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Integration is a central component of health system change. Like competition, integration is a means to an end, not an end in itself. Several types of integration activities offer the prospect of reduced administrative costs; lower medical care prices, utilization, and expenditures; and higher quality of care. For example, to cut medical care costs, it is possible to pay lower prices or to do the same things with fewer people and supplies. But beyond a certain point, it is necessary to change the way that either administrative activities are organized or medical care is delivered—both of which require integration activities, as do efforts to improve quality of care.

Some forms of integration lead to a less positive end. Having too few integrated firms and contractual networks increases the prospect of oligopolistic markets (that is, too few competitors), with higher prices and premiums and slower efficiency and quality gains than in competitive markets. Already, among the fifteen communities in The Robert Wood Johnson Foundation’s Community Snapshots study, the three smaller, partly rural markets (Fargo, North Dakota/west central Minnesota, north central Florida, and Des Moines) had two dominant hospital systems. Two markets (Des Moines and Minneapolis/St. Paul) had only two dominant managed care insurers. Although fierce price competition among insurers and providers was common in most of the communities, which were studied during 1995, in at least one market (Minneapolis/St. Paul) dominant vertically integrated firms had raised purchasers’ fears of diminished competition. Moreover, the creation of large horizontally and vertically integrated firms and contractual networks was occurring rapidly in other markets.

This paper provides an overview of different integration activities in the fifteen Snapshot sites, indicating some recent patterns and trends in integration as well as obstacles. The paper focuses on three sectors that are most active in firm- and network-building efforts: insurers (health plans), hospitals, and primary care physicians. Among hospitals, for-profit and
nonprofit community hospitals tended to lead in creating integrated firms and contractual networks, whereas, with the exception of Houston, Boston, and north central Florida, academic health centers did not. Public hospitals did not do so, either. Among physicians, primary care physicians were the focus of much firm- and network-building activity, whereas specialists (which were in excess supply) were not.

It was difficult to analyze the precise amount and content of the types of integration in the fifteen communities, which were chosen to reflect the diversity of the U.S. health care marketplace. The Community Snapshots study was designed to generate hypotheses quickly, to be followed by a project designed to test hypotheses in a more deliberative manner. As a result, the study obtained limited information on each site (without a highly structured organizational survey), at only one point in time, and for only fifteen markets. Moreover, although much information was valuable, it was not collected and reported as uniformly as would have been the case in a study with different objectives and a different time horizon. Much of the information collected pertained to the creation of integrated firms and contractual networks, rather than other types of integration.

**Types Of Integration**

Creation of integrated firms and contractual networks. The most visible aspect of health-sector integration is the creation of integrated firms and contractual networks, involving such deal-making activities as mergers and acquisitions (ownership agreements) or longer-term contractual agreements among firms. The term integrated firm describes a vertically or horizontally integrated firm with one managerial hierarchy. Vertical integration means that one firm produces the products that either suppliers or customers could produce, or acquires the latter, whereas horizontal integration involves acquiring a firm that produces similar goods and services. At the other end of the spectrum of relationships among firms are vendor relationships between anonymous buyers and sellers. The term contractual network describes nonownership contractual relationships (vertical and horizontal) between firms with separate managerial hierarchies that agree to coordinate some activities with each other over time. Contractual networks often are described as partnerships or alliances. In the spectrum of relationships among firms, contractual networks lie in between integrated firms and vendor relationships. Possible variations in “ties that bind” within contractual networks are great, depending on such factors as duration or extensiveness of contracts and difficulty in breaking the intent of the contracts.

Health care firms can coordinate activities with unified ownership (in the integrated firm) or without unified ownership (in the contractual
Moreover, ownership and contractual network relationships can be mixed, as when a hospital purchases a medical group's assets while contracting with medical group members to provide services to enrollees.

Different theories offer different determinants for decisions to create integrated firms, rather than contractual networks. We could not systematically analyze those determinants because, in some cases, the community reports contained insufficient detail on ownership and contractual relationships.

Creating integrated firms and contractual networks (assembling the pieces) can be a prerequisite for three other types of integration (making the pieces work together) that can actually affect health care costs and medical practice. Robin Gillies and others have identified these types as clinical, physician/system, and functional integration. Clinical integration. Clinical integration is "the extent to which patient care services are coordinated across the various functions, activities, and operating units of a system. The extent to which care needs to be coordinated is largely a function of the nature of the patient's illness and decisions made by the patient's physicians. In our view, it is the most important type of integration, in that it focuses on the ultimate consumer." For example, in Orange County the Friendly Hills Medical Group used multidisciplinary action plans (MAPs), based on treatment protocols, to drive patient care. Each MAP included a patient time line and schedule for clinical activities, from actions by subspecialists and ancillary personnel such as pharmacists and dietitians to patient education, across all sites of care, including the patient's home. Friendly Hills was integrated thoroughly with a hospital that it owned. Also in Orange County Bristol Park Medical Group managed high-cost cases, used a small group of internists to admit all hospital patients, coordinated its information systems and activities with those of the hospitals it used, and employed secondary prevention techniques, such as automatic appointment scheduling, to regulate care for persons with chronic conditions.

Physician/system integration. This type of integration, according to Gillies, is "the extent to which physicians are economically linked to a system; use its facilities and services; and actively participate in its planning, management and governance. Physicians affiliated with the system share common objectives with the system and respond to incentives that foster collaboration with the system." For example, Bristol Park Medical Group managed physicians' clinical practice with a combination of a sophisticated reimbursement system; ongoing audits, evaluations, and feedback to physicians; and a physician-driven utilization management process, peer pressure, relatively open communications, and quality incentive awards. It carefully selected physicians, closely monitored and educated
new physicians in the first-two-year probation period, and encouraged physicians to acquire an equity stake in the medical group.

**Functional integration.** This is the “extent to which key support functions and activities (such as financial management, human resources, strategic planning, information management, marketing, and quality improvement) are coordinated across operating units so as to add the greatest overall value to the system.”

Although the terms clinical, physician/system, and functional integration were developed to analyze hospital-based organized delivery systems, I use them in this paper to refer to activities in any delivery system that integrates services.

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**Overview Of Integration Activities**

Many creative, innovative, and successful integration activities were occurring in the Snapshot communities, and organizations were constantly advancing the leading edges of those activities. There was much experimentation and dynamism among and within many organizations. However, the pace was highly uneven among types of integration and among communities.

Generally, it appeared to be much easier to assemble the pieces than it was to make the pieces work well together. The term “frenzy” was used in several reports to describe the pace of merger and alliance activity in a few communities, and activity (and anticipation of further activity) was substantial in most communities.

Some functional integration appeared to be taking place in all communities. However, although creation of integrated firms often was followed by a reduction in administrative personnel and the initiation of joint purchasing, it did not appear to be easy to achieve unified information, accounting, and financial systems across all hospitals and physicians within a system. The Snapshots study produced little information on functional integration in contractual networks.

On the other hand, there were few reports of physician/system integration occurring very quickly. Certainly, few (if any) hospital systems had claimed that they had become physician-driven organized delivery systems. Similarly, few medical groups claimed that they had figured out how to motivate most of their physicians to work hard and well together and to produce high-quality care. Development in this area appeared to be particularly uneven among and within communities. With the limited information available, clinical integration also appeared to be very unevenly developed both within and among communities, with some communities showing substantial clinical integration activity and others only beginning. Across all communities, few systems appeared to have closed hospitals or consoli-
dated expensive surgical units.

**Communities with higher HMO penetration.** Snapshot communities with higher HMO penetration include San Diego; Orange County; Portland, Oregon/Vancouver, Washington; Minneapolis/St. Paul; and Boston (each with a moderate to large population), as well as Albuquerque (with a smaller population). Market conditions during 1991-1992 (when the latest burst of purchaser, competition, and integration activity began) in these communities differed from those in communities with lower HMO penetration because of higher past levels of organization among insurers, hospitals, and physicians. Among the many factors that had contributed to different market conditions, each community with higher HMO penetration had one or more staff/group-model HMOs with a long history of substantial integration activities of all types that often provided a model for other organizations within those communities.

In such communities, insurers, hospitals, and physicians in 1991-1992 were further up the integration learning curves than were their counterparts in markets with lower HMO penetration. As new or intensified competition forced a continual ascent up the learning curves, vertically integrated firms and contractual networks came to dominate in Minneapolis/St. Paul, Portland/Vancouver, and Albuquerque. Cost-cutting pressures led to additional physician/system and functional integration in each of the six communities, including implementation of more sophisticated information systems, utilization controls, physician incentives, and feedback to physicians. More important, it led to more implementation of clinical guidelines, protocols, and pathway and disease management techniques, at least in large organizations, than was the case in communities with lower HMO penetration. With the easiest cost-cutting gains achieved in these communities, further gains depended heavily on these additional integration activities.

Among communities with higher HMO penetration, great diversity existed in integration activities, which made creating market typologies difficult. For example, Portland/Vancouver and Minneapolis/St. Paul each had two vertically integrated health plan/delivery systems, and a third strong integrated firm or contractual network was emerging in each community. In contrast, San Diego and Orange County each had only one long-standing, vertically integrated health plan/delivery system (Kaiser), and no others were on the visible horizon. Given market conditions, FHP and CIGNA even divested themselves of direct ownership of their provider organizations in Southern California. As another example, whereas San Diego and Boston had roughly similar HMO penetration levels, “true” managed care (for example, extensive capitation of providers) was much more developed in San Diego than in Boston, as was the level of each type of integration.
Different individual community health system histories contributed to this diversity. In Minneapolis/St. Paul the extent of vertical integration was due in large part to a long history of “home-grown” HMOs and large medical group organizations, purchasers that became active in 1989 (before most other purchasers), and 1992 legislation that hastened vertically integrated firms and contractual networks. Even the first factor (having large HMOs and medical groups) was not common to many other communities.

Even within each community with high HMO penetration, great diversity in various integration activities also existed. Solo or small-group physicians with weak management and information systems that served only fee-for-service or preferred provider organization (PPO) patients struggled to coexist with physicians in large, fully integrated medical groups with sophisticated management and clinical information systems (and substantial clinical integration) that served only capitated enrollees.

Communities with lower HMO penetration. Among Snapshot sites, the five medium or large communities that had moderate or low HMO penetration included St. Louis, Indianapolis, Houston, south Florida, and Wilmington, Delaware. Four small and/or rural communities with moderate or low HMO market penetration were Fargo/west central Minnesota; Columbia, South Carolina; north central Florida; and Des Moines. In markets with lower HMO penetration, the creation of integrated firms and contractual networks appeared to have been far ahead of physician/system and clinical integration again, because it is easier to consummate deals than it is to reshape the practice of medicine. Semirural communities were at least as advanced in creating firms and networks as were their larger-city counterparts. In Fargo/west central Minnesota, Des Moines, and north central Florida two urban/rural health systems dominated.

Clinical and physician/system integration activities appeared to be much less complex in communities with less rather than more HMO penetration, in part because physicians had less experience with organizations, while hospitals and insurers had less past pressure (and therefore less time) to improve their management skills to manage and work with physicians. Moreover, organizations in these communities had less incentive to attempt to obtain gains from more complex integration activities because they could obtain relatively easier cost-cutting gains—for example, paying lower prices or doing the same things with fewer workers—that had already been achieved in communities with higher HMO penetration.

Stakeholders in communities with lower HMO penetration were learning quickly about how to integrate. At times intense competitive pressures, as well as expectations of future rapid changes and continued competition, drove integration activities. Regional or national organizations elsewhere were exporting knowledge, management skills, and capital resources to
communities with lower HMO penetration, thereby facilitating integration activities. For example, nationwide HMOs, national for-profit hospital chains (especially Columbia/HCA), increasingly regional nonprofit hospital chains, and physician practice management companies were injecting their knowledge and economic resources into many communities. In addition, an entire industry has expanded to provide information to local stakeholders via consultants, lawyers, investment bankers, and conferences and newsletters, again facilitating different types of integration.

Within each type of integration, substantial diversity existed among and within communities with lower HMO penetration, because of differences in past organizational or community histories and the effects of outside organizations. For example, overall organization and integration of primary care physicians into systems appeared to be painfully slow, in part because most communities with lower HMO penetration tended not to have a history of widespread medical groups and physician organization. Yet Fargo/west central Minnesota had well-organized primary care physicians, because of the latter’s familiarity with large medical groups that formed elsewhere in the region. As an example of diversity, the physician community in Houston showed a high level of disorganization and lack of coordinated activity, yet sophisticated integration occurred in one large medical group practice with a relatively long history of such activities.

Players In The Integration Game

Physicians. As the current focal point of the emerging system of managed care, primary care physicians were becoming increasingly organized in all communities. This is a radical departure from the past predominance of solo and small-group practice. Primary care physicians in most communities now have a scarce resource that keeps them in demand for integration activities: They can be the front-end “gatekeeper” and integrator of services. Patients’ loyalty to primary care physicians—often greater than consumers’ loyalty to insurers or hospitals—accords these physicians additional clout. However, primary care physicians tended not to take the lead in organizing themselves in most communities, especially those with lower HMO penetration, because they lacked the needed management skills and capital. Under the old indemnity insurance system, there was little demand for primary care physician leaders and capital resources that are vital to organization building, whereas the old system encouraged hospitals and insurers to develop management skills and to accumulate capital. As a result, hospitals and health plans have tended to take the lead in organizing primary care physicians.

In part because managed care physician leaders are relatively few and
needed changes are many, it has proved difficult to find the appropriate mix of financial and administrative incentives to motivate physicians to contain costs while maintaining and improving quality of care through clinical integration, especially as more primary care physicians become either “employees” or anonymous “vendors” within much larger organizations. The slow pace of physician/system integration has slowed clinical integration, because the former facilitates the latter.

**Hospitals.** Hospitals took the lead in creating integrated health care firms and contractual networks in virtually every community. Hospitals have been forced to integrate more quickly than insurers have. Hospitals in most Snapshot communities were in a weak market position because demand was declining for their product, which increasingly has become an undifferentiated commodity. Moreover, nonprofit hospital chains tended to be smaller than for-profit insurers and had less financial reserves and more at stake (and thus less leverage) in any one set of payment rate negotiations. As a result, hospitals were highly motivated to integrate horizontally, because they needed large market share to gain leverage in negotiations with insurers, protect referral bases, and cut costs, while geographic expansion enabled hospitals to offer insurers one-stop-shopping convenience. Hospitals also wanted to diversify away from their own declining sector and integrate vertically into the primary care physician and insurer sectors.

Hospitals also were often in the best position to integrate quickly, compared with either insurers or physicians. Hospitals had more capital and management expertise than primary care physicians have had. Also, local or regional nonprofit hospital system managers in many communities tended to have more of a history of working closely with each other and with physicians than out-of-area insurers had.

Hospitals tended to share the role of physician-organizer that HMOs held during the period of explosive growth of individual practice associations (IPAs) in the mid-1980s. Hospitals attempted to integrate with physicians in many ways, such as creating management services organizations (MSOs) that offered management services to physician practices, providing capital and management to develop physician/hospital organizations (PHOs) and IPAs, and acquiring primary care physician practices.

Some hospitals also attempted to assume the insurers’ role by creating new HMOs. Some hospitals faced major obstacles in adopting this role, as some strong HMOs “punished,” or threatened to punish hospital systems offering their own HMO by sending enrollees to hospitals without an HMO. New hospital-sponsored health plans may be easier to introduce in communities with lower HMO penetration because HMOs are not as large and entrenched there and have less leverage to punish hospitals that offer their own plan. However, even in Houston, with its low HMO penetration,
the largest HMO stated that it would direct enrollees elsewhere if the newly launched Memorial/Sisters of Charity HMO appeared likely to succeed. Even in communities with low HMO penetration, insurers that offer PPO plans and have ambitions to build their own HMO can direct their PPO members away from a hospital system that is developing its own HMO.

Although the pace was slow, hospital partnerships with existing health plans occurred to some extent, across a diverse range of communities (for example, in Minneapolis/St. Paul, Portland/Vancouver, Des Moines, and Fargo/west central Minnesota). Hospitals’ acquisition of health plans (or the reverse) was much less common.

Clearly, many hospital systems that were integrated firms were attempting to functionally integrate hospitals within their systems, although plans appeared to outstrip actual accomplishments. Again, there were few examples of informants’ claiming great success in physician/system or clinical integration.

**Insurers.** Insurers were under great pressure to expand horizontally, by entering new markets and by increasing market share in markets in which they had operated in the past. Because insurers tended to have a stronger market position than hospitals had, insurers were under less pressure than hospitals were to integrate vertically, although vertically integrated firms and contractual networks were being created.

Insurers in many communities continued to play a major role in organizing physicians. HMOs created new IPAs and improved the management of existing ones, acquired primary care physician practices and established their own clinics, and created some nonownership, mostly nonexclusive partnership agreements with physicians. Nevertheless, there was no uniform trend in HMOs’ efforts to integrate with physician organizations. For example, FHP and CIGNA, which operated in Orange County, divested ownership of their staff clinics.

Insurers initiated only a limited amount of integration with hospitals. In a period of excess hospital bed supply, it can be cheaper for insurers to “buy” rather than to “make” hospital services. Such decisions can lead to divestment or closure of insurer-owned hospitals. For example, in Portland/Vancouver Kaiser announced the closure of one of its two hospitals and rented capacity from the Providence system. Some health plans, however, did enter into several “partnership” agreements with hospital systems, including exclusive contracting in Houston and Indianapolis, a small joint venture in Des Moines, a major joint venture in Portland/Vancouver, and some narrowing of the network and/or closer administrative coordination in Orange County and San Diego.

Insurers were adopting highly divergent strategies for creating integrated firms and contractual networks, ranging from complete ownership of deliv-
ery systems to commodity vendor relationships. Even within the same community, different insurers can adopt polar-opposite strategies and a single insurer can adopt multiple strategies, partly in recognition of different needs on the parts of employers, enrollees, and physicians.

Orange County provided examples of multiple strategies in one community. (1) Kaiser was retooling its model of a physician-driven, hospital/medical group delivery system that offers a health plan and contracted with an insurer to create a point-of-service plan. Systemwide, Kaiser is rethinking its position of owning hospitals. (2) FHP/TakeCare and CIGNA were divesting their ownership stake in their delivery systems-in all markets for FHP and in southern California for CIGNA. Previously, FHP/TakeCare and CIGNA had contracted with providers outside of their firms, and they moved to do so entirely. Again, this move reflected the plans’ view that they could “buy” more cheaply than they could “make.” (3) Prudential and Aetna attempted to integrate their health plans with primary care physician clinics, by acquiring physician practices or IPAs. Because this process was slow, both also contracted with providers outside their firms. (4) PacifiCare made the greatest effort among HMOs to effect nonownership, nonexclusive, long-term contractual networks (partnerships) with providers, by signing multイヤyear partnership agreements with selected medical groups and IPAs. PacifiCare offered a guaranteed share of premium to some partners, while attempting to direct new enrollees to them, either through new enrollee growth or by dropping some physician organizations that were not its partners. PacifiCare’s strategy was to differentiate its HMO plan product by differentiating its network from its competitors, without owning its own delivery system. (5) Health Net and Blue Cross of California remained almost completely separated from delivery systems and engaged mostly in price-driven commodity vendor relationships with physician organizations and hospitals. They have transferred many utilization and quality assurance functions to providers.

New players. For-profit hospital systems have become a powerful force in several markets. Columbia/HCA, the Nashville-based nationwide hospital chain, had a strong presence in Houston, south Florida, and north central Florida; had announced a joint hospital/physician organization venture with the nonprofit Sharp HealthCare system in San Diego; and was negotiating to acquire an interest in nonprofit hospitals in Boston and Columbia. Given the predominance of nonprofit hospitals, for-profit hospital systems increasingly have had to negotiate mergers or joint ventures with nonprofit hospitals. The presence or the threat of entry of Columbia/HCA and other for-profit chains spurred firm- and network-building activity among nonprofit hospitals in some communities. Physician practice management companies also have played an increas-
ingly important role in organizing primary care physicians. Like hospitals and insurers, they have supplied the management and capital that the primary care physician sector lacks, by acquiring primary care physician practices, providing management services to primary care physicians, and creating or improving the management of IPAs. For example, Caremark acquired large medical groups in Houston and Orange County.

Obstacles To Integration

Competitive pressure in the Snapshot communities was forcing hospitals and physician organizations to create integrated firms and various types of contractual networks, to gain leverage in negotiations with other organizations and to facilitate functional and clinical integration that is needed to cut costs. However, features of the old fee-for-service/indemnity insurance system continued to slow the progress of integration. Because competition is forcing the reinvention and integration of a mature industry, obstacles to integration vary greatly from those in a new, emerging industry.

Fragmentation. The old system was remarkably fragmented and non-integrated as recently as 1982, and in some communities as recently as 1992—or even today, in the physician sector. This has made integration of any type, in particular involving physicians, a daunting task. The fee-for-service/indemnity insurance system had at its core a cottage industry of physicians with hundreds of thousands of little businesses, with thousands of separately governed hospitals that courted those businesses. Under the fee-for-service payment method, the health care industry required far less organization than was the case in other industries. Fee-for-service payment created only modest incentives for firm and network building, and especially few incentives for physician/system and clinical integration.

Management. The dearth of appropriate management skills—especially in the primary care physician sector—has been a crucial impediment to integration. Most physicians were not trained as managers or even as organizational team players. Meanwhile, the management skills developed by insurers and hospitals under the old system often were not the skills required to lead physician organizations. Physician/system and clinical integration was not part of the experience of many hospital or insurer managers. Even organizing primary care physician practices (often solo or small group) into integrated firms or contractual networks requires different skills than those that insurers or hospital managers had acquired in the hospital or insurance sectors.

Organizing and managing primary care physicians successfully appears to be the most important, and most difficult, task in the emerging health care system. It seemed to be extraordinarily difficult to motivate primary care
physicians appropriately, and in no Snapshot communities did “cookie-cutter” approaches to organizing primary care physicians work well. Motivation problems likely were greater in organizations that physicians perceived to be dominated by hospital or insurer leadership and agendas.

**Consumer choice.** In all communities consumers have become accustomed to unlimited choice of providers. This discourages the creation or expansion of the old type of vertically integrated staff- and group-model HMOs. However, it can lead to contractual networks, as a delivery system may offer multiple types of physician organizations to enrollees. Sharp HealthCare in San Diego had four different physician arrangements, while Harvard Community Health Plan in Boston had at least three.

**Nonprofit hospital ownership.** The hospital sector is one of the few remaining sectors of the economy that nonprofit organizations dominate. Nonprofit hospital systems, including those governed by religious boards, predominated in all but one Snapshot community, south Florida. Nonprofit status, mission, and governance can slow integration.

Nonprofit hospital boards can put nonmonetary obstacles in the way of market-driven creation of integrated firms and contractual networks. In St. Louis, Indianapolis, and Orange County some boards discouraged or encouraged mergers on religious grounds. Nonprofit boards tended to move more slowly on mergers and acquisitions than did for-profit hospital systems. Moreover, the new competitive system tended to turn the community-oriented nature of “mission-vision” organizations from a virtue into a financial vice, as nonprofit boards were reluctant to close hospitals or consolidate operations such as cardiovascular surgery units. With the exception of some activity by the for-profit Columbia/HCA, there were few reports of hospital closures or consolidation of expensive units.

Nonprofit status has tended to slow the redistribution among hospitals of the capital needed for integration—for example, to acquire other organizations or set up extensive networks, purchase new information systems, or pay for hospital closures. In some communities, such as Houston and San Diego, there was some mismatch between hospitals that either had capital or had access to capital and those hospitals that were most successful in their clinical or functional integration activities. Some nonprofit hospitals gained their capital from their success in the old system—not the new, emerging system. In fact, past management skills and vision that led to success under the old system could hinder performance under the new. Moreover, past financial success in some nonprofit, capital-rich organizations likely made present change (including integration activities) less pressing. For-profit systems tended to avoid most of these obstacles.

Nonprofit status also lessens access to capital (especially equity markets) compared with public, for-profit chains, thereby reducing the money avail-
able for various types of integration activities. This can become an impetus to convert to for-profit status; it certainly confers an advantage to some for-profit hospital systems.

Finally, nonprofit status slows even for-profit chain acquisitions, as the latter run out of for-profit hospitals to acquire. Although it is possible to integrate for-profit and nonprofit hospitals, it remains a difficult task.

**Fee-for-service payment.** A capitated delivery system has strong incentives to coordinate, integrate, and manage care across sites of care and keep hospital beds empty, not full. Yet only about a quarter of all insured persons were HMO enrollees, and even in communities with high HMO penetration, HMOs tended to pay hospitals per diems and still pay some physicians fee-for-service. When HMOs did capitate, they capitated primary care physician organizations (with risk-sharing incentives for lower hospital use), but either the HMOs or the medical groups usually paid hospitals per diems. This set up a clash between incentives in the hospital and physician sectors. Hospital systems attempted to overcome that conflict by creating PHOs, but progress in obtaining joint capitation contracts (especially where both sides were capitated) was slow.

**Separation of health plans and providers.** Insurers that are separate from delivery systems have an incentive to keep purchasers and delivery systems from negotiating directly with each other, and some HMOs threatened to punish delivery systems that did so. Thus, separation and conflict between health plans and providers have slowed provider-sponsored HMO vertical integration and even HMO-led vertical integration with providers. Health plan/provider separation also can slow integration within provider sectors when health plans refuse to pay capitation to providers, out of concern of appearing irrelevant to purchasers.

Without much full capitation, there were few examples of physician-centered delivery systems with hospital origins that depended on their success with full capitation, even though hospital system managers talked about that model as a goal. Remarkably, some hospital systems still offered manager reward systems that emphasize “heads on the beds,” rather than empty beds.

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**Conclusions And Implications**

As we studied health system integration in the fifteen Community Snapshot sites, it was hard not to be excited about some of the innovations found in medical practice and care of populations, especially those involving clinical integration. Physician leaders were emerging, and management skills were being renewed or imported into the health care sector. Much integration activity tended to focus on creating integrated firms and con-
tractual networks. Some form of firm or network often is a precondition for other forms of integration—clinical, physician/system, and functional—that could lower costs and improve quality of care.

Nonetheless, while creating integrated firms and contractual networks helps to develop the potential for improving the health care system, it does not necessarily lead to improvements. Moreover, creating firms and networks is in part a pursuit of market power. If creation of firms and networks races ahead of other forms of integration that change the health care system and simply produces greater concentration of firms or networks, it might reduce competitive pressures to cut costs and improve quality of care and thus slow down clinical, physician/system, and functional integration, to the detriment of the community.

In almost all communities, highly competitive markets have allayed the immediate concern about too few competitors. However, purchasers in the most concentrated large market, Minneapolis/St. Paul, already have reacted to the perceived threat of too few competitors. The Buyers’ Health Care Action Group is trying to limit the effects of health plan-led horizontal and vertical integration by attempting to identify logical delivery systems, contract with those delivery systems (regardless of who owns them), and hold those delivery systems accountable for the care that they provide. In effect, purchasers are attempting to determine directly the content of some of the integration in the health care system. It is unclear whether this is a model for the future, because Minneapolis/St. Paul has been unusual in many ways, including the bold activity of its purchasers.

Despite the rush to horizontal and vertical integration in ownership, integrated firms will not necessarily be the only type of organizational form that remains. James Robinson observes that although there are many advantages to ownership integration, there are important disadvantages to common ownership as well, including incentive attenuation, influence costs, and organizational insularity.15 Recent divestment actions underscore the fact that caution is necessary in thinking about the future configuration of organizational structures in the health care system.

Beyond the current mitigation of premium and cost growth, the most important legacy of capitation may well be the clinical integration that it is facilitating, which has clear benefits for quality of care and, so far, for cutting costs. Moreover, as long as pressure persists to improve quality of care and cut costs, increasing clinical integration likely will continue.

The policies that purchasers adopt to promote competition will help to determine the extent, pace, and content of integration. Price competition is driving the creation of integrated firms and contractual networks and is affecting clinical, physician/system, and functional integration. Each purchaser policy that encourages competition based on quality of care could
help to facilitate the latter types of integration. It likely will not be possible for delivery systems to compete successfully on the basis of quality without achieving those types of integration. For example, without such integration, it would be virtually impossible to produce and report measures that could used as the basis for competition, let alone coordinate and integrate care of populations with chronic conditions.

As the health care system continues to evolve, the nature of competition will shift, and clinical integration will be affected. How the nature of competition shifts depends on purchasers. Once again, the social responsibility of purchasers is great, because the nature of the competition that they settle upon ultimately will help to determine the quality of health care provided—and the extent of clinical integration in whatever health care system emerges.

NOTES

1. See P.B. Ginsburg, “The RWJF Community Snapshots Study: Introduction and Overview,” Health Affairs (Summer 1996): 7-20. The fifteen communities are Boston, Massachusetts; Wilmington, Delaware; Columbia, South Carolina; north central Florida; Miami/Ft. Lauderdale, Florida; St. Louis, Missouri; Indianapolis, Indiana; Des Moines, Iowa; Minneapolis/St. Paul, Minnesota; Fargo, North Dakota/west central Minnesota; Houston, Texas; Albuquerque, New Mexico; San Diego, California; Orange County, California; and Portland, Oregon/Vancouver, Washington.


4. Ibid.


8. Ibid., 469.

9. Ibid.


12. Shortell et al., Remaking Health Care in America.

