Strategies for Integrated Health Care Systems

Several years ago we were certain that vertical integration was the way to go—the strategy of the future. We acquired some primary care practices and for a while even owned a share of a health plan. We sold out of the health plan, but not before losing several million dollars. Now we are wondering what to do with our primary care offices.

HOSPITAL CEO IN THE MIDWEST

Vertical integration was one of the most controversial health care strategies of the late 1990s. The envy of the early to mid-1990s, a number of these systems have been unable to increase market share and demonstrate positive financial performance. The “experts” are calling for virtual integration and an end to the type of integration where all elements of the system—physician practices, hospital, and health plan—are owned by a single entity.

This chapter deals with future strategies for integrated health care systems under alternative future scenarios. We believe certain types of integrated systems have a bright future, especially if consumerism and technology are dominant. After defining integrated health care and describing the characteristics of two different types of integrated systems, we identify and discuss several strategies for the future. We begin the discussion of strategies by presenting an analysis prepared by the management team of Methodist Community Hospitals Indianapolis of the impact of each of the four scenarios for the future that we propose.

What Is Integrated Health Care?

Our definition of vertical integration is shown in Figure 10.1. This definition is based on an examination of the vision and mission statements of a number of advanced integrated systems. In these statements there is an emphasis on teamwork, quality of care, cost-effectiveness, and meeting the needs of people in the communities and regions served.

For many of the integrated systems we studied, the definition would also include this sentence: The medical care we provide will be enhanced by a commitment to education and research.

Another approach we have used in defining integrated health care is to describe the characteristics of these systems. We developed ten broad criteria, and a number of subcategories, which we have found useful in measuring the extent of integration among various types of health care organizations. The ten characteristics are shown in Exhibit 10.1.

We have taken our definition a step further and developed weighting factors for each of the criteria and a checklist for evaluating the extent of integration in various organizations. For example, the Mayo Foundation and Kaiser Permanente would receive more than ninety out of one hundred possible points, and we would consider these organizations to be highly integrated. On the other hand, the typical community hospital that has acquired primary care practices would receive a rating in the twenty-five to thirty point range. As a general rule, organizations led by a multispecialty clinic tend to rank much higher in terms of their degree of vertical integration. Two broad types of integrated systems are discussed next.

**Figure 10.1. Definition of Integrated Health Care Systems.**

An integrated health care system provides a comprehensive spectrum of high-quality, well-coordinated health care services on a cost-effective basis to residents of its service area. To accomplish this, physicians, hospitals, and other health care providers work together for the benefit of customers.

Coddington, Ackerman, Fischer, and Moore, 2001, Chapter 1.
Two Broad Types of Vertically Integrated Systems

There are at least a dozen different types of integrated systems, but for the purposes of this book, we consider two broad types: those led by multispecialty clinics and those initiated by hospitals or multihospital systems.

The biggest difference between the two types of integrated systems is how they began: physicians played a key leadership role in one type, and hospital executives were usually leaders in the other. Where an integrated system has been formed under the leadership of a hospital, there are usually efforts made to place physicians in leadership roles, ranging from physicians in key positions on the management team to joint CEO-physician leadership.

We do not contend that one type of integrated system is superior to another. However, in our view, it is more difficult for a hospital to form a successful integrated system that has most of the characteristics listed in Exhibit 10.1. At the same time, we are beginning to see hospital-led systems displaying many of the integration characteristics and successfully serving their markets.


1. Comprehensive scope of clinical and health-related services.
2. Total focus on meeting the needs of patients.
3. Physicians organized.
4. Strong physician leadership.
5. Increased emphasis on quality improvement.
6. Strong governance structure that includes physicians and community representatives.
7. Geographic coverage of the service area or region.
8. Development of IT to support coordination and integration.
9. Financial plan for meeting investment needs and maintaining economic viability.
10. Strong reputation in the marketplace.

Source: Coddington, Ackerman, Fischer, and Moore, 2001, Chapter 1.

Integrated Systems Led by Multispecialty Clinics

The most prominent examples of integrated systems led by multispecialty clinics are Mayo in Rochester, Jacksonville, and Scottsdale; Marshfield in Wisconsin; Park Nicollet Health Services in Minneapolis; the Cleveland Clinic in Ohio and Florida; Dartmouth-Hitchcock in New Hampshire and Vermont; Carle in Urbana, Illinois; Scott & White in Temple, Texas; and Fallon in Worcester, Massachusetts.

All of these integrated systems began as multispecialty clinics. They took on the characteristics of integrated systems when they developed regional networks of primary care physicians, owned or had a special relationship with a hospital, and, in some cases, established their own health plans. All of these organizations continue to place a high priority on clinical integration.

Integrated Systems Led by Hospitals

Examples of hospital-led integrated systems include Aurora in eastern Wisconsin; Advocate in Chicago; Sutter in northern California; Intermountain Health Care in Utah and southern Idaho; Scripps in San Diego; Stormont-Vail in Topeka, Kansas; and Inova in the Virginia–Washington, D.C., area. Most hospital-led integrated systems make a serious effort to promote medical groups and physician leadership. Many develop primary care networks, own health plans (or have in the past), and maintain a close relationship with a variety of physicians and medical groups.

In many respects, it is less complex to make integration work from the starting point of a multispecialty clinic. Physicians are already in leadership positions, they have had years of experience in governing themselves, and they are accustomed to making strategic and management decisions. However, many of the hospital-led integrated systems often have better access to capital, enjoy greater community support, and may be more stable over the long term.

Virtual Integration

The question frequently comes up as to whether an integrated system should own all of the key elements—medical groups, hospitals, and health plans—or whether the various components should
be tied together contractually. The latter is often referred to as “virtual” integration.

In reality, most of the large and successful integrated systems include elements of virtual integration. For example, Marshfield Clinic does not own hospitals, but it has a close relationship with Ministry Corporation, Sisters of the Sorrowful Mother, based in Milwaukee. Over 99 percent of the admissions to Ministry’s St. Joseph Hospital, in Marshfield Clinic’s service area, are patients of Marshfield Clinic physicians. Naturally, Marshfield Clinic and Ministry Corporation have developed a close working relationship.

Park Nicollet Health Services was formed as the result of a merger between the Park Nicollet Clinic and Methodist Hospital. Park Nicollet Health Services does not own its own health plan but contracts with a number of health plans and is a “care system” for the Buyer’s Health Care Action Group, a coalition of thirty-five employers in Minneapolis–Saint Paul.

Even Kaiser Permanente of Colorado, an advanced integrated system that combines the five-hundred-physician Permanente Medical Group and the Kaiser Foundation Health Plan (with over four hundred thousand subscribers in the Denver and Colorado Springs metropolitan areas), does not own a hospital. Kaiser Permanente contracts with the five-hundred-bed Saint Joseph Hospital, part of the Sisters of Charity of Leavenworth, Kansas, for inpatient and other hospital-related services. (Saint Joseph Hospital, along with Lutheran Medical Center and physicians associated with both hospitals, is also part of Exempla Health System.)

Strategies of Integrated Systems: Overview

Our research indicates that the strategies of integrated systems led by multispecialty clinics differ somewhat from the strategies of hospital-led integrated systems. For example, hospital-led systems often have problems in dealing with independent physicians who continue to use the hospital but are not part of the core medical group (or groups). In our research and experience, we have found that hospital-led integrated systems may also be more concerned about the “poor” financial performance of their primary care practices.

For their part, integrated systems led by multispecialty clinics may be more likely to experience financial problems. Some of these organizations do not have direct access to the tax-deferred debt markets that are readily available to most hospital systems. Carle Clinic, for example, considered merging with Carle Foundation, owner of Carle Hospital (which is colocated with the clinic), primarily to improve its access to capital. (Another reason for merger is to reduce potential problems associated with self-referral and private inurement.)

William Corley, CEO of Methodist Community Hospitals in Indianapolis, a hospital-led integrated system, defined nine core strategies for his organization. These are shown in Table 10.1 along with his opinion on the degree of emphasis each strategy should receive under each of our four different scenarios for the future of health care.

Some of these strategies—patient satisfaction, cost containment, the uninsured, investment in information systems—would be the same for an integrated system led by a multispecialty clinic. However, most clinic-led integrated systems would not have a strategy with regard to physician integration. They might very well have other strategies, such as enhancing their corporate culture, developing more seamless delivery of care (or “microsystems of care”), and ensuring sufficient financial resources. The discussion that follows combines the strategies of the two major types of integrated systems.

Growth and Improved Market Positioning

Although not specifically mentioned by Corley, integrated systems of all types are concerned about maintaining or improving their market position. Almost every integrated system is focused on growth or at least on gaining sufficient size to achieve economies of scale and balance within the system—for example, the right number of primary care physicians to generate the referrals needed for specialists and for the hospital or an adequate base to support teaching and research.

Geographical Coverage

In our experience, clinic-led systems tend to have larger service areas, and their markets often include small communities in rural settings. The service area of one clinic-led system, Scott & White, and the locations of its care centers, are shown in Figure 10.2.
Table 10.1. Overview of Strategies

Source: Provided by Scott & White.
MeritCare, which involved the former Fargo Clinic, has a large service area including parts of northwestern Minnesota, eastern North Dakota, and northeastern South Dakota. MeritCare has thirty-five locations, plus its main campus in Fargo.

As part of its efforts to solidify and expand the boundaries of its service area, Carle Clinic in Urbana, Illinois, played a lead role in forming Stratum Med, an organization of fifteen multispecialty clinics in central Illinois and parts of Iowa. Robert Parker, M.D., former CEO of Carle Clinic and a founder of Stratum Med, stressed the importance of this alliance to Carle. He said, "Under a future where consumerism and technology dominate, we might sell off some of our assets in order to have money to invest in strengthening our regional network. This is where we would maximize our market position, especially with consumers" (interview, Feb. 2000).

Market Clout with Managed Care Plans
Even if an integrated system owns a health plan or has a partnership relationship with a managed care organization, these types of plans seldom account for a majority of the patients and revenues of the system. Therefore it is important for most integrated systems to develop a strong position vis-à-vis other health plans.

Developing market clout is not necessarily about higher payment rates. Avoiding exclusion from a health plans’ panel of providers could be more important. Most integrated systems, especially those that serve rural areas where they may be the only providers, give priority to making their services available to all residents living in these areas.

Despite criticism of primary care as a strategy, a primary care network is one of the most fundamental ways for an integrated system to develop and maintain market clout with health plans. Without these networks, some health plans would be tempted to exclude some specialists and hospitals.

Brand Name and Reputation for Quality
Establishing a brand name and a reputation for quality is a priority for every integrated system, and many systems have been successful in developing both of these in their service areas. Not every integrated system can be a Mayo Clinic, with a national and international reputation. But most integrated systems can develop strong reputations within their regions.

Among the clinic-led integrated systems we have studied, most have strong regional reputations. These include Lovelace, MeritCare, Park Nicollet, Deaconess-Billings Clinic in eastern Montana and northern Wyoming, Dartmouth-Hitchcock, and Scott & White.

Hospital-led integrated systems have more than held their own in developing brand names and strong reputations in their service areas. Examples include Aurora, Intermountain Health Care, Sutter, Scripps, Sisters of Providence on the West Coast, Allina in Minnesota, and Baptist Health System in Alabama.

Growth Imperatives
Robert Waller, M.D., former CEO of the Mayo Foundation, told us that stopping growth was not an option for Mayo. Several years ago Mayo considered its alternatives, including a no-growth strategy, and concluded that one strategy that should be pursued was to expand nationally. The main reason for this decision was patient mobility—Mayo needed to position itself to be convenient to its patients (interview, Sept. 1999).

We have observed many large integrated health care systems pursuing growth strategies. One goal of these strategies is to build the capacity to serve more patients. Another goal is to maintain a balance between primary care physicians and medical specialists; without growth the systems might end up with too many specialists. As noted earlier, economies of scale are a factor, particularly for integrated systems that run medical schools.

Regional Networks
Establishing or operating primary care offices in their service areas or regions continues to be among the most fundamentally important yet controversial strategies for integrated systems. We are continually struck by the dichotomy between the many hospitals that shed their primary care practices (or drastically restructure their agreements with physicians) and the hospitals that expand their primary care networks. Many integrated systems continue to report that their regional primary care networks are among their most valuable assets.

Related to this last point, the CEO of a hospital-based integrated system in New England told us, “Our thirty-five primary care physi-
cians are valuable. They directly and indirectly account for over half of all admissions to the hospital and [contribute] to our outpatient volume. Sure, we have to subsidize this group, but on a systemwide basis the benefits far exceed the costs.”

**Regional Care Centers Offer More Services**

It is becoming increasingly clear that regional offices must offer more than primary care services—patients want access to medical specialists. Often, obstetrician gynecologists, otolaryngologists, general surgeons, pediatricians, and other specialists from the main campus of an integrated system make half-day or one-day visits to a satellite office on a weekly or monthly basis. This is an important consumer-friendly strategy, and one that is likely to pay off, especially in the new health care marketplace.

**Regional Networks: Conclusions**

We believe that under almost any scenario of the future, integrated systems will benefit from their regional networks of primary care centers augmented by visiting specialists. With consumers valuing convenience, specialized services at the local level, and the personal touch, this type of networking strategy will be successful regardless of how the future of health care unfolds.

**Quality Improvement**

Every mature, successful integrated system has invested heavily in quality improvement—a key aspect of added value, as described in Chapter Two. These investments in time and effort have often been in the form of clinical guidelines, or information systems and analysis, that identify and promote best practices. Integrated systems that have been national leaders in the development of clinical process improvement include Intermountain Health Care, Dartmouth-Hitchcock, Lovelace, and the Mayo Clinic. These organizations, and most other integrated systems, have long recognized that the extreme clinical variation existing across the country is becoming unacceptable to employers, health plans, Medicare, and consumers.

Kevin Fickenscher, M.D., former chief medical officer of Catholic Healthcare West and senior vice president of CareInsite, told us that developing clinical guidelines is only part of the story. “These systems,” he said, “have to finish the job by putting in place the clinical and administrative processes to make sure these guidelines are implemented. This may be the toughest part, but until it happens, the payoffs will be minimal” (interview, Sept. 1999).

Frank Villamaria, associate medical director for quality and board member at Scott & White Clinic, told us that guidelines have to be designed so that they can be easily implemented. As he noted, however, “This is not always possible.” He added, “When the guidelines are too complicated, or take too much time to understand, the chances of their being used are greatly diminished.” Scott & White had reduced the number of guidelines to fifteen in late 1999 and was focusing on developing retrospective measures of physician performance and overall quality. Villamaria said, “We have found that providing physicians data showing how they compare with their peers works well in improving practice patterns and reducing clinical variation” (interview, Nov. 1999).

At Dartmouth-Hitchcock the focus is on continuing to encourage physicians and other clinical practitioners to develop “microsystems of care” that are based on careful analysis of patients’ needs, best clinical outcomes, and cost-effectiveness. A physician leader told us, “This is slow work, and it is difficult. We have to have champions who really believe in these kinds of models. However, we can see progress over the past decade, and we are encouraged that clinical process improvement is critical for improving health care.”

**Investment in Information Technology**

In our analysis of various types of health care organizations over the past decade, we have found that integrated systems have been leaders in investing in and developing comprehensive information systems. Furthermore, the efforts of most of these systems have been ambitious, spanning the medical group, hospital, and often the health plan and incorporating the Internet.

**Examples of Paperless Systems**

Robert Waller, M.D., of the Mayo Foundation told us that the Mayo site in Jacksonville is paperless: “Physicians can pull up a medical record from anywhere in the clinic. Physicians in Jacksonville would
never go back to the paper medical record" (interview, Sept. 1999). However, given the much larger size of the medical enterprise in Rochester, Minnesota, the Jacksonville information system is not scalable up to the much larger Rochester clinic.

Kaiser Permanente in Colorado has a paperless medical record. This $160 million system was created in a joint venture with IBM. As of early 2000 this paperless medical record was being introduced in other Kaiser Permanente regions, beginning with Hawaii. Toby Cole, M.D., former head of the Permanente Medical Group in Colorado, told us, "There are no paper records except in storage. Physicians keyboard their notes into the electronic system" (interview, Jan. 2000). Kaiser Permanente expects significant productivity improvements and better service to members.

Partial Development of Information Technology
In many integrated systems, IT is a work in progress. For example, at Dartmouth-Hitchcock in New England, an EMR is partially developed. Peter Johnson, chief information officer of the IT group, said, "In addition to the electronic medical record, our definition of information systems includes telephone systems, the Internet, our intranet, e-mail, physician notes, pharmacy, and laboratory. We are proceeding on all fronts and at a pace that meets the needs of our physicians. Ours is definitely an incremental approach." Development of an EMR at Dartmouth-Hitchcock is facilitated by the fact that hospital and clinic medical records have been combined for decades. Johnson said, "We don't have to fight that battle, and that makes it easier." Johnson also noted that Dartmouth-Hitchcock had benefited from the investment in IT by other large systems, including Intermountain Health Care (interview, Jan. 2000).

Some of the large integrated systems say that the high capital investment required for full implementation of IT is beyond their means, and they are seeking partners, such as IBM (which partnered with Kaiser Permanente) and 3M (which partnered with Intermountain Health Care). The CEO of one system told us, "It is critical that we move in the direction of a paperless system, but we can't afford it on our own. We are going to have to have a partner."

Our conclusion is that gaining economic benefits (such as reduced costs of dictation), achieving time savings for physicians and nurses, replacing telephone calls with automated systems, increasing consumer satisfaction, and gaining physician acceptance are the drivers of the development and adoption of IT in integrated systems.

Clinical Integration, or Seamlessness
Most integrated systems have the goal of improving clinical integration, "which can be defined as the seamless delivery of care to patients, or the right care at the right place at the right time" (Young and McCarthy, 1999, p. xi). We have heard about seamlessness time and again in our ongoing research into integrated systems. What seamlessness really means is total coordination of patient care—eliminating duplication of effort and ensuring the smooth transition of patients among physicians. At Dartmouth-Hitchcock this is accomplished through dozens of microsystems of care within the overall organizational structure.

Gigi Hirsch, M.D., CEO of IntelliNet, based in Boston, said that the biggest challenge for the future is creating true care teams and involving patients in these teams. "Our collective adversary is illness and its related suffering," Hirsch said. "We need to work on involving physicians in these types of change processes" (interview, July 1999).

Unfortunately, the health care market does not reward seamlessness as much today as it likely will in the future. Therefore we do not anticipate that clinical integration is a strategy that would pay large dividends for integrated systems under a business-as-usual scenario or under poor economic conditions. However, we fully expect integrated systems to pursue clinical integration even if the financial rewards are not immediately evident.

However, when consumers take charge, supported by greater access to information and technology, we expect interest in clinical integration to increase dramatically. The same would be true of the "first cousin" of clinical integration: chronic disease management. Stories of consumers being inconvenienced, being asked the same questions over and over, undergoing duplicate tests, and suffering poor coordination of care (for example, when medical staff does not administer beta-blockers to heart attack victims) are common. We do not believe that consumers will tolerate a lack of coordination when they find there are better ways.
Corporate Culture

Among integrated systems, the development and enhancement of corporate culture are a top priority. Of all the health care organizations we have worked with and studied over the years, the major integrated systems, usually led by multispecialty clinics, have the most impressive corporate cultures. Indeed, they could not function without strong corporate cultures.

Corporate culture primarily refers to core values, which can include a commitment to patient care, quality, service, research, medical education, teamwork, mutual respect, and loyalty to the organization. Related to this aspect of core values, one physician leader of a large integrated system (a surgeon) told us that although he personally would prefer spending his time performing surgery, taking on management and leadership responsibilities was more important. “I love this organization, and I will do anything I can to make it successful,” he said. Expressions of strong loyalty to the organization are not uncommon in many of the more advanced integrated systems.

However, over a period of time, the stresses and strains on many integrated systems, especially those led by hospitals, tend to create divisiveness and mistrust. Many coalitions formed between hospitals and physicians fall apart. The personal relationships that are a necessary part of a strong corporate culture never have a chance to develop and mature.

We believe that when consumers increasingly take charge, health care organizations with strong core values will enjoy a significant competitive advantage. These values almost always put the interests of the patient above all other interests. Organizations with these kinds of core values can move quickly in response to changing consumer needs. And they can do so in a unified manner, with physicians working together and with the medical group and hospital coordinating their efforts.

Development of Physician Leadership

F. Kenneth Ackerman Jr., a longtime leader of the Geisinger System in Pennsylvania and a vice president of McManis Consulting, believes that developing physician leadership continues to be a major strategic issue for integrated health care systems. He said, “There is some progress being made, but it is going to take a number of years before we have a large supply of proven physician leaders” (interview, Oct. 1999).

Based on our research, we believe that physician leadership tends to develop more naturally in integrated systems led by medical groups. In these types of organizations, there is a culture of physicians willingly spending time on management and leadership. For example, the seven physicians on the board of the Scott & White Clinic spend at least five hours a week (7 A.M. to noon every Wednesday) governing and managing the clinic. Physician members of the boards of governors of Mayo and Dartmouth-Hitchcock make substantial time commitments.

One physician leader of an integrated system, a cardiologist, told us that he makes an effort to read books on management and leadership and participates in professional organizations that focus on leadership issues. “In effect,” he said, “I have burned some bridges in my medical practice; I no longer do invasive cardiology. But I believe that I can impact the health of more people by taking a leadership position in this organization.”

We believe that physician-led integrated systems, more than any other type of health care organization, have the best chances of developing physician leaders. This kind of leadership will be especially important as consumerism and technology become more important. The new health care marketplace will involve massive shifts in the way health care is organized and delivered, and we expect physicians to lead these efforts.

Improvement of Financial Performance and Access to Capital

Improving financial performance has emerged as one of the most important issues for health care systems of all types, and integrated systems are no exception. Despite doing many things right from a market and clinical perspective, the financial results have often been disappointing. Just as a number of hospitals and health plans posted significant operating losses in the late 1990s, including some of the most prestigious in the country (Kaiser Permanente and Harvard Pilgrim among them), integrated systems have had difficulty demonstrating profitable operations. This kind of incon-
sistency leads to problems in ensuring long-term access to adequate capital.

Responding to Pricing and Reimbursement Pressures

Pricing and reimbursement were key issues for integrated systems in the late 1990s, and the pressure is unlikely to abate—particularly if resources are limited because of weak economic conditions. In late 1999 at a meeting we participated in with twelve CEOs of integrated systems, coping with the BBA was the most important issue. One CEO said, “We anticipate some additional relief, but not enough to really solve the problems we are facing and expect to face in the future. We are going to have to cut programs.” The chairman of the board of one large integrated system told us that the system had lost $30 million in 1999—“We were blindsided on this one,” the chairman said—and that it was all attributable to poor Medicaid reimbursement. Furthermore, the losses were expected to be higher in subsequent years.

The reasons for the poor financial performance of some integrated systems run the gamut: being squeezed by health plans and Medicare, poor medical management, information system errors (underreporting of costs), acquisition of medical practices that do not perform up to expectations, poor rate setting for health plans, high administrative overhead, high costs of outlying primary care clinics, merger with another organization, and (sometimes) undoing a merger.

Reducing Operating Expenses

Like hospitals and medical groups, integrated systems have experienced difficulty in controlling their operating costs. One CEO told us that his system would be cutting its costs by 10 percent in the coming two years. “But,” he added, “we aren’t sure that will be enough, given the constraints of the BBA and the pressures of managed care.” The CEO of a metropolitan-area integrated system that experienced significant operating losses in 1998 and 1999 told us, “I would like to believe that revenue enhancement would be the answer for us, but we can’t count on it. We have to do everything we can to cut costs.”

The chief financial officer of an integrated system led by a multispecialty clinic in the Upper Midwest said that one of the advantages of an integrated system, as compared with a stand-alone hospital, is that an integrated system is somewhat protected from the impact of the BBA: “In some ways, physician reimbursement comes out ahead. We don’t have home health, a skilled nursing facility—and very few interns. While the BBA has had a negative impact on the hospital, these other considerations minimize the overall effects.”

Another CEO disagreed with placing too much focus on the cost-cutting strategy, saying, “If our only strategy is to cut costs, we will disappear.” In our interviews with the leaders of integrated systems, we often heard statements such as, “You can’t downsize your way to survival. This is a one-way street.”

Propping up Primary Care

Long before the current concern over subsidizing primary care practices, the leaders of integrated systems recognized that primary care offices rarely cover their full costs. One physician leader of an integrated system told us, “We don’t think of it as a subsidy. If we didn’t have our regional network, overall system profitability would suffer. You can’t look at the financial performance of just one piece of an integrated system.”

While showing patience with the financial performance of their primary care networks and reaffirming the importance of those networks, most integrated systems are searching for organizational and technological approaches that will reduce costs and, they hope, lead to something close to break-even operations for these regional networks. Their approaches include using an MSO model, working more closely with small community hospitals, adding ancillaries (for example, a laboratory or pharmacy), improving information systems, achieving economies of scale by eliminating very small practices, and enhancing specialty services in the field.

Merging with Hospitals

Mergers with hospitals have been a partial solution to the problem of weak financial performance and lack of access to capital. A number of multispecialty clinics and hospitals that have been partnering in virtually integrated systems have merged, or are considering merger, in order to streamline the care process and improve access to capital. The desire to eliminate duplication, lower costs, and re-
duce complexity is also a motive for these types of mergers. Here are four examples of such mergers:

- Billings Clinic, a 120-physician multispecialty clinic, merged with the 306-bed Deaconess Medical Center, in Billings, Montana.
- In 1993 Fargo Clinic, with 250 physicians at the time, merged with the 311-bed St. Luke’s Hospital in Fargo, North Dakota, to form MeritCare. According to MeritCare executives, the immediate-term impact on the bottom line was highly beneficial.
- In 1995 Q&R Clinic, comprising 90 physicians, in Bismarck, North Dakota, merged with Medcenter One, a 230-bed hospital.
- Since the mid-1980s the Mayo Foundation has acquired two hospitals in Rochester and one in Jacksonville and has built its own hospital in the Phoenix area.

At the time of this writing, a number of other for-profit multispecialty clinics were seriously considering merging with not-for-profit hospitals, primarily to improve access to capital and reduce concerns over inurement. One clinic administrator told us, “We are getting tired of spending so much time on internal negotiations between the hospital, clinic, and health plan. By becoming a single entity, we can focus on meeting the needs of people in our area and on being more competitive.”

Gaining Access to Capital

Although a limited number of large integrated systems have deep pockets and few financial worries, most are concerned about their ability to finance the new technology (with IT at the head of the list) and infrastructure (or teaching and research programs) needed to be successful during the first five years of the twenty-first century. The BBA has created enormous problems and challenges for these types of systems.

A future characterized by constrained resources would be a financial disaster for many integrated systems. An incremental-change scenario would not be particularly favorable either, in that the marketplace would be unlikely to reward the more coordinated,

comprehensive systems of care. However, a scenario in which technology and consumerism dominate would provide the kind of environment where integrated systems could perform well financially and therefore be able to attract the capital they need to develop technology and provide a wider variety of services.

Conclusions

Despite reports to the contrary, integrated health care is far from dead. In fact, true vertical integration is not on the defensive or declining. It may appear to be in decline because of the wide publicity given to the many hospitals with a 1990s-type vision of integration that have dropped their health plans, severed their mergers with other hospitals, and either reduced or eliminated the number of employed physicians. Many of these hospitals have rejected the integration strategy, deciding instead to “get back to the basics.”

By the end of the 1990s most integrated systems had long since made the decision to focus on consumers, employers, and health plans as their primary customers. By contrast, many hospitals had decided to focus on physicians as their customers. In the more advanced integrated systems, physicians and hospitals are both leaders and partners in meeting consumer needs. This is an important point that must be taken into account in order to understand the true focus of vertical integration and to understand why we believe those systems that are faithful to their vision and core values will succeed in the future.

Nearly everyone on the boards or management teams of integrated systems realizes that those systems have to improve their financial performance in order to generate investment dollars and secure their future. The focus has to be on doing a better job of meeting the needs of consumers, and at a lower cost. This is especially important for integrated systems. If they cannot demonstrate substantially greater added value for their customers, they will not survive in their present form.

We believe that most integrated systems will thrive in the new health care marketplace, where consumerism and technology will be the key drivers. The more that technology dominates and consumers make their own decisions and control their own care, the better the chances of success for organizations that focus on coordinated care.