

Re-Designing the US Health Care System: The Third (4th, 5th, 6th) Category

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We see two categories that already exist in the dialogue around the ‘crisis in the US health care delivery system’: the status quo of market controlled health care; and the efforts towards changing that system towards ‘single payer’. We wish to propose a third category.

The first category is the status quo: the health care system as controlled/shaped by entrenched health system industries. The medical profession of doctor--its history of professional sovereignty-- now no longer provides the ‘bottom line’ in health care. The ‘bottom line’ belongs to a different bottom: the marketplace.

Second category is single-payer, functioning as a challenge(perturbation)to aspects of category one, market dominated health care. Single-payer is built on the ethic that health care is a right of all people--an ethic we share--and, if enacted in legislation, would be a crucial macro-level policy change in the US. Single-payer is a much-needed mechanism that would enable all people to have access to a health care system, but is not meant to serve as a design of a system, itself.

We add a ‘third’ category, to act as a portal(doorway) opening up to other people offering fourth fifth sixth seventh, etc categories. This category is a call for creativity and variety, with a political edge: to design health care delivery systems built according to the desires of the participants, not the mandates of the status quo. The political edge?--these systems would function as parallel institutions to and perturbations of the current health care (disease management) system. The mandate for creativity is a linked to a mandate for infectious opposition: we would like to popularize the sentiment, “Hands Off, America: It’s Not Good Business to Make Health Care a Business”.

This brief position paper, and its more fulsome 30 page background paper, describes the third category and the contexts of our thinking.

Statement of the problem

United States 2006: When the financing of health care upstages the delivery and culture of health care, we’re in trouble, because opportunistic market behavior has damaged the delivery of health care, and, more ominously, has *become* its culture.

Further, even in dialogues around change of the US health care system, the market continues its monopoly of the discussion. Whether one is a market corporatist, or a single payer activist, the question “Who will pay for this health care system which is so expensive that 48 million Americans have no access to health care” is given an uncontested role as the focus of attempts to change the system.

That the entrenched health system industries (the health insurance, pharmaceutical,

medical technology, and hospital corporations) focus on the question ‘Who will pay’ makes sense from their point of view, as it’s in their interests to do so. Corporations are legally responsible to stockholders; they must act in order to make financial enterprises attractive to investment capital. Econ 101.

But what about us--- we who wish to fundamentally change the system? (which means, to anyone who cares to listen, to change the fundamentals of the system).

Does it make sense from our point of view to use the terminology, reasoning, bottom lines, behaviors, decision-making, and ultimately the value system of the market when we oppose its control over health care?

No. Language 101.

Someone could ask at this point, does this mean you think that financing is unimportant? No, we don’t think it’s unimportant. But we do consider its importance to be part of the problem, and wish to change that positional value in the scheme of things.

While the health system industries as yet control the actual economics of health care, why would we also let them control the language and culture of health care delivery--even the discourse around fundamental change?

Why use their framing?

Frames:

This from a health care policy blog, Health Wonk Review, spring, 2006:

“Major change in US health policy is imminent...The question has changed from ‘should we do something different about health care?’ to ‘what should we do about health care?’ Who should pay? What should we pay for? Does a single-payer system make sense, or should individuals buy their own health insurance? What role, if any, should employers play? How much can technology help? What should we be investing in?”

We reject this framing of the ‘crisis in US health care’--it’s a symptom in the direction of the problem, not in the direction of the solution. The framing--typical of discourse over the past 30 years, though this blog acts as if it’s all new---highlights market concerns again, to the neglect of other important aspects of social design, again.

Our frame, which we’re calling the 3rd category (welcoming the 4th, 5th, 6th) goes like this:

Given that there’s a call for fundamental change in the US health care system, we respond by saying “that means, DON’T act like a corporation”.

How do we play this out?

Since corporations focus on homogeneity of language and culture, on hierarchies, on profit, and on lack of popular participation, we focus on a call for variety and creativity--with an edge. We're asking people who care about care to design those many areas in health delivery systems that are open to change, are open to design.

Design is the connection between what I want and a resistance to 'settling for'. It refuses the idea of 'it can't change'. A person 'designs' when she connects things in ways that haven't been connected before, according to her desires and intentions.

In asking people to 'design', we're attempting to seed a variety of local pockets and pockets of local variety in health care systems.

And 'the edge' ? We want these 'pockets of variety' to run parallel to the current health care (disease management) systems, and to be loosely linked to one another so as to act as perturbations to the system.

Perturbations are ideas/actions that "put the system on the spot" with the aim of destabilizing it, of making it "trip" on itself. When thinking of perturbations, we aim at the system moving itself in a new direction under its own weight and inertia, as it attempts to compensate for our 'putting it on the spot'. This is different from 'reforming' or 'improving' a system, where we aim at ourselves moving the system.

Why perturbation rather than simple direct improvement and reform?

We turn to perturbation when we humbly admit that folks, we're in a David-and-Goliath position here as regards to change of health care system, in that:
the system we want to change is in the control of people/institutions who have power over us;
the system 'as it is'--unchanged-- benefits them enormously;
these people/institutions have no intention of allowing change of that system, no matter how reasonable and ethical are the arguments for change,
no matter how compelling the evidence of human suffering and human waste, no matter how many compromises activists are willing to make towards these people/institutions.

Unlike our friends, the single payer activists, who work toward directly affecting outcomes, we humbly submit that given our understanding of systems change and of the dynamics of the US health care system in 2006, we can only hope to trip the system up. In short, to perturb it, to put it on the spot. In terms of perturbation, we do have a chance: the health care system in the US is so big, so complicated, so bureaucratic, with parts unable to connect to other parts, so insensitive to the mood of its environment, so unable to see its consequences---that falling by means of its own weight is a possibility.

How to bring that about?

Perturbation is the action of desperate and thoughtful people.

“Who will pay” is such a volatile question to organized business, as it hits them in the pocket book which is about the only book they read, that we think the question better addressed if we sneak up on it from the back door than rather than coming in on it squarely from the front. “Sneaking up on something from the back door” is a folksy way of saying, “perturbation”.

The ‘back door’ in this context means category 3(4,5,6,): inviting people who participate in health care on the day-to-day level (‘front lines’) to design: shape the elements that will become the culture of health care delivery systems.
no-These designs can function as perturbations to such questions as, “Who will pay”?

Category 3: Design, in order to Perturb

What Can Be Designed?

We propose that designing those elements of health care that will become the culture of health care systems is something we can do. Now. It is within our powers to shape health care on the day-to-day “micro” level---its myriad of daily interactions and events--- according to the significances we want.

Do we have a choice about anything in health care systems? Yes. Lots. Where we have a choice, there we can design.

Selected items from our check list, open to choice:

1. **hierarchy, rank abuse**--Health care interactions inherit a culture of hierarchy, rank abuse, posing. This is something a group of people, in shaping their health care facility along the lines they want, can support, oppose, change, alter.

---this is something that can be designed

2. **health of individual nested within a larger group**--- In our consumerist culture, health/sickness is identified as being an individual property--a person sees her health as her own individual state, she ‘battles against her disease’, alone. (This, in the face of many studies that show a person has better health outcomes if she feels her well-being integrated within that of a larger group). A group of healers/designers can come up with a language--frames and metaphors--that oppose this isolationist consumerist tendency, and situate the health of the individual with the health of a group.

---this is something that can be designed

3. **health of the staff as important as the health of the patient** In Patch Adams’ design of his hospital project, “Gesundheit”, he insists that the health of the staff needs to be just as much a priority as the health of the patient. Just as the patient needs to feel her well-being is nested within the well-being of a larger group, so does the staff.

---this is something that can be designed.

4. **participating in health as a people’s popular movement** Commercial culture

names a patient as 'consumer' and a doctor/nurse as 'provider' . Given this framing, health care interactions are experienced as a form of shopping, for both patients and healers. Beyond 'stopping at the counter' to get a pill, patients in the United States do not participate in health, health care, or health care systems. Designers can oppose this state of affairs and make elements in their facility (by means of language, imagery, structure) that enable popular participation in all aspects/levels of health, health care, and health care system.

----this is something that can be designed

5. **nesting** Currently health care has been 'nested' in bureaucratic and financial institutions. This can be counter-acted: healing interactions need to be protected by nesting them in larger beneficial social groups.

-----this is something that can be designed

6. **solidarity** We need to rescue the concept/feeling/action of 'solidarity' from North America's garbage heap. In the current culture, each person feels "you're on your own", "everyone for himself". Thus under-staffing of nurses is experienced as the nurses' problem, not the problem of the doctor, medical student, patient, family, technician. This reveals a lack of solidarity between people whose interests are fundamentally in common. How is it that some doctors have been wooed to invest in hospital corporations, to see themselves as part of the opportunistic entrepreneurship? This reveals that the lines of solidarity need to be refreshed and redrawn. There need to be discussions about whose interests are being represented. Does the design move in the direction toward creating constructs where solidarity between the greatest number of different people/groups is supported?

----this is something that can be designed

7. **decision-making** who makes decisions? is decision-making about health care system dilemmas communicated to/from the people? does the health care system listen, in addition to talk?

---this is something that can be designed

8. **communication** how is information communicated and disseminated? where is it?
---to be designed

9. **motivation of actors** who stands to benefit? in whose interests are decisions made? are the motivations of the others clear to each? differences of power?

---to be designed

10. **seek out, comes to** do people 'seek out' health care, or does health care 'come to' them? Is the health care system visible only when a sick person looks for it, or does a person have the sense she is nested in care?

---to be designed

11. **cure or care?** In the health care facility, is there a behavior which values 'cure' over a commitment to 'care'?

---to be designed

12. **spaces** Does the space (rooms, hallways, waiting rooms) support the values we want?

---to be designed

13. **presentation of self in everyday life** The way healers, staff, and patients act in everyday life is a choice and can be a tremendously valuable input to desirable health care interactions. There is no neutral interaction.

---to be designed.

Calls for change in the US health care system are, amongst other things, calls for creativity. We need a variety of new ideas, projects, designs, configurations, proposals--alternatives to look at and weigh.

There are some problems where the solutions are not there yet. Action to be taken: we have to make up solutions.

Why is there so little call for creativity and variety, in relation to the 'US health care crisis'? I consider it symptomatic of the 'stuckness' of the situation and the identifying signature of those who consider themselves the 'players'. Entrenched industry is not creative, nor is it looking for creativity. Rather, under the guidance of these 'players' the discussion is pitched at the level of choosing between already available policy options within market capitalism.

The health care crisis, is, amongst other things, a crisis of bankrupt ideas. People recognize that things need to change; they do not recognize that something has to be made up.

Under the control of the market, mesmerized, we obey a homogeneous culture of disease management, instead of creating and supporting a variety of cultures of health care.

Category 3: Oppose/Expose the Undesirability of Market Controlled Health Care
Single payer activists, our friends, are making coalitions with health system industries in order to enact health care reforms legislation on the state level.

We admire our friends' integrity, we admire even more their tenacity, but we admire less this strategy. (However, every David supports the efforts of every other David in the fight against this Goliath! So--good work UHCAN friends!)

Our strategy is this---rather than priding ourselves in 'working with organized business', we want to oppose and expose the undesirability of market controlled health care, and to popularize a 'hands off health care, corporations' sentiment in Americans and in business-people themselves.

We take our cues from an historical analysis made by economist Robert Kuttner, re-introducing the term "passive intervention". Kuttner writes:

"... In 1965, armed with a rare working majority, the Democrats were able to enact both Medicare and Medicaid. . . Though the AMA was implacably opposed to the whole idea, Congress and the Johnson administration offered doctors a costly sweetener--and found sugar coating for the hospital, insurance, and drug industries as well: The government would do almost nothing to alter the existing structure of the private health care system. It would simply pay the cost of bringing new subscribers into it---

creating new profit opportunities for these powerful industries. . . All this created a huge new market for the medical-industrial complex, and increased the inflationary bias.

My colleague Paul Starr terms this characteristically American approach to social reform “passive intervention”. Organized business has immense political power in the United States. Occasionally, reformers muster enough countervailing power to extend social benefits to new groups of citizens--but not to challenge the structural power of dominant industries. This brand of reform, then, comes at a terrible price, since it reflects and inflates existing inefficiencies. In the 1960's, this failure to challenge entrenched provider groups and the structure of their system led the Johnson administration to enact a medical-insurance program with a profound inflationary bias. In the 1990s, the same failure to confront entrenched industry structures led the weaker Clinton administration to a spectacular political failure. Everything for Sale-- the Virtues and Limits of Markets

An Error?

We see that certain outcomes and patterns are conserved in the medical system--whether they are unethical or not--because they benefit a small group of people who hold power in that system.

The lack of medical care for all people is not an ‘error’ in the system, something that had been overlooked and now needs to be fixed. The lack of medical care for all people is an intended consequence of the current system. The abundance of bureaucracy in the medical system--the paperwork, the over-seeing of diagnostic decisions by insurance companies, etc--is not an error in the system. It is the intended consequence of the current system. If the system is so constructed that one out of every dollar spent on health care goes to administration, then this plays itself out in our everyday experience. The system is being maintained at the expense of the well being of its members.

When we Americans say we want fundamental change of the US health care system, this means we want a change of fundamentals.

We no longer allow market forces to control health care. Hands off health care, big business---it's not good business to make health care a business.

Talking points:

1. We question at every opportunity the appropriateness of market capitalism (“free market”) to control(‘nest’) the delivery of health care. We discuss the limits of ‘free markets’ and the need for non-market regulation of ‘experiential goods’ (a term in economics for services whose outcome is uncertain). We point out that in the case of a relationship-dominated good such as health care, cutting costs in overhead results in cutting care itself.
2. We debate the assumption that health care is (needs must be) expensive. The

expense of health care is not a property of it in itself; the expense is an engineered condition, a consequence of the present design. We debunk the framing that health care will always be costly by making reference to counter-examples.

We Invite media and wireless activists to demonstrate how the use of technology in health care can be free.

Everytime the question, “Who will pay for this expensive sysem” is asked, we ‘balance’ this with our question, “Who has been profitting such that this system is expensive?”

Health care, by its nature, is inexpensive--it’s primarily a relationship with some tools. We keep that image in mind so that we avoid playing into the assumptions of the market. The ‘high cost of care’, the ‘complexity of the system ‘ are all images/terms that fuel the symbolic capital of the current system.

3. We caution that when big business says “we’re committed to cutting costs in health care” this DOES NOT mean “we’e committed to making health care inexpensive”. It doesn’t mean that. Within market capitalism ‘cutting costs’ means lowering overhead (worker’s wages, resources) to keep profit at margins attractive to investment capital. It does not refer to lowering the cost of health care so that it’s easily available to we who need it. Market forces always say they want to ‘cut costs’; the question of lowering their profit margins is never brought up.

4. We rename the ‘health care system’ the ‘disease management system’. When a person ‘gets into the medical system’ that person is ‘getting ‘ disease management, not health care. ‘Disease management’ is a far smaller domain than the domain of ‘health care’. ‘Health care’ is a huge domain of interactions, happening primarily outside ‘the medical system’, available to all, only not organized. John Glick MD says, “Every moment is a health care moment”. When does ‘health care’ start?--- when you decide to take a walk early in the morning? When you ‘feel like you’re getting a cold’, and a friend gives you echinacea drops in a cup of tea?

What is health care at its indispensable minimal? Against the noise tunnel of the expensive and complicated ‘disease management system’ we need to keep in mind the simplicity of a desirable health care relation: it’s a bi-directional relation of care, always available, always findable--as a matter of fact you don’t have to look for it, it’s looks for you. One has a sense of being ‘inside’ caring, of being nested in care--there’s someone to turn to, to talk to, they suggest a few things to do, you try them, you turn to them again.

The protection of this simple relation, of its friendly permeating steadfast presence, is the primary function of any system/culture built around it. Thus the system/culture would be so designed that this relation is either freely offered or offered at a low cost (supported by communal and social structures in a variety of ways); that the

formation of any bureaucracy around it would be a sign of malfunctioning or predators, and steps would be taken to eliminate that; that creativity and variety would go into the design of the supporting nest into which the relation is put, and into the relation itself. So einfach.

5. Do we attempt to work with market institutions to change health care? Organized business is interested in discussing financing and administration, not health or health care. Thus, to “sit down at the table with these major players in health care industries” means to sit down with people who frame every discussion of health/health care as a discussion of money and administration. If any other consideration is brought up, they will look at you with a patronizing eye ---after all, they know their business--and turn it back into a discussion of financing.

So we can sit down with them, “at the table”, but we have to realize we’re sitting down with opponents to any direction of creating a desirable health care system available to all.

6. Garner support from business people, on a person-by-person basis, for ‘hands off health care’ initiatives. Appeal to faith communities, whose morals lead them to ethical political positions. Every business person has his fatherhood looking over his shoulder; has his son-hood, brother-hood. Every business woman is also a mother, daughter, sister, friend. Do they want to overhear, in the waiting room, that ‘cutting costs’ was a factor in why their grandchild died on the operating table? At some point in their lives, someone they care about will be ‘in’ the system too. Their own pricey insurance policies cannot be transferred to everyone they care about.

7. We consider what is happening to health care in the US a ‘local version’ of the same market theories that initiated ‘structural adjustment’ programs across the globe by WTO and World Bank. (‘Structural adjustments’ primary focus is to shape institutions/countries so that they’re attractive to long distance investment capital.)

Structural adjustment policies have been tried in South America, and met, in growing cases, with resistance. Let’s link our resistance to structural adjustment policies at home, to the resistance made by allies across the globe who are also fighting these policies.

Final Remarks

The components of what we’re calling “Category 3 (thus 4,5,6, etc)” are two calls: one is a call for a variety of designs of those elements that will become the culture of health care; and the second is a call for the sentiment: “hands off health care, big business” to become infectious in the Americas. Both these calls are efforts to perturb the system.

In 2006, people in the United States have a diagnosis of the problem of our health care system that is clear and intelligent. If you read blogs/letters/emails from the 'common person' they articulate their discontent with the health care system in a sophisticated way. (See document from MoveOn.Org).

People want a fundamental change in the health care system. This means, we want a change in the fundamentals.

We need to be prepared for the language/framing in response to this desire for change. When Medicare Plan D came out in May 2006, it was a 122 page document with lots of complicated sections, written for older Americans, telling them how to get pharmaceutical drugs. 122 pages? Hunh? How was this allowed? Did the writers lack schooling, lack funding, lack time to do a better job? We don't think so. Plan D was a linguistic display of 'passive intervention'.

We need to watch out: the existent 'players' (entrenched industries, along with their current protectorate: the government) will respond to our clear desire for fundamental change with an engineered Tower of Babel. The column of language is coming at us now: fundamental change in the health care system is re-framed as the question "who will pay for this expensive system?", as a debate between various complicated payment schemes, as a mandate for 'consumer choice'. 'Universal insurance' will be used, to confuse us into thinking this means 'single payer'.

The language will befuddle us, discourage us.

The temptation will be to leave the discourse around health care to the experts. They seem to know what they're talking about, right? None of these 'experts' will challenge the structural power of the entrenched industries, the huge salaries of the health care corporations CEO's, the fact that pharmaceutical corporations top the chart for profit returns, etc.

Will we permit 'passive intervention', again?

The statistics are said, over and over again, that in the richest country in the world, nearly 48 million Americans do not get health care.

We say that in the richest country in the world, 300 million Americans do not get health care. Yes, of these 300 million, many people do get into the disease

management bureaucracy, as they have insurance. But what is happening 'inside the medical system' is no longer care; the 567, 000 licensed doctors are not permitted to doctor; the 2.4 million nurses are being thwarted at nursing. The culture of health care in America is being morphed into something else.

When hospitals/clinics are businesses, and doctors/nurses become business people, who will we then turn to for health care?