

Public policy and inequalities of choice and autonomy

Tania Burchardt, Martin Evans and Holly Holder

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Editorial note

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Abstract

This article explores the conceptualisation of choice as autonomy using three components – self-reflection, active decision-making, and quality and range of options – and investigates empirical inequalities in autonomy, using newly-collected data for the UK. ‘Choice’ has been promoted in social policy across many developed welfare states, often on the grounds that it is instrumentally valuable: choice by service users is said to incentivise providers to enhance quality and efficiency. But egalitarian and capability-based theories of social justice support the idea that choice – understood in the deeper sense of autonomy – has an intrinsic value. The empirical findings indicate that disabled people are most likely to experience constrained autonomy in all respects, while being from a low socio-economic group and/or lacking educational qualifications is a risk factor across several components. The fact that limited autonomy maps onto existing socio-economic disadvantage is not surprising, but points to the importance of taking into account underlying inequalities when developing choice-based policies. We conclude that improving the ‘choice’ agenda for policy requires opportunities for people to reflect on their objectives throughout the life course and that the removal of barriers to active decision-making would require effective support and advocacy, especially for disabled people. We suggest that major structural inequalities associated with restricted autonomy should be addressed – poverty, ill health and geographical inequality – because they place significant restrictions on the autonomy of those who are already disadvantaged as well as their immediate effects on living standards and quality of life.

Key words: Choice; autonomy; inequality

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1. Introduction

The importance of autonomy as a richer alternative to the concept of ‘choice’ is under-recognised in social policy. Choice has been promoted as an objective in a range of social policy areas in many welfare states – for patients in healthcare, for parents in education and childcare, for service users in social care, and for employees in pension provision. Considering autonomy as an aspect of choice allows us to distinguish two quite different motivations for promotion of ‘choice’. ‘Instrumental’ motivation suggests that choice by service users will incentivise providers to respond with enhanced quality and efficiency of services (Le Grand, 2007; Clarke et al, 2007), and that this in turn will produce better outcomes. On the other hand, ‘intrinsic’ motivation suggests that ensuring individuals have greater control over key aspects of their lives, such as health, education, housing, and employment and family life, is important in its own right (Stevens et al, 2011). Autonomy is central to the intrinsic motivation for pursuing policies that promote choice..

Recognition of the core importance of autonomy has been given in the development of the Equality Measurement Framework (EMF) in the UK, based on the capability approach and the fundamental importance of ‘substantive freedoms’. The EMF provides tools for monitoring and evaluating inequality in the substantive freedoms enjoyed by people with different socio-demographic characteristics in Britain in the 21st century (Burchardt and Vizard, 2011). As ‘substantive freedom’ is not directly observable, the EMF measures three aspects of substantive freedom in order to build up a picture of the overall concept: outcomes, treatment (in the sense of how people are treated by others), and autonomy.

In this article, we focus on autonomy. We start by discussing the role of choice and its relationship to autonomy in recent social policy across Europe. We then present original empirical evidence for the UK on inequalities in individual autonomy of people in different aspects of their lives and the extent to which these inequalities map onto better known socio-economic inequalities. We conclude with some reflections on how existing policies could be reshaped to reduce such inequalities and what new policies would be needed to actively support autonomy as opposed to merely ‘choice’.

2. Choice and autonomy

Theoretical approaches to the intrinsic value of choice are based on its relationship with freedom, and draw on a spectrum of philosophical positions, from libertarian perspectives through to the capability approach. A libertarian posits freedom as the absence of interference from others, or ‘negative liberty’ (Berlin, 1969). Self-ownership in this sense is a basic and intrinsic right, and being able to choose whether or not to do something, for example whether to enter into an exchange, is inherently valuable (Nozick, 1974). One implication of the libertarian position is that the act of choosing is important (whether you voluntarily decide to do something rather than having it imposed on you), but the range of options available to you is not, since the

menu is determined by the ‘invisible hand’ of free exchange, any interference with which would infringe someone’s basic rights. Moreover, a person’s preferences are sovereign, irrespective of whether his/her choice is in fact in his/her best interests.

Liberal egalitarians agree on the importance of libertarian ideas of self-ownership and non-interference, but emphasise self-determination in addition: the ability to pursue your own conception of the good life. Such pursuit requires two things: individual reflection on goals and formation of a plan to achieve them (seen as an essential part of being a fully human agent), and secondly, having a fair chance to pursue them. The notion of a ‘fair chance’ is controversial, but according to Rawls (1971) rests on social and economic institutions designed to ensure that every individual has access to ‘primary goods’, including income, wealth and status, and such that any inequalities in the distribution of these primary goods operate to the advantage of the least well-off. Liberal egalitarians, adopt a positive interpretation of freedom which allows for, and indeed requires, consideration of external constraints – such as the distribution of resources - in contrast to the negative liberty conception of the libertarians. For them, the opportunities to choose (i.e. the act of choosing) are less significant than opportunities for self-reflection, and for pursuing your conception of the good life.

By contrast, the capability approach focuses on substantive freedom, understood as the set of things that people value and have reason to value, and which they are actually able to be and do (Sen, 1985, 1999). Substantive freedom can be restricted in many ways. People may be hampered in identifying the things they truly value because, for example, their expectations have become conditioned by enduring years of deprivation. They may be pressurised, oppressed or coerced by others. The public and private resources available to them may be limited, or it may be difficult to convert their resources into the things they want to be and do, as a result of personal characteristics such as impairment or as a result of institutional barriers. ‘Choice’ does not play a major role in the capability approach, but the broader concept of ‘autonomy’, as reflected in the idea of substantive freedom, is central.

3. The ‘choice’ agenda in welfare states

To date, most conceptualisations of choice in policy appear to be closer to the libertarian end of the spectrum. The Swedish ‘choice revolution’ of 1991 reformed healthcare, education, childcare and care for older people alongside an expansion in private provision and rights for patients, parents and care users to choose a provider (Blomqvist, 2004). Corporatist welfare states like France, Germany and the Netherlands promoted ‘choice’ through giving payments to older people to purchase care services, while France adopted similar approaches for parents to purchase childcare (Morel, 2007). Choice of social insurance fund has been promoted across several European welfare states (Thompson and Dixon 1996). In Italy, the rhetoric of freedom of choice in welfare is established (Fenger, 2009; Graziano, 2009) but patient choice has put financial strain on geographically fixed services (Fabbri and Robone 2008).

The promotion of ‘choice’, when understood primarily as choice between providers in a socially regulated market, fits with ‘liberal welfare state’ ideology. The objective is to frame the choices ‘consumers’ of public services face in such a way as to encourage them to select providers on the basis of quality rather than merely convenience. This framing, as a form of external direction, can itself be seen as in tension with intrinsic, autonomy-based, motivations for the promotion of choice. Australian reforms have included vouchers for childcare (Warner and Gradus, 2011), individualised budgets for disabled service users (Spall et al, 2005) and school choice (Whitty and Power, 2000). A new emphasis on choice in public services emerged in the 1980s in the UK: with the ‘Right to Buy’ for council tenants, the creation of GP fundholders, and parental choice of secondary school (Clarke and Newman, 1997). Subsequent New Labour choice mechanisms aimed to imitate market processes in public service reforms (Clarke, Newman and Westmarland, 2007), especially in healthcare, but also in school education with the creation of school league tables, in housing through ‘choice-based lettings’, and in social care with the expansion of direct payments and later individual budgets. The Coalition government’s healthcare reforms extend competition between, and choice of, providers, and education reforms extend choice to include Free Schools. Greve (2009) argues that the consequences of choice requires empirical studies but interpretation of such evidence remains controversial (Dixon et al, 2010; 6, 2003; Le Grand, 2007; Cooper et al, 2011; Pollock et al, 2011).

There has been little reflection in the UK or elsewhere of egalitarian or capability-inspired conceptualisations of the value of choice. The one exception is in social care services (Glendinning, 2008). The disability movement campaigned for many decades for disabled people to have greater ‘choice and control’ over their lives, arguing that this was of value for its own sake and a matter of basic rights. The campaign influenced the introduction of direct payments in the 1996 Community Care Act in the UK, and their subsequent expansion in the 2000s (Morris, 2006). Even so, the resulting policies bear close resemblance to voucher mechanisms (and thus efficiency-based instrumental choice) that have been developed in other sectors: direct payments to and individual budgets for disabled and older people are given to purchase care rather than receiving services directly from social services. Stevens et al (2011) argue that such innovations have only partly lived up to their original purpose and that, in reality, the ‘antagonisms of choice’ - reproduction of inequalities, power imbalances, and the gap between ‘consumer’ decisions and public priorities - can all be detected in relation to individual budgets. The approach remains rooted in a conception of choices made as consumers rather than choices made through active, democratic and collective participation as citizens.

Overall, instrumental motivations for promoting choice have dominated policymaking leading to the concentration on services rather than outcomes as the locus for choice: we are invited to choose between hospitals, schools, care agencies, and pension providers, but all such services are a means to an end rather than ends in themselves. The degree of control we may or may not be able to exercise over the outcomes that we actually value - our health, education, daily life and security in old age is mostly overlooked or ignored by this approach. The concept of ‘choice’ itself has

consequentially been narrowed to the act of ‘choosing’, losing the richer shades of meanings associated with intrinsically-valued choice such as opportunity, empowerment, freedom and autonomy.

4. The intrinsic value of choice: autonomy as an alternative concept

Clarke et al (2007) argue that, ‘choice as an abstract liberal value does not centre on the market... Rather choice is about the capacity for self-direction exercised by a self-possessed individual in the personal, social, economic and political arrangements’ in which they find themselves (p248). Choice is not a simple or singular concept. *Having, making and realising* choices are different processes and socio-economic inequalities may mean that one does not translate into the other, for example in school choice (Clarke et al, 2007). Taylor-Gooby (1998) also criticises the choice agenda in welfare policy as being over-simplistic and points to the numerous ways in which decision-making in practice deviates from the ‘ideal’ model conceived by rational choice theory, demonstrating the importance of ‘anchor’ points that lead to loss and risk aversion, the limits on the range and type of information people can process (bounded rationality), and the salience of social context and pre-existing beliefs and normative commitments. Levett (2003) argues that choice has been construed in an overly-individualistic way because choices are constrained in practice, by context and by the choices made by others, while some goals – such as public goods – can be obtained only through collective rather than individual decision-making.

We explore the capability approach as one way to encapsulate the intrinsic value of choice – conceived as autonomy – as an alternative to viewing choice in purely instrumental terms. This approach can generate a different, and perhaps richer, concept than that derived from libertarian and associated ‘consumer’ perspectives; developing concepts that resemble the engagement and participation discourse, incorporating ideas about improved decision-making, participation and self-reflection through processes that may be joint with others rather than necessarily in competition with them.. We demonstrate below one way to capture, measure and apply such an approach empirically, yielding new insights into inequalities in autonomy as experienced by different sections of the British population, with implications for policy design.

Our analysis forms part of the development of the EMF, based on the capability approach. Autonomy in the EMF approach is broken down into three components, with corresponding barriers to the achievement of autonomy, as summarised in Table 1.

Table 1: Autonomy - conceptual scheme

<i>Components of autonomy</i>	<i>Constraints on autonomy</i>
Self-reflection	Conditioned expectations; false consciousness
Active or delegated decision-making	Passivity; pressure from others; coercion
Wide range of high-quality options (perceived and actual)	Structural constraints; lack of resources; lack of information, advice and support

This conceptual scheme draws on both the capability approach itself and a wide-ranging cross disciplinary literature review on autonomy and closely-related concepts such as agency, empowerment, self-determination, and ‘choice and control’ (see Burchardt and Holder, 2012). Our conceptual scheme incorporates both accounts which take autonomy (and its cognates) to be a purely internal characteristic of an individual - a state of mind, a disposition, or a set of mental processes (Chirkov *et al*, 2003; Ryan and Deci, 2006) – and those which take account of the external environment, including the quantity and quality of options available to the individual (Cole *et al*, 2000; Morris, 1998; Alsop and Heinsohn, 2005; Narayan, 2005; Bavetta and Peragine, 2006).

‘Self-reflection’, reflecting on and evaluating your objectives and preferences, is present in almost all conceptualisations of autonomy, and is central to Doyal and Gough’s (1986) influential theory of human need. Empirically, Taylor-Gooby (1998) reaffirmed that social context and the individuals’ set of beliefs were an important influence on how individuals evaluated the choices on offer.

‘Active or delegated decision-making’, links the purely internal self-reflection component and the third, external, ‘range of options’ component. As Clarke (2010) observes, making a complex choice requires reacting to the world, appraising it, making sense of contextual information, and identifying a response – a process which can be emotionally and intellectually demanding. It is important to allow for possible of delegation of decision-making, or undertaking it jointly with one or more others. Provided the decisions to delegate or share are freely taken, it implies no reduction in autonomy.

‘Autonomy’ must extend beyond the individual to consideration of his/her circumstances and in particular to the menu of real opportunities which s/he faced, both in order to reflect the concept of substantive freedom described above and to be of applied policy relevance. The existence of real opportunities is necessary but not sufficient. Such opportunities must be both *perceived* and *realisable*, hence the third component of autonomy in our scheme, ‘wide range of high-quality options (perceived and actual)’.

The importance of this final component is confirmed in applied literature in social policy; D'Souza, Conolly and Purdon (2008) comment on the need to take into account context of choice and quality of options available when considering how freely parents have made decisions about employment versus staying at home to look after the children, while Exworthy and Peckham's (2006) study highlights the way in which travel times and logistics constrain patients' ability to exercise choice in healthcare.

The three components of autonomy are both cumulative and independent in the sense that it is possible for someone to be reflective but not to make an active decision, or to make an active decision but from a very limited range of options. To be fully autonomous, all three components need to be in place.

The capability approach in general and thus the concept of autonomy in particular are not without their critics. Firstly, the approach is sometimes accused of being overly individualistic (Stewart, 2005; Dean, 2009). Individuals are interdependent and so are the decisions they make; thus one person's autonomy cannot sensibly be evaluated separately from another's. In response, it is important to make the distinction between ethical individualism and methodological individualism. The capability approach shares with the rest of the liberal tradition a presumption that it is ultimately individuals that matter, rather than some collective entity such as the state, the family or a cultural group – in contrast, say, to communitarianism. However there is no implication that any individual's circumstances can be understood without reference to their significant others or their wider social and economic relations. Our concept of autonomy is ethically individualist – we are interested in the individual's autonomy or lack of it rather than some idea of group autonomy – but not methodologically individualist: in evaluating the autonomy of individuals, we must take account of their past, the cultural influences on them, their interaction with others in decision-making (positively through shared decisions and commitments or negatively through coercion), and crucially, the structural constraints which operate to define the range of possibilities available to them and to others.

A second criticism, as advanced by Dean (2009), is that the capability approach fails to acknowledge fundamental macro- socio-economic constraints, and in particular the inherent contradiction between promoting substantive freedom and the exploitation of labour under capitalism 'the systemic impediments to human freedom that are associated with the capitalist mode of production' (pp271-2). It is not our intention to argue against economic determinism but to understand its effects, and contribute to developing strategies to ameliorate its worst effects. By concentrating specifically on autonomy, we can identify who is disempowered and disadvantaged under existing social and economic arrangements – and do so in a way which is often overlooked by conventional analysis of poverty and inequality.

5. Measuring autonomy: data and methods

Our research to empirically capture measures of autonomy began with a review of existing survey instruments that indicated that although aspects of autonomy might be captured by particular scales and questions (such as the Rotter (1966) locus of control scale and the OPHI (2008) empowerment module), there was no comprehensive measure fit for our purpose. We therefore developed our own questionnaire, drawing on tried and tested questions where possible, and supplementing them where needed to ensure our conceptual framework was reflected as fully as possible. These are difficult concepts unfamiliar to many people and thus difficult to empirically test by survey. We subjected draft questionnaires to cognitive interviewing prior to a full survey - a process in which respondents are asked retrospectively what they understood by each question (Beatty, 2004). The results are reported in Burchardt and Holder (2012). Our final, shorter, questionnaire comprising 17 main questions with sub-questions which was fielded as part of the Office for National Statistics (ONS) Opinions Survey in July 2009. The Opinions Survey is a face-to-face household survey, designed to be nationally representative (including of the disabled and older populations). However the response rate is only around 50 per cent, so population weights are applied to the data where appropriate to counteract non-response and sample design bias. The achieved sample size in the relevant month was 1,051 adults aged 16 or over. Table 2 provides descriptive statistics.

Table 2: Descriptive statistics

	Weighted percentage of whole sample	Unweighted number in sample
Male	49	446
Female	51	605
White British	84	904
Any other ethnicity (1)	16	147
Not disabled	83	822
Disabled (2)	17	227
of which:		
Male	8	99
Female	9	128
Age 16-44	4	41
Age 45-64	6	76
Age 65 plus	7	110
High occ group/qualified	5	62
Low occ group /no quals	10	145
Other	2	19
Age 16-24	15	81
Age 25-44	34	337
Age 45-54	17	157
Age 55-64	15	178
Age 65-74	11	146
Age 75 plus	9	152
High occ group / qualified (3)	38	401
Low occ group / no quals	45	509
Other	16	139
All	100	1051

Notes:

(1) Although a more complete ethnic categorisation is recorded in the survey, the sample size is not large enough to permit analysis by sub-group.

(2) Disability status is based on a positive answer to two questions: 'Do you have any long-standing illness, disability or infirmity?', and 'Does this illness or disability limit your activities in any way?'

(3) This is a combined socio-economic status/educational qualifications variable, based on four categories of socio-economic classification (NS-SEC) (professional and managerial; intermediate; routine and manual; not classified) and four categories of highest educational qualification (degree or equivalent; below degree level UK-recognised qualification; other; and none) and is constructed as follows: (1) 'High occ group / qualified' = Professional and managerial OR intermediate socio-economic group, AND has degree or below degree level qualifications; (2) 'Low occ group / no quals' = Routine and manual socio-economic group OR no qualifications. (3) 'Other' = not covered by (1) or (2) ie 'not classified' socio-economic group OR 'other' qualifications

Four types of question were asked¹: (1) overall measures of autonomy; (2) questions on overall autonomy in relation to specific areas of life (health, family life, employment, etc); (3) questions on each component of autonomy as defined by the conceptual framework; and (4) detailed questions on each component of autonomy in relation to three areas of life (major household expenses, work/life balance, and relationships). Overall measures of autonomy included, ‘I am able to do the things that are important to me’ on a scale of 1 to 5, where 1 represents ‘never or almost never’ and 5 represents ‘always or nearly always’; and a 10-point scale for responses to the statement, ‘Some people feel they have completely free choice and control over their lives, while other people feel that what they do has no real effect on what happens to them’.² The latter scale was also asked in relation to specific areas of life. Components of autonomy were assessed using a battery of questions as listed in Table 3.

The use of multiple indicators ensures greater coverage of the concept of autonomy and is also likely to enhance the reliability of the overall measure because measurement error on one indicator may be offset by measurement error on another (Groves et al, 2009). High item response rates occurred and responses were generally correlated in the expected ways, which, together with the prior cognitive testing gave us confidence in the overall validity of the measures. However, it should be remembered that there are limits to what we can expect to learn from self-assessments of autonomy; people may believe they are in control of aspects of their lives when they are in fact not, or they may believe they have no opportunities when in fact they do. This was particularly apparent in relation to the first component of autonomy, ‘self-reflection’: it is difficult to meaningfully ask people to reflect on whether they are self-reflective, or on the extent to which their preferences have become adapted to their circumstances. These limitations imply firstly that careful interpretation of the results is required, and secondly, that measures of autonomy need to be put alongside other, more objective, indicators of a person’s ‘beings and doings’ to get a full picture of their capabilities (Burchardt and Vizard, 2011).

We carried out confirmatory factor analysis on the questions that were intended to capture each component of autonomy in order to test and validate our conceptual framework. Factor analysis examines the correlation between variables and allows one to group the variables into a smaller number of ‘factors’ (Bryman and Cramer, 2000). The variables within each factor are more strongly associated with one another than with the variables in other factors. The factor analysis produced six factors, and using a threshold of a factor loading of 0.4, the questions can be grouped as shown in Table 2.³ The table also shows ‘Cronbach’s alpha’ for each group of questions, which is a measure of the internal consistency of a scale.

¹ The questionnaire and the survey data have been deposited and are available at the UK Data Archive (Study Number 6826).

² This question was taken from the OPHI (2008) empowerment module.

³ Factor analysis using unweighted least squares extraction method and Oblimin with Kaiser

The factor analysis suggests a good fit with the conceptual framework but with some interesting deviations. As we noted earlier, the self-reflection component was not well captured and the items grouped here under factor 1 are only a loose conceptual fit; we therefore label it ‘self-direction’ rather than ‘self-reflection’. The active decision-making component split in the factor analysis into two different forms of constraint on decision-making: which we here call ‘fatalism’ and ‘pressure from others’. The items in the fatalism factor have good face validity (‘My life has shaped itself without me making choices’, and ‘There is no point trying to improve my life, there’s nothing that can be done’) but a low Cronbach’s alpha. Five of the items in the ‘pressure from others’ factor have good face validity, the remaining three less so, but overall the scale has a good Cronbach’s alpha. Finally, the factor analysis suggested three different forms of structural constraint: those relating to ill-health, poverty, and location, each of which has strong face validity and a respectable Cronbach’s alpha.⁴

normalization rotation method. There is no agreed threshold for interpreting factor loadings and the decision must be informed both by the purpose of the exercise and in the light of the underlying theory. Four questions did not load sufficiently on any factor to be included: ‘I tend to be influenced by people with strong opinions’; ‘I judge myself by what I think is important, not by what others think is important’; ‘There’s really no way to solve some of the problems I have’; and ‘Lack of self-confidence prevents me from doing things that are important to me’.

⁴ Interestingly ‘discrimination towards me’ loads onto Factor 6, associated with location, rather than Factor 3, associated with the attitudes of others.

Table 3: Results of factor analysis on components of autonomy

Factor 1: Self-direction

- I have a clear idea of how I want to lead my life
- I feel I am free to decide for myself how to live my life
- I feel free to plan for the future
- *I feel that life is full of opportunities*

(Cronbach's alpha = 0.69)

Factor 2: Fatalism

- My life has shaped itself without me making choices
- There is no point trying to improve my life, there's nothing that can be done

(Cronbach's alpha = 0.45)

Factor 3: Pressure from others

- Sometimes I feel that I am being pushed around in life
- Other people's attitudes prevent me from doing things that are important to me
- Someone else prevents me from doing things that are important to me
- Pressure from others...
- Disapproval from others...
- *Lack of support...*
- *Lack of advice...*
- *Family responsibilities...*

(Cronbach's alpha = 0.83)

Factor 4: Health constraints

- My health prevents me from doing things that are important to me
- My age...

(Cronbach's alpha = 0.65)

Factor 5: Money constraints

- Shortage of money prevents me from doing things that are important to me
- Being in debt...

(Cronbach's alpha = 0.69)

Factor 6: Location constraints

- Where I live prevents me from doing things that are important to me
- Lack of transport...
- A community I am part of...
- *Discrimination towards me...*

(Cronbach's alpha = 0.69)

Italics indicate items which belong statistically but are less clearly relevant to the factor from a theoretical perspective.

The '...prevents me from doing things that are important to me' questions offered respondents a 5-point scale from 'Never or almost never' to 'Always or nearly always'. All other questions offered a 5-point scale from 'Strongly disagree' to 'Strongly agree'.

6. Results: inequalities in autonomy

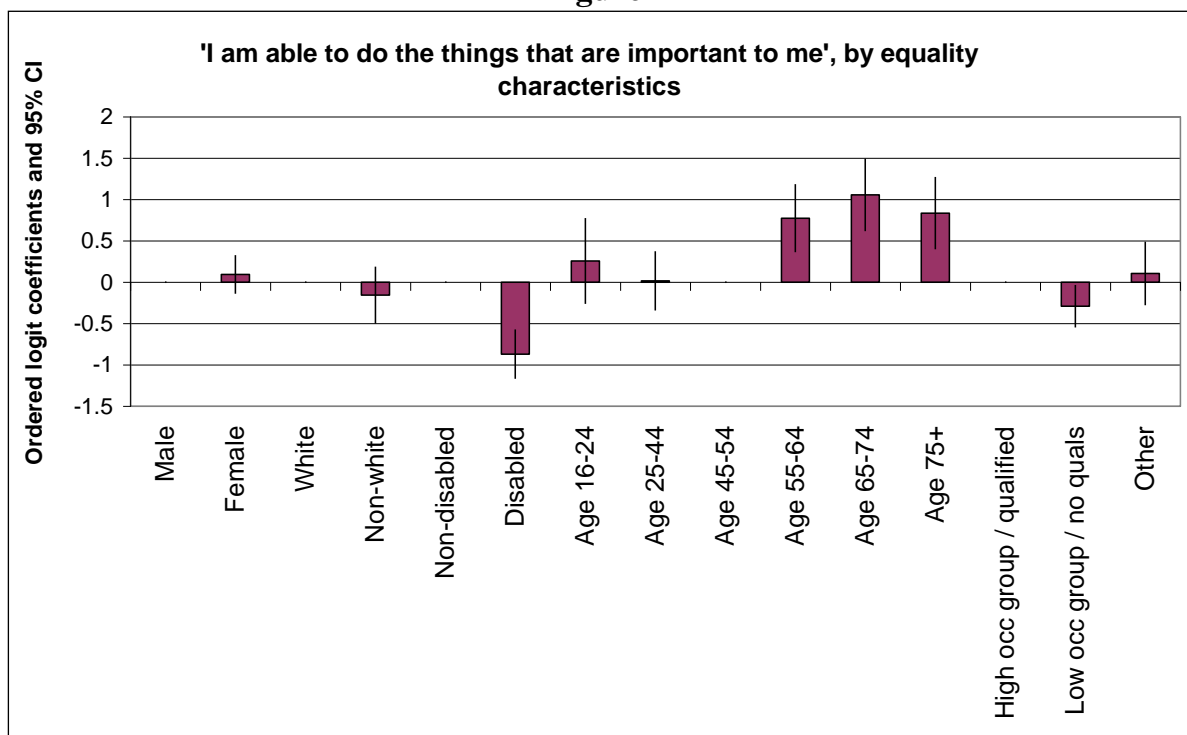
Our results demonstrate that intrinsically valuable autonomy is unequally distributed across the population and is linked to other socio-economic inequalities. The implications of these findings for choice-based welfare policy are explored in our concluding discussion.

6.1 *Inequality in overall autonomy*

Over a third of respondents (36%) said ‘always or nearly always’, ‘able to do the things that are important to me’ while 45% said ‘often’. Fewer than 2% said ‘never or almost never’. A similar distribution, skewed towards the ‘high autonomy’ end of the spectrum, was observed for the 10-point scale on ‘Some people feel they have completely free choice and control over their lives, while other people feel that what they do has no real effect on what happens to them’. Responses to the two questions were significantly and positively correlated (correlation coefficient +0.27, significant at the 99% level). This is reassuring in terms of the validity of the questions. The ‘things that are important’ question is taken as our core measure of overall autonomy in the analysis that follows, although we return to the ‘choice and control’ ladder when considering specific areas of life.

These initial questions on overall autonomy suggest that the majority of people enjoy reasonably high levels of autonomy. But who lacks autonomy? Figure 1 shows the results of an ordered logistic regression on ‘I am able to do the things that are important to me’ by socio-economic characteristics. Bars above the horizontal axis indicate the characteristic has a positive association with autonomy (and below the line a negative association), controlling for the other characteristics listed. The reference category is a White, non-disabled, 45-54 year old man in a professional, managerial or intermediate socio-economic group with some qualifications. The whiskers show 95% confidence intervals; where the whiskers cross the horizontal axis no statistically significant relationship exists. The socio-demographic characteristics together account for relatively little of the overall variation in autonomy but as the models here are being used to explore inequalities in autonomy rather than to *explain* autonomy overall, this is not such an important limitation.

Figure 1



Source: author's calculations using ONS Opinions Survey Autonomy Module, July 2009

Notes: N = 1019, Pseudo R² = 0.03, Cut points 0.5, -1.3, -2.9, -4.3.

The most striking association is that with disability: disabled people (here measured as experiencing a limiting long-standing illness or disability) are significantly less likely to be 'able to do the things that are important' to them. There is also an association between low socio-economic group/lack of educational qualifications and low autonomy.⁵ The relationship with age is somewhat complex: older people aged 55 and above report higher levels of autonomy than the middle aged (25-44 and 45-54), but the youngest age group (16-24) may have slightly higher levels of autonomy again, though this is not statistically significant. There is no significant association between overall autonomy and gender or ethnicity – here measured crudely by a White/Non-White categorisation because the sample size unfortunately does not allow for a more fine-grained approach.

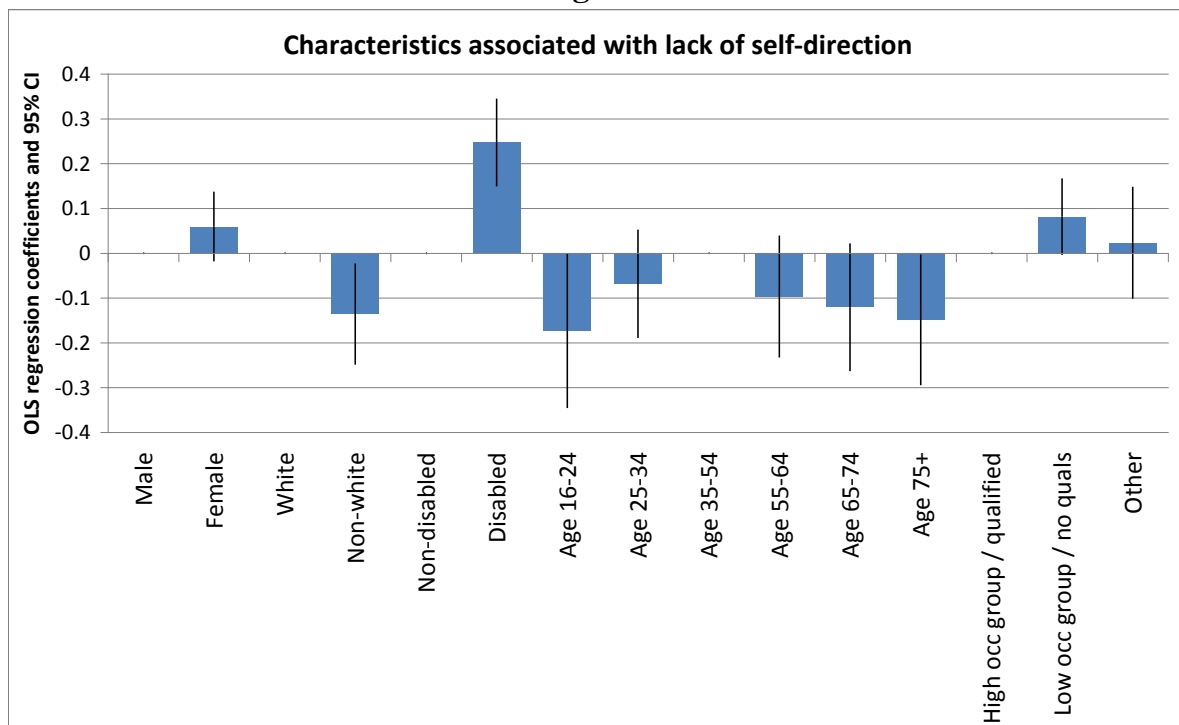
⁵ Socio-economic group (NS-SEC) and educational qualifications were initially entered separately into the regression analyses. NS-SEC was significant in some models and educational qualifications in others. They are strongly correlated. In the interests of simplifying the presentation of results, a combined indicator was created. The combined socio-economic group/educational qualifications variable is based on four broad categories of current or most recent occupation (NS-SEC) (professional and managerial; intermediate; routine and manual; not classified) and four categories of highest educational qualification (degree or equivalent; below degree level UK-recognised qualification; other; and none) and is constructed as follows: (1) 'High occ group / qualified' = Professional and managerial OR intermediate socio-economic group, AND has degree or below degree level qualifications; (2) 'Low occ group / no quals' = Routine and manual socio-economic group OR no qualifications. (3) 'Other' = not covered by (1) or (2) ie 'not classified' socio-economic group OR 'other' qualifications.

Disability status turns out to be significant in relation to several aspects of autonomy. For this reason, we also explored whether disability interacted with sex, age or socio-economic classification, in other words, whether the association of disability with limited autonomy was greater for some sub-groups of disabled people than for others. For this measure of overall autonomy, we found the association with limited autonomy was particularly strong among younger disabled people (aged 16-44), and also among those who were in routine or manual occupations or who lacked educational qualifications.

6.2 *Inequality in constraints on autonomy*

Each of the six components of autonomy identified by the factor analysis are correlated with overall autonomy, with coefficients ranging from -0.37 for pressure from others, down to -0.19 for fatalism.⁶ But different constraints on autonomy are experienced by different people, as shown in Figures 2 to 7.

Figure 2



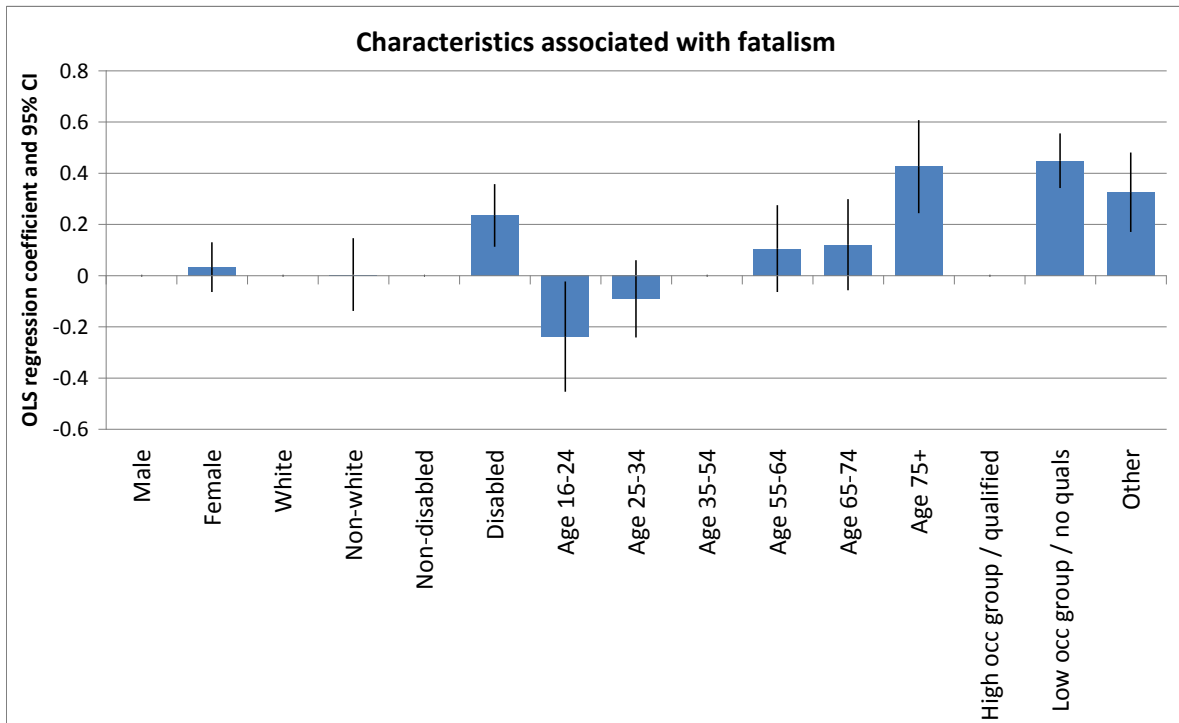
Source: author's calculations using ONS Opinions Survey Autonomy Module, July 2009

Notes: N = 1005, Adjusted R² = 0.03, Constant 2.1

⁶

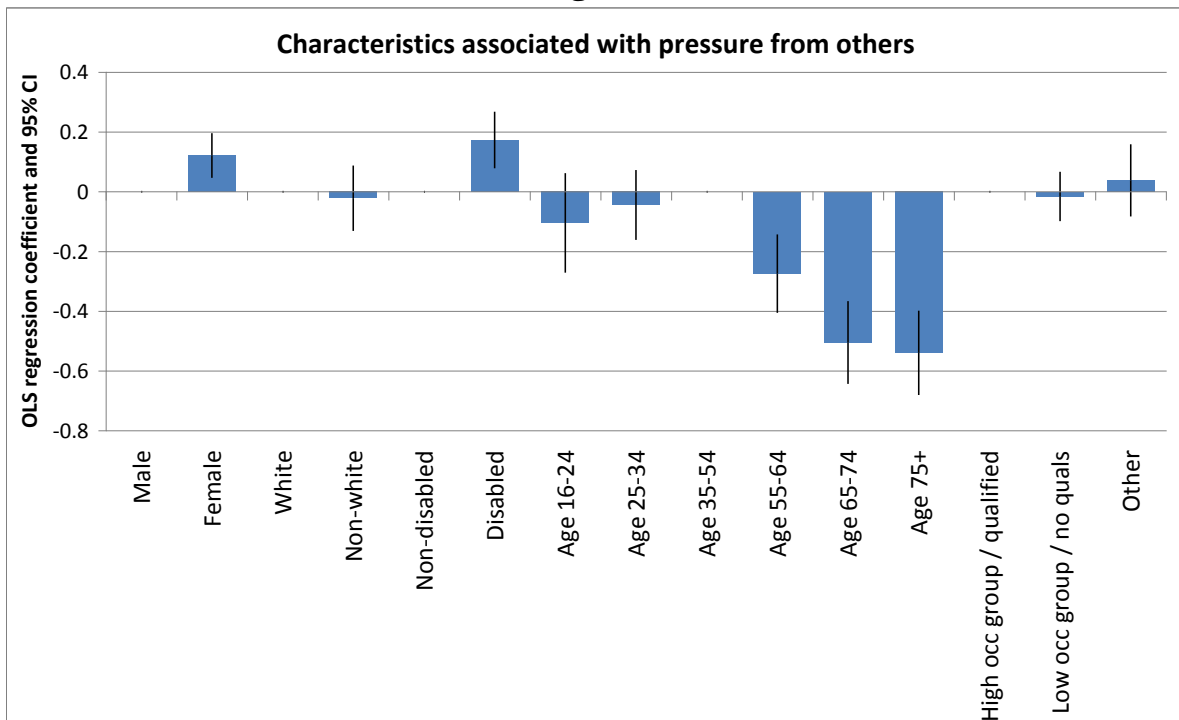
The correlation coefficients between the 'choice and control' measure of overall autonomy and each component are similar, for example -0.29 for pressure from others and -0.20 for fatalism.

Figure 3



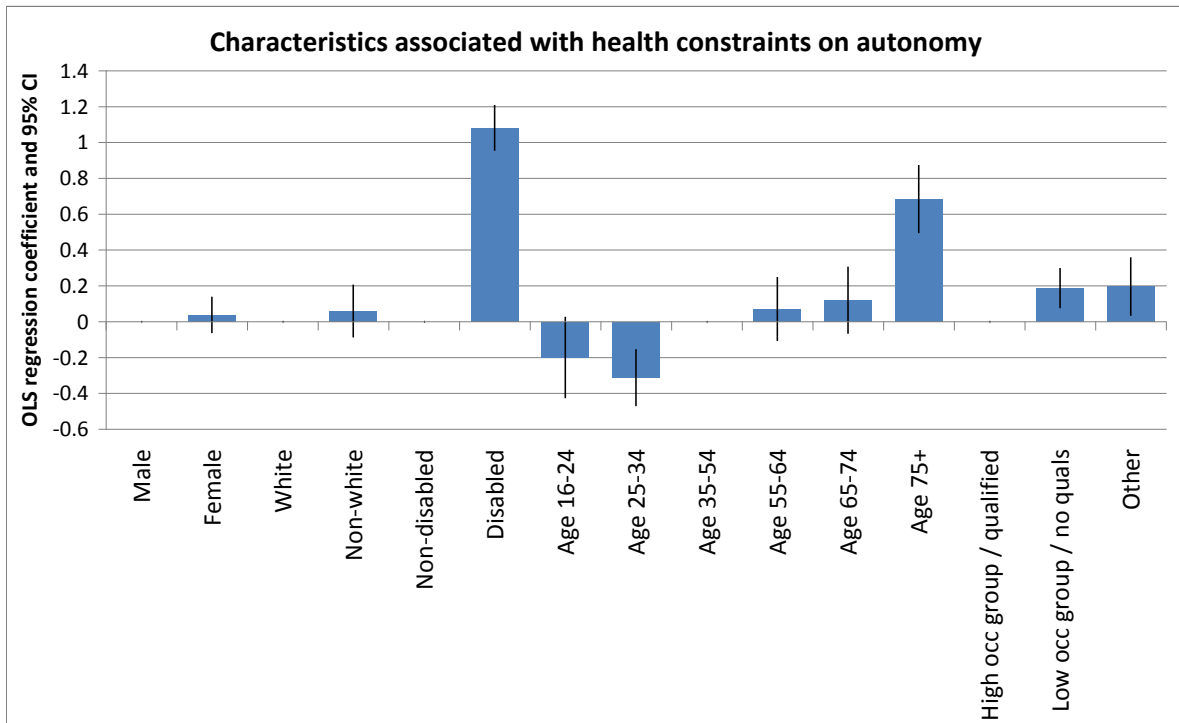
Source: author's calculations using ONS Opinions Survey Autonomy Module, July 2009
 Notes: N = 1003, Adjusted R² = 0.15, Constant 1.9

Figure 4



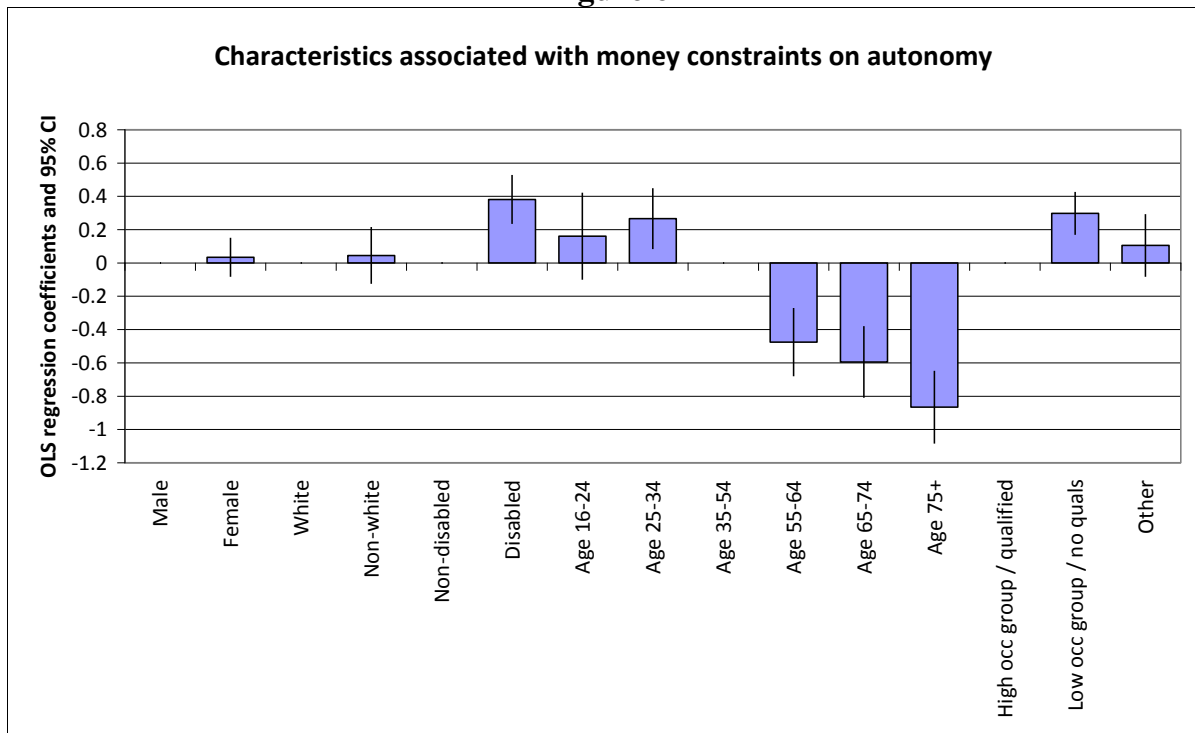
Source: author's calculations using ONS Opinions Survey Autonomy Module, July 2009
 Notes: N = 1001, Adjusted R² = 0.11, Constant 2.1

Figure 5



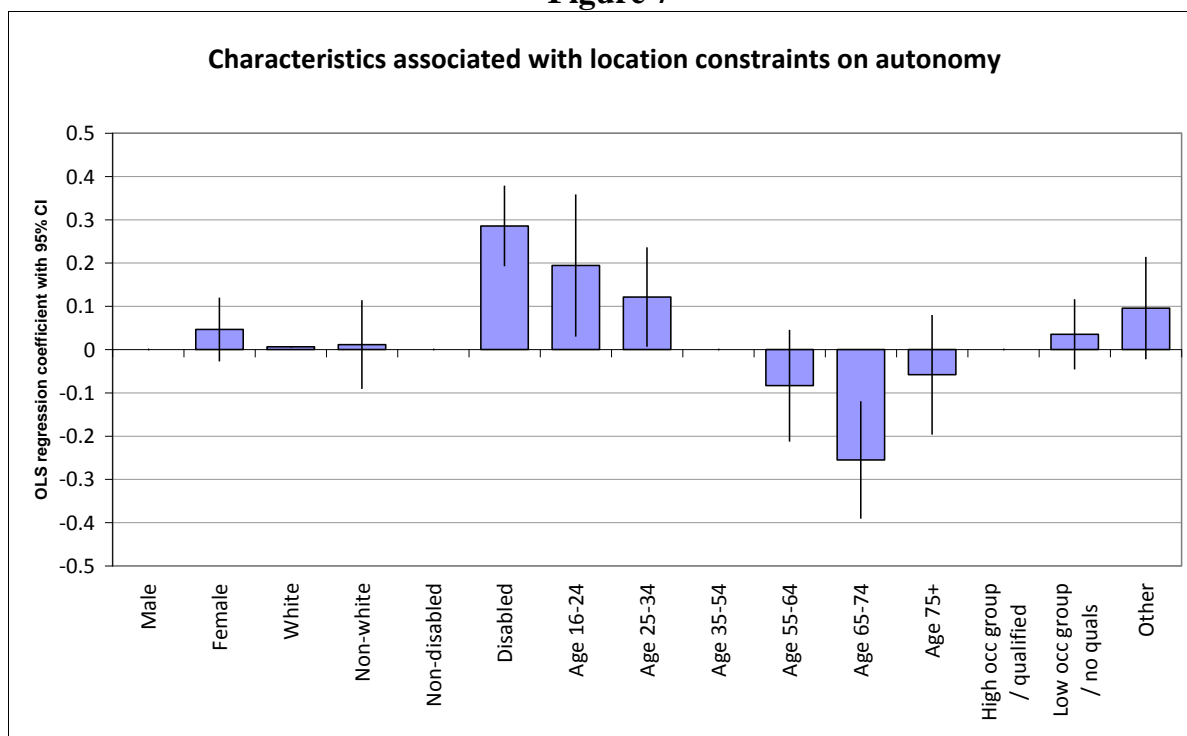
Source: author's calculations using ONS Opinions Survey Autonomy Module, July 2009
 Notes: N = 1018, Adjusted R² = 0.38, Constant 1.8

Figure 6



Source: author's calculations using ONS Opinions Survey Autonomy Module, July 2009
 Notes: N = 1018, Adjusted R² = 0.16, Constant 2.3

Figure 7



Source: author's calculations using ONS Opinions Survey Autonomy Module, July 2009

Notes: N = 1014, Adjusted R² = 0.07, Constant 1.4

To what extent, then, do inequalities in ‘choice as autonomy’ overlap with existing inequalities in a way which has potential policy resonance? We can see that disabled people are more likely to experience constrained autonomy in all six respects: lack of self-direction, fatalism, pressure from others, ill health, lack of money and constraints as a result of where they live. Among disabled people, those in a low socio-economic group and/or lacking educational qualifications are at significantly greater risk of fatalism, and of experiencing constraints due to ill health than those in a higher socio-economic group with qualifications. Both younger (age 16-44) and older (age 65 plus) disabled people are at greater risk of constraints due to where they live than middle aged disabled people.

For the population as a whole, being in a low socio-economic group and/or lacking educational qualifications is a risk factor for fatalism, and constraints on autonomy due to lack of money and ill health. Gender is significant only in relation to pressure from others, which women are more likely to report than men (controlling for other characteristics). Finally the different age groups experience different predominant constraints on autonomy: young people are at risk from constraints related to where they live and lack of money, middle age appears to be associated with a higher risk of pressure from others relative to older groups, while the older age groups are more likely to report constraints related to ill health and to express a degree of fatalism.

6.3 Inequality in choice and control in different areas of life

Thus far we have considered autonomy and constraints on autonomy evaluated in terms of a person's life as a whole. We turn now to consider different domains of a

person’s life in which they may have reason to value autonomy. Table 4 reports the average ‘choice and control’ score based on the 10-step ladder in relation to ten areas of life. It shows that employment and work/life balance are the areas in which people feel they have least choice and control, followed by major household expenses, their health and where they live. Family life, relationships, and especially religion and belief are areas in which people report higher levels of choice and control.

Table 4: Choice and control in relation to different areas of life

‘Some people feel they have completely free choice and control over their lives, while other people feel that what they do has no real effect on what happens to them’, evaluated on a 10-point scale in relation to...	Mean	Standard deviation
Employment*	6.23	2.90
Work/life balance*	6.34	2.70
Major household expenses	6.82	2.96
Health	7.01	2.59
Where you live	7.09	2.82
Opportunities for learning	7.25	2.46
Personal safety	7.56	2.21
Family life	7.79	2.33
Relationships	8.02	2.34
Religion and belief	9.20	1.66

Source: author’s calculations using ONS Opinions Survey Autonomy Module, July 2009

Notes: * For respondents aged < 65 only. Valid N varies between 700 for * items and a maximum of 1018

Once again there are significant variations in who reports low choice and control in relation to each of these areas. Disabled people, those with low socio-economic status/no educational qualifications, and people aged 45-54 were more likely than others to report low choice and control in relation to employment, and in relation to work/life balance, controlling for other characteristics.⁷ For major household expenses, it was disabled people, the young and those with low socio-economic status /no educational qualifications who had least choice and control, while for health it was women and disabled people. Disability was associated with low choice and control across all domains, and low socio-economic status/no educational qualifications across a large number (including relationships and opportunities for learning, in addition to those already mentioned).

⁷ Based on OLS regression of ‘choice and control’ in relation to each area of life on gender, ethnicity (White/non-White), disability, age groups, and the combined occupational social class/educational qualifications indicator described above. All results reported in the text are statistically significant at the 95% level or above. Full results available from the authors on request.

7. Discussion and conclusions: reshaping policies to promote autonomy

Our analysis confirms that autonomy is inherently multi-dimensional. An adequate concept must encompass the internal (mental) and external (situational) aspects of autonomy, and the interaction between them. The empirical analysis shows that although the components of autonomy are correlated with each other and with summary measures of autonomy, they are independent and reveal different inequalities.

How does this affect the distinction between instrumentally and intrinsically valuable choice? To focus on the act of choosing, the dominant approach in the ‘choice’ policy agenda, risks missing much that reflects constrained autonomy. But even if we do concentrate on the ‘active choosing’ aspect of autonomy, the analysis indicates distinct ways in which decision-making can be derailed – through pressure from others (as typified by the statement ‘Sometimes I feel that I am pushed around in life’) or through fatalism (‘There’s no point trying to improve my life, there’s nothing that can be done’). Simply ensuring that options are on the table - handing patients a list of local hospitals or providing parents with a school league table - is not going to be sufficient to ensure that everyone can make an active decision.

Prior to the point of choosing, it is also important that person has been able to form, and reflect on, an idea about what they want – based on a rich understanding of what might be possible. This is not something that can be achieved overnight and points to the importance of developing and reinforcing autonomy through the lifecourse. For children and young people, this could include expanding opportunities to participate in identifying priorities, making plans and reaching decisions in the family, at school and in the wider local and political community. It needs to be supported by exposure to, involvement in, and chances to critically reflect on, a wide range of experiences, cultures, beliefs and ways of living. In middle-life, the analysis here suggests that people may be particularly likely to experience pressure from others, for example in the form of restrictions imposed by the attitudes and behaviour of others, and also a lack of support and advice. This points to both macro and micro level interventions: on the one hand, to society-wide efforts to tackle prejudice, discrimination and intolerance, and on the other to more effective provision of support and advice, targeted on those areas of life where people feel they have least choice and control – employment, work/life balance, and household expenses. For older age groups, the dominant limitations on autonomy seem to be related to ill health and a tendency to develop a fatalistic attitude. These may of course be related – if restrictions on daily life as a result of physical impairments seem to grow inexorably, it is easy to conclude that ‘There’s no point trying to improve my life’. But as the social model of disability reminds us, there is nothing inevitable about the link between physical impairment and limited capability: the provision of appropriate aids, adaptations and practical support can ensure that older people can continue to do the things that are important to them.

Recognising the intrinsic value of choice means that internal and external aspects of autonomy need to be tackled together. You cannot make a meaningful autonomous choice if the options available to you are all deeply unattractive – between sleeping on the streets or in a hostel where you fear for your safety and your few belongings; or between relying on your frail life-long partner to bathe and toilet you or being separated to go to live in a care home. The idea that there are structural inequalities in the real opportunities available to people comes as no surprise to social policy analysts, of course, but the pernicious effects not just on inequality of outcome but also on inequality of autonomy may be less well understood.

The concept of autonomy, incorporating but not limited to the act of choosing, reveals important and systematic inequalities in who enjoys this intrinsically valuable good. It is not surprising to find that low socio-economic status and lack of educational qualifications is associated with experiencing greater restrictions on autonomy. To put it starkly, those at the bottom of the ladder are less able to do the things that are important to them, across many areas of life. As Dean (2009) reminds us, this is inherent to capitalism. But the degree of inequality generated varies even within capitalist systems, and it is important to document and quantify this further manifestation of an inequality that is more familiar to us in terms of economic and social exclusion.

It is also not surprising to find that disabled people are more likely to experience limited autonomy than non-disabled people, controlling for other characteristics. But the scope of this lack of autonomy – across components of autonomy and across areas of life – is striking. It affects family life, relationships and personal safety as well as the more familiar problem areas of education and employment. Disabled people are at greater risk of experiencing barriers to autonomy related to poverty and location as well as health, and face a significant problem of pressure from others; and among disabled people, those with low socio-economic status are worse affected. Disabled people themselves have been aware of this for a long time, of course, hence the demands for ‘choice and control’ that date back several decades in the disability movement. There have been policy developments in the organisation of social care in response to these demands, but the evidence presented here suggests they have not yet gone nearly deep enough, or wide enough.

Having a range of high quality of services available is of course an important precondition for autonomy in a number of important areas of life and it is right that considerable attention should be given to both improving the quality of what is on offer and to establishing the mechanisms which facilitate the best possible match between a person’s needs and the service they get. But considering inequalities in autonomy, as opposed to the narrower concept of choosing, presents challenges for the mechanisms advocated by the efficiency argument for choice in public services: if people are unreflective, pressurised by others, fatalistic, constrained in multiple respects and in ways that interact with other areas of their life, their ability to choose service providers in a way that maximises their own interests and hence gives the correct signal to the providers is seriously restricted. The fact that disadvantage in

autonomy maps onto existing socio-economic inequalities such as disability and social class implies that a system based on responding to these signals will tend to be more sensitive to the expressed preferences of the already advantaged.

Can choice over services – even a choice over high-quality services – be sufficient to secure the intrinsic good of autonomy for individuals in relation to key aspects of their lives that they have reason to value? Our findings suggest not. A real ‘choice’ agenda requires opportunities for people to identify and reflect on their objectives and this needs to be cultivated throughout the life course – with implications for schooling, youth participation, multiculturalism policy and advice services, as outlined above. Removing barriers to active decision-making requires effective support and advocacy, especially for disabled people but also for others at risk of being pressurised by others or feeling disempowered, including women in coercive relationships. There are some examples of good practice (such as Support Circles: Glendinning 2008) but these too tend to focus on services rather than outcomes. Finally, the major structural inequalities need to be addressed - poverty, ill health and geographical inequality – not only because of their immediate effects on quality of life, but also because of the significant restrictions they impose on the autonomy of those who are already disadvantaged.

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