Chapter 4

# *Entrepreneurial Challenges to Integrated Health Care*

James C. Robinson

The U.S. health care system is an ongoing experiment in the effort to achieve social goals through market mechanisms—to pursue the public good through private interests. The era of managed care encouraged competition among insurers, capitation contracting between health plans and providers, and the organizational integration of physicians and hospitals to contain costs and foster access to primary care. The ensuing consumer and provider backlash and the failure of many diversified organizations to deliver improvements in quality and efficiency have today substituted a different set of social goals. These include the unwinding of many consolidated organizations, unconstrained access to specialty services, and a commensurate reversion to broad insurance networks and fee-for-service payments. As before, much of the energy for change comes from the private sector. Rather than focus on reducing costs and integrating organizations, however, the entrepreneurial emphasis today is on enhancing revenue and creating niche organizations such as ambulatory surgery centers and single-specialty hospitals.

The record of the private sector during managed care was mixed. That sector marshaled the energy to overcome the organizational fragmentation of the indemnity era but then engaged in overconsolidation. The contemporary drive toward specialization is producing an analogous mix of desirable and undesirable effects. Unbundled services foster managerial and clinical focus, learning-curve efficiencies, and competition within an otherwise consolidated industry. Yet entrepreneurial entrants are targeting only services and patients whose payment rates exceed treatment costs, thereby undermining the implicit subsidies for underpaid services and underinsured patients.

Specialized niche firms also threaten to create a new form of corporate conglomerate by establishing chains of facilities across geographic regions and the nation. Despite talk of focus, the entrepreneurial drive for more revenue is pushing firms into new markets and new products, with the axis of growth shifting from diversification across services within markets (the integrated physician-hospital organization) to diversification across markets within service lines (chains of ambulatory centers and specialty hospitals).

In this environment, integrated delivery systems are shrinking, hobbled by the diseconomies of scope that attend efforts to incorporate services with distinct technologies, professions, customers, and regulatory regimes. Service-specific chains are expanding but face new challenges as they seek to penetrate new geographic markets. Multiservice hospitals—both nonprofit and for profit—are defending themselves by creating subsidiaries and physician joint ventures to achieve the efficiencies attributed to their focused competitors without losing the benefits of diversification. Policy responses—in the form of certificate-of-need regulation and bans on physician referrals to facilities where they have an ownership interest—protect both the public interest (by supporting general hospitals that subsidize care for the needy) and private interests (by sparing general hospitals the rigors of competition).

The remainder of this chapter analyzes the rise of single-specialty hospitals and freestanding ambulatory facilities, emphasizing product and market diversification as alternative strategies for growth. Emphasis is placed on the entrepreneurial, for-profit firms that inject most of the creativity and chaos into the health care delivery system and on responses by nonprofit, full-service institutions. I conclude by highlighting the tendency of every good idea to be pressed too far and every innovative startup to expand beyond the products and markets where it has a distinctive advantage.

## Diversification across Services

Depending on one's perspective, the health care ecosystem is either very stable or in a state of continual turbulence. Despite innumerable proclamations of social and corporate transformation, most physicians continue to practice in very small groups, and most hospitals remain full-service, nonprofit institutions. Yet the organizational structure of medicine has seen major experiments in recent decades—some successful and most not. Particularly salient were efforts to integrate professional and institutional services both vertically and horizontally. This entailed creating "integrated delivery systems" (IDS) composed of primary care and specialty physicians, acute and subacute inpatient facilities, ambulatory surgical and diagnostic centers, and other major components of care.

Such integrated entities pursued the administrative and clinical economies of scope that can accrue to organizations that offer mutually supportive products and services (Panzar and Willig 1981; Teece 1980). These efficiencies included cheaper procurement of supplies and information technology; coordination of care from outpatient to inpatient to subacute settings; elimination of excess capacity and duplicate equipment; use of evidence-based guidelines for managing chronic disease; enhanced branding and cross-marketing of services; and financial gains from capitation payments for a full range of services.

The profit opportunity latent in clinical and administrative integration did not escape the notice of those whose mission it is to seek out such opportunities. Investor-owned hospital chains and physician practice management (PPM) firms recognized that most existing delivery systems combined moneymaking with

money-losing activities, with losses dissipating any gains. By targeting remunerative services and avoiding services that suffered from below-cost payment, firms could avoid undermining their gains and lay the financial foundation for regional or national expansion.

Investor-owned firms thus adopted a somewhat narrower scope of services than the traditional IDS, focusing on inpatient facilities (hospital chains), physician services (multispecialty PPM firms), or one form of care (specialty PPM firms and rehabilitation or ambulatory surgery chains). These firms expanded by diversifying across markets, thereby obtaining new opportunities while reducing their exposure to the economic and political idiosyncrasies of each region (Lutz, Grossman, and Bigalke 1998; Lutz and Gee 1998; Coddington, Moore, and Clarke 1998; Burns and Robinson 1997; Robinson 1999). The logic of growth then drove many investor-owned firms to diversify across services as they approached the limits of diversification across markets. PPM firms that once focused on primary care added multispecialty clinics, multispecialty PPM firms added independent practice associations and emergency room physician services, hospital chains acquired physician practices, and rehabilitation chains moved into ambulatory services.

The rest is history. The perceived profit opportunity that drew venture capital and entrepreneurial energy into the health care system also attracted the attention of governmental and corporate purchasers, who naturally believed that any surplus should remain with them. The aggressive stance of private purchasers toward health insurance plans in the mid-1990s, compounded by the federal Balanced Budget Act of 1997, cut payments to hospitals and (via the HMOs) to physician organizations.

These moves transformed the profit opportunity from coordinating a full range of services to selectively targeting those that continued to enjoy advantageous payment rates. The squeeze on revenues was accompanied by accelerating costs for multispecialty consolidators, and economic fate was especially harsh for systems that had grown through mergers and acquisitions. Such organizations often found themselves owning overlapping, noncooperative, and overpriced physician and hospital properties, and afflicted with excess capacity, low productivity, and culture clashes.

Many consolidations occurred through bidding wars in which organizations overpaid even for well-performing units, and the practices and facilities most willing to sell were those consolidators should have been least willing to buy. Such acquisitions transformed physician practices from mom-and-pop enterprises—where every dollar saved was a dollar earned—to multispecialty bureaucracies that spread rewards and penalties over the entire system rather than focusing them on responsible parties (Robinson 1999, 2001). Rather than spurring coordination, the amalgamation of primary, specialty, inpatient, outpatient, and ancillary services often led to a financial and cultural war of all against all (Burns and Pauly 2002). Many nonprofit systems and for-profit chains found that the whole of their overbuilt organizations was worth less than the sum of the parts, and they began to divest.

The refocusing of the health care system was nasty, brutish, and short. As

usual, Wall Street first sensed the change in industry prospects from high growth to no growth and made an expeditious exit. The collapse of share prices and an inferno of shareholder litigation destroyed PPM firms, which dumped their medical groups onto the market. Many hospital systems also divested the physician practices and ancillary facilities they had acquired, albeit in a more deliberative fashion to retain patient admissions. Investor-owned hospital chains retrenched from national expansion and spun off facilities in markets they could not dominate. Bankruptcy courts opened their arms to embrace the fallen, and one cycle of organizational growth and contraction was complete.

## Diversification across Markets

In the aftermath of managed care, a new set of organizational strategies and structures emerged in the health care delivery system. Rather than seek growth and profits by reducing costs under capitation, health care organizations now seek growth and profits by increasing revenues under fee-for-service. Rather than trying to coordinate a continuum of clinical providers and services, entrepreneurial energies now focus on particular specialties, facilities, and procedures where the price-cost margin is most attractive. Primary care physicians and full-service hospitals have been displaced by specialty physicians and single-specialty hospitals, ambulatory surgery centers, and freestanding diagnostic facilities as the heralded components of a new consumer-oriented health care system (Herzlinger 1997; Weaver and Waugh 2002; Triple Tree 2003).

### *Freestanding Ambulatory Surgery Centers*

While much attention has recently focused on single-specialty inpatient facilities, the more important challenge to full-service hospitals is the freestanding ambulatory surgery center. Outpatient procedures as a proportion of total surgeries rose from 20 percent in 1981 to 80 percent in 2003, with almost half of these procedures performed in freestanding facilities or physician offices rather than hospital outpatient departments.

Outpatient surgery has risen partly because changing technologies and incentives have spurred more procedures per capita (Schramm and Gabel 1988; Kozak, McCarthy, and Pokras 1999). The growth in freestanding centers, meanwhile, derives partly from their ability to schedule procedures free from emergency interruptions, enhanced roles for physicians in governance, better architectural designs for operating rooms and supporting facilities, and smaller-scale and more convenient suburban locations. The prospects of these ambulatory surgery companies fluctuate with the financing and regulatory environment. The late 1980s and early 1990s saw an investment surge, as Medicare's payment system reduced the attractiveness of inpatient alternatives, while the late 1990s brought a major contraction owing to pressure from the Balanced Budget Act. Over the past several years the number of freestanding centers has grown dramatically, rising from 2,314 in 1996 to 2,755 in 2000 to 3,400 in 2002 (Cain Brothers 2003; Triple Tree 2003).

Many ambulatory surgery centers are owned by individual physicians or physician partnerships (including specialty group practices), but a growing number are consolidating into national investor-owned chains, including both multiservice hospital chains (such as HCA, Tenet, Universal Health Services, and Triad) and outpatient chains (including AmSurg, United Surgical Partners International). The strong and committed presence of multiservice hospital chains indicates that diversified conglomerates can seize growth opportunities outside their core model. Still, the majority of chain facilities are not affiliated with inpatient hospitals.

HealthSouth, the nation's premiere "focused factory," dwarfs all these ambulatory surgery companies. HealthSouth has fallen on hard times owing to its exceptionally aggressive growth strategy. Formed in 1984 with an emphasis on inpatient rehabilitation, HealthSouth quickly diversified into outpatient rehabilitation and then outpatient diagnostic services, owning 50 outpatient centers by 1990 and 250 by 1994. In 1995 it acquired Surgical Health Corp., the nation's second-largest chain of ambulatory centers, with 37 facilities, plus 12 surgical centers from the nonprofit Sutter Health system in California. The following year HealthSouth acquired Surgical Care Affiliates (67 surgical centers), Health Images (55 diagnostic imaging centers), ASC Network Corp. (29 surgery centers), and National Imaging Affiliates (8 diagnostic imaging centers). In 1998 HealthSouth acquired HCA's ambulatory surgery subsidiary (34 centers) and National Surgery Centers (40 centers).

The firm's acquisitions and growth then stalled, in part because of slowing revenue growth attributable to the Balanced Budget Act and in part because of the inherent difficulties of integrating this many acquisitions so quickly. Throughout the growth period HealthSouth was acclaimed in industry circles as the leading example of what single-service focus and geographic diversification could achieve. However, much of HealthSouth's apparent success was fraudulent, disguised by senior management to its benefit and the detriment of shareholders. Under a wave of government investigations and shareholder lawsuits, all senior managers were replaced (many facing criminal indictments), the firm faced bankruptcy, and creditors insisted that the company divest its surgery centers to cover its financial obligations (Mollenkamp 2003).

***Specialty Hospitals***

Specialty hospitals resemble ambulatory surgery centers in that they focus on a narrow range of surgical procedures, but the former add inpatient beds and hence can provide more intensive and expensive treatments. The General Accounting Office identified 92 specialty hospitals operating as of February 2003—up from 29 in 1990, with 20 more under development (U.S. GAO 2003a). These facilities included 17 focused on cardiac procedures, 36 on orthopedics, 22 on general surgery, and 17 on gynecology. Three-fourths of the facilities had physician investors or co-owners, and 20 percent were owned completely by physicians. While the ownership stake of any one physician in a specialty hospital is low—usually less than 2 percent—half the facilities with some physician investment reported group ownership stakes of 25 percent or greater (U.S. GAO 2003a). In some

markets specialists are merging their practices into larger single-specialty groups precisely to purchase clinical equipment and ambulatory surgical suites (Casalino, Devers, and Brewster 2003). Nonphysician investors in specialty hospitals include nonprofit full-service hospitals, privately held for-profit entities, and one publicly traded corporation. Some one-third of specialty hospitals are independent, one-third are owned by chains, and one-third are owned by general hospitals—the latter usually in the form of joint ventures with local physicians (U.S. GAO 2003b).

The Indianapolis experience illustrates the dynamics of the specialty hospital market, which involves local specialists, outside chains, and incumbent full-service hospitals (Cain Brothers 2003; Katz, Hurley, and Devers 2003; Abelson 2003). In that city a proliferation of heart hospitals began with the threat of a joint venture between local cardiologists and a specialty hospital chain. Two of four multiservice hospital systems then created their own freestanding heart hospitals: St. Vincent Health, in collaboration with the Care Group physician organization, and Community Hospitals Indianapolis, with its staff physicians. Indiana University and Methodist Hospitals then created a cardiac hospital-within-the-hospital, and St. Francis Hospitals moved its heart program to a new facility.

The Center for Studying Health System Change identified ten specialty hospitals in three of the twelve communities it has tracked since 1996 (including Indianapolis). Of these, one was physician owned (medical group), three were owned by local hospitals, two were joint ventures between physicians and local hospitals, and four were joint ventures between physicians and investor-owned chains. The presence of a large single-specialty physician group and the absence of certificate-of-need legislation (under which regulators approve new facilities and equipment) at the state level facilitated the creation of specialty hospitals (Casalino, Devers, and Brewster 2003).

As the sole publicly traded chain of specialty hospitals, MedCath has received the greatest attention, evoking both praise as the harbinger of a new disaggregated health care delivery system and criticism as a financial drain on community hospitals that rely on cardiac surgery profits to subsidize money-losing services such as trauma care. The evolution of MedCath exemplifies the impetus for growth and diversification (Cain Brothers 2003).

Founded in 1988, MedCath went public in 1994 as an operator of mobile cardiac catheterization laboratories; its first heart hospital opened two years later. Caught in the firestorm of investor disillusion with specialty physician practice firms, MedCath went private in 1998 through a management-led leveraged buyout, and then returned to the public capital market with its second initial public offering in 2001. It now co-owns nine facilities with local cardiologists and/or a local hospital, with its stake ranging from 51 percent to 71 percent, and has another three facilities in various stages of development. The newest MedCath facility departs from the smaller, cardiac-only prototype, which averages 58 beds: it contains 112 beds, 12 labor/delivery suites, 16 ICU (intensive care unit) beds, and 36 pure cardiology beds.

The successes enjoyed by the specialized firms reflect astute selection of services and markets as much as efficiency in delivering care. If the business model

of a limited range of services were itself the source of competitive advantage, we would observe niche firms in every health care sector. In practice, focused factories concentrate in surgical and diagnostic services where clumsy payment mechanisms by Medicare and private insurers leave money on the table, creating profit for all participants. Traditional hospitals object to the new freestanding entrants precisely for this reason.

Yet the reliance of specialty chains on payment inefficiencies and operating efficiencies leaves them exposed to an eventual wakening of the sleeping giant. There is no reason to assume that Medicare will not slash payments to ambulatory surgery and specialty hospital chains just as it balanced the federal budget on the backs of nursing home and home health chains a few years ago. Implicit but important in the business model of all entrepreneurial health care firms is an exit strategy. Diversification across products and services enables nimble firms to refocus their activities and revenue streams as payment and profit opportunities rise and fall across sectors.

## Organizational Hybrids

Rather than the single-service, multi-market chain or the multiservice, single-market hospital dominating the health care delivery system, hybrid organizational forms will likely play a prominent role and share the market with their more focused competitors. In the major non-health sectors of the economy, corporate holding companies with multiple divisions—each responsible for its own products, suppliers, customers, and profit-and-loss accounting—have balanced the virtues of focus and specialization with the virtues of scale and scope. In the language of organizational economics, M-form firms (with multiple semi-autonomous divisions) often dominate U-form firms (those with unitary organizational hierarchies) (Chandler 1962, 1990; Williamson 1985). It is hard to find a single-product firm in any sector, and hard to find a single-market firm among any but the smallest organizations. The M-form firm pursues the advantages of specialization by establishing divisions that mimic the focus of single-product competitors, but it supplements these with the financial, political, and managerial resources of a larger entity.

The M-form organization is already evident in health care. Full-service community hospitals and academic medical centers are experimenting with subsidiaries and physician joint ventures for services most attractive to chain competitors: surgery centers and specialty hospitals. Nonprofit hospitals can create for-profit subsidiaries in which physicians invest, though care must be taken to avoid violating legal and cultural prohibitions on self-referral and fee-splitting.

These subsidiaries take the form of cardiac and orthopedic surgery hospitals, women's health centers, and MRI (magnetic resonance imaging) facilities, among others. They can be located near the mother facility or at other locations that are convenient for physicians and patients. They feature intimate settings for patients and efficient throughput for physicians, who participate as referral sources as well as clinicians. Such facilities can refer more difficult cases to the full-

service facility without raising charges of patient dumping. Physicians share governance and net earnings in proportion to their investment and referral volume, rather than equally across the larger hospital's medical staff. Management can be compensated based on the financial performance of the subsidiary in addition to that of the entire organization.

Besides mimicking the potential advantages of single-specialty chains, M-form health care organizations can gain the economies of scale and scope of multi-product firms. The single-specialty subsidiary can be viewed as contributing to the success of the larger organization rather than undermining it—important to physicians, patients, and politicians who worry about the sustainability of institutions that offer unprofitable teaching, safety net, trauma, and primary care services. The M-form is also less likely than the out-of-town chain entrant to evoke the ire of hospital labor unions, philanthropists, and state regulators.

While highlighting the autonomy and accessibility of its subsidiaries, the M-form organization can impose some system-wide requirements, such as that physician-investors also provide care in the mother facility and that some of the subsidiary's profits subsidize money-losing patients and procedures elsewhere. The M-form organization can pursue the "economic credentialing" of its medical staff, denying admitting privileges to physicians who refer their profitable patients to a single-specialty competitor. The M-form firm can tap the larger system's cash flow and borrowing capacity to obtain financial capital, though the value of the diversified firm as an internal capital market varies by its operating margin, debt burden, and credit rating (Standard and Poor's 2003).

The multidivision organization can also plan capacity in a unified manner, responding to rising demand by channeling new beds into specialty facilities rather than expanding the multispecialty hospital. If specialty chains have attracted superior managerial talent through their culture of entrepreneurship, the M-form firm can contract with them to manage their specialty facilities.

The new M-form hospital organizations may be more efficient than the organizations built during the 1980s and 1990s, despite their often diversified, holding-company structures, as they are designed with a clearer emphasis on return on investment. As shown outside the health sector, the least efficient form of diversification is that pursued by large entities in declining industries, where consolidation permits high operating profits, but where possibilities for growth within traditional sectors are limited (Jensen 1986; Jensen and Ruback 1983). Firms with free cash flow (earnings beyond profitable investment opportunities in the industry of origin) are tempted to expand into adjacent products and markets.

Rarely, however, do managers who are well adapted to one set of products, technologies, and customers prove equally successful in new contexts. Much more common are low or negative returns in the new lines of business that must be subsidized by traditional profitable activities. In a competitive economy, these conglomerates will be challenged and ultimately brought down by more focused and efficient competitors, or by hostile takeover (leveraged buyout). In the nonprofit health care sector, competitors in the product market appear in the form of spe-

cialty chains, while competitors in the capital market appear through conversions and acquisitions by investor-owned chains (Voelker 2003; Robinson 2000).

During the 1980s and 1990s, the inpatient hospital sector suffered from excess capacity and a lack of internal growth opportunities because of technological changes and capitation payments favoring outpatient care. Many an IDS was built by hospital managers unwilling to fade quietly into the background of the health care industry they once dominated. The acquisition of primary care practices—to say nothing of unproductive mergers with other over-bedded hospitals—were consummated in apparent disregard for financial returns. Now, however, the industry has sweated out excess inpatient capacity, utilization rates are rising, and many hospital organizations need to finance core services (Robinson 2002).

The renovation and expansion of physical facilities, continual updating and replacement of expensive clinical machinery, and long-deferred investment in information systems are making hospitals ever more attuned to the perspectives and priorities of capital markets. The sector has no more free cash flow. Operating surpluses are substantial, at least in consolidated markets with rising hospital admissions, but every dime earned can be invested profitably in the core business. Now hospital systems, both nonprofit and for profit, must justify their capital strategies to investment bankers, equity analysts, bond rating firms, bond insurers, and the other entities that collectively promote the accountability of borrowers to creditors (Gordon, Federbusch, and Nelson 2003). The emerging M-form hospital conglomerate will be subject to line-of-business financial analysis to an extent unknown in previous decades.

## The Pyramiding of Regulation

The success of ambulatory surgery chains and specialty hospitals in some markets, coupled with the evident willingness of Wall Street to finance a national expansion, has prompted a virulent response by general multiservice hospitals. The industry has promoted state certificate-of-need (CON) legislation and the extension of federal bans on physician referrals to facilities in which they have an ownership interest. These two types of regulation, singly or in combination, would stifle the challenge from specialized upstarts; almost all specialty facilities are in states without CON legislation, and almost all have physician investors. Proponents of these policies argue that they redress imperfections in the marketplace, while opponents argue that they merely protect incumbents from the rigors of competition.

### *Certificate of Need*

CON statutes date back thirty years to the era when the perceived problems in health care were excess capacity and high-cost technologies in general hospitals, which prompted states to require regulatory approval of new facilities and equipment. CON laws were only partially effective in achieving their goals, as incumbent hospitals lobbied through their desired expansions. Academic critics labeled such influence a form of regulatory “capture,” but it appears to have stopped

specialized facilities from entering the market (Payton and Powsner 1980). Today incumbent hospitals have an interest in the effectiveness rather than the impotence of regulatory commissions.

The policy argument in favor of CON oversight of specialty facility construction is that general hospitals rely on patients and procedures whose payments exceed costs to subsidize patients and procedures whose payments fall below costs. Specialty facilities that focus their services on the most profitable patients and procedures undermine this cross-subsidy and ultimately may force denials of care in multispecialty general hospitals. More broadly, CON constitutes a form of capacity planning or "upstream rationing," which, in the eyes of its supporters, is needed owing to rampant technological diffusion and cost-unconscious consumer demand. Whereas health planning and regulation fell into disfavor during the two decades of enthusiasm for market-oriented health policy, they now may revive in the wake of the backlash against capitation, vertically integrated delivery systems, and other features of managed care (McDonough 1997).

Critics of CON acknowledge inefficiencies in the mix of health care payment methods in the health care market but despair at the form of entry regulation that CON represents. The standard history of regulation in other industries begins with one market imperfection for which regulatory intervention is the proffered solution. The ensuing regulatory equilibrium is then undermined by changes in technology, consumer demand, and competing products. The declining efficacy of the original regulatory structure generates calls by the regulated industry to limit competition from new sources that heretofore had escaped control (Posner 1971; Banks, Foreman, and Keeler 1999).

Rate regulation of railroads, for example, was justified originally as a response to the potential for exploitive pricing by natural monopolies, and then was used to finance subsidies from highly traveled inter-urban lines to thinly traveled rural lines. The nascent trucking industry targeted inter-urban routes where regulators maintained rates above costs, thereby undermining subsidies to rural routes and leading to an extension of rate regulation to trucks. The regulation of interstate trucking led to high prices, excess capacity, and a range of inefficient practices until it was repealed in the face of intense opposition from the trucking industry and labor (Peltzman 1989; Winston 1993).

The extension of CON to cover specialty hospitals follows a parallel logic, even if the specifics are different. The reliance on administered pricing by Medicare creates categories of profitable and unprofitable procedures, and of profitable and unprofitable patients within each diagnostic category (as hospitals are paid the same rate for patients with illness of different severity levels). The unwillingness of the polity to finance universal health insurance deepens the disparities among profitable (insured) and unprofitable (uninsured) patients. Reliance on general hospitals as the locus of subsidies for unprofitable procedures and patients makes it difficult to subject them to market pressures, as the institutions with the strongest commitment to serving the underserved are most hampered in the effort to attract insured patients. Yet protection of general hospitals from competitive entry

by specialty facilities and ambulatory surgery chains also protects them from pressure to improve their performance and hold down their costs.

Over the past decade many hospital markets have become increasingly concentrated through mergers among former competitors, leading to more bargaining power and higher prices (Cuellar and Gertler 2003). The Federal Trade Commission has been unsuccessful in limiting this consolidation. The best hope for competition in local health care markets may come from ambulatory centers and specialty facilities that compete for limited types of services, as new full-service hospitals face high barriers to entry in all but the fastest-growing metropolitan areas.

The pyramiding of regulation is clear. Administered pricing and incomplete insurance coverage create the social need for cross-subsidies, which are threatened by competitive entry. CON limits entry to protect these subsidies but also defends consolidation and monopoly power. Monopoly power in the hospital sector then generates demands for more complete regulation of pricing, presumably through rate setting for all payers. Rate regulation would create new opportunities for cross-subsidies, requiring broader regulation of price and entry for physician services and ancillary providers whose activities might endanger the regulatory equilibrium.

***Bans on Referrals to Physician-Owned Facilities***

Regulatory prohibitions on physician referrals of Medicare patients to outpatient diagnostic, laboratory, and ancillary facilities in which they have a financial interest date back ten years to reports of excessive and inappropriate referrals (Mitchell 1995; U.S. GAO 1994). Ambulatory surgery facilities and specialty hospitals have been exempt from these so-called Stark regulations—an omission that facilitated their growth. General hospitals support an extension of the self-referral ban to all types of facilities. The 2003 Medicare drug benefit legislation imposed an eighteen-month moratorium on the construction of new specialty hospitals, giving the Medicare Payment Advisory Commission time to study the economic impact of these facilities on general hospitals, and could prompt a permanent extension of self-referral prohibitions to the entire hospital sector. However, these proposed bans pose both conceptual and policy dilemmas, as they undermine the integration between physicians and facilities, thereby throwing out the baby of clinical coordination along with the bathwater of abusive referral practices.

The relationship between a referring physician and a facility in which the physician has an ownership stake is a form of partial vertical integration, intermediate between the extremes of no ownership relationship and full organizational integration (physician as employee of the hospital organization). The ban on physician self-referral would not affect the referral practices of physicians employed in multispecialty medical groups and integrated delivery systems, which expect physicians to refer patients to the facilities of the larger organization.

Indeed, the promotion of vertical integration between physicians and hospitals was premised on the principle that it would facilitate capacity planning, higher utilization rates, attention to a continuum of care, and the ability to measure and reward performance at the system rather than the “silo” level. Stark regulations

embody a completely different perspective—one that is skeptical of organizational integration and favors arms-length relationships that do not influence physicians' choices of where to refer patients.

In economic language, the regulations embody a "spot contract" approach to physician and facility relationships. A spot contract is one in which payment and delivery are clearly defined and occur in the same period—as opposed to relational contracts in which price, quantity, and quality are less certain and determined in the future, and depend on long-term mutual dependence among the trading partners (MacNeil 1978). The investment by a physician in an ambulatory surgery facility or specialty hospital provides an incentive for the physician to cooperate with that facility without becoming an employee. Partial integration through investment (targeted by Stark regulations) may not be less desirable than full integration through employment (vertical integration) or arms-length relationships with no ownership incentive (spot contract). Full integration through employment within an IDS potentially creates the same incentive to overutilize a service as investment in a freestanding facility, whereas arms-length spot contracting creates no incentive for coordination between physicians and facilities.

Extension of Stark regulations to ambulatory surgery and specialty hospitals cements one form of organizational relationship—the arms-length spot contract—that has contributed to the fragmentation and inefficiency of the system and is now being superseded by more integrated organizational relationships. The logic of the ban on referrals to services and facilities in which a physician has an ownership interest would prohibit surgical procedures done in a physician's office as well as the ownership of radiological and other clinical equipment by a physician practice. Taken to the extreme, these regulations would prohibit the dual role of the physician as an agent who both diagnoses conditions and recommends treatments, on the one hand, and actually provides (some of) those treatments, on the other. A surgeon who evaluates a patient and recommends a procedure, for example, could be seen as having a conflict of interest if he or she were also a candidate to perform that procedure.

Physicians' opposition to extending self-referral bans stems in part from a longstanding reluctance to become employees of hospitals, which they term the corporate practice of medicine. Bans on physician referrals, state bans on corporate practice of medicine, and CON entry barriers all contribute to the rigidity of the health care system and its difficulty in fostering new organizational forms in response to changes in epidemiology, clinical technology, and patient preferences.

## The Health Care Market as Roller-Coaster Ride

Specialty hospital and freestanding ambulatory facilities—combined in multimarket chains, partnered with local physicians, and fueled by venture capital—challenge the organizational status quo in health care. The excessively diversified health care organization presents inviting targets to entrepreneurial entities that target markets, procedures, and patients offering the widest divergence between price

and cost. Specialty hospitals and ambulatory facilities potentially reap the administrative and clinical benefits of specialization and replication, doing more of the same thing with the goal of finding ways to do it better and cheaper. The chain structure permits the upstarts to obtain economies of scale in purchasing supplies, hiring managerial talent, and performing back-office functions. More importantly, the chain structure offers the potential for developing benchmarks to monitor, improve, and reward performance across the enterprise. Scale economies and geographic diversification combine with growth opportunities afforded by changes in demography and technology to make the specialty inpatient and outpatient chains the hottest health care sector among capital investors.

But if specialty hospitals and ambulatory facilities offer potential efficiency gains to the U.S. health care system, they also pose new challenges through their tendency to undermine the fragile system of financial subsidies and physician professionalism. The health care system manifests a chaotic mix of payment mechanisms for particular procedures and patients, relying on general hospitals to serve as the locus for the social pooling of health risks. Hospitals earn financial surpluses on services such as cardiac surgery and incur losses on services such as burn care, and hence are imperiled by competitors who provide the former but not the latter. Hospitals tend to earn income from patients covered by commercial insurance and often lose money on patients covered by Medicaid, and hence are imperiled by competitors who focus on the former and avoid the latter. Tensions also arise from the roles of physicians as both referral agents and clinicians, and from the fact that they may earn more money based on their decisions about which patients to refer to which facility than for the care they personally provide.

The health care system manifests numerous inefficiencies that attract entrepreneurial talent and venture capital willing to take high risks for the possibility of reaping high rewards in the largest industry in the largest economy in the world. Once incubated and launched into the delivery system, startups face internal and external expectations for continued growth, which drive them to diversify outside their original niches to new products and new markets. Diversification strategies—whether across products (as in multi-product hospitals) or across markets (as in specialty chains)—inevitably lead startups into domains where their comparative advantages are weak and incumbent competitors are strong. Ignoring warning signs and the lessons of business history, entrepreneurial firms often press forward rather than fall back, apparently pursuing growth as an end in itself. We thus can expect continued cycles of innovation, expansion, and diversification, followed by periods of crisis and contraction, in turn succeeded by new cycles of experimentation, excitement, disillusion, and misery.

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