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Information asymmetry in social policy towards people with blindness and visual impairment

SUMMARY

Information asymmetry is a term that describes the unequal distribution of information between two or more actors that, depending on the context in which it occurs, leads to inefficiency, mistrust and, in extreme cases, deception when one party (participant in the relationship) exploits an information advantage over the other. The description of the concept of information asymmetry in social policy towards people with blindness and visual impairment creates a framework in which it is possible to observe and recognize difficulties in the provision of information and the use of rights and services in social and health care. Due to the occurrence of information asymmetry, people with blindness and visual impairment are in a disadvantaged position, as they are not sufficiently informed about services and opportunities for additional social and health care and therefore do not perceive the services as such, which contribute to their development and improvement of living conditions. The aim of this paper is to provide an overview of the relevant literature and to update the occurrence of information asymmetry in the area of the above-mentioned systems and policies. The paper addresses three key aspects of information asymmetry for people with blindness and visual impairment: the impact on people with blindness and visual impairment, the role of experts and the factors that make it difficult for them to reach their professional standards in the field of information, and, finally, the aspect of social policy and opportunities for policy development.

Keywords: information asymmetry, social policy, social care, healthcare, people with blindness and visual impairment.

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INTRODUCTION

The concept of information asymmetry essentially refers to the relationship between the provider and the recipient of a service that arises from an imbalance in the quantity and quality of information that the parties to this relationship possess about the object of interest. The concept of information asymmetry appears in various fields, especially in economics, where it is considered as an important factor influencing economic transactions and market dynamics. Through its effects, information asymmetry can lead to inefficiency, mistrust, and, in extreme cases, deception when one party (stakeholder of the relationship) exploits an information advantage over the other (Barbaroux, 2014; Clots Figueras, Hernán-González & Kujal, 2015; Li, 2020; Papadimitriou, 2023; Salhi, 2020). Despite its negative character, which leads to negative/undesirable results, information asymmetry can also open certain opportunities. Barbaroux (2014) notes that asymmetry holds the potential for entrepreneurs to capitalize on information advantages and develop new products and services. Although it is firmly embedded in economic concepts and in communication, information asymmetry is an everyday phenomenon that, due to its dual role (undesirable outcomes versus opportunities) and its complex nature, also applies and needs to be discussed in social and health care systems for persons with disabilities (PWD).

The problem of information asymmetry is particularly relevant and justified in the field of bioethics, as it has a direct impact on fundamental ethical principles such as autonomy, informed consent, fairness, and responsibility in professional practice. In the context of people with blindness and visual impairment (BVI), information asymmetry can lead to a power imbalance between people with BVI and professionals that threatens their ability to make independent and informed decisions about their own lives, rehabilitation, and rights. Bioethics as an interdisciplinary field recognizes the importance of equal access to information as a prerequisite for ethical action, especially in situations where people are in a more vulnerable position. Analyzing information asymmetry therefore enables a deeper understanding of the structural and communicative barriers that can limit the autonomy of individuals and provides guidelines for ethically responsible and inclusive practice in health and social care.

This paper aims to position and present the main aspects of information asymmetry in the social and health care system for people with BVI. The paper addresses the following issues:

1. How does information asymmetry affect access to social and health services for people with BVI?
2. What role do experts play in creating or overcoming information asymmetry?

3. What challenges does social policy face in implementing solutions to reduce information asymmetries?

The literature review aims to provide a conceptual and analytical framework for understanding information asymmetry in the field of social and health care for people with BVI. The review draws on relevant theoretical and empirical sources to critically consider the existing evidence and arguments and identify directions for future research. The literature review is based on a targeted search for papers analyzing the phenomenon of information asymmetry in the context of disability, with a particular focus on people with BVI. The Web of Science, Scopus and Google Scholar databases were searched and reports from international organizations and policy bodies (e.g., WHO, UNCRPD, European Commission) were also analyzed. The literature was searched using key terms including "information asymmetry," "disability rights," "visual impairment," "policy barriers," and "access to healthcare." The selected sources include empirical studies, theoretical papers, and policy analyses that address the role of information in access to social and health services. The papers were selected based on their relevance to understanding the mechanisms of information asymmetry and its impact on people with BVI. The findings of the literature were analyzed along three interrelated dimensions: (1) how information asymmetry affects people with BVI in accessing social and health services; (2) what barriers and challenges exist in the provision of information by experts in these systems; and (3) how public policy can respond to the problem of information imbalance.

THEORETICAL FRAMEWORK

Theories of information asymmetry in economics analyze how information inequalities between actors (parties involved in the process) lead to inappropriate outcomes in different contexts. Understanding this concept in economics allows for a better understanding of market dynamics, pricing, and/or market efficiency. As a basic framework for discussing information asymmetry, the foundational work of Akerlof's (1978) Lemon model is used, which illustrates how information asymmetry leads to adverse selection, where the seller has more information about product quality than the buyer, leading to market inefficiency (Alogoskoufis, Malliaris & Stengos, 2023; Bar-Isaac, Jewitt & Leaver, 2021; Downing, 2024; Suri & Adnan 2016; Revilla, 2021). This basic concept has been extended to different contexts and applications, influencing policy and economic modelling in various sectors, including the labor market and insurance (Bar-Isaac, Jewitt & Leaver, 2021).

When describing the theoretical framework, it is important to introduce the concept of social justice. This concept is not in opposition to economic thinking about information asymmetry, but rather enables its reflection in broader human actions and policy decisions, especially with regard to groups that are in some way marginalized and at risk of social exclusion. Social justice theory is a framework and set of hypotheses for understanding the human condition, within which systemic changes for equality are promoted and demanded while attempting to challenge injustices in various social structures (Killen, Yee & Ruck, 2021). The concept of social justice has evolved over centuries, inspiring and integrating various philosophical, socio-political, and practical fields. Thus, theories of social justice have been shaped by various actors, from ancient thinkers to modern scholars who have emphasized justice for marginalized communities (Hantal, 2022). In contemporary times, social justice is applied in areas such as education (Jornet-Meliá, Sancho-Álvarez & Bakieva 2015), healthcare (Hosseinzadegan, Habibzadeh & Jasemi 2024), public administration (Abel, 2014), transport planning (Adli & Chowdhury, 2021), and employment (Moffa & Longo, 2016).

The dimensions of social justice and information asymmetry for PWD encompass key aspects that shape individual experiences. Distributive justice focuses on the fair distribution of resources, including information, where unequal access to information can exacerbate existing inequalities (e.g., a lack of access to digital technologies). Research shows that resources such as accessible digital tools are often inadequate, resulting in PWD having limited access to important information (Danermark & Gellerstedt, 2004; Pudrianisa, Astari & Agustina, 2024). The digital divide is a significant barrier, as many PWD have difficulty accessing tools that facilitate access to information (Pudrianisa, Astari & Agustina, 2024). Procedural justice refers to the fairness of processes and systems. Barriers to access to information are often the result of inadequate legal and institutional procedures that do not provide for the necessary adaptations such as sign language interpreters or accessible documents (Mor, 2019; Paikah, 2024). The digitalization of justice further complicates the approach because although digital platforms offer potential benefits, they can create new barriers if they are not designed inclusively (Creutzfeldt et al., 2024). Interactional justice involves respect and fair treatment in interactions, and interactional injustices can lead to the exclusion of PWD from information exchange. Research shows that professionals, such as social workers, are often not adequately trained to interact appropriately with PWD, perpetuating information asymmetries (Boda, 2022; Goulden et al., 2023). Equality of recognition emphasizes the importance of acknowledging diverse identities and experiences. A failure to recognize disability as a valued aspect of diversity contributes to information asymmetry. Excluding the perspective of PWD in policy making and service delivery leads to policies that do not meet their particular needs and thus perpetuate their marginalization (Danermark & Gellerstedt, 2004; Thill, 2019). Dealing with information asymmetry requires a multidimensional approach that encompasses all dimensions of social justice. The dimensions of social justice — distributive justice, procedural justice, interactional justice, and recognition justice — are closely interlinked when it comes to creating and maintaining information asymmetries for PWD.

Although economic theories of information asymmetry and theories of social justice originate from different theoretical frameworks, they are connected by a shared recognition of social inequality and its effects on both individual groups and society as a whole. By combining the insights of these theories, we create room for discussion and a deeper understanding of how information asymmetry contributes to socio-economic inequalities, as well as how social justice–based solutions (focused on the equal distribution of resources and opportunities) can help overcome these inequalities. In this context, information asymmetry can be considered as one of the factors contributing to social injustice. Social justice theory provides a framework for addressing inequalities caused by information asymmetry and advocates for fair, comprehensive and timely access to information and resources.

When we apply social justice theory to the discussion of disability, social justice theory is not only about ensuring basic rights, but also about creating an environment in which PWDs can fully participate in society. Social justice theory recognizes the importance of autonomy and choice. PWDs are often confronted with paternalistic approaches, that is, decisions are forced upon them under the pretense of protection. The autonomy-based social justice theory emphasizes the protection and promotion of an individual's ability to lead an autonomous life. It assumes that a just society should invest in the competencies of its members in order to reach the threshold of autonomy (Claassen, 2022). A society that is considered inclusive must ensure that PWD can make their own decisions in all areas of life. In this sense, it is necessary to recognize socially imposed limitations and vulnerabilities that threaten the autonomy of the individual and work towards their removal (Anderson & Honneth, 2005). PWDs need to be empowered to make their own choices, with comprehensive information playing a central role (Begon, 2023). Freedom of choice means not only the ability to choose between available options, but also the right to create conditions that enable choice. For PWDs, this connection is extremely important because in their everyday lives, their choices are often limited by a lack of information, inaccessible spaces or discrimination.

HOW DOES INFORMATION ASYMMETRY AFFECT ACCESS TO SOCIAL AND HEALTH SERVICES FOR PEOPLE WITH BVI?

The occurrence of information asymmetry in accessing information about social and health services is a major challenge for people with BVI. Information asymmetry in access to health and social services for people with BVI occurs when different actors in the system (users, service providers, and institutions) do not have equal access to information that is crucial for decision-making (Sikirić, 2023). When relevant actors in one or both systems withhold information or provide only partial details about a right or service, people with BVI (blind and visually impaired) may be denied access to essential resources, or face significant uncertainty about how and to what extent that right or service can be exercised. As Rossi (2016) notes, the presence of information asymmetry is a challenge in accessing social benefits.

Research shows that people with BVI face multiple, interrelated challenges in accessing information about health and social care services. Stolwijk and colleagues (2023) and Kim, Jang, and Lim (2022) suggest that a lack of information from healthcare providers limits access to services for people with BVI. Speedwell, Stanton, and Nischal (2003) emphasize that people with BVI need to be provided with timely and comprehensive information and that the lack of accessible information contributes to inequalities in access to healthcare services (Nguyen, 2024). People with BVI have a high need for various information in the health and social care system, that are often neglected in traditional methods of information dissemination (Beverley, Bath & Booth 2004). Visual impairment is associated with high levels of unmet need, where individuals need to build complex networks of formal and informal support to fulfil their needs (Hodge et al., 2015), and many people with BVI are unaware of the rights, services, or support systems available to them. Wang and Yu (2017) state that people with BVI feel excluded from information that would help them resolve critical situations in their daily lives, including information about social rights. The same authors also say that people with BVI focus primarily on familiar sources such as family and friends when seeking information, and that this dependence hinders access to information through broader networks. According to Beverley (2009), several factors influence the information-seeking process of people with BVI, including the accessibility of information, the availability of information sources (civil society organizations (CSOs) are cited by people with BVI as the main source of information), personal preferences and needs, the ability to use technology, and the influence of social factors, such as support from the immediate and wider social environment. Varma, Singh, and Kumar (2020) and Olaopa (2017) emphasize in their research the issue of information literacy, that is, the ability of people with BVI to identify, evaluate, and use information. Beverley, Bath, and Barber (2007) identify the following key challenges in accessing information: 1) inappropriate information formats, which relate to both format and timeliness as well as level of detail; 2) communication barriers, which include poor communication strategies; 3) the complexity of information needs; 4) lack of information on important topics; and 5) trust in information sources.

Lack of information occurs in various possible situations and is the result of different utilization of information. The hypothesized situations include (Sikirić, 2023): 1) the actor of the system or institution that should provide the information does not have or is not fully familiar with the content or procedure that should be communicated; 2) the actor of the system or institution that has the information but does not provide it to the person who needs it (and when it is needed); 3) the information is provided, but the people with BVI do not process the information for individual reasons; and 4) the people with BVI do not request the information.

The first situation indicates that the system or the individual is unable to obtain information that is crucial for the fulfilment of their professional duties. The second situation, which leads to a lack of information, occurs when an individual or system that has the information does not pass it on to the person who needs it. The reasons for this series are the lack of competency of individual professionals in communicating with people with BVI (verbally or in writing), the lack of time to pass on the information, the professional identity, or the attitude of individual professionals toward the abilities of people with BVI and their rehabilitation needs. It is possible that people with BVI build up an image and trust toward all future actors based on these experiences and view them with the same distrust from this position. Due to feelings of inferiority, helplessness, disbelief, anger, aggression, sadness, and rage, the relationship between people with BVI and the institutions and individuals involved in the social protection and welfare system (Sikirić, 2023) is permanently damaged, making it difficult to access rights and benefits that would ensure adequate living conditions for the individual. Past experiences lead to a reluctance to seek help in the future. The result is negative reactions to help-seeking, ingratitude, dissatisfaction, sadness, or anger (Frank, 2003). The healthcare system produces and shares information about health and services that result from impaired health (Bloom, Standing, & Lloyd, 2008). If we extend this statement to the social care system, considering how medical care (diagnosis and care of eye damage) continues in the social care system, we can reflect on how the social care system also produces and shares information about social protection and social care services. In this context, an information imbalance or asymmetry is possible. Experts in the system often use technical information that users do not fully understand, especially when it comes to specialized health services or complex social rights. Communication can be further complicated for people with BVI if clear and understandable terminology is not used.

In this context, people with BVI do not make informed decisions because they do not fully understand the information provided. The situation is further complicated by the lack of expertise of service providers since social workers, doctors, administrative staff, and others do not know the specifics of people with BVI. Therefore, it is not uncommon for a paternalistic approach (Pourgholam, Shoghi & Borimnejad, 2022; von Humboldt, Silva, & Leal, 2024) to be viewed as the best for people with BVI, without active involvement in decision making. The complexity and diversity of the health and social care system often puts people with BVI in a situation where they must rely on their own initiative to manage these processes, which penalizes those who have not developed self-advocacy skills (Hodge et al., 2015). The lack of awareness of the services available logically affects the utilization frequency of these services.

The third situation relates to the psychological impact on the uptake and understanding of information provided to individuals with BVI at any point of contact. People with BVI, particularly those with acquired (non-congenital) visual impairments, often experience intense psychological pressure following the onset of vision loss—pressure that stems from the trauma and shock of adjusting to profound changes in daily living (Binder, Wrzesińska & Kocur, 2020; Boerner & Wang, 2012; Demmin & Silverstein 2020; Dodds et al., 1991; Holloway et al., 2015; Lundeen et al., 2022; Nyman, Gosney & Victor, 2010; Stevelink, Malcolm & Fear, 2015; Sun et al., 2012). In cases where information is provided through health and social services, people with BVI in the described context are often unable to access the information fully or to the same extent as it is provided by professionals. Haas-Wilson (2001), in the context of patients' ability to access information, points out that people who need information are often unable to gather and understand information related to diagnosis and further treatment and rehabilitation procedures in times of poor health. Brashers and colleagues (2000) point out that in some cases when information is provided, other contextual barriers hinder the acquisition and understanding of information. For example, they cite a decrease in cognitive ability when people are faced with increased levels of stress or anxiety due to an illness or medical procedure. The occurrence of a psychological block or an inability to process information helps explain situations where, on one hand, individuals with BVI feel inadequately informed, and on the other, professionals assume they have communicated effectively without confirming how, or to what extent, the information has been received and understood.

The fourth situation in the information process concerns the behavior of people with BVI, which is shaped by how information is accessed and by the possibility of avoiding information altogether. There are various reasons why individuals with BVI might choose not to seek information, even when doing so could provide crucial insights into their diagnosis, the current status of their visual impairment, or available options for care and support. As Brashers, Goldsmith, and Hsieh (2002) note, the reasons for this may be a lack of information-seeking skills (direct or indirect), a lack of motivation (a conscious decision to avoid information), doubts related to relationship or identity (a desire to respect authority and confront the needs of experts), or a combination of the above. Confronting the reality of life with visual impairment and its long-term prognosis can lead individuals with BVI to consciously avoid information related to everyday adaptations and the need for extended rehabilitation. This avoidance may stem from a desire to maintain a sense of control and independence, and to delay or resist acceptance of their new identity as a person with BVI within society. Help-seeking (including information) implies helplessness and dependence rather than autonomy and independence, and the person feels inadequate when seeking help and therefore avoids seeking help or information to maintain their self-confidence (Addison, 2017; Case et al., 2005; Frank, 2003). In the context of the four types of information deprivation described above, it is interesting to consider the adult's personal responsibility to seek and gather information. In a given context, it can be assumed that adults themselves are responsible for finding out about rights and services in certain care systems. In fact, the responsibility can be attributed to the adult at the moment when all conditions are met for the person to search for information independently. In the age of the internet and digital information, access to information seems to be a simple and short-term task. However, if we apply the same mindset to people with BVI who have lost their sight at a later age and have no experience in using technology under the conditions of visual impairment, we end up in a vicious circle of shifting responsibility, not providing information and not taking the necessary measures aimed at social and health protection and improving the living conditions of people with BVI. People with BVI must be able to inform themselves about their rights and benefits, although these skills are acquired precisely through psychosocial rehabilitation, which is one of the services provided by the social system. The expectation that people with BVI will independently learn how to use the same resources to obtain appropriate information without formal or informal training in the use of assistive devices is unfounded. Brashers, Goldsmith, and Hsieh (2002) note that people with the greatest need for health information and information about rehabilitation services may have difficulty with the technology required to access the Internet. The same authors note that even when people have access to technology, the information may be confusing and contradictory, or they may be overwhelmed by the amount of information. However, if we assume that people with BVI are educating themselves in the use of information technology, they will encounter websites where navigating and finding information is inaccessible. This does not mean that the responsibility lies solely with the policy-driven system or with the experts in the information chain, but it does explain that there are certain prerequisites for taking responsibility that the system and the experts have not provided. People with BVI face marginalization and lower expectations from society, which also affects their willingness to seek help or information. If they are also confronted with a non-transparent system, their commitment to exercising their rights decreases. In addition to the lack of customized formats, another challenge lies in the complexity of administrative procedures, which are often not intuitive even for the general population (Numans et al., 2023). For example, many systems require visual interaction (filling out forms or accessing digital platforms), which exacerbates the problem of providing adequate information. Important information should be designed inclusively, with materials that can be easily translated into non-visual formats and accessed through multiple modalities (Harrison & Lazard, 2015; Wang & Yu, 2017).

Due to information asymmetry, people with BVI are in a disadvantaged position as they are not sufficiently informed about services and opportunities for additional social and health care and therefore do not perceive the service as contributing to their development and improvement of living conditions.

Considering that there is no financial benefit here, as in the case of the market economy, in addition to the reasons described for each series, the motivation of the service provider for withholding information and maintaining a position of information power to the detriment of people with BVI remains unclear. It should be noted that information asymmetry is not necessarily the result of the expert-patient relationship, that is, the information that the parties seek and/or share with each other also contributes to this relationship. Brashers, Goldsmith, and Hsieh (2002) note that the parties involved may have different ideas about what is needed (further procedures) or that individuals (potential service users) withhold important information from the service provider.

WHAT ROLE DO EXPERTS PLAY IN CREATING OR OVERCOMING INFORMATION ASYMMETRY?

Given that we are dealing with two interconnected systems relevant to people with BVI, we will examine the role of professionals within both systems. To make the discussion more concise and focused, we will concentrate on two experts whose role is unavoidable in the context of the health system and the social system. When entering one and/or the other system, they are the experts with whom the person must come into contact and where the further process of treatment/rehabilitation/realization of other rights is not possible without consulting these experts. In the healthcare system, the role of primary informant is performed by ophthalmologists; in the social system, by social workers. Of course, other experts can also act as informants, especially educational rehabilitators and psychologists, but the way the care system for people with BVI is currently organized, they only meet after certain requests for services and rights have been made, that is, after the primary informants have already provided sufficient information.

In this section, we will also focus on CSOs, which are actors in the provision of information and other services and whose presence is increasingly emphasized. We will consider CSOs as a factor in their own right and place them on an equal footing with experts in the context of a combined social policy. After all, their expertise is based on many years of practical work, the use of professionals of different profiles (educational rehabilitator, psychologist, social worker), the implementation of professional projects, and co-operation with institutions and users of their services. We argue that their expertise is grounded in an understanding of the everyday challenges faced by people with BVI. As such, their role extends beyond mere advisory functions to actively informing and educating individuals.

Healthcare workers are confronted with a variety of problems that affect their availability and present them with major challenges. The Croatian healthcare system faces challenges related to the efficient use of human resources, which is critical for maintaining a sustainable healthcare system. This includes ensuring that healthcare professionals are adequately supported and that their work environment is conducive to high-quality care (Šimunković & Babić, 2023). One of the main problems is the imbalance between the demand for healthcare services and the supply of qualified professionals, which is exacerbated by the global labor shortage (Džakula, Relić, & Michelutti, 2022). The same authors emphasize that this shortage is not just a problem of numbers but is also about having the right skills in the right place at the right time, which has a direct impact on the quality and accessibility of healthcare services. In Croatia, for example, the total number of healthcare workers is sufficient but unevenly distributed, with urban areas having a higher concentration of healthcare facilities and professionals than rural and remote regions (Džakula et al., 2024). This geographical inequality leads to unmet medical needs, particularly in rural areas, where recruitment and retention of healthcare workers is hindered by factors such as family responsibilities and lack of professional support (Džakula et al., 2024). In addition, healthcare workers are burdened by poor management and organizational inefficiencies, which are perceived as major financial problems in the healthcare system (Orešković & Benković, 2024). Many experts believe that the financial management of the system is flawed, leading to irrational spending, and suggest that part of the public services should be offered to the private market to improve efficiency (Orešković & Benković, 2024). The Croatian healthcare system faces challenges related to the efficient use of human resources, which is critical for maintaining a sustainable healthcare system. This includes ensuring that healthcare professionals are adequately supported and that their work environment is conducive to high-quality care. The COVID-19 pandemic has further highlighted the challenges for mental health and burnout of healthcare workers and emphasized the need for comprehensive human resource management and support systems to effectively address these issues (Džakula, Relić, & Michelutti, 2022). Furthermore, political influence on healthcare management decisions in Croatia is seen as an obstacle to accountability and efficient resource allocation. Experts argue in favor of data-driven decision-making and improved governance to improve the efficiency of the system (Orešković & Benković, 2024). These challenges highlight the complexity of healthcare workforce management and the need for strategic planning that considers both the needs of healthcare workers and the populations they serve.

In the healthcare system, ophthalmologists occupy a unique position in the information process. When discussing people with BVI, the first step following the onset of visual impairment is typically the diagnosis and medical treatment of the eye. This is exactly why ophthalmologists are called primary informants, because people with BVI cannot bypass them or have them bypassed. A diagnosis by an ophthalmologist is required for any right or benefit. Although ophthalmologists have a clear picture of the diagnosis and prognosis of the development of the situation, they fail to provide information in terms of support and rehabilitation. Brashers, Goldsmith, and Hsieh (2002) cite several authors in their paper who reinforce the difficulties in providing information. Doctors spend little time providing information to patients. They overestimate the amount of time spent on information and, at the same time, underestimate the patient's desire for information (Waitzkin, 1985, as cited in Brashers, Goldsmith & Hsieh, 2002). Furthermore, Guttman (1993, as cited in Brashers, Goldsmith, and Hsieh, 2002) states that doctors overestimate the amount of information patients possess, while Hines and colleagues (2001, as cited in Brashers, Goldsmith & Hsieh, 2002) believe that the information provider and patients have different ideas about what information is needed.

The characteristics of the information provider may also influence the likelihood that a person will seek help and act on the information provided. For example, cancer patients have reported that they most value information support from healthcare professionals and other cancer patients or survivors, rather than from well-meaning but less knowledgeable relatives and friends (Dakof & Taylor, 1990, as cited in Brashers, Goldsmith & Hsieh, 2002). 'Weak' network connections (i.e., supporters who are outside one's primary network of family and friends with whom one typically interacts less frequently or intimately) may be particularly useful as sources of information support because they increase access to new information, promote social comparison with various others, facilitate low-risk discussion of high-risk topics, and foster a sense of community (Adelman, et al., 1987, as cited in Brashers, Goldsmith & Hsieh, 2002).

There are several lines of evidence supporting the importance of ophthalmologists in some of the information problems mentioned. For example, Power and Dell Orto (1980, as cited in Moore, 1984) state that early and appropriate communication and information by healthcare professionals generally reduces anxiety and allows the family to begin to adapt to the visual impairment. Appropriate communication was clearly recognized as a question of information. Accessibility in healthcare also means accessible communication between healthcare professionals and PWDs with certain impairments, such as the blind, visually impaired, deaf-mute, people with intellectual disabilities, etc., which includes the removal of communication barriers – creation of accessible information materials, knowledge of sign language, adaptation of the way of ordering, and providing information (Šogorić, Sanković & Štefančić, 2018). Many healthcare workers are insufficiently informed about the purpose and benefits of certification and registration (Boyce et al., 2014). Consequently, only a small number of healthcare workers are aware of what the welfare system offers to certified and registered people with BVI.

The role of social workers is equally important in relation to ophthalmologists; however, due to the heterogeneity of the population they serve and the working conditions, the fulfilment of their role is the most complex of all those involved. Social workers working in social care have community work tools and the ability to identify people with BVI in their area, but struggle to fulfil this role in practice due to documentation overload of documentation and the number of people they care for (Sikirić, 2023). Asch and Mudrick (2013) set out several principles for social workers working with people with BVI. The focus should be on the individual perspective of the problem when assessing and responding, rather than assuming that the visual impairment is the main problem to be solved or the main cause of the person's problems. The second principle is not to assume that the presence of a severe visual impairment or blindness prevents the person from actively participating in everyday activities such as education, employment, personal relationships, leisure activities, etc. Social work with people with BVI should aim to facilitate inclusion in such activities and to develop certain environmental adaptations and personal skills that enable full participation. The third principle is to focus on the strengths and individual potential of people with BVI. Fourth, social workers should be familiar with a wide range of services and programs for people with BVI while supporting independence and independent decision-making. The role of social workers as advocates is important, as is awareness of discrimination and exclusion in accessing services. While the above authors discuss which aspects of a social worker's work are crucial for communicating and informing people with BVI, in addition to the difficulties mentioned above, social workers in the Republic of Croatia are also burdened by the number of changes that are completely out of their control. Due to the numerous legal and administrative regulations they must follow in their work, the professionals of the Institute of Social Welfare are often perceived by the public as a mechanism of state control, with the emphasis on detecting misconduct rather than on the quality of professional work (Podobnik & Ilijaš, 2021). According to the same authors, experts in the field of social work argue in favor of reducing the administrative burden[1] of the institution to create space for professional work and the quality of services for users.

Improving working conditions and increasing the number of staff working with users opens up the possibility of increasing the development of individual plans (currently hindered by the administrative burden) and the time spent working directly with users on the full range of social work objectives (Podobnik & Ilijaš, 2021). Some of these difficulties in the work of social workers are confirmed, but many others are also mentioned by Milić Babić, Žganec, and Berc (2021). In their findings, they point out that social workers face problems in working conditions, which include insecure funding, insufficient number of professionals, inadequate spatial conditions, lack of official vehicles, excessive work and administrative burden, difficulties in cooperating with users, other institutions and experts, etc. In their study, Milić Babić, Žganec, and Berc (2021) show that social workers are concerned about the safety aspect and protection at work. Filipaj and Buljevac (2021) also mention the constant overload of too many beneficiaries and additional administrative tasks in the work of social workers as the main obstacles to adequate access to the rights and services of the social system for current and potential beneficiaries.

Gović and Buljevac (2022) demonstrate an example of inequality and arbitrariness in the process of information about services and rights, as they recorded social workers' professional bur also unprofessional behavior. However, in addition to the traditional role of social workers in the welfare system, it is interesting to consider the possibility of their involvement at an earlier stage, through the provision of healthcare to people with BVI. A social worker available to eye clinics would have the opportunity to reach out to people with BVI and establish a link and communication between the welfare and healthcare systems and inform about the rights of the individual in each of these systems.

The role of healthcare social workers, according to Milić Babić and Laklija (2019), is to help patients and their families, as part of the work of a multidisciplinary team, to understand a particular illness, the associated emotions and the diagnostic process, and to advise them on the decision to be made. The role of a healthcare

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[1] The continuous support of vulnerable people (including PWDs) is a great burden due to the framework conditions formed by administrative requirements, imposed tasks, and strict legal controls (Podobnik & Ilijaš, 2021).

social worker may include, but is not limited to, an initial interview with the patient and family, a psychosocial assessment of the patient, helping the patient understand the illness, helping the patient and family adjust to the changing roles that have arisen with the onset of the illness, exploring the emotional/social response to the illness and treatment, assisting in communication with members of the medical team and family members; education about rights and services in the local community; professional support in decision making for the patient and their family; educating medical staff about the patient's psychosocial difficulties; promoting communication and collaboration between members of the healthcare team; coordinating healthcare services and planning future treatments and services; and promoting patients' rights to information and decision making (Milić Babić & Laklija, 2019). The research participants (Milić Babić & Laklija, 2019) define their role in the healthcare system through the role of the informant and the process of informing patients and families about the rights and condition and needs of a child or adult family member, but also about other service providers in the local community. Despite the fundamentally defined role in the health care system, the same research shows that social workers in the Republic of Croatia face two basic problems in their work in the health care system: discrimination and a hierarchically subordinate position (dissatisfaction with communication by healthcare staff, discrimination against the profession, interference of medical staff in the work of social workers, lack of autonomy at work) and poor working conditions (lack of clear structure and job descriptions; numerous roles but poor position; small number of social workers in the healthcare system; lack of communication among social workers in the healthcare system; low salary coefficient).

Brodkin and Majmundar (2010) describe an organizational approach whose central premise is that social policy does not work by itself, but depends on organizational practices that produce it. The practices that these authors discuss emerge at the interface between formal rules that establish explicit criteria for the realization of certain rights and/or benefits (extent of documentation and frequency of re-collection of the same documentation), management style (relationship between incentives and practices), which indirectly influences organizational behavior, and informal activities[2] (reading medical records, showing up for scheduled appointments, determining whether a person really wants a service or needs a change in environment, providing information only about financial entitlements) of professionals interacting with people claiming a particular right. Informal procedures can be influenced not only by the legal framework, but also by working conditions and management characteristics. Šućur (2004) mentions, among other obstacles to access to social assistance in the Republic of Croatia, the frequent changes in legal provisions that

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[2] Brodkin and Maimundar (2010) also use the term procedural discretion. In fact, it refers to shortcuts that experts use in triage of users seeking a right or service to separate those who fulfil the criteria from those who do not.

lead to confusion among social workers and other professionals, which is due to frequent changes and, consequently, waiting for additional provisions, which often take longer to be adopted than the adoption of a new law. As Ilijaš and Podobnik (2019) note, such instability undoubtedly leads to unfavorable outcomes for all stakeholders, as it makes it difficult or impossible for users to exercise their rights and leads to great uncertainty of action and, often, to an additional workload for experts. Administrative exclusion occurs when organizational practices, which can be formally designed and informally created, influence participation in public programs rather than a person's material status or preferences (Brodkin & Majmundar, 2010). Administrative barriers behave like a vicious circle of factors, where one causes the other. However, the relationship is often two-sided and reciprocal, so that the roles of cause and effect frequently change. According to Brodkin and Majmundar (2010), organizations act as gateways to public goods and are formally empowered to interpret and apply rules for access to certain services. Outside of their specific role, they also act as informal "gatekeepers," developing different functional models that influence the facilitation or obstruction of the process of exercising rights or services. In their research findings, authors Crudden and Sansing (2011) cite a large number of cases handled by professionals and a large amount of documentation that needs to be collected as hindering factors in accessing services for people with BVI. The same authors also cite the non-standardized provision of services by different local service providers, including non-standardized information and lack of family support services. Rossi (2016) argues that social and health service providers have more information than service users, which ultimately gives them more power in the relationship, although their assumed relationship is a partnership and aims to co-create the service.[3] Rossi (2016) also argues that information asymmetry hinders the ability to align institutional policies and organizational and professional activities with the needs and demands of users.

One of the central concepts that characterize modern civil society is the right of citizens to freedom of association. Civil society is the space between the family, the state, and the market where citizens come together to promote common interests. The non-profit sector means that these organizations are not founded and do not operate primarily for profit and that they are active in an area that cannot always be organized on a commercial basis. Civil society refers to organizations and initiatives that have a positive approach to social problems and contribute to the common good (associations, foundations, private institutions, some cooperatives and unregistered initiatives) (Bežovan & Zrinščak, 2007). This definition expresses the key role of CSOs in general. The area that CSOs focusing on people with BVI occupy includes

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[3] Co-creation - citizen participation in the provision of public services and includes various ways in which citizens and/or the CSOs participate in the design and implementation of policies (Pestoff, 2012).

providing advice and information on rights and services for people with BVI, as well as implementing some parts of the rehabilitation program for those members who are not satisfied with the content or manner of service provision at state service providers. In cases where the services are provided by non-profit organizations, this is referred to as social entrepreneurship and social economy (Bežovan, 2009).

As an actor in bridging social capital,[4] CSOs for people with BVI have a unique opportunity for relative access to people with BVI who have left the health system and have not yet entered the welfare system. In addition to the information seekers and providers identified by Beverley, Bath, and Barber (2007), information processors were also identified, with organizations for people with BVI identified as the main information processors for the benefit of members. They have an absolute reach to people with blindness if they are also their members, but given the extensive support network, they also have a relative reach to people with blindness who are not members. CSOs are also associated with a form of negative social capital (Portes, 1998), namely the exclusion of non-members. As their name suggests, they are organizations that deal with blind people. Membership in these organizations and, therefore, the services they offer, are linked to the international classification of blindness. In this context, people with visual impairments, who do not fulfil these criteria, do not fall within the remit of CSOs.

CSOs play a key role in creating bridging social capital in society. They can serve as bridges that connect different groups of people and ensure that the resources and services they offer are accessible to all. In the context of people with BVI, CSOs can connect them to the various resources and services they need but might not otherwise have access to. CSOs can support people with BVI in their efforts to integrate into society and in various activities. In addition, the use of CSOs as bridging social capital can lead to the creation of new networks and relationships between people from different social and cultural groups and help to break down prejudices and stereotypes. CSOs are not always sufficiently organized or equipped to adequately support people with BVI. However, as they are important actors in the implementation of continuous social policy, their position has considerable potential to prevent information asymmetry. Strengthening the capacity of CSOs to provide support and information can be achieved through collaboration with other CSOs, structured and formal participation in decision-making, securing financial support for core programs, and building professional communication capacity at the policy-maker level (McVeigh et al., 2021).

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[4] Bridging social capital is inclusive and is created through networks and associations that bring together people who are dissimilar. Such a connection creates trust, reciprocity and social capital that positively influences economic and political development (Bežovan & Matancevic, 2017).

WHAT CHALLENGES DOES SOCIAL POLICY FACE IN IMPLEMENTING SOLUTIONS TO REDUCE INFORMATION ASYMMETRIES?

Due to the way social policy is implemented, although it aims at an inclusive society, it leads to the social exclusion of vulnerable groups (Numans et al., 2023). As key challenges in the implementation of inclusive social policy, Numans and colleagues (2023) cite the excessive bureaucracy that individuals encounter when interacting with the professionals involved; rigid protocols that professionals must follow which do not allow for flexibility or adaptation to the individual's needs; financial constraints that further limit the possibilities of individualized support; and inappropriate practices by professionals where the approaches they use do not match the dynamics and complex needs of the individual. Based on the conclusions of Numans and colleagues (2023), it is necessary to develop more transparent and accessible communication channels for health and social care system actors, as well as to improve professionals' communication through training to understand individual needs and ways of communicating, all with the aim of overcoming the information gap. Regarding access to information about health and social services as key challenges and social policy interventions, Noreau and colleagues (2020) cite inconsistent access to services, rapid technological change, cultural barriers (stigma and stereotypes, low awareness of PWD and/or people with BVI, resistance to change), policy framework challenges (inadequate legal framework, fragmented services), and insufficient support for families of PWD.

Although Speedwell, Stanton, and Nischal's (2003) research focus was on the provision of information to parents of children with blindness, the findings related to information asymmetry and implications for social policy are significant. They found that the key elements in the provision of relevant information are the timing of information and the general lack of knowledge about where and to whom to turn when seeking information. As part of these findings, the formation of Patient Liaison Teams is being considered, whose role would be precisely to provide important, comprehensive and timely information about both visual impairment and all other aspects of health and social care. Buechel and colleagues (2023), discussing information asymmetry in general, emphasize the role of communication channels in the dissemination of information. In this context, it is necessary to change those channels that prove to be inefficient or hinder the even distribution of information. Beverley, Bath, and Booth (2004) and Sharby, Martire, and Iversen (2015) speak of the need for a coordinated approach and collaboration between health professionals, social care system experts and information providers. Through his research on the accessibility of written information for the use of medication, Nguyen (2023) emphasizes the need to develop tools to standardize information, to maintain the tools that have been shown to be effective, and to use easy-to-understand language and information in multiple formats (Braille, audio, electronic), including the compatibility of digital content with assistive technologies. The focus is also on professionals who need to be trained on how and when to use each format.

Following the work of Dari-Mattiacci, Onderstal, and Parisi (2021) in the field of information asymmetry in the context of economics, we can observe certain principles in the context of health and social policy. First, it is about a basic understanding of what information asymmetry is and in what way and with what results it affects people with BVI. The authors also propose asymmetric solutions as a means of overcoming asymmetry, as a symmetric approach is not effective in all scenarios. The concept of incentive alignment can also be applied to the discourse on the information asymmetry of people with BVI. Incentive alignment is interpreted as a process in which we ensure or encourage the motivation of actors who have information in order to make it more accessible and understandable. This form of incentive requires a systematic approach that includes not only technical and organizational adjustments, but also investment in education and resources. A key component of this approach is the training of experts in effective communication with people with BVI, with a focus on developing skills that enable the clear transmission of information through alternative channels. In addition, the provision of appropriate tools such as tactile and auditory materials and the provision of time and support to adapt the communication process further contributes to the motivation of professionals to adopt the practice of inclusive information. This process not only improves access to information, but also promotes systemic responsibility and awareness of the need for inclusive action.

Hodge and colleagues (2015) recognize similar challenges and advocate for solutions related to the proactive provision of information and services, where health and social system actors accept a proactive approach to people with BVI that goes beyond diagnosis by providing information, referral to other support actors, follow-up or regular needs assessments and more. As a further solution, the development and integration of the role of CSOs in providing support and information is encouraged.

Based on the literature, the most important challenges for which health and social policy makers must find a solution can be identified. The main challenges for social and health policy in relation to people with BVI and information asymmetry are: proactive provision of information and services, timely provision of information, standardization of information, defining the role of experts in the information process and providing appropriate training, reducing the bureaucratic burden on experts, developing support/information systems including the development of liaison teams and developing and integrating the role of CSOs. Timely information is the basis of an inclusive policy. For people with BVI, this means providing the necessary information at the right time and in a way that suits their communication needs and the psychophysical state they are in due to their visual impairment. The timely provision of information is important for decision-making, especially in situations that require a rapid response. Experts such as health professionals, social workers and educational rehabilitators play a central role in reducing information asymmetries. Their competencies in communicating complex and specific information are essential for strengthening the capacity of people with BVI in terms of autonomy and decision-making based on comprehensive information. These competencies require continuous training and the development of specific communication skills, bearing in mind that such training cannot be limited to technical aspects, but also includes the development of empathy, cultural sensitivity and awareness of the challenges faced by people with BVI. Bureaucratic simplification opens the possibility of additional development of services and support networks for people with BVI. Reducing excessive administrative burdens will free up additional time for direct work and a personalized approach to service seekers. By strengthening the social policy framework and investing in experts and developing an effective information process, the system will have the opportunity to be proactive and not rely on the passive expectation that people with BVI will seek out information themselves in a context that is not accessible for effective information gathering. The development of social and health policies that integrate these elements requires the coordination of different sectors, such as the aforementioned social welfare and health care, but also the education, pension, and justice systems. On the one hand, the implementation of such a policy reduces information asymmetry and increases the efficiency of the system, by reducing the need for subsequent interventions and corrections due to inadequate communication, on the other.

FINAL CONSIDERATIONS

Information asymmetry undoubtedly plays a key role in access to and utilization of health and social care services by people with BVI, but it is not the only factor influencing their participation. Although many people with BVI have basic information about their rights and the services available, these are still underutilized in practice, particularly in the area of social care. This phenomenon points to the need for a more comprehensive understanding of the interaction between information, economic, access and psychological barriers.

The example of psychosocial rehabilitation as a service of the social system illustrates that the availability of information does not automatically mean that the service will be utilized. Due to the link with other rights – such as the inclusion allowance (Act on the Inclusion Allowance, NN 156/2023), which is suspended during institutional rehabilitation – families often postpone the decision on integration, even if they are informed about the possibilities. Such an intertwining of social rights and their (in)compatibility in application points to a systemic information asymmetry that requires intervention in the area of regulation and communication of rights.

In addition to financial accessibility, the physical accessibility of spaces and the information and communication accessibility of digital platforms represent further levels of limitations. If digital solutions are not adapted to people with BVI, the asymmetry is not only not alleviated, but even deepened. Thus, digital exclusion builds on existing vulnerability and reduces opportunities for active inclusion in society.

Personal factors such as denial of visual impairment or lack of motivation to access services also contribute to the complexity of the decision to exercise rights. However, these internal barriers often interact with professional practices and systemic deficiencies, confirming the need for trained and sensitized professionals who can recognize, understand, and address psychological resistance in the context of professional communication.

The literature confirms that there is a gap between the need for information and the concrete forms of information provision for people with BVI. Although some authors (e.g., Rossi, 2016) point to potentially constructive aspects of information asymmetry when users take an active role in seeking and advocating for services, such an outcome is only possible with the support of structured, proactive and accessible information mechanisms. In situations where people with BVI do not have basic insight into their rights, we cannot speak of true autonomy or equal participation.

Therefore, it is crucial that policies and practices targeting people with BVI include clear strategies to overcome information asymmetry: from standardization of communication formats and proactive information to training of professionals and digital inclusion. In addition, systemic changes – including reducing bureaucratic hurdles, shortening procedures and improving cross-sector coordination – must accompany these efforts in order to lead to real improvements.

Introducing the concept of information asymmetry into the social policy discourse allows for a more precise definition of the system's weaknesses and provides a basis for developing more inclusive and effective practices. Recognizing and systematically addressing this phenomenon is crucial for ethically sustainable and socially just policies towards people with BVI.

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Informacijska asimetrija u socijalnoj politici prema osobama oštećena vida

SAŽETAK

Informacijska asimetrija pojam je koji označava neravnomjernu distribuciju informacija između dva ili više dionika, a koja, ovisno u kontekstu kojem se događa dovodi do neučinkovitost, nepovjerenje te u krajnjem slučaju i obmanu, gdje jedna strana (dionik odnosa) iskorištava informacijsku prednost u odnosu na drugu. Opisivanje pojma informacijske asimetrije u socijalnoj politici prema osobama oštećena vida stvara okvir u kojem je moguće promatrati i identificirati poteškoće u informiranju te korištenju prava i usluga u socijalnom sustavu i sustavu zdravstva. Zbog pojave informacijske asimetrije, osobe oštećena vida su u nepovoljnom položaju budući nisu na adekvatan način informirane o uslugama i mogućnostima dodatne socijalne i zdravstvene zaštite te tako uslugu ne percipiraju kao onu koja će pridonijeti njihovom razvoju i unapređenju životnih okolnosti. Cilj ovog rada je pružiti pregled relevantne literature te aktualizirati pojavu informacijske asimetrije u prostoru navedenih sustava i politika. U radu se problematiziraju tri ključna aspekta informacijske asimetrije za osobe oštećena vida, kroz aspekte samog utjecaja na osobe oštećena vida, uloge stručnjaka i čimbenika koji otežavaju ostvarivanje njihovih profesionalnih standarda na području informiranja te završno kroz aspekt socijalne politike i mogućnosti razvoja politika.

Ključne riječi: informacijska asimetrija, socijalna politika, sustav socijalne skrbi, zdravstveni sustav, osobe oštećena vida.