Routledge Advances in Social Economics

HEALTH *CARE* ECONOMICS

JOHN B. DAVIS AND ROBERT MCMASTER

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The analytical approach of standard health economics has so far failed to sufficiently account for the nature of care. This has important ramifications for the analysis and valuation of care, and therefore for the pattern of health and medical care provision. This book sets out an alternative approach, which places care at the center of an economics of health, showing how essential it is that care is appropriately recognized in policy as a means of enhancing the dignity of the individual.

Whereas traditional health economics has tended to eschew value issues, this book embraces them, introducing care as a normative element at the center of theoretical analysis. Drawing upon care theory from feminist works, philosophy, nursing and medicine, and political economy, the authors develop a health *care* economics with a moral basis in health care systems. In providing deeper insights into the nature of care and caring, this book seeks to redress the shortcomings of the standard approach and contribute to the development of a more person-based approach to health and medical care in economics.

Health Care *Economics* will be of interest to researchers and postgraduate students in health economics, heterodox economists, and those interested in health and medical care.

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From John, his genuine gratitude to his family, immediate and extended, for their care, kindness, and support over many years in so many ways in connection with this project as in others.

And from Robert, his sincere gratitude, love and deepest affection to Allison and Ailidh for their love, seemingly endless toleration, kindness, and for teaching me so much about care and caring.

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FOREWORD

Health care economics, as currently understood and practiced by the mainstream of the economics profession, is neither about "health" nor about "care" but instead focuses almost exclusively on markets for medical services. This is not to say that there are not interesting problems that mainstream economics can address: markets with asymmetrical information give rise to principal–agent problems; publicly provided health services raise interesting issues about allocation in the absence of good price data; insurance markets introduce their own complexities even without heavy regulation. But these are all issues about the operation of imperfect markets that could, in principle, occur in any application. Is there something specific about health care?

We have recognized for many years that "health" is about much more than the provision of medical services. The social or upstream determinants of health have attracted research across disciplinary boundaries into issues such as the association between health, social, and economic inequalities, or how the built environment affects health, or how health and social institutions interact for racialized populations. Indeed, access to medical services accounts for no more than 15–25 percent of observed health disparities (depending on jurisdiction) while the socioeconomic aspects of an individual's life account for as much as 50 percent. This suggests that mainstream health economists have defined their field narrowly.

The authors of this book argue that health care economics is even narrower than we have acknowledged. With an almost exclusive focus on utility-maximizing individuals making rational decisions in markets for medical services, the field has little to say about large parts of the health system defined by the World Health Organization to include "all activities with the primary goal of improving health – inclusive of family caregivers, patient–provider partners, part-time workers (especially women), health volunteers and community workers." That is, even if we focus on interventions at the level of the individual intended to promote better health outcomes, health care economics lacks the tools required to understand and assess how these interventions are accessed and experienced by either the recipients or the providers.

Davis and McMaster have brought a philosophical lens to these issues. Treating individuals as socially embedded and recognizing that economic motivation alone cannot account for the provision or experience of caring labour, the authors have drawn together insights from medical (especially nursing), social work and feminist scholarship to address moral issues at the heart of care. Acknowledging the centrality of human dignity and focusing on developing capabilities, the authors ask us to both recognize the limitations of how we have traditionally defined health care economics and to acknowledge the possibilities offered by a broader conception of health economics that allies itself with insights from other fields of study.

Evelyn L. Forget
University of Manitoba

PREFACE AND ACKNOWLEDGEMENTS

This book is the culmination of a number of years' work and multiple transatlantic trips. We apologize for the latter and the carbon footprint we may have inadvertently left in producing this book. This was an unintended side effect of our work. Perhaps more importantly, conceptually, standard health economics treats care in the same way – an unintended side effect. This is the starting point of our argument and analysis. How can care be an unintended spillover effect or externality arising from the relationship between a medical professional and a patient in the delivery of medical care? Our interest in matters of health and economics is partly stimulated by what we view as this unfortunate conceptualization. That said, we have shared an interest in health and economics for some time, not least due to the obvious, to us, interface between ethics and economics in this area. John Davis has a long interest in methodological issues in economics, and edited the seminal *Social Economics of Health Care*, published in 2001, to which Robert McMaster contributed. This volume was an attempt to develop a social economic analysis of health that contrasted with the standard approach. Since then there have been further attempts to advance non-mainstream analyses of health issues. For the most part these contributions, while valuable and highly insightful, have been uncoordinated in the interest of developing a coherent alternative to standard health economics.

For us, a defining moment in this emerging literature was Gavin Mooney's (2009) *Challenging Health Economics*. Mooney was a significant scholar of the mainstream approach, who came to see many of its weaknesses. His incisive mind identified and exposed what he considered to be the fundamental flaws of the standard paradigm, and how for him it critically led to ill-founded policy advice. That Mooney's life was brought to a premature end was an obvious tragedy at a personal level, but it also dealt a blow to the progress of a new paradigmatic approach. We owe a debt of gratitude to Mooney in demonstrating the potential basis for another way of investigating health and economics. We also admire his academic courage in critically reflecting on his previously held beliefs about health economics. We agree with much of Mooney's assessment, and seek to constructively criticize aspects of it in our attempt to add to a new paradigm.

We are both long-term members of the Association for Social Economics (ASE), Davis having recently served as the Association's President. The ASE is a well-established body that challenges the positive-normative divide in economics promoted by neoclassicism and the mainstream. The aims of the ASE have also shaped our thinking about health and medicine. How can an economic analysis of health – essential to our being – be value free? Despite mainstream health economics' claims to the contrary, the standard approach is heavily value-laden. In this work, we do not disguise our own values, and indeed argue that these values are consistent with and necessary to the promotion of individual dignity in a caring institutional architecture. By contrast, standard health economics emphasizes the maximization of what is taken to be measurable net health benefits associated with discrete medical care procedures. Medical interactions are assumed to resemble those of market transactions. As we argue in this book, this at best marginalizes care, overlooks the individual, and hence does not constitute an appropriate basis for the analysis of individual dignity and therefore human flourishing. For us, this is a fundamental flaw that has serious consequences for the institutional structuring and delivery of health and medical care. Our book is a modest attempt to contribute to the development of an approach that addresses this. We recognize that our aims are more ambitious than a single book, but we hope that our work to date continues Gavin Mooney's pioneering and inspiring efforts.

The project as a whole has benefited either directly or indirectly from the support, critical insights, and encouragement of many people, including Wilfred Dolfsma, Zohreh Emami, Evelyn Forget, Allison Greenhill, Geoff Hodgson, William Jackson, Joan Tronto, Kathryn Wagner, anonymous reviewers, and the numerous participants who commented on and queried our arguments at various conference and seminar presentations, particularly Vikki Entwistle, Sue Himmelweit, Martha Starr, and Irene van Staveren. Geoff Hodgson and Joan Tronto, in particular, provided excellent suggestions and critical guidance, which has strengthened the analysis of argument at key junctures. We are grateful for their time and wisdom. We are also grateful to colleagues at Marquette University's College of Nursing, who hosted a seminar centered on the subject matter of our work, and who made many valuable suggestions. Robert McMaster also expresses his gratitude to colleagues at the University of Glasgow's Adam Smith Business School who provided encouragement, support, and insight, especially Andrew Cumbers, Deirdre Shaw, and Thomas Anker. Of course, we do not implicate anyone but ourselves in any way in terms of the arguments and errors we have made. We also gratefully acknowledge the financial support of the Adam Smith Business School at the University of Glasgow, the Carnegie Trust for the Universities of Scotland, the Department of Economics at Marquette University, Marquette University's Miles Research Fund, Milwaukee, and the Royal Society of Edinburgh. We gratefully acknowledge the World Health Organization in granting us permission to reproduce Figure 8.1 in

Chapter 8 of the book. We would also like to thank Elanor Best, and Emily Kindleysides of Taylor & Francis for her patience with us, her belief in the project, and her gentle encouragement.

Glasgow and Milwaukee,
November 2016

1

HEALTH *CARE* ECONOMICS?

"The place of care in the economy is everywhere."

(Nelson, 2016: 12)

1.1 Introduction: mainstream health "care" economics?

In his last book, *Challenging Health Economics*, the late Gavin Mooney[1] (2009: 3) recommends that the field of what he terms "health care economics"[2] be re-named "health economics" to help better focus research in health issues on the many specifically social determinants of health, which he argues mainstream "health care economics" largely ignores. In his view, the social determinants of health are not only economic, and those that are economic are not only associated with market-type exchanges. The field as it is currently constituted, then, is too narrow, and seeing it rather as "health economics" might encourage researchers to investigate a greater range of issues and factors involved in the determination of health. Were this to happen, mainstream health care economics might then become a subfield of "health economics," would primarily investigate individual decision-making behavior in what Mooney takes to be health care markets, and would perhaps be better re-named "the economics of health care markets."

We entirely agree that Mooney's conception of "health care economics" in its current form misses much that explains health – especially as practiced in the United States where the development of the field over the last several decades has been closely tied to the study of US health care markets. But we have a concern additional to Mooney's, and argue that the mainstream approach is even narrower than he believes it is in that in our view it does not even include a genuine concept of care. If we are right, then in Mooney's terms, "health care economics," or even "the economics of health care markets," are misleading labels, and mainstream practitioners operate under what we regard as an even more serious misunderstanding regarding the subject matter of their field. This book develops this case in arguing that concept of care itself has been misconceived and has consequently been neglected in contemporary "health care economics." Our aim is to make an adequate concept of care central to an economic analysis of health – a step we regard as both complementary to Mooney's initiative and potentially transformative of the field as is his emphasis on the social determinants of care. We propose an approach that embraces moral values aimed at enhancing human flourishing.

Our starting point, then, is the puzzle we think arises if "health care economics" (Mooney's terminology) is not actually about care. Mooney says that "health care economics" is not really about health; we say it is also not really about care. What is left – "economics" – is an important clue to our puzzle. Following Lionel Robbins (1932), many standard economics textbooks describe "economics," that is, mainstream microeconomics, as about applying standard neoclassical economic reasoning to the analysis of choice in whatever form this happens to take. Nothing in this analysis, which assumes rational individuals always seek to maximize utility, says anything about the concept of care per se. Microeconomic theory, including standard health economics, does recognize other-regarding behavior, for example in the form of altruism (see, especially, the work of Gary Becker, 1976b). Care may have some altruistic features, but it need not. The temptation for health economists is to conceptualize care as altruism thereby conflating the two. We believe this is a substantial error. By conflating altruism and care, people's utilities are assumed to become aligned. We believe that care goes beyond individual preferences in that it encompasses moral, instinctive, habitual, and practice dimensions. Care is both individual and social. We believe that care for most people involves some kind of caring activity or caring attitude which individuals exhibit towards others often in some sort of selfless way when they care for them. Indeed, this is a common understanding of care and, as we argue later in the book, this conception of care seems to be quite the opposite of utility-maximizing behavior, which supposes individuals are always motivated by the prospect of payoffs for themselves.

Standard health care economics, then, is simply the result of taking conventional microeconomic tools and concepts, and applying them to yet another set of choices aimed at utility maximization, in this case those that are assumed to be "markets"[3] in which the commodity being transacted is health care. Indeed, since standard microeconomic theory is believed to be a universal engine of analysis that can be applied to all situations at all times in all locations, irrespective of their apparent institutional or cultural differences, there is a temptation to argue that there is little distinctive about "medical care markets" (see, for example, Pauly, 1978). Yet many "health care economists" think of health as "distinctive" (for example, Arrow, 1963; Culyer and Newhouse, 2000a). They do so frequently on the basis that "health care markets" on both demand and supply sides depart from the standard microeconomic textbook analysis of markets. Thus, for example, consumers of health care may be ill-informed about costs and benefits; the supply of health care (what we later term as medical care) may be subject to trade-offs between personal financial incentives and morally informed preferences, and the demand and supply of health care may exhibit spillover effects – externalities. Nonetheless, this analysis retains important assumptions about the centrality of what is taken to be market exchange and the rationality of individuals. The implication of this is that caring activities in health care markets must accordingly be explained in terms of the behavior of rational utility-maximizing individuals, and that any caring behavior that does not fit this specification is irrational or does not play a role in the way health care, as economists conceive it, works. Thus the solution to our puzzle about what can health "care" economics be about if it is not about care is that it is about this substitute rational utility-maximizing concept of "care," not about what we believe most people think the idea of care involves.

Of course "health care economists" could be right and most people wrong about what the idea of care involves. This book argues, however, that economists are wrong and most people are right, and thus that it is important to re-appraise the nature and place of care in the health care economy. To defend these conclusions, this chapter begins by first examining how the concept of care has been interpreted in standard "health care economics" as the idea of a special type of externality: a caring externality. It then goes on in subsequent chapters to set out how care is understood in various other literatures, including philosophy, medicine, and feminist works, as well as what we believe to be broadly involved in caring activity in normative and behavioral terms. Our view is that: (1) health care cannot be successfully explained using the standard economic model; (2) health care is relational in nature and must be explained in terms of social relationships between people, which goes beyond the mainstream economic account; and (3) an alternative health economics is needed to account for what is involved in producing good health and medical care.

The second section of this chapter describes standard microeconomic reasoning about markets for health care that uses principal–agent analysis to account for clinician–patient relationships as being between utility-maximizing individuals.[4] The third section then explains the specific conception of care this type of analysis employs as a special type of market externality – a "caring externality" – that is especially characteristic of health care markets. The fourth section critically evaluates the "caring externality" idea as a concept of care by arguing that it is problematic in ways that undermine it as a concept of care as commonly associated with caring attitudes and activities. We also trace these difficulties back to the individualist, market-based approach to health care from which the "caring externality" idea is derived. The fifth section of the chapter then advances an alternative view of the individual as socially embedded, and argues that this accommodates a different conception of care in the clinician[5]–patient relationship. The sixth section returns to the subject of what an alternative health economics ought to involve. The seventh section outlines the argument and the chapters of the book as a whole, and summarizes its main conclusions.

1.2 The microeconomics of health care markets: principal–agent theory, moral hazard, and care

Standard microeconomic theory assumes that in market transactions individuals behave rationally, and act in such a way as to maximize individual utility, or expected individual utility when outcomes are probabilistic, subject to their incomes, their endowments, and market prices. Health care economics uses an important development of this analysis – principal–agent theory – to explain how people seeking health care and medical professionals interact in health care markets (for example, Mooney and Ryan, 1993). In principal–agent theory, information about the quality, performance, and value of goods and services being transacted in markets is incomplete and asymmetric across the individuals participating in those markets. Individuals who lack this information on the demand side of the market are thus at a disadvantage relative to those individuals on the supply side who possess it, and if the former are sufficiently risk averse, they may choose not to participate in the market. However, if this information problem can be overcome, both sides stand to gain, and so both have incentives to reach agreements that offset the information asymmetry between them. This occurs when those lacking information, now referred to as the principals, enter into principal–agent relationships with those who have it, now referred to as the agents, such that transactions between them are structured so as to make it in the agents' interest to act in the principals' interest. Both principals and agents are then able to maximize expected utility, and carry out their desired transactions despite the market's special informational characteristics (Fama and Jensen, 1983).

In health care economics, health professionals such as clinicians on the supply side of the market are the agents of individuals seeking health care on the demand side of the market who as their patients are the principals. The principals lack information about the cost, effectiveness, and variety of different forms of medical care, which is known by physicians or clinicians, but on the standard view principal–agent relationships develop between them that make it the interest of clinicians to act in the interest of their patients, so that they each maximize their respective expected utilities. These principal–agent relationships are usually embedded in health insurance systems, which establish the scope of health care coverage, prices for that coverage, and the corresponding responsibilities and compensation of medical professionals. Insurance systems use third-party payment market mechanisms that displace direct, two-party negotiation in the market over health care between principals and agents, standardize the relationship between them, and further mitigate the effects of information asymmetry in the market. The market still operates indirectly between clinicians and patients as individual expected utility maximizers, but insurance systems remove the need for them to work out the terms of agreement themselves, and are thus efficient in the sense of maximizing gains from exchange to both patients and clinician/physicians.

At the same time, insurance systems create a potential for moral hazard. Moral hazard exists when individuals who are insured against risk act less cautiously than they would were they not insured and exposed to risk. Essentially insurance creates additional incentives beyond those that already exist in the underlying market relationship by changing people's behavior. So while insurance helps secure the principal–agent clinician–patient relationship, it also creates incentives on both sides of the market that work to weaken that relationship. Thus patients on the demand side of the market have an incentive to seek more health care than they may need when that additional care is insured, while clinicians on the supply side of the market have an incentive to supply less care than they are capable of providing when insurance systems establish levels of minimum care and predetermine their levels of compensation. That said, health economists have long acknowledged the potential for supplier-induced demand, where physicians have the incentive to over-supply, especially if service provision is linked to their remuneration (McGuire, 2000, 2011). Insurers seek to reduce the demand for unnecessary care and see that sufficient care is supplied (especially if reduced care in the short run leads to more costly care in the long run), but they also face information asymmetries with respect to both sides of the market that limit their ability to do so. This in turn creates a role for health care economists whose task in this connection is to help design efficient health care insurance markets that most effectively align individual incentives across the two sides of the market. Thus though the relationship between patients and clinicians is a complicated one, it is still explained as a market relationship.

The question this summary leaves us with, then, is this: what is there in this analysis that justifies including the term "care" in health care economics? The foundation of standard microeconomic theory, whatever its application, lies in individual utility-maximizing behavior and the self-regarding incentives which individuals face when they interact in markets. This implies that in health care markets, as in all other markets, individuals really only "care" about their own utility. Further, since what changes hands in markets is a commodity whose measure of value is its price, what changes hands in health care markets must also be a commodity whose value is its price. It is true that the commodity supplied and demanded in these markets is labeled health care and that health care suppliers are often called caregivers. But the idea that there is something distinctive about health care as a commodity and caregiving is undermined by the fact that in standard microeconomic theory health care is bought and sold in markets just like any other commodity (see, for example, Pauly, 1978). Thus just as the theory reserves no place for caring attitudes and caring activities that many people associate with the idea of care in its analysis of markets for steel, consumer appliances, etc., so there is no place in the analysis of markets of health care for the idea of care, despite the customary reference to care and caregivers, and despite longstanding protestations that health is somehow "different" (for example, Culyer, 1976). At the same time, health care economists are still reluctant to give up any association of health care markets with care, and have accordingly sought to link caring attitudes and activities to the market in the form of what standard theory calls an externality, in this case a "caring externality." What, then, does this involve? And does it successfully make care in the wider sense a part of health care markets?

1.3 Care as a market externality: caring externalities

The standard microeconomic view of an externality is of a spillover effect from a market transaction between two agents onto a third agent or agents not party to the transaction. Externalities that are costly to third parties (for example, pollution) are negative externalities, and the usual recommendation is that they be reduced by government taxing or regulating the transaction so as to force the parties to the transaction to bear the spillover cost, that is to "internalize" it and disburden third parties. Externalities that benefit third parties (for example, education) are positive externalities, and the usual recommendation is that these spillovers be promoted by government by subsidizing or otherwise supporting the original transaction to increase their beneficial effects. Both kinds of externalities, then, are effects of market activity not captured by the transaction between its parties, which as a result have an accidental or unintended character (if not always for the market participants, at least from the point of view of the theory of markets).

Noted health economist Tony Culyer has generalized this reasoning to health care markets, arguing that they often generate the positive type of externality, what he terms "humanitarian spillovers," whereby people gain utility when the health status of others improves because they sympathize with them (Culyer, 1976: 88). Care is thus defined as an externality based on a sympathetic regard for others. "Individuals are affected by others' health status for the simple reason that most of them care" (*ibid*.: 89; also cf. Culyer, 1971). This "caring externality" could operate as a third-party effect as described above when family, friends, or people in general sympathize with those receiving health care, but it could also operate as a spillover directly onto patients themselves from clinicians who exhibit sympathetic concern for them. The spillover in this case is automatically internalized without government intervention in the market, though it still counts as an externality, because the caring behavior that clinicians adopt towards their patients goes beyond the market-driven requirements of simply supplying medical services, as shown by the fact that these services can also be delivered without sympathetic caring behavior on the part of clinicians toward their patients. Why, then, would some clinicians behave in caring or sympathetic ways towards their patients? As we understand the standard health economic approach there are two plausible reasons: altruism and social capital.

Following Elias Khalil's (2003) examination of the notion of altruism in standard economics, it is possible to distinguish three approaches: "egoistic", where altruism revolves around the expectation of the accrual of future benefits to the altruist; "egocentric", where there is an interdependency of utilities; and "altercentric", which, for Khalil, refers to a particular personality trait. In other words, an individual is pre-disposed – regardless of (monetary) incentives – to be other-regarding. Thus, an altercentric individual may be inclined to behave altruistically by virtue of their ability to demonstrate concern for another where this concern is *not* centered on or motivated by issues pertinent to the self.

We argued in Davis and McMaster (2015) that health economics adopts the egocentric orientation by virtue of its conceptualization of interdependent utility functions, meaning that one person's utility increases – here the clinician's – when another person's utility increases – the patient's (see, for example, Mooney and Ryan, 1993). On this account, sympathy is frequently considered as a form of altruism, or is conflated with it in mainstream theorizing (Collard, 1978; Khalil, 2003). Thus, if physicians have such feelings towards their patients, and engage in caring behavior, this can be utility maximizing, despite the fact that a market transaction does not require it. If the clinician, in addition to supplying health care services, behaves in a caring way towards patients, this is likely to cause the patients' utility to be higher. The result is that the sympathetic clinician's own utility is then higher as a spillover from the patient's higher utility. Interdependent utility functions consequently operate outside of the market, because they involve a relationship between individuals that is not mediated by the price–quantity logic of the market. Further, when individuals' utility functions are interdependent, they behave toward one another in an other-regarding way rather than in a self-regarding way. Strictly speaking, in the utility function framework other-regarding behavior is also a form of self-regarding behavior, albeit a non-standard one, since when utility functions are interdependent people gain when others gain with whom they sympathize. Moreover, in the history of economics utility maximizing behavior has generally been interpreted as basically self-interested. Recent behavioral and experimental economics have begun to blur the boundaries between self-regard and other regard, and mainstream microeconomists have long argued that self-interest does not mean selfish. But these qualifications aside, health care economics still generally assumes that individual incentives in the sense of pay-offs that accrue primarily to the independent individual "crowd out" and dominate sympathetic caring motives in health care markets.[6]

This is not the ordinary meaning of altruism, which many associate with the idea of selfless sacrifice (for example, Nagel, 1970), or Khalil's idea of altercentric altruism. Relatedly, a concept of care based on utility-maximizing sympathy would also be different from a concept of care based on the idea of commitment, where the latter is understood to be a matter of making choices that put aside the question of individual utility payoffs, thus driving "a wedge between personal choice and personal welfare" (Sen, 1977: 97). Individuals who form "care commitments" would not be considered rational according to traditional microeconomic theory, though they would be considered rational if rationality is more broadly defined as "the discipline of subjecting one's choices – of actions as well as of objectives, values and priorities – to reasoned scrutiny" (Sen, 2002b: 4).

The second way that care may be conceived in standard health economics, social capital, aligns to the potential public goods-like qualities of medical care. For example, Tuohy and Glied (2011) discuss the distribution and status of medical care as a merit good. Like other standard approaches, Tuohy and Glied make no attempt to analyze care per se, instead focusing on the distribution of resources from a utilitarian-informed perspective.

Conceiving care as an externality, in our view, also makes it a dimension of social capital, as social capital is frequently defined in terms of non-rivalrous public goods (Folland, 2006) and explicitly as an externality (Portes, 1998). As we have argued elsewhere (Davis and McMaster, 2015), social capital accounts suppose that caring social relationships possess important health benefits, either directly or indirectly through socioeconomic and environmental variables that influence health. There is evidence, as we understand it, that some health economists' modeling resonates with such an interpretation. For instance, Bobinac *et al.*'s (2010) theorization of informal care invokes a "caregiver effect" that refers to the benefits accruing to the provider of care as well as the recipient of that care. This corresponds to Culyer's "humanitarian spillovers" noted earlier.

How, then, should we judge health care economists' idea of care as sympathy as expressed as 'caring externalities' as a convincing conceptualization of care? The discussion in this section and the last shows that this idea was developed in such a way as to be consistent with standard microeconomic analysis of individuals interacting through markets. The question this raises is whether that analysis with its individualist emphasis is really compatible with what people often think is involved in the concept of care. In the next section we argue that on closer inspection the caring externalities idea is problematic in ways that diminish its value as a concept of care.

1.4 The problematic nature of caring externalities

Consider first the incidental nature of care when seen as an externality. According to standard microeconomic theory an externality is something that occurs outside the normal functioning of the market. The theory does not explain how frequent or rare externalities are. It could allow that externalities are common and are found empirically to be associated with most or even all markets. The point, however, is not how pervasive externalities are but rather that what counts as the normal form of interaction between people is that in which individuals are isolated from one another in the sense that they interact indirectly and at arm's length through the market medium of their bids and offers to buy and sell goods. The sort of person-to-person more direct contact and communication which externalities involve that occurs without the intermediation of prices is from this perspective not important to the explanation of human interaction. Such behavior has an essentially incidental character in that were we to ignore it, or treat it *ceteris paribus* as exceptional in nature, our explanations of people's behavior would still be basically correct. Thus treating care as a sympathetic regard for another, while perhaps interesting for some health economists, does not change the understanding of the basic principal–agent relationship between patients and clinicians. Indeed, prices can be influenced by caring externalities, but are not determined by them.

Accordingly, Mooney's "health care economics" is not really about care, but rather about transactions in markets in which the commodity transacted is labeled health care. This label originates outside of economics in the medical profession's designation of remedies for health problems as care and in its codes of care, such as the Hippocratic Oath. But while health care economics takes over the term care, it does not take over the ethic of care that animates the medical profession. Rather it substitutes for that caring behavior which underlies normal practice a conception of medical professionals as utility-maximizing individuals for whom sympathetic regard for their patients counts as a secondary, incidental consideration in the clinician–patient relationship. Put differently, it substitutes for the direct person-to-person contact between clinicians and patients an indirect market relationship between them mediated by the price mechanism. In effect, the concept of caring externalities turns the medical profession upside down, and reduces the role of care, in the sense of a personal and professional concern for the well-being of patients, to a non-essential factor involved in the supply of medical care commodity services. Of course it might be argued in response to this that health economics' method of analysis does not turn the medical profession upside down, that it operates as it always has, and that microeconomic theory only accounts for how markets work "as if" people were utility maximizers. But this would fail to recognize the influence that microeconomic theory has on the conceptualization and design of health care markets. When the theory treats sympathetic caring as inessential to the supply of health care, this encourages medical care providers to see themselves in a market relationship that diminishes the role of care.

These conclusions concern the secondary status of care as an externality in health care economics. We might also ask, however, whether the idea of care as an externality is really even coherent. Recall the distinction between sympathy and commitment. The latter idea makes a clear distinction between self-regard and other-regard. A caring commitment is in some way counter-preferential, meaning that one's own preferences and utility are irrelevant when one makes a commitment to another. In contrast, with sympathy one's concern for another must be in one's interest. Why, then, should we even say that sympathy for another that is in one's own interest, where this is the individual's dominant motive, is really a concern for another? What grounds does standard theory offer to lead us to believe that self-regarding utility maximizers do sympathize with others? The answer is that utility functions can be interdependent, and that this demonstrates the existence of sympathy. But the idea that utility functions can be interdependent has no demonstrated empirical foundation. Indeed the interdependence idea is simply an abstract concept arrived at by generalizing the externalities concept from such settings such as pollution effects on third parties where spillover costs are measurable. In contrast, it is not even clear how one would go about measuring sympathy spillover effects. To be clear, note that there is much evidence that people are affected by the wellbeing of others and sympathize with them, as noted by Culyer in the passage above. But this is different from showing that sympathy derives from utility-maximizing self-regard and not rather from something like commitment. So given that other-regard and self-regard are on the surface opposites, we have yet to see any reason to say that the caring externality idea is coherent.

Moreover, there are problems with the use of altruism in this context. Recall that standard health economics' conceptualization of care allows for the possibility of altruism. Yet this altruism still needs to be individualistic in that it does not appeal to a moral obligation associated with a particular social role, such as that of a clinician. Therefore, in our view, this gives altruism an ephemeral quality, which, especially in the mainstream approach, may be subject to instrumental calculations. In other words, altruism is sensitive to the whims of a particular individual and is not necessarily socially embedded in a sense of duty or responsibility.

We add further reason to think this by noting the paradoxical nature of the caring externality idea (Khalil, 2003). First, since clinicians gain utility interdependently when exercising a caring attitude toward their patients, they should prefer patients to be in ill health, since their condition would then more readily elicit a caring attitude than in the case of healthy patients. But how can clinicians who are concerned with the wellbeing of their patients prefer them to be in ill health? In Davis and McMaster (2015) we argued that mainstream theory normalizes the extreme sadomasochistic case. Here a physician may ultimately gain utility in the scenario of allowing a patient's condition to deteriorate in anticipation of medicating to improve it, thereby enriching his or her own utility, and to repeat the process ad infinitum. Accordingly a physician is not seeking to cure or, we venture, even care for a patient. They merely wish to maximize their utility.

Second, since caring externalities are based on feelings clinicians have toward their patients, should these feelings change toward their patients, or be overridden by other feelings, they might no longer care for their patients. But part of what seems to be involved in the idea of caring for other people is that one does so irrespective of whether one feels like doing so. We suggest, then, that these problems arise, because the way the altruism and sympathy concept works is to make the clinicians' concern for their patients instrumental to their own self-regard. This renders regard for others always secondary to self-regard, demonstrating the fundamental ambiguity in the caring externalities idea. As a result, it is never clear that sympathy is genuine rather than just masked self-regard. We conclude that there is no clear reason to suppose that the caring externalities concept should be regarded as a concept of care. It seems rather to be simply an *ad hoc* device consistent with standard microeconomics that appears to make the idea of care a part of health care economics' analysis of health care markets, but which on closer inspection is only nominally about care. In the following section, then, we explain what we believe a genuinely other-regarding concept of care involves. To do so we advance a conception of the individual alternative to the standard one on which the caring externality idea depends, and show how it allows for a different understanding of care.

1.5 Care and the socially embedded individual

In the *Homo economicus* view of the individual people's choices depend only on their own individual characteristics, namely their subjective preferences, and so the only way those choices are influenced by others is indirectly through the price mechanism. Game theory and the "new" behavioral economics modestly extends this *Homo economicus* view by treating people's choices as strategic, which means that choice is interdependent and people consider how other people's choices affect their own. Nonetheless, what choices individuals make still depends on their subjective preferences. This framework thus assumes that people are essentially atomistic and have only a limited, indirect contact with one another through the markets.

This indeed captures the way many markets work in which people have little contact with whoever is on the other side of the market, but it does not capture the way many other markets work in which direct and personal contact between people exists and is important. In this work, we set out a view of the individual alternative to the *Homo economicus* one in order to provide foundations for an account of non-instrumentally rational other-regarding behavior which we think is needed to incorporate a stronger concept of care in health economics.

The alternative conception of the individual we employ is that of individuals as socially embedded. Here we will use the expression "socially embedded" to mean that people's choices depend not only on their own private preferences but also on their institutional surroundings and non-market personal contact with others. Obviously there exists a whole range of ways of explaining this idea of a non-market personal contact, especially when it is framed in terms of the impact of social relationships on individual behavior, since the idea is central to social science in general and particularly psychology and sociology. Our goal, however, is not to remake health economics in terms of what these fields have to offer, but rather to focus on the boundary between these other social science fields and economics in order to explain the impact of social relationships on individual behavior. That is, we are specifically concerned with the clinician–patient relationship as a social relationship operating in some sort of institutional setting, including in markets. We suppose, therefore, that as individuals, clinicians and patients are socially embedded in the clinician–patient relationship, and that this social embedding determines how they make choices as individuals as well as the nature of any market relationships between them. To explain this we need to explain how the clinician–patient relationship differs from a market relationship, how this difference depends on seeing individuals as socially embedded, and how this all entails that clinicians and patients together make non-instrumentally rational choices regarding patient health care. There are two levels on which we explain the clinician–patient relationship as a social relationship between socially embedded individuals as opposed to a market relationship between atomistic individuals: first in terms of the special intentionality characteristics of that relationship and second in terms of its social institutional character.

First, we modify the standard microeconomic asymmetric information analysis of the patient–clinician principal–agent relationship by saying that it is not just patients who have limited information relative to what clinicians know, but also clinicians who have limited information relative to patients' knowledge of their own health and their ability to pursue recommended health care therapies. When information is asymmetric in this way both effectively need to undertake *both* roles. We argue that to do this both must rely on what we treat as a type of bilateral conditional communication that can be represented as leading to the formation of what are called shared or collective intentions regarding care behavior that underlie choice behavior in the clinician–patient relationship. Shared or collective intentions are contrasted with personal intentions in that the former get expressed in first-person plural speech ("we will do *x*") whereas the latter get expressed in first-person singular speech ("I will do *x*").[7] While this may seem to be a minor linguistic difference, the two types of intentions work quite differently from the point of view of the individual in regard to their respective conditions of successful expression (a key issue when we seek to identify intentions). In the case of the more familiar personal intention, successful expression basically depends on only clear communication on the part of the person having a particular intention. In the case of shared intentions, however, the person expressing a "we" intention must also determine as a condition of success in expressing that intention that those others to whom the "we" applies agree to the intention expressed. A person who proposes "we will do something" but finds that others disagree has not succeeded in expressing a shared intention.

Our first point, then, regarding what makes the clinician–patient relationship a social relationship between socially embedded individuals is that the dual principal–agent character of this relationship when both lack information the other possesses puts both clinicians and patients in the position of needing to express shared intentions regarding patient care. Clinicians express intentions that prescribe care as treatment, but these intentions are (at least implicitly) expressed in "we" terms which require that patients accept and share the associated prescriptions for care. That is, implicit in clinicians' care recommendations is the assumption that since clinicians and patients share the goal and strategies of the recommended care, they also share the intention to pursue them. In effect, they function like a team. Of course patients may fail to act as recommended, and clinicians may not use the language of "we" in communicating with their patients. However, neither of these points shows that patient care does not depend on implicit collective intentions held by clinicians and patients. We believe such intentions are present because they are inherent in the shared goal of patient health underlying the clinician–patient relationship. To further support this view, we will argue in the balance of this section that the case for treating such intentions as foundational to the clinician–patient relationship is strengthened when one looks upon that relationship less episodically and more as an enduring relationship in a larger social institutional framework. From this overall perspective, then, we argue that the appropriate concept of care is non-instrumentally rational and other-regarding rather than instrumentally rational and self-regarding.

Second, then, consider the clinician–patient relationship as specifically a social institutional relationship. By this we refer to characteristics that people have as members of social groups and in their involvement with others in specific types of enduring relationships that stand over and above their status as individuals. We explain these characteristics through the lens of their different social identities, and following the social psychology literature on social identity distinguish between two main kinds of social identities that people have. There are: "(i) those that derive from interpersonal relationships and interdependence with specific others and (ii) those that derive from membership in larger, more impersonal collectives or social categories" (Brewer and Gardner, 1996: 83; also cf. Brewer, 2001). The former are referred to as relational social identities and are associated with role relationships. The latter are referred to as group or collective social identities and are associated with membership in social aggregates. The clinician–patient relationship is an example of a relational social identity in which clinicians and patients occupy a role-based interpersonal relationship and are interdependent with one another. However, clinicians are also members of the group of all medical professionals and patients are members of the groups of all patients. Thus both have both relational and group types of social identities. Note then that the different social identities people have are interlinked in ways that allows us to see the social structures that operate within society. For example, patients also have relational social identities with family members, employers, and others in the communities they live in, and clinicians also have relational identities with other medical professionals and medical care system administrators, as well as the family and community relationships patients have. As settled types of social structural relationships, this interlinked network of relationships exhibits the social institutional nature of health care. We explain this here specifically in terms of the structure of connections between individuals' different social identities. In this regard, the doctor–patient relationship is a social relationship, not only as a relational social identity but also in its embeddedness in a network of interlocking social identity relationships, both relational and collective social identities.[8]

Consider, then, how clinicians and patients might be thought to behave when they share a relational social identity. In general, relational social identities (employee–employer, parent–child, student–teacher, etc.) come with expectations about what the reciprocal roles in the relationship entail, and these expectations create prescriptions and rules for what people should and should not do. These prescriptions and rules derive from individuals' understanding of how the roles they occupy fit together in a combined undertaking. Rule-driven behavior, however, is non-instrumentally rational in that one does what one is supposed to do as dictated by the role, irrespective of one's preferences. Indeed, people often associate following rules with responsibilities, obligations, and habit, while seeing acting in accordance with them as rational because these responsibilities and obligations are rational from the perspective of the roles that generate them. Note that this alone does not imply that rule-following behavior is other-regarding. Per se it is just "rule regarding." But rule-following behavior is also other-regarding when the role-based relationship is one in which the responsibility of one person, such as a doctor, is to care for the wellbeing of another person, a patient. That is, the clinician–patient relationship is a particular type of relational social identity that specifically functions to promote the wellbeing of one party to that relationship. In this particular case, then, the non-instrumentally rational, rule-driven character of behavior is also other-regarding in nature.

Note again, then, that the clinician–patient relationship is a relational social identity with many network connections through all the other relational and collective social identities clinicians and patients have. Thus its specific set of rules and responsibilities is related in an interlocking way to these many other sets of rules and responsibilities associated with all the different sets of interconnected social identities individuals have. The point here goes back to our claim that one ought to look upon the clinician–patient relationship as an enduring social institutional relationship. We say that it is enduring not just because of the long record of medical care in human history as a vocation and a need, but because many other social relationships have been built up around it that effectively lock in its scope and character. One can see this from the medical professions' side of the relationship in that clinicians' position within this domain helps determine clinicians' roles and responsibilities vis-à-vis other health providers. Similarly, on the patient side relationships within families and social institutions such as insurance systems help determine others' responsibilities to individuals who are patients as well as patients' own responsibilities regarding their health. Thus rather than an episodic, market-centric view of clinicians and patients, as is suggested by the idea that their relationship can be explained in terms of their individual supply-and-demand characteristics, we see clinicians and patients as being in long-term relationships with one another. This leads us to lay out what we think is involved in an alternative health *care* economics.

1.6 An alternative health economics

As we say above, we do not seek to replace the economic analysis of health by an essentially psychological or sociological approach to the subject, but rather wish to focus on the boundary between economics and these fields in order to show how personal contact in the socially embedded clinician–patient relationship helps explain clinician and patient choices and economic behavior. We seek to do this not only for more market-type settings, as investigated in standard health care economics, but also for social insurance systems which depart significantly from market principles but which still leave an important role for cost and demand considerations in the provision of health and medical care, as in Mooney's recommended health economics. However, we take our focal point – and the subject of this book – to be the nature of the concept of care, because we believe this concept is pivotal for understanding health in connection with clinician–patient relationships. And, as the discussion in the last section shows, the way we approach care involves both attention to its special normative characteristics as rational and other-regarding, and also attention to how the social institutional world of health provision supports this conception of care. That is, we see rational other-regarding care as itself socially embedded, and thus seek to build an alternative health economics around this idea.

This approach has particular implications for the economic methodology appropriate to an alternative health economics. Standard health care economics employs an understanding of economic methodology that is the result of applying conventional microeconomic tools and concepts to all social economic circumstances at all times and in all locations in which health services are provided, modeling them as a market exchange between rational self-regarding individuals, while minimizing institutional or cultural differences that may distinguish one situation from the next. It assumes that these conventional tools and concepts function as an abstract, universal engine of analysis, and thus rules out in advance that care can be interpreted differently in any important respects in different clinician–patient social settings. We reject this top-down approach. We do undertake an analysis of the care relationship, as initially set out in this chapter and further pursued in this book, but we frame our analysis in an open-ended way by deriving it from relationships between individuals, which themselves need to be understood in concrete social circumstances. Our analytical method, that is, depends upon relational constructs that direct us to their social foundations – not a top-down or even a bottom-up sort of approach but one that seeks to combine both ends of the methodological spectrum, and accommodate analysis and the empirical to one another.

This relational approach is meant to depart from the individualist *Homo economicus* one that defines mainstream economics. At the same time, it should be emphasized that we also take individuals to be fundamentally important as both agents of economic activity and as centers of social wellbeing. We in fact think that the standard *Homo economicus* view of the individual fails to do justice to the concept of the person in its full range of normative and behavioral dimensions. But fuller discussion of the poverty of *Homo economicus* as an individual conception in its traditional and in the more recent versions found in economics is pursued by one of us elsewhere (Davis, 2003, 2011), and in this book we seek to elicit a view of the individual specifically appropriate to an alternative health economics that makes caring behavior a key to understanding clinician–patient relationships. Our view of the socially embedded individual consequently only really emerges in the chapters that follow where we examine not just the clinician–patient relationship but also the many sorts of relationships between health providers of all kinds and people, as well as the different views people have about the meaning of care outside the domain of health where there are other similar personal care relationships.

It might seem ironic, then, that while we lend our support to Mooney's proposal that the name "health care economics" be changed to just "health economics" to help refocus health research on the social determinants of health, we are primarily interested in the place of care in this health economics. But if it is a puzzle that standard health care economics is not actually about care, we do not see any problem in saying that the proposed health economics is about care. That this health economics fundamentally concerns care we take as a given when the object of investigation is the provision of health. Rather the irony – one that seems reflective of the state of much contemporary discourse regarding health – is that the status of the concept of care seems problematic at all. Why is there even room for debate about the concept of care, where by this we mean care as other-regarding? We hope to show in the chapters that follow that in fact there is no room for debate about this, and that when we look more carefully at what many have said about care relationships in the world today that there is actually considerable consensus about what care means. We hope the same will hold for health economics in the future.

1.7 Outline of the argument of the book

The remainder of the book is divided into three parts which seek to develop our argument for a reconfigured health economics that centers on care. The two chapters in Part I – Health Care Notions: Health Economics and the Biomedical Approach – outline and analyze the biomedical approach to care and caring, its foundations, and its contrasts with health economics, and then discusses the organization of care as treatment. Chapter 2, "Health Care, Medical Care, and the Biomedical Approach," highlights the distinctions between health and medical care, the latter nested in the former, and how a Cartesian founded biomedical representation of illness and health potentially contributes to the medicalization of social problems. The tensions between this and the Hippocratic ethos are also considered, and further contrasted with the basis of standard health economics. Chapter 3, "On Identifying and Categorizing Health and Medical Care," outlines the institutional distinctions between health and medical care as well as the array of institutions providing and delivering medical care. The different manifestations of care in medicine, for instance across acute and therapeutic services, are discussed in the context of providing a platform for our subsequent argument.

In Part II – Theories of Care: Towards Health and Medical Care – we develop our analysis of care in the context of medicine and health. Chapter 4, "Economics and Care," investigates how economics, especially the mainstream of the discipline, has largely overlooked the importance of care. Yet there is some recognition of the importance of care, such as in Adam Smith's *Theory of Moral Sentiments* and Kenneth Boulding's notion of the love economy. A more consistent and coherent approach has been formulated by feminist economics, which may be associated with a wider feminist literature. This is discussed in Chapter 5, "Capturing Care" where we investigate conceptions of care and caring in order to develop a more meaningful approach to care in health economics. We consider feminist contributions, as well as the philosophical analyses of Heidegger and Foucault in emphasizing the centrality of care to humanity. The ethics and gendered dimensions of care are also discussed in the context of linear portrayals of the caring process, such as that associated with the work of Joan Tronto. We investigate the properties and conditions of an authentic care promoted by writers such as Nel Noddings and Joan Watson. In doing so, we query whether their approach overlooks the importance of institutional settings, which we interrogate in Part III – Care Systems, Human Flourishing, and Policy.

Part III is composed of four chapters. Chapter 6, "Institutions, Groups, and the Morality of Care," draws from the insights of the original institutional economics associated with the pioneering work of Thorstein Veblen, to emphasize the social embeddedness of care. Here we argue that an appreciation of the individual as socially embedded and properties of institutions as social rules systems is vital to exploring the complexities and value of care in health and medicine. Chapter 7, "Developing Capabilities and the Dignity of the Individual," introduces the capabilities approach and the concept of health capabilities. We distinguish four main types of health capabilities, associate different types of shared intentions with each, and then emphasize the specific moral values each involves. Our goal here is to give a ground-up view of the normative objectives of health care systems. Chapter 8, "Social Values in Health Care Systems," then takes a top-down, public health approach to the normative objectives of health care systems. We set out a "social causation" model of health provision, and look at how social stratification and social inequality constitute barriers to health care provision. We then argue that these barriers can be overcome when the inherent dignity of the person is employed to link ground-up moral values and top-down social goals of public health systems. Chapter 9, "Towards Dignity in Comprehensive Health Caring," concludes the book's argument with our view of the need for a social economics not only for health but which embodies a broad vision of the economy as a social provisioning process.

Notes

1 In December 2012 Gavin Mooney and his wife were tragically murdered. We deeply regret his premature passing, and acknowledge his highly insightful work in health economics. In his later work, Mooney expressed deep dissatisfaction with the state of mainstream health economics. We feel indebted to him for his leading role in attempting to reconstruct health economics in a way that enhances the dignity of the person.

2 We use "standard," "mainstream," or "conventional" health economics to refer to that body of applied economics that focuses on issues of "health." Mooney's preferred terminology – "health care economics" – refers to the same body of work. In our view the approach is embedded in neoclassical economics. We develop this claim throughout the book.

3 There are compelling criticisms of mainstream economics' conception of markets in that it fails to adequately define markets, or acknowledge markets as institutions that can only function as part of a system with other institutions, such as the state and money (see, for example, Rosenbaum, 2000).

4 There are of course many types of health and medical care professionals, and we pay closer attention to the differences between them in subsequent chapters. Here, however, for ease of explanation we simply refer to clinicians in a generic way.

5 We employ the terms clinician and physician interchangeably. This is shorthand for reference to all medical professions engaged in the delivery of care services, such as doctors, nurses, and other specialist professional medical staff.

6 However, since Culyer's work welfare analysis in health care economics, as opposed to choice analysis, does take caring externalities into account.

7 Shared intentionality theory was developed by philosophers as an extension of the standard analysis of personal intentions. It has been used to explain joint action and team behavior. See Tollefsen (2002) for an introduction to the literature as applied to social science.

8 Social identity relationships are only one of many ways of explaining network relationships. See Kirman (2011) for an introduction to network theory in economics.

PART I

Health care notions

Health economics and the biomedical approach

2

HEALTH CARE, MEDICAL CARE, AND THE BIOMEDICAL APPROACH

> "It must now be understood that what has turned health care into a sick-making enterprise is the very intensity of an engineering endeavor that has translated human survival from the performance of organisms into the result of technical manipulation."
>
> (Ivan Illich, 1976: 7)

2.1 Introduction: health care and medical care

In Chapter 1 we argued that standard health economics does not provide an adequate conceptualization of care, relying on the notion of interdependent utility functions to account for care and caring. Some health economists also distinguish between health and medical care, a distinction we consider to be important in terms of conceptualizing care in medical and other health settings. In this chapter we endeavor to develop these differences and explore their background in relation to the conceptualization of care. We believe this is an important step toward providing a more adequate account of care in the economics of health care.

Care, we will argue in following chapters, transcends institutional boundaries and is multi-layered. Care is relational in nature, and is molded by institutions and social systems through learning, habits, and values. It thus resembles an emergent property, and therefore evolves. Hence, different institutions and ethical systems will engender different types of care according to their particular contexts and contingencies. For instance, families and other close social groupings would be expected to demonstrate care in the form of intimacy associated with the "to care for" idea (see Chapter 5), whereas the institutional arrangements of clinical-medical care centering on the relationship between clinician and patient would not.

In this chapter we outline two types of distinctions that will frame the development of our argument in following chapters. The first distinction is between health care and medical care, while the second is located within medical care and is between a Cartesian grounding of care in the biomedical model of health and the Hippocratic tradition with a potentially very different understanding of care.

The distinction between health care and medical care partly lies in institutional arrangements. For medical care, a particular institutional configuration with a certain array of social relations immediately highlights two principal roles – clinician and patient. Health care encompasses this, but additionally involves a system of institutions that does not center on the clinician–patient relationship. Thus medical care as nested in a broader system of health care also concerns public health, environmental contexts, and social medicine. For example, roadway crash barriers by *preventing* injury and fatalities are in effect a form of health care, broadly interpreted (Hurley, 2000). Health and safety at work legislation and regulations may be similarly designated. Also, recent high-profile health initiatives, such as the proscription of smoking in enclosed public spaces, may be viewed in health care terms, as well as in standard economic terms as potentially addressing an external cost.

Standard health economics primarily concentrates on the provision and delivery of care by medical professionals (Mooney, 2009), i.e. medical care, although its boundaries extend beyond this (for example, Burge *et al.*, 2010; Jones, 2006). There is an explicit recognition of the distinction between the health and the medical spheres within the mainstream health economics literature. For instance, in his seminal analysis Michael Grossman (1972) differentiates between the demand for "health" and the demand for "health care." In Grossman's study "health care" is defined in functional and instrumental terms as a derived demand for improved health (status). It encompasses those goods, services, and activities where the principal purpose is either to prevent deteriorations in or improve health (see, for example, Hurley, 2000). As Grossman observes, such an activity, or range of activities, is not the sole preserve of medical practitioners, and can be usefully associated with the individual and the household as well as other institutions. Therefore a broad interpretation of health care permits a distinction between it and medical care. Yet, despite the promptings of the eminent health economist Victor Fuchs (2000) for health economists to take greater cognizance of language, history, and institutions in health, the standard approach largely eschews such concerns, and, we believe, therefore does not fully appreciate the insights of Grossman and Hurley.

As we will argue, the institutional configurations of medical care exhibit some potentially important distinctions, although all are at least nominally influenced by the Hippocratic ethos. One lies in the delivery of care for the mentally ill and acute episodes of care (see Chapter 3). The former may involve prolonged residential treatment over a course of years, while the latter typically involves a relatively short visit to the emergency department of a local hospital. For us, such differences impact the nature of care and caring, and perhaps the evolution of caring.

The next section, then, reviews the biomedical model, which arguably dominates Western medical thought and its descriptions of care. Of central importance to our analysis of this model is the linear causation between its particular rendering of "illness," "disease" and therefore "health" and its conception of care *as treatment* intended to ensure "health" (or at least to address the diagnosis of "disease"). Care in this respect, we argue, has a decidedly functional character – it is a means to an end, and its "value" or "functionality" is assessed by its results. It is thus possible to think of regimes of care, where care *as treatment* follows particular protocols. We characterize this as a Cartesian approach that conceptualizes the mind and body as distinct and separate entities, and then invokes the metaphor of the body as machine.

Our emphasis on the centrality of the biomedical approach bears on our interrogation of the standard health economics' conception of care, as both share similar Cartesian underpinnings. The following section thus examines the resonance between the biomedical approach and standard health economics. In this respect, we identify the central characteristics of standard health economics as its consequentialist emphasis, associated with its efforts to measure cardinal utility in comparative analyses of health, and its modeling approach that seeks to generalize disease–treatment relationships.

The section following sets out the main criticisms of the biomedical approach and the tensions between it and the Hippocratic tradition in medicine. Here we allude to the social dimensions of illness and disease, and the tendency for disease to be medicalized in biomedical approaches in contrast to other approaches to health and illness. In the final section of the chapter we return to the delineation of medical and health care, identifying the latter with public health and social medicine movements. This enables us to focus on the diversity of medical care in Chapter 3.

2.2 Medical care: the biomedical approach

The biomedical model of illness is frequently criticized but nevertheless retains its dominant position in Western medical thought (for example, Freidson, 1970; Groopman, 2007; Jarvis *et al.*, 2002; Wade and Halligan, 2004). In essence, the biomedical model is predicated on the idea that all illnesses are either mainly or exclusively a consequence of some disruption to or malfunction of the biological process (for example, Frankenberg, 1980; Freidson, 1970; Jarvis *et al.*, 2002). For Wade and Halligan (2004) this is derived from Rudolf Virchow's[1] claim, made in the nineteenth century, that all diseases are traced to cellular abnormalities. Thus a linear causal chain is established from some biological source that manifests itself either immediately or after some time as an array of symptoms. This manifestation enables the trained physician to analyze this association and address its source, if medically possible.

Hence all disease, physical and mental, has a common source arising from some abnormality, such as a malfunction or structural problem, within the body: disease is somatic. In the case of mental "illness" or "disorder" the physiological dimension is privileged over potential behavioral and emotional dimensions, which indeed may even be entirely disregarded (Engel, 1977, 1980). As Jarvis *et al.* (2002) explain, the mental phenomenon of depression as a diagnosis is conceived of in terms of some imbalance in one or several neural bio-chemicals, such as serotonin, as opposed to the patient's perception of, for instance, low self-esteem. In other words, somatic pathogens are the root of illness and disease, and hence human need in the context of health.

The foregoing is based on the further important assumption that diseases can be identified as discrete (and hence separable) entities (Singer, 2004). This has given rise to various official compendiums of disease, such as the *International Classification of Diseases* (Singer, 2004) and the *Diagnosis Related Groups* (DRGs). It has been argued that development of the latter was primarily motivated by a desire to trace and systematize hospital cost sources in North America (Mooney, 2009; Wade and Halligan, 2004). There are also important ontological and epistemic implications of this. Singer (2004: 9) argues:

> Every specific case of disease expression in an individual patient is understood in biomedicine as an objective, clinically identifiable part of material reality, a thing-in-itself. Even if the disease is outside of patient awareness and consequently the patient suffers no experiential symptoms … the physical existence of the disease as an *isolatable* part of nature is accepted. (Emphasis added)

Illness and disease thus exist outside or beyond their social context and even the social groups in which they may be evident. The social sphere is at best relegated in terms of its potential bearing on illness, and it is not inconceivable that it is totally disregarded. This prompts an important line of criticism which we will consider below. It also promotes a particular regime of care seen as treatment, and has significant implications for the allocation of resources, issues to which we now turn.

The biomedical explanation of disease and illness establishes a standard format for the regime of care, where care is associated with treatment, and a specific institutional configuration that promotes the dominance of a particular clinical group – doctors. We postpone a fuller consideration of the latter until Chapter 6.

The biomedical care regime commences with the consultation between the individual displaying symptoms of some illness – designated as the patient – and the physician. The physician examines the patient, where the procedure consists of some inspection of patient history, a physical examination, sampling and laboratory testing, and possible referral to specialists. The examination process should lead to a diagnosis and thereafter appropriate treatment to address the disorder or remove its cause (Barbour, 1995; Freidson, 1970; Groopman, 2007). "Care," on this account, is the product of a linear process of investigation culminating in a particular treatment founded on a specific biological etiology. The patient is passive, responds to clinical guidance, and indeed is expected to be passive throughout the process as directed by the physician.

The foregoing reflects the correspondence of the biomedical model of care to a Cartesian view of the world, particularly the Cartesian duality. This posits that an individual is a compound of two distinct entities – *res cogitans* (the mind) and *res extensa* (the body). The duality is complete; the two are ontologically separate as the mind has no corporeal properties and the body has no cognitive properties (Cottingham, 1986; Descartes, 1996, 2006, 2008). Descartes was influenced by Ancient Greek thought, which held that the soul and the body are entirely different substances, with the body imprisoning the soul. For Descartes, the body was ontologically privileged in that it requires no proof of existence while the mind does. This was famously captured by his *cogito ergo sum* – "I think, therefore I exist" proof (Descartes, 1996: 68). In effect, we cannot question our own existence unless there is a self to do the questioning (see, for example, Cottingham, 1986; in the medically related literature, see, for example, Engel, 1977; Kennedy, 1981; Tonelli, 1998).

Cartesian thought complements Christian theology, where the body is seen as the vessel of the soul. Arguably, Christian theology is more significant than Descartes' work in influencing the evolutionary trajectory of medical science, and hence the evolution of the nature of medical care, as it was a major factor in the ecclesiastical endorsement of anatomical examinations and post-mortems. However, Christian churches were steadfastly resistant to any scientific investigation of the mind, and hence the soul, preferring instead spiritual guidance and the teachings of the Church in this domain (Engel, 1977; Unschild, 2009). It is difficult to exaggerate the impact this had on early medicine and the historical framing of medical science. For instance, surgery has its origins in the Cartesian idea of the body as machine – technical skills repairing the defective machine were viewed as "scientific." In contrast, medicine, with its more ambiguous bio-chemical basis, is closer to religious rites and magic (Risse, 1999; Unschild, 2009).

Therefore, the Cartesian disembodiment of the person directs the sculpting of care regimes in terms of the allocation of resources to the repair of dysfunctional or broken "machines." In other words, the role of a specifically curative medicine is privileged (for example, Doyal and Gough, 1991; Mooney, 2009; Tonelli, 1998).

Care on this understanding of disease gravitates toward care as treatment and/or care as cure. Moreover, care is a means to an end, and its "value" or "functionality" is apprehended and assessed by its results. This produces a consequentialist assessment of the value of care to the effect that if "care as treatment" does not produce the desired outcome in the form of relief from a malfunction or the curing of a disease then it does not offer much, if anything, of benefit. This dovetails, as we argue in section 2.3 below, with issues of resource allocation and health economics. The outcomes of procedures demonstrate the value of these procedures, accordingly demonstrating that cost-effectiveness in a cost-benefit analysis takes on a heightened significance. There is, however, further reason to believe that a consequentialist form of evaluation is embedded in medicine in connection with the recent rise of evidence-based medicine (EBM).

Indeed, arguably the biomedical model's dominant position, at least in Western medical thought, is further facilitated by the recent adoption and diffusion of EBM (Kristiansen and Mooney, 2004; Sackett *et al.*, 1996). EBM has a spectacular history. Prior to 1992 the term was absent from the medical literature; yet in fifteen years the terminology and its emphasis has become pervasive in Western medical education and research – it has virtually taken the medical community by storm! As some of its leading proponents contend, the principal aim of EBM is to equip clinical practitioners with the means to cope with a fluid technical environment, and to expedite the dissemination of information, thereby offering the prospect of a "gold standard" in medical care (Sackett *et al.*, 1996). Through quantitative techniques and analysis it provides the norms or guidelines for best practice medicine, and thereby democratizes the provision of care by furnishing both patients and clinicians with objective evidence about the performance of medical pharmaceuticals, procedures, treatments, etc. EBM is explicit in its invocation of a hierarchy of evidence and information, with randomized controlled trials (RCTs) and meta-analyses of RCTs ranked ahead of other types of information and evidential sources, such as observational data sources derived from case control, cohort studies, and experiential evidence (McMaster, 2008). RCTs are explicitly based on a biomedical rendering of the source of illness. In an RCT a group of patients is separated on a random basis into control and experimental groups. These groups are followed up for the outcomes (of treatment, procedures, etc.) and variables of interest.[2]

Despite its dominance in medicine, and the "wealth" of supportive evidence for biological findings (Wade and Halligan, 2004), the biomedical model is constructed on a set of contested beliefs. We examine this in section 2.4 below, emphasizing that we do not aim to provide a comprehensive nor exhaustive analysis. Prior to this, however, we turn our attention to outlining the commonalities between health economics and the biomedical approach.

2.3 Health economics and the biomedical approach

In Chapter 1 we sought to establish the standard health economics conceptualization of (health) care. We argued that the mainstream approach does not fully examine the nature of care and caring. This, to a large extent, reflects the central characteristics and focus of standard health economics.

Health economics' analytical approach is drawn from Kenneth Arrow's (1963) seminal paper on the welfare economics of medical care. Arrow used the conventional analysis of markets as his analytical entry point. His emphasis on the "departure" of the "market" for medical care services from what economists consider to be characteristic of a market established the association of "market failure" with medical care. Indeed, Arrow was careful to identify his analysis as relating to *medical* care. For Arrow, what determined this point of departure was the inherent uncertainty associated with the demand for medical care, the quality of its provision, and outcomes of treatment. He states that the usual assumptions of the market "are to some extent contradicted" (1963: 967). Arrow's argument privileged not only the analytical role of markets, but also outcomes. This has an obvious correspondence with the treatment of disease and illness in the biomedical care regime, noted in section 2.2.

In Arrow's analysis there is no obvious consideration of processes of care beyond that represented by the linear process of the biomedical approach. Nonetheless, he does explicitly recognize the importance of what he terms "non-market relations" (1963: 967) in the delivery of medical care in that the support offered by family and beyond is significant in addressing issues of uncertainty, such as those associated with treatment outcomes. Moreover, Arrow was explicit in stating that the provision of medical care was inherently normative; this partly accounted for, in his view, the profusion of non-profit institutions and the practice of income discrimination, or means testing, frequently applied to ensure access to treatment. In effect, normative distributional concerns may supersede the conventional efficiency rubric. In this respect, Arrow appears to go beyond the confines of neoclassical economics, and also of the biomedical approach. His analysis unambiguously accommodates the potential for social factors to have some bearing on the allocation of medical resources. However, he does not provide much in the way of detail for this, and his analysis remains decidedly individualistic in orientation. Nevertheless, his invocation of distributional and social aspects of care as integral to its medical provision represent analytical components not immediately apparent in biomedicalism, or indeed much of neoclassical economics.

Arrow is credited with raising the importance of "health" in economic analysis. A year prior to the publication of Arrow's "Uncertainty and the Welfare Economics of Medical Care," Selma Mushkin (1962) advocated using human capital theory in conceptualizing health as an investment good distinct from education, which would have potentially beneficial effects on economic growth prospects. Arguably, Mushkin's piece was overshadowed by a more formal approach. Ten years following the publication of Mushkin's paper, Grossman (1972)[3] presented a model of the demand for health *and* health care, the latter derived from the former. As noted, Grossman's distinction between the two is important, but Grossman also established health as the maximand in the standard approach (see also, Grossman, 2000, 2004). For Grossman, health may be conceptualized as a capital stock – health capital – with both consumption and investment properties. He argues:

> Health is demanded by consumers for two reasons. As a consumption commodity, it directly enters their preference functions, or, put differently, sick days are a source of disutility. As an investment commodity, it determines the total time available for market and nonmarket activities. (1972: 225)

In these terms, health is very similar to other capital goods, such as human capital and housing – they have, according to the literature (see, for example, Barr, 1998), consumption and investment aspects, which allows the rational individual to trade-off between the two. In the more specific case, Grossman's description of health is freedom from illness; it is a functional quality. Grossman (2000) cites Jeremy Bentham as recognizing that the "relief of pain" was one of the fundamental arguments in a utility function (see also Jones *et al.*, 2006). Health may thus be seen as a constraint, a source of utility, and a conduit of utility. Poor health constrains an individual's ability to work and so derive utility from an income stream, whereas good health permits this. As we discuss in section 2.3.2 below, this presents a rather dualistic definition – ill or healthy – that is nonetheless popular with public agencies, such as the World Health Organization (WHO). It also resonates with the biomedical approach, where, as we have seen, illness is regarded as mainly or exclusively a functional disruption from what is considered to be a normal state. The principal aim of biomedicine, then, is to restore functionality and eliminate (as much as possible) abnormalities. For us, there is a clear correspondence between Grossman's functionalist account of health and the biomedical account. This may not be surprising given the prevalence of usage, and may even be seen as advantageous in drawing economics and medicine onto a common ground where each may exchange ideas and concepts that benefit both.

From our perspective, Grossman's argument is important for at least three reasons that it establishes or reinforces: a conception of health as the *de facto* focus of health economics; the Cartesian duality of mind and body in (mainstream) health economics, and an instrumental or consequentialist basis for evaluation. All are shared with the defining aspects of the biomedical approach.

The popularity of Grossman's model embedded the human capital approach in the health economics literature and further endorsed the idea of health as a maximand (Mooney, 2009). This prompted extensive efforts to measure health objectively as part of a process of advancing allocative efficiency in health services (Forget, 2004). Mooney (2009), for instance, reports how this occurred in the 1970s and 1980s through the influential works of Torrance and Williams (see, for example, Torrance, 1986). The measurement Quality Adjusted Life Years (QALYs)[4] and its later related concept – Disability Adjusted Life Years (DALYs) – became synonymous with research in this field. QALYs are claimed to offer considerable advantages as a method for quantifying the effectiveness of the outcome of medical interventions and treatments using a single metric that captures the extent of any improvement in health status and the duration of this improvement (where the latter also measures the extent of any increase in life span).[5] Duration is measured in years and quality is assessed by an index ranging from 0 to 1, where 0 is death and 1 is perfect health. Hence alternatives may be assessed so as to allow the allocation of resources to those treatments and interventions producing the most QALYs. The number of QALYs produced for each patient is simply aggregated to provide the overall measure for the treatment's effectiveness. If an intervention is expected to increase life by 1 year and provide perfect health then it has a measure of 1 QALY. If a treatment produces a 0.4 quality of life measure and extends life by 5 years it has a measure of 2 QALYs. Some health economists have advocated a more nuanced employment of QALY type measures, which they argue may capture expected utility (Bleichrodt and Pinto, 2006; Culyer, 1990), but not willingness-to-pay, which may be associated with, for example, "non-health-enhancing aspects of the process of care," which yield utility (Birch and Donaldson, 2003; Donaldson *et al.*, 2006: 393). Contingent valuation techniques, such as discrete choice experiments, have also become increasingly evident in the literature (see, for example, Donaldson *et al.*, 2006; Ryan *et al.*, 2006).

Leaving aside the nuances discussed within the health economics literature, our main point is that QALYs (and more contentiously contingent valuation techniques) are solely focused on consequences. This clearly lines up with a biomedical expression of efficacy, where the process of care is assessed by its results. Moreover, in common with the biomedical approach, the QALY measures employ the biomedical assumption that illness and disease can be identified as discrete phenomena, and therefore that treatments and other medical interventions are as well. In effect, issues of co-morbidity, i.e. where a patient is subject to more than one defined condition – the assumption of discreteness may no longer be applicable – are either disregarded or dismissed (see, for example, Rogers' (2004) critique of EBM). We consider this further in section 2.4.1 below.

In addition to the instrumental and consequentialist properties of standard health economics, there is further resonance with biomedicine through a similar affinity to Cartesian dualism. For instance, reference to the variants of Grossman's model reveals a Becker-inspired instrumentally rational conception of the individual. Every individual is assumed to be (exogenously) endowed with a specific stock of health capital; individuals faces a time allocation problem in their attempt to maximize utility. Grossman retains consumer sovereignty in his format, so the problem for the individual lies in calculating the appropriate investment in this health capital stock to generate future benefit flows as well as current satisfaction in the form of consumption. In effect, Grossman disembodies the individual – the mind simply becomes a rational calculating entity that seeks to generate the greatest net benefit over time from the capital stock that is their body. The duality is pronounced in its extreme, if taken literally. However, even if Grossman's approach is confined to the status of rhetoric or analogy the central argument still revolves around Cartesian dualism.

In other approaches in standard health economics a similar affinity to Cartesian dualism is evident. In the agency model of the patient–clinician relationship the idea of the fully informed agent is abandoned. As we noted in Chapter 1, and following Arrow's (1963) work, health economists have tended to invoke the notion of interdependent utility functions to model the patient–clinician relationship (for example, McGuire, 2000; Mooney and Ryan, 1993). In this analysis the clinician gains utility from the knowledge that the patient's health improves following treatment – while the patient also gains utility. As we have argued elsewhere (Davis and McMaster, 2007), the portrayal of the individual as patient demonstrates Cartesian qualities – the patient adopts the mantle of an object that may represent a source of utility for the clinician. Rather like the body-as-machine-as-capital stock idea in Grossman's model, the patient resembles a body-as-machine. There is an instrumental quality to this conceptualization by virtue of the emphasis on the patient as a source of utility. Again, the health status of the patient plays a key role in the generation of this utility stream. The connection may be less direct than Grossman's, but it is, to our minds, evident in this framework as well.

Nonetheless, there remain important differences between biomedical and health economic evaluations: witness, for example, Maynard's (1997) and Whynes' (1996) concerns that medicine frequently lacks reference to cost effectiveness and therefore provides an inadequate basis for allocating scarce resources; the presumption is, of course, that health economics does. For instance, in his critique of EBM, Maynard argues that this movement represents a retrograde step from the insights afforded by health economics. He argues:

> Unfortunately, I believe that the leading proponents of evidence-based medicine … are taking us back to the days before the work of … [pioneering

> health] economists … when treatment decisions were dominated by clinicians and the individual-patient ethic of effectiveness, *rather than by the population-health ethic of efficiency*. If evidence-based medicine and the individual ethic are allowed to determine treatment choices, resources will be used inefficiently and unethically. (Maynard, 1997: 126, emphasis added)

Yet, Maynard's position does not undermine the close association between the main orientations of biomedicine and standard health economics. Both share an inherent instrumentalism in their methods; they have a common Cartesian foundation in their binary divide between mind and body, and they focus on some potentially measurable notion of health. We believe there are further correspondences between the two – tendencies to medicalization and reductionism. We postpone comment on these until the following section, where we outline some contested aspects of biomedicalism.

2.4 The biomedical approach to medical care: issues and concerns

A major issue identified in the medical literature regarding the biomedical approach is its inherent reductionism. As noted, this derives from the idea that all disease is, if not entirely a result of biological processes, then at least has them as its principal cause. Yet by reducing pathology to its most basic medical elements this potentially neglects important social factors (for example, Engel, 1977; Groopman, 2007; Jarvis *et al.*, 2002; Singer, 2004). Moreover, the potential depersonalization associated with the biomedical approach may also engender tensions with the historical framing of health in the Hippocratic tradition of medicine and medical practice. Each is considered in turn, as is the conception of *salutogenesis* (Antonovsky, 1996).

2.4.1 Disease, illness, and the social sphere

The medical and medical-related literatures offer powerful arguments contesting the reductionist tenor of the biomedical approach. Among the more prominent contributors are medical anthropologist Ronald Frankenberg (1980) as well as George Engel (1977), and epidemiologists such as Nancy Krieger (2001, 2005), S. Leonard Syme (2007), and Syme and Berkman (1976). While in the medical literature more generally Howard Waitzkin (1981), Allen Barbour (1995), Ivan Illich (1976), Jerome Groopman (2007), and Ian Kennedy (1981) offer insightful critiques. Prominent social scientists emphasizing the importance of social construction, and its evolution in defining disease, include Kenneth Boulding (1966) and Michel Foucault (1975). Some economists and health economists, such as Birch (1997), Birch and Gafni (2004), and Sen (2002a), also query the dismissing of social contributors to disease and health.

For our purposes, the crux of the argument is that health, illness, and disease are to some extent socially influenced and constructed, and therefore cannot be wholly biologically determined. Frankenberg (1980), for example, argues that it is possible to identify three processes in the medical "domain": the making of disease, the making individual of diseases, and the making social of disease (see also Kennedy, 1981; Singer, 2004).

In the first process – the making of disease – the physician has to assemble evidence of symptoms in order to construct a diagnosis. The notion of constructing a diagnosis is the key to apprehending this argument. According to Frankenberg, symptoms may be less than clear cut, and the physician is frequently presented with opaque evidence. Groopman (2007) devotes extensive attention to this issue, highlighting interpretation difficulties as a source of medical error in the form of misdiagnoses. He argues:

> Clinical algorithms can be useful for run-of-the-mill diagnosis and treatment … But they quickly fall apart when a doctor needs to think outside their boxes, when symptoms are vague, or multiple and confusing, or when test results are *inexact*. (2007: 5, emphasis added)

There are compelling grounds for believing that test results frequently do not present definitive evidence, and that interpretation and judgment have to be employed by medical professionals beyond the patient–physician relationship, such as laboratory staff. Thus interpretation of unclear results and the consequent "construction" of disease indicate extensive roles for medical professionals' judgment, and what is at issue are the forces shaping these judgments (Groopman, 2007; Upshur and Collak, 2003). For Horton (1998: 249) this is the crux, as he states: "… argument is the fundamental unit of medical thought" (see also Upshur *et al.*, 2001, and Upshur and Collak, 2003). In this regard, Horton questions the ability of physicians to "reason" by interrogating a clinical argument to establish its validity and weaknesses. Groopman makes a similar case in arguing that doctors are beset by communication difficulties, and should, he maintains, engage in a dialogue with their patients, where patients are viewed as partners who can help address clinicians' "cognitive errors." Drawing extensively from the cognitive science approach to medicine, he maintains that physicians are beset by inherent biases that contribute to errors in the examination of patients and in apprehending patients' histories. These errors arise from a host of sources, including: clinician prejudices – "attribution errors" – and "search satisfying behavior," where a physician prematurely halts the search for a means of addressing a patient's condition or problem as soon as a finding is discovered that satisfies the physician. Among the other sources are: "confirmation bias" where a clinician selects elements of the available information to confirm the initial judgment, even if it is wrong, and "commission bias," where a clinician prefers to do something rather than nothing, irrespective of the available evidence (Groopman, 2007).

Singer (2004: 11) sums up the foregoing convincingly:

> Understood in this way as constructed processes, diagnosis, laboratory assessment, and other aspects of medical practice are unavoidably open at various

> points to influence from the "cultures" of the medical profession (including national, regional, ethnic, medical, family, and other heritages).

The above recalls Foucault's (1975) notion of the importance of medical perception as an organizing concept. How this perception is shaped by socio-cultural influences, such as religion, is significant (see also Freidson, 1970). Similarly, Boulding (1966) employs pragmatist notions of knowledge in arguing that definitions of both health and illness are, to varying degrees, matters of social construction. He notes: "Societies and cultures do exist in which what is now defined here as ill health is somewhat admired … In some societies, epilepsy is regarded as a sign of divine favor" (1966: 213). Kennedy (1981) highlights how homosexuality was judged by some medical practitioners as an illness "to be cured." He observes that in 1974 the American Psychiatric Association voted *against* designating homosexuality as an "illness." Drawing from Foucault, Singer (2004) argues that the definitions of disease, health and illness evolve. For example, a propensity to revolt ("revolutiona") and desiring freedom from slavery ("drapetomania") are no longer regarded as "bona fide" diseases. Wade and Halligan (2004) also demonstrate how the social construction of illness can have important consequences. Soldiers suffering from severe stress following harrowing experiences were occasionally shot for malingering; presently such soldiers are considered victims.

It is fairly well established – indeed there are various surveys in the literature – that comparative medical techniques are influenced by culture and place (Boulding, 1966; Engel, 1977; Singer, 2004). For instance, there is evidence that US physicians have a greater propensity to prescribe antibiotics than either their French or German counterparts where biomedical beliefs emphasize the robustness of the immunological system to a greater extent. It is also well documented that US surgical techniques are relatively more invasive than in Western Europe within women's medical care, for instance greater recourse to caesarean sections and hysterectomies (see, for example, the recent WHO background paper by Lauer *et al.*, 2010; Taffel *et al.*, 1987, and Childbirth Connection, 2011).

Frankenberg's second process – the making individual of diseases – involves the development of patient awareness of disease. Here medical power and authority are pivotal. According to Frankenberg's argument, patients come to the physician with a range of emotions, beliefs, and ideas, which may be inconsistent with the biomedical model. Thus for Frankenberg an important aspect of the patient–physician interaction consists in influencing the patient to believe their comprehension of the medical is tenuous and hence suspect, whereas the physician carries authority (see also Freidson, 1970). Horton's (1998) emphasis on the centrality of argument, noted earlier, is consistent with this view. There is an extensive literature in medical sociology investigating the distribution of power in patient–physician relations (Heritage and Maynard, 2006; Pilnick *et al.*, 2009). For instance, Karnieli-Miller and Eisikovits (2009) present a study of episodes of patient–physician interactions in Israel that finds that doctors actively engage in processes of persuasion as opposed to consultation. Groopman (2007) also highlights the finding that doctors will typically interrupt their patients within 18 seconds of the patient commencing to recount a description of their symptoms. Of course, patients may "defy" medical advice, refuse treatment, and even where intentions are shared outcomes may diverge from intent due to errors in practices (see, for example, Cramer, 2011).

In defining illness two propositions have to be addressed: first, some designation of what constitutes a normal state; and second – and following on from this – deviations from this defined norm should then be considered as illness. From these propositions the social construction of the meanings of health, disease, and illness appears to render medicine an inherently normative undertaking (see, for instance, Boulding, 1966; Kennedy, 1981; Tonelli, 1998). According to Barbour (1995), the way the biomedical approach tends to define "illness" is the most subjective element as it relates to the way the individual feels, and therefore clearly refers to the person. "Disease" follows from pathology and is attributed to science and objectivity. As noted, it concerns a malfunction or disordered element of the structure (body), and therefore refers to a "part" of the body. "Health" is freedom from disease. This raises two immediate issues – the tendency to "medicalize" and the tendency to judge health as an absolute condition. We defer comment on the latter to section 2.4.2 below.

When an individual experiencing job-related stress consults their physician, the symptoms may be manifest in a host of ways (Groopman, 2007; Singer, 2004). The physician, following the biomedical approach, could, for example, prescribe sedatives. As opposed to addressing the causes of the individual's condition, the physician's action merely masks the symptoms. In this way the physician's actions are not neutral; they do not address the root of the patient's problem (see also Engel, 1977). For Singer (2004: 15) this

> involves clinical acts of privatization, with diagnosis and intervention focused at the individual level, whatever the social origin of the disease in question.

Following Waitzkin (1981), medicalization involves the extension of a biomedical pathology to encompass new conditions and behaviors. This may inappropriately transform the nature of a problem where the etiology lies in the social, such as indigence and the demands of work, into an individualized issue requiring a biomedical "solution." Care, following the biomedical model, as embodying diagnosis and treatment seems ironically misconceived even from an instrumentalist perspective: masking is not curing. Moreover, masking it may reinforce existing patterns of social relations.

Such concerns have also been expressed in regard to the biomedical basis of EBM and its favoring of RCTs. Rogers (2004) and Upshur *et al.* (2001) are among those critical of the discrete nature of testing in RCTs.[6] In testing a procedure or treatment there is a desire to isolate and control specific variables in order to measure and assess the differences between treatment and control groups. Consequently, those subjects recruited to participate in trials are usually screened to ensure they do not have any other conditions that may interfere with the control of variables – indicative of a closed system of modeling (McMaster, 2008). The effect of these exclusions is to marginalize individuals demonstrating co-morbidity (Rogers, 2007).

> Yet comorbidity is an ever present fact of life in groups with socioeconomic deprivation, which means that many EBM derived guidelines are inapplicable to their care. (Rogers, 2007: 142)

Rogers further notes that gender and ethnic variations may not be captured in many RCTs. From an economics perspective, Birch (1997) has also argued that since "social groupings" are not usually of interest to clinical epidemiological research, information on social groupings is not normally collected, and is hence unavailable to both researchers and clinical decision-makers. On this basis Birch argues that reliance on RCTs can disadvantage some groups in society. Indeed, the more general criticisms of mechanical quantification and scientism are amplified in medical care provision. Evaluation, both economic and in the form of RCTs, presumes a relatively straightforward subjective–objective duality, and promotes a particular form of information as more "scientific" without sufficiently recognizing the framing effects involved in measuring, interpreting, and judging data (Hildred and Watkins, 1996).

Here, the third of Frankenberg's processes – the making social of disease – is of considerable importance to this line of argument. The concern lies in the revelation of the patterns of social relationships that influence the preceding two processes – the making of disease and the making individual of diseases (see also Freidson, 1970). The important work of Engel, in his advocacy of a bio-psychological model stressing the complex interaction of the biological, the psychological, and social dimensions of illness (see also Borrell-Carrió *et al.*, 2004, and Suls and Rothman 2004), resonates with Frankenberg's argument. Also, Krieger's (2001, 2005) and Syme's (2007) work is similar in their emphasis, and this is also apparent in the WHO's recent pronouncements on the importance of social factors such as indigence and consumption on longevity and the incidence and geographical distribution of particular diseases (WHO, 2004; see also Wade and Halligan, 2004).

Notably, Nancy Krieger (2001, 2005) argues that humans are social beings as well as biological organisms, and therefore the former will impact the latter and vice versa. Accordingly, Krieger advocates the notion of "embodiment" as central to what she terms as "ecosocial theory." This position advances three claims centering on the relationship between the social and biological. These claims are that our bodies "tell stories" (Krieger, 2005: 350) of our wider environment. Thus, first, our biological state cannot be divorced from our social environment. Second, individual accounts of illness or how one is feeling often but not always correspond to what is manifest in our bodies. Third, our bodies may reveal conditions that we cannot or will not articulate. Thus embodiment is an expression of how we as living organisms biologically incorporate "the world in which we live, including our societal and ecological circumstances" (Krieger, 2005: 351).

Similarly, Engel's (1977, 1980) analysis does not seek to denigrate the important advances in understanding disease and illness afforded by biomedical research.

Rather, Engel expresses disquiet at what he views as the reductionist and exclusionist properties of biomedicine.

> [Biomedicine is] *reductionist* … [in] that all behavioral phenomena of disease must be conceptualized in terms of physicochemical principles; and … *exclusionist* … [in] that whatever is not capable of being so explained must be excluded from the category of disease. (1977: 130, original emphases)

Engel's argument is, of course, familiar, but he argues that both properties of the biomedical approach render it dogmatic. In terms recalling Thorstein Veblen and John Dewey, Engel argues that the biomedical approach is a culturally derived belief system (see also Chapter 6). The history of the analysis of disease in Western medicine, partially shaped by religious strictures of body and soul, demonstrate to Engel the social construction of knowledge. Indeed, for Engel Western medical thought resembles a "folk model" which "molds" the attitudes and beliefs of physicians even before they enter the profession.

> The biomedical model has … become a cultural imperative, its limitations easily overlooked … It has now acquired the status of *dogma*. In science, a model is revised or abandoned when it fails to account adequately for all the data. A dogma, on the other hand, requires that discrepant data be forced to fit the model or be excluded. (1977: 129, original emphasis)

Engel, as we have seen, is by no means alone in expressing such a position. As noted, critics such as Groopman, Kennedy, and Waitzkin are among those articulating similar misgivings about the dehumanization of medicine and the disempowerment of patients that they believe accompanies dogmatic adherence to the biomedical approach. Engel, however, is one of the more prominent advocates of an alternative methodological grounding in his advocacy of a more holistic orientation in the analysis and praxis of medical care, and he strongly aligns his bio-psychosocial approach to systems theory (Borrell-Carrió *et al.*, 2004; Engel, 1977; Suls and Rothman, 2004). For us, this is significant in that it supports an important objection to the linear model intrinsic to the biomedical approach, and also corresponds with Veblenian and Deweyan approaches to the analysis of knowledge. We postpone further comment and analysis of this and its implications for our arguments over the conceptualization of care in health economics until Chapter 5 and thereafter. In the meantime, and in the context of Frankenberg's "the making social of disease," Engel's analysis supports the reinterpretation of illness as a complex of biochemical, social, and psychological phenomena. In particular, Engel argues that illness and its appearance are not solely a consequence of biomedical factors; a diverse range of causal factors, including individual psychological factors and those located at a social level, interact to engender illness. Moreover, psychological factors are significant influences on an individual's susceptibility to illness. In this regard, Engel refers to the placebo effect to emphasize the importance of psychological effects on the success of biomedical treatments.

At a social level Engel refers to the importance of patient experience and understanding of illness and disease. Specifically, the presence of a biomedical disorder does not necessarily illuminate the meaning of any symptoms for the individual patient. Engel refers to the "somatic disease" of diabetes and the "mental disease" of schizophrenia to demonstrate his case. In both cases the existence of biochemical defects "at best" establishes a necessary but not sufficient condition for the individual to experience the illness. In other words, the biochemical condition may be evident, but the individual does not "feel," and hence experience, any illness associated with the condition.

Also, as Groopman (2007) further emphasizes, for the physician, it does not necessarily suggest special aptitudes and attitudes are required to gather information and knowledge of an individual's condition. Designating an individual "ill" or "sick" is thus socially constructed, and opens up the possibility that an individual may be assigned and adopt the role of "ill" regardless of the presence of biological factors. In this respect, the relationship between physician and patient is highly influential and can impact medical outcomes, even if only due to its shaping of the care regime.

Engel's approach points to complex feedback on causal influences, non-linear relations, and the importance of various evidential sources in the interrogation of illness. As such, Engel's analysis offers a challenge to biomedical EBM (see Borrell-Carrió *et al.*, 2004; Upshur and Colak, 2003). We will make further recourse to Engel's pioneering work. For the moment we refer to the notion of *salutogenesis* advocated by Antonovsky (1987, 1996) as a means to further develop the significance of the social dimensions on health and illness.

2.4.2 Of salutogenesis*: a preference for "health-ease" as opposed to "dis-ease"*

The etymology of *salutogenesis* lies in the Latin terms *genesis* as "source" and *saluto* as "health." In promoting the notion Antonovsky seeks to shift emphasis away from pathogenesis and notions of illness in the medical sciences to the construction of "health." In this regard he is critical of absolutist approaches to defining "health," such as the definition in the WHO's constitution, which has not been amended since its establishment in the late 1940s:

> Health is a state of *complete* physical, mental and social well-being and not merely the absence of disease or infirmity. (Emphasis added)

While the WHO's statement attempts to highlight the positive dimensions of health in associating it directly with wellbeing, as opposed to a more negative connotation in the absence of illness, it has been subject to extensive criticisms, Antonovsky's being one. Huber *et al.* (2011), for example, powerfully argue that the WHO definition has not stood the test of time – what was pertinent in 1948 is not necessarily the case now. They identify three principal limitations: first, the definition contributes to the medicalization of social problems. This is unintentional, but nonetheless the requirement for completeness encourages professional associations and the pharmaceutical industries to redefine diseases in order to extend the range of medicine. Second, global disease patterns have changed since 1948 with public health interventions enabling those with chronic conditions to live comfortably and for longer. For Huber *et al.*, this is the "norm" of aging; yet by the WHO definition such people are defined as ill. This implies that the definition in effect

> minimizes the role of the human capacity to cope autonomously with life's ever changing physical, emotional, and social challenges and to function with fulfillment and a feeling of wellbeing with chronic disease or disability. (Huber *et al.*, 2011: 2)

Third, again due to the onus on "complete," the notion of health becomes inoperationable; in effect, it loses practicality.

Antonovsky (1996) criticizes both the biomedical approach and WHO's definition as they perpetuate a binary framing of health and illness. In a tone recalling Engel, he argues:

> It perpetuates dualistic thinking and prevents us from seeing that all human distress is always that of an integrated organism, always has a psychic (and a social, I might add) and a somatic aspect. (Antonovsky, 1996: 11)

Antonovsky's research investigates how people cope with stress and sources of stress (for example, Antonovsky, 1987). Since the late 1960s he has argued that poverty is a major contributor to disease and ill-health/morbidity (and mortality) as the poor experience greater exposure to stressors and simultaneously possess less capacity in their resilience to stressors. By stressors Antonovsky refers to social factors that create stress which have deleterious effects on individual health. Individuals with an acute ability to cope with stress – Antonovsky describes this in terms of a "sense of coherence" – will wish to be motivated to cope (meaningfulness), believe that the challenge is understood (comprehensibility), and believe that there are sufficient resources available to cope (manageability). Those factors that produce a sense of coherence are an individual's optimism, will to live, resilience, empowerment, and learned resourcefulness (Antonovsky, 1996: 15). While an individual's sense of coherence is not "culture-bound," according to Antonovsky, it is nonetheless "shaped" by an individual's life experience, including an "underload-overload balance" of stressors and stress, the "consistency" of this, and the participation in "socially valued decision-making," which are all strongly influenced by an individual's place in society and their social roles. There is an obvious intuitive appeal in this framework in that it identifies the vulnerabilities of particular groups within society. This is also significant for the argument we develop, as it corresponds with our emphasis on the social construction of illness,[7] and with the consequent importance of the concept of individual dignity, which we address in Chapter 7.

Based on his analysis of morbidity rates in industrialized economies, Antonovsky rejects the binary division between health and illness. He argues that at least a third of the population (and perhaps even a majority) in "modern" advanced economies can be characterized by some morbidity condition (Antonovsky, 1987). He highlights studies conducted in the 1960s in the US and UK that suggest that in a population of 1,000 adults in any given month approximately 750 people will experience some episode of illness and 250 of those will consult a medical practitioner in some way. This leads Antonovsky (1996: 14) to advocate:

> A continuum model, which sees each of us, at a given point in time, somewhere along a healthy/disease continuum is, I believe, a more powerful and accurate conception of reality …

Rather than disease eradication Antonovsky's case consequently revolves around the promotion of health – a sense of coherence – and viewing people as "integrated organisms" where the mind and body are intimately and complexly related. Antonovsky's analysis contributes further doubts regarding the widespread acceptance of the biomedical approach and the implications of this for our conceptions of care and regimes of caring. Given this, we turn to the relationship between the biomedical approach and the Hippocratic tradition.

2.4.3 Tensions with the Hippocratic tradition

Here we do not intend to offer a comprehensive analysis since this has long been the subject of ongoing debate within medicine, and there is an extensive literature on the subject in medical ethics. Our intention is rather to demonstrate its relevance to our argument concerning the orientation of standard health economics.

Medical care is strongly associated with the Hippocratic Oath, which dates back to ancient Greece by some estimates around 400 years before the Christian era. There is no evidence that the Oath was written by the physician Hippocrates or that he approved of it or even knew of its existence! Further there is no evidence that the Oath was legal and binding or a sacred document (Miles, 2004). Yet Hippocrates is credited with the establishment of medicine as an entity distinct from religion. This was certainly a radical intervention in an era when illness was frequently perceived as punishment from the gods. By contrast, Hippocrates considered illness a natural phenomenon (Miles, 2004).

The Hippocratic Oath appears to have been the final part of an apprenticeship where students vowed to repay their teachers and remain faithful to the principles of the Oath in being "good" physicians, although it is debatable whether this was a widespread practice or whether the Oath was even common knowledge at the time. There has also been extensive debate over the saliency of the Oath to both contemporary medical practice and the practice of the time. For instance, there are documented cases of ancient Greek physicians performing abortions and euthanasia (Maclean, 1993; Miles, 2004).

Nevertheless, despite its historical ambiguity, the Oath is commonly associated with a commitment on the part of the newly qualified physician to "do no harm" to their patients, act according to the principle of "beneficence," and to share their medical knowledge. Miles (2004: 176) believes:

> In the West, the *Oath*'s core message is still powerful. Medicine is a moral enterprise upheld by personal moral commitment … and integrity … Physicians must share knowledge, benefit the ill, and promote justice. (Original emphasis)

In a modern version[8] Lasagna (1964) states:

> I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

These passages suggest medicine is not only normatively laden with references to justice and commitment, for instance (Maclean, 1993; Tonelli, 1998), but also is relational. Indeed, the medical literature exhibits an abundance of such references (see, for example, Aasland, 2001; Eriksson, 2002; Groopman, 2007; Lipman, 2004; Sulmasy, 1993; Watson, 1997). For Daniel Sulmasy (1993) the history of medicine treats the medical relationship as a covenant, a solemn and binding accord. In the Roman and Medieval eras physician remuneration was considered as an honorarium, and physicians were expected to treat and care for patients regardless of patients' ability to pay (Miles, 2004; Sulmasy, 1993). It may be a little fanciful to presume that this remains the case, but as a small (unfortunately) number of health economists, such as Victor Fuchs (2000), recognize, in stressing that history matters, there are potentially important historical framing effects in medicine.[9] For instance, Sulmasy makes reference to two possible sources of framing: the non-proprietary nature of medical skills contained in the idea that medical knowledge should be shared, and the idea that medicine is a "calling" in that it invokes a binding commitment to individuals who are ill.

Sulmasy draws parallels with the skills of firefighters, police, and medical professionals. They are deemed to serve the "public trust" and therefore not to "own" their skills. In other words, there is an important ethical commitment to the wider community, which is embodied in the sharing of particular skills and capabilities. By contrast, other occupations do not possess the same virtue of civic service or ethical commitments to wider society, and therefore cannot claim similar "public trust." In such occupations there is proprietorship over the individual's skills. Boulding (1966) anticipates such an argument when he states that medical care encapsulates a highly idiosyncratic relationship: one that may be episodic and discrete; one that entails extensive trust; and certainly one that potentially involves high dependency. This is underlined by Sulmasy's argument that when an individual consults a clinician *the individual* her/himself is the issue, not, for example, her/his accounts or car. In effect, the central action of medical care is *care*. Sulmasy thus somewhat sardonically states:

> When was the last time anyone called an accountant at 3am because of acute tax worries? Who has ever been impressed that a young accountant had a wonderful ledgerside manner? (1993: 38)

Sulmasy's second framing (that medicine is a "calling") draws an obvious parallel with the meaning of work in the classics of political economy, and the institutional and social economics literature (for example, Figart and Mutari, 2008; Spencer, 2009). For instance, in Volume 1 of *Capital* Karl Marx (1990) notes the distinction between "work" and "labor," and together with Veblen identifies work as a significant source of an individual's identity. For both Marx and Veblen work offers the opportunity to express an individual's creativity and humanity. Of course both produced excoriating critiques of the division of labor brought about in capitalist production methods which transforms work into labor, where the latter is typified by mundane routine that robs workers of their creative potential, divorces them from the products of their work, and separates them from their essence as human beings. Witness Marx's famous analysis of workers' alienation (*Entfremdung*) and Veblen's (1994) discussion of how the early twentieth-century American business organization undermines the "instinct of workmanship." In this connection, Sulmasy clearly makes an exception for the provision of medical care, or at least doctors' contribution to it, from Marx's and Veblen's critiques of capitalist production. Doctors, on Sulmasy's argument, are not alienated and remain committed. Commitment, we venture, is a potentially important dimension of care and caring, which we explore further in Chapters 5 and 6 in particular.

More recently, "heterodox" economists have argued that work is embedded in social relations within institutional architectures that are themselves embedded in other social relations (Figart and Mutari, 2008). Therefore work *can* reflect wider social relations and also has the potential to be a source of considerable empowering of the individual in that it enhances and fosters dignity, autonomy, and capabilities, as well as affording important dimensions to an individual's identity. Of course the reverse is also the case (Spencer, 2009).

Bellah *et al.* (1985) present a useful description of the multiple dimensions of work. A "job" is viewed simply as a role in which an individual attains the means of earning money. The value and meaning of a job reside solely in its consequences as measured by monetary return. This is a decidedly instrumental and utilitarian rendering, in which the commitment an individual has to a job is determined only by financial incentives. A "career" for Bellah *et al.* involves a deeper relationship between the self and an activity or role. It suggests a durable relationship that invokes notions of progression and a sense of growing self-esteem and social status. The ongoing and durable nature of careers further implies a greater degree of commitment on the part of the individual than that just associated with a job.

A "calling" involves the "moral inseparability" of the self's identity and those of the activities associated with the role. The individual's commitment to their role is conveyed by the idea that a role is a "calling" understood as shaping or sculpting an individual's values and beliefs, as well as their social status and self-esteem. This appears to have some support from surveys of medical students. For instance, the 2005 Association of American Medical Colleges' survey of first-year medical students highlighted the "opportunity to make a difference to other people's lives" as the primary factor motivating student choice (Nash *et al.*, 2006). Similar results have been obtained in other surveys (for example, Saad *et al.*, 2011, for Pakistan). An issue is whether this may accommodate a dualistic approach in the apprehension of disease, illness, and the individual.

If the foregoing lines of argument are correct, then there are some grounds for emphasizing the tensions with the biomedical approach. The emphasis, for instance, on commitment and relational focus would seem to be inconsistent with the Cartesian notion of the body as detached from the mind. The relational references, as interpreted by many contributors to the literature (such as Antonovsky, 1987; Engel, 1977; Groopman, 2007; Sulmasy, 1993; Watson, 1997) certainly infer the whole individual as opposed to a part of the individual. Of course, it is well known that there are concerns within the medical literature regarding the tendency for modern medicine to depersonalize (Aasland, 2001). Moreover, the argument here also queries the instrumental property of biomedicalism. Care by virtue of its relational dimension has unconditional and non-instrumental qualities. Indeed its classical meaning in medicine, as expressed in the Hippocratic Oath, has this sense. For some, care, in the history of ideas, is expressed as the *caritas* motive, which also conveys the basic value of all forms of caring in alleviating human suffering (Eriksson, 2002). We further develop our argument about the relational property of care and medicine as shared commitment in Chapter 5, and we also consider the tension between the biomedical approach's reductionism and the allusion to justice in the Oath's "core message" (Miles, 2004) in later chapters. In the final section of this chapter, we address the delineation between medical care and health care.

2.5 Delineating medical care and health care

This section anticipates some of the discussion in the following chapter, and reiterates the importance of the distinction between medical and health care. To some degree this difference is recognized by health economists. As we noted in Chapter 1, Culyer's (1976) "humanitarian spillovers" define care as sympathetic other-regardingness, which may involve a sense of justice. Some health economists also emphasize equity in health and access to care (for example, Wagstaff and van Doorslaer, 2000; see also Mooney, 2009; Sen, 2002). Mooney, however, is highly critical of the confinement of health economics to what we term medical care; for instance, he drew attention to the 2005 International Health Economics Association (iHEA) conference where there were six sessions on obesity, but none on hunger. Similarly, at the 2015 Eleventh World Congress on Health Economics – themed "*De Gustibus Disputandum non Est!" Health Economics and Nutrition* and convened under the auspices of the iHEA – out of a total of 366 sessions, there were four dedicated to obesity, three to smoking, two were explicitly devoted to equity issues, one to accessing health care, and two were devoted to efficiency of "health care systems" issues arising from the financial crisis. None of the session titles explicitly referred to poverty. Indeed, a few were explicitly devoted to advancing "health econometrics." At the 2011 World Congress on Health Economics, the last we believe attended by Mooney, there were 108 sessions with a similar emphasis to the 2015 conference, although one was devoted to paradigm change in health economics which featured Mooney as a presenter. There was no similar session at the 2015 congress. Further, from our perspective, several sessions of the 2015 congress were interesting in their application of the term "care." Twenty-one sessions at the 2015 conference explicitly used the term in their titles (it was eight in 2011), but they tended to relate to health care systems, i.e. the organization and/or finance of medical provision, although one session was devoted to informal care and another to alternative care. The papers in these sessions were also overwhelmingly empirical, and not one appeared to offer any analysis of the conceptual aspects of care. The meaning of care appeared to be taken as given.[10]

Mooney (2009: 20) makes a compelling point when he further argues:

> The extent to which (health) economists have analyzed the impact on health of investing in housing, access to clean water, education, and social structures more generally on health has been disappointing.

At the same time, there is a long history of legislation in many countries meant to address issues of health, and this legislation has had a far greater impact on health outcomes for the population than clinical care and treatment. As Doyal and Gough (1991: 202) observe:

> It has become a truism that a major part of the decline in mortality in the First World over the last century has been due to environmental improvement than to the provision of curative medicine.

Of course, the distinction is well recognized elsewhere in the literature, and is central to public health, which has long supported such initiatives as clean water and the construction of sewerage systems, occasionally under the auspices of pioneering nineteenth-century philanthropists or social campaigners such as Edwin Chadwick in England and Rudolf Virchow in Germany – both motivated by what they perceived as inherent injustices. Other initiatives, such as slum clearance in UK cities, were partially associated with the concerns at the physical state of recruits to the armed forces at the outset of World War I.

These references to the social dimensions of health draw our attention to the social medicine movement. This sought, and seeks, to emphasize the social and structural influences on health, and notably found expression in the pioneering works of Rudolf Virchow and more recently in South America during the 1970s under the auspices of Salvador Allende while president of Chile.

Virchow is a prominent figure in the history of medicine; among his accomplishments was the establishment of cellular pathology (Silver, 1987). Based on his experience researching the etiology of a typhus epidemic in nineteenth-century Upper Silesia he advocated the need to understand the links between social conditions and disease (Porter, 2006; Silver, 1987).

Allende was heavily influenced by Che Guevera's "revolutionary medicine," which stressed the social origins of illness, and the need for social change to engender health improvements (Porter, 2006; Waitzkin, 1981). Social medicine is strongly associated with a socialist or Marxist reading of social relations. By contrast, public health approaches, especially in the United States during the twentieth century, adopted a biomedical orientation. Public health as a discipline and practice in the US thus became increasingly influenced by a behaviorist approach to clinical epidemiology that favored prevention based on the management of risk factors to the individual (Brandt and Gardner, 2000). Studies into the relationships between consumption of fatty foods, obesity and morbidity, and mortality focused on lifestyle and relegated issues of socioeconomic class (Porter, 2006).

In concluding, we wish to emphasize the difference between medical care and the more broadly conceived health care. There are ontological differences between them arising partly from the configuration of institutions involved in the provision and delivery of care. Consequently, health care is more ambiguous than medical care. Also, as noted, to some degree health care is focused at the level of population and on prevention. Thus it revolves around issues of risk management, such as in epidemiology, and may be therefore strongly related with public health. By contrast, while the *provision* of medical care is population-focused, its *delivery* is frequently at the individual level, and is centered on particular social relations. Moreover, while health care and social medicine can dovetail into medical care and its practice, especially through epidemiology in the former case, the ontological differences between them reflect different histories and professional influences, which we will develop in our analysis of care and health institutions in Chapter 6. Prior to this we develop our argument in terms of taxonomies of medical care in the following chapter; in Chapters 4 and 5 we explore theories of care and caring.

Notes

1 Virchow did, however, posit an association between social conditions and disease (Porter, 2006; Silver, 1987; see section 2.4 below).

2 The advocacy of RCTs is based on the important work in the late 1960s and early 1970s of the eminent medical researcher Archie Cochrane. Cochrane advocated the increased scrutiny of the medical profession through the incorporation of empirical evidence, and for Cochrane the primary data source to increase the flow of reliable information for clinicians was the RCT (Kristiansen and Mooney, 2004).

3 Interestingly, Grossman (1972) does not cite Arrow's (1963) paper. This is also the case in his retrospective piece published in the *Journal of Health Economics* in 2004. Indeed, there he is explicit in acknowledging the influence of Gary Becker's human capital model on his work (see also Grossman, 2000). During his PhD studies, Grossman was taught by Becker.

4 There is some doubt over the origin of the term; for instance, some associate it with the 1976 work of Zeckhauser and Shepard on the assessment of life saving interventions (WHO, 2012: http://www.who.int/neglected_diseases/shepard/en/index.html), while others argue that there is some evidence of its antecedents in the evaluation of public policy (for example, Torrance, 1986).

5 DALYs similarly attempt to measure effectiveness, but on this occasion the variable in question relates to morbidity and mortality and the enhancement of biological functioning.

6 For a more general critique of quantitative clinical and economic evaluation, see Hildred and Beauvais (1995) and Hildred and Watkins (1996).

7 Antonovsky (1996) approvingly cites Engel's bio-psychosocial model.

8 There are several modern versions of the Hippocratic Oath, including the British Medical Association's (BMA) draft revision submitted to the World Medical Association (WMA) in 1997. Following discussion at a conference the BMA withdrew its submission, and the WMA subsequently published a Medical Ethics Manual (second edition, 2009) based on the work of its (international) ethical committee (http://www.wma.net).

9 Unfortunately, history is ignored by standard health economics, and most conventional health economists seem to regard it as irrelevant to their practice, and indeed remain largely unaware of the history of the applied field (Forget, 2004; Fuchs, 2000). Forget argues that this is by no means unique to health economics in that it is fairly common to all applied economics fields.

10 The programs for the Eighth and Eleventh World Congresses may be accessed at http://www.healtheconomics.org/congress/2011/ and https://www.healtheconomics.org/congress/2015/, respectively.

3

ON IDENTIFYING AND CATEGORIZING HEALTH AND MEDICAL CARE

> "An ounce of prevention is worth a pound of cure." (American idiom, *Free Dictionary*, http://www.thefreedictionary.com/)

3.1 Introduction

In Chapter 2 we outlined the distinction between health care and medical care, describing how the latter is nested in the former, and how the two correspond to differences in the array of institutions and institutional arrangements shaping them. Our delineation reflects the position of WHO, which in its 2006 World Health Report *Working Together for Health* stated that health care is ubiquitous; at some stage we all care. Of course, medical anthropologists and sociologists have long recognized this. For example, in the 1970s the medical anthropologist David Landy (1977) notably articulated the notion of pluralism in health care when he referred to the simultaneity of alternative care systems, especially in developed Western economies. Health care, by virtue of its ubiquity, is manifest as a parent caring for a child, a friend offering solace, a son or daughter escorting their parents to hospital, and participating in a self-help group. What is important about this from our perspective is the sociability of humans and therefore the relational dimension of caring activities. Indeed, the WHO definition of health systems resonates with this. For WHO care consists of

> all activities with the primary goal of improving health – inclusive of family caregivers, patient–provider partners, parttime workers (especially women), health volunteers and community workers. (WHO, 2006, http://www.who.int/whr/2006/overview/en/)

We also discussed in Chapter 2 how medical care has been heavily influenced by the biomedical paradigm founded on Cartesian dualism, and how this engenders a particular orientation in care and caring. In this chapter we attempt to describe, delineate, and categorize health and medical care. We identify the distinctive arrangements made for the delivery of medical care, which are partly influenced by the condition of the patient, and then note how these institutional arrangements involve different types of care. In anticipation of the theoretical discussions of Chapters 4 and 5, we draw upon some work from the nursing literature that further conceptualizes care and caring in terms of five overlapping categories: caring as a human trait, a moral imperative, an affect, an interpersonal interaction, and a therapeutic intervention.

This chapter initially considers the standard health economics approach, and then introduces our conception, which emphasizes the pluralism and multi-level dimensions of the health care systems in which medical care is nested. Importantly, health care systems are not situated in a social vacuum, and thus reflect society's pluralism, which ensures a durable ontological distinctiveness. The following section focuses on one sector of health care in presenting an overview of the functional division, or delivery levels, of care in medical care systems – primary, secondary, tertiary, and quaternary care types, and then notes how other categories of care – preventive, curative, and palliative – are enmeshed within those functional delivery types. We explore the principal distinctions between these types and briefly consider their contrasting histories. The chapter is not intended to provide a comprehensive categorization or taxonomy, nor does it seek to review or evaluate more thorough approaches tailored to the development of detailed glossaries (see, for example, Porcino and MacDougall, 2009). Rather our objective here is primarily indicative in presenting the principal distinctions and properties. In doing so, we seek to draw from various medical and health care bodies, including WHO. WHO, we assume, in accordance with its position as the "directing and coordinating authority for health matters within the United Nations" (WHO, 2011, http://www.who.int/about/en/), provides a legitimate source of definition and description of various health and medical care terms. We also, where relevant, draw upon various professional medical bodies, such as the American Medical Association (AMA). However, such associations appear to place greater emphasis on the articulation of professional values and ethics, codes of practice, and quality assessment than nuances in the delineation of care categories per se. Nonetheless, this is an important source that informs our analysis in this chapter and beyond.

Section 3.4 considers the different measures of medical care – preventive, curative, and palliative – and briefly identifies their institutional and historical differences, as well as potential areas of conflict or contestation. Curative and palliative care are focused on the individual; the former may be further divided into acute and therapeutic domains. The biomedical paradigm is especially prevalent in acute care provision. Tensions with the biomedical approach surface in therapeutic and palliative measures. For instance, the conception of pain in palliative care often invokes the person in contrast to the body (Cassel, 1982). Preventive care possesses both individual and population characteristics and invites considerations of individual autonomy and medical paternalism. To reiterate, this is a vast, complex terrain; our aim is not to explore it comprehensively, but to provide an outline as a means of developing our own specific arguments focused on health economics.

3.2 The array and types of health care

In considering the array of different arrangements for health care the positions of standard health economics and our own, which has affinities with medical anthropology and sociology, stand in marked contrast. As we argued in Chapter 1, for the former the analytical starting point appears to be health (Mooney, 2009) with a particular institutional constellation – the market – used to explain this further, whereas social relations constitute our focus. For us, this furnishes further grounds for our argument that the standard health economics approach is reductionist. For the present we confine ourselves to outlining the different arrangements for health care in each literature.

3.2.1 Health economics and the array of health care

In Chapter 2 we noted that the work of Grossman (1972) and Hurley (2000) explicitly recognizes the intrinsic distinctions between health care and medical care. Despite these contributions, health economics tends to focus on the provision of medical care services (see, for example, the collections edited by Culyer and Newhouse, 2000a, and Jones, 2006). Arguably, for many this constitutes the scope of the field. Mooney (2009), for instance, remonstrates against what he views as an excessively narrow prospectus in the standard approach, and views Grossman's seminal work on the demand for health as a principal source of this. As we observed, Mooney (2009: 16) contests that health economics' emphasis "has been almost exclusively on health" and its "sub-set … health *care* economics …" (original emphasis). This derives from the central insight of Grossman's theory: demand for health care is a derived demand. Individual agents demand health and health care may be seen as a way of attaining this preference. Thus the scope of the standard approach has focused on measuring "health", which in the 1990s stimulated considerable interest in the Quality Adjusted Life Years (QALYs) measure and more recently issues of "extra welfarism" (see, for example, Birch and Donaldson, 2003; Culyer, 1991).[1]

In their introduction to the *Handbook of Health Economics*, Culyer and Newhouse (2000b: 5) are explicit about the "conceptual foundation" of the field – health. They review the subject as follows: first, it is concerned with the determinants of health, including those factors other than "health care," then demand for "health care" and supply of "health care," thereafter "market analysis" and microeconomic appraisal, followed by evaluation of health policy instruments such as regulation and budgeting, and finally a systemic evaluation using equity and efficiency criteria. Culyer and Newhouse's schematic reference to the supply of "health care" buttresses the grounds of Mooney's critique. They identify the supply-side as "the health care 'industry'" (Culyer and Newhouse, 2000a), which is composed of "the material to be expected in supply-side economics" (*ibid.*), such as hospital production functions, input substitutions, labor markets, the response of industry actors to changes in their environments, and so forth. For the authors the "industry" – they repeatedly use scare quotes – comprises hospitals, general practitioners, medical supplies, and "other caring agencies," such as community care of the elderly. The "other caring agencies" appear be treated as a residual with the main emphasis on *formal* care bodies, i.e. those employing professionalized staff. Informal care may be regarded as the overarching term to embody everything else. Indeed, standard health economics appears to proceed on this basis with only a few studies specifically focused on "informal" care, i.e. those models beyond the physician–patient setting (for example, Bobinac *et al.*, 2010, and Burge *et al.*, 2010).

Thus, according to the standard approach, in essence, health care in general and the supply of health care in particular are confined to what we have characterized as medical care. The insights of Grossman and Hurley, noted in Chapter 2, appear to be largely ignored. Moreover, medical care is taken to be an industry that is critical to the "production" of "health" and is accordingly to be evaluated on the basis of its efficacy.

The industry allusion also reveals the importance of markets in the conventional approach. Indeed, Grossman (1972) discusses the demand for health in terms analogous to that of capital stock. In doing so, he argues that as capital stock health has investment and consumption properties, and his model imbues individuals with the ability to vicariously trade-off their stock of health through time via adjustments in health investments. Health on this account is a commodity, and "health care" is portrayed in identical terms (see, for example, Culyer, 1990; McGuire *et al.*, 1982; Mooney, 2009; McMaster, 2013). Few health economists explicitly say what they mean by "commodity"; Culyer (1990) is a notable exception to this rubric. He describes commodities as:

> goods and services in the everyday sense, whose demand, supply, and growth have been the focus of economists' attention, and whose personal distribution has been the traditional focus of all social scientists having an interest in distributive justice. (1990: 10)

Culyer follows Grossman in concentrating on the characteristics of health care: demand is derived. McGuire *et al.* (1982) also define health care in commodity terms, but depart from Grossman's rendering of health as a commodity. They argue:

> Health itself is not tradable in the sense that it cannot, strictly, be bought or sold in a market: it can be no more than a *characteristic* of a commodity. Thus health is a characteristic of health care, seat belts, fire extinguishers, wholemeal bread, etc.; but health is not exchangeable. (1982: 32, emphasis added)

These narratives potentially have significant consequences in terms of the analytical framing of care and policy advice (Cohen and Ubel, 2001; McMaster, 2013), both of which we analyze in later chapters. Presently, the main implication in the context of the arrangement of health care is that it is market-centered. By virtue of this focus, standard health economics makes specific ontological and epistemological claims, or perhaps more accurately adopts canons of faith. The first is that the array of types of health care at least resembles that of a market, and the second claim is that the most appropriate way to interrogate and explain the phenomena of health care is through market analysis. We develop our analysis of the basis of this claim in Chapter 6.

3.2.2 Health care institutions: types, structure, and social embeddedness

There are of course many different types of health care institutions and many different ways in which they are interconnected. The medical sociology literature identifies at least three sectors – popular, folk, and professional (Kleinman, 1980), which we investigate in Chapter 6. The professional medical sector can be seen as embedded within broader health care, and across societies some of the main institutions themselves are remarkably similar (hospitalization, general practitioner-specialist protocols, insurance systems, etc.), though their exact form and relative importance clearly vary. Nonetheless, taken together societies' medical care institutions play a highly important role in determining the nature and meaning of care in those societies. We discuss health care institutions more fully in Chapter 6, while in this introductory discussion we only lay out a simple taxonomy of medical care institutions and map some of their more basic connections to achieve a general picture of health care institutional landscapes. Our first goal is to demonstrate the social extension and institutional dependence of health care provision, which we contrast with market-centric views of health care that tend to reduce the social basis for health care to a series of market transactions – only one sort of institution, and one developed in widely different ways across different societies. Our second goal in this subsection is to describe the most common structure that most institutions possess in order to show how institutional structures influence people's behavior in health care systems.

We distinguish three main levels of health care institutions – *delivery institutions*, *human capital institutions*, and *social system institutions* – and distinguish them according to their proximity to the delivery of care acts. How societies differ in the degree to which they have developed these institutions then influences the nature of health care in those societies. Within each level there are also different kinds of institutions that are 'horizontally' connected in that they work together and aim in interrelated ways at the same goal. Across the three levels institutions are 'vertically' connected in that institutions that are less proximate to the delivery of care condition the operation and functioning of institutions that are more proximate to it. We put aside more complicated accounts of the connections between individual institutions on any level with individual institutions on other levels. Indeed we only aim here to outline the extent and diversity of health care institutions.

Delivery institutions as the name indicates are those institutions immediately involved in providing medical care (primary, secondary, urgent, etc.). They include: (1) the care providers themselves taken as an organized body of people with a division of labor according to different professionalizations; (2) the sites of care including hospitals, clinics, mobile facilities, long-term health facilities, etc., plus all the individuals who staff and administer these sites beyond the actual care providers themselves; (3) public health systems which promote health in general, often in broad ways (anti-tobacco campaigns, safe driving advice, etc.), plus all the individuals who staff and administer them beyond care providers; (4) families and community networks which make it possible for individuals to receive and take advantage of care, including individuals who provide personal support, those responsible for care transportation systems (emergency and normal), and those sustaining care regimes for people outside of formal care sites.

Education and training institutions are one step removed from delivery institutions in that they produce the individuals who ultimately deliver care. They include: (1) formal provider education systems; (2) all other training and education systems that prepare people who are not health care providers for activities needed for the delivery of care; (3) professional societies which influence care provider and non-care provider standards and accepted practices; (4) traditional family and community practices and expectations regarding needed levels of care and principles regarding the distribution of responsibility for seeing that it is appropriately pursued.

Social system institutions are those institutions that frame both delivery and human capital institutions. They include: (1) social insurance, private insurance, and other kinds of health and medical finance systems; (2) government taxation and expenditures dedicated to health and medical care support; (3) countries' legal systems which govern practices, rights, and responsibilities throughout their health care systems; (4) science and health research which sets horizons for care and designs potential care therapies; (5) the market system itself which governs the nature and rate of economic growth as well as the distribution and allocation of resources both generally and the share that goes to health.

Though highly compact, this simple taxonomy of health care institutions nonetheless tells us several things about the social extension and institutional dependence of health care provision. First, it makes it obvious that many people beyond care providers and patients are involved in care. Thus one can hardly explain health care by narrowing one's attention to the point of delivery. Second, we also see that a tremendous variety of people are involved in one way or another in a country's health care system. Many go unrecognized in this regard, and this can lead health analysts to underestimate the extent of a society's resource commitment to health care provision. Third, it especially needs to be emphasized that social institutions structure individuals' interaction. Individuals of course influence how institutions evolve, as will be argued below, but institutions stabilize patterns of interaction between individuals, and therefore go a considerable distance in explaining the nature of countries' health care systems. How they do this is the subject of Chapter 6 in which we discuss the basic structure of any institution in order to get further understanding of institutions' influence on behavior. In the following section we outline some of the complexity of the delivery institutions in medical care.

3.3 Delivery levels of medical care

Given the plurality of care and its ontological diversity, providing taxonomies is, to say the least, a challenging task, and again we do not aim to be comprehensive in this regard. Yet we feel that an, albeit incomplete, outline will provide a better understanding of the nuances of care in health and medicine. To this end we describe the organization of the delivery and type of medical care as a means of exhibiting the stratified properties of its provision and delivery. Intertwined with this are conceptual distinctions which transcend these structural elements. We do not in this part of our argument consider whether the organization of medical care is specifically tailored to meet human needs. Some of our following observations certainly touch on this contentious subject. Facets of our analysis in Chapter 2 also related to this, but we defer further fuller analysis to Chapter 6 and beyond.

A focus on the nature of treatments and specialisms delivered in medical care conventionally points to at least five distinctive, but potentially overlapping, levels of delivery: primary, secondary, tertiary, quaternary, and home/community.

3.3.1 Primary care

Primary care is frequently the first point of contact between a patient and a medical practitioner. Primary care provision tends to be local and can involve a wide range of treatments, procedures, and consultations. The emphasis is the relationship between patient and practitioner, but consultations and practitioners exhibit considerable variety. General practitioners (GPs), nurses, pharmacists, dentists, opticians, etc. may all be considered to be involved in primary care provision of some sort. Moreover, in less developed regions practitioners of "traditional medical" techniques are also consulted. Indeed, providers of alternative medicines may for some provide ongoing consultation.

The range of kinds of primary care provision thus reflects the diversity of patients, their conditions, and institutional arrangements. Primary care caters to all ages and a wide range of medical complaints, illnesses, and diseases, as well as contributing to public health through the provision of preventive measures such as the administration of vaccinations. Thus primary care is the site of a diverse variety of interactions: consultations may involve providing information; they are also the focus for check-ups and the treatment of minor chronic conditions; they are based on the knowledge of the practitioner and are where patients may be referred to more specialist treatments in the secondary care sector. Primary care is also therefore the site and institutional configuration where an array of symptoms may be interpreted, evaluated, and translated into a biomedical determination of a particular medical condition. In this way GPs in many medical care systems act as gatekeepers in filtering access to secondary care services and treatments. Many health economists view this function as a potentially important efficiency source (for example, Iversen and Lurås, 2006; McPake *et al.*, 2002; Scott, 2000). In standard health economics the alignment of GP incentives is also a prominent determinant of the efficiency characteristics of a given institutional arrangement of primary care. Some studies, such as Scott and Vick (1999), do recognize the importance of the dynamics of patient–physician relations and the ability of the latter to communicate effectively.[2] However, such approaches rely on agency theory, which, as we noted in Chapter 1, has its own limitations.

Primary medical care has been associated with economic development as well as an improvement in overall health status (WHO, 1978). Indeed, under the auspices of WHO and the United Nations Children's Fund (UNICEF) in the 1970s and 1980s there was a determined campaign to enhance the role of primary care in medical care policy. This reflected the findings of such influential works as Ivan Illlich's (1977) *Medical Nemesis* and Thomas McKeown's (1976) *The Modern Rise of Population*. It also echoed the claims of the social medicine movement (Waitzkin, 1981) referred to in Chapter 2, which challenged the efficacy of the primacy of hospital-based medical provision. Other influences included the experience of the "barefoot doctors," which were part of the huge expansion in rural medical services in 1960s China. This resulted in dramatic reductions in preventable diseases and child mortality rates. WHO articulated the case for comprehensive primary care as a means of containing and eradicating disease, preventing illnesses, and therefore as a conduit of socioeconomic development (WHO, 1978). It also presented a decidedly skeptical view of the biomedical paradigm, criticizing the role of expensive and sophisticated medical technologies that had little relevance to the conditions of the indigent. More generally, there was a questioning of

> … urban hospitals in developing countries. These institutions were perceived as promoting a dependent consumer culture, benefiting a minority, and drawing a substantial share of scarce funds and manpower. (Cueto, 2004: 1867)

Nonetheless, in the 1990s UNICEF's support for a comprehensive primary care system was diluted in favor of a selective provision of medical care based on a more biomedical trajectory. This shift in policy trajectory occurred under the leadership of executive director James Grant, who had an economics and law training (Cueto, 2004). According to Cueto, Grant was heavily influenced by the critique that holistic primary care was ambiguous and fraught with practical difficulties that rendered its realization as at best inherently problematic (Walsh and Warren, 1980). Grant directed resources to establishing primary care programs in developing economies that offered greater financial transparency. Chief among those was the GOBI (growth monitoring, oral rehydration techniques, breast-feeding, and immunization) initiative that seemed to offer the prospect of clear targets and a greater means for quantitative evaluation. GOBI was supplemented by the acronym FFF, which emphasized food supplementation, female literacy, and family planning, all of which were considered crucial to the success of health programs. In their argument, Walsh and Warren (1980) explicitly advocate the employment of economic cost-effective techniques as a vehicle for assessing the efficacy of primary care activities (see also Berman, 1982). In contrast, Gish (1982) advocates a more holistic perspective in criticizing Walsh and Warren's argument for selectivity as diversionary in terms of relegating the social causes of illness and disease, and an emphasis on how technical measures may engender funding myopia. Cueto (2004) further associates it with a neoliberal influence. There was also a concern that selectivity promoted the idea that primary care should be concentrated on simplified technologies and represented a very basic provision fashioned for the indigent – the inferior cousin to the more sophisticated procedures in hospitals.

To some degree this repeats the earlier recommendations of WHO's Commission on Macroeconomics and Health (CMH) published in 2001. The report, as noted in Chapter 2, recognizes the importance of preventive actions as a means of reducing or averting the incidence of diseases, particularly cardiovascular disease, diabetes, and cancers. The report also argues that the most effective method of delivering medical care is what it terms as "close-to-client" provision – in other words, primary care.

More recently WHO has expressed concern about the seeming de-emphasis on primary care in medical care systems, and how this may adversely impact the prospects for development, the enhancement of social justice, and the promotion of greater equity. Indeed, its 2008 *World Health Report* was subtitled *Primary Care (Now More Than Ever)*, and in it WHO expressed the following concern:

> Three particularly worrisome trends can be characterized … health systems that focus disproportionately on a narrow offer of specialized curative care; health systems where a command-and-control approach to disease control, focussed on short-term results, is fragmenting service delivery; health systems where a hands-off or laissez-faire approach to governance has allowed unregulated commercialization of health to flourish. (WHO, 2008: xiii)

We reserve further comment on and analysis of this until Part III.

3.3.2 Secondary care

Unlike primary care, secondary care is usually, but not exclusively,[3] focused on a particular institution – the hospital – and involves greater medical specialization. By virtue of the gatekeeping role of GPs and other primary care providers and the localized nature of primary care, secondary care is usually not the first point of contact patients have with medical professions, although this depends upon the structuring of medical services in a particular locale, and there are also obvious exceptions, such as in the case of emergency treatments provided in some hospital sites. Moreover, some primary care facilities, such as GPs and dentists, may also be located in hospitals.

Hospitals are perhaps the most visible institutional site of medical practice, and they attract by far the most medical caring activities resources (WHO, 2008). There are a variety of hospitals, ranging from general hospitals, which deal with many types of illnesses, diseases, and injuries and usually have emergency facilities, to specialized hospitals, such as geriatric, children's, rehabilitation, and psychiatric. There are also considerable differences in the duration of admissions to such institutions, and indeed some patients may be consulted on an outpatient basis. At the same time, there is a downward trend in patients' duration of stay in many Western general hospitals. For instance, in the European Union, as a whole, there has been a steady decline in the average length of stay in hospital for in-patients over the decade from 2003 (Eurostat, 2016).[4]

Similarly, in specialist hospitals, such as geriatric and psychiatric, there has been an emphasis on reducing the length of stay, but in many cases extensive durations of stay are considered necessary. Importantly, for our later discussion, variations in stay point to differences in patient dependency.

Given the wide variety of illnesses and injuries modern general hospitals are tailored to accommodate and treat, there are usually extensive specialist departments, staffed by myriad medical professions, from, for example, surgical, nursing, pharmacists, pathologists, and radiologists, as well as a host of support or auxiliary non-clinical activities.

Both the variety of patient conditions and how these are organized according to medical specialisms have implications for the institutional arrangements of care. For instance, the episodic consultation allied with the treatment of a chronic condition may exhibit differing relational patterns and properties of care and caring than those associated with long-term residential treatment. For the purposes of our argument, we consider all types of residential-based care as secondary. We note that the discernible pattern of secondary medical care institutional arrangements has evolved from and has been framed by the initial establishment of hospitals, hospices, and similar institutions as sites of care and treatment as well as the emergence of medical professions, especially in the nineteenth and twentieth centuries.

The terms 'hospital' and 'hospice' come from the Latin *hospes* and *hospitium*. The former refers to a stranger and a guest, while the latter signifies hospitality and friendliness to a guest (*Oxford English Dictionary*, 1997). The term thus reflects the function of the institution that was more extensive than the contemporary understanding of the term suggests. Hospitals, certainly in medieval Europe, also served as almshouses for the indigent, lodgings for travelers or pilgrims, and hospital schools (Goldin, 1985; Risse, 1999). Religious sites and the hospital were intricately bound, as medicine was embedded in religion (Goldin, 1985; Risse, 1999; Unschild, 2009; Wujastyk, 1997), and indeed, monks and nuns delivered treatment and care (Goldin, 1985). In the ancient empires of Egypt and Greece temples were frequently the sites of medical care and learning. There is also documentary evidence of basic surgical procedures assisted by the administration of soporific substances, principally opium, during this period (Risse, 1999). Independently in Asia, primarily the Chinese, Indian, and Persian empires, there is evidence of dedicated buildings for the assistance of the diseased and the destitute dating from around 400 BCE (Unschild, 2009). Indeed, the earliest known medical encyclopedia is in Sanskrit (Wujastyk, 1997). According to Wujastyk (1997), this combined with other accounts suggests that India was the first part of the world to develop an institutionally-based medical system. The Roman and Islamic empires also had dedicated sites and institutions for medical provision.

In Europe the close bond between hospitals and religious sites began to unwind in the seventeenth and eighteenth centuries as medicine evolved in a more secular and scientific trajectory, and with it care evolved under the influence of Cartesianism. In this era and beyond, hospitals became increasingly associated with philanthropic donations and other collective endeavors (see, for example, Goldin, 1985; Webb, 2002). The scale of hospitals also increased with rising urban populations in Europe and North America that accompanied the industrial revolution, the increasing professionalization of medicine, and developments in medical theory and practice. In his history of the development of the hospital in North America, Charles Rosenberg (1995) argues that two developments in medical thinking further made the hospital the predominant space of medical praxis: first, greater emphasis on the body as the site of disease, reflecting increasing anatomical knowledge, akin to the emergence of a Cartesian orientation; and second, the development of the germ theory of disease (see also, Connor, 1990). The second factor, in particular, had marked social effects in that disease came to be seen as socially acceptable and not merely confined to the poor and/or the morally corrupt (Rosenberg, 1995; see also, Webb's 2002 history of hospital provision in York, England). For Rosenberg this meant that there was a gradual reorientation from the paternalistic sort of hospital management in the earlier part of the nineteenth century in North America to a more "entrepreneurial" and business orientation thereafter, as the middle and upper classes were prepared to pay for better quality treatment. Of course, Europe and other parts of the world have evolved differently.

3.3.3 Tertiary and quaternary medical care

Tertiary and quaternary medical care facilities are highly specialized and are usually typified by patient referrals from either the primary or secondary sectors. Without being exhaustive, examples of tertiary care include specialist burns units, neurosurgery, specialist cancer management and treatment, and cardiac surgery. These highly specialized care regimes are located within secondary care hospital sites. Similarly, quaternary medical care refers to highly specialized and even experimental medical and surgical measures and procedures. Both tertiary and quaternary medical care are not widely available, if available at all, typically being located in regional or national centers.

3.3.4 Care beyond medical facilities

As noted in section 3.2, there is an extensive range of care interventions that are conducted beyond the confines of medical facilities. Most apparently, care professionals located within communities provide assisted living, home care, and so forth, and other examples may relate to treatment for substance abuse. Certainly in Europe and North America such activities are frequently delivered by local authorities, or other bodies such as charities, not necessarily integrated into medical care systems. This is also the case, as noted in Chapter 2, of bodies providing activities promoting public health, for example from food and hygiene regulators to various programs providing amenities, resources, guidance, education, solace, and so forth, as well as for family planning and for individuals suffering from a variety of problems such as alcoholism, and post-traumatic stress.

The foregoing provides an outline of the organization of, primarily, medical care delivery. This suite of institutional arrangements also accommodates various types of medical care measures: preventive, curative, and palliative. We now turn to each of these, anticipating our theoretical discussion of care in the chapters which follow.

3.4 Medical (and health) care as distinctive measures

Each of the following is subject to some degree of controversy within the medical literature, in some cases regarding the effectiveness of various types of measures. Again, we do not intend to provide a comprehensive analysis. Our ambition is far more modest in seeking to provide an illustrative backdrop to inform the thrust and development of our principal argument. The parentheses around 'and health' in the section heading is indicative of the overlap that exists between some medical measures and a more overarching health care narrative, usually under the rubric of public health. This is especially the case in more population-focused preventive care to which we now turn.

3.4.1 Preventive care and medicine

Preventive care and medicine, or prophylaxis, is specifically adopted not to cure or treat the symptoms of illness or disease; the intention is instead to prevent diseases and illnesses. Like all forms of medicine and medical care, preventive care and medicine have evolved with recent changes in emphasis and policy orientations, which have courted some controversy.

A distinction may be drawn between preventive care and medicine in that the former is not solely the responsibility of the medical profession, and therefore transcends medical modes of production. Preventive care can range from riding a bicycle to work, to brushing teeth, to washing hands, to a balanced diet, to the prohibition of smoking in public places, and so on. As such it potentially involves a range of institutional arrangements from the family, to the market, to professional bodies, such as epidemiologists associated with population and public health, to government and state, and from customary learned practice, to legislation that may both enable or constrain firm and individual behaviors. It may also refer to the supply of information relating to health issues by health-related bodies and government, such as relating to nutrition, alcohol consumption, and the potential health risks associated with certain behaviors. It can be located at both individual and population levels, hence its affinity with conventional references to public health. Indeed, the boundary between the two is ambiguous and porous.

Preventive medicine is the site of further controversy relative to preventive care. Again, like preventive care, it is multi-layered and may be delivered by both primary and secondary institutions, specifically primordial, primary, secondary, and tertiary and quaternary. Primordial prevention refers to strategies intended to avoid the development of diseases potentially emerging from predisposing environmental and social factors (for example, [Australian] National Public Health Partnership, 2001; Cribb, 2005), and clearly resonates with population-based public health. Given its environmental and social foci, initiatives of this nature involve non-medical institutions, such as government. Thus, activities promoting the health benefits of particular behaviors would be an example of this (with a clear overlap with preventive care). Primary, secondary, and tertiary preventive medicines are aimed at improving function, preventing significant morbidity, minimizing impact and complications (for example, Cribb, 2005; Starfield *et al.*, 2008). The distinction between levels may be overemphasized (Starfield *et al.*, 2008), with primary relating to medical strategies aimed at the avoidance of the development of disease, secondary concerning the diagnosis and treatment of diseases in their early stages, and tertiary procedures aimed at reducing the impact of established disease.

A further level – quaternary – is of particular interest in that it refers to the intention to avoid the iatrogenic problems of medical care, i.e. the over-prescription of potentially addictive and harmful medications by medical professionals, chiefly doctors, which Doyal and Gough (1991: 202) have described as "legion" and is one of the most pressing issues in Western contemporary medicine. Starfield *et al.* (2008), however, have identified other definitions of quaternary prevention across medical specialisms that are not necessarily consistent. For instance, they identify cardiovascular specialists as defining quaternary prevention in terms of "rehabilitation or restoration of function" (Starfield *et al.*, 2008: 580).

Quaternary prevention, if defined as seeking to obviate iatrogenic problems, is controversial in that it can be conceived as a critique of the biomedical paradigm, and potentially the prescribing behavior of physicians and the influences on this. As discussed in Chapter 2, the biomedical orientation has been criticized as reductionist and exclusionist (Engel, 1977). By framing and constructing disease in almost exclusively biomedical terms, clinicians' mode of thought becomes focused on establishing specific *medical* treatment protocols in curing particular discrete instances of clinically defined disease (see section 3.4.2 which follows). Reflecting this concern, Doyal and Gough (1991: 202) have argued:

> The more conservative medical research is, the more it will restrict itself to the conceptualization and treatment of illness only in specific aetiological terms … This can lead to health resources being spent on expensive diagnostic and curative technologies rather than on preventive measures which are more cost effective.

Since Doyal and Gough's work was published, however, there has been a distinct reorientation of health care policy in the West from cure to prevention (for example, Gérvas *et al.*, 2008), perhaps for the reason Doyal and Gough identify: cost effectiveness (see also WHO, 2010). Yet this is not devoid of controversy due to the inherent uncertainties of preventive approaches, and issues in defining and measuring population health and health inequalities (Krieger, 2012). This may be seen in connection with Gordon's (1987) well-cited classification of the levels of disease prevention – universal, selective, and indicated. Universal is the dissemination of information on a population basis; selective focuses on particular groups in society on the basis of such characteristics as socioeconomic status and genetic heredity; and indicated refers to screening processes for individuals. All levels involve some sort of assessment of risk and identification of risk factors. As with deductive reasoning, this may be relatively unproblematic at the population level, but it can present difficulties at more selective levels when applied to the individual. Predicting future benefits and risks is more difficult for an individual than that for a group (for example, Gérvas *et al.*, 2008; Julious and Mullee, 1994; Starfield *et al.*, 2008; Upshur *et al.*, 2001). Indeed, given human biomedical heterogeneity, prevention is unlikely to be of equal value to everyone. To some extent all preventive approaches are predicated on the rather consequentialist belief that the particular approach offers the individual future benefits over any present costs associated with the measure. Starfield *et al.* (2008: 581) argue:

> A preventive activity might be justified in one setting but not in another just because of differences in prevalence, even though the relative risk based on the exposure is the same. What works in one clinical setting may not work in another … Population-based studies of the predictive value of exposures consistently find lower likelihood of disease in the presence of a risk factor than do clinically based studies.

Such risks are clearly increased with more invasive medical procedures, such as the administration of powerful and potentially harmful drugs to healthy individuals, or the preventive surgical procedure that carries the prospect of harmful side-effects. Therein lies a latent paradox in preventive medicine – the implementation of preventive measures may engender the very iatrogenic problems they were intended to avoid. In a controversial critique, one of the founders of evidence-based medicine (EBM) David Sackett (2002: 363) accused preventive medicine of displaying the three attributes of arrogance – aggressive assertiveness, presumptuousness, and being overbearing – in its prescriptive "pursuit of symptomless individuals" in instructing them how to remain healthy, and in its assumption that "on average" preventive measures do more good than harm. The nature of Sackett's critique resonates with overarching concerns regarding paternalism and health care, a subject we will further explore in later chapters. Ironically, given Sackett's definitive role in the emergence of EBM, an increasing biomedicalization of prevention may also herald the ignoring of socioeconomic sources of illness (McMaster, 2008). Starfield *et al.* (2008) are among those who have identified an increasingly medical orientation in and interpretation of prevention, which focuses on specific diseases as opposed to illness per se. Thus the designation of elevated blood pressure as a disease medicalizes what may be a symptom of an individual's socioeconomic conditions. Again this may invite iatrogenic difficulties as physicians seek out medical means to address what may be inherently social problems.

3.4.2 Curative medical care

Curative care contrasts with preventive medicine and care in that it actively seeks to treat and *cure* diseased patients under the auspices of the medical professions, and is therefore principally delivered via primary and secondary institutions. It may be divided into acute and therapeutic approaches.

3.4.2.1 Acute medical care

Acute medical care usually refers to the urgent administration of some form of short-term treatment, or a suite of treatments, for a patient suffering from some disease or injury and is usually delivered under the auspices of the secondary care sector (Health Foundation,[5] 2011; WHO, 2006). Accordingly, this form of care as treatment is not readily available outside of hospitals and therefore involves the combination of teams of medical professionals and specialized equipment. According to the Health Foundation approximately 50 percent of patients treated in secondary care facilities in the UK are emergency cases requiring acute care.

Given the analysis of Chapter 2, acute care procedures can arguably be more readily coupled with biomedical approaches to caring. As noted, the focus of acute medical procedure is on the short-term treatment of a specific medically defined condition or a variety of discrete and separable conditions that are presented to medical professionals in circumstances frequently of an urgent nature. Thus the function or intention of acute medical care is on addressing the immediate condition of a patient in order to assist their recovery or convalescence under either informal care from family and friends or formal professional care within the community and away from hospital. Within this there is the possibility of outpatient treatments and longer-term medical monitoring in order to secure either complete or satisfactory recovery.

Yet even within acute medical care there have been recent changes in the composition and organization of services. Given the long-term demographic changes in Western populations, over the past decade or so patients admitted for emergency treatment are presenting with a different set of conditions. As Scott *et al.* (2009) report, admission rates of emergencies in Western hospitals are rising, which they argue is mainly associated with increasing cases of elderly patients with multiple chronic conditions. In an editorial in the *Journal of Accident and Emergency Medicine*, Hardern (2000) also observes that in the UK an average emergency department will receive five times more critical medical cases than trauma and surgical cases combined. Accordingly, there has been a shift towards the development and provision of acute medicine, which is dedicated to the immediate specialist treatment of incoming patients with multiple conditions, through the provision of acute medical assessment units. These units are designated hospital wards staffed and equipped to receive patients exhibiting a wide range of symptoms and to assess and treat them over a short period of time (typically between 24 and 72 hours) prior either to transfer to a specialist medical ward or discharge (Dowdle, 2004; Scott *et al.*, 2009). The units are supervised by consultants. This marks a departure from earlier practices where consultants tended not to be involved in immediate care and assessment (Dowdle, 2004; Hardern, 2000). According to Dowdle, this has prompted concerns in the specialist journals and other pertinent forums regarding the quality of care. Dowdle (2004: 652) argues: "In truth only the increased presence of appropriately trained consultant physicians at the front door of medicine could bring the quality change that was needed."

Scott *et al.* (2009) is among the relatively small number of studies that have attempted to investigate the efficacy of this recalibration of acute medical care. They note this dilutes the strength of their conclusions, but nonetheless they suggest that the available evidence is consistent in finding reduced in-hospital stays, increased discharge rates, and improved patient and staff satisfaction.

In the UK, the field developed rapidly following the publication of a joint report in 1998 of the Royal College of Physicians of Edinburgh and the Royal College of Physicians and Surgeons of Glasgow (Dowdle, 2004). Scott *et al.* (2009: 398) report that in the last census of the Royal College of Physicians in the UK over 90 percent of UK hospitals dealing with emergencies now admit "acutely unwell" patients to an acute medical assessment unit. This reflects an international movement towards a greater coordination between acute and emergency medical care. Indeed, Dowdle (2004) reports a shift in the thinking of the UK's Royal College of Physicians, which now recommends that acute care consultants also have some level of work commitment to emergency and high-dependency units.

A further dimension to the provision of acute medical services is ambulatory care. In essence it refers to treatment, consultation, or some other medical intervention on an outpatient basis, i.e. where the patient is discharged on the same day as they are admitted. Thus treatments can include minor surgical procedures, dental treatments, medical tests, and so forth. The location of ambulatory care can include clinics, outpatient departments of hospitals, physician offices and surgeries, and community health centers (for example, Berman, 2000; Hawkins and Groves, 2011). In some respects, the locational diversity of ambulatory medical care would seem to transcend the boundary between primary and secondary care. Moreover, increasing resources have been directed to this type of provision following advances in medical technologies, such as keyhole surgery, which reduce the length of patient stay in medical facilities (Brennan, 2007; Dowdle, 2004; Schall *et al.*, 2009). Given trends in medical care provision and costs the importance of this mode of service provision seems set to increase.

3.4.2.2 Therapeutic medical care

This dimension of curative medical care perhaps eludes definitional precision in that it can take on many forms and can span institutional boundaries. This is to some extent recognized by AMA, which notes the widespread incidence of therapeutic techniques (http://www.ama-assn.org/) as do standard medical dictionaries (see, for example, the renowned medical dictionary: *Webster's New World Medical Dictionary*, MedicineNet[6]). To be concise, therapeutic care is "that branch of medicine that deals specifically with the treatment of disease" (*Webster's New World Medical Dictionary*, MedicineNet). It thus possesses a curative intent and can embody a range of activities from the "therapeutic" administration of drugs, to activities that support mental and emotional wellbeing, such as a member of clinical staff offering encouragement to a patient, or a psychiatrist offering a patient the opportunity to communicate their fears, or a professional masseur treating a sports injury.

Unlike acute medical care, therapeutic services may be long term; they may involve long stays for patients in some type of medical institution. This has long been recognized in the literature; for instance, Greenblatt *et al.* (1956) notably report the results of an experiment at Boston Psychiatric Hospital where the treatment regime was switched from restraint and sedation to one emphasizing therapeutic caring. Greenblatt *et al.* hailed the experimental program as a great success in terms of significantly higher discharge rates. Indeed, it is well recognized in various literatures that therapeutic care can provide beneficial health outcomes (for example, Adams and Nelson, 2009; Armstrong *et al.*, 2008; Dossey *et al*, 1992; Groopman, 2007; Kontos and Naglie, 2009; Watson and Smith, 2002). Dossey *et al.* (1992) contest that therapeutic care provided in nursing is a means of enhancing human capability and autonomy, a theme we develop in Chapters 7 and 8. Dossey *et al.* argue (1992: 8):

> A nurse-healer guides the patient in developing all areas of human potential. The patient is offered the knowledge of the inner journey of self discovery, but the nurse as guide does not assume to know what is the best course for the patient.

In the context of nursing and gender, Adams and Nelson (2009) similarly note that many desirable activities focused on therapeutic care are necessarily time costly and attempts to impose codified, standardized procedures are likely to diminish important aspects of caring, such as the development of relations that potentially elicit more effective diagnoses (see also Armstrong *et al.*, 2008; Groopman, 2007; van Staveren, 2001). This is consistent with Kontos and Naglie's (2009) argument that caring does not develop through theoretical learning, and involves experience (tacit knowledge) and "embodied selfhood," i.e. a synthesis of primordial and social being. It also resonates with Dossey's (1992) reference to music as a source of therapy, specifically types of music that enhance relaxation in patients. According to Dossey, music with an individual appeal is a conduit for the transcending of ordinary states of awareness and shifts perceptions of time. She states (1992: 32):

> Slow, relaxing music lengthens the perception of time because memory has more time to experience the events … and the spaces between the events.

> With increased relaxation, sensory thresholds are lowered, and the patient has an expanded awareness state that is dominant. This … creates an end-result of healing …

There is evidence to support the beneficial effects of music on healing processes. Dossey refers to studies of patients in coronary care units – differentiated by their exposure to soothing music – that find beneficial outcomes in terms of decreased apical heart rates and various other measures of stress.

There is an abundance of wide-ranging examples of therapeutic care, which is also obvious from attempts to develop taxonomies of health and medical care – usually motivated by attempts to cost out medical procedures (Mooney, 2009). For instance, in their integrated taxonomy, Porcino and MacDougall (2009: 4) identify an overarching structure of health care, which they describe as "any system or modality, or technique, which is used as a healing resource." They distinguish several levels – systems, domains, modalities, and techniques. In brief, "systems" relate to biomedicine and "complementary" alternatives. "Domain" refers to a host of activities related to particular areas or aspects, such as chemical/substance-based work, device-based work, soft-tissue focused manipulation, skeletal manipulation, mental/emotional-based work, spiritual-based work, and assessment. "Modalities" refer to medical/health disciplines and specialisms and "techniques" refer to specific actions and practices which Porcino and MacDougall recognize are not unique to any individual modalities or domains.

Therapeutic medical care transcends those delineations and as a consequence has a certain ambiguity. Nonetheless, it has properties that suggest a relational aspect to care and caring in the process of healing, hints at a challenge to the mind–body duality associated with the biomedical paradigm, and also raises issues of gender and power in medical service provision. Each of these represents a substantive subject area in their own right, and extensive literatures analyze them. For our present purposes we acknowledge the complexity of therapeutic care and return to these issues at later points.

3.4.3 Palliative care

Similar to curative care, palliative care focuses on the individual. Unlike acute care, palliative care is not tailored to curing patients' conditions, rather it seeks to ease their symptoms. WHO describes it as:

> Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. (WHO, 2011)[7]

Research aligned with palliative care has developed the concept and understanding of pain, which to some extent challenges the biomedical orientation of much of curative care. Indeed, the scope of palliative care encapsulates medical treatment in all disease stages, i.e. from chronic conditions such as arthritis to near death. Palliative care is strongly coupled with patients suffering from cancer and AIDS, and is also associated with a particular institution – the hospice. We briefly outline each in turn.

Pioneering contributions in the medical literature in the 1950s and 1960s, in some cases influenced by the philosophical work of Heidegger, Jaspers, Kierkegaard, and Sartre on suffering, challenged the presumption that the concept of pain has only biomedical and somatic meanings (Strang *et al.*, 2004). Chief among those is Cicely Saunders, the founder of the modern hospice movement. Saunders, influenced by her Christian, nursing, and social work backgrounds, advocated a multidimensional conception of pain. She argued that mental distress may be the most intractable pain (Cassel, 1982; Strang *et al.*, 2004). This contributed to Saunders' conception of "total pain," which included the physical symptoms, mental distress, social problems, and spiritual needs. This, as Strang *et al.* observe, resonates with Eric Cassel's (1982: 640) well cited definition of suffering:

> A state of severe distress associated with events that threaten the intactness of the person … any aspect of the person – physical, social, psychological, or existential.

However, as Strang *et al.* indicate, Saunders' conception has not been universally accepted. For example, the International Association for the Study of Pain focuses their definition on "unpleasant sensory and emotional experience" associated with actual or potential damage to tissue, thereby somewhat de-emphasizing Saunders' emphasis on spiritual, social, and existential sources. This contrasts with the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, which explicitly recognizes a relationship between sensory and existential factors. As Strang *et al.* (2004: 242) state: "Namely, there exists a mutuality between somatic pain and existential suffering."

Although there may be a lack of definitional precision to the notions of total and existential pain, they can both be understood in terms of human suffering as well as pain expressed in biomedical terms. Saunders' pathbreaking work has an obvious resonance with the promotion of social medicine and with Krieger's (2001, 2005) notion of embodiment outlined in Chapter 2, and invites suggestions of complementarities with the pluralism of medical and health care provision discussed in section 3.2.2 above, as well as the broader perspective offered by therapeutic care noted previously. Any association with social medicine further suggests consideration of the provision of palliative care as a right (for example, Brennan, 2007; WHO, 2011) as it may be tailored to ensuring and promoting the dignity of the individual. This is an issue we explore further in Part III. In addition, Stjernswärd *et al.* (2007) argue that palliative care carries important public health properties. The authors argue that there is a global unmet need for palliative care: for example, they estimate that of the 58 million people dying annually, at least 35 million (60 percent) would benefit from palliative care. They point to demographic changes in the world's population where the rapidly aging population and those with cancer and AIDS highlight the growing need for palliative care to "improve the quality of life of more than 100 million people annually worldwide" (Stjernswärd *et al.*, 2007: 487).

Stjernswärd *et al.*'s emphasis on the elderly and terminally ill does not necessarily reflect that of WHO. In its definition of palliative care, WHO highlights the specialist field of palliative care for children. WHO (2011) identifies several principles that should apply to pediatric chronic disorders and terminal illness, including "total care" of the child's "body, mind and spirit," which extends to family support; that "health care providers" must evaluate and alleviate the child's physical, psychological, and social distress; and that effective care requires a multidisciplinary approach that may be provided in a host of institutional settings, including children's homes.

Clearly, palliative care extends over institutional boundaries and involves a host of professional and non-professional agents. It further suggests pluralism in health and medical care. That said, one institution in particular is readily identified with the provision of palliative care. As noted, Cicely Saunders established the modern hospice movement with the founding of St Christopher's Hospice in 1967 in England. Prior to this there is evidence that religious orders in nineteenth-century England and Ireland provided facilities for the terminally ill and dying. Since the 1960s the provision of hospice services, whether dedicated facilities or home services, has expanded rapidly in the West, although the institutional configurations demonstrate some differences. For instance, in the UK there is a tendency to provide dedicated hospices, which may be funded under the auspices of charities or the NHS. In the US palliative care units are frequently aligned with hospitals (for example, the Center to Advance Palliative Care).[8] In 2009 the Norwegian University of Science and Technology established the first pan-European research center dedicated to improving patient end-of-life medical care in Trondheim. This center coordinates the activities of groups in several European countries including Denmark, England, Germany, Scotland, and Switzerland, and has established links with groups in North America and Australasia (Norwegian University of Science and Technology).[9]

The principles advocated by WHO as well as those embodied by the hospice movement founded on Saunders' conception of "total pain" indicate a caring regime that may differ from the separation of mind and body associated with Cartesianism. Palliative care would then, prima facie, seem to demand that medical care providers possess a set of attributes that are not necessarily equivalent to those of a surgeon providing curative acute care. Again, for us, the association of care and particular skills and aptitudes is emphasized. Such relations carry a normative dimension, which we analyze in Part III below.

3.5 Some concluding thoughts

In this chapter we have attempted to demonstrate the diversity in the delivery of medical and health care, acknowledging the range of institutions and geographical, cultural-religious, and historical contingencies. It is notable that the system is evolving with improvements in health generating further medical (and health) challenges – the most obvious of which is the issue of an aging population.

Our review of medical and health care categories further reinforces our belief in their obvious heterogeneity, and also the nested nature of caring and caring practices. The physician's ability to treat an ill child in an acute ward of a hospital is predicated on the availability of other caring functions and practices, such as the support provided by laboratory technicians, cleaning staff, and so on. Moreover, the efficacy of the physician's provision of acute care may be augmented by a nurse's therapeutic caring. Therein lies a further dimension to which we have not alluded – care and gender. We argue in Chapter 5 that gender has a significant impact on the framing of care, and hence the allocation of resources to care activities. It also prompts the question as to whether standard health economics' limited analysis of care reveals unintended gender and power biases.

Our analysis in this chapter further demonstrates the relational dimensions of care and caring, the tensions between the different types of caring, and the realization that the need for care exceeds the capacity for caring. We investigate this further in Part II.

Notes

1 "Extra welfarism" and welfarism in standard health economics is essentially a dispute about the appropriate measure in the evaluation of the effectiveness of medical care "outputs." Welfarists employ traditional aggregation of individuals' cardinal utilities arising from the care in the context of overall welfare. Extra welfarists, by contrast, advocate that the "output" of medical care should be assessed on the basis of its contribution to the maximization of health. In other words, the dispute relates, at least partly, to the relevant maximand (see Birch and Donaldson, 2003).

2 Scott and Vick's (1999) study usefully emphasizes the importance of the ability of physicians to communicate, a concern which has been widely expressed in the medical literature (see, for example, Groopman, 2007). However, the standard health economic approach, such as that of Scott and Vick, assumes information asymmetry and in doing so potentially conflates information with knowledge. This has the prospect of important ramifications for the recommendations of how physicians *should* behave.

3 Psychiatry and physiotherapy services, for example, are frequently *not* located in hospitals.

4 Eurostat (2016): http://ec.europa.eu/eurostat/statistics-explained/index.php/Hospital_discharges_and_length_of_stay_statistics#Average_length_of_hospital_stay_for_in-patients. Only four of the 27 EU members reported an increase in the average length of stay, and one of those (Portugal) recorded a fall between 2005 and 2010 followed by a subsequent increase.

5 The Health Foundation is an independent charity that aims to enhance the quality of medical care in the UK (http://www.health.org.uk/areas-of-work/topics/acute-care/acute-care/#.TpiaHkY_HpE.email).

6 Located at: http://www.medterms.com/script/main/art.asp?articlekey=18811.

7 The WHO statement may be accessed at: http://www.who.int/cancer/palliative/definition/en/#.TpiWnhTgsC0.email.

8 Center to Advance Palliative Care: http://www.capc.org.

9 Norwegian University of Science and Technology: http://www.ntnu.edu/news/european-palliative-care-research-centre.

PART II

Theories of care

Towards health and medical care

4

ECONOMICS AND CARE

> "What is called affection is in reality nothing but habitual sympathy. Our concern in the happiness or misery of those who are the objects of what we call our affections; our desire to promote the one and to prevent the other, are either the actual feeling of that habitual sympathy, or the necessary consequences of that feeling."
>
> (Adam Smith, *The Theory of Moral Sentiments*, 2000 [1759]: 323)

4.1 Introduction

In Chapter 2 we distinguished health care and medical care. Though medical care is an important part of health care, sometimes health care is mistakenly seen to be equivalent to medical care. Understanding why medical care is not the same as health care is important not only for appreciating what health care is, but also for comprehending the concept of care itself. Chapter 2 thus discussed how this understanding of medical care has been shaped by the influential biomedical paradigm in medicine, and outlined tensions between this biomedical conception of medical care and ethical codes of medical care informed by the Hippocratic tradition in health care as well as found in other caring professions. Our general goal is to frame medical care in terms of health care nested in terms of the broader concept of care rather than health care in terms of medical care, especially in biomedical terms. In Chapter 3 we continued with this wider scope and went on to provide an analysis of theories of care informed by work within and beyond the medical literature. Our general conclusion from these two chapters is that care is a relational concept and thus that health care is fundamentally relational in nature. This perspective constitutes our main point of departure from standard health care economics, which we showed in Chapter 1 conceives of care as simply an incidental spillover or externality in a market exchange between independent individuals. The more relational conception of care constitutes our basis for an alternative health economics.

In this chapter we trace and analyze the disparate and fragmented economic approaches to care. "Approaches" may be endowing too much in the way of acknowledgment, as we believe that economists of all sorts – with the exception of feminist contributions – have either overlooked or failed to appreciate the significance of care as a property of human behavior. All too frequently care is dismissed as a burden, a cost without any analysis of its virtues. For instance, some mainstream models include "care" as a time allocation decision variable, usually between paid labor, unpaid labor (a proxy for care), and leisure (van Staveren, 2005). We argue that there nonetheless exists a platform for the development of a coherent conceptualization of care in economics in general and in health economics in particular. In section 4.2 we investigate the framing of care and what we think of as the potential (institutional) conditions of care and caring in earlier times prior to the dominance of neoclassical economic thought. Specifically, we contrast the approaches of Smith, Marx, and Veblen, and find that Smith attempted to study care most directly. Of the three, Smith furnished the most comprehensive examination of care as instinctive and as a learned, other-regarding, virtuous behavior bound up with affection and sympathy. All provide an analysis of the conditions of care and caring, but disappointingly, given his humanist background, Marx's work is arguably the least developed in this area. To the best of our knowledge, other prominent figures in the history of economics, such as Keynes, were not overly preoccupied with developing a conception of care, given its perceived lack of relevance to the focus of their work. This may have some bearing on the failure of non-mainstream economics, beyond feminist economics, to appreciate care.

In sections 4.3, 4.4, and 4.5 we turn to more recent contributions to understanding care. In section 4.3 the systems analysis and health economics of Kenneth Boulding are examined. We find that Boulding's work provides important foundations for the interrogation of care, and that his neglected work on health anticipates the medical care view of care and the medicalization of social problems, but Boulding fails to develop an explicit narrative on care. From here, section 4.4 explains the care relationship as a direct, personal interaction between care providers and patients by employing Gavin Mooney's recent communitarian paradigm for health economics, which makes participation and reciprocity constitutive of health care provision. Section 4.5 concludes the chapter by introducing arguments about the nature of care that are close to ours that were made earlier by feminist economists and social scientists, who have long objected to market-based representations of care and who have also worked within a relational, socially embedded understanding of care. We see that feminist accounts of care bring out a further dimension of the care relationship, namely a focus on human capabilities, to which we return in Chapter 7 in our discussion of health care capabilities.

4.2 Care in "early" economic thought

In this section we discuss prominent works in the history of economics that make reference to care and examine the contributions of Adam Smith, Karl Marx, and Thorstein Veblen.

4.2.1 Adam Smith and care

For most economists, the seminal contribution to economics is Smith's *Wealth of Nations* in 1776. The *Wealth of Nations* is frequently portrayed as establishing the basis for *Homo economicus* and the motivation of utility maximization (for example, Becker, 1976a). Smith's allusion to the *Invisible Hand* in his famous butcher-baker tale indeed provides a powerful pro-market message: the way markets work seems to ensure that the pursuit of self-interest will benefit all. This vision has been powerfully promoted by Gary Becker, the Chicago School, and the Mont Perelin Society, among many others.

In terms of conceptualizing care, the *Wealth of Nations* also appears to provide a foundation for the mainstream perspective on health care we outlined in Chapter 1. Altruism *qua* care is beneficial when it is a particular argument in the altruist's utility function. As we argue throughout this book, there are many reasons to question such a characterization of care (and altruism). Here, though, we concern ourselves with Smith's understanding of care. Undoubtedly Smith's butcher-baker tale diminishes beneficence and benevolence in generating material wellbeing. Yet to presume that this is all Smith said on the subject would be to commit a grave error of omission. As Jerry Evensky (2005) argues there are critical differences between the "Chicago Smith" and the "Kirkaldy Smith" (*sic*).[1] Evensky argues that the Chicago School representation of Smith is highly reductionist in that it ignores Smith's moral philosophy as set out in his *The Theory of Moral Sentiments* (see also, for example, Samuels, 1977). For Evensky (2005: 203):

> Adam Smith was not an economist offering a materialist vision of humankind's progress based on the *Homo economicus* assumption. Smith was a moral philosopher modeling a complex coevolution of individuals within a simultaneous system of social, political, and economic institutions.

There is also reason to believe that Smith was concerned with strengthening the arguments of *The Theory of Moral Sentiments* which he worked on revising shortly before his death. He did not devote this much attention to revising *The Wealth of Nations*. There are also those who emphasize the disjuncture between the apparent promotion of self-interest in the *Wealth of Nations* and *The Theory of Moral Sentiments*, as well as the inconsistencies within the *Wealth of Nations* itself (for example, Foley, 2006). We acknowledge the debate and controversy over the two works, but we are more interested in what Smith stated explicitly about care in *The Theory of Moral Sentiments*, the expression of Smith's ethical thinking (Samuels, 1977).[2]

At several points in *The Theory of Moral Sentiments*, then, Smith appears to anticipate later contributions to the theorizing of care, which we will outline in Chapter 5. In contrasting beneficence and justice, Smith observes that the former demands gratitude whereas the latter does not. He notes that justice can be applied forcefully, whereas beneficence is "free" and cannot be "extorted by force" (Smith, 2000 [1759]: 112). Further, he associates beneficence with generosity, and how this requires an acknowledgement on the part of the beneficiary of acts of beneficence. He argues that there is never a debt of charity, generosity, or friendship, but there is a "debt of gratitude." Smith develops his theme further when he argues (2000 [1759]: 117):

> Beneficence and generosity we think due to the generous and beneficent. Those whose hearts never open to the feelings of humanity, should, we think, be shut out in the same manner, from the affections of all their fellow-creatures, and be allowed to live in the midst of society, as in a great desert, where there is nobody to *care for* them, or to enquire after them. (Emphasis added)

Interestingly, in his further analysis Smith argues that beneficence is virtuous, and that there is a duty to recognize it as such. In other words, there is a social responsibility for the beneficiary to acknowledge this, and if this is not done then there is no obligation for the benefactor to continue to provide for the beneficiary. The passage above further highlights Smith's affinity to other-regarding features of human behavior (and obligations to do so), and hence, in our view, emphasizes the social embeddness of the individual. Smith's invocation of "care for" also appears to anticipate the complexities of care as relational, embodied in acts and emotions – primarily affection – and as captured to some degree by Smith's notion of sympathy (or fellow feeling) and invoking benevolence and beneficence. He further explores this in later parts of *Moral Sentiments* on the foundation of judgements relating to individual conduct, sentiments, and a sense of duty (Part 3), and in Part 5, Section 2 on the other-regarding properties of virtuousness. Indeed, Smith makes explicit reference to care in the title of Chapter 1 of Section 2.

In discussing "just and unjust" conduct Smith invokes the notion of "general rules" as providing the foundations for standards of judgement. Like Thorstein Veblen, Smith argues that general rules are "fixed in our mind" by "habitual reflection" (2000 [1759]: 226). Moreover, these rules constrain individuals' pursuit of self-interest at the expense of regard for others. In our view, however, Smith appears to go further than arguing that social rule systems are *only* constraints – as in contemporary mainstream economic theory – since he uses a particular terminology, "correcting the misrepresentations of self-love." Further, Smith's use of "habitual" and reference to "fixed in our mind" suggest that rules instill values in our thought that are deemed culturally acceptable. Thus we believe Smith's framing is consistent with the argument that caring, as a virtue, is partly shaped by the system of rules governing social conduct and relations. This is a far more sophisticated rendering of human behavior than that portrayed by *Homo economicus*.

We venture further. When discussing virtue in Part 5, Smith represents care in terms of concentric rings. "Every man, as the Stoics used to say, is first and principally recommended to his own care" (2000 [1759]: 321). From the self, care as other-regarding extends to one's immediate family or kin – with greater sympathies directed at children – and then on to familiar others. Place and relationality play an important role in Smith's analysis here. His thinking here is perhaps informed by his friend David Hume's concern with the issue of distance on morality, in his *A Treatise of Human Behavior*. Hume was hugely influential on Smith's analysis of the economy and morality (for example, Dow, 2002; Dow and Dow, 2006). On distance, Hume observed:

> The breaking of a mirror gives us more concern when at home, than the burning of a house, when abroad, and some hundred leagues distant. (Hume, 1978: 429, cited in Tronto, 1993: 44)

This is obviously reflected in Smith's discussion of how affection may be diminished with distance, even between family members. For Smith, distance does not make the heart grow fonder. This is due to the key role Smith ascribes to habit: "What is called affection is in reality nothing but habitual sympathy" (2000 [1759]: 323), and for this proximity is a key influence.

Care, then, is bound up with affection, sympathy, and virtue. It is, as we have seen, also associated with beneficence and is deeply relational in Smith's schema. Yet Smith readily appreciates how the prevailing conditions of society may change general rules and therefore the conduct of relations between individuals. Smith also draws a distinction between "pastoral" and "commercial" countries, where the former do not possess legal frameworks sufficiently developed to ensure the "security of every member of the state" (2000 [1759]: 326). In pastoral societies different branches of a family and its associates coalesce to ensure their mutual "security." Smith refers to the clan system of Highland Scotland as an example. He suggests that in less developed societies deeper bonds exist between its members, certainly at a local level, and that there is likely to be greater affection, sympathy, and care. With commercialization there is no need for such bonds, as the legal apparatus assumes this function. This invites us to ask whether for Smith economic progress means that we care less for each other.

Nonetheless, regardless of the state of social development, Smith believes that mutuality and kindness are intrinsic to being human. He states:

> Nature, which formed men for that mutual kindness so necessary for their happiness, renders every man the peculiar object of kindness to the persons to whom he himself has been kind … Kindness is the parent of kindness" (2000 [1759]: 331)

Smith even suggests a virtuous cycle – kindness begets kindness – and importantly that the well-being of individuals is predicated on their sociality. No notion of scarcity here: exercising kindness does not exhaust some 'stock'. Instead, it renews and replenishes. Far from the atomistic individual of basic neoclassical economics, Smith envisions a complex milieu in which socially embedded individuals negotiate their daily affairs by reference to social rules, and where care, affection, and sympathy play a significant role in the conduct of human relations.

Yet while Smith explicitly refers to care, he offers no precise definition.[3] From the context of his narrative it is obvious to us that care should not be construed as an externality. Smith's analysis entangles care with what he describes as virtuous properties of human behavior: kindness, sympathy, beneficence, attention, affection, and so forth. It appears that Smith was aware of the complex nature of care and caring – witness his references to "nature" and kindness, the emphasis he placed on proximity and relations, and the role of habit (and hence learning) in framing care. It seems a pity that economics has largely ignored and overlooked this promising platform. Of course, Smith's analysis was not directly aimed at developing a concept of care per se, and perhaps as a consequence it is clouded in vagueness. Without offering a definition of care, care can be confused with sympathy. As we noted, there is the perennial question of Smith's seemingly conflicting emphases between *The Theory of Moral Sentiments* and *The Wealth of Nations*. For example, as Foley (2006: 44) says in regard to Smith's examination of the social and (capitalist) economic domains: "Smith's inconsistencies betray a tension between his economic theology and his good sense." This may be the case and may have contributed to the "Chicago Smith," but we put this issue aside here. For us the interesting aspect of Smith's thinking is the significance of care in human social relations, conduct, and behavior, which when recognized in its complexity anticipates later developments in the theory of care (that we explore in Chapter 5). Economists' fixation on the *Wealth of Nations*, then, has excluded them from a fuller awareness of the full range of Smith's contribution.

4.2.2 Karl Marx

Indeed, to some extent the same accusation could also be extended to prominent figures critical of Smith. Marx, for instance, from his Aristotelian and humanist perspective develops a compelling critique of early capitalism and many aspects of Smith's framework. Yet as far as we are aware, he offers nothing that *directly* develops a theory of care. At the same time, Marx's understanding of capitalist market exchange does address the conflict between market-based interactions and social conditions that would facilitate care. Specifically, in Chapter 1 of Volume 1 of *Capital*, in what he terms the "fetishism" of the commodity, Marx argues that exchange value always dominates use value. Indeed, he speculates that if commodities could speak they would say: "We relate to each other merely as exchange-values" (Marx, 1990 [1867]: 177). In other words, the value of all things comes to be measured by prices – a monetary measure of the value for which a 'thing' can be exchanged. This monetization of things contaminates and corrupts other values in social relations, and collectivism and cooperation give way to individualism and exploitation. Thus the prospect for care and caring beyond the self, and perhaps other-regarding attitudes and behaviors, is seriously diminished. As Marx dramatically argues:

> As a capitalist, he is only capital personified. His soul is the soul of capital. But capital has one driving force, the drive to valorize itself, to create surplus-value … absorb the greatest amount of surplus labor. Capital is dead labor which,

> vampire-like, lives only by sucking living labor, and lives the more, the more labor it sucks. (1990 [1867]: 342)

A manifestation of this crowding-out effect emphasized by Marx is in the length of the "working day." The exploitative nature of production relations always acts to lengthen the "working day" and limit the time workers have to attend to their social and other needs. For him, the production arrangements of capitalism, such as the length of the working day and division of labor, are therefore inherently dehumanizing.

Nonetheless, to reiterate, the concept of care is not directly evident in Marx's analysis, and his thoughts about it can only be inferred from other things he says. Indeed, to our knowledge, where Marx does employ the term "care" its meaning is either as a burden (as in all the cares of the world) or as an exercise of diligence, such as, "the capitalist takes good care that the work is done in a proper manner" (1990 [1867]: 291). Perhaps this treatment of care is not surprising given the pivotal role of conflict in Marx's analysis of capitalism. Yet, given Marx's (and Engels') emphasis on value theory, which extends beyond the confines of exchange value, and their critique of the monetization of social relations, they provide a platform for the circumstances of care and caring. Indeed, as we explore in Chapter 5, the Marxist emphasis on production relations and the reproduction of those relations is the basis of a definition of care and of conceptualizing care as central to human existence (for example, Schwarzenbach, 1996). Moreover, Marx's historical and material dialecticalism powerfully signals a change in dominant value structures underpinning production and wider social relations (for example, Milonakis and Fine, 2009). It is therefore not inconceivable that, for example, Marx's conception of "primitive communism" points to a more caring society in that it is typified by sharing and cooperation rather than the materially wealthier "capitalism" at the focus of his writing. His vision of a communist society that eventually succeeds capitalism appeals to a more caring sense of social relations. Joan Tronto (1993), for example, notes that Marx's analysis advances the proposition that under capitalism frequently the individual (proletarian) cannot see much beyond their own (desperate) plight in order to be other-regarding, so that capitalist relations are almost necessarily around care-for-the-self. However, when an individual's own needs are sufficiently met they become increasingly sensitive to the needs of others. Here the potential for the relational aspect of care and caring is reiterated.

4.2.3 Thorstein Veblen and the "parental bent"

The final figure we wish to highlight is Thorstein Veblen. Unlike Marx, Veblen is explicit in his work about the importance of what he terms the "parental bent." He explored this in his *The Instinct of Workmanship and the State of the Industrial Arts* published in 1914.

Veblen's theoretical analysis of human behavior was heavily influenced by American instinct-habit psychology (Hodgson, 2004). He believed that human instincts are part of our evolutionary biology in the form of innate and persistent propensities and drives (for example, Camic and Hodgson, 2011). He identified three basic instincts, including: "workmanship," which is an impulse to work to make things useful; "idle curiosity," which refers to humans' drive to comprehend the external world, perhaps through imagination; and the "parental bent" (Veblen, 2011). The parental bent is explicitly other-regarding and far broader than the "mere proclivity to the achievement of children" (Veblen, 2000 [1914]: 16). He continues by describing the parental bent as:

> Beyond question that this instinctive disposition has a large part in the sentimental concern entertained by nearly all persons for the life and comfort of the community at large, and particularly for the community's future welfare. (Veblen, 2000 [1914]: 17)

Veblen depicts the parental bent as a "naïve impulse" (*ibid.*) that is manifest in two ways: an active interest in the common good, and hence other-regarding, and a bias to the future. For him, the emphasis on the future is in stark contrast to the mainstream presumption of the discounting of the future by current generations, such as in consumption decisions. Instead, Veblen contends that there is an "unselfish solicitude" (Veblen, 2011: 561) expressed as a concern for the "highest efficiency" (*ibid.*) to ensure the well-being of the incoming generation. In other words, current generations make sacrifices to enhance the life chances of the young.

Despite identifying the parental bent as one of the two most important human instincts – the other being workmanship – Veblen devotes remarkably little text to exploring and elaborating upon it. As the title of his work suggests, his principal focus is workmanship. Nonetheless, he does consider how the two instincts may relate to one another in guiding behavioral impulses. Instincts are translated via habits into behavior, and through habits instincts may become corrupted. Veblen illustrates the parental bent in the context of authoritarian rule by elders in some tribal societies, and how the perpetuation of particular habits leads to an institutional pattern that demarcates clear class distinctions. Other than this, Veblen does not emphasize or develop the parental bent concept, or explicitly relate it to the terminology of care. Nevertheless, for us it is clear that Veblen's conceptualization strongly resonates with notions of care and caring. The instinctive property, highlighted by Veblen, is an obvious corollary. Within this, Veblen's delineation of care is expressed by other-regarding, concern or interest, and a future orientation. Again, as we discuss in Chapter 5, these constitute aspects of care and caring. What remains unexplored in Veblen's analysis, yet constitutes an important part of Smith's approach, is the idea of care as a virtue. This may be unsurprising given the respective orientations of Smith's *Theory of Moral Sentiments* and Veblen's *The Instinct of Workmanship*, and perhaps this deserves some reflection on the possibilities of synergies between Smith and Veblen's analyses of care. In the relevant parts of *The Instinct of Workmanship* Veblen makes no reference to Smith. We explore Veblen's approach in more detail in Chapter 6.

Of the three figures we have identified, then, Smith provides the most thorough examination of care, and yet his thinking is still under-elaborated. Veblen's allusions are indirect and under-developed, while Marx provides only a hint of the conditions involved in caring, which can be inferred from his excoriating critique of the corrupting effect of the monetization of social relations. Moreover, as may be expected given the nature and historical contexts of their works, none of the foregoing is consciously related to the provision of health and medical care. Given that care was not the primary focus of these authors there is only a disjointed, fragmented approach to care. For instance, in the case of Veblen the parental bent is presented as one of the two most important human instincts; nevertheless, as noted, it is subsequently marginalized in his work. As we also note, Marx's Aristotelian roots and humanism are suggestive of an emphasis on care, but one has to read between the lines to discern this. Yet to varying degrees all three anticipated later developments in theories of care. Unfortunately, economists of all kinds, with a few exceptions, have tended to overlook the possibilities of these early contributions. This even extends to Kenneth Boulding, whose neglected work on the need for health services provides another piece in the puzzle of the economics of care, which we analyze in the following section.

4.3 Kenneth Boulding: health economist?

As an economist Kenneth Boulding is perhaps best known for his interdisciplinary approach to the analysis of the economy, which reflected his systems-based and evolutionary analyses (Dolfsma and Kesting, 2013), and his strong belief that all sciences are infused with values, economics being no exception (Boulding, 1969; Davis, 2013a, 2013b). Boulding is rather less noted for his work on health (Boulding, 1966). In this regard he promoted the view that the need for health care differed markedly from the standard economic conception of demand, and that the notion of health is partially socially constructed. For us, Boulding represents a challenge to mainstream health economics' market exchange framing of health and care and to the Cartesian view of illness (noted in Chapter 2). For these reasons, Boulding's argument deserves more attention than it has received to date.

Boulding is forthright in asserting that science is a human activity that occurs within a community, and all communities and human activities are types of culture that provide ethical guidance regarding what is right and wrong. Therefore science cannot be divorced from morality. Boulding thus utterly rejects the Humean Guillotine between facts and values so important to mainstream economics. But he goes further. In his 1968 American Economics Association address he denounces the ethical foundations of Pareto optimality (Boulding, 1969). This is important in connection with our evaluation of health economics since many mainstream health economists appeal to the Paretian principle as the foundation of their evaluation techniques (Mooney, 2009). Boulding (1969: 5) contends:

> [The Paretian principle] rests on an extremely shaky foundation of ethical propositions. The more one examines it … the more clear it becomes that

> economists must be extraordinarily nice people even to have thought of such a thing, for it implies that there is no *malevolence* anywhere in the system. It implies, likewise, that there is no *benevolence*, the niceness of economists not quite extending as far as good will. (Emphasis added)

Benevolence, of course, is what Smith in his *Theory of Moral Sentiments* connected with care and other-regarding. By this argument, then, almost at the outset of its analysis the mainstream marginalizes care. Boulding's (1969, 1973) assessment is predicated on his three systems of social organization conception, the "threat," "exchange," and "integrative" systems, which he argues are evident in every society. In the threat system the dominant motive is fear; in contrast the integrative system is dominated by love. The systems overlap and evolve. For instance, Boulding argues that the integrative system sustains the exchange system: benevolence gives rise to reciprocity, a prerequisite for exchange (Boulding, 1973). However, he also notes that the exchange system is partially shaped by the threat system, which is also influenced by the integrative system. The threat system is the basis of power politics, as exchange is the basis of economics. In his many works on this he describes the multitudinous manifestations of the threat system, frequently summoned by the State. Thus Boulding refers to an evolution of spiritual threats, legally sanctioned coercion, physical threat, slavery, and so forth throughout human history.

Love centers on other-regarding through identification. Boulding argues that there are areas of life that do not involve exchanges or threats, but in which we identify with others. Boulding (1973) describes love of spouse, family, country and so on as part of our identity. He also argues that the three systems depend on learning. Without learning benevolence would not lead to reciprocity; without learning we would not appreciate the nature of subtlety in the threat system and threats would be reduced to the coarse exercise of physical power. Through learning, Boulding reinforces his case that all sciences are morally based. He demonstrates this with even greater specificity in his study of need and health care.

He starts from the proposition that needs and wants are profoundly different. Demand represents individual choice and autonomy whereas need refers to the choices of others made on one's behalf, and hence to the absence of autonomy. In the case of medical care, demand is for expertise and knowledge, or the results of medical knowledge. This demand is derived from what Boulding terms a "homeostatic need" and the perception or knowledge of this. Homeostatic need is described as what is required to maintain the operability (or functionality) of a given system. Boulding draws a comparison between cars and humans – both need fuel of various types, produce waste, are subject to physical deterioration, and require professionals to address these needs, especially the effects of physical deterioration. He argues that basing need on homeostasis is never successful, as no matter what the nature and combination of inputs, "virtually all known organisms and organizations exhibit the phenomenon of aging … Aging introduces a very tricky problem into the concept of need for maintenance" (Boulding, 1966: 206–7). When is it appropriate to cease maintaining something? Boulding argues that this is problematic enough with a machine, where present value calculations can be used, but one of "excruciating delicacy" (1966: 207) in the case of a human being. He observes (*ibid.*):

> A machine is generally regarded as having no value in itself … its value is purely instrumental … In the case of the human being, the problem of the person himself becomes very acute, because persons cannot be regarded as purely instrumental. That is, they are not merely good for something else, they are good in themselves. They are, in other words, something *for which* other things are good. (Original emphasis)

This is a significant passage – it expresses Boulding's rejection of the Cartesian mind–body dichotomy (Chapter 2) and also parts of mainstream health economics' depiction of the body as a stock of capital (Grossman, 1972). Instead, Boulding suggests that the mind and body are inseparable; they constitute what it is to be a person, and hence are intrinsic to our humanity. Therefore, the body cannot be an instrument in the same way that a machine may be. This then lays a basis for emphasizing the importance of dignity as a moral factor in the provision of medical care in a way that is absent from the Cartesian interpretation of the body. Boulding also unhesitatingly aligns dignity with autonomy and hence the ability to articulate one's demands as opposed to simply have needs. "One sobering thought … is that a person virtually ceases to be a legal person when he ceases to have demands and has only needs" (*ibid.*). Invoking the spirit of the Hippocratic Oath, he argues that the patient, as a person, should possess the right to decide when to die. For Boulding, this appears to be the ultimate exercise of autonomy (and hence demand). Prima facie, there are parallels to Grossman's model of the demand for health and health care, where the individual agent makes the decision to end life when the benefits of preserving life are outweighed by the costs. However, as we have seen, Grossman's approach is predicated on a narrow conception of health as a capital stock akin to a machine. Boulding openly rules out this instrumental approach.

Whatever the merits of Boulding's thoughts on an individual's right to choose the timing of death, his analysis highlights the relationships between capability, power, health, and illness. As we have seen, Boulding emphasizes the social construction of illness and health, especially mental health, stating "health is a matter of social definition" (1966: 213). He refers to the cases of homosexuality and epilepsy. Is the former a condition to be 'cured', or is it a genuine and natural dimension of behavior? Or, is it deviance, as in the consumption of psychedelic drugs? He also notes how historically epilepsy in some societies was considered to be an indicator of "divine favor" (1966: 213). Moreover, who gets to decide what is an illness or not? As noted in Chapter 2, Boulding's analysis anticipates the tenor of critiques leveled at Western medical power in the 1970s and 1980s (for example, Engel, 1977; Kennedy, 1981). He refers to Samuel Butler's (1872) satirical and fictional *Erewhon*, a society where crime is treated by medical professionals and illness by the police. Again, Boulding's point is that power relations in society shape what is healthy and moral, and what is illness and immoral. In doing so, he recognizes there are profound social conflicts in medicine. Medical provision focuses on the individual; even public health centers on environmental factors that affect an individual's health. Yet, for Boulding little attention has been given to "societal health," which he explains in terms of the factors that influence the health of the whole of society. Provocatively, he inquires whether the concept of illness can be applied to moral and political ideas that adversely affect the health of society, noting that individuals may be healthy while society is sick. He asks whether there can be a "disease of moral judgments"?

Boulding's arguments demonstrate a concern with the medicalization of social problems and the wider role of science in society. Rather than the shift in orientation to individual behavior in public health that has arguably occurred over the past few decades (see Chapter 2), Boulding is concerned with the use of genetic manipulation and widespread drug use to produce "various types of euphoria." Science is value-laden and needs to reflect on its value systems continuously. In this connection, Boulding returns to his specific concern with the distinctions between need and demand. He argues that a connotation of "need" is "needy" in the sense of what cannot be had due to indigence. In this way "need" is what Boulding terms an "equalitarian" concept. In contrast, "demand" is a libertarian conception that is grounded in individual autonomy.

> Demand, perhaps because of its … stress on autonomy and freedom is libertarian rather than equalitarian, and liberty is seldom equally divided. If medical care is distributed according to demand, the rich will get most of it and the poor very little. (1966: 217)

For us, this clearly situates the provision of medical care in his integrative system or grants economy. Thus Boulding intentionally does not frame medical care provision in terms of the market – or the exchange system, the conventional economic default institutional arrangement. His analysis is accordingly distanced from standard health economics in that the two are based on different value systems – the integrative system is dominated by benevolence; the (market) exchange system is not. The latter ends up modeling care as an externality in a market system; in an integrative system care is a fundamental property of the system.

All this has significant implications for the meaning of professionalization. In the standard account physicians are primarily self-interest-seeking, although physicians' utility can be aligned with that of their patients when associated with professional values, such as the Hippocratic Oath. Nonetheless, as we have seen, trade-offs are likely according to the conventional agency relation. In contrast, Boulding emphasizes the importance of professional and scientific values in shaping legitimate courses of action and ways of thinking and learning. This is quite different from consequentialist mainstream health economics, where the value of actions rests solely on their expected utility. Boulding's view, then, is closer to a deontological account in which duties and responsibilities shape decision-making and actions. Nevertheless, Boulding worries about a paternalism that might curtail individual autonomy, and hopes there might be "an uneasy Aristotelian mean" (Boulding, 1966: 216) between the consumer sovereignty assumed by mainstream economics and an "authoritarian" paternalism. He does not provide a definitive way to balance these, but urges that the medical profession be seen as an important part of a wider network of health care – not least one that acknowledges the importance of societal health.

Nonetheless, there is a serious lacuna in Boulding's stimulating analysis: there is no explicit mention or reference to care. Care and caring may be inferred from his emphasis on professional values and his situating medical provision in the integrative system with its dominant value of benevolence, but surprisingly Boulding makes no particular virtue of caring, especially in a medical or clinical context. The central characteristic of the integrative system, the bonding effect of love via identity, is similar to the familiarity and care argument articulated by Smith in the *Theory of Moral Sentiments*. Yet the absence of explicit reference to care and caring is disappointing. Boulding provides the platform, but seems to overlook its potential to emphasize care. We believe our approach, then, will travel further in the direction toward which he points, and aim to develop this in Part III below. Here we investigate additional economic contributions to the conceptualization of care: first Gavin Mooney's recent work and then the contributions of feminist economists.

4.4 Gavin Mooney on health care: from community ties to participation to reciprocity

Like Smith and Boulding, Mooney's communitarian paradigm for health economics sees people as first and foremost members of communities, not abstract individuals, and argues that membership in a community cannot be explained in terms of isolated individuals acting out of their self-interest (Mooney, 2009). For Mooney and other communitarians, membership in a community cannot be understood only as a means people adopt to achieve private ends. That instrumental view does not really describe membership in a community but more the idea of an incidental association of people without significant ties to one another. Communities involve stronger connections between people. They are built up out of personal ties people have to one another, and these ties have a binding quality people recognize and accept. Ties in this sense carry a sense of obligation that motivates people beyond whether they are expected to generate individual payoffs. We can accordingly say that the value people place on being members of a community is the value they place on the ties that bind them to one another in direct personal relationships, recalling Boulding's integrative system. In the case of medical care relationships, it is this direct, personal interaction that, Mooney argues, care providers and patients value. Our view is also that this personal interaction between care providers and patients is foundational to a whole network of social relationships built around it that together constitute a community concerned with the provision of health care, despite the increasingly common representation of the provider–patient relationship as an arm's length market relationship. Standard health care economics, we believe, misses this, because *Homo economicus* as an atomistic, isolated being without ties to others, obscured from seeing the value people place on the ties people have to one another. Indeed, the market-centric view of health care rejects the idea that communities in this stronger sense exist altogether since the idea of "community" itself is a fiction when the only relationships said to exist between people occur in markets where they interact at a distance on the basis of self-interest. This is a notion rejected by Smith, Marx, Veblen, and Boulding. Put differently, personal relationships between people simply do not, indeed cannot, exist in a world explained solely in terms of markets (Sandel, 2012).

But what exactly is it about the ties that people have to one another that they judge valuable? Mooney has an answer to this question. People value their ties to one another because quite simply they value the activity of interacting with other people, or, as he understands it, they value their participation in direct, personal relationships with other people. Mooney (2009: 127) states:

> Communitarians emphasize the importance of mutuality, reciprocity, and sharing of not just identities, but also values, moral commitments, and obligations.

That is, people place a value on interaction, communication, exchange, agreement, disagreement, cooperation, conflict, contact, etc. with others, even should this sometimes produce less than desirable outcomes. But note that not all interaction between people can be regarded as participatory. To say that people participate in a relationship, one has to rule out that the relationship is one-sided or determined by only one party. That is, if a relationship lacks some sort of give and take, where what Mooney means by this is that it fails at some level to be reciprocal, then it is not participatory. Thus for him ultimately the value people place on the ties they have to one another depends on their somehow being reciprocal. Consequently, Mooney's communitarian paradigm for health economics is built around understanding care as a direct personal, participatory relationship based on reciprocity.

Moreover, resonating with Veblen and Boulding, Mooney seeks to differentiate communitarian reciprocity from market exchange. He argues:

> Liberalism and certainly neo-liberalism in the market place is about freedom of individual choice, with the added assumption that individuals are willing and able to exercise consumer sovereignty … Communitarians, on the other hand, are very much concerned with the shaping of society. They do not believe that this can be left to individuals qua individuals. It is citizens as products of the society or community who shape and, importantly, who are shaped by the society of community. (Mooney, 2009: 139–40)

Consider what this means in terms of the care provider–patient relationship in connection with the diagnostic stage of care. Practically speaking, diagnosing a health problem generally requires a give-and-take process between the provider and patient. What tests might be ordered depends on the patient's description of symptoms. How patients explain their symptoms depends on how well they are able to communicate with their care providers and thus how well the latter help them interpret their symptoms. But communication involves more than an exchange of words. Both providers and patients need to be committed to communicating information to one another. This applies also to their interaction over what test results might indicate and how such results are to be interpreted. Consider also, then, what is involved in pursuing a course of care, a further dimension in the care provider–patient relationship. While communication remains important in diagnosing care needs, for the course of care to be effective both the provider and the patient also need to monitor and interpret its effects in light of their previous exchange and communication regarding diagnosis. Thus providers and patients develop direct personal relationships with one another which have the latter's well-being as their shared objective. The more they are successful in this exchange the more likely they will be successful in improving the patient's health.

Care, therefore, cannot be an incidental outcome (an externality) of a market transaction between providers and patients since in market transactions there is no shared objective nor need to develop direct personal relationships. Direct personal relationships involve some level of commitment between the parties involved; market transactions only involve some coincidence of wants. We argue, then, that the communitarian paradigm, with its focus on personal ties and view of care as participatory and reciprocal, correctly describes the core aspects of a relational care conception for health care economics, and take this alternative view of the care relationship to be foundational to the network of social relationships in which it is embedded. But how it is "foundational" and how care thus understood is embedded in those other social relationships needs to be further explained. We agree with Mooney that communities are built up out of (overlapping) sets of personal ties across the various social relationships people have to one another. To more fully explain this idea we will extend the scope of reciprocity from the care relationship to the linked additional social relationships in which care providers and patients participate which support care relationships. We will do this by emphasizing the role that shared intentions and shared social identities play in sustaining networks of social relationships that surround care relationships.

4.5 Caring labor as a characteristic human activity: feminist economics

Feminist economics has significantly increased its profile over the past twenty or so years, particularly with the publication of the international journal *Feminist Economics* and the establishment of the International Association for Feminist Economics (IAFFE) in 1990. IAFFE's objectives include: "to further gender-aware and inclusive economic inquiry and policy analysis with the goal of enhancing the well-being of children, women, and men in local, national, and transnational communities" (IAFFE, http://www.iaffe.org/pages/about-iaffe/miss/). Feminist economists question the adequacy of standard economic practice and method, although some feminist economists employ mainstream techniques. One particular issue identified is the value-laden and partial approach of the conventional model. Economics is heavily gendered in its alleged objectivity, preference for quantification, abstraction, rivalry, logical consistency, absence of emotion, rigor, and hardness – properties associated with masculinity (for example, Nelson, 1995, 2016; van Staveren, 2001). By contrast, subjectivity, qualitative approaches, cooperation, emotion, and intuition are associated with femininity, and are characteristics that are usually considered to be inferior to masculine ones. At the center of this difference is the selfish, disconnected, optimizing *Homo economicus*. Feminists argue that this is an utterly inadequate account of both male and female behavior. The absence of connectivity in the mainstream account of human behavior also overlooks Smith's emphasis in the *Theory of Moral Sentiments* on other-regarding properties: a dimension of behavior embraced by feminist economics. Not surprisingly, care is a prominent concern for feminist economists.

The origins of the care concept in feminist social science, economics, and philosophy lie in recognition of the importance of unpaid labor in non-market domains, especially household and community settings, in which women's work has gone undervalued (and often unvalued altogether) because it is not priced in the marketplace (van Staveren, 2001). This oversight and omission became increasingly apparent when women's labor force participation rates began to rise in the 1970s (especially in the US and other developed economies). National income accounting methods then recorded national income increases based on the replacement of women's unpaid labor in the household by paid labor in the market (both from women's market employment and from market replacement of formerly unpaid home labor services), though essentially all that had happened was that the form of labor was different. This made it clear that previously unaccounted for, unpaid labor outside the market was valuable, leading to the conclusion that national income accounting required that unpaid labor should somehow be included (Ironmonger, 1996; Wagman and Folbre, 1996). Though there were different ways in which this accounting could be done, all of them involved placing a market value on the labor that went unpaid in non-market household activity. But this meant the ultimate arbiter of the value of unpaid labor was the market, and it also held the further implication that unpaid labor had no value unless it could be measured in market terms. This led to the question whether the market was even an appropriate means of evaluating unpaid labor. For example, van Staveren (2005) lists the principal features of (the few) mainstream models that explicitly incorporate care via unpaid labor as a variable as: consumption and production choices are solely informed by relative prices, implying that the choice of care providers is highly substitutable, and care is valued in terms of the monetized opportunity costs of its time. There is no acknowledgement of the meanings or values of caring relationships. For van Staveren (2005: 582), such models can only provide insight into what she terms as the "economic structure of care," i.e. time allocation decisions across a range of activities. As we have seen, care becomes a standard argument in a utility function frequently conflated with unpaid labor (or even leisure). Other aspects of care, such as its relational dimension, considered important by Adam Smith, are overlooked. Indeed, we may ask how the relational dimension of care and caring is subject to standard measures of productivity? Himmelweit (2007: 585) persuasively expresses an important implication of this:

> Caring because it is the development of a relationship, is manifestly an activity … in which the output is the care itself … This means that it is hard to raise the productivity of caring.

In articulating this, Himmelweit draws on Baumol and Bowen's (1965) analysis of the economics of the arts. They argue that productivity rises more quickly in areas of the economy that benefit directly from innovation, investment, and/or technological enhancements. However, the arts, according to Baumol and Bowen, cannot benefit from these effects. They use the example of a string quartet – reducing the number of players or demanding the musicians play more quickly may raise productivity in terms of the number of pieces performed per musician over a given period of time but would substantially alter the nature of the piece. The problem arises from the attempted objectification of the arts. The same can be said about the nature of care.

Similarly, many feminists argue that even if markets could be used to value unpaid labor, they would likely lack any way of adequately valuing caring labor. This then led to an investigation of what the distinctive qualities of caring labor were (for example, Bergmann, 1986; Himmelweit, 2007; van Staveren, 2005).

Consider, then, the difference between unpaid labor and unpaid *caring* labor. A key issue in this regard is whether caring labor is a special type of activity or has a particular kind of motivation (Waerness, 1984; Tronto, 1987, 2011; Himmelweit, 1995, 2007). Were it simply a special type of activity (such as preparing meals, cleaning, laundry, shopping, etc.) caring labor would require no reference to the beneficiaries of care and could then be priced in terms of similar services provided by the market. In contrast, if caring labor was distinguished by the motivation involved in carrying out those activities – the desire to benefit others or the caring aspect of these activities – then it would be difficult to see how it should be priced since people are assumed to be motivated by self-interest in markets. This would be inconsistent with what most people believe to be true about people who engage in caring labor, namely that they have genuine concern for those they care for. It also would imply that people who perform caring labor in the marketplace (nurses, child care workers, teachers, etc.) have no real concern for those they care for, seeing them only as means of promoting their own self-interest. Both conclusions, that is, would explain caring labor by denying that they involve caring! Thus the general consensus among feminists is that it made more sense to say that caring labor is distinguished by having a particular kind of motivation rather than being a special type of activity.

This means that explaining paid caring labor in markets solely in terms of self-interest is a mistake, and that understanding paid caring labor requires showing how people somehow balance the self-interest incentives markets generate and their concern for those they care for. Our approach, then, is to distinguish caring labor markets, where people do have a significant regard for others, from other labor markets in which there is little need to have any special regard for those with whom one interacts. This distinction of course is not as clear as it might seem, because many personal services not customarily thought of as involving caring labor (for example, legal and tax services) also involve provider concern for clients. Moreover, in many long-term business relationships people develop a personal regard for others, something akin to if not identical with caring concern. So it is better to think in terms of a spectrum of markets ranging from those in which care and concern for others is an unmistakable characteristic of the activity involved to those where self-interest alone seems to operate. Nonetheless, in order to isolate the distinctive nature of caring labor, which we believe is central to the provider–patient relationship, we follow feminists in sharply contrasting caring labor markets from most ordinary market transactions.

We put this more strongly, then, by saying that caring labor has the unique feature that those activities which care for others involves are inseparable from caregivers' caring attitudes. Having a caring attitude, that is, involves not just an orientation on the part of the caregiver, but also a personal engagement with the overall wellbeing of the recipient of care. Feminist economists have given further meaning to this idea of personal engagement by characterizing caring labor as that activity which provides "a face-to-face service that develops the human capabilities of the recipient" (England *et al.*, 2002: 455). That is, a caring orientation on the part of the caregiver engages the care recipient not just in terms of whether that person's immediate needs in a caring transaction are addressed, but in a longer-term way where the caregiver is concerned with the overall lifetime capabilities of the recipient beyond the immediate occasion of care. Human capabilities can then be defined as all the different ways in which people can be and function in life across the many different activities they choose to pursue (Nussbaum, 2011; Sen, 1993). Thus a caring concern for the development of a person's capabilities is essentially a concern for the person as they choose and hope to be in life. We thus turn to health capabilities as an especially important set of human capabilities in Chapter 7.

We saw a similar view in Mooney's understanding of health care as involving commitment on the part of the care providers to patients. Mooney also emphasizes the personal nature of health care associated with the direct interaction between providers and patients. What feminists add to this, then, is an explicit emphasis on the care relationship being anchored in concern for the recipient's lifetime wellbeing rather than short-run care needs. This deepens the concept of care by making the person receiving care the subject of care. Regarding caring labor as only a specific type of activity or set of things caregivers can be described as doing can thus be misleading. For feminists, caring labor depends on a particular type of motivation, namely one that makes the caregiver's commitment to the wellbeing of the care recipient fundamental.

Needless to say, this dimension of care is not particularly evident in a world explained primarily in terms of markets. What gets counted in markets is what is directly transacted, for example in markets for health care the delivery of a specific set of health care services such as clinic appointments, diagnostic tests, inpatient care, etc. For feminists, consequently, the aspect of care which distinguishes caring labor – the concern for the person receiving care – is not only not valued by the market, but also goes largely unrecognized in its contribution to social welfare. In standard economics, social welfare is explained in terms of private goods which are consumed individually and public goods which are consumed collectively. Compared to private goods, however, public goods contribute to the wellbeing of large numbers of people whether or not people contribute to their provision. This gives rise to the well-known problem of non-contributors free riding on what contributors provide. In terms of caring labor, then caregivers are contributors to an important public good, because the care they provide to individual people has additional wide-ranging benefits for society as a whole. Clearly many people benefit when others are healthy, well-educated, and able to participate in civic concerns. But the public good contribution caregivers make goes largely unrecognized when caring labor is seen as only a type of activity or set of labor services transacted in markets. As a result, society's willingness to support caring labor is undermined (England, 2005). In effect, the market-centric view of caring labor makes it difficult to appreciate the non-market reach and social importance of caring labor, particularly in terms of the long-run contribution it makes to a well-functioning society of healthy people.

Feminist economics and social science are often thought to explain care strictly in terms of gender and women's caring labor. That is, a common misapprehension is that care is an activity that basically only women provide. But while caring labor has indeed been disproportionately provided by women, whether as unpaid labor outside markets or as paid labor, there is no reason to say that men cannot or do not perform caring labor, and thus see caring labor as a distinctive type of activity in virtue of its motivation and orientation toward its beneficiaries rather than as deriving from biological characteristics (Nelson, 2013). Caring labor is obviously carried out by men in a variety of market and non-market activities, including health and medical care. Indeed, Julie Nelson (2016) insightfully seeks to reclaim the term "husbandry" as a masculine-connected ethic and practice of care. We thus see the feminist contribution to the explanation of care as emphasizing the importance of human concern for others as inseparable from the provision of care. This is central to our relational conception of care that constitutes our basis for an alternative health economics.

The following chapter, then, broadens and deepens what the care concept involves by examining its explanation by social scientists and philosophers who have seen it as central to the human condition. We use this discussion to frame our treatment of health capabilities that follows in order to explain health care as directed to enhancing people's health capabilities.

Notes

1 Evensky's article misspells Smith's birthplace. "Kirkaldy" is not "Kirkcaldy." As far as we are aware there is no "Kirkaldy" in Fife, Scotland. There is, however, a "Kirkcaldy."

2 Samuels identifies four domains to Smith's approach to moral philosophy: natural theology, ethics, justice, and concern for wealth (expediency). Ethics was explored in the *Theory of Moral Sentiments* and plutology in the *Wealth of Nations*.

3 Michael Meranze (2016) observes that the notable eighteenth-century psychoanalyst Donald Winnicott argued that medical and religious practice had a shared denominator: cure. For Winnicott, at the root of cure was care. He viewed them as equivalent. Meranze highlights how "cure" and "care" do not have a shared etymological heritage. The former is derived from French with Latin roots, while the latter (care) is descended from Old German. Yet, Meranze observes, Winnicott identified a close relationship between cure and care that meant they had a shared dependency – could there be one without the other? This is illustrative of the discourse about the nature of care in medical (and religious) circles around the time of Smith's work. It is beyond the scope of this book to speculate on how much this influenced Smith's thinking on care.

5

CAPTURING CARE

> "In general, caring will always create moral dilemmas because the needs for care are infinite."
>
> (Tronto, 1993: 137)

5.1 Introduction

Care is obviously a broad term, and in this chapter we seek to explore the dimensions and properties of care, the centrality of care to humanity, and the controversies of defining and describing its scope. In Part III we examine the moral imperative of care, and its implications for reconfiguring health economics. There is, we feel, good reason for this since, as Wendy Holloway (2006) observes, the care literature (or literatures) is extensive and therefore deserving of considered – "careful" – analysis in the context of a health economics centered on "care." In her research, Holloway identifies two groups of care literature (interestingly, economics does not explicitly feature). For her, there are philosophical, social work, and social policy literatures – the latter is, she argues, advocacy-directed in a bid for securing greater caring resources. This clearly evokes the potential for an economic perspective, to which, of course, we hope to contribute. Perhaps Holloway's description can be further nuanced: philosophical contributions to the nature of care have come from feminist theoretical approaches that encompass politics, sociology, and economics; other subjects include geography, education, medicine (especially nursing), anthropology, theology, and so on (see, for example, Baier, 1982; Blustein, 1991; Churchland, 2011; Engster, 2005; Fisher and Tronto, 1990; Folbre, 1995; Folbre and Nelson, 2000; Gilligan, 1982; Held, 2006; Mol, 2006; Morse *et al.*, 1992; Nelson, 2016; Noddings, 2003; Tronto, 1993, 2013; van Staveren, 2001; Watson, 2008; Yeates, 2011).

In examining these contributions, we orient our analysis to the development of a challenge to standard health economics, and therefore advance the arguments presented in Chapter 4. In doing so, we draw upon the renowned and pathbreaking philosophical works of Martin Heidegger and Michel Foucault in emphasizing the centrality of care to humanity, without any wish to be drawn into debates concerning the efficacy and attractiveness, or otherwise, of poststructuralism and postmodernism usually associated with Foucault's work. Our intention is rather to acknowledge the role of both Heidegger and Foucault in emphasizing the significance of care as an analytical focus.

More importantly, for us, the understanding of care has been advanced by the subsequent and extensive feminist literature on the subject. This literature, in particular, investigates the various asymmetries in care: caring is heavily gendered, and invokes notions of need, dependency, and capacity. Some theorists, such as Nel Noddings (2005), argue that care is highly gendered, given that biology and society privilege mother–infant as the archetypical caring relation. It is partly a function of (mammalian) biology that infants are inculcated to the notion that females are more caring (and more capable of caring) than males. From this perspective, care is confined to the private (household) domain, and in a male-dominated society becomes under-valued and marginalized. Care is also associated with "soft" skills, such as empathy, and hence is feminine. Thus it is at once instinctive and socially constructed and hence reflective of prevailing power relations in society. In her latest book, *Caring Democracy*, Joan Tronto (2013) argues that society – she concentrates her analysis on the US context – is subject to a "caring deficit": the needs for care outweigh the capacity and capability to meet those needs. Of course this invites the question as to which caring needs *should* be addressed and by whom? Who decides? For Tronto these questions cannot be disentangled from issues of justice and power.

Within the context of medical care, as Chapter 2 explored, the biomedical conceptualization of care is contested in that it is predicated on a profoundly Cartesian grounding and a reductionist medicalizing approach to illness and disease. The work of Jean Watson in nursing science is especially prominent in articulating the tensions between caring as "*caritas*" and the "technologically high-paced, task-oriented biomedical practices and institutional demands" (Watson, 2009: 467) of conventional Western medical practice. Watson's approach resembles Noddings and others in its emphasis on caring as a profoundly relational process embodying various caring practices imbued with caring values. Indeed, Watson established the non-profit Watson Caring Science Institute and International Caritas Consortium (http://watsoncaringscience.org/) in 2008 to promote a relational ontology of caring in medical services. The Institute's mission statement is:

> To restore the profound nature of care-healing and unify with stewardship the current health system to retain and nurture its most precious resource, caring professional and transdisciplinary care team members. (http://watsoncaringscience.org/)

Similarly, Annemarie Mol (2006) contrasts the humane property of care with a cold, unfeeling technology, yet while contending that the two are not mutually exclusive. Mol's critique instead centers on the inconsistencies of patient as consumer and consumer choice with care. For Mol, framing the patient as a consumer is reductionist in that it relegates the personal ontology of caring.

We believe the foregoing contributions provide grounds for extensive reflection about the basis and trajectory of standard health economics. We also agree with Tronto and Watson in their arguments that care and economics need not be inconsistent. However, the present emphases of the mainstream approach do not instill confidence. The remainder of the chapter is structured as follows: we initially consider the definitions of care and note the emphasis on care as practice. The importance of care in the philosophical approaches of Foucault and Heidegger are briefly outlined in the following sections. Both identify an existentialist dimension of care in emphasizing care of the self. From here the chapter considers the aims of care and caring, noting its reproductive quality. Conceptualizing care as phases and distinctive types is then discussed.

5.2 An overarching definition of care?

Care and caring possess ambiguous and hence, to some extent, contested qualities. Care may express feelings of intimacy and love, or it may be synonymous with a burden or some sort of concern. In this section we reflect on various approaches to defining what care is, commencing with broad definitions, primarily the overarching definition offered by Fisher and Tronto (1990), and then consider how this can subsequently frame and situate more particular definitions and conceptualizations.

The *Oxford English Dictionary* (*OED*)[1] presents at least five broad meanings for the noun "care" and at least as many for "care" as a verb. Nonetheless, the emphasis for the noun is on concern or burden. The *OED* refers to, *inter alia*, mental suffering, grief, trouble, "a burdened state of mind arising from fear," doubt, anxiety, attention, caution – as in take care – and so forth. The *OED* traces the term to the Germanic languages, in particular Old Norse references to "bed of trouble or sickness." Etymologically, it is not related to *caritas* – the Latin word for charity. However, the *OED* does note the breadth of the term in referring to care as having desire, inclination, or a liking *to* or *for* something. Also noted is "care of" signifying having "charge or oversight with a view to protection, preservation, or guidance," where to have care of something is to "look after it." A related formulation refers to "in need of care," especially with reference to a destitute child requiring protective guardianship. It appears that over time the term has broadened in its meaning. While the *OED*'s definitions acknowledge the breadth and multiple meanings of care there is less emphasis on caring practices. Interestingly, by contrast, the care literature, to our knowledge, emphasizes the inclination, responsibility, and *practices* of care. For instance, Tronto has long defined care in broad terms:

> On the most general level, we suggest that caring be viewed as *a species activity that includes everything that we do to maintain, continue, and repair our "world" so that we can live in it as well as possible.* That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex

> life-sustaining web. (Fisher and Tronto, 1990: 40; Tronto, 1993: 103; Tronto, 2013: 19, original emphasis)

There are a number of striking aspects to this definition. First, as noted, the emphasis lies in practice or activity. Fisher and Tronto's care as activities are intentional and goal-directed – the goal being to live "as well as possible." With this goal the Fisher/Tronto configuration, prima facie, appears to resemble the neoclassical economic dictum of utility maximization. Both seem to imply a striving for optimality subject to constraints. To be sure, on this basis it could be argued that the *OED*'s reference to care as burdensome may represent a set of constraints to utility maximization, whereas the Fisher/Tronto conceptualization could refer to its pursuit. Second, why is care defined at "the most general level"? Held (2006), for example, is critical of such breadth, arguing:

> This definition seems almost surely too broad. Vast amounts of *economic* activity would be included, like retail sales, house construction, and commercial cleaning, and the distinctive features of caring labor would be lost. (Held, 2006: 31–2, emphasis added)

Of course, more activities could be added to Held's list – even the financial crisis could be located within a caring narrative! Instead, for Held, care is a labor that is intrinsically relational and potentially transformative; it involves reason and emotion, and is directed at particular others in addressing their needs. There is, in Held's view, an emotional commitment in caring (see also Cancian and Oliker, 2000) which, she argues, is not captured in the breadth of Fisher and Tronto's definition. Held's allusion to "economic activity" implies a dichotomy between care and economics – the economic domain is seemingly devoid of the emotional dimension of care. We are uncomfortable with such a binary. As we have reiterated throughout this work, for us the economy is embedded in the social world. We are skeptical of attempts to neatly separate the two spheres. As Karl Polanyi (1944) argued some time ago and as Michael Sandel (2012) more recently and adroitly articulated, there is also a danger that a market economy may translate into a market society. This may be underpinning Held's position. Yet Polanyi (and Sandel) never argued that one sphere would completely dominate the other – in Durkheimian terms, there is no purity. By Held's argument there can be no care in "house construction" and "commercial cleaning," but surely this rather overlooks the *possibility* that those involved in producing such commodities may *care about* what they do and how they do it. Certainly, as we have argued, such caring may be subject to crowding out, or may become corrupted, but this is different from presenting a proposition between "caring" and, by implication, economic activities. Julie Nelson (2016) also notes that there should be no bifurcation between care and the economic domain. Indeed, she argues that this is unhelpful in that it serves to sentimentalize and marginalize care in economic thinking.

However, there is another aspect of Held's view that warrants further reflection. As noted, there may be some commonality with neoclassical economics in the generality sought by Fisher and Tronto. The basis of some arguments and defenses of the utility maximization assumption relates to its alleged ubiquity – every action and every living entity endeavors to maximize utility (see Hodgson, 2001). Of course, as Hodgson argues, the great problem with such a position is that it absolutely fails to explain differences and specificities and geographical and historical contingencies. Ultimately, and ironically, utility maximization as a scientific proposition becomes unfalsifiable; its auxiliary assumptions carry the burden of testability. Does the Fisher/Tronto definition of care demonstrate a similar property? The appeal to the "most general level" and the allusion to "everything that we do to maintain, continue, and repair …" appears to have some correspondence with the desire to attain a covering law. However, according to Tronto, the breadth of the definition should not be interpreted as implying that care is homogenous, nor that it is necessarily always good. She states (2013: 19):

> In arguing that care is an activity, a kind of practice, we (Fisher and Tronto) left open the possibility that there might be other forms of care that are not on this "most general level." Thus, it is possible to think about other ways to understand the meaning of care as more specific caring practices that are *nested* within this larger practice of care. (Emphasis added)

Thus Tronto appears to be trying to establish an overarching definition of care within which particular and contingent activities and practices of care may be situated. In doing so she acknowledges that narrower definitions are "useful" in more specific contexts. Moreover, Tronto's attempt at providing an embracing, abstract definition is recognition that, unlike utility maximization,[2] care is indeed ubiquitous, as we explore in section 5.3. At a more general level, Geoff Hodgson (2015) is highly supportive of the academic benefits of broad definitions. He contests that objecting to a definition on the basis of its breadth is "misguided." Definitions do not imply perfect correspondence, but suggest some commonality of essential characteristics, which may be further refined into sub-sets. Hodgson highlights how "institutions" include firms, language, political structures, and so forth. All are different, yet demonstrate the essential features of an "institution." Matthias Klaes (2004) makes a similar argument in supporting "evolution" as an umbrella term. Indeed, in discussing care, Held (2006: 3) herself readily observes:

> It [care] has the potential of being based on the truly universal experience of care. Every human being has been cared for as a child or would not be alive.

We thus find that the Fisher/Tronto approach in providing an overarching frame is a highly effective analytical entry point. We accept that it is extremely broad and therefore may be susceptible to criticisms, such as those expressed by Held, but for us the significant aspect of the definition is that it signifies the centrality of care to human (and other species') activity, and therefore raises a number of questions about the organization of institutions that may enhance the caring prospectus – the assumption being, of course, that care is generally a good thing. In particular, such a manifesto provides a platform counter to the market-oriented, efficiency rubric of standard health economics.

Moreover, there is for us a correspondence between the Fisher/Tronto emphasis and other approaches, such as the "Instrumental Valuation Principle" (IVP) and the capabilities approach.

The IVP is derived from the work of the pragmatist philosopher, John Dewey (1963), and advocated by institutionalist economists such as Warren Samuels (1995) and Marc Tool (1995). The capabilities approach is associated with the pioneering work of Martha Nussbaum (2011) and Amartya Sen (2009). We substantiate our analysis and claims about care and capabilities in later chapters. However, it is worthwhile noting here how Fisher/Tronto resonates with the IVP in particular – though this potential association has not, to the best of our knowledge, been explored previously. The essence of the Principle is that the value of actions and decisions should be focused on the maintenance of human life. As Tool (1995: 23) states, the Principle recommends that we should:

> Do or choose that which provides for the *continuity* of human life and the noninvidious re-creation of community through the instrumental use of knowledge. (Emphasis added)

For us the emphasis on "continuity" in Tool's rendition of the IVP has an obvious resonance with the Fisher/Tronto references to "maintain" and "continue." It is this reproductive feature of care that has been highlighted in the feminist literature with Streuning (2002: 87), for example, describing care as a social practice which is "essential to the maintenance and reproduction of society." Other references to this effect have been made by Annette Baier (1994) and Eva Feder Kittay (2001a, 2001b) among others. Perhaps in echoes of Marx, Sibyl Schwarzenbach (1996) frames this in terms of what she calls "reproductive labor," which refers to "rational activities" such as addressing others' needs, for example cooking meals, administering medicines, etc., that maintain or preserve a set of loving relationships between individuals over time. By contrast, productive labor concerns the acquisition of resources that enables individuals to engage in reproductive labor (for example, Meillassoux, 1972; Thomas, 1993). In this respect productive labor only has an indirect bearing on the reproduction of human life, i.e. through reproductive labor (care).

From the perspective of the discussion so far, Schwarzenbach's bifurcation of productive and reproductive labor offers two notable points of interest: it privileges care as the principal means for the maintenance and reproduction of human society, and it appears to reiterate the basis of Held's criticism of the broad formulation of Fischer and Tronto's definition of care.

First, by placing care at the center of reproduction Schwarzenbach emphasizes an existentialist dimension to caring. This claim echoes the work of Martin Heidegger. In *Being and Time*, Heidegger (1962) argued that care was a prerequisite to being-in-the-world. Other prominent philosophers, such as Harry Frankfurt (1988) and Baier (1982), have also emphasized the importance of care in this context.

Second, similar to Held's outline of "caring" labor, Schwarzenbach's distinction between reproductive and productive labor is arguably based on a reductionist account of care as solely other-regarding. Certainly, the relational aspect of care is significant, and the literature emphasizes this, but confining reproductive labor to other-regarding implies the marginalization of self-care. Indeed, Held's references to "retail sales, house construction, and commercial cleaning" (2006: 31–2) noted above may be manifestations of self-care, as may be the case with the greed of certain individuals that contributed to the financial crisis. Arguably, this may not be entirely consistent with Carol Gilligan's (1982) rights-based argument that care of the self is entirely legitimate. In this context Gilligan (1982: 129) referred to the feminist argument that self-development was a "higher duty" than self-sacrifice. Gilligan's invocation of a rights-based approach clearly appeals to a moral imperative in care and, more specifically, care for the self.

Perhaps more contentiously, a further aspect emerges in this narrative: *disregard* for the other does not necessarily mean the absence of care. It may imply activity incommensurate with the wider "common weal," but not, to paraphrase Fisher and Tronto, the maintenance and continuance of an individual's "world," *as the individual sees it*. This is not to say that the individual is utterly misguided, but it is another thing to argue that individuals don't care at all. In other words, there is the potential for care to be inappropriate and for there to be tensions within caring activities, which we investigate further in section 5.5 below.

Interestingly, Patricia Churchland's (2011) recent work on morality and neuroscience argues that the basic survival instinct is founded on self-preservation, i.e. care. She states, "In the most basic sense … *caring* is a ground-floor function of nervous systems" (2011: 30, original emphasis). Holloway (2006) questions the notion that the capacity to care is natural. She argues that the acquisition of the morality that is a prerequisite for "good" care is a complex process associated with psychological development. Again, the ambiguities and the nuances of care are revealed – what is meant by "good"? Churchland's reference to care as a capacity is not necessarily related to any correspondence with the morality of good – it is rather more primordial than that.

5.3 Care of the self

Churchland's approach recognizes the interlacing of care and the self, which, of course is a particular dimension of the Fisher/Tronto understanding. It also reflects the earlier pioneering works of Heidegger and Foucault (for example, Holloway, 2006; Noddings, 2005; Tronto, 2013).[3] Here we briefly consider the potentially existentialist nature of care before analyzing the potential functions of care that may be drawn from Schwarzenbach's notion of reproductive labor, and then identify the phases of care.

5.3.1 Heidegger: care as existentialist

Martin Heidegger's contribution to twentieth-century European philosophy, especially existentialist and phenomenological explanations of ontology, is well documented, and his influence extends to architecture, psychotherapy, cognitive science, and literary criticism (for example, Wheeler, 2013). His most celebrated work is *Being and Time*, which was originally published during his time at Freiburg in 1927 and predates his regrettable involvement with the Nazis.

In *Being and Time*, Heidegger offers a highly abstract presentation based on his ontological rejection of the binary subject/object in much of Western philosophical thinking. Instead, he thinks in terms of *Dasein*, which loosely refers to the human state of being. *Dasein* always finds itself in a mood or state of mind. Moods are aspects of what it means to be *in* the World – it refers to our devotion to the World, our state of being. If we are depressed then the World will seem to the individual to be a dismal place (Wheeler, 2013). Moods though change with our encounters with the World. In Heideggerian terms, moods are preceded ontologically by "disposedness" – receptiveness – which, according to Wheeler, means finding things that matter to oneself. These are accompanied by other aspects of *Dasein*: "understanding" and "fascination" with the World. The foregoing is combined with notions that being-in-the-world may be conceived as "thrownness," "projection," and "fallen-ness" (Heidegger, 1962). "Thrownness" refers to individuals finding themselves in a world that matters to them, where they confront some sort of "concrete" situation. "Projection" denotes a range of possibilities for acting. "Fallen-ness" follows from "projection", where *Dasein* moves from itself as an "authentic potentiality". There is a search for novelty ("curiosity"); perhaps a loss of sensitivity to understanding and superficiality ("ambiguity"), and unexamined and uncritical acceptance of facts pertaining to the World ("idle talk") (Wheeler, 2013). Heideggerian thought further contemplates the temporal dimension so that thrownness and disposedness are associated with the past, fallen-ness and fascination with the present, and projection-understanding with the future.

Thus, for Heidegger, the fundamental basis for *Dasein*'s being-in-the-world is care. As with the *OED* definitional emphasis noted earlier, this is expressed in terms of concern. Witness *Dasein*'s aspects: disposedness, understanding, and fascination – all highlight care as concern (*Sorge*). Heidegger (1962: H56) states:

> Being-in-the-world has always dispersed itself … into definite ways of Being-in. The multiplicity of these is indicated by the following examples: having to do with something, producing something, attending to something, make use of something, giving something up and letting it go, undertaking, accomplishing, evincing …

The very essence of being is embodied in *Sorge*. Moreover, Heidegger differentiates between the individual and the collective – the authentic (my) and inauthentic (they) selves. Conforming with others – being-with-one-another – threatens to "dissolve" the individual's *Dasein* (Wheeler, 2013). According to Wheeler, of the dimensions of care – thrownness, projection, and fallen-ness – it is the latter that ensures the uniqueness of the self; it is not a mode of others. Wheeler states: "as a mode of the self, fallen-ness is … part of Dasein's existential constitution. It is a dimension of *care*, which is the Being of Dasein" (2013: 2.2.7, emphasis added).

In this very brief account, the Heideggerian conception of care is centered on the individual in existential terms, where the individual acts as both caregiver and receiver. Ignoring care, in essence, leads to the disappearance of the individual. As with feminist explanations, care is multi-dimensional. Heidegger's analysis further acknowledges a place for valuation – for example, note the allusions to "having to do with something" and making "use of something," as well as references to novelty and fascination. For us this suggests a sense of care about our surroundings and our situation, our sense of being – emotion (as in the key role of mood), a temporal aspect (Wheeler, 2013), and disposition. Moreover, and importantly for our later argument, the basis for Heidegger's position suggests the individual is socially embedded. As Wheeler notes, Heidegger's conception of mood follows from what it means to be *in* the World; moods are not subjective additions to this "in-ness." Given an individual's relations with others – as demonstrated by Heidegger's authentic and inauthentic selves – individuals are open to others (arguments, conversations, etc.): "being-with-one-another" and hence our moods are socially conditioned. Thus, while Heidegger's work focuses purposefully on individual *Dasein*, this individual is not socially isolated. Care of the self occurs in a socially embedded ontology.

In her analysis of care and education, Nel Noddings (2005) acknowledges that her approach is in the Heideggerian tradition in that care is inevitably ontological, and that it is a complex activity where an authentic caring attitude is partially influenced by experience. Noddings argues that in order to ensure authentic care, such experience should challenge every individual. She talks in terms of "accusation, confession, forgiveness, and penance" (2005: 95). There is an obligation that, in education, the practices of caring should instill such an orientation in other individuals. Similarly, in a series of publications, Patricia Brenner (1984, 1994; Brenner *et al.*, 2009) stresses the centrality of experience and the development of caring. She readily acknowledges the influence of Heidegger on her work on the development of nursing practice and ethics. Heidegger (1962) suggests that the individual learns from unexpected and disappointing outcomes by asking such questions as: "why did this happen? why is this happening? what should I have done?" and so forth. From such critical reflection, the individual attempts to establish possible causes in their quest for knowledge. In effect, practice and experience inform knowledge. Brenner utilizes this insight to interpret and make sense of her empirical studies of the development of nursing skills (Brenner, 1984). She establishes five stages in the acquisition of nursing skills: "novice," "advanced beginner," "competent," "proficient," and "expert." Each stage is typified by reflection on practice by the individual. The key role of knowledge has some appeal in this analytical approach.

Nonetheless we concur with Tronto's (2013: 48) criticism of such Heideggerian framing to care. The focus on the individual implies a privileging of the individual's disposition as opposed to the relational and social dimensions. Also, the Heideggerian approach remains abstract – it conveys a sense of being necessary, but is not sufficient for the practices of care. We develop this further in Chapter 6.

5.3.2 Foucault: power, knowledge, and care of the self

Similar to Heidegger's emphasis, the later work of Michel Foucault – *The Care of the Self* – provided an important contribution to the analysis of the socially embedded individual.[4] Here though, arguably, the similarity becomes strained, as Heidegger's concern centers on the abstract *Dasein*, whereas for Foucault the intractable web of power and knowledge is the crux.

Foucauldian analysis identifies the nexus of power and knowledge as the centerpiece of the study of human society (for example, Foucault, 1986; Frank, 1998; Gutting, 2005, 2013; Sybylla, 2001). Throughout his works Foucault identified "circuits" of power-knowledge-practice as critical to the production of the self. For Foucault, modern "disciplinary" society is controlled by three interrelated and mutually supporting principal techniques: hierarchical observation, normalizing judgement, and the examination.

Hierarchical observation through, for example, surveillance is an incredibly powerful instrument, according to Foucault. Thus the rows of seats in a stadium can afford spectators a great view of the arena, but they also enable easy surveillance of the spectators themselves (Gutting, 2013). There are obvious examples from Bentham's proposed "Panopticon" in prison architecture to the delivery of medical care in a hospital or other facilities. Of course, the implication for trust along the hierarchy is a moot point. The awareness of the potential of being observed may instill "appropriate" or "normal" behavior by the individual. Obviously the normalization of behavior may be seen as consistent with the existing power structure of a society as demonstrated by a society's norms and standards – as well as its laws. In effect, there is a corrective for deviance. Thus, in Western societies in particular, there are standards for myriad activities and services, such as curriculum requirements in educational programs to accounting standards to the provision of medical care services, for instance under the auspices of evidence-based medicine (see McMaster, 2008). From our perspective the standardization of care and caring practices is of clear significance. As we argued in Chapter 2, this may reinforce particular approaches to medical care, especially the biomedical approach, and by the same token marginalize others, such as social medicine. It may be further buttressed by the "examination," such as of students in an educational establishment or patients in a medical care setting, which in Foucault's analysis instills particular establishment-legitimated knowledge, thereby controlling behavior, and therefore acceptance of establishment-legitimated truth. Foucault's position emphasizes that:

> The power inherent in knowledge is to convince people to seek to become certain sorts of selves and to institute practices … that promise to effect the transformation of self. (Frank, 1998: 335)

As Foucault himself argues:

> The principle of care of oneself … took the form of an attitude, a mode of behavior; it became instilled in the ways of living; it evolved into procedures, practices … (1986: 44)

From this perspective, as noted in Chapter 2, the medical patient is dependent upon the legitimate knowledge of the clinician and is expected to adopt the role of compliant patient, a passive recipient who may not even be aware of the medical diagnosis that sets in place a treatment template. Foucault (1986), however, sought to challenge such passivity.

In *The Care of the Self*, Foucault (1986) was not interested in defining "care of the self" per se, but in analyzing the practices associated with the terminology. Care for the self concerns the issue of individual identity and the ability to effect transformation of self within the power-knowledge-practice circuits, and is thus influenced by "technologies of the self." In this context, technology refers to certain knowledge that may potentially be used by the individual to transform the self to attain a certain desired state or states. There are echoes of Heidegger's notion of care as a concern of individual being, although in a Foucauldian framing the "production" of selves, or the self, in a more overtly power nexus assumes greater prominence. It also implies that the individual is transformed by being empowered and is therefore free to be curious and creative, and therefore challenge hierarchical power structures. Therefore Foucault's approach articulates care in an affirmative mode, raising the prospect that not only is care ubiquitous, but that we may potentially perform roles as caregivers and most certainly as care-receivers. The importance of practice in Foucault's thought makes the notion of care transformative and hence normatively laden.

Foucault's significance in the development of the postmodernist movement is well recognized (for example, Bertens, 1995). Postmodernism (and the closely related post-structuralism) remains controversial in the history of ideas. Our coverage of Foucault is not necessarily an endorsement of a postmodernist approach. Nonetheless, there is much in this that holds some appeal: its rejection of over-generalization, deductivism, and reductionism allied to its promotion of pluralism – variety in dialogue – are attractive qualities to some non-mainstream economists (Cullenberg *et al.*, 2001). Also, its criticism of the notion of the atomistic individual embodied by mainstream economics and the presentation of a socially embedded individual, where social processes may transform and hence constitute part of an individual's identity (Davis, 2001), has considerable affinity with the arguments we develop here. Yet the idea that each individual creates their own reality and a rejection of essentialism does not accord with our own views, which are closer to a realist orientation that, to paraphrase John Searle (1995), the world exists independently of our representations of it.

5.4 The aims of care

From the foregoing it may be argued that one aim of caring lies in the realm of (re)production. While Heideggerian and Foucauldian approaches concentrate on the self, their endorsement of the individual as socially embedded entails a significant relational dimension. As we have acknowledged, feminist thought emphasizes this in its conceptualization of care. For instance, Selma Sevenhuijsen (2000) expresses care as process, practice, activity, and other-regarding. She contends:

> Care [is] … a social process and … a daily human activity. It should be seen as a human practice that entails a moral disposition or a set of moral orientations oriented at the question of how needs should be interpreted and if and how they can be fulfilled. (2000: 12)

Sevenhuijsen's definitions anticipate our later discussion of the normative dimensions of care and caring, and also reiterate the Fisher/Tronto reference to activity – an important aspect of care is 'doing.' In Sevenhuijsen's depiction, as with the feminist approach more generally, this set of activities is directed at another, and focuses on addressing the perceived needs of the other: an *aim* of care and caring. In terms of identifying caring activities or practices the foregoing definitions imply a multitude of potential acts. For instance, caring acts may range from nurturing, as in the paradigmatic–infant relation, to offering or having affection, sympathy, or empathy for someone, to listening, to having an interest, to having responsibility, to the discharge of acts such as changing nappies or dressings, to cooking, and so forth, where those acts may be associated with a particular role and the responsibilities entailed by this role.

Drawing from Schwarzenbach (1996), Daniel Engster (2005, 2007) usefully presents three basic aims of caring: individual survival, development, and social reproduction. In delineating these aims, we feel that Engster provides an insightful augmentation of the Fisher/Tronto definition and Sevenhuijsen's expression of caring, and moreover, perhaps, situates Heideggerian and Foucauldian thinking about care for the self within this broader framework.

With individual survival Engster adopts a more pragmatic orientation than that associated with Heidegger's *Dasein*. Here Engster's emphasis is on care for the self and others in terms of species function, i.e. addressing basic biological needs, such as food, clean water, shelter, rest, basic medical care, and protection, and for children comforting contact.

The second aim is development, which involves enabling *others* to develop and sustain sufficient capabilities for basic functioning in society. Among the "capabilities" Engster refers to are emotion, movement, speech, reason, imagination, ability to affiliate with others, and so forth. He also includes literacy and numeracy. Engster explicitly differentiates his list of capabilities from the list of capabilities advanced by Nussbaum (2011). The rationale is that Nussbaum's list of capabilities has been criticized as being elitist and for potentially imposing Western "bourgeois values" (Engster, 2005; Okin, 2003). Accordingly, Engster expresses a strong preference for assisting individuals to develop and sustain what he terms "basic or innate capabilities." He considers this to be equivalent to Nussbaum's "Innate equipment … necessary for developing more advanced capabilities, and a ground for moral concern" (Nussbaum, 2000: 84, cited by Engster, 2005: 52), but even "more basic" than John Rawls' (1971) list of primary goods – rights and liberties, opportunities and powers, income and wealth, and self-respect necessary to realize an individual's plan of life.

Engster's third aim is to help individuals avoid pain or to relieve the suffering of those in pain in order to enhance their capabilities to live life as well as possible. As he readily acknowledges, there is overlap here with the first two aims, but this is only partial given the stress on pain avoidance. From our perspective, the third aim privileges an intimate relationship between health and care, and identifies the importance of health to the enhancement of human capabilities. This may seem obvious, but the functional importance of conceiving care in a developmental role is worth emphasizing as it prompts a more economic orientation in reflecting on the value of care and caring. It also echoes Heidegger's existentialism, since care, by virtue of its foundational role in enhancing development, must surely then contribute to the wider performance of an economy – even if the assessment is made through conventional measures. On this basis, Tronto's "care deficit" has potentially significant economic implications. Absent or de-emphasizing Engster's second and third aims and the implications for well-being – even in standard economic terms – seem substantial.

Interrogating Engster's third aim then invites an analysis of the particular aims of care in the medical domain – a subject touched on in Chapters 2 and 3.

5.4.1 Medical care: Watson's caritas

In medical care an obvious aim is cure, but as Chapter 3 demonstrated, there are many instances of palliative caring, for example where pain relief and other aims, such as the preservation of dignity, assume overriding importance. Similar issues arise in therapeutic care. The distinctiveness of caring categories in medical caring explored in Chapter 3 not only acknowledged the array of delivery levels of medical care, but also the dominance of the biomedical model in shaping such arrangements. Chapter 2 set out the nature of and challenges to this biomedical framing of health and illness. Its Cartesian basis suggests that medical practice is, or should be, aimed at fixing "broken or malfunctioning machines" and treating the source of such deviance as somatic.

This rather monochrome characterization of medicine has been challenged by Jean Watson (2006, 2008, 2009). In her work, Watson has sought to question the standard biomedical perspective on the aims of medical provision. She, as noted, has established the non-profit Watson Caring Science Institute and International Caritas Consortium to promote a relational ontology of caring in medical services. She is prominent in the nursing literature for advocating a relational approach in the delivery of medical care, appealing for it to be transformed into a "*caritas* process." The traditional Cartesian dichotomy is rejected and Watson's work highlights the potential importance of "spiritual practices" in the healing and caring processes. Thus, for Watson, a principal aim of medical *care* is "assistance with the gratification of human needs" (Watson, 2008) in ways that foster a trusting relationship between carer/medic and cared-for/patient, "honors the unity of the whole human being" (Watson, 2006: 51), and preserves dignity, relationships and integrity (Watson, 2006, 2008).

Moreover, Watson is careful to distinguish between caring as "healthogenic," i.e. emphasizing overall physical, mental and social functioning, and freedom from illness, and curing with its biomedical overtones. Yet, importantly, according to Watson's analysis, "the science of caring" is complementary to "the science of curing" (Watson, 2009). Indeed, following her argument the latter may be partly conditional on the former.

Interestingly, Mol (2006)[5] explicitly seeks to avoid distinguishing between "care" and "cure." For Mol, care resides in activities that make or aim to render "daily life more bearable" (2006: 1), while cure concerns the possibility of healing. The two sets of activities overlap to such an extent, according to Mol, that there is little point in distinguishing them. For example, Mol argues that "caringly dressing a wound may help its cure" (*ibid.*), and that as many illnesses are chronic there is no cure, by definition. On this account, cure becomes a subset of care, and its aims are accordingly subsumed within Mol's aim of "making life more bearable." By contrast, Watson conceives of care and cure as overlapping but distinct entities, with care augmenting the possibility of cure. While both authors appear to understand "cure" in the same way, their discussions of care and hence its aims exhibit some differences: Watson emphasizes the relational dimension of care and hence its *caritas* attribute whereas Mol's emphasis lies in caring activities, accordingly with less reliance on a certain behavioral disposition. Nonetheless, like Watson, Mol does recognize the importance of respect, and is critical of the linear biomedical conception of the treatment process (see Chapter 2; also Groopman, 2007). The obvious similarities cannot camouflage the nuanced difference: by delineating care and cure as distinctive and complementary domains, Watson's approach may offer a less radical challenge to the biomedical model than Mol's. Arguably, following Watson's rationalization, a cheerful and kindly (female) nurse augments the "science of curing" delivered by the clinician presumably trained in biomedicine. With Mol, care subsumes cure. Might this represent a more sustained challenge to biomedical dominance of the conception of medical "care"?

Further, both Mol and Watson offer prospectuses that seem consistent with Engster's broad aims of care. Mol's reference to "making life more bearable" is consistent with Engster's allusion to relieving pain. Watson's notion of "healthogenic" corresponds to the wider perspective of enhancing capabilities. Therefore Mol and Watson are clearly broadly aligned in their conceptions of the aims of care, yet their distinctive emphases prompt questions over the realization of those aims. Does this have any implications for the nature of health economics? To consider this question we need to further reflect on the possibility of distinctive types and categories of care.

5.5 Phases and types of care

In trying to capture the essence of care we have attempted to convey its complexity as well as its contested definition. The ubiquitous nature of care as at once instinctive and hence natural (Churchland, 2011) and yet also socially constructed, thus learned and situated in particular social practices and roles (Held, 2006; Kittay, 2001a; Schwarzenbach, 1996; Sevenhuijsen, 2000; Tronto, 2013). We have investigated how care may be manifest in a series of practices, and how care can be pivotal to individual development. Here we analyze how care as a process may be deconstructed, and further note the importance of the grammar of care in differentiating types of care and caring.

Nel Noddings' work on understanding the provision of education according to an ethic of caring has attracted substantial attention. She argues that caring relations are the foundation of effective pedagogical activity (Noddings, 1984). While citing Heidegger's reference to care as the ultimate reality of life, Noddings seems to de-emphasize care for the self in asserting that the primary interest of care is relational. She argues:

> A caring relation is, in its most basic form, a connection or encounter between two human beings – a carer and a recipient of care, or cared-for. In order for the relation to be properly called caring, both parties must contribute to it in characteristic ways. (Noddings, 2005: 15)

Despite expressing reservations about the efficacy of a systematic analysis of the requirements of care (Noddings, 1984), she does nevertheless make a number of suggestions. According to Noddings' conception, care is dyadic, and the caregiver *must* be attentive to the needs of the cared-for. Indeed, she discusses this in terms of "engrossment" and "motivational displacement" from the self to the other. She characterizes the practices of caring as a "way of being in [a] relation" as opposed to a set of specific behaviors or practices (2005: 17). The care-receiver *must* also recognize, be receptive, and respond to the caregiver. Without this, Noddings claims there would be no "completion" of care. She asserts that this is necessary citing how caregivers can become "worn-out" if the cared-for are incapable of responding or unwilling to respond. Thus her caring encounter possesses three elements:

1. A cares for B – in this A's awareness is characterized by "engrossment" and "motivational displacement" – A is sympathetic to B.
2. A undertakes some act or activity that corresponds with (1), above.
3. B is receptive, recognizes, and responds to (1) and (2).

Noddings thus presents care as a type of relationship between two individuals, one characterized by a particular set of virtues. Hence her account focuses far less on the practices of care than on the virtues of caring. There is a clear distinction between care and non-care even in regard to the same act or activity if it is not buttressed by the appropriate virtues. In other words, without (1) above, (2) is *not* an act of caring. Care then has a conditional quality that does not reside in acts. Indeed, Noddings (2002) uses the example of the Western aid program following a devastating earthquake in Afghanistan in the 1990s in which food and clothing were donated, while building materials were required yet not donated. For Noddings, the West was not sufficiently "engrossed" or "motivationally displaced" by the care needs of Afghanistan – condition 1 was not met and hence the program of Western aid cannot be considered to be an act of caring; they were more acts of superficial tokenism that betray an underlying indifference. In this way Noddings usefully introduces an examination of authentic care and differentiates it from other actions.

Watson's (2008) theory of care in nursing strongly resembles Noddings' dyadic relational emphasis. Watson conceives of "caring moments," akin to Noddings' caring encounter, that convey a "transpersonal" caring relationship embodying "higher spiritual" caring that is based on "honoring" the wholeness of mind-body-spirit of the self and of the other. It is worth quoting the Watson Caring Science Institute's (2010: 1) description of the "caring moment":

> Heart-centered encounters with another person: when two people, each with their own "phenomenal field"/background, come together in a human-to-human transaction that is meaningful, authentic, intentional, honoring the person, and sharing human experience that expands each person's worldview and spirit leading to a new discovery of self and other new life possibilities.

As the quote above demonstrates, Watson's notion of care as *caritas* invokes a particular set of values that require the caregiver to be more than merely other-regarding. Similar to Noddings' "engrossment," Watson's "intention" of "doing" for another and "being" with another in need of care demands a particular virtue. Indeed, Watson (2005, 2008, 2009) translates *caritas* as "love" as opposed to compassion or charity. This "love" requires that the caregiver "honors" the other's needs, wishes, routines, and rituals. It therefore suggests a level of intimacy that enables a fulfilling shared experience in caring. The caregiver is further encouraged to be reflective about the meaning of caring, how the carer can make a difference to their patient's life in terms of easing suffering and aiding the healing and dying processes, and in expressing their commitment to their patients. In this way the carer is supposed to attain a higher level of understanding of caring. Indeed, Watson also stresses the need for "multiple ways of knowing," which embraces science, ethics, art, the spiritual and cultural, and the aesthetic.

There is much to commend Noddings' and Watson's emphases on the relationship between virtues and caring. For instance, in treating care as process and practice, Sevenhuijsen (1998: 82) suggests:

> Care is a cognitive and moral activity in its own right. This is difficult to understand if we conceive of care solely in terms of the dichotomy between labor and love. Care is not just changing nappies, cleaning the house, and looking after the elderly; it is an activity in which the understanding of needs is central.

Held's (2006) work too envisages care as both practice and value. For instance, Held argues that through caring practices, individuals – she emphasizes children – may be transformed into "morally admirable" people. Encouraging caring practices that foster trust is especially important to Held as trust, for her, is a significant "social asset." Held's argument resembles some social capital type analyses that highlight the importance of trust to economic performance. More specifically, Held, in emphasizing this social dimension, reinforces the relational aspect of care and that caring processes may involve a host of individuals – caring is socially embedded in various networks.

By contrast, however, Noddings' and Watson's modeling of care as a dyadic relationship is, for us, rather reductionist and recalls the atomistic conception of the individual in mainstream economics as a whole and in standard health economics in particular. It appears to disregard the social domain and how this can shape caring relations. Tronto (2013) advances a similar critique with her notion of care as nested in wider care relations. The apparently dyadic relationship between clinician and patient is embedded in other complex social relationships, such as between the clinician and support, laboratory, and administrative staff. The patient also has relations with family and friends who share the same intention. In short, the individual is socially embedded (Davis, 2003, 2011). We extend our analysis and consider the implications of this further in later chapters.

Tronto (and Fisher and Tronto, 1990) conceives of care in phases, and focuses on care as labor (or as an activity or practice):

1. "Caring about": there is some recognition of unmet caring needs. This presupposes some valuation or judgement regarding what makes *x* worth caring about.
2. "Caring for": following from (1) some individual or group assumes responsibility to ensure that needs are addressed.
3. "Caregiving": the delivery of care – the act of caring; this may be a range of activities, from listening, to changing a dressing, to offering solace, and so forth.
4. "Care-receiving": response from the individual, animal, thing to which the caring activity was directed. Tronto explicitly acknowledges that a response may not be forthcoming from the recipient of care, but some assessment of the effectiveness of the actions/activities – the delivery of care – has to occur. This may be by the caregiver, care-receiver, or others.
5. "Caring with": Tronto (2013: 23) makes specific reference to the institutional framework of caring in that the context in which caring needs are identified and addressed needs to be consistent with "democratic commitments to justice, equality, and freedom for all."

The first four phases of Tronto's approach are linear and to some extent overlapping. The fifth, and most recent, does not fit the linearity of the preceding four phases and may be reflective of Tronto's overarching definition. For this reason we feel that "caring with" may be more appropriately envisaged as the first phase. If "caring with" is not reflective of Tronto's rather idealist allusions to democratic commitments then the capacity to "care about" may be eroded. Tronto's highlighting of a "caring deficit" also seems to reflect such an ordering. In effect, we believe that the judgement or valuation exercised in the first of Tronto's phases would at least be informed by the institutional context (Tronto's fifth phase). An institutional configuration that privileges a particular assortment of values, such as embodied by religious tenets, would in our view shape the recognition of what constitutes unmet caring needs.

Other authors have drawn on Tronto's notion of care phases (see, for example, Sevenhuijsen, 1998). Carse and Lindemann Nelson (1996) also identify "caring for" and "caring about" as distinctive types of care and caring, but offer rather different definitions. "Caring for" is discussed in terms of the exercise of a "moral skill" on the part of the individual in regard to how they position themselves to act in a fashion that "best" cares for what the individual cares about. As with Tronto, "caring about" assumes some valuation of what makes "*x*" worth caring about (Carse and Lindemann Nelson, 1996). This, according to the authors, need not be directed to a particular person; it may also be relevant in the abstract, for example in the future or in the situation of persons unknown. This contrasts markedly with many feminist contributions which, as we have noted, stress the centrality of the relational property of care. For instance, like Noddings and Watson, Diemut Bubeck (1995) considers that care is constituted by face-to-face encounters between a caregiver and receiver – the relational element is critical. Moreover, for Bubek the distinguishing feature of care rests on dependency (see also, for example, Engster, 2005, 2007; Holloway, 2006; Kittay, 2001a, 2001b; Kittay *et al.*, 2005). For example, undertaking a task for children who cannot meet their need themselves, such as cooking a meal, is a caring activity, whereas cooking the same meal for another adult capable of undertaking the activity is *not* care but a "service." Unlike Noddings, Bubeck further argues that the caring relationship does not necessarily involve or invoke any specific emotional attachment. This stance, however, has been criticized as reducing care to a consequentialist relation – the value of caring rests almost entirely on addressing needs with the "attitude" of the carer being overlooked (Held, 2006). In this sense the issue of what constitutes "good care" is raised – obviously a utilitarian might concentrate on the outcomes of care without the same emphasis on the "how" of Tronto's "caregiving."

In his geographical examination of care, Smith (1998) describes "care for" and "care about" in terms of beneficence and benevolence. For Smith (1998: 16) the former is a behavioural manifestation as in "doing good or showing *active* kindness" (emphasis added), whereas the latter refers to intent: "the *desire* to do good or charitable feeling" (emphasis added) (see also Silk, 2000). Again, Smith's description draws us into an examination of an "ethic of care" as well as translating beneficence into benevolence and the possible tensions between the two. For us, Jeffrey Blustein's (1991) rather overlooked[6] delineation of caring offers further insight into the nuances of the grammar of care and the possibility of defining different types of care around the notion of commitment. The significance of this enables an emphasis on the multi-dimensional properties of care (also acknowledged in the works of Smith and Tronto), and also permits recognition that some forms of care are emphatically not what may be considered to be "positive." Blustein (1991), thus, identifies four overlapping forms of care, which we reproduce in Table 5.1.

TABLE 5.1 Blustein's (1991) forms of care

Form of care	*Description and properties*	*Types of relations and acts*
"To care for"	Affection or love for specific others.	Intimates, lovers, family, friends, kin. Expectation of attention and sensitivity to caring needs.
"To have care of"	Responsibility or duty of providing for or attending to the needs of another. This may be frequently instrumental or functional acts of caring, such as washing.	Social position – legitimate acts of caring associated with that position, such as teacher, parent, guardian, physician, etc.
"To care about"	Some commitment of interest – a disposition to act in certain ways to enhance or maintain the state of the entity of interest. Some valuation is involved.	Providing medical attention, parenting, providing advice, listening attentively, treating with respect, even the outcomes of events.
"To care that"	Concern perhaps in the form of benevolence – no specific caring act(s), e.g. concern may be expressed over conflicts in distant parts of the world.	Not focused on a particular individual; more abstract and less concrete.

Arguably, our depiction should acknowledge that the boundaries between the distinctive types of care are overlapping and porous, hence our representation through dotted lines. In contrast to Tronto, Blustein does not depict a linear representation of phases of care. Rather his framework stresses the contingent nature of types of care and their sensitivities to the nature of the relationships, commitment, and the possibility that care may not be directed at a particular "other."

More specifically, "to care for" refers to having some emotional involvement as in affection for another, as in a loving or other intimate relationship. Watson's (2008) conceptualization of the (nursing) "caring moment," which evokes "love," would seem to be compatible with Blustein's description. "To have care of" refers to having some responsibility or duty for supervising or managing, providing for, or attending to the needs of another. Thus care in this category is dependent upon an individual's social position and the consequent range of activities inherent in this position, such as the functional or instrumental acts of care, for example a physician examining a patient or a nurse dressing a wound (see also Mol, 2006). In this categorization, the level of emotional engagement may not be expected to be of the same form as "to care for," or as intense. Yet it is feasible, for example, for a clinician to *care for* an ill relative, while simultaneously *having care of* this relative by virtue of their social position (combined with circumstance).

"To care that" is not focused on a particular person; it is more abstract and less concrete and has some situation as its object. For instance, it is possible for us to "care that" people are working in poor factory conditions to produce our clothing. While this indicates that an individual is interested, or "invested" in Blustein's terminology, there may be benevolence but no action, or beneficence to affect a process or outcome. There may be limitations to an individual's ability or disposition to act.

For our purposes the most significant form of care described by Blustein is "to care about" relating to a commitment to action. Indeed, he identifies this as the most complex form. The notion of "interest" is critical in clarifying "to care about" (Blustein, 1991: Ch. 2). There is a "stake" for the individual in caring about something – there is valuation in caring (see also Carse and Lindemann Nelson, 1996; Sevenhuijsen, 1998; Tronto, 1993, 2013). In Blustein's analysis this may be positive or negative. With a positive disposition the individual may gain if the nature or condition of "*x*" is enhanced; the reverse applies to a negative disposition. Thus, with a positive disposition if the condition of "*x*" is diminished then the individual will experience some degree of distress. It is also conceivable, however, that an individual may gain satisfaction from the diminution of the condition of "*x*," such as the state of someone or something in which an individual has a "negative interest." As Blustein (1991: 29) observes, "It is in my interest that my enemies at least do not prosper, because I stand to gain if they do not and to lose if they do." This also implies the possibility that "caring about" may benefit the recipient without benefiting the provider. In this case "caring about" is described as "disinterested" by Frankfurt (1982), and can be discerned in such behaviors and inclinations as loyalty, benevolence, and unselfishness (Blustein, 1991).

Given the foregoing, different manifestations of care and caring acts reveal incongruities. Certainly, there is explicit recognition of this in Blustein's hypothetical example of a schoolteacher who takes a particular interest in the welfare of a student to demonstrate "to care about." The teacher is attentive yet does not find the student to be especially appealing or likeable; hence, according to Blustein, it is possible to "care about" and not "care for." Nancy Folbre's (1995) discussion of the scenario of an ill-humored nurse providing better medical care than a loving parent provides a further demonstration. The nurse may perform the requisite acts, but in a perfunctory manner. In such circumstances, the nurse's actions may exhibit the binding qualities of the membership of her group – in terms of medical norms – in that the motivation of care is manifest as "caring about" and "*having* care of," but her or his individual predilections do not lend themselves to "caring for" the child. In this case the nurse may demonstrate limited empathy and be attentive to her/his medical needs, but there is a lack of sympathy or even beneficence. Bubeck's (1995) argument, noted earlier, obviously echoes the tenor of this.

Following Noddings (2002, 2005) – and arguably Watson (2008) – such an example represents an absence of care due to the lack of "engrossment" and "moral displacement" (sympathy) or, in the case of Watson, there is a lack of spiritual engagement on the part of the caregiver. It is not consistent with care in a caring fashion (Engster, 2005, 2007). As noted, a key feature for Noddings is the attentiveness – the "engrossment" – of the caregiver, and the focus of their concern on the needs of the recipient of care. In arguing this position Noddings sets the threshold of care fairly high; it also appears to suggest a binary between care and "non-care." Watson's theory of care seems to reiterate this demanding benchmark. Blustein's differentiations are indicative of a more nuanced approach – thus Folbre's nurse may be attentive to the *medical* needs (in a biomedical fashion) of the child and lacking in attentiveness to the child's *emotional* needs. Of course, this begs questions about the nature of needs and whether they are separable, and if so, to what extent. Moreover, it may also highlight a rather misplaced homogeneity in Noddings' demarcation of care and "non-care," although this may be less obvious with Watson who seems to present an idealization of care.

Tronto's analysis provides further grounds for admitting the contingent nature of care. Phase transitions may fail to materialize for a host of reasons, including resource constraints, which could be of the form of time pressures or lack of staff availability, and so on. There may be recognition of caring needs – caring about – but no individual can or will assume responsibility – caring for – and therefore no caring act occurs (caregiving). Similarly, with the Blustein teacher and Folbre nurse examples, recognition and responsibility are assumed, and arguably appropriate care is given. Judgement on this, however, hinges on the interpretation (and valuation) of the *caring about* phase, i.e. have caring needs been adequately recognized? We believe that this is where the importance of Tronto's mis-ordered fifth phase – caring with – is revealed. Institutional frameworks, we will argue in Part III, shape the ability, inclination, and moral imperative of caring about.

A further dimension to the nuances of caring is well-recognized in various literatures. For example, in geography, Smith's (1998) analysis of care identifies tensions between beneficence and benevolence, and spatiality and human similarity. Smith suggests that caring feelings will not always translate into caring acts (see also Tronto, 1993, 2013). Smith historically situates the issue of spatial differentiation in caring intensity, noting that interdependence and ease of communication are very recent phenomena in human history. Prior to this the prevalence of small-scale communities restricted the treatment of strangers to certain short-term "codes of hospitality" (Smith, 1998: 17). Similarly, Churchland's (2011) neurological analysis of mammalian behavior in particular intimates that the instinct of survival as care-for-the-self maps to other-regarding on the basis of the extended self: similarity. With attenuated similarity – same species but beyond family, group, offspring, or clan, etc. – the disposition to care and other-regarding dissipates. Of course, Churchland's findings are unsurprising, but they do emphasize sociality and caring.

Finally, Blustein's categorization of care considers the intensity of caring: Noddings' "engrossment." According to Baier (1982) a measure of an individual's intensity of caring can be determined by an "intolerance of ignorance" concerning the state of what is cared about. For us, Baier's condition is not as challenging as Noddings' "engrossment" prerequisite. This reveals further nuances – care may become peripheral by Baier's test where an individual will tolerate ignorance of the state of "*x*." It also signals the potential for an overly intensive or invasive approach to caring, where the imposition of care leads to the loss of autonomy (Sybylla, 2001) and unmet needs – as in Noddings' (2002) reference to the Western aid response to the Afghan earthquake of the 1990s. For Blustein it signals differential commitment. Commitments have two distinct elements: they presuppose a belief or beliefs in something, and involve a dedication to actions implied by that belief or beliefs (see also Sen, 1977). Blustein (1991: 11) claims:

> Though there cannot be commitment without care, there can be care without commitment.

In effect, an ethic demonstrating an overtly caring orientation is more likely to engender a shared intention among group members that encourages a dedication, or motivation and habit, to "care about," to be attentive, than a group or institution where this ethic is absent or attenuated. The attrition of such an orientation could entail a further erosion of the system of beliefs or norms and, hence, a dilution of motivations and commitments to care, which may change care as an activity: for instance, where "caring about" becomes "caring that." Under such conditions the intensity of care can also be diluted. We investigate these aspects further in Chapter 6 and Part III.

Dispositions to care are sensitive to patterns of social interaction (Mol, 2006). In this respect, commitment is pivotal to Blustein's (1991: 48) case:

> If commitment to something is to give my life meaning, then I must believe that my commitment is impersonally recommended and that the value of what I commit myself to does not emanate simply from myself.

Blustein elaborates further on this when he argues that the individual must believe that others would similarly value the objects of the individual's care "with full understanding and without personal bias" (*ibid.*) of the individual's situation, and abstracting from their own circumstances. The analysis here is strongly suggestive of the importance of the social domain in the formation and maintenance of an individual's commitment to something – even someone? Similar arguments are found in Folbre and Goodin's (2004) analysis of altruism in economics. They argue that dispositions to act may be honed by training and education more generally, and the values instilled in such processes and in the development of the individual as in the site of education and training institutions we identified in Chapter 3. Nonetheless, Tronto (1993, 2013) is keen to caution against overemphasizing dispositions to care, such as Smith's (1998) references to benevolence, as this reduces care to the province of the individual. This type of criticism, as we have reasoned, may also be applicable to Watson's approach to nursing care. The institutional apparatus of nursing is de-emphasized in preference for an emphasis on the individual nurse and the personal virtues she should demonstrate in order to provide effective and valuable care.

In her 1993 critique of Blustein, Tronto accuses him of disregarding the activities of care in preference for "emotional investments" as a pre-condition to care. This entails an individualization of care through a person's ideals whereby care fits their world-view, risking a romanticized and idealized perspective on care. For Tronto, this also risks reducing care to a sentimentalized vision of the mother–infant relation and confining it to the private domain of the home.

We feel Tronto's apprehensions are well founded, especially with regard to Watson's approach, but her application to Blustein's approach may be exaggerated or even misplaced. Contra Tronto, we take a different line. Blustein, in developing his conceptualization of commitment, willingly endorses the significance of the other and the social in the formation of an individual's commitment and hence disposition, as the quote in the preceding paragraph indicates. What both Blustein and Tronto do share though is the compellingly held view that acts of and dispositions to care have a moral imperative.

5.6 Some final thoughts

It is perhaps contentious to differentiate and separate economic and non-economic approaches to care. In doing this are we not succumbing to the view that the economic and social domains are separate? Surely the two have some common roots. There must be *some* overlap. Or does the economic domain represent a contradistinction to that of care? This reflects the argument frequently articulated regarding the alleged bifurcation between Adam Smith's *Theory of Moral Sentiments* and the *Wealth of Nations* (Foley, 2006), and perhaps also recalls the contrast between the "public or political" and "private" spheres of life – with care confined to the latter and hence heavily gendered and marginalized. In this chapter we have touched on this issue with regard to Virginia Held's (2006) demarcation of caring labor in her criticism of the Fisher/Tronto definition of care. What this reveals, *inter alia*, is that the boundaries of care are ambiguous and subject to some debate.

To return to the initial point: we firmly believe that the economic domain is to a considerable extent embedded in the social. For us there is a compelling case to this effect from a host of sources including Pierre Bourdieu, Thorstein Veblen, Karl Polanyi, and Karl Marx, among many others. Therefore our starting position is that if care is central to the social domain it must have some relevance to the economic domain. Feminist economists have demonstrated this, as have the earlier accounts of Smith, Veblen, and Boulding we outlined in Chapter 4. There we argued that mainstream – and much of non-mainstream – economics resolutely ignores the potential importance of care. More specifically, we feel that standard health economics is ill-equipped to adequately conceptualize care as it assumes, following Becker, that the social is embedded in the economic, the antithesis of our view argued in Chapter 1. By drawing on the seminal works of Heidegger and Foucault in describing and analyzing the nature of care we have accordingly sought to establish and demonstrate the centrality of care to human life and the constitution of the individual. Put simply, without care there can be no flourishing of the individual. This essentialist property is especially pertinent to health and medicine, and it encourages some reflection over the manifestations of care in this context. It further demonstrates the value in the breadth of the Fisher/Tronto definition. Medical care can be seen as nested in an overarching care framework. For us this is an important insight as it emphasizes the importance of the institutional architecture of care and therefore the ethics of care. Is care a moral imperative?

An institutional approach to care also questions the individualistic accounts of Noddings and Watson. We accept that care is relational, but that caring relations are themselves embedded in institutional arrangements. In our view Noddings' and Watson's approaches do not sufficiently recognize this. Instead, they privilege a dyadic explanation of care grounded on behavioral dispositions and the virtues of caregivers. We readily accept that caring virtues are of considerable importance, but that institutions play a prominent role in either inhibiting or enhancing such virtues. Indeed, institutions can inculcate individuals in embracing a certain pattern of values. Given this, we consider that Tronto and Blustein, in different ways, through their phases and types of care offer an insightful platform with which to further investigate the institutional and social aspects for a moral imperative of care. We now turn to this understanding.

Notes

1 Online edition (http://www.oed.com/): accessed July 2013.

2 Utility maximization may be unfalsifiable, but it is subject to a profound problem of infinite regress. In order for every action to be considered as optimal – in terms of the expected utility of the action – it must be subject to a calculus of its cost and benefits, and the costs and benefits of the calculation should also be calculated, and so on.

3 Interestingly, much of the feminist literature on care either offers passing references to Heidegger and Foucault, or only refers to either one of them – usually, to the best of our knowledge, Foucault. For example, Held (2006) makes no reference to either. It may be that Heidegger's affiliation with the Nazis in Germany during his tenure at Freiburg is, to say the least, offputting.

4 Gutting (2013) notes Heidegger's influence on the intellectual environment in which Foucault was educated in the late 1940s.

5 Mol does not refer to Watson's work in the *Logic of Care*.

6 To the best of our knowledge, Blustein's (1991) *Care and Commitment* is not prominently discussed in the literature. For instance, Tronto cites and criticizes his approach in her 1993 work, but there is no reference to him in her later (2013) work. Both Held and Sevenhuijsen cite Blustein, but he is absent from the indexes of both works, suggesting a lack of significance. *Care and Commitment* does not feature significantly in the works of other authors, such as Engster and Kittay.

PART III

Care systems, human flourishing, and policy

6

INSTITUTIONS, GROUPS, AND THE MORALITY OF CARE

> "As to diseases, make a *habit* of two things – to help, or at least, to do no harm."
> (Hippocrates, *Epidemics*, Book I, Chapter 2, emphasis added)

6.1 Introduction

Chapters 4 and 5 of Part II explored theories and definitions of care, arguing that the concept is under-explored in the economics literature of all schools of thought. In developing our argument we drew upon the phases of care theory developed by Joan Tronto, emphasizing that care embodies a range of activities that proceed in a linear fashion, and that these phase transitions may break down. Care may be partial, inauthentic, and contingent. Our attraction to Tronto's theory, as opposed to those of Nel Noddings and Jean Watson, for example, is that it is consistent with our emphasis on institutions and the social embeddedness of the individual. We develop this link further in this chapter.

Institutional economics in the tradition of Thorstein Veblen, Clarence Ayres, John Commons, and Wesley Mitchell explains institutions as durable social rules that partially constrain, enable, and mold the individual. Individuals, this literature argues, inhabit an evolving system of institutions – "institutional furniture" in Veblen's terms – and simultaneously those institutions reside *within* individuals through the development of habits. In short, human reasoning is always situated in a context. In this sense the individual is an institutional and socially embedded being.

Institutions also function as value or moral systems and as such ensure the reproduction of assemblages of values and value systems. We note, in particular, the power of "we" language as an expression of collective or shared intentionality that appeals to a more demanding ethical standard than "I" language. The individual uttering "we" language has to be sure that others share the meaning and values embodied in the language. In other words, shared intentionality implies shared mental models. Our position diverges from the mainstream economics and health economics idea of the atomistic individual especially in regard to how an appreciation of the importance of individual social embeddedness and the properties of institutions is central to exploring the complexities and value of care in medicine and health. We have argued throughout that the standard economic approach is wanting in these important areas and therefore cannot provide a suitable basis for the apprehension of care in the context of health. In this chapter we further develop the theoretical approach we feel is necessary for a more comprehensive analysis of care.

The following section outlines our understanding of institutions based on the institutionalist approach of Veblen, Ayers, Commons, and Mitchell. In this we discuss how institutions are human artefacts that possess emergent and self-organizing properties and are rule systems predicated on a fundamental institution: language. We note the importance of habits as behavioral propensities and then examine the characteristics of the socially embedded individual. The following section draws on the work of medical sociology in seeking to develop these themes in the context of health and medicine, identifying, for example, overlapping health care sectors and professional medicine. From there we identify moral groups of care, and situate the notion of care we analyzed in Chapter 5 within this framework. The final section then applies this all to professional medicine.

6.2 Institutions and institutional economics

The renowned institutionalist and evolutionary scholar Geoffrey Hodgson defines institutions as "systems of established and prevalent social rules that structure social interaction" (Hodgson, 2006: 2). In a later article Hodgson (2009: 3) wryly observes, "we are all institutionalists now" in reference to the "revival" in interest across the social sciences in the notion of institutions (Rutherford, 2001). From the arguments advanced here, we believe that the conceptualization of the institution is of considerable importance in apprehending care. In economics, however, there is a diversity of definitions of what institutions are, a subject we discuss prior to investigating the relationship between institutions and the human mind.

6.2.1 Definitions of institutions

The recent rise of a "new" institutionalism in contemporary economics has been notable, especially with *Sveriges Riksbank* Prizes in Memory of Alfred Nobel going to Ronald Coase (1991), Douglass North (1993), and Oliver Williamson (2009). Williamson coined the term "new institutionalism" to differentiate his approach from the earlier institutional economics of Veblen, Ayres, Commons, and others (Hodgson, 2009). The key distinctions between these two institutionalisms lie in the role of the individual and the definition of the institution (Dequech, 2002; Dugger, 1990; Rutherford, 1995, 1997). As with neoclassical economics, in new institutional economics the individual has the main explanatory focus, and individuals are assumed to be relatively autonomous agents. For instance, Williamson's transaction cost framework is based on boundedly rational, opportunistic individuals constrained by specific governance arrangements or institutional rules (Dequech, 2002; McMaster and White, 2013; Williamson, 2000). Williamson's work does not establish any convincing definition of an institution, or of transaction costs for that matter. Instead, Williamson's focus is highly functionalist: institutions are economizing. For instance, he argues that firms "have the main purpose and effect of economizing on transaction costs" (1985: 1). In his review of the state of new institutional economics in 2000, he repeatedly claims that various levels of institutional artefacts, such as the "institutional environment," for example the judiciary, possess an economizing function. Somewhat flamboyantly he later asserts: "Resources are allocated to their highest value as the marvel of the market works its wonders" (Williamson, 2000: 598). Despite his definitional vagueness, there is, to our minds, a well-established orientation in Williamson's work. The continuous references to the need for governance structures to "economize" on bounded rationality and limit opportunism emphasize institutional frameworks as fundamental constraints to diseconomies associated with misaligned interests. This is the stuff of individualist agency theory (see also the later work of the likes of Acemoglu and Johnson, 2003, and Bowles, 2004). Nonetheless, Williamson does acknowledge that firms are distinct from markets to a greater degree than do some agency theorists. At the same time, Williamson's focus on opportunism and bounded rationality encounters a number of logical difficulties. As Hodgson (1988: 300) points out, how is it possible to economize on rationality?

By contrast, Veblen's early, original description of institutions is broader in scope, albeit rather succinct:

> As a matter of course, men order their lives by these principles [of action] and, practically, entertain no question of their stability and finality. That is what is meant by calling them institutions; they are the *settled habits of thought* of the generality of men. But it would be absentmindedness … to admit that … institutions have … stability [that is] intrinsic to the nature of things. (1969: 239, emphasis added)

Hodgson (2003: 163) usefully augments this as follows:

> Institutions are durable systems of established and embedded social rules and conventions that structure social interactions … Institutions both constrain and enable behavior. However, a constraint can open up possibilities: it may enable choices and actions that otherwise would not exist … But a hidden and *most persuasive* feature of institutions is their capacity to mould and change aspirations, instead of merely enabling them. This aspect of institutions is neglected in the "new institutional economics." (Emphasis added)

Hodgson powerfully articulates the "original" institutionalist tradition founded on Veblen and "second generation" institutionalists Ayres, Commons, and Mitchell.

In sharp contrast to neoclassical and mainstream economics (and health economics), for institutionalists, the individual is emphatically not an autonomous agent. Veblen (1969) famously dismissed the notion of *Homo economicus* as devoid of both antecedent and consequent. Instead, he argued that the individual is socialized – individuals are born into a system of institutions, particular in space and time, which partially constrain, enable, and mold.

Drawing from this, at least four broad interrelated features of institutions may be discerned:

1. Institutions possess both artificial and natural characteristics, the former in that institutions are human artefacts, the latter in that they are frequently emergent and self-arranging (Potts, 2007).
2. Language is the fundamental institution underlying all other institutions (Davis, 2003; Hodgson, 2004, 2006; Searle, 2005). Stable and durable conversational procedures embed communication. The communicative and recursive qualities of language are central to its coordination and organizational capacities. Institutions establish individuals' "deontic powers," i.e. duties, obligations, roles, and their legitimacy (Avio, 2004; Searle, 1995, 2005). These powers are disseminated and accepted within and by communities through language. This extends beyond verbal utterance; individuals' mental representations of institutions are partly constitutive of those institutions, since institutions can only exist if people both possess and communicate their attitudes and beliefs about those institutions.
3. Following on from (2), institutions, as rule systems, are manifestly social in that they are various forms of patterned interactions between groups or individuals. Broadly speaking, a rule may be of the form: in circumstances *X* do *Y*. Rules may be injunctions or dispositions as well as explicit or formal.

   Note what is suggested when we say that institutions are systems of rules. That an institution's collection of rules has a systemic character means that its rules are interrelated in such a way that following them causes people to engage in a generally distinguishable kind of activity. In this way institutions permit individuals to act so as to negotiate "their daily affairs" (Lawson, 1997: 187). Also, they "provide the social nexus of communication which provides shared symbols, sites of practice, and some degree of certainty which reduces the social cost of human intercourse" (O'Hara, 2000: 37). In this individuals are located in a range of different positions that determine roles and status, which partially conditions and molds individuals' propensities to act in particular ways, impacting different individuals differently. In short, to reiterate, institutions have the potential to *partially* constrain, enable, and mold an individual.

   Institutionalism affords institutions temporal priority but not priority in reality or in causation over individuals. For instance, in his criticism of Marx, Veblen rejected the argument that the individual is "exclusively a social being, who counts in the process solely as a medium for the transmission and expression of social laws and changes" (Veblen, 1897, cited in Hodgson, 2004: 133).

Individuals through their instinctive capacity for creativity and hence freewill have the potential to influence institutions. Importantly, Veblen's reasoning reveals feedback effects between the individual and the institution: institutions have the power to partially shape an individual's aspirations, preferences, beliefs, and capacities. By doing so, they potentially change that individual. However, institutional reproduction is reliant upon individuals who through either accident or design have the capacity to change rules. Indeed, the term "reproduction" in evolutionary thinking refers to change in contrast to "replication" which does not. Specifically, rules and norms necessarily require individuals to interpret them. Individuals possess discretion, have recourse to different repertoires of habit and experience, and misinterpret what is required of them (Dolfsma *et al.*, 2011). Differences in interpretation can have consequences for action and carry potential ramifications for the reproduction of an institution. Following this, institutions demonstrate differences in scope, durability, scale, and level, and therefore exhibit multiple meanings and roles for individuals (Lawson, 1997). In short, institutional reproduction is not mechanical. Institutions are dependent upon individual behavior without being reducible to it (Bush, 1987; Myrdal, 1978; Rutherford, 2001; Samuels, 1995).

4. Following on from (3), the structural properties of institutions are historically contingent and subject to evolutionary and entropic forces. Evolution, especially in the Darwinian sense, is a strong theme in Veblenian thought. As Hodgson (2009) observes, Veblen believed that changes in the "institutional fabric" are outcomes of individuals' conduct, and simultaneously institutions "direct and define" those individuals' aims and conduct.

This conception of institutions and the relationship between institutions and individuals, the agency and structure issue in social science, highlights evolutionary change on multiple levels – coevolution – and hence underlies the idea of emergent properties. Indeed, "From Veblen's … perspective, individual and social structures were in a process of coevolution, rather than one being determinant of the other" (Hodgson, 2004: 133). In other words, in a stratified ontology the different levels of reality change or evolve at different rates, and produce unexpected and emergent forms and relationships (for example, Fleetwood, 2008; Hodgson, 2013; Hodgson and Knudsen, 2010; Lawson, 1997, 2003; Nelson, 1995).[1]

The nuances of Veblen's Darwinian understanding of evolution are beyond the scope of the argument we present here. However, the concept does have an indirect bearing on the framing of our analysis in that it guides us away from the equilibrium reasoning that pervades mainstream health economics and shapes its restrictive view of care. Moreover, emphasizing evolution and historical contingency enables us to chart what Hodgson (2013) terms "moral communities." For us, this constitutes a further distinguishing feature of institutions nested in (2) above – rules as values or morals. Rules obviously possess an ethical quality regarding what is believed to be right and what is not. We investigate this further below, in connection with Tronto's (2013) alignment of the phases of care with particular ethical qualities. For the moment, we firmly believe that the institutionalist approach presents a compelling basis for seeing the individual as socially embedded, and from our perspective this provides the basis for a more thorough examination of the importance of care in medicine and health than that associated with standard health economics. We proceed by outlining the mechanism by which institutions shape individuals' beliefs (and hence values), aspirations, and orientations, *inter alia*.

6.2.2 Habits, instincts, and calculation: towards a socially embedded individual

The German Historicists, Marx, and Darwin were particularly influential on Veblen's analysis of the economy. Veblen and the other original institutionalists also drew from the American pragmatist tradition, chiefly Charles Sanders Peirce (1955), and instinct psychology to construct an alternative to the utilitarian hedonistic conception of *Homo economicus* (Hodgson, 2004, 2013; Twomey, 1998). Instinct psychology is associated with the work of William James and William McDougall at the turn of the nineteenth and twentieth centuries (Damasio, 2006), and in essence sees the human mind as possessing a multi-layered structure – instinct, habit, and conscious deliberation – which gives it various abilities appropriate to environmental demands. The Cartesian dichotomy assumes a singular rationality of thought (Peirce, 1955). By contrast, instinct psychology employs the hierarchical structure of thought involved in creating knowledge. From this perspective, *Homo economicus* is constrained by its utilitarian and Cartesian framing: every action has to be the consequence of calculated deliberation in the form of maximizing expected utility or some other payoff. The Cartesian isolation of *Homo economicus* as a calculating machine thus entails an asocial individual and disembodied mind. We believe, however, that the instinct, habit, and conscious deliberation model of the mind offers a more convincing basis for the analysis of care in health economics.

In Chapter 4, we noted Veblen's idea of a "parental bent" (toward care and other-regardingness) as one of the basic human instincts. To reiterate, instincts are inherited propensities and drives to behave in particular ways when subject to an assortment of triggers, such as emotions, urges, and/or reflexes. As such, instincts provide a platform for higher thinking. William James' work emphasized how instincts, habits, and conscious reasoning not only coexist, but that higher-order thinking emerges from instinct. Accordingly, humans are more intelligent than other animals because our instincts take on the form of tailored capabilities and propensities (Damasio, 2006; Dewey, 1922; Twomey, 1998).

Habits unlike instincts are learned. Like instincts, habits are propensities to behave in specific ways subject to cues or triggers associated with situations in which individuals find themselves. Importantly, habit, as a propensity to behave, need not be repetitive, but may lie dormant for some time, and then be triggered not only by some conditioned reflex, but also by "conscious resolve" (Hodgson, 2003). On this Dewey writes:

> We may think of habits as means, waiting, like tools in a box, to be used by conscious resolve. But they are something more than that. They are active means, means that project themselves, energetic and *dominating* ways of acting. (Dewey, 1922: 25, emphasis added)

Habits as learned dispositions arising from repeated actions or thoughts are formed in particular institutional settings. They are predicated on our unique experiences of such institutions. Thus institutions are embedded within us through acquired habits and at the same time lie beyond us in that they exist independently of any particular individual. Hodgson (2003: 164) states: "Institutions are simultaneously objective structures 'out there', and subjective springs of human agency 'in the human head.'"

Similarly, the work of Pierre Bourdieu makes numerous references to habit, using the Latin term "habitus" (Fleetwood, 2008), which he defines in terms of:

> A system of lasting, transposable dispositions which, integrating past experiences, functions at every moment as a matrix of perceptions, apperceptions, and actions and makes possible the achievement of infinitely diversified tasks, thanks to analogical transfers of schemes permitting the solution of similarly shaped problems. (Bourdieu, 1998: 82)

As with Veblen, Bourdieu's conception of habit (habitus) is not mechanistic – it involves an unconscious disposition to act in a specific way, but it is not necessarily unchanging: it is more a *tendency* to act in a specific way (Fleetwood, 2008; Trigg, 2001). More specifically, there are two important dimensions to how institutions structure individuals' behavior. First, because rules have an "established" character in the sense that they are generally enduring and well recognized, the way in which they structure people's behavior is by encouraging people to act repeatedly in particular ways or in a habitual manner. Habit, then, is essential to following rules consistently, because as a recurring way of acting it replaces the need to deliberate over what to do every time new occasions for action occur (Bourdieu, 1998; Damasio, 2006; Dewey, 1922; Hodgson, 2003, 2004; Twomey, 1998). In effect, habit has an economizing property in that it acts as a repository of knowledge. This is made possible by the fact that rules typically come with cues that inform people when they apply. In the case of language, for example, one type of speech act, say a salutation, cues another, a response salutation. Observing the cue, then, allows habit to take over, making people on the whole more efficient in achieving whatever the purpose is that a given set of rules promotes. From the perspective advanced here, Dewey offers an interesting scenario. Consider "hard-drinkers" who wish to cease drinking: they must, according to Dewey, address the cues that lead to drinking – the stimulus of the habit. By instituting an approach that suppresses or avoids these cues individuals may reach their desired goal. In Dewey's scenario, actions (drinking) are based on habit, but circumstances – as with institutions – can change, or be changed, and therefore habits may also be changed. This is not to say that this is necessarily easy or straightforward for the individual, as the old adage about attempting to change the "habits of a lifetime" suggests; rather, the point is that institutions via habit have a key role in influencing behavior. In Dewey's illustration, alcoholism may thus be partly induced by environmental triggers – in other words, health and illness are partially social.

Second, because rules create settled patterns of behavior, they create expectations about how people *ought* to act in various circumstances. If people do not then act as expected, not only does this disrupt other individuals' habitual behaviors, but it also calls into question the institutions' rules as well. This highlights the value dimension of institutions as rule systems. Habits facilitate the absorption of values and act as a conduit of those values. Returning to our example above, if a person offers another a salutation and this cue is not reciprocated in terms of a response greeting, then it is likely that the non-response, or similar, is perceived as "bad" or undesirable and disruptive. This, of course, presumes an ethical position over what is "good" and "bad" as defined by the cultural norms and institutions-as-rules inculcated in habits. An inappropriate action, such as in the case of the exchange (or non-exchange) of greetings, may impact individual A's beliefs about individual(s) B and also their habits; for example, individual A may be less inclined to offer a salutation or voluntarily interact with individual(s) B.

This change in a form of interaction points us toward how institutional change can impact habit and values. Veblen in the *Theory of Business Enterprise* (2005 [1904]) and *The Theory of the Leisure Class* (1994 [1899]) argued that the institutional framework could encourage certain forms of instinctive behavior[2] and suppress others, and by doing so engender particular patterns of habits of thought and therefore particular value systems. The crux of his analysis was that early twentieth-century American capitalism, through "business enterprise," favored the accumulation of wealth and conspicuous consumption (Trigg, 2001). The basic drive was predatory – instinctive behavior associated with predation was privileged by simple pecuniary gain. Investment for profit dominated investment for technical efficiency. By contrast, engineering and industrialists were, according to Veblen, driven partly by the instincts of idle curiosity and workmanship, which are manifest in the industrial process as a habitual search for "mechanical efficiency." This "machine process" shapes the dominant habit of thought through a preference for precision and explaining facts "in terms of material cause and effect" (Veblen, 2005: 15). Standardization and precision came to be valued ahead of craftsmanship with the advent of mass production. With the evolution of "business enterprise" the pursuit of pecuniary rewards tends to dominate industrial concerns. In this way Veblen demonstrates how institutional change reconfigures habits of thought and therefore the prevailing system of values over which way of doing things is acceptable. Of course, for Veblen, industry was the source of technological and social progress, whereas "business enterprise" was unproductive and fostered greed. As Hodgson (2004: 167) puts it:

> Instincts are "essentially simple" and directed at "some concrete objective end." Habits are the means by which the pursuit of these ends could be

> adapted in particular circumstances. In comparison to instinct, habit is a relatively flexible means of adapting to complexity, disturbance and unpredictable change.

Given this, instincts are prior to habit and habits are prior to beliefs (about right and wrong) and belief is prior to deliberation (Hodgson, 2004). It is the instilling of values through habits of thought within an institutional setting that is central to the Veblenian-inspired original institutionalist analysis in this area. It is one which we draw on and apply in our analysis of care in a medical context below.

Nonetheless, as we have emphasized, institutions through habits do not "brainwash"; agency, at least partially, still resides with the individual. Through instincts and habits individuals are capable of conscious deliberation. Instincts and habits prevent data overload, freeing the "conscious mind from many details" (Hodgson, 2004: 174). Conscious deliberation refers to processes involved in reasoning or problem-solving. This, however, is not necessarily an endorsement of utility maximization. Instead, it echoes Herbert Simon's (1997) notion of bounded rationality – humans have limited cognitive capabilities. Famously, Simon's analysis suggests "satisficing" as opposed to maximizing as the deliberative strategy and type of agent behavior. In effect, people seek out possible courses of action that are sufficient – or good enough. Simon (1997: 119) contends:

> Because administrators satisfice rather than maximize, they can choose without first examining all possible behavior alternatives and without ascertaining that these are in fact the alternatives … they can make decisions with relatively simple rules of thumb that do not make impossible demands upon their capacity for thought.

Indeed, there are many examples of perfect information games, such as the Rubik's Cube and chess, where players have been shown to employ sub-optimal strategies. Expert chess players, for instance, satisfice by adopting strategies that involve the memorization of a collection of scenarios, frequently generated by powerful computers such as IBM's Blue Gene/P, in a game that has some nine million possible positions after three moves per player (*Financial Times*, 2014). During play they look for patterns that are, in Simon's terms, "good enough" to cope with the complexity of the game (Hodgson, 1988, 2013).[3]

In sum, we endorse the original institutionalist formulation of the socially embedded individual – institutions partially constrain, mold, and enable individual thought and action. This is not to deny individual agency: as Hodgson (2013: 117) acknowledges, "we are not passive receptors of cultural norms." Therefore there are individual dimensions to habits and reflective thinking as in conscious deliberation that are unique to the individual. Yet institutions also suggest what Denzau and North (1994) term "shared mental models." Next, we analyze the importance of "I" and "we" language, or shared intentionality in the conceptualization of the socially embedded (and institutional) individual.

6.2.3 Shared intentionality and the socially embedded individual

As we noted at the outset of this work, the notion of shared intentionality is important to our understanding of a morality of care in health care economics. Recent work in social economics, to our mind, augments and develops the case for the notion of a socially embedded individual as alternative to the standard and highly reductionist model of the individual. The argument draws on the thinking of Raimo Tuomela (1995) on shared (or collective) intentionality. The case rests on the crucial language distinction between "I" and "we" intentions. The simple difference between first person *singular*, or "I" intentions, and first person *plural*, or "we" intentions, individually expressed, points to fundamental differences in individual behavior. An "I" expression relates only to that individual uttering it. The intent of any feeling, desire, preference, and so forth relates only to that individual. In short, "I" expressions relate only that individual's attitude. By contrast, "we" expressions are markedly different and more demanding. If an individual uses the term "we" it entails that the other individuals associated with the expression would similarly use the term as the individual employing it. These other individuals can be termed a "group" in Tuomela's approach.

Davis (2003) notes that two characteristics are central to Tuomela's analysis: First, an individual articulating a "we-intention" believes that other group members also hold this intention. Second, the individual expressing the intention believes that all group members mutually hold it. Of course, this is open to individual belief and interpretation – errors can occur, such that "we-intentions" are misattributed. Tuomela is alert to this possibility and relies on a weak mutuality in his framework. Hence shared intentionality can hold when there is a sense that group members tend to or in general hold the same attitude. Davis (2003: 135) notes:

> The main point is that we-attitudes are a group attitude not in the sense that a group over and above its members has an attitude towards something, but in the sense that individuals "generally" in a group have some such attitude that they express in "we" terms. Thus, saying that they "generally" have a we-attitude depends not just on the mutual belief condition but on both conditions which when combined give us reason to suppose that individual members of a group are justified in saying what they (that is "we") intend.

Thus shared intentionality is sensitive to the power structure of a group. For instance, it is possible that the individual uttering the "we" expression does so on the basis that they conflate group attitudes with their own regardless of what these group attitudes may be. Such a situation would exist where a specific individual dominates and can disregard others' views. Obviously while such a scenario is conceivable, and can and does exist, it falls at one end of the spectrum of "we" expressions. More generally, "we" expressions reflect the ethical nature of shared intent as outlined in Tuomela's two conditions. In the dominant individual situation the individual need not care about the attitudes of others in the group, or at least can disregard them.

This is not the case with shared intentionality; the individual uttering the "we" expression *has* to care about the views of fellow group members. By virtue of their group membership individuals are impelled to be other-regarding.

In contrast to institutions which we have defined as durable social rule systems, social groups are collections of individuals with shared characteristics that specify membership of those groups. Groups can be diverse, such as a profession or a family. They possess sets of rights and responsibilities that support individuals' shared intentions. Individual group members will have a certain position within their group based on their role(s) and rights within the group. As opposed to rules, groups rely on norms, which are a "network of mutual beliefs" (Davis, 2003: 135). These substitute for explicit agreements between individuals, and instead are reciprocally established between individuals on the basis that each individual believes that their belief is accepted and shared by others, and vice versa. As with the notion of shared mental models the commonality of beliefs is reinforcing. Accordingly, they are normatively laden and also represent a web of values or morals. In short, shared intentions provide the basis for reciprocal obligations, and "we" expressions are articulated in the belief that the views they express are consistent with other group members' attitudes. These mutual obligations are thus rational by virtue of individuals freely binding themselves by them when in interaction with their fellow group members.

Hodgson (2013), we noted, has compellingly defended the notion of "moral communities." Unfortunately, from our perspective, he says little to define "communities" (the idea does not appear in the index of his book). Nonetheless, as he uses the idea "communities" seem to refer to individuals sharing some form of proximity, or interests, or identity, and therefore we feel it shares a commonality with our description of groups. Indeed, Hodgson argues that mainstream economics' conception of the individual is under-socialized, and that there is a need to recognize the crucial role of social structures. He then analyzes the nature of morality and moral and ethical judgements. The analysis is evolutionary, and in applying a Darwinian approach emphasizes the emergence of certain patterns of values and rules. Drawing from the work of Richard Joyce on the *Evolution of Morality*, Hodgson describes moral judgements as possessing the following characteristics: they express belief and attitude; they invoke the emotion of guilt, if conduct is perceived as immoral; they transcend individual interests and common conventions; they imply notions of justice and desert; they counter selfishness and reign over social relations; and they are inescapable (Hodgson, 2013: 78). As Hodgson notes, these notions are absent from the mainstream economics model in general, and for us health economics in particular. As we explored in Chapter 1, judgements of all sorts in health economics are reducible to the expression of individual preferences. Clearly, mainstream (health) economics makes no use of the idea of shared intentionality. Standard economics' atomistic conceptualization of the individual means that people express intentions that apply only to themselves, and that their choices are instrumental to maximizing individual utility means reference to others is at best incidental. Even where other-regarding behavior is modeled, as in the interdependent utility functions approach developed in some mainstream health economic agency models, this is accomplished in such a way as to render the individual (patient) as no more than an argument in a (clinician's) utility function. In other words, the individual is only relevant in so far as they feature in another's utility function. There is no binding quality to the relationship in terms of mutual obligations. In contrast, with shared intentionality, individuals express intentions that apply to themselves through the relations they have with others. In effect, the constraints that shared intentions produce are "internal" to the *relationships* between individuals rather than "external" to the two atomistic individuals' interdependent utility functions in the standard analysis. In other words, the individual is socially embedded.

We argue that health and medical care systems should be taken to be networks of institutions built up around the interaction between these social groups involved in patient–clinician relationships within an assortment of institutional settings (Davis and McMaster, 2007, 2015). Our framework then attempts to explain the provisioning of care socially through how many individuals as members of many social groups interact both directly and indirectly in the social provision of care.

6.3 Health and medical care institutions: medical pluralism and the three sectors of health care

In Chapter 3 we set out a delineation of health and medical care institutions, describing three levels: delivery, education and training, and social systems. Delivery institutions are immediately involved in the provision of health and medical care. Education and training refers to the institutions providing training and education and professional associations, and so forth. Social systems are those institutions that frame the environment of delivery and education and training institutions. This can be related to the nature and involvement of health and medical care institutions in the market system, legal systems, government expenditures dedicated to health and medical care, etc. Thus, in our view delivery institutions are nested in education and training which are in turn nested in social system institutions. Our approach assumes that any society's medical and health care systems are not isolated from the rest of that society, and therefore cannot be examined in isolation from the other aspects of that society. We believe that this offers a contrasting ontological and epistemological perspective to that of the standard health economics framework which treats the market as a relatively autonomous activity. For us, then, the analytical entry point is not the market, it is society. Following institutional economics, then, medical systems are influenced by and influence a society's socioeconomic dimensions. Hence the nature of care and caring regimes are reflective of wider social values, and indeed feed back on and influence the evolution of those values.

Our approach complements noted works in medical sociology, including David Landy's (1977) notion of the social embeddedness of medical systems and Arthur Kleinman's (1980) overlapping sectors in the health care view. Other notable contributions include Freidson (1970) and Illich (1976) *et al.* We discuss these in turn, and then analyze the special case of Erving Goffman's (1968) notion of the "total institution."

6.3.1 The social embeddedness of medical systems

Landy identifies two interrelated dimensions in medical systems: the cultural and the social. The cultural refers to practices shaped by dominant value systems and commonly held opinion – a conventional wisdom regarding fundamental understandings and concepts. For example, it can be argued that Western medical thought is heavily influenced by a biomedical approach (though, as we explored in Chapter 2, there are grounds for a culture of medical pluralism given the tension between biomedicalism and the Hippocratic ethos).

The social dimension refers to the pattern of relations in medical systems and the rules governing these relations, all within particular constellations of institutions. Thus medical care is organized in ways that assign specific roles to individuals, centered on the physician and patient. Of course, there are also many other roles, such as laboratory technicians and hospital domestic staff, in medical systems. All relations are subject to rules that, to varying degrees, define the rights and obligations of individuals. There are also specific sites where these rules are prominent and operational, thus the hospital may be perceived as the domain of a particular professional class or group. Issues of power reside in such sites. For Landy this is most evidently demonstrated by the legitimizing role of law that enables one form of medical (and health) care to dominate others. In Western societies the medical profession is imbued with particular powers by the legal system that are not replicated in other medical systems beyond the confines of the *official* profession or professions. Thus, while homeopathy, massage, acupuncture, and chiropractic may be organized on a professional basis with associations issuing codes of practice and specifying membership criteria and consider themselves to be a part of medical care, they remain beyond the legally legitimated medical professions. This reflects a pluralism in medical systems in that distinct types of medical practices can coexist and evolve in different ways. Relatedly, Helman (2007) sees immigration as a potent source of medical pluralism (see also, for example, Lipson and Meleis, 1999). Helman refers to religious-based and culturally diverse sources of medical care, such as Hindu *vaids*, or spiritual leaders, who are "often" consulted by immigrants to the UK from the Indian subcontinent. These analyses reflect what we term social system institutions in our multi-level conception of health care, with their important role in shaping rules, values, and hence habits.

6.3.2 Overlapping health care sectors

Our notion of social embeddedness also operates in Kleinman's (1980) identification of three health care sectors – "popular," "folk," and "professional." With "popular," Kleinman introduces an ontological level additional to Landy's cultural and social aspects.

The popular sector, which resembles a part of our description of delivery institutions, is mainly concentrated in the institutional arrangement of the family. It refers to the initial recognition and definition of illness by an individual, or a member of the individual's family, and the consequent *therapeutic* options considered and measures undertaken. This type of activity does not involve the professional or folk sectors, at least initially. In Kleinman's analysis the measures include: self-treatment/medication; advice and/or treatment from a family member, friend, colleague, etc.; participation in self-help groups or similar, such as religious sects and consultation with a layperson with some acknowledged experiential knowledge. The family is the principal location for this type of care, and consequently caring of this nature is strongly biased to women's involvement. Thus care in this environment occurs where there are extensive bonds of kinship, friendship, or other similar forms of association between individuals. Accordingly, there is likely to be considerable congruence of beliefs between "patient" and "healer" (Helman, 2007). Indeed, the roles of "patient" and "healer" will alternate from time to time. However, there are circumstances where an individual will perform a more prominent role in being a source of advice and care. Helman (2007) lists these circumstances as including: the possession of experiential knowledge of a range of life events, such as particular illnesses and/or treatments, childbirth, occupational backgrounds or associations with the medical professions, and so forth, and those involved in organizing self-help groups and religious organizations, for instance.

Kleinman also describes what he terms as a "hierarchy of resort." Initially an individual feeling ill will typically self-treat or medicate and then seek the assistance and care of others, in the first instance, if possible, a family member. Culture is influential in this "hierarchy." Perceptions of illness are informed by beliefs about the structure and function of the body and the nature of illness. This is reflected in the courses of treatments and actions tailored to address the illness and restore health. Such treatments may include a concoction of medicines, rest and various rituals which may have religious roots, and traditional remedies, such as short-term changes in food and drink consumption. Indeed, food and drink may have a prominent role in treatment – for instance, the administration of hot whisky mixed with sugar or honey to those suffering from a heavy cold, regardless of age, is fairly common in Ireland and Scotland – and in the maintenance of health.

Self-help groups are another institutional arrangement beyond the family identified in this analytical approach. Again, there is likely to be a commonality, or at least a trajectory towards a confluence of beliefs and shared experiences in such groups. An obvious example of a self-help group is Alcoholics Anonymous, the format of which has been tremendously successful as it has replicated throughout the West and beyond since Robert Smith and William Wilson founded it in the US in the mid-1930s (Finlay, 2000). By affording their members a forum and an opportunity to articulate their experiences, self-help groups can become knowledge repositories as well as offering their members solace for what may be a stigmatized condition and advice on coping and coping strategies.

Of course, popular health care can adversely impact the health condition of individuals. Families, like all other institutions, not only enable but also constrain. There is some evidence to suggest that families and other groups can impede an individual's recovery or treatment through ill-informed but well-intentioned actions (for example, Bille, 1992; McCubbin, 1999).

The folk sector covers those relations between an individual believed to be suffering from some illness or condition and a "healer." The "healer" is not a member of the legally legitimate medical care system but does possess some status in the locale and community. Such positions are frequently, but certainly not exclusively, buttressed by religious beliefs and are especially prominent beyond Western societies. In many cases the conception of illness reflects prevailing culturally informed beliefs that may be spiritual and take a holistic view of health which may include physical, emotional, and moral dimensions (Boulding, 1966; Kleinman, 1980). It is therefore not uncommon for illness to be viewed as some sort of spiritual judgement on a person's alleged "moral deviance." In making such diagnoses spiritual healers may consider an individual's family history as well as consulting more ritualistic and superstitious sources. On this account, the relationship between "patient" and "healer" is certainly not one of equals. Healers are afforded an elevated or privileged role by virtue of a host of factors, such as birth inheritance and position within a family and so forth. Nonetheless, anthropological studies have argued that health care provision in this institutional setting concentrates on the person, frequently involving the individual's family as opposed to the disease, and therefore potentially offer "a closeness, a shared world-view, warmth, informality and the use of everyday language in consultations …" (Helman, 2007: 87) which seems well beyond the biomedical model.

Of course there is much criticism of the role of such "healers" and professional medical thought is especially suspicious of much of folk health care (Groopman, 2007). Of particular interest is the line of criticism within medical anthropology that it has romanticized the folk sector. Hemmings (2005: 95), for example, notes,

> Western thought has led to advantages in development. Many anthropologists would view this as colonialist, even racist. But that defies the reality that people in developing countries know the benefits of scientific medicine and they want more of it, not less.

Kleinman's third sector – the professional sector – comprises the legally legitimated, professionalized salaried employees that usually constitute Westernized scientific medicine, although in some parts of the world, such as China and India, aspects of traditional medicine possess similar legitimacy and professionalization. For instance, Helman (2007) reports that in the mid-2000s in India there were 101 officially recognized religious medical schools (91 Hindu – *Ayurvedic* – and 10 Muslim – *Unānī*), and in China traditional medical outlets, including acupuncture and herbalism, are viewed as complementary to biomedically oriented provision.

This supports our perspective and the work of Landy (1977) relating to medical pluralism as in the coexistence of different medical and health care systems. However, this view is not without its critics. For example, Han (2002) has argued that pluralism of this sort is more imaginary than real, given the domination of professionalized medicine. Indeed, Han argues that "orthodox" medicine occasionally adopts the seemingly contradictory strategies of undermining alternative approaches and preserving them at various times. Such strategies are operationalized through medical institutions such as professional journals and medical practitioners. They are not always contradictory and incoherent since alternative medicine is far from being a homogenous entity. Han points to "traditional" Chinese medicine, which differs in practice from Australia and China, for example. Moreover, the practices of Chinese medicine have evolved, and therefore changed, from past beliefs, practices, knowledge, and facilities (see also the earlier work of Berliner and Salmon, 1980). In this regard, Han agrees that medical systems reflect (and contribute to) prevalent socioeconomic relations and modes of production. From a critical realist perspective, Han argues that the mode of production is of considerable importance in appreciating the organization of society, and hence medical systems embedded within society. Contemporary Western society is, according to this Marxist argument, characterized by "large-scale monopoly capitalism" (Han, 2002), which tends to encourage the domination of a specific mode of production. Drawing from the work of Berliner (1982) and Navarro (1983), three typical (but not exhaustive) modes of production in medicine can be identified as home, "petty commodity," and "monopoly-capitalist."

Home production is intended to be directed to family members exclusively. The petty commodity mode of production refers to the situation where an individual's medical skill can be sold, and hence commodified, as a means of livelihood. Monopoly-capitalist refers to both the private sector employment of salaried staff and the production of commodified care as well as state provision that offers a range of services that may be subsidized through taxation and partly provided on a commodity basis. These typifications aid identifying the commonalities across medical provision in contemporary society in that, with the exception of home production, they involve a carer–patient relationship, which has become more distinct with the commodification of medical services engendered by a "hegemonic struggle" in social systems institutions leading to increased recourse to markets (Filc, 2014). For Han, all medical activities have some reference to the market, whether it is the pursuit of medical training to gain employment or the supply of pharmaceuticals and equipment or increasing consumerism. In this type of analysis there is appreciation of the tendency of medical providers to medicalize disease and illness while de-emphasizing pertinent social factors – an argument we outlined in Chapter 2. Other developments identified as market-oriented in this literature include professionalization and competition. The latter refers to rivalries within and between different traditions aimed at enhancing their reputation, superiority, and financial resources.

Ironically, Han's argument has some resemblance to the standard health economics position – health care as a commodity (McMaster, 2013). Nonetheless, a Marxist emphasis on power is important in analyzing the provision of care. Drawing from our analysis of delivery institutions in Chapter 3, we recognize the heterogeneity of the professional sector, and hence some sort of pluralism, with various specialist and allied fields contesting, mutually buttressing, and reproducing medical power. The "profession" focuses on an area of highly specialized knowledge, expertise, and competence that is not easily acquired and therefore affords the 'profession' a legitimized and powerful position in society. As we have argued, this is infused with values conveyed by habits, which can shape the nature of shared intention – the use of "we" language in groups. An interesting dimension of this relates to the notion of the "total institution."

6.3.3 The "total institution"

The noted sociologist Erving Goffman (1968) coined the term "total institution" in his work on asylums. He defined (1968: 11) the total institution as:

> A place of residence and work where a large number of like-situated individuals cut off from the wider society for an appreciable period of time together lead an enclosed formally administered round of life.

For Goffman, the bureaucracy of the total institution is its hallmark: this delineates staff from "inmates," engenders a particular range of incentives and work for staff, and separates both staff and "inmates" from wider society. From our perspective, Goffman's notion offers a potentially intriguing insight into the nature of care and caring over a prolonged period of time in a specific location with the physical attributes specific to that location. It points to the potential for care to be highly routinized and functional in terms of the delivery of activities associated with care. Nonetheless, given the long-term duration of many "inmates" there is a relational aspect that may prompt sympathy on the part of care-providers, and indeed the ethical characteristics allied with authentic caring. Yet Goffman's theory only seeks to provide a general conception modeled on his portrayal of asylums. In other words, Goffman conflates residential institutions using the formality of their administration as their defining feature. "Inmates" reside in such places either through misfortune or transgression; residency is usually involuntary. This certainly places autonomy and agency at the heart of analysis, with which we agree. However, not all residency is either involuntary or isolationist. Only in the more extreme circumstances can an institution and its inhabitants be considered to be closed off from other institutions. Goffman, to be fair, acknowledges this, but his framing of the notion is not compelling. Sociologists have critically developed the total institution idea. An interesting example is provided by Christie Davies (1989), who argues that Goffman fails to capture the difference between those institutions characterized by a totality of residence, such as residential care homes for the elderly, orphanages, asylums, and prisons, and those demanding a totality of commitment, such as religious orders and some political ideologies, which he terms as "greedy institutions". Such institutions are all-consuming of an individual's obedience to the aims and values of the institution, and identity. There is, according to Davies, an overlap between the two institutional arrangements.

In terms of our argument, Goffman's notion presents an interesting case of variations in the needs for care: the requirements of long-term residential care present distinctive challenges compared to short-term care and treatment, which we explored in Chapter 3. This aside, we find the conception of the total institution in the context of developing a health care economics not to be of particular importance. Instead, we believe that institutions cannot exist in isolation – there is mutual support in a system of institutions. Thus, even in Goffman's paradigmatic case of asylums staff are presumably trained and therefore subject to professional norms and practices, as in our notion of education and training institutions. Such professions again are not (and cannot be) entirely divorced from other cognate professions. Instead, we feel that greater insights into care may be provided by an appreciation of the inculcation of behavioral propensities through habit and the value systems they reproduce.

6.4 Moral groups of care

So far we have emphasized the importance of institutions in partially constituting the individual, and have argued that the evolution of learned habits is vital to the transmission of rules and hence social values. We have also made a case for considering the individual as socially embedded and have noted the role of groups in exercising shared intentions and moral judgements. Thereafter, we have explored distinctive groups and institutions in health care. We now seek to further analyze the ethical and moral dimensions of care – specifically in terms of the phases of care we noted in Chapter 5.

Hodgson (2013) argues that our instincts as humans combined with the evolution of habits convey certain patterns of values found in all human societies. Drawing from the work of Jonathan Haidt and his colleagues on the evolution of morality, Hodgson (2013: 114) identifies five universal moral dispositions:

1. Care for others in the form of protecting them from harm.
2. Treating others fairly and justly – there is reciprocity.
3. Loyalty to group, kin, and other identities, such as nationality.
4. Respect for tradition and legitimate authority.
5. The avoidance of repellent things, foods, actions. Hodgson notes that this is framed in terms of "purity."

From our perspective the first item in Hodgson's list is of obvious interest, although the others do have a bearing on our analysis. The universal moral disposition to care, on this account, is explicitly other-regarding, aimed at avoiding harm, and therefore underlies a drive for survival. In Chapter 5 we discussed the nuances of the phases of care in the frameworks of Blustein (1991) and Tronto (2013). We also commented on the resemblance between Tronto's (2013) broad definition of care and the IVP advocated by some institutionalists such as Marc Tool (1995) and Warren Samuels (1995), and noted the emphasis in the aims of care (section 5.4 of Chapter 5) on survival, development, and social reproduction. Here we wish to draw out the ethical implications of these aims and associate them with their institutional framing through habit.

TABLE 6.1 Tronto's phases of care and ethical qualities

Phase of care	*Meaning*	*Ethical quality*
Care about	Awareness of a care need	Attentiveness
Caring for	Following identification of needs, taking responsibility to meet those needs	Responsibility
Caregiving	Action of care	Competence
Care receiving	Observing and assessing the effectiveness of the care action	Responsiveness
Caring with	Care identified and given should be consistent with commitments to justice, equality, and freedom for all	Plurality, trust, communication, respect, solidarity

Adapted from Tronto (2013).

In her analysis Tronto matches particular ethical qualities with the phases of care she identifies (see Table 6.1).

In earlier work Daniel Engster (2005) identified three ethical qualities necessary to meet the aims of caring – attentiveness, responsiveness, and respect – and therefore for care to be authentic.

For Tronto (2013: 34), attentiveness is the suspension of self-interest and the ability to "genuinely" place oneself in the position of the individual in need of care. This appears to go beyond standard definitions of "attentiveness," which are usually expressed in terms of being mindful or paying close attention to something, being polite, and "assiduously attending to the comfort or wishes of others" (*OED*, 2014). Tronto's description is more demanding in that it requires the appreciation of another's position, and the ability "to look from the perspective of the one in need" (*ibid.*). In this respect, Tronto's account appears distinct from Noddings' (2005) requirement that caring should be characterized by "engrossment" and "motivational displacement" on the part of the carer, noted in section 5.5 of Chapter 5. Instead, Tronto's conception appears to have some affinity with Adam Smith's notion of sympathy, as in possessing the capacity to imagine another's situation as our own, especially if these circumstances are seen to be undesirable. This has the potential to engender compassion, even pity on the part of the sympathizer. Yet, in the *Theory of Moral Sentiments*, Smith did not think of sympathy as a virtue, rather as a passion derived from our ability to imagine. There is an extensive literature examining the multiple uses of "sympathy" in the writing of Smith (in economics, for example, Sugden, 2002), and the distinction between "sympathy" and "empathy." Empathy, for example, can mean the ability to understand the feelings of others by virtue of having shared the same or a similar experience (*OED*, 2014). On this understanding, Tronto's analysis is closer to "sympathy," yet the term is conspicuous by its absence from her discussion.

By contrast, Engster is explicit in linking attentiveness with empathy. He argues that attentiveness "usually" involves empathy and an anticipation of the needs of another. This is less exacting than the condition specified by Tronto: there is no apparent requirement on the part of the carer to place himself or herself in the position of the individual requiring care. These may be subtle distinctions, but they may potentially impact those charged with caring roles. How sympathetic or empathetic should they be? In effect, this may be an issue that Blustein (1991) identified as a degree of commitment (Chapter 5, above), which we will argue below has some bearing on the institutional framing of care.

The assumption of responsibility is seen as the appropriate ethical virtue aligned to "caring for" in Tronto's schema. A specific individual, or group, from the point of their social role and position has an obligation to assume responsibility for the caring needs identified. This is most obviously an institutional influence.

The next phase is caregiving, and this Tronto associates with competence as an ethical quality. She argues that this is not merely a "technical" feature of the activities and practices of caring, but a moral one. If someone in a position of responsibility does not have the requisite skills to meet the needs of caring, then they will fail to meet their moral obligation. The ability to listen to another's concerns can be important. We feel that this is a key argument, given that in fiscally challenging times there is a temptation to cut costs by reducing the numbers of skilled staff and engaging labor that may not be as adept as the workers being replaced.

Care receiving is aligned with responsiveness. Both Tronto and Engster frame this in terms of engaging in a dialogue with the individual receiving the care. Again, the ability to listen and respond may be significant. Engster maintains that a diminished responsiveness is likely to impair the effectiveness of caring. More generally, Tronto reasons that animals, plants, and the environment subject to caring acts will respond in some way, and those providing care are obligated to be sensitive and make judgements about such responses.

Engster's third virtue is respect, which is also advocated by Tronto in the bundle of qualities she associates with "caring with." This is most clearly situated in social systems institutions. The values prevalent at this level, we contend, shape the habits of thought developed in education and training institutions and reproduced in delivery institutions. Therefore, in medical care, if social systems do not engender the ethical qualities of "caring with," it is likely that the ethical qualities Tronto identifies in other phases of care may be impaired and contribute to an enlarged "caring deficit." Moreover, Boulding's (1969, 1973) demarcation between "threat," "exchange," and "integrative" systems is relevant here. If the domain of the integrative system contracts, its underlying value basis – love, in Boulding's terms – also diminishes. This would certainly imply an attenuation in beneficence as a virtue, and hence suggest a weakening of the environment conducive to "caring with."

Other parts of the literature on care also allude to the elements identified by Tronto. For example, Sevenhuijsen (1998) refers to respect when she identifies the requirements of caring in terms of recognition of "dependency, vulnerability, and otherness." For Sevenhuijsen the properties of respect are allied with commitments to trust, plurality, and communication. Tronto draws on these and adds "solidarity." This is surely a complex bundle of related and entwined characteristics.

Respect is the idea that others are worthy of attention and responsiveness, and therefore should be treated in a way that does not degrade or humiliate them (Engster, 2005). It therefore has a foundational dimension in establishing authentic care. Without respect there is no ethical obligation to be attentive or responsive – in short, there is no duty to care. There is a similar foundational quality to Tronto's reference to respect. In combining this with the other features she emphasizes, Tronto attempts to convey the importance of the institutional context of care. She is explicit in noting that her list of virtues is not comprehensive and is keen not to overly stress the ethical values of care. She argues:

> The problem with all theories of care-as-virtue is that they are not relational. They do not begin with the premise that the important ethical issues concern relationships and meeting needs, not the perfection of the virtuous individual. Starting from an ethic of care-as-virtue returns the focus to the caregiver's performance; this preoccupation makes too remote the political concerns of unequal power among caregivers and care receivers. (2013: 36)

Not only does Tronto emphasize that care and caring is profoundly relational, she also highlights the dangers of an overly paternalistic "caring regime" where the care receiver's autonomy is disregarded. Carse and Lindemann Nelson (1996), Mol (2006), and Sybylla (2001) are also alert to the possibilities of care imposition that leads to the loss of autonomy. Carse and Lindemann Nelson, for example, write (1996: 22–3):

> The imposition of care on another without consulting her wishes or trying to understand her needs from her own point of view is rightly excoriated as paternalism; when we care for another solely on our own terms, we act arrogantly.

This echoes Boulding's (1966) view, noted in Chapter 4, that we cease to be human if all we have are needs without demands. While the care literature conveys some unease about an "excessively" ethical orientation, the basis of this concern is itself ethical, arising chiefly from the need to respect the individual care receiver. Arguably, this lies at the heart of the care-as-relational approach. Indeed, for us, the relational aspect of care entails the ethical implications identified by Tronto and others – the two are inextricably linked. This is what shared intentionality and a socially embedded individual approach imply. On this we find common cause with Engster's (2005) case that care obligations rest on our common dependency. Thus humans require care in order to survive, develop, and thrive; individuals valuing their survival must acknowledge that care is a necessary but not always sufficient condition; individuals have rights to be cared for when in need, by virtue of our humanity; and caring sustains and reproduces society. Moreover, in recognizing the importance of the relational characteristic of care, Engster contends that it is most effectively practiced in particular relations where the caregiver can exercise attentiveness, be responsive, and be respectful. Caring is, in short, necessary to ensure a decent society and a good life for its members. It is, for Engster, the most fundamental human value. He thus concludes:

> Care theory does not posit the duty to care for others as superior to all visions of the good life, but it does identify caring as a basic morality that obligates all who are capable of providing to do so in some measure … Care theorists have reconceptualised caring as a practice rather than a moral orientation, developed some general caring principles, and outlined a number of moral justifications for our duty to care. (2005: 69–70)

In our view, the care literature's emphasis on the ethics of caring, caring as relational, and caring as practice demonstrates the value of the concepts of shared intentionality and habit. Throughout the analysis of Baier, Engster, Mol, Tronto, and others there is an ongoing invocation of "we" and "our" in terms of rights and obligations. The individual is not viewed as an atomistic agent, but one embedded in a complex milieu of social relationships. To care is to see the individual as socially embedded and in an institutional setting. This also reflects the importance of habit in conveying the morality of care: one cares by virtue of one's social role and the habits of thought intrinsic to this role. We apply this thinking more directly to the medical context in the following section.

6.5 Medical groups of care

All health care institutions – whether they are care delivery institutions, education and training institutions, or social system institutions – are framed by values and ethical principles about what people should and should not do and what people regard as morally good. Here we only seek to elicit the values, ethics, and morals that our relational conception of care involves. They are explicit in our descriptive account of the care relationship, explored above, and in how that relationship is socially embedded in social networks and health care institutions. Most standard economists, including health economists, operate with a positivist understanding of their field, whereby ethical values and policy recommendation operate fully outside the explanation of that subject matter, and can consequently be ignored in that explanation. But this view of economics is misconceived for many reasons, chief among which is what has been called the 'entanglement' of facts and values in ordinary language and human experience (Putnam, 2002; cf. Davis, 2013b).

The evolution of medical care itself exhibits how the normative dimension of the phases of care operates within the institutions of medicine. In Chapters 2 and 3 we charted the history of the rise of biomedicalism and the configuration of Western medical care delivery institutions. There is an extensive critical literature in this area (for example, the noted contributions of Barbour, 1995; Freidson, 1970; Illich, 1976; Kennedy, 1981), but for our purposes Paul Starr's (1982) imaginative casting of the rise of professional medicine in the US as a three-act drama is especially insightful.

Act 1 centers on the nineteenth-century growth in medical power from a period of "disarray" to professionalization founded on the emergence of a Cartesian science-based paradigm – marked by the standardisation of norms, record-keeping, and the transformation of medical education into an institutional system that inculcated substantive professional values, fostered technical competencies and a unified community of expertise (Barbour, 1995; Freidson, 1970; Groopman, 2007; Kennedy, 1981; Langlois and Savage, 2001; White, 2004). Starr's second act concerns the twentieth-century consolidation of nascent medical power, where the profession shapes clinical-medical institutions – principally hospitals and insurers – in its own interest: power and prestige are unprecedented. The autonomous professional decision-maker is afforded discretion in what Langlois and Savage (2001) term a "practitioner's toolkit of routines" within an overarching protective professional network. As Langlois and Savage note, the process of standardization through medical education and record-keeping (medical interfaces) shaped the process of innovation, encouraging further specialization and localized knowledge. This tacit knowledge, they argue, was a potent source of change in the practice and technology of medicine in the nineteenth century and is still pertinent.

The final, unfinished act focuses on the emergence of fiscal pressure partly arising from the exercise of medical power in Act 2. Starr predicts that accelerating medical inflation will prompt a reaction from the state in the form of structural reform that will erode physician autonomy and power. In that regard Starr anticipates the broad thrust of market-oriented reform, which he laments, but also he ignores the nuances of emerging properties. At the level of social systems institutions, White (2004) contends that there is a pattern of deteriorating trust in medical institutions and tensions engendered by an increasing consumerism, which may be associated with the increasing availability of information via the Internet, although this may also run counter to physician power and function as a conduit for increasing the democratization of medical care (for example, Fox, 2001; Silence *et al.*, 2007).

Starr's analysis of these traits usefully establishes a broad institutional background, where the medical profession is portrayed as a more or less homogenous entity. This, of course, is open to some contention. There is an extensive medical literature that examines the contradictions in the historical framing of clinical-medical care. As we explored in Chapters 2 and 3, there is a tension between the Cartesian biomedical foundation of Western medical practice and the Hippocratic ethos. The former would seem to suggest a profession articulating a specific model of care-as-treatment, whereas the latter suggests an approach closer to the relational reading of care.

As we outlined in Chapter 2, Groopman (2007) is among those highlighting doctors' propensities to make errors. Groopman classifies these as: "attribution errors," "search satisfying behavior," "confirmation bias," and "commission bias" (see section 2.2 of Chapter 2). From Groopman's analysis, the frequency and range of physician error does not readily correspond to a care regime embracing the ethical value of responsiveness to the recipients of care. Indeed, there are numerous studies showing a one-way discourse in medical consultations, where the clinician dominates conversation (for example, Karnieli-Miller and Eisikovits, 2009). In terms of education and training institutions, the shaping of medical professional norms is relevant here.

There is a large literature on professionalism (for example, Perkin, 2002; Wueste, 1994) in which there is consensus on its central features: the centrality of specialized knowledge to tasks, which enables professionals to claim authority over certain activities; the activities involved promote social values; role-specific norms govern these activities, and professionals are generally located in bureaucratic organizations (Wueste, 1994). This, as DeMartino (2011) maintains, imbues professional groups with institutional power that arises from an "intellectual monopoly" (see also Freidson, 1970). Professional practice tends to be governed by four principles: nonmaleficence, autonomy, beneficence, and justice (DeMartino, 2011). There is a clear alignment with those principles and the moral and ethical virtues identified in the care literature. Indeed, professional medical associations stress the competence of the medical practitioner as a key principle (World Medical Association), and of course refer to the absence of malevolent intent in the Hippocratic admonition, *Primum Non Nocere* (First Do No Harm). The uncertainty of medicine is embodied in these dictums – the normative stricture is that clinicians should conduct themselves in a way that does not worsen a patient's condition. Yet there is a tension in the caring principles of medical groups. The biomedical model assumes a medical orientation to illness which, as we have argued, crowds out attention to social ills. Boulding's (1966) elegant observation that an individual may be healthy in a sick society seems pertinent. Moreover, there is nothing in the biomedical approach that acknowledges the autonomy of the patient, and indeed, despite its relational emphasis, there is also nothing in the Hippocratic Oath that promotes patient autonomy (DeMartino, 2011). This, according to the care literature, would occasion superficial and inauthentic care in that it lacks compassion on the part of the care-provider.

The foregoing has an important implication for the mainstream conception of care in terms of altruism. As we argued, this conception presents care as essentially one-dimensional and ignores the importance of ethical framing and institutional influences. Altruism is individualistic in that it does not invoke a moral obligation associated with a particular social role – there is no sense of duty or responsibility. Accordingly, there is an ephemeral property to altruism that makes it subject to instrumental calculations, and therefore makes it *less* socially embedded than compassion. Care is also to a large extent socially constructed in that it is conceived and developed in particular institutions, such as Western medical education. There are obligations, responsibilities, and duties to care arising from an individual's social position. Care need not be altruistic or necessarily a matter of altruistic acts. Thus care refers not only to series of functional practices or acts, but is imbued with ethical qualities; this is particularly the case with medical care. The responsibilities and obligations of caring, in general, are to be founded on our common dependency – that at various times in our lives we will be dependent on others for our wellbeing and therefore when in a position to be able to offer care we are obligated to do so. In medical care, then, there is an obvious duty for clinical professionals to offer care on the basis of their social position.

Recently, arguments promoting patient autonomy, and clinician responsiveness as caring, have been advocated. DeMartino (2011), for instance, highlights a new draft of the Hippocratic Oath at Yale University that encourages patient participation in medical decision-making. However, this does not appear at the current Yale medical school website, where the closest statement to patient participation is:

> I will assist my patients to make informed decisions that coincide with their own values and beliefs and will uphold patient confidentiality. (http://www.medscape.com/viewarticle/550118_4)[4]

We examine such issues more extensively in Chapters 7 and 8 in the context of a capabilities approach to care.

Notes

1 There is a further point of advantage offered by a Veblenian approach to agency and structure: it avoids the errors of reification and voluntarism (Hodgson, 2004), i.e. the former treats institutions as necessarily concrete entities determining the individual, while the latter is individualistic and therefore ignores the pre-existence of social structures.

2 As Hodgson (2004: 165) notes, Veblen drew the distinction between instincts and instinctive behavior. The former are innate and cannot be changed, but the latter can through countervailing habits or learned behavior.

3 As noted previously, there is also a logical challenge to the process of utility maximization in that it is subject to a process of infinite regress. Agents calculating the costs and benefits of a particular action would also have to calculate the costs and benefits of their calculation, and then of that calculation of the calculation, and so on (Field, 1984).

4 Accessed 9 September 2014.

7

DEVELOPING CAPABILITIES AND THE DIGNITY OF THE INDIVIDUAL

> "Without health nothing is of any use, not money nor anything else."
>
> (Democritus)

7.1 Introduction

To address how health and medical care contributes to human flourishing, the goal of this third part of the book, we need to discuss the normative objectives of care systems. But where do the normative objectives of care systems come from? How do care systems come to have certain normative objectives and not others? In the last chapter we took care systems to be networks of institutions built up around the interaction of people in and across the social groups involved with and concerned about patient–clinician relationships. We identified and discussed how medical and health care institutions can convey a particular moral position in their "caring" activities. Delivery institutions are nested in education and training ones, which are embedded in the wider social system, which for us highlights an evolutionary dynamic to care and caring regimes. As the likes of Lesley Doyal and Imogen Pennell (1979) and others have long recognized, the provision of care is not immune from wider social forces, and is reflective of existing power structures in society. We absolutely agree with this fundamental point, and have set out our position in preceding chapters. As we have argued consistently, care is partly habitual in that it is a learned disposition and group of behaviors. The authenticity of care is sensitive to social forces that shape professional ethos. Care is also instinctive, and this may be suppressed, to some extent, by those social forces.

In this chapter, we frame our discussion of the normative objectives of care systems in terms of how this social interaction determines the fundamental objectives of care. We argue that the normative objectives of care emerge ground-up, as it were, from the direct contact with and interaction between people who are immediately concerned about the nature and provision of care. These objectives then take on additional form in the wider interaction between social groups that produces the health and medical care institutions that make up entire care systems. At this level, the normative objectives of care get formulated in broad cross-institutional terms that guide society's general policies and values regarding care. That is the subject of the chapter that follows this one. In effect, then, this chapter concerns the micro basis for normative objectives in health care systems, and the next chapter concerns their macro (institutional and system) basis.

In the last chapter, we provided our understanding of what institutions are, discussed how institutions socially embed individuals, and explained how this social embedding generates shared intentions and expectations about care between people. This interaction between embedded individuals produces "moral communities" in the sense of Hodgson (2013), whose values pervade the entire space of institutions and care systems. What we argue in this chapter, then, is that only certain specific types of values and normative objectives regarding care arise out of the interaction between socially embedded individuals. Mainstream health economics essentially fails to recognize the existence of these types of values and normative objectives, and consequently operates with a deficient understanding of care, because it operates with un-embedded, socially isolated individuals, who by nature do not develop shared intentions and expectations about care. Thus our view is that understanding the normative foundations of care depends on understanding the social connection between people who interact closely with one another in the provision of care.

What this perspective requires, we argue, is that we think about care in terms of capabilities, the well-being concept developed especially by economics Nobel laureate Amartya Sen (cf. Sen, 1993, 1999) and the philosopher Martha Nussbaum (Nussbaum 2011).[1] In contrast to mainstream economics' utility concept of wellbeing formulated in terms of the preferences of un-embedded, socially isolated individuals, for Sen and Nussbaum capabilities have an inescapably social character because individuals' capabilities are always exercised in social settings in interaction with others. This applies to all the capabilities for the many different things that people can be and do (referred to as their functionings), and it particularly applies to the capability for having good health, which depends not only on the social interaction in the patient–clinician relationship but also ultimately on all the other social relationships connected to that relationship. Indeed, in this regard, the capability for having and being in good health is, as the epigraph above from Democritus says, a central human capability. Because the capability for good health is so important to having so many other human capabilities, its provision is arguably more deeply and widely embedded in the webs of social relationships that make up life in moral communities than any other capability, as reflected in the array of health and medical institutions built up around care as well as the development of whole health (including medical) care systems.

In what follows, in section 7.2 we first explain the nature of the health capability, and then explain how people's different health capabilities are socially embedded in care relationships. We then show in section 7.3 how this social embeddedness promotes only certain specific types of values and normative objectives regarding care – ones that are different from those promoted by mainstream health economics. Our argument here augments Tronto's (2013) linear representation of the phases of care and their alignment with particular ethical values, which we discussed in Chapters 5 and 6. Finally in section 7.4, we discuss what the nature of the person is who is the focus of care in socially embedded care relationships. Our view is that the specific types of values and normative objectives regarding care that we identify imply a particular normative conception of the person, namely a person intrinsically worthy of being treated with dignity. This conception of the person is missing from standard health economics. Our argument resonates with conceptions of need discussed in various literatures by, for example, Kenneth Boulding (1966), Len Doyal and Ian Gough (1991), and Daniel Sulmasy (1993). We develop this line of thinking by arguing that the conception of the person as intrinsically worthy of being treated with dignity underlies the case for regarding equity in health as a foundational value in the design of social policies for the development of health care systems in the broadest sense, the subject that we address in the following chapter.

7.2 Health capabilities and their social embeddedness in care relationships

The capabilities approach is associated with the pioneering work of Amartya Sen (e.g. 1999, 2002b, 2009) and Martha Nussbaum (e.g. 2011). It is based on the Aristotelian notion of human flourishing, and offers an alternative framework to Utilitarianism for the evaluation of wellbeing, impoverishment, and justice (e.g. Clark, 2005; Robeyns, 2005, 2011; van Staveren, 2015). The approach resonates with Isaiah Berlin's (1969) conception of positive freedom. For Sen (1999: 5), freedom is:

> What people can positively achieve … is influenced by economic opportunities, political liberties, social powers, and the enabling conditions of good health, basic education, and the encouragement and cultivation of initiatives.

The literature – especially associated with Sen's approach – distinguishes between:

- Capabilities as *what* an individual is *able* to do or be – an individual may have the ability to avoid hunger but chooses to fast (Clark, 2005) – may be viewed as freedom to achieve (advantage – potential achievements) (Martins, 2007).
- Functionings as an individual's *actual* being and doing – may represent the use an individual makes of commodities under their command. This is likely to be dependent upon personal and social factors.

Functionings are realised capabilities, and capabilities are potential functionings. Functionings are akin to achievements, and Sen considers that wellbeing reflects actual achievements (functionings). In his work, Sen advocates equality of basic capabilities (for example, education, health and health care, food security), but not in functionings, as he argues that this would impinge on an individual's agency to act in certain ways. This has generated some controversy with critics arguing that Sen in effect conflates capabilities and freedom (for example, Gasper, 2002; Gasper and van Staveren, 2003; Levine, 2004; van Staveren, 2001). In other words, greater acknowledgement should be given to the translation of capabilities into functionings. Nonetheless, this may be a problem for the interpretation of the capabilities approach as well as its application in certain contexts (Sayer, 2014). We have some sympathy with Sayer's argument, and feel that capabilities offer an appropriate way of developing our thinking on care in health economics.

The approach also complements conceptions of need in a wider political economy context, which again recognize human flourishing and acknowledge the importance of social environments in shaping flourishing (for example, Boulding, 1966; Doyal and Gough, 1991). Need in the context of health in particular highlights our mutual dependency (Engster, 2005), which is an important dimension of care. Recall Boulding's (1966) distinction between wants and needs. With the articulation of wants there is individual autonomy. By contrast, in the case of needs another agent decides, in the extreme implying a complete loss of autonomy (and power). Doyal and Gough's analysis has some affinity with Sen's identification of basic capabilities in that they identify objective human needs and reject the basis of examining needs as preferences, which, as we have argued, is the basis of standard health economics.

On the basis of the foregoing we can think of health in terms of capabilities rather than utility measures of health in that this creates a distinction between health achievements and the ability people have to pursue good health. Health achievements are an outcome measure of health care, but when we also include the ability people have to pursue good health in our thinking, we include people acting as agents of their health in our assessment of their wellbeing. We may thus question the efficacy of utility-based measures of health, such as quality-adjusted life year (QALY) or disability-adjusted life year (DALY) employed by most health economists. There are a number of reasons why one should adopt this perspective. First, the risk of thinking of health only in terms of health achievements is that doing so tends to put the emphasis on average health needs and misses the heterogeneity of health needs across people. The latter comes out when we see how individuals act as agents of their own health. Second, when we focus only on health achievements, we miss the many relevant aspects of health that depend on what people do. Health is not just a state a person is in, but involves a whole variety of activities and practices in which the person's health undergoes continual management by themselves in collaboration with clinicians, family, and community. Third, when we think only in terms of health outcomes, we tend to impose consequentialist framing on the value of caring, and moreover conflate it with narrow acts of biomedical treatment of a mechanistic sort we identified in Chapter 2. Health then becomes a matter of disease diagnosis and epidemiology, not a care relationship, and this risks making health care a matter of a paternalistic delivery of care services with the potential loss of individual autonomy.

Jennifer Ruger's *Health and Social Justice* characterizes health capability as "a person's ability to be healthy" (2010: 3). The emphasis on ability as a potentiality is important, and has some affinity with Antonovsky's (1996) *Salutogenesis* and emphasis on the development of "health" as opposed to the prominence of illness in biomedicine we outlined in Chapter 2. Among other things, people's actual health achievements reflect their access to care, which may be quite uneven across individuals and social groups, and thus often fall short of what they could achieve were health resources more abundant or differently distributed. Again, this resonates with the arguments of Engel (1977) and Krieger (2005) about the biological manifestation of social influences discussed in Chapter 2. As Sen puts it, when we see people not receiving health care, we judge there to be a "lack of opportunity … because of inadequate social arrangements" (Sen, 2004: 23). The other side of the care that people do receive, we might then say, is the care they don't receive. This for us encapsulates Tronto's (2013) references to a "caring deficit." Ruger captures this by framing the health capability concept in opportunity terms as the idea of a health capability gap. We will say more about what this involves below, but here emphasize that methodologically it means we need to think of the provision of health as simultaneously a practical and a normative concern (see also Sulmasy, 1993). In particular, how we characterize and describe care arises directly out of our normative objectives regarding what care people should achieve.

Contrast this with the utility-based QALY approach which first records in a purely descriptive way what people prefer regarding different health states as a kind of neutral data, and then goes on to introduce normative criteria to determine the distribution of care, such as in the "fair innings" approach which attaches "equity weights" to sets of QALYs to achieve a normative objective independent of the nature of people's preferences (Williams, 1998; Culyer and Wagstaff, 1993). The problem with this is that normative criteria introduced after the fact have a certain degree of arbitrariness about them. Why not other criteria? In the capability approach, however, the emphasis on opportunity as a measure of health directs us immediately to what people believe good health involves and the kind of life they wish to live so that our normative criteria are implicit in our understanding of care from the outset.

Ruger thinks of care in terms of human flourishing or as the idea of people being able to develop their capabilities across the many desirable dimensions of life – physical, psychological, and social – through their own agency and in collaboration with others. This shows us that a reason the health capability is centrally important to life is because one cannot flourish without it. The human flourishing idea also underlies the social nature of health, because one cannot successfully pursue it and flourish except in interaction with others. Ruger thus regards health capability as intrinsically valuable. At the same time, she recognizes that the many different kinds of health capabilities are not all equally important. Following Sen, she accordingly distinguishes between health capabilities regarded as "central" and health capabilities regarded as non-central or "secondary" with the difference between them being their importance for human flourishing (*ibid.*: 4). Sen regards "basic capabilities as 'crucially important capabilities dealing with what have come to be known as 'basic needs'" (1993: 40). For example, for him (Sen, 2002a) "basic" health capabilities are being able to avoid premature mortality and being adequately nourished, whereas a "secondary" health capability is being able to enjoy recreational activities. Accordingly, "basic" health capabilities are essentially prerequisites for "secondary" health capabilities, and should thus receive priority in advancing people's overall health capability.

We interpret this to mean that providing people with "basic" health capabilities constitutes a common ground of understanding for people across the many different overlapping, interconnected care relationships that make up systems of health care that incorporate medical care institutions. That is, across all these care relationships, people share an intention regarding what the "basic" health capabilities are that people should all have. In virtue of their being "basic" they are seen as health capabilities that all people ought to equally enjoy, and are consequently ordinarily referred to as what "we" ought to provide to everyone. That is, inherent in the idea, for example, of being able to avoid premature mortality and being adequately nourished is the idea that any person should have these capabilities and any shortfall regarding them has priority in the provision of health care in its *widest* sense. As Sen (2002a: 660) argued:

> We have to go well beyond the delivery of health care to get an adequate understanding of health achievement and capability. Health equity cannot be understood in terms of the distribution of *health care*. (Original emphasis)

To be clear, Sen's use of "health care" in this instance refers to *medical* care provision. Like Boulding, Sen is one of those economists who explicitly recognize that health is heavily influenced by social factors such as poverty. This is less obvious, as Mooney (2009) argued, in the standard approach to health economics. Following Sen, health equity becomes an element of wider issues of justice, and invites some reflection on care as a part of justice. Indeed, there is some correspondence here with Engster's (2005) articulation of obligations and responsibilities to care, an aspect we turn to later in this chapter.

In terms of capabilities, matters are clearly more complicated when we turn from "basic" to non-central or "secondary" health capabilities. When we focus on needs, people broadly share the same intentions about the importance of care irrespective of their own individual circumstances. When we focus on non-central health capabilities, people's shared intentions about them form differently across people rather than in the same way for everyone – in effect more "locally" in relation to the specifics of the care relationships involved – because people have such different health care goals when we go beyond needs. "Basic" capabilities, actually, are rather exceptional among health capabilities because with them, unlike so many other health capabilities, individual agency is less important in securing them and the achievement side of health is all-important. When we go beyond needs, then, we need to consider not just what society can achieve for people, but also the ability people themselves can have to act as agents of their health, akin to Boulding's (1966) point linking autonomy to the essence of humanity. Of course, the ability people have to pursue good health partly depends on their collaboration with health and medical providers and medical providers' collaboration with their patients. So the agency side of health capabilities is two-sided and in this respect very much a matter of shared intentions. At the same time, because the range of health capability gaps must span the wide range of people's different health goals, there must be a multitude of different ways in which health providers and patients find themselves forming shared intentions about care.

One might consequently suppose that this would make it difficult to make sense of the general nature of people's health capability gaps, and accordingly also make it difficult to say anything very specific about the values and normative objectives of health care beyond the equality of need. This challenge derives from the fact that agency and achievement can vary in their importance across different health capabilities. Sen, however, provides us a framework that allows us to lay out a spectrum of cases according to the different roles that agency and achievement play in contributing to, as he puts it, "an individual's advantage." It employs two distinctions regarding how we understand the different dimensions of human advantage. One distinction is between what promotes a person's well-being versus what promotes the person's overall agency goals, or "goals other than the advancement of his or her well-being" (Sen, 1993: 35). The second distinction is between a person being able to actually achieve something versus the person simply having the freedom to pursue the objectives she wants to achieve (*ibid.*).

In Table 7.1 we apply Sen's framework to distinguish four different (yet interdependent) ways in which we can understand people's health according to the relative importance played by agency and achievement: (1) wellbeing achievement; (2) agency achievement; (3) wellbeing freedom; and (4) agency freedom. We explain and illustrate each case in terms of characteristic health capabilities.[2] This then provides a spectrum of types of health capability gaps that differ not only according to the space people have in pursuing good health, but also according to how shared intentions between health providers and patients differ in each case. This is particularly important to our discussion in section 7.3 of the different normative objectives people have regarding care, since there we argue that the different ways in which

TABLE 7.1 Classification of different types of health capabilities with examples

	Wellbeing	*Overall agency goals*
Achievement	*Wellbeing achievement* e.g. prenatal and neonatal care, children's vaccinations, etc.	*Agency achievement* e.g. social access for the disabled
Freedom to achieve	*Wellbeing freedom* e.g. chronic hypertension	*Agency freedom* e.g. women's control of their fertility

TABLE 7.2 Different types of health capabilities and corresponding shared intentions

Type of health capability	*Form of shared intention*
Wellbeing achievement e.g. prenatal and neonatal care, children's vaccinations, etc.	Generally shared intentions regarding capabilities all people should have
Wellbeing freedom e.g. chronic hypertension	"Local" shared intentions of health providers and patients about different health capabilities
Agency achievement e.g. social access for the disabled	Overlapping sets of shared intentions about a type of health capability in multiple domains
Agency freedom e.g. women's control of their fertility	Universal idealized shared intention

people are socially embedded in care relationships – the source of their shared intentions – determines the basis for their normative understanding of care where, among other things, this includes their views of the responsibilities and entitlements of providers and patients in care relationships.

In what follows, we discuss each case with examples of health capabilities. We start with the need case in which achievement is foremost – wellbeing achievement – and move last to the case in which agency is paramount – agency freedom. We address wellbeing freedom ahead of agency achievement to emphasize an important difference in who the "providers" are that bears on the shared intentions involved. In each case we explain the form of shared intention involved. Table 7.2 summarizes this discussion.

Wellbeing achievement is the domain of "basic" health capabilities or needs regarding health care which all people should have, irrespective of their individual circumstances. Sen's examples of being able to avoid premature mortality and being adequately nourished are generic examples, but it is not difficult to identify more specific ones, such as the relief of pain. On this, Saunders' wider conception of pain to which we alluded in Chapter 3 has some resonance here. Indeed, when one emphasizes being in a state of need, and places less weight on care recipients' agency in promoting these capabilities, prenatal and neonatal care come quickly to mind. Children's vaccinations and primary health care are another example. Agency is not irrelevant because people must also take steps themselves to secure these health achievements. But that these health capabilities involve needs puts important weight on what society does in ensuring that people achieve good health in this respect. Regarding shared intentions, we thus say that people generally share the same intentions about care in this case. That is, in regard to "basic" health capability gaps the specific circumstances of care and the particular individuals involved do not enter into our assessments of when and where "we" believe health capability gaps exist and ought to be addressed.

In the case of *wellbeing freedom*, what the person freely does in the pursuit of good health becomes more important. The actual achievement of wellbeing is still quite central to a life of human flourishing, because being in a state of good health underlies having so many other capabilities. But in this case the freedom individuals have to pursue good health influences the extent to which they achieve it and can flourish in life. Consider the example of chronic hypertension. Because this condition is often a reflection of other possible health conditions that can put the individual at risk for hypertension (diabetes, a family history of cardiovascular disease, exposure to environmental contaminants, etc.), the person's overall health wellbeing is directly involved. At the same time, because people can have some influence over the extent to which they suffer from hypertension (through such things as tobacco use, lack of exercise, poor diet, etc.), and can also influence the extent to which they mitigate hypertension, clearly their freedom plays an important role in determining the state of their health, although, as we noted in Chapter 6, habits may be an inhibiting factor here. The freedom aspect of the wellbeing freedom health capability also tells us something about the "local" nature of shared intentions between health providers and patients it produces. In order to embark on a course of care, the provider and patient must agree on what the health strategies they agree "we" will adopt. The patient must freely adopt these strategies, but the provider needs to help design these strategies according to what the patient can embrace. This might require a set of repeated efforts on their part in which they work to discover their shared intention regarding the patient's health. Thus the freedom aspect of this capability extends to both.

Sen's *agency achievement* case addresses goals people want to achieve that are distinct from wellbeing as a goal (though they can be related). One such goal is personal autonomy or the ability to be independent, to do various things on one's own, and to not always depend on others, whether or not this contributes to improved states of wellbeing.[3] An example of a personal autonomy health capability is social access for disabled persons, whatever their form of disability. In general, disability limits what the disabled can do compared to others, and thus limits their personal autonomy. According to WHO (2014) about 15 percent of the world's population suffers from the sort of disability that limits their personal autonomy and social access. Achieving access to places of employment, health care services, commercial activity, transportation services, entertainment venues, etc. can improve disabled individuals' wellbeing, but it is also valuable to them whether or not it does. Having personal autonomy, then, is one example of an agency achievement type of health capability.

Needless to say, however, this type of health capability is different from what many people regard as health capabilities, seen as medically linking health providers and patients. Indeed, the "providers" in this case include people in public health programs who work to design access for the disabled, those who pass and enforce laws requiring it, and those who take it upon themselves to increase access in whatever ways possible to prevent discrimination against the disabled. This case is similar in some respects to the wellbeing achievement case, since many people who are not classified as health professionals can be involved in securing people's needs. We nonetheless distinguish this case as involving a lower level of generality across shared intentions between "providers" and those who benefit. In the wellbeing achievement case, all people should have all their basic needs fulfilled, but in the case of agency achievement, differences in people's agency or personal autonomy mean quite different things with regard to what health involves according to the form of disability involved. Thus we treat this as a case of different, overlapping shared intentions regarding improving access for the disabled.

Agency freedom, Sen's fourth case, is applied to health capabilities in which achievement is framed by agency, and the freedom to pursue these capabilities is not a means to other goals but is valued as a goal purely for itself. For Sen, this involves the concept of a person "who acts and brings about change, and whose achievements can be judged in terms of her own values and objectives" (1999: 19). A person who exercises agency freedom is consequently one who determines her own values and objectives, which then provide the measure of her achievement. In terms of health capabilities, Sen uses the example of women's control of their own fertility (*ibid.*: 198ff.). Child-bearing and child-raising responsibilities are commonly imposed on women across cultures. Others determine women's goals in this regard for them, and as a result their health can be adversely affected in multiple ways. Conversely, when women are able to control their fertility, access family planning, and act as agents in regard to child-bearing and child-raising in relation to their other goals, their health improves as it comes under their own direction. Their health capability gaps as determined by their own values and objectives are then reduced. This demonstrates that there is an important pure agency aspect to health that depends on how the person herself understands her health. Of course freedom and agency are also involved in wellbeing freedom and agency achievement, but the difference here is the link between health and the person's determination of their goals for health.[4]

Clearly, then, health capabilities associated with agency freedom have many dimensions. Indeed, when women determine fertility, they do so in connection with their pursuit of many other non-health capabilities, for example in regard to employment and education. Thus their determination of their health objectives is also a determination of how good health fits into their lives and thereby a determination of what a life of flourishing is for them. We believe that the ambition to live a life of flourishing is universal among people, though needless to say they commonly disagree about what this entails. This then makes for a rather unusual kind of shared intention since people universally share this intention but also disagree about its object. We accordingly label this kind of shared intention a universal idealized shared intention. Everyone says they share the intention that people be able to pursue good health as makes sense in their lives as an ideal. This characterization may well seem an empty one, and perhaps what some think should instead be said is that there are no shared intentions at all about lives of flourishing, including how this involves health. But we will argue in section 7.4 that the idealized content of this shared intention is tied to the idea that people are intrinsically worthy of being treated with dignity, and that the key to understanding this agency freedom idea is that others cannot determine what a life of dignity and flourishing means for the individual person. Thus this universal shared intention, one all people can express using the language of "we," is necessarily ideal, despite it also providing a foundation for endless disagreement about what a life of flourishing involves.

7.3 The values of socially embedded health care capabilities

We argued above that an advantage the capability approach has over the positivist utility framework is that it makes the moral values people associate with good health immediate to our understanding of health. Our view is that one cannot really describe and understand what health and medical care involve unless one understands what people value in health and in the provision of care. What our discussion of the four different kinds of health capabilities then implies is that there are different moral values associated with each of these four different kinds of health capabilities. Our view, moreover, is that since these different kinds of health capabilities are each associated with different forms of shared intentions, the different sorts of moral values associated with each of the four different kinds of health capabilities derive from how shared intentions regarding care are formed in each case. That is, we explain the social basis for moral values in terms of how the interaction between people in the provision of care generates shared values.

Of course people differ significantly both with respect to what moral values they believe are important and with respect to what moral values they believe appropriate in different domains of life. However, when they form shared intentions regarding care, this leads them to settle on shared values they agree underlie that care. In effect, their shared values are the product of the type of social interaction the care relationship involves, and which we discussed at length in Chapters 5 and 6. This does not mean, of course, that all the other differences regarding what moral values people hold disappear. It only means that, when their interaction in health settings causes them to adopt single courses of action regarding the provision of care, differences in their respective sets of moral values become secondary to their moral common ground. In our view this is what makes the care relationship unique among human relationships, whether in the health domain or elsewhere. When people adopt shared intentions regarding care, they commit themselves to finding shared moral ground. Of course, as we discussed, in the care literature views on this vary considerably. For example, Noddings (2002) has consistently argued that authentic care requires that the caregiver is "engrossed" in the needs of the care-recipient, whereas Blustein (1991) offers a less exacting and idealistic threshold. In any event, what particular shared moral ground they adopt then depends on the nature of the care relationship. In effect, they become socially embedded in the care relationship, and are no longer appropriately described using the standard utility framework's idea of the isolated individual.

Thus in this section we discuss how each type of health capability and the shared intentions associated with it give special prominence to a particular moral value. Table 7.3 summarizes this framework. We consider the four different moral values associated with health and health care.

TABLE 7.3 Health capabilities, shared intentions, and moral values

Type of health capability	*Form of shared intention*	*Moral values*
Wellbeing achievement e.g. prenatal and neonatal care, children's vaccinations, etc.	Generally shared intentions regarding capabilities all people should have	Equality for all
Wellbeing freedom e.g. chronic hypertension	"Local" shared intentions of health providers and patients about different health capabilities	*Ex ante* responsibility
Agency achievement e.g. social access for the disabled	Overlapping sets of shared intentions about a type of health capability in multiple domains	Human rights
Agency freedom e.g. women's control of their fertility	Universal idealized shared intention	Negative and positive freedom

7.3.1 Wellbeing achievement and the value of equality

The kinds of health capabilities that correspond to wellbeing achievement are what Sen sees as basic capabilities or human needs (Doyal and Gough, 1991). Our examples are prenatal and neonatal care and children's vaccinations. What is characteristic of this kind of health capability is that it is necessary for simple survival, the most elementary form of human flourishing. Consequently, the form of shared intention that people have regarding this kind of health capability is a generally shared intention that all people should achieve such capabilities irrespective of who they are. That is, people differ neither in their attitudes towards people achieving such capabilities nor in regard to everyone having such capabilities. When people say people's basic needs should be met, everyone says this about everyone.

The moral value that follows from generally shared intentions is equality, or the value of treating all people the same on these specific grounds. As a moral value, equality is often applied unevenly across people. People may be treated equally if they have earned a certain entitlement to being treated equally, such as access to employment for people of the same qualifications apart from differences in race and gender. In such cases, individual agency plays a role in determining the scope of equality since the entitlement depends on what the individual has done to acquire the relevant qualifications. However, when we address basic health needs, individual agency is irrelevant, and so the scope of equality is fully general and not conditional upon people's actions. People are equally entitled to basic health capabilities by virtue of being people, and thus the formation of shared intentions regarding providing basic health capabilities is fully general.

7.3.2 Wellbeing freedom and the value of ex ante *responsibility*

The health capabilities associated with wellbeing freedom – our example is chronic hypertension – are capabilities developed directly in the (medical) care relationship between clinicians (and other providers) and patients. We characterize the shared intentions involved as "local" because they depend on a reciprocal understanding between providers and patients regarding the course of treatment as an important part of the care relationship. As part of this relationship, providers need to sympathetically appreciate how patients comprehend their own care and patients need to understand how providers understand the treatment recommended. When this is achieved, they are able to form shared intentions regarding a course of care that imposes different yet interlocking sets of responsibilities on each. The shared intentions are "local" in the sense that they are tied directly to the provider–patient relationship rather than include other sets of people.

Extending our analysis of Chapters 5 and 6, we characterize the value of responsibility in this case as an *ex ante* responsibility to distinguish it from the value of *ex post* responsibility. One says someone has an *ex post* responsibility when we explain responsibility in terms of a causal chain that can be traced back to an agent responsible for an action (Ballet *et al.*, 2014: 29–30). While this is an important meaning of responsibility, traceability depends on social circumstances, such that it is often difficult to say when circumstances are complex, who and who to what degree bears responsibility for something that happens. In contrast, when one speaks of *ex ante* responsibility one makes responsibility an inherent characteristic of the identity of the individual and their social role (Ballet *et al.*, 2014: 39). The person sees his/herself as having a particular set of responsibilities according to who they believe they are. In regard to wellbeing freedom, then, when the person exercises her freedom to achieve a state of wellbeing, she does so with an understanding that this is their personal responsibility – whatever the ultimate consequences may be from an *ex post* responsibility perspective. In the care relationship, then, both providers and patients have an *ex ante* responsibility regarding this relationship by virtue of the reciprocal nature of their roles. The shared intentions they form, then, presuppose they see themselves as having these interlocking responsibilities. In articulating this position we acknowledge the mutuality of caring and our mutual dependencies in a similar vein to Engster (2005). We believe this contrasts with Tronto (2013) and other care theorists, such as Noddings, in that they emphasize that the care provider assumes responsibility for recognizing care needs and for addressing them. In our case, the issue of responsibility is more nuanced, and we believe reflects the responsibility identified by Engster that we have to care for ourselves if we are capable of doing so. Indeed, Engster strongly advocates this on the basis that it frees resources for those who are unable or incapable and therefore in potentially greater need.

7.3.3 Agency achievement and the value of human rights

The type of health capability associated with agency achievement concerns goals people want to achieve that are distinct from wellbeing as a goal, such as personal autonomy or the ability to be independent, and to not always depend on others, whether or not this contributes to improved states of wellbeing. Our example for this kind of health capability is social access for disabled persons. The shared intentions involved in this case differ from the sort of "local" interlocking shared intentions discussed above, because here shared intentions form across a variety of different types of domain, by virtue of the many ways in which the disabled suffer lack of access, rather than in just the provider–patient setting, and because many different kinds of people are involved in determining social access, ranging from building designers to public health officials and of course the disabled themselves. Thus we characterize the shared intention included in this case as overlapping. Though there are different kinds of people involved and access means different things on account of differences in disability and ways in which it can be limited, nonetheless all these instances bear a "family resemblance" to one another (Wittgenstein, 1953) that justifies regarding the shared intentions involved as overlapping.

The moral value people then place on this type of health capability is the value of respecting human rights. There are of course different kinds of rights, but human rights accrue to people simply by virtue of what it means to be a person. That is, human rights are the "basic moral guarantees that people in all countries and cultures allegedly have simply because they are people" (Nickel, 1992: 561). One thing consequently inherent in this idea is the ability to be independent. Individuals lose their status as persons when they are highly dependent or confined in ways to which they object (for example, Boulding, 1966). To be a person, that is, one needs to be self-determining according to the standards society sets for people generally. Thus in a society understood to be made up of individuals having the status of persons, individual people have a human right to what is required to achieve this status, whether or not it contributes to their wellbeing. This accordingly applies to disabled individuals with regard to whatever limits their ability to be self-determining.

7.3.4 Agency freedom and the value of freedom, negative and positive

The type of health capability agency freedom involves concerns being able to determine one's own values and objectives, as well as the measures of their achievement. Agency freedom can be compared to agency achievement in the following way. Whereas agency achievement concerns people determining *which* goals they wish to pursue, agency freedom concerns simply being able to determine one's goals. That is, agency freedom makes freedom a capability. Our example to illustrate a health capability of this kind is women's control of their fertility (see also Nussbaum, 2011). When one considers what this involves, it becomes clear that there are two dimensions to women's control of their fertility. One is associated with the concept of negative freedom, or a freedom to not be interfered with by others in one's pursuits. As is well known, women are often limited by laws and customs in their decision-making about whether they will have children. The second dimension of this is associated with the concept of positive freedom, or the freedom to take control of one's life and be self-directed (Berlin, 1969). This dimension of freedom is no less important to the capability of controlling one's fertility since a person could be free of external constraints but be unable to make a decision. This is not a matter of simply being ambivalent or undecided. An absence of positive freedom is an absence of being able to be self-directed.

We characterize the shared intention in this case as a universal idealized shared intention. The weight falls on the notion "idealized." When we discuss a deep concept such as freedom, in either its negative or positive dimensions, there are so many different ways in which we can describe what having or not having freedom involves that it is really impossible to catalogue a set of conditions which would allow us to say when a person is unconstrained and self-directed. However, people feel strongly about the concept of freedom, clearly distinguish cases of negative and positive freedom, and accordingly can be said to have an idealized grasp of it. Moreover, people generally share intuitions about freedom in these two dimensions, even when they disagree about examples. Thus we characterize the shared intention in this case as a universal idealized shared intention. There are indeed many things about which people exhibit this special sort of shared intention, but in our view health is one of the most important, as we believe is evident from our example of women's control of their fertility.

7.4 The nature of the person as a focus of care in socially embedded care relationships

Our view, then, is that the types of values and normative objectives regarding care that we have identified above imply a particular normative conception of the person, namely a person intrinsically worthy of being treated with dignity. In this section, we defend this claim on two levels: first in terms of what thinking in terms of capabilities tells us about the conception of the person, and second in terms of what thinking in terms of the four main normative values discussed above tells us about one's conception of the person. We take this task to be especially important because in our view a fundamental problem with mainstream health economics is that it operates with a normative conception of the person inadequate to a health economics that emphasizes care (Davis and McMaster, 2015). Consequently, this section and chapter close by contrasting the mainstream conception and our conception of the person that emphasizes care.

7.4.1 The capability approach and the dignity of the person

We saw in the last section that Sen's capability framework allows for four different ways in which individuals' development of their capabilities contributes to their personal advantage. If we then take these different kinds of functionings and capabilities as what makes up what a person is, people can be represented as the collections of capabilities that they develop and seek to develop. But how do the different capabilities that people have and seek to acquire add up to give us a single conception of the person or to a cohesive personal identity? Sen has long emphasized that a special characteristic of the person is being able to be a self-scrutinizing agent who judges and deliberates about her opportunities rather than simply reacting to them based on some set of hard-wired or given preferences.

> A person is not only an entity that can enjoy one's own consumption, experience, and appreciate one's welfare, and have one's goals, but also an entity that can examine one's values and objectives and choose in the light of those values and objectives. (Sen, 2002b: 36)

We suggest, accordingly, that an important dimension of Sen's concept of agency freedom, the capability of being able to reflect on one's goals, is that it functions as a kind of second-order capability, or meta-capability, by which a person is able to not only judge the relative importance all the first-order capabilities she has and seeks, but also to see how they all fit together in the life she chooses to pursue.

This special second-order capability associated with agency freedom might be termed a personal identity capability (Davis, 2009, 2011). Its character as a second-order capability derives from its reflexive nature, that the person takes herself and her capabilities as her object. That people are able to reflect upon themselves and their personal identities has long been a subject of research in social psychology that investigates how people employ self-concepts as representations of themselves (e.g. Markus and Wurf, 1987). The self-concept as a representation of personal identity acts as an organizing frame for the many different activities people engage in. However, this organizing frame is not thought to be static and unchanging. Rather it evolves together with the range of activities people pursue. That is, people operate with dynamic self-concepts or, in Sen's capability approach framework, the personal identity capability is a capability people develop together with all the first-order capabilities that they develop.

In Sen's capability approach, then, people are intrinsically worthy of being treated with dignity because they are essentially self-determining types of beings. This does not mean that people's lives and their conceptions of themselves are not also influenced by many other things. The point is that, were people's lives generally determined by forces beyond themselves, that is were their lives largely socially and other-determined, then their normative value would be derivative of these other social forces. For example, a person's value could be seen as being determined by their contributions to a larger cause such as the advancement of science. Then it is this larger cause that is intrinsically valuable, not the people whose efforts are a means to it as an end and who are thus only instrumentally valuable. In Sen's approach, however, when people exercise agency freedom, they make themselves ends in the process of reflecting upon and deliberating over what they believe their goals should be. It is exercising this second-order, self-determining personal identity capability that invests the person exercising it with intrinsic value and dignity.

Note that dignity is the idea of being due respect, and respect in this regard is commonly accorded to what is seen to be valuable in itself (Donagan, 1977; Wood, 1999). Respect is different from other forms of approval where valuing something depends upon it contributing to the realization of something else valued in itself. Thus in the capability conception of the person, what underlies the normative value of the person is being intrinsically worthy of respect and being treated with dignity. We return to this issue in the last section below where we argue that the utility conception of the person is only able to accord weaker, instrumental forms of approval and value to people, and thus cannot explain care in terms of dignity.

7.4.2 The normative values of social embedded health care and the dignity of the person

We also see people as having dignity and deserving respect on account of the particular normative values arising out of care relationships in health we discussed above. Our view is that certain types of normative values exist in medical care systems because these values are emergent upon interaction between socially embedded individuals in care settings. What we then address in this section is how four particular values – equality, *ex ante* responsibility, human rights, and freedom in both the negative and positive senses – each supports a normative conception of the person intrinsically worthy of being treated with dignity. We set out our explanation in relation to our capability conception of the person.

In the capability conception, an individual made up of many capabilities is a single person by virtue of being able to exercise a personal identity capability. What Sen's breakdown of different kinds of individual advantage and associated different capabilities provides us, then, is a broad structure to people's personal identities. The normative values we connect to these capabilities are accordingly values tied to people being able to have and develop their personal identities in terms of this structure of individual advantage. Further, since a capability as opposed to the atomistic utility understanding of the individual is a relational conception of the person, these normative values are framed in terms of relationships between people. We took as evidence of this that these values can be explained in collective intentionality terms or as what people would take to be the shared normative values underlying their interaction.

First, in the case of wellbeing achievement, individual advantage is a matter of attaining a minimum threshold level of achievement with respect to what is needed to survive as a human being. Anyone achieving this elementary level of well-being counts as a person in this very minimal sense, and all individuals are then equal by this single standard. People of course vary in terms of what the elementary requirements of wellbeing and survival involve, but the need to meet whatever those requirements are in each case is the same. Equality in this specific regard – treating equals as equals – is a base value for being a person. But being a person, even in this very basic sense, is still not instrumental to any other goal, and thus it remains something intrinsically valuable in itself. This gives the value of equality in our treatment of capabilities and health a specific role and interpretation, namely as a value foundational to human dignity. In effect, were it not that all people are counted the same, and some were more valued than others, then the latter might be subordinated to the former and only have instrumental value. Making wellbeing achievement a minimal requirement of being a person rules out this possibility.

Second, wellbeing freedom is distinct from wellbeing achievement in that it allows for differences between people regarding what they freely choose to do to produce individual wellbeing. Wellbeing is then understood not in terms of minimal requirements of survival but in relation to the exercise of freedom. Accordingly, since how people exercise freedom differentiates them, equality is no longer the value we should focus on to understand the nature of individual advantage in this case. Rather the focus becomes how individuals use their freedom to achieve wellbeing. Wellbeing, then, conditions the exercise of freedom.[5] For this reason, we have associated *ex ante* responsibility with wellbeing freedom. The person has responsibility before action – *ex ante* – to exercise their freedom in a way that must be responsible to advancing her own wellbeing. This means that this freedom carries a burden of possible failure since freedom with a specific goal can always be inadequately exercised. The link to human dignity is consequently also different in this case. Any failure is the person's alone – the idea of personal responsibility – because the consequences of it accrue strictly to the individual person's exercise of freedom. We regard this as a further measure of the dignity of the person, that the person uniquely bears this burden of responsibility.

Third, in the case of agency achievement individual advantage derives from being able to achieve goals other than a person's own individual wellbeing. These can be other personal goals, such as the ability to be autonomous emphasized above, but can also be goals that concern others, such as the wellbeing of others or others' autonomy. What is thus characteristic of agency achievement is that a person's individual advantage resides in being able to abstract from her own wellbeing and act to achieve any sort of goal irrespective of whose it may be. That this form of individual advantage concerns the achievement and not just the pursuit of other goals is important, because this gives a general entitlement to people's goals. That individual advantage accrues to people in the achievement of other individuals' goals then underlies our position that the normative value involved is human rights. There are of course many ways in which the concept of human rights has been explained, but here we simply interpret human rights as a broad entitlement to realizing human goals. That this is a right derives from this being a form of individual advantage. That this broad entitlement is a matter of human dignity follows from taking human goals as given and thus as intrinsically valuable.

Fourth, we turn to agency freedom, which we link to the value of freedom in both its negative and positive aspects. We argued in the last section that being able to exercise agency freedom underlies having a personal identity capability, because determining one's own goals also makes the person self-determining, and being self-determining involves having and developing a self-concept. Since freedom must be understood as both freedom from external constraint and freedom to take control of one's self, for a person to be self-determining, both aspects need to be present. Indeed, not only must both aspects be involved, but the person must be able to know how to integrate them, understanding how they balance and when one or the other should be the focus. Needless to say, there are no special rules or easy ways of knowing how to proceed. The quality of being able to exercise agency freedom in this sense is not something that can be explained but is a matter of what having and developing a personal identity involves. Thus we take this to be a special measure of human dignity as well, and see the person's management of their negative and positive freedom as being central to it.

7.4.3 The dignity conception of the person compared to the utility conception

In this chapter we argued that normative values associated with care in health and medical systems and institutions arise out of the interaction between people and groups. The conception of the individual in standard health economics, however, is of an un-embedded, socially isolated individual. To the extent, then, that standard health economics associates normative values with health care, it restricts them to what relate to people's private concerns understood in terms of individual preference satisfaction, as in the QALY framework. This leads to the problem that normative criteria used to determine care, for example in the "fair innings" approach that attaches "equity weights" to different sets of QALYs (Williams, 1998; Culyer and Wagstaff, 1993), have a certain degree of after-the-fact arbitrariness about them. In contrast, our socially embedded individual approach is framed in terms of health capabilities, which are determined in care relationships. The different ways in which we explain these care relationships, according to the types of health capabilities we distinguish, then generate the normative values appropriate to the provision of care in each case.

Our argument in the preceding section, then, is that the specific types of values and the normative objectives regarding care that we have identified using a capability approach imply a particular normative conception of the person, namely a person intrinsically worthy of being treated with respect and dignity. Here we follow others who have linked capabilities and the ideal of person-centered care with its emphasis on treating people with dignity (Entwistle and Watt, 2013). The ideal of person-centered care is well-established in health care, but saying what a "person" is has naturally been less easy. The capability framework, however, provides a clear way of addressing what a "person" is because it allows us to say what is important in an individual being able to function as a person. We have further expanded on this idea by emphasizing both the role of a special, second-order personal identity capability (Davis, 2013c), and by treating the four different types of capabilities people have as a personal identity structure that the person manages. The personal identity capability is a reflexive, second-order capability whereby the person takes herself and her first-order capabilities as her object. That there is such a structure to her capabilities follows from the distinction between wellbeing and other goals and the distinction between achievement and freedom to achieve in Sen's framework.

The basis for our characterization of the person as worthy of being treated with dignity derives from the idea of something being valuable in itself. This is in sharp contrast to the instrumental conception proposed by Grossman (1972) outlined in Chapter 2. For Grossman, the Cartesian duality between mind and body means that the latter merely becomes an element of an optimization calculation of the former. The body is the site of the health investment decision in the (depreciating) stock of health. Dignity does not enter the equation. In contrast, by our line of argument, a person able to judge herself and her capabilities in a reflexive manner makes herself intrinsically valuable and is the object of dignity. Such a person is the focus of person-centered care.

The focus of this chapter was the micro basis for person-centered health and medical care. In the following chapter we turn to the macro basis for this ideal of care in the wider interaction between social groups that produces the health and medical care institutions that make up entire care systems. Here we argue that the configuration of normative values we describe as working at the micro level in care systems works together at the macro level to make equity a foundational value for social policies underlying the development of health care systems.

Notes

1 See Crocker (2008) and Robeyns (2011) for a general review of the capability approach. Sayer (2014) highlights the radical potential of the capabilities approach.

2 Strictly speaking, Sen associates wellbeing achievement and agency achievement with what he terms functionings, the actual being in a state or the doing of something, rather than as a capability, the ability to be in a given health state. Since he also broadly sees capabilities as freedoms, we still treat these cases as health capabilities, understood as freedoms people have to achieve certain health states.

3 Other agency goal capabilities are social interaction, involvement in social causes, and pursuing one's own vocation. What is common to these non-wellbeing goals is being active in something or being engaged in an activity. To be able to be active at something is an achievement in its own right. If the activity also produces a state of wellbeing, then the activity is additionally valued for wellbeing reasons.

4 Sen's example of women's control of their fertility provides an especially clear example of an agency freedom health capability. Other examples in which the person determines their own health objectives are people's choices regarding pain management, integration of physical activity in work–life balance, and end-of-life decision-making.

5 In contrast, in the case of agency freedom, where people determine their goals, freedom instead conditions their goals, whether they are wellbeing goals or other kinds of goals.

8

SOCIAL VALUES IN HEALTH CARE SYSTEMS

> "[Health is] a structural, functional, and emotional state that is compatible with effective life as an individual and as a member of family and community groups."
>
> "[Health is] a sustainable state of equilibrium or harmony between humans and their physical, biological and social environments that enables them to coexist indefinitely."
>
> (Last, 2007, cited in White *et al.*, 2013: 3)

8.1 Introduction

In the last chapter we began our discussion of the normative objectives of care systems by taking a ground-up approach and by looking at the direct contact and interaction between people who are immediately concerned with the nature and provision of care. We framed this discussion in terms of health capabilities rather than in cost-utility terms as in mainstream health economics. The capability approach makes a distinction between health achievements and the ability people have to pursue good health. Health achievements are an outcome measure of health care, so when we also include the ability people have to pursue good health, we add in the importance of people acting as agents of their health in our assessment of their wellbeing. This puts us in a position to develop a more complete appraisal of the normative objectives of care systems, compared to the truncated one in mainstream health economics tied to its consequentialist methodological approach. We also framed our approach in terms of shared intentions rather than economics' standard atomistic individuals approach in order to reflect the ways in which care results from social interaction. As we have argued throughout, the individualistic mainstream approach in economics ignores a whole range of moral values associated with how people form shared intentions about care, so paying attention to them also puts us in a position to develop a more complete appraisal of the normative objectives of care systems.

The main results of our ground-up approach appeared in Table 7.3. The moral values we identified there in connection with the four different types of health capabilities we distinguished are: equality for all, *ex ante* responsibility, human rights, and negative and positive freedom. But the moral values that direct social interaction promotes do not alone generate the normative objectives of an entire care system. While we say that the normative objectives of care systems are emergent upon the social interaction between people and caregivers, we recognize that societies' normative objectives regarding health are also the product of top-down health policies and the social values institutionalized in entire health and medical care systems. These top-down policies and social values, then, feed back on and combine with the moral values that derive from the interaction between people involved in the provision and delivery of care. This chapter thus turns to the top-down side of this overall dynamic, and then addresses the tensions that arise from the differences between these two types of social process.

Note, then, that whereas ground-up health processes derive from the direct provision of care and the immediate interaction between people, top-down policies toward health and the social values institutionalized in care systems operate at an aggregative level and are accordingly the concern of public health programs. As we noted in Chapter 3, public health addresses the physical, mental, and social health of entire communities (Krieger, 2012; White *et al.*, 2013). It deals with the prevention and treatment of disease, emphasizes what contributes to healthy behaviors, and pays special attention to how social environments are or are not conducive to good health. That is, public health is concerned not only with the state of health in a community but also with the social determinants of health in a community, and a population more generally.

When we focus on the social determinants of health, however, we cannot ignore the fact that societies are made up of many communities, and exhibit a variety of forms of inequality across those communities. Accordingly, investigating the social determinants of health also involves investigating the social determinants of inequalities in health across individuals and social groups. This is well recognized in the extensive population and public health and social epidemiology literatures (for example, Krieger, 2001, 2012; Solar and Irwin, 2010; Wilkinson and Pickett, 2010; White *et al.*, 2013), and in the social sciences (for example, Doyal and Pennell, 1979; Doyal and Gough, 1991; Sen, 2002a, 2004).

This is where we begin in section 8.2 where we discuss the relationship between social inequalities and health inequalities. To do so, we provide a brief outline of the principal sources identified in public health before we focus on employing a "social causation" model in which each affects the other, and then use this model to address how public health programs can adopt policies and strategies to improve health for entire communities. Then in section 8.3 we reframe this discussion in terms of health capabilities, and argue that public health programs understand improvement in health capabilities in terms of a general development in human capabilities across communities. On this basis, section 8.4 returns to the normative objectives of health care systems, broadly conceived. We use the top-down public health perspective to identify the social goals of entire health care systems, and ask how these correspond to the ground-up moral values that emerge from the concrete interaction of people involved in the provision of care. We then identify possible conflicts and tensions that the combination of these two processes create, and finally argue that the basis on which they can be resolved lies in a recognition of the central importance of a conception of the person as intrinsically worthy of being treated with dignity and thus deserving of care. The final section 8.5 draws together the themes from the three chapters in the last part of the book, and again emphasizes the importance of understanding health in terms of the idea of care as a fundamental human quality.

8.2 Public health and the social causes of inequalities in health

Social epidemiologists identify three overlapping themes in the investigation of the social determinants of health inequality (Krieger, 2001; Solar and Irwin, 2010). First, psychosocial factors argue that individuals' perceptions and experiences of their status in unequal social hierarchies impacts their vulnerability to disease (for example, Wilkinson and Pickett, 2009). Second, a political economy or social production of disease "tradition" emphasizes the structural causes of underlying inequalities as opposed to the psychosocial manifestations. This is a materialist account that turns on the distribution of income and wealth, and the allocation of public resources such as education. Third is Nancy Krieger's (2005) "ecosocial" approach we noted in Chapter 2. To reiterate, Krieger argues that our environment impacts our biology, so that there is a process of "embodiment": the economic, social, and biological are intricately linked in a "web of causation."

As incoming Director-General of WHO in 2003, Lee Jong-wook instigated a Commission on Social Determinants of Health (CSDH), which published a number of influential reports (for example, Solar and Irwin, 2010). These reports strongly associated health equality with social justice. Of course, this was by no means the first examination of the issue by policy-makers. In 1980 the Black Report investigating health inequalities in Britain argued that its roots partly lay in education, housing, and welfare, and that reform in these areas was necessary to address health inequalities. This prompted further similar government-sponsored studies in the Netherlands, Spain, and Sweden (Solar and Irwin, 2010).

In their report, Solar and Irwin attempt to develop a hierarchy of social influences on health inequalities, noting the role of power, and the distinction between the social causes of health and the social factors determining the distribution of these causes. They summarize their framework as shown in Figure 8.1.

The hierarchy of determinants is of interest in that it strongly corresponds with our line of argument regarding care. As Figure 8.1 shows, underlying institutional structures such as social values frame a person's social positions, which then act upon intermediary determinants, such as material circumstances and our biology that then impact an individual's health and wellbeing. As Figure 8.1 demonstrates, then, inequalities in health have both social and natural determinants. It also

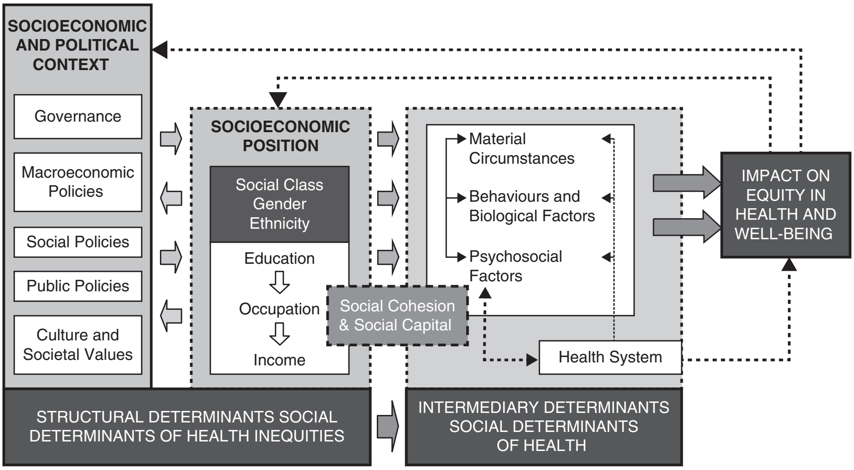

FIGURE 8.1 Final form of the CSDH conceptual framework
Source: Solar and Irwin (2010: 6).

highlights the prescience of Boulding's (1966) observation that it is possible to be a healthy individual in a "sick society," as well as the tenets of social medicine we noted in Part 1.

Natural influences on health are associated with differences in genetic endowments and environmental conditions, and are beyond what we address here. Our view is that while natural determinants of health differences cannot be entirely eliminated, their differential effects on people's health can be minimized when societies adopt public health programs meant to compensate people for naturally determined shortfalls in health. When this occurs, differences in health are then basically associated with social inequality. In this regard, Solar and Irwin strongly advocate a "gradients" policy focus as a means of addressing health inequalities. In short, they focus on the social health gradient at a population level. Of course, there is an extensive literature investigating how health inequality can and should be measured, and the extent to which the distribution of power in society influences the determinants of health outcomes. For our purposes we focus on identifying potential feedback loops in the social causation model and the impact of social stigmatization. This will inform how we view the framing of care in broadly conceived health care systems.

8.2.1 The "social causation" model

While there is considerable evidence that social factors correlate with mortality and morbidity statistics, understanding this in causal terms is challenging (Krieger, 2012; White *et al.*, 2013). On the one hand, it can be argued that social inequalities cause health inequalities, for example by limiting access to health and medical facilities. On the other, it can be argued that health inequalities reduce social opportunity and

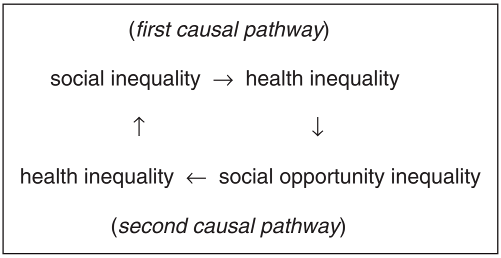

FIGURE 8.2 The "social causation" model of social and health inequality

lower social status, and social opportunity inequality causes health inequalities, which in turn leads to social inequalities. What we do here, then (see Figure 8.2), to address both of these causal pathways is employ a "social causation" model (Marmot, 2004; Marmot and Wilkinson, 2006) in which both causal pathways operate, and can do so either in such a way as to reduce the correlation between social and health inequality and decrease both, or in such a way as to increase their correlation and increase both. That is, if social causes of health inequalities can be reduced – the first causal pathway – then people's health differences are less likely to feed back on and adversely affect how their social opportunities and social status affect their health – the second causal pathway. This is a virtuous circle social causation model of social and health inequality that public health programs seek to realize. Alternatively, when social causes of health inequalities become stronger – the first causal pathway – then people's health differences are likely to feed back on and worsen the effect of their reduced social opportunities and social status on their health – the second causal pathway. This is the vicious circle "social causation" model of social and health inequality that public health programs seek to overcome.

Where, then, does one enter this "social causation" model from the perspective of the public health goal of bringing about the virtuous circle, and what would such an entry point tell us about the normative objectives of health care systems? When we focus on the first causal pathway, and how social inequality limits access to health resources, income is a central concern, since there is considerable evidence that income is an important determinant of health. Thus if we associate low levels of income with material deprivation and poverty – essentially a lack of access to basic resources required to meet human needs – it is clear from high mortality numbers, especially in developing countries with lower per capita gross domestic products, that health is worse at lower average income levels. Yet this relationship breaks down for higher income countries where per capita gross domestic product and mortality are not very well correlated across all countries (Marmot, 2004). At the same time, there is evidence in these countries that income still plays a role in determining health as a *relative* rather than a purely material deprivation through the relation between income inequality and mortality (Krieger, 2001; Wilkinson, 1992, 1996). It is not only the average level of income in a society that affects health, then, but also income distribution that matters. Indeed, there is evidence that the degree to which a country's income inequality produces differences in health is influenced by the degree to which inequality operates across society in other non-income dimensions (Daniels *et al.*, 2004; Pickett and Wilkinson, 2009). Thus pervasive relative deprivation in a society has effects on health, even when there are social policies toward health meant to counter income inequality's adverse effects on health.

Further, relative deprivation and relative poverty concern not just how the resources required to meet health needs vary across people, but also how differences in the resources that people have add up relative to the norms and standards of life in their society. One might, then, be relatively well-off materially compared to others, but still not be well off at all if one still falls short of meeting the norms and standards for living a healthy life in one's own society (Sen, 1999: 87ff.; Solar and Irwin, 2010; cf. Runciman, 1966). To illustrate, consider the relationship between transportation and health when private transportation in a society is the norm, as for example in much of the United States. In such circumstances, small differences in income between people can be associated with whether one has private transportation or relies on scarce public transportation. Dependence on the latter, however, can significantly limit access to health services. So relative deprivation and health inequality need to be understood in terms of societies' norms and standards for living a healthy life.

We emphasize this norms and standards dimension of health inequality in order to introduce an especially important, yet sometimes overlooked, further set of social factors that influence health inequalities. In mainstream economics, a society's norms and standards for living a healthy life are taken to pertain to consumption and work as if they could be understood largely apart from any attention to the fabric of social relationships in societies with which they are associated. Witness, for example, Grossman's (1972) model of the demand for health and health care, noted in Chapter 2. Grossman focused on health solely in functional terms, and assumed an atomistic individual omnipotent in calculating their optimal life span given resource constraints. Taking this narrow view, however, sets aside all those long-standing ways societies have of maintaining social inequalities regarding work and consumption whereby individuals are treated better or worse than one another according to their different inherited social characteristics. Specifically, across most societies people are treated unequally according to such things as their ethnicity, heritage, race, gender, age, sexual orientation, religious beliefs, politics, disabilities, where they happen to live, the reputation of others to whom they may be connected, etc. Essentially, most societies have institutionalized systems of social discrimination, and these function as determinants of how a society's norms and standards influence what is needed for living a healthy life.

Consequently, public health systems that aim to address material and relative deprivation framed in terms of prevailing social norms and standards also need to address health inequalities in relation to these many forms of social discrimination. To take again the example of transportation and health, if individuals dependent on scarce public transportation are further limited in their access to transportation because of, say, inadequate accommodations for disabilities or lack of safeguards for older individuals, then these discriminatory practices also need to figure into the design of public health. To be clear, this is not to say that public health authorities have the responsibility of eliminating systems of social discrimination; rather their task is to design public health and medical systems that recognize the negative effects of social discrimination and work to counter those effects.

We see this further extension of what lies behind relative deprivation, then, as particularly valuable in giving us a way of more clearly understanding how the second causal pathway of the social causation model – where people's social opportunity differences adversely affect their health states – can be integrated with the first causal pathway – how social inequalities cause health inequalities. Public health programs operate on the first part of the model because they can be designed to offset identifiable health inequalities (for example, by the location of medical facilities in low-income neighborhoods), but are not designed to address inequalities in social opportunity and status. Yet targeting the first pathway effectively depends on anticipating the second, feedback pathway concerning the effect on health of differences in social opportunities. If discriminatory practices are well-embedded in a society, though public health can target socially caused health inequalities, discriminatory practices that limit social opportunity can nonetheless still prevent improvement in health outcomes. In effect, the second causal pathway short-circuits the virtuous circle model of health and inequality.

These points are indeed quite general, but in the following subsection we provide further analysis of the second causal pathway in order to explain how social discrimination limits social opportunities and social status. Our view is that having a specific understanding of how and when social discrimination limits opportunity, such as in the transportation and health case above, puts those designing public health programs in a position to not only address health inequalities but also offset the effects of discrimination. Our theoretical approach, then, employs a recent non-mainstream economics approach to social inequality termed "stratification economics" that explains social discrimination in terms of hierarchical social organization. A hierarchically organized society creates barriers to opportunities to certain social groups, and thus perpetuates social inequalities. Thus reducing health inequalities becomes a matter of addressing the effects of these barriers on social opportunities.

8.2.2 The effects of discrimination on economic inequality

While there are many theories of how discrimination produces social and economic inequality, the "stratification economics" approach is distinctive in that it investigates discrimination in connection with (1) stable, self-reinforcing hierarchical structures that rely on multiple social practices to discriminate across individuals; (2) according to their social group positions (Arestis *et al.*, 2014; Darity, 2003, 2005, 2009; Darity and Deshpande, 2003; Goldsmith *et al.*, 2006; Mason, 2007; Stewart, 2008a, 2008b).[1]

Consider each of these two ideas. First, a society organized around stable, self-reinforcing hierarchical structures that sustain social inequality is a society in which significant barriers exist to individuals moving upward (but not downward!) across social-economic levels or strata within a society that are ranked according to privilege and advantage. Discriminatory social practices provide the actual mechanisms by which these barriers are maintained, the effect of which is to limit opportunities in life, including the pursuit of good health, for individuals who find themselves occupying lower levels of society. Second, these discriminatory practices target individuals not as individuals but as representatives of social groups. That is, individuals are "stigmatized" in the sense that their individual identities are replaced by their social group identities (Blumer, 1958; Goffman, 1963; Davis, 2015). Social group identities are defined as socially constructed categories (statistical and ideological) that are used to characterize collections of individuals who happen to share some characteristic – a "categorical" social group identity (Brewer and Gardner, 1996).

In a socially and economically stratified world, then, individuals' opportunities for better health and the other goods they seek are limited by their membership in social groups that are consigned to lower strata. This produces the vicious circle version of the "social causation" model of social and health inequality in which poor opportunity and status (the second causal pathway) continuously undercut public health programs' efforts to counteract how inequality produces health differences (the first causal pathway). Public health authorities can design programs that compensate for social inequalities, but this becomes an endless task that makes little progress when the social system in which they operate continually reinforces inequality. Let us focus on what the social stratification approach tells about how in principle a virtuous circle version of the model can replace the vicious one.

We argue that what sustains the second causal pathway whereby less opportunity undermines health is the practice of stigmatization which assigns status to individuals in terms of the status of the groups of which they are members. When some social groups are ranked lower than others, the identification of individuals with those groups then transfers those group rankings to these individuals. Since lower-ranked groups in hierarchical societies are ranked lower in expected health states, the expectation of their entitlement to health resources is also less, both in the eyes of society and also in the eyes of those in need of those resources. We accordingly treat stigmatization as a key mechanism by which the second causal pathway operates in hierarchical societies (see Figure 8.3).

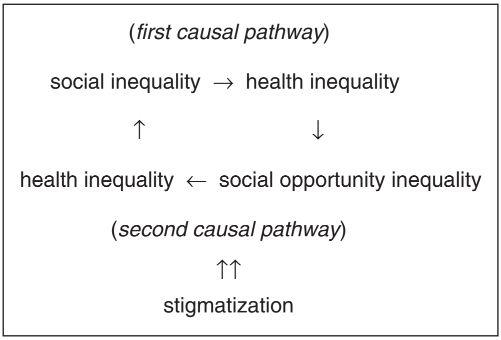

FIGURE 8.3 The role of stigmatization in the "social causation" model

We do not say, however, that breaking out of the vicious circle version of the "social causation" model of social and health inequality depends on putting an end to the hierarchical social organization of contemporary societies. Rather we see combating stigmatization and the practice of assigning group identities to individuals as a concrete step that can be taken with some likelihood of success for achieving the goal of improving health despite social stigmatization practices. But how does one actually take this step? We give one straightforward answer here in regard to the scope and basis of public health programs, and then a more complex answer in the next section in connection with our further framing of our discussion in terms of health capabilities.

From our analysis, the health inequality problem that stigmatization creates is that people who are members of lower-ranked groups are treated as representatives of those groups rather than as individuals, and thus limited in their individual social opportunities in the ways those groups are. Consider then the top-down nature of public health programs. Public health programs are concerned with the physical, mental, and social health of entire communities and populations (Krieger, 2012). Of necessity this requires attention to people's average health outcomes understood in terms of the circumstances of whole groups of people. Thus in hierarchical social circumstances, societies' biases towards individuals associated with their social group memberships are automatically incorporated in the outcomes-based measures of health that public health authorities need to rely upon. In effect, average outcome measures strip out differences between people, particularly with regard to how individuals differ in the ways they pursue good health and wellbeing.

The point here is not to complain about the nature of public health programs, which generally deserve more praise and credit than they often receive. The point is rather that their normative structure – wellbeing conceived in terms of social aggregates – leaves out another especially important normative concern – people's abilities to pursue their respective individual opportunities. Recall, then, that this chapter follows the discussion in the last chapter of the bottom-up emergence of normative values reflecting people's interaction with one another in the provision of care. Our view, then, is that both the bottom-up and top-down perspectives are required to give a complete appraisal of the normative objectives of care systems. We see this reflected in the way in which the "social causation" model, seen in the context of a hierarchical social world, is left incomplete with regard to the issue of individual opportunity. In the following section, accordingly, we integrate our bottom-up and top-down perspectives on the normative objectives of care systems by reframing our "social causation" analysis using the capability approach and our classification of health capabilities provided in the last chapter.

8.3 Public health and health capability improvement

One of our concerns about using mainstream health economics to understand public health and health care systems is that, because it employs a consequentialist methodological approach, it focuses exclusively on outcomes and ignores the role individual agency plays in the determination of health. Needless to say, outcomes are important! The issue is rather how and when outcomes also need to be understood in terms of what people can do to achieve them by acting as agents of their own health. Whereas outcomes tell us one set of things in normative terms about health, what contributes to bringing about outcomes tells us something additional in normative terms about health, specifically something about the importance of freedom and individual autonomy.

An advantage of the capability approach is it makes a distinction between health achievements and the ability people have to pursue good health. At the same time, the role that agency plays in determining health varies according to the type of health state at hand – or according to the type of health capability in question. As we saw in the last chapter, in the set of health capabilities we distinguished (using Sen's two ways of explaining capabilities) there are health capabilities which emphasize achievement and de-emphasize agency (or the freedom to achieve), health capabilities which emphasize agency and de-emphasize achievement, and health capabilities in between (see Table 7.1). What we do in what follows is examine the role that different health capabilities can play in securing the virtuous version of the "social causation" model when social group stigmatization affects public health.

First, let us begin with the type of health capability where agency plays a comparatively minor role in order to be clear about the end of the spectrum of health capabilities where the achievement of health is primary and emphasizing outcomes is appropriate. We characterized this type of health capability as aimed at well-being achievement, and gave as examples such things as prenatal and neonatal care and children's vaccinations. While no doubt even here agency is important, since women and families need to be engaged in receiving care, what is more important is that the health services needed be available and accessible. In effect, public health authorities create health opportunities for people, reducing the need for them to act as the primary agents of their own health. Thus, in this case, public health authorities can act effectively on the first causal pathway in the "social causation" model, which entails addressing how social inequalities, especially in terms of access to health facilities, act on health inequality. Indeed, public health authorities generally operate on an ethic of setting aside social group differences across people, so that social biases generally do not come into play. Consequently, with respect to this type of health capability the virtuous circle version of the "social causation" model generally works well.

Second, now consider the type of health capability that we characterized as combining achievement and freedom to achieve – wellbeing freedom – for which we gave chronic hypertension as an example. In this instance, what people do and especially what they can do for themselves to produce good health – their freedom to achieve – becomes important. Access to health providers and medication – central to the wellbeing achievement health capability – is necessary but insufficient for good health in the case of wellbeing freedom, because people who have hypertension sometimes ignore their health opportunities even though there are steps they can reasonably take to make use of them. We argued that this means individuals in lower-ranked social groups have lower expected health states and a lower expectation of entitlement to health resources, both in the eyes of society and also in their own eyes. This then sets limits on how they exercise their opportunity to pursue good health in two ways. On the one hand, it can simply discourage their use of health facilities. On the other hand, and more seriously, it can undermine their sense of the need to address hypertension by negatively influencing their expectations of good health.

The strategy that we argue needs to be adopted here draws on the link we made between health capabilities and shared intentions in the last chapter, and in particular the form of shared intentions we associated with this type of health capability, namely what we called "local" shared intentions that operate between specific medical care professionals and their patients. Note again that the role that social stigmatization plays is that it reduces individuals to social categories; thus it essentially undermines people's capacity to act as agents of their own health. However, when stigmatized individuals form shared intentions with others not socially stigmatized, in this case care providers in public health programs, they can gain "local" partners in improving their health who share an agency with them. This individualized relationship in pursuit of better health outcomes can strengthen the agency of stigmatized individuals with hypertension. Accordingly, public health authorities have a potential avenue of effectiveness in hierarchical societies when they design programs for this particular type of health capability that rely on the appropriate shared agency mechanism. In this instance, addressing hypertension depends on a close ("local") interaction between patient and provider that allows them to develop, reinforcing reciprocal intentions about the patient's care. A virtuous circle "social causation" model is again the goal.

The third type of health capability we distinguished was agency achievement, which aims at achievement of non-wellbeing types of agency goals. Our example was social access for the disabled. Though social access for the disabled can be understood in terms of wellbeing, it nonetheless goes beyond wellbeing in that the disabled desire access to societies' opportunities and facilities, even if it does not improve their wellbeing, as a right and to increase their freedom. Indeed, this type of health capability is quite like our first type, wellbeing achievement, in that the emphasis falls on achieving the health state in question, though with the difference that the type of goal achievement is different. Agency does not play the quite same kind of role it does in the hypertension case. Rather we take the desire of the disabled to act as agents as a given, such that the burden of provision of care falls on society to secure social access.

In Chapter 7, we characterized the shared intentions involved in this case as sets of overlapping shared intentions across multiple social domains. In effect, "local" shared intentions regarding social access for the disabled need to form across multiple sites in a society. Though the individuals involved have a broad common goal, the disparate ways in which social access can be achieved for different disabilities often make what they seek to achieve quite dissimilar, for example as is clear in regard to hearing impairment and paraplegia. This also means that how their agency can be strengthened works differently than in the hypertension case. Improving access for the disabled often does not depend on a local, personalized type of interaction between a caregiver and the care recipient. An architect who designs building access for people in wheelchairs is likely to have little if any contact with those who will benefit. Similarly, technicians who fabricate hearing aid devices may have little involvement with those who are ultimately fitted with those devices.

At the same time, the stigmatization of the disabled still relies on one general mechanism whereby individuals are reduced to a lower social category. Consequently, though there are many different types of people concerned with combating stigmatization and improving social access for the disabled, these different people actually share a single overarching intention. Here, then, we see another opportunity for public health. If the different sets of shared intentions people have about the disabled are dispersed and unconnected, the project of constructing their "overlappingness" belongs to public health authorities through advocacy campaigns and other practical strategies they can undertake that make the disabled common cause for often very different kinds of disabilities. That is, public health programs are in a position to construct common agency and create shared intentions across many types of people regarding the complex problems of disability. In this case, then, the virtuous "social causation" circle depends on another way in which agency is developed since public health authorities exercise an agency that interacts with the agency of those concerned with the disabled and the agency of the disabled themselves. Without an understanding of this complex interaction, we are likely to see underprovision of the agency achievement health capability.

The fourth type of health capability we distinguished was agency freedom, and the example we gave was women's control of their fertility. In this case, we are at the opposite end of the spectrum of health capabilities from wellbeing achievement. Agency freedom is essentially about people being agents of their health. Further, their goals when we emphasize freedom are not wellbeing goals, but agency goals or goals that individuals possess irrespective of whether they contribute to their wellbeing. The emphasis, that is, rests on the person's freedom understood especially in an autonomy sense of her determining her own goals. A woman's control of her fertility accordingly exhibits this in that it involves not just her decisions regarding children and families but her decisions about herself and how she determines her own health and indeed identity.

In this case, we characterized the form of shared intentions in a particularly abstract way, namely as universal, idealized shared intentions. We chose the terms "universal" and "idealized" because the process of individual self-determination that freedom involves in a person setting her own goals is so open-ended that we cannot put concrete boundaries on how people form shared intentions appropriate to this kind of health capability. On the one hand, people share highly "idealized" intentions about self-determination because what this involves is often difficult for them to describe in either an individual or in a common way. On the other hand, people's shared intentions about self-determination are quite universal because people generally agree that they wish to be able to set their own goals (even when they fail to do so).

It is fair to ask, however, why should we associate a type of health capability with this conception of the person? Our answer is that a fundamental aspect of health is the person's conception of herself as a healthy person. Given, then, that agency plays a role, in varying degrees, in the other three types of health capabilities, the person's sense and experience of agency developed in this fourth case in our view plays a pivotal role in motivating their exercise of agency in the others as well. Yet as central as agency freedom is to a person's individual health, it still is the case that people are not isolated in the exercise of this agency, since they depend on others, social institutions, and societies' values in doing so. Thus our characterization of the form of shared intentions people develop regarding health and agency freedom as idealized and universal is also meant to comprehend how whole societies form common commitments to health. "Health" itself is a universal "idealized" goal or ambition, though as such still depends on the steps people take to achieve it. In this regard, then, public health itself stands as the tangible embodiment of this comprehensive goal and as an expression of agency freedom at the level of society. However, societies might discriminate against individuals or function in ways that adversely affect some people's health. We emphasize that public health embodies the need to bring about the virtuous "social causation" circle.

What we have set out to do in the discussion in this section, then, is to show how our health capability framework can be integrated with the objectives of public health programs to close the circular "social causation" model of health and inequality in a socially desirable way, particularly by attending to the different agency aspects of different health care capabilities. Let us now then return to our general concern in this chapter with the normative objectives of health care systems. In the following section, we accordingly examine how the moral values that emerge in the ground-up provision of care interact and combine with the ethical goals of top-down public health programs.

8.4 The normative objectives of health care systems

In this chapter we have characterized the chief ethical goal of public health programs as promoting health while paying particular attention to the relationship between health inequality and social inequality. In effect, from their health care systems perspective, public health programs seek to promote health and level the health inequality playing field at the same time. Our argument, then, was that the constraint such programs face when individuals are stigmatized in hierarchical societies can in principle be addressed when we move beyond the pure outcomes focus of standard health care thinking and emphasize the abilities that people have to act as agents of their own health. When people's agency is promoted, recognizing the role that shared intentions play in activating agency, people are individualized rather than categorized, and are more likely, we believe, to act to improve their health wellbeing.

But why should we suppose this? Our answer lies in our understanding of people's motivations. When people are reduced to labels rather than treated as individuals, not only is their motivation to act as agents undermined, but their sense of themselves as moral agents is also undermined. In contrast, when people are treated as individuals, they not only see themselves as agents able to act on their own behalf but also see themselves as moral agents motivated by ethical values. Social science often misses this. Aiming to be free of ideological bias, it can overlook the fact that values are behaviorally important also – indeed sometimes supremely important to people! We sought to demonstrate this in the last chapter by deriving moral values directly from the social interaction between people involved in the provision of care via their formation of shared intentions regarding that care. Shared intentions play a key role in stabilizing moral values in specific care circumstances, because they lock in a kind of normative common ground between people who can come to their interaction with whole arrays of different moral ideas. This then has the effect of stabilizing people's moral motivations. They not only know which moral values matter to them in what circumstances, but they also acquire a sense of what their agency – their moral agency – involves in those circumstances. Let us consider this in regard to the moral values we associated with the four types of health capabilities.

8.4.1 Combining top-down social goals and ground-up moral values

In the previous chapter, the four types of health capabilities we distinguished were respectively associated with four different moral values: equality for all, *ex ante* responsibility, human rights, and negative and positive freedom (see Table 7.3). It consequently follows that when public health authorities seek to promote health and address health inequalities, depending on which type of health capability is their immediate concern, they need to formulate their programs in a manner that builds on the moral values and moral agency appropriate to that type of health capability.

Take wellbeing freedom and the example of hypertension. Here the key moral value is *ex ante* responsibility, the idea that people take responsibility before the fact. Thus we can promote health and address health inequality by emphasizing the way in which provider–patient shared intentions interconnect when each bears a before-the-fact responsibility for a particular care regimen. The patient must actively adopt the recommended strategies, while the health/medical provider needs to help design these strategies according to what the patient can embrace. Or take agency achievement and our example of disabilities. The key value we identified in this case is human rights. To promote health and address health inequality attention again needs to be paid to the form of shared intentions involved, in this instance across often quite different sets of people in varying circumstances who, despite a broadly common objective, may believe themselves engaged in addressing quite different disability concerns. The cause of the human rights of the disabled, however, can serve to unify people, and accordingly constitutes a way in which public health authorities can help elicit people's moral agency. We believe that similar arguments apply for the wellbeing achievement and agency freedom health capabilities as well. The moral values these cases involve also function as a means for realizing public health goals in connection with these types of health capabilities.

Thus in our view the normative objectives of entire health care systems are the result of how the broad top-down goals of public health and the ground-up moral values derived from the direct provision of care, when they work together, have the effect of fitting broad social goals and concrete moral practices to one another. Essentially, the former further facilitate the latter and the latter give specific shape to the former. That health care systems should be thought to combine these different sorts of values in this way in our view reflects something important that thinking in terms of capabilities contributes to explaining health. In the capability approach, a person's ability to develop any one set of capabilities often depends on her ability to develop other capabilities, both because so many capabilities are interdependent and because developing any capabilities improves the person's capacity to act as an agent of her own capability development (Sen, 2009). At the same time, one person's capability development also often depends on other people's capability development. This then recommends a more holistic view of health which, in value terms, involves seeing how societies' system-wide health goals are interconnected with how individuals choose to pursue health. So we think the capability approach provides the basis for a more integrated normative view of health care.

Yet it would be a mistake to suppose that top-down social goals and ground-up moral values are never in conflict, particularly in hierarchical societies in which the social stigmatization of individuals is well established and pervasive, rather in the way to which we alluded in Chapter 6 in our discussion of the role of habit. Indeed, social stigmatization is itself a normative practice – albeit an objectionable one – since it relies on a set of recommendations regarding how people ought to be treated, namely according to their social group identities. Accordingly, in the next section we identify the kind of ethical reasoning that the practice of stigmatization employs, and then describe how recourse to this reasoning in hierarchical societies creates conflicts within a society's structure of values that limit the provision of care to stigmatized individuals. In the section following, we then discuss what resolving these conflicts requires in normative terms. Specifically, we argue that societies' integration of top-down social goals and ground-up moral values needs to be organized around a single lynchpin moral principle – the inherent dignity of the person as deserving of care – if the undesirable effects of social stigmatization on the provision of care are to be successfully addressed. In this the Hippocratic principle of *Primum Non Nocere* – "First, Do No Harm" – with its orientation to acts of "beneficence" should also feature as a social value system that should be fostered.

8.4.2 The conflict between social goals and moral values under social stigmatization

Social stigmatization reduces individuals to social group identities that are accorded low status, and thereby deprives them of care to which they would otherwise be entitled as individuals. In effect, individuals are regarded as simply typical representatives of social groups. Note, then, that the kind of ethical reasoning underlying this practice – consequentialism – is quite basic and well accepted in ethics (cf. Graafland, 2007: 150ff; Pettit, 1991.). Leave aside for the moment the fact that certain social groups are accorded low status in most societies. If we just think in consequentialist terms alone, or in terms of the idea that what ought to be promoted is what is good for the greatest number, then health care systems indeed ought to promote care that benefits large groups of people, and in such circumstances it is reasonable to see individuals simply as members of groups of people who would generally benefit from programs of care framed in terms of the needs of the average individual. The problem, that is, does not lie in the nature of this reasoning, but rather in its mis-application in hierarchical social contexts where it does not benefit the greatest number but rather benefits some at the expense of others. How, then, does consequentialist reasoning come to underlie the stigmatization of individuals?

The answer, we suggest, lies in the relationship between social status and social entitlement, where the latter is defined as individual opportunities, public services, and the state of wellbeing people can expect to have in their society. As a social expectation, "entitlement" has two interconnected meanings. First, it describes what is actually the case in society in virtue of prevailing beliefs. Thus in hierarchical societies people in social groups accorded low status are as a simple matter of fact entitled to less than people in social groups accorded high status. Second, expectations about what people's entitlements actually are also have the effect of setting norms regarding what it is believed people ought to have. This norm-setting then effectively legitimizes people's actual entitlements according to their social group affiliations. It follows that when social group affiliation becomes the standard frame of reference in a society, the logic of promoting the greatest good for the average individual within this frame makes sense. Consequentialist reasoning about what people ought to have – as an entirely reasonable form of normative reasoning – is therefore applied according to a society's understanding of "entitlement" in such a way as to reinforce the stigmatization of individuals by their social group affiliations.

The wide scope of consequentialist reasoning – what ought to be done for large numbers of people – makes it a basic tool of normative reasoning for top-down public health programs, which are concerned with promoting health in entire societies. Thus it is understandable that in societies in which social bias and discrimination are well established that the combination of top-down social goals and ground-up moral values generate conflict and tension within a society's structure of values. The ground-up moral values we have emphasized – equality for all, *ex ante* responsibility, human rights, and negative and positive freedom – are all centered on individuals as moral agents. Thus demoting individuals by reducing them to social group labels disrupts the integration of top-down broad social goals and group-up moral values in a fundamental way. If the former are seen as facilitating the latter, and the latter are seen as giving specific shape to the former, then the advantages that social stigmatization accords some and the disadvantages that it accords others radically distorts a health and medical care system's provision of care.

What goes wrong in such circumstances is a breakdown in a key companion idea to care: deservingness. In Chapter 5 we argued that care is a fundamental dimension of human life. Valuing human life thus implies people are equally deserving of care. But the practice of social stigmatization makes some people less deserving and others more deserving and contradicts this. We alluded to this in our outline of different medical care providers in Chapter 3. Thus different types of illnesses and disease typically receive potentially significantly different resourcing. For instance, we noted how acute care provision receives greater medical and financial resourcing than therapeutic and mental health care. The remedy to this is to refocus a care system's normative objectives on the person. We discuss how one can think in these terms in the following section by contrasting two individual-focused clinical concepts of care: person-centered care and patient-centered care.

8.4.3 Person-centered care rather than patient-centered care: the dignity of the individual deserving of care

It might well seem that the concepts of person-centered care and patient-centered care refer to the same thing. After all, the subject of health care is the patient and the patient is a person. Nonetheless there is an important difference between these two concepts. Consider what the concept of a patient involves. The word itself is derived from the verbs to wait, endure, bear, or suffer, and stoical (*Oxford English Dictionary*). Patients, then, are indeed the recipients of care, but as we argued in Chapter 2, as patients they are more seen as passively involved in their own care than actively engaged in it. As Vikki Entwistle and Ian Watt (2013) observe, the patient-centered care concept can generate paradoxical views of clinician practice. If care is patient-centered, clinicians should respect what their patients want and their autonomy in determining it. At the same time, clinicians with their expert knowledge need to make decisions for their patients. Entwistle and Watt's view is that the way this paradox is resolved is by reducing our understanding of patient autonomy to a narrow non-interference view. But that not only gives us limited insight into how people can be actively involved in their own care, but also provides us with little understanding of the clinician–patient relationship.

What Entwistle and Watt consequently recommend is that the patient be seen explicitly as a person, where this means an individual who is embedded in many social relationships, not just in the clinician–patient relationship. This shifts us from a non-interference conception of a personal autonomy associated with the clinician–patient relationship to a wider relational conception of personal autonomy associated with people's many social relationships. A person is not an isolated *Homo economicus* type figure defined atomistically apart from others in terms of her own characteristics alone, but rather someone defined in terms of her unique collection of relationships to others. Entwistle and Watt then use the capability approach to further explain this. They recognize that people develop many important capabilities as they pursue their lives – certainly including health capabilities. They also distinguish a particular subset of individual capabilities that they term "person-al capabilities," which are capabilities especially characteristic of the person as an independent individual. In particular, these capabilities reflect what the person is and does in maintaining her distinct or personal identity. We accordingly call these "person-al capabilities" personal identity capabilities (Davis, 2011, 2013c).

For Entwistle and Watt, an individual's "person-al capabilities" are the result of what society does to treat people as persons and what people do to treat themselves as persons. They describe an individual's "person-al capabilities" as being promoted in three ways. The first concerns the respect and compassion that society has for the person. "Our guiding idea requires that interactions between healthcare staff and patients reflect relationships of equality-mutuality in terms of entitlement to ethical consideration within and as part of a social group" (Entwistle and Watt, 2013: 35). Second, they emphasize the need for responsiveness to people's subjective experiences, unique biographies, identities, and life projects. People of course keep accounts of themselves as individuals, formally and informally, often by way of self-narratives or other types of autobiographical records (e.g. Schectman, 1996). Recognizing that these things are important to people then makes the idea that people are engaged in personal identity capability development part of the idea of what care involves. The third way "person-al capabilities" can be promoted is in terms of the commitment which caregivers and society have to supporting individuals' autonomy in principle, however people may differ in their needs in regard to this. Autonomy itself is a type of capability that people seek to develop, even though they typically seek to do so in very different ways according to their differences in experience and health.

Thus the idea of person-centered care is based on a conception of a person actively engaged in developing a personal identity as a collection of "person-al capabilities." Its distinctiveness as a concept of care lies in how it draws on both the capabilities approach and the relational view of personal autonomy. In contrast, patient-centered care, while valuable in its focus on the individual, still makes care depend primarily on caregivers' attitudes towards their patients, and as such tends to be framed in terms of an outcome-based view of care. Our view, then, is that the person-centered concept of care employs a normative conception of the dignity of the person inherently deserving of care, and that this conception can act as a lynchpin moral principle that links top-down public health social goals and the ground-up moral values emergent from the delivery of care that can combat the ill effects of social stigmatization. We argue this as follows.

In promoting health in society, public health systems aim to level the inequality playing field. The problem they face in doing so is that societies often operate with a view of deservingness that penalizes some and favors others. Though health programs seek to achieve equal treatment for all, in practice social discrimination can limit individual access to care and treatment. However, the idea of person-centered care sets aside people's social group identities and prioritizes their identities as individuals. It reframes the idea of deservingness in the strongest normative terms, and this acts as a corrective against the arbitrariness associated with characterizing people in terms of social identities they accidentally happen to have. It does so in large part by advancing a conception of the person that enlists individuals as agents in their own care and that of others. In our view, then, it is this alternative vision of care that offers the greatest promise of bringing together societies' social goals regarding health and the moral values people develop in the provision of care.

8.5 The institutional and normative foundations of health care

This chapter completes our three-chapter discussion in this third part of the book, "Care Systems, Human Flourishing, and Policy," in which we examined the institutional and normative foundations of health care. What we have tried to do is show that how health care is institutionally organized and delivered depends on a society's normative objectives regarding care. We have devoted this last chapter to discussing how these objectives are constituted, both because it is often thought, under the influence of the biomedical paradigm for health, that the provision of care is primarily an organizational question of delivering a collection of health services, and because determining what a society's normative objectives are is a more complicated matter than sometimes thought. In Chapter 6 we consequently examined the institutional foundations of care as a moral system, and then in this and the previous chapter we discussed how a society's normative objectives emerge from two directions on this institutional foundation.

Our basic view is that having a holistic ethical vision of care is essential to its provision and its having positive effects on wellbeing – something we sought to demonstrate using a "social causation" health system model of care. Of course people will frequently disagree about particular aspects of care and their normative dimensions. We allowed in the last chapter that others might see the moral values each of our health capabilities involved differently. Yet advancing an overarching vision of the place and nature of care in society, and particularly in the promotion of health, seems to us both necessary and feasible. That vision, we have then argued, centers on the straightforward ideas that every person is inherently deserving of being treated with dignity, and that care is a fundamental human expression of that deservingness.

Note

1 See Z13 in the JEL classification of economic literature.

9

TOWARDS DIGNITY IN COMPREHENSIVE HEALTH CARING

> [Care has] "the potential of being based on the truly universal experience … Every human being has been cared for as a child or would not be alive."
>
> (Held, 2006: 3)

9.1 The polarity in conceptions of care

At the outset of this book we referred to Gavin Mooney's (2009) distinction between "health care economics" and "health economics." For Mooney, the sub-discipline of conventional health economics, to which he was a significant contributor, was confined to what he termed "health care," but which we have defined as medical care. Mooney argued that mainstream analysis therefore ignores or overlooks significant determining factors of health, in particular poverty. By doing so, Mooney argued the standard approach has evolved in a way that supports the medicalization of health problems. He offers a communitarian-based analysis that seeks to redress this by advocating what he calls a "paradigm change" in which the social determinants of health are emphasized to a far greater degree.

We agree with much of Mooney's argument, but in this work we go further. Mooney's advocacy of a "paradigm change" is well made, yet in making this case he, like the mainstream he criticizes, does not sufficiently acknowledge the centrality of care to issues of health. We have sought to address this substantial weakness in both mainstream health economics and in Mooney's proposition. For us Mooney's criticisms may be necessary, but they are not sufficient for an adequate recasting of the economic investigation of health. If we are to accept the basis of Mooney's criticisms of the standard approach and also the argument we propose here, in our view we arrive at a most unfortunate conclusion for mainstream health economics. According to Mooney, conventional "health care economics," as he expresses it, is not really about health, and following our analysis it is not really about "care" either.

Unlike Mooney we advocate a "health *care* economics" that fully embraces a thorough examination of the nature of care. In this way we feel that our case offers a more compelling critique of and alternative basis to the mainstream. By defining "health care economics" in the way he does, Mooney's analysis does not recognize the breadth of care. Indeed, he endorses an approach that relies on dual utility functions: an individual's utility function accompanied by an "independent" social welfare function, which he claims is not an aggregation of individual utilities, but a reflection of Amartya Sen's (1977) notion of "commitment" to social factors, such as sympathy expressed in the form of interdependent utility functions. Thus altruistic acts, provided at individual costs that seem to be irrational by the standard *Homo economicus* account, are rational by reference to the social welfare function. However, as we have argued elsewhere (Davis and McMaster, 2015) the dual utility argument is susceptible to the theoretical possibility that there is a meta-function that serves as the maximand with the trade-offs between other-regarding and selfish behaviors and preferences. In short, it is likely that narrow financial incentives will again dominate. In other words, Mooney does not convincingly escape the weakness of the mainstream case we identified in Chapter 1.

In Chapter 1 we outlined how standard health economics marginalizes the conception of care. Care is conflated with altruism in theorizing it in terms of interdependent utility functions. Under this representation care is always susceptible to being crowded out by financial incentives. Moreover, we demonstrated that there is a logical problem in treating care as an externality. If care is central to the physician–patient relationship how can it be an unintended side effect? These are profound problems which we believe the mainstream approach either ignores or of which it seems blissfully unaware.

In our analysis of the mainstream health economics' conceptualization of care, we identified its affinity with aspects of the biomedical approach. Biomedicalism, we argued in Chapter 2, is essentially predicated on the Cartesian mind–body duality in that illness and disease is a consequence of disruption to biological processes. In other words, somatic pathogens are the source of malfunction: the body is analogous to a machine.

Michael Grossman's (1972) human capital model of the demand for health and health care represents the body – or the stock of health capital – as separate from the mind as the site of calculating optimality. Grossman connects the fundamentals of standard health economics to biomedicalism in that it provides a functionalist representation of health. Grossman defines health in terms of the ability to function "normally" (in labor markets, for instance), and the biomedical approach refers to health in terms of "normal" biological function. The body is an instrument in both. For biomedicalism it is instrumental in biological processes, for mainstream health economics it is the site of the stock of health capital.

Grossman's model vies with Kenneth Arrow's (1963) welfare analysis of medical care as the principal influence on the evolutionary trajectory of health economics. The health economics literature regards Arrow as the seminal contributor to the field. However, as Mooney (2009), for example, notes, Grossman's human capital approach has been highly influential in shaping the development of health economics, especially in its endorsement of health as the maximand in evaluation studies which dominate the field.

We argue that this presents a particular institutional formulation for care as a regime of treatment. According to this, care as treatment follows a linear process with specific social roles – physician and patient – that entail certain behaviors. For instance, the physician assumes the role of empowered expert whose aim is to remedy the disorder following the protocol of examination that concludes with a particular treatment or set of treatments. The patient is assumed to be passive and compliant. Of course, when health economics is added to the mix the treatment protocol is subject to a form of cost-benefit analysis such as QALYs, ultimately as a means of establishing whether the procedure should occur in the first place. On this understanding, care amounts to no more than a means to a given end. Care is subject to a consequentialist assessment of its "value," and is therefore potentially measured through imputed monetary values. Care under this regime is "clinical." In other words, it is technical and devoid of any intrinsic relational value. It is analogous to a market transaction conducted between atomistic individuals, little different to consulting a mechanic about the condition of a car.

This for us represents a stark scenario, but one that follows from a standard health economic account of care. On this, in Chapter 3 we attempted to demonstrate how medical care is heterogeneous and nested within a broader system of health care. A standard health economic approach may privilege acute medical care with its curative aims at the expense of therapeutic and palliative caring, where outcomes are at best difficult to quantify, as in therapeutic activities, or certain, as in palliative care, but process may also elude quantification. Here the adage about economists knowing the costs of everything and the value of nothing seems especially fitting.

Of course, as we noted in Chapter 2, concern about the crowding-out of the kernel of the Hippocratic ethos has been the subject of decades-long dialogue in the medical sciences. Aasland (2001), for instance, is one of a significant number of medical scientists who have expressed concern that medical practice should not be devoid of compassion. Therein lies a tension between Hippocrates and Descartes. Does the former suggest *cura personalis* (care for the whole person) and the latter the disembodied person? In our view the standard health economic conception of care suggests the latter.

In the second part of the book we attempted to develop an alternative conception of care, which endorses a more Aristotelian vision of human flourishing and the "embodied person" advocated by authors such as Nancy Krieger (2001) and George Engel (1977). In doing so, in Chapter 3 we alluded to Cicely Saunders' description of "total pain" which goes beyond physical symptoms to include mental suffering, associated social problems, and spiritual needs that undermine the "intactness" of the person. It is this emphasis on the "person" which we believe is a fundamental aspect of care and caring.

Given the centrality of care to human existence, noted in Chapter 5, economists of all schools of thought have a lamentable record in attempting to analyze it.

In Chapter 4 we identified notable exceptions, including Adam Smith in *The Theory of Moral Sentiments* and Thorstein Veblen's idea of the "parental bent" instinct, while more recently feminist economics has provided valuable insights. We also acknowledged Kenneth Boulding's three systems of organization – "threat," "exchange," and "integrative" – where the "integrative" system is dominated by "love." This is the closest Boulding comes to analyzing care, although to the best of our knowledge there is no direct reference to "care" as a phenomenon. However, in the context of health and medical care we feel that Boulding's argument offers a contrast to the standard account. He emphasizes the distinctions between wants and needs, examines how need engenders dependency and hence power across relationships, and how health and illness are partly socially constructed. In short, we believe that Boulding anticipates much of the later care literature. Nonetheless, it is the feminist economics literature that fundamentally questions economics' ability to model care. For instance, the conventional measure of productivity is inimical to care and caring, as care is an output of a range of relational activities (Himmelweit, 2007). How therefore, is it possible to raise the "productivity of caring"? This avenue of investigation opens up the possibility that devoting more time to the practices of care may lead to a more caring context, akin to Boulding's "integrative" system, and here we may discuss abundance as opposed to the conventional microeconomic scarcity rubric. In short, caring does not exhaust (or consume) some finite quantity or "stock" of care as may be inferred from standard economic reasoning. Rather, as Adam Smith recognized in *The Theory of Moral Sentiments*, caring is self-reinforcing, demonstrating positive feedback effects. To care encourages the flourishing of caring: care begets care.

We sought to expand on this understanding in examining the properties of care and caring in Chapters 5 and 6. Care is complex. It is a series of ethically laden and potentially emotionally motivated practices. It therefore has philosophical, psychological, and labor dimensions. Parts of the care literature (for example, Engster, 2005) identify three basic aims of care: survival, development, and social reproduction. Survival can relate to care for the self, and therefore possesses an existentialist dimension, as Heidegger and Foucault explain. Development involves enabling others to acquire capabilities for survival and functioning in society. Social reproduction concerns the maintenance of capabilities in others, and therefore relates to the relief of pain and suffering. This obviously embeds health in care.

Other contributions to the care literature identify linearity in the provision of care. The pioneering work of Joan Tronto (2013), for example, aligns particular ethical qualities with various phases of care. Thus being aware of a need for care ("care about") is associated with the ethical quality of attentiveness. The second phase, "caring for" is associated with the assumption of responsibility for addressing the identified care needs. The following phase, "caregiving," is the action of care, which is aligned with competence. "Care receiving" refers to observing the effectiveness of care action, and has the ethical quality of responsiveness. Finally, Tronto identifies "caring with," which is consistent with commitments to justice, equality, and freedom, and is associated with the ethical qualities of trust, respect, solidarity, and so forth. Other authors, such as Nel Noddings (2003) and Jean Watson (2006), emphasize a dyadic relational quality to caring, where the provider of care is "engrossed" and motivationally "displaced," and where "caring moments" attain a "higher spiritual" level.

Following our analysis of the role of institutions and the work of Jeffrey Blustein (1991), we find Noddings' and Watson's approaches to be overly reliant on a dyadic approach that relegates the importance of the system of institutions in which the caring relation and acts of care are embedded. Noddings' and Watson's notion of authentic care is rather idealistic, and suggests that only a very narrow range of acts could meet their rather strict conditions. We venture that relationality is important to care, but following Blustein care – "care that" – can be a more abstract entity, where concern is not directed at a particular person, but perhaps a situation. Blustein argues that there can be care without commitment, but not commitment without care. For us this reveals the centrality of institutional systems and how they may influence instincts to care (Veblen's "parental bent") through learned habits and dispositions. In developing this we classify three levels of institution in a system of health care: delivery, education and training, and social system institutions. Delivery institutions are nested in education and training institutions, which are nested in social system institutions such as government and social values. It is here that Tronto's "caring with" concept is most applicable. Unlike Tronto, we argue that caring practices in delivery institutions by medical groups of care, for example, is conditional on the degree of "caring with" instilled from social system institutions via education and training institutions. On this we observe how the delivery of medical care (and cure) has evolved in the West. Care is not immune from wider social forces, including the distribution of power across communities and groups.

Central to our analysis is the notion of shared intentionality. This is defined in terms of the specific use of language. "We" terminology is more demanding than "I" first-person singular speech. In the case of "we" language the individual expressing this must determine that the other individuals constituting the "we" agree with the intention expressed. It is shared intentionality that (voluntarily) binds individuals to groups, and implies that care is not dyadic but a group concern.

We thus conceptualize care as a complex and emergent phenomenon which is not amenable to standard economic modeling. Care is moral, instinctive, and learned. Therefore any investigation of care has to acknowledge institutional systems.

In Chapters 7 and 8 we refine our analysis further to focus on the aims of care as developing capabilities and enhancing dignity, and the social values that facilitate this. We argue that the capability of having and being in good health is a central human capability upon which other capabilities are predicated. Therefore, the provision of health capability is widely embedded in webs of social relationships throughout the system of health care institutions we identify.

Chapter 7 analyzes how bottom-up social embeddedness promotes certain values and objectives. We draw on Sen's (1993) framework to develop our case. Thus, in Table 7.3, we identified "wellbeing achievement," which refers to the shared intention of the basic capabilities all people should have; "wellbeing freedom," which refers to shared intentions of groups of health care providers about patients' capabilities; "agency achievement," which refers to overlapping sets of shared intention concerning a type of capability over a range of domains, and "agency freedom," which is universal idealized shared intention. With those capabilities four moral values are identified: equality for all, *ex ante* responsibility, human rights, and negative and positive freedoms. There is some resonance with the ethical qualities Tronto associates with "caring about" (responsibility) and "caring with" (solidarity, trust, and so forth). We feel our case, however, is rather less linear than Tronto's phases of care framework. Our emphasis relates to the socially embedded individual through shared intentionality within a system of institutions.

The development of an individual's capabilities of health relates to their autonomy, or agency, and to the dignity of the person. This is crucial to our argument.

The argument is extended in Chapter 8, where we examine the "top-down" promotion of normative objectives and policy. The social determinants of health are considered in our examination of a social causation model. Here (public) health programs can be understood in terms of the enhancement of general (population) based capabilities. We identify social goals of health care systems and outline possible conflicts such as social stratification. We argue that the resolution to such conflict lies in the premise that the person is intrinsically worthy of dignity and deserving of care.

The difference between our conception of a health *care* economics and the standard health economic approach to care is unambiguous. The mainstream account cannot provide a conceptualization of care, and the person becomes disembodied as health is reduced to a functional issue of the repair of depreciating capital assets. By contrast we identify the individual as socially embedded and embodied. We also highlight the complexities and nuances of care as a value-laden concept that *should* be directed at enhancing an individual's capabilities.

9.2 The importance of dignity

We have emphasized the importance of human dignity as a social value throughout this book. In closing we will try to explain why dignity has this central place both in our arguments regarding care and in health and medical care systems. To put matters in perspective, for us human dignity is the lynchpin that holds together how one should think about the many dimensions of care and the central aspect around which complicated health care systems should function. Thus we believe that one fails to understand care if one fails to think of it in terms of dignity and will fail to think clearly about health and medical care systems if one does not think in terms of how they sustain and promote human dignity. These are strong claims, but we think they are highly plausible once considered.

Note first, then, an obvious objection to emphasizing a social value in any analysis and explanation of the nature of health care and health care systems. Many would say that values have no role in explanations and only provide us means for assessing their normative implications. That is, they assert that there is a strong separation between the positive, descriptive activity of explaining the world and the value-based normative activity of judging it, such that the former can and should proceed independently of the latter. However, we dispute this strong separation on the grounds that we believe that one cannot explain care *without* understanding the values we hold regarding care. Philosophers call this the "entanglement" thesis, and argue that our language and thinking inextricably mix values and descriptions (Putnam, 2002). This does not mean, as some suppose, that our explanations when they employ values must then be subjective. Quite the contrary. On the one hand, our important ethical values are also objective, since we know that respect for others, freedom, happiness, fairness, kindness, and many other values are fundamental features of human life. On the other hand, we still aim to produce normative accounts of the world that are not biased by our personal opinions. Avoiding bias does not involve neglecting the role our values play in our explanations of the world, but rather in understanding the particular role and contribution they make to those explanations.

The concept of care is a paradigmatic example. Caring is defined as having a concern for the wellbeing of another. Thus the explanation of care, in whatever forms and ways in which it is manifest in the world, in health and medical care, and in so many other domains of life, is a matter of determining whether this concern for the wellbeing of another is involved. One might get an explanation of care wrong, or in a particular case not get whether concern for the wellbeing of another is truly involved, but these issues presuppose that we know what care is and our basic understanding of care.

Unfortunately, the positivist view that explanations must be value-free is widespread in economics and too infrequently scrutinized. Applied to the concept of care, this leads to explanations that are at best blandly descriptive of relationships between caregivers and care recipients and ultimately say nothing about the idea of care. We argued this explicitly in our first chapter's treatment of mainstream health care economics' spillover view of care. In order to interpret exchange relationships between health and medical care providers and patients as relations between caregivers and care recipients, care ends up being treated as an accidental by-product of those exchanges since it is clearly not part of how those relationships are explained in the first place. But being an accidental by-product of those relationships is exactly the opposite of what care is in concern for the wellbeing of another!

Faced with this explanatory omission in standard health economics, we believe that we have identified a wealth of thinking that addresses this shortfall. We have tried to deepen our explanation of it by emphasizing two aspects of care: the relational nature of care tying caregivers and care-recipients together, and the attendant formation of shared intentions between them regarding the provision of care. We believe these further aspects of behavior can be found in all caring relationships, and give further meaning and content to the basic idea of concern for the wellbeing of others.

How, then, does this fuller understanding of care depend on emphasizing the importance of human dignity? First, what understanding care in relational terms means is that caregivers and care-recipients see each other as jointly committed to a course of care centered on the wellbeing of the care-recipient. Commitment is a kind of behavior not based on whether a payoff in means-ends terms might result, but rather a behavior based on doing something that is intrinsically valuable or an end in itself. In the case of health and medical care, what caregivers and care-recipients jointly commit to as intrinsically valuable is the health of the care-recipient. Contrast this with economics' standard account of the instrumental rationality of caregivers in which the recipients of care are valued as means to the caregiver's maximization of utility, and have no value beyond what they contribute to this. From a dignity perspective, this turns things upside down, but to reverse the picture the behavior motivating care needs to be seen differently, and this comes from not seeing caregivers and care-recipients in means-ends relationships with one another but as jointly committed to one intrinsically valuable end.

Second, following this, by treating the individual in an instrumental way, as a means to an end, the standard approach to health economics raises the specter of stigmatization and humiliation for the individual. Both stigmatization and humiliation may be seen in terms of circumstances where a person considers their self-respect to be harmed (Margalit, 1996). Self-respect reflects an individual's sense of self-worth about how they feel they are entitled to regard themselves by virtue of their inclusion or exclusion from various social relations. Thus self-respect can be undermined by exclusion, exploitative relations, and a sense of powerlessness. By focusing on outcomes, standard health economics effectively bypasses the person and therefore does not provide an appropriate basis for the fostering of individual self-worth, self-respect, and hence dignity. Indeed, it may be the antithesis of this.

Third, what understanding care in terms of shared intentions involves is an emphasis on the adoption of a common attitude motivating the provision of care. People always act on the basis of their motivations. However, on the standard view in health care economics there is no need for caregivers and those receiving care to share the same motives regarding care, and accordingly they may only share the same object of providing care by accident. Thus in order that they share the same object of care – the wellbeing of the care recipient as an end in itself – they need to adopt a common attitude toward this care. That common attitude, we argue, is respect for the dignity of the person receiving care, since respect in this sense is an attitude that unilaterally focuses on the person as an end. Of course people can form shared intentions regarding many different goals, but on a relational view of care that makes those receiving care intrinsically valuable, the shared intention in question needs to have a proper aim. Respect for the dignity of the care-recipient is thus the shared intention involved.

We certainly recognize that promoting health in the world today involves many different types of people interacting in many different kinds of relationships in medicine, in health care systems, and in public health. So it might seem that saying this can all be understood with the framework we have developed that makes dignity the lynchpin of health asks too much. Our view, however, is that all we have done is elicit the fundamental meanings and dimensions of the idea of care, which organizes the many ways in which we understand the provision of health. If anything, it is rather ironic that care as such a fundamental dimension of human life is not understood in more straightforward terms than it seems to be. We take the reason for this, as we have argued in this book, to be due to the imposition of the idea of market exchange on the way people understand care today. The market view of care is inimical to the idea of care, because market participants are self-regarding whereas care requires people to be other-regarding. So were the market interpretation of health and health care systems to be seen as foreign to the understanding of care, it seems fair to imagine that the basic aspects of care, which we have tried to set out here, would explain the complexity of health provision. Those basic aspects, we argue, center on the importance of human dignity.

9.3 Health policy for today and the future

In this book we have tried to explain the nature of care in order to understand health and medical care, and how this may frame a health care economics. Of course, considerations of policy follow this, but this would require a further potentially book-length treatment. For the moment, we content ourselves with some general policy implications, in the broadest sense, which follow from our arguments. We begin, then, with the foundations of contemporary health policy that lie in the 1948 UN Universal Declaration of Human Rights Article 25 that states:

> Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, illness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. (http://www.un.org/en/universal-declaration-human-rights/)

Clearly the scope of health itself is broad and far-reaching in that it concerns all the dimensions of life that being in good health might involve, not just those requiring medical care obviously, but the full range of factors that enter into people's wellbeing and ordinary livelihood. Some might find this too wide a scope to provide direction for any concrete set of policy initiatives. But our view is that the importance of human dignity to the concept of care provides a basis for designing health policies throughout life that promote individual and social wellbeing. Following Vikki Entwistle and Ian Watt, we characterize policies aimed at promoting health in this way as a program of person-centered care framed in terms of the capability approach (Entwistle and Watt, 2013).

There are many interpretations of person-centered care, as one might expect, since there are many views about what personhood and the dignity of the person involves. But we believe that this openness actually points us to a shared view of what the person is that provides the basis for health policy in all its possible domains and applications. Thus, rather than say that personhood involves some given collection of characteristics, we believe that what the many different views of the person share is an understanding of the person as an open-ended set of opportunities. People are inescapably diverse because their opportunities, the many different things that they pursue in life, are inevitably different from one person to the next. Oddly, one might say that one thing people have in common and share is being different, not some single type of sameness we can find in each. So for Entwistle and Watt, an overarching understanding of person-centered care that captures how people are different from one another needs to be formulated in terms of opportunities or, more specifically, in terms of the capabilities people seek to develop for themselves.

In connection with health, as we argued in Chapter 7 following Jennifer Ruger (2006, 2010), this is first and foremost a matter of thinking in terms of people's *health* capabilities. Health capabilities include all the valued functionings that specifically concern how people maintain their health, physical, emotional, social, and psychological. People's health capabilities are consequently the particular responsibility of health care providers, public health agencies, and health policy-makers. Entwistle and Watt's conception of person-centered care, however, makes a person's health capabilities part and parcel of their whole life plan of developing their individual capabilities in all the ways they wish. To capture this, they refer to each individual's "person-al capabilities" as a core of individual capabilities that are nonetheless tied to each person's relations to others and ability to function as individuals in a dynamic social world. Thus health policy, as the UN Universal Declaration of Human Rights Article 25 states, concerns the very basis for good health in people's individual capability development as they understand it.

While this focus on individuals accordingly gives us the human foundations of health policy, at the same time it is important to recognize that the reach of health policy needs to be seen as truly global. Global health policy goes beyond national health policies and the comparative analyses of health policy strategies across nations to the activities and responsibilities of global and international health policy institutions, today in particular the World Health Organization, UNICEF, the International Red Cross and Red Crescent Movement, the UN High Commissioner for Refugees, the UN Development Program, the UN Food and Agriculture Organization, and health NGOs such as Care International, Oxfam, and Médecins Sans Frontières. These agents occupy themselves with not only health risks and challenges occurring internationally, such as pandemics that cross national boundaries and multi-country health initiatives affecting people from many countries, but also with how health influences the promotion of the wellbeing of people world-wide associated with the aims of human development (Brown *et al.*, 2006). Clearly for health policies to have such wide scope the main ambitions regarding improving and promoting health must be universal in nature. And this cannot be reduced to simply eliminating disease and overcoming disability in an instrumental way because what doing these things involves depends on both social circumstances and what people believe good health involves for them.

Thus as we have argued throughout this book, what acts as a common denominator for all the different ways in which health is promoted is the concept of care as a fundamental human relationship. Care is at once both a relational and an ethical matter that invokes strong feelings and the most characteristic of human behaviors. This is hardly controversial of course, and consequently what we have sought to do in the book is show what a health care economics and associated health policy would involve were they to make care central rather than peripheral, as we believe is currently the case.

On this, we believe that conceptualizing health and medical care as a market transaction is a misleading caricature that is inimical to the promotion of human dignity. The institutional design of health policy, broadly conceived, should have some affinity to Boulding's notion of an "integrative" system as opposed to an "exchange" system that typifies market transactions. The dominating values of the integrative system – benevolence and "love" as an other-regarding bond – support the idea of care and caring. Indeed, as we have contended, the institutional architecture underpinning the health and medical care system – social system, education and training, and delivery institutions – has to engender "caring with" as a necessary, but not sufficient condition in the promotion of care and dignity. In short, as one of us argued:

> Making human dignity a central value of socio-economic policy, then, means changing social institutions to *eliminate* humiliating institutions. (Davis, 2006: 81, emphasis added)

We leave our argument here, and in the final section make one short comment on the state of an economics that treats care as but a spillover or an externality on a transaction.

9.4 Whither economics?

Our points extend beyond health economics to the economics that has produced contemporary health economics. For example, in her investigation of the history of standard health economics, Evelyn Forget (2004) convincingly argued that it is grounded in neoclassical economics[1] in that it attempts to provide measures of cardinal utility in its assessment of welfare, assumes *Homo economicus*, and is value-neutral in promoting an efficiency rubric either founded on Pareto optimality or utilitarianism. Indeed, in their defense of health economics David Parkin, John Appleby, and Alan Maynard (2013) appeal to Maurice Chevalier's reference to old age as lacking in desirability but being better than the alternative. In other words, without health economics there would be no basis for efficient resource allocation in medical care. They assert that mainstream economics is merely a "toolkit that enables better understanding of how people live, and how societies work" (2013: e11). For us, such a representation tacitly assumes a benign instrumentalism. On this account standard economics resembles a hammer: like a hammer it has no intrinsic value, its use (for good or harm) is entirely functional. We strongly believe that this position is utterly mistaken about economics in general, and especially health economics. We believe that the arguments presented here highlight the normative basis of economic thinking in health, care, and health and medical care.

Economics, like medicine, is embedded in value systems that prioritize some things over others. Certainly many health economists explicitly acknowledge this in their discussions of equity in health and medical care. Maynard himself recognized this when he and Hutton stated: "No country is interested in efficiency alone in its health care system: if countries used the efficiency criterion alone, many low birth weight babies would be left to die!" (Hutton and Maynard, 2000: 92). Surely this implies a normative dimension to health economics? To compound this, Parkin *et al.*'s (2013: e14) allusion to the Pareto Principle as a "key theoretical" concept rather gives the game away. The Pareto Principle is much criticized as predisposing the decision-making process, for example, over the allocation of resources to the status quo. Thus we believe that standard health economics is value-laden in such a way as to privilege market exchange as the basis of health and medical care provision.

However, we will not repeat our arguments regarding why contemporary mainstream economics and health economics fail to address care and health in any kind of satisfactory way. Rather we ask: how can an economics so removed from what care and health involve even be sustained in the long run? This is also not the place for a further examination of the history of recent economics, or the place for further critical evaluation of standard economics' philosophical presuppositions. Instead we only speculate on the future of economics and health care economics taking the fundamental importance of care in human society as our Archimedean point.

Our view is simple. Economics' mistaken view of care and inapt explanations of health care and health policy are not sustainable in the world to come. Scientists often discover that their explanations of the world need to be revised, are based on incorrect theories, do not stand up to the evidence, and do not generate good predictions for the future. They then undertake a reworking of their views. This is the ordinary process by which science develops. But it is an altogether different and exceptional matter when a science builds itself around ideas clearly at odds with a long-established, widely held understanding of how the world works. How the world works in the case here is that it makes care central to health. The provision of health and medicine depends on caring behavior. So care and health cannot be treated separately from one another, or care redefined in such a way as to not be care. Indeed, the caring professions and social sciences other than economics recognize this. Our view is thus that economics will inevitably need to rebuild its explanations of health care around a genuine concept of care in the future. How this might occur would be the subject of future research and discussion – a research and discussion to which many have already contributed and to which others will contribute in the future. We have only attempted in this book, following others before us, to lay out some of the major issues and questions which we believe are important to understanding care and health. We hope they will stimulate others' contributions to health care economics' reinvention of itself and changed pathway in the future.

Note

1 Despite the changes in the mainstream over the past two or three decades, principally the incorporation of game theory and more recently the behavioral "turn," and the subsequent challenge to some neoclassical tenets such as *Homo economicus*, health economics has, in the main, retained a strong affinity to neoclassical micro theory.

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