [England and Wales] and Germany is available at Paterson et. al. (2003). We present detailed references to Spain and Portugal in Garoupa (2004).¹ Information concerning

¹ For the Portuguese and Spanish cases, the questionnaire was mailed to the Portuguese and Spanish law bars (Ordem dos Advogados and Consejo General de la Abogacia Española) and the Portuguese and Spanish medical associations (Ordem dos Médicos and Consejo General de Colegios Oficiales de

Switzerland (for the medical profession), Norway, France, Belgium and Netherlands, Portugal and Austria was also obtained by local experts.

5.1 THE QUESTIONNAIRE

The questions are divided across the five dimensions we have considered in previous sections: entry, organization, price, advertising, and conduct regulations.

Most of the information used to answer this questionnaire for the United States, the United Kingdom [England and Wales], Germany, Belgium and the Netherlands (except questions four and twenty-one for doctors and questions four, thirteen, and twenty-one for lawyers) has been made available at Faure et. al. (1993) and Paterson et. al. (2003), the latter only for the legal profession. In Faure et. al. (1993), the data was obtained by direct questionnaire to local experts in the five countries analyzed, in some cases the authors of the respective chapter in the book. In Paterson et. al. (2003), questionnaires were sent to the fifteen national law bars. In some very minor cases, we note inconsistencies between those two sets of information.

The construction of our index is based on the spirit of Table four. Therefore, a certain number of points is assigned every time the answer to the question means promotion of free competition or no existence of regulation, unless that regulation is clearly consistent with the market failure approach. Some points might be more controversial, so we look at them in more detail here:

Question One: Registration and licensing seem to be the most efficient way for regulating the market for legal and medical services (Ogus, 1994, page 221). Insurance is an expensive alternative (e.g., the Dutch medical profession).

Question Two: After obtaining a degree in Law or in Medicine, additional training and further examination controlled by the professional body seems unnecessary.

Question Three: Submitting the right to practice as a doctor or as a lawyer to periodical review would certainly indicate rent-seeking motivation (control of the profession) and can hardly be justified on efficiency grounds.

Médicos). Only the Portuguese law bar replied and the information provided by them was used to compile the answers. For the other three cases, we have used information available by means of codes of professional conduct or other information available at their webpages.

Question Four: Product differentiation is a signal of competition whereas product homogeneity imposed administratively by the Government or the professional body has no substantive efficiency justification.

Question Seventeen: Continuing education is expected to raise the quality of the professional service. Mandatory continuing education is efficient in the absence of market incentives (due to asymmetry of information).

Question Eighteen: Keeping records and mandatory disclosure of those records to the disciplinary body cannot be justified for efficiency reasons since professionals should be free to decide on what type of information they want to record and eventually disclose. These rules increase production cost (hence prices) with no obvious gain for customers, either legal clients or patients.

5.2 OUR FINDINGS WITH RESPECT TO LAWYERS

We provide a summary of our own cross-national comparisons as well as a detailed analysis of previous research by Faure et. al. (1993) and Paterson et. al. (2003).

Tables five and six present the results for each regulatory instrument. Besides a simple index constructed by adding up the points obtained in the twenty-one questions, we have considered two weighted averages, the first where the same weight is given to each regulatory intervention, and the second where entry restrictions get 50% and each of the other four gets 12.5%. The former is constructed to overcome the problem that the number of questions varies for different regulatory interventions, the latter aims at taking into account the fact that economists tend to judge entry restrictions to be more important for purpose of market efficiency.²

With respect to lawyers, we can immediately see that the United States regulatory framework seems closer to improving market performance for legal services than most European jurisdictions essentially due to the fact that the United States is not so much regulated and is more competitive. Within the EU we identify three groups: the Netherlands and Belgium that seem to have a regulatory framework producing a result similar to the United States, a second group of jurisdictions (Norway, England and Wales, France, and Spain) with a performance below the United States and Benelux countries but clearly above the performance of the third group (Portugal, Germany, and Austria). Germany's result is justified by excessive regulation of

² I thank Fernando Branco for suggesting this third indicator.

fees. In the case of Austria and Portugal, we should add excessive restrictions on organizational forms.

It should be noticed that there are no major ranking differences across the three indicators, with the Netherlands and Belgium on one hand and Germany and France on the other hand changing positions when more weight is given to entry restrictions.

The overall result for the United States-Europe comparison is not surprising. European law bars subscribe to a professional code (the so-called Code of Conduct for Lawyers in the European Union) that provides minimum common standards, though it is recognized (it says in its preamble that it is not possible nor desirable) that a general unified regulatory framework should not be developed. Common standards include: (a) Personal advertising and publicity is forbidden unless explicitly allowed by the local bar; (b) Contingent fees (*pactum de quota litis*) are banned; (c) Multidisciplinary partnerships are restricted since lawyers cannot share honorariums and fees with other professionals unless explicitly allowed by the local bar; (d) Lawyers should not conflict with other lawyers, but if they do, the local bar should be asked to intervene before the case goes for litigation; (e) A lawyer should not accept instructions to represent a client in substitution for another lawyer in relation to a certain matter if the client has not fully paid and reimbursed the first lawyer. The Code also refers to the "corporate spirit of the profession" by which a relationship of trust and cooperation should be developed (a principle regulated under the name of duty of solidarity among lawyers).

More recently, the association of European law bars has emphasized that: (a) Contingent fees (i.e., an agreement between a lawyers and his client by virtue of which the client undertakes to pay the lawyer a share of the result regardless of whether in the form of money or any other benefit) being forbidden is a necessary rule of the profession; (b) Fee sharing with non-lawyers is a consequence of the duty of confidentiality and avoidance of conflicts, thus multidisciplinary partnerships should not be permitted since they offend the core values of the profession; (c) These restrictions cannot be considered a restriction of competition under EU competition law since they are applied in the specific context of a profession; (d) Comparative conclusions with respect to different regulations across Europe should be avoided because they follow from legal and cultural intrinsic differences, and are respected by the jurisprudence of the ECJ (CCBE Response to the European Commission Competition Questionnaire on Regulation in Liberal Professions and its Effects, May 2003, in relation to the report by Paterson et. al., 2003).

5.3 OUR FINDINGS WITH RESPECT TO PHYSICIANS

With respect to physicians, we can see that the United States regulatory framework again seems closer to improving market performance for medical services than most European jurisdictions. Within the EU we identify two groups: the first group (Norway, France, England and Wales, Switzerland, Belgium, and Spain slightly below) with a performance below the United States but clearly above the performance of the second European group (Portugal, the Netherlands, Austria and Germany). Most of these results are consistent with previous evaluations, with the exception of the Netherlands. This is essentially due to the fact that we mark as negative the Dutch system having no registration (since the market failure approach relies on some degree of consumer protection). Looking at the cases of Austria, Germany and Portugal, the reasons for performing so badly are very severe restrictions on fees, advertising, and organizational forms.

Contrary to rankings for legal services, it should be noticed that there are important ranking differences across the three indicators, the only consistent results being the United States as first, Spain as number seven, and Portugal as last in all three indices. Major changes are observed for Belgium (gets to the third position when entry restrictions have more weight and falls to number six otherwise), France (gets to the second position when entry restrictions have more weight, but falls up to number five in the weighted average indicator), Norway and Switzerland (number five and six respectively when entry restrictions have more weight, but number two and three in the weighted average indicator). Such observations indicate that while Belgium and France seem to have less restrictive entry regulations than Norway or Switzerland, the opposite happens with other regulatory interventions (namely, fees, advertising, and conduct). Minor changes are noted for Germany, the Netherlands, and Austria.

In figures 2 and 3, we plot the weighted indices for both professions (lawyer and physician). Immediately we can see that the United States comes out as having the most efficient regulatory setup for professions, followed by a group of European countries including Belgium, England and Wales, Norway, and at some distance by France and Spain. Clearly, Germany, Austria and Portugal form a second European group that performs badly in the current exercise (notice that Switzerland is not included due to the lack of information for assessing regulation of the legal profession). The Netherlands comes out as an outlier with efficiency problems concerning the regulation of the medical profession.

5.4 RELATIONS BETWEEN INDICES

Our rankings are close but do not match exactly the rankings offered at Faure et. al. (1993) for three reasons: (a) They offer three indices (libertarian, efficiency, and consumer protection) that

in our view are less compelling, (b) We average out questions within the survey by relevant item while they simply add all questions with equal weight (therefore the issues covered with more questions carry more weight in their final ranking), and (c) We include other aspects of the regulatory setup (professional education, professional litigation and the management of legal aid in the sample countries).

In Tables seven and eight we present the results for libertarian (Faure a), efficiency (Faure c), and consumer protection (Faure b) as well as their rankings for a sample of five countries (England and Wales, the United States, the Netherlands, Belgium and Germany). The libertarian index measures the absence of restrictive rules, the optimal framework being free competition without any limits. One point is assigned whenever a regulation is not used in a country and zero is assigned whenever the regulation is enforced. The efficient index looks for regulations only for market failures commonly accepted in economics (therefore, this is the index closer in spirit to ours). Finally, the consumer protection index accepts regulations that a country adopts in order to minimize losses of welfare for consumers thought at the expense of freedom of competition.

Paterson et. al. (2003) also provide an index of regulation for different professions based on entry (IAS entry) and conduct (IAS conduct) restrictions. They measure how much a given profession is regulated, hence producing a result somehow similar to the libertarian index provided by Faure et. al. (1993). The entry and conduct indices are aggregated in a composite index which we do not present since it is just the sum of the points obtained in each of the regulation indices.

In Table seven we can see the ranking for the legal profession (the medical profession was excluded from their project though there was the intention of carrying on such study in the original proposal) for a sample of fifteen countries (all current members of the European Union). We compare their indices with our entry indicator (first line of Table five) and a simple aggregation of the other four regulatory interventions (adding-up from second to fifth lines on Table five). Notice that the conduct index takes into account fewer aspects than ours. Their ranking does not always match ours because we look at improving market performance given the existence of a market failure. Hence we look at quantitative issues (e.g., number of restrictions), but also at quality and nature of regulatory instruments and constraints.

Notably, five countries have a different performance in our ranking than previous exercises. Spain and France perform considerably better in our assessment, Portugal and England and Wales do less well. The reason relies on the different weighting of the aspects of the regulatory

setup, in particular we pay more attention to structure of law firms, advertising, and conduct than Paterson et. al. (2003). With respect to Belgium, the differences are essentially due to the recent changes operated in the regulatory setup for legal professional services in this country.

In Table eight, we have the comparative institutional analysis for physicians. Our rankings are fairly consistent with previous research. For reasons discussed previously, the Netherlands is the only relevant exception performing less well in our ranking than in Faure et. al. (1993). US is consistently first in the different indices.

6. CONCLUSIONS

In this paper we have presented a systematized summary of the economic literature on regulation of professionals, with a special application to legal and medical services. A comparative analysis of medical and legal professional bodies has been developed for US and Europe. A set of indices to measure quality of the regulatory set-up has been constructed where aspects related to entry, fees, organizational forms, advertising, and conduct restrictions are included. A country getting a higher number of points is interpreted to have a professional regulatory framework more consistent with improving market performance (given the existence of a market failure).

The United States perform well in our study, closely followed by Norway, England and Wales, and then by Belgium, France, and Spain. Austria, Germany and Portugal perform less well, but evidence suggests that for legal services they are not too far away from the EU average whereas for medical services they are clearly below average. The Netherlands, for the medical profession, ranks poorly due to our view concerning the lack of registration whereas for the legal professions performs quite well. Switzerland also performs fairly well for the medical profession (unfortunately no information was obtained for the legal profession).

Some policy conclusions can be extracted from the exercise with respect to the European Union. For the legal profession, the European Union should look at Belgium and the Netherlands as good examples of regulatory setups. With respect to the medical profession, Norway, Switzerland, and England and Wales seem to be the examples to have in mind. Altogether, it should be noticed that the United States performs extremely well for both professions. Finally, in a quick comparison across professions (some care should be exerted in drawing policy conclusions from a direct comparison of indicators for the legal and medical professions), it seems that on average European countries have less efficient regulatory setups for the medical than for the legal profession.

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TABLE 1 – NUMBER OF LAWYERS PER 100,000

COUNTRY	1983	1990	2000	% 1983-2000
US	250	261	338	35%
GREECE	-	-	296	-
UK	100	-	283	183%
SPAIN	135	-	241	79%
PORTUGAL	54 (1980)	116	188	248% (1980)
ITALY	80	-	160	100%
BELGIUM	122	137	155	27%
GERMANY	70	-	142	103%
NORWAY	-	-	116	-
DENMARK	-	-	81	-
NETHERLANDS	30	57	77	157%
FRANCE	51	-	68	33%
AUSTRIA	-	-	51	-
JAPAN	-	-	18	-

Source: Faure et. al. (1993), World Bank Legal and Judicial Reform Practice Group, Council of the Bars and Law Societies of the European Union, own calculations.

TABLE 2 – NUMBER OF PRACTICING PHYSICIANS PER 100,000

COUNTRY	1980	1990	2000	% 1980-2000
ITALY	263	470	599	128%
SPAIN(*)	232	383	454	40%
GREECE	245	339	438 (1999)	79%
BELGIUM	231	327	385	67%
GERMANY	222	301	359	62%
PORTUGAL(*)	199	282	325	63%
NETHERLANDS(*)	192	252	321	67%
DENMARK	218	293	316 (1999)	45%
AUSTRIA	164	224	309	88%
FRANCE	194	262	300 (1999)	55% (1999)
NORWAY	197	313	280 (1999)	42% (1999)
US(*)	200	245	280 (1999)	40% (1999)
SWITZERLAND	119	156	195	64%
JAPAN(*)	130	170	190	46%
UK	128	141	179	40%

(*) Licensed Physicians

Source: Faure et. al. (1993), WHO Regional Office for Europe Statistics, World Bank Health Indicators, OECD Health Data, EU Health Statistics, own calculations.

TABLE 3– NUMBER OF PHYSICIANS PER 100.000 ENTERING THE WORKFORCE

COUNTRY	1992	1993	1994	1995	1996	2000
US	-	-	-	5.9	-	5.6
UK	-	-	-	-	-	-
ITALY	15.3	-	-	-	-	-
GERMANY	-	-	-	15.4	14.8	-
BELGIUM	-	-	-	10.9	10.1	-
NETHERLANDS	-	-	-	9.1	9.9	-
PORTUGAL	-	-	-	4.1	-	-
SPAIN	-	-	-	-	-	-
FRANCE	-	8.5	-	-	-	-
AUSTRIA	-	-	14.1	-	-	-
NORWAY	-	-	-	-	-	-
SWITZERLAND	-	-	-	10.6	-	-
GREECE	-	-	-	-	-	-
DENMARK	-	-	-	7.3	-	-
JAPAN	-	-	-	-	-	-

Source: European Observatory on Health Care Systems, US National Center for Health Workforce Analysis.

TABLE 4 – SELF-REGULATION OF PROFESSIONS

	ENTRY RESTRICTIONS	FEE RESTRICTIONS	ADVERTISING RESTRICTIONS	ORGANIZATION RESTRICTIONS	CONDUCT RESTRICTIONS
PUBLIC INTEREST	MINOR	MINOR	PRICE	NO	MORE ON SUBSTANCE
PRIVATE INTEREST	SEVERE	SEVERE	PRICE QUALITY	YES	MORE FORMAL

TABLE 5 – COMPARATIVE INSTITUTIONAL ANALYSIS: LAWYERS

	US	NET	BEL	NOR	SPAI	E&W	GER	FR	AUS	POR	TOTAL
ENTRY	4.5	3.75	4.25	3.25	4	3.25	2.75	3.75	3	2.75	6
FEES	4	3.42	2.42	3.5	3.75	3.75	1.58	3.75	2.25	2.75	4
ORGAN.	1.5	2.5	2.5	1.5	2.5	1.5	2	1.5	1	1	3
ADVERT.	2	1.16	1.67	1.5	1	1.16	1.34	1	1.34	1.16	2
CONDUCT	5	4	4	4.5	2	2.5	3	2.5	2	2	6
TOTAL	17	14.83	14.84	14.25	13.25	12.16	10.67	12.5	9.59	9.66	21
SUM	80.9%	77.0%	72.2%	67.9%	59.1%	57.9%	53.2%	54.8%	50.4%	44.4%	100%
OVER	(1)	(3)	(2)	(4)	(5)	(6)	(8)	(7)	(9)	(10)	
TOTAL											
WEIGHTED	81.7%	76.1%	73.0%	68.3%	60.4%	59.5%	57.1%	56.3%	51.3%	46.2%	100%
AVERAGE	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	
ENTRY	79.2%	71.1%	75.3%	63.0%	62.8%	57.5%	52.9%	52.3%	50.8%	46.1%	100%
WEIGHTED	(1)	(3)	(2)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	
AVERAGE											

TABLE 6 – COMPARATIVE INSTITUTIONAL ANALYSIS: PHYSICIANS

	US	NOR	SWITZ	E&W	FRA	BEL	SPAI	AUS	GER	NET	POR	TOTAL
ENTRY	4	2	2.25	3.75	5	4.75	2.75	2.75	2.25	4	2.25	6
FEES	3	2.3	1.7	1.7	2.2	1.9	1.9	0.9	1.5	0.4	1.7	3
ORGAN.	3.5	4	3.5	4	2.5	2.5	2.5	2	2	3.5	1	4
ADVERT.	1.67	1.5	1.34	1	0.67	0.67	1	1	0.5	0.33	0.33	2
CONDUCT	5	4.5	5	3	3.5	3	3.5	4.5	3.5	1.5	3	6
TOTAL	17.17	14.3	13.79	13.45	13.87	12.82	11.65	11.15	9.75	9.73	8.28	21
SUM	81.8%	68.1%	65.7%	64.1%	66.0%	61.0%	55.5%	53.1%	46.4%	46.3%	39.4%	100%
OVER	(1)	(2)	(4)	(5)	(3)	(6)	(7)	(8)	(9)	(10)	(11)	
TOTAL												
WEIGHTED	84.2%	72.0%	66.4%	63.8%	62.2%	57.7%	56.0%	50.2%	44.2%	41.8%	37.1%	100%
AVERAGE	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	
ENTRY	77.6%	57.5%	55.6%	63.3%	70.1%	65.8%	52.2%	48.5%	41.7%	51.1%	37.2%	100%
WEIGHTED	(1)	(5)	(6)	(4)	(2)	(3)	(7)	(9)	(10)	(8)	(11)	
AVERAGE												

TABLE 7 – COMPARATIVE INSTITUTIONAL ANALYSIS: LAWYERS

	<i>NETH</i>	<i>US</i>	<i>BEL</i>	<i>E&W</i>	<i>GER</i>	<i>SPAIN</i>	<i>POR</i>	<i>FRA</i>	<i>AUS</i>	<i>NOR</i>	<i>SAMPLE</i>
Faure a)	3.08 (1)	2.60 (2)	2.33 (3)	2.30 (4)	1.50 (5)	-	-	-	-	-	5
Faure b)	2.55 (2)	3.10 (1)	2.07 (5)	2.30 (3)	2.22 (4)	-	-	-	-	-	5
Faure c)	3.28 (1)	3.00 (2)	2.53 (3)	2.30 (4)	1.90 (5)	-	-	-	-	-	5
Garoupa Weighted	7.61 (2)	8.17 (1)	7.30 (3)	5.95 (6)	5.71 (7)	6.04 (5)	4.62 (10)	5.63 (8)	5.13 (9)	6.83 (4)	10
IAS	2.1 (3)	-	2.5 (6)	2.9 (8)	3.7 (12)	3.4 (9)	3.5 (10)	3.9 (14)	4.1 (15)	-	15
Entry	3.75 (4)	4.5 (2)	4.75 (1)	3.25 (5)	2.75 (8)	4 (3)	2.75 (8)	2.75 (8)	3 (7)	3.25 (5)	10
IAS	1.8 (5)	-	2.1 (6)	1.2 (4)	2.8 (10)	3.1 (12)	2.2 (8)	2.7 (9)	3.3 (13)	-	15
Conduct	12.41 (2)	12.5 (1)	10.42 (4)	8.91 (5)	8.42 (7)	8.42 (7)	6.58 (10)	8.75 (6)	7.59 (9)	11 (3)	10
Garoupa Others											

Notes: In brackets, the ranking position.

IAS also includes Finland (1 and 1), Sweden (2 and 2), Denmark (3 and 3), Ireland (5 and 6), Italy (7 and 14), Luxemburg (13 and 10), and Greece (10 and 15).

TABLE 8 – COMPARATIVE INSTITUTIONAL ANALYSIS: PHYSICIANS

	<i>US</i>	<i>E&W</i>	<i>BEL</i>	<i>GER</i>	<i>NETH</i>	<i>SPAIN</i>	<i>POR</i>	<i>FRA</i>	<i>AUS</i>	<i>NOR</i>	<i>SWI</i>	<i>SAMPLE</i>
Faure a)	2.00 (1)	2.00 (1)	1.63 (4)	1.10 (5)	1.80 (3)	-	-	-	-	-	-	5
Faure b)	2.90 (1)	2.30 (2)	1.78 (3)	1.21 (5)	1.40 (4)	-	-	-	-	-	-	5
Faure c)	2.40 (1)	2.40 (1)	2.03 (3)	1.30 (5)	2.00 (4)	-	-	-	-	-	-	5
Garoupa Weighted	8.42 (1)	6.38 (4)	5.77 (6)	4.42 (9)	4.18 (10)	5.60 (7)	3.71 (11)	6.22 (5)	5.02 (8)	7.20 (2)	6.64 (3)	11

Note: In brackets, the ranking position

FIGURE 1

CROSS COMPARISON OF LAWYERS AND PHYSICIANS per 100,000

FIGURE 2

**REGULATION OF PROFESSIONS
WEIGHTED AVERAGE**

FIGURE 3

TABLE 9
CROSS NATIONAL COMPARISON WITH RESPECT TO LAWYERS

		E&W	US	GER	BEL	NET	SPAIN	POR	FRA	AUS	NOR	POINTS YES	POINTS NO
	ENTRY REGULATIONS												
1	A law degree obtained from a recognized law school in the country is required for practice as an attorney?	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	1/4	0
	Registration is required?	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	1/4	0
	License is required?	YES	YES	YES	YES	NO	YES	YES	NO	YES	YES	1/4	0
	Membership of professional body is required?	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	0	1/4
2	Additional training is required? If Yes, how long?	YES (12)	NO	YES (24)	YES (36)	YES (36)	NO	YES (18)	YES (24)	YES (60)	YES (24)	0	1/2
	The additional training ends with an examination?	YES	--	YES	NO	YES	--	YES	YES	YES	YES	0	1/2
3	The right (license) to practice as a lawyer is valid for the rest of one's active life?	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	1	0
4	Are law schools very competitive with respect to attracting students and faculty by US standards?	YES	YES	NO	YES	YES	NO	NO	NO	NO	NO	1	0
5	Do only attorneys have the right to plead before courts in your country?	YES	NO	NO	NO	YES	YES	YES	NO	NO	YES	0	1/4
	Does the right to plead depend on additional requirements?	YES	YES	NO	NO	NO	NO	NO	NO	NO	NO	0	1/4
	Do attorneys have the right to plead before any court in your country?	NO	NO	NO	YES	YES	YES	YES	NO	YES	NO	1/4	0
	Do only attorneys have the right to provide legal	NO	YES	YES	NO	NO	NO	YES	NO	NO	NO	0	1/4

	advice?												
6	Are attorneys established in any EU member country allowed to provide legal advice in your country?	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	1/4	0
	Are attorneys established in any EU member country allowed to plead before your courts?	NO	YES	YES	YES	YES	YES	YES	YES	NO	YES	1/4	0
	Are there any barriers to establishment?	YES	YES	YES	YES	YES	YES	YES	YES	YES	NO	0	1/4
	Are these requirements discriminating against attorneys from other EU member countries?	YES	YES	YES	YES	YES	YES	YES	YES	YES	NO	0	1/4
	STRUCTURE OF LAW FIRMS												
7	Can attorneys enter into partnerships?	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	1	0
8	Can attorneys enter into multidisciplinary partnerships?	NO	NO	YES	YES	YES	YES	NO	NO	NO	NO	1	0
9	Can attorneys incorporate?	YES	YES	YES	NO	YES	NO	NO	YES	NO	YES	1/2	0
	With respect to incorporation, do any further restrictions apply?	YES	YES	YES	--	YES	--	--	YES	--	YES	0	1/2
	PRICE/FEEs												
10	Fees payable for legal service are freely negotiated?	YES	YES	NO	YES	YES	YES	YES	YES	NO	YES	1/3	0
	The government sets fees (min, max, or fixed, or recommended)?	NO	NO	YES	NO	NO	NO	NO	NO	YES	NO	0	1/3
	The self-regulatory organization of attorneys sets (min, max, or fixed, or recommended)?	NO	NO	NO	NO	NO	YES	YES	NO	YES	NO	0	1/3
11	Fees can be based on hours worked?	YES	YES	NO	YES	YES	YES	YES	YES	NO	YES	1/4	0
	Fees can be based on litigation value?	YES	YES	YES	YES	YES	YES	YES	YES	YES	NO	1/4	0

	Fees can be based on the complexity of the case?	YES	YES	NO	YES	YES	YES	YES	YES	NO	YES	1/4	0
	Can attorneys use contingent fees?	NO	YES	NO	NO	NO	NO	NO	NO	NO	NO	1/4	0
12	Can attorneys who are more competent than others charge higher fees?	YES	YES	NO	YES	YES	YES	YES	YES	YES	YES	1	0
13	Are legal aid boards run by the professional association of attorneys?	NO	NO	NO	YES	NO	NO	YES	NO	NO	NO	0	1
	ADVERTISING												
14	Advertising is allowed subject to the same constraints as any other services?	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	0	1/3
	The state restricts the advertising of attorneys relative to other services?	NO	YES	YES	YES	NO	NO	NO	NO	YES	YES	1/3	0
	The self-regulatory body restricts the advertising of attorneys?	YES	NO	YES	NO	YES	YES	YES	YES	YES	YES	0	1/3
15	Advertising is very limited (e.g., phone book and the name plate)?	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	0	1/6
	Special expertise can be advertised?	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	1/6	0
	Fee level can be advertised?	YES	YES	NO	NO	YES	NO	YES	NO	NO	YES	1/6	0
	Is comparative advertising possible?	NO	YES	NO	NO	NO	NO	NO	NO	NO	NO	1/6	0
	Co-operation with other attorneys can be advertised?	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	1/6	0
	Co-operation with foreign attorneys or partners can be advertised?	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	1/6	0
	QUALITY STANDARDS AND ENFORCEMENT												
16	The state defines the codes of conduct?	NO	YES	NO	NO	NO	NO	NO	NO	NO	YES	1/2	0

	The self-regulatory body defines the codes of conduct?	YES	NO	YES	YES	YES	YES	YES	YES	YES	YES	0	1/2
17	Is continuing education required as one of the items of the code of conduct?	YES	YES	YES	YES	YES	NO	NO	NO	YES	YES	1	0
18	Are lawyers required to keep records on all details of a case?	YES	YES	YES	YES	NO	YES	YES	YES	YES	NO	0	1/2
	Must the records be supplied to the disciplinary body, when a complaint is filed?	YES	YES	YES	YES	NO	YES	YES	YES	YES	YES	0	1/2
19	Does the law require attorneys to give best advice?	NO	YES	YES	YES	YES	YES	YES	YES	NO	YES	1/2	0
	Does the self-regulatory body require attorneys to give best advice?	NO	YES	YES	YES	YES	YES	YES	YES	YES	YES	1/2	0
20	If the client of an attorney can prove that he did not obtain best advice and that as result he suffered a loss (e.g. lost a case), can the self-regulatory body punish the attorney?	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	1/2	0
	Could the sanction be the expulsion from the professional association?	NO	YES	YES	YES	YES	YES	YES	YES	YES	YES	1/2	0
21	Is liability for professional negligence usually applied by courts?	YES	YES	NO	YES	YES	NO	NO	NO	NO	YES	1/2	0
	Is independent legal expert witnessing common in professional litigation?	YES	YES	NO	YES	YES	NO	NO	YES	YES	NO	1/2	0

Source: Faure et. al (1993), Paterson et. al (2003), Interview with the Chairman of the Portuguese Bar, José Miguel Júdice (Portugal), Estatuto General de la Abogacía Española (Spain), Reports from Bruno Deffains (France), Ehrling Eide (Norway), Michael Faure (Belgium and Netherlands), Wolfgang Weigel (Austria).

TABLE 10
CROSS NATIONAL COMPARISON WITH RESPECT TO DOCTORS

		E&W	US	GER	BEL	NET	SPAIN	POR	FRA	AUS	NOR	SWITZ	POINTS YES	POINTS NO
	ENTRY REGULATIONS													
1	A medical degree from a recognized medical school in the country is required for practice as a doctor?	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	1/4	0
	Registration is required?	YES	YES	YES	YES	NO	YES	YES	YES	YES	YES	YES	1/4	0
	License is required?	NO	YES	YES	YES	NO	YES	YES	NO	YES	YES	YES	1/4	0
	Membership of professional body is required?	NO	NO	YES	YES	NO	YES	YES	YES	YES	NO	NO	0	1/4
2	Additional training is required? If Yes, how long?	YES (60)	YES	YES (60)	NO	YES (12)	YES	YES (18)	NO	YES (36)	YES	YES	0	1/2
	The additional training ends with an examination?	NO	YES	YES	NO	NO	YES	YES	NO	NO	NO	YES	0	1/2
3	The right (license) to practice as a doctor is valid for the rest of one's active life?	YES	YES	YES	YES	YES	YES	YES	YES	YES	NO	NO	1	0
4	Are medical schools very competitive with respect to attracting students and faculty by US standards?	YES	YES	NO	YES	YES	NO	NO	YES	NO	NO	YES	0	1
5	Do most doctors work privately or for private insurance companies?	NO	YES	NO	NO	NO	YES	NO	YES	NO	NO	NO	1/2	0
	Do most doctors work for the national health system?	YES	NO	YES	YES	YES	NO	YES	NO	NO	YES	YES	0	1/2
6	Are doctors established in private practice in	YES	NO	NO	YES	YES	NO	NO	YES	NO	NO	NO	1/4	0

	any EU member country allowed to provide medical services in your country?													
	Does the doctor have to establish himself in your country before he can practice medicine?	NO	YES	YES	NO	NO	YES	YES	NO	YES	YES	YES	0	1/4
	Are there any barriers to establishment?	YES	YES	NO	NO	NO	YES	NO	YES	YES	NO	YES	0	1/4
	Are these requirements discriminating doctors from other EU member countries?	YES	YES	NO	NO	NO	YES	NO	YES	YES	NO	NO	0	1/4
	STRUCTURE OF DOCTOR'S FIRMS													
7	Can doctors enter into partnerships?	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	1	0
8	Can doctors enter into multidisciplinary partnerships?	YES	YES	YES	YES	YES	YES	NO	NO	YES	YES	YES	1	0
9	Can doctors incorporate?	YES	YES	NO	YES	YES	YES	NO	YES	NO	YES	YES	1/2	0
	Do any further restrictions apply?	NO	YES	--	YES	NO	YES	--	YES	--	NO	YES	0	1/2
10	Can doctors be employed by professional managers who are not doctors?	YES	YES	NO	NO	NO	NO	NO	YES	NO	YES	YES	1	0
	Only by recognized hospitals?	--	--	YES	YES	NO	YES	YES	--	YES	--	--	0	1/2
	PRICE/FEES													
11	In private practice the dominant mode of payment for doctors is fee for service?	YES	YES	YES	YES	NO	YES	YES	YES	NO	YES	YES	1/2	0
	In private practice the dominant mode of payment for doctors is capitation fee?	NO	NO	NO	NO	YES	NO	NO	NO	YES	NO	NO	0	1/2
12	Is the fee freely negotiable between the doctor and the patient?	NO	YES	NO	NO	NO	NO	NO	NO	NO	YES	NO	1/5	0

	Is there a minimum or maximum fee (or fee schedule)?	NO	NO	YES	YES	NO	NO	NO	NO	NO	NO	YES	0	1/5
	Is there a fixed fee (or fee schedule) which is typically applied (say in more than 90% of the cases)?	YES	NO	YES	NO	YES	YES	YES	YES	YES	NO	YES	0	1/5
	The government sets fees (min, max, or fixed, or recommended)?	YES	NO	YES	NO	NO	YES	YES	YES	YES	YES	NO	0	1/5
	The doctors association or some other doctors' organization sets the fees (min, max, or fixed, or recommended)?	YES	NO	YES	YES	YES	NO	YES	YES	NO	NO	YES	0	1/5
13	Can doctors who are more competent than others charge higher fees in the private sector?	YES	YES	YES	YES	NO	YES	YES	YES	YES	YES	YES	1/2	0
	Can doctors who are more competent than others charge higher fees in the public sector?	NO	YES	NO	NO	NO	NO	NO	YES	NO	NO	NO	1/2	0
	ADVERTISING													
14	Advertising is allowed subject to the same constraints as any other services?	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	0	1/3
	The state restricts the advertising of doctors relative to other services?	NO	YES	NO	YES	NO	NO	NO	YES	YES	YES	YES	1/3	0
	The self-regulatory body restricts the advertising of doctors?	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	0	1/3
15	Only the academic title and the special expertise can be advertised?	NO	NO	YES	YES	YES	YES	YES	YES	NO	NO	NO	0	1/6
	Advertisements in newspapers can be placed at any time?	YES	YES	NO	NO	NO	YES	NO	NO	NO	YES	YES	1/6	0
	Or only when a practice is opened?	NO	NO	YES	YES	YES	NO	YES	YES	YES	NO	NO	0	1/6

	Advertising is basically limited to the announcement of the opening and closing of a practice, the listing in the phone book and the nameplate?	NO	NO	YES	YES	YES	NO	YES	YES	YES	NO	YES	0	1/6
	Fee level can be advertised?	NO	YES	NO	NO	NO	NO	NO	NO	NO	NO	NO	1/6	0
	Co-operation with other doctors or specialists can be advertised?	NO	YES	YES	NO	NO	YES	NO	NO	YES	YES	YES	1/6	0
	QUALITY STANDARDS AND ENFORCEMENT													
16	The state defines the codes of conduct?	NO	YES	YES	NO	NO	NO	NO	NO	NO	YES	YES	1/2	0
	The self-regulatory body defines the codes of conduct?	YES	NO	YES	YES	YES	YES	YES	YES	YES	YES	NO	0	1/2
17	Is continuing education required as one of the items of the code of conduct?	NO	YES	YES	YES	NO	YES	YES	NO	YES	YES	YES	1	0
18	Are doctors required to keep records on all details of a case?	YES	YES	YES	NO	YES	YES	YES	YES	NO	YES	YES	0	1/2
	Must the records be supplied to the disciplinary body, when a complaint is filed?	YES	YES	YES	YES	YES	YES	YES	NO	YES	YES	YES	0	1/2
19	Does the law require doctors to give best advice and therapy?	YES	YES	YES	NO	NO	YES	YES	YES	YES	YES	YES	1/2	0
	Does the self-regulatory body require doctors to give best advice and therapy?	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	1/2	0
20	If a patient can prove that he did not obtain best advice or therapy and that as result he suffered a loss (e.g. lost a case), can the self-	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	1/2	0

	regulatory body punish the doctor?													
	Could the sanction be the expulsion from the professional association?	YES	YES	NO	YES	YES	YES	YES	YES	YES	YES	YES	1/2	0
21	Is liability for professional negligence usually applied by courts?	YES	YES	YES	YES	YES	YES	NO	YES	YES	YES	YES	1/2	0
	Is independent medical expert witnessing common in professional litigation?	YES	YES	NO	NO	NO	NO	NO	YES	YES	YES	YES	1/2	0

Source: Faure et. al (1993), Estatuto do Médico, Regulamento sobre Publicidade and Código Deontológico (Portugal), Código de Ética y Deontología Medica (Spain), Reports from Nathalie Brunner (Switzerland), Bruno Deffains (France), Ehrling Eide (Norway), Wolfgang Weigel (Austria).