INTRODUCTION

Tying—a producer’s decision to link the sale of one product or service to another—is a frequent phenomenon in the marketplace. It has also posed difficult antitrust issues for the courts. An important tying case that was ultimately decided by the Supreme Court in 1984—Jefferson Parish Hospital v. Hyde—provides a good illustration of these difficulties.

JEFFERSON PARISH: THE FACTS

In the late 1960s, Jefferson Parish,1 Louisiana, decided to build a new hospital, and in 1971 it opened the East Jefferson Hospital in the New Orleans suburb of Metairie. Shortly before commencing operations, the hospital contracted with Roux & Associates, a recently formed firm of anesthesiologists, to provide for all of the hospital’s anesthesia requirements. The hospital was to provide all of the necessary space, equipment, supplies, and, subject to Roux’s approval, nurses. Roux, in turn, was to provide all of the anesthesiologists. The hospital apparently prospered; by 1980 over 10,000 surgical operations per year were performed there.

The dispute that eventually resulted in this case began in July of 1977, when Dr. Edwin G. Hyde approached the hospital for privileges. Dr. Hyde

1A parish in Louisiana is the same as a county in most other states.
was a board-certified anesthesiologist, and Dr. Hyde wanted to practice anesthesiology at East Jefferson Hospital. The hospital’s board of directors denied Dr. Hyde’s application, indicating that to grant him privileges would be inconsistent with its intent to use only Roux for anesthesia services. Dr. Hyde then sued under, among other laws, Section 1 of the Sherman Act, seeking an injunction that would compel his admission to the medical staff.

Dr. Hyde and East Jefferson Hospital had their day in court not once, but three times. In 1981, the U.S. District Court for the Eastern District of Louisiana heard all of the evidence—testimony and documentary exhibits—and considered the arguments of each side’s lawyers. The District Court denied Dr. Hyde’s request, first finding that East Jefferson Hospital lacked any significant monopoly power in hospital services and then reasoning that therefore its contract with Roux was competitively innocuous.²

Dr. Hyde appealed, and in 1982 the same evidence led the Fifth Circuit Court of Appeals to the opposite conclusion. The Court of Appeals found that the hospital did have monopoly power and that its contract with Roux & Associates constituted a “tying arrangement,” one in which the patient was forced to use Roux’s anesthesia services if he or she wanted to use East Jefferson’s operating rooms.³ Concluding that that was per se illegal, the Court of Appeals reversed the District Court.

East Jefferson Hospital then appealed to the Supreme Court, which accepted the case for review. Both parties subsequently filed briefs with the Court, joined by amicus curiae (“friend of the court”) briefs from interested groups (among others, the American Society of Anesthesiologists, siding with Dr. Hyde, and the American Hospital Association and the U.S. Department of Justice, siding with East Jefferson Hospital). Reversing the Appellate Court’s reversal of the District Court, the Supreme Court found in favor of the hospital in its relationship with Roux & Associates.⁴

Jefferson Parish has for over a decade been the leading Supreme Court case on the commercial practice of tying.⁵ But Jefferson Parish is also a case regulating the permissible range of a hospital’s competitive conduct, and to understand it requires at least a stylized understanding of the way in which hospitals compete.⁶ Therefore, this chapter first sketches some of the peculiarities of hospital competition and then outlines some of

³ 686 F.2d 286 (5th Cir. 1982).
⁵ Jefferson Parish Hospital District No. 2 v. Edwin G. Hyde, 466 U.S. 2 (1984). The Supreme Court amplified its views on tying in the 1992 Kodak case, but, perhaps because Kodak was confounded with legal and evidentiary issues apart from the analysis of tying as such, Jefferson Parish continues to this day to be cited for legal authority on tying. See Eastman Kodak Co. v. Image Technical Services, Inc., 112 S.Ct. 2072 (1992), discussed by Jeffrey MacKie-Mason as Case 16 in this volume.
the essentials of tying and exclusive dealing as they apply in that context. After those preliminaries, the chapter explains the economic theories and evidence stressed by the litigants and reports their reception by the Court. It concludes with some observations on tying and its treatment under the law.

## HOW DO HOSPITALS COMPETE?

The process begins with a typical consumer of hospital services—say, a patient whose medical condition would be improved by surgery. The patient must choose a surgical specialist who will perform the surgery and who in turn must choose the hospital at which the surgery will be performed. The next choice, also generally made by the surgeon rather than the patient, is the array of specific complementary inputs necessary for the surgery; this could include a radiologist to do the preoperative X-rays, a backup surgeon and a team of nurses to assist in the operation, and an anesthesiologist to keep the patient sedated. Only after all of these inputs have been selected will the surgical operation be performed.

A surgical operation is a complex bundle of complementary inputs. Because each input is essential for surgery, there is no demand for any one of these providers’ services unless there is a corresponding supply of each of the other providers’ services. By extension, the demand for any one provider’s service is enhanced by a greater supply—that is, a lower price or higher quality—of the other providers’ services.

To set the stage for the Jefferson Parish case, it is useful to divide physicians into two camps: admitting physicians and hospital-based physicians. “Admitting physicians” are defined loosely as those physicians (frequently surgeons) who are responsible for the management of the patient’s overall course of treatment, including the selection of the hospital. Depending on the patient’s illness, admitting physician specialties could run the range from general practice to neurosurgery.

“Hospital-based physicians,” on the other hand, never admit patients, or at least not in their capacity as hospital-based physicians. The medical specialists in pathology, radiology, and anesthesiology probably best exemplify the concept. Their job is to be ready on the sidelines to assist the patient-generating “rainmaker”—the admitting physician—with their specialized skills and expertise. Although they may often be more intensively trained in their own medical specialties than are the admitting physicians in theirs, in this analytical framework the hospital-based physicians fall into the same category as the nursing staff and the pharmacy: just one more support input, whose supply the hospital must ensure if it wants to keep the admitting physicians happy.

How does a hospital compete in this sort of environment? It has become an industry bromide to say that “hospitals don’t compete for pa-
tients, they compete for doctors.” The implication is that, since patients usually pick doctors rather than hospitals, the patient admissions will come automatically if the hospital attracts many doctors to its admitting staff. But this answer raises the next question: How, then, does the hospital compete for doctors?

A common, and accurate, answer is that the hospital does so not only by improving the quality of the facility itself, which is under the hospital’s direct administrative control, but also by attaching to itself an attractive constellation of all of the other complementary inputs that the doctor considers in making the patient-admitting decision but that are not under the hospital’s direct control. The hospital competes in the first instance by increasing its own attractiveness: for example, by keeping the operating rooms spotless, the food tasty, and the technological gadgetry extensive and up-to-date. But, as noted above, this by itself is not sufficient; even a state-of-the-art hospital and an assembly of crackerjack admitting surgeons will be hamstrung if the pathologist fumbles the lab tests or all of the anesthesiologists are out playing golf. So the hospital competes further by doing what it can to ensure the reliable and high-quality supply of all of the other independent inputs that must be affiliated with it before it can do its job.

For purposes of antitrust analysis, there is a straightforward “buyer and seller” characterization of these relationships. In essence, the hospital “buys” the services of the hospital-based physicians and “sells” its own package of services to the admitting physician. In this framework, the anesthesiologist is an upstream input supplier to the hospital, and the admitting physician (acting as an agent of the patient) is the downstream customer of the hospital. This model of the market process is illustrated in Figure 14-1.

At issue in Jefferson Parish is the role that the hospital plays as intervenor between the hospital-based anesthesiologists and the admitting physicians, a role that varies depending on how the hospital chooses to attract its anesthesiologists. At one extreme, the anesthesiologists may be hospital employees, a practice more common forty years ago but relatively rare today. At the other extreme, for an “open-staff” hospital, any qualified anesthesiologist can apply for privileges to be available to the surgeon, thus making his relation to the admitting physician similar to that of the hospital. Finally, for a hospital that arranges for anesthesia through exclusive contract, the contracting firm of anesthesiologists serves at the pleasure of the hospital, just as an individual employee anesthesiologist would, with the distinction that the money received by the anesthesia firm typically comes directly from the patient without passing through the hospital’s treasury.

These differences among the alternative ways in which a hospital intermediates the access of the admitting physicians to the hospital-based physicians were what caused the Jefferson Parish controversy. They also
create an analytical issue—the distinction between the practice of tying and the practice of exclusive dealing—that the next section explains.

TYING AND EXCLUSIVE DEALING

Tying

Tying and exclusive dealing are forms of vertical restraint that appear frequently in business relationships. Economic analysis shows them to be somewhat related, but antitrust law has treated them in importantly different ways.

Tying is a practice whereby the seller of product A will sell A only on the condition that the buyer also purchase product B. A is referred to as the “tying product” and B as the “tied product.” Most of the tying cases in the legal literature concern “requirements tie-ins,” in which the buyer can get product A only if he agrees to purchase all of his requirements of B from the seller. For example, at one time a customer could lease an IBM tabulating machine only by also purchasing all of the necessary punch cards from IBM.7

7International Business Machines Corp. v. U.S., 298 U.S. 131 (1936). IBM would only lease, not sell, its tabulating machines and would terminate the lease of any customer found evading the tie-in.
The other principal type of tie-in is a “package tie-in,” also called “product bundling.” Here the seller defines the product as one unit of A plus one unit of B and will not sell the A component separately. For example, a consumer who buys a Chrysler automobile (product A) gets it with a Chrysler car radio (product B), regardless of whether he or she wants to purchase a radio from a different vendor or even wants a radio at all.8

Why tie?9 There are a number of benign, or at least neutral, explanations for tying. One is that it helps ensure quality; for example, surgeons engage in a form of requirements tying when they insist on using a favorite brand of sutures. Another explanation is that tying lowers transaction costs; for example, automobile manufacturers engage in package tying every time they make some features standard equipment, thereby reducing the number of separate options. In such circumstances, tying ordinarily raises no serious concerns about competitive issues.

There are also less benign explanations for tying, explanations that stress the profitable exploitation of monopoly power. Most prominent among these is tying as a form of price discrimination. Here we must suppose that (1) the seller has monopoly power in product A, the tying product; (2) customers differ in the level of their demands for A; and (3) their demands for product B, the tied product, are correlated with their demands for any given quantity of A. In the earlier IBM illustration, IBM (assumed to have a monopoly in tabulating machines) could have set a single profit-maximizing price, and each customer would pay the same amount per machine. But customers with high demands for tabulating services typically use the tabulating machine more intensively and therefore use more punch cards. So if IBM produces (or buys from a supplier) punch cards, ties them to the sale of its machines, and marks up the price of the cards (with an offsetting price cut on the machines themselves), it will increase its profit from the simple monopoly level to a discriminating monopoly level, by effectively charging higher prices to the more intensive machine users.10

**Exclusive Dealing**

Exclusive dealing is a conceptually distinct practice, although as we will see it can be related to tying. It occurs when a buyer agrees to purchase all of its requirements of a product from a single seller. The initiative for an

---

8This practice has in fact generated a number of antitrust complaints; for example, Town Sound and Custom Tops, Inc. v. Chrysler Motors Corp., 959 F.2d 468 (3rd Cir. 1992) (Chrysler radios), and Heattransfer Corp. v. Volkswagenwerk, A.G., 553 F.2d 964 (5th Cir. 1977) (Volkswagen air conditioners).

9For a more extensive discussion of tying, see Carlton and Perloff (1994, pp. 467–479) or Scherer and Ross (1990, pp. 565–569). Its earliest comprehensive treatment is probably Bowman (1957), who credits Aaron Director with developing much of the underlying theory.

10At the time of the 1956 antitrust case, IBM's revenues from the cards were one-third of its revenues from the machines. Note that under this method of price discrimination, IBM does not need to identify in advance the customers with high demands for tabulating services.
exclusive dealing arrangement may come from either the seller—who may refuse to sell except on an exclusive basis—or the buyer—who may offer exclusivity to a seller if the seller offers favorable terms.

Why deal exclusively? Here, too, there is no single explanation, and under different circumstances exclusive dealing may have different effects. Economically beneficial explanations often stress the property rights incentives for long-term investment that are fostered by a grant of exclusivity. To illustrate, suppose that a hospital and its radiologists would benefit if the radiologists upgraded the department, but that after the radiologists incurred the necessary sunk costs, the hospital would likely admit numerous additional radiologists to the staff. The resultant dilution of the original radiologists’ gains could make the entire sequence unprofitable to the radiologists, and the improvement in quality likely would not be undertaken. But a properly structured contract that prohibits such postcontractual opportunism might permit a deal to be struck, which the absence of exclusive property rights would have prevented.

Exclusive dealing also has its share of “dark side” explanations. Perhaps the most common is that it is a way for sellers to foreclose their competitors’ access to customers (or, symmetrically, for buyers to foreclose their competitors’ access to input suppliers). As an illustrative story, suppose that the manufacturer of a popular brand of shampoo informs all of the salons to which it sells that it will no longer deal with them unless they use its shampoo exclusively. The salons would rather offer a variety of shampoos, but, forced to choose between the popular brand only or the lesser brands only, each agrees (because it is more profitable) to exclusivity. This cuts off the other shampoo manufacturers’ access to the salons and thus increases further the popular brand’s share of shampoo sales. Exclusive dealing has much in common with vertical integration and is often characterized as integration through contract rather than through ownership.

THE LEGAL TREATMENT OF TYING AND EXCLUSIVE DEALING

Tying and exclusive dealing are typically treated as distinct phenomena in the economics literature, but the two practices often appear in tandem. Consider a hypothetical example of a common industrial practice. Ford solicits bids for its next year’s requirements of tires, and after the bidding, it selects Goodyear as its exclusive supplier. Ford also refuses to sell its new cars without tires; if the consumer wants to buy a Ford, the consumer must also buy the Goodyear tires that come with it. Another tire manufacturer—say, Firestone—may be unhappy with this outcome, but what is the source

of its unhappiness? Firestone’s basic problem is that it does not have practical access (for the term of the contract) to Ford purchasers. But its complaint against Ford could be framed either as opposition to Ford’s exclusive dealing—Firestone wants a piece of the action at the factory floor—or to Ford’s tying of tires to cars—Firestone wants the business it could get if Ford purchasers could put Firestone tires on their cars (and, of course, have the cost of the Goodyears deleted). In principle, elimination of either practice would give Firestone a chance for some of the business that instead is exclusively Goodyear’s.

Although tying and exclusive dealing often arise together, they need not do so in all circumstances. Ford might instead have bought tires from scores of suppliers, without dealing exclusively, and still engaged in tying tires to cars. Conversely, if Ford’s independent dealers routinely offered customers a “tire delete” option (perhaps because they also sold tires on the side), then from the consumer’s point of view (if not the dealer’s) the Ford-Goodyear arrangement would be exclusive dealing but not tying.

The distinction between tying and exclusive dealing is less clear when a hospital enters into an exclusive contract for the provision of hospital-based physician services. If a hospital patient could bring along his favorite anesthesiologist for his surgery, that would eliminate the tying, but it would also necessarily eliminate the exclusivity of the anesthesiology contract. And if another anesthesiologist could obtain staff privileges side-by-side with the contract anesthesiologists and offer his services to patients, that would eliminate the exclusive dealing, but it would also gut the tying arrangement. In short, the disputed practice in Jefferson Parish involved both tying and exclusive dealing.

As a matter of economic analysis, this distinction should be only a detail. Whether we call the practice tying, call it exclusive dealing, or call it a banana, the elements of the practice are comprehensible and imply certain economic studies to determine whether the practice is injurious to consumer welfare. In effect, the terminology is not critical to the economic analysis.

Jefferson Parish, however, was not an abstract exercise in economic analysis. It was a lawsuit tried in a U.S. Federal District Court, and there the standards by which legality is judged depend importantly on whether the hospital’s exclusive contract is treated as a tying case or as an exclusive dealing case. Tying arrangements up to the time of Jefferson Parish (and, we will see, after it) have been judged per se illegal, at least once certain important factual preconditions have been proved. (The most important of these preconditions is that the defendant possess monopoly power in the tying product.) In contrast, exclusive dealing, like other forms of vertical integration, is judged under the rule of reason.12 Thus, because of the divergence of

---

12 Other cases, both before and after Jefferson Parish, have treated factually similar contracts primarily within a vertical exclusive dealing framework; see, for example, Dos Santos v. Columbus-Caneo-Cabrini Medical Center, 684 F.2d 1346 (7th Cir. 1982), and Collins v. Associated Pathologists, Ltd., 884 F.2d 473 (7th Cir. 1988).
legal standards in judging tying and exclusive dealing, the parties in this case had an obvious interest in characterizing the challenged practice in different ways.

THE PARTIES’ ECONOMIC ARGUMENTS

As could be expected, the plaintiff and the defendant offered substantially different economic analyses to buttress their respective positions in the case.

Dr. Hyde’s Position

Dr. Hyde, the plaintiff, sought to establish a number of factual propositions that together would imply that East Jefferson Hospital’s contract with Roux & Associates was a per se illegal tying arrangement. The plaintiff also sought to show that the arrangement at issue actually had stifled competition and injured consumer welfare, evidence that would be relevant if the court treated it as a rule-of-reason case.

First, Dr. Hyde wanted to establish that this case was about tying, and not about exclusive dealing. The plaintiff identified three findings that would put the hospital’s contract into the tying pigeonhole. The first was that there were in fact two separate products involved, not just one.13 This, it was said, was obvious on its face. The service provided by the hospital was the maintenance of the surgical operating room, and the service provided by Roux was the provision of anesthesia. The separateness of these services was suggested by the presence of other hospitals in the New Orleans area where anesthesia was provided independently, and billed independently, by anesthesiologists with nonexclusive staff privileges.14 In fact, Dr. Hyde himself had active privileges in anesthesia at Lakeside, another Metairie hospital.15 So, the argument concluded, there were two inherently separate products—operating rooms and the professional services of anesthesiologists—that did not need to be bundled together.

That established, Dr. Hyde’s next element was to show that the two separate products were in fact tied. On this there was no serious dispute: If a patient wanted surgery at East Jefferson Hospital, he got his anesthesiology from Roux & Associates, or he didn’t get it at all. Access to East Jefferson was the tying product, and Roux’s anesthesia was the tied product.

The final element that Dr. Hyde needed to establish was that East Jefferson Hospital possessed monopoly power in the tying product. This was a troublesome issue for Dr. Hyde. When the District Court found against

14Ibid., p. 42.
15Ibid., p. 31.
him, it did so largely because it found that the hospital lacked monopoly power; and when the Appellate Court went the other way, its principal basis was a finding that the District Court was wrong, and that the hospital did have monopoly power. In both of those decisions, and in the appeal to the Supreme Court, the principal focus of the monopoly power inquiry was the extent of the relevant geographic market for hospital services and East Jefferson’s share of it. The plaintiff’s argument urged the Supreme Court to affirm the Appellate Court’s finding on this point. That, in the plaintiff’s argument, was by itself sufficient to declare the arrangement a violation of the Sherman Act, but the argument went on to detail some of the actual adverse competitive consequences supposedly caused by the arrangement. Among them were that (1) since Roux had a “monopoly” of the anesthesia that flowed through East Jefferson Hospital, patients at that hospital were deprived of their freedom to choose their own anesthesiologist; (2) patients were provided with lower-quality care (for example, anesthesia administered by nurse anesthetists rather than by M.D. anesthesiologists); and (3) patients were subjected to higher prices for anesthesia. These consequences, it was argued, flowed from the complete elimination of “intrahospital” competition within East Jefferson Hospital, allowing the anesthesiologists there to become sluggish and unresponsive to consumer preferences. And not only were consumers injured, but Roux’s competitors were too; Dr. Hyde, denied access to East Jefferson Hospital, found part of his market foreclosed. Thus, Dr. Hyde’s story was simple. The defendant hospital had a monopoly of, or monopoly power in, a market for hospital services. Other complementary input suppliers—for example, anesthesiologists—did not have such power, or would not have it without the hospital’s conduct. But the hospital had in effect bootstrapped its monopoly power in hospital services into monopoly power in anesthesia, by tying the latter to the former. It was this incremental monopoly power that was said to injure consumer welfare, for all of the usual reasons.

**East Jefferson Hospital’s Position**

The defendant hospital, not surprisingly, saw things differently and argued (among other things) for a completely different analytical approach to the case. In the hospital’s view, this case was fundamentally about exclusive

---

16Ibid., pp. 36–38.
17Ibid., pp. 20–29. The argument about higher anesthesia prices was weak, in view of the complete absence of empirical evidence presented to the District Court and the Appellate Court’s finding that “[I]t is true that the tying of anesthesia services to operating rooms in the instant case did not lead to a higher charge for anesthesia services.” 686 F.2d 286, 291 (5th Cir. 1982).
19Ibid., pp. 32–34.
dealing, and if tying was involved at all, it was only as a tangential by-
product. After all, the hospital pointed out, a patient’s choice of anesthesi-
ologist at any one hospital is always limited—even at open-staff hospitals,
the number of anesthesiologists with staff privileges was comparable to the
number in the Roux group—yet no one would consider that a tying arrange-
ment. Instead, said the hospital, limitation of anesthesiologist choice was a
simple fact of life, and all that this case concerned was the way in which the
“chosen few” at East Jefferson Hospital were chosen.

If this was so, the hospital argued, then Dr. Hyde was looking at the
wrong market. Dr. Hyde had focused on the market in which the patient
received the hospital’s service and, whether tied or untied, the services of
other complementary providers. That may be a market, said the hospital,
but it is not the market that is directly affected by the exclusive contract.
Instead, the directly affected market is the one in which anesthesiologists
(and other hospital-based physicians) seek out hospital staff positions.
That market, the affected market, is essentially national in scope—the sta-
tistics in evidence showed that hospital-based physicians are extraordi-
narily mobile—and no hospital has monopoly power in it.

The hospital offered an analogy to the earlier Tampa Electric case. In
that case, Tampa Electric, a Florida public utility, entered into a long-
term exclusive contract with a Tennessee supplier of coal, and the com-
petitive effect of the contract’s foreclosure of other coal suppliers was at
issue. There, it was irrelevant that every resident of Tampa bought elec-
tricity from Tampa Electric alone; the directly affected market was not the
one in which Tampa Electric sold its output, electricity, but rather the geo-
graphically broader one in which it bought one of its inputs, coal. Analo-
gously, in the present case, the directly affected market was not the one in
which the hospital sold surgical output, but rather the one in which it
“bought” (that is, selected) anesthesiology inputs.

The hospital also denied the idea that the contract should be treated as
tying because, as a practical matter, there really were not two separate
products involved here, at least not in any meaningful sense. A hospital
stay, in this characterization, is just one single, albeit complex, product. If
a patient cannot have a hospital surgical stay without all of the necessary
inputs, then what sense does it make to treat each of the inputs as a sepa-
rate product? Moreover, to treat this arrangement as tying is to treat virtu-
ally every product as tying. By way of examples, a consumer cannot ordi-
narily buy a car without getting the engine, or a razor without getting the
blade. These, and virtually all, products are really just bundles of indi-
vidual components, and the reason they are sold as bundles is that it is effi-
cient to allocate some of the packaging to the seller.

---

20 Brief for the Petitioners, pp. 43–45; Reply Brief for the Petitioners, pp. 2–5.
23 Brief for the Petitioners, pp. 39–42.
East Jefferson conceded that it was possible to characterize the contract as a tying arrangement. But the hospital argued that even if its exclusive contract did in some sense tie separate anesthesia services to hospital services, and even if it did enjoy monopoly power in a hospital services market, the contract could not logically be explained through any of the standard economic scenarios by which tying could be used to enhance monopoly profits. In particular, the hospital pointed out (and Dr. Hyde did not dispute) that, unlike our earlier IBM example, operating-room access and anesthesia were used in essentially fixed proportions. This observation alone sweeps away the standard price-discrimination explanation for tying, and it also wipes out the applicability of all of the analytically interesting variable-proportions input-substitution explanations for tying.

In fact, the hospital asserted, anticompetitive tying in this case would be illogical even if anesthesia were used in price-responsive variable proportions. For one reason, since the hospital has the ability to charge the patient separately for every individual element of treatment that he receives, including time spent in the operating room and the use of anesthesia itself, the hospital could already balance the relevant price ratios; a tie-in of Roux’s professional services adds nothing. Furthermore, a tie that resulted in Roux and his associates’ being paid more than a competitive price actually would reduce the hospital’s profit, since the demand for the hospital’s own services is net of the price paid for all of the other inputs (including physicians’ services) that are complementary to a hospital stay. In addition, as to the point that competition among anesthesiologists practicing within East Jefferson Hospital was extinguished, the hospital’s rejoinder was that competition for the contract itself had supplanted contemporaneous patient-by-patient competition. Competition in anesthesia was vigorous, and the hospital had simply chosen to take advantage of it in its own way.

All of these arguments, the hospital pointed out, are wholly applicable to a hospital with monopoly power. But it would have been imprudent to ignore or concede the monopoly power issue—the Appellate Court’s reversal of the District Court had hinged on it—and the hospital did neither. It argued that the statistics cited by the Appellate Court showed that East Jefferson Hospital in fact competed in a market that was geographically broader than just East Jefferson Parish. There were only two relevant statistics in the record on which such a determination could be made. One was that, from East Jefferson Hospital’s point of view, it got only 70 percent of its admissions from residents of East Jefferson Parish, and thus 30

---

24Ibid., p. 22.
25See, for an early and elegant example, Vernon and Graham (1971).
26Brief for the Petitioners, pp. 21–22.
27Ibid., pp. 22–23.
28Ibid., pp. 37–39. The point is similar to that made in Demsetz (1968) and Baumol, Panzar, and Willig (1982).
29Brief for the Petitioners, pp. 30–34.
percent from other parishes. The other statistic was that, from the patient’s point of view, only 30 percent of the hospitalized residents of East Jefferson Parish went to East Jefferson Hospital, and 70 percent went to some other hospital, either in Jefferson or in some other parish. (The equality of the percentage pairs is a coincidence.) On that basis, said the hospital, the District Court had been justified in including the adjoining East Bank of Orleans Parish within the market. In that market, which included New Orleans, East Jefferson Hospital competed with over twenty hospitals and had a share (based on all patient admissions) of just 9.0 percent, far below any level suggestive of monopoly power.\textsuperscript{30}

THE ECONOMIC ANALYSIS OF THE SUPREME COURT

It is hard to distill “the economic analysis” in a decision as divided as Jefferson Parish. Five justices signed the majority opinion, written by Justice John Paul Stevens, while four justices filed a concurring opinion, written by Justice Sandra Day O’Connor, that agreed with the result of the majority opinion but disparaged its reasoning.

The Majority Opinion

The controlling majority opinion of the Court ultimately found in favor of East Jefferson Hospital, ruling that its contract with Roux & Associates did not violate the Sherman Act. This does not mean that the Court agreed with all of the hospital’s arguments, of course. For example, the hospital had denied that there really were two separate products at issue.\textsuperscript{31} But the Court rejected the hospital’s conception of a single product:

Unquestionably, the anesthesiological component of the package offered by the hospital could be provided separately and could be selected either by the individual patient or by one of the patient’s doctors if the hospital did not insist on including anesthesiological services in the package it offers to its customers. As a matter of actual practice, anesthesiological services are billed separately from the hospital services petitioners provide.\textsuperscript{32}

The Court indeed found two elements that might qualify the arrangement for an economic definition of tying: Two separate products, with one tied to the other. But not all tying qualifies for legal condemnation as tying. For that, Dr. Hyde had to prove a key third element: monopoly

\textsuperscript{30}Ibid., Appendix B.

\textsuperscript{31}“Petitioners argue that the package does not involve a tying arrangement at all—that they are merely providing a functionally integrated package of services.” 466 U.S. 2, 18 (1984).

power in the tying product, which was the most prosaic issue in the case and had been the principal issue of disagreement between the District Court and the Appellate Court. And on this issue, it was East Jefferson, not Dr. Hyde, that carried the day.

As noted above, the empirical evidence in the record on the extent of East Jefferson Hospital’s relevant geographic market and on its share of such a market was skimpy. On this slim factual base, the Court simply held that there was no basis to find that the hospital had monopoly power in hospital services, the tying product.33 Without that factual predicate, the contract could not be condemned on a per se basis.

The Supreme Court’s finding was not based solely on its own reading of the record. It also pointed out that the Court of Appeals opinion would have had the same reading, but for that court’s inappropriate injection of “market imperfection” minutia into the analysis:

The Court of Appeals . . . recognized that East Jefferson’s market share alone was insufficient as a basis to infer market power, and buttressed its conclusion [of market power] by relying on “market imperfections” that permit petitioners to charge noncompetitive prices for hospital services: the prevalence of third party payment for health care costs reduces price competition, and a lack of adequate information renders consumers unable to evaluate the quality of the medical care provided by competing hospitals. 686 F.2d, at 290. While these factors may generate “market power” in some abstract sense, they do not generate the kind of market power that justifies condemnation of tying.34

In a way, this dismissal of industry-specific “factors” is ironic. Hospital and medical defendants had for years argued that the special characteristics of medicine called for correspondingly special (and lenient) treatment under the antitrust laws. For years, the Supreme Court regularly replied that such characteristics created no special absolution under the law.35 In Jefferson Parish, the Court completed the loop by noting that no special thumbscrews were called for either.

East Jefferson Hospital may not have escaped the clutches of the tying characterization, but it did at least win on its view of the correct relevant market for analysis of the exclusive dealing aspects of the contract. The majority held that Dr. Hyde would not have prevailed under that approach to the case either:

[T]he burden of proving that the Roux contract violated the Sherman Act . . . necessarily involves an inquiry into the actual effect of the exclusive contract on competition among anesthesiologists. . . . Without a showing of actual adverse effect on competition, respondent cannot make out a case under the antitrust laws, and no such showing has been made.36

In other words, if we have a tying case, we look downstream from the hospital in Figure 14-1, and if we have an exclusive dealing case, we look upstream. Either way, in this case the hospital wins.

THE CONCURRING OPINION

Suppose that East Jefferson Hospital had been found to have monopoly power. The majority’s analysis would seem to suggest that in that event, the hospital would have been liable because tying in the presence of monopoly power is (still) per se illegal. This strikes many economists as a triumph of formalism over logic: The effects of tying on consumer welfare are theoretically ambiguous, and tying is sometimes necessary to obtain the beneficial effects of exclusive dealing. If this is so, then how can tying be thrown into the same category as naked price fixing, a practice so obviously and always harmful to consumer welfare that it may be condemned without question?

The concurring minority apparently had a similar reaction. The minority would have dumped entirely the per se treatment of tying and would have required a plaintiff in a tying case to prove not just that there was a tie-in, but also that it in fact caused competitively injurious effects. The minority observed that although per se treatment sounds simple—“If they did it, they’re guilty”—when the treatment is applied to tying, it still requires a complex and laborious determination of monopoly power in the tying product. But, once that intensive factual investigation is completed, any resultant evidence of procompetitive effects is completely suppressed, even if it shows the tie to be wholly beneficial to consumer welfare.37 The concurrence went on to assert that the only circumstances under which tying could be competitively objectionable would be those in which the practice would create market power in the market for the tied product. This is a questionable proposition; tying can in theory injure consumer welfare in the tying product market irrespective of perfect competition in the tied product market. However, the proposition may be consistent with the principle that a monopolist is free to exploit its monopoly power in

---


37“The ‘per se’ tying doctrine incurs the costs of a rule of reason approach without achieving its benefits: the doctrine calls for the extensive and time-consuming economic analysis characteristic of the rule of reason, but then may be interpreted to prohibit arrangements that economic analysis would show to be beneficial.” 466 U.S. 2, 34 (1984).
whatever way it sees fit (so long as it has come by the monopoly power legally), but is no more allowed to monopolize a second market than anyone else is.

Since the concurrence also found in favor of East Jefferson’s contract, the hospital won 9-to-0 on liability. The minority identified an additional reason why the contract did not create a tying arrangement: They agreed with the hospital’s “one product” view of the case:

[T]here is no sound economic reason for treating surgery and anesthesia as separate services. Patients are interested in purchasing anesthesia only in conjunction with hospital services, so the Hospital can acquire no additional market power by selling the two services together.38

The point might be read as an endorsement of the “one unified product” view of the world when two components of the final product are consumed in essentially fixed proportions.39

SOME OBSERVATIONS ON THE ECONOMICS OF JEFFERSON PARISH

Though economic issues were prominent in this case, there were significant omissions in the use of economic evidence and in the treatment of some economic questions.

Market Definition, Market Share, and Market Power

The judicial analysis of Jefferson Parish suffered from the absence of explicit expert economic testimony at the trial court level. There were, to be sure, statistics and testimony placed in the record that had economic significance, but neither party introduced an economist to try systematically to assemble, analyze, and interpret the relevant economic data and evidence. Thus, by the time it was necessary to shape and support the economic arguments for presentation to the Supreme Court, the effort was hampered by the absence of clearly framed and focused empirical evidence within the citable trial record.

Perhaps nowhere was this more evident than in the assessment of the relevant geographic market. Data had been available on patient origin and destination patterns in the New Orleans metropolitan area. These data could have been used, for example, to identify specifically the hospitals most


39Note that with (1) fixed proportions, (2) a monopoly of product A, and (3) a competitive supply of product B, the final product price (of A + B) is the same whether the monopolist ties B to A or not.
directly in competition with East Jefferson Hospital. But that analysis would have to have been introduced during the initial trial in 1980; by the time of the final appeal, the record on the extent of the geographic market was limited to the two bare summary percentages discussed earlier.

In a tying case, the market definition question is factually important because the market power issue is legally important. Roughly put, the per se rule in tying seems generally to be: No power, no harm; no harm, no foul. If a seller has rivals who can bundle or unbundle their products as they (or as the customers) wish, then the seller has little or no leeway to sustain a pattern of product packaging (e.g., tying) that the customer dislikes.

Empirical evidence aside, the Court made at least a modest contribution to the legal treatment of the question, “Does a given market share imply market power?” In particular, it brushed aside a number of supposed “market imperfections”—here, high information costs and low price sensitivity—as a basis for finding market power when the plain fact of a low market share would imply otherwise. But it was less direct in clarifying what level of market power is required for what sort of antitrust violation. When economists use the term market power, they usually mean only that a firm has the ability profitably to elevate market price above the competitive level.40 But a market share sufficient to confer this ability may be insufficient to allow a firm profitably to impose a tying restriction. The reason is that the conventional explanation for monopoly tying (e.g., the earlier IBM example) implies price discrimination, and it may take a significantly higher market share to make price discrimination stick than it does to exercise simple nondiscriminatory market power.

To illustrate, consider a firm with a 60-percent share of a market for a perfectly homogeneous good, with the other 40 percent supplied by rivals who are at capacity (i.e., their collective supply curve is vertical). Assume that the firm has and exercises conventional market power: Market price is significantly above the level we would see if the firm produced at price equal to marginal cost. Can the firm profitably price discriminate, by tying or by any other means? If it tries to do so, it will raise the price to the customers with relatively inelastic demands and lower it to the customers with elastic demands. But in response, all of its inelastic customers will flock to its rivals, and all of its rivals’ elastic-demand customers will come to it. If 60 percent or more of the prior market demand was from elastic-demand customers, then the only effect of the attempt to discriminate is to reallocate customers by their intensity of demand, and the attempt will fail.41

40See, for example, Landes and Posner (1981).

41The key assumption here is that the product is homogeneous, so that interfirm cross-elasticities of demand are very high. If the firm’s output is instead differentiated from all others, then even in this example discrimination might work. When Phlips discusses “discriminating oligopolists,” he warns that “This [concept] may cause some surprise, given that only monopolists are supposed to price discriminate, according to the standard literature.” But in some cases, he observes, “[D]uopolists, oligopolists, and small competitors in differentiated markets can price discriminate.”
Thus, different degrees and types of market power are necessary for different types of competitive conduct. A clarification of this “sufficient market power” point with respect to tying—as some courts have done with respect to predatory pricing—would have been useful, although perhaps not necessary to resolve Jefferson Parish.

Economic Interest

One essential economic point that the Supreme Court never considered was the economic interest of the tying seller in the provision of the tied product. If, in our earlier illustration, monopolist IBM increases its profits by tying overpriced punch cards to tabulating machines, it does so by collecting for itself the markup or overcharge on the cards. It is impossible for IBM to increase its assumed monopoly profits by tying overpriced punch cards if it simply requires machine purchasers to buy their cards from, say, International Paper. (This is so whether IBM or International Paper sets the card price.) If cards are a complement to machines and are sold by independent vendors in which IBM has no financial stake, then IBM’s interests are best served if cards are supplied at the competitive price. In practice, this means that if IBM for some reason “ties” someone else’s cards to its tabulating machines—for example, by requiring its customers to purchase cards directly from International Paper—then its interests would be best served by an agreement from International Paper to sell at the competitive price in return for being named the sole card vendor.

But this feature of the IBM case applies directly to the Jefferson Parish case. If a given hospital maximizes profits, then whether the hospital has monopoly power or not, we may assume that it sets every element of its own prices at the profit-maximizing level. But the hospital recognizes, in principle, that patients are influenced not only by the hospital bill as such, but also by the bills of the hospital-based physicians affiliated with the hospital. Ignoring the information cost issue (as did the Supreme Court), we would expect that patients would shun the hospital just as much for a $1000 increase in the hospital-based physician’s bill—the radiologist who reads the X rays, the pathologist who runs the lab tests, the anesthesiologist who sedates the patient—as for a $1000 increase in the hospital’s bill. The only difference is that in the first case, the hospital gets none of the gain. It is notable, given this, that East Jefferson retained

---

Philips (1981, pp. 16, 39; emphasis modified). The key distinction, of course, is whether the firm’s control over its own price—measured by the elasticity of demand for the firm’s output—comes from a large share of a homogeneous product market, or instead from the sale of a significantly differentiated product.

42This point is discussed explicitly and at some length in Todorov v. DCH Healthcare Authority, 921 F.2d 1438 (11th Cir. 1991).
complete discretion over the level of fees that Roux charged its patients for anesthesiology.43

Thus, we see that the premise upon which tying theory was applied to this case is flawed. Anticompetitive tying involves a monopolist of one product increasing its profits through the tie of a second product over which it does not initially have a monopoly; this practice is not likely to involve the channeling of that profit into someone else’s pocket. The fundamental logical problem with Jefferson Parish, and indeed most other hospital privileges cases involving exclusive contracts, is that the preferred theory implies that the hospital is voluntarily acting against its own interests by conferring a gratuitous benefit on the contracting physicians.

Although the Supreme Court has not spoken on this issue in tying, some courts have found that the theory of anticompetitive tying makes no economic sense if the defendant has no financial interest in the tied product. For example, when a developer of condominiums insisted that purchasers also take the services of a specified but independent property management firm, the Seventh Circuit Court of Appeals declined to find an illegal tie-in because of an absence of financial interest in the tied product.44 The absence of a coherent economic theory of competitive injury is sometimes enough to get a lawsuit dismissed; as the Supreme Court noted in a later case, “[I]f the claim is one that simply makes no economic sense—[plaintiffs] must come forward with more persuasive evidence to support their claim than would otherwise be necessary.”45 As a counterpoint, a later anesthesia privileges case provided a theory (and facts) that avoided this flawed economic logic.46 St. Peter’s Hospital, the only hospital in an isolated town, had canceled Mr. Tafford Oltz’s anesthesia privileges (he was a nurse anesthetist) in order to benefit the incumbent M.D. anesthesiology group, which promptly raised its fees by a handsome increment once Mr. Oltz left town. Why, the theorist asks, would the hospital do such a thing? Because, the Oltz court found, the M.D. anesthesiologists had threatened the hospital with a boycott. The hospital would not have wished for this circumstance; it was doing fine with both providers. But faced with the choice of just the M.D. anesthesiologist group or just Mr. Oltz,

---

43 Brief for the Petitioners, p. 3. The plaintiff responded that this discretion was less than absolute, stressing the hospital’s consultation with Roux in the process of fee determination. Brief for the Respondent, pp. 8–9.

44 Carl Sandburg Village Condominium Association v. First Condominium Development Co., 758 F.2d 203 (7th Cir. 1985). The opinion noted, however, that the interest of the tying seller in the tied seller need not be limited to outright ownership; commissions or kickbacks, for example, might be enough. In a later hospital exclusive-privileges case, the Fourth Circuit rejected any characterization of the exclusive contract as a tying arrangement because “the lack of the hospital’s economic interest in the tied product is sufficient to defeat [the] tying claim. . . .” White v. Rockingham Radiologists, 820 F.2d 98 (4th Cir. 1987).


46 Oltz v. St. Peter’s Community Hospital, 861 F.2d 1440 (9th Cir. 1988).
the hospital’s economic interest in setting up an anesthesia monopoly coincided with the anesthesia group’s. Thus, under those circumstances, there was no irrationality inherent in the hospital’s anticompetitive tying of an independent group’s anesthesia services to its own hospital services.

POSTSCRIPT

Two post-1984 developments since Jefferson Parish bear mention. One concerns hospital exclusive contracting, the economic activity at issue. The other concerns tying, the legal doctrine at issue.

At the time that the Court was deciding Jefferson Parish, there were no solid statistics on the actual extent of exclusive contracting for the services of hospital-based physicians. Available studies of the frequency of hospital contracts with physicians did not distinguish between exclusive and nonexclusive arrangements, so the Court had no way of knowing whether its decision affected most hospitals or only a handful. But in 1984, the year the Supreme Court decided Jefferson Parish, the American Hospital Association added a carefully focused question to its annual survey to determine the prevalence of this practice. The results were surprising: Exclusive contracts with hospital-based physicians were the norm, not the exception.47 The percentage of hospitals with exclusive arrangements varied by physician service:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathology</td>
<td>62.3%</td>
</tr>
<tr>
<td>Radiology</td>
<td>59.9</td>
</tr>
<tr>
<td>Emergency</td>
<td>48.7</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>30.2</td>
</tr>
<tr>
<td>Any specialty</td>
<td>73.4</td>
</tr>
</tbody>
</table>

Thus, postdecision information showed that the contracts that the Jefferson Parish decision affected were widespread and, correspondingly, widely affected by the decision. However, those who had thought that Jefferson Parish would settle the law in this area in a way that would reduce litigation were proved incorrect; the volume of hospital exclusive contract lawsuits has risen substantially since 1984.48

These same data have been analyzed further to investigate the monopolization theme of hospital exclusive contracts.49 Loosely stated, the hypothesis was that if “bootstrapping” a hospital’s monopoly power to benefit the

47The findings of the survey are reported in Morrisey and Brooks (1985).
48See the dozens of such cases cited in BCB Anesthesia Care, Ltd. v. Passavant Memorial Area Hospital Assoc., 36 F.3d 664 (7th Cir. 1994).
hospital-based physician was an important reason for exclusive contracts, then we ought to see relatively more of these contracts in highly concentrated hospital markets, where hospitals might have monopoly power. But the data do not support that hypothesis. Instead, the finding was that

[T]here is no support for the contract monopoly or market power explanation. . . . [W]e find essentially no relation between concentration and the weighted frequency with which hospitals adopt hospital-based physician exclusive contracts. . . . We conclude that, whatever the diverse reasons why, under certain circumstances, hospitals and hospital-based physicians find it in their mutual interest to contract exclusively, conferring market power on the favored specialist does not appear to be one of them.50

The other subsequent development concerns the legal treatment of tying, regardless of the industry in which it is found. The Supreme Court recently revisited the subject in the Kodak case.51 Some observers thought that this might be the case in which the Court finally abandoned the per se rule in tying cases. Because of turnover on the Court since Jefferson Parish, the potential for change seemed high.

The change never came. Both the majority opinion and the dissent in Kodak took it as settled precedent that tying was a per se offense, implying liability if the requisite market power in the tying product is found. The dissent (by Justice Antonin Scalia) noted in passing that a rule-of-reason analysis would be preferable, but that the disposition of the case did not require a renewal of that debate. Thus, as matters still stand, the economic analysis of tying in a legal setting remains truncated by the per se presumption of liability once the necessary predicate factual conditions are established.

REFERENCES


50Ibid., p. 413.

51Eastman Kodak Co. v. Image Technical Services, Inc., 112 S. Ct. 2072 (1992); see the chapter by MacKie-Mason and Metzler (Case 16) for further discussion.


