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Commentary

Patient Choice Has Become the Standard Practice in Healthcare Provision: It is Time to Extend its Meaning

Comment on "Is Patient Choice the Future of Health Care Systems?"

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Abstract

The key argument of this commentary is that patient choice has a broader meaning than suggested by consumerist choice models. In increasingly marketized health care systems with diversified and knowledge-based service arrangements, patients are continuously obliged to choose insurers, physicians or hospitals and treatments—whether they like it or not. However, health care users refer to a wide range of roles and resources while taking health-related decisions. They are patients, consumers and co-producers at the same time. Therefore, as it is argued, healthcare policies have to recognize users' multiple identities by providing more balanced choice frameworks. In particular, two aspects are crucial: first, opportunities for users to voice worries and concerns and to co-design default options of health care choices; secondly, taking the significance of interpersonal trust in choice-making processes into account.

Keywords

Patient Choice, Healthcare Users' Roles, Voice, Interpersonal Trust, Equity

Background

In her recent debate "Is Patient Choice the Future of Health care Systems?", Professor Marianna Fotaki (1) expresses strong skepticisms about the potential of choice-driven reforms in health care provision. She argues that choice policies, as empirical results demonstrate, do not lead to more efficiency and higher quality in health care (2), have, in particular, negative consequences on equity between patients (3) and fail to meet patients' most important interests, i.e. a local provision of services and choosing treatments (4). According to Professor Fotaki, these non-achievements are due to the application of a narrow consumerist choice model, defining health care users simply as rational actors. Instead, Professor Fotaki favors a broader understanding of choice, including other aspects of decision-making such as patients' cultural backgrounds, beliefs and values.

Overall, the author shares Professor Fotaki's reluctant attitude towards market-type choice policies in health care; treating patients indiscriminately as market-savvy consumers will hardly change health care provision to the better and ignores users' individuality in terms of needs and preferences. However, Professor Fotaki's justified criticism tends to overlook the fact that patient choice is rather the present than the future of health care systems. In increasingly marketized health care systems with diversified and knowledge-based service arrangements, patients are continuously obliged to choose insurers, physicians or hospitals—whether they like it or not. Rejecting to take such complex choices seems almost impossible. Hence, for those who are challenged to make proper health care decisions, dismissing the current use of choice mechanisms is of little help. But how should "multidisciplinary frameworks" (1) for choice policies be shaped?

Recognizing users' multiple identities

First of all, we have to revise our understanding of the 'chooser' in health care provision. Current choice policies, exclusively inspired by rational choice theory, reduce health care users to the rather simple assumptions of the homo economicus model (2). Remarkably, this intellectual shortcoming takes place while mainstream economics slowly rediscover 'real' human beings, partly behaving irrational (that means not in accordance with their objective needs), as economic agents (3). Notwithstanding, in health care the figure of the 'smart consumer' has replaced the 'needy patient' as a reference point. However, this dichotomy is—more than ever—misleading. On the one hand, health care users are nowadays, contrary to what Krugman suggests (4), patients and consumers at the same time, claiming unconditional help and freedom of choice. On the other hand, they refer to a wide range of roles and resources while taking health-related decisions. Furthermore, health care users are entitled citizens (having a right for a certain level on service guarantees), co-producers of health care treatments (e.g. negotiating shared decisions with professionals) and community members (receiving support in their families, informal networks and self-help groups). In practice, these roles are gaining (or losing) weight depending on health care users' personality, state of health, values and respective health care decisions to face. However, all roles have an impact on choice-making processes. Therefore, choice

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architects should recognize health care users' multiple identities and address them as socially embedded individuals.

How could this be realized? In short: by taking more balanced requirements for users' health care choices into account. So far, current choice models are one-sidedly based on economic incentives and measurable factors, e.g. service costs and indicators of health care providers' performance. Moreover, users of respective choice frameworks are (without exception) supposed to have a strong agency capacity. For instance, (healthy) users should scout insurance markets for value for money tariffs. Also chronically-ill people, searching for tailored service packages, are required to benefit from rationally framed choice options, promising good and affordable care. However, most of the users, especially those who are less healthy, less active and less informed, assess health care choices in the light of at least two other aspects: first, with regard to existing opportunities to voice their worries and concerns and, secondly, whether their relationships to medical professionals are trust-based.

Why voice and trust are important?

To the first aspect: voice can be conceived as the flipside of choice by complementing rather than substituting it. According to Hirschman (5), policies that are based on an "elusive optimal mix of exit [the then term for choice] and voice" are most likely to produce favorable outcomes. Applied to health care provision (6), this means not only to voice dissatisfaction but to give users a say on what exactly they can choose, e.g. concerning default options of insurance portfolios or service designs. Likewise, upgrading voice mechanisms includes users' involvement in the governance of choice-based health care arrangements, be it collectively via mandated user organizations or by setting up bodies with an ombudsman function. Representatives of user organizations can also be charged by individuals to choose their insurance schemes as 'health care proxies'. As a rule, it can be stated: making users' claims heard differs significantly from nudging them, as libertarian paternalists suggest (7), in the supposedly 'right' direction, e.g. by incentivizing subscriptions for disease management programs. Instead of presenting users predefined choices, voice promises participation on 'what is at stake'. Thus, reconciling choice and voice in health care arrangements may renew, as Professor Fotaki rightly puts it, "long standing users' demands for autonomy and greater control over health care resources".

To the second aspect: choice (and voice) in the process of diagnosis and therapy are even higher rated by patients than choice of selecting healthcare providers. Here, the significance of interpersonal trust comes into play. As co-producers, patients contribute emotional knowledge to the doctor-patient relationship (8). They alone know best 'how it feels' to be ill—an aspect that should be considered in the choice of medical treatments. However, patients remain merely 'experts by experience' and are therefore interested in close consultations with doctors. Ideally, in processes of shared decision-making the latter act as "citizen professionals" (9) by applying their scientific knowledge to the particular case of the individual patient. In this respect, choice becomes a relational procedure where it is less important who decides but how the decision has been developed. For instance, patients may decide (given their state of health or in the view of the complexity of the matter) to "exercise their royal powers by delegating authority to someone else" (10). Then a person in their confidence, normally their doctor, chooses a treatment on their behalf. Apparently, such an interactive way of making health-care choices, allowing patients to entrust themselves to professionals, have less in common with consumerist models rewarding individual agency and economic thinking only.

Choice: a 'boon and bane' for users

Finally, the problem of equity remains. Choice keeps a 'boon and bane' for health care users (11). Skilled users may benefit from personalized and high-quality service arrangements that are more suitable to their needs than large-scale and standardized health care services of the past. On the contrary, a worse quality of services (e.g. regarding dental prosthesis where good quality requires high co-payments by users), paternalistic managed care programs or even a lack of health care coverage are looming, if users' literacy concerning health and/or the health care system is low. This dilemma, even if it cannot be solved easily, does not justify a withdrawal of choice schemes in health care. Rather the persistence of the equity problem reminds us to design choice policies in the full sense of their meaning: users should be addressed as humans, being able to weigh options of health care provision and treatments carefully in cooperation with relatives, professionals or peers. If they refuse to do so, basic guarantees, providing a decent level of service quality, should protect them of harm.

Ethical issues

Not applicable.

Competing interests

The author declares that he has no competing interests.

Author's contribution

BE is the single author of the manuscript.

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