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Toward an Ethnography of the Uninsured: Gay Becker's Work in Progress

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Gay Becker's following article on the uninsured, submitted to *Medical Anthropology* before her untimely death in January 2007, was innovative in placing the issue of the uninsured squarely at the heart of her analysis of the U.S. health care system. Becker's novel contribution lay in examining the lack of universal health care in the U.S. as a mode of governance that produced certain subjects—subjects whom the system trained to view themselves as undeserving of care. Interrogating the means by which such a system is normalized, she further showed how a fragmented and discontinuous health care safety net served to contain the problem of the uninsured by discouraging them from seeking necessary treatment.

There is a uniquely American history to the issue of the uninsured—one that is deeply rooted in the American values of productivity, autonomy, and individual responsibility. While historically, the uninsured have been equated with the unemployed and thus "undeserving," pioneering medical anthropologist Gay Becker consistently debunked this myth during the last decade of her three-decade career. Even as a new "imperative of health" (Lupton 1995) holds individuals accountable for adopting a healthy

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lifestyle (Porter 1999), Becker saw that increasing numbers of uninsured persons lacked access to the care necessary to maintain their health. She showed that the plight of immigrants—who contribute significantly to the workforce yet are less likely to have health insurance (Carrasquillo, Carrasquillo, and Shea 2000)—illustrates the falsity of equating ''productivity'' with health citizenship. She documented what she called ''the human cost of the lack of health insurance'' (305), and revealed the ideologies of individual responsibility and deservingness that normalize a broken health care system.

Becker, who died last January 7, 2007 in Bangkok after becoming ill while travelling in India and Nepal, left her mark on many research areas—aging and chronic illness, disability and stigma, infertility and reproductive health, trauma among refugees, and the health of (and lack of health care available to) the uninsured. It is to this last topic that she devoted much of her attention and focus in recent years. Becker had submitted the article, ''The Uninsured and the Politics of Containment in U.S. Health Care,'' to *Medical Anthropology* last summer and it was still out for peer review at the time of her death. She was working on a book manuscript on the topic as well.

In her previous work on the topic, Becker focused on the experiences of persons who are chronically-ill and uninsured to both humanize the issue and showcase flaws in the system. While persons with chronic illnesses urgently require physician supervision and regular medication to manage their illnesses, Becker found that the health care system ironically worked to discourage their use of care (Becker 2004; 2006). Due to their lack of insurance, lack of income, and desire to avoid dehumanizing interactions with county hospital staff, the persons who are chronically ill and uninsured often avoided seeking care until faced with circumstances that are life threatening. Sounding a theme she developed more fully in the article on the politics of containment published here, she argued that the safety net ''can be viewed as inadvertently training people to delay seeking care'' (Becker 2004:270).

The article published here extends the themes of Becker's previous work and is in many ways the most anthropologically ambitious. A work-in-progress that Becker had not had the chance to revise, this article moves toward an analysis of the American health care system as a *mode of governance*. It raises further questions about strategies of health care governance and the subjectivities they produce. It draws attention to the many norms different types of

health care systems, as modes of governance, instill in their subjects. It is also perhaps the most explicitly political of her published pieces, as it uses the experiences of chronically-ill, uninsured minorities she followed to highlight central flaws of the health care system.

In this article, Becker placed the issue of the uninsured squarely at the heart of our fragmented health care delivery system rather than viewing it as an erratic exception to the system's otherwise orderly machinations. Historically, our health insurance system has been employment-based, which served the nation well during a stable era of large manufacturing. However, with the loss of full-time jobs and the growth of part-time and temporary contract work, the linkage between employment and insurance has broken down (Sered and Fernandopulle 2005). Health insurance premiums skyrocketed after 2000, even as unemployment rose and income levels declined, making health insurance increasingly out of reach for the middle class as well (Holahan and Cook 2006). The number of workers and their dependents with job-based insurance has steadily declined, and three-quarters of that decline has been because of the loss of employer-sponsored coverage (Clemans-Cope and Garrett 2006). Eighty-one percent of the uninsured are now in working families (Kaiser Commission 2006).

The uninsured are not peripheral to our system of financing and delivering health care but rather ''lie at its very heart,'' Becker wrote in this article (22). Given the moral and technical challenge that the uninsured pose to the system, both policymakers and health care staff must attempt to ''contain'' the problem of the uninsured, she argued. A large part of this strategy of containment lies in the way the health care system—and large, bureaucratic county hospitals in particular—inadvertently teach the uninsured to delay care by communicating a message of ''unwelcome'' (25). First, the newly uninsured experience a ''rude awakening'' when they are denied care from doctors who have attended to them for years. Then, their experiences of ''discrimination, depersonalization, and disenfranchisement'' (316) in bureaucratic public-sector health care lead them to avoid the system as much as possible. The net result of this approach, she argued, is policies that obscure and contain the magnitude of the problem. She insightfully wrote: ''Although exclusion may be an unintended consequence of these policies, it nevertheless works to give the appearance of keeping the problem under control: if fewer people seek health care, the problem appears to be more manageable'' (317).

The failure of the United States to offer adequate health insurance to its population, she suggested, is as much a policy as any other—it is a form of governance through willful neglect. She asked: What subjectivities does such a system produce? How is it that this lack of basic health care has become normalized? If, as Cris Shore and Susan Wright argued, policy is a technology of power that "works upon the individual's sense of self," Becker reasoned, then the study of our discontinuous and haphazard health care safety net—the *de facto* insurance system for the uninsured—would reveal the "processes by which new norms of conduct . . . come to be adopted and internalized by individuals" (Shore and Wright 1997:29). Following this approach, Becker argued that policies regulating the health care safety net "foster an organized approach to contain the uninsured, an approach that trickles down into specific encounters and affects how the uninsured respond" (302). The accounts of disrespect and dehumanization in the article published here serve as vivid testimony to the sense of second-class citizenship this system instills. People feel "talked down to" and "treated like specimens; they run an 'obstacle course' just to receive 'assembly-line care'" (311). Their avoidance of the system illustrates their internalization, although not always acceptance, of this status. Meanwhile, ideologies of individual responsibility for health and illness normalize this two-tiered health care system, in sharp contrast to the sense of collective responsibility once fostered by social insurance (Ewald 1991; Rose 1999:158–160).

In the introduction to her unfinished book manuscript, Becker offered a damning indictment of the role of our "two-tiered system" in participating in this policy of "containment" and preventing comprehensive reform. Writing for a popular audience, Becker was concerned with driving home the contradictions of the system in clear and straightforward prose.

The inadequacy of safety net health care and the continued lack of universal health insurance can be seen as one way the moral order is reproduced. Deeply rooted cultural views about self-sufficiency are upheld even though they are inappropriate to the current situation. Long-standing inequalities that have undermined the health of poor people and ethnic minorities have now expanded to include the white middle class. These inequalities are masked, however, by reframing health care in terms of managed care and by designating the loose conglomeration of charity-oriented health care services as a health care safety net. This system contributes to high mortality rates and greater illness and disability, and reflects the perpetuation of long-standing inequalities that are being shrouded in a new guise. (n.d. 16)

Cut short by her untimely death on January 7, 2007, Becker's full thinking on the topic will sadly remain unknown.

Now, more than a decade after Becker's work on this topic began, there is again discussion of how to fix a broken health care system. In the absence of a comprehensive federal solution, a number of states have taken action, and universal health care insurance is again a buzzword among presidential candidates. As policy-makers offer a variety of solutions, what might be the role of medical anthropologists in the debate? In her 2004 piece in *Medical Anthropology Quarterly*, Becker turned to her mentor, Joan Ablon, as offering a model to overcome ''passivity at the political level.''

[F]ocusing on the everyday difficulties of people's lives, [Joan] sought to put a human face on social problems that were tacitly acknowledged and readily overlooked. Her aim . . . was to reach beyond anthropology to policymakers, health care providers, the general public, and her respondents themselves in order to change perceptions, foster advocacy, and ultimately influence policies. Her legacy is a charge to anthropologists to work to reduce inequality, no matter how daunting the task may be. (2004:147)

It is perhaps a fitting irony that the words Becker wrote to honor her mentor could equally describe Becker herself and the invigorating challenge she has left as her legacy to the field of medical anthropology. Becker would likely find no greater satisfaction than to see her colleagues, students, and the many others whose lives she has touched, take up this challenge.

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