

THE ENCLOSURE OF HEALTHCARE

Shadow Access, Emergency Overload, Moral Injury,
and the Transition to Life-Coherent Health Systems

A Caribbean-Grounded Global Analysis

ACADEMIC WHITE PAPER



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“Responsibility rises with power; access follows need.”

Life-Coherence Framework

Suggested Citation

Sahely, B. (2026). The enclosure of healthcare: Shadow access, emergency overload, moral injury, and the transition to life-coherent health systems—A Caribbean-grounded global analysis. Academic white paper.

AI Use Disclosure

Generative artificial intelligence was used under the author's direction to assist with conceptual development, literature identification, drafting, structural editing, and visual design. The author determined the argument, selected and reviewed the evidence, revised the interpretations, and retains full responsibility for the accuracy, integrity, and final content of the work.

Abstract

Healthcare systems across diverse political and economic settings are confronting a convergent crisis of preventable disease, emergency congestion, unequal access, escalating cost, workforce depletion, and declining public confidence. These pressures are commonly treated as separate problems—insufficient funding, inadequate beds, fragmented patient flow, unhealthy behaviour, professional burnout, or poor governance. This paper argues that they are interacting expressions of a single system architecture. The analysis begins with a reconstructed and fully de-identified critical incident originating in a private professional conversation. A physician seeking assistance for a hospitalized relative activated a colleague within the institution. The compassionate intervention exposed a deeper question: what happens to the similarly ill patient who lacks money, transport, professional knowledge, social status, or a personal connection inside the healthcare system? The paper develops six linked concepts. Healthcare enclosure occurs when a nominally shared life-good becomes practically accessible according to privately held capacities. The shadow access system consists of personal advocacy, insider navigation, private payment, and improvised professional workarounds that compensate for unreliable formal pathways. Differential friction describes how the same institutional obstacles impose unequal consequences upon persons with different resources. The multiple curves of healthcare unsustainability connect preventable illness, acute deterioration, congestion, cost, unequal access, workforce attrition, and public distrust. The healthcare viability gap arises when legitimate need and avoidable system friction exceed sustainably renewable capacity. Institutional self-consumption occurs when services preserve short-term function by depleting the workers, relationships, and material conditions required for future care. The paper rejects the false choice between structural reform and personal responsibility. Individual agency matters, but responsibility should correspond to actual power, knowledge, freedom, capacity, and control. A life-coherent health system must reduce avoidable illness while preserving credible capacity for unavoidable illness. It must combine health-supporting public policy, trusted primary care, coherent emergency and critical-care pathways, universal navigation, workforce viability, accountable governance, and regional cooperation. Its governing ethical test is whether policies and practices protect, restore, and enlarge human life-capacity without consuming the persons and conditions required for future care. The required transition is from rescue by connection to care by right.

Keywords

healthcare enclosure; shadow access system; differential friction; emergency-department crowding; patient boarding; patient navigation; primary health care; health promotion; disease prevention; moral distress; moral injury; burnout; workforce attrition; social determinants of health; health equity; universal health coverage; Caribbean health systems; small island developing states; healthcare viability gap; institutional self-consumption; life-coherent healthcare; civil commons

Executive Summary

A health system reveals its true operating principles not only through legislation, policies, and organizational charts, but through what a frightened family must actually do to obtain timely care. The critical incident that prompted this

paper began when a physician sought help navigating care for a hospitalized relative with a potentially serious infection. A colleague within the institution offered assistance. The intervention was humane and professionally understandable. The need for it was diagnostically important.

The conversation soon produced an informal access formula: reliable transportation, substantial funds, social standing, and a direct relationship with someone inside the institution. Other clinicians described emergency-department congestion, admitted patients remaining in emergency areas, critical-care constraints, transfer difficulties, operational bottlenecks, and similar experiences in several health systems. The exchange exposed a shadow access system operating alongside the formal service: personal calls, insider knowledge, professional advocacy, private payment, and improvised workarounds that help particular patients cross institutional barriers.

The shadow system can protect life, but its protections are unequally distributed. Patients possessing financial, geographical, informational, relational, and institutional capacities can often reduce or bypass friction. Patients without those capacities face accumulated delay, repeated attempts, uncertainty, debt, abandonment of care, or deterioration. A service can therefore be publicly owned and formally universal while its practical use becomes privately mediated. This paper names that process healthcare enclosure.

The analysis is grounded in the Caribbean but addresses a global pattern. Jamaican policy documents already recognize fragmented referrals, inadequate continuity, pressure on emergency departments, workforce challenges, maintenance problems, and the need for integrated primary care. The 2026 report of the University Hospital of the West Indies Institutional Review Committee separately documented longstanding governance, management, oversight, and financial weaknesses while affirming the hospital's major national and regional contribution. The private conversation is not used to prove any clinical allegation; it is an interpretive seed whose themes are examined against official and scholarly evidence.

Healthcare unsustainability is not one curve but several reinforcing curves: preventable disease; acute deterioration caused by delayed detection or weak continuity; emergency and inpatient congestion; escalating downstream expenditure; widening access inequality; workforce exhaustion and departure; and public distrust leading to later presentation. These curves converge in a healthcare viability gap: legitimate need and avoidable friction exceed sustainably renewable clinical and institutional capacity.

Institutions often close this gap temporarily through borrowed capacity—overtime, skipped rest, unpaid professional labour, family caregiving, insider intervention, and private out-of-pocket substitution. Borrowed capacity preserves service today by consuming the capacity required for tomorrow. The system appears to function because compassionate workers and families absorb its deficits. This is institutional self-consumption.

Burnout alone does not capture the ethical dimension. Moral distress occurs when professionals know what ethically appropriate care requires but cannot provide it because of constraints. Moral injury may arise when those constraints are repeated, severe, or experienced as institutional betrayal. A clinician may be exhausted by volume yet injured by repeatedly witnessing treatable suffering, apologizing for delays, rationing inadequate attention, or being held personally answerable for conditions beyond professional authority.

Prevention is indispensable but cannot replace credible acute care. People will continue to experience infections, injuries, malignancies, obstetric emergencies, and unpredictable deterioration. Equally, acute-care expansion cannot indefinitely compensate for disease-producing conditions, weak primary care, and delayed intervention. A sustainable system must reduce avoidable demand while renewing equitable response capacity.

The dispute between personal responsibility and structural responsibility is therefore a false choice. Individual agency matters, but responsibility must be proportional to power, knowledge, freedom, capacity, and control. Governments, institutions, employers, commercial actors, communities, families, professionals, and individuals possess different powers to shape health and must carry correspondingly different obligations. The guiding rule is: responsibility rises with power, while access follows need.

The paper proposes a life-coherent health-system architecture with seven mutually dependent domains: health-supporting social and ecological conditions; trusted primary and preventive care; emergency, inpatient, and critical-care capacity; access justice and universal navigation; workforce viability; accountable governance and resource

stewardship; and regional cooperation, resilience, and pooled capacity. These domains are linked through a regenerative cycle: Protect → Detect → Respond → Restore → Support → Learn → Renew → Realign.

The practical transition is from heroic rescue to dependable reliability. Human solidarity should remain, but it should enrich a functioning system rather than compensate for institutional absence. The goal is that every person—including the poor, rural, disabled, unconnected, and socially marginalized—can convert legitimate need into timely, dignified, effective care without privileged mediation and without destroying the workers upon whom future care depends.

Central thesis

Contemporary healthcare unsustainability arises not simply because demand exceeds funding, but because many systems permit disease-producing conditions to persist, concentrate resources downstream, distribute practical access through unequal private capacities, and compensate for institutional weakness by consuming the moral and physical reserves of patients, families, and health workers.

Ethical, Methodological, and Positionality Statement

This paper was prompted by a private professional messaging-group discussion concerning healthcare access, hospital congestion, critical-care scarcity, prevention, and professional distress. The conversation is used solely as a reflective critical incident and conceptual seed. It is not presented as a representative dataset, verified clinical case, formal qualitative study, or evidentiary basis for allegations against any person or institution.

The opening vignette is reconstructed, condensed, and generalized. No names, telephone numbers, specific facilities, or directly identifying details from the conversation are reproduced. No verbatim statement made by another participant is published. Reported clinical events are treated as experiences and perceptions communicated within the discussion, not as adjudicated findings of fact. No conclusion is drawn about the clinical management, responsibility, or preventability of any individual outcome.

Institutional claims are based on independently available policy documents, official reviews, and scholarly evidence. The paper distinguishes three evidentiary levels: lived testimony, which reveals how systems are experienced; documented policy and research evidence, which assesses broader patterns; and conceptual interpretation, which develops the life-coherent framework advanced here. Any subsequent empirical study of the concepts proposed in this paper should undergo appropriate research-ethics review.

The author is a Caribbean internist and was a participant in the originating discussion. This positionality provides experiential knowledge of clinical work, healthcare access, professional burnout, and moral injury, while also shaping interpretation. The paper therefore makes its normative commitments explicit and invites empirical testing rather than presenting its conceptual constructs as settled measures.

Ethical boundary

The humane act of helping a colleague's relative is not treated as wrongdoing. The ethical concern is the unequal necessity for such intervention when ordinary pathways are unreliable.

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1. Introduction: When Care Depends on Connection

1.1 A critical incident

A physician learns that a family member has been admitted to hospital with a potentially serious infection. Concerned about deterioration and uncertain about what is happening, the physician asks a professional group whether anyone knows a clinician in the emergency department or admitting medical service. A colleague happens to be present at the institution and offers assistance.

At one level, the episode is ordinary. Medicine depends on collegiality, consultation, and professional solidarity. Clinicians routinely help one another identify responsible teams, interpret uncertainty, and communicate urgent concerns. Such cooperation is part of the relational fabric of care.

At another level, the event poses a disturbing counterfactual: what happens to the similarly ill patient whose family has no physician, no professional network, no colleague inside the hospital, and no one able to translate institutional complexity into effective action? The ethical problem is not that one patient received help. It is that timely recognition and navigation may be more reliably available to those able to activate privileged relationships.

The conversation that followed widened the lens. Participants described access as dependent on transportation, money, social status, and insider relationships. Others reported comparable pressures in different countries, severe emergency-department congestion, admitted patients waiting in emergency areas, critical-care scarcity, transfer problems, uncertain procedures, and mundane logistical failures with major clinical consequences. The discussion moved from individual navigation to the sustainability of the entire healthcare architecture.

1.2 Three overlapping systems

The incident revealed three systems occupying the same institutional space. The formal system consists of laws, policies, facilities, professional roles, referral pathways, triage protocols, and publicly stated entitlements. The operational system consists of what patients and workers actually encounter: queues, missing information, scarce beds, changing rules, delayed diagnostics, informal workarounds, and variable coordination. The shadow access system consists of the personal calls, private payments, professional networks, insider knowledge, and discretionary interventions used to make an unreliable operational pathway work.

The formal and operational systems are never identical. Complex organizations always require judgment, adaptation, and informal cooperation. The shadow system becomes ethically significant when its use is not exceptional enrichment but a recurrent condition of timely access. At that point, non-clinical privilege begins to influence whether a patient is seen, heard, transferred, investigated, or treated in time.

Official Jamaican policy documents already identify many components of this gap. Vision for Health 2030 recognizes the need to balance prevention and treatment while improving accountability, efficiency, coordination, human resources, bed capacity, maintenance, and administration. Jamaica's Primary Health Care Reform 2021–2030 acknowledges that seamless movement, continuity, and information-sharing remain incomplete and seeks integrated, client-centred networks linking individual care, population health, and prevention (Ministry of Health & Wellness, Jamaica, 2019, 2022). These documents show that the problem is not absence of policy insight; it is the difficult conversion of recognized priorities into dependable lived pathways.

1.3 Research question and contribution

This paper asks: How can health systems move from reactive, socially enclosed, and workforce-depleting arrangements toward life-coherent systems that prevent avoidable illness, provide equitable access to necessary care, and preserve the human capacities upon which healthcare depends?

Its contribution is conceptual and integrative. It develops six linked constructs—healthcare enclosure, shadow access, differential friction, multiple curves of unsustainability, the healthcare viability gap, and institutional self-consumption—and joins them to a practical architecture for reform. The framework is Caribbean-grounded because small-island contexts expose the consequences of limited redundancy, workforce loss, transport barriers, import

dependence, and climate vulnerability with particular clarity. It is global because the underlying mechanisms recur across differently financed systems.

Governing ethical question

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

2. Healthcare Enclosure and the Shadow Access System

2.1 Availability is not access

Health systems often describe capacity through the presence of facilities, personnel, beds, equipment, programmes, and covered services. These measures are necessary, but they do not establish whether a person can convert formal entitlement into timely and effective care.

A service can exist without being meaningfully accessible. A hospital may possess an emergency department while a patient lacks transportation. A specialist may be employed while the referral pathway is opaque or delayed. A bed may be physically present while staffing or coordination prevents its use. A diagnostic service may be listed as available while equipment downtime, supply shortages, or unaffordable charges place it beyond reach. A patient can enter an institution yet remain unable to obtain recognition, movement, or definitive treatment.

Universal health coverage requires access to quality services when and where they are needed without financial hardship across promotion, prevention, treatment, rehabilitation, and palliative care. The 2025 global monitoring report shows that progress has slowed and that large gaps in service coverage and financial protection persist (World Health Organization & World Bank, 2025). Formal inclusion that cannot be translated into timely usable care is administratively present but clinically absent.

**Formal entitlement → reachability → entry → recognition → coordination → treatment
→ continuity → protected or restored life-capacity**

Healthcare access is a conversion chain; failure at any link can nullify nominal availability.

2.2 The six gates of practical access

The originating discussion can be generalized into six gates that patients must traverse:

1. Geographical and logistical access: distance, transport, ambulance reliability, opening hours, roads, weather, and the ability to leave work or caring responsibilities.
2. Financial access: direct charges, indirect costs, transport, medication, diagnostics, lost income, accommodation, family care, and the risk of catastrophic expenditure.
3. Informational access: knowledge of where to go, how urgent the situation is, which documents are needed, how referrals operate, and whom to contact when the pathway fails.
4. Relational access: the presence of someone able to advocate, translate, attract attention, or use social and professional connections.
5. Institutional recognition: whether suffering and urgency are recognized as legitimate rather than discounted through stigma, bias, disability, age, communication style, or social status.
6. Coordinated clinical capacity: the ability to convert recognition into action through staff, diagnostics, medicines, equipment, beds, transport, referral acceptance, and continuity.

2.3 Differential friction and private access capacities

The same institutional obstacle does not impose the same consequence on every person. A delayed public diagnostic test may be an inconvenience to someone able to pay privately and a dangerous interruption to someone who cannot.

An unclear referral process may be manageable for a clinician's family and impenetrable for a person with limited literacy or no advocate. Transport delay may be bypassed by a private vehicle but become decisive for a rural or island patient.

This unequal burden is differential friction. The friction is generated institutionally, but its effects are distributed according to private capacities: money, transport, information, confidence, social influence, family availability, and functional ability. Healthcare enclosure occurs when these privately held capacities become necessary to unlock or accelerate a nominally shared public good.

Enclosure does not require legal privatization. A publicly funded service can become enclosed in practice when the means of converting entitlement into effective care are privately supplied. The public finances the institution, while households privately finance the transport, navigation, advocacy, waiting, and substitution required to make it usable.

2.4 The ethical ambiguity of shadow access

The shadow access system is adaptive infrastructure. It emerges because people cannot always trust formal pathways to recognize urgency, coordinate movement, or communicate clearly. Personal telephone calls, informal consultations, private diagnostics, appeals to administrators, and exceptional effort by staff can prevent harm. They often express the best of professional solidarity.

The same system is stratifying. Its protections are distributed according to social capital and purchasing power. People already disadvantaged by poverty, rurality, disability, migration, stigma, or social isolation are also less likely to possess influential networks. A shadow system can therefore save individual lives while reproducing population-level injustice.

The proper response is neither to shame patients and families for seeking help nor to forbid clinicians from helping. Reform should universalize the humane functions that insider assistance provides: orientation, urgency recognition, communication, coordination, escalation, and accountability. What privileged patients obtain through a personal contact should become part of ordinary care.

Non-blaming principle

Patients and professionals should not be condemned for using informal relationships to protect life where formal pathways are unreliable. The target of reform is the unequal dependence upon such relationships.

FIGURE 1. FROM FORMAL ENTITLEMENT TO EFFECTIVE CARE: HEALTHCARE ENCLOSURE AND THE SHADOW ACCESS SYSTEM

Healthcare access is a conversion process. Failure at any gate prevents timely and effective care.

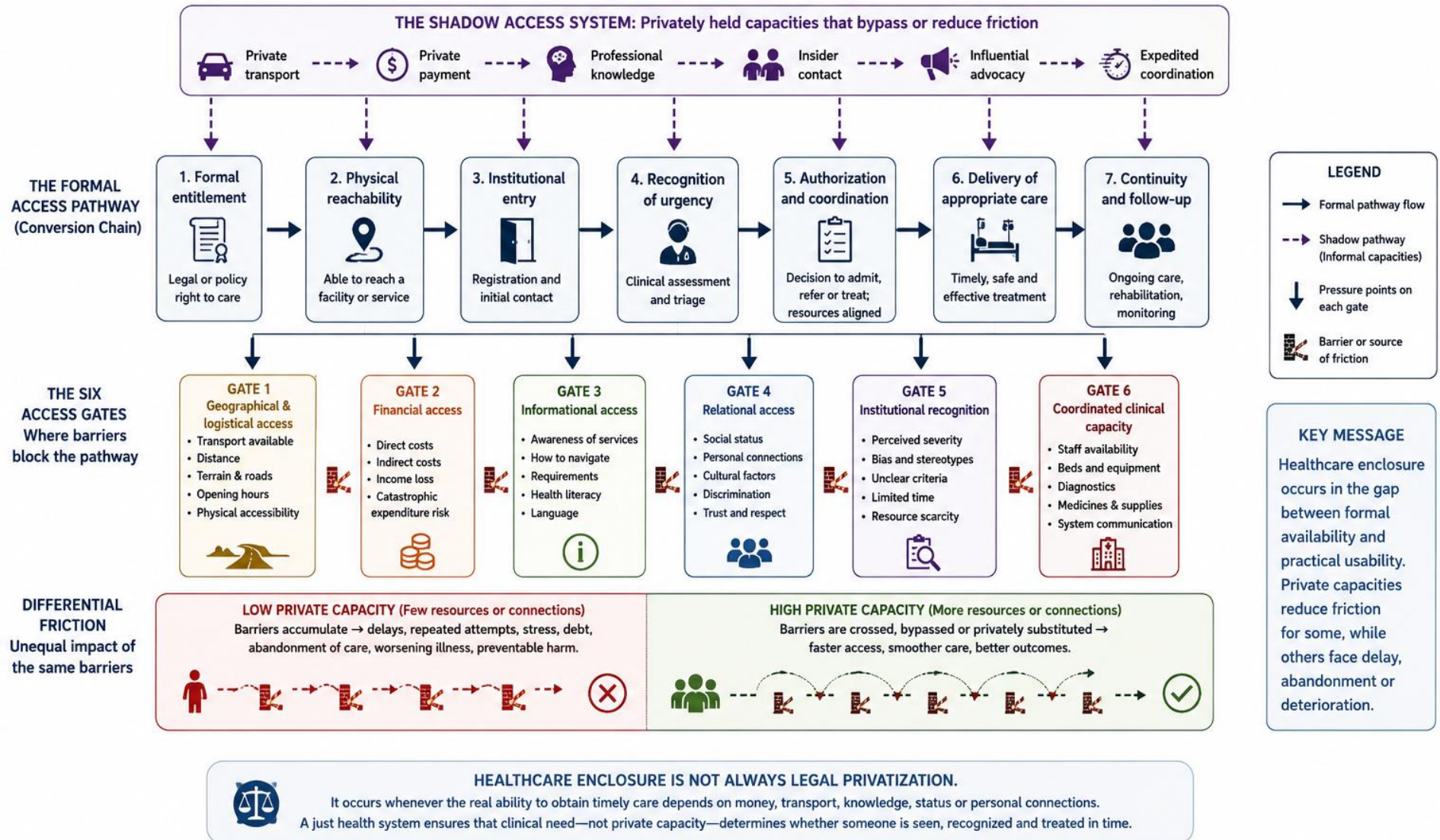


Figure 1. From formal entitlement to effective care: healthcare enclosure and the shadow access system. Access is a conversion process rather than a binary entitlement. Private capacities may reduce friction for some patients while others accumulate delay, abandonment, or deterioration. A just system makes clinical need—not private capacity—the primary determinant of recognition and timely treatment.

3. The Multiple Curves of Healthcare Unsustainability

3.1 Beyond a single crisis curve

The language of “flattening the curve” captures an important systems principle: even when total need is theoretically manageable, a health system can fail when demand is concentrated beyond available capacity. Contemporary healthcare confronts not one curve but several coupled curves that intensify one another.

The first is the preventable disease curve. Noncommunicable disease, mental distress, injuries, avoidable complications, and environmentally or commercially mediated harms increase the population’s need for care. The 2025 WHO report on social determinants of health equity emphasizes that health is powerfully shaped by the conditions in which people are born, grow, live, work, and age, together with access to power, money, and resources (World Health Organization, 2025a).

The second is the acute-deterioration curve. Chronic illness does not automatically become emergency demand. Deterioration is mediated by primary-care access, medication availability, monitoring, continuity, early diagnosis, health literacy, transport, and trust. Hypertension becomes stroke, diabetes becomes renal failure or infection, heart failure becomes respiratory distress, and treatable infection becomes sepsis when upstream detection and response fail.

The third is the congestion curve. Emergency attendance, boarding, inpatient occupancy, delayed transfer, postponed procedures, and critical-care scarcity interact across the whole system. Reviews consistently describe emergency crowding as a system-level problem whose causes extend beyond the emergency department and whose consequences include delayed care, compromised adherence to recommended treatment, poor patient experience, and safety risk (Morley et al., 2018; Sartini et al., 2022; Agency for Healthcare Research and Quality, 2025).

The fourth is the financial-escalation curve. Late, severe, and complex disease consumes intensive resources—emergency intervention, advanced diagnostics, dialysis, surgery, critical care, prolonged hospitalization, and repeated admission. As downstream demand absorbs budgets and attention, less capacity remains for prevention, continuity, maintenance, and workforce renewal. Households also absorb transport, medication, diagnostic, caregiving, and lost-income costs.

The fifth is the access-inequality curve. When formal capacity becomes scarce, the value of private money, information, mobility, and influence rises. Scarcity therefore does not affect everyone equally; it increases the return on privilege.

The sixth is workforce depletion. Overload increases time pressure, moral conflict, sickness absence, reduced hours, migration, retirement, and departure. Each loss raises the burden on those who remain, producing a reinforcing loop.

The seventh is public distrust. When people expect long waits, disrespect, failed referrals, unavailable medication, or unaffordable costs, they may delay care. Delay increases severity, which intensifies congestion and confirms the expectation that the system is difficult to use.

3.2 Coupled feedback rather than isolated failure

These curves are commonly divided among programmes: noncommunicable disease, emergency care, finance, human resources, quality, and public education. Specialization is necessary, but fragmented management can hide causal interaction. Poor chronic-disease control increases emergency demand; congestion compromises care and damages trust; distrust leads to later presentation; later presentation increases severity and cost; excessive workload drives workforce departure; departure further weakens chronic-disease continuity.

The same logic applies to governance and material reliability. Procurement or maintenance failure delays diagnosis and treatment, prolongs length of stay, reduces usable bed capacity, increases cost, and burdens staff. An apparently administrative weakness becomes a clinical determinant.

3.3 The healthcare viability gap

A health system is viable when its capacities are sufficient to meet legitimate need and are continuously restored. The relevant quantity is not merely current output, but sustainably renewable capacity.

System pressure = legitimate need + avoidable friction + preventable harm

Healthcare viability requires sustainably renewable capacity to remain sufficient relative to this pressure over time.

Healthcare viability gap = system pressure – sustainably renewable capacity

The gap widens when demand rises, friction accumulates, or capacity is depleted faster than it is renewed.

3.4 Borrowed capacity

Institutions often conceal the viability gap through borrowed capacity. Workers extend shifts, skip meals and rest, accept unsafe workloads, make personal calls, perform unpaid coordination, and carry responsibilities beyond formal roles. Families remain at bedsides, transport patients, purchase supplies, and monitor deteriorating relatives. Those with resources substitute private diagnostics or treatment. These actions can preserve short-term service.

Borrowed capacity is not free. It transfers the cost into worker illness, family burden, debt, attrition, and future incapacity. The system appears functional because the losses are distributed outside formal accounts. When sacrifice becomes normalized, today's compassion conceals tomorrow's collapse.

3.5 Tipping points and nonlinear decline

Health systems do not always deteriorate smoothly. A small staffing loss may be absorbed when reserve exists and destabilizing when every unit is already at its limit. One unavailable bed may seem minor but can propagate backward through wards, emergency care, ambulances, and community services. One specialist's departure can disrupt an entire national service in a small state.

Near a tipping point, delays lengthen, communication becomes brittle, errors and conflict rise, sickness absence increases, experienced workers leave, mentoring deteriorates, and leaders have less time to redesign the system. The institution becomes consumed by surviving the present and progressively less capable of preventing the future.

FIGURE 2. THE MULTIPLE CURVES OF HEALTHCARE UNSUSTAINABILITY AND THE HEALTHCARE VIABILITY GAP

Reinforcing loops drive demand, overwhelm capacity, injure the workforce and displace prevention.

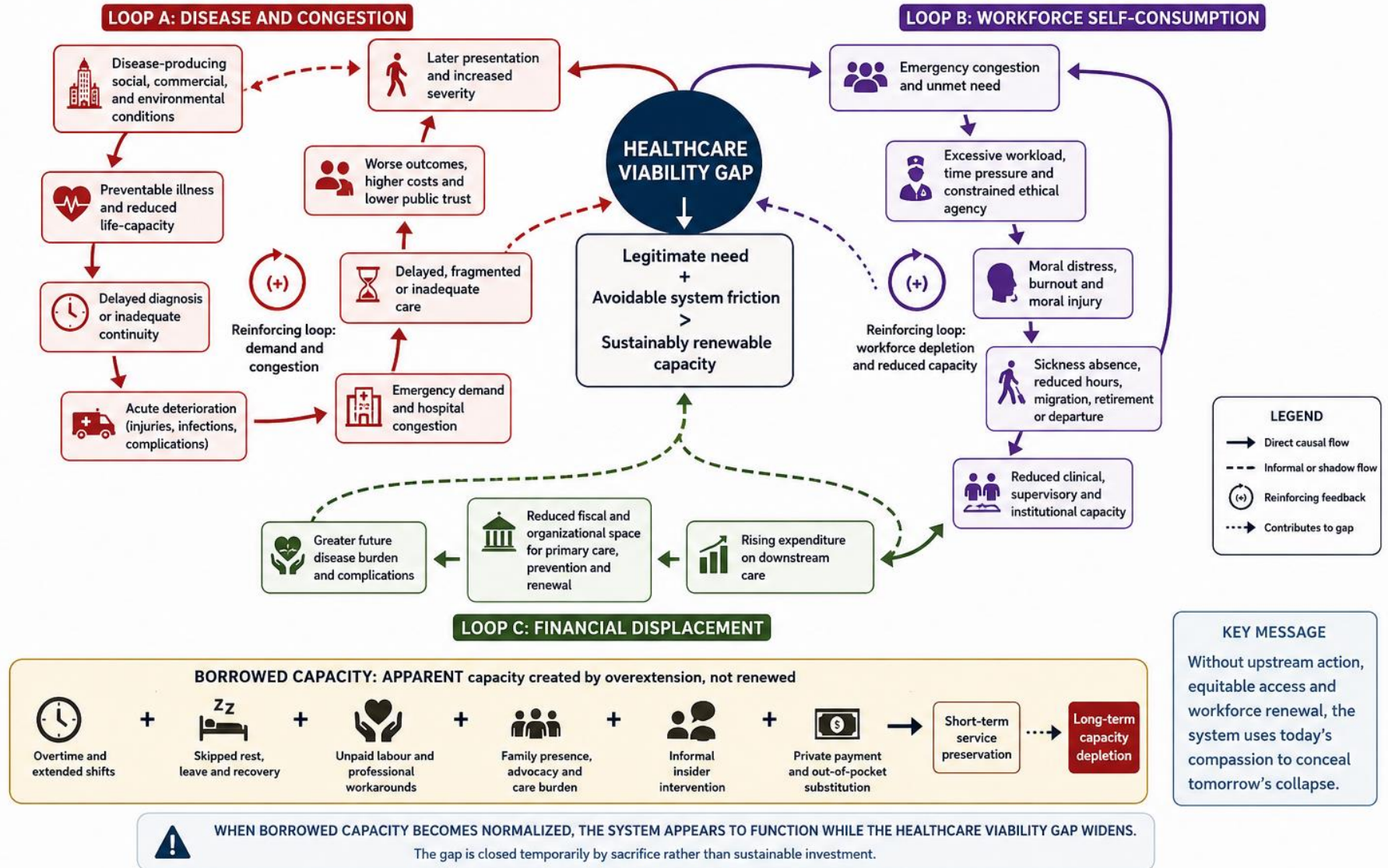


Figure 2. The multiple curves of healthcare unsustainability and the healthcare viability gap. Disease and congestion, workforce self-consumption, and financial displacement form reinforcing loops. Borrowed capacity creates the appearance of short-term continuity while deepening long-term depletion.

4. The Reactive-Care Trap: Prevention, Acute Capacity, and Distributed Responsibility

4.1 Why downstream rescue dominates

Acute illness imposes an immediate moral demand. A patient with sepsis, stroke, myocardial infarction, respiratory failure, trauma, or obstetric emergency cannot wait for long-term social reform. Hospitals and emergency services therefore command attention, financing, and political visibility. Their outputs are countable and dramatic: beds opened, ambulances purchased, scanners installed, operations performed, lives rescued.

Prevention has a visibility problem. Its successes are events that do not occur. No emergency admission records the myocardial infarction prevented by years of blood-pressure control. No intensive-care statistic records the infection treated early in primary care. Prevention's costs are immediate, while its benefits are distributed across future budgets, institutions, families, and political terms.

This asymmetry creates the reactive-care trap: crisis demand rises, resources shift downstream, prevention and continuity weaken, and future crisis demand rises further. The trap persists even when leaders sincerely endorse prevention because immediate rescue repeatedly displaces long-term protection.

4.2 Prevention and acute capacity are complements

A simplistic prevention narrative can become another form of abandonment. Even the healthiest population will experience infection, injury, congenital disease, malignancy, ageing, obstetric emergencies, and unpredictable deterioration. A life-coherent system must maintain reliable emergency, surgical, inpatient, critical-care, rehabilitation, and palliative capacity.

The opposite error is to imagine that downstream expansion can indefinitely compensate for preventable disease-producing conditions. More emergency rooms, beds, dialysis units, and intensive-care spaces will be rapidly absorbed if the inflow of severe illness continues to increase. Sustainable care therefore requires a dual-capacity strategy: reduce avoidable demand and renew equitable response capacity.

Primary health care provides the bridge. WHO defines it as a whole-of-society approach integrating comprehensive services, multisectoral action on wider determinants, and the empowerment of individuals, families, and communities (World Health Organization, 2025b). Jamaica's reform programme similarly emphasizes integrated, client-centred networks and coordination across the life course (Ministry of Health & Wellness, Jamaica, 2022).

Dual-capacity imperative

A sustainable health system must reduce the avoidable production of serious illness while continuously renewing its capacity to respond to unavoidable illness.

4.3 Prevention beyond lifestyle instruction

Prevention is often narrowed to advice: eat better, exercise more, stop smoking, reduce alcohol, take medication, attend screening, and seek help earlier. These actions matter, but advice does not create the conditions required to follow it.

A person may be advised to eat nutritiously while healthy food is unaffordable, to exercise while working multiple jobs or living in an unsafe neighbourhood, or to attend follow-up while transport is unreliable and clinic hours conflict with employment. Commercial systems may aggressively promote harmful products and then attribute the resulting disease burden to deficient personal discipline. The social and commercial organization of choice must therefore be included in any serious account of prevention.

Life-coherent prevention joins clinical prevention, public-health protection, health-supporting social policy, regulation of commercial determinants, environmental protection, community capacity, and individual agency supported by genuine options.

4.4 The capacity and power conditions of responsibility

Individual agency is real, but responsibility is meaningful only where a person possesses some genuine capacity to act differently. That capacity depends on knowledge, comprehension, realistic alternatives, material resources, physical and psychological ability, freedom from coercion, and a reasonable expectation that the action will help.

A second principle concerns actors who shape the field of choices. Governments influence transport, housing, food policy, education, labour, taxation, regulation, and health-service access. Institutions shape waiting, continuity, communication, and medication availability. Employers shape time, income, and occupational exposure. Commercial actors shape formulation, price, marketing, and political influence. Responsibility should rise with the power to create, amplify, prevent, or repair harm.

The relevant standard is therefore neither punitive individualism nor paternalistic denial of agency. It is proportionate, distributed responsibility.

4.5 A distributed responsibility matrix

Actor	Primary capacities	Corresponding responsibilities
Individuals	Daily self-care, communication, participation	Reasonable self-care, truthful communication, adherence where feasible, timely help-seeking where accessible, and respect for others.
Families and communities	Mutual aid, accompaniment, local knowledge, social norms	Support vulnerable persons, sustain health-promoting relationships, communicate priorities, and participate in local prevention.
Health professionals	Clinical knowledge, judgment, advocacy, stewardship	Provide competent and respectful care, communicate clearly, disclose unsafe conditions, learn continuously, and advocate ethically.
Health institutions	Workflow, staffing, equipment, data, organizational authority	Ensure safe staffing, transparent pathways, continuity, functional equipment, equitable triage, learning, and worker protection.
Governments	Law, taxation, financing, regulation, infrastructure, social policy	Secure universal access, public-health capacity, health-supporting conditions, workforce planning, accountability, and equitable financing.
Commercial actors	Product design, price, marketing, employment, political influence	Prevent foreseeable harm, market truthfully, provide safe work, accept environmental responsibility, and avoid obstructing health policy.

Shared-responsibility formula

Responsibility should be distributed according to power, knowledge, freedom, capacity, and control. Causal understanding should guide prevention; it should never determine a person's human worth or right to care.

5. Emergency Congestion, Operational Friction, and Blocked Flow

5.1 Congestion is a whole-system output

Emergency departments are the visible pressure gauge of the health system. They receive undifferentiated illness, social distress, delayed primary-care problems, ambulance arrivals, and patients who have no other dependable point of access. When admitted patients cannot move to inpatient beds, incoming patients encounter reduced space, delayed assessment, fragmented monitoring, and longer exposure to risk.

Boarding is not simply an emergency-department inefficiency. It reflects the relationship among community access, ambulance services, diagnostics, specialty review, admission authority, ward staffing, critical care, operating theatres, discharge coordination, rehabilitation, long-term support, and social care. A bottleneck anywhere in the pathway propagates backward.

The AHRQ summit on emergency-department boarding emphasizes that boarding is a patient-safety and public-health problem requiring hospital-wide and system-wide action rather than solutions confined to the emergency department (Agency for Healthcare Research and Quality, 2025). This is consistent with international reviews identifying input, throughput, and output causes of crowding (Morley et al., 2018; Sartini et al., 2022).

5.2 The patient-flow chain

Community and primary care → transport → emergency assessment → diagnostics → specialist decision → admission or transfer → inpatient care → discharge → rehabilitation and follow-up

Flow depends on the reliability of every transition, not merely the efficiency of any single department.

5.3 Small frictions, large consequences

Some high-impact failures are mundane: a ward bed opens but no porter is available; a nurse cannot safely accept a patient during a shift transition; an ambulance awaits authorization; a diagnostic result is not communicated; a device is purchased without maintenance support; a discharge is delayed because medication, transport, home support, or follow-up cannot be arranged. Each delay appears local while its consequences accumulate system-wide.

Operational friction is clinically important because time has different biological meanings. A two-hour administrative delay may be tolerable for one condition and catastrophic for another. Safe systems therefore require clear escalation rules, real-time information, and authority aligned with responsibility.

Friction also produces inequality. Patients with clinicians in the family, assertive advocates, private transport, or money can sometimes cross blocked boundaries. Those without such resources experience the full delay. Operations management is therefore inseparable from access justice.

5.4 Governance as a clinical determinant

Governance is sometimes treated as distant from bedside care. In reality, governance determines whether roles are clear, financial information is credible, procurement is lawful, equipment is maintained, accountability exists, and corrective action follows known failures. These conditions shape the clinical environment.

The 2026 UHWI Institutional Review Committee affirmed the hospital's major contribution to Jamaican and regional health while concluding that chronic governance and management failures, ambiguous responsibility, inadequate oversight, poor compliance, strategic-planning weaknesses, and financial challenges had reduced institutional effectiveness (UHWI Institutional Review Committee, 2026). The report did not adjudicate any individual clinical case. Its relevance here is systemic: excellent clinicians can compensate for governance weakness for a time, but the compensation itself can deepen dependence on heroic labour and informal problem-solving.

Governance is therefore a distal but powerful clinical determinant. Procurement, reporting, maintenance, workforce planning, and authority lines are not administrative abstractions; they determine whether recognition can become treatment.

5.5 Universalizing navigation and escalation

The shadow system reveals functions that the formal system must provide. A personal contact often offers orientation, interprets urgency, identifies the responsible team, coordinates a transition, reassures the family, and creates accountability. These are components of quality care, not luxuries.

Health systems can institutionalize them through patient-navigation services, named care coordinators, publicly accessible referral criteria, transfer centres, real-time capacity information, integrated records, family communication standards, independent advocates, and escalation pathways when deterioration occurs or care stalls. Navigation programmes can improve linkage between primary care and community health and social services, although implementation must be adapted to local needs and evaluated carefully (Teggart et al., 2023).

The goal is not identical waiting for every patient. It is clinically equitable movement in which urgency and need, rather than influence, determine priority.

6. Moral Injury and Institutional Self-Consumption

6.1 The workforce is not merely an input

Health-system planning often treats labour as a count of physicians, nurses, pharmacists, technicians, porters, administrators, and community workers. Staff numbers matter, but they do not capture the living capacities through which care is produced: attention, judgment, memory, ethical commitment, trust, practical experience, teamwork, and relational continuity.

A hospital can possess buildings, beds, medicines, and equipment while remaining unable to deliver coherent care if the human relationships that connect these elements have deteriorated. Workforce capacity includes competence, psychological safety, institutional memory, ethical agency, and the physical and emotional ability to remain attentive under pressure. These capacities are renewable but not inexhaustible.

6.2 Burnout, moral distress, and moral injury

Burnout, moral distress, and moral injury overlap but should not be collapsed. Burnout concerns the effects of chronic occupational stress—exhaustion, detachment, cynicism, and diminished efficacy. Moral distress occurs when a professional recognizes the ethically appropriate action but is constrained from carrying it out. Moral injury refers to deeper moral or spiritual harm that may arise when a person perpetrates, witnesses, fails to prevent, or experiences betrayal in relation to events that violate deeply held commitments.

In healthcare, moral injury may accumulate rather than arise from one dramatic event: repeatedly apologizing for delays one cannot correct; knowing that a patient requires closer monitoring while carrying an unsafe workload; watching treatable illness worsen because transfer or access failed; discharging patients into conditions likely to reproduce illness; or feeling compelled to normalize practices that violate professional standards.

The empirical literature remains conceptually heterogeneous, but organizational pressures, workload, resource constraints, hierarchy, inability to provide appropriate care, and institutional relationships recur as important triggers of moral distress and moral injury (Čartolovni et al., 2021; Beadle et al., 2024). These experiences should not be medicalized as individual weakness when their sources are organizational.

6.3 Ethical load transfer

When an institution lacks sufficient resources, coordination, or authority, the unresolved burden does not disappear. It moves downward and outward: from hospital to family, management to frontline worker, daytime service to night team, primary care to emergency care, public system to private expenditure, or formal process to individual conscience.

The frontline worker is left holding an impossible residue: the patient needs this; the institution cannot provide it now; and I remain personally answerable to the person who is suffering. This is ethical load transfer. The system preserves administrative continuity by transferring the moral consequences of scarcity to those closest to the patient but least able to repair the causes.

Patients may interpret the worker as uncaring. Workers may interpret structural inability as personal failure. Anger moves horizontally between persons injured by the same arrangement while the vertical source of the failure remains obscured.

6.4 The compassion paradox and borrowed labour

Healthcare institutions frequently survive because professionals do more than formal roles require. They remain after shifts, make calls from home, purchase supplies, arrange informal referrals, find beds, transport samples, mentor colleagues, and follow patients outside assigned duties. Families supply unpaid monitoring, transportation, feeding, and emotional care.

These acts are admirable, but they create a compassion paradox: the more committed the workforce and families, the longer an incoherent system may continue without confronting the full consequences of its design. Extraordinary effort becomes normalized, and institutions acquire a hidden subsidy composed of unpaid time, emotional overextension, and conscience.

The correct response is not to discourage generosity. It is to stop governing as though generosity were an unlimited resource.

6.5 Institutional self-consumption and migration

Institutional self-consumption occurs when an organization maintains current function by depleting the capacities required for future function. Chronic understaffing, repeated overtime, inadequate rest, unsafe environments, moral conflict, unreliable equipment, and the expectation of silent compensation gradually erode attention, health, trust, mentoring, and institutional memory.

As reserves decline, errors and near misses become more likely, staff conflict increases, sickness absence rises, experienced workers reduce hours or leave, junior staff lose supervision, and recruitment becomes harder. The institution consumes not only current labour but future capacity.

Migration can be a personal strategy of repair. A clinician may leave for safer conditions, predictable schedules, functioning equipment, professional autonomy, education for children, or relief from chronic ethical conflict. For the source country, the loss includes much more than one vacant post: public investment, specialist expertise, mentorship, leadership, networks, and service redundancy. PAHO's Health Workforce 2030 policy identifies shortages, maldistribution, planning failures, difficult conditions, and retention challenges as threats to resilient systems (Pan American Health Organization, 2023). Jamaica's health labour market analysis is intended to examine supply, distribution, performance, compensation, retention, and migration in a systematic way (Pan American Health Organization, 2025a).

6.6 From worker wellness to workforce viability

Counselling, peer support, reflective practice, rest, and resilience-building can help workers recover. They become incoherent when used as substitutes for changing predictably harmful conditions. Mindfulness cannot create a missing nurse, repair a transfer pathway, maintain a ventilator, or give a clinician sufficient time to assess an unsafe number of patients.

Workforce viability is more fundamental than wellness. A viable workforce has sufficient numbers, distribution, competence, material support, authority, protection, and restoration to meet legitimate need without chronic self-sacrifice. It requires safe staffing, predictable rest and leave, psychological safety, ethical agency, reliable equipment, fair recognition, participatory governance, and intelligence about why workers remain, reduce hours, retire, migrate, or leave.

Workforce covenant

The institution will not preserve access for today by predictably destroying the persons needed to provide access tomorrow.

7. Caribbean and Small-Island Health-System Viability

7.1 Shared global pattern, distinctive regional constraints

The pressures described in this paper are not uniquely Caribbean. Emergency congestion, unequal access, cost escalation, and workforce strain occur in wealthy and lower-resource systems. The Caribbean nevertheless has distinctive conditions that affect the intensity and reparability of these pressures.

Caribbean health systems vary in income, population, geography, governance, and institutional development. They should not be treated as homogeneous. Many nonetheless share small populations, dispersed island or rural geography, limited specialist pools, dependence on imported medicines and equipment, exposure to international price and supply shocks, outward migration, high noncommunicable-disease burdens, limited fiscal space, climate vulnerability, and reliance on overseas referral for selected services.

7.2 The small-numbers paradox

In a large system, the departure of one specialist may be absorbed across several institutions. In a small state, one intensivist, anaesthetist, specialist nurse, biomedical engineer, laboratory professional, or pharmacist may represent a substantial share of national capacity. The same applies to equipment: one failure can eliminate an entire service rather than merely reduce throughput.

This is the small-numbers paradox: absolute losses may appear numerically minor while producing disproportionately large functional effects. Performance assessment must therefore ask not only how much capacity exists, but how concentrated it is, whether backup exists, how quickly it can be restored, and whether regional alternatives are reliably accessible.

7.3 Geography, transport, and referral completion

Island and rural geography shapes time to care. Referral may depend on roads, ambulances, ferries, aircraft, weather, night-time staffing, immigration or administrative clearance, receiving-facility acceptance, and the family's ability to travel. A referral decision is not the completion of care. Transfer is complete only when the patient reaches an appropriate team within a clinically meaningful interval.

Transport is therefore part of the clinical pathway, not an external convenience. A coordinated transport and transfer service may be among the highest-leverage reforms for reducing deterioration, emergency congestion, and rural inequity.

7.4 Import dependence and life-cycle capacity

Many Caribbean systems depend on imported medicines, consumables, equipment, parts, fuel, and technical expertise. A device can be acquired yet become unusable because maintenance contracts are absent, consumables are incompatible, replacement parts are delayed, or trained technicians are unavailable.

This distinguishes acquisition capacity from functional capacity. Procurement is life-coherent only when it considers the full service ecology: staff, training, power, space, consumables, maintenance, repair, data integration, and replacement. A purchase is not capacity until it can be operated reliably over time.

7.5 Climate, disaster, and routine-system resilience

Small island developing states are particularly exposed to hurricanes, extreme heat, water insecurity, coastal hazards, disrupted transport, and supply-chain interruption. Health facilities must maintain power, water, communications, essential supplies, safe buildings, trained staff, and backup referral arrangements through disruption.

PAHO's Smart Health Care Facilities initiative links structural and operational safety with environmental sustainability and disaster resilience in Caribbean facilities (Pan American Health Organization, 2023b). Its deeper lesson is that emergency resilience depends on routine capacity. Strong primary care, reliable laboratories, communication, maintenance, and supply systems are simultaneously everyday services and emergency infrastructure.

Resilience must include transformation. Returning after a shock to the same congested, inequitable, workforce-depleting baseline is not sufficient.

7.6 Regional cooperation as pooled life-capacity

No small state can efficiently reproduce every specialist service, reference laboratory, procurement system, training programme, biomedical-engineering function, and emergency reserve. Regional cooperation is therefore not optional diplomacy; it is a method of pooling life-protective capacity.

Regional public goods can include shared specialist networks, reciprocal transfer agreements, pooled procurement, reference laboratories, teleconsultation, joint training, portable credentials, coordinated workforce planning, regional stockpiles, and shared biomedical engineering. Their effectiveness depends on operational protocols for acceptance, transport, financing, handover, information, and continuity—not goodwill alone.

The Caribbean health-workforce roadmap for 2025–2030 reflects growing recognition that workforce viability requires coordinated regional action (Pan American Health Organization, 2025b). Ethical regionalism must protect worker freedom while improving conditions, training capacity, career pathways, return opportunities, and shared posts so that neighbouring states do not merely compete for the same scarce professionals.

8. A Life-Coherent Architecture for Health-System Repair

8.1 Healthcare as a life-grounded civil commons

Healthcare is commonly described as an economic sector, professional service, fiscal liability, or collection of institutions. Each description is partial. At its foundation, healthcare is part of the civil commons: organized social provision through which a community secures conditions necessary for life and human flourishing (McMurtry, 2013).

Its primary value cannot be reduced to revenue, throughput, bed occupancy, procedures, or return on investment. The governing outcome is viable life-capacity: the ability to breathe, move, think, communicate, relate, care, learn, work, participate, recover, and live meaningfully with limitation. A health system must also protect the conditions that make future care possible—workers, trust, knowledge, social solidarity, ecological stability, public financing, and institutional memory.

8.2 Definition

Life-coherent health system

An organized social system whose policies, resources, relationships, and clinical practices prevent avoidable harm, enable equitable access, restore or support human capacities, protect dignity and agency, address upstream causes of illness, and renew the human and material conditions required for future care.

8.3 Seven interdependent domains

7. Health-supporting social and ecological conditions: food, housing, education, decent work, transport, water, sanitation, environmental protection, climate resilience, social protection, and regulation of health-damaging commercial practices.
8. Trusted primary and preventive care: first contact, continuity, screening, vaccination, early detection, chronic-disease management, community outreach, rehabilitation, and connection with social services.
9. Emergency, inpatient, and critical-care capacity: transparent triage, timely diagnostics, safe admission, surgery, critical care, transport, transfer, patient flow, discharge, and follow-up.

10. Access justice and universal navigation: understandable information, no wrong door, patient navigation, escalation, financial protection, disability access, rural access, and independent advocacy.
11. Workforce viability: safe staffing, fair conditions, rest, leave, occupational safety, psychological safety, development, ethical agency, retention, and return pathways.
12. Accountable governance and resource stewardship: clear authority, transparent finance, life-cycle procurement, maintenance, evidence-informed policy, quality improvement, integrity, and public reporting.
13. Regional cooperation, resilience, and pooled capacity: shared specialists, diagnostics, procurement, training, information, emergency support, disaster readiness, and service recovery.

8.4 The regenerative loop

The domains operate through a regenerative cycle:

- Protect: reduce avoidable biological, social, commercial, and environmental harm.
- Detect: identify vulnerability, disease, and deterioration early.
- Respond: deliver timely, proportionate, safe, and equitable care.
- Restore: rebuild function and participation as fully as possible.
- Support: sustain meaningful life where complete restoration is not possible.
- Learn: examine failures, near misses, inequities, and lived experience.
- Renew: restore the workforce, infrastructure, trust, and resources consumed through care.
- Realign: change policies, incentives, environments, and institutional rules that reproduce avoidable harm.

This loop prevents healthcare from ending at discharge. Every clinical encounter can inform prevention; every failure can generate learning; every act of care must be accompanied by renewal of the capacities that made it possible.

The architecture also clarifies what efficiency is for. Throughput that exhausts staff is not life-coherent efficiency. Cost reduction that transfers burden to families is not economy. Digitalization that automates fragmentation is not integration. Prevention that blames individuals while leaving disease-producing environments intact is not prevention.

FIGURE 3. THE LIFE-COHERENT HEALTH-SYSTEM ARCHITECTURE

A health system organized to protect, restore and enlarge human and community life-capacity.

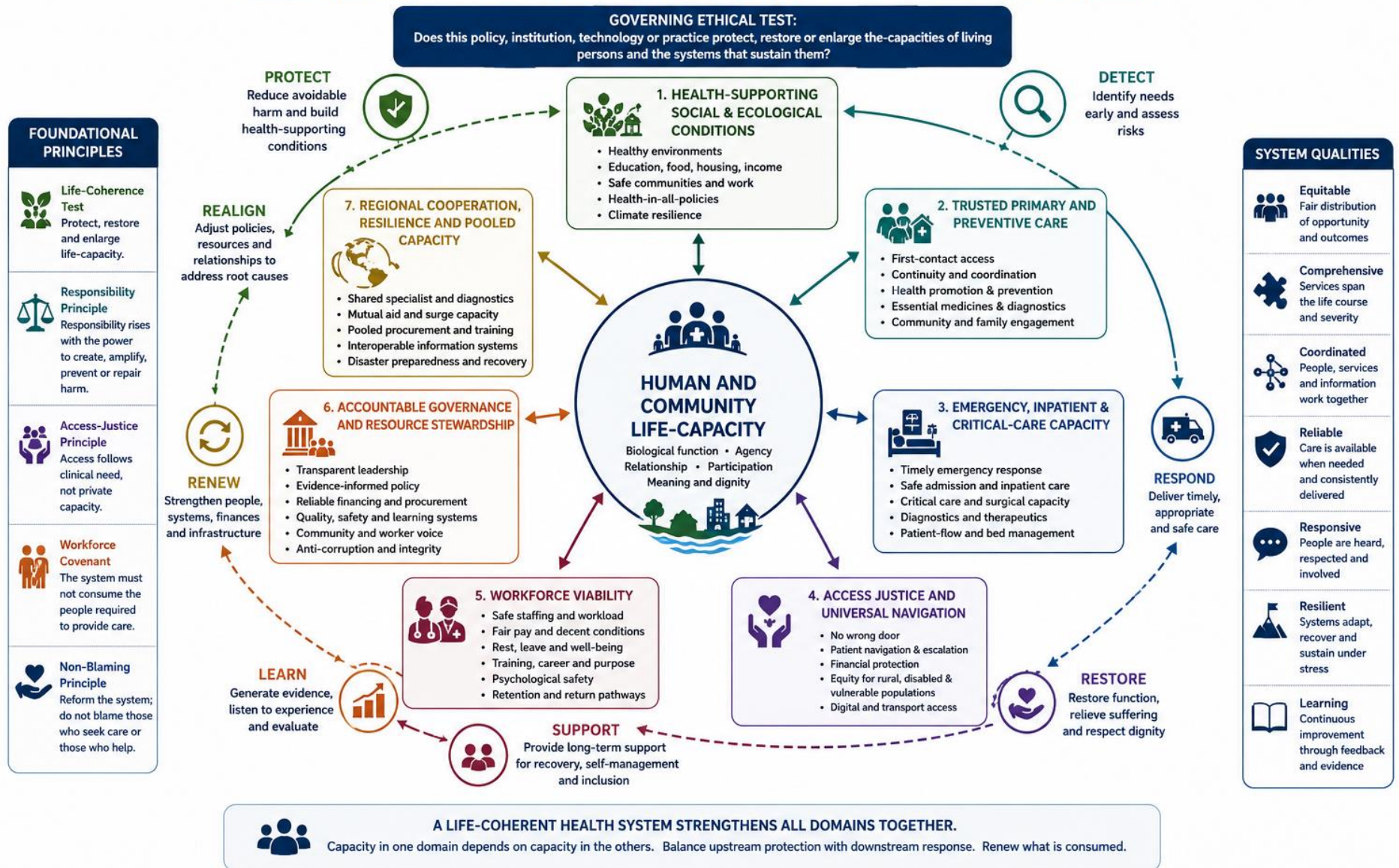


Figure 3. The life-coherent health-system architecture. Human and community life-capacity is the organizing purpose. Seven mutually dependent domains are linked through a regenerative loop of protection, detection, response, restoration, support, learning, renewal, and realignment.

9. From Policy Recognition to Operational Transformation

9.1 The implementation paradox

Many health systems do not lack diagnosis. Policy documents already recognize the importance of primary care, prevention, workforce retention, integration, maintenance, governance, resilience, and equity. Yet lived pathways remain fragmented. A system may know what must change while remaining organized in ways that prevent the change from occurring.

Policies can endorse prevention while budgets remain dominated by downstream rescue. Plans can endorse integration while information, authority, payment, and professional hierarchies remain fragmented. Workforce strategies can emphasize retention while daily conditions continue to drive departure. The implementation gap is therefore not simply lack of will; it is misalignment among purpose, authority, resources, workflow, incentives, accountability, and learning.

9.2 The implementation-conversion chain

**Problem recognition → shared purpose → legitimate authority → protected resources
→ operational responsibility → workflow redesign → frontline adoption →
measurement → corrective action → institutionalization**

A policy becomes real only when the entire conversion chain functions.

Problem recognition without shared purpose produces competing explanations. Shared purpose without authority produces powerless reform teams. Authority without resources produces unfunded mandates. Resources without workflow redesign add staff or technology to dysfunctional processes. Redesign without frontline participation produces protocols that do not fit practice. Measurement without accountability produces recurring reports and no correction.

Healthcare reform should therefore be treated as capacity-building rather than announcement. A reform is not complete when a programme is launched, equipment is purchased, or a committee is appointed. It is complete when ordinary pathways function under pressure, responsibilities are clear, performance is visible, inequities are detected, and the system adapts without depending on exceptional individuals.

9.3 Friction and shadow-system audits

Transformation should begin where patients and workers repeatedly lose time, information, dignity, or clinical opportunity. A health-system friction audit maps failed contacts, repeated registration, missing records, unclear referrals, delayed diagnostics, equipment downtime, bed-transfer barriers, stockouts, discharge delays, and uncertainty about responsibility.

A shadow-system audit asks where personal intervention is routinely required: Which stages depend on knowing the right person? Which tasks occur through unofficial messaging? Which staff function as indispensable but unrecognized coordinators? Which services require private substitution? What happens when key informal helpers are absent? Who is least able to activate assistance?

The purpose is not to punish workarounds or expose individuals. It is to identify the useful functions they provide and build those functions into the formal system.

9.4 Frontline knowledge and transformation governance

Frontline workers know which forms create delay, which referrals fail, which equipment is unreliable, which rules conflict, where information disappears, and which workarounds hold the system together. Patients and families know where they felt abandoned, confused, unheard, or forced to use influence. Leaders and technical teams know the financing, legal, information, and governance constraints that local perspectives may not see.

Implementation intelligence requires all of these forms of knowledge. A dedicated transformation function should possess senior authority, multidisciplinary expertise, protected financing, access to operational data, patient and workforce representation, and the ability to escalate barriers that cross departmental boundaries. Frontline participation must be resourced rather than added as unpaid work to exhausted staff.

9.5 High-leverage priorities

High-leverage reforms alter several loops at once. Context determines priority, but recurrent candidates include:

- A coordinated transport and transfer service linking prehospital, emergency, inpatient, and regional referral systems.
- Real-time patient-flow coordination connecting beds, diagnostics, wards, critical care, discharge, and community services.
- Reliable medication and diagnostic continuity in primary care to prevent acute deterioration.
- Standardized critical-care escalation and transfer pathways with clear clinical criteria and accountability.
- Patient-navigation and escalation services that universalize the beneficial functions of insider access.
- Safe-staffing, retention, maintenance, and procurement interventions that protect existing capacity while larger reforms mature.

9.6 Accountability without blame; transparency without theatre

Punitive accountability can drive problems underground. A just system distinguishes deliberate misconduct, reckless disregard, ordinary human error, inadequate training, defective workflow, insufficient resources, and governance failure. Responsibility should be located where the authority and capacity to act exist.

Reform theatre occurs when visible activities substitute for substantive change: policies without budgets, equipment without maintenance, committees without authority, consultations without feedback, digital systems that add documentation without coordination, and volume targets that ignore delay, equity, or workforce depletion.

Public transparency should make a shared reality possible. Institutions should report waiting, boarding, transfer performance, stockouts, equipment downtime, staffing vacancies, complaints, inequities, and corrective action in an interpretable form. Transparency is not punishment; it is a condition of trust and learning.

9.7 The implementation test

14. Life-capacity: Whose capacity will the reform protect, restore, or enlarge?
15. Access: Will it reduce dependence on money, geography, status, or personal connections?
16. Workforce: Will it renew or further deplete the persons required to deliver care?
17. Operational reality: Which specific pathway, decision, or workflow will change?
18. Accountability: How will patients, workers, leaders, and the public know that the change occurred?

10. Measuring a Life-Coherent Health System

10.1 What is measured becomes visible

Health systems traditionally measure facilities, beds, employees, visits, admissions, procedures, and expenditure. These indicators are necessary but ambiguous. More emergency visits may represent access or primary-care failure. High bed occupancy may represent efficiency or dangerous absence of reserve. Increased output may represent improved care or exhausted overproduction.

A life-coherent measurement system asks whether the system prevents avoidable harm, converts need into timely care, distributes access equitably, restores function, preserves its workforce, and renews the resources consumed through care. It measures pathways rather than departments, distributions rather than averages, and renewable rather than merely current capacity. OECD work similarly emphasizes that health-system performance is multidimensional and shaped by institutional features rather than reducible to one model or output (OECD & The Health Foundation, 2025).

10.2 Life-Coherent Health-System Dashboard

Domain	Illustrative measures	Central question
Conditions of life and prevention	Avoidable premature mortality; disease incidence and control; vaccination; screening; food insecurity; housing instability; environmental exposure; preventable injury.	Is the wider society reducing or producing avoidable illness?
Primary care and continuity	Time to first contact; usual source of care; continuity; essential medicines and tests; referral completion; abnormal-result follow-up; post-discharge follow-up; patient trust.	Can people obtain trusted care before illness becomes crisis?
Acute-care flow	Ambulance and transfer times; arrival-to-assessment; admission-to-bed time; boarding hours; diagnostic turnaround; critical-care access; delayed discharge; readmission.	Can urgent need move coherently through the system?
Access justice	Unmet need; cost-related abandonment; geographic and disability disparities; financial hardship; private substitution; reported dependence on influence.	Does access follow need rather than private capacity?
Workforce viability	Vacancies; workload; overtime; leave; sickness absence; turnover; intention to leave; migration; workplace violence; psychological safety; ethical adequacy of care.	Is the system renewing or consuming its workforce?
Governance and reliability	Budget execution; procurement timelines; stockouts; equipment downtime; maintenance; audit implementation; complaint resolution; corrective-action completion.	Are resources converted reliably into usable care capacity?
Resilience and regional capacity	Power, water, communications; emergency stocks; simulation performance; service restoration; backup specialists; referral reliability; mutual aid.	Can essential care continue, adapt, and recover under disruption?

10.3 Shadow Access Dependency Index

A distinctive measurement proposal is the Shadow Access Dependency Index: a patient-reported measure of the extent to which ordinary, timely care depends on informal or privately held capacities. Candidate items would ask whether a person needed a personal contact, influential intervention, private payment, specialist knowledge of the system, continuous family presence, unofficial escalation, or repeated attempts to advance care.

The index should not identify or punish helpers. Its purpose is to measure whether formal pathways are reliable for people who lack privilege. Development would require qualitative work, cognitive interviewing, ethical review, pilot testing, reliability analysis, construct validation, and examination of differential performance across settings.

- Did you need a personal contact inside the institution to obtain timely attention?
- Did someone influential intervene on your behalf?
- Did you pay privately because the public pathway was unavailable or excessively delayed?
- Did you need professional knowledge to identify the correct service or escalation route?
- Did family members have to remain continuously present to ensure that care progressed?
- Did transport, communication, or unclear responsibility delay or prevent care?
- Do you believe your care would have differed without personal advocacy?

10.4 Measuring the viability gap and borrowed capacity

The healthcare viability gap should be assessed through an interacting dashboard rather than prematurely collapsed into one score. Relevant measures include demand relative to safely staffed capacity, boarding, delayed transfer, vacancy duration, turnover, equipment downtime, deferred preventive work, unmet need, and reliance on overtime or family labour.

Systems should distinguish available capacity, usable capacity, sustainably renewable capacity, and borrowed capacity. A workforce may be numerically present yet functionally depleted. A bed may be counted yet unusable

without staff. High output achieved through chronic overextension should be recognized as a warning rather than celebrated as efficiency.

10.5 Narratives as system data

Administrative data cannot fully capture abandonment, uncertainty, humiliation, contradictory instructions, unexplained delay, and the burden placed on families. Patient and worker narratives are therefore essential system signals.

A single narrative cannot establish prevalence. The appropriate sequence is narrative signal → structured inquiry → validation → corrective action → public learning. Measurement must remain non-punitive and interpretive: higher adverse-event reporting may reflect improved safety culture, and higher moral-distress reporting may reflect greater psychological safety to speak.

11. Phased Roadmap and Priority Recommendations

11.1 Phase zero: ethical preparation and shared reality

Begin with de-identified patient and family listening, workforce listening, pathway mapping, review of audits and policies, identification of workarounds, baseline measurement, and agreement on governing ethical principles. The aim is not immediate consensus on every cause, but a sufficiently shared reality from which action can begin.

11.2 Phase one: stabilize and make the system visible

- Establish daily patient-flow coordination and a mechanism for escalating stalled care.
- Clarify emergency, transfer, and critical-care pathways.
- Identify critical staffing, medication, equipment, and maintenance risks.
- Measure boarding, transfer delay, overtime, vacancies, and deferred preventive work.
- Conduct the first friction and shadow-system audits.

11.3 Phase two: repair high-risk pathways

Prioritize pathways associated with severe harm, repeated delay, or high dependence on informal intervention—for example sepsis recognition, critical-care referral, interfacility transfer, emergency admission, diagnostic-result follow-up, medication continuity, discharge, and rural access. Each pathway should have defined authority, timelines, escalation rules, communication standards, measures, and a feedback process.

11.4 Phase three: rebalance upstream

- Strengthen multidisciplinary primary-care teams and continuity.
- Ensure essential medicines and diagnostics at the first level of care.
- Link hospital data and adverse events to prevention and community programmes.
- Use health-impact assessment across major policies in food, transport, housing, work, and environment.
- Protect upstream budgets from repeated displacement by acute crises.

11.5 Phase four: renew the workforce

- Implement safe-staffing and workload standards based on complexity and urgency.
- Protect rest, leave, occupational safety, psychological safety, and continuing education.
- Create career, retention, return, circular-migration, and regional specialist pathways.
- Give workers structured authority to report hazards and influence redesign.
- Treat inability to provide ethically adequate care as an organizational performance signal.

11.6 Phase five: institutionalize accountability and learning

- Publish a life-coherent dashboard with equity stratification.
- Track implementation of audit and review recommendations.

- Create independent review of major delays, transfer failures, and inequities.
- Build patient and workforce participation into routine governance.
- Protect reform across political and leadership cycles through multiyear financing and public reporting.

11.7 Phase six: build regional resilience

- Operationalize shared referral and transport agreements.
- Expand pooled procurement, reference laboratories, specialist networks, and biomedical engineering.
- Develop interoperable information and teleconsultation arrangements where feasible.
- Test mutual-aid and disaster pathways through simulation.
- Coordinate workforce planning and ethical recruitment regionally.

11.8 Twelve priority recommendations

19. Recognize healthcare enclosure as a policy and equity problem rather than assuming formal coverage equals access.
20. Measure and reduce dependence on shadow access while protecting compassionate assistance during transition.
21. Treat emergency congestion as a whole-system output and redesign the entire patient-flow chain.
22. Protect prevention, primary care, maintenance, and workforce renewal from downstream budget displacement.
23. Make workforce viability a core performance objective, not an optional wellness programme.
24. Integrate prevention of moral distress and moral injury into organizational governance and staffing.
25. Align responsibility with power, knowledge, freedom, capacity, and control.
26. Adopt life-cycle procurement so that purchases create durable functional capacity.
27. Create transparent, accountable transfer and critical-care pathways.
28. Provide universal navigation, communication, and escalation support, especially for vulnerable populations.
29. Publish a Life-Coherent Health-System Dashboard and empirically develop the proposed indices.
30. Build dependable Caribbean pooled capacity for workforce, diagnostics, procurement, referrals, engineering, and disaster resilience.

11.9 Limitations and research agenda

The originating conversation is not representative evidence and cannot verify the circumstances of any individual clinical event. This paper is conceptual rather than a formal empirical study. The proposed constructs and indices require qualitative development, observational research, patient surveys, workforce studies, and cross-country comparison.

Priority questions include the prevalence and distribution of insider navigation; the relationship between social capital and time to care; emergency boarding and outcomes in Caribbean settings; moral injury and departure; the functional effect of specialist loss in small states; private cost-shifting around public care; the effectiveness of navigation models; and methods for estimating sustainably renewable capacity.

Health systems differ substantially, and similar outcomes may arise through different financing and governance mechanisms. Prevention cannot eliminate uncertainty, tragedy, or all acute illness. Measurement can distort priorities if indicators become targets detached from purpose. The standard is not perfection, but whether foreseeable harm is reduced, access is fair, learning occurs, and capacity is renewed.

12. Conclusion: From Rescue by Connection to Care by Right

The conversation that seeded this paper began with a request for help. A physician's relative was hospitalized with a potentially serious illness. A colleague inside the institution offered assistance. The intervention was compassionate, professionally understandable, and potentially important.

Yet the need to ask exposed a deeper problem. What happens to the patient whose family cannot activate a professional group, contact a clinician, arrange transport, pay privately, or persuade someone inside the system to intervene?

That question opens onto the hidden architecture of healthcare access. A formal health system may promise universality while an operational shadow system distributes recognition, navigation, and urgency through unequal private capacities. Money, transport, knowledge, status, and relationships become unofficial access technologies.

The people who use these technologies should not be blamed. They are responding rationally to uncertainty and trying to protect life. The professionals who help them should not be condemned. Their solidarity expresses the humane core of medicine. The injustice lies in a system that makes such intervention necessary for ordinary safety.

Healthcare enclosure is intensified by a reactive architecture that permits avoidable illness to accumulate upstream, concentrates resources in downstream rescue, overloads emergency and hospital services, and transfers unresolved ethical burdens to patients, families, and frontline workers. The workforce becomes the final absorber of system failure.

Clinicians, nurses, and other workers compensate through effort, informal coordination, personal advocacy, and moral commitment. These acts preserve care in the present while concealing the degree to which the institution is consuming future capacity. Burnout and moral injury are therefore not peripheral wellness concerns; they are evidence that the relationship among need, authority, resources, and ethical responsibility has become incoherent.

The debate between personal and structural responsibility cannot resolve the crisis when framed as an opposition. Individuals possess agency, but agency operates within conditions shaped by institutions, governments, employers, markets, communities, and ecology. Responsibility must rise with the power to shape those conditions. The right to care cannot depend on retrospective judgments of virtue.

A life-coherent health system must do several things at once. It must reduce avoidable disease without blaming the ill; strengthen primary care without abandoning rescue; maintain acute and critical-care capacity without treating hospitals as the whole health system; establish reliable pathways without suppressing compassion; measure performance without mistaking exhaustion for efficiency; and protect patients without destroying the people upon whom their protection depends.

The decisive transition is from disease production to health protection; delayed crisis to early response; socially mediated access to access justice; heroic improvisation to dependable pathways; workforce sacrifice to workforce viability; institutional self-consumption to renewal; and rescue by connection to care by right.

The humane act that began the conversation should remain. What must disappear is the unequal necessity for it.

Final integrative proposition

A life-coherent health system is one in which preventable illness is reduced, unavoidable illness receives timely and equitable care, responsibility corresponds to actual power and capacity, and the human, institutional, social, and ecological conditions required for future care are continuously renewed.

FIGURE 4. FROM RESCUE BY CONNECTION TO CARE BY RIGHT

A transition from an enclosed, reactive system that depends on privilege and sacrifice, to a life-coherent system that delivers equitable care through dependable pathways.

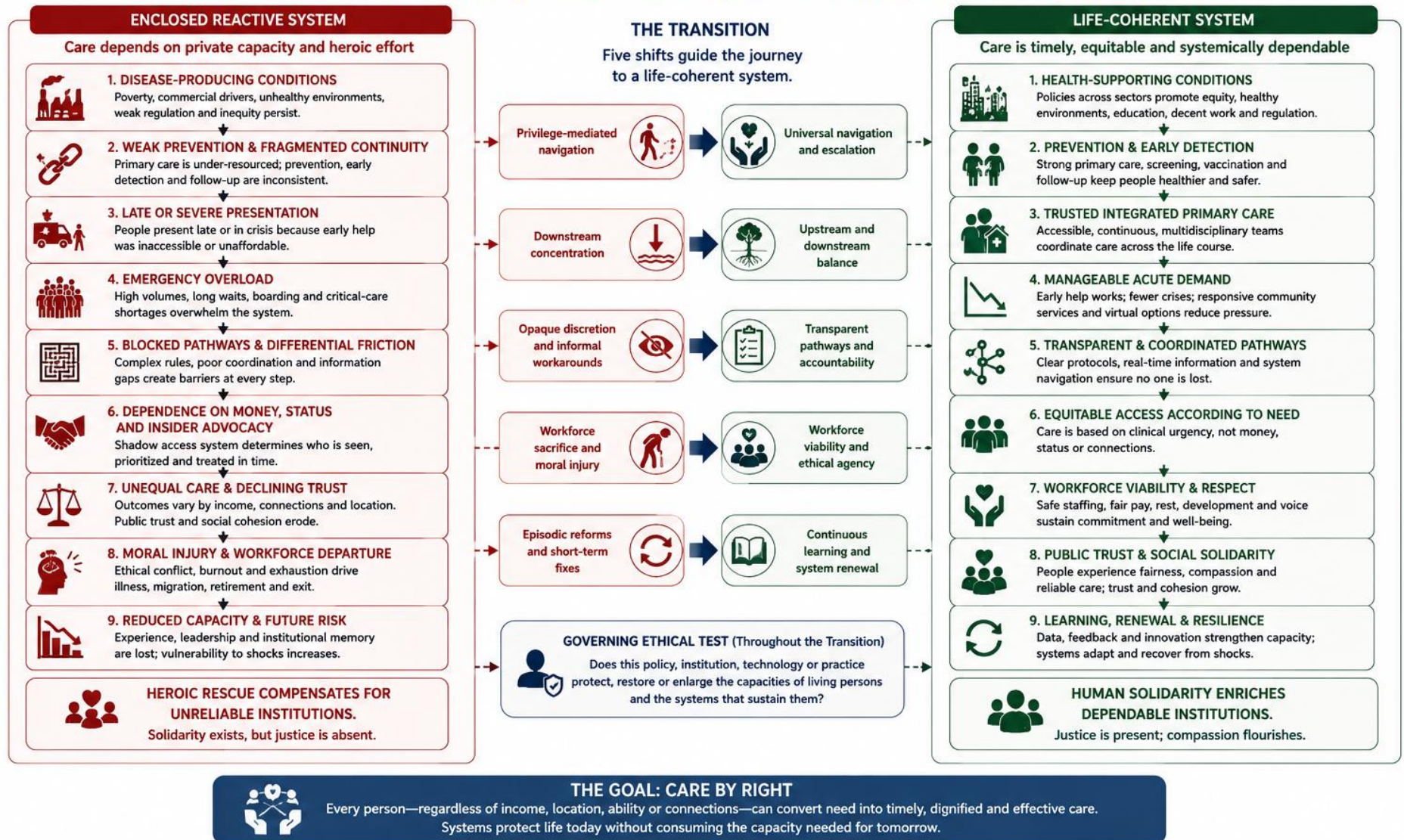


Figure 4. From rescue by connection to care by right. The transition does not eliminate solidarity or professional discretion. It changes their institutional role: from unequal compensation for unreliable pathways to humane enrichment of dependable, equitable care.

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Appendix A. Conceptual Lexicon

Healthcare enclosure: The practical conversion of a nominally shared healthcare good into a service whose timely use depends upon privately held capacities.

Shadow access system: The informal network of personal advocacy, insider knowledge, social influence, private payment, and professional workaround used to overcome failures or delays in formal pathways.

Differential friction: The unequal effect of the same institutional barriers on persons with different financial, geographical, informational, relational, and functional capacities.

Access justice: A condition in which clinical need, rather than non-clinical privilege, primarily determines whether urgency is recognized and appropriate care is delivered.

Healthcare viability gap: The difference between legitimate need plus avoidable system friction and the sustainably renewable capacity available to respond.

Borrowed capacity: Temporary service capacity produced through overextension, unpaid labour, family burden, informal rescue, and private substitution rather than renewable institutional resources.

Institutional self-consumption: The preservation of short-term function through progressive depletion of the human, ethical, relational, and material capacities required for long-term viability.

Ethical load transfer: The transfer of unresolved system constraints and their moral consequences to patients, families, and frontline workers who lack sufficient authority to correct them.

Life-coherent health system: A system organized to prevent avoidable harm, provide equitable care, restore or support human capacity, protect dignity and agency, and renew the conditions required for future care.