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THE DYNAMICS AND LIMITS OF CORPORATE GROWTH IN HEALTH CARE

by James C. Robinson

Prologue: In 1996 major players in the health care industry are scrambling to find the right combination of size and services to compete in the high-stakes market of managed care. Analysts predict more consolidations, which will leave the industry dominated by fewer large corporations. Policymakers and consumers are watching these developments with concern, and purchasers are wondering whether they will be the losers in this merger contest. Jamie Robinson identifies the major forms of organizational growth and integration in health care, predicts which ones will prove most important, and explains their implications. He draws on the experiences of a health plan (WellPoint Health Networks), an integrated delivery system (UniHealth America), and a diversified physician organization (Mullikin Medical Enterprises), each of which is expanding rapidly into new products and markets. Robinson emphasizes questions relevant to recent mergers: Is bigger better? When does size become a hindrance to efficiency? Should antitrust lawyers be storming the gates of these empires? He has reassurance for consumer advocates and industry analysts who fear that consolidation will stifle competition and discourage innovation, and counsels against overreacting to these new forms of organizations. He concludes that “Researchers, regulators, and antitrust enforcers must acknowledge the often disastrous effects of well-intentioned but poorly directed meddling in health care organization and observe a new Hippocratic oath for health care policy: Above all else, do no direct harm.” Robinson is an associate professor of health economics at the University of California, Berkeley, where he obtained a doctorate in economics. A version of this paper was presented at the conference, “The New Competition: Dynamics Shaping the Health care Market,” sponsored by The Robert Wood Johnson Foundation and conducted by the Alpha Center, in Washington, D.C., 9 November 1995.
Abstract: This paper analyzes the economic dynamics of five forms of organizational growth in health care: horizontal integration within a single geographic market; horizontal integration across different geographic markets; diversification among multiple products and types of service; diversification among multiple distribution channels; and vertical integration with suppliers. These principles are illustrated through brief case studies of three firms that have grown by way of internal expansion, mergers, acquisitions, and diversification: WellPoint Health Networks, UniHealth America, and Mullikin Medical Enterprises. The paper analyzes the potential limits of organizational growth in health care and explores the implications of integration and diversification for antitrust policy.

The transformation of the health care system offers both remarkable opportunities and redoubtable risks. The increasingly integrated and diversified organizations promise enhanced coordination of clinical services, reductions in excess capacity, and continuous improvement in quality and cost-effectiveness. They also evoke fears of monopoly power, bureaucratic inertia, and the depersonalization of relations between physicians and patients. On a deeper, more symbolic level, the managed care revolution reawakens the American ambivalence toward large and complex organizations. Americans admire entrepreneurs who break away from the pack, develop innovative products, and shatter the status quo in a gale of creative destruction. Yet they fear the horizontally and vertically integrated corporations that have grown by precisely those means. As the twentieth century draws to a close, we continue to embed a Schumpetrian health economy within a populist political culture. Is the integrated health care organization a natural monopoly that should be regulated as a public utility, or an unnatural monopoly that should be broken up by the antitrust agencies? Or is it no monopoly at all?

Scholarly treatises and policy debates almost invariably confound quite different forms of organizational growth in health care. These include mergers of similar firms within one local market, expansion of one firm across different geographical markets, a firm’s addition of new offerings to its product line, development by a firm of new distribution channels, and the linkage between a firm and its suppliers along the chain of production. It is important to distinguish these forms of organizational growth, however, since they have different causes and are likely to have different consequences. Some can proceed through contractual means and through joint ventures among separate firms, while others will occur through internal expansion or through mergers and acquisitions. Most are likely to be pro-competitive and enhance efficiency, but some may be anticompetitive and concentrate market power.

This paper distinguishes five forms of organizational growth and integration in health care: increased share of a particular market for a particular product (within-market horizontal integration); expansion into new geographic regions (across-market horizontal integration); development of
new services (product diversification); entry into new marketing and distribution niches (channel diversification); and linkages to suppliers (vertical integration). I illustrate these forms of expansion using case studies of a large managed care firm (WellPoint Health Networks, including its relations with Health Systems International [HSI] and Massachusetts Mutual), a large health care delivery system (UniHealth America, including its relations with PacifiCare Health Systems), and a large physician practice management firm (Mullikin Medical Enterprises, including its relations with MedPartners and Pacific Physicians Services). I then highlight the limits to horizontal integration and organizational diversification, based on the economic literature on transaction costs and agency relationships. I conclude with a brief consideration of the implications of alternative forms of organizational growth for public policy and, in particular, for enforcement of antitrust statutes.

The Dynamics Of Organizational Growth

Horizontal integration within one market. Analytically the most convenient, politically the most debated, and economically the least important form of organizational expansion is the merger of two firms producing the same service in the same market. This same-product, same-market growth, which also can be achieved through internal expansion by one firm or through contracts and joint ventures, potentially can improve efficiency by achieving economies of scale, eliminating duplicative facilities, and improving the use of capacity. Increased market penetration by one firm raises concerns about market power and, at the extreme, about monopoly. The trade-off between efficiency and market power is the bread and butter of antitrust law and economics. Debate often focuses on technical details related to product characteristics and breadth of the geographic market, but not on the basic principle that monopoly is undesirable.

In health care, the most familiar example of same-product, same-market integration has been mergers among hospitals in small and medium-size cities. Much heat has been generated debating whether the “hospital” product includes ambulatory surgery and other nontraditional services and whether facilities in nearby cities or distant referral centers should be included in the concentration index. Hospitals predict that mergers will cause significant increases in scale economies and use of capacity, while purchasers and insurers raise questions over postmerger pricing policies. This form of horizontal integration is analytically the most convenient because it ignores the complexities introduced by performance competition from firms with substitute products, from different regional markets, using different distribution channels, and with different linkages to suppliers. It is
politically the most debated form of integration since it is the most visible and often involves major local institutions. Economically, however, same-product, same-market horizontal integration is the least important because health care is inherently a geographically localized complex of services marketed through many different channels to many different purchasers. Nevertheless, the temptation to increase market share, raise prices, and earn monopoly profits is ever present and explains at least some of the merger mania that is under way in health care markets.

**Horizontal integration across geographic markets.** Health care markets are inherently local, yet they often are dominated by subsidiaries of regional or national companies. The classic examples of geographic expansion in past decades were chains of hospitals and nursing homes. More recently, however, we observe geographic expansion by health maintenance organizations (HMOs) and, increasingly, by medical groups and integrated delivery systems. Horizontal expansions or mergers across different local markets can achieve efficiencies through spreading administrative overhead expenses and by volume purchasing of supplies. The more important dynamic today, however, is the drive to apply organizational competencies acquired in one set of markets to other contexts in which managed care principles have yet to be fully accepted.

Populist sentiments often resent the acquisition of a local organization by a large outside firm, especially when local nonprofit organizations are consumed by national for-profit firms. Mainstream antitrust policy, however, usually is unconcerned with cross-market expansion so long as the firm’s penetration of each local market remains modest. Economic theory views across-market expansion as conducive to competition and efficiency. The greatest pressures for efficiency and low prices in local markets often come not from rivalry among incumbent firms but from fear of the entry of new firms from other regions. Local markets with low barriers to entry are “contestable,” manifesting quite competitive patterns of behavior even if the share distribution among incumbent firms is quite concentrated.

**Diversification: multiple products.** The single-product firm is an analytic convenience for economists and antitrust attorneys that bears little correspondence to the real world. All firms produce more than one product, and many firms produce thousands of distinct goods and services. Multiproduct diversification is a hallmark of the modern corporation and the single most important form of organizational expansion in health care. Diversification among related products typically occurs in the context of a jointly used input or core competency that gives the firm a competitive advantage in broadening its product line. Diversification among unrelated products is more difficult to explain and may be due to the comparative advantage of the conglomerate organization in allocating investment re-
sources among projects and divisions, compared with the external capital market. Unrelated diversification frequently ends in failure and the refocusing of the firm onto a narrower product line, however; this exemplifies the difficulties in transferring competitive advantage and in outperforming external capital markets at what they do best.\footnote{7}

Diversification among related products is sweeping the health insurance and health care delivery systems. Indemnity insurers are developing or acquiring HMOs and other managed care “products,” while HMOs are acquiring indemnity carriers. Many major plans offer a full spectrum of HMO, preferred provider organization (PPO), point-of-service, and managed indemnity products. Health plans are buying or building capabilities in dental, life, pharmacy, mental health, and other “specialty” products. Hospital systems are diversifying into subacute units, home health agencies, and ambulatory diagnostic and surgical facilities. Multispecialty medical groups are linking with more loosely structured individual practice association (IPA) networks and with management services organizations that offer a variety of practice options to physicians.

The presence of joint assets or core competencies need not push a firm to produce new goods or services itself if the contractual alternative is available. The value inherent in some core technologies can be gained by licensing to other firms, thereby saving the costs and risks of in-house production.\footnote{8} Joint ventures, strategic alliances, and partial ownership stakes are possibilities in other contexts. Antitrust policy can exert a perverse encouragement for multiproduct diversification at the expense of contractual networks if it invariably interprets information sharing among competing firms as a collusive means toward price fixing rather than as a pro-competitive alliance for product and process innovation.\footnote{9}

**Diversification: distribution channels.** Many firms begin by selling their services through one particular distribution channel or market “niche” but then discover that they can obtain much larger revenues if they promote the service in different ways to different populations. HMOs often began in the large-group commercial market but now find the best growth opportunities among small firms, individuals, and Medicare and Medicaid beneficiaries. Integrated delivery systems typically rely on insurers or managed care plans to access their patients but often would like to contract directly with employers or with public sponsors such as the Health Care Financing Administration (HCFA).

Public policy in health care has encouraged channel diversification in managed care, often as a means of reducing the demographic segmentation of insurance pools. For example, HCFA has required HMOs to enroll at least one commercial patient for every Medicare beneficiary they enroll. Some state programs limit Medicaid risk contracting to HMOs that have
substantial non-Medicaid enrollment. Publicly sponsored purchasing alliances provide an institutional mechanism by which small firms can pool their resources and purchase managed care from the same HMOs that traditionally have targeted the actuarially more stable large-firm sector. Channel diversification typically has procompetitive impacts by reducing barriers to entry into new market niches. Firms that are strong in one market niche, such as commercial risk contracting, are well suited to enter or threaten entry into other niches, such as Medicare risk, and vice versa. Channel diversification is revolutionizing the health insurance markets for small firms and the self-employed as HMOs develop one-on-one marketing techniques and move beyond the open-enrollment marketing methods developed for the large-group market.

**Vertical integration.** Health care is in many ways a process industry, with patients being transferred from physician offices to hospital wards to skilled nursing facilities and then to home health agencies over the course of their illnesses. Historically, each of these clinical services has been owned and managed independently, which has raised overall costs because of misaligned incentives, duplication of services, excess capacity, inadequate scale, and other failures of coordination. This fragmentation has been targeted by insurers, hospital systems, and other organizations that seek to integrate along the continuum of care. Hospitals have integrated into ambulatory surgery and into postdischarge services such as subacute care, nursing homes, and home health agencies. As capitation payment methods have spread, many hospitals have sought to acquire medical groups and individual physician practices to develop the “integrated delivery system.” Some provider organizations have integrated forward into insurance, developing their own HMOs, while some health plans have integrated backward by employing physicians and/or purchasing hospitals.

Vertical integration has received considerable attention among researchers and policymakers because of its potential to enhance the efficiency of clinical services. Experience to date has been mixed. Vertically integrated staff-model HMOs have performed well against fee-for-service systems but not against “virtually integrated” networks that coordinate insurance, physician, and hospital functions through contractual rather than ownership linkages. In some of the most competitive local markets, such as Los Angeles, prominent staff-model HMOs that are divesting their provider systems and prominent physician/hospital organizations are coming apart. This phenomenon mirrors larger trends away from corporate hierarchies and toward network forms of organization in the nonhealth economy. Antitrust law is adopting a wait-and-see attitude, rejecting an earlier interpretation of vertical mergers and contracts (“vertical restraints”) as mechanisms for leveraging power from one product back to its
supply markets or forward to its retail markets. Antitrust economists argue that vertical relationships generally enhance competition and efficiency unless real monopoly power exists in at least one market, which is rarely the case in health care contexts.  

Three Illustrations

**WellPoint Health Networks.** WellPoint is a publicly traded managed care company that was created out of the nonprofit insurer Blue Cross of California. Blue Cross traditionally had offered nonmanaged care akin to the other Blues plans but also was an early pioneer in the development of HMO products, including Health Net (now part of HSI) and TakeCare (now part of FHP). It led the way for other Blues and commercial carriers by converting its indemnity enrollees to managed care, including the Prudent Buyer PPO and the CaliforniaCare HMO. It owns a workers’ compensation subsidiary and other specialty products, all of which are run according to managed care principles. It is dominant in the small-group and individual markets in California and has been able to rebuild some of the position in the large-group market that it lost along with its Health Net and TakeCare subsidiaries in the turbulent 1980s. The turnaround from virtual bankruptcy to its current position as one of the most profitable firms in the managed care industry was achieved in part by reorganizing by distribution channel (small firm, large firm) rather than by product (HMO, PPO) and by developing, pricing, and cross-selling multiple products for each market segment. Its relation to supplier firms (hospitals and medical groups) embodies neither vertical integration nor virtual integration as conventionally understood. Rather, WellPoint is known for an arm’s-length, hard bargaining approach to provider organizations that permits it to offer consumers some of the lowest premiums in the individual and small-group markets.

In the past year WellPoint has pursued a strategy of horizontal integration and diversification designed to overcome its remaining weaknesses: limited Medicare risk contracting, only modest penetration of the large-firm market, and geographic overreliance on the California market. The now-abandoned merger project with HSI would have provided precisely the breadth and diversification needed to complement WellPoint’s strengths (or, from another perspective, to complement HSI’s strengths). HSI’s Health Net subsidiary is the largest HMO in California after Kaiser; holds a commanding share of the large-group market, with purchasing alliances such as the Pacific Business Group on Health (PBGH) and the California Public Employees Retirement System (CalPERS); and has developed a strong Medicare risk product. Through its Qual-Med HMOs and other subsidiaries, HSI is well represented in many western states and has
acquired potentially important footholds in the Northeast.

The WellPoint/HSI merger aborted because of differences among the respective leaders; each firm is now pursuing the same basic strategy of geographic, product, and channel diversification in competition with the other. WellPoint recently announced the acquisition of the Massachusetts Mutual health insurance subsidiary, an indemnity carrier that had found itself unable to develop strong managed care products and had decided to refocus on other lines of business. Although Massachusetts Mutual is not as complementary a partner as HSI, its acquisition offers a relatively low cost means to convert indemnity patients to managed care and a broad geographic reach. It is only a stepping stone toward the bigger potential partners: Blue Cross and Blue Shield plans with millions of covered lives in unmanaged insurance products that know they must link with an organization that understands managed care or watch their market shares erode.

**UniHealth America.** UniHealth was formed originally through hospital mergers in Los Angeles but was an early enthusiast of diversification and vertical integration. It was instrumental in the formation of PacifiCare Health Systems, now the nation’s largest Medicare risk plan and a major presence in the commercial HMO market, as well as the CareAmerica HMO (focused on the small-group market). UniHealth was one of the first hospital systems to acquire medical groups and to establish tax-exempt medical “foundations.” The promised synergies and efficiencies of vertical integration were slow to manifest themselves, however. PacifiCare and CareAmerica did not account for the majority of admissions to the UniHealth hospitals; the hospitals were not the principal providers of inpatient services to the health plans; and the medical groups often admitted patients to non-UniHealth hospitals. At times UniHealth has resembled a corporate holding company more than a coherently organized producer of health care and insurance services.

The challenge facing UniHealth in the early 1990s was to gain focus and coherence. It pursued this objective by abandoning the mantra of vertical integration and pursuing diversification with an emphasis on the medical-group sector. It now owns only a minority share in PacifiCare, which is publicly traded, and has used the revenues from the gradual sale of PacifiCare stock to invest in multispecialty medical groups and IPAs. It has not sought to extend its hospital holdings and has sold them where possible. UniHealth has discussed contracting alliances with hospital systems based in San Diego, San Francisco, and Sacramento, but little has come of these initiatives since no real horizontal integration is envisaged.

The geographic reach of UniHealth’s capitated physician groups has grown significantly with the addition of the Beaver multispecialty group east of Los Angeles, the San Jose and Good Samaritan multispecialty
groups and Redwood IPA in the San Francisco area, and the remarkable growth of the Huntington IPA (which also contains multispecialty groups) throughout southern California. The UniHealth medical groups and IPAs now cover 600,000 capitated HMO patients and have set their sights on passing the one-million mark within the next year. UniHealth does not envisage these physician organizations as feeders for its hospital beds but, rather, as the crown jewels of the organization. Most medical group and IPA acquisitions have been in markets where UniHealth owns no inpatient facilities and where it has no intention of investing in bricks and mortar. Even in Los Angeles, the Facey multispecialty group and Huntington IPA admit many of their patients to hospitals that compete directly with adjacent UniHealth facilities. The dominant factors are patients’ and physicians’ preferences and prices, not vertical ownership linkages. UniHealth thus represents a case of refocusing through diversification followed by horizontal integration in its medical group line of business (avoiding horizontal and vertical integration in its hospital line of business).

PacifiCare has rapidly expanded geographically to northern California, the Pacific Northwest, Texas, Florida, and other states. It has broadened its product line to include a PPO and specialty products such as mental health benefits and workers’ compensation. It has pursued new distribution channels beyond its core strength in the Medicare risk program (Secure Horizons) and the large-firm market. PacifiCare is aggressively competing for the small-firm market both directly and through the state’s public purchasing alliance and has developed individual and Medicaid risk products. It is pursuing a strategy of virtual integration with selected medical groups and integrated delivery systems, signing multiyear contracts on a percentage-of-premium basis to foster cooperation in marketing, methods of managing care, and information systems.

Mullikin Medical Enterprises. The Mullikin physician system began in Artesia as a multispecialty medical group that early recognized the possibilities offered by global capitation for professional and institutional services. It grew rapidly through mergers with other multispecialty groups in Los Angeles and was one of the pioneer delivery systems for the network HMOs as they spread from the large-firm market to Medicare risk contracting, the small-group and individual market, and now Medicaid managed care. Mullikin was the first medical group in southern California to purchase a hospital, thereby gaining access to hospital capitation, and sold a minority stake to the Daughters of Charity hospital system. Vertical integration was never a strategic objective, however, once Mullikin outgrew the Artesia and Long Beach area. Mullikin promoted its vision of the “physician equity model,” in which the health care delivery system would be organized around medical groups owned by physicians that were not beholden to
nonprofit boards and excess hospital capacity. Mullikin was one of the first multispecialty groups to recognize the value of channel diversification within the physician services market with the formation of the Mullikin IPA in 1991, as a means of further penetrating the Los Angeles market and as a vehicle for entering northern California.

The most dramatic phase of horizontal growth and diversification began with the merger in 1995 with MedPartners. MedPartners had access to venture capital and the public equity markets and a sizable portfolio of medical group management contracts and ownership positions in the Southeast. It had little managed care experience, however, and no presence on the West Coast. The MedPartners/Mullikin entity now is a diversified physician equity and practice management company that can enter new markets with a multispecialty group model, an IPA model, and practice management offerings through its management services organization. It recently announced the acquisition of Pacific Physician Services (PPS), one of the largest capitated medical groups in the Inland Empire area of California and a regional complement to Mullikin’s geographic concentration in Los Angeles. Together Mullikin and PPS provide fully capitated managed care services to more than 650,000 HMO patients in California.

The Limits Of The Firm

There are numerous reasons why organizational expansion by health plans and providers should continue, and no obvious reason why it should stop. However, the evidence from nonhealth industries suggests that after some point firms become too large. They appear to slow down, introduce fewer innovative products, price above the competition, and gradually lose market share to younger and smaller rivals. Many industries manifest a cycle from atomistic competition toward oligopolistic concentration and then on to renewed competition. What are the limits of the firm?

Scholars interested in the rise of the large corporation have identified three problems that must be solved if economic organizations are to grow. First, any entrepreneur or manager faces cognitive limits on how much information can be absorbed and how much activity can be supervised. Oversight responsibility must be delegated over many persons, including those who do not own the enterprise. Second, firms need mechanisms for motivating and coordinating all of the numerous employees and organizational subdivisions. The single bottom line of the integrated organization spreads the responsibility and the reward for all activities over all participants, and individual incentives need to be instilled. Third, the capital requirements of large firms typically exceed the personal wealth of the owner and the willingness of banks and bondholders to bear risk. The risk
of capital investment needs to be spread in exchange for sharing the reward of ownership. The modern corporation, characterized by a managerial hierarchy, distinct subdivisions with internal transfer pricing, and diffused equity ownership, is the organizational solution to the cognitive, incentive, and financial limitations of the owner-managed entrepreneurial firm.\textsuperscript{17}

The managerial, structural, and financial strengths of the modern corporation force a second and deeper look at the limits of the firm. Why do not the publicly traded, multidivisional corporations just grow and grow and grow? No solution to this intellectual puzzle is yet available, but the beginnings can be found in the concepts of incentive attenuation, influence costs, and organizational insularity. Each of these requires explicit comparison of integrated firms with contractual networks as mechanisms for economic adaptation in a changing environment.

Firms tend to rely on salaries rather than unlimited sharing of profit and loss to compensate employees and on cost-based transfer pricing rather than competitive bidding to motivate and evaluate internal subunits. Low-powered evaluation and compensation mechanisms minimize unproductive internal competition, inattention to the value of materials and capital resources, and other types of pursuits. They evaluate and reward individuals based on group performance and thereby foster group cooperation and a group culture. They also reduce the direct financial incentives for individuals. At the extreme, some organizations develop a civil-service culture in which tenure and compensation are divorced from performance. By way of contrast, market contracting between different firms and self-employed persons offers the full profit reward for success.\textsuperscript{18}

Influence costs arise because individual managers, employees, and suppliers compete over how available resources should be divided and do not simply cooperate to increase the quantity of the firm’s resources. The value produced through innovation and cooperation within the firm in principle belongs to the stockholders but in practice is up for grabs. Workers can seek a share explicitly through unionization and strikes for above-market wages or implicitly through effort reduction. Managers can pad their expense accounts and offer themselves ever more generous compensation packages. Subunits can set high transfer prices on their outputs and demand low transfer prices on their inputs. As the firm gets larger and more surplus value is produced, the potential rewards for haggling, coalition-building, and back-scratching come to exceed the rewards for effort, innovation, and entrepreneurship.\textsuperscript{19}

By its very nature, the successful firm is a group of individuals who work better with each other than separately, who know their jobs better than others do, and who want to share in the rewards from cooperation without diffusing those rewards to every outsider. Insularity can facilitate coopera-
tion, protect trade secrets, and nurture a corporate culture. However, insularity taken too far can deafen the firm to consumer preferences, isolate it from new ideas, and create an ethos according to which whatever worked well in the past should be done again in the future.

Large firms struggle daily against incentive attenuation, influence costs, and insularity. Myriad techniques are deployed in the never-ceasing effort to mimic the market’s strengths in incentives, autonomy, and flexibility. In the end, the pseudomarket mechanisms developed by organizations cannot replicate the wonder of the real market. Especially in the context of rapid technological and market change, firms find that unified ownership, employment, and managerial hierarchies often cannot match contractual relationships, small companies, and organizational networks. The challenge facing large firms today is the fostering of competencies and complementarities that permit geographic, product, and channel diversification without losing focus and organizational coherence.

A Hippocratic Oath For Antitrust Policy

The organizations that finance and deliver health care are merging, spreading to new geographic regions, diversifying into new products, developing new distribution channels, and linking with suppliers and other firms along the service continuum. This stunning growth is raising anxious fears among purchasers, consumers, and policymakers. Will the overregulated, lackadaisically nonprofit, and excessively fragmented health care system of yesterday evolve into an underregulated, aggressively for-profit, and monopolistic industry tomorrow? Does competition inevitably end in concentration? What are the limits to the scale and scope of the firm?

Before contemplating an activist antitrust policy, it is important to recognize that incentive attenuation, influence activities, and organizational insularity impose increasingly severe burdens on firms as they grow. The economy at large exhibits no secular trend from competition toward concentration, but rather a plethora of industry-specific oscillations from fragmentation toward consolidation and then again toward renewed fragmentation. All corporate executives may desire monopoly power, but the miracle of modern capitalism is that none is able to gain and keep it for more than a moment. Organizational scale and scope tend to foster rather than to impede performance competition from rivals with different products, different geographic strongholds, different distribution channels, and different supplier networks. This is clearly evident in health care. During the same period when some insurers, hospital systems, and physician management companies are merging and diversifying, others are downsizing and refocusing. We observe contractual networks as well as unified corpora-
tions, virtual integration as well as vertical integration. Some of the largest and most powerful insurer and provider organizations of the past face very bleak prospects for the future. Rarely have we witnessed in so short a time span the fulfillment of the prophecy that the first shall be last.

Antitrust policy to date has focused on one form of organizational growth in health care: the merger of similar firms with similar products within the same geographic market. These cases have generated debate over the appropriate definition of the product and the appropriate definition of the market, but the underlying principles are well understood and not excessively controversial. The expansion of antitrust enforcement to other forms of health care organizational growth has a much weaker foundation in economic theory and is much more controversial. Expansion across geographic markets, diversification into new products, diversification into new distribution channels, and integration with selected suppliers generally tend to foster performance competition based on product innovation. Horizontal integration and multiproduct diversification are reducing barriers to entry and increasing the contestability of local health care markets.

The U.S. health care system is undergoing a process of organizational and contractual innovation that is unprecedented in the history of modern medicine. Competition cannot be interpreted meaningfully in terms of price rivalry among producers of the same service in the same region using the same distribution channel and the same network of supply. Rather, competition must be interpreted in Schumpetrian terms as based on radically new ways of managing and marketing health care services. The new forms of managed care strike not at the margins of the profits and the outputs of the preexisting insurance and delivery organizations but at their foundations and their very lives. This performance competition is as much more effective than static price rivalry as a bombardment is in comparison with forcing a door. Researchers, regulators, and antitrust enforcers must acknowledge the often disastrous effects of well-intentioned but poorly directed meddling in health care organization and observe a new Hippocratic oath for health care policy: Above all else, do no direct harm.
NOTES

1. The dominant tradition in microeconomic theory and antitrust policy emphasizes price competition among similar firms producing similar products and downplays product and process innovation as competitive strategies. It casts a skeptical eye on large firms and hence on the horizontal and vertical integration, product diversification, and channel diversification that permit those firms to grow large. This conceptual framework is embedded in the populist political tradition in America, according to which big is bad (big business, big government). The alternative tradition, attributed most prominently to Joseph Schumpeter, focuses on innovation as a competitive strategy and develops a more favorable interpretation of large scale and scope, integration, and diversification. See J.A. Schumpeter, Capitalism, Socialism, and Democracy, 3d ed. (New York: Harper and Row, 1950). Other prominent works in this tradition include R.R. Nelson and S.G. Winter, An Evolutionary Theory of Economic Change (Cambridge, Mass.: Harvard University Press, 1982); and A.D. Chandler, Scale and Scope: The Dynamics of Industrial Capitalism (Cambridge, Mass.: Harvard University Press, 1990).


5. Chandler, Scale and Scope.


9. Information sharing among competitors raises fears of collusion and price fixing. The Department of Justice and the Federal Trade Commission are exploring the antitrust implications of cooperative activities among physicians who do not share risk (for example, through capitation), which has heretofore been interpreted as a per se violation of the antitrust statutes. See Prepared Statement of Robert Pitofsky, chairman, Federal Trade Commission, before the Committee on the Judiciary, U.S. House of Representatives, 27 February 1996. The case for flexible interpretation of cooperative efforts among competing firms in dynamic industries is made by T.M. Jorde and D.J. Teece, “Antitrust Policy and Innovation: Taking Account of Performance Competition and Competitor Cooperation,” Journal of Institutional and Theoretical Economics 147
(1991): 118-144; and D.J. Teece, “Information Sharing, Innovation, and Antitrust,” 
Antitrust Law Journal 62 (1994): 465-481. Jor de and Teece do not consider the health care applications of their argument. It is quite possible that the physician services market is an instance in which antitrust concern is warranted, given the long history of anticompetitive behavior and boycotts.


14. Information on WellPoint was obtained from the trade press and from interviews with Leonard D. Schaeffer (chairman and chief executive officer), Ron Williams, Andrew Allocco, Max Brown, David Ludwig, Ferial Bahremand, and others.

15. Information on UniHealth was obtained from the trade press and from interviews with Terry Hartshorn (president and chief executive officer), John Austin, Dennis Strum, Layton Crouch, James Yoshioka, Arthur Southam (CareAmerica), Barbara Shaw and Victor Corsiglia (San Jose Medical Group), Steven Aharonian (Facey Medical Group), Frederick McKay and Reginald Friesen (Huntington Provider Group), and others. Information on PacifiCare was obtained from Alan Hoops (president and chief executive officer), Craig Schub, Chris Wing, Rick Badger, Cathleen Batteer, Sam Ho, and others.

16. Information on Mullikin was obtained from the trade press and from interviews with Mark Wagar (chief operating officer, Western Region), Norman Vinn (Mullikin IPA), Andrew Adams, Richard Ferreira, Gertrude Carter, David Mintz, and others.


22. The cognoscenti will recognize this language. Others can trace it to Schumpeter, Capitalism, Socialism, and Democracy, 84.