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Consumer Satisfaction in Loose Monopolies: The Case of Medical Care

Alan R. Andreasen

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Consumer Satisfaction in Loose Monopolies: The Case of Medical Care

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Increasing deregulation will force attention upon the problems of achieving consumer satisfaction in industries _not_ regulated. This article examines the problems of regulating performance in a public service domain of growing interest to marketers -- health care. Hirschman's concept of loose monopolies is found to be useful in explaining existing control problems in medical practice and in pointing the way for near term improvements.

CONSUMER SATISFACTION IN LOOSE MONOPOLIES: THE CASE OF MEDICAL CARE

It is by now a relatively well documented part of the conventional wisdom in business and government circles that the service sector generates a disproportionate share of consumer dissatisfaction in virtually every economy. Auto, home, and appliance repairs, moving and storage and funeral services typically rank in the top 10 or 20 categories generating unsolicited complaints to public agencies [Advertising Age 1979; Marketing News 1980]. In a more systematic study of both voiced and unvoiced complaints, Andreasen and Best [1977] found that while services accounted for 27 percent of the purchases in their national study, they generated 32 percent of volunteered cases of non-price problems. In a separate analysis, Andreasen found that among ten selected products and services where complaint-handling experience was factored in, three of the five worst performing categories were services [Andreasen 1977].

Since it is also well documented that the service sector is growing very rapidly in importance in world economies [Eiglier et al 1977], we may also expect that increasing attention will be given to the problems of reducing consumer dissatisfaction with these services. The difficulties of this task in both measurement and control are only slowly being realized. However, some halting efforts at solutions are underway [e.g., Day and Bodur 1977; Braden 1977; Lovelock and Young 1979].

To this point, however, most attention by marketing scholars and researchers as well as some public policymakers has been given to private sector services. Yet as marketers are increasingly drawn into the non-profit area, there is growing cognizance of the fact that this, too,

is a domain in which consumer dissatisfaction with services is quite marked. Indeed, the public is constantly being bombarde with books and articles calling our attention to the "fact" that Johnny can't read, that social welfare is a scandal, that public safety has sadly deteriorated, and that little is being done about any of this! Thus as marketers move into these new areas, we may expect that at least some will turn their attention to these issues of "consumer" satisfaction. Indeed, some initial steps have already been taken in this direction by Day and Bodur (1977); Pfaff and Blevice (1977) and Arndt and Gronhang (1979). However, this work has in the main focused on the problems of measuring the extent and nature of dissatisfaction in the public sector not on its reduction and control.

Attention to the control issue is particularly appropriate at this stage of marketing's development because of a third force that, along with the shift to services and to public-sector is likely to have a very significant effect on how marketing performance will be evaluated in the months and years immediately ahead [Andreasen 1980]. This force is the political and social pressure currently being brought to bear to deregulate a number of industries. It may be expected that marketing professionals will increasingly be asked in future to shed light on three issues: (a) what industries should be deregulated; (b) how and to what extent should such deregulation take place; and, finally (c) what can be done to decrease consumer dissatisfaction and market performance of those industries that are not deregulated.

The present paper takes up the last of these questions, focusing on a particular industry that reflects the other two trends affecting marketing in the 1980's: the growth of services and the involvement of marketing professionals in the public sector.

Medical Care: A Case Study

The case in point is medical care. Marketers have become increasingly involved in medical marketing programs at the federal, state and local levels including helping the National Institutes of Health to get people with high blood pressure to follow a control regimen, to get smokers to give up or cut down on their smoking habit and to get women to practice breast self-examination [Bloom and Novelli, forthcoming; Andreasen, 1980a]. They have given advice to neighborhood health centers and have become both line or staff managers or consultants to local hospitals and clinics. At the same time, it is clear that health care is a major and growing source of consumer dissatisfaction.

> "Perhaps the most disturbing aspect of the health care crisis in America is the questionable quality of much health care...[Some] Americans without realizing it are getting poor medical care. Other Americans are given services, particularly surgery, when there is no need for it, and still others are given incomplete health services. It is not necessarily a matter of income. Even the affluent receive poor care in many cases. [Kennedy 1972, p. 152]

In part, this concern is growing because of the extremely rapid growth of health care costs [Herzlinger 1978]. But, in part, it is also growing because of increases in the sophistication of medical consumers. As Gribben noted in 1975:

> Patients--consumers--no longer choose to regard doctors as gods, hiring them, taking their medicine whether it works or not, and sometimes their guff, too and then shutting up and paying the bill [Gribbin, 1975, p. 10].

Indeed, the increased involvement of marketers in health care may be seen as an indicator of growing sensitivity of providers that success for them and their organizations and for society as a whole will only come about with increased attention to the satisfaction of consumer needs and wants.

Normative Questions

If we are to offer concrete suggestions for improving consumer satisfaction with medical care, we must first consider what long run consumer satisfaction looks like. To say that consumers want something called "optimum physical and mental health" is to consider only one goal, refering to an outcome of the health care marketing system. As has been pointed out elsewhere [Andreasen, 1979], marketing must (and will) also be held accountable for the process whereby these outcomes are delivered. Friedson makes the point for health care: "Medical service must be of the best possible technical quality, true, but it must also be of the most satisfying possible human quality...it is...a moral necessity" [Friedson 1970, p. 209].

Indeed, a review of past efforts by medical sociologists and others to develop quality control systems in health care indicates that process and outcome measurements constitute two of the principal indicia they have used. The third indicator is what Donabedian [1969] calls a "structural" measurement, an evaluation of the facilities, systems and

staff qualifications of health providers that are presumed to lead to better quality health care.

These measurements have been applied to evaluate three types of programs designed to secure long run optimum physical and mental health:

1. Preventative programs that seek to keep target audiences from contracting health deficiencies of any kind;
2. Detective programs that seek to discover target audience members who have contracted health deficiencies and to get them involved in some curative program.
3. Curative programs that seek to remove or control contracted health deficiencies and keep them removed or controlled.

However, it is generally acknowledged that the key to these programs, indeed the major marketing contact between the health care system and consumers is, the doctor-patient relationship. And while the medical community is becoming much more active as a "channel of distribution" for preventive and detective programs [Bloom and Novelli forthcoming; Andreasen 1980a], the bulk of such encounters involve a sickness episode and curative programs. As Jonas has said, the medical practice "...is the focus, the *raison d'etre*, of any health care delivery system. Whoever controls medical practice, therefore, controls the keystone on which the rest depends" [Jonas 1977, p. 382]. Jonas puts his finger on the key issue: *who* is to control medical practice? That is, who is going to police the quality of care, both outcomes and process, to ensure long rum consumer satisfaction? Six possibilities present themselves:

1. Medical practitioners themselves.
2. Other members of the private sector health care systems, hospital boards, insurers, and HMO administrators.

3. Government regulators.

4. The marketplace.

5. Organized consumer groups.

6. Individual consumer groups.

Each of these will be taken up briefly in turn, in each case, asking to what extent the "controllers" can reduce consumer dissatisfaction at the individual and the aggregate level. Reducing disatisfaction rather than maximizing satisfaction. One might try to develop control systems that in some sense maximize consumer satisfaction. However, as Andreasen has argued [1975] this is an elusive goal, depending as it does on consumer knowledge and expectations as well as on the performance of the system. It is more realistic to try to develop a control system that corrects problems--removes dissatisfactions. This control can be exerted at two points: (a) before problems occur by causing practitioners to change undesirable practices or by eliminating those who are unwilling or unable to change (aggregate level control); and (b) after problems occur by establishing mechanisms where-by specific patient dissatisfactions/problems are removed (individual level control). Thus, each of the possible "controllers" should be judged on their efficacy at achieving satisfactory control at both levels.

1. Medical Practitioner Control

Physicians argue that implicit and explicit pressures within the medical community itself are sufficient to assure quality care. Three mechanisms are seen as contributing to these pressures:

a. Medical education combined with the Hippocratic Oath supposedly will train practitioners to be selfless servants of suffering humanity.

b. Social and professional interaction with other physicians will provide examples, inquiries, and admonishments that will encourage peers to keep up with the latest standards of practice and to produce only good word-of-mouth from patients, hospitals and personal staffs.

c. The desire to be admitted to successful or potentially successful practices, partnerships or clinics and/or for to be the benefit any of a growing stream of lucrative patient referrals will force physicians to keep their skills up, to correct undesirable behaviors and to pay attention to consumer dissatisfactions to assure good word-of-mouth recommendations.

However, while collectively these mechanisms can have some effect on some physicians, many practitioners develop approaches to patient care that either consciously or unconsciously counter the effects of these controls and get in the way of their truly meeting the latters' needs and wants. As Friedson has noted: "...good intentions on the part of administration and profession cannot overcome their inevitable bias in perspective. Each perspective has its own legitimate interest that prevents it from adequate sensitivity to the perspective of the patient" [Friedson 1977, p. 726].

Some of these inhibiting perspectives could be described in medical jargon as syndromes.

1. The Holier-Than-Thou Syndrome. Many physicians believe that patients do not really know what is in fact in their own best

interests. Patients find illness threatening and so have a distorted perception of their true needs. Further, they simply lack the technical knowledge of the physician to judge what is needed and what is not [Korsch, Gozzi and Francis 1968]. Physicians can therefore ignore their complaints.

2. <u>The They're-Not-Paying-For-It-Anyway Syndrome</u>. Since third party insurers frequently bear much of the cost for medical care, patients can (and should) be scheduled for tests or for medication or for return office visits that may have only marginal value. Time and inconvenience costs to patients are ignored as are their complaints about excessive tests and medicines and about medical costs in general.

3. <u>The Higher-Opportunity-Cost Syndrome</u>. Since physicians perceive themselves as in the business of saving lives, they frequently assume that their time is much more valuable than that of patients. The latter therefore should not complain about adjusting to the physician's convenience or paying high fees for his or her services.

4. <u>The I-Want-to-be-Alone Syndrome</u>. Four out of five physicians are in solo practices. Many are there because they cherish the independence that makes them immune to the peer pressures on which much of medical community control relies.

5. <u>The They're-Out-to-Get-Me Syndrome</u>. Many physicians seem to behave as if all patients have a lawyer friend or relative ready to bring a malpractice suit at the drop of a suture. Such physicians will schedule excessive self-protective tests and procedures and will

tend by demeanor to discourage any consumer questioning of their medical care that might escalate into a malpractice claim.

6. The Mystique-of-Omnipotence Syndrome. Since a positive patient attitude towards the illness and its cure is often an important contributor to the cure itself, many physicians believe that unswerving faith in the physician is essential to such a positive outcome. Creating a mystique of omnipotence requires that one brook no questioning of the physician's methods and outcomes.

Finally, it should be noted that the peer-pressure mechanisms can well backfire if poor word-of-mouth and a dropping off of referrals and other peer contacts only leads the below-average practitioner to withdraw from peer contact making his or her weak performance even less observable and therefore less subject to any further peer review and pressure.

2. Control by Other Members of the Health Care System

It has been suggested that physician behavior could be regulated by other members of the health care system who, in fact, could withold some of the rewards available to physicians. For example, health insurance companies could exert an influence on physicians who schedule unnecessary procedures or tests, charge excessively and/or prescribe unneeded or too-costly drugs by refusing to pay for or otherwise holding down the physicians' remuneration for such poor quality care. They could also accept consumer complaints about problems with specific treatments, refusing reimbursement to physicians until the complaints were satisfactorily resolved. Thus, insurers, if they were willing,

could exert some control over both aggregate and invidiual consumer dissatisfaction. And, indeed, there is precedence for accepting such responsibility in the industry. Insurers have consciously encouraged safe driving, the design of safer cars and non-smoking by offering reduced rates to individuals behaving in "better" ways or owning "better" products. They have also actively lobbied for safer cars (e.g., for airbags) and sponsored advertising to encourage people to wear seat belts. Incentives for individual health insurers to adopt such an aggressive stance are available if they felt that patients and/or employers would shift patronage to the more responsible firms or that state insurance commissioners would treat them more favorably in rate and service hearings.

There are, of course, serious practical impediments to the implementation of such a control system. First is the question of whether there really is much incentive for the insurance industry to police physicians if consumers and employers will not change patronage on the basis of insurer responsibility. This in effect shifts the real control burden to the marketplace where, as we shall see below, a significant number of non-competitive forces exist. Second, for insurers to exercise the proposed control there would be need in most states to secure permission from state commissioners to adopt such a policy (since it presumably involves changes in contracts with insurees). This makes the change in effect a political issue and brings the insurers in conflict with powerful medical lobbies. This is not an insurmountable obstacle. But again it would require a major groundswell of countervailing support from the general public.

Finally, there is the question of whether a system reliant in part upon consumer complaints would work. That is, would consumers complain? At the moment, as we shall note below, the answer is: not likely!

A second, similar source of policing could be the hospitals with which most physicians are affiliated. One problem of course is that only a fixed and perhaps small proportion of consumer dissatisfactions with physicians involve hospital care. More importantly, there is the question of whether hospitals can and will exert <u>real</u> control over their physician-staffs since as Goldsmith [1980] notes: "Physicians... determine how and how much a hospital is used [and therefore] exert enormous power in allocating resources...[they] are often beyond managers' control" [p. 101]. And to the extent that key hospital administrators are <u>also</u> physicians, many of the inhibitors affecting a consumer orientation mentioned in the previous section would undoubtedly apply.

A new force on the scene that many believe holds significant promise in policing physician behavior is the Health Maintenance Organization (HMO). The HMO movement after a slow start is now growing rapidly (Business Week, 1980). Therefore, access to the HMO movement's growing clientele will be very important to many physicians. This yields considerable potential for control. Faltermayer (1978) states the ideal case:

> Such plans would be run by administrators close to the scene and staffed with doctors who were forced to stay within each year's subscription income or see the organizations go broke. These better medical mousetraps, the prophets said, would not only strive to avoid the waste that is rampant elsewhere, but would also, by their mere competitive presence induce the rest of the system to mend its ways [p. 115].

In Minneapolis-St. Paul where there are currently eight HMOs, Faltermayer reports the following outcomes clearly benefiting consumer welfare:

- "Conventional insurers in the area have started to crack down on waste, particularly the excessive hospitalization of patients."
- "Some HMOs have begun to stress what physicians call compliance--telephoning to make sure the patient is actually taking the medicine or doing the exercises the doctor orders."
- "They are also helping to keep incompetent doctors from practicing medicine...they have fired physicians."
- "[In one HMO] a doctor's fee can be withheld in toto if he sends a patient to a hospital for non-emergency reasons without 'pre-admission certification'."
- "[One physician has said]...if that's what it takes to make the plan work...I'll do it. We physicians must provide a service the public is demanding, or we may be on the outside looking in." [pp. 115, 120]

It may be that these phenomena will be short-lived, reflecting only initial skirmishes in a growth area. If practitioners come to perceive patient-subscribers as virtual captives to the HMO they've chosen to join (at least for a year), much of depersonalization and maltreatment problems that have been experienced for years by ghetto residents captive in free neighborhood clinics may emerge as consumer features of middle-class HMO's. There are other problems. HMO administrators may prove just as reluctant as hospital directors to crack down on the physicians whose minimal performance is essential to make the HMO survive. Further, HMO's will not enroll all patients. Remaining patients choosing physicians in the popular solo practices may find the latter effectively immune to indirect system pressures from the HMO movement.

The Government

Through its licensing powers for individual practitioners and its funding of many health care programs and facilities, the government has considerable potential to regulate the quality of physician performance. There are, however, several difficulties.

With respect to licenses, each state has delegated responsibility to Medical Boards which examine entry level candidates, issue licenses and--in theory--maintain quality standards through their ability to eventually revoke licenses. However:

1. Physicians dominate virtually every state Medical Board [Derbyshire 1969].
2. "There is little evidence of accountability, either to the public or the legislature; indeed in most instances Medical Board proceedings are entirely confidential." [Jonas 1977, p. 383]
3. As already noted, there is a "reluctance to enforce sanctions against fellow practitioners (perhaps in part because of close professional and personal interrelationships)" [Ellwood, et al. 1973, pp. 30-31]
4. Many states do not have sanctions less severe than revokation of licenses and Boards are extremely reluctant to depriving someone of his or her livelihood.
5. Many boards apparently fear lawsuits from delicensed physicians.

Whatever the reasons, the evidence makes it clear that these sanctions are very rarely used to police poor patient care. For example,

The New York Times (1976) has reported that between 1971 and 1974 there was an average of only 72 licenses revoked each year by State Boards with fewer than two percent of these for incompetence.

Licensing of institutions is often carried-out by government agencies or voluntary accrediting bodies. In the main, however, whatever review is carried out here is based on what Donabedian [1969] calls the "structural approach," which as noted earlier effectively ignores "process" and "outcome" considerations.

Other involvements of government agencies in health care quality control include:

1. Auditing is carried out of billing and medication practices of doctors receiving exceptionally high repayments from Medicare and Medicaid. Such audits, however, only affect a few physicians and then only consider a very narrow set of non-qualitative problems.

2. Comprehensive health planning legislation establishes regional planning councils to analyze community problems, set goals and approve specific facilities. In a recent evaluation of CHP's Brown (1978), however, concluded:

> To date, the experience has not been heartening.... Most CHP's [Community Health Planners] had governing boards composed of the power structure of the health care system--doctors, nurses, hospital administrators, consumers and so forth--and each had priorities that differed significantly from those of his colleagues. Under such circumstances, a list of all problems with a failure to set priorities was an obvious outcome. In addition...their efforts were futile from the onset. The law gave no power to the CHP to implement any recommendations [pp. 38-39].

These CHP's were replaced in 1975 by health systems agencies (HSA's). The local HSA's apparently have developed much of the same problems as the CHP's. Funding is inadequate and the boards running each are "de facto profession-dominated, despite consumers being in the majority" [Brown 1978, p. 42].

3. HEW has begun to implement Professional Standards Review Boards (PSRO's) in 203 geographic areas. PSRO's were established to facilitate professional peer review of the process and outcomes of physician hospital practices. PSRO's have been somewhat more rigorous than state Medical Boards in policing medical care but have frequently succumbed to many of the inhibitions and provider domination the latter have experienced. [Decker and Bonner 1973]

4. Outside the U.S., it is, of course, not uncommon for the government to directly control all of medical care through some form of national health care or national health insurance. In his comparative studies of health care in welfare states and socialist countries, Roemer concludes: "As the financing of health care by the whole population becomes more collectivized, pressures mount for greater regulation to control both the costs and quality of services (1977, p. 80)." In England, for example, the government limits the number of patients a GP can have. In Germany, "computerized reviews [are conducted] of each doctor's practice habits, as measured by such criteria as the number of drug prescriptions per case, number of office visits and laboratory tests per case, rates of certain surgical

procedures and so on....Such identification is regarded only as a screening step, to be followed up by detailed examination of the individual doctor's work (Roemer 1977, p. 177)." Penalties include payment of only fractions of claims or, ultimately, elimination from the social insurance program altogether.

It is, however, unlikely in the present U.S. political environment that any kind of national health insurance, except possibly for catastrophic illness, is a realistic possibility despite advocacy by many prominent politicians (Kennedy 1972).

The Marketplace

A regulatory mechanism that many would like to adopt from the private sector is the classic marketplace mechanism. Indeed, Roemer (1977, p. 176) characterizes the U.S. system as "laissez-faire." In an ideal medical market, patients unhappy with their "supplier" could exercise what Hirschman (1970) calls the "exit" option; they could not buy the "product" or take their business elsewhere. Eventually, those providing inadequate medical care would either reform or go out of business. Temporary revenue gains by remaining physicians would be relatively quickly captured by new suppliers coming into the marketplace.

The problem, of course, is that on both the supply and demand sides, the assumptions of competitive markets are clearly violated in medicine.

1. Restricted Entry. State licensing of physicians (by other physicians, as we have seen) clearly restricts entry of new physicians.

Further, the fact that licensing is by state implicitly restricts geographic mobility of practitioners who cannot easily flow with consumer demand. Finally, even in the absence of such barriers, the long gestation period needed to train an M.D. would make entry adjustments "sticky" at best. As Friedson points out [1970, pp. 194-5], a real consequence of a shortage or maldistribution of physicians is that in many communities doctors will be seriously overburdened. As a result, they invevitably will cut down on services. They will spend less time with each patient in part by assigning routine contacts to paraprofessionals, cutting out calls outside the office, insisting on prearranged appointments, discouraging trivial complaints and overall giving each patient less counselling time even for serious ailments.

> "His services assume more of a take-it-or-leave-it character than is the case in other circumstances, and the patient must fit his anxieties, ignorance, and desires into the physician's brief encounter with rather less give-and-take than would exist in a market place where more choices were available to him (Friedson 1970, p. 195).

2. Restricted Information. Until recently, physicians could not advertise and the vast majority still do not do so. Most patients are inhibited by custom and social norms from visiting many "show-rooms" before buying. Published evaluations of community physicians have been unknown until very recently.

3. Buyer Ignorance. Most consumers do not know enough to detect poor care if offered. And, as we have noted, the attitude of many physicians is expressly designed to discourage the acquisition of the requisite knowledge. Further, consumers may not believe that

records and x-rays can be transferred, thus making them overestimate the cost of switching. It may also be that, again as encouraged by physicians, many patients overvalue the rapport they have established or the history they have shared with their physician as a loss to be given up under an "exit" option.

4. Long Repurchase Cycles. For many maladies, poor performance by the physician may take a very long time to appear, again causing the demand side of the market adjustment mechanism to react slowly.

5. Lack of Impact. For the exit strategy to police the market, it must be both observable and meaningful to the physician. Given that there are monopolistic elements on the supply side, physicians once established may have enough "new business" to effectively mask any defections due to patient dissatisfaction. Further, even if physicians do note patient attrition, they may simply ignore it since they have already accumulated enough income by charging high fees for a large volume of sales that are afforded by the restricted supply of competitors.

6. Psychological Inhibitions. Many dissatisfied consumers may find it psychologically painful to change physicians because:
   a) an exit decision implies a "slap" at another human being with whom one has discussed relatively intimate topics;
   b) as compared to changing, say, gasoline service stations, changing physicians cannot easily be done anonymously, especially if one wishes to transfer records and history;
   c) for many, especially the elderly, the doctor-patient relationship may be perceived as a friendship to be valued independent of the quality of care.

Organized Consumers

As suggested earlier, many regional health care planning organizations as well as many hospitals rely on organized groups of consumers--consumer panels--to give them planning input and sometimes health care evaluations. The problems here are twofold. First, there is a serious danger that consumer representatives will be co-opted by the medical professionals. The latter will have more "expertise" on most topics, more experience, and longer tenure that can easily intimidate consumer non-professionals. Second, where this does not happen but is seen as a potential threat by consumer representatives, the latter's positions may polarize, and an adversarial style of group confrontation may develop. Neither cooptation nor polarization is likely to lead to increased consumer satisfaction. In any eventuality it does not at all guarantee satisfaction of individual consumer problems.

Individual Consumers

To secure individual satisfaction in industries where the exit option is not a realistic possibility, the patient's major alternative is what Hirschman [1970] calls the "voice" options. That is, a consumer can obtain redress of a grievance or can police poor practice only by complaining to practitioners or to independent complaint-handling agencies; or, in the extreme, filing a malpractice suit, an increasingly common occurrence (de Lessups 1977). As Hirschman indicates, the more elastic the demand, the more the exit option is used but "with a given potential for articulation, the actual level of voice feeds on inelastic demand, or on the lack of opportunity for exit" (1970, p. 34).

The problem is that many of the features that inhibit _exiting_ also inhibit voicing. That is, consumer-patients may be reluctant to speak up since:

1. they do not trust their own judgments,
2. they are convinced physicians are close to omnipotent,
3. they do not want to hurt their physician's feelings,
4. they cannot voice anonymously.

In addition, many physicians' responses to patients' past efforts at voicing dissatisfaction or simply raising questions about treatment may discourage such efforts. As we have noted, physicians' behavior may be the result of being overburdened because of supply side restrictions on the number of doctors.

Whatever the reasons, it is clearly the case that patients are reluctant to speak up. In Andreasen and Best's 1977 study of consumer satisfactions and complaint behavior (Andreasen and Best 1977), 14.9 percent of the respondents reported that they had experienced some form of non-price problem with their medical or dental care (i.e., they didn't merely say that it cost too much). As indicated in Table 1 this compares with an overall problem rate of 20.9 percent for all services (or 22.85 for non-medical-dental services). Whether this reflects generally higher satisfaction with medical care or merely patients inability (and/or unwillingness) to recognize poor care is not clear from the data.

Table 1 about here

The striking feature of Table 1, however, is not the relatively positive perception of medical and dental care but the rarity with which people speak up about these problems. Only *one in three* voiced their complaints either to the practitioners or to third parties. The rate for all other services and for high cost, infrequently purchased products is almost *one in two*. The poor voicing experience is only slightly better than the lowest rate in the entire study, that for legal services, a category also beset with many of the same supply-side market restrictions as medicine.

These results are surprising in that the problems in both categories are presumably very serious. In many of the other product and service categories reported in the study, one would expect many consumers to not bother voicing because of the triviality of the problem compared to the cost and effort of voicing. Thus, the one-in-two voicing figure for other services probably substantially understates what the voicing rate would be for service problems that were of equal seriousness as those involving medical/dental care and legal services.

Table 1 also offers support for the contention that patients are often actively discouraged from further complaining by their physician's responses to earlier protests. As indicated in the last column of Table 1, only 34.5 percent of all voiced complaints that were resolved at the time of the survey were perceived by the patients as satisfactorily handled. This again was the second worst figure in the entire study, after car parking. When the results in the last two columns are combined, we see that only 11.3 percent of all non-price problems medical and dental patients perceive are ever voiced *and* satisfactorily

resolved. This is one-half the rate for all other services in the study and the latter, one will recall, presumably include a great many relatively trivial problems. This means, among other things, that in health care, there is a very large amount of unresolved dissatisfaction that patients harbor long after their encounters with the health care system. If "pending" cases in the Andreasen/Best study turn out as those already resolved, it may be that as many as thirteen percent of all patients will have some unresolved problem rankling them at any point in time.

CONCLUSION

What, then, can one say about an ideal control system for medical care? Clearly, each of the six mechanisms outlined above has its weaknesses. Those designed to weed out poor practitioners have frequently been ineffective because of inadequate (or unwilling) peer control, because of the malfunctions of the medical marketplace, and because of inhibitions placed upon organized or individual consumer voicing.

What is to be done? In my opinion, the ideal toward which the system should adapt is that of the private marketplace. This system through the exercise of both voice and exit option would allow both the addressing of individual grievances and the weeding out of poor providers. The difficulty is that the health care market as it presently operates is what might be called an imperfect or, in Hirschman's term, a "loose" monopoly. By this is meant that it is possible for patients to exit, but it is unlikely that they will do so. And, as we have seen, when they don't exit, they don't voice and when they do voice it doesn't very often help.

Hirschman has an explanation for this phenomenon. He points out that in terms of exit and voice, a tight monopoly is preferable to an imperfect or loose one since those "locked into" the monopoly will have considerable incentive to exercise the voice option. Where exit is possible for some: "those customers who care most about the quality of the product and, who, therefore are those who would be the most active, reliable, and creative agents of voice are for that very reason also those who are apparently likely to exit first in the case of deterioration" (Hirschman 1970, p.). Hirschman cites examples as diverse as the Nigerian railway system and U.S. education to demonstrate his point. The present analysis suggests that one might add U.S. medical care to the list.

The results in Table 1 may well be evidence that those patients who would have been vocal are exiting perhaps because they correctly perceive that voicing doesn't often work. Those who remain effectively locked into the system, if nothing else by their own inhibitions, are the less vocal As shown in Table 1, they do not exercise the voice option and are not influential when they do.

The answer to this problem is to find a mechanism that will keep quality-conscious patients from merely exiting physicians offering deteriorating service while giving the remaining patients some effective voice in redressing their legitimate grievances. An innovative solution would be to require that as a condition of retaining their professional status, physicians secure systematic feedback on the quality of care received from all patients whom they treat. The procedure for securing this feedback could be left to state legislatures which in turn and

where appropriate could delegate the responsibility to individual hospitals, clinics, HMOs and group practices. While the procedures might vary in detail, each should require that at minimum every patient be given a form to fill in that would be sent to an _independent_ review body. This form would have the patient rate the medical care received, point out problems where they arise and ask for redress where it is merited. In effect, patients would be put in the position of turning the tables on physicians and _prescribing_ regimens and medicines to cure _their_ ills.

Professional Standards Review Organizations (PSRO's) also could be the organizations given the necessary authority to implement and use this system. Experimentation with various concrete approaches is clearly necessary, particularly in order to observe the vigor and efficacy with which the review agencies carry out the "prescriptions." However, having patients prescribing for physicians clearly has the potential of keeping quality conscious consumers from simply exiting a less-than-ideal situation, while giving the less vocal patients an anonymous, yet effective, vehicle for speaking their concerns. We still need to educate both vocal and less-vocal groups to be better evaluators of medical care and therefore better problem detectors. Still the system proposed here is a modest and, it would appear, realistic adaptation to the present loose monopoly conditions in the medical care system that paradoxically _can_ achieve many of the virtues of the oft-feared _complete_ monopoly.

Full competition with easy supply entry and easy demand exit would in the long run be preferable. But there are obvious virtues in restricting entry by licensing practitioners in a profession which literally life-and-death powers. Given that we are also unlikely in the near future to "progess" to a complete monopoly under a national health care program, we must adapt to loose monopoly conditions. In the process we must also be realistic and adapt to the present attitudes and behaviors of the doctor population and the social norms that restrict exit behavior. Systematic feedback and its rigorous utilization appears to be the only realistic alternative that can make a substantial improvement in consumer satisfaction in this crucial domain.

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Table 1

Complaint Experience for Selected Products and Services

	No. of Cases	% Satisfactory	% Non Price Problems	% Voiced[a]	% Satisfactoril Resolved[b]
Infrequently Purchased Products	7241	89.8	19.9	49.5	57.5
Frequently Purchased Products	13550	87.6	20.0	35.3	65.8
Car Repair	1277	75.1	35.0	60.0	49.8
Appliance Repair	563	75.7	29.5	65.5	35.5
Home Repair	537	79.8	28.4	64.8	52.6
Car Parking	683	75.5	23.4	53.7	29.8
Film Developing	1250	89.1	18.5	36.2	45.2
Legal Services	388	87.6	15.4	28.8	*
Credit	1191	90.5	10.6	53.7	49.3
Medical or Dental Care	1910	90.6	14.9	32.7	34.5
All Services	7783	84.5	20.9	47.7	43.9

*Fewer than 13 resolved cases.

[a]Base: Respondents with non-price problems.

[b]Base: Respondents voicing complaints.

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