sharedcare

design oriented innovation scan of informal health

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A thesis submitted to the School of Design, Carnegie Mellon University, for the degree of Master of Design in Communication Planning and Information Design

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abstract

Shared Care is a paradigm shift that addresses informal health, which probes into health for the healthy and care that is non-institutional. A shift from 'my health is my problem' to informal care systems based on proximity and trust. The community is mutually responsible for the health of its members and shares common goals of wellbeing.

A growing population in urban contemporary cities, as they transition through different phases of life are not foreseeing the effects of place, social support and care in their long term wellbeing. With the lack of faith in a healthcare system that equates good care to insurance, the opportunity is to move away from problem & symptom-based, fee-for-service care to focus on preventative care that lies outside of the current system in the US.

The hypothesis that guided the research considered the intersection between health and social as an alternate / complimentary approach to preventive care as understood today. By using design as a research tool, rich narratives of personas were created that enabled crystallizing the potential to shift from the 'me' to the 'we' paradigm of one's wellbeing. Disclosing emergent spaces where service design can be used as an entrepreneurial approach to envision solutions that enable informal support systems between weak tied individuals based on physical proximity.

Motivations, infrastructure and characteristics of designing for these emergent spaces in housing, mobility, work life, food systems and sociality, were identified as holistic components of ones overall wellbeing. By applying the 'we' paradigm framework to the design of services we can further investigate the transition towards health related sociality within communities.

colophon

Title text
Museo Sans
designed by Jos Buivenga 2008

Body text
Benton Sans
designed by Tobias Frere-Jones 1995

Everything happens to everybody sooner or later if there is time enough.
- George Bernard Shaw

To Ma, in your strengths I have found mine. For your infectious laughter and sharing cups of tea over skype for the last two years.

To Pa, for always being right.

To Misba, for always challenging my way of thinking.

To Cameron Tonkinwise, for making coming back to grad school for the second time absolutely worth it. And also, a memorable optimally functional advisor advisee relationship.

To Dan Boyarski, for giving me the opportunity to teach and reminding me constantly of why I love design.

To Mark, Christiana, Nicolas, Jung, Gilbert and Brynn for your moral support, friendship and hugs.

To Gambitoff and their blind faith in what I do.

To all my colleagues at CMU for being a wonderful small family.

And lastly,

To Ram, for your tireless patience, persistent belief and love.

each of us is responsible for everything and every human being

– Dostoevsky as quoted by Simone de Beauvoir

prologue

Now, what about the future? In this matter I would like to share with you the insight of my good friend, the distinguished Argetinean ecologist Dr. Gilberto Gallopin, who has proposed three possible scenarios.

Scenario one, is the possibility of total or partial extinction of the human species. The most obvious way for this to come about would be a nuclear holocaust, which, as we know, is based on the principle of Mutually Assured Destruction.

Scenario two, is the barnarianization of the world, a new way of turning humankind into barbarians. Part of this scenario will be the resurgence of the repressive regimes cooperating with the wealthy bubbles and imposing further hardships on the poor.

Scenario three presents the possibility of a great transition–the passing from a dominant rationality of blind economic competition and greed to a rationality based on the principles of sharing and solidarity. We might call it the passing from a Mutually Assured Destruction to an era of Mutually Assured Solidarity. But can we do it? Have we the tools, the will and the talent of constructing a mutually assured solidarity? Can we overcome the stupidity that keeps such a possibility out of our reach? I believe that we can, and that we have the capacity. But there may not be too much time let.

Neef, Max, Human Scale Development, New York and London : Apex, 1991, Print.

[1]
Neef, Max, Human Scale Development, New York and London : Apex, 1991, Print.

[2]
Tulsian, Indri, Circles of Care, London : RCA, 2004

As opposed to Maslow's hierarchy of needs simplistically depicted in a pyramid, Max Neef's human scale development [1] addresses needs as an organic coexistence of being, having, doing and interacting. Where the foundation of subsistence lies in physical, mental and social wellbeing. There isn't any hierarchy of needs but what becomes evident from the interrelations is that social setting and interaction is a fundamental satisfier in the sustenance of human beings. The stupidity of the way of life today as he rightly identifies has strained our understanding of physical and mental wellbeing by equating health to economic stability and in return the choice that it provides in the autonomy and control of ones lives. Where social support and trust is no longer seen as a valuable currency of existence.

The following theses is an inquiry of health as a social concern. If interacting and being in the world with 'they'/'others' is a fundamental human need then how can we as creative practitioners and critical thinkers re imagine the world that affords solidarity in the maintenance of our wellbeing. The current landscape of the maintenance and repair of ones health oscillates between dispirit value systems of individual care / self care practices and institutional / expert care. From 'my health is my problem' to in the situation of breakdown seeking expert help / care. The 'in between' [2] space between self help and institutional care is what the research further explores with respect to the role designers and creative practitioners can play in considering new frameworks to enable transition towards social health behaviours that would build stronger communities that are based on physical proximity between weak tied individuals.

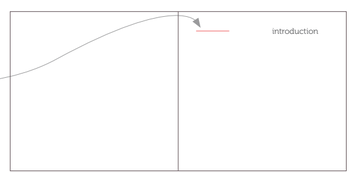
how to read this report?

The report consists of four sections

Introduction	Part 1	Part 2	Conclusions
Sets the background, context and relevance of this particular type of research.	Sense making and mapping the problem space.	Projecting a future in the identified problem space through design scenarios.	New frameworks for future applications

Within each section there are key **questions** that are highlighted on the left hand side of the book. These questions have been key moments of insight, reasoning and understanding of a very complex and messy space of research that I have constantly found myself wading through. They will also help hold a continuous narrative of my research process.

References are cited on every page.



Definition

Shared Care is a paradigm shift, which addresses health for the healthy and care that is non-institutional. A shift from 'my health is my problem' to informal care systems based on proximity and trust. Where the community is mutually responsible for the health of its members and shares common goals of wellbeing.

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Type of Research

Design as a research tool to provoke participants and industry experts to respond to future scenarios of care and reflect on current practices. Generating frameworks to breakdown and gather insight into the factors affecting accepted norms of individual health.

Method

Mapping correlated parallel practices and systems of individual and institutional care. A scan involving understanding current precedents supporting the need for alternate approaches to long term systemic commitment to social health.

About

The in-between space between individual care and health practices and institutional maintenance, support and care. Non expert based informal human network of support and care in the enabling of healthy behaviour towards oneself and the community based on physical proximity between weak tied individuals.

content

What do we know already?

Health a growing concern - The research looks at the western practices of individuals and healthcare system. Primarily focusing on the US. Currently health and wellbeing are matters of great concern. Healthcare in America in most expensive in the world with almost 17.6% of it's GDP spent on it. Healthcare is directly linked to insurance in the country with almost 47% of the population uninsured. Which means in the case of an emergency not only does the hospital have to invest more in expensive procedures due to the seriousness of their condition but also in most cases it results in further worsening of the conditioning which might even lead to long term care and support which the healthcare system cannot support/provide.

http://rockhealth.com/resources/digital-health-facts

People who have support systems are healthier, and healthy habits spread to people around you – The world's longest lived people are born into social networks that support healthy behaviours. Social network studies have proven that obesity runs in social circles and other evidence that support communities help people live long and better, and having like minded people around helps people reach goals they already have, either knowingly or latently. Examples of bright spots- Nike +, Weight Watchers and AA groups have seen tremendous benefits of having supportive peers who help them overcome a challenge.

https://www.bluezones.com

Lack of faith in the system - Due to it's continuous sky rocketing costs and direct dependency on private health care providers who seem to become the custodians of ones health future there is a growing lack of faith with the institutions in the US. After a dysfunctional government healthcare is the next most contested concern of the masses of this nation. They are looking for an alternative that is not heavily tied down to medication-heavy institutional care.

http://theamericanhealthcareparadox.com/

Support for alternate preventive approach – There is a growing awareness and realization even within the medical community to focus on preventive care and coping versus solving but it is unclear what the larger implication of that would be. Recognition that we need to move away from problem & symptom-based fee-for-service care and focus on preventative care and how people can live better with long-term illness and diseases such as diabetes, but that there is a lack of know-how to do this, and healthcare establishment is essentially ill-prepared to do this. The entire system is built on old approach, including financial incentives for providers & insurers and the type of training and research that is done within healthcare is still vastly focused on problem-solving, not problem-finding and preventing. Doctors and medical institutions are not well equipped to provide the new services and understanding we need to make this shift.

Jones, Peter. Design for Care : Innovating Healthcare experience. Brooklyn, New York. 2013. Print.

[7]
Sttersten, Richard and Ray. E. Barbara. Not Quite Adults. Bantam, 2010. Print

[8]
http://www.nielsen.com/us/en/newswire/2014/ihealth-how-consumers-are-using-tech-to-stay-healthy.html

introduction

A techno centric approach to solving the rising health concerns of the west may seem like the trending momentum of the present, but it cannot be viewed as a compelling mechanism to cope with commitment to long-term health and wellbeing. Historically and culturally unlike the east, the west is known to herald individuality and nuclear upbringing [7] to fuel it's principles of a thriving economy. Even maintenance and commitment to health is seen as an individual's prerogative and outcome of a complex healthcare system that equates care to insurance. The explosion of fitness wearable's, sensors and mobile devices can be seen as the natural progression towards a conspicuous channel to empower health seekers to take control of their life. But there is still a huge gap in the population (70%) [8] actively working to be healthier and the ones investing in technology (15% in wearable fitness devices) despite increasing awareness.

A greater percentage of the population still relies on family and social support as supplementary health seeking behaviors. With the growing distance between families and primary support structures due to transitions through phases of life and lifestyle change it is harder to reach out and maintain constant connection with close support systems in the day to day maintenance of ones health as well as when something really goes wrong ie. sickness. It is a well established fact that family ties, friends and peer to peer relationships that comprise social health is an equal component of ones holistic wellbeing along with it's physical, mental, environmental and spiritual components. Social support is not connected to any financial institution or governing systems that could possibly have adverse effects on ones health. Hence, between individual care that is based on motivation, consciousness and multiple auxiliary factors like upbringing and place and institutional care, which is expert based treatment of an illness

Healthcare in the United States is a mess. Technically, a “mess” is a complex set of problems with inextricable interdependencies. The overall system of healthcare—from services to payment to policy—has grown so complicated that a redesign of its components would not change the system substantially. New design thinking is called for, yet where do we start? Designers have no access to the system levers, and most of our work today is aimed at making the components run better and safer.

Design for Care : Innovating Healthcare experience by Peter Jones

there is a rich space ‘in-between’ which relies on power of the people in our life who are active participants and contributors in our health seeking behaviours. They could be neighbors, friends, colleagues, family and alternate social networks who need to be leveraged as complimentary care systems in our long term commitment to health and wellbeing. In return reducing the burden on archaic institutional systems that treat individuals in isolation sickness based without considering the connected community they are a part of that could/ should be prepared to provide care in the time of need.

Currently much of the human centered design application is implemented in mainstream healthcare systems like medical devices, home care for chronic ailments, prosthetics, neuroscience and support towards the elderly to name a few. As well as innovative applications in the individual health maintenance, efficiency and support with fitness monitors, wearable technologies, sensors and some around individual behaviour change. Although incredible contributions continue to be made they are all addressing existing immediate problems that have been an accumulated result of outdated institutional practices that actually need rethinking. The healthcare debate no doubt is messy and the goal of this research is not redesign the healthcare system, but it is to identify to bring to the forefront the before mentioned ‘in-between’ space which needs the critical eye of design to re imagine complimentary care systems that could be the foundation of the beginning of transition towards long term commitment to health that is no longer left at the onus of an individual but as collective understanding of new practices and routines in the social health space.

There is a need for complimentary pro social but non-techno expert centric approaches to helping people begin to transition towards new lifestyles that are built on the foundation of community support and informal place based care towards ones health. By investing and committing in people and place can we build alternate support systems of trust where technology is seen as a means and not the end solution?

What is the future of preventive care?

What are current individual health seeking behaviours?

What role does social network play in the the maintenance of ones health?

What is the influence of the healthcare system over people's understanding of their health?

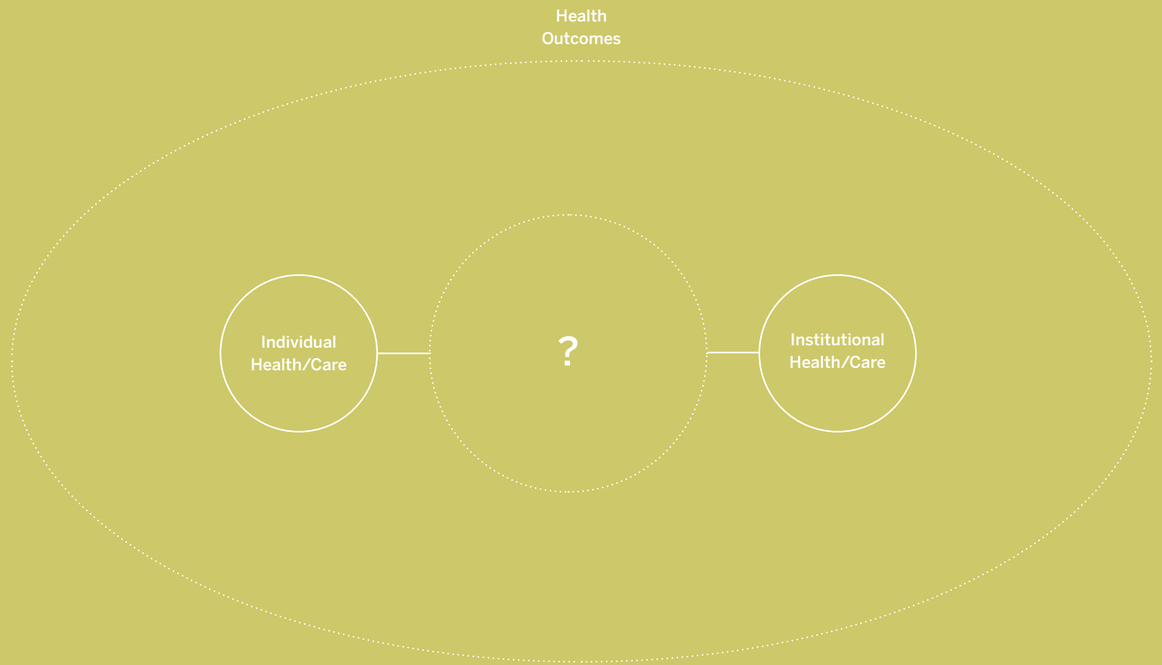
What could be complimentary approaches to preventive care of the future?

Can there be peer to peer based support networks that act as a buffer between self care and insitutional care?

significance

As designers is our prerogative to not only use human centered design methods to tend to wicked problems of today but also use design as a research tool to disclose new worlds of possibilities where we reimagine alternate practices that question and provoke age old systems that have not been questioned due to it's financial power. This research is a step back from the identifiable processes of design and a higher-level scan of a very complex space. Through the activity of gradual scanning across the vast territory of individual health seeking practices to influences of institutional systems, it begins to question current languaging and it's implications towards design. Along with constantly mapping existing practices that are misnomers and weak signs of anomalies that are trying to break away from the existing norms of individual health. By analyzing current behaviours through the lens of the social it builds a case for the rich in-between space of informal health practices that are non-expert pro social. In order to trigger a gradual transition towards the informal health realm it identifies new roles of designers who project a future, which may seem unacceptable in the present. A future where one would invest in micro community based social networks between weak tied individuals who become an integral part of ones health seeking routines and practices.

The significance of a research of this undertaking is to help clarify existing language and it's implications and dogma's around changing health behaviours and using that to build frameworks for designers to better understand to propose alternate frameworks for new products, services and systems. With social health as its core value which could reshape the future application of preventative complimentary care.



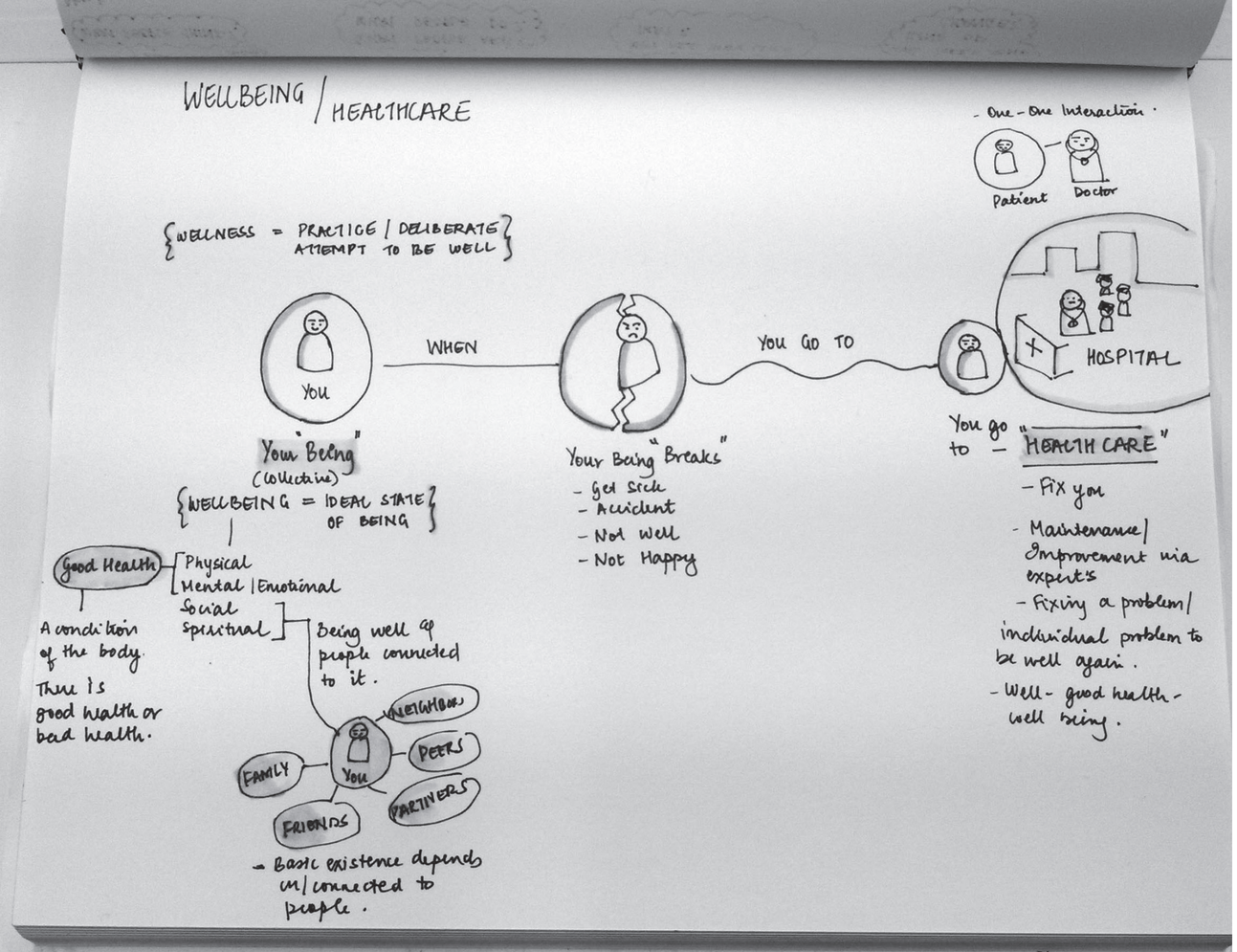
innovation scan

The research is framed as an innovation scan deliberately due to the vastness of the terrain of health it attempted to cover. The intention of the theses from the beginning was not to reach to a final solution to the current problems of maintaining good health and the implications of a complicated healthcare system. But, it is to critically question the interrelations and interactions between the two, the existing language and values associated with expert and non expert care and scanning for emerging opportunities to rethink the norms of today.

The intention of the scan is for it to be used by designers and key stakeholders in re-imagining services and systems of the future of the intersection of health and social. The frantic need for an alternative if not complementary health systems calls for new approaches in tackling the convoluted value system that has been fueled by economic interests of private enterprises. The scan spans across the spectrum of individual health and care practices towards institutional care systems. The middle ground between the two which is the buffer space or the in-between space is what the scan opens up for discussion and inquiry as the 'we' paradigm of complementary health systems which is non expert driven but based on social ties, not necessarily related.

The infrastructure and technology today already afford immense sociality in the digital world. The role of designers and stakeholders today is to identify emerging spaces of interventions, such as in this case the domain of informal health and reconfigure existing infrastructure and technology to open up new practices that lead to long term adoption and behaviour change for the greater good of humanity.

part 1
understanding a messy space



Health
Wellbeing
Wellness
Healthcare
Care
Care givers
Fitness
Insurance
Hospitals
Doctors
Sickness

initial hunches

Definitions

Health The state of being free from illness or injury. A person's mental or physical condition.

Wellbeing A state of good health. A state of being comfortable, healthy or happy.

Wellness Practice of maintaining good health.

Healthcare The maintenance and improvement of physical and mental health, especially through the provision of medical services.

Care The provision of what is necessary for the health, welfare, maintenance, and protection of someone or something. Serious attention or consideration applied to doing something correctly or to avoid damage or risk.

If one's overall wellbeing is a combination of physical, mental, social, environmental and spiritual health then why is it that the definition of ones health is the state of being free from illness or injury? The biggest concern of the role of the healthcare system today is expert maintenance, improvement and support in the time of a disease/ sickness or ill condition of health. When the health of an individual breaks and one turns to the healthcare system, the reactive solution is to provide care to an individual but most often not considering the social support structures needed to cope with recovery. Health concerns today hence oscillate between disparate values between individual and institutional care.

User research group

Millenials - The research is primarily focused on the understanding and practice of health in the US but participants across different cities in the world were interviewed to get contrasting views. The key user group that were targeting and interviewed were millennial (22-35 yrs), living in cities and transitioning through different phases of life. This particular user group was chosen as a sample set to as they are right now at a point in their life where they are young enough to be still healthy but slowly making it towards the time in their life where some are beginning to show signs of deteriorating health due to lifestyle choices. Health is yet not the top of the list of priorities as they are still coping with transition. Specifically a few were people who had recently been diagnosed with a health condition and were recovering or coping with changing their lifestyle to live healthy. Hence, to get a deeper understanding of what might enable them to consider and begin to take long term health measures that are not necessarily driven by institutional pressures and individual motivations but alternative communal measures that could become a routine practice in the future.
Sttersten, Richard and Ray, E. Barbara, Not Quite Adults, Bantam, 2010, Print.

Subject matter experts - Subject matter experts across the domains of government, non-profit and for profit organisations who are actively involved in the healthcare sector.

exploratory research

The exploratory research phase covered interviews, literature reviews, surveys and finding precedents of existing practices that are weak signs of alternate health behaviours.

Each segment of the exploratory research phase was designed to focus on inquiry within the spectrum of individual and institutional health practices. The user interviews focused on current motivations and understanding of health practices. What are people influences in maintaining good health? Do they have support systems that encourage them to stay healthy? What has their experience with the healthcare system? to name a few. The Literature and Survey study focused on Social support and networks of individuals and it's application in known medical fields to understand frameworks that could be implemented outside the expert domain. A running list of precedents showing evidence of alternate products, services and systems establishing transition in smaller communities was maintained throughout the project to gauge a deeper understanding of the circumstance and need to seek newer approaches to wellbeing.

research participants

7 participants. All living in cities.

Participant A - 34 yrs, Health Investment Banker. Recently went through surgery and has been making active changes in his life to become healthy. Lives with wife and daughter.

Participant B - 32 yrs, Marketing for 'Formoms'. Active and extremely health conscious. Lives with wife.

Participant C - 32 yrs, Graduate student. Active and naturally health conscious. Live with husband.

Participant D - 25 yrs, Graduate student. Recently underwent a painful back problem that needed weeks of bed rest. Now started running and actively changing lifestyle. Living with roommates

Participant E - 25 yrs, Consultant. Few years ago went through a back surgery. Maintains a healthy lifestyle since then. Lives with roommates.

Participant F - 27 yrs, works in the non-profit sector. Struggles to maintain a healthy lifestyle. Although naturally inclined to not put on weight. Lives with roommates.

Participant G - 27 yrs, Consultant. Tries very hard to keep up with a healthy routine. Lives alone.

3 experts

Expert A - Worked for a web based service that provided medical information to everyones.

Expert B - Works for the mayor's office. Focus on healthcare policy for the city.

Expert C - Runs a non - profit for care givers in the city through workshops and information session.

research methods

The research exercises and questions were designed around word associations, card sorting, social network mapping and walk-through of speculative designs. The methods used were to gauge responses under the following categories

1. Understanding of terminologies Health, Wellbeing, Healthcare, Care and Wellness

2. Individual practices of being healthy. Motivations/ Challenges/ Influences/ Triggers / recent lifestyle change or illness

3. Key social relations in terms of sharing health and care

4. Social network with respect to geographical proximity and trust

5. Prioritising the different aspects of health

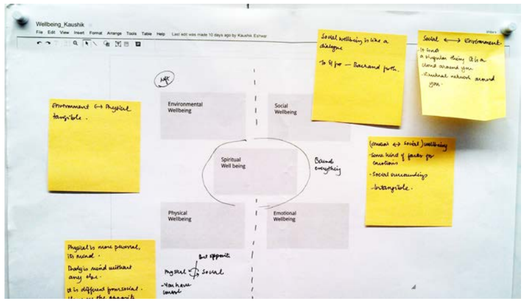
6. Experience with the Healthcare system and their opinions on role of doctors and institutional care

7. Speculative provocations of possible future scenarios of shared care. Group diagnosis, Care pact and Trust Insurance.

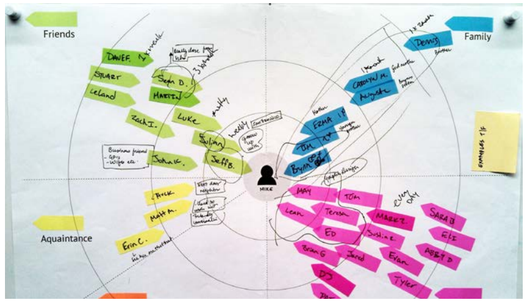
Health practices - What are people doing to be healthy? What influences their decisions? What are their challenges and motivations to being healthy? They did card sorting exercise to plot which aspects of their health they considered most important to them.

Social network mapping - On a matrix they plotted their close network of relations from friends, family, acquaintances and colleagues and talked through people they considered close and trusted and in close physical proximity.

Current experiences with the Healthcare system - Where they did word associations and did in depth walk through's of any recent experience with the system.



Social support system talk aloud - After mapping the key social network on the matrix they were asked to talk through their relationships and interactions with the few they considered as close and would reach out to in the case of health emergencies.



literature study

Health and social supprt a Fundamental Human need
Why does health matter in the fundamental survival of human beings? What role can solidarity play in the existence of humanity?

Current Healthcare practices affecting health seeking behaviours - What influence does the structure of the healthcare system today have on the notions of health?

Behaviour change around health practices - What are alternative theories in the behaviour change realm that demonstrate adopting new approaches to systems and services.

Social Capital and Social Support- In what way can investing in community and building capital lead long term healthy relationships and social wellbeing?

Design as a research tool to disclose new worlds - What are new ways in which designers can imagine and project a future that is unlike the solutions in the space.

survey

A survey was sent out to the identified user group to get a general sense of the values relating to healthy living and commitment to long term wellbeing.

The survey had 70 respondents.

Within the logic of choice scientific knowledge is taken to be a growing collection of facts that gradually increase in certainty. Professionals need to know these facts.

With the relevant facts laid out, someone has to determine the value of various possible courses of action. What might be better? A pen or a pump? Tight or mild regulation? This insulin or that other? Once a decision is made, providing or implementing the chosen technique is a professional task again. But as making the decision is a matter of balancing values, there is no particular reason why doctors or nurses should be doing this. Since treatment interferes with the life of patients, it is the values of patients that should count for most. Framed in this way, the logic seems inescapable. **And it is: in the logic of choice. But not in the logic of care** [9].

[9]
Mole, Marie Anne, Logic of Care, Amsterdam : Routledge, 2008, Print

"social relations of mutual benefit characterised by norms of trust and reciprocity". In this sense, reciprocity relates to the assumptions and expectations underlying the obligations which people, groups and institutions have to one another.

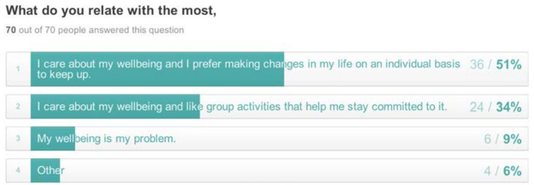
Social support is the primary buffer whilst recovering from any illness or chronic disease. In many instances support has been reported as a critical stress buffer when dealing with day to day concerns of life. Studies have shown continuous access and engagement in an active social community also increases chances of early detection and action towards many unnoticed psychological symptoms of depression and loneliness that if gone undetected many times leads to the built up of chronic fatal diseases. Hence, having buffer systems within friends, family, neighbors, co-workers and multiple networks can be a helpful and life changing release towards holistic health [10].

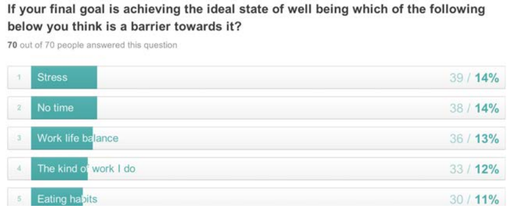
[10]
Cohen, Sheldon Ed, and S. Syme. Social support and health. Academic Press, 1985.

" Holding on to an anomaly as an anomaly is not easy to describe; it is a matter of constantly being sensitive to whatever oddity is happening in one's life, in our case a matter of remaining sensitive to the fact that the entrepreneur's work was not producing any concrete or abstract thing, but nevertheless he was working." [11]

[11]
Disclosing New Worlds : Entrepreneurship, Democratic Action and the Cultivation of Solidarity. Charles Spinosa, Fernando Flores, and Hubert Dreyfus Cambridge, Mass.:MIT Press, 1997

The role of the designer hence is of someone with a hunch and the sense of an anomaly and by actualizing it through her/his entrepreneurial activity bring to the world what a perceived future would look like. These could be experiments that then become artifacts of provocation and research insights to get a deeper understanding of either resistance or acceptance of perceivable change that could lead to identifying concrete deeper problem framing within a vast space of intervention.





precendents

Existing research, services and products in the 'inbetween' space of social health.

Radical Redesign, Australia
Australian organisation - Rethinking old age care. Family by family / In with forward.

Care reflect, Australia
Australian Centre for innovation rethinking social care.

Welfare Review, London
bring about social change by giving grants to localised communities. Through collaboration and building trust within communities.

Ithaca Health Alliance, USA
Subsidized insurance and alternative to care support to communities. Communities Self-insure for Cooperative Healthcare.

Villa Breda, Finland
Rethinking organising municipal services in cities based on wellbeing of the communities.

Planettree
Curated health and wellbeing content.

P2P foundation, Italy
Social coops where individuals with mental illness can spend time and build stronger ties with the communities through social work.

Harvard Medical School
Shared medical appointments.

Peers for project
Support group for health and disease.

ITN America
Transportation alternatives for older people.

Making room
Design an array of accomodating, desirable, safe living units for singles, shared households, and extended families, without the current restrictions.

People powered health
Project by public policy lab on collaborative care

Lambert Collaborative, UK
Providing support through collaborative for mental health

Connect and do Lambert
Online platform to find out about things to do and people to share with in neighborhoods.

Coalition for Collaborative Care
Care for people with long term illness through peer support networks

Time Banks
Sharing time as a reciprocal activity to give back in time.

Health Hacks
Health hacks where communities share with each other DIY solutions to problems.

Patients like me
Patients share data about their disease or chronic illness with everyone. Through the exchange of data they share they are able to better cope with recovery.

Taltiono, Finland
Citizen health information platform.

INSTITUTE FOR THE FUTURE

IFTF - Institute of the Futures, Palo Alto
From the late 2000's IFTF has been contributing towards research and innovation in the realms of future systems and scenarios of healthcare practices through their 'Health + Self' initiative.

What usually are funded programs by private organisations, the resulting forecast maps, wellbeing maps, future of managed care, booting up mobile health and wellbeing perspectives lean towards the sharing social component of health and wellbeing in the future. The insights from these mapping domains clearly affirms a shift that will gradually arise or we will be forced into where the intersection between health and social components of ones life cannot be avoided in order to survive from economic unrest and exponential cost turn around. Not to suggest that financial strain is the probable reason to bend in this alternate direction but they do present already existing experiments within smaller communities that are exploring new ways of living and peer to peer sharing to not only live sustainably but also maintain long term health through connected networks and support systems.

Nesta

NESTA - United Kingdom
Across the other side of the Atlantic, Nesta is an innovation lab that is truly pioneering experimenting with community support and engagement in rebuilding and rehabilitating the elderly population in Lambert Hall, UK. They have been field-testing multiple design interventions in the peer to peer support realm to provide scaffolding for an aging population. By engaging and training the youth in communities they are experimenting with building a support network that is collaborative and sustainable across generations. This lies completely outside of financial institutions like insurance and expensive medicare.

Hence, the reliability is completely based on the motivation to continue getting better and growing their social network. Although their work in primarily focused towards the elderly, their methods raises questions around it's application and scalability across different populations where based on the same intent contextually relevant services and systems could be designed.

CIRCLES of Care

Circles of Care - Indri Tulsian, RCA, 2004
Circles of Care was a project done at RCA which focused on the role of social networks in providing support to an individual through the different transitions of phases of life. It is here that the term 'in-between' space was used to define the gap between individual care/health practices and institutional care/health practices. The difference between expert and non expert care was established against the background of the current healthcare system's healthcare costs and reactive measures of care.

research findings

1. To the transient population health is not the top priority. They are coping with constant change and having to deal with stressful lifestyle.

2. As they move further away from home their **primary systems of social support are no longer in the same cities as them.** Parents, school friends and relatives are no longer in close proximity to directly rely on in case of an emergency.

3. Emerging roles as caregivers. Millennials are soon realising their roles as caregivers to their parents. Considering most of them no longer live in the same cities, they are beginning to learn about what the future of their responsibilities might be like.

4. Building stronger social networks that are no longer limited to physical proximity. They make an effort to reach out and keep in touch with friends and family around the world. Digital tools like fb, instagram, whatsapp, viber, skype and snapchat are all part of their day to day rituals of maintaining relationships of care.

5. Trust in selected social network despite distance. It is earned and built over years of knowing.

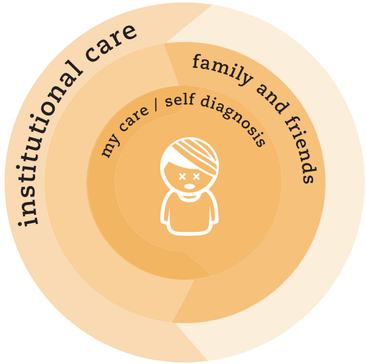
6. Slowly beginning to consider the **value of place but still not completely committed** due to the situation/ stage of their life.

7. Balance between **physical and mental health is key to a stress free and happy lifestyle.** Maintaining work life balance is very important to stay healthy.

8. Health Care system is really expensive and complicated - Those who had a bad experience with the healthcare system had feelings of fear, distrust and helplessness. They considered it was built for the privileged and people with money and the ones with no monetary support suffered the most. But those with good health continue to believe that as long as nothing goes wrong they don't mind paying the price for it.

9. Insurance is a necessary evil - As there is no official alternative to combat the complicated healthcare system, they buy into it because they would rather be safe than sorry in time of a desperate need. Money is the only assured guarantee of trust than people at this point. One would rather pay and not worry about it.

10. Scope to re-envision preventative care and bridge the gap between cure and care - The way the current system is set up is only when something really bad or extreme happens with respect to ones health. There needs to be new ways of thinking about preventative care that is cheap and the fundamental right of every citizen towards healthy living.



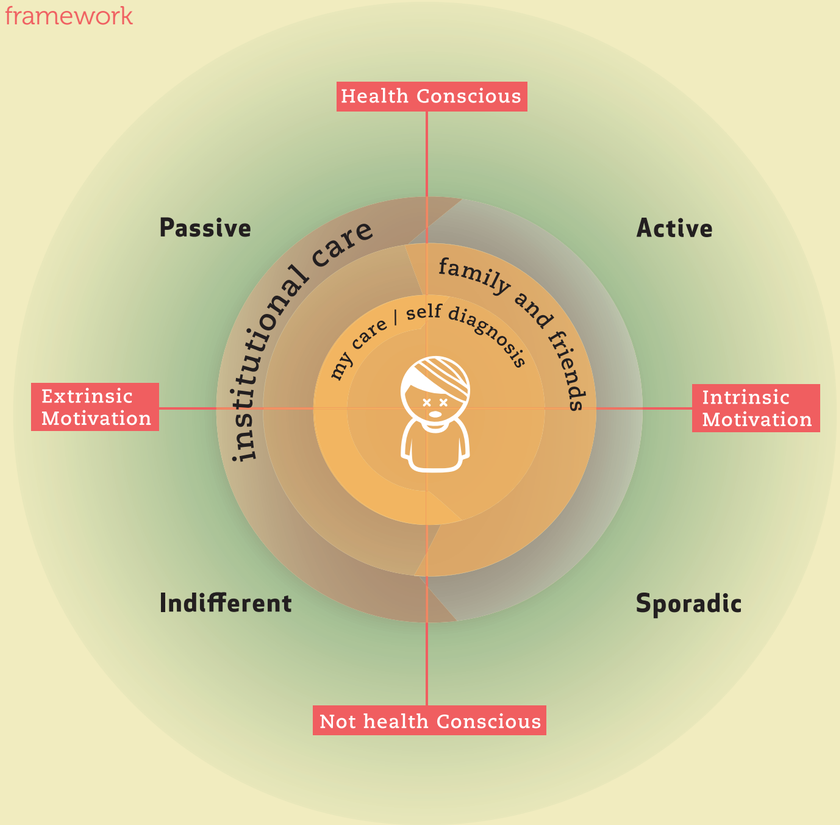
fix people through drugs and technology
quantity of life equals taking drugs to live longer
reactive care, personal care
doctor-patient relationships
let's fix what is wrong
my health is my problem
follow-the-money

'me' paradigm

The predominant theme that emerged from the conversations with the participants and experts is the latent unsaid understanding of the 'me' paradigm. The 'me' paradigm is the outcome of the influence of the current healthcare system and supporting infrastructure which leads people into an inward 'me' centric thinking around their health. When it comes to the everyday maintenance and support of their wellbeing it is understood that it is upto to the individual to take care of themselves. The infrastructure and support are all directed towards an individuals motivations and consciousness to act upon. Hence, it is not uncommon to find most people 'trying' to maintain their health.

The way the current care system is set up, only in the situation of an illness/sickness/disease that one would resort to expert help/care. The rest of the time one would resort to self diagnosis/care or reach out to immediate family. The understanding of expert care in the US is predominantly 'Insurance'. Which is also based on an individuals ability to back it up with enough funding to pay for the obscenely expensive expert care. What becomes clear is that although there is a growing concern towards the maintenance and support of health, there is also the paranoia towards having no support in the time of emergency which leads to fueling the complicated healthcare system through financial incentives. This viscous two way fortifying of mislead values is what is making it harder for current system shapers and policy makers to break away from solving the wicked problems from a fresh new perspective.

self care framework



Active
Active are those who are aware of what needs to be done to stay healthy. They are intrinsically motivated to make the small changes in their life to keep up with a healthy routine. Most technology products and services are targeted towards the active archetype. The fitbit's and jawbones as people need to work with these products when it comes to actual behaviour change.

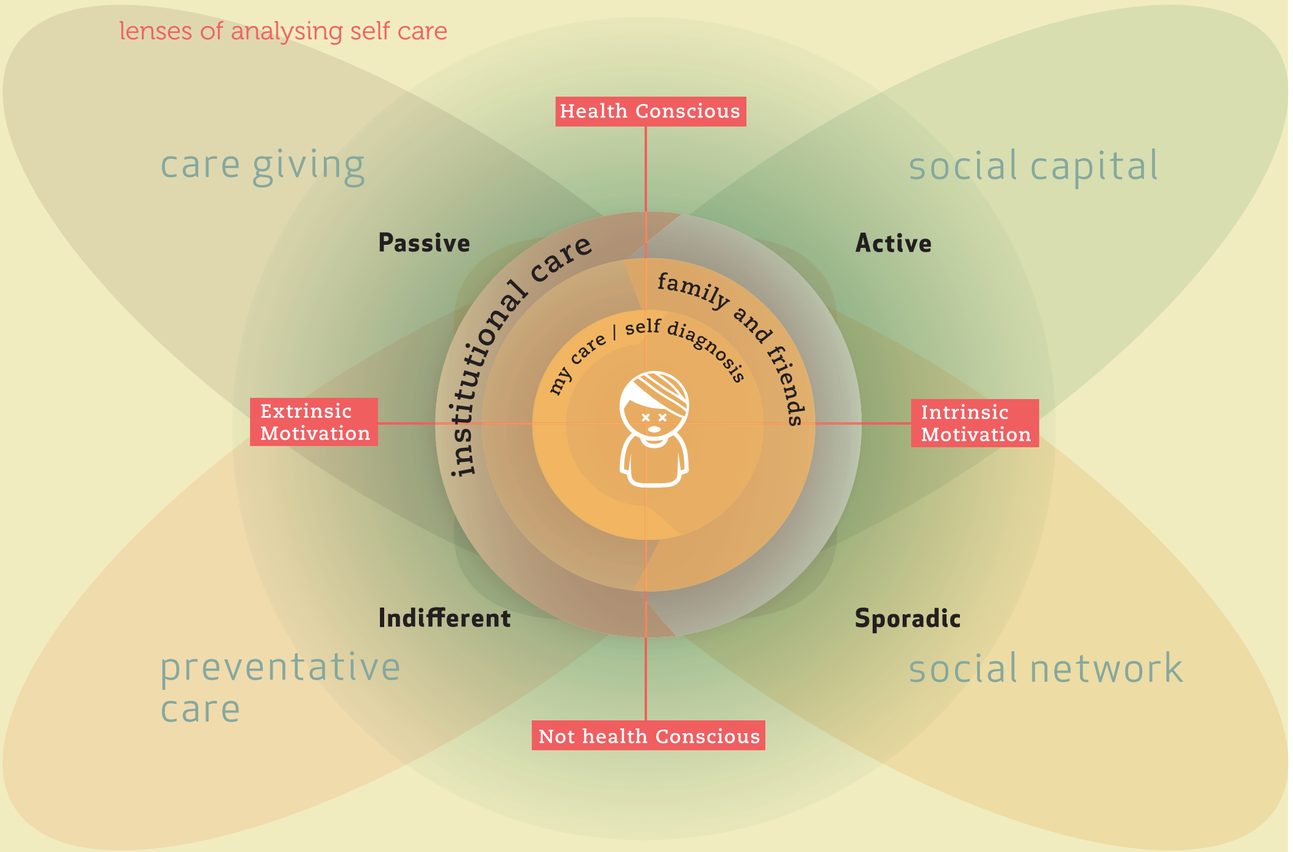
Passive
The passive are an archetype in which a major chunk of today's population falls under. They know they need to be healthy and are conscious of it's implications but are not entirely motivated to adopt accepted norms of healthy practices. That could be exercise, running or eating healthy. Although they know that these are good for you. It's the passive archetype that suffers the most in terms of stress and lifestyle influences.

Indifferent
The indifferent are in most cases the archetype that is most difficult to consider to change at least through immediate design intervention. They are less aware and motivated because of which are prone to bad health choices and even problems in the long run. It is due to the indifferent cases that the a lot of systemic problems of rising healthcare costs even arise as they are not invested in preventive measures.

Sporadic
The sporadic archetype are the motivated kind but not necessarily motivated towards being healthy. It is the activity that motivated them to take action.

The framework helps gain a deeper understanding of why the current individual self care practices are so varied and rooted in their everyday routines. The framework is a collected summary of the interviews with participants, experts and literature that affirmed the 'me' paradigm that began with a hunch about the current setting of health. By establishing the framework to understand the 'me' paradigm it also opens up opportunities to map existing products and services that are targeted towards individuals in the health segment. Fitness products and services can be better analysed once we view them from the lenses of these archetypes of users. It could also explain much of the problem with retention and considerable behaviour change that is so hard to achieve with respect to adopting health seeking behaviours.

The self care framework is the starting point to begin rethinking existing behaviours. The next step from here was to analyse the individual frame from the lenses of external agents that often shape and support health seeking behaviours.



The four predominant lenses of analysing the 'me' paradigm emerged from existing challenges and precedents faced in the everyday health seeking routines of individuals. These stood out an anomalies as they were all connected to people in their lives and not just themselves. The research approached these anomalies as opportunity seeking lenses that could be explored as an opening for design interventions.

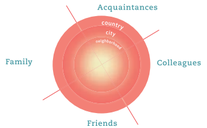
Care giving

"I know I should be taking care of my parents, I do think about it. But I am not there yet in terms of doing something about it, maybe because they are not in the same city."

"I feel responsible for my wife and making sure she is happy and I am providing enough."

Challenges

- Accepting the role of future care givers
- Distance from close family members and loved ones
- Work life balance.



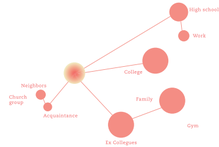
Social Capital

"My brother lives in the same city and I always have him to rely on for any personal or family emergencies."

"My wife helps me stay healthy, she cooks meals for me and makes sure I get enough exercise."

Challenges

- Investing time, effort and energy into building networks that are not long term
- Closeness is built over time and through sharing similar interests. Someone who has a stake in it
- Trusted support networks of people are no longer in physical proximity [12] [13]



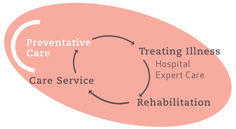
Social Network

"I realized when my sister moved out I had to reach out to my high school community to make new friends."

"I use running as a means of hanging out with my friends."

Challenges

- Coping with change and uncertainty. Constant flux in urban living
- Struggle to maintain work-life balance and maintain healthy distance within networks
- Scattered social circle. Blurred boundaries with digital and physical networks



Preventive Care

Personal

Diet and exercise
Family doctor
Therapy
Quantified self

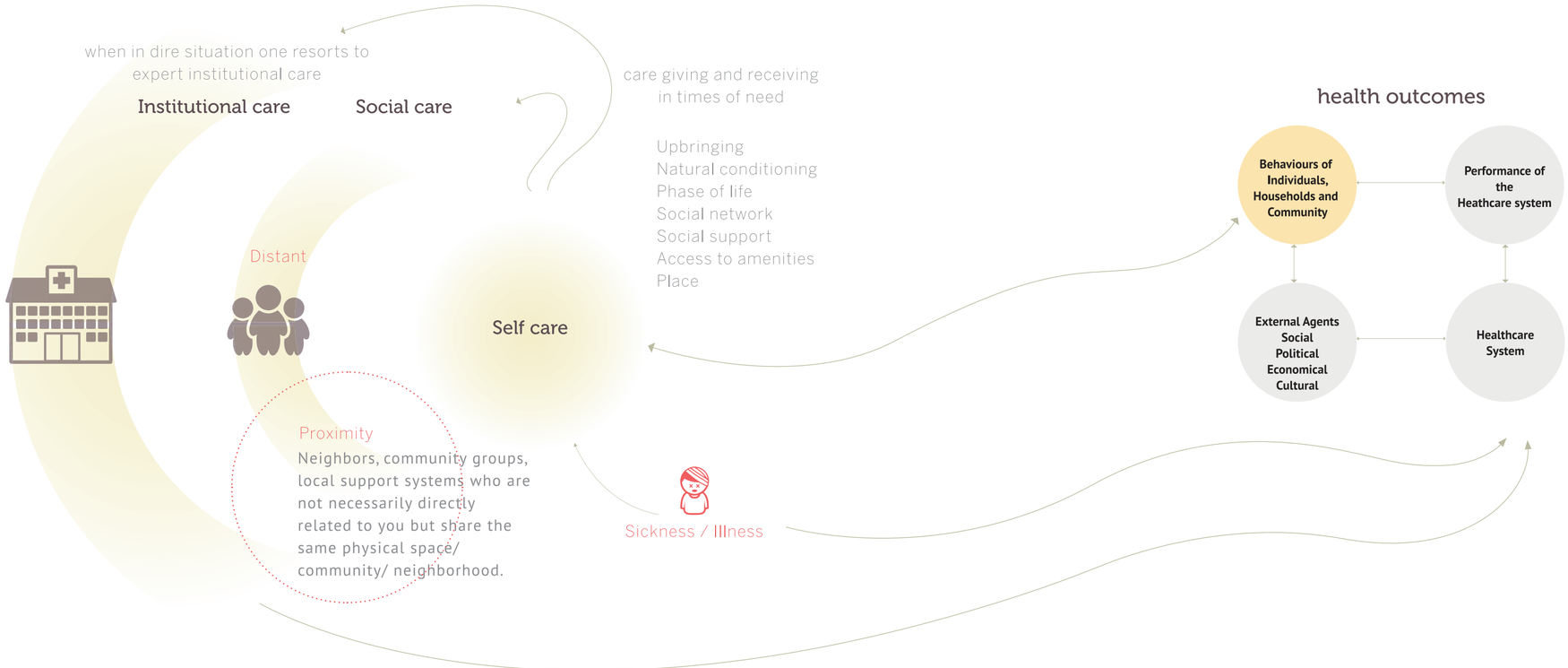
Institutional

Regular health check-ups
Vaccination
Insurance plans

Challenges

- The current care system does not recognize social practices beyond the financial structure of the system.
- Insurance as a trigger for fear
- Motivation and consciousness

landscape of self care and institutional care



new definitions

Health outcomes are dependant on behaviours of individuals and the influence of the healthcare system today. The 'me' paradigm is situated within the individual behaviours outcomes. The research establishes new definitions based on a deeper understanding of the self care framework with respect to it's relationship with institutional care and the in-between social care.

Informal Health is non expert driven maintenance, support and care towards ones overall being that is based on the social support from ones network of people preferably in close proximity.

Shared Care is the practice of informal health. It is the sharing of health with the community and its people through informal care systems based on proximity and trust. The premise of shared care is to enable investment in place and its people to build long term relationships of care. Hence, within the territory of health outcomes it is the bridge between self care and institutional care. A rich space that requires attention and needs to be tapped into to address complementary preventive systems of wellbeing that can leverage human capital and support instead of unnecessary financial systems that have no relation to ones health.

Enemies of Shared Care

Logic of Choice and Expertise - In a system where the doctor and the healthcare system is trusted and considered to have the supreme decision making power when it comes to ones health it is also a deterrent in terms of building complimentary approaches to health that are not necessarily expert driven. What is often not accepted is that not all aspects of ones health requires expert intervention. When it comes to everyday care and maintenance of ones wellbeing it is social interactions and environmental support that leads to a holistic way of living. Most of the social interactions are ones in our immediate social network or physical proximity. Maintaining healthy relationships on that level is what enables reduce the stress and overwhelming burden of coping with the lifestyle changes of today.

Depleted Social Capital - A greater amount of the population today is in constant flux and moving from one city to another. It is not uncommon to not know your neighbors in an urban setting and live secluded singular lives. In many cases as people have transitioned from one phase of life to the other they have moved further away from their families and fundamental support structures. It is due to which there is a lack of trust and paranoia around investing in new ties and relationships when the eventual move is always on the horizon as life transitions towards the new.

Emphasis on Privacy - The current setup of the healthcare system has created a looming myth around privacy of ones health data. The current Insurance structures and healthcare providers have lead to myths around exploitation of ones health by pharmaceutical companies and corporates who are looking to make money. Policy makers and the government have further encouraged a closed system of managing and supporting healthcare due the economics involved in funding these programs.

What is health for healthy and care that is non institutional?

problem framing & emergent spaces

Shared Care as a social innovation
How can design work to establish the current intersections between health and social as an alternative type of preventative care that would have implications on future healthcare policies and design of healthcare systems?

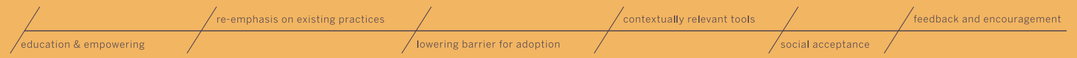
‘Place’ through connected people
Can the conception of ‘place’ be through the network of people? How can design enable commitment to build the social capital of a place in order to foster shared care and a sense of belonging whilst in transition?

Informal urban trust networks
How can design enable informal, proximity- based urban trust networks that make shared care an alternative to insurance? What role can design play in creating conditions of trust to enable frictionless care?

part 2
projecting a future in shared care

Phases of transition

For any kind of behaviour change or transition in practice to occur there needs to be an initial hunch or vision of a projected future. The following transition model from the 'me' to the 'we' paradigm was created from the combined anecdotes from interviews, literature and existing services that were successful in bringing about small scale behaviour change over time. These phases will act as a guideline in created rich narratives of applications of Shared Care and it's adoption by different user archetypes.



designing for shared care

Having validated initial hunches and gained deeper insight into the landscape of the health outcome domains multiple directions for further inquiry emerged from the first stage of research. Instead of directly jumping into the solutioning phase the theses used design as a research tool to project future scenarios of complimentary health seeking behaviours that are social as a mechanism of discerning the future roles of designers and stakeholders.

shift from the 'me' to the 'we' paradigm

The role of design in enabling Shared Care is by creating conditions for transition to occur from the 'me' to the 'we' paradigm. This transition will occur over a period of time. For any new kind of paradigm and innovation to instill and be implemented there needs to be gradual setting up of scenarios where new interactions and thinking can thrive. The role design can play in its manifestation is through the design of products, services and systems that facilitate behaviour change and new thinking around ones health.

'we' paradigm

The 'we' paradigm is the shift from the existing accepted norm that 'your health is your problem'. The 'we' paradigm is a change in approaching every day living and systems that we interact with to consider social health and avenues of instrumentalising the re-imagining of existing norms and practices around community involvement and investment in ones life. Instead of equation health to individual motivation and expert care the 'we' paradigm is based on a circular value flow of support towards the people in ones immediate environment. Through rich narratives of user archetypes can the 'we' paradigm be better illustrated and its context validated.

personas of shared care

Generative Research
The insights from the exploratory research helped crystalise archetypes of users within the transitional millennial group that would adopt Shared Care practices to embrace long term commitment towards their health from an earlier stage in life. The stages of transition would depend on whether they need, re-build, discover or share Shared Care.

Process
By developing rich narratives specific to each archetype we were able to realise the potential and scope of what the intersection of social health practices would entail. Key considerations were geographic proximity, unrelated connections, informal non-expert-care and investment in place.

Concept direction
The scenarios were deliberate attempts to balance the sociality of health along the preventive care spectrum. Focusing on lowering barriers within existing infrastructure and behaviours that consider building stronger ties through sharing between micro-communities.

The entrepreneur transforms the style of a disclosive space by reconfiguring its practices. He or she does this by producing a new product, service, or practice which people will find themselves inclined to use. The virtuous citizen cross-appropriates practices by means of his or her speaking. And the culture figure articulates important practices which we are ignoring.

Charles Spinosa, Fernando Flores & Hubert Dreyfus (1995): Disclosing new worlds: Entrepreneurship, democratic action, and the cultivation of solidarity, Inquiry, 38:1-2, 3-63

disclosive design space - experiments

Any entrepreneurial activity according to Spinosa, Flores and Dreyfus is the process of holding onto an anomaly and through the design of products, services and systems disclosing the anomaly to the world. It is in the act of realising a product, service or a system the anomaly actualises and comprehensible by the world. Anomalies by their definition usually hunches of a projected future that would not necessarily be acceptable norms of the present. Hence, it is through the courage of an entrepreneur to bring to life to an anomaly that true innovation occurs.

In order to realise Shared Care, rich narratives of future scenarios were designed. The user archetypes were used to ground the design scenarios around probable used cases of Shared Care services. A few of the scenarios were taken a step further and detailed out as working experiments of what the look and feel of these services would be like. What would the context of use be? The detailing of concepts was also an experiment in using the design process as an evaluative method to raise research questions. Instead of directly jumping into AB testing and user research this exercise was used as a mechanism to frame narrower research problems that then could be explored further. Hence, the design experiments were only seen as an initial research probe in identifying more specific tracts of inquiry. [14]

[14]
Steyaert, Chris. "'Entrepreneuring'as a conceptual attractor? A review of process theories in 20 years of entrepreneurship studies." Entrepreneurship and regional development 19.6 (2007): 453-477.

“when I’m sick I want to be left alone”

self carer

sarah needs to build shared care

Kin - Healthline

A community run non profit organisation that is funded by the local municipality and care centers. It is helpline run by the people of community who give support and care in the case of small time emergencies that don’t always require being rushed to the hospital.

Kate has been down with the flu for a few days. Today she couldn’t get to work because it got really bad! Usually she would take medicines or call her mom to ask for help if it got really bad.

She reads about ‘Healthline’ as she is checking her mail box.

Kate finds out that there have been more cases of the flu on her street. She is recommended to stay indoors and asked a few basic questions about her condition.

She was told that this was nothing serious as the other reported cases got cured in a couple of days. It was only due to the sudden drop in temperature.

As Kate was calling in for the first time she was also informed that she was elligible for a care pack from ‘Healthline’

Kate is payed a visit by one of the healthline volunteers who delivers her care pack. The volunteer happened to be one of building residents. Who volunteered for healthline a couple of days a week.

He shared some useful information about healthlines radio show every evening that gives health updates of the neighborhood. As well as some useful information in case her condition got worse and numbers to call directly.

Kate finds that care pack had some really basic essentials like a blanket, thermometer and important contact information and helpful brochures of resources she might need in the next few days of recovery.

She also tuned in to the radio show in the evening and was able to get a better sense of what was happening in her community but also learn about all the things out there for her to explore.

Transition Stage

Kate’s roommate recently moved out of her apartment so now she realises she needs to build Shared Care. She begins by educating herself about healthline and then slowly transitioning toward adopting it.

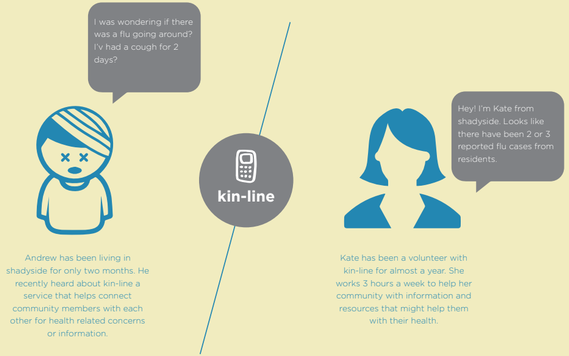
Needs addressed

Healthline addresses the need for early adopters of Shared Care who are testing the waters and not necessarily ready to be completely involved in terms of participation. By beginning to first only access information and seeking help it hopes to build trust over time with the community that is supporting the service.

Deliverable

Healthline is a phone service but it would also have a digital app component on the phone which the members of the community could use to send out text messages, access information and data about the health of the community and neighborhood.

how might we enable complimentary services that provide information, support and care towards preventive health supported by the collaboration between non expert community members?



Andrew has been living in shadyside for only two months. He recently heard about kin-line a service that helps connect community members with each other for health related concerns or information.

Kate has been a volunteer with kin-line for almost a year. She works 3 hours a week to help her community with information and resources that might help them with their health.

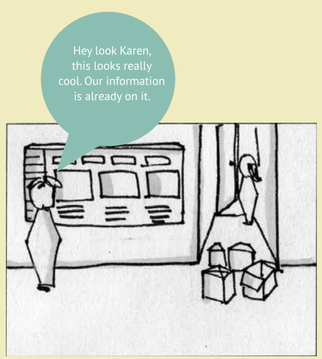
“when I’m sick I only rely on my trusted friends”

conscious carer

jeremy needs to re-build shared care

Kin - Apartment dashboard

kin in a software platform for apartment dwellers to manage, share and maintain their everyday routine within a closed network of individuals living in the same apartment.



Jeremy recently moved to Pleasantville to be with his girlfriend. They just moved into their new apartment.

Jeremy discovers the apartments digital bulletin board at the entrance of the building. He was plesantly surprised to find really interesting and useful information listen on it. He also found that his contact was already stored in the system.

Jeremy explores it further to find that it had some really helpful listings and resources including setting up time slots of laundry, parking maps and other amenities usage information. It also had listings of other neighborhood resources like grocery stores, hospitals and important numbers to call.

He discovers there is also a section where people to sign up for carpools.

Since Jeremy just moved to the city and he didn’t have a car he was looking for alternative modes of transport in the initial days. He sees that someones heading out to a garage sale in the same neighborhood in a couple of hours!.

He decides to request if he could get a ride and take the look at the sale.

Jeremy meets Tim who offered the carpool to the garage sale. Tim offered to help Jeremy with any other kind of help he would need since he’s lived in the neighborhood for almost 3 years.

Jeremy was really happy with his decision to live in the apartment and its sophiscated information board that immedietely helped him build connections with his neighbors.

Transition Stage

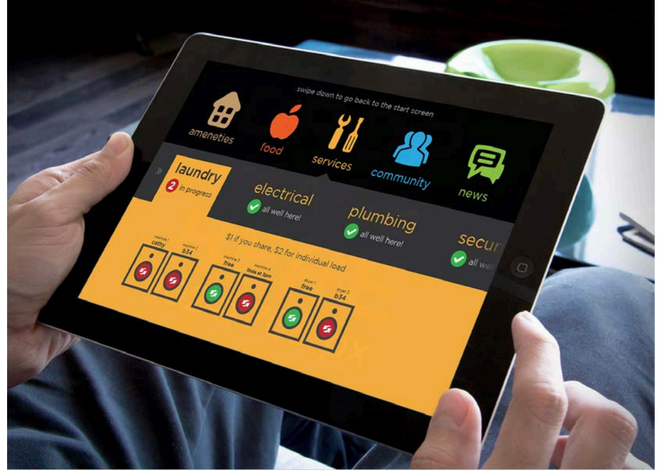
Jeremy just moved to a new city and is looking to rebuild his Shared Care by reaching out to potential social network in his proximity.

Needs addressed

He is new to the city and needs to learn about his neighborhood and people he could build connections with who could potentially be his support system. For simple everyday tasks one can reach out to their neighbors and community to share experiences and interests.

Deliverable

The dashboard is a platform restricted within the proximity of apartment dwellers to connect and build closed ties of support and trust to carry out everyday routines. It is manifested in the form of a physical screen in the vicinity of the apartment and is tied to a digital component that is cross platform to access information exchange.



how might we enable social engagement and sharing of everyday routines and wellbeing within closed apartment networks of weak tied individuals?

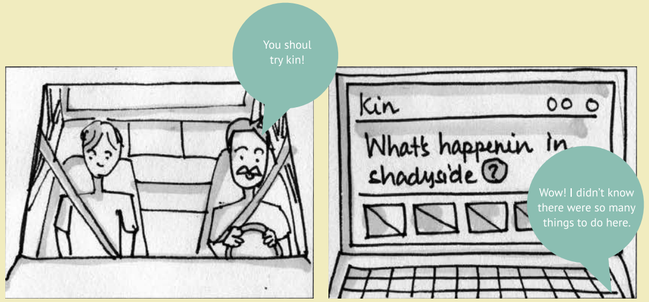
“when I’m sick I only rely on my trusted friends”

conscious carer

jeremy needs to re-build shared care

Kin - Apartment dashboard

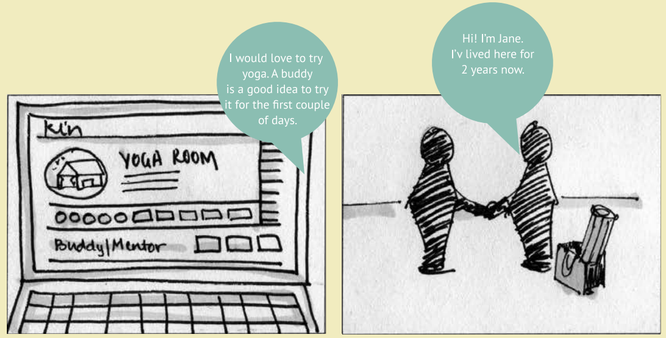
kin is a community driven service that aims to bring people together through shared care. It is a place based digital platform that enables inhabitants of the same neighborhood to build relationships based on sharing resources, time and discoveries.



Jeremy recently moved to Pleasantville to be with his girlfriend. They just moved into their new apartment.

He has been carpooling with one of his neighbor’s. He has been looking for ways to engage in his hobbies like yoga and climbing but hasn’t really found a reliable source.

Jeremy decides to try kin. kin is a service that shows you community based feed of locals and visitirs who engage in activities and interests specific to the neighbor-hood. It even shows active members of the community who are willing to mentor/ help people transition into a new place by developing new hobbies.



Jeremy sees that there is a yoga class in his neighborhood and decides to give it a try. When he sees the option of signing up with a buddy he thinks ‘why not?’. It would also be a good way of getting a localites impression of what works and not and will help him with the akwardness of not knowing anyone.

Jeremy meets Jane his assignmed buddy for the class. She comes to pick him up and they both walk to the studio whilst talking about other fun activities to engage in the neighborhood.

Transition Stage

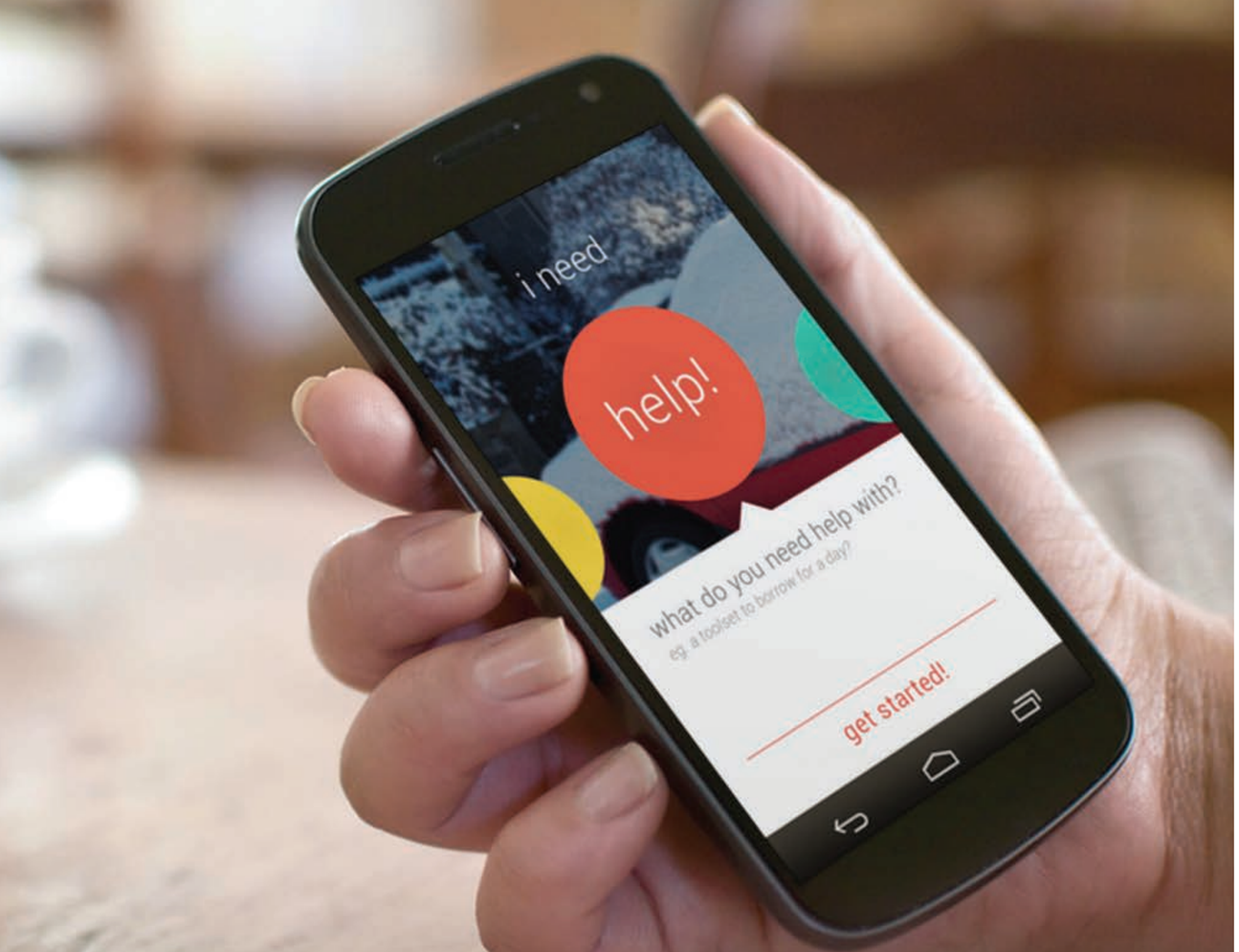
Jeremy just moved to a new city and is looking to rebuild his Shared Care by reaching out to potential social network in his proximity.

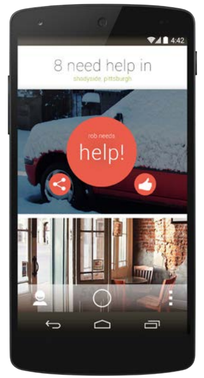
Needs addressed

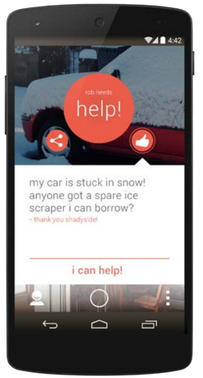
He is new to the city and needs to learn about his neighborhood and people he could build connections with who could potentially be his support system. For simple everyday tasks one can reach out to their neighbors and community to share experiences and interests.

Deliverable

A cross platform service that enables neighbors to share and look for information relevant to their specific neighborhood. A micro-community based sharing platform. The mobile app allows for quick updates and feedback based on location to reach out for everyday routines.







how might we enable informal sharing in communities that would help them build relationships of support, trust and care?

Health of the Neighborhood

An online platform that tracks the health of the community. A user generated platform where local members of the community can share data, resources and valuable knowlegde related to health.

Kate has been down with the flu for a few days. Today she couldn't get to work because it got really bad! Usually she would take medicines or call her mom to ask for help if it got really bad.

She had heard about 'Health Chronicle' from one of her colleagues. She decides to check if it had any useful information for her.

On 'Health Chronicle' Kate is able to see data specific to her neighborhood tailored to all kinds of health concerns. Under resources she sees listed health centres and hospitals. Under data she finds really useful information she never thought existed about recent outbreaks of diseases in her community. All the information was provided by local residents and they shared their experiences.

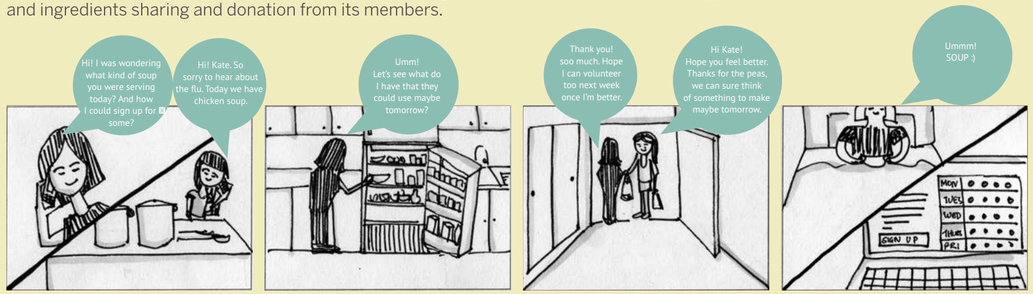
Kate finds that there was indeed a flu outbreak in her neighborhood last week and there were a few more cases being reported. However, it was just a result of the sudden drop in temperature and that in a few days it would pass.

It also listed useful tips and resources that might be helpful for people still under the flu. It also showed contacts of residents in the community to had reported for any further enquiry.

Kate finds that the local soup kitchen was enlisted as one of useful resources that another neighbor used when she had the flu. The kitchen was giving out free soup to folks under the weather every evening from 5pm to 8pm in return for either a few hours of volunteer work in the future or sharing any ingredients from home that would help them with their next recipe.

Soup Kitchen

A locally run service supported by the neighborhood grocery store. It runs every evening for a couple of hours and give away free soup to its community members based on volunteer support and ingredients sharing and donation from its members.



Kate has been down with the flu for a few days. Today she couldn't get to work because it got really bad! Usually she would take medicines or call her mom to ask for help if it got really bad.

She was about to order some food when she came accross Soup Kitchen at the grocery store she always goes to in her neighborhood. She calls them and tells them about her flu and asks how she could contribute to the kitchen.

Kate is recommended to share any extra ingrdient she might have in her kitchen in exchange for the soup. She is also offered a free home delivery since they recognised she was a known customer and down with the flu.

Kate rummages through her fridge to find some extra bread and frozen peas in her fridge that she thought they could use for some other recipe.

Kate is delivered hot soup in the next 20 minutes by one of the volunteers of Soup Kitchen. She chat with her all about the kitchen and how it runs and is delighted by this new service that the grocery store started.

She realised how helpful and thoughtful it was for people especially when sick. Also, a great way to get to know her neighborhood better through its people.

Kate enjoys her soup in bed and is already starting to feel better knowing that there is useful support in the neighborhood she lives in.

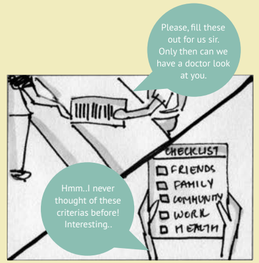
She decides to sign up for next weeks slots to volunteer to make soup and help some of the other members of her community.

Peer care insurance

A new kind of insurance plan that helps you identify and priorities your health through a series of checklists and criterias that help identify the current health condition based on which you can choose which plan to pick. The healthy you are the less you pay.

Jeremy recently moved to Pleasantville to be with his girlfriend. He got the flue a few days ago and decided to visit the care centre in his neighborhood just to have it checked.

He is new to the city and other than his girlfriends friends he doesn't really know many people.



At the centre the nurse hands him out a few documents to look at and fill out on his first visit.

He notices a brochure about Peer care insurance. He is intrigued by the list of checklists that they provided and it really made him think about his recent move and prioritising his health.

Jeremy goes home and takes a closer look at the checklists that the centre had provided. It raised some very thoughtful questions about who were really in his immediete supprt network and people he relied on.

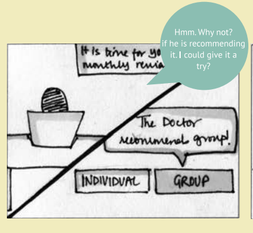
Based on his current supprt system and health condition would the company then prescribe and identify the most appropriate plan. The healthier he was holistically the less he would have to pay for institutional care.

Jeremy decides to reach out to his girlfriend's friends to begin building new relationships and support networks considering he had aready made the move.

He gets a routine medical check up to see his current health status and finds out that he is indeed really healthy and is slowly beginning to also build a social circle. He decides to sign himself and his girlfriend up for the new plan!

Group consultation

Shared consultations with care givers and doctors for those coping with the same stage of recoverry/ illness. One can choose to either meet individually or as a group but the doctor often sends recommendations depending on stages on consultation.



Leo has been recovery from very bad episode of lower back spasms. He has been undergoind physio for the last 2 months and it has been a slow recovery since then.

He gets a notification from his doctor's office of his next appoinment. This time the doctor recommends a group consultation.

Leo reaches the doctor's office to find a different set up for this consultation. It was more open and bigger room with a wide table with coffee and a few other people in the same room. At first he felt a little uneasy sitting next to strangers.

The doctor came in and then as everyone began to slowly start talking about their recovery and experience Leo found it really help to hear about others coping with the same issues he was going through.

After the first 30 mins of group consultation depending on individual needs they were either taken to a more personalised check up or they left. Leo felt very comfortable with this new format his doctor was trying and definitely felt he benefitd from shared experiences of others.

After his consultation he stays back and chats briefly with a the others who were also present at the group consultation session. They shared their stories and reports more openly and decided to meet again for the next round of consultation.

Reciprocity in care giving & receiving is the foundation of shared care with respect to investment in time, incentives and motivation

Self location along the spectrum of Preventive care and Expert care Infrastructure that can provide scaffolding to current practices to enable shared care

Transitioning from sociality to health related sociality based on mutual understanding and acceptance of sharing wellbeing

New Service Design paradigm which is micro-community; place based and does not run based on the models of for-profit or non-profit's but a DIO collective which has social sharing of well being as it's key strategy

key findings

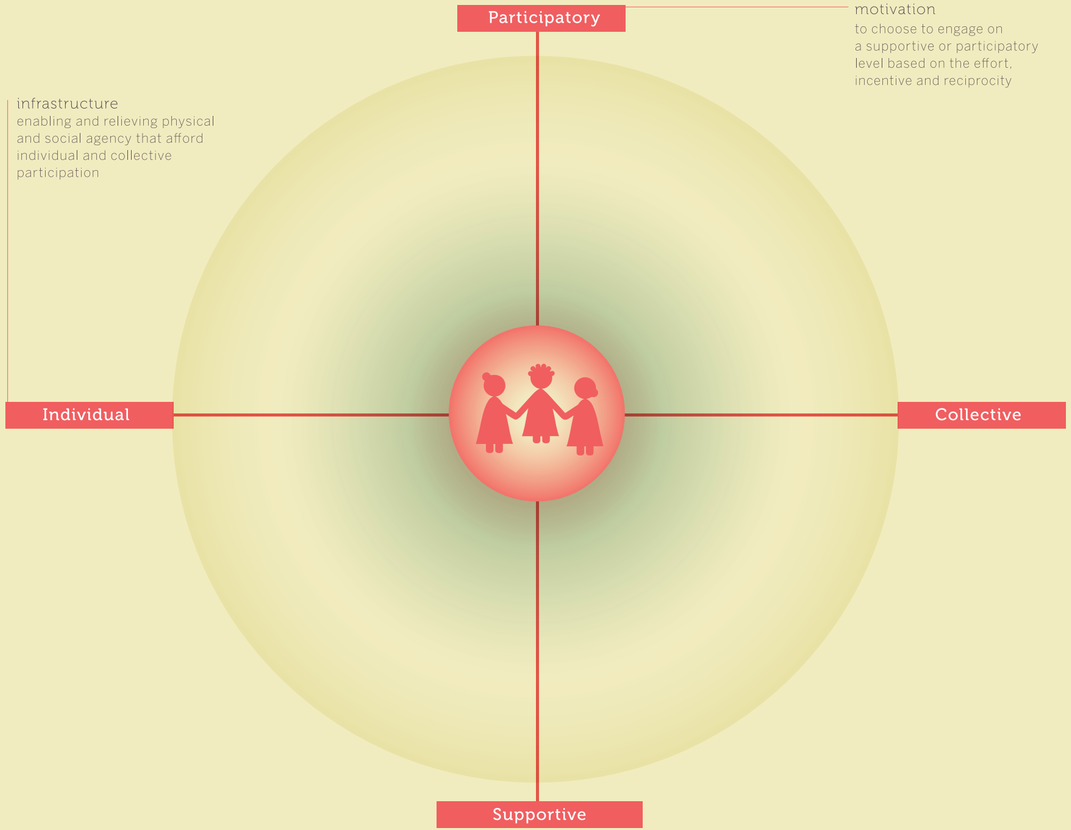
The key findings from the design exercise was the understanding that in order to enable transition to Shared Care practices there are two factors that are key in the adoption of any kind of behaviour change.

Infrastructure

With any new entrepreneurial endeavor to material there needs to be the relevant contextual tools and infrastructure that afford seamless integration into ones everyday routines with minimal cognitive load. As in the case of creating the right conditions for people to begin to approach Shared Care as an acceptable practice there needs to be enabling and relieving physical and social agency that affords individual and collective participation. Technology and tools today are at the perfect juncture to facilitate sharing, it is a matter of finding optimal combinations of engagement that is focused towards the intersection of health and social.

Motivation

Motivation is key for any kind of health seeking behaviour change to occur. Especially in the case of empowering people to share their health with a community that they would never consider interacting with. The key trigger for motivation in this case would be to design services that affords them to choose to engage on a supportive or participatory level based on effort, incentive and reciprocity. Once these boundaries are established it is easier to begin dialogue around the extent of involvement. Motivation is key even within individual health seeking behaviours and once they are able to cross over to the participatory side to sharing support it will be easier to maintain their motivation by experiencing favourable results in their own wellbeing.



we paradigm

preven tive care
community wellness
people helping each other
circular flow of value & support
environmental & behavior causing problems
social support system

framing the shared care problem space

Based on the key insights from the design exercise the research proposes a new framework to analyse and understand Shared Care practices. At the core of it's application is the 'we' paradigm. It draws from the common focal point of the self care framework where motivation is key to any health seeking behaviour but in this case the contrasting coordinate of infrastructure considers enabling technologies and tools that are already in existence that could act as the means for transition to new health seeking behaviours that are social and invested in community.

By framing the problem space as one in which the foundation of any kind of motivation is supportive leading to the optimal that would be participatory involvement it opens up challenges to designers to ensure engagement that fits the minimal criteria without it falling back on the existing individual centric practices. Similarly, it proposes to push the involvement of infrastructure that could span across the everyday domains to consider individual and collective scenarios. This leads to considering opportunities where designers can begin to think of creative ways of contextually situating technology and existing practices around health seeking behaviors that are pro social and now exploits new realms of application.

housing

working

mobility

food systems

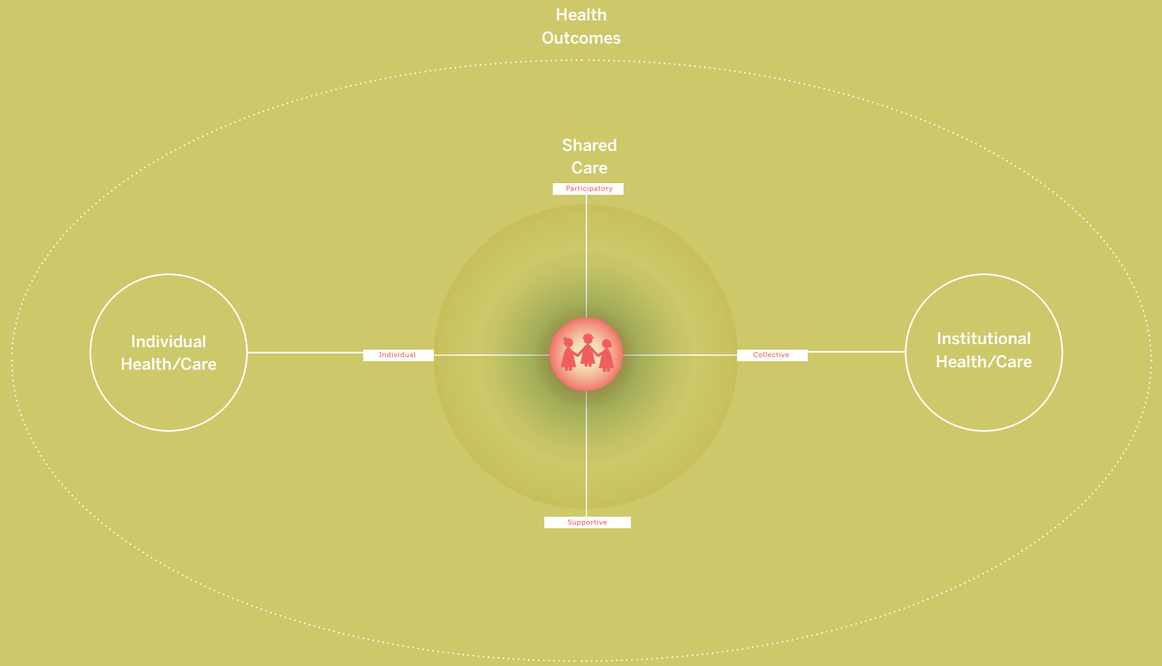
social

mapping insights

By mapping the design experiments on the proposed framework it establishes the diverse potential to consider and approach informal health from a service design paradigm. In this case the services are supported and maintained to a great extent by the citizens of the community itself. What is key to note is that each of these potential applications of Shared Care are actually deeply situated in everyday infrastructure and activities of individuals. Housing, working, mobility, food systems and social to name a few. By explicitly identifying the specific area of intervention design can now enable more focused inquiry within each domain.

The framework also establishes a critical approach for designers to consider whilst investing in entrepreneurial endeavors in creating products and services to ensure limitations and parameters of technology. As mentioned at the beginning of the theses ensuring pro social non tech-no centric solutions to the impending health concerns of the west should be the prerogative of creative practitioners and policy makers of today as they project a future in Shared Care. By thinking in a way of contextually mapping the present systems and finding complementary ways to frame existing problems can we really begin to innovate for a future that is rooted in solidarity.

conclusion



future directions

The future direction of a research of this kind is to unfold potentially rich spaces for further inquiry through design. By establishing new paradigms of practice and behaviour change to transition to it questions existing norms. Shared Care is a practice that has been prevalent in many cultures across the world over centuries. The mediums and infrastructure for it's implementation may have been different but social support through communities and informal care systems is not a new norm discovered. However, with change in values and dynamics of the economy governing much of the philosophy shaping health seeking behaviours in the US, there was a need to critically examine and question why?

The future of Shared Care is in it's cross disciplinary understanding and implementation across the diverse sectors closely tied to informal health. The frameworks developed to understand the current systems as well as the projected future can be used to gather foundational understanding of the significance of the way behaviours are shaped around systems. **The key stakeholders who will need to collaborate would be designers, architects, policy makers, non-profit organisations, technology companies, product retailers and the healthcare system** to name a few. They are all key players in the shaping of the projected future and it is role of designers to now create conditions of dialogue and collaboration in order to mobilise the application of the Shared Care paradigm.

emergent spaces

Opportunities to consider new paradigms of service design in the realm of informal health practices that are micro-community centric and place based between individuals with weak ties as an alternative long term approach to complimentary medicine along the spectrum of preventative care

	housing	working	mobility	food systems	social
Motivation *care giving and receiving, incentives*	Building, discovering and maintaining new dimensions of care giving and receiving in every day activities that enable efficient breakdowns of chores through collective effort. eg. Community laundry, sharing amenities and cutting costs.	Establishing richer network of expertise and growing network within professional realms to enable maintenance and build wellbeing. Building stronger professional ties and trust for long term commitment. eg. group work routines and sprints with exercise regimes.	Discovering and maintaining mobility practices that reduce costs and enable sharing through immediete community network. By sharing resources, energy and knowledge about alternative practices the community builds stronger ties and develops long term practices.	By engaging and investing in social food systems that support and nurture healthy food practices leads to long term investment in building community. Sharing skills and expertise an emerging domains of sustainable micro community building.	Adapt, build and connect with people with similar interests and contribute to a growing pool of transient population on the move. By investing in place and community an individual becomes involved in building trust accross cultural diversity.
Infrastructure *scaffolding existing practices to self locate*	Alternate living solutions that afford and enable well rounded opportunities for people to consider environmental wellbeing as their prime priority. eg. shared space for group activities, community gardens, free group exercise activities via neighbors.	Allowing flexibility in building routines focussed around individuals as well as group health dynamics that can afford sharing information, practices and regimes. eg. enforcing collective involvement in routines that involve both work and fitness and shared space initiatives.	Collaborative incentives with local governing bodies and public transportation to afford alternative mobility practices. Redesigning and thinking connectivity within communities by shared network of resources and information. eg. tax benefits to using public transport.	Impetus for the community to engage in locally grown food and maintaining healthy practices. Coupling space and infrastructure withlocal assets to grow awareness around healthy food habits and behaviour change.	Physical and environmental infrastructure that enables serindipitous encounters with community members and neighbors. Platforms to share hobbies, interests and skills that lead to building social capital and place based support systems.
Characteristics *not for profit based DIO social / sharing models of services*	Community managed services that are low scale and organic digital platforms as management tools to enable over time use and maintenance of shared services within neighborhoods and apartment buildings.	Considering both professional realms of specific expertise as well as broadening sharing accross professional networks to guage a better understanding of long term patterns and outcomes of individuals.	Services that empower individuals to connect, collaborate and share resources and undiscovered practices that could lead to innovative combination use cases with respect to public transportation and alternative sustainable solutions.	Coupling grocery stores and local food services like cafes , bakeries and restaurants in running collective kitchens and sharing food systems that encourage less waste and efficient use of the communities produce.	Social platforms that enable sharing health information and data for long term tracking and understanding place based health rituals and the effect of physical and social environments.

“By 2000, it was estimated that Americans who use alternative health care spend about $500 out of pocket annually. The market for nutritional supplements was estimated at between $92 billion and $200 billion. Small wonder that 70 per cent of consumers told pollsters that availability of alternative care was a top criterion in their choice health plan.”

(Zuboff S, 2003)

epilogue

This world is tired of grand solutions. It is tired of people that know exactly what has to be done. It is fed up with people walking around with a briefcase full of solutions looking for the problems that fit those solutions. I strongly believe that we should start respecting the capacity of reflection and the power of silence a bit more.

This world probably requires something extremely simple—to be together with it, and enjoy the magnificent diversity such an effort can bring about. But when I say be, I mean be, not be this or be that. This is in my opinion the greatest personal challenge each of us is faced with: to be brave enough to be.

How many of us actually understand the problems we are trying to solve? Problem solving belongs to the realm of knowledge and requires fragmented thinking . In the realm of understanding problem posing and problem solving do not make sense, because we must deal with transformations that start with, and within, ourselves.

Neef, Max, Human Scale Development, New York and London : Apex, 1991, Print.

The journey of this theses has unfolded as an anomaly in itself. As a design student one is expected to find solutions to wicked problems through human centered design approaches and make the world a better place. But, from the beginning what was certain about the output of this research was that there is going to be no absolute solution to a really convoluted wicked problem. Coming from a really contrasting value system and geographic setting, the US and it's value system has been a thought provoking encounter, reflecting on what is coming for the millions trying to catch up. It is not enough to fix what is wrong today and provide solutions that will be obsolete by the time all the stakeholders align their interests. The role of designers today is to be critically examining the past, the present and posing the right questions for the future. The questions could be products and services that become the interface for dialogue, but the intention of designing today has to be seen as a practice of fierce adaptability and questioning in what it creates and gives to the world.

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