

Empowerment and Health Portals

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INTRODUCTION

We know that interest in employing Web portals for communication between the health care sector and the public is constantly increasing (Kapsalis, Charatsis, Georgoudakis, Nikoloutsos, & Papadopoulos, 2004). We can also find an increasing demand for various kinds of such communication (Sciamanna, Clark, Diaz, & Newton, 2003). It promises to become an important and valuable tool for e-health (i.e., computer-based health care and health care management). Patients can log into a Web portal in order to find an appropriate medical treatment, communicate personal matters, and/or find the right way and place to find adequate health care.

In the last 10 years, we have also seen “empowerment” flourish, not least in an Internet context. In conventional research about Internet and Web portals, empowerment refers to a quite general process of gaining influence over events and outcomes. For example, it is argued that people are becoming more informed and managing their situations in better ways thanks to portal solutions and thereby becoming more empowered (Fergusson, 2004). Empowerment is central in the discourse of health and an important analytical concept to understand how portals work and can improve health care (Cathain et al., 2005).

In this article, I will argue that empowerment is indeed a fruitful concept to capture the potential of Web portals (in the health care sector). However, what is largely missing in the contemporary analyses is a more dynamic approach to analysing empowerment than found in conventional research, and how from such an approach we may justify the way Web portals are used to reach better results. The argumentation will be supported and illustrated by empirical material based on how different health portals are used.

UNDERSTANDING EMPOWERMENT: A TERM BASED ON POWER

As a researcher coming mainly from the social science and not medical science, it is natural to base an analytical discussion about empowerment on central thoughts on the concept of power. A modern definition of power tells us that power has to do with circumstances where one actor is able to make another actor perform against his or her will and interests (Lukes, 1974). Hardy and Leiba-O’Sullivan (1998) use Luke’s definition of power and explore it in

terms of empowerment, in a way that could be very relevant to health portals too. They discuss how power is exercised by using various resources to influence the outcome of the decision-making processes. Several assumptions underlie this view of power. It says that all individuals are aware of their grievances and act upon them by participating in the decision-making process and using their influence to determine key decisions. We can find a whole range of possibilities related to health care where the physician brings different resources into the discussion (authority and information, etc) or hides information from the patient. Power could also be maintained by patients. They can abuse their power by giving the physicians spurious information for their own sake (to get drugs for example) or by misusing the health resources. The physician can also offer some information to the patient who becomes the sole decision maker. It is a situation that often is related to differences in cultures and deep values (e.g., Hofstede & Hofstede 2005) between paternalism and autonomy and between fidelity and humanity.

Power, rather than simply being exercised within decision-making processes, could also be used to exclude certain issues and patients from that process. Physicians could have the possibility to squeeze patients out and not let them come to the places where the decisions are made.

What both these two dimensions of power are based on is a situation where all parties more or less know their status and their will. But what about if the patients do not know what is best for them because the communication has been distorted? What this third dimension of power tells us is the importance of investigating what the fundamental base is that takes place in the decision arena. The patients could be said to be duped, coerced, or manipulated into political inactivity (or the opposite way around) via a Web portal (or by not accessing one).

Inspired by these thoughts we can draw the scheme presented in Table 1.

The scheme can help us to analyse empowerment in the context of Web portals; for example, can patients gain access to the decision arena thanks to a portal, etc? By using such a scheme, we also say that technology performs in a determined way and is therefore, in principle, determinable. However, to understand Web portals and empowerment I suggest it could also be fruitful—in a quite pragmatic way—to loosen up such a view by linking the discussion to the insight that we also apprehend and constitute the world through a technological frame, which is not innocent in this context.

Table 1.

	First Dimension	Second Dimension	Third Dimension
Power of A over B.	Control of resources.	Control of decision-making processes.	Control of meaning.
Empowerment of B requires.	Acquisition of resources and ability to mobilize them.	Ability to gain access to the decision arena.	Consciousness-raising.

What I mean is that Web portals do not strictly answer this or that question, satisfy this or that demand, or extend this or that capacity. Rather, as Arnold (2003, p. 236) calls a substantive approach:

Technology works at a more fundamental level, it enframes the world such that the question is changed in a certain social context along with the answer; the need is changed along with its gratification, and direction is changed along with the mechanism.

So, a Web portal also enframes a particular brand of reality and functions therefore as a kind of knowledge making. This world is continually working to structure our thoughts and our thinking and acting processes.¹ The problem with the conventional way of regarding empowerment and Web portals is that the logic does not allow for opposite effects to be placed within the same effect frame. My argument is that an analytical discussion about Web portals and empowerment has much to gain from being complemented by a more—what could be called—dynamic approach. I will illustrate this by examples taken from two case studies—one focuses on Vårdguiden (Edenius & Westelius, 2004) and the other one on different patient communities² (Edenius & Åberg, 2005). Both of these case studies are based on interviews of users and owners of different health portals.

EMPOWERMENT AND HEALTH PORTALS: TWO MINI CASES

Vårdguiden

Vårdguiden is the Stockholm County Council’s Web portal for health care and telephone consultation. The portal is a neutral arena where citizens in Stockholm can get information about the health care sector and get health care advice. What could be said to be unique with Vårdguiden, compared with most other Web health portals, is that it includes some interactive services. At the time of our study (2004), the portal included three such different communication services. Patients who had registered as users of the system could book, alter, and

cancel appointments with physicians. They could also renew a prescription and renew registration on the sick list.

The patients really loved the portal. They said that they can reach health care in a good way thanks to the portal. The patients stress how thanks to the written language they have been able to communicate certain matters in different ways. They have been able to use the written discussion with the physicians as qualitative check. They can always go back to what they have discussed and the physicians’ answers. They also say that thanks to the portal they have gotten important information about their illnesses, information, and knowledge they can bring with them to their meeting with the health care. It is not a big leap to say—even if the analysis is quite schematic for illustrative purpose—that using the portal could help the patient in many different ways to become more empowered (cf. ability to mobilize resources, gaining access, and consciousness-raising). But, something else is going on at the same time. A more dynamic approach tells us something in addition.

Thinking in Terms of a Booking System

Several patients expressed a desire for more control over finding an appropriate date and time to see a physician. In the system, patients could request an appointment either morning or afternoon, adding a few sentences in free format. The reason for this (limited) selection of options was that the design group, while giving the patient some possibility to specify preferences, had decided to allow the health care provider considerable discretion in the booking procedure. However, the ability to request an AM or PM appointment did not decrease the patients’ desire for an even more sophisticated time-booking system. One user said for example:

You could do it like the motor vehicle inspection site. There, you can decide on the date and the time. You can tick the time you want, and then it’s yours.

In this case, the users only seem to be concerned with the functionality of the portal as a booking system. They do not view it as a means of making contact with their health care provider. Compared to their previous experiences with

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