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December 2008

Retrieved on 3rd September 2021 from members.tripod.com

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The health-care industry is a textbook example of what Ivan Illich, in Tools for Conviviality, called a "radical monopoly." State intervention artificially skews the model of service toward the most expensive kind of stuff. For example, the patent system encourages an R&D effort focused mainly on tweaking existing drugs just enough to claim that they're "new," and justify getting a new patent on them (the so-called "me too" drugs). Most medical research is carried out in prestigious medical schools, clinics and research hospitals whose boards of directors are also senior managers or directors of drug companies. And the average general practitioner's knowledge of new drugs comes from the Pfizer or Merck rep who drops by now and then.

The government having made some forms of treatment artificially lucrative with its patent system and licensing cartel, the standards of practice naturally gravitate toward where the money is. The newly patented "me too" drugs crowd out drugs that are almost (if not entirely) as good, so that the cost of medicine is many times higher than necessary. The licensing cartel requires diagnosis and treatment by someone with an MD's level of training, when something much less might be all that's needed.

Result: Illich's radical monopoly. The state-sponsored crowding-out makes other, cheaper (and often more appropriate) forms of treatment less usable, and renders cheaper (but adequate) treatments artificially scarce.

In the typical metropolitan area, healthcare is likely to be cartelized among a handful of big hospitals, with several hundred beds each. They are likely to share essentially the same pathological institutional culture: multiple tiers of prestige-salaried management, excessive credentialling and "professionalization" of all aspects of work, and smarmy corporate garbage like "mission statements." As Paul Goodman wrote in People or Personnel, this pattern, typical of the large corporation and the centralized government agency, has become the dominant form of organization in our society. It has spread to contaminate even the cooperative and non-profit sectors.

That's why you can't pick up your local newspaper's "Society" section without seeing the usual suspects from the chamber of commerce–people who would be lined up for the guillotine in an ideal world–walking with pink ribbons, kissing pigs for diabetes, or playing tug-of-war with a giant check. Charity, rather than something workers do for each other (as they did in the sick benefit societies, burial societies, and other mutuals of a century ago), has become a hobby for the provincial celebrities in the local Rotary Club and Junior League, or a competition between local CEOs to see who can take credit for the biggest Red Cross blood donations or contributions to the United Way by the employees in their respective feudal domains.

The idea of radical monopoly applies to most aspects of life. Centralized, high-tech, and skill-intensive ways of doing things make it harder for ordinary people to translate their own skills and knowledge into use-value. "Education," synonymous with schooling, is something you can only get from somebody with a degree from a teacher's college, according to a state-prescribed curriculum. In the field of housing, around a third of which was still self-built

in the U.S. as late as the 1940s, self-building is now virtually illegal thanks to local housing codes set by licensed contractors and their lobbyists. This despite the fact that the available technology for self-building (modular houses, "cob" building, etc.) is far more user-friendly than it was sixty years ago. And healthcare, finally, is something you can only get from somebody who's spent eight years in school, jumped through the hoop of his local licensing cartel, and done a residency.

The medical licensing cartel outlaws one of the most potent weapons against monopoly: product substitution. As the Chinese barefoot doctor system demonstrated, much of what an MD does doesn't actually require an MD's level of training. Things would likely be quite different in a private system of accreditation with multiple tiers of training. The "barefoot doctor" at the neighborhood cooperative clinic might, for example, be trained to set most fractures and deal with other common traumas, perform an array of basic tests, and treat most ordinary infectious diseases. He might be able note your symptoms and listen to your lungs, do a sputum culture, and give you a run of Zithro for your pneumonia, without having to refer you any further. For cases clearly beyond his competence, he would call in the MD the clinic kept on retainer.

Many free market advocates like to talk about a hypothetical "grocery insurance" to illustrate the problems with the current healthcare system. If we had third-party payments for groceries, they say, people would be eating a lot more filet mignon. But the problem with the current system is that, while there are multiple tiers of financing, there is only one tier of service delivery: there's nothing available but filet mignon, whether you can pay for it or not.

I'm very big on the idea of reviving the mutuals or sick-benefit societies that working people organized for themselves, back in the days before the state and the capitalist insurance companies conspired to destroy them. One small-scale attempt at doing this

sort of thing is the Ithaca Health Fund, created by the same people involved in Ithaca Hours.

But this alone is not enough. The problem with such systems is they handle only the financing end of things, while delivery of service is still under the control of the same old institutional culture.

Any real solution will have to involve cooperative control over the provision of healthcare itself, as well.

Imagine, for example, a cooperative clinic at the neighborhood level. It might be staffed mainly with nurse-practitioners or the sort of "barefoot doctors" mentioned above. They could treat most traumas and ordinary infectious diseases themselves, with several neighborhood clinics together having an MD on retainer for more serious referrals. They could rely entirely on generic drugs, at least when they were virtually as good as the patented "me too" stuff; possibly with the option to buy more expensive, non-covered stuff with your own money. Their standard of practice would focus much more heavily on preventive medicine, nutrition, etc., which would be cheap for members of the cooperative who didn't have to pay the cost of an expensive office visit to an MD for such service. Their service model might look much more like something designed by, say, Dr. Andrew Weil. One of the terms of membership at standard rates might be signing a waiver of most expensive, legally-driven CYA testing. For members of such a cooperative, the cost of basic medical treatment in real dollars might be as low as it was several decades ago. No doubt many upper middle class people might prefer a healthcare plan with more frills, catastrophic care, etc. But for the tens of millions who are presently uninsured, it'd be a pretty damned good deal.

In a genuinely free market society of decentralized production by small, local firms, with most people self-employed or employed in producers' or consumers' cooperatives, the overall structure would likely be quite different from the present system. In such a society the decentralized, bottom-up pattern of organization would be the dominant norm, and the large firm (where it existed)

would be the anomaly struggling to exist in a cooperative sea. In fact, the large firm, in cases where it has to exist, would likely be "contaminated" by the organizational style of the cooperative; it might well even be built from cooperatives, with federations of small producers pooling their capital to buy expensive machine tools when necessary.

Finally: I object strenuously to those who see a single-payer system, or a government-controlled delivery system like the UK's National Health, as the solution. I'd like to give those who talk about healthcare being a "right" the benefit of the doubt, and assume they just don't understand the implications of what they're saying. But when you talk about education, healthcare, or anything else being a "right," what that means in practice is that you get it in the (rationed) amount and form the State wants you to have, and buying it in the form you want becomes much more difficult (if not criminalized). It means the providers of the service will be cartelized, and that the provision of the service will be regulated according to the professional culture and institutional mindset of the cartels. As with "public" education, "public" healthcare means that the existing "professional" institutional culture is locked into place, but that you get their services at taxpayer expense.

Making something a "right" that requires labor to produce also carries another implication: slavery. You can't have a "right" to any good or service unless somebody else has a corresponding obligation to provide it. And if you're obligated to provide a good or service at a cost determined by somebody else, you're a slave. Nobody is born with a "right" to somebody else's labor-product: as Lilburne said, nobody is born with a saddle on his back, and nobody is born booted and spurred to ride him.