Exclusive Arrangements in the Hospital Industry

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There have been numerous antitrust cases concerning exclusive hospitals privileges. The plaintiff often alleges both that he was foreclosed from the market and that an illegal tying agreement exists. This paper which draws heavily from the cases concludes both that the relevant market for hospital based physicians is national and that the impact on competition is minimal. The hospital frequently initiates the exclusive arrangement which suggests that efficiency is enhanced. Our analysis also shows that the tying claims are generally unpersuasive. However, exclusive arrangements on occasion may be a device to exclude competitors. Finally, economic criteria are developed to help determine the desirability of particular exclusive arrangements.

INTRODUCTION

There have been numerous antitrust cases concerning the issue of a hospital entering into an exclusive agreement with a physician or a group of physicians to provide certain services or procedures at that hospital. The plaintiff is usually a doctor or medical professional who has been denied privileges because of an exclusive arrangement and claims foreclosure of the market. Many of these cases involve hospital based physicians (HBPs) such as anesthesiologists, pathologists, radiologists, and emergency room physicians. For the most part hospitals have been successful in defending these exclusive arrangements. In this paper we review and analyze the economic and legal aspects of hospital exclusive arrangements. We draw heavily from various cases to analyze such issues as the relevant product and geographic market, and whether the services provided constitute one or two products. The effect of such arrangements on competition and consumer choice is examined. Also discussed are the costs and benefits of such arrangements and the conditions under which they are undesirable.

RELEVANT MARKET

In the case of services provided by hospital based physicians, one must initially determine the purchaser of these services. Is it the consumer, the physician, or the
hospital? In health care this has been a perennial issue. By way of an analogy, a college professor is an employee of a university and is hired by it and not by the individual students. Students may desire to matriculate at a given university because of a certain professor just as patients may want to be admitted to a hospital because of a certain doctor. A hospital employs a HBP as an input and is actually the purchaser of HBP services. Lynk claims with much validity that the following buyer and seller markets exist in health care: the HBP’s customers are hospitals, the hospital’s customers are the primary physicians, and the primary physician’s customers are the patients. Also as Lynk notes there are exceptions to this market definition. Thus, we can view the primary physician as the agent of the consumer, purchasing for him the appropriate level of medical care. As the court stated in Dos Santos v. Columbus-Cuneo-Cabrini Medical Center:

> It may thus be more appropriate for antitrust purposes to treat the hospital as the purchaser, in view of the hospital’s responsibility for assuring the availability of anesthesia services for its patients, its incentive to maximize the use of its surgical facilities, and its potential liability for negligent rendition of anesthesia services in its operating rooms. If the hospital rather than the individual patient is regarded as the purchaser, the relevant market could be defined as the area in which Associates [the anesthesiological firm] operates and in which the Medical Center (rather than the patient) can practicably turn for alternative provision of anesthesia services.

Thus, for antitrust purposes the sellers’ market, individual HBP service, is the market we examine. The product market for these professionals is their unique specialty. (However, in some cases there are close substitutes such as nurse-anesthetists.) However, the real issue is the geographic market for this supply.

The geographic market for HBPs is the entire United States, for example, in Collins v. Associated Pathologists, Ltd, the court stated that “the focus is . . . whether pathological jobs are available in the relevant market and how many such jobs are available in comparison with the number of job opportunities foreclosed by the arrangements between the hospital and APL.” The court further stated that “the only evidence in the record regarding the relevant market is that a nationwide market exists for hospitals to hire pathologists and the pathologists to seek employment with hospitals.” To support this market definition the court noted that most of the doctors employed by Associated Pathologists which is located in Illinois were from out of state and the plaintiff, Dr. Collins, obtained employment in California. Similarly, anesthesiologist unwilling to agree to a hospital’s contractual offer left northern New York state to obtain employment in New Jersey. In another case, a South Carolina hospital was conducting a nationwide search for a pathologist: the successful recipient of that hospital’s exclusive agreement was from Wisconsin. In Gonzales v. Insignares applications were received from applicants from fourteen different states. Finally, a physician denied the right to practice nuclear medicine in Pennsylvania obtained a position in Arizona. A qualified and competent HBP can obtain a job anywhere in the nation.

It is easier to recruit one person to change locations than it is to convince a group to change locations. Thus, the larger the exclusive arrangement group is, the smaller would be the available pool. Also, if the hospital believes that the market for exclusive arrangement is not competitive enough, the hospital has the option of using salaried employees. In terms of foreclosure, the seller’s market will remain competitive even with exclusive arrangements, and it is the seller’s market which is important in terms of the percentage