**Reconsidering Consumer Access to Healthcare**

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**EXTENDED ABSTRACT**

The importance of access to quality healthcare services for physical, mental, and social wellbeing is undisputed. Yet, healthcare access barriers are numerous, spatial inequities are long-standing (Bradshaw, Bloor, and Doran 2018), and many healthcare services are confusing and disconcerting for consumers. Well-known access frameworks assess dimensions such as availability, acceptability, adequacy, and geographic accessibility (Saurman 2016). These conceptualize access as relating to consumers’ ability or willingness to enter a healthcare system (Penchansky and Thomas 1981) dependent upon properties of the system (availability of clinical appointments) and/or the individual (ability to afford).

We argue that continuing to accept this view confines our appreciation of what access

involves and restricts our understanding of what is required from marketing to tackle barriers currently hindering the realization of health benefits for many consumers. Drawing on Ribot and Peluso’s (2003) theory of access for property and natural resources, we proffer an alternative conceptualization of healthcare access which identifies individual and systemic barriers and broadens our understanding of what access means. Consequently, we reconceptualize healthcare access as *the ability to realize value.* This reconceptualization expands our attention from solely gaining entry to a focus on how, even when a consumer gains admission to a healthcare system, myriad barriers to gaining value still exist.

We build our new healthcare access framework in hospice and end of life care (EOLC). We collected data from 245 consumers who were receiving care from 9 different EOLC units. We used pathographies, which are stories of illness experiences; experiential narratives that put the patient at the center (Hunsaker Hawkins, 1999). Pathographies were audio recorded and then transcribed verbatim. Taking our new definition of access as ‘ability to derive value’ as our starting point, we manually thematized the data utilizing the procedures suggested by Spiggle (1994), and for this paper we searched for themes that constricted people’s ability to realize value.

Numerous and varied factors hampering value realization emerged. We classified these into three interrelated sets of contrivances: value communications, value constellation, and value density. *Value communications*pertains to the value-related dialogue and understanding of the benefits of the healthcare service. We identified several communications barriers. Myths surrounding hospice and death taboos (EIU 2015) abounded. Current communication channels were ineffective in breaking down these barriers, while gatekeepers often hindered consumer’s access attempts. *Value constellation*incorporates the complex service system that consumers need to navigate. Collaboration within the value constellation was highly problematic. Institutional arrangements between parts of the system led to perceptions among consumers of a disjointed service. As a result, consumers were confused, and access was delayed. *Value density* refers to the consumer’s resources that, when leveraged, can aid value realization. We identified an absence of priming and subsequent confusion after diagnosis, all of which contributed to a lack of agency for patients and their families. Differing levels of health literacy made many encounters difficult, and we identified a great deal of power imbalance between clinician and patient, perpetuating feelings of helplessness among consumers. For some, such experiences led to a lack of faith in healthcare systems.

Long recognized as an aspect of healthcare that has myriad barriers to access (Parajuli et al. 2020), even those who had managed to gain entry to EOLC services had endured delays, frustrations, and obstructions at every stage. We heard from bereaved families how, for some, entry to the system had come too late. Yet, from a policy perspective, they had gained access because they had gone through the referral process. We therefore suggest there is a need to transform standard definitions of healthcare access.

Our reconceptualization has several advantages over previous definitions. First, it overcomes conceptual and methodological limitations inherent in earlier definitions that confine our understanding to availability and utilization. These are inadequate because availability does not always equate to levels of need, while measures of utilization do not consider benefits (Allin et al. 2007). A focus on realized value includes availability and utilization, while extending our understanding of what healthcare access means. Hence, conceptualizing access from one of infrastructure and entry to one mediated by myriad and diverse contrivances that enable or hinder a person’s ability to derive value immediately shifts our thinking from organizational factors to a focus on the consumer. Healthcare has a long way to go before the paradigm of person-centred care, reflective of the transition from disease focused to individual patient need, is achieved. We suggest that a change to the way we define access to one that focuses on ability to derive value has the potential to be significant in helping to drive this profound philosophical shift.

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