REGULATION OF PROFESSIONS IN PORTUGAL:

A CASE STUDY IN RENT-SEEKING*

Nuno GAROUPA**

Universidade Nova de Lisboa

CEPR, London

January 2004

*I am grateful to the Scientific Committee of the Bank of Portugal's Second Conference on the Economic Development of Portugal for helpful comments on earlier drafts as well as to Fernando Araújo, Anthony Ogus, and Frank Stephen for useful discussions and suggestions. The usual disclaimer applies.

**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. An application to the regulation of professions in Portugal is developed, including recent evolution for the legal and medical professions, and we draw comparisons with other European countries plus EU law. We suggest an index to measure the quality of regulatory restrictions (hence exposing rent-seeking) in Portuguese professional activities. Some possible lines for institutional reform are detailed in the conclusion.

Keywords: Regulation, Rent-Seeking, Lawyers, Physicians

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).

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.

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 Portugal is developed. We briefly analyze current regulation and recent evolution for the legal and medical professions, and we draw comparisons with other European countries plus EU law. A very quick look at the US is presented. We suggest an index to measure the quality of regulatory restrictions (hence exposing rent-seeking) in Portuguese professional activities. Some possible lines for institutional reform are detailed in the conclusion.

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).

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 some 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. It should be noted, nevertheless, than in Sweden and Finland there are no restrictions on who can provide legal advice and representation while in Spain only a university law degree is required.

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).

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 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 UK jurisdictions (Stephen, 2003). In the US, 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).

Entry restrictions can collide with competition law in Europe and anti-trust in the US. 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 US 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.

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 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).

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).

Even more difficult to understand is why physicians are not allowed advertising, but managed care organizations can do it (e.g., Médis in Portugal). 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.

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. In Belgium and the Netherlands a recommended legal fee schedule is produced by the professional body and in Belgium there is a recommended minimum. Medical fees are set by the government in most public health services (e.g., NHS in the UK or SNS in Portugal) or by managed healthcare organizations (e.g., Médis in Portugal).

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.

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.

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 UK, 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 UK is inconclusive (Bishop, 1989; Ogus, 1993; Bowles, 1994).

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 US, 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 US experience, the medical malpractice explosion does not seem to have come to an end yet (Faure and Koziol, 2001).

4.6 A GUIDELINE FOR RESEARCH ON RENT-SEEKING

Table one 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 well-known methodology developed for European comparative analysis of professions (Faure et al., 1993).

5. PORTUGUESE EXPERIENCE

As far as I know and have been able to look for, there is no previous economic analysis of the market for professionals in Portugal with the possible exception of Amorim and Kipping (1999). In this part of the paper we investigate the current regulatory framework in Portugal with respect to lawyers (Ordem dos Advogados) and medical doctors (Ordem dos Médicos). The choice of these two professions is justified by the fact that, in order to make international comparisons, they are easily defined and delimited in terms of the services they offer. Other professional bodies are more difficult to compare due to less well-specified services (e.g., Ordem dos Economistas). Second, this group of professions has been the focus of several controversies and, to some extent, the Portuguese Government has recently enacted reforms of their regulatory setups. We find evidence of rent-seeking in the way these markets are regulated, though more in the market for medical services than for legal services.

The Portuguese case is presented in a comparative way within the Western world. We make detailed references to Spain since neither Faure et. al. (1993) nor the most recent research report on legal services by Paterson et. al. (2003) present an overview of this country. Details on US, UK, the Netherlands, Belgium and Germany are not presented since they can be found at Faure et. al. (1993) for legal and medical professions. For legal services, a detailed report for Denmark, Italy, France, UK (England and Wales) and Germany is available at Paterson et. al. (2003).

5.1 LAWYERS

5.1.1 ENTRY RESTRICTIONS

In Portugal, intending lawyers (advogados) must have a recognized law degree. The organization of professional training after graduation from law school is within the competence of the professional body (Ordem dos Advogados, created by the Government in June 1926). There are six districts (Lisbon, Oporto, Coimbra, Évora, Algarve, Madeira and Azores) with competence to regulate the traineeship. Training follows for a mandatory period of eighteen months. This training period compromises a bar examination and supervised practice by a senior lawyer who must attest the moral and professional capacity of the trainee.

Lawyers have a very wide and nearly exclusive power of representation in courts as well as legal advising. The use of a lawyer is obligatory in court cases in which ordinary appeal is admissible, in legal action in which appeals are always admissible independently of the value of the case, and in appeals and in legal action in superior courts (article 36 of the Civil Procedure Code). Legal consultancy and legal advise are an exclusive power for lawyers with very minor few exceptions (article 53 of DL 49/84, Portuguese Bar Statute, Estatuto da Ordem dos Advogados).

The profession in Spain is organized by the professional body (Consejo General de la Abogacia Española). There are eighty-two districts, though only three, apart from Madrid, have over five thousand resident lawyers. Before taking up pursuit of the profession an oath to observe the constitution and judicial order must be taken. Once inscribed, the lawyer is immediately vested with all the rights and duties of a full member of the profession. There is no requirement for any further training.

Most entry regulations applied in Europe and in the US are similar to Portugal and Spain. Lawyers must belong to their professional association. There are no competing bar associations in the same jurisdiction. They are usually powerful interest groups.

Educational requirements do vary. A law degree is enough for practicing law in Spain and in the US, 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.

In general in Europe lawyers can plead before any court. There are however limitations in UK, Germany and the US. The division between barristers (specializing in advocacy) and solicitors (specializing in advice to clients) is only observed effectively in the UK and Ireland.

The evolution of the legal profession can be observed in Table two, where we show the number of lawyers per 100,000 in several countries. One can see immediately that jurisdictions with less restrict entry rules (Spain as well as the US) have a substantially higher number of lawyers per capita. Not surprisingly, the Spanish Government pressed by the Spanish Bar is preparing a new law that will make entry more restrictive and stipulate mandatory training. Madrid alone had 40,467 resident lawyers in 2001 (twice as much as Portugal) followed by Barcelona with 14,193 and Valencia with 8,015. The Portuguese Bar has also expressed some concern over the growing number of lawyers (easily explained by the development of numerous private law schools after 1987 and new public law schools in the middle of the 90s), in particular looking at the growth rate between 1980 and 2000 (the highest of the sample in Table two). There were 5,134 lawyers in 1980; 11,319 lawyers in 1990; and 18,629 lawyers in 2000 according to figures published by the Portuguese Bar. The figure of 24,000 is expected to have been achieved in 2003. Predictably minor legal consulting services that were not under the obligation of membership in the professional body are now being questioned (Guedes da Costa, 2003, page 139).

European directives (namely Directive 77/249, Directive 89/48, and Directive 98/5) have been implemented. The regulation approved by the Portuguese Bar in 1994 specifies the requirements necessary for the inscription of EU lawyers, by which an exam, written and oral, in Portuguese has to be successfully passed. The Spanish Ministry of Justice has regulated in 1996 the requirements necessary for accession to the profession by EU lawyers; an aptitude test has to be passed. More severe restrictions are applied in Belgium where registration with the local bar is subject to a law degree from Belgium.

5.1.2 OTHER RESTRICTIONS

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, for example, by article 83 of DL 49/84, Portuguese Bar Statute, and article 34 of Real Decreto 658/2001, Spanish Bar Statute, Estatuto General de la Abogacia Española). Nevertheless, with respect to this matter, in Portugal, rules tend to be stricter, for example, lawyers are forbidden from expressing publicly opinions concerning legal matters taken care by another lawyer unless agreed by the latter (article 86 of DL 49/84, Portuguese Bar Statute).

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).

Price advertising is banned in most jurisdictions, except the US (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, a pressure also felt in Portugal (Boletim da Ordem dos Advogados, May 2003). Nevertheless, publicity cannot refer to any particular case or reveal names of current or previous clients (article 80 of DL 49/84,

Portuguese Bar Statute). Overall, the regulation of publicity for legal services is still more restrictive in Portugal, Spain and France and much less restrictive in the UK and the Netherlands, Germany and Belgium being intermediate cases with a trend for deregulation (Guedes da Costa, 2003, page 181).

The arguments against deregulation of publicity for legal services used by the professional body are: (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 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, page 182).

With respect to fees, in most countries prices can be freely negotiated and usually more competent lawyers charge higher fees, except in Germany. Recommended fees exist in Belgium, the Netherlands, and to some extent in Portugal (Guedes da Costa, 2003, page 208). Fees are usually based on hours worked, litigation value (except in Belgium), and complexity of the case. Contingent fees are allowed in the US but not in Europe (in Portugal contingent fee or *pactum de quota litis* is strictly forbidden by article 65 of DL 49/84, Portuguese Bar Statute). Usually legal fees take the form of hourly fees or flat fees (in Portugal, the so-called avença). A first exception was developed in UK 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, and under consideration in Portugal (Boletim da Ordem dos Advogados, May 2003).

Legal aid is usually run by independent government funded bodies (Netherlands and US), legal aid boards (Scotland and Spain) or courts (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. A new protocol between the Portuguese Ministry of Justice and the Portuguese Bar (March 2003) has just transferred to the professional body the management and control of legal aid by creating the Institute for Access to Justice (Instituto de Acesso ao Direito). Though it has been presented as a way to improve performance and quality of legal aid (under the usual argument that lawyers know best how to evaluate and control quality), our expectation is that an increase in Government's expenditure on legal aid will follow.

Apart from disciplinary action (in Portugal, it is an exclusive power of the professional body, article 90 of DL 49/84, Portuguese Bar Statute, though before the creation of the Portuguese

Bar in 1926, courts could engage in disciplinary action), lawyers can be liable for their wrongdoings while serving their clients. Not only tort liability is not well developed for legal services in Portugal (in fact, for professional services in general), but there is no mandatory liability insurance in clear contrast with recommendation by the Code of Conduct for Lawyers in the European Union (apparently it will be introduced after a new law concerning the organization of law firms is approved, see below). The current situation is justified by the professional body under the argument that, while in other countries such as the US and the UK there is a system of competitive legal services (the so-called advogacia livre) necessary under the supervision of courts, in Portugal as well as in Spain, France or Italy, we have a system of collegial legal services (the so-called advogacia colegial) under the supervision of professional bodies with regulatory exclusionary powers (Guedes da Costa, 2003, page 329).

The structure of legal firms in Europe, including Spain and Portugal, 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, not in Portugal) and multidisciplinary organizations (not allowed in Portugal and Spain). These changes in the structure of legal firms have pushed the Portuguese Government and the Portuguese Bar to elaborate a new framework for law partnerships (first steps were taken with DL 237/2001 but a new law is being prepared by the Portuguese Law Partnerships Institute). Though they explicitly recognize that EU competition in the market for legal services is the main cause of this reform, the new law will still not allow incorporation (due to the so-called principle of non-commercialization of legal services) and multidisciplinary organizations (the argument here is that these organizational forms dilute the control mechanisms of professional quality). Limited liability (subject to mandatory liability insurance) and mandatory rules for promotion within the partnership are the major changes. Mergers of law partnerships are subject to approval by the professional body and cooperation (the so-called consórcio) between them is allowed for limited periods.

The entry of foreigner law firms or partnerships in the Portuguese market for legal services is not helped by current regulations. In contrast with the Spanish case (article 28 of Real Decreto 658/2001, Spanish Bar Statute), where entry regulations have been reformed to allow for the establishment of multinational law firms and partnerships (the use of their original denomination as well as their original organizational form are allowed under certain conditions), the situation in Portugal is of a more closed market and very strict regulations apply to the use of original denominations and organizational forms.

5.2 PHYSICIANS

5.2.1 ENTRY RESTRICTIONS

According to the Portuguese Medical Association (Ordem dos Médicos, created by the Government in 1938), there were around 29,000 medical doctors in Portugal in 2000, more than 21,000 employed by the national health system (SNS), and all registered at one of the three regional sections of the professional body (Norte, Centro and Sul). General practitioners account for around 35 percent and hospital doctors (secondary care) are more than 46 percent. From Table three, it is clear that there has been a steady increase in the number of physicians in Portugal, though still below the European average (the UK being the exception), at an intermediate growth rate (above UK, US, and Germany but below all the other countries). The most worrying statistics is however that the number of doctors entering the workforce in the period 1992-2000 is the lowest in Europe (European Observatory on Health Care Systems, 2000), 4.1 new doctors per 100,000 in Portugal against 9.1 in the Netherlands or 10.9 in Belgium (see Table four).

There are currently seven medical schools in Portugal (two open after 2000). All medical training programs are similar. Three years of core basic sciences are followed up by three more years of clinical program oriented to specialization. After graduating, a general internship for 18 months takes place. After successful completion of the internship, a physician is free to practice medicine without supervision. However, if a medical career in the national health system is the objective, further training is required for specialization, from three to six years (there is a proposal by the Government to reform medical internship and further training for specialization, reducing its duration in two years from 2007 on). The Government and the Portuguese Medical Association are jointly responsible for certification of specialist training. The most popular specialty is internal medicine (almost 20 percent) followed closely by gynecology, general surgery and pediatrics (data from European Observatory on Health Care Systems, 2000).

According to international databases (Table three), Spain has one of the highest relative number of physicians (the second highest after Italy). Doctors are organized in fifty-two provincial associations belonging to the Spanish Medical Association (Consejo General de Colegios Oficiales de Médicos). Many work for the national health system, but the growing number of doctors has pushed for the development of the private sector in the early 90s (Mutuas). In Spain, the postgraduate training of medical specialists and general practitioners is structured in a system (the MIR) of practical work for three to five years. Certification in a

certain specialty is governed by a national commission made up of representatives of university professors, scientific societies and the Spanish Medical Association.

Entry regulations are not very different across our sample of countries, 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).

European directives (namely Directive 93/16) have been growingly implemented. 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). 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.

5.2.2 OTHER RESTRICTIONS

Portuguese physicians must comply with a professional code issued by the Portuguese Medical Association, the Portuguese Medical Association Statute (Estatuto da Ordem dos Médicos, DL 282/77) and the Medical Profession Statute (Estatuto do Médico, DL 373/79), which among other things: (a) Establishes that doctors should always act in the defense of the collective interests of the profession; (b) Explicitly forbids doctors to reduce fees in order to compete with other doctors (though doctors can provide medical services for free); (c) Makes clear that doctors are expected to follow the fees recommended by the Medical Association; (d) Forbids doctors from criticizing other doctors without prior consultation with the professional body.

Advertising is regulated in most jurisdictions, US and UK being less restrictive and Portugal being one of the most restrictive. 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 body to issue a new document on publicity, General Regulations Applying to Publicity of the Medical Profession (Regulamento Geral sobre Publicidade, June 2000), clarifying the strictness of the rules justified by the so-called principle of non-commercialization of medical services and alleged protection of consumers. In this

document, the professional body urges the Government to apply and extend these prohibitions to managed healthcare organizations (which are not under the regulatory jurisdiction of the Portuguese Medical Association), and threatens doctors who cooperate with advertising of these organizations in violation of professional rules with appropriate disciplinary action. Advertising is allowed in Spain as long as it does not convey false information or bad publicity to the medical profession.

With respect to fees, Portugal alongside with Germany and the Netherlands has the least competitive market (in fact, competition is strictly forbidden by the professional body in Portugal). Recommended fees exist and are expected to be observed in Portugal. Fees are flexible in Spain in the private sector though the Spanish professional code points out that medical services should not aim at profits. Nevertheless, Spain as well as the UK have a powerful national health service that effectively restrains fee competition. The same does not happen in the US, where fees can be freely negotiated.

In Portugal, most doctors work for the national health service, but sole practitioners or small professional partnerships exist. Corporations and multidisciplinary organizations are not allowed. Most countries regulate the structure of doctor's firms, usually imposing limitations to incorporation (e.g., in most states of the US professional corporations can only provide services in one profession, or in Belgium unlimited personal liability applies), though Portugal seems more restrictive than average.

Liability for medical negligence not only is underdeveloped in Portugal, but it is also extremely complex. 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 period of twenty years to sue the physician after the wrongdoing (article 309 of the Civil Code), for extra-contractual liability, the same patient has three years from the moment s/he knows a wrongdoing took place (article 498 of the Civil Code). A similar liability dichotomy exists in the UK, but the development of expert witnessing and the different structure of the legal system has not produced the chilling effect that is observed in Portugal. Moreover, these liability rules clearly undermine incentives for private medical services. However, this is not the only odd rule. 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. Overall, the situation is confusing and difficult to understand even for legal scholars (Boletim da Ordem dos

Advogados, December 2002). Not surprisingly, lawsuits for medical negligence are occasional and unlike to succeed in Portugal.

6. COMPARATIVE INSTITUTIONAL ANAYSIS

Ranking the different institutional frameworks is a difficult task given the very distinct institutional details. Although modern techniques allow a more rigorous construction of indices, including a factor analysis approach, we provide a more simplified approach. 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 index 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 weighted averages).

We provide a summary of our own cross-national comparisons (Tables seven and eight) as well as a detailed analysis of previous research by Faure et. al. (1993) and Paterson et. al. (2003) (Tables nine and ten). Our index is based on a a set of questions (Tables five and six). 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.

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 one).

6.1 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 (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. 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 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.

The answers to questions four (differentiation of professional schools), twenty-one (use of professional malpractice), and thirteen for lawyers (legal aid) were based on our own understanding of professional education, professional litigation and the management of legal aid in the sample countries.

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

Question One: Registration and licensing seem to be the most efficient way of 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.

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.

6.2 RELATIONS BETWEEN INDICES

Our points do not match exactly the rankings offered at Faure et. al. (1993) for two reasons: (a) They offer three indices (libertarian, efficiency, and consumer protection) that in our view are less compelling, and (b) We average out questions within the survey by relevant item.

In Tables nine and teen we present the results for libertarian (Faure a)), efficiency (Faure b)), and consumer protection (Faure c)) as well as their rankings for a sample of five countries (UK, US, 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 a)) and conduct (IAS b)) 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 nine 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). Their ranking does not 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.

As mentioned in the context of our own index, we should note that equal weight was given to the questions in both research projects (with the exception of multiple questions relating to similar issues) and therefore the issues covered with more questions carry more weight in the final ranking.

We have made use in our questionnaire of data available at Faure et. al (1993) and Paterson et. al. (2003). In the first project, 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 the second project, questionnaires were sent to the national law bars. In some very minor cases, there are inconsistencies between those two sets of information.

6.3 OUR FINDINGS WITH RESPECT TO LAWYERS

Tables seven and eight present the results for each regulatory instrument. We also add a weighted average where the same weight is given to each regulatory instrument to overcome the problem that the number of questions varies for different regulatory instruments.

With respect to lawyers, we can immediately see that the US regulatory framework seems closer to improving market performance for legal services than most European jurisdictions essentially due to the fact that the US is not so much regulated and is more competitive. Within the EU we identify three groups: the Netherlands that seem to have a regulatory framework producing a result similar to the US (a result consistent with Faure et. al., 1993), a second group of jurisdictions (UK and Spain) with a performance below the US but clearly above the performance of the third group (Portugal, Germany, and Belgium). Belgium and Germany's results are justified by excessive regulation of fees and advertising.

With respect to other available indices, we obtain different results for some countries. Belgium performs less well in our ranking than in Faure et. al. (1993) and in Paterson et. al. (2003). Our index averages out what they call efficiency (where Belgium performs reasonably well) and what they denote by consumer protection (where Belgium performs very badly) in Faure et. al. (1993). Our index also looks at number of regulatory constraints as does Paterson et. al. (2003) (where Belgium performs well) but unlike them we give some weight to the quality of these constraints (where Belgium performs less well). Spain performs better in our ranking than in Paterson et. al. (2003) because we value more the less restrictive entry rules applied in this country.

Looking at the case of Portugal, we identify two main sources of problems with respect to correcting for market failures without running into capture. The more serious problem is of course restrictions on organizational forms that are clearly more restrictive in Portugal than average. The recent developments have been pushed by EU competition, but they are still insufficient by not allowing law firms to become commercial societies. Though data is not available, we do have the feeling that the Portuguese legal market has been able to resist for longer to penetration by UK and American law firms than Spain or Belgium, and multidisciplinary partnerships (lawyers, business consultants and accountants) are actively opposed by the legal profession. For example, various London-based-law firms appeared in the

Dutch market after 1999, and forced the Dutch bar to become more business-minded with regard to fees, advertising and professional liability. In Spain, big auditing firms have been associated with well-known partnerships to create large modern and US-style law firms.

The second source of problems concerns restrictions on conduct, namely the inexistence of effective professional litigation and the fact that the codes of conduct rely on the will of the professional body, and not on the Government. Negligence for professional conduct is still not sufficiently developed in Portugal (Boletim da Ordem dos Advogados, December 2002).

With respect to entry restrictions and advertising rules, they are similar to most of other European jurisdictions. The pressure introduced by the sudden increase of law schools in the late 80s has probably done more to relax some of the constraints than actual competition from outside.

The Portuguese market for legal services is quite competitive in terms of fees as most of the European markets (with the exception of Germany), however legal aid being run by the professional body (an institutional design also developed by Belgium) is hardly consistent with improving market performance.

6.4 OUR FINDINGS WITH RESPECT TO PHYSICIANS

With respect to physicians, we can see that the US 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 (UK, Belgium, and Spain slightly below) with a performance below the US but clearly above the performance of the second group (Portugal, the Netherlands, and Belgium). Most of these results are consistent with Faure et. al. (1993), 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 case of Portugal, the reasons for performing so badly are very different from the Netherlands, but somehow similar to Germany, the difference being that German regulations are not so restrictive. We find that restrictions on fees, advertising, organizational forms, and conduct are too severe, plus the lack of access to medical schools makes entry very restrictive.

Portugal has the most severe restrictions on advertising and organizational forms of our sample of countries. Though most medical services are provided by the national health service (hence the problem of fees chosen by the Government is similar in Portugal as well as in the UK or

Germany), the Portuguese Medical Association is the only one that forbids competition and makes clear that recommended medical fees are to be observed (hence they are in fact mandatory). In fact, just by comparing the Portuguese and Spanish medical professional codes one can immediately detect not only that restrictions are much more severe in Portugal, but also competition between physicians is to be avoided at all costs. Whereas the Spanish professional code emphasizes what doctors should and can do, the Portuguese professional code is overwhelmingly about what doctors cannot and should not do. These differences are somehow reflected in Table eight.

Professional liability is much weaker in Portugal than in any other country of our sample, thus deterring lawsuits and eliminating any possibility for regulation by private parties. The absence of effective medical expert witnessing (chilled out by professional regulations that forbid doctors from criticizing other doctors without the consent of the professional body) helps the dilution of liability for malpractice.

7. 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 case-study of Portuguese medical and legal professional bodies has been developed. An index of 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).

Portugal does not perform well in our study, but evidence suggests that for legal services it is not too far away from the EU average whereas for medical services it is clearly below average. Hence our policy recommendations are quite different with respect to both professions. Nevertheless, a word of cautions is necessary here. The enactment of some of these reforms should be the subject of a more detailed and focus-oriented cost-benefit analysis.

For regulation of legal services, we have identified some target areas that would need reform: (a) More flexible rules with respect to organizational forms (including the possibility of incorporation); (b) Further development of professional liability for malpractice; (c) Promotion of market penetration by UK-based and US-style law firms; (d) Adoption of legal aid institutions more in the line of legal aid boards (UK-style or Dutch-style) rather than the Belgium system; (e) Monitoring of professional rules and enforcement by the Competition Authority (in

compliance with ECJ jurisprudence) treating the Portuguese law bar (Ordem dos Advogados) as one of the many industry-specific regulators.

For regulation of medical services, we recommend a serious and more profound reform of the regulatory framework: (a) Reform of the professional code along the lines for example of the Spanish professional code; (b) More flexible rules concerning advertising and organizational forms; (c) Abolishment of recommend fees by the professional body; (d) Education and training should be less controlled by the professional body; (e) Promotion of competition between medical schools with the aim of increasing significantly the number of doctors entering the workforce; (f) Development of effective professional liability for medical malpractice and independent medical expert witnessing; (g) Monitoring of professional rules and enforcement by the Competition Authority (in compliance with ECJ jurisprudence) treating the Portuguese medical association (Ordem dos Médicos) as one of the many industry-specific regulators.

Not surprisingly, the professional bodies oppose openly to most of these reforms. They argue that these reforms will harm the public interest by downgrading the quality of the service they provide. However, most countries have in some ways relaxed these restrictions, and the quality of medical and legal services can hardly be characterized as being inferior to Portugal.

REFERENCES

Agrawal, G. B. and Hall, M. A., 2003, What if You Could Sue Your HMO? Managed Care Liability Beyond the ERISA Shield, St. Louis University Law Journal 47.

Amorim, C. and Kipping, M., 1999, Selling Consultancy Services: The Portuguese Case in Historical and Comparative Perspective, Business and Economic History 28, 45-56.

Andrews, P., 2002, Self-Regulation by Professions - The Approach Under EU and US Competition Rules, European Competition Law Review 23.

Arlen, J. and MacLeod, B., 2003, Torts, Expertise and Authority: Liability of Physicians and Managed Care Organizations, New York University Law Review, forthcoming.

Benham, L. and Benham, A., 1975, Regulating Through the Professions: A Perspective on Information Control, Journal of Law and Economics 18, 421-447.

Bishop, W., 1989, Regulating the Market for Legal Services in England: Enforced Separation of Function and Restrictions on Forms of Enterprise, Modern Law Review 52, 326-351.

Bowles, R., 1994, The Structure of the Legal Profession in England and Wales, Oxford Review of Economic Policy 10, 18-33.

Carr, J. and Mathewson, G. F., 1988, Unlimited Liability as a Barrier to Entry, Journal of Political Economy 96, 766-784.

Carr, J. and Mathewson, G. F., 1990, The Economics of Law Firms: A Study in the Legal Organization of Firms, Journal of Law and Economics 33, 307-330.

Cave, M., 1985, Market Models and Consumer Protection, Journal of Consumer Policy, 335-351.

Curran, C., 1993, The American Experience with Self-Regulation in the Medical and Legal Professions, in Regulation of Professions, Antwerpen, Maklu.

Danzon, P. M., 1985, Liability and Liability Insurance for Medical Malpractice, Journal of Health Economics 4, 309-331.

Danzon, P. M., 1991, Liability for Medical Malpractice, Journal of Economic Perspectives 5, 51-69.

Danzon, P. M., 1997, Tort Liability: A Minefield for Managed Care?, Journal of Legal Studies 27, 491-519.

Darby, M. R. and Karni, E., 1973, Free Competition and the Optimal Amount of Fraud, Journal of Law and Economics 16, 111-126.

Dauer, E. A. and Marcus, L. J., 1997, Adapting Mediation to Link Resolution of Medical Malpractice Dispute with Health Care Quality Improvement, Law and Contemporary Problems 60, 185-218.

Dingwall, R. and Fenn, P. T., 1987, A Respectable Profession? Sociological and Economic Perspectives on the Regulation of Professional Services, International Review of Law and Economics 7, 51-64.

Donabedian, B., 1995, Self-Regulation and the Enforcement of Professional Codes, Public Choice 85, 107-118.

Emons, W., 1997, Credence Goods and Fraudulent Experts, RAND Journal of Economics 28, 107-119.

Faure, M., 1993, Regulation of Attorneys in Belgium, in Regulation of Professions, Antwerpen, Maklu.

Faure, M., Finsinger, J., Siegers, J., and Van den Bergh, R., 1993, Regulation of Professions, Antwerpen, Maklu.

Faure, M. and Koziol, H., 2001, Cases on Medical Malpractice in a Comparative Perspective, Tort and Insurance Law, Vienna, Springer-Verlag.

Fine, D. K., 2003, Physician Liability and Managed Care: A Philosophical Perspective, Georgia State University Law Review 19.

Gehrig, T. and Jost, P., 1995, Quacks, Lemons, and Self Regulation: A Welfare Analysis, Journal of Regulatory Economics 7, 309-325.

Gravelle, H., 1990, Medical Negligence: Evaluating Alternative Regimes, Geneva Papers on Risk and Insurance 15, 22-26.

Guedes da Costa, O., 2003, Direito Profissional do Advogado, Lisbon, Almedina Editora.

Hadfield, G., 2000, The Price of Law: How the Market for Lawyers Distorts the Justice System, Michigan Law Review 98, 953-1006.

Hägg, G. T., 1997, Theories on the Economics of Regulation: A Survey of the Literature from a European Perspective, European Journal of Law and Economics 4, 337-370.

Hau, H. and Thum, M., 2000, Lawyers, Legislation and Social Welfare, European Journal of Law and Economics 9, 231-254.

Hellingman, K., 1993, An Economic Analysis of the Regulation of Lawyers in the Netherlands, in Regulation of Professions, Antwerpen, Maklu.

Kaplow, L. and Shavell, S., 2002, Fairness versus Welfare, Cambridge, MA, Harvard University Press.

Kessler, D., and McClellan, M., 1996, Do Doctors Practice Defensive Medicine?, Quarterly Journal of Economics 111, 353-390.

Kessler, D., and McClellan, M., 1997, The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care, Law and Contemporary Problems 60, 81-106.

Kessler, D. and McClellan, M., 2002a, Malpractice Pressure, Managed Care, and Physician Behavior, in Regulation through Litigation, Washington, DC, AEI-Brookings Joint Center for Regulatory Studies.

Kessler, D. and McClellan, M., 2002b, How Liability Law Affects Medical Productivity, Journal of Health Economics 21, 931-955.

Kessler, D. and McClellan, M., 2002c, Malpractice Law and Health Care Reform: Optimal Liability Policy in an Era of Managed Care, Journal of Public Economics.

Klein, B. and Leffler, K. B., 1981, The Role of Market Forces in Assuring Contractual Performance, Journal of Political Economy 89, 615-641.

Kleiner, M. and Kudrle, R. T., 2000, Does Regulation Affect Economic Outcomes? The Case of Dentistry, Journal of Law and Economics 43, 547-582.

Leffler, K. B., 1978, Physician Licensure: Competition and Monopoly in American Medicine, Journal of Law and Economics 21, 165-186.

Leland, H. E., 1979, Quack, Lemons, and Licensing: A Theory of Minimum Quality Standards, Journal of Political Economy 87, 1325-1346.

Love, J. and Stephen, F., 1996, Advertising, Price and Quality in Self-Regulating Professions: A Survey, International Journal of the Economics of Business 3, 227-247.

Lueck, D., Olsen, R. and Ransom, M., 1995, Market and Regulatory Forces in the Pricing of Legal Services, Journal of Regulatory Economics 7, 63-83.

Maks, J. A. H. and Philipsen, N. J., 2002, An Economic Analysis of the Regulation of Professions, in The Regulation of Architects, Antwerpen, Intersentia.

Matthews, R., 1991, The Economics of Professional Ethics: Should the Professions be more like Businesses?, Economic Journal 101, 737-750.

McChesney, F., 1987, Rent Extraction and Rent creation in the Economic Theory of Regulation, Journal of Legal Studies 26, 101-118.

Miller, F. H., 1997, Medical Discipline in the Twenty-First Century: Are Purchasers the Answer?, Law and Contemporary Problems 60, 31-58.

Miller, J., 1985, The FTC and Voluntary Standards: Maximizing the Net Benefits of Self-Regulation, The Cato Journal 4, 897-903.

Miller, G. and Macey, J. R., 1995, Reflections on Professional Responsibility in a Regulatory State, George Washington Law Review 63.

Murphy, K. M., Shleifer, A., and Vishny, R., 1991, The Allocation of Talent: Implications for Growth, Quarterly Journal of Economics 106, 503-530.

Noll, R., 1989, Economic Perspectives on the Politics of Regulation, in Handbook of Industrial Organization II, Amsterdam, North-Holland, 1253-1287.

Ogus, A., 1993, Regulation of the Legal Profession in England and Wales, in Regulation of Professions, Antwerpen, Maklu.

Ogus, A., 1994, Regulation: Legal Form and Economic Theory, Oxford, Oxford University Press.

Ogus, A., 1995, Rethinking Self-regulation, Oxford Journal of Legal Studies 15, 97-108.

Olsen, R. N., 1997, The Efficiency of Medical Malpractice Law: A New Appraisal, Research in Law and Economics 19.

Olsen, R. N., 1999, The Regulation of Medical Professions, in Encyclopedia of Law and Economics, Ghent, University of Ghent, 1018-1053.

Paterson, I., Fink, M., and Ogus, A., 2003, Economic Impact of Regulation in the Field of Liberal Professions in Different Member States, Study for the European Commission, DG Competition, Vienna, Institute for Advanced Studies.

Peltzman, S., 1976, Toward a More General Theory of Regulation, Journal of Law and Economics 19, 211-244.

Pashigian, B. P., 1979, Occupational Licensing and the Interstate Mobility of Professionals, Journal of Law and Economics 22, 1-25.

Posner, R. A., 1974, Theories of Economic Regulation, Bell Journal of Economics and Management Science 5, 335-358.

Posner, R. A., 1975, The Social Costs of Monopoly and Regulation, Journal of Political Economy 83, 807-827.

Rizzo, J. A. and Zeckhauser, R. J., 1992, Advertising and the Price, Quantity and Quality of Primary Physician Services, Journal of Human Resources 28, 381-421.

Rubin, P. H. and Bailey, M. J., 1994, The Role of Lawyers in Changing the Law, Journal of Legal Studies 23, 807-831.

Shaked, A. and Sutton, J., 1981, The Self-Regulating Profession, Review of Economic Studies 47, 217-234.

Shaked, A. and Sutton, J., 1982, Imperfect Information, Perceived Quality, and the Formation of Professional Groups, Journal of Economic Theory 27, 170-181.

Sheperd, G. B., 2000, Cartels and Controls in Legal Training, Antitrust Bulletin 45, 437-466.

Shinnick, E. and Stephen, F., 2000, Professional Cartels and Scale Fees: Chiselling on the Celtic Fringe?, International Review of Law and Economics 20, 407-423.

Sloan, F. A. and Hall, M. A., 2002, Market Failures and the Evolution of State Regulation of Managed Care, Law and Contemporary Problems 65, 169-208.

Stephen, F., 2002, The European Single Market and the Regulation of the Legal Profession: An Economic Analysis, Managerial and Decision Economics 23, 115-125.

Stephen, F., 2003, An Economic Perspective on the Regulation of Legal Service Markets, Evidence submitted to the Justice 1 Committee's Inquiry into the Regulation of the Legal Profession.

Stephen, F. and Love, J., 1996, Deregulation of Legal Services in the UK: Evidence from Conveyancing, Hume Papers on Public Policy 4, 53-66.

Stephen, F. and Love, J., 1999, Regulation of the Legal Profession, in Encyclopedia of Law and Economics, Ghent, University of Ghent, 987-1017.

Stephen, F., Love, J., and Peterson, A., 1994, Deregulation of Conveyancing Markets in England and Wales, Fiscal Studies 15, 102-118.

Stigler, G., 1971, The Theory of Economic Regulation, Bell Journal of Economics and Management Science 2, 3-21.

Van den Bergh, R., 1993, Self-Regulation in the Medical and Legal Professions and the European Internal Market in Progress, in Regulation of Professions, Antwerpen, Maklu.

Van den Bergh, R., 1999, Self-Regulation of the Medical and Legal Professions: Remaining Barriers to Competition and EC Law, in Organized Interests and Self-Regulation: An Economic Approach, Oxford, Oxford University Press.

Van den Bergh, R. and Faure, M., 1991, Self-Regulation of the Professions in Belgium, International Review of Law and Economics 11, 165-182.

Viscusi, W. K., 2002, Overview, in Regulation through Litigation, Washington, DC, AEI-Brookings Joint Center for Regulatory Studies.

Zerbe, R. and Urban, N., 1988, Including Public Interest in Theories of Regulation, Research in Law and Economics 8, 4-5.

TABLE 1 – 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 2 – NUMBER OF LAWYERS PER 100,000

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

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 3 – NUMBER OF PHYSICIANS PER 100,000

COUNTRY	1980	1990	2000	% 1980-2000
PORTUGAL	205	285	318	55%
SPAIN	217	225	429	98%
UK	133	140	181	36%
GERMANY	245	298	358	46%
BELGIUM	232	350	419 (2001)	81% (2001)
NETHERLANDS	192	251	328 (2001)	71% (2001)
US	200	245	280 (1999)	40% (1999)
ITALY	335 (1983)	490	567 (1999)	69% (1983-1999)
FRANCE	188 (1983)	265	330 (2001)	76% (1983-2001)

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

TABLE 4 – NUMBER OF PHYSICIANS PER 100,000 ENTERING THE WORKFORCE

COUNTRY	1992	1993	1995	1996	2000
PORTUGAL	-	-	4.1	-	-
SPAIN	-	-	-	-	-
UK	-	-	-	-	-
GERMANY	-	-	15.4	14.8	-
BELGIUM	-	-	10.9	10.1	-
NETHERLANDS	-	-	9.1	9.9	-
US	-	-	5.9	-	5.6
ITALY	15.3	-	-	-	-
FRANCE	-	8.5	-	-	-

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

TABLE 5
CROSS NATIONAL COMPARISON WITH RESPECT TO LAWYERS

QUESTION NUMBER		UK	US	GER	BEL	NET	SPAIN	POR	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	1/4	0
	Registration is required?	YES	YES	YES	YES	YES	YES	YES	1/4	0
	License is required?	YES	YES	YES	YES	NO	YES	YES	1/4	0
	Membership of professional body is required?	YES	YES	YES	YES	YES	YES	YES	0	1/4
2	Additional training is required? If Yes, how long?	YES (36)	NO	YES (30)	YES (36)	YES (36)	NO	YES (18)	0	1/2
	The additional training ends with an examination?	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	1	0
4	Are the law schools very competitive with respect to attracting students and faculty?	YES	YES	NO	YES	YES	NO	YES	1	0
5	Do only attorneys have the right to plead before courts in your country?	YES	NO	NO	YES	NO	YES	YES	0	1/4
	Does the right to plead depend on additional requirements?	YES	YES	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	1/4	0
	Do only attorneys have the right to provide legal	NO	YES	YES	NO	NO	NO	YES	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	1/4	0
	Are attorneys established in any EU member country allowed to plead before your courts?	NO	YES	YES	YES	YES	YES	YES	1/4	0
	Are there any barriers to establishment?	YES	YES	YES	YES	YES	YES	YES	0	1/4
	Are these requirements discriminating against attorneys from other EU member countries?	YES	YES	YES	YES	YES	YES	YES	0	1/4
	STRUCTURE OF LAW FIRMS									
7	Can attorneys enter into partnerships?	YES	YES	YES	YES	YES	YES	YES	1	0
8	Can attorneys enter into multidisciplinary partnerships?	NO	NO	YES	NO	YES	NO	NO	1	0
9	Can attorneys incorporate?	YES	YES	NO	YES	YES	YES	NO	1/2	0
	With respect to incorporation, do any further restrictions apply?	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	1/3	0
	The government sets fees (min, max, or fixed, or recommended)?	NO	NO	YES	NO	NO	NO	NO	0	1/3
	The self-regulatory organization of attorneys sets (min, max, or fixed, or recommended)?	NO	NO	NO	YES	YES	NO	NO	0	1/3
11	Fees can be based on hours worked?	YES	YES	NO	YES	YES	YES	YES	1/4	0
	Fees can be based on litigation value?	YES	YES	YES	NO	YES	YES	YES	1/4	0

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

	The self-regulatory body defines the codes of conduct?	YES	NO	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	NO	NO	NO	NO	1	0
18	Are lawyers required to keep records on all details of a case?	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	NO	YES	YES	0	1/2
19	Does the law require attorneys to give best advice?	NO	YES	YES	NO	YES	YES	YES	1/2	0
	Does the self-regulatory body require attorneys to give best advice?	NO	YES	YES	NO	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	1/2	0
	Could the sanction be the expulsion from the professional association?	NO	YES	YES	YES	YES	YES	YES	1/2	0
21	Is liability for professional negligence usually applied by courts?	YES	YES	NO	NO	YES	NO	NO	1/2	0
	Is expert witnessing common in professional litigation?	YES	YES	NO	NO	YES	NO	NO	1/2	0

Source: Faure et. al (1993), Interview with the Chairman of the Portuguese Bar, José Miguel Júdice (Portugal), Estatuto General de la Abogacía Española (Spain).

TABLE 6
CROSS NATIONAL COMPARISON WITH RESPECT TO DOCTORS

QUESTION NUMBER		UK	US	GER	BEL	NET	SPAIN	POR	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	1/4	0
	Registration is required?	YES	YES	YES	YES	NO	YES	YES	1/4	0
	License is required?	NO	YES	YES	YES	NO	YES	YES	1/4	0
	Membership of professional body is required?	NO	NO	YES	YES	NO	YES	YES	0	1/4
2	Additional training is required? If Yes, how long?	YES (60)	YES	YES (60)	NO	YES (12)	YES	YES (18)	0	1/2
	The additional training ends with an examination?	NO	YES	YES	NO	NO	YES	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	1	0
4	Are the medical schools very competitive with respect to attracting students and faculty?	YES	YES	NO	YES	YES	NO	NO	0	1
5	Do most doctors work privately or for private insurance companies?	NO	YES	NO	NO	NO	YES	NO	1/2	0
	Do most doctors work for the national health system?	YES	NO	YES	YES	YES	NO	YES	0	1/2
6	Are doctors established in private practice in any EU member country allowed to provide medical services in your country?	YES	NO	NO	YES	YES	NO	NO	1/4	0

	Does the doctor have to establish himself in your country before he can practice medicine?	NO	YES	YES	NO	NO	YES	YES	0	1/4
	Are there any barriers to establishment?	YES	YES	NO	NO	NO	YES	NO	0	1/4
	Are these requirements discriminating doctors from other EU member countries?	YES	YES	NO	NO	NO	YES	NO	0	1/4
	STRUCTURE OF DOCTOR'S FIRMS									
7	Can doctors enter into partnerships?	YES	YES	YES	YES	YES	YES	YES	1	0
8	Can doctors enter into multidisciplinary partnerships?	YES	YES	YES	YES	YES	YES	NO	1	0
9	Can doctors incorporate?	YES	YES	NO	YES	YES	YES	NO	1/2	0
	Do any further restrictions apply?	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	1/2	0
	Only by recognized hospitals?	--	--	YES	YES	NO	YES	YES	1/2	0
	PRICE/FEES									
11	In private practice the dominant mode of payment for doctors is fee for service?	YES	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	0	1/2
12	Is the fee freely negotiable between the doctor and the patient?	NO	YES	NO	NO	NO	NO	NO	1/5	0
	Is there a minimum or maximum fee (or fee schedule)?	NO	NO	YES	YES	NO	NO	NO	0	1/5
	Is there a fixed fee (or fee schedule)	YES	NO	YES	NO	YES	YES	YES	0	1/5

	which is typically applied (say in more than 90% of the cases)?									
	The government sets fees (min, max, or fixed, or recommended)?	YES	NO	YES	NO	NO	YES	YES	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	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	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	1/2	0
	ADVERTISING									
14	Advertising is allowed subject to the same constraints as any other services?	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	1/3	0
	The self-regulatory body restricts the advertising of doctors?	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	0	1/6
	Advertisements in newspapers can be placed at any time?	YES	YES	NO	NO	NO	YES	NO	1/6	0
	Or only when a practice is opened?	NO	NO	YES	YES	YES	YES	YES	0	1/6
	Advertising is basically limited to the announcement of the opening and closing of a practice, the listing in the phone book	NO	NO	YES	YES	YES	NO	YES	0	1/6

	and the nameplate?									
	Fee level can be advertised?	NO	YES	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	1/6	0
	QUALITY STANDARDS AND ENFORCEMENT									
16	The state defines the codes of conduct?	NO	YES	YES	NO	NO	NO	NO	1/2	0
	The self-regulatory body defines the codes of conduct?	YES	NO	YES	YES	YES	YES	YES	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	1	0
18	Are doctors required to keep records on all details of a case?	YES	YES	YES	NO	YES	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	0	1/2
19	Does the law require doctors to give best advice and therapy?	YES	YES	YES	NO	NO	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	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-regulatory body punish the doctor?	YES	YES	YES	YES	YES	YES	YES	1/2	0
	Could the sanction be the expulsion from the professional association?	YES	YES	NO	YES	YES	YES	YES	1/2	0
21	Is liability for	YES	YES	YES	NO	NO	YES	NO	1/2	0

	professional negligence usually applied by courts?									
	Is expert witnessing common in professional litigation?	YES	YES	NO	NO	NO	NO	NO	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).

TABLE 7 – COMPARATIVE INSTITUTIONAL ANALYSIS: LAWYERS

	UK	US	GER	BEL	NET	SPAI	POR	TOTAL
ENTRY	3.25	4.5	2.75	4	4	4	3.5	6
FEES	3.75	4	1.58	2.17	3.42	3.75	2.75	4
ORGANIZATION	1.5	1.5	2	1.5	2.5	1.5	1	3
ADVERTISING	1.16	2	1.34	0.66	1.16	1	1.16	2
CONDUCT	2.5	5	3	1	4	2	2	6
TOTAL	12.66	17	10.7	9.33	15.58	12.59	10.91	21
SUM/TOTAL	57.9%	80.9%	50.8%	44.4%	71.8%	58.3%	49.6%	100%
W. AVERAGE	59.5%	81.7%	53.8%	44.1%	72.0%	58.8%	50.4%	100%

TABLE 8 – COMPARATIVE INSTITUTIONAL ANALYSIS: PHYSICIANS

	UK	US	GER	BEL	NET	SPAI	POR	TOTAL
ENTRY	3.5	3.75	2.25	4.75	4	2.75	2.25	6
FEES	1.75	3	1.5	2	0.5	2	1.75	3
ORGANIZATION	4	3.5	2.5	3	3	3	1.5	4
ADVERTISING	1	1.67	0.5	0.67	0.33	0.83	0.33	2
CONDUCT	3	5	3.5	3	1.5	3.5	3	6
TOTAL	13.25	16.92	10.25	13.42	9.33	12.08	8.83	21
SUM/TOTAL	63.1%	80.6%	48.8%	63.9%	44.4%	57.5%	42.0%	100%
W. AVERAGE	63.3%	83.4%	46.6%	60.9%	40.0%	57.5%	40.0%	100%

TABLE 9 – COMPARATIVE INSTITUTIONAL ANALYSIS: LAWYERS

	UK	US	GER	BEL	NETH	SPAIN	POR	SAMPLE
Faure a)	2.30 (4)	2.60 (2)	1.50 (5)	2.33 (3)	3.08 (1)	-	-	5
Faure b)	2.30 (4)	3.00 (2)	1.90 (5)	2.53 (3)	3.28 (1)	-	-	5
Faure c)	2.30 (3)	3.10 (1)	2.22 (4)	2.07 (5)	2.55 (2)	-	-	5
IAS a)	2.90 (8)	-	3.70 (12)	2.50 (6)	2.10 (3)	3.40 (9)	3.50 (10)	15
IAS b)	1.20 (4)	-	2.80 (10)	2.10 (6)	1.80 (5)	3.10 (12)	2.20 (8)	15
Garoupa a)	5.79 (4)	8.09 (1)	5.08 (5)	4.44 (7)	7.18 (2)	5.83 (3)	4.96 (6)	7
Garoupa b)	5.95 (3)	8.17 (1)	5.38 (5)	4.41 (7)	7.20 (2)	5.88 (4)	5.04 (6)	7

Notes: In brackets, the ranking position.
IAS a) also includes Finland (1), Sweden (2), Denmark (3), Ireland (5), Italy (7), Greece (10), Luxemburg (13), France (14), and Austria (15).
IAS b) also includes Finland (1), Sweden (2), Denmark (3), Ireland (6), France (9), Luxemburg (10), Austria (13), Italy (14), and Greece (15).

TABLE 10 – COMPARATIVE INSTITUTIONAL ANALYSIS: PHYSICIANS

	UK	US	GER	BEL	NETH	SPAIN	POR	SAMPLE
Faure a)	2.00 (1)	2.00 (1)	1.10 (5)	1.63 (4)	1.80 (3)	-	-	5
Faure b)	2.40 (1)	2.40 (1)	1.30 (5)	2.03 (3)	2.00 (4)	-	-	5
Faure c)	2.30 (2)	2.90 (1)	1.21 (5)	1.78 (3)	1.40 (4)	-	-	5
Garoupa a)	6.31 (3)	8.06 (1)	4.88 (5)	6.39 (2)	4.44 (6)	5.75 (4)	4.20 (7)	7
Garoupa b)	6.33 (2)	8.34 (1)	4.66 (5)	6.09 (3)	4.00 (6)	5.75 (4)	4.00 (6)	7

Note: In brackets, the ranking position.