Perspectives on the Free Choice of the Source of Personal Health Care

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IN THIS ESSAY I SHALL DEAL WITH ONLY A SMALL part of the much larger topic of free choice as a principle in the organization and delivery of health care services. I focus my attention on the choice of a source of care by clients. I narrow the scope of my inquiry even further by putting aside, at least for now, the closely related issue of free access to clients by practitioners, including the reasons for wanting to place restrictions on that access.

Even though, in these ways, I have greatly simplified my task, I hope to be able to show the remarkably complex ramifications of the principle of free choice even within this restricted domain. For though I can hardly expect to say anything new about the principle itself, I hope that I shall be able to demonstrate the many, and often conflicting, considerations that flow from the principle of free choice when it becomes operational. Far from remaining a softly comfortable abstraction to which one can safely pay lip service, free choice now becomes a hard (and sometimes intractable) reality that the administrator must learn to handle.

My method in this exposition will be to look at the consequences of free choice from several different perspectives that I shall identify

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as I develop my theme. I shall also keep in mind that restrictions on free choice can affect entry, exit, or both; and that they can appear as pressures to join or quit, or as obstacles to doing either.

The Client's Perspective

It is reasonable to begin an examination of free choice with the viewpoint of the client. From this perspective, free choice from among the largest possible number of alternatives, or from among as many as the client may care to consider, is no doubt regarded as a value in its own right. It is a reaffirmation of freedom, one more evidence (of which there can never be too many) of personal dignity and worth.

Beyond this more general, largely symbolic meaning, the ability to hire and fire may be thought by the client to have more specific and profound effects on the practitioner-client relationship itself. Under free choice the practitioner can be seen to be more truly the client's own—more closely attached, more committed, more loyal. Accordingly, free choice becomes more important to the client in situations that are regarded as particularly perilous, or those that involve some degree of conflict between the client's private interests and those of others who are considered capable of influencing the practitioner's judgment or behavior. These potential adversaries could be an employer, an insurance agency, a government program, or society itself, represented by any of the instrumentalities through which it acts on individuals in matters that involve health and health care.

Finally, freedom of choice offers the opportunity, through repeated trials if necessary, of matching the social and psychological attributes of clients and practitioners in a manner that is likely to improve the satisfaction of both parties, and to make the client-practitioner transaction therapeutically more effective. The very fact that we know so little about what goes into the process of successful matching makes the resort to the trials and errors of free choice even more appropriate and necessary (Donabedian, 1980:35–76).

Thus, upon a first examination, free choice seems to bring nothing but advantages to the consumer. It is only when we look again from different vantage points that the picture darkens with disturbing shadows.

The Provider's Perspective

My next vantage point is that of the provider of care. It is possible to gather under this heading the interests of individual practitioners, of an institution such as a hospital, and of an organization such as a group practice, even though the views of these diverse categories of providers may differ, at least in the importance they give to each of the several interests that they share.

From the viewpoint of the provider of care, freedom of choice for the client becomes freedom of access to clients. Therefore, providers who are able and willing to compete for clients in general insist on unrestricted choice; and, in particular, each demands to be included as a candidate for choice. Anything other than this appears to them as an unwarranted interference that threatens the economic well-being, even survival, of those providers whose access to clients is in some way hampered.

The passion to be included on an equal footing is particularly fierce among those providers who are ordinarily at a disadvantage because they are outside the mainstream, or are new to the marketplace. This explains the fervor with which chiropractors have waged their largely successful campaign for eligibility under private health insurance, as well as under public programs such as Medicare and Medicaid. Similarly, prepaid group practices could not hope to prosper without the prospect of at least equal treatment by these programs.

All providers, but in particular organized programs that provide care, have another selfish reason for wishing to grant the client the freedom to join and to quit. Prepaid group practices appear to have suffered in the past from unwise arrangements under which an acutely unhappy minority of subscribers has not had the opportunity to seek care elsewhere without significant financial sacrifice. The principle of dual choice or multiple choice is now well established. It serves the interests of the consumer. At the same time it unburdens the provider of the disruptive presence of permanently disgruntled clients (Donabedian, 1969).

We see, then, that with regard to free choice the interests of clients and providers are in happy harmony. But this is not completely the case. At the most fundamental level, the freedom of clients to enter and exit must be balanced by the corresponding right of the provider to reject and terminate. This necessary symmetry of rights is easy to

appreciate and grant in a transaction between an individual client and an individual provider. It is not so immediately obvious when the provider is an organization. This intuitive hesitancy leads us to what may be a fundamental principle of social morality: that a symmetry of rights is acceptable only in a context that one may describe as possessing a symmetry of circumstances. The liberty of the provider to reject or terminate is justifiably abridged, without corresponding constraints on the client, if the client cannot receive equal care without significant disadvantage at an alternative source, if the provider's grounds for action are socially discriminatory, or if the provider has explicitly or implicitly accepted public responsibility to provide care under certain conditions. In these circumstances the right of the client for care causes an abridgement in the right of the provider to refuse or terminate care.

Another kind of asymmetry is found in a number of situations in which selective obstacles to the free entry and exit of clients are advantageous to at least some providers who, therefore, seek such advantage. For example, specialists would welcome a stipulation that third parties may pay for certain procedures only if performed by the subgroups of physicians to which the specialists belong. By contrast, generalists would heartily endorse a proposal that specialists be seen only on referral by a generalist. Similarly, physicians who have a panel of patients for whom they are paid per capita would not be averse to administrative deterrents to easy termination of the relationship by the client.

The advantages of these kinds of restrictions on free choice are perhaps best seen from the viewpoint of an organization that provides care, such as a group practice. Here, it is possible to distinguish two levels of analysis: that of joining and quitting the group as a whole, and that of the internal operations of the group.

At the first level of analysis, it is obvious that a large enterprise faces serious problems in getting started. For that reason some degree of "favored" or even "pressured" enrollment would serve the organization handsomely; and, for the same reason, some brake on disenrollment would probably be welcomed. Later on, the organization might itself wish to eliminate unwanted members, probably by refusing a subsequent enrollment rather than by seeking to terminate an existing one.

At the level of internal operations, the organized practice would

probably want to limit access to specialists in order to control costs, strengthen the role of the generalist, and mollify the specialist who wishes to restrict his practice to cases that require his particular skills. At the same time, the organization could see many advantages in assigning patients to physicians as if the latter were interchangeable. This would equalize work loads, alleviate competitive tension among physicians, reduce the time patients must wait as well as the time physicians remain idle, and perhaps would make the organization less dependent on a few physicians who are particularly popular with patients (Donabedian, 1973:277–284).

In some way these many advantages of selective restrictions on choice will have to be balanced against the advantages of free choice, which I presented earlier. But the balance sheet is not yet complete, since it must also include the powerful influences that flow from the exigencies of prepayment.

The Perspective of the Financing Organization

The financing of care, whether as an independent activity or in conjunction with the delivery of care (for example, through a prepaid group practice, or some other form of health maintenance organization), introduces what are perhaps the most powerful inducements to restrictions on free choice. This threat to free choice arises from the actual or expected behavior of clients that has been called "moral hazard," and from its consequences to the organization, which are known as "adverse selection." Very briefly, it is expected that those who are particularly in need of health care will be more likely to obtain insurance, and that everyone who has insurance is, for that reason, more likely to seek care.

Actuarial adverse selection is the disproportionate concentration of persons who need and demand care in the membership of any given plan. Organized practices are sometimes exposed to yet another form of adverse selection that may be called social. This is the threat, seldom openly acknowledged, of attracting a disproportionate number of members who, often because of social class or ethnicity, are stigmatized in a prejudice-ridden society.

Adverse selection, whether actuarial or social, results from selective

enrollment, selective disenrollment, or both. Additional problems arise from rapid turnover in membership, independent of its composition. One problem is that there are costs attached to the acquisition and termination of memberships. It is also believed that in many situations, though not in all, new members tend to use more services during the earlier months of enrollment than they do later on, when they have become more "seasoned" members (Donabedian, 1976a:101–107; Yesalis and Bonnet, 1976). Finally, rapid turnover may lead to a lower degree of stability and predictability in the overall membership of the plan and in its monetary situation.

Some have speculated that turnover in membership can be too slow as well as too rapid, because the aging of a cohort of members gradually increases its need for care. Thus, the financing organization may hope that older members will disenroll (in addition to having their numbers depleted by death), and that younger, healthier persons will take their place.

In the light of these considerations it is easy to see why an organization that bears some of the financial risks of health care should want to restrict or "manage" choice in a manner that lessens the risk and makes it more predictable. An organization would want any plan, irrespective of prepayment, to remain socially attractive to the mainstream of its potential clients. It would therefore take steps, short of being reprehensibly discriminatory, to achieve what has been euphemistically called a "balanced" enrollment. Self-serving though they are, these steps are also not without socially redeeming value. If the public has a stake in wishing the health maintenance organizations to prosper and multiply, it would not want them to be under a financial disadvantage from the very start. And although public policy should not countenance the discriminatory exclusion from membership of segments of the population who often are most in need of a stable source of care, it should also want to avoid creating a two-class system of medical care by having a category of providers that is too heavily identified with one class of patients.

The provisions of the Health Maintenance Organization Act of 1973 and of its amendments are an excellent illustration of the desire to steer a middle course that would curb possibly discriminatory practices while maintaining diversity of membership and financial solvency (U.S. Congress, 1973; 1976; 1978).

Public policy, then, serves as an arbiter of what kinds and amounts

of restriction on free choice have a net benefit. Thus, we come to the final vantage point on free choice that I want to discuss in this essay.

The Perspective of the Collectivity

The collectivity perspective is that level of analysis that attempts to identify the more general consequences of actions in a society, so that these consequences can be taken into account in the formulation of public policy. In this light it is not sufficient to know whether free choice is offered. One also needs to know whether choice is exercised—in what ways, with what effect, and at what price.

I have already suggested that there is a price to pay for free choice, for example, in the cost of handling enrollments and disenrollments, and in the inefficiencies that result from limits on the interchangeability of personnel, so that while some are overly burdened, others are only partially occupied. Frequent changes in the source of care may also cause repetitious, discontinuous, and uncoordinated management, with unhappy consequences to both cost and quality.

The major problem with free choice is not that it is sometimes abused, but that it often cannot be appropriately implemented and, as a result, fails to produce its desired effects. The alleviation of administrative restrictions and financial obstacles does not necessarily produce access to a representative cross-section of providers. Because of ethnic, geographic, and other reasons, access may remain restricted, and the broadening of choice may in fact be harmful to the consumer while it is costly to society. The physicians who serve the urban poor tend to be generalists who are graduates of foreign medical schools, and who have no hospital affiliations. Medicare and Medicaid, by making it possible for the urban poor to transfer from the more established public institutions to this private sector of care, may have encouraged excessive doctoring with either deterioration of, or little improvement in, the quality of care. Thus, free choice may mean the opportunity to choose inferior physicians and facilities (Donabedian, 1976b).

The inability to choose wisely is, of course, not limited to any particular segment of the population. In varying degrees everyone is exposed to this danger. It is the most pervasive, most fundamental flaw that afflicts free choice as an instrument of public policy, not

only of health care. But one could argue that with regard to health care the choice is so difficult, and the consequences of the wrong choice can be so serious, that some degree of paternalistic protectiveness is permissible, if not necessary (Dworkin, 1972).

In fact, society may be said to have gone a long way in accepting this protective function. It has implemented this role through a variety of devices such as educational standards, licensure, certification, accreditation, conditions for the participation of providers in public programs, and the requirement that care in these programs be monitored for quality as well as quantity and cost.

By these means society has attempted not only to mitigate the more disastrous consequences of imprudent choice, but also to preserve a wide variety of more clearly defined choices. In steering this middle course between license and control, public policy has attracted the criticism of those who say it has done too little and those who complain that it has done too much. It has done too little because faulty and wasteful care continues to be practiced on an alarming scale (J.W. Friedman, 1965). It has done too much in that its restrictions on practice have been abused by those who have been granted an exclusive privilege to provide care (M. Friedman, 1963). Moreover, quite unintentionally, private insurance and public programs, by partially protecting the client against the financial consequences of choice, have weakened the ability of competition to curb costs.

Free choice may fail to bring about the benefits expected of it, not only because clients do not choose wisely, but also because those who provide care are, for whatever reason, unresponsive to its stimulus. In a brilliant exposition, Hirschman (1970; 1980) has reminded us that free choice (which he calls "exit") is the traditionally acceptable means by which the consumer unobtrusively but effectively works his will in a competitive market. Through the consumer's decision to buy or not to buy, firms receive the unmistakable signals to which they must respond if they are to survive. Hirschman also points out, however, that under some circumstances (which I find remarkably reminiscent of aspects of the medical care system), free exit fails to have these effects. For example, a troubled public enterprise, such as a school system, is further weakened without being either eliminated or improved, when it is abandoned by the subset of better informed, more vocal parents. The analogy to a municipal hospital system is remarkably close.

When exit fails to work its magic or when it places too big a burden on the consumer, the alternative is to strengthen "voice," which is the propensity to complain and to resort to political action. In fact, by intentionally limiting exit, one fuels the political fires that eventually bring about reform. Under these circumstances at least some restriction on choice would seem to be better than free choice.

It is a brilliant argument, but like all justifications for coercion in the public interest it is one that I hesitate to accept. It does serve to remind us, however, that the mere presence of free choice may not be sufficient. Consumer pressure, both individual and collective, is a necessary adjunct. And when exit is inevitable, it should be both reluctant and vociferous.

Speaking more generally, it is always necessary also to provide realistic alternatives accompanied by accurate information about cost, the process of care, and the outcomes of care. It is a legitimate, even necessary, public role to assure individuals that each provider (or, at least, each category of providers) is precisely what each seems or pretends to be. I am also not averse to arrangements that require each consumer to bear a fair share of the cost of care, provided this does not inhibit initial access and evaluation, so that the choice to continue care is based on accurate and reasonably complete information.

Since the best laid plans tend to miscarry in ways that are sometimes least expected, another public responsibility is the monitoring of the choice and the study of its consequences. One consequence, happily, is that individuals will sometimes make choices that others may consider unwise. This is a right to be cherished. But even if, more generally, free choice fails to produce all the benefits expected of it, the easy resort to coercive solutions should be obstinately resisted. Though, in the end, some compromises may have to be accepted, our deepest impulse should be not to abandon or weaken free choice, but to make it work.

References

Donabedian, A. 1969. An Evaluation of Prepaid Group Practice. *Inquiry* 6 (September):3–27.

———. 1973. *Aspects of Medical Care Organization: Specifying Require-*

ments for Health Care. Cambridge, Mass.: Harvard University Press.

———. 1976a. *Benefits in Medical Care Programs.* Cambridge, Mass.: Harvard University Press.

———. 1976b. Effects of Medicare and Medicaid on Access to and Quality of Health Care. *Public Health Reports* 91 (July–August):322–331.

———. 1980. *Explorations in Quality Assessment and Monitoring, Vol. I: The Definition of Quality and Approaches to its Assessment.* Ann Arbor: Health Administration Press.

Dworkin, G. 1972. Paternalism. *The Monist* 56 (January):64–84.

Friedman, J.W. 1965. The Value of Free Choice in Health Care. *Medical Care* 3 (April–June):121–127.

Friedman, M. 1963. *Capitalism and Freedom.* Chicago: The University of Chicago Press. See especially the chapter on occupational licensure, 137–160.

Hirschman, A.O. 1970. *Exit, Voice, and Loyalty: Responses to Decline in Firms, Organizations, and States.* Cambridge, Mass.: Harvard University Press.

———. 1980. Models of Man and Models of Policy: Reflections on *Exit, Voice, and Loyalty* Ten Years Later. *Milbank Memorial Fund Quarterly/Health and Society* 58 (Summer)3:430–453.

U.S. Congress, Senate and House of Representatives, 93d Congress, 1973. *Health Maintenance Organization Act of 1973,* P.L. 93-222. Washington, D.C.: Government Printing Office.

———. 1976. *Health Maintenance Organization Amendments of 1976,* P.L. 94-460. Washington, D.C.: Government Printing Office.

———. 1978. *Health Maintenance Organization Amendments of 1978,* P.L. 95-559. Washington, D.C.: Government Printing Office.

Yesalis, C.E., III, and Bonnet, P.D. 1976. Effect of Duration of Membership in a Prepaid Group Health Plan on the Utilization of Services. *Medical Care* 14 (December):1024–1036.

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