FRAGMENTING COMMUNITIES AND THE WANTIFIED SELF

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DESPATCH FROM:
Wellthcare Explorers' Meeting 2

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WELLTHCARE

Reimagining the role of health care in society

The Wellthcare's Explorers' meeting described in this Despatch was held on Tuesday 8th October 2013 and this report was published on Tuesday 22nd October 2013. The next Wellthcare Explorers' meeting is on November 4th 2013.

The Exploration Correspondent, Leigh Carroll, a Research Associate with the Institute of Medicine's Board on Global Health prepared this report. Leigh has worked on projects covering chronic disease, HIV/AIDS and violence prevention. Before working at the IOM, she taught high school science in rural Tanzania through the Peace Corps and is interested in how neighbourhoods can support education in primary and secondary schools.

SUMMARY

Pritpal opened the call by introducing the concept of the "wantified self" as a way to more deeply understand what people want in order to provide the appropriate care. He asked Explorers to consider a system of health care that is driven by demand (what people want) rather than on supply (determined by the industry).

The Explorers noted that understanding people's wants and meeting them where they are is the only way to achieve success in any endeavour, and a focus on the wantified self will allow Wellthcare to provide services that address the core of what matters to people.

The Explorers engaged in a discussion of needs and wants, concluding that they often overlap and can be indistinguishable from each other. Several Explorers contended that Wellthcare's focus should not be trying to distinguish between wants and needs but rather on understanding how to give people the tools to reach both their expressed and unavowed goals.

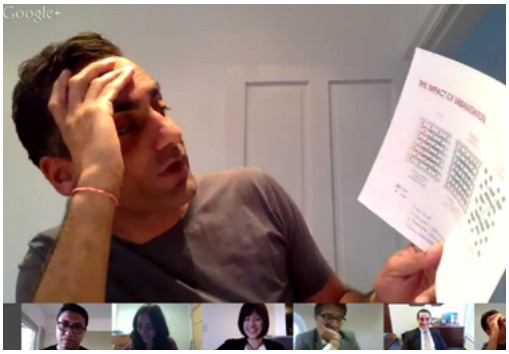
There are many people working on the notion of goal-oriented care, and Explorers discussed several examples of ways in which people are trying to measure what is meaningful to people in order to provide more personalized care. They also discussed how a better understanding of the "self" might lead to a clearer understanding of people's wants and goals.

There are many limitations to focussing only on health and disease, and if Wellthcare is to be successful it must work within the broader sphere of life. Explorers discussed the quantified self movement as one attempt to reach into and put numbers on parts of life that lie beyond health care. However, they noted that quantification in the absence of context is meaningless.

Wellthcare could be an opportunity to build on the quantified self movement by delving into the context that surrounds the numbers and uncovering patterns in the outer circle of life beyond health. This context includes a network of others, and Explorers described ways in which a person's wants are contextualized and complicated by social environments.

Communities and the structures of social networks are changing, and Pritpal suggested that part of the work of the Explorers might be to better understand the shape of future communities in which Wellthcare will operate. Several Explorers observed that sometimes communities look fragmented, but if people look beyond the linear geometry they're accustomed to they will see a great deal of order and cohesion that did not exist in the past. These emerging connections and communities will be the future protectors and creators of wellth.

Finally, several brief comments alluded to an emerging definition of wellth, and how wellth relates to care and communities.



This image and similar ones below are screen shots of the Wellthcare Explorers' meeting, which was conducted as an invite-only Google Hangout.

Wellth, the reclaimed currencies of health that are created, delivered and nurtured by intimate communities, is being explored by its Pioneer, Pritpal S Tamber, with a view to delivering it in 2014. To contact Pritpal email: pritpal@wellthcare.com.

THE WELLTHCARE EXPLORERS

PRITPAL S TAMBER

The Pioneer of Wellthcare and the Clinical Editor of TEDMED, a community of innovators and leaders in health and medicine, Pritpal's background is in how information can improve care, which is not only about how it is created, validated and delivered, but also about cultural readiness to change. Pritpal is based in London, UK. See Pritpal's LinkedIn profile and follow him on Twitter and via the Pioneer's Log.

LANDSCAPE

Wellth and Wellthcare are evolving concepts being explored by a small group of thinkers and doers called the Wellthcare Explorers. The starting definition of Wellth is: "the reclaimed currencies of health, created, delivered and nurtured by intimate communities". Wellthcare is the over-arching term for the tools and mechanisms for the exploration and creation of Wellth.

The first meeting of the Wellthcare Explorers highlighted concepts that needed to be defined to hone our understanding of Wellthcare. There were two broad categories: how we define value; and whether it would be possible to demarcate aspects of care as Wellthcare as opposed to health care.

At the start of the second meeting, Pritpal shared his reflections on the first meeting and contended that Wellthcare has to start from the needs of people as opposed to the recommendations of health care professionals. In doing so, it means that it is left to people to define what value is, which is what you'd see in most other industries. Also in doing so, it side steps the potential red herring of what is provided by the health care industry rather than some new Wellthcare industry. His contention was that Wellthcare, as a concept, is about getting to the root of people's health-related needs, not an alternative form of care provision.

Being healthy is usually a means to an end, however, which led Pritpal to ask the Explorers whether we really understand what people want to do with their health. Understanding this would enable us to develop a deeper, needs-based understanding of the demand for care. Once needs are understood it becomes possible to debate which needs are met by the existing health care system and which can be met by new sources of health-related value. This thinking was communicated to the Explorers prior to the meeting via a Log post entitled, "The Wantified Self".

An example of new, health-related value being created outside of the existing health care system is emerging from an initiative being started by Jersey Post. Given the ageing population of the island, they are devising a service called "Call&Check" whereby delivery staff will call on up to 5000 vulnerable members of the community. This system is likely only possible because the residents of Jersey know and trust their delivery person.

To contextualise the discussion further, the Explorers were provided with an illustration communicating the fragmentation of communities as a result of urbanisation. The intention was to communicate a new social context that is forming in our communities within which any effort to stimulate Wellth would have to operate. See Appendix A.

In this, the second meeting of the Wellthcare Explorers, they were asked for their reflections from the previous meeting and whether they agreed that the "wantified self" is at the heart of Wellthcare. What follows is a faithful description of the discussion ("Exploration") followed by my analysis ("Analysis").

THE WELLTHCARE EXPLORERS

SALLY OKUN

A former palliative care nurse, Sally has spent much of her career learning what people really want during illness and caregiving, especially during complicated aging and at the end of life. At Patients Like Me, a platform that lets patients share their experiences creating opportunities for real-time research, she has overseen how patients' words are turned into data, which led to her TEDMED talk, "Does anyone in health care want to understood?". Sally is based in Cambridge, MA, USA. See Sally's LinkedIn profile and follow her on Twitter.

EXPLORATION

"WANTIFICATION" AS THE SEED OF DEMAND-DRIVEN CARE

Pritpal opened the call by introducing the concept of the "wantified self" as a way to more deeply understand what people want in order to provide the appropriate care. He reflected on the first call, in which Explorers repeatedly voiced concerns that the wrong groups of people are defining what care is in the current health care system.

Pritpal then asked Explorers to consider a system of health care that is driven by demand (what people want) rather than on supply (determined by the industry). He suggested that Wellthcare begin upstream by understanding people's wants and then work forward to determine how care can meet their needs.

Scott Liebman agreed that understanding people's wants and meeting them where they are is the only way to achieve success in any endeavour. He contended that wants and desires are at the origin of success because they form the basis of people's motivations.

A focus on the wantified self will allow Wellthcare to provide services that address the core of what matters to people. Scott encouraged Explorers not to think too much about where Wellthcare fits into health care or wellness, but instead to step back and understand the motivations that lie at the core of health. "Starting with the wantified self isn't upstream or downstream," he contended, "but is the seed of everything that blossoms."

DEFINING WANTS AND NEEDS

Rupert Dunbar-Rees noted that health care professionals often differentiated patients' wants from their needs in order to ration resources. Clinicians often claim they are prepared to give people what they need, but may not be able to give everyone what they want.

Kerry Byrne added that when talking about wants and needs, one must consider their temporal component. She noted the difference between short term and long term needs, and pointed out that medical settings often address acute (short term) needs rather than longer term goals that play out over the course of a person's life.

Scott contended that Wellthcare's focus should not be trying to distinguish between wants and needs but rather on understanding how to help people reach their goals. If Wellthcare starts at goal-oriented care, then it can determine how to bring people to their goals regardless of whether it addresses a need or a want. Naomi Adelson agreed that trying to differentiate wants and needs may be a red herring.

"Starting with the wantified self isn't upstream or downstream, but is the seed of everything that blossoms."- Scott

THE WELLTHCARE EXPLORERS

SCOTT LIEBMAN

A health care compliance lawyer, Scott has a deep understanding of FDA and state rules and advises pharmaceutical, device and biotechnology companies on how to satisfy federal and state mandates, while advancing the organisations' health care missions. He is Vice President of Porzio Life Sciences, LLC, and Chair of its Compliance Committee. Scott is based in New York, USA. See Scott's LinkedIn profile and follow him on Twitter.

There may be some usefulness in distinction of needs and wants, but Lisa Shufro suggested that it is useful only in the examination process and only if needs and wants are later reintegrated to reach the desired goal. For example, when a person explains that she is fatigued, her health care provider might identify the need to raise her iron levels. Ultimately, however, the goal would be to lessen her fatigue so she is able to address life with more energy and productivity (her want). Pritpal summarized this by suggesting that perhaps distinguishing wants and needs matters in a person's examination but not in the manifestation of their care (see Diagram 1).

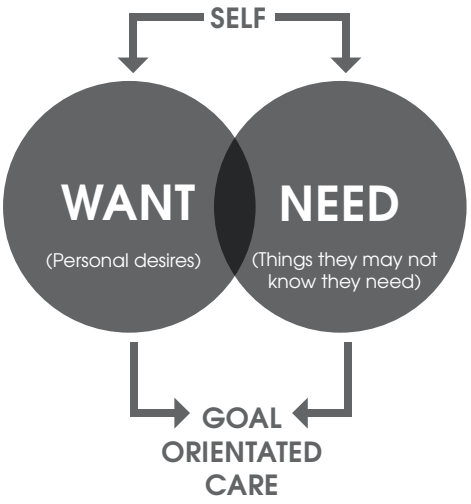


Diagram 1 - Pritpal's diagram of the overlap between wants and needs.

LEVERAGING AVAILABLE ASSETS

Kerry proposed shifting away from a conversation on rationing limited resources toward a conversation on leveraging available assets. She noted that a lot of work is being done to look at asset based approaches, which are grounded in the understanding that people already possess resources and capabilities that can be built on for better health. For example, one can look to the assets that are already available in a person's network or family when determining how to best provide care for that person.

Lisa added that what a practitioner should ultimately want is not to heal or fix a person but to give them the tools to take care of themselves. In her work as a Feldenkrais instructor, Lisa explained that they did not pathologise the person seeking care but instead helped them learn about their bodies. As a result they call them "students" as opposed to patients, partly also because the term "patient" implies suffering. Taking this approach means that students learn they have numerous capabilities that can be combined to overcome other barriers in their lives, whether present now or waiting around the corner.

Lisa went to on to describe how the Feldenkrais Method defines health as "the ability of an individual to achieve their unavowed dreams", the point being that when someone acquires new capabilities they often reassess their potential and want more from their lives – things that they previously had not thought of.

DYNAMIC NATURE OF WANTS AND NEEDS

Rupert mentioned that a person's desires are complex and often evolving. He noted that Kingshuk Das once commented that "needs are verbs", and added that needs "are not static things, these are inherently dynamic things."

"(Needs) are not static things, these are inherently dynamic things."
-Rupert

THE WELLTHCARE EXPLORERS

RUPERT DUNBAR-REES

A former primary care physician, Rupert has worked at England's Department of Health and BDO, an accountancy and advisory firm, as a finance-trained clinical leader in the commissioning of health services, including measuring their effectiveness. He now offers strategic advice on value-based approaches to health care through his organisation, Outcomes Based Health care. Rupert is based in London, UK. See Rupert's LinkedIn profile and follow him on Twitter.

EXPLORATION

BLURRING THE LINE BETWEEN WANTS AND NEEDS

Throughout the discussion, the Explorers alluded to the amorphous nature of needs and wants. Kingshuk, for example, noted that there is not a black and white distinction between needs and wants; they are not two separate buckets.

He illustrated the dialogue between needs and wants with examples from his previous work. At one health care provider he met clinicians who were trying to provide care to a girl with multiple complex conditions. However, they were measuring their progress based on what a healthy child can do rather than what the girl wanted or was potentially able to do. He felt the clinicians were pursuing an outcome that did not fit the girl's circumstances and so were creating unjustified expectations and an unnecessary sense of pain and failure for the family and clinical team.

The clinicians finally opened up a dialogue with the girl's parents and found out what really mattered to them was that she be well enough to fly to Mexico to meet her grandparents for what might be the only time in her life. The uncovering of this goal allowed the clinicians to focus their efforts on providing the girl with the resources and services needed to make the flight possible.

Another girl that Kingshuk met had parents who decided to seek out the medical attention necessary to allow her to enjoy one of her favourite activities. This girl loved going to the beach, and often many of her symptoms decreased when she was there. The parents were able to find the medical care that enabled annual trips to the beach, where they were able to see their daughter happy in a way that they could not see the rest of the year.

GOAL-ORIENTED CARE

Kingshuk claimed that there are many people working on the notion of goal-oriented care. These goals can be complex, and he pointed out that goals are co-created by patients, families, social workers, priests, physicians, therapists, and others who touch an individual's life. He challenged Explorers to join others in this attempt to "figure out, in the spectrum of a million things you could possibly shoot for, what it is that is meaningful to people."

Kerry mentioned goal attainment scaling as one method of attempting to measure what is meaningful to people in order to provide personalized care. She used this method in previous work at a geriatric rehabilitation unit, and often found that people's goals were related to basic everyday activities. For example, some of the patients expressed the desire to be able to walk to the grocery store and back. The goals that this method exposed often looked quite different than the goals that other clinicians set.

Kerry added that even though clinicians used goal attainment scaling to discern the unique goals of an individual, they did eventually begin to move toward a standardized base of measurement. Clinicians in the rehabilitation unit began to see themes emerging from their assessments of patients and they used these themes to develop a menu of options to accomplish the most achievable changes. This saved time when it became difficult for providers to go through the entire goal attainment scaling process with each person.

"Figure out, in the spectrum of a million things you could possibly shoot for, what it is that is meaningful to people." -Kingshuk

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KINGSHUK DAS

A well-versed translator between the worlds of strategy, social research, and design methodologies, Kingshuk is the Director of Health care Practice at Jump Associates, a growth consultancy. In his work he has helped numerous organisations, from health care to consumer goods, create new markets. In health care he has worked with folks like the Mayo Clinic, Medtronic, and the American Red Cross to identify new care delivery models, create medical navigation systems, improve patient experiences, and design new facilities. See Kingshuk's LinkedIn profile and follow him on Twitter.

EXPLORATION

UNDERSTANDING THE "SELF"

Rupert suggested that perhaps there is a way to address wants and needs by trying to make sense of them through an understanding of the 'self'. He noted that often people articulate their dynamic needs differently depending on their circumstances, and that often their desires are driven by much more than the state of their health. If care providers look at people only as patients defined by a disease, they will miss the other factors that drive goal formation and contribute to the complexity of human wellbeing. However, if they are better able to understand the variety of wants and needs that are wrapped up into one self, perhaps they could more effectively group and care for people based not on health status but on the other characteristics that people feel most defined by.

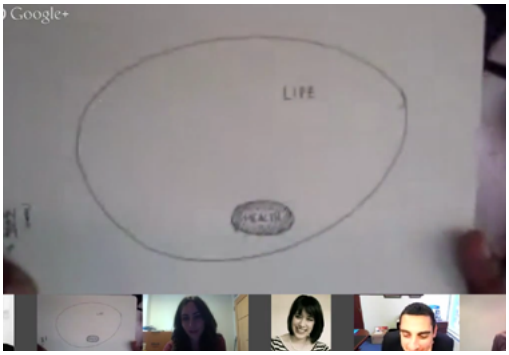
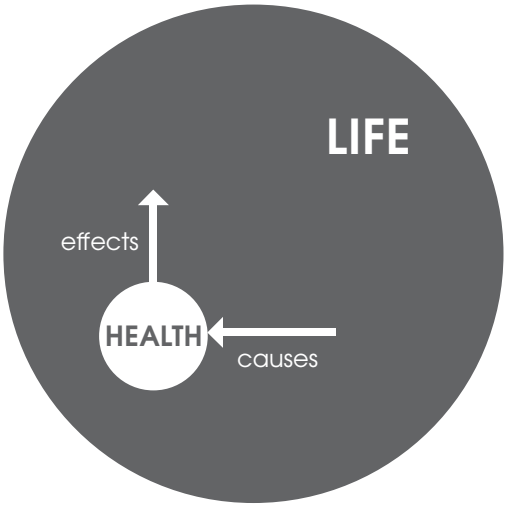


Diagram 2 - Kingshuk's diagram of the small "circle of health" within the big "circle of life".



STEPPING OUTSIDE OF THE HEALTH SANDBOX

Kingshuk also noted the limitations of focussing only on health and disease and contended that it will be necessary to create new skills and a new culture in which people can improve their broader lives. He pointed out that currently "all our supply—all our skills, capabilities, training, institutions—are centred around that small circle of what's traditionally called health." However, he continued while pointing at an image he'd drawn (see Diagram 2), "we're finding again and again… that the bigger circle of life is the source of a lot of the causes of what end up in the smaller circle, and the effects of what we do in the smaller circle proliferate out into life."

Kingshuk added that "traditional healthcare lacks the curiosity and skills needed to affect that outer circle effectively, and is thus limited to doing repair work in the smaller circle". In other words, "we don't know how to improve things in the outside (part) of life," he said, "so we play in the small sandbox, which is traditional health, because we know how to fix broken bones and things like that."

"WANTIFICATION" AS A TOOL TO UNDERSTAND CONTEXT IN THE BIG CIRCLE OF LIFE

Kingshuk pointed out that the quantified self movement is an attempt to put numbers to the activities in the bigger circle of life, such as running, sleeping, and waking up. He noted that the quantified self community has no illusions about the limitations of their work; they understand that they're not actually synthesizing anything. They acknowledge that they're doing the first level of work, which is to attach numbers to certain points in life and then track those numbers. The next level of evolution will come from adding context and meaning to these numbers.

Maneesh Juneja agreed, adding that: "this information that's being generated right now is probably meaningless". He went on to describe the importance of context. For example, if his heart rate is elevated, it could be because he was happily reminiscing about college with an old friend in a café, or because he was stuck in traffic and anxious, or because of another health condition. The tracking device would merely say that his heart rate is elevated at 9am and this would most likely be assumed to be a bad sign. It may not be.

Wellthcare could be an opportunity to build on the quantified self movement by delving into the context that surrounds the numbers and uncovering patterns in the outer circle of life beyond health. Kingshuk explained that he likes the wantified self's deliberate nod to quantified self, and Maneesh expressed his hope that the concept will help to question whether technology will be enough to provide what people need. Maneesh suggested that perhaps wantification could be a way to consider human connection, design, and emotions.

"(The) information that's being generated right now is probably meaningless; it's actually about context." - Maneesh

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MANEESH JUNEJA

With almost two decades of experience of turning observational data into real world evidence, Maneesh is a digital health futurist and the founder of Health 2.0 London, part of the international Health 2.0 movement. He is also an alumnus of Singularity University's FutureMed programme and runs his own data analysis consultancy, MJ Analytics. Maneesh is based in London, UK. See Maneesh's LinkedIn profile and follow him on Twitter.

EXPLORATION

INDIVIDUAL WANTS TIED TO SOCIAL ENVIRONMENTS

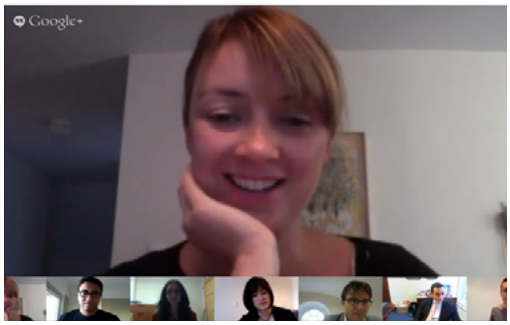
Beyond the individual wantified self lies a network of others, and Kerry noted that all "situations are heavily contextualized by family and friends." This contributes to a complexity in determining wants, needs, and goals, as each situation is framed by both the individual's goals as well as the goals of the family or network.

Lisa similarly noted that "needs and wants (are) defined by our social environments." She added that the needs and wants of the individual "get convoluted or confused or added to by our networks."

Lisa shared two examples from her experience as a Feldenkrais practitioner of instances in which goals were influenced or complicated by social environments. The first described a Feldenkrais student who had cerebral palsy and other conditions that differentiated him from his peers. When asked about what he wanted to achieve, the boy said that he wanted to get to the point where other kids in the school would bully him or be willing to punch him. Lisa explained that the boy did not actually want to be punched, but that being punched was a symbol to him that he was as strong as his peers.

The second example involved an older woman with several children. She was at the end of her life, and the practitioners finally discovered that what she really wanted was to die. However, she was unable to express this because what her children wanted was for her to live as long as possible. This reinforces the idea that expressions of wants and goals cannot be viewed out of context and in isolation from the people and circumstances that influence the individual.

Kerry emphasised that "looking at how an individual's network positively or negatively influences the goals of the individual is pretty key from a network perspective." From there, one can develop a better understanding of how networks affect health, she added.



"Situations are heavily contextualized by family and friends...looking at how an individual's network positively or negatively influences the goals of the individual is pretty key ." - Kerry

CHANGING COMMUNITIES AND SHIFTS IN TRUST

Communities and the structures of social networks are changing, and Pritpal suggested that part of the work of the Explorers might be to better understand the shape of future communities in which Wellthcare will operate. Pritpal contended that communities are becoming more fragmented and wondered how wellth can be activated from a more fragmented base. This he communicated through an illustration included in this Despatch as Appendix A.

He also noted that people are becoming less likely to trust patriarchal structures and organizations, and thus Wellth will mostly likely come from relationships grounded in more personalized, micro-sources of trust. He observed that it is possible that, "as people move away from each other physically and emotionally because they don't have these external forces holding them together, Wellth is now something that has to flow over greater distances."

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KERRY BYRNE

With expertise in health and home care, care transitions, family caregiving, network models of care, online networks and the adoption of technology in health and social care, Kerry is the Director of Research at Tyze Personal Networks. At Tyze she has built a programme of research focused on measuring the impact of Tyze on family caregivers, clients and care provider organisations. Kerry is based in Vancouver, Canada. See Kerry's LinkedIn profile and follow her on Twitter.

EXPLORATION

Kingshuk reflected that when communities change, old connections are broken and new connections are made. In some cases old connections are broken but not replaced, in which case one has to ask how to fill that vacuum.

Kingshuk predicted that a challenge of Wellthcare will be to design a system that addresses multiple types of communities. Some communities are breaking up, such as when Kingshuk's family spread to various parts of the world. Other communities, such as those in the Central Valley of California, are still very tightly knit and strongly influence the behaviours and health management of their members. These are examples of changes in geographic communities, but still there are other communities that are virtual.

COMMUNITY COHESION ACROSS MULTIPLE PLANES

Lisa observed that sometimes communities may look fragmented, but if people look beyond the linear geometry they're accustomed to they will see a great deal of order. She elaborated using the example of the Downtown Project, which is a community for people who value geographical proximity and face-to-face interaction. Part of Lisa's work in the Downtown Project is to link the proximal residents with the external networks that are brought together through digital communication. These communities may seem disparate, but Lisa contended that: "the limitation is not that we're fragmented but that we have not learned to see how things are actually organizing along a different and more fluid plane."

Rupert agreed, adding that perhaps future communities are evolving to be far more cohesive than ever before because they are more built around common selves. "I'm not sure it's more fragmented," he said, "I think it's just cohesive in a different way." He has found that when you look beyond a disease based model of grouping people and start to consider other dimensions for grouping, the types of needs and expectations expressed within these groups are coherent and consistent. Traditionally, receivers of care have been grouped by disease, but they often want much different things from each other because of their different environments and experiences.

Noami commented in an email that it is not necessarily the case that communities and care are now fragmenting; nor can people presume that past models of health care in any society were fully integrated or equitable. In the past, people found comfort in certain methods of care, but quality was uneven and people died young. Naomi elaborated that First Nation communities in Canada are trying to maintain their knowledge of local medicines but also clearly understand that in the past people died – and died younger – from diseases that would not kill them today. On the other hand, although today's contemporary medicine does wonders, inequities still exist and in some cases, such as chronic pain, biomedicine remains under-equipped.

"The limitation is not that (communities) are fragmented but that we have not learned to see how things are actually organising along a different and more fluid plane."-Lisa

THE WELLTHCARE EXPLORERS

LISA SHUFRO

As the recently appointed Magic Awesomeness Catalyst of the Downtown Project, Lisa will be focussing on integrating health-related efforts outside of the clinic walls. In her previous role as the Managing Editor and Producer of TEDMED she led the organisation's efforts to identify, select, and prepare presenters for the stage programme, reviewing nearly two thousand nominations for the stage each year. Lisa will soon be based in Las Vegas, USA. See Lisa's LinkedIn profile and follow her on Twitter.

EXPLORATION

Naomi added that Explorers should consider the fascinating transformation in care and communities that is taking place through technology. She noted that the Internet makes integration more complex and is transforming one's potential circle of care and ideas of health and illness. She cautioned that Explorers "not look at the question of wellth as something that was once to be found as an integrated model but rather as something that might emerge out of today's potential."

An example of Wellth emerging out of a community coalescing in a new way is the community being developed through Jersey Post's intended "Call&Check" service (see Landscape). Through this service, Rupert explained, a community may form around a shared identification of being old and frail.

This community grouping is important for two reasons: First, by identifying the characteristics that most defined the elderly Jersey residents, the service was able to be designed with a more targeted focus that would reach a large number of the people most in need.

Second, the elderly people receiving the service could potentially have a new avenue for communication between each other via the postal worker. Before the service, the network of an elderly woman in Jersey may have only been her children, neighbour, doctor, and several nearby shop owners. Now, the postal carrier connects her to other communities, and presents the opportunity for her to send messages to other elderly women like her in the neighbouring towns.

Kingshuk noted that there are many types of connections, and perhaps, as Lisa and Rupert suggested, evolving communities will make better use of these connections in non-linear, more fluid ways. He pointed out, for example, that there are geographical and social connections and it may be possible to integrate them for enhanced community interaction. In his previous work as an architect and urban designer, he and his colleagues looked at applying a social network analysis to the design of office spaces in order to strengthen existing connections and make new ones. A better understanding of human relationships and the self may inform community building and enhancement of wellth as communities continue to change.

EMERGING DESCRIPTIONS OF WELLTH

After the call, Naomi commented that the Exploration consisted of both a discussion on medical care and a discussion on wellth, and these discussions may be very different. She explained that wellth is not merely the constitution of individual-focussed care. Care is something that is anticipated and expected, whereas wellth (like health) is something inherent in a present state.

"Don't look at the question of wellth as something that was once to be found as an integrated model but rather as something that might emerge out of today's potential." - Naomi

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NAOMI ADELSON

As an Associate Professor of Anthropology at for the Faculty of Liberal Arts & Professional Studies, York University, Toronto, Naomi's theoretical interest lies in the critical examination of cultural meanings of health in social, cultural and political contexts. Since 1989 she has conducted research in collaboration with the James Bay Cree of northern Quebec, Canada, and her current research includes the uses and integration of e-health as a resource for First Nations women and the digital mediation of discourses of health. See Naomi's institutional page.

ANALYSIS

The following unanswered questions arose from the call and may help to guide future Explorer discussions.

CAN WELLTHCARE BE BE CLEAR ABOUT GOALS AND NEEDS?

A central part of Wellthcare will clearly involve understanding people's wants and goals, and then determining what is needed to reach them. This will result in a shift away from striving towards goals determined by what the health care system wants to supply to reaching goals as defined by patient demand. Once people have identified their goals, everything required to get them there perhaps becomes a "need".

CAN WELLTHCARE UNDERSTAND EXISTING ASSETS?

Wellthcare must understand how to best leverage the assets that people already have and use only the additional resources necessary to help people reach their goals. Ultimately, this system will preserve resources by providing the right combinations of care and limiting the provision of excess resources that do not contribute to the realisation of these goals.

HOW WILL WELLTHCARE ADDRESS THE DYNAMIC NATURE OF DESIRES?

It will also be important for Wellthcare to resist being limited to static desires that people express. If, as Rupert and Lisa mentioned, wants are dynamic and evolving, people may need to be guided to reach goals that they haven't yet realised. In some cases, people might be initially resistant to a change that would ultimately bring more fulfilment in the future, and Wellthcare needs to determine whether or how to address this without reverting back to patriarchal methods.

WHAT IS THE ROLE OF SOCIAL CONTEXT IN WELLTHCARE?

Understanding an individual's health-related goals will ultimately be most helpful if Wellthcare also understands the context of these goals. Lisa and Kerry described the complexity of an individual's wants, which influence and are influenced by other external factors. Maneesh and others commented on context being important in understanding whether a point in a person's life signifies a positive, negative, or neutral change.

Perhaps at the heart of Wellthcare lies not only the wantified self, but the wantified self as seen as a component of a larger network of relationships and human interactions. Wellthcare will eventually need to delve into deeper learning of how one's networks influence a person's desires and the behaviours one then employs to achieve their goals. Perhaps a better understanding of behavioural contagions or the social expectations that drive goal-setting will provide light on how networks can be leveraged in ways that are helpful or detrimental to health.

In doing this, however, Wellthcare will need to be aware of the multi-faceted nature of human relationships and the implications of making judgments and recommendations regarding one's networks and social interactions. For example, a relationship between two people might have slightly negative influences on the health of one of the two, but overwhelmingly positive influences on the health of the other. Furthermore, a network that has negative influences on one's health might provide other things that the person values just as much as or more than health.

ANALYSIS

WHAT ARE THE LIMITATIONS OF WANTIFICATION?

An additional note is that while "wantification" may be a useful guiding concept, Wellthcare should still be aware of its limitations. A better understanding of one's goals may be useful in some practical senses, but, like quantification, a new methodology used to pinpoint wants will not capture the depth of the human spirit and psyche.

Perhaps most importantly, Wellthcare needs to ask, do people want to be wantified? Most likely, many people do not want their desires, emotions, or ideologies to be monitored and put into a two-dimensional box. Nor do people always want be told what their goals mean about how they should seek out care. Numerous examples can be found in which people repeatedly choose freedom and individuality over health. Wantification has the potential to be used well for specific means within boundaries, but it will fall short if, like the quantified self movement, it tries to do more than that.

WELLTHCARE ACROSS POPULATIONS

If Wellthcare ultimately aims to activate social networks to provide care it will need to consider ways of addressing the goals of everyone in that network. What are the goals of the son, postal carrier, colleague, or therapist who make up the community of a sick person and how does provision of care help them to attain their goals?

Kingshuk noted that goals are co-created by many people in a person's life. Perhaps Wellthcare could look at this idea of team goal building as a way to enhance compatibility of the goals of many people who have distinct personal wants.

WHAT DRIVES PEOPLE BESIDES "WANTS"?

To understand how the goals of people align or relate, Wellthcare may need to look at motivations beyond what one wants. For example, Wellthcare should consider the role of empathy in human interaction, or how one's sense of responsibility to a person or a greater good informs or challenges what he wants.

WELLTHCARE AND TRUST

In order to determine which people and networks to engage, Wellthcare will need to consider how to work within the trust that binds a person to another person, group, system, or world view. If, as Pritpal discussed, people are losing trust in organized care provision, where will they turn to receive the care they need to achieve their goals? This questioning may be informed by learning from current and historical groups who do not trust the typical providers of care, such as some minority groups who don't or can't trust the criminal justice system. Often these groups find strength and cohesion elsewhere in their communities, and perhaps Wellthcare could rely upon and build similar models of support.

WHAT TYPES OF COMMUNITIES WILL WELLTHCARE WORK IN AND BUILD?

Explorers discussed many types of communities during the call, and it may be helpful to develop a shared system of distinguishing these different types for clarity in future discussions. For example, as Kingshuk noted, there are both geographical and virtual communities. There are communities based on social compatibility, or shared work, religion, hobby, or health condition. Some communities are based on similarities, while others are made of very different people who are brought together by chance, limitations, or because they were attracted to very different aspects of a space or idea.

ANALYSIS

To better understand the future communities in which Wellthcare will be working, the Explorers should consider what people need from their communities and how these qualities can be preserved and enhanced as communities change.

Once Wellthcare identifies the elements of communities that are beneficial, it can better understand the types of community changes that will allow wellth to thrive. On the other hand, it will also be able to identify the types of community fragmentation will crush any potential for wellth development, and determine how to step in to prevent this fragmentation.

WHAT IS THE FUTURE LANDSCAPE OF HEALTH THAT WELLTHCARE WILL ADDRESS?

If Explorers are thinking about the future role of Wellthcare within communities, they must also imagine what health will look like in the future. The world's has seen shifts from infectious diseases to chronic diseases and it seems as though many populations are now undergoing a shift to "states of being" diseases. For example, with fragmenting geographic communities, longer lifespans, increasing wealth leading to decreasing use of communal tools and spaces, and hindered development of the ability to be solitary and alone in a fulfiling manner, might one lurking disease of future generations be chronic loneliness? If so, what will Wellthcare do to address this?

WHAT IS WELLTH?

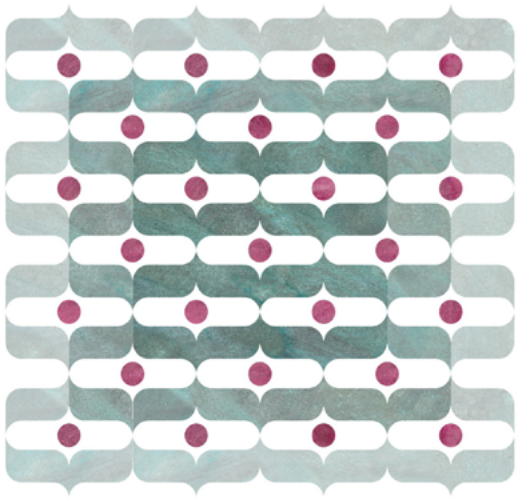
There was some mention of wellth in the discussion, but Explorers have yet to describe the substance that this word refers to. Pritpal explained it as "the reclaimed currencies of health, created, delivered and nurtured by intimate communities", but Naomi seemed to suggest that its qualities may have more than a transactional relevance. This needs clarifying and agreeing.

The views expressed by the Wellthcare Explorers and the Exploration Correspondent are their own and do not reflect those of their institutions. At the time of writing the conflicts of interest of the team have not been collected but they will be as the meetings progress.

APPENDIX A

To contextualise the discussion, the Explorers were provided with the following illustration communicating the fragmentation of communities as a result of urbanisation..

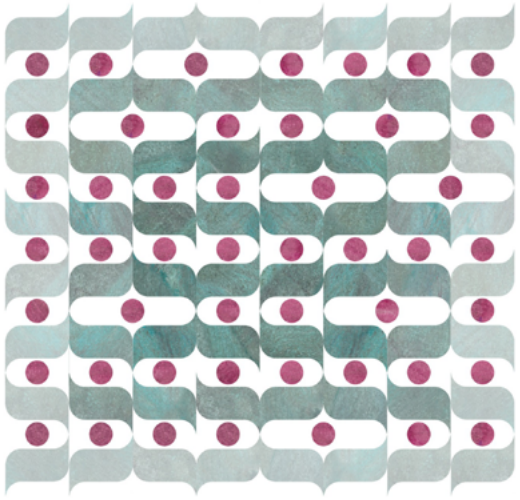
PAST



- SOCIAL COHESION -
-PATRIARCHY -
- AFFORDABLE CARE -

PRESENT

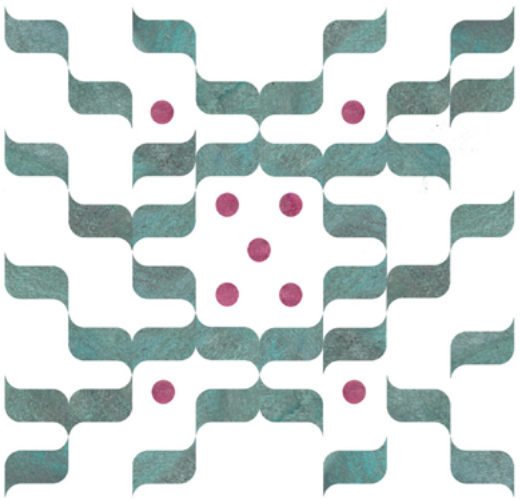
EG. Jersey Post



- FRAGMENTED COMMUNITIES -
- ERODING TRUST -
- COST OF HEALTH CARE CAPPED -

FUTURE

EG. Wantified Self



- FRAGMENTED COMMUNITIES -
- PERSONALISED TRUST -
- NEW HEALTH RELATED VALUE -