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# Gatekeepers in the healthcare sector: Knowledge and Bourdieu's concept of field

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ABSTRACT

Choice is an imperative for patients in the Australian healthcare system. The complexity of this healthcare 'maze', however, means that successfully navigating and making choices depends not only on the decisions of patients, but also other key players in the healthcare sector. Utilising Bourdieu's concepts of capital, habitus and field, we analyse the role of gatekeepers (i.e., those who control access to resources, services and knowledge) in shaping patients' experiences of healthcare, and producing opportunities to enable or constrain their choices. Indepth interviews were conducted with 41 gatekeepers (GPs, specialists, nurses, hospital administrators and policymakers), exploring how they acquire and use knowledge within the healthcare system. Our findings reveal a hierarchy of knowledges and power within the healthcare field which determines the forms of knowledge that are legitimate and can operate as capital within this complex and dynamic arena. As a consequence, forms of knowledge which can operate as capital, are unequally distributed and strategically controlled, ensuring democratic 'reform' remains difficult and 'choices' limited to those beneficial to private medicine.



## 1. Introduction

Choice is a core value in the Australian healthcare system. Patients are encouraged to 'choose' whether to buy private health insurance, whether to use private or public healthcare services, who to consult about health conditions, and what health goods and services to consume, including surgical procedures, over-the-counter medications and complementary therapies. Yet sociologically, choice is a problematic notion. Recognising that choice has become an imperative in health systems which demand patients become 'active' consumers of health, there is a growing interest in how choices are structured and constrained within the healthcare system, and concern over this differential capacity to choose (Harley et al., 2011; Collyer et al., 2015a).

The notion of choice also co-exists uneasily with the complexity of healthcare systems such as those found in Australia, where there is a dynamic policy, market and consumer environment and a composite of public and private providers and facilities. This complexity makes a healthcare system more a maze than a 'system' (Collyer et al., 2015a), and successfully navigating the maze requires more than a map and a compass for a patient. Their success depends, in part, on the quality and quantity of resources that individuals possess prior to, or can amass during, their journey through the maze. Equally important is the very context of the healthcare system: how it is organised, the accessibility, cost and appropriateness of its services, the information available and whether this is adequate to assist patients to find services that meet their medical, and many social and cultural needs.

Within the healthcare 'maze', multiple decisions are made, not just by patients, but by health-workers and policymakers, including about how services should be provided, organised and funded, and by whom. This aspect of choice has been less researched. The sociology of knowledge and the sociology of science have begun to open up decision-making processes in areas of social life such as the laboratory (e.g., Camic et al., 2011; Latour and Woolgar, 1979), but have yet to make a significant impact in the study of the organisation of healthcare. Where we do find studies of decision-making

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in the social sciences, the term 'gatekeeper' has, since the 1970s, increasingly been used to describe the key actors and groups involved in this activity. The term has become ubiquitous in fields such as research methods (e.g., Crowhurst, 2013), media/communications (e.g., Soroka, 2012) and network analysis (e.g., Marks et al., 2013), to indicate individuals with a key role and set of specified tasks. In the medical sociology literature, where it appears less frequently, the notion of a gatekeeper is generally reserved for the GP (a general practitioner or community-based doctor) (e.g., Segar et al., 2013), although there are a few examples where it has been used for doctors in hospital settings (e.g., Mizrachi et al., 2005); other health-workers such as pharmacists (Chiarello, 2013); and non-health-workers, such as parents where their child is the patient (Dimond, 2014) and medical receptionists (Vassy, 2001; Hammond et al., 2013).

In naming the GP or other actor as a 'gatekeeper', the idea is to suggest a figure with a significant social role to control access to resources. This may involve the screening of individuals seeking entry and allowing only some to pass 'beyond the gate'. The gatekeeper is often, particularly in the research methods literature, an under-theorised and abstract figure, overly rational (Crowhurst, 2013) and in Marxist or political economy analyses of healthcare, an agent rather than actor. For example, in private healthcare systems, such as the United States, the gatekeeper is conceived as an 'agent of capital', for they act to limit the legal and financial responsibilities of corporations such as health insurance companies or Health Maintenance Organisations (e.g., Budrys, 1993). In this context, the gatekeeper can only be self-interested and profit-oriented, and where a decision is in the patient's interest, it is coincidental (Collyer, 2015:50). In state-run health systems, with health-workers on fixed salaries regardless of patient turnover, or in countries (such as Australia or Canada) with state-funded insurance systems and laws that are effective in prohibiting the payment of financial incentives to refer patients to particular businesses/services; the gatekeeper is more likely to be referred to as an 'agent of the capitalist state' (e.g., Bíró, 2013), for they assist the state to control public outlays for diagnostic tests, specialists and hospitals - because patients are only subsidised for these costs when they have been referred by a GP or other registered health-worker (Collyer et al., 2015b). In the latter context, the gatekeeper may or may not be acting in their own financial self-interest, but there are nevertheless assumptions they are responding to system imperatives, they have very limited roles, and little interest is shown in the individuals who 'play' these roles. Indeed, even in the broader literature, instead of examining those who 'monitor the gate', the focus is on those who are 'outside the gate' (Budrys, 1993:356). The gatekeeper is rarely portrayed as a fully *social* being with their own motivations and capacities for action. The gatekeeper responds only as directed by the demands of the system: 'demands' narrowly focused on organisational profits or budget efficiencies.

An argument can clearly be made for re-working the concept of the gatekeeper to enable greater sociological insight into rarely investigated aspects of the healthcare system, where decision-making fundamentally shapes both patient care and the operation of the system. One of the current limitations in the gatekeeping literature is its focus on the entry point to healthcare, rather than the many other potential gatekeeping processes that take place throughout healthcare provision (Chiarello, 2013:320). For example, decisions about who should receive care and of what kind, but also how services should be organised and financed. This would require looking not just at doctors but other significant individuals, organisations and institutions. Moreover, the re-working and expansion of the concept should entail a more thorough sociological approach in which gatekeeping is conceived as a fully social process, a complex of actions that go beyond the filtering of individuals, and indeed beyond the concept of healthcare rationing, where decisions are made about what services will be funded. Such a broad range of tasks cannot be performed by rationally calculating robots, but must emanate from social actors *in situ,* in key positions with access to relevant knowledge and a capacity to act on this knowledge. As a sociological concept, gatekeeping needs to be conceived not as the performance of a role, but a process which produces the possibilities for action. For the healthcare field, gatekeeping is one of the more important ways in which pathways or structures are created, maintained and modified over generational time, and these guide, enable and constrain the 'choices' of patients, health-workers and policymakers about possible therapies, providers and services.

Employing this extended understanding of the gatekeeper, we can inquire more deeply into the human processes that configure and organise the healthcare system, and into the myriad of ways in which the choices and decisions of participants (whether patient, doctor or policy maker) might be circumscribed. If, as de Maio (2010:93-4) argues, healthcare systems reflect the dominant values of the society and are '… outcomes of political struggle; they reflect the end result of competition between complex forces', then we need to understand the connections between the organisation of the system and the decision-making and actions of the key actors within it.

Our focus is therefore on gatekeeping, and the gatekeepers of the healthcare system. On those actors who, in the main, are knowledgeable, highly competent, and caring, and yet contribute to a system which does not always operate most effectively for the patients for whom it is supposedly designed, nor most efficiently for the government that must manage the healthcare budget. Thus we ask questions about the kinds of knowledge produced within the healthcare field, how knowledge is controlled within the field, the kinds of knowledge available to gatekeepers, and the extent to which their knowledge and positions within the field may allow or restrict their capacity to build effective pathways within the system and assist patients with their healthcare choices. To address such questions, we designed an empirical study of gatekeepers and their practices in the Australian healthcare sector. We employ the concepts of Bourdieu - particularly his notion of the field - to map the various actors and relations of power within the field, and examine gatekeeping in action. This study is described in the next section, followed by a discussion of Bourdieu's concepts and then findings from the project.

## 2. The study

The gatekeeper study is part of a larger research program which aims to investigate the way patients navigate the healthcare system in Australia. Both the gatekeeper study and its companion, the patient study (reported elsewhere, e.g., Willis et al., 2016), focused on a series of research sites to ensure the inclusion of individuals from low and high socio-economic areas, metropolitan, regional and remote areas, across three Australian states and one territory. After approval from the Human Ethics Committee (HEC) at the University of Sydney, (and the various authorities with responsibility for ethical conduct in the public hospital system in the three states and one territory), participants were selected using internet searches of appropriate sites (such as hospitals and general practices) through theoretical sampling, and invited to participate. Between 2014 and 2015 we interviewed 41 individuals for the gatekeeper study, and these included GPs and nurses in private and public general practices and hospitals, specialists in both private and public practice, clinical directors, managers and CEOs in private and public hospitals, consumer and professional association