NON-COMPETE AGREEMENTS: MIGHT THEY BE PROCOMPETITIVE IN HEALTHCARE?

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I. INTRODUCTION

Non-compete agreements and restrictive covenants in employment contracts have received renewed attention from policy makers and antitrust practitioners, with many raising concerns that these agreements may restrict competition and labor-force mobility.[2] For example, federal antitrust agencies have sought comments on the topic,[3] state attorneys general have voiced concern over the use of these agreements,[4] and federal and state legislatures have contemplated or enacted new laws restricting the use of these agreements.[5] Healthcare is no exception in this trend, and there has been both ongoing and renewed attention and policy concerning non-compete agreements in healthcare settings.[6]

On their face, non-compete agreements appear to be plainly anticompetitive – the very name states "an agreement to *not* compete." And yet there is a long history of recognized *procompetitive* justifications for the use of non-compete agreements where these agreements are used to facilitate another legitimate purpose (i.e. the agreement is ancillary to another goal). The economic literature outlines the benefits of non-compete agreements, and contractual restraints generally, as a means of addressing the investment hold-up problem, which arises when an

2 We will focus this article on non-compete agreements but acknowledge that other policy literature often moves fluidly between non-compete agreements and other restrictive covenants (e.g. no-poach agreements) that also potentially restrict worker mobility. Moreover, we use the term "agreement" to refer to uses of non-compete covenants in contracts generally, whether as standalone agreements or as clauses within broader agreements.

3 U.S. Department of Justice, Antitrust Division, Public Workshop On Competition In Labor Markets (September 23, 2019) ("DOJ Workshop"), available at https://www.justice.gov/atr/public-workshop-competition-labor-markets; Federal Trade Commission, Non-Competes in the Workplace: Examining Antitrust and Consumer Protection Issues (Jan 9, 2020) ("FTC Workshop"), available at https://www.ftc.gov/news-events/events-calendar/non-competes-workplace-examining-antitrust-consumer-protection-issues.

4 Karl A. Racine, Attorney General for the District of Columbia, et al., Public Comments of 20 State Attorneys General in Response to the Federal Trade Commission's January 9, 2020 Workshop on Non-Compete Clauses in the Workplace (March 12, 2020), available at https://www.regulations.gov/contentStreamer?documentId=FTC-2019-0093-0322&attachmentNumber=2&contentType=pdf; Press Release, Washington State Office of the Attorney General, Attorney General Bob Ferguson Stops King County Coffee Shop's Practice Requiring Baristas To Sign Unfair Non-Compete Agreements (October 29, 2019), available at https://www.atg.wa.gov/news/news-releases/attorney-general-bob-ferguson-stops-king-county-coffee-shop-s-practice-requiring.

5 Noncompete Agreements and American Workers: Hearing Before the U.S. Senate Committee on Small Business and Entrepreneurship, 116 Cong. (November 14, 2019), available at https://www.sbc.senate.gov/public/index.cfm/2019/11/noncompete-agreements-and-american-workers; Wash. H.B. 1450 (2019), available at http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/1450-S.SL.pdf.

6 Transcript from the FTC Workshop, *supra*, n. 3 ("FTC Transcript"), Starr, 163:8-13 (There are "several bans that occurred in the late seventies and eighties of non-competes for physicians. And so there's been a recent move by several states to ban non-competes for physicians, but it's actually an old policy that was adopted in the late seventies and eighties.");.Fla. Stat. tit. XXXIII, § 542.336 (2019), available at http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0500-0599/0542/Sections/0542.336.html; Mass. Gen Laws ch. 112, § 12X (2018), available at https://www.mass.gov/info-details/massachusetts-law-about-noncompetition-agreements.

investment by one party is dependent on the cooperation of another party.[7] Non-compete agreements can thereby promote greater investment and output than would otherwise exist if such agreements were prohibited. Case law tracing back centuries to English common law also recognizes the benefits of non-compete agreements along the same lines.[8] At present, most U.S. courts have recognized numerous justifications for non-compete agreements, such as protection of trade secrets, protection of customer relationships, retention of unique employees, protection of firm-sponsored training, and protection of specialized capital investment by firms.[9]

In healthcare, policy and research criticizing non-compete agreements has mostly focused on (a) potential reductions in worker mobility[10] and (b) potential reductions in access to healthcare due to reduced entrepreneurship.[11] Many states have bans on the use of non-compete agreements specific to healthcare, particularly as it concerns physicians.[12] These views and policies, however, focus mainly on worker wages or frequency of employment changes and on incomplete measures of healthcare access (e.g. counts of establishments). They generally overlook the procompetitive justifications for non-compete agreements, thereby missing many of the *investments* made by firms as a result of these agreements that may actually increase access and improve quality in healthcare.[13] To this end, more recent empirical economic research on non-compete agreements – specifically in healthcare settings – has focused on quantifying the procompetitive investments facilitated by these agreements. This literature, although still fairly nascent, has found some evidence suggesting non-compete agreements facilitate greater investment by healthcare firms.[14]

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7 See generally, books by Nobel laureates Oliver Williamson and Oliver Hart, both of whom earned recognition in a large part for their work concerning restraints and investment. Oliver Williamson, Markets and Hierarchies: Analysis and Antitrust Implications (1975); Oliver Hart, Firms Contracts and Financial Structure (1995). See also, e.g. Jean Tirole, The Theory of Industrial Organization (1989), 16 ("the possibility of 'hold-up' or 'opportunism' (the confiscation of the gains associated with one party's investment by the other party) … A long-term contract must *ex post* guarantee the parties a fair return in order to *ex ante* encourage specific investment."), 23-24 ("*Ex post* trade inefficiency gives the parties incentives to contract *ex ante* to avoid or limit this inefficiency. … Some constraints (if possible, simple ones) on the second-period decision process must be contracted for."), and 29 ("This *ex ante* specification of the terms of the contract may well prevent specific investments from being expropriated."); Jean Tirole, Incomplete Contracts: Where Do We Stand?, 67 Econometrica 741 (1999), 749 ("[T]he allocation of property rights determines the bargaining powers in the ex post determination of the terms of trade and that the holders of property rights are somewhat protected against the expropriation of their specific investment. Property rights thereby boost the holders' incentives to invest.").

8 *Mitchel v. Reynolds*, 24 E.R. 347 (1711); Mallan v. May, 11 M. & W. 652 (1843); *Nat'l Soc'y of Prof'l Engrs. v. United States*, 435 U.S. 679, 688-689 (1978) ("This principle is apparent in even the earliest of cases applying the Rule of Reason, *Mitchel v. Reynolds*, supra. *Mitchel* involved the enforceability of a promise by the seller of a bakery that he would not compete with the purchaser of his business. The covenant was for a limited time, and applied only to the area in which the bakery had operated. It was therefore upheld as reasonable, even though it deprived the public of the benefit of potential competition. The long-run benefit of enhancing the marketability of the business itself -- and thereby providing incentives to develop such an enterprise -- outweighed the temporary and limited loss of competition. The Rule of Reason suggested by *Mitchel v. Reynolds* has been regarded as a standard for testing the enforceability of covenants in restraint of trade which are ancillary to a legitimate transaction, such as an employment contract or the sale of a going business.").

9 Employee Non-competes: A State- by-State Survey, Beck Reed Riden LLP (January 13, 2019), available at https://www.faircompetitionlaw.com/wp-content/uploads/2019/10/Noncompetes-BRR-50-State-Survey-Chart-20191019.pdf.

10 FTC Transcript, Lavetti, 138:18-139:3.

11 FTC Transcript, Starr, 163:25-164:3 (Empirical results "suggesting that the non-competes were, in fact, holding down medical – the number of medical establishments in the area, that banning them would increase access to care.").

12 *Supra*, n. 9 (17 states have some form of healthcare-specific restrictions on the use of non-compete agreements); *supra*, n. 6.

13 FTC Transcript, Lavetti, 139:8-19 ("I also want to think about -- talk a little bit about the context-specific welfare tradeoffs and the extent to which the welfare effects might be heterogenous across contexts. … we might want to distinguish between research-intensive firms, manufacturing firms, and service firms, and thinking about the reasons why firms might benefit from non-compete agreements and the justification for using them in different contexts."), 147:3-6 ("There's much more fluid referral of patients across doctors within groups that use [non-compete agreements]. And these gains don't seem to occur in states that have nonenforceable [non-compete agreements] laws."), 151:2-13 ("If you were to extrapolate that to estimate what the impact would be of a national ban on the enforceability of non-competes on just physician spending alone, it would be $25 billion per year. So potentially very large consequences for consumers in terms of prices. Now, a lot of this, I want to caution, comes from the fact that we see smaller establishments. Because establishment size is shrinking, small establishments tend to have higher overhead and, therefore, higher prices, and so this is really operating through an organizational channel.").

14 Kurt Lavetti, Carol Simon, and William D. White, The Impacts of Restricting Mobility of Skilled Service Workers: Evidence from Physicians, J. Human Res. (February 7, 2019), pre-print available at http://kurtlavetti.com/UlPNC_vf.pdf, p. 1 ("These effects are consistent with [non-compete agreements] enabling practices to allocate clients to new physicians through intra-firm patient referrals, reducing a form of investment holdup."); Jessica Jeffers, The Impact of Restricting Labor Mobility on Corporate Investment and Entrepreneurship (December 24, 2019), available at https://ssrn.com/abstract=3040393, p. 3 ("I then show that investment rates increase following more enforceable [non-compete agreements]. … I find that knowledge-intensive firms drive the increase in investment rate when [non-compete agreements] become more enforceable.");Naomi Hausman and Kurt Lavetti, Physician Practice Organization and Negotiated Prices: Evidence from State Law Changes (2018), available at http://kurtlavetti.com/NCA_price_vc.pdf, pp. 2-3 ("We provide a variety of evidence on the effects of NCA law changes on physician practice organization. Changes in NCA enforceability significantly affect the rate of physician establishment job separations and the creation of new establishments, which in turn affects the distribution of establishment sizes. … The negative net relationship between concentration and prices suggests there may be important efficiency gains from physical consolidation of practices.").

In what follows, we discuss the possible investments encouraged by non-compete agreements in healthcare. First, we observe that healthcare settings are likely to exhibit large and frequent hold-up problems. Non-compete agreements are a tool to help alleviate these problems, encouraging investment by firms that would otherwise not occur. Thus, economic theory adapted to the idiosyncrasies of healthcare suggests that (a) non-compete agreements in healthcare can often be supported by positive investment-enhancing justifications and (b) we should continue to see growth in the empirical literature demonstrating this result. Second, we should be mindful of the effects on investment caused by policies to ban non-compete agreements. In particular, there are many settings in healthcare where there are severely underserved or completely unserved markets – policies that discourage investment may further exacerbate shortages in these areas. Thus, we caution against additional policies promoting restrictions on the use of non-compete agreements in healthcare without carefully weighing the potential procompetitive benefits, like investment, against any theoretical harm.

II. POSITIVE JUSTIFICATIONS FOR NON-COMPETE AGREEMENTS

A. Economic Theory and Case Law

Economists have long recognized the investment hold-up problem. This problem generally describes a situation in which a party to a future transaction must make a relationship-specific investment prior to the transaction. Absent an agreement to protect this investment, the party may refrain from making the investment out of fear that the counterparty will expropriate the value of the investment. If left unresolved, the hold-up problem can lead to lower-than-optimal investment and, therefore, generate welfare (and competition) inefficiencies.

In the context of labor markets, non-compete agreements are a common way to help facilitate and protect investments subject to the hold-up problem, and they can promote benefits like information sharing, on-the-job training, transfer of client relationships, and costly but complementary capital investment. For example, consider a well-reputed healthcare system that is contemplating investment in a new, expensive piece of medical equipment (e.g. an MRI machine, linear accelerator, or surgical robot). Due to the complexity of the equipment, a specialized team (i.e. a physician of a specific specialty and supporting technicians) is needed to operate the equipment. Moreover, significant recruiting and training costs are also associated with matching this specialized physician and team to the specialized equipment (e.g. identifying the proper candidates, training to meet the firm's standards, etc.). These many investments are financed by the firm and are highly relationship-specific, and they hold little to no value absent continued tenure by the carefully matched team of specialists. Further, once the combined investment is made (i.e. "sunk"), the physician and staff can depart with much of the value, and the firm has little or no practical means of recoupment (e.g. the firm cannot reclaim the workers' post-tenure reputation or knowledge).

Unaddressed, this situation is a classic example of the hold-up problem, since the firm faces potentially significant losses if a specialist's tenure is cut short, and the whole team is virtually always able to leave at a moment's notice due to at-will employment. Non-compete agreements mitigate this hold-up problem by preventing the team from expropriating the value of firm's investments and using the investments to directly compete against their former firm. This, in turn, better ensures the investment remains solvent, and the firm might refuse to make the investment recognizing the likelihood of the hold-up equilibrium absent the non-compete agreement. Overall, relative to the world without the non-compete agreement, consumers have access to both more medical equipment and more healthcare services.

Case law recognizes many possible forms of relationship-specific investments that firms may make and that risk being undercut by hold-up without protection from non-compete agreements. These benefits include protection of trade secrets, customer relationships, unique employees, employee training, and capital investments.[15]

Protection of trade-secrets is often cited as a justification for enforcing non-compete agreements. *Gallagher Healthcare Ins. Serv. v. Vogelsang* is one such example of a court recognizing this justification.[16] Gallagher Healthcare Insurance Services ("GHIS") acquired a firm and the services of its employee, Vogelsang, whose responsibilities included building strong personal relationships with clients. Due to his job function, Vogelsang had access to confidential information, including client lists, business practices, and product pricing, all of which GHIS incurred substantial costs to gather and develop. A Texas appeals court found that the confidential information shared with Vogelsang was worthy

15 *Supra*, n. 9.

16 *Gallagher Healthcare Ins. Serv. v. Vogelsang*, 312 S.W.3d 640 (Tex. App. 2009), available at http://www.search.txcourts.gov/SearchMedia.aspx?MediaVersionID=df-52cf11-5140-4af0-a7b8-adacc8f7bddc&coa=coa01&DT=Other&MediaID=42751d45-db7c-4486-9b16-7d71d431b9da.

of protection and that his non-compete agreement was enforceable.[17]

Customer relationships are another common justification for non-compete agreements. In *Healthcare Servs. of the Ozarks, Inc. v. Copeland*, non-compete agreements were enforced to protect a healthcare firm's customer relationships.[18] Two employees resigned their employment with a home health service firm in order to work for a direct competitor. The Supreme Court of Missouri found that the non-compete agreements the two signed were enforceable because the firm's patient base was a protectable interest "just as customers are protectable in a business context."[19]

"Unique" employees are yet another recognized justification for non-compete agreements in industries with highly specialized workers, such as healthcare, technology and entertainment industries.[20] In *Karpinski v. Ingrasci*, an oral surgeon, Karpinski, successfully grew his referral networks through legitimate efforts and decided to open a second office.[21] He hired the a second surgeon, Ingrasci, as an employee, who at the time just finished his oral surgery training. Karpinski paid for office rent and equipment and supported Ingrasci as the practice grew. After a few years, Ingrasci left to open his own practice, taking patients from Karpinski's practice with him, and forcing the eventual closure of Karpinski's practice. A New York appeals court concluded that the employer, Karpinski, had a "rightful interest" in the practice that he built over many years, and the court enforced the non-compete agreement to protect against the loss of the practice.[22]

Employee on-the-job training is another justification frequently upheld by courts. In *Community Hosp. Group v. More*, the Supreme Court of New Jersey enforced a non-compete agreement to protect investment in costly training that an employee received on the job. The court found that the firm made a substantial investment in training its employee, Dr. More, and that training, generally, is a legitimate protectable business interest that justifies a non-compete agreement.[23]

Lastly, employers may make costly and specialized capital investments that are complementary to specific employees. In *Reddy v. Community Health Foundation of Man*, the Supreme Court of West Virginia found that a clinic's investment to provide equipment and supporting staff to its physicians – so that the physicians could engage in medical practice without undertaking a substantial financial risk from owning a practice – was a legitimate business interest to be protected by a non-compete agreement.[24]

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17 *Id.*, 20-21 ("According to its summary judgment evidence, GHIS's confidential information (1) took years to acquire; (2) is only shared with employees and agents of GHIS on a 'need to know basis'; (3) is not 'readily ascertainable by its competitors'; and (4) gives GHIS 'a valuable competitive advantage in the insurance brokerage industry.'… We conclude that GHIS presented summary judgment evidence to show that its confidential information was an interest worthy of protection.") (Internal citations omitted).

18 *Healthcare Services v. Copeland*, 198 S.W.3d 604 (Mo. 2006), available at https://scholar.google.com/scholar_case?case=9744857035705482206&hl=en&as_sdt=2006.

19 *Id.*, 613. See also, Lavetti, Simon, and White, *supra*, n. 14 ("Firms that provide skilled services face unusual difficulty controlling their assets, the most valuable of which are often the relationships that exist between their workers and clients. … [I] n many cases such as medicine there may be legal restrictions to writing a contract that even implicitly assigns a price to patient referrals.").

20 *Reed, Roberts v. Strauman*, 40 N.Y.2d 303, 308 (1976) ("[I]njunctive relief may be available where an employee's services are unique or extraordinary and the covenant is reasonable. … This latter principle has been interpreted to reach agreements between members of the learned professions (e.g. Karpinski v Ingrasci, 28 N.Y.2d 45)."), available at https://scholar.google.com/scholar_case?case=6906663183339910981&q=Reed,+Roberts+v.+Strauman&hl=en&as_sdt=2006.

21 *Karpinski v. Ingrasci*, 28 N.Y.2d 45 (1971), available at https://scholar.google.com/scholar_case?case=7561492754060308676&q=Karpinski+v.+Ingrasci&hl=en&as_sdt=2006.

22 *Id.*, 53 ("The hardship necessarily imposed on the defendant must be borne by him in view of the plaintiff's rightful interest in protecting the valuable practice of oral surgery which he built up over the course of many years… In sum, then, the plaintiff is entitled to an injunction barring the defendant from practicing oral surgery in the five specified counties and to damages actually suffered by him in the period during which the defendant conducted such a practice in Ithaca after leaving the plaintiff's employ.").

23 *Community Hosp. Group v. More*, 869 A.2d 884, 887 (2005) ("In this case, the evidence established that JFK made a substantial investment in Dr. More by giving him the opportunity to accumulate knowledge and hone his skills as a neurosurgeon. Indeed, Dr. More acknowledges that it 'takes years of education, practical experience and accumulated skills and knowledge, as well as an innate talent, for a doctor to reach [his] level of practice.' ") (Internal citations omitted), available at https://scholar.google.com/scholar_case?case=8303630126937898778&q=Community+Hospital.+Group+v.+More&hl=en&as_sdt=2006.

24 *Reddy v. Community Health Foundation of Man*, 298 S.E.2d 906, 919 (W. Va. 1982) ("In the case before us the employer urges that its provision of equipment and supporting staff to Dr. Reddy made it possible for the doctor to engage in a medical practice in Man and gain the good will of sufficient patients to allow him to undertake his own practice without substantial financial risk…[Physicians] enjoyed the benefits of building a practice in a risk-free environment where all costs of their acquiring patient good will are borne by others. The covenant is thus a response to the unjust enrichment of doctors that would be the result of the Foundation's labors if the clinic were left unprotected."), available at https://scholar.google.com/scholar_case?case=2321770070398239230&q=Reddy+v.+Community+Health+Foundation+of+Man&hl=en&as_sdt=2006.

As these examples illustrate, there are many settings and many courts in which the relationship-specific investment facilitated by non-compete agreements might outweigh the restrictions imposed by the same agreement.

B. Applied to Healthcare

As any experienced antitrust practitioner will readily admit, whether the benefits to investment from a non-compete agreement outweigh the costs rests on the facts of each individual case. And yet some generalization is nonetheless possible: many healthcare settings suffer from significant investment hold-up. In healthcare, we are likely to see investments that depend on *two or more* of the above justifications *at once*. As the following examples illustrate, healthcare is an industry characterized by its highly specialized and hard-to-replace workforce, frequent dependency on client relationships, and costly, upfront, specialized capital investments and training.

Consider the decision to open a new dialysis clinic and hire specialist physicians to oversee and work within the clinic. Opening a dialysis clinic requires enormous relationship-specific investment that is made up-front and is dependent on the ongoing tenure by the physicians hired to work within the clinic. To start, a new clinic requires specialized *capital investment*, such as hemodialysis machines, that have little use outside of their intended purpose. Then, specialized "*unique*" staff must be recruited, notably, at least one specialized physician to oversee the clinic. On top of that up-front investment, the clinic's success is dependent on the firm's investment in its reputation and operations (i.e. *trade secrets* that are responsible for the brand's recognized success), building provider-patient trust (i.e. *customer relationships* that the firm helps to grow but cannot "own" due to regulatory and moral constraints in healthcare), and extensive ongoing *training* of its physicians and other staff.

Not only does this example demonstrate *all* the above, recognized, legitimate justifications for the use of a non-compete agreement, but also the confluence of *all* those justifications at once demonstrates the significance of the hold-up problem. The firm stands to lose not one but a plethora of investments simply by the departure of one of its complementary inputs – its carefully recruited, matched, hard-to-find workers. Non-compete agreements are a means to protect against that possibility, incentivizing firms like these to further make investments.

Many other settings may not necessarily exhibit as many justifications for non-compete agreements at once. For example, manufacturing cars generally requires significant specialized capital investment and trade secrets in developing and streamlining the assembly line and operations, but it is not also simultaneously dependent on personalized customer relationships nor does it involve unique employees so intimately in its production process. As another example, car repair is dependent on reputation, customer relationships, and specialized know-how, but despite this, its workforce is not as unique nor does it require the same level of specialized capital investment. And the same can be said in other instances: e.g. retail services, such as restaurants and plumbers, are dependent on customer relationships and reputation but lack capital intensity; or the telecom industry is capital intensive and specialized but is not dependent on personalized customer relationships. Most healthcare settings, particularly healthcare provider settings, are like the dialysis example above and exhibit a vast array of investments that each might justify a non-compete agreement.

Research undertaken by pharmaceutical and medical device firms, as another example in healthcare, also requires many simultaneous and large investments that can create a hold-up problem. For instance, developing a novel drug takes significant investment up-front, with the likely time to see pay off measured in years or decades. Like all research-driven industries, pharmaceutical firms face a hold-up problem concerning their intellectual property (i.e. *trade secrets*). In addition, highly specialized clinicians and a large amount of situation-specific capital investment – both products of the complex discipline and extensive regulatory hurdles – are needed to bring a product to market. Thus, pharmaceutical and other healthcare research firms face a significant hold-up problem, a general result of the winner-take-all nature of research, but also a result that is compounded by the specialization and regulatory burden that is particular to healthcare.

The above are but two examples of the holdup problem healthcare. Due to the specialized, capital-intensive nature of healthcare and the complementarity of healthcare capital and labor, hold-up is a significant problem in many healthcare settings. As a result, non-compete agreements are an important and commonly used tool to incentivize investment in healthcare.

III. SETTINGS WHERE GREATER INVESTMENT CAN PROMOTE WELFARE

To be clear, non-compete agreements present a trade-off, both in terms of competition over time, and ultimately, in terms of welfare. On the one hand, non-compete agreements incentivize and make possible up-front investments that would otherwise not occur. And yet, on the other hand, non-compete agreements do indeed have potential to restrict future competition by preventing workers from becoming future competitors to their former firm. In any specific case, key facts can be vetted and a rule of reason analysis can be used to determine, in the context of a particular non-compete agreement, whether the benefit of investment is greater than the cost of future restrictions on workers.

The above discussion of investment-promoting effects of non-compete agreements in healthcare is not a total welfare analysis. But the analysis need not be "total" in order to nonetheless present some important and tangible settings where non-compete agreements are likely to provide an overall positive effect. In healthcare, it seems there are enough settings with potential investment hold-up that policy makers and regulators might reconsider views that condemn all non-compete agreements without more closely looking at the effects to investment from such bans.

In particular, there is extensive literature highlighting underinvestment and shortages in healthcare in many areas, especially in rural communities and vulnerable populations. Bans to non-compete agreements risk discouraging investment and, therefore, risk further exacerbating supply shortages in these settings. Consider these examples to illustrate some settings with potentially significant underinvestment in healthcare:

- There are currently 1,388 geographic areas that face a shortage of primary care. Those areas account for roughly 80 million people in the United States.[25]

- A large number of rural communities do not have a local hospital and face significant travel distances to obtain hospital care.[26] This is an increasing problem as the United States has seen a wave of recent hospital closures.[27]

- There continue to be thousands of rare but untreated diseases, despite the success of pharmaceutical programs like the U.S. Orphan Drug Act.[28]

In these instances, competitive forces are struggling to supply even the requisite output to the market. There are, of course, many factors contributing to shortages in these settings, so it is not to say that promoting the use of non-compete agreements is the cure-all. But that does not diminish the corollary observation – more comprehensive bans to non-compete agreements may further reduce already low investment in these settings.

IV. CONCLUSION

The ability of non-compete agreements to incentivize investment suggests that we need a balanced approach that assesses the welfare implications to both workers and firms. Proponents of restrictions on non-compete agreements generally focus only on the potential limitation of worker mobility, and they typically fail to consider the beneficial effects to investment from these same agreements. This is especially true in healthcare, where labor specialization and specific, upfront, complementary capital investment are inherent. Furthermore, there are potentially many settings in healthcare in which underinvestment is an acute problem. Policy seeking to ban non-compete agreements should be mindful of exacerbating shortages in these settings. Developing empirical research appears consistent with these views that, in healthcare, there are net potential benefits from non-compete agreements through their ability to promote investment. Even without more research, however, there is a clear basis in healthcare to look at overall effects of non-compete agreements.

25 As of March 31, 2020, 1,388 counties or parts of counties were designated as a Primary Medical Health Professional Shortage Area. Bureau of Health Workforce, Health Resources and Services Administration, U.S. Department of Health & Human Services, Designated Health Professional Shortage Areas Statistics: Designated HPSA Quarterly Summary, as of September 30, 2019, available at https://data.hrsa.gov/topics/health-workforce/shortage-areas (accessed April 6, 2020).

26 Pew Research Center, How Far Americans Live From The Closest Hospital Differs By Community Type (December 12, 2018), available at https://www.pewresearch.org/fact-tank/2018/12/12/how-far-americans-live-from-the-closest-hospital-differs-by-community-type/.

27 United States Government Accountability Office, Rural Hospital Closures: Number and Characteristics of Affected Hospitals and Contributing Factors (August 2018), available at https://www.gao.gov/assets/700/694125.pdf.

28 Aarti Sharma, et al., Orphan Drug: Development Trends and sSrategies, 2 Journal of Pharmacy and Bioallied Sciences 290 (2010).

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