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Modernizing concepts of access and equity

MARTIN GULLIFORD*
King's College London, Department of Public Health Sciences, King's College, London, UK

Introduction

Former UK Prime Minister Tony Blair once observed that 'the purpose of the twentieth century welfare state was to treat citizens as equals; the purpose of the twenty-first century reforms must be to treat them as individuals as well' (Blair, 2002). Emphasis on the individual is evident in recent UK health service policy, which identifies the aims of 'personalizing services [by] making [them] fit for everyone's needs. That includes those people traditionally less likely to seek help or who find themselves discriminated against in some way' (p. 9). 'The National Health Service needs to give patients more rights and control over their own health and care' (Department of Health, 2008: 33).

The objective of making government funded services responsive to the needs and choices of individuals is characteristic of 'Third Way' philosophies. For health services, the Third Way represents a middle path between two polarities. At one extreme, obtaining needed health care is regarded as the responsibility of individuals and families. At the other, health care is delivered by centrally planned, top-down government services. Through the Third Way, governments play a role in facilitating access to needed care, but are respectful of individual autonomy and choice with services being delivered through either public or private providers. The aim is to make health services more consistent with the outlook of modern societies in which individuals are enabled to chart the course of their own lives and there is tolerance of the diversity that flows from individuals' choices.

Access and equity

The accompanying papers explore the implications of this shift in thinking for the meaning of access and equity (McIntyre *et al*., 2009; Goddard, 2009; Mooney, 2009). 'Access' is concerned with the processes of gaining entry to the health care system. This may be extended to include the processes of gaining entry to higher levels of care, for those already admitted to lower levels, sometimes referred to as 'in-system' access. Conventional models of access recognize

*Correspondence to: Martin Gulliford, Professor of Public Health, Department of Public Health Sciences, King's College London, London SE1 3QD, UK. Email: martin.gulliford@kcl.ac.uk

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the availability of services (having access) and utilization of services (gaining access) as key dimensions. Geographical, organizational and financial barriers, as well as personal, social and cultural influences, may facilitate or impede the uptake of services. The appropriateness of services, and their effectiveness at achieving desired health outcomes, are also considered to fall within the scope of conventional access models (Gulliford *et al.*, 2002).

McIntyre *et al.* (2009) draw on the classic paper by Pechansky and Thomas (1981), which characterized access as the 'degree of fit' between patients and health services. McIntyre *et al.* go on to introduce a new dimension by making individuals' capacity to realize their preferences and choices a key element of their definition of access. Empowerment of the individual to reach his or her own decisions on health service use is elevated to become the highest principle of access to health care. Empowerment offers individuals the opportunity to realize their preferred choices, which may encompass non-use as well as use of health services. According to this definition, if the potential to use a service exists, then access is present even when an individual makes the choice not to use care. Mooney (1983) makes a similar point. This is in contrast to traditional models in which utilization, a more tangible measure, is considered proof of access.

Goddard (2009) points out that empowering individuals is only one of the strategies that has been adopted to improve access to health care in the UK in recent years. Others include improving the availability of primary care services in deprived areas; streamlining organizational barriers that impede entry and 'in-system' access; and setting access targets to performance-manage service providers. Goddard draws back from adopting the concept of empowerment and instead refers to Dixon-Woods' (2006) concept of 'candidacy' which recognizes the role of health services as well as individuals in jointly negotiating eligibility for access.

What is empowerment?

Empowerment belongs to a class of words that is difficult to define and may be used with several different meanings. The author of a Wikipedia entry observed that 'the term human empowerment covers a vast landscape of meanings, interpretations, definitions and disciplines ranging from psychology and philosophy to the highly commercialized self-help industry and motivational sciences' (Wikipedia, 2008). One type of empowerment is at the community level, it includes representation of marginalized groups in decision-making processes as well as delegation of control over resources. This type of empowerment is exemplified when an indigenous community becomes engaged in the organization and delivery of its own health services. This represents political empowerment; it is advocated by the World Health Organization's Commission on Social Determinants of Health (2008) as an approach to reducing inequalities in health.

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Another type of empowerment is at the individual level. This requires the transfer of information from service providers to service users, so as to facilitate decision-making by individuals in keeping with their values and preferences. Individual empowerment was defined by Giddens (1991) as 'the power of human beings to alter the material world and transform the conditions of their own actions' (p. 138). Giddens argues that individuals in modern societies are able to reskill themselves by obtaining relevant knowledge and assert their right to make decisions that impact on their lives, thereby reappropriating power that was previously the exclusive preserve of expert service providers. This concept of empowerment has much in common with the notion of informed choice, or informed decision-making, which Marteau and colleagues (2001) define as choice 'based on relevant knowledge, consistent with decision-makers' values and behaviourally implemented'. These concepts of empowerment or informed choice emphasize the importance of individual autonomy in decision-making. However, the behaviours of individuals and health services are not fixed but show 'reflexivity' in response to the consequences of previous interactions.

What does 'access as empowerment' mean?

The suggestion that 'access to health care represents the empowerment of an individual to use health care' (McIntyre *et al.*, 2009: 5) can be interpreted in several ways. One interpretation is that empowerment is an ideal or aspiration; another is that access is realized through empowerment; a third is that access should be measured in terms of empowerment.

Donabedian (1972) argued that utilization of health services is the proof of access to health care. The concept of access as empowerment appears straightforward if utilization occurs and empowerment is present, or if utilization and empowerment are both absent. However, problems arise if utilization and empowerment are inconsistent.

Does access to health care exist if health service utilization occurs in the absence of empowerment? Suppose an older person collapses unconscious in the street and is carried to hospital where all necessary care is delivered for her stroke. If it turns out that the individual previously expressed a desire to be cared for at home by her friends and relations when her time came, it would appear that the individual was unwittingly disempowered by the emergency services. Should we conclude, in this case, that access to health care does not exist? Another example is provided by the compulsory treatment of an individual with psychosis. We may be prepared to accept that the individual should be disempowered for the common good, and perhaps also for the benefit of the individual, but is it correct to argue that this form of utilization of care does not amount to access? Of course, utilization without empowerment is not confined to those who are unable to participate in decision-making because of the nature

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of their condition. This suggests that empowerment may be an aspiration or ideal that is perhaps seldom achieved, yet access may be realized in its absence.

The non-use of services that are available also poses problems for the concept of access as empowerment. A hypothetical example is provided by the antecedent history of the person who had a stroke. Suppose the individual's family physician had earlier measured her blood pressure, found that this was raised and informed the individual that she had hypertension requiring life-long drug treatment. The individual may decline this offer of treatment of her own free choice after considering all available information – a not uncommon decision among individuals with high blood pressure, taking into account the risks and potential benefits of treatment and the perceived risks of treatment side effects (Morgan, 1995). This is consistent with Giddens' (1991) suggestion that decisions about the use of health care may represent lifestyle choices. According to one argument, the individual is empowered to choose whether to take treatment for her blood pressure and access exists, even though the choice was not to use services. A different argument may be that the medical treatment offered was unacceptable and access to care was compromised. McIntyre and colleagues (2009) draw attention to the close relationship between acceptability and empowerment. If the required intervention is acceptable, then individuals are empowered to use it; if the intervention is unacceptable individuals are disempowered. If individuals choose not to use a service, is the service acceptable? The service offered may sometimes be the only feasible service; if this is unacceptable is access to be regarded as being denied?

The evaluation and measurement of 'access as empowerment' therefore presents difficulties. The question of whether the presence or absence of empowerment should be judged by the individual or by an observer emerges as being of particular importance. It seems clear that only the individual can judge whether he or she has been empowered to make choices based on his or her values. It follows that objective measures of empowerment do not exist and that empowerment must be self-assessed. Consequently, the assessment of the relationship between access and need will be difficult under this approach. The difficulty of evaluating health system responsiveness, in the World Health Organization's framework, provides a useful parallel (Murray *et al.*, 2001).

What is the role of societal and provider interests in individual decision-making?

Another difficulty with the concept of access as empowerment concerns the role of community and provider interests in shaping the values and choices of individual citizens. Suppose a teenage girl wishes to become pregnant and have a child. The value we attach to empowerment requires that health services offer opportunities for safe motherhood; access will be realized through this process. However, we may consider that the girl has been so disempowered by the

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deprived circumstances of her upbringing that her values have been distorted, resulting in inappropriate choices. Social marketing strategies may be employed to modify her beliefs and behaviours, as well as those of her peers. By shaping her values and choices, we believe that we have empowered her to delay her first pregnancy, for the benefit of herself, her child and the common good. However, the remodelling of socially unacceptable attitudes may not be consistent with the initial notion of empowerment.

The role of for-profit organizations is also of concern. In the US and New Zealand, prescription only drugs may be directly marketed to consumers but this has led to concerns for inappropriate prescribing. One observer commented: 'critics point out that cheaper, generic drugs are often available as alternatives, and that doctors are really best placed to decide on suitable treatments, without coaxing from patients who have been seduced by commercials' (Clark, 2008). Patient pressure groups have in some cases accepted funding from drug companies to facilitate lobbying for access to new medicines (Templeton, 2006). These observations draw attention to the difficulty of ignoring the interactions that occur between the individual, community and societal levels, with societal institutions playing an important role in shaping individual choices.

What relevance has individual empowerment for societies that do not embrace 'modernity'?

The role of community-level influences is often of particular importance in middle- and low- income countries. Bhugra and Minas (2007) characterize these as having a more sociocentric or collectivist outlook than the egocentric and individualistic world-view that is prevalent in high-income countries. Giving priority to individual choices and values represents a distinctly 'modern' outlook that is not universally shared. Tradition, culture and religion provide the standards for individual behaviour in many contexts, not just those of middle and low-income countries. Dutiful adherence to societal norms may be regarded as being of greater importance than individual choice. In the United States, for example, there is a divergence of opinion concerning the options available to a woman who has an unplanned pregnancy. For some, there is the possibility of choice; for others there is no choice because only one course of action is believed to be right. Mooney (2009) asks whether it represents a distinctly Western value to assert the right of individuals to make fateful choices in their own health care? One response is that this is not a Western value but a human value (Blair, 2002). Grayling (2003) argues that religious observances, such as obedience to the 'will of God' as interpreted by religious leaders, represent the antithesis of modernity and are incompatible with good living. Others are more inclined to extend the tolerance of 'modern' societies to other cultures and traditions (McIntyre *et al.*, 2009), perhaps even when the latter may be intolerant of individual empowerment.

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Does individual empowerment promote public goods?

Health services are important in generating public goods. This is most readily appreciated in the control of infectious diseases. The immunization of a high proportion of individuals generates 'herd immunity' and reduces the risk of outbreaks of disease; the treatment of individuals with tuberculosis reduces the spread of the disease to others; the prudent use of antibiotics by individuals reduces the emergence of drug resistant organisms. More generally, a healthy population is a societal resource that can facilitate economic development. National and local governments have a responsibility, through their stewardship role, to protect and promote the health of their populations (Nuffield Council on Bioethics, 2007). The achievement of societal objectives is sometimes inconsistent with individual empowerment. Thus, the decision to implement population-wide preventive medical interventions is usually made at the societal level. Individuals may be offered immunizations or screening tests as routine procedures with limited discretion in participation (Gostin, 2000). The exercise of individual choice may confound the societal objectives of these programmes. In England and Wales where parental choice has contributed to lower uptake of the measles, mumps and rubella (MMR) vaccine, the number of measles cases rose to more than 1000 in 2008 compared with 56 cases in 1998 (Health Protection Agency, 2008). A requirement for individual empowerment may also hinder the implementation of community-level interventions that yield individual benefits, such as water flouridation. Individual empowerment necessarily encompasses the freedom to make choices that may lead to unintended outcomes. As noted above, the media, professional groups and vested interests may each play a role in shaping individuals' choices.

What are the implications for equity?

Mooney's (2009) paper considers the implications of this new thinking for understanding of equity of access to health care and equity in health. He raises the question of whether any consistent conception of equity can be identified. Sen (1995) observes that most models of equity propose equality of something, but disagree over what should be made equal among individuals. The concept of equity that can be derived from the model of 'access as empowerment' is one of equality of individual empowerment to use health services. Leaving aside the question of whether this is an optimal measure to equalize, three observations follow. First, this form of equity will not require the same distribution of health care as that which results from traditional models that require equality in the availability or use of services in relation to need. Secondly, this kind of equity may be unusually hard to achieve. Goddard (2009) reviews evidence from England that suggests that implementation of schemes to offer choice to individuals had the effect of increasing inequalities in access. Lower socioeconomic groups, older people and some ethnic minorities are disadvantaged.

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Thirdly, the concept of equity as equality of individual empowerment will not always be consistent with equity in health. Individuals may have different conceptions of health and evaluate the potential risks and benefits of health interventions differently, leading to different choices. These choices may lead to differences in health outcomes that may not be favourable for some individuals, as is illustrated by the re-emergence of measles in England and Wales.

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