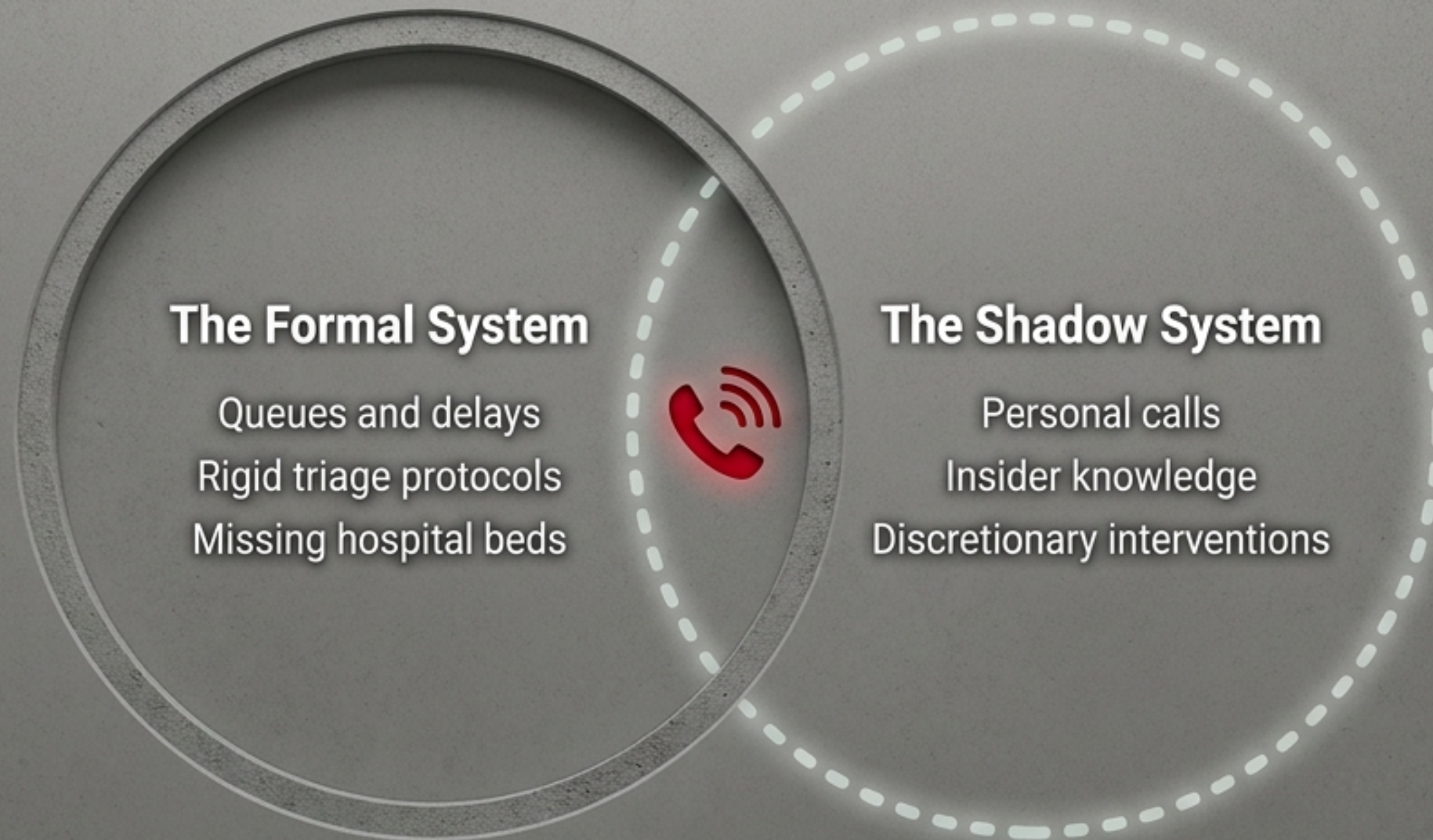


THE ENCLOSURE OF HEALTHCARE

Moving from Rescue by Connection to Care by Right.



A Caribbean-Grounded Global Analysis by Dr. Bichara Sahely.



The Incident

A doctor makes a private call to a colleague to secure a hospital bed for a sick relative.

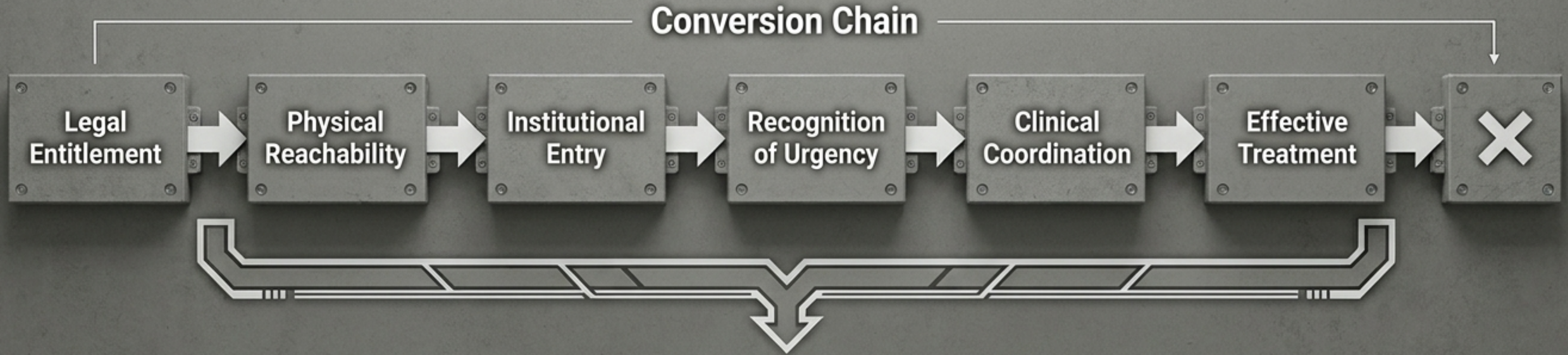
The Ethical Friction

It is a humane act of professional solidarity. But what happens to the similarly ill patient who lacks money, transport, social status, or a personal connection inside the institution?

The Insight

The true operating principles of a health system are revealed by what a frightened family must actually do to obtain timely care.

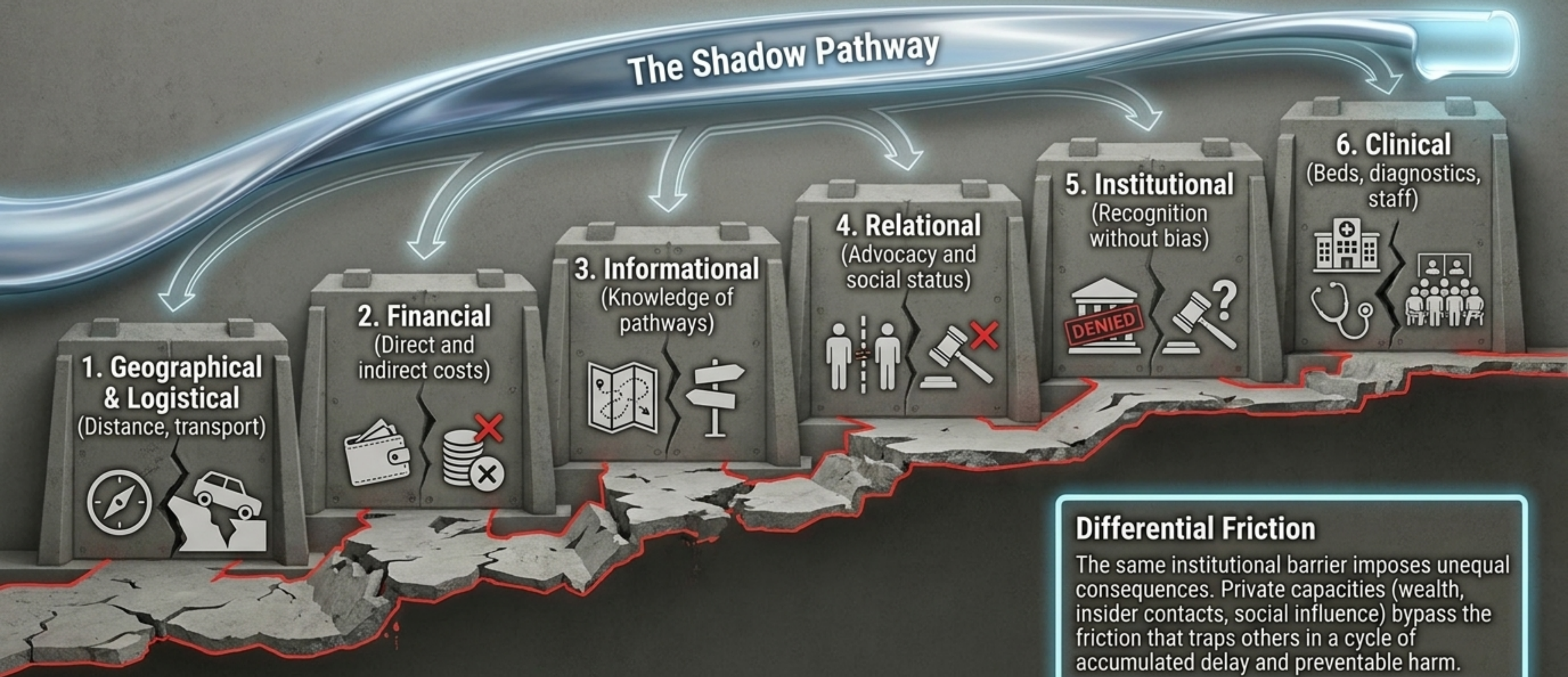
Formal availability does not equal practical access



**FAILURE AT ANY SINGLE LINK NULLIFIES
THE ENTIRE FORMAL ENTITLEMENT.**

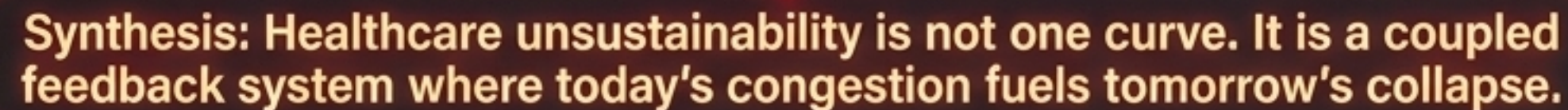
A bed, a specialist, and a policy do not equal access if a patient cannot navigate the gap between nominal availability and usable care. Formal inclusion without timely reachability is clinically absent.

The shadow access system and the six gates of friction

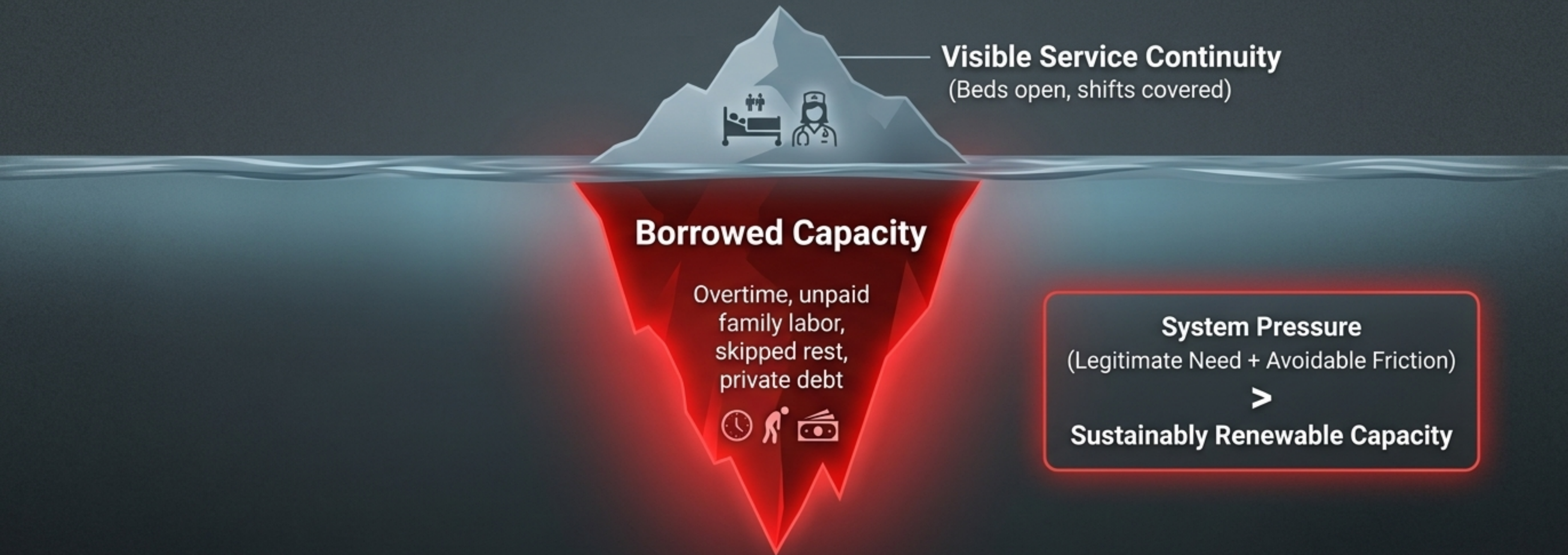


Loop 1 (Demand): Disease-producing environments drive preventable illness.

Loop 4 (Workforce): Emergency overload drives severe workload, triggering moral injury and workforce departure, which further crushes the remaining capacity.

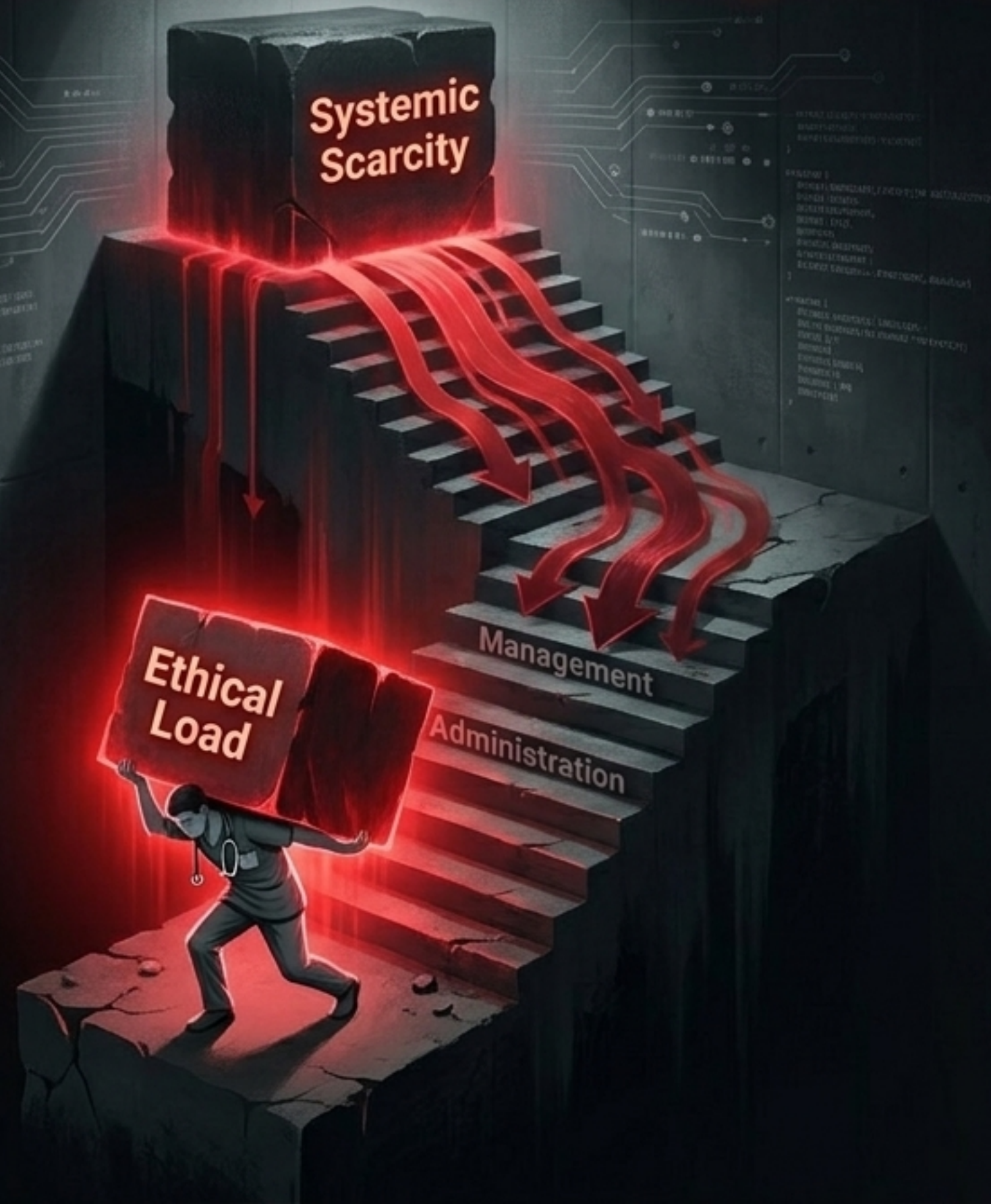


The Viability Gap: Surviving today by consuming tomorrow



The system appears to function only because compassionate workers and families absorb its deficits. Normalized sacrifice conceals structural failure.

Institutional self-consumption and the transfer of moral injury



Ethical Load Transfer: When an institution lacks resources, coordination, or authority, the unresolved burden does not disappear. It is pushed downward.

The Frontline Reality: The worker is left holding an impossible residue—knowing what the patient needs, knowing the institution cannot provide it, yet remaining personally answerable to the suffering person.

The Consequence: The institution preserves short-term administrative function by systematically consuming the ethical, relational, and physical capacities of the workers required for long-term care. Migration becomes a personal strategy for survival.

The small-island context accelerates systemic fragility

The Small-Numbers Paradox

In large systems, losing a specialist is a strain. In small states, losing one intensivist, engineer, or specialist nurse disables an entire national capability.

Import Dependence

Procurement is not functional capacity. A device is useless without regional supply chains, maintenance contracts, and specialized technicians.

Geography as a Clinical Determinant

A referral decision is not care. Transfer is only complete when a patient physically crosses water, roads, and weather to reach a team. Transport is the clinical pathway.

The reactive-care trap demands a dual-capacity approach



The Trap: Acute illness imposes an immediate moral demand. Resources continuously **shift downstream** to rescue, starving long-term protection and ensuring future crisis demand rises.

The False Choice: We cannot indefinitely expand acute care to compensate for disease-producing conditions. But we also **cannot abandon rescue** for **pure prevention**.

The Solution: We must build a **Dual-Capacity approach**—reducing avoidable demand upstream while continuously **renewing** equitable response capacity downstream.

Distributed responsibility: Responsibility must rise with power

Actor	Primary Capacity	Corresponding Responsibility
Individuals	Daily self-care	Truthful communication, timely help-seeking
Health Professionals	Clinical judgment, advocacy	Competent care, disclosing unsafe conditions
Health Institutions	Workflow, staffing, data	Safe staffing, transparent pathways, equitable triage
Governments	Law, infrastructure, social policy	Universal access, workforce planning, health-supporting conditions
Commercial Actors	Product design, pricing, marketing	Prevent foreseeable harm, safe work environments

The Guiding Rule: Responsibility corresponds to actual power, knowledge, and control. Access follows need.

Designing the Life-Coherent Health System



The Definition:

An organized social system whose policies and practices prevent avoidable harm, enable equitable access, restore human capacities, and renew the material conditions required for future care.

The Governing Ethical Test:

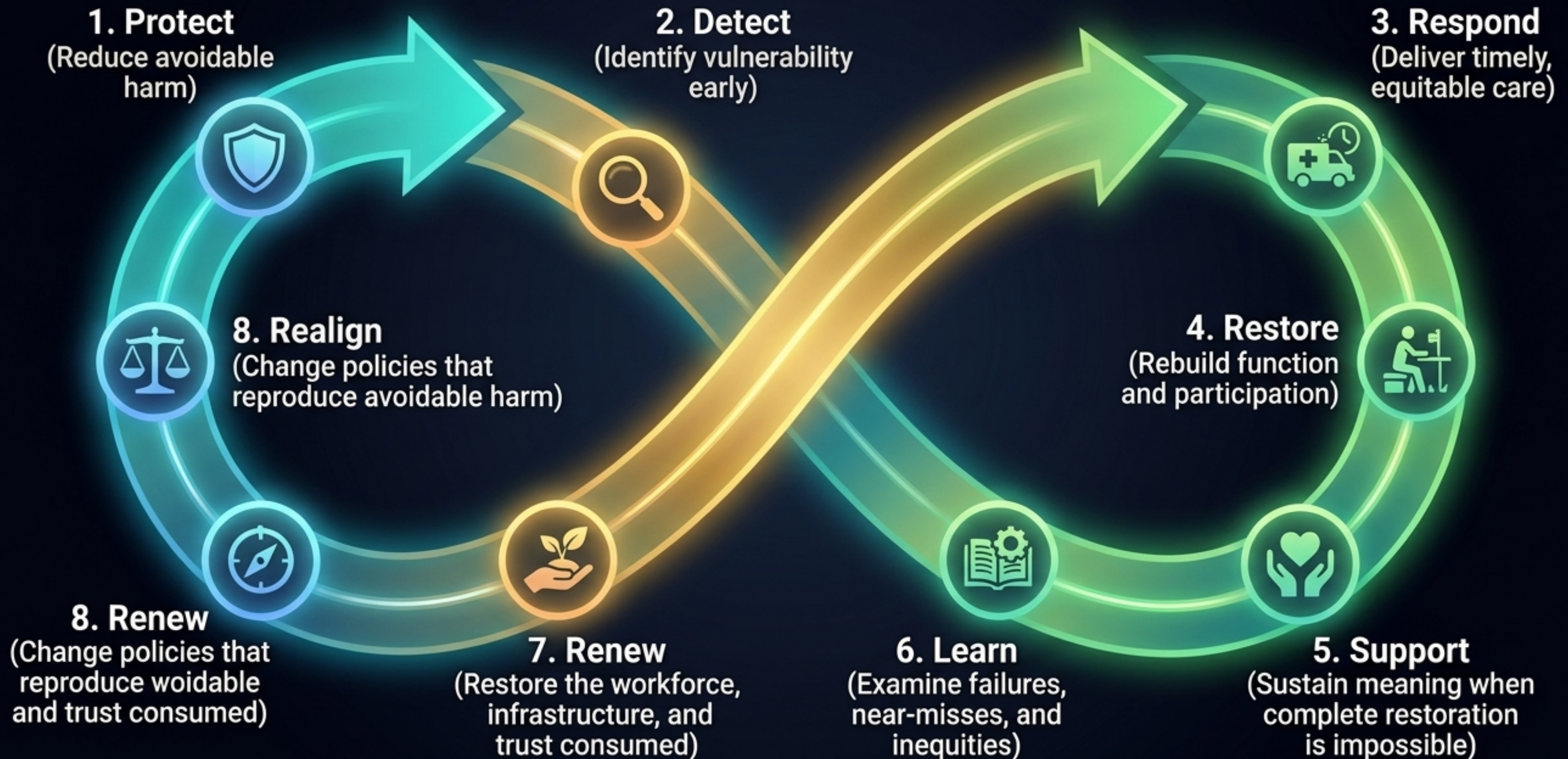
Does this policy, institution, technology, or practice protect, restore, or enlarge the capacities of living persons and the systems that sustain them?

Seven pillars of a life-coherent architecture



Core message: Capacity in one domain depends entirely on capacity in the others.

The Regenerative Loop: Care does not end at discharge



The Transition: From Enclosure to Life-Coherence

ENCLOSED REACTIVE SYSTEM



Privilege-mediated navigation
(Shadow access dictates who is seen).



Downstream concentration
(Late/severe presentation overloads emergencies).



Opaque discretion and
informal workarounds.



Workforce sacrifice
and moral injury.



LIFE-COHERENT SYSTEM

Universal navigation and
escalation (Clear protocols
ensure no one is lost).



Upstream & downstream
balance (Manageable
acute demand).



Transparent pathways
and accountability.



Workforce viability and
ethical agency.





Care by Right

Human solidarity should enrich a functioning system, not compensate for institutional absence.

Every person—regardless of income, location, or connections—must be able to convert legitimate need into timely, dignified care.

It is time to design systems that protect life today without consuming the capacity needed for tomorrow.