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Defining the Relevant Market in Health Care Antitrust Litigation:
Hospital Mergers*

INTRODUCTION

The health care system in the United States has undergone
numerous changes in the past decade,1 with hospitals, in partic-
ular, leading the way.2 This $136 billion a year industry3 has
experienced changes in the manner of receiving payments4 that

* The author wishes to express his appreciation to Professor Harold Weinberg
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1 See D. STARKWEATHER, HOSPITAL MERGERS IN THE MAKING (1981); Mullner,
Hospital Closures Remain Stable, Hosp., July 16, 1985, at 91. See also M. RAFFEL, THE
U.S. HEALTH SYSTEM (2d ed. 1984). The changes in the health care industry include
technological advancement of equipment, proliferation of outpatient facilities, more
stringent regulatory laws, and a more restrictive payment system. Id. at 187-256.

2 See generally J. GOLDSMITH, CAN HOSPITALS SURVIVE? (1981) [hereinafter J.
GOLDSMITH, HOSPITALS]. The hospital industry is the largest segment of the health care
delivery system. It is the institutional core and the most capital intensive component of
the health care system. Id. It is also labor intensive, and in 1980 employed 3.8 million
people nationwide. RAFFEL, supra note 1, at 187-203; J. Goldsmith, Outlooks For
Hospitals: Systems Are the Solutions, 1 BIOETHICS REP. 502, 508 (1985) [hereinafter J.
Goldsmith, Systems]. The hospital industry includes various institutions that provide
inpatient and outpatient care. These institutions are general and specialty hospitals and
range in size and function. Id.

3 AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS (1984 ed.). This figure
includes all general and federal acute care hospitals for the calendar year 1983.

4 The Prospective Payment System (PPS) went into effect in October 1983. It
replaced the retrospective payment system that the Medicare program utilized since its
inception in 1965. The retrospective payment of health services allowed hospitals to bill
for any reasonable charges for services provided to the patient, no matter how extended
his stay. As long as the charge was allowable there was no incentive to be efficient. This
system allowed most hospitals to survive without actively pursuing patients and physi-
cians. Consequently, traditional characteristics of competition were absent. See Teitel-
man, Taking the Cure, FORBES, June 1984, at 82; Note, Hospital Antitrust: The Merging
Hospital and the Resulting Exposure to Antitrust Merger and Monopolization Laws, 24
WASHBURN L.J. 300, 301 n.90 (1984-85) (citing Teitelman, Taking the Cure, FORBES,
June 1984, at 82).

PPS affects short-term acute care hospitals and limits the amount of reimbursement
to those hospitals by pre-determining a fixed price for a particular diagnostic related
group (DRG). This payment system accounts for a substantial portion of hospital revenue
and has an overall effect of making hospitals more cost efficient because diagnosis,
have caused decreased utilization of inpatient services. As a result, hospitals have altered the way they conduct business. They have become more competitive and now can be compared to the many other profit-oriented businesses from which they are borrowing effective managerial and marketing techniques.

Through strategic planning, hospitals are diversifying into related areas to establish a broader revenue base and a larger

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rather than the amount of services provided, determines how much money the hospitals will receive. See Federal Health Insurance for the Aged and Disabled, 42 C.F.R. § 405 (1985); J. ZIEGENFUSS, DRG'S AND HOSPITAL IMPACT 5 (1985).

5 See R. CATERINICCHIO, DRG'S (1984). After implementation of the Prospective Payment System, hospitals have been forced to reduce utilization of inpatient services but to increase their admissions to remain financially viable. The effect has caused a decrease in the length of stay for most services and a shift toward providing more care on an outpatient basis. Id. In 1984, the hospital industry experienced both decreasing length and number of admissions as a result of the new reimbursement system. In turn, the utilization of outpatient services increased substantially. See Freko, Admissions Fall But Margins Are Up, Hosp., May 1, 1985, at 70. See also ZIEGENFUSS, supra note 4, at 104-31. "Hospitals still may change their emphasis to ambulatory-based services, and may accelerate into clinic . . . [moreover] [h]ospitals will seek to cut the average patient length of stay and limit the number of tests and services provided." Id. at 104.


7 Hospitals have recognized the need to attract more paying patients. Marketing programs that include newspaper and television advertisements are commonplace. Alternative methods of attracting patients such as satellite centers, Preferred Provider Organizations, Health Maintenance Organizations, and insurance programs have proliferated. Many hospitals build physician office buildings near their institutions to attract physicians who might find it convenient to admit their patients to the adjacent facility. Also, many hospitals are initiating ambulance programs via ground and air in order to increase their patient volume. See generally J. GOLDSMITH, HOSPITALS, supra note 2.

8 Traditionally, hospitals were not operated in a manner similar to retail stores or other businesses that serve the general public. Today the emphasis is on public image and profitability, an approach which is not readily distinguishable from other consumer-oriented service industries. Id. See E. JOHNSON, HOSPITALS IN TRANSITION (1982). Hospitals currently are seeking to apply successful management techniques from other industries. These considerations demonstrate an emphasis on profitability and efficiency as opposed to the purely humanitarian focus that is associated with medical care. Terms such as "strategic planning" and "portfolio analysis" are now widely used in this multimillion dollar industry. Id.; Stuart & Steele, Can a Hospital Mean Business?, HEALTHCARE FIN. MGMT., Dec. 1983, at 26-28.

9 Strategic planning entails the linking of hospital financial, operational, planning, and marketing activities. This focuses the hospital's activities to insure proper analysis of new programs and future direction. See Gregory & Klegon, The Value of Strategic Marketing to the Hospital, HEALTHCARE FIN. MGMT., Dec. 1983, at 16-20.
profit margin. Institutions failing to implement these changes likely will be purchased or cease to operate.

In the field of antitrust law, the traditional view of hospitals as non-competitive entities no longer exists. At one time, the structure of the industry discouraged competition because the demand for health care was independent of the price of services or the activities of normal consumers. Therefore, neither courts nor commentators applied traditional theories of antitrust com-

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10 Currently the hospital industry is in a situation similar to that of the defense industry in the mid-1960's and the cable television industry in the mid-1970's. To meet the challenge, hospitals are diversifying and broadening their revenue base. As a result, Health Maintenance Organizations and Preferred Provider Organizations are being developed. See Coddington & Pottle, Hospital Diversification Strategies: Lessons from Other Industries, HEALTHCARE FIN. MGMT., Dec. 1984, at 19-24.

11 See NHLA Seminar Probes Antitrust Exposure of Practices Within Health Care Sector, 48 ANTITRUST & TRADE REG. REP. (BNA) No. 1200, at 239 (Jan. 31, 1985). Three hundred hospitals closed their doors from 1976 to 1983. Another five hundred are expected to close during the next ten years. Id. at 243.

12 Prior to 1976 there was a general indifference to hospital merger activities. Although much of this activity arguably affected interstate commerce, antitrust laws were not applied. In 1976, the Supreme Court held that the relocation and expansion of a local hospital had the requisite substantial effect on interstate commerce to bring the defendants' acts opposing expansion under the Sherman Act. See Hospital Bldg. Co. v. Trustees of Rex Hosp., 425 U.S. 738, 744 (1976). Epstein, New Antitrust Reality, Hosp., Oct. 16, 1983, at 60, states:

[W]e are witnessing the steady transition of a field that was so largely characterized by such unusual incentives that, until relatively recently, . . . some courts were motivated to urge special antitrust treatment for that field. It is increasingly difficult, and probably inappropriate, to urge special treatment any longer in the face of the emerging economic relationships and characteristics of the modern hospital system.

See also D. STARKWEATHER, supra note 1, at 489-91.

13 Hospital care was not economically competitive because the demand for health care was not dependent upon the price of services. In a theory explaining the demand for medical care, Joseph P. Newhouse hypothesized that insurance coverage acts like a subsidy to the cost of medical care and lowers the per unit cost. Consequently, the demand is elastic (dependent upon price) and as a result of insurance, healthcare demand is increased. However, demand changes in response to insurance coverage and not necessarily the cost of healthcare. In addition, Newhouse hypothesized that the demand for healthcare is indifferent unless the consumer becomes ill. When the health status changes, it affects the individual's expenditures on health. This causes the demand for healthcare to become inelastic (not dependent upon price).

Note, supra note 4, at 303 n.23 (citing J. NEWHOUSE, THE ECONOMICS OF MEDICAL CARE 4-15 (1978)).
petition. Recently, however, recognition of the industry's burgeoning competitiveness has brought the hospital industry under tighter scrutiny of the antitrust laws.

Even though this increased competition among hospitals has increased the potential for antitrust litigation, the relevant market, an essential element of antitrust analysis, has been defined by the courts in a haphazard manner. As a result, few unifying principles can be derived from the case law. A precise definition of the relevant market is important to the hospital industry because of the potential increase in hospital merger litigation.

Primarily, four antitrust provisions are applicable to mergers in the health care industry: (1) section 1 of the Sherman Act, which prohibits concerted activity that actually restrains trade;
(2) section 2 of the Sherman Act,22 which prohibits unlawful monopoly;23 (3) section 5 of the Federal Trade Commission Act,24 which prohibits unfair trade practices;25 and (4) section 7 of the Clayton Act,26 which is intended to arrest anticompetitive tendencies in their incipiency.27 Section 7 specifically prohibits mergers and acquisitions of stock or assets in any line of commerce or in any section of the country where the effect of such an acquisition may substantially lessen competition or tend to create a monopoly.28 Thus, section 7 uses both product and geographic characteristics in determining whether an antitrust violation exists.29

This Comment first examines general principles for defining the relevant market. Second, it examines the approach taken by...
two recent Federal Trade Commission (FTC) cases that addressed the issue of relevant markets. Finally, this Comment concludes that the United States Justice Department Merger Guidelines and the principles enunciated in bank merger cases sufficiently address the problem of defining the relevant market in hospital merger situations and therefore should be used as a basis for further court decisions.

I. GENERAL PRINCIPLES FOR DEFINING THE RELEVANT MARKET

The determination of the relevant market is crucial to the outcome of an antitrust case because it is the first step in analyzing potential violations. The relevant market is composed of both product and geographic elements and is the area of effective competition where antitrust violations potentially occur. Consequently, finding an antitrust violation depends upon the court’s interpretation of the effective area of competition. This interpretation serves as the basis for analyzing the violator’s ability to exert influence in the defined area. Defining the relevant market in antitrust litigation is a continuing problem and courts have struggled to establish a methodology for producing consistent results.

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30 See ABA ANTITRUST SECTION, ANTITRUST LAW DEVELOPMENTS (2d ed. 1984) [hereinafter cited as ABA]. By defining the relevant product market too broadly or too narrowly, the real effect on competition cannot be evaluated properly. A broad product market “tends to minimize the competition between firms that already compete....” Conversely, a narrow product market “can result in high market shares” for those competing in the same market. Id. at 150. Similarly, the relevant geographic market that is too broadly or narrowly defined will not accurately reflect the area of competition between the firms. Id. at 154.

31 A relevant market is composed of products that the merging firms supply for a geographic area. A merger’s impact on competition can be measured only in geographic relevant product and geographic markets. To determine if a merger contravenes the antitrust laws, the court must define the relevant market. By defining the relevant market, a merger’s impact on competition can be evaluated. See BRUNNER, supra note 18, at 89-163.


33 See, e.g., 370 U.S. 294, 324 (1962).

34 The ability of the merging firms to exact a price for goods above what a competitive market would tolerate might indicate that the firm has excessive market power within a monopolized market. See Grand Union Co., 102 F.T.C. 812, 1040 (1983).

35 See BRUNNER, supra note 18, at 87. Market definition techniques included
A. Defining the Relevant Product Market

In Brown Shoe Co. v. United States, the United States Supreme Court found it necessary to determine the relevant product market before deciding if a violation of section 7 of the Clayton Act had occurred. The Court stated: "[T]he relevant market must be drawn with sufficient breadth to include the competing products of each of the merging companies and to recognize competition where, in fact, competition exists.

Brown Shoe also introduced the submarket concept to antitrust litigation. Submarkets are divisions of a product market used to determine whether a single product has sufficiently peculiar characteristics to constitute a relevant market in itself. The Court listed seven practical indicia of a submarket: "industry or public recognition of the submarket as a separate economic entity, the product's peculiar characteristics and uses, unique production facilities, distinct customers, distinct prices, sensitivity to price changes, and specialized vendors." The use of submarkets allows inspection of one segment of a product market to determine if there is a reasonable probability of lessened competition. If so, any merger affecting that product market is proscribed. Initially, this concept was controversial, but it has become a practical and useful tool for relevant market

cross-elasticity as a basic test, broad product markets that encompass smaller submarkets, product and service 'clusters' and subjectively drawn geographic markets." Id. The Supreme Court's methodology became more consistent by the mid 1960's. Consequently, ad hoc techniques gave way to a more predictable analysis. Two bank merger cases decided in 1974 effectively disavowed the methods of the prior decade, "yet the imprecision and subjectivity of the [market definition in] lower courts did not abate." Id.


Id. at 324.

Id. at 326.

Id. at 325.

See, e.g., id. at 326-28.

Id. at 325. The Court later indicated that all of the criteria set forth in Brown Shoe need not be present to find a submarket. United States v. Aluminum Co. of Am., 377 U.S. 271, 276 (1964).

42 "[I]t is necessary to examine the effects of a merger in each such economically significant submarket to determine if there is a reasonable probability that the merger will substantially lessen competition." 370 U.S. at 325.

43 Id. The proscription expressed in § 7 of the Clayton Act applies to actual and potential competition in corporate mergers when there is a tendency toward monopoly
analysis. Submarkets have been broadly applied to numerous industries and were relied upon recently in hospital merger litigation.

B. Defining the Relevant Geographic Market

The United States Supreme Court decision in United States v. Pabst Brewing Co. was an important development in defining the relevant geographic market. The Court declared that a geographic market need not be defined "by metes and bounds as a surveyor would lay off a plot of ground." Consequently, a case will not be dismissed due to the lack of precision in the definition of the relevant market. Pabst illustrates that section 7 of the Clayton Act "require[s] merely that the [plaintiff] prove the merger has substantial anticompetitive effect somewhere in the United States." This broad statement, however, left unresolved questions about the commercial realities of defining the geographic market in a specific "section of the country." The Supreme Court later clarified this ambiguity by defining it as the "area in which the acquired firm is an actual, direct competitor."


The Court found that within a broad market, distinct well-defined submarkets could exist. Each submarket could constitute a product market for antitrust purposes. 370 U.S. at 325.


See In re Am. Medical Int'l., 3 TRADE REG. REP. (CCH) ¶ 22,170, at 23,038-39 (July 2, 1984). (Several of the Brown Shoe criteria were used in defining the relevant product market.)


Id. at 549 (citing Times-Picayune Pub. Co. v. United States, 345 U.S. 594, 611 (1953)).

Id.

Id.

Id. "Section of the country" is the specific language used in § 7 of the Clayton Act. See note 27 supra.

418 U.S. at 622.
C. Bank Merger Cases

Several United States Supreme Court bank merger cases provide guidance in determining the relevant market in hospital merger litigation. The bank cases provide useful analogies because of the unique and highly regulatory nature of both the banking and hospital industries. There are facilities within each industry that create competition by providing comparable services. Within the banking industry, major competitors are banks and savings and loans. Generally, savings and loans provide products and money management services similar to commercial banks. Hospitals also have numerous competitors, such as physician’s offices, outpatient surgical centers, and free-standing emergency centers. These outpatient facilities perform many medical services that are provided by most hospitals. Consequently, although these competitors are not hospitals, they have been considered as important factors in defining the relevant product market in hospital merger litigation.

The most frequently cited bank merger case in hospital merger litigation, United States v. Philadelphia National Bank, de-

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Each has competitors competing for customers with similar products. In this sense, banks compete with savings and loans, credit unions, and other financial institutions while hospitals compete with numerous non-hospital facilities. Because banks and hospitals offer unique services, however, their competitors are not considered within the same product market in antitrust litigation. See United States v. Philadelphia Nat’l Bank, 374 U.S. 321 (1963); TRADE REG. REP. (CCH) ¶ 22,170 (July 2, 1984).

The Court defined credit to be the unique cluster of products provided by commercial banks. This included personal and business loans, mortgage loans, tuition financing, bank credit cards, and revolving credit funds. 374 U.S. at 326 n.5, 356.

The Court found that commercial banks provided several services that were insulated from competitors, including demand deposits from individuals and corporations, estate and trust planning, safety deposit boxes, and investment advice. Id. at 356.

Non-hospital based physicians typically maintain private offices where numerous patients are seen. The typical office visit is for routine treatment.

Outpatient surgical centers perform minor surgery that traditionally has been provided on an inpatient basis at hospitals.

Most emergicenters provide episodic primary care for fractures, skin lacerations, and ear, nose and throat complaints. Just five years ago emergicenters were almost non-existent. Today approximately 2,500 exist. C. Stromberg, Emergicenters, HEALTH SPAN, June 1985, at 2.

374 U.S. 321.
parted from the *Brown Shoe* submarket concept and introduced the "clusters of service" concept. A service cluster is an economic entity whose characteristics are so unique that it operates free from effective competition. The cluster composes a distinct line of commerce that is insulated from a broad range of substitute services provided by competing institutions.

In *Philadelphia National Bank*, one of the distinct services considered was personal loans. While both commercial banks and savings and loan associations provided this service, the small savings and loan rates were invariably higher than that of commercial banks, placing them at a significant competitive disadvantage with respect to this service. Commercial banks were determined to be a unique entity, free from effective competition, and therefore they alone composed the relevant product market. The Court held that the banks' loan services were "so distinctive that they [were] entirely free of effective competition from products or services of other financial institutions." Thus, the proposed merger of the commercial banks was enjoined.

*Philadelphia National Bank* also influenced judicial determination of the relevant geographic market. The geographic market was defined as a "workable compromise ... which avoids the indefensible extremes." The Court recognized that a certain amount of "artificiality" and "fuzziness" is present

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61 Id. at 356.
62 Id. at 356-57.
63 Id. In the business of commercial banking, for instance, checking accounts, trust administration, personal loans and twenty four-hour banking are specific services provided at many banks. These services are also provided at savings and loans. When viewed individually, these services may be unique and constitute a specific line of commerce that is free from effective competition. In addition, when viewed collectively, the uniqueness of the group of services (service cluster) is such that the entity providing the services is free from effective competition. Therefore, checking accounts, trust administration, personal loans and twenty four-hour banking are services that constitute a unique cluster. The commercial banks that provide these services are unique economic entities that function free from competition in a distinct line of commerce known as commercial banking.
64 Id. at 356.
65 Id.
66 Id. at 357.
67 Id. at 356.
68 Id. at 372.
69 Id. at 361.
even in the most exacting attempts to define the geographic dimensions of the relevant market.\footnote{Id. at 360 n.37.}

Another bank merger case relied upon in the health care context, \textit{United States v. First National Bank and Trust Co. of Lexington},\footnote{376 U.S. 665 (1964).} stated that "where merging companies are major competitive factors in a relevant market, the elimination of significant competition between them, by merger . . . , itself constitutes a violation of § 1 of the Sherman Act."\footnote{Id. at 671-72.} The \textit{First National Bank} Court defined the relevant geographic market as the county in which the banks were located because most customers confined their banking transactions to that county.\footnote{Id. at 668 (Over 95\% of the bank's business originated in the local county.).} That geographic boundary reflected the economic realities of the banking industry by recognizing convenience and accessability as factors that affect competition.\footnote{Id.}

In \textit{United States v. Marine Bancorporation}\footnote{418 U.S. 602 (1974).} and \textit{United States v. Connecticut National Bank},\footnote{418 U.S. 656 (1974).} the Supreme Court further laid a foundation for determining the relevant product and geographic markets. In \textit{Marine}, the relevant product market was the business of commercial banking\footnote{418 U.S. 602 at 618-19.} and the relevant geographic market was the area where the acquired firm was a direct competitor.\footnote{Id. at 622.} The case clarifies the definition of the relevant geographic market by indicating that for section 7 purposes the "section of the country" and the "relevant geographic market" are the same.\footnote{Id. at 619-23.} In \textit{Connecticut National Bank}, the unique cluster of services provided by commercial banks was the basis for product market determination.\footnote{418 U.S. 656 at 666.} The geographic market was the local area where the merging firms were in direct competition.\footnote{Id. at 667.}

The lower courts have been slow to adopt the United States
Supreme Court's guidance in defining the relevant market. \(^{82}\) This is especially evident in health care litigation because hospital mergers involving very similar facts have yielded different results. For example, in *American Medicorp Inc. v. Humana, Inc.* \(^{83}\), the relevant product market was found to include only short-term acute care community hospitals, \(^{84}\) while in *In re Hospital Corporation of America* \(^{85}\), the Federal Trade Commission (FTC) found that a relevant product market included all general acute care services. \(^{86}\) Although both cases involved general acute care facilities, the relevant markets were defined very differently. \(^{87}\)

**D. The Department of Justice Merger Guidelines**

The U.S. Department of Justice has set forth merger guidelines to assist the courts in establishing unifying principles. \(^{88}\) The Justice Department Merger Guidelines (Guidelines) use the market power concept to define the relevant market or markets. \(^{89}\) That principle requires, "identifying firms that, were they to act as a single entity, could profitably raise and maintain price[s]". \(^{90}\) All relevant evidence is examined to determine the potential for monopolization of the market. \(^{91}\) In particular, price movements, \(^{92}\) product configuration, \(^{93}\) and buyer's and seller's per-

\(^{82}\) See note 35 supra.
\(^{84}\) Id. at 605.
\(^{85}\) 3 TRADE REG. REP. (CCH) ¶ 22,301 (Oct. 8, 1985).
\(^{86}\) Id. at ¶ 22,301.
\(^{87}\) See notes 83-86 supra and accompanying text. Although these cases classified the relevant product market in different terms, there does not appear to be a rational basis for defining the market differently.
\(^{88}\) See generally U.S. DEPT. OF JUSTICE MERGER GUIDELINES, reprinted in 2 TRADE REG. REP. (CCH) ¶ 4500, (No. 655 Part II) (June 18, 1984) [hereinafter MERGER GUIDELINES].
\(^{89}\) Market power is the ability of one or more firms to profitably maintain prices above competitive levels for a significant period of time. Id. at 30-31.
\(^{90}\) BRUNNER, supra note 18, at 88.
\(^{91}\) See MERGER GUIDELINES, supra note 88, at 36-37.
\(^{92}\) Id. at 36.
\(^{93}\) Id.
\(^{94}\) Id.
ceptions of the market are emphasized. The Guidelines examine the effect of a small, hypothetical, nontransitory price increase above prevailing or future price levels to determine the relevant product market. This departs from the "reasonable interchangeability of use" standard the courts employed in determining the relevant market. The Guidelines also use the hypothetical price increase to define the relevant geographic market by determining how many consumers would be lost to other competitors.

The Guidelines deviate from the case law standards by quantitatively and qualitatively giving form to supply and demand dynamics that drive real markets. Market power is the underlying quantitative measure that determines the market share of each firm. In effect, the Guidelines seek to define relevant markets more precisely through quantitative measures. The American Bar Association also assists the courts by providing general concepts to determine relevant markets. The general concepts are gleaned from an examination of past and present methodologies used in defining the relevant market.

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95 Id.
96 Id. at 37. [T]he Department will begin with each product (narrowly defined) produced or sold by each merging firm and ask what would happen if a hypothetical monopolist of that product imposed a "small but significant and nontransitory" increase in price. If the price increase would cause so many buyers to shift to other products that a hypothetical monopolist would not find it profitable to impose such an increase in price, then the Department will add to the product group the product that is the next-best substitute for the merging firm's product and ask the same question again. This process will continue until a group of products is identified for which a hypothetical monopolist could profitably impose a "small but significant and nontransitory" increase in price. The Department generally will consider the relevant product market to be the smallest group of products that satisfies this test.

97 See 377 U.S. at 276 (copper wire compared with aluminum wire); 374 U.S. at 356-57 (commercial banks compared with savings and loans); 445 F. Supp. at 599 (development of hospitals compared with proprietary ownership).
98 See MERGER GUIDELINES, supra note 88, at 32-34.
99 See BRUNNER, supra note 18, at 103.
100 See note 120 infra and accompanying text.
101 Id.
102 See ABA, supra note 30, at 147.
103 Id.
II. DEFINING THE RELEVANT MARKET IN HOSPITAL Mergers

A. The Relevant Product Market

American Medical International104 (AMI) and Hospital Corporation of America105 (HCA) are the leading hospital merger cases. AMI was the first hospital merger case brought before the full Federal Trade Commission board (FTC).106 The FTC’s complaint charged that AMI attempted to monopolize the San Luis Obispo hospital market by purchasing a 138-bed community hospital in the city.107 The purchase, combined with a 172-bed facility previously owned by AMI, gave AMI sixty percent of the hospitals operating in the city.108 More importantly, the acquisition gave AMI approximately eighty percent of the acute care hospital beds in the city.109

In determining the relevant product market with sufficient “breadth” to recognize relevant competition,110 there is significant potential for manipulation of factors.111 Using quantitative and qualitative means set forth in the Merger Guidelines, the Federal Trade Commission seeks to increase the consistency with which the relevant product market is defined.112 The Guidelines employ a product’s interchangeability of use and its sensitivity to cross-elasticity to determine the outer boundaries of the product in a specific market.113 In this context, an element of cross-

104 In re Am. Medical Int’l., 3 TRADE REG. REP. (CCH) ¶ 22,170 (July 2, 1984).
105 In re Hosp. Corp. of Am., 3 TRADE REG. REP. (CCH) ¶ 22,301 (Oct. 8, 1985).
107 “AMI acquired French Hospital in 1979, giving the company control of three of the five hospitals in the San Luis Obispo County. A 1981 FTC complaint alleged AMI had attempted to monopolize the hospital market in both the city and county of San Luis Obispo...” 3 TRADE REG. REP. at 23,029.
108 Id.
109 Id. at 23,056.
110 See text accompanying notes 36-38 supra.
111 Brown Shoe Co. v. United States, 370 U.S. 294, 326 (1962). In defining the relevant product market, overinclusion or underinclusion of products can lead to different antitrust findings. Therefore, precisely defining what is included is the major point of contention for each party. Id.
112 See text accompanying notes 88-101 supra.
113 Id. at 325. Cf. United States v. Columbia Steel Co., 334 U.S. 495, 510-11 (1960). (The demand for steel plates and shapes must be measured against all other comparable rolled products because rolled steel producers can make other products interchangeable with shapes and plates.).
elasticity is the responsiveness of the sales of one product in relation to the price changes of another product. Therefore, "[i]f a slight decrease in price . . . causes a considerable number of customers . . . to switch . . . then the products compete in the same market." In AMI the definition of the relevant product market was critical to the outcome of the case. The FTC sought to determine if there was a high cross-elasticity of demand for medical services provided at hospitals and other facilities such as outpatient clinics and free-standing emergency centers. If so, this would indicate the existence of a common product market. The issue was whether related services placed significant constraints on the ability of the merging firms to raise their prices, or lower the supply or quality of their service. General acute care hospital services were found to be the relevant product market and therefore the appropriate service upon which to evaluate the effects of the acquisition. The FTC relied on market power to determine AMI's market share.

115 Id. at 400.
116 If general acute care services constitute the product market in most hospital merger situations, it will be increasingly difficult for most acquisitions to take place where one or more institutions are owned by the same entity. 3 TRADE REG. REP. at 23,040. See notes 1-10 supra and accompanying text. The courts primarily use § 7 of the Clayton Act when examining antitrust violations in merger settings. See ABA, supra note 30, at 150.
117 If the cross-elasticity is high, then products belong in the same market. See 3 TRADE REG. REP. (CCH) ¶ 22,170, at 23,039 n.8. "The purpose of product market analysis is to ascertain what grouping of products or services should be included in a single relevant market." Id. at 23,039 (quoting statement of Federal Trade Commission concerning horizontal mergers, reprinted in CCH TRADE REGULATION REPORTS, No. 546 at 84 (June 16, 1982)).
118 3 TRADE REG. REP. (CCH) ¶ 22,170. After losing the argument of antitrust exemption for the hospital industry, AMI's second defense was the product market limitation. Id. If AMI was successful in establishing a broad product market, then the market concentration would have been significantly lower. Therefore, by seeking to have non-hospital providers included in the product market, lessened competition was less likely to be found.
119 Id. at 23,040.
120 AMI contested the use of market power to determine the effects of the acquisition. At issue was the traditional presumption that a substantial increase in market concentration or in a firm's market share results in a lessening of competition.
AMI argued that the health care industry does not respond in the traditional economic manner. AMI contended that implicit in the market share presumption
The AMI finding suggests that primary level acute care facilities have services that are differentiated from other non-hospital providers. Primary level facilities, which are often community hospitals, provide the least technical care of the three types of acute care facilities. Certain care provided at these institutions is also provided by surgical centers and outpatient clinics. AMI, seeking to have numerous outpatient substitutes included in the product market, disputed the exclusion of these non-hospital facilities.

Similarly, in Philadelphia National Bank, the defendant sought to have non-commercial bank substitutes—savings and loans—included in the service market. As in Philadelphia National Bank, the FTC in AMI found that the services provided by the hospital had sufficient peculiar characteristics to negate reasonable interchangeability, and thus constituted a unique "cluster" of services. The FTC recited the factors essential to the "cluster" market definition as

is the notion that market power is based on the existence of a competitive price and the price sensitivity of buyers and sellers. Moreover, AMI argued that increased market share does not necessarily enhance market power in the health care industry where price sensitivity is absent. AMI claimed that the third party payment system limited the ability of a sole provider to exact charges in excess of what it could get in a more competitive market.

The FTC, however, upheld the use of market power and pointed to its use in other industries including a previous application in the health care industry. Furthermore, the FTC concluded that price constraints influence the decisions made by both buyers and sellers in the health care industry and give rise to price and non-price competition. Id. at 23,042-43.

The non-hospital providers that are interchangeable include clinics, physicians' offices, and medical laboratories. See 3 TRADE REG. REP. (CCH) ¶ 22,170, at 23,039. Hospitals are categorized according to the level of care provided at the institution. The categories include primary, secondary and tertiary. The most technologically advanced care is provided at the tertiary facility and basic inpatient care is provided at the primary level institution. Tertiary facilities are generally university-teaching facilities that provide care on a regional level. Primary level facilities are typically small community-oriented institutions. See generally J. Goldsmith, HOSPITALS, supra note 2.

Id.

3 TRADE REG. REP. (CCH) ¶ 22,170 at 23,039 (July 2, 1984).


There were identical substitutes for almost every service provided by commercial banks. Id. at 356-57.

Although each individual service that comprises the cluster of general acute care hospital services may well have outpatient substitutes, the benefit that
the functional complementarity and integration linking the products,” the “degree of commonality in the technology and manufacturing processes involving the components of the market,” whether “all products are marketed through similar channels and to the same group of buyers” and whether “this market has recognition in the industry,” . . . “whether there are competitive relationships between the lines of commerce warranting them to be aggregated as a group for the purpose of measuring the impact of the merger on competition,” . . . or “where for technological or other reasons, there is commonality in production and distribution resulting in a distinct and recognized ‘industry’ of firms who sell a broad line of such products. . . .”

Additionally, the FTC recognized that government agencies, state law and industry treat general acute care hospitals as a distinct class of health care providers. The FTC also noted that free-standing surgical or emergency treatment facilities were absent from the area, and that entry barriers effectively barred new suppliers of general acute care services. The FTC further recognized that AMI could provide these services on an outpatient basis. The complementarity of the individual services constituted the unique cluster and the comprehensive

accrues to patient and physician is derived from their complementarity.

There is no readily available substitute supplier of the benefit that this complementarity confers on patient and physician.

3 TRADE REG. REP. (CCH) ¶ 22,170 at 23,040 (July 2, 1984).

124 Id. at 23,039-40 (citations omitted) (quoting British Oxygen Co., 86 F.T.C. 1241, 1345 (1975), rev’d on other grounds sub nom. BOC Int’l Ltd. v. FTC, 557 F.2d 24 (2d Cir. 1977) (industrial gases)).

125 These are state health planning agencies. Id.

126 Every state has provisions for hospital licensure. This is often done by category according to whether the care provided is acute or long term. Id.

127 Id.

128 Even if these non-hospital providers were present, it is unlikely that the court would have reached a different result. Id.

129 The barriers to entry of new competition is an important element in finding a violation of the antitrust provisions. Because of this factor the cross-elasticity of supply for hospital services is low. Federal and state planning laws effectively prevent the building of new hospitals without demonstrating need. Consequently, entry by a competitor would be difficult and monopoly power could be exerted in certain situations. Id. at 23,041.

129 Id. at 23,040.

130 Id.
integrated care within the hospitals distinguished these entities from non-hospital services.\textsuperscript{137} In short, there were no readily available substitute suppliers of services.\textsuperscript{138}

In \textit{Hospital Corporation of America},\textsuperscript{139} monopolization of the acute care hospital services in the Chattanooga, Tennessee urban area was alleged\textsuperscript{140} after HCA acquired the management agreements and hospitals of two competing companies.\textsuperscript{141} At the time HCA acquired the acute care facilities in Chattanooga, they owned one of eleven licensed facilities in the area.\textsuperscript{142} After the acquisition HCA became owner or manager of five of the eleven hospitals.\textsuperscript{143} Prior to the acquisitions, HCA controlled approximately fourteen percent of the licensed acute care beds\textsuperscript{144} and had approximately fourteen percent of the total inpatient hospital days during the previous year.\textsuperscript{145} After the acquisitions, HCA controlled approximately twenty-seven percent of the licensed beds\textsuperscript{146} and had twenty-six percent of the patient days.\textsuperscript{147}

The FTC argued that the definition of the product market should include only those facilities that provided acute inpatient hospital services and emergency hospital services to the critically ill.\textsuperscript{148} This definition excluded non-hospital outpatient services\textsuperscript{149}

\begin{footnotesize}
\begin{enumerate}
\item \textit{Id.}  \\
\item \textit{Id.}  \\
\item \textit{3 Trade Reg. Rep. (CCH) 122,301.}  \\
\item \textit{Id. at 23,325.}  \\
\item HCA acquired Hospital Affiliates International (HAI) in a stock transaction valued at $650 million in August 1981. HAI owned or leased 57 hospitals and managed 78 hospitals nationwide. Of the 78 management agreements, 5 were in the Chattanooga, Tennessee area. Approximately four months later, HCA acquired another hospital corporation, Health Care Corporation (HCC), in a stock transaction valued at $30 million. At the time of the acquisition HCC owned one hospital in the Chattanooga area. \textit{Id.} at 23,328.  \\
\item \textit{Id.}  \\
\item There are eleven general acute care hospitals in Hamilton County, Tennessee and the Georgia suburbs of Chattanooga. This area is defined as the Chattanooga urban area. \textit{Id.} at 23,331.  \\
\item \textit{Id. at 23,346.}  \\
\item \textit{Id.}  \\
\item \textit{Id.}  \\
\item \textit{Id. at 23,332.}  \\
\item This included free standing emergency centers as well as non-hospital providers of inpatient services such as nursing homes. \textit{Id.} at 23,332-33.
\end{enumerate}
\end{footnotesize}
except for care provided to critically ill patients in the emergency room. HCA argued for the inclusion of outpatient and inpatient care facilities in the relevant product market. HCA's argument was similar to the one expressed by AMI. HCA pointed to the proliferation of numerous outpatient providers competing with hospitals for ambulatory care patients. Ultimately the relevant market included outpatient services that hospitals provide, but excluded outpatient services that non-hospitals provide.

Here, as in AMI, the unique cluster of services that hospitals provide was the basis for excluding non-hospitals. Hospitals were included in the same market because "acute care hospitals compete with each other in offering both kinds of care and . . . outpatient facilities feed patients to the inpatient facilities." Even though neither side appealed the administrative law judge's ruling, the FTC noted that the judge's relevant product market definition did not provide a happy medium between the two competing positions. Instead, the FTC suggested that the competitive realities of the market are accurately reflected by defining the market as inpatient hospital services alone.

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150 Id. at 23,333.
151 Id.
152 3 TRADE REG. REP. (CCH) ¶ 22,170, at 23,039.
HCA's expert witness testified that outpatient care is growing rapidly for hospitals, as well as for free-standing facilities such as emergency care and one-day surgery centers. This is due in part to the changes in medical technology. There are a growing number of procedures that can be done on an outpatient basis. 3 TRADE REG. REP. (CCH) ¶ 22,301 at 23,333.
154 Id. at 23,329. The FTC did not decide the issue in its opinion because neither side appealed the ruling of the administrative law judge concerning the relevant product market. Id.
155 The administrative law judge held that the market should include outpatient services provided by hospitals but excluded outpatient services provided by non-hospitals. The unique combination of services that only hospitals can provide proved to be the controlling factor in this decision. Id. at 23,333.
156 Id.
157 Id.
158 The FTC noted that the evidence tended to show both that free-standing outpatient facilities compete with hospitals for many outpatients and that hospitals offer, and inpatients consume, a cluster of services that bears little relation to outpatient care. Consequently, it was suggested that defining the cluster of hospital inpatient services as a separate market better reflects the competitive realities of this case. Id.
Defining the relevant product market as inpatient hospital services focuses on the basic element of the hospital industry: the acute care bed. This element allows accurate compilation of information regarding hospital revenue, operations, and utilization of service. Therefore, FTC recognition of inpatient hospital services as the relevant product market, and inpatient hospital beds as the major element of inpatient hospital services, is appropriate for the health care industry.

B. The Relevant Geographic Market

Determination of the relevant geographic market—like determination of the relevant product market—is necessary to find a violation of section 7 of the Clayton Act. "The geographic market must both 'correspond to the commercial realities' of the industry and be economically significant." Furthermore, the relevant geographic market or "section of the country" refers to the geographic area where the acquiring and acquired companies effectively compete in the marketing of the relevant product.

Both the product and geographic markets were considered in AMI. The analysis of the geographic market focused in part on the Justice Department Merger Guidelines, which utilize hypothetical price changes within different geographic areas to

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159 Hospital beds are usually defined according to the type of case and client served, which is generally adult acute care licensed beds. See generally Raffel, supra note 1, at 234-37.
160 Revenue is often calculated by hospital service, which is further broken down by designated beds per service. Id.
161 A myriad of operational information is maintained by most hospitals. The focus of much of the information is on the hospital bed. Id.
162 This is generally defined by the particular specialty for which the bed is designated. Id.
164 370 U.S. at 336-37 (quoting American Crystal Co. v. Cuban-American Sugar Co., 152 F. Supp. 387, 398 (S.D.N.Y. 1957), aff'd, 259 F.2d 524 (2d Cir. 1958)).
165 418 U.S. at 620.
166 Id. at 622.
167 3 Trade Reg. Rep. (CCH) ¶ 22,170 at 23,038 (July 2, 1984).
168 Id. at 23,041.
define the relevant geographic market. Consequently, the court defined the relevant geographic market as the city and county of San Luis Obispo. AMI disputed this finding, arguing that the relevant market should have included a broader area. To rebut this assertion the FTC relied on patient flow statistics of hospital service utilization in the city and county. The relevant considerations were where patients actually go for care and where they practically may go for care. The detailed conclusions supporting the city and county market definitions considered geographic barriers and industry recognition, which are commercial realities that affect competition in the hospital services market.

The FTC cited several other factors important to their decision, including the technological disparity between the city and county hospitals. This factor is important because it relates to the ability of one institution to compete effectively with other institutions in a defined geographic area. The FTC determined that the hospitals in the city were more technologically advanced than those in the county and therefore were not competitors. Another factor considered was that most of the physicians in the area had offices located in the city. Because those physicians with offices located in the city tended to admit the majority

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169 Id.
170 For antitrust purposes, the Commission upheld the finding of two relevant geographic markets. Id.
171 AMI argued that many county residents travel outside county boundaries for care and that city hospitals rely on out-of-city residents to occupy their beds. Id.
172 The patient flow statistics demonstrated the patient inflow to county hospitals and the migration of patients to hospitals beyond those in the county. The evidence indicated that 90 percent of the people in the five county hospitals were residents of that county. The statistics further showed that few patients traveled outside the county for care. Id.
173 Id.
174 Id.
175 Id.
176 The technology level is an important element in the health care industry. The city hospitals offered cardiac catheterization and open-heart surgery and also were equipped with advanced diagnostic equipment. The county hospitals could not compete with the city hospitals because of the disparity in sophistication. Id. at 23,042.
177 Id.
178 Id.
179 Many hospitals are building physician offices adjacent to the facility to promote utilization of that hospital. Id.
of their patients to the hospitals in the city, the argument for the existence of two separate geographic markets was strengthened. The final indication of separate geographic markets was the view of local hospital patients that the city and county were distinct geographic markets.

In *HCA* the relevant geographic market was the Chattanooga urban area. The complaint alleged that HCA's acquisition threatened to substantially lessen competition in the inpatient hospital service market. In analyzing the market the FTC Complaint Counsel argued that a static snapshot of the Chattanooga urban area inadequately reflected the likelihood of future anticompetitive behavior. Instead they argued that current market behavior should be viewed in a dynamic framework considering the possible competitive responses of firms outside the current market area to anticompetitive behavior of firms within the market. The Complaint Counsel sought an expanded geographic market including the Chattanooga Metropolitan Statistical Area (MSA). Factors offered in support of this position included the general trade and commuting patterns that reflect potential competition among hospitals located in the MSA, and the federal government's use of the MSA to determine Medicare reimbursement under the new prospective payment system.

179 Id.
180 Id.
181 3 TRADE REG. REP. (CCH) ¶ 22,301.
182 Id.
183 Id. at 23,334.
184 Id.
185 Id. at 23,335. By adopting this definition, three additional hospitals would be included in the relevant market. Two of the three hospitals were acquired by HCA in the acquisition of HAI. Consequently, this would increase HCA's market share and divestiture of these institutions would be sought. Id.
186 Id. at 23,335-36. The Complaint Counsel's argument for this definition took on a different form because of the Medicare prospective payment system. Counsel argued that full implementation of this program would further stimulate integration of the MSA's into distinct hospital markets. Those hospitals outside of the MSA would be disadvantaged in their capacity to compete with nearby MSA hospitals because the reimbursement for those hospitals in the MSA would be significantly higher. Consequently, the "rural" hospitals would be less able to expend funds to improve their services. Moreover, at least with respect to those patients enrolled in the Medicare
HCA countered that the relevant market should be limited to the Chattanooga urban area.\(^{187}\) HCA's argument was primarily based upon physicians' admitting practices and the role that physicians played in determining where a patient received care.\(^{188}\) The FTC found that the weight of the evidence supported HCA's argument and the administrative law judge's findings.\(^{189}\) In particular, it was noted that physicians almost invariably decided where patients were admitted.\(^{190}\) Further, "[w]ith few exceptions, every physician who admitted [patients] to Chattanooga urban area hospitals admitted exclusively to other hospitals in the Chattanooga urban area."\(^{191}\) This point was closely examined by the administrative judge below, who applied the Elzinga-Hogarty test, which measures the amount of commerce that enters and leaves the market in question.\(^{192}\) The FTC agreed that the Chattanooga urban area was the relevant section of the country for this case.\(^{193}\)

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\(^{187}\) Id. at 23,334.
\(^{188}\) The expert witness for HCA testified that the relevant geographic market is determined to a great extent by physician admitting practice. He suggested that physician practice, rather than patient choice, determines to what hospital the patient will be admitted. To further this point, HCA introduced a study that listed, by speciality, for each hospital in the Chattanooga area, the physicians who admitted to each particular hospital. The study showed the number of inpatient days for which each physician was responsible. With few exceptions, every physician who admitted to Chattanooga urban area hospitals admitted to other hospitals exclusively in the Chattanooga urban area. Id.

\(^{189}\) See id. "Complaint Counsel's argument does not convince us that the hospitals to the northeast and southeast of Chattanooga would be less able to exert a restraining influence on urban area hospitals than the hospitals to the west of the city." Id.

\(^{190}\) Id. at 23,334. The FTC found no reason why "doctors would be more willing to obtain admitting privileges at outlying MSA hospitals than at the more modern and better equipped" hospitals in the urban area. Id. at 23,336.

\(^{191}\) Id. at 23,334. See note 188 supra and accompanying text.

\(^{192}\) See id. at 23,334-35 n.7. The "E-H" test is based on LIFO ("little in from outside") and LOFI ("little out from inside") statistics. As applied to hospital geographic markets, the LOFI statistic demonstrates the percentage of patients of an area's hospitals who reside in the area rather than outside the area. The LIFO statistic demonstrates the percentage of hospital patients from a particular area who use hospitals in their area rather than use hospitals in other areas. Id. "Evidence that few patients leave an area (LIFO) and few patients enter an area to obtain hospital services (LOFI), strongly supports the conclusion that the area constitutes a relevant geographic market, according to the analysis." Id.

\(^{193}\) Id. at 23,337.
Both *HCA* and *AMI* demonstrate that it is a difficult task to define the relevant geographic market in health care litigation. Nevertheless, the uniqueness of the industry should not preclude accurate assessment of the market. Patient flow data and other relevant data maintained by local planning agencies and regulatory authorities are invaluable in determining the relevant market. All of these avenues of information should be used, because the relevant geographic market can vary tremendously in size and requires an "all facts and circumstances" test to be properly defined.

**Conclusion**

The decisions in *American Medical International* and *Hospital Corporation of America* were built up on the foundation laid in *Brown Shoe* and *Philadelphia National Bank*. The *Philadelphia National Bank* cluster of service concept provided the basis for distinguishing between inpatient and outpatient hospital services and the submarket concept of *Brown Shoe* allowed even further analysis. For example, the peculiar characteristics of the services, industry and public recognition, sensitivity to changes in price, and uniqueness of facilities were all important factors the courts considered in arriving at their decisions.

*American Medical International* was the first major hospital merger case to come before the full Federal Trade Commission. By applying concepts from the bank industry, which has had antitrust problems similar to the hospital industry, the task of litigating a merger in the complex hospital industry was much easier. In *Hospital Corporation of America*, the second major hospital merger case to come before the full Federal Trade Commission, the FTC used a similar approach.

There were differences, however, in the product market definition in the two cases. In *AMI*, the product market was defined as the cluster of general acute care hospital services. This ex-

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194 The FTC's use of patient flow data has been influential. See note 171 supra.
195 See Merger Guidelines, supra note 88. In this context, patient flow refers to the ingress and egress of patients from one geographic area to another.
196 State health planning agencies and local hospital associations.
197 This includes the state and federal government.
cluded outpatient substitutes, because the benefit that accrues to the patient and physician is derived from the complementarity of those services. In *HCA*, the relevant product market was defined as the cluster of services that acute care hospitals offered, including both outpatient and inpatient care. This did not prove to be outcome determinative in *HCA*, but in other hospital merger cases it could be quite significant. The Commission recognized this point and in future cases probably will seek to have one distinct product market for inpatient services and another for outpatient services, to analyze the anticompetitive effects.

Hospital mergers force the courts to face a problem important to the well-being of every individual receiving medical treatment in the United States. With the rapidly changing health care system, the need to establish clearly defined principles for hospital acquisitions is paramount. The Commission recognized this point and in future cases probably will seek to have one distinct product market for inpatient services and another for outpatient services, to analyze the anticompetitive effects.

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In particular, the cluster of service concept is the most persuasive and important precedent in defining the relevant product market in hospital merger cases. It allows specific services to be categorized in sufficiently competitive markets, thereby demonstrating the effects of competition in that category. The recognition of the health care industry's unique geographic features and entry barriers is also critical to analyze and define accurately the relevant geographic market.

The Justice Department Merger Guidelines appear to be effective in defining the relevant market. The Guidelines rely on economic factors and consequently have had limited use in the hospital merger context because of the industry's unique "non-economic" history. With increased litigation in the health care industry it is probable that the Merger Guidelines will be applied more frequently. The 1984 revision of the Guidelines reflect a move toward their expanded application in health care mergers.

The choice between the case law principles and the Merger Guidelines will vary according to the type of case presented. If the case is litigated there will likely be a reliance on case law principles when defining the relevant market rather than the untested principles of the Merger Guidelines. Although the use of both theories is appropriate at the present, the variety and
complexity of future mergers will certainly require revisions and alterations in the theories until a truly satisfactory standard that offers uniformity and equity is produced.

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