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EFFECTS OF MARKET REFORMS ON DOCTORS AND THEIR PATIENTS

by David Blumenthal

Prologue: In assessing the impact of competition in the health care marketplace, David Blumenthal presents an important but often overlooked point: “The course of market-based health care reform will depend most critically . . . on how well our restructured health care system meets the needs of patients . . . [which] will be determined in large measure by how, if at all, reforms affect what happens behind the closed doors of physicians’ examining rooms.” A physician himself, Blumenthal reminds us that patients’ trust in their physicians is more than a nicety—such issues are frequently factors in patient litigation against providers. Here Blumenthal explores how physicians are both responding to and initiating change in today’s health care market and how patients are being affected by these changes through their interaction with physicians. The administrative techniques and financial incentives that health care organizations employ to influence physicians’ behavior may reduce costs and improve quality as intended (although evidence at this time is scant). However, they may have a negative impact on patients’ perceptions of their physicians and on physician and patient satisfaction, both of which ultimately affect quality of care. He argues that although many will benefit from a market-based health care system, historically vulnerable populations such as the elderly and the chronically ill likely will continue to be at a disadvantage. Blumenthal is chief of the Health Policy Research and Development Unit at Massachusetts General Hospital in Boston and associate professor of medicine and health care policy at Harvard Medical School. This paper was presented at an invitational conference, “The New Competition: Dynamics Shaping the Health care Market,” conducted by the Alpha Center and sponsored by The Robert Wood Johnson Foundation, 9 November 1995, in Washington, D.C.
Abstract: The outcome of the competitive revolution in health care will depend critically on how it affects physicians’ behavior and their interaction with patients. From the standpoint of physicians, competition often seems mediated by three influences affecting their day-to-day practice environment: the organizational phenomenon, the customer phenomenon, and the commodification phenomenon. A careful examination of these three phenomena offers reasons to believe that both the supporters and detractors of competition may be partially correct. Competitive markets may work extraordinarily well for some consumers and very poorly for others. The competitive restructuring of our health care system will accentuate the divisions and inequalities that existed in our society before the transition to a market-based health care system.

Nowadays The Wall Street Journal, not The New England Journal of Medicine or Annals of Surgery, often seems the de facto publication of record in health care. This is a revealing fact. All eyes are turned now to the continuing series of mergers, acquisitions, initial public offerings, antitrust actions, hirings, firings, and bankruptcies that indicate the extent to which the ownership and financing of health care organizations have come to resemble, at least superficially, other sectors of the U.S. economy. For some, The Wall Street Journal’s chronicle of these events is gratifying evidence that our health care system has finally entered the modem world. For others, it is like watching a train wreck in slow motion. Whatever the reaction to these stories, they are riveting—and potentially distracting for those who wish to understand and predict the ultimate consequences and future direction of the changes now occurring in health care.

The course of market-based health care reform will depend most critically not on which capitalist gladiator is up or down in the arena of the marketplace, but on how well our restructured health care system meets the needs of patients in the day-to-day world of health care delivery. And this in turn will be determined in large measure by how, if at all, reforms affect what happens behind the closed doors of physicians’ examining rooms all across the nation.

The aim of this paper is to pursue this argument by asking how competition in our health care system will influence the clinical practice of medicine generally, and interactions between patients and doctors in particular. For purposes of discussion, I break this question down into four parts: (1) What is competition? (2) How will competition affect physicians, their practices, and their interactions with patients? (3) How are physicians responding to market changes? (4) What are the possible long-term effects of the competitive dynamic on physicians and their patients?

What Is Competition?

The term competition refers to rivalry among health care plans and providers for customers, through reducing prices and/or improving quality
of care. In the daily lives of physicians, however, the restructuring of health care markets may be experienced most directly as a series of influences that underlie the competitive dynamic and are reinforced by it. These influences include what I call the organizational phenomenon, the customer phenomenon, and the commodification phenomenon.

The organizational phenomenon consists of the rapid growth in the number of patients and physicians who receive and provide care either within or under the supervision of health care organizations. This includes but extends beyond the proliferation of managed care organizations. These organizations are so variable in their approaches and structures that about all we can reliably say about them is that they enroll patients, direct patient flow, and attempt to affect the cost and quality of the care that their patients receive. The one common denominator of the organizational phenomenon is that it requires physicians increasingly to interact with or to join organizations in order to attract and care for patients.

The customer phenomenon is manifest in the increasing assertiveness and power of nonprofessional purchasers of health care. Physicians experience this development in a number of ways. For instance, patients sometimes demand that their doctors take their wishes into account or else risk losing business to other, more customer-oriented colleagues. Also, physicians find that they must deal simultaneously with customers other than patients: employer groups, public agencies, purchasing alliances, managed care organizations, and combinations thereof.

The least tangible of the three major phenomena described here—the commodification of health care—may be the most important. Society is telling physicians in multiple ways—the trend toward investor ownership of health care organizations and the adoption by these and other organizations of marketing techniques used in other economic sectors—that they should regard health care as a commodity much like many others that are exchanged in the marketplace. The implication is that the practice of medicine is an economic transaction, not a professional calling. This raises the question of whether medicine is in the process of deprofessionalization.¹

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**Effects Of Competition On Physicians**

A convenient way to think about the effects of competition on physicians, their clinical behavior, and their interactions with patients is to examine the potential effects of the organizational, customer, and commodification phenomena. This approach makes the general concept of competition somewhat more concrete and suggests the relevance of empirical literatures, whose usefulness might not be so apparent otherwise. However, one should keep in mind that past experiences may resemble full-
blown competition about as much as a strong wind or a high tide resembles a hurricane.

**The organizational phenomenon.** Through the organizational phenomenon, physicians come under the influence of health care organizations that affect—both intentionally and unintentionally—the microenvironment of medical practice: the administrative rules, financial incentives, and conditions under which physicians work.

**Administrative interventions.** Modern health care organizations use a variety of administrative interventions to influence the behavior of physicians. In a 1994 survey of a national sample of managed care organizations, the Physician Payment Review Commission (PPRC) found that 63 percent of these organizations hold primary care physicians responsible for referrals to specialists (part of the intervention called “gatekeeping”); 95 percent employ some type of utilization management; 63 percent use practice guidelines; 74 percent use physician profiling; and 83 percent do focused studies of quality of care. Interestingly, plans tend to rate administrative interventions as equally important as or more important than physician payment methods in assuring organizational success. Nevertheless, evidence of the effectiveness of these techniques in reducing costs or improving quality is scant. Evidence of their effect on clinical decision making and on physician/patient interactions is sparser still.

One of the administrative interventions that health care organizations commonly use to manage physicians is the requirement that primary care physicians take responsibility for approving all of the care that patients receive. On the positive side, both theory and practice suggest that this gatekeeping requirement reduces the intensity of services by decreasing use of laboratory, specialty, and emergency room services. This in turn is associated with an increase in the use of primary care services and in the continuity of primary care. Researchers view these as highly desirable developments, and evidence suggests that long-term relations with a primary care provider improve both patient satisfaction and quality of care. However, remarkably little information exists about the effect of gatekeeping per se (that is, independent of other financial and organizational influences) on the technical quality of care, including outcomes. Gatekeeping reduces the cost of outpatient services but has less effect on hospital care, and its effect on overall costs remains unclear.

On the negative side, gatekeeping can strain physician/patient interactions by putting primary care physicians in the position of denying patients access to specialty care and emergency services. This is likely to occur most commonly among patients (such as the chronically ill) who are accustomed to using such services, and recent evidence suggests that such patients are less likely than healthy patients to be satisfied with arrangements that
restrict their choice of physician. Controversy also surrounds the question of whether primary care gatekeepers are encouraged or required to practice outside their areas of competence, especially when gatekeeping and financial incentives to restrict use of services are combined.

Another administrative intervention is utilization management or review. This consists of a series of techniques used by health care organizations—usually third parties—to reduce health care costs by trying to influence the clinical decisions of physicians on a case-by-case basis. A number of studies in the 1980s demonstrated the effectiveness of utilization management in reducing inpatient costs, suggesting that it changes physicians’ clinical decisions. Other studies have shown less positive results, and the effectiveness of utilization review programs in reducing societal expenditures remains controversial.

Information on how utilization management/review affects quality is difficult to find. Physicians tend to be extremely hostile toward utilization management techniques, partly because they view them as interfering with the process of matching services to individual patients’ needs and detrimental to the physician/patient relationship. However, despite this often voiced antagonism, capitated physician groups tend to rely on these techniques to roughly the same extent as do other types of organizations.

For a number of years utilization management/review has seemed to affect physicians’ satisfaction more than patients’ satisfaction. Recently, however, the potential for this approach to influence the latter has become apparent in the consumer revolt against restrictions on lengths of hospital stay after childbirth. A number of state legislatures have passed or are considering legislation to prevent managed care organizations from requiring that women be discharged within twenty-four hours of childbirth. These bills have been supported by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. The alliance between consumer groups and doctors in this matter suggests that the organizational phenomenon may bring doctors and patients together in opposition to certain organizational restrictions on physician autonomy.

The affiliation of physicians with organizations sometimes makes them subject to guidelines adopted by those organizations to manage the cost or quality of care. From a theoretical standpoint, guidelines can contribute to quality of care by reducing unjustified variation in clinical decision making and by providing physicians with concise, practical advice on the diagnosis and treatment of illness. In practice, guidelines have not yet fulfilled their potential to improve quality or control costs, in part because they seem to have limited efficacy in changing physicians’ behavior. Their impact may increase when and if the use of computerized systems for ordering laboratory tests, making referrals, and providing treatments and drugs becomes wide-
spread in health care organizations, a development that will make it possible to compare physicians’ decisions with guidelines in “real time.”

However, some people worry that guidelines could drive a wedge between physician and patient. The reason is that guidelines are informed by the health care experience of populations and cannot take into account differences in patients’ preferences for care, including documented variation in their preferences for positive and negative outcomes of services. Differences in patients’ wishes—and in the availability and quality of services in particular locales—suggest that some variation in diagnostic and therapeutic services is required to optimize quality and satisfaction. If organizations apply guidelines with a heavy hand, the result could be reduced quality of care and reduced physician and patient satisfaction.

Financial tools. Recent discussions of the restructuring of markets have focused much less on the administrative interventions available to organizations than on financial tools for influencing physicians’ behavior. The tool that has captured the most attention is risk sharing, especially complete or partial capitation of physicians. According to the PPRC, only 37 percent of managed care organizations use capitation as a predominant method for compensating primary care physicians, and only 18 percent for specialists. However, 60 percent of plans share risk in some form with their physicians. Capitation—as the purest form of risk sharing—is increasingly used by the most rapidly growing form of health care organization networks and thus deserves the close scrutiny it has received.

The potential effects of risk sharing generally, and capitation in particular, are manifold. The benefits of capitation include reductions in the cost of care by reducing unnecessary utilization and administrative expenses, and increases in quality of care by encouraging cost-effective use of available resources. No other method of payment offers responsible health care providers greater opportunity to innovate in pursuit of improving patients’ health. Anecdotes abound about the liberating effects of capitating primary care physicians, who are able to provide efficacious services that were never compensated under fee-for-service arrangements. These include outreach workers who visit elderly patients in their homes to reduce risks of injury from slips and falls or to assist with medication use, demand management techniques, and more intensive use of nurse practitioners. However, balanced against these potential benefits are a series of potential risks whose magnitude is enhanced by commodification, with its inherent threats to professionalism. First is the danger that physicians will underserve patients in an effort to reduce their costs and thus increase their incomes. Second is the concern that physicians will avoid costly—that is, sick—patients for the same financial reasons. Evidence suggests that managed care organizations—whether from patients’ choices or their own re-
I recently participated in a discussion of whether the group of primary care physicians with whom I work should accept risk for caring for Medicare patients. A number of participants expressed deep apprehension that capitation would change their attitudes toward sick patients. They feared that they would come to resent such patients as threats to their financial well-being.

It is not necessary for risk sharing to take the explicit form of capitation to have such effects on physicians’ attitudes. Last spring I received something completely unexpected: a check for $1,200 from a local health maintenance organization (HMO) along with a letter congratulating me for spending less than predicted on their 100 or so patients under my care during the previous quarter. I got no bonus the next quarter because several of my patients had elective arthroscopies for knee injuries. Nor did I get a bonus from another HMO, because three of their 130 patients under my care had been hospitalized over the previous six months, driving my actual expenditures above those expected for this group. One was wheelchair-bound and has an implantable cardiac defibrillator to treat his recurrent ventricular fibrillation. The second, a woman with uncontrolled diabetes, transferred her primary care to me for evaluation and treatment of a narrowing of her carotid artery. The third patient sought out a Massachusetts General Hospital physician after he developed angina and was later hospitalized for a myocardial infarction and subsequent cardiac catheterization. Neither HMO had risk-adjusted my expected expenditures beyond using simple age and sex adjustments, Nor does it seem likely that existing risk stratification methodologies—explaining at most 10-20 percent in the variance of health care expenditures—would have captured adequately the major differences in health status among these patients.

It would be tempting to leap from anecdotes such as these to overwrought warnings that capitation and other risk-sharing arrangements will have intolerable corrupting effects on physicians. The danger does exist. Capitation will create potential conflicts of interest between physicians’ financial well-being and their patients’ needs and expectations. There are, however, a number of mitigating considerations. One is the opportunity created by capitation to innovate in designing ways to maximize the value of the care physicians provide. Another is the fact that some conflicts of interest may be more apparent than real: To the extent that physicians are encouraged to refrain from providing unnecessary, even hazardous, care, both the patient and the physician are better off if the service in question is withheld. Fee-for-service medicine, after all, had its own built-in conflict of interest: the incentive to provide more service than required.

A third potential mitigator is that conflicts can be diluted and managed
through a number of devices. These include capitating organizations rather than individuals and limiting the individual physician’s upside gain and downside risk. For example, the direct influence of capitated risk sharing on physicians’ medical decision making may be reduced when a middle-size or large physician group (say, more than twenty physicians) accepts capitated payment for patients and then compensates its physicians through a completely different method, such as salary or fee-for-service. In such arrangements the financial incentives of risk sharing are much less intense than in situations in which individual physicians or small physician practices are directly capitated for the care of individual patients.

The complex potential effects of risk sharing, and the opportunity to manage it well or poorly, suggest that we need empirical information before we can reach sound judgments about its ultimate effect on physicians’ clinical behavior and physician/patient interaction. Such information is extremely limited. Most data on capitation and its effects on physicians and patients have been collected from the experiences of large, traditional HMOs in which physicians were salaried. In other cases, studies of the managed care phenomenon do not shed light on the risk-sharing arrangements that prevailed in the organizations under study. In general, studies of the processes and outcomes of care provided by managed care organizations, which were themselves capitated and may have capitated some physicians, suggest that patients in HMOs receive as much or more outpatient care (including preventive services) and less inpatient and specialty care than patients in fee-for-service arrangements receive. When studied, outcomes of care have not shown measurable differences, with one exception: Low-income, chronically ill patients may do less well under capitated arrangements than under fee-for-service, although the evidence is mixed.

While we await better information on the effects of risk sharing on physicians and their patients, one particular problem must be dealt with early and often: the potential effects of capitation on patients’ perceptions of their physicians and their motives. Patients may attribute to physicians’ financial motives the inconveniences and restrictions that result from other organizational influences, such as limitations on the availability of specialists and requirements for utilization management. This could lead to a generalized loss of trust in the medical profession and reduced satisfaction on the part of both patients and physicians.

The customer phenomenon. As the market ethic increasingly pervades the health care system, it encourages and is promoted by a profound change in the balance of power between consumers and providers. Large purchasers of health care are increasingly applying the tenets of quality management that have helped them to improve their competitive positions in other realms. They are pushing providers to produce evidence that consumers are
receiving high-quality care and service. Often, purchasers’ approach is
guided by the principles of Total Quality Management (TQM), which
considers the customer to be the ultimate arbiter of quality.25

Some health care organizations are responding by adopting selected
elements of TQM themselves. One increasingly popular element is sensitiv-
ity to customers’ needs and expectations. Providers that were deeply suspi-
cious of patient satisfaction surveys in the past are now surveying every-
thing that moves and feeding the results back to groups of administrators
and physicians, who breathlessly await evidence of how they are performing
(translating data on customer satisfaction into plans for improvement is a
much more difficult challenge). Health care organizations are incorporat-
ing these data into calculations of physician payment incentives.

One should not exaggerate this development. In a recent survey of
physicians in several western hospital chains, Stephen Shortell and col-
leagues found that only 10 to 14 percent had ever heard of TQM.26 Never-
thless, in this enlightened manifestation, market forces could powerfully
reinforce and complement the professional ethic of the physician, which
traditionally has taught that the patient always comes first—but not, as
TQM suggests, that the patient is always right. The latter perspective has
always run counter to the professional pride and paternalism that have
often made physicians uninterested in eliciting and responding to patients’
preferences for care or amenities of service.27

From the standpoint of the physician, the customer phenomenon poses
several major challenges. One is that physicians have multiple customers,
including purchasers (managed care organizations, federal and state govern-
ments, and employers), their own health care organizations (when these are
different), and patients. It may be argued, with some justification, that the
obligation to serve multiple customers is not really new for physicians.
Physicians’ decisions about the care of individual patients have always
affected groups and individuals outside physicians’ examining rooms—for
example, by increasing costs of care and premiums on health insurance,
thereby reducing workers’ take-home pay. In competitive markets the de-
mands of organized purchasers of care merely make explicit and tangible
physicians’ obligations to the larger society.

The problem, however, is that the purchasers empowered by market
forces may be imperfect representatives of the public interest, or even of the
consumers they explicitly represent. Publicly traded, investor-owned man-
aged care organizations have a primary obligation to protect their investors’
interests by keeping profits and stock prices high. It is also reasonable to
question how well a single purchaser—even the best intentioned—can
know the wishes of tens of thousands of persons who may participate in the
plans that it sponsors.
Research on the customer phenomenon is needed to better define what it means to be customer-oriented in health care settings. Then the consequences of being customer-oriented for both patient satisfaction and technical quality of care need to be rigorously assessed.

The commodification phenomenon. Discussion of commodification is difficult because the topic invites ideological debate and polarization. The purpose here is not to pass judgment on whether health care should be treated like other commodities in our capitalist system, but to explore the implications of the changing perceptions of health care for physicians’ behavior and physician/patient interactions.

When opinion leaders—usually physicians—decry commodification and the consequent threats to professionalism, their anguished warnings sometimes seem either antiquated or self-serving—reflecting impractical nostalgia or an attempt to beat back threats to the economic power and social status they enjoyed in the past. However, policymakers and health care managers must realize that physicians are part of the society in which they practice and are influenced by its prevailing beliefs and norms. If current trends continue, they will come to see themselves more as economic agents and less as professionals, and they will feel less bound by traditional professional obligations. These include improving themselves and their profession through research and learning; resolving conflicts of interest in patients’ favor (including the obligation to provide charity care); and supervising the conduct of their fellow professionals through peer review.

Cynics undoubtedly believe that physicians had already abandoned many of these standards of conduct long before the advent of competitive markets, so that little is lost through current private-sector reforms. Whether the general public agrees with this, and is ready for the changes in physicians’ behavior that may occur, remains to be seen.

What might some of those changes be? Again, one can identify positive as well as negative potential effects. The commodification phenomenon, like the customer phenomenon, may mitigate the undesirable concomitants of professionalism: physicians’ paternalism and elitism. If more physicians believe that health care is a classic economic good, then more also will believe that their customers are capable of making decisions for themselves about what they need and want. In this context, it is important to recall that TQM arose out of market pressures and, particularly, out of the need for U.S. companies to compete in international markets. This suggests that it is possible for cutthroat competition to breed successful adaptations that are humane and progressive and, indeed, embody some of the attributes that professionalism has sought to instill.

However, it would be naive to expect only positive effects from the commodification of health care. More likely, it will lead to a decline in
physicians’ altruism and, particularly, reduced willingness to provide free care to uninsured and poor patients. After all, since when do banks, car dealers, stockbrokers, and supermarkets feel that they are obligated to give away services to persons who are unable to pay their bills? In a 1991 survey of a nationally representative sample of 4,000 physicians, we found that when physicians in group practices perceived their local markets to be very or somewhat competitive, they were significantly more likely than their colleagues in less competitive areas to report that their group practices discriminated against uninsured patients.31

The commodification phenomenon also is likely to change patients’ perceptions of physicians and to encourage any erosion of trust resulting from changing financial incentives. Promarket policy analysts who ignore this potential effect of competition are in danger of losing touch with the average citizen, in much the same way that advocates of a single-payer health care system lost touch with the basic wishes and desires of middle-class Americans during the 1994 health care reform debate. Perhaps the best evidence that patients wish to trust their physicians comes from studies of why patients sue their doctors.32 In a recent study that is consistent with much of the literature on motivations for malpractice litigation, Howard Beckman and colleagues found that “perceived interpersonal process issues”—failures of communication, perceptions of lack of caring, and inattention to patients’ wishes or discomfort—were the most commonly cited reason (71 percent) for patients’ suits against providers.33

There is a pressing need for further research on the importance of and origins of trust in physician/patient relationships, whether market restructuring is affecting levels of trust, and whether this matters for processes and outcomes of care, including patients’ satisfaction with their own physician and with the health care system generally.

**Physicians’ Responses To Market Changes**

Assessment of the consequences of market changes for physicians’ behavior and physician/patient interactions is complicated by the fact that the restructuring of local markets is a moving target. One of the elements in motion is physicians’ practice arrangements, which are changing as physicians seek to adapt to restructuring markets. These arrangements have taken a number of forms.

**Physician groups.** The first is the aggregation of physicians into groups. Physician groups are antidotes in part to the organizational and customer phenomena. When acquired by larger organizations, groups have bargaining power that allows them to negotiate internal administrative and financial arrangements that reflect their own preferences. When independent,
groups increase the market power of physicians with respect to managed care organizations and purchasers of care. By pooling their resources, groups of sufficient size also can afford to hire professional managerial staff who can negotiate with organizations and purchasers and assist with quality improvement and cost reduction to increase their competitiveness.

The formation of physician groups has been occurring for some time in health care markets. This response to market restructuring thus can be viewed as accelerating an existing trend. Nevertheless, at least two things seem to have changed about physician groups as a result of market restructuring. First, doctors who never before would have considered surrendering their independence are now joining group practices. Second, the purposes of such groups are different from what they were in the past; thus, their organization and functioning are likely to have changed as well. In the past, one suspects, physicians joined groups for control over their hours, predictability of income, and interaction with colleagues. Now, many physicians in solo practice are seeking protection from what they perceive to be imminent financial disaster. Consequently, the ability of groups to enhance physicians’ competitive position seems likely to be a paramount concern.

This could affect the manner in which groups influence physicians’ behavior. In particular, groups may be driven to employ many of the same devices for controlling costs that are used by other organizations in the health care system. The only difference may be that physicians will find these changes more tolerable when they are imposed by their peers than when they are imposed by external agents. Paradoxically, internal controls may be even more stringent as a result.

**Integrated systems.** A second response of physicians to market restructuring is physician formation and ownership of integrated health care systems. In the past, some of the most successful health care organizations in the country have been owned and managed by physicians. Examples include the Mayo Clinic, the Cleveland Clinic, and the Park Nicollet Health System. Physician ownership and management of integrated health care systems can be seen as an effort to build on the success of these historical precedents. The end stage of physician ownership is the aggregation of such organizations into structures large enough to dominate and control the supply of provider resources in a community. This may create oligopolies that protect physicians’ and other providers’ interests from the pressures of the market.

It has been speculated that physician ownership will mitigate the potentially negative effects of the organizational and commodification phenomena, since physician owners are more likely than nonphysicians to incorporate traditional professional values into the cultures of provider organizations. Whether this is true should be the subject of future research.
Physician empowerment. A potential response by physicians to market restructuring is to seek empowerment within health care organizations that are owned and controlled by others. This would be a way for physicians to make certain that their interests—and perhaps the interests of their patients—are heard. Such representation could take the form of membership on boards of directors and key internal committees and the development of formal medical staff structures with bylaws and elected officers. Whether integrated health care systems would agree to such structural safeguards will depend a great deal on the power of physicians in future health care labor markets. If large corporations are able to bust physician organizations the way they have busted unions in the past, then physicians may not be able to secure effective representation within these organizations.

Long-Term Effects Of The Competitive Dynamic

Under the influence of the organizational, customer, and commodification phenomena, some physicians undoubtedly will find themselves with unprecedented opportunities to put their training to work for their patients. Freed by capitation to innovate in health care delivery, supported by professional management and state-of-the-art information systems, newly sensitive to consumers’ wishes, and spurred on by the example of competing organizations, these physicians will deliver care of unprecedented quality and efficiency. An organizational culture that honors the customer will produce an ethic of service among physicians that will be almost indistinguishable from the professional ethic. This result seems most likely to occur when savvy, enlightened purchasers with highly educated workforces are able to identify and form partnerships with well-managed provider organizations that employ competent, conscientious physicians.

However, in other cases, the result of the competitive dynamic may not prove so happy. Some customers—for example, the chronically ill; the frail elderly; and low-income, poorly educated workers—will not be represented by enlightened purchasers, nor will they have the resources to make wise decisions in choosing providers. They may find themselves enrolled in health care organizations that employ deprofessionalized physicians who are more responsive to the administrative and economic controls of their employers than to the needs and wishes of individual patients. Such physicians, and the organizations for which they work, may deliver care that is far inferior in quality and efficiency to what they would provide under non-competitive circumstances.

The fact that the competitive dynamic may produce such widely disparate results should come as no surprise. Markets work extraordinarily well for those who enter the competitive fray with the necessary endowments.
For the less fortunate, markets offer no guarantees. In its effects on physicians and their interactions with patients, the restructuring of our health care system likely will accentuate the divisions and inequalities that existed in our society before the transition to a market-based health care system.

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NOTES

5. B. Starfield, Primary Care: Concept, Evaluation, and Policy (New York: Oxford University Press, 1992); and Blumenthal et al., “The Efficacy of Primary Care.”


24. Spragins, “Beware Your HMO.”


