Within the System of No-System

MY WAITING ROOM IS BIGGER THAN YOURS. IT SEATS 228 and by mid-afternoon it is usually packed. On a good day patients will wait two to three hours to see me or one of the other clinicians who work here. On a bad day the wait can reach five or six hours. Not as many patients complain as you might think. Almost all are uninsured, and they have nowhere else to go. Our "acute care" clinic is a large county-hospital walk-in clinic—the portal of entry to the public health care system in a county in which 360 000 of the 1.3 million inhabitants are uninsured. The numbers are alarming, but the stories underlying them are even worse.

1. A woman with flank pain, dysuria, and a temperature of 103 who had been seen in a local emergency department the previous night. She was given some type of injection for pain and sent home. No tests had been done. Results of urinalysis done in our office confirmed pyelonephritis.

2. A man with a sore throat who had spent the previous night in our hospital's ED and left after waiting more than 16 hours to be seen. He had a peritonsillar abscess and needed the care of an otolaryngologist, so we sent him back to the ED. This time he went with a diagnosis.

3. A man who said that his cardiologist sent him to our clinic for "blood pressure medication and a pacemaker." He had fainted during a recent treadmill examination at the cardiologist's office. He then lost his health insurance and could no longer be seen there.

4. A man with a large bandage on his hand. Three days earlier, the fourth and fifth fingers of his left hand had been amputated in a chain saw accident and then reattached at another hospital. Because he had no insurance, he was sent to our walk-in clinic for follow-up.

5. A child sent home from school two weeks earlier with "pink eye." The child's school administration would not readmit her without a doctor's note, and her parents needed two weeks to gather the money for a doctor visit so they could obtain the necessary note.

6. A 22-year-old man with dyspnea, a heart rate of 160, and a large globular heart on his chest film. He came to see us instead of his "usual" physician because he had recently lost his job and his health insurance because of frequent medical absences caused by his lupus.

7. A middle-aged man with severe shoulder pain and a ruptured short head of his biceps. The consultant refused to see him on an expedited basis, explaining, "These people get free care; they should expect to wait."

8. A homeless man who is a heavy drinker with arm pain. He had been seen several weeks earlier at an ED for the same problem and released without treatment. His humerus was grossly angulated, and a fracture was evident on x-ray. Examination of his head revealed a large depressed skull fracture.

9. An HIV-negative man with fever, cough, weight loss, and *Mycobacterium kansasii* growing from his sputum. He had been seen in the county TB clinic but was discharged six months earlier when his culture was reported as not *Mycobacterium tuberculosis*. He was told to "see a doctor."

10. A man in his early 20s with a worsening dental infection who was unable to afford a dentist. He finally saw a physician who prescribed an antibiotic, but the patient was unable to pay for the prescription. He presented to our clinic with sepsis and spread of the infection to his mediastinum. He died soon after admission.

I wish this was a top-ten list of lamentable stories, but it is not. The egregious is commonplace in our setting. My colleagues and I are part of what is widely known as the health care "safety net" for the uninsured, but to work here is to realize that, for many, the safety net does not provide a soft landing, nor are its failures the random "accidents" implied by the image of missing a net.

In actuality, events such as these are the product of a system, an increasingly coherent system of exclusion that denies care to the uninsured: the system of no-system. The system of no-system's components are the fragmented resources locally available to the uninsured, embedded within the national nonsystem of health care. It is a netherworld of closed doors and shrinking services. The paradox of the system of no-system is that it is becoming increasingly systematized. Unintended consequences of changes in health care organization and financing, positive feedback loops enabled by the nonsystem, and maladaptations to the health care market are solidifying the barriers to care for the uninsured.

Features of the System of No-System

Inversion. In the system of no-system, the relationship between needs and resources is inverted. Services are least available to those who need them most, a situation aptly named the "inverse care law" in 1971 by the English general practitioner Julian Tudor Hart.[1] As Tudor Hart pointed out, the inverse care law is exacerbated by a market distribution of medical care because poor people suffer the highest levels of disease and distress but offer the least financial incentive for services. Thirty years later the inverse care law still prevails, implacably enforced by the system of no-system.

Concentration. When medicine was a cottage industry, the uninsured faced many barriers, but individual physi-

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cians could choose to provide pro bono care on a small scale, and, in the aggregate, the number of uninsured served this way was quite sizable. Now that we are well into medicine's new economic revolution, the pressure for profitability in many large systems of care is closing the doors on the uninsured and concentrating them in public facilities.

Fragmentation. With a shrinking public sector and a disinterested market, identifying sources for a comprehensive range of services has become considerably more difficult. For example, except for patients with acute psychosis or suicidal intent, obtaining timely mental health services is nearly impossible in many publicly funded health care settings.

Evasion. Despite legislation to prohibit patient "dumping,"[2] it still occurs. To survive, it has mutated into a less visible form. Private hospitals are no longer shipping indigent patients off to public EDs in a taxicab. Instead, they now offer perfunctory treatment, forego any diagnostic procedures, and discharge patients with instructions to "follow up tomorrow with your primary care physician." They might as well be advised to see their personal banker.

Degradation. The inverse care law is not invisible to the uninsured. The system of no-system exposes patients to a number of transactions for which the price they pay is their own dignity, such as being turned away when they cannot pay in advance for services, waiting interminable hours for care, and coping with clinicians and staff who show them little respect. In overwhelmed systems, the people served become the problem.

It would be easy for our patients to conclude that they are worth something only as potential research subjects. The bulletin boards of our office feature equal numbers of flyers encouraging us to refer subjects for various studies and offering regrets that due to cutbacks or increased patient load, certain clinics will no longer accept new patients.

Resignation. Working within such a system slowly erodes professional standards, as clinicians yield principles to realities. What is practiced is the art of the minimal.

Amplification. Healthy systems maintain stability through self-correction: threats to the system's integrity activate compensatory mechanisms that restore stability. In unhealthy systems, disturbances may trigger a response that creates an even larger disturbance: an amplification loop in which things go from bad to worse. An example is the loop enabled by employer-based health care when an employee becomes seriously ill and is fired, thus losing his health insurance and his access to medical care (COBRA protection is a mirage for the working poor, with an annual cost per family of more than $7000[3]). And those in most jeopardy for being fired because of sick time are at the lower end of the socioeconomic spectrum, thus creating a synergy between the greatest risk and the greatest consequences. A similar dysfunctional response occurs when, as the cost of health care rises, employers take steps to reduce their medical costs, one of which is hiring more temporary workers not covered by medical insurance. These workers are disproportionately from low-income groups and are thus less able than others in the population to cope with rising health care costs.[4]

The most important example of how problems are amplified in the system of no-system is seen in the public health-care infrastructure, which is being stretched thinner and thinner, essentially being pulled apart by increasing numbers of uninsured on one side and falling revenues on the other. A vicious circle ensues of falling revenues leading to cutbacks in levels of service, driving insured patients to other facilities, causing a further fall in revenues. Medicaid managed care has been successful in mainstreaming patients to community health care providers, but with an unintended consequence of choking off one of the main sources of income for public facilities.

Maladaptation. The system of no-system does not exist in a vacuum. It is embedded within the health care market and society at large. As those responsible for providing services within the system of no-system cope with these larger structures, maladaptations ensue. Some of the maladaptations result from attempting to maintain services modeled after the mainstream market without sufficient resources or personnel. Others arise when public institutions' strategies to survive in the market distort the decisions about what services should be pursued, leading to the paradox of high-tech citadels in Third World–like communities.

Time to Rescue the Uninsured

In 1996, the *Bulk Challenge*, a leaky freighter with 4000 Liberian civil war refugees aboard, sailed along the coast of West Africa for nine days seeking a port while neighboring countries, already overrun with refugees, refused to accept the ship.[5] The vessel had one toilet and little food or water on board. There was an outbreak of dysentery and people began to die. At the time, I remember thinking that for a cost equivalent to one MRI, one could saves hundreds of lives on that boat. We are now in an analogous situation with the uninsured in the United States. The boat is overcrowded and leaky, and people are suffering for want of services.

It is time to rescue the 39 million Americans who are forced to seek care within the system of no-system. If there is to be universal health care, we cannot keep having the same dialogues about the government vs the market, equality vs liberty, efficiency vs bureaucracy. Stripped of all the ideology, the need and the suffering are there, now, plain for all to see. Stop by my waiting room sometime and I'll show you.

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