Navigating public/private healthcare boundaries:
choice and healthcare capital

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Abstract:

While choice is a central value in Australia’s public and private healthcare system, there has been little sociological research on the complexities and experience of choice. This paper proposes a theoretical framework, organised around the concept of ‘healthcare capital’, to inform multi-method research on healthcare choice in Australia. We outline its potential for explaining differential capacity to choose and the ‘choice’ of different pathways through the healthcare maze, and illuminating the complex relationships between construction, perception and enactment of choice.

Thematic group: Health Sociology

Key words: health care; choice, public/private health care; healthcare capital
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Introduction
Choice is central to Australia’s public and private healthcare system. We ‘choose’ whether to buy private health insurance (PHI); whether to use private or public facilities; who to consult about health conditions. We are encouraged to ‘choose’ to consume health goods and services, including surgical procedures, medications and complementary therapies. However, sociologically, the notion of ‘choice’ is problematic. Entwined within the rhetoric of choice are ideas about information (consumers generally have less information than providers), evidence (often contested), trust (increasingly conditional in the healthcare encounter) and responsibility (who is responsible for ‘wrong’ choices?). The ‘freedom to choose’ can be construed as an ‘obligation to choose’ (Rose, 1999), yet the factors which structure and constrain those choices remain under-researched. There has been little exploration of the complexities of choice – including the differential capacity to choose, and whether our ideas about choice are realised in healthcare decision-making – in a healthcare system characterised by a rhetoric of choice.

There has been little sociological research on how and why healthcare choices are made in Australia (Collyer 2011; Willis and Broom 2004). There has been some on policy and marketing discourses of choice (Elliot 2006; Harley et al. 2011; Irvine 2002); decision-making about treatment options (Broom 2009; Thorpe 2008) and PHI (Natalier and Willis 2008); and limits to consumerism in hospitals (Henderson 2002). We believe more research is needed to elaborate the structure of choices and constraints in Australia’s complex public/private system of health care. In this paper
we suggest that ‘healthcare capital’, derived from Bourdieu’s work, provides a theoretical framework to inform our multi-method research, and outline some reasons for its potential to explain health choices. We focus on the Australian context for choice, the concept of healthcare capital, and the relationship between construction, perception and enactment of choice. We conclude with questions about the role of trust.

Healthcare Choice in Australia

Australian health care is more a maze than a ‘system’, for it is not ‘coherent, integrated or systematic’ (Palmer and Short 2010: 1). The extensive marketing of private healthcare services co-exists with public provision and funding. Choices are encouraged in the context of a complex mix of public responsibilities in health provision, the marketisation of private products, and a broad array of players in the healthcare market. Scholarship on European healthcare systems demonstrates the increasing blurring of public/private boundaries (Saltman 2003), and similar phenomena can be seen in Australia.

Australia’s healthcare system has been significantly transformed in the past half century. Postwar attempts to introduce an NHS-style system were opposed by the medical profession and others who objected to being conscripted into a monopoly system (Palmer and Short 2010; de Voe and Short 2003). The British Medical Association in Australia sought to protect doctors’ and patients’ freedom to choose. A voluntary PHI system with a minimal safety net prevailed. Australia shifted toward a universal public health system in 1975, then back to a voluntary insurance model, and re-introduced a universal system in 1984 (de Voe and Short 2003). Over recent
decades we have witnessed a growing reliance on the private provision of healthcare services (Collyer 1997; Collyer and White 2001).

In the 1990s, the Howard Government introduced powerful incentives to promote increased PHI membership, accompanied by policy narratives advocating a discourse of choice (Elliot 2006). This reflects a widely-held view that healthcare services can be purchased like other consumer goods. Patients, as consumers and purchasers, are presumed to behave as rational actors, making choices based on calculations designed to maximise self-interest and minimise loss (Irvine 2002). However, healthcare choices and needs are complex, with many poorly equipped to make choices alone (Gabe and Calnan 2000: 265-66). Decisions may involve fear of morbidity or mortality and are pervaded by unpredictability and uncertainty, and healthcare services cannot be returned if they are unsatisfactory (Henderson 2002: 105; Palmer and Short 2010; Titmuss 2004).

**Healthcare Capital**

We propose that ‘healthcare capital’ provides a way to understand the complexity of choice in the field of public and private care. Our starting point is Bourdieu’s (1986; 1984) sociological concept of ‘capital’. Bourdieu’s work has endured through critical exploration and elaboration in health sociology and elsewhere. For instance, his ideas have been used to theorise relationships between class, health and lifestyles (Williams 1995), illuminate competing currents in medical research (Wainwright et al. 2009), analyse GP practice in a changing policy context (McDonald 2009), and examine healthcare interactions (Shim 2010) and the ways families deal with a degenerative childhood disease (Scambler and Newton 2011). ‘Health capital’ has been used to
emphasise the class-based nature of embodied health as a social resource (Blaxter 2010). Bourdieu’s theoretical framework provides a sociological way of thinking about the variety and potency of resources brought to healthcare decision-making; the complex and unequal ways in which social context and position enable and constrain particular choices; and who has the power to define ‘good choices’.

The role of Capital: Different Types, Different Choices

Bourdieu uses ‘capital’ to describe the differential structuring of opportunities and constraints in the social world: it is ‘what makes the games of society – not least, the economic game – something other than simple games of chance offering at every moment the possibility of a miracle’ (1986: 241). Capital is a resource that can accumulate, whether through conscious strategic investment or unconsciously through social experience. Importantly, Bourdieu (1984; 1986) identifies different forms of capital – not just economic but also particularly cultural, social and symbolic capital – with their relative salience a matter of struggle in particular fields.

While more research is needed on the differential capacity to choose and different pathways through the healthcare maze, we know that choice is socially structured along multiple dimensions. Our hypothesis is that healthcare capital – understood not as one of, but a complex interplay between, the four forms of capital identified by Bourdieu – is relevant in structuring the field and understanding individuals’ differential capacities to navigate the healthcare maze. We now outline each of the forms of capital and suggest their relevance in the field of healthcare.

Cultural capital is a strongly hereditary form of capital, transmitted in the family and
acquired through time spent in education. It is embodied as ‘cultivation’, the capacity to culturally appropriate cultural objects (its objectified state) and institutionalised in academic qualifications (Bourdieu 1986). In the specific field of healthcare, cultural capital describes the acquisition of skills required to engage in healthcare decision making, through formal or informal education, and supported by family background and experience. Of some relevance is Shim’s ‘cultural health capital’, defined as a form of cultural capital that ‘can be leveraged in health care contexts to effectively engage with medical providers’ and acquired ‘in and through the repeated enactment of health-related practices’ (2010: 3). In the specific context of patient-practitioner interactions in the contemporary US health system, she identifies characteristics including: medical knowledge and vocabulary; capacity to efficiently communicate relevant knowledge to healthcare personnel; proactive, instrumental, self-disciplined and future-oriented stances towards one’s health and body; ability to tailor appropriately one’s interactional styles; and capacity to communicate social privilege (Shim 2010: 3).

We can see that formal or informal education in medicine or other health fields would convey a particular advantage in the interactions with health practitioners described here. And education in general, and specifically in relation to health care, is also likely to shape the capacity to identify and choose between healthcare options (including funding mechanisms and systems, treatments, practitioners and hospitals), and to find, interpret and assess different sources of healthcare information, which is consistently considered an important element of health decision-making (e.g. Charles et al. 1999; AUSSA survey data also reveals associations between attitudes to PHI and education level (Collyer et al. 2010)). One anecdotal example concerns the clever
and distinctive pathways forged by some general practitioners giving birth, combining quality private medical antenatal care and use of public hospital birthing centres (Harley et al. 2010). The hereditary nature of cultural capital can also be seen in Natalier and Willis’s (2008) findings about how family traditions inform young people’s decisions to purchase PHI. And Shim’s (2010) work usefully points to the ways in which health-related practices, including experience making healthcare decisions, either for oneself or on behalf of others, might develop healthcare capital and influence choices.

In Bourdieu’s (1986) framework, social capital refers to the ways in which relationships and membership of groups (particularly those that connect someone with high-capital individuals and groups) enhance social opportunities, including through leveraging individuals’ own ‘capital’ resources. A systematic literature review on the effect of social capital (understood in fairly general terms) on healthcare access has found some empirical evidence that ‘bonding social capital’ (social ties in strong, informal, horizontal groups) improves access, but this depends on the quality of relationships and group norms and values (Derose and Varda 2009). Strong, numerous social ties in general are likely to increase individuals’ access to support in negotiating healthcare decision-making – for instance to attend appointments, provide advocacy in healthcare contexts or suggest alternative paths. Those whose social networks and memberships connect them to influential or knowledgeable players within the healthcare field (or who themselves occupy such a position) are likely to be particularly advantaged, illustrated for instance in the way Lance Armstrong was able to mobilise support from different sources following his cancer diagnosis (Armstrong and Jenkins 2009).
We think that *symbolic capital*, effectively prestige or ‘reputation for competence’ (Bourdieu 1984: 291), is likely to be relevant to healthcare choice in two ways. The first is by affecting the capacity to negotiate with healthcare gatekeepers to optimise decisions made (although perhaps too much ‘patient expertise’ may hinder quality of care? (Shaw and Baker 2004)). The fact that 85% of Australians referred by a GP to a specialist in the previous 12 months had seen that specialist (ABS 2010) points to the important gatekeeping role of GPs. Second, symbolic capital is relevant in thinking about who has power to define which are the ‘good choices’ in the healthcare field.

While Bourdieu (1986) is keen to counter the argument that the other forms of capital are simply reducible to *economic capital*, he considers that material resources play an important role. Economic capital clearly shapes the healthcare choices available to individuals or groups. For instance, in the Australian system, those with higher incomes are considerably more likely to purchase PHI – in the 2007 AUSSA survey, 90% of those in the highest individual income group (> $78,000) had PHI, compared to 45% in the lowest group (< $15,600) (Collyer et al. 2010) – and some treatment options involve significant out-of-pocket costs. The 2009 Patient Experience Survey shows that while approximately equal numbers of hospital admissions in the previous year were public (53%) and private (47%), this was significantly related to PHI status and a variety of socioeconomic variables (ABS 2010: Table 4). While investing in PHI might predispose individuals to choose private care, 24% (almost 300,000 people) of those with PHI chose public treatment (ABS 2010: 23). We suggest this is an area where we need to look at economic capital in combination with its other forms to understand healthcare choices.
A theoretical and empirical question for our research concerns how healthcare capital interacts with other elements affecting healthcare choices, such as geographic location and embodied health. These may be incorporated into some of the four forms of capital mentioned above (e.g. geography affects employment and networking opportunities, hence economic and social capital) but may also have independent salience (geographic or locational capital?).

One likely outcome of this research is a set of ‘ideal types’ associating certain positions within the healthcare field with dispositions to negotiate particular choice trajectories around or across public/private healthcare boundaries. For instance, extrapolating from research into cultural tastes, one ‘type’ might be healthcare ‘omnivores’, with sophisticated capacity to understand, choose between and combine public and private treatments in ‘their own terms’ (Emmison 2003; Peterson and Kern 1996). Others might have sufficient economic capital to purchase PHI and private treatment, but not the resources to question the advice of their providers and insurers (thus healthcare advice offered alongside PHI (Harley et al. 2011) might be seen as a mechanism for converting economic capital to a form of cultural capital that disposes individuals to prefer private healthcare options). The concept of healthcare capital may also help explicate cases when particular healthcare choices increase risk. For example, why do some women with PHI ‘choose’ caesarian section, and thereby increase their health risks? Answering such questions requires a theory that can incorporate the relationships between social ideas, material and symbolic resources and medical power.
Capital, Field, Habitus: Construction, Perception and Enactment of Choice

Bourdieu’s inter-linked trio of capital, field and habitus can provide a way to conceptualise the complex relationships between construction, perception and enactment of choice.

For Bourdieu, ‘the social’ is constituted by fields, which are relational sites of struggle. Fields are structured by different forms of capital, which in turn define positions and opportunities available for individuals and groups. In Australia, the healthcare field is shaped by public policy, the competing interests of parties (including different healthcare professionals, public and private providers and funders, medical and CAM practitioners, drug companies, public health advocates, national and state governments, and health consumer groups), and funding models and employment practices. These constrain the context within which healthcare choices are made.

It is through the ‘habitus’ that capital is linked with the field and the individual. Habitus is acquired in social settings, initially the family, and describes the internalisation of capital. It disposes individuals to be comfortable with some situations and actions and not others: ‘when habitus encounters a social world of which it is the product, it is like a “fish in water”: it does not feel the weight of the water and it takes the water around itself for granted’ (Bourdieu and Wacquant 1992: 127). Thus Bourdieu’s conception of the habitus provides a way of questioning the notion that rational individuals make calculated choices in engaging with health care systems. There is an affinity here with Natalier and Willis’s (2008: 408) finding that most of their young interviewees with PHI came from families with cover: ‘the good
of private health insurance is part of received family wisdom and, as such, largely unexamined in any critical way’.

In relation to health care, we know that perceptions and enactments of choice are not always or equitably aligned. The policy discourses noted above, and similarly those of PHI (Harley et al. 2011), construct the public/private system as offering choice, and PHI as increasing choice. Despite this policy emphasis, only 40% of ABS interviewees admitted to hospital in the previous 12 months reported having been given a choice of being treated as a public or private patient, with young, healthy people with PHI somewhat more likely to be offered a choice (ABS 2010: 23-24). National Health Survey results show that while ‘choice of doctor’ and the option of private treatment are nominated as reasons for having PHI by 29% of those with cover, ‘security or protection or peace of mind’ is significantly more popular (54%) (ABS 2009): suggesting choice may not be as important to individuals as it is to marketers. And Natalier and Willis’s (2008) study of young people with PHI shows a disjuncture between perceptions and realities of the capacity of PHI to enhance choice. For example, one Northern Tasmanian interviewee perceived PHI as providing the choice of private obstetric care in a private hospital, when in reality the only available local facility was the public hospital birthing unit, where the $2000 obstetrician appeared after midwives delivered her baby (Natalier and Willis 2008: 404).

The notion of healthcare capital, linked to field and habitus, can illuminate misalignments in the constructions, perceptions and enactment of healthcare choices. There is competition within the field over who has the power to define ‘good
choices’; and taken-for-granted ‘habitual’ practices may conflict with perceptions of choice.

The Question of Trust

We have set out above two key ways in which Bourdieu’s formulation provides a foundation for research on healthcare choice in Australia. We are cognisant of critical debates about Bourdieu’s framework, for instance whether it is overly deterministic, too general, overstates the role of class, leaves insufficient room for agency and resistance, and adequately accounts for social change – and will consider these in relation to the healthcare context and our theoretical framework. In this conclusion we introduce another issue which may require reformulation of Bourdieu’s work – the importance of trust.

Recent research on PHI marketing discourses identified the centrality of increased choice and the importance of individual responsibility. However, an emphasis on partnership paradoxically conveys an understanding of the difficulties of taking individual responsibility for healthcare choices and suggests a role for trust (Harley et al. 2011). An Australian survey reports higher levels of trust in private than in public hospitals, and greater trust in Medicare than PHI (Hardie and Critchley 2008). This seems paradoxical. Interviews about Australians’ decisions to purchase PHI found that perceptions of choice, control and trust were salient, rather than government policy, rationally calculated decision-making or the clinical experience (Natalier and Willis 2008). Research in the English NHS, where there is less scope for choice than in Australia, reveals a subtle relationship between choice and trust (Calnan and Rowe 2008). Exercise of choice is based on trust in the doctor’s competence and hospital
cleanliness; performance information did not inform patients’ choices about where to be referred, but influenced their subsequent response to referral decisions. As Calnan (2010) argues, the concept of trust appears crucial in understanding the nature of choice in the unpredictable field of health care.

Unlike the relatively communitarian model of social capital adopted by authors such as Putnam (2000), Bourdieu’s framework is not typically associated with trust. However, Siisiäinen (2000) suggests a Bourdieusian version of trust as a symbolically legitimated objectification of the hidden interests of the powerful. While there is literature to suggest that health professionals can engender patient trust (Meyer and Ward 2008), might not questions of where individuals place their trust be shaped by their habitus? We welcome the opportunity to put these ideas to the empirical test.

References


Cambridge: Harvard University Press.


