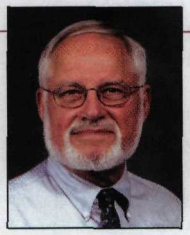
"Covering the Uninsured" Is a Flawed Moral Frame



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A moral *frame* is the crisp, pointed presentation of a complex issue that goes to the heart of the matter.[1] In this article, working with this definition, I will argue that:

- "Covering the Uninsured" (CTU), or some variation of that slogan, is the dominant but unexamined moral frame for those of us who seek health care reform in the United States.
- Unfortunately, however, the CTU frame leads us down the wrong path and does significant disservice to the health care reform movement.
- I propose that we frame reform in terms of *system, not symptom,* along these lines: "Create the system we never built."

To those of us who work within a Catholic context, such a change may sound puzzling at best and traitorous at worst—an abandonment of our commitment to the poor and marginalized. In what follows, I hope to clarify and justify my proposal.

Moral Outcomes and Moral Frames

An essential first step is recognizing the difference between moral outcomes and moral frames.

Moral Outcomes A moral *outcome* is a result—behavioral or structural—that better serves human dignity than does the status quo. In a complex issue like health care reform, there are many desired moral outcomes—covering the uninsured, improving quality, establishing equitable financing, among others. Clearly, a major moral outcome of reform must be coverage for every person.

That we Americans should so prodigally spend our common resources for health care (an annual expenditure greater than France's entire Gross Domestic Product) and exclude from this care more U.S. residents than there are citizens in Canada—this is an outrage that demands change. Because this injustice is so outrageous, it can appear to be at the heart of the moral challenge. But advocating reform aimed at the moral outcome of universal access is one thing; making universal access the moral frame for understanding and strategizing—that's another thing entirely.

Of course, we reform advocates must work in every way we can to get the uninsured covered. Major efforts now under way deserve our support. Nothing I say in this article should be seen as questioning such efforts.

But these efforts should be seen as what they are: alleviating an outrageous symptom, not reforming an outrageous system. I liken efforts to cover the uninsured to supporting the Underground Railroad in 1850. Helping the victims of the brutal injustice of slavery was certainly an immediate and pressing call to conscience. But those who operated the Underground Railroad recognized that their efforts addressed only the *symptoms* of the problem and that its real resolution lay in a *system-level reform—abolition of slavery.*

Moral Frames Moral frames are different from moral outcomes. They are *ethical tools of community enablement. They make it possible for the community to analyze, evaluate, and strategically improve social reality in a comprehensive and abiding way.*

Unfortunately, a desired moral outcome—even an extremely important one—is not necessarily an effective moral frame for achieving that outcome. The most common reason for this discrepancy is that outcomes can exist on the level of *symptoms,* whereas the moral frame needs to address the *root cause* of the symptom. I believe this is precisely the case with "covering the uninsured"—it is a symptom frame, not a root-cause frame.

A Better Rallying Cry

Every successful social movement has galvanized its adherents with a short, pithy call—a trumpet blast of vision and energy. The slogan that has captured the attention of us health care reformers—secular or religious, physician or shop organizer—is some version of CTU. Among reformers, there is virtually no exception. The American Hospital Association, CHA, American Medical Association, Institute of Medicine, U.S. Catholic bishops, Robert Wood Johnson Foundation, Congress—for all, CTU has become the rallying cry of reform (see **Box**, p. 8). The most concise expression of this approach appears on the website of Campaign for a National Health Program Now:

> We reformers are agreed on the nature of the problem. Nearly 44 million people in the United States have no health insurance. Another 40 million are uninsured during some part of every year. Still another 80 million are only partially covered. Worst of all, most people who don't have health care insurance have full-time jobs. . . . We also agree on the solution to the problem: Secure a system of comprehensive national health care for everybody in the United States.[2]

Here we see that the frame is CTU—both the problem and the solution are framed in terms of the uninsured. Below, I will attempt to do two things: 1) explain why this frame is flawed; 2) explain why a system-focused frame is needed.

Why Not "Covering the Uninsured"?

My critique of CTU as a moral frame is grounded in some basic assumptions about moral analysis and action—principally about language, how the mind works, and social change. I will begin by sketching these assumptions.

The human mind cannot work systematically without frames (sometimes called "mental models" or "paradigms"). Just as we cannot write or converse without using words/concepts, we cannot do systematic reasoning without the additional and more complex mental tools called frames. These mental tools manage complexity by focusing, selecting, simplifying, emphasizing, muting, and ignoring.

The scholar Rudolf Arnheim notes that the human eye and mind, working together in the process of cognition, do not simply register images that are "already out there." "We find instead that direct observation, far from being a mere rag picker, is an exploration of the form-seeking, form-imposing mind, which needs to understand but cannot until it casts what it sees into manageable models."[3] So the mind comes with the organizing filters we call frames, using them to render reality as mind-sized pieces that we can mentally manipulate and use for systemic analysis, evaluation, and improvement.

The human mind cannot work systematically without frames.

On any given issue there is a continuum of possible frames—ranging from outstanding to outlandish. Good frames essentially focus our attention on the issue's central dimensions in an integrated and comprehensive way. Good frames stake out hierarchies of importance and keep our minds and hearts on the "big stuff."

Bad frames, on the other hand, are such because they hide and/or severely distort an issue's central dimensions. The historical frames of "slavery as a states' rights issue" or "slavery as an issue of private property"—powerful and tenacious though they were—were bad frames because they obscured slavery's foundational corruption: treating persons as possessions. Still, bad frames can capture and contain the hearts and minds of whole nations for centuries. One way of understanding social movements—those for universal education, woman suffrage, and others—is as a series of victories of better frames over worse ones.

My general argument here is that CTU is a good moral goal, but a bad moral frame. It functions as a major frame that triggers and reinforces many lesser bad frames and buries many essential frames.

Let us examine some subordinate bad frames that can be triggered by CTU.

CTU Can Reinforce the Broad Assumption that Health Care Is a Commodity Commercial insurance is a high-profit, high-cost market good. Most Americans implicitly frame health care as a commodity, a market good—a good for which unions negotiate, a good that comes with better jobs, a reward for growing old and having paid into Social Security.

In all other developed countries and in Catholic

social teaching, health care is recognized as a social good—an indispensable good required for the flourishing of society and the individuals in it. The insurance frame implied by CTU tends to reinforce the common misconception of health care as a market commodity.

CTU Inclines Us to Accept, Rather Than Challenge, Commercial Insurance as an Appropriate Social Mechanism for Providing the Basic Social Good of Health Care Commercial insurance is an appropriate social mechanism for financing and allocating *some* human goods. For other human goods, it is a ridiculous mechanism.

Some social problems can be solved only by a transformation of public understanding and conscience.

If someone were to suggest providing primary education (or national defense or police protection) through the mechanism of commercial insurance, we would immediately recognize that as foolishness. The historical fact is that the United States backed into commercial health insurance as the heart of our system during the national wage freeze imposed during World War II. Offering employer-provided health benefits was one way businesses could circumvent the wage freeze and still attract and retain scarce workers. But our reform efforts should challenge, not silently support, the continuation of such an increasingly wasteful and discriminatory mechanism for gaining access to a basic social good.

CTU Inclines Us to Frame Reform in Terms of Legislative Change Legislative and policy change is, of course, an absolutely necessary aspect of health care reform. But we must remember that although some issues—Balanced Budget Amendment relief, for example, or not-for-profit status—might be effectively addressed in a legislative forum, others cannot. Some social problems, because they are rooted much more deeply in culture and society, can be solved only by a transformation of public understanding and conscience.

In these latter instances—woman suffrage and the abolition of slavery, for example—public-policy and legislative change *follows, and flows from,* such deeper cultural/moral public transformation. There are serious reasons for concluding that health care reform involves such deep cultural/moral transformation.[4] This challenge of transforming public consciousness and conscience is hidden, rather than revealed, by the CTU frame.

CTU Tempts Reformers to Support Almost Any Effort that Expands Coverage, Even If It Also Deepens Longer-Term Systemic Problems To the extent that we reformers tend to see access as the health care problem, we focus our time, energy, and resources on expanding access. Unfortunately, doing so keeps us from examining the ways a short-term effort might involve us in deeper, and longer-term, dysfunctional systems.

An example of such an effort is employer-mandated legislation that promises to expand coverage—but at the price of embracing two dysfunctional components: 1) the volatile and fragmenting mechanism of employer-based coverage; and 2) the discriminatory mechanism of commercial insurance.

CTU Encourages the Public to Find Individuals at Fault, Rather Than a Deeper Systemic Dysfunction When the public hears about health care funding problems, it tends to do so via a frame that encourages moral indignation at those—business people and lawmakers—whom the public holds responsible for the funding. But the lawmakers and business people are not seldom simply trying to be responsible stewards of limited resources in an irrational system. Indignation at people identified as indifferent, callous, and greedy keeps the public (often including us reformers) from recognizing that the root cause is *systemic* corruption, not the corruption of individuals or groups.

CTU Deepens the Public's "We/They" Biases At present, a majority of Americans still have coverage, but see it inflating in cost and eroding in coverage. Studies show that making moral appeals to this threatened majority to expand coverage to the uninsured tends not to awaken the public conscience but to trigger fear and defensiveness and make the uninsured appear as one more threat in an already precarious situation. Increasing the volume and urgency of these appeals can actually exacerbate this alienation quotient.

An Alternative Frame

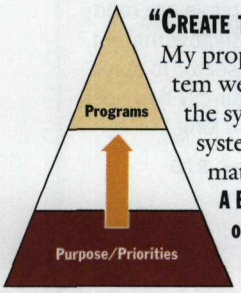
I believe that the quality movement in health care offers us an important lesson that we should apply to the larger question of health care reform: *Systemic dysfunction demands systemic analysis for diagnosis and systemic intervention for lasting improvement.*

Failure to apply this lesson to health care reform has kept us reformers scrambling from symptom to symptom while deeper systemic roots remain invisible and unchanged.

The comments by Lucian L. Leape, MD, on the importance of a system frame for addressing the problem of medical errors can cast some light on our situation:

> Why has healthcare been so lax at error reduction? Principally, I believe, because we have been locked into an ineffective paradigm. That paradigm, which is rarely questioned, is that mistakes can be avoided if everyone is trained not to make them and punished when they do. Some have referred to this as the "train and blame" approach. Not only has it been proved to be ineffective, it is also counterproductive.
>
> This focus on the individual as being solely responsible for his/her errors ignores a large body of scientific information that industry—the aviation industry in particular—has applied extremely effectively to prevent errors. Research in cognitive psychology and human factors has shown that, although errors are almost always made by individuals, error results from defects in the systems in which we work. These are failures in the design and management of processes, tasks, and training, and in the conditions of work that make errors more likely.[5]

We know that moving from the individual to the system frame has transformed the dimension of quality in U.S. health care. How much more important is the system frame for reforming the entire health care enterprise.

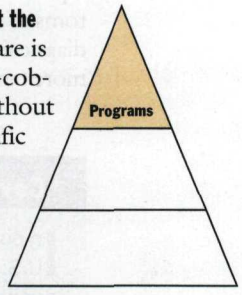


"Create the System We Never Built"

My proposed frame—"Create the system we never built"—puts our focus on the system, not the symptom. Such a system frame presses us to deal with matters like the following.

A Basic Law of Systems: Purpose and Priorities before Programs It is essential that complex social systems grow from a clear and robust vision of the system's particular purpose and from the explicit priorities required to achieve that purpose. Only on such a foundation can the system's infrastructure and program emerge coherently, consistently, and adequately.

This is a law of systems, and it prevails whether the system is a drugstore, a fast-food chain, or the U.S. space program. It has the force of the law of gravity. It will inevitably punish anyone who disregards it, and the punishment will be proportionate to the disregard. The more vast and complex the system, the more robust the consensus on purpose and priorities must be if the system is to function successfully.



The History of U.S. Health Care: Chronic Fixation at the Program Level The history of U.S. health care is one of episodic, crisis-oriented, program-cobbling—piling one program on another without the foundation of clear purpose and specific priorities. This program-cobbling got its start with employer-based insurance—the backbone of current U.S. care. As noted above, employer-based health insurance was introduced as an entrepreneurial strategy, a "loophole remedy" for business during a wartime wage freeze—and having nothing to do with thoughtful health policy.

Twenty years later, despite many thousands of employer-sponsored programs, more than 50 percent of senior citizens were still left without coverage, along with countless mothers and children. In the 1960s, Medicare and Medicaid, run by each of the 50 states, were cobbled together to cover seniors and unmarried mothers. Medicaid itself has proven to be a model of endless cobbling as states react to economic and political changes. California, for example, has developed 58 county-based Medicaid programs and a hefty 800-page eligibility manual to guide them. California employs some 16,000 full-time eligibility workers to certify children for public programs, only to have up to 70 percent of these children needing to be recertified at year's end.

In 1997, 50 further unintegrated State Children's Health Insurance Programs were introduced to this mix—with new criteria, services, and funding—in part to make up for the inadequacy of past patchwork programs intended to provide health care for children. Medicare Part D is a virtual monument to program-cobbling, with 70 different programs in Los Angeles alone.

A systems frame could reveal our Americans fixation on program-cobbling and its cruel and costly consequences. It could turn our attention to root causes and systemic reformation.

A Systems Frame Reveals the Root Cause of Apparently Unrelated Problems The systems frame helps us see the underlying cause of what might otherwise appear as random dysfunctions—including unremitting infla-

tion, the irrational opening or closing of facilities, and underfunding of essential dimensions of the care continuum: mental health, dental care, home health, and others. If we view these as discrete problems, we will pursue them separately with various, often self-contradictory, tools and strategies of repair. If, on the other hand, we see these as symptoms of a common, system-level root cause, our diagnosis, strategy, and transformation will be more comprehensive and abiding.

A Systems Frame Demands Attention to the Indispensable Components of a System and Their Importance for Reform

Systems are not arbitrary couplings of elements—like a string of freight cars in a train. Systems have constitutive, interdependent components—mission, goals, leadership, planning, budgeting, and accountability structures, among others. Systems have essential qualities—integration, subsidiarity, transparency, and comprehensiveness, for example.

"Cover the Uninsured" Is the Dominant Reform Frame

In contemporary talk about U.S. health care reform, the dominant "frame" is "Covering the Uninsured" (CTU).

- In October 2003, Senate Majority Leader Bill Frist (R-TN) announced the creation of a Republican Task Force on the Uninsured charged with taking a fresh look at the issue of the uninsured and developing new policy options for extending coverage to Americans lacking insurance. Frist said that the "uninsured are the next big challenge," the "overriding issue" of the next three years.
- In 2003 the Robert Wood Johnson Foundation, the nation's largest philanthropy devoted exclusively to health and health care, announced that it would help fund "Cover the Uninsured Week," a national event devoted to advocating coverage for those who lack it. (CHA, the U.S. Chamber of Commerce, the AFL-CIO, and some 800 other organizations are cosponsors.) 2006 will see the fourth Cover the Uninsured Week.
- In September 2004, CHA's board unanimously approved the Covering a Nation (CAN) project.
- Covering America: Real Remedies for the Uninsured, a program conducted by the Washington, DC-based Economic and Social Research Institute (www.esresearch.org) also frames the problem in CTU terms. In introducing its program, the institute says, "We have put in place a structure designed to draw the best, most knowledgeable, and most creative policy thinkers and analysts who are concerned with fundamental reform and achieving the ultimate goal of universal coverage."
- The American Medical Association (AMA) has also developed a plan "to work toward a solution to the persistently high portion of the United States population lacking health insurance."[1] The AMA plan "presents a number of steps that can be taken to assure that individuals are fully enabled to obtain not only health insurance, but specifically the health insurance that they want."
- Between October 2001 and June 2003, the Institute of Medicine's Committee on the Consequences of Uninsurance published six reports whose very titles—*Insuring America's Health: Principles and Recommendations; Hidden Costs, Value Lost: Uninsurance in America; A Shared Destiny: Community Effects of Uninsurance; Health Insurance Is a Family Matter; Care Without Coverage: Too Little, Too Late; Coverage Matters: Insurance and Health Care*—suggest the breadth and depth of the "cover the uninsured" frame in the nation's discussion of the problem.
- In its September 2004 advocacy bulletin, St. Joseph Health System, Orange, CA, stated that, "as a nation, we need to find common sense solutions to the challenge of extending health coverage to all Americans. Hospitals are ready to join forces with government and the private sector to solve a problem that simply has been neglected far too long."

—John W. Glaser, STD

NOTE

1. American Medical Association, *Expanding Health Insurance: The AMA Proposal for Reform*, Chicago, 2003, p. 1, available at www.ama-assn.org /ama1/pub/upload/mm/363/expandinghealthinsurance.pdf.

The system frame can awaken us to how indispensable a system is for an enterprise as big and complex as U.S. health care; to how starkly naked of essential systemic components U.S. health care is; and to how inevitable are the many injustices and irrationalities that occur in such a system-nakedness. We are in the situation of trying to manage a socioeconomic reality the size of Germany, but with no constitution; no federal/state governing structures; and no coherent and integrated system of laws, taxes, or fiscal stewardship.

A Systems Frame Emphasizes the Importance of the General Public If U.S. health care is ever to leave behind its current addiction to crisis-triggered "fixes" at the program level and become a true system, it will do so as the result of a broad public consensus, strong and clear enough to demand bold action from legislators who are unclear and politically disoriented by their dependence on numerous special interests. And because a public movement will be required, we reformers must begin thinking about how such movements are begun, nurtured, and brought to fruition.

A Systems Frame Reminds Us Reformers that We Have Embarked on a Long Journey Systemic framing, unlike the notion of legislative "fixes," calls us to think in terms of longer time frames. It helps those who do the framing to calibrate their expectations, because it suggests a multiphased process with various coherent, short-term goals that ultimately lead to an agreed-on endpoint. The process is long but has an internal coherence that can be mapped and measured.

Beyond "Fixes" to Creating a System

Justice and compassion demand short-term, immediate work to provide care to all U.S. residents who are currently excluded by our brutal and Byzantine practices. Such efforts are about covering the uninsured.

Justice and compassion demand long-term creation of a system we have never built. Such a system will, indeed, cover the uninsured but it will do far more. Its success will be accelerated by a frame that wrestles with the entire system, not one of its symptoms. ■

NOTES

1. An excellent resource for understanding and utilizing frames in policy can be found at the website of the Frameworks Institute, www.frameworks institute.org.
2. "Healthcare for All—We Can Do It Now," Campaign for a National Health Program Now, available at www.healthcare-now.org.
3. Rudolf Arnheim, *Visual Thinking,* University of California Press, Berkeley, CA, 1969, p. 278.
4. See John W. Glaser, "Health Care Reform Demands Seismic Shift in Thinking," *Network Connection,* March-April, 2004, pp. 3-5; and Daniel Callahan, *False Hopes: Overcoming the Obstacles to a Sustainable, Affordable Medicine,* Simon and Schuster, New York City, 1998, especially pp. 13-24.
5. Lucian L. Leape, "Can We Reduce Medical Errors?" *Ethical Currents,* vol. 51, Fall 1997, p. 1.