In the Literature

Rhiannon Tudor Edwards, D.Phil., M.A.

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BLIND FAITH AND CHOICE

Comparing her first experience navigating the American health care system with a visit to the local Baskin-Robbins ice cream parlor—famous home of the '31 flavors'—a British health economist asks, "Can we treat health care like ice cream? Does more choice raise collective society benefit or well-being?"

During a year spent in Seattle as a Commonwealth Fund Harkness Fellow in Health Care Policy, Rhiannon Tudor Edwards was "overwhelmed" by the choices offered among coffee, TV channels, and health care options, she recounts in her essay, "Blind Faith and Choice" (*Health Affairs,* Nov./Dec. 2005). But when Edwards, a senior research fellow in health economics at the University of Wales, developed a serious sinus infection, she had trouble tracking down a provider that would both agree to accept her "comprehensive" health insurance and schedule a timely appointment. Noting that in the U.K. waiting a day or two for an appointment with a general practitioner is routine, Edwards observes ironically that "in the U.S. there was more choice of providers unable to offer me an immediate appointment."

Edwards eventually visited a health clinic that accepted walk-ins—not so much as a result of informed choice as one of immediate need. She was surprised when American friends later quizzed her about the brand of antibiotics she had been prescribed; as a Briton, she would not have thought that she had a choice in the matter.

Proponents of the individual health insurance market and health savings accounts promise they can provide consumers choice among health plans, providers, and even treatments. Such policies are grounded in economic theory positing that the "invisible hand" of the competitive market can efficiently balance supply and demand. This can work when consumers are fully informed, goods or services are homogeneous, and there is free entry into and out of the market. But, Edwards argues, none of these conditions exists in the U.S. health care system.

Rather than freely choosing among providers, patients typically depend on their doctors to act in their best interest. Edwards cites a 2002 Harris Interactive survey of U.S. adults that found only 1 percent of respondents had made a decision to change health plans, doctors, or hospitals on the basis of performance evidence.

What's more, choice has yet to produce outstanding health status or equitable access to needed care in U.S., especially when compared with other modern health systems. Patients without insurance have few or no choices about their care. In fact, policies such as health savings accounts can actually isolate patients, Edwards finds, forcing them to take on greater financial responsibility and risk.

"Ultimately, choice comes at a price. As consumers, we are expected to pay for the privilege of choice, and if we cannot pay, we do not *get* to choose and, more than likely, do not *get* at all," concludes Edwards. "I left the U.S. convinced that having less choice in health care is a price well worth paying for universal coverage."