On the need for a heterodox health economics[1]

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Introduction

This paper is a plea for greater cognizance of the errors of omission and commission committed by mainstream health economics, and the potential orientation in treating health and health care as (metaphorical) commodities that the unfettered influence of health economics may be prompting. Economic criticisms of mainstream health economics are evident, especially in the collection edited by John Davis (2001), but tend to be rather fragmented and lacking in credibility with our mainstream brethren. Contentiously, seeking the approval or otherwise of the mainstream is perhaps not as important as in other areas of economics, if indeed it is the case at all, but gaining the attention of other social scientists, medics, and policy makers may be of considerable consequence. The paper does not seek to speculate on strategies for addressing these bodies; instead it concentrates on the nature of the message.

It is frequently argued that *all* health care systems share a universal feature: a predisposition for cost escalation that results in health care "consuming" ever greater proportions of GDP (see for example, Newhouse, 1992). Health economics, given its emphasis on scarcity, opportunity costs and efficiency (Fuchs, 1996; Birch and Donaldson, 2003, etc.) would seem to be well placed to contribute to policy discussions on this seemingly inexorable growth in health care expenditure, both in tracing its sources; such as ageing populations, the rising costs of medical technologies, and/or misaligned incentives, and in addressing the problems this pattern may pose. Despite Victor Fuchs' (1996) protestations, health economics is displaying increased currency among policy makers. In the UK there has been a substantial growth in the number of institutions offering courses in health economics and in research institutes commissioned to contribute to policy evaluation. Indeed, the World Bank's website highlights the importance of health economics. Culyer and Newhouse (2000: 1) observe, "… by almost any criterion, health economics has been a remarkably successful sub-discipline", and Fuchs (2000) optimistically considers that the "strong demand for health economics will continue".

Yet, as Fuchs recognises, as it is presently constituted, health economics demonstrates weaknesses (Fuchs is bullish about overcoming those weaknesses he identifies, I am much less so). Evelyn Forget's (2004) excellent paper on the contested histories of health economics reveals some of the dangers of a fallacy of omission in a lack of historical consciousness. Forget considers that health economists are indelibly ahistorical (which Fuchs comes close to acknowledging), and consequently have little acuity of alternatives: the ground is set; a variation of *de gustibus non est disputandum*. Famously, for Stigler and Becker (1977) tastes were taken as stable and given; for health economics it's an unquestioning taste for Paretian-Utilitarian and Cartesian foundations that masquerade as scientific "objectivity", and posit the individual as socially disembedded. These fallacies of commission are fairly well recognised by critics (see for instance, Cohen and Ubel, 2001;

[1] This paper represents an overview of part of an on-going exercise exploring conceptual issues in health economics. I am grateful to the participants, too numerous to identify, of various conferences and workshops for their insightful and helpful criticisms, observations, and encouragement. I am also extremely grateful to John Davis for his comments on this paper and for his collegiality on other related work. Of course all errors, omissions and views expressed are mine alone.

Davis and McMaster, 2005; Hurley, 2000), but the potential ramifications tend to be under-emphasised. Of course, much of the foregoing is not unique to health economics *per se*, with mainstream economics, *in toto*, often being accused of demonstrating such contested traits. This aside, there are several factors that accent the significance of this area of criticism of health economics: First, as Forget identifies, its employment of cardinal utility measures embodies certain uniqueness. Second, as noted, the health economics project has experienced a remarkable growth in the past twenty-five years, and concurrently its influence on policy has also burgeoned. Arguably, more than any other area of applied economics is the reductionist calculation mode of reasoning of the mainstream likely to have such a direct short-term impact on people's lives. Third, health economics may also have the potential to act as a conduit to a fundamental shift in the praxis of medicine. For these reasons, and undoubtedly for others, health economists', perhaps unintentional, propensity for *de gustibus non est disputandum* requires to be challenged.

The remainder of the paper is structured as follows: the following section offers a brief characterisation of health economics, endeavouring to avoid constructing a straw man. The third section considers some of the potential ramifications of the basis of health economics in terms of theory, and method. The final section urges the deployment of a heterodox approach(es) to offer greater pluralism in the theatre of health economics.

A résumé of (mainstream) health economics: Of Pareto, Descartes and Utilitarianism?

Mainstream health economics textbooks adopt a familiar structure in that material is organised according to the neoclassical dual of demand and supply, and then usually followed by issues of economic evaluation. Nevertheless, from the emergence of the sub-discipline many core neoclassical tenets have been queried, with health economists prominent in questioning their "validity" (for example, Culyer, 1989; Rice, 1998). The "distinctive features" of health and health care as "commodities" likely to invoke market failure are highlighted, with the latter exhibiting the characteristics of a derived demand (consumers are presumed to demand "health", and only demand health care as a means of attaining better health); interdependent demand and supply sides; externalities; information asymmetries between providers and patients; and the frequent uncertainty over the efficacy, and outcome, of medical procedures. There are those who dissent from this emphasis. For example, Pauly (1988) has argued that a significant proportion of medical care procedures are sufficiently routine to consider them analytically equivalent to other consumer-initiated purchases. Indeed, in a foreword to a recent World Bank publication Julian Le Grand (2003) makes a related point in arguing for the potential expansion of private sector participation in health care provision. He states (2003: *x*):

> "Quite why it should be morally objectionable to make profits from the provision of health care than in other areas of equal or even greater importance to human welfare where private provision was common, such as food or housing, was never made clear".

Modelling the demand for health adopts a decidedly Beckeresque construction. Grossman's (1972) seminal contribution draws heavily from the human capital literature identifying health as an analogue to a commodity possessing both investment and consumption properties. Like Becker, Grossman assumes that households produce as well as consume health. Individuals are endowed with a "stock" of health that they can choose to

invest in by engaging in activities that contribute to this stock (including health care) and offset depreciation; subject to constraints, such as income and, more controversially, educational attainment. Grossman portrays an intriguing exercise in the extension of rational choice over an extended time frame. The simpler version of the model implies that the rational individual can, in effect, calculate her/his optimal lifespan subject to changes in discount rates. Thus, a possible interpretation is that poorer, less well-educated people die earlier as low income acts as a more binding constraint in the optimising algorithm: it is "rational" (sic) for them to die earlier.

Grossman's model bridges the supply and demand sides of health, and this is analytically reproduced to some extent in the analysis of health care provision. The development of agency models in health economics departs somewhat from the standard framework. This is partly a vestige of health economists' delineation of the characteristics of health care, especially "uncertainty", and the theoretical acknowledgment of interdependent utility functions. Health economic approaches tend to model patient-physician interactions as principal-agent (see, for example, Dranove and Satterthwaite, 2000), where the clinician-agent gains utility directly from either acting in a patient's best interest or from vicariously experiencing a patient's recovery. This reflects the inclusion of medical ethics in the physician's utility function (Arrow, 1963; Mooney and Ryan, 1993; McGuire, 2000), a "caring externality" (McGuire, *et al*., 1982), or a "humanitarian spillover" (Culyer, 1976). The literature considers that different physicians may have different propensities in this, suggesting that health care is an experience good where the "consumer" (sic) faces an adverse selection problem. Indeed, McGuire (2000) argues that differences in physicians' "caring" is analogous to brand differentiation. Of course, the foregoing is subject to constraints, and the "caring externality" is potentially tradable should the circumstances dictate. US health economists, in particular, have contested that physicians will have incentives to engage in some form of supplier-induced demand, where clinicians manipulate patients' demand for services to the benefit of the former as opposed to the latter (Evans, 1974; Fuchs, 1996; McGuire, 2000). Conceptually, supplier-induced demand is a potentially invidious source of inefficiency.

As with mainstream economics generally, efficiency is the dominating rubric, and is manifest most obviously in the economic evaluation techniques that dominate the literature (see for example, Donaldson, *et al*, 2002). Health economists have been among the most innovative (and controversial) in their development of evaluation procedures. It is in this area that health economics is evoking considerable policy interest. Economic evaluation is firmly embedded in the cost-benefit architecture, with two broad approaches discernible: cost minimization studies of interventions with identical outcomes, and allocative efficiency analyses of different types of procedures with no common unit for outcome measurement. It is in this latter area that most work is concentrated, with a range of techniques emerging in the literature: from cost-utility analysis to contingent valuations (of willingness to pay) based on discrete choice in conjoint analyses (see, for example, Ryan, 1999). There is a quest for fungibility in each of these approaches, frequently through monetization, with the controversial QALY[2] (quality adjusted life years) measure of health states retaining some popularity among health economists. Here welfare economics exhibits an obvious influence (Culyer and Newhouse, 2000; Hurley, 2000), although there has been recent debate between "extra-

[2] QALYs is claimed to permit direct comparisons across diverse health care procedures and interventions as it furnishes a measure for the quantity of life (mortality) and captures changes in life quality (morbidity).

welfarists" and "welfarists" regarding the form of this influence[3]. Birch and Donaldson (2003) and Hurley (2000) argue that the two share key elements; principally, a consequentialist orientation and limited capacity to accommodate equity concerns. The latter are frequently invoked by health economists as a check on an efficiency rubric. Hutton and Maynard (2000: 92) express this in stark terms,

> "… 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!"

That there is an overtly normative element in health economics (in its own terms) is well recognised by health economists (Culyer and Newhouse, 2000; Fuchs, 2000). This adopts a particular appearance, being shaped by utilitarianism and Paretianism. Sen's (1987) discussion of ethics in economics characterises utilitarianism as: consequentialist; welfarist, and as sum-ranking. Of course, mainstream discourse has arguably retained its consequentialist credentials through instrumental rationality, whilst shifting away from sum ranking and welfarism following the rejection of interpersonal comparability, the adoption of ordinal and revealed preferences, and Pareto optimality. Nevertheless, as argued above, such a retraction is not as marked in health economics, where there is evidence of sum ranking via the persistent invocation of cardinal utility (Forget, 2004). Culyer (1998) considers that one of the advantages of the Pareto criterion is that it affords the minimisation of any infringement of "personal values" by invoking a criteria that any change should not be to the cost of any individual, which for Culyer (1998: 364) "seems innocuous enough". As Culyer recognises, the Paretian metric requires "demanding" conceptual assumptions that may render it inoperative in health care: hence his advocacy of extra-welfarism. Despite Culyer's reservations, Pareto remains the litmus test for many health economists. Whynes (1996) is typical of mainstream economists in his appeal to two philosophical foundations in his analysis: utilitarianism and Paretianism (see also, for example, Diamond, 1998, and Birch and Donaldson, 2003). From the perspective of the argument presented here there is also a discernible Cartesian flavour in health economics, principally through Cartesian dualism and rationalism[4]. These views are substantiated upon below, as are the potential ramifications for the analysis of health care provision.

Ramifications and the nature of a critique

In a thoughtful and reflective piece on the future of health economics, Fuchs (2000) lists five areas where health economics makes a substantial contribution: endogenous preferences and technology; social norms; principal-agent relations; human behaviour, and

[3] Extra-welfarists are associated with Culyer's (1991) attempts to integrate Amartya Sen's capabilities approach in an economic evaluation framework through the incorporation of non-goods characteristics into a social welfare function, typically featuring subjective assessments of health (as measured by QALYs) as the maximand. Birch and Donaldson (2003) provide an example of the criticisms of extra-welfarism. They argue that extra-welfarism through its "narrow" focus on health as a maximand ignores trade-offs between health and other commodities and/or characteristics, and consequently furnishes a restrictive account of opportunity costs.

[4] Descartes' dual is associated with his delineation between mind and body, where the essence of the former is self-conscious thinking, whereas the latter is matter. The body is conceptualised as a machine operating according to mechanical principles. Cartesian rationalism is Plantonic in that it considers that knowledge is derived from innate ideas and constructed by reason. For Descartes only eternal truths, such as mathematics, the epistemological and metaphysical foundations of sciences, were derived from reason alone. There is a role for experience in generating other forms of knowledge.

the measurement and analysis of quality of life. He then catalogues what he considers as the weaknesses of current health economics' practice as: psychological experimentation, the use of survey research, and most importantly (given the space dedicated by Fuchs) an insufficient consideration of institutions. Fuchs (2000: 149) states, "Institutions *matter* … particularly in health care … in part because history matters" (original emphasis). This is a highly refreshing recognition of the institutional lacuna in health economics, and Fuchs is to be commended for this. However, Fuchs shows no cognisance of the sources for this omission. Despite Fuchs' laudable message there are compelling grounds to conjecture that the core propositions of health economics will not enable Fuchs' lacuna to be addressed. There is insufficient space here to take issue with Fuchs' "strengths" of health economics; only some indicative remarks are offered by way of a critique. Obviously the general criticisms of the underlying philosophical foundations of health economics have a similar currency of applicability to health economics itself. This section, however, concentrates on three areas: health and health care and clinical-medical care as commodities[5], the resulting reliance on quantification, and the conceptualisation of care.

Health, health care and clinical-medical care as commodities?

As is well known, Marx (1990) observed that commodities possess both use and exchange values. It is in the latter that their defining feature may be discerned: as a commodity is an entity that may be potentially monetized. In short, the distinguishing characteristic of a commodity is that it can be sold for money (Fine, 2002), is produced *for* sale in a market (Polanyi, 1944), and therefore property rights to the entity can be defined and transferred. This is of considerable import, as treating health and health care as analogous to a commodity can be viewed as an attempt to create commensurability in the measurement of the value of the activity.

The process of commodification has two major ramifications with relevance to the discussion here: first, commodification engenders a particular pattern of social relations broadly but not exclusively, encapsulated in markets. For Radin (1996) and O'Neill (1998) commodification denotes a particular form of social construction and process of valuation of things that can be apprehended as commodities. It is this specific social arrangement that founds a particular means of valuation that is highly contested for some activities. However, for some commentators, markedly Gary Becker and Richard Posner, all aspects of social interaction are, and can be, treated as commodities. Becker's treatise on family relations is the exemplar par excellence: children are treated as commodities, and all household decisions and interactions are consequences of rational choice.

Radin (1996) argues that, analytically, Becker may be employing 'children as commodities' as a rhetorical device. She distinguishes between literal and metaphorical commodities: the latter permits what she terms as "universal commodification". Thus, individuals can be considered as commodity traders, either buying or selling at particular episodes: interaction is exchange, and the value of interactions corresponds, or is reduced, to exchange value. Radin identifies this commodity trading via 'universal commodification' as a

[5] It is possible to distinguish between health care and clinical-medical care. The former is more general than the latter, whilst the latter can be viewed as a sub-set of the former. A broad interpretation of health care can invoke a host of measures, actions and commodities. As Hurley (2000) observes crash barriers on roadways may be conceived as health care given that their intention is the prevention of serious injury. By contrast clinical-medical care is usually provided within a particular institutional arrangement centring on the relationship between the clinician and patient (see McMaster, 2006).

central aspect of a particular conception of human freedom, rights, and autonomy (see also, O'Neill, 1998). Trading, and trading possibilities, represent both the exercise of choice and choice sets respectively. If the market exchange of commodities, both literally and metaphorically, constitutes human liberty, then why should health and health care be any different? It is a powerful, albeit highly contentious rhetoric and mode of thought that has informed the trajectory of policy in recent decades. Thus, in health economics Grossman's rhetoric of health status as a capital stock that the individual may choose to invest in depending on constraints bears all the features of the freedom of choice. Health stock may be traded for other commodities should the circumstances (incentives) dictate.

A reading of Grossman produces some interesting explanations. For instance, the average life expectancy for males in some parts of Glasgow, Scotland is declining and is now in the region of 68 years: similar to levels recorded in the 1940s. Following Grossman, a plausible explanation (requiring empirical testing) would be along the following lines: income constraints are becoming more binding for certain groups, or their tastes have changed, in this particular locale and accordingly rational individuals reduce their demand for health, implying that their health stock depreciates more quickly. Like Becker, instrumental rationality is at the centre of Grossman's explanation. Here the association between poverty and poor health status is recognised as a constraint: the individual trades-off health stock for other utility yielding commodities subject to a more binding constraint. The individual is socially disembedded in an institutional vacuum.

Famously, Marx (1990: 163) referred to capitalism as generating "commodity fetishism", which he regarded as the tendency to view a proportion of one commodity to be worth the equivalent of the proportion of another, and hence confined to exchange values, which reveal little or nothing of underlying social relations. Marx was in effect advocating an analytical focus on socially embedded relations that admit historical specificity.

This recognition of social emddedness keys into Polanyi's seminal work, and his notion of a "commodity fiction". The fiction is perpetrated on the basis of a failure to appreciate the definition of a commodity. Moreover, as Polanyi goes on to demonstrate, *treating* all entities *as if* they were commodities, as in metaphorical representations, is a dangerous fiction that entails a self-regulating market without the social protection for individuals or the environment. It is a consequence of a failure to recognise the social embeddedness of markets. Markets are inherently destructive as well as constructive: it is obviously the former property that presents considerable dangers for civil society.

From here, exchange as embodied by commodification entails a reductionist disembedded representation of social connections: what Georgescu-Roegen (1971) and Potts (2000), drawing from the philosopher Alfred Whitehead, have described as the fallacy of misplaced concreteness. Yet, for the mainstream economist who conceptualises connections in a singular fashion questions remain: is there really a problem of "commodity fetishism" and "commodity fiction" as reference to Marx and Polanyi, respectively, suggests? Is there a dichotomy between commodities and gifts (the latter frequently associated with the delivery of medical care)? In other words, does the commodification of health care drive out the altruistic or gift elements of health care and render it incompatible with the enhancement of human capabilities? *Prima facie*, the answer would appear to be no. After all, a Cartesian interpretation would formulate bodily health in the mechanical terms of its functionings. Moreover, critical elements of medical care are commodities. Health care, however, encapsulates considerable differences in the process of provision: the process of *care*.

Drawing from Polanyi, it is this process of care that is altered through the commodification of care: it is the social embeddedness of care that is crucial, and what is missing from mainstream analysis (Davis and McMaster, 2005). In Polanyi's terms, the social relations typifying health care provision, the patterns of social integration, come to be overwhelmingly dominated by exchange: what Ouchi (1980) has referred to as the transformation from clan to market exchange.

The potential theoretical expression of Polanyi's "commodity fiction" and Radin's "universal commodification" in health economics can be further demonstrated in the principal-agent model. The conception of clinician-agency and patient-principal, inculcates the notion of patient as consumer or client. This is suggestive that the 'demand' for health care (and health) is broadly comparable with the demand for commodities generally (as Le Grand, 2003, cited above appears to suggest). Rice (2001) notes that 'consumer choice' in health care is not always desirable: there are important impediments to the process of choice. To note one major constraint: consumer choice is predicated on consumer sovereignty, which in mainstream economics, is grounded on the agent possessing information of the relevant costs and benefits of an action, presuming its outcome is knowable. As noted, mainstream health economics explicitly recognises this.

Yet this is a partial recognition. The relationships between conceptions of need, exigencies, necessities and wants are as complex as they are subtle, and some health economists have contributed highly insightfully to this area (see Culyer, 1995, and Williams, 1988) Yet mainstream health economists persist in employing the term commodity (see Rice, 1998)[6].. It is only possible here to engage with this in an exiguous fashion. Needs, exigencies and necessities can be associated with basic human rights, whereas wants are less convincingly associated with such rights. Moreover, needs, exigencies and necessities possess a fundamental quality that eludes wants. Thus, Boulding (1966) talks of health care as frequently meeting fundamental need and explicitly not a want. Following Galbraith (1979) commodities are associated with wants, and treating needs as wants conflates their meaning. The commodification of needs *is hardly analogous to the exercise of a human right* (see Anand and Wailoo, 2000), as commodities are coupled with markets, prices and property rights, none of which resonate with the universality of provision. Wants, on the other hand, are not fundamental, and as Galbraith *et al*. have noted, may be moulded by corporations and other institutions that potentially generate frivolous wants; health care is not exempt from this[7].

Conceptions of need and necessity can be traced to the Ancient Greeks. Aristotle identified several senses of necessity. The most apposite for the argument here refers to that which an organism cannot live without: it is intrinsic to the functioning of an organism; something that wants are not. Obviously classifications of commodities, such as the generic term 'food' may be deemed as necessities. Thus we *need* food and nutrition, but may *want*,

[6] Mainstream health economists are not the only culprits, as Hurley's (2000) critical coverage of the normative basis of health economics continually refers to health and health care as "commodities".

[7] Following this line of argument, pharmaceutical companies have an interest in creating new markets to perpetuate and expand demand; perhaps it is overly cynical to suggest that there is an incentive to create new illnesses! Nonetheless, Reinhardt (2004) reports that pharmaceutical corporations' outlays on marketing activities are approximately double research and development expenditure (see also Dunn, forthcoming, and Keaney, 2002). Moreover, pharmaceutical and other medical supplies companies may be unintentional beneficiaries of the marketing activities of corporations in the alcohol, food, and tobacco industries, which aims to increase consumption in those industries, but has a deleterious impact on health (Fine, 2002, see also WHO, 2002).

or desire, particular foodstuffs. Fuchs (2000) claims that health care, more accurately clinical-medical care, is a necessary commodity. Necessary commodities serve universal needs; not wants. Clinical-medical care is focussed on the individual, although medical facilities are not. This is an important distinction. Individual clinical need is contingent upon certain circumstances, which may or may not be socially constructed, and accordingly is not universal. It is conceivably the case, even in contemporary society, for an individual to go through life without *requiring* clinical-medical care (Sulmasy, 1993). Thus, clinical-medical care is primarily relational, i.e. institutional, and is state contingent. It does not serve a universal need in the sense of water, vitamins, air, and food do. *Pace* Fuchs, it is not a necessary commodity, or indeed a commodity.

The wants-needs conflation is compounded by a further conflation apparent from the information-theoretic basis of the agency approach – agency advantage stems from information asymmetries – implying a conflation of information with knowledge. Theoretically, by generating greater information about the "value" of services and procedures agency advantage is eroded and the consumer is again sovereign. Such a notion is predicated on deeply flawed bases that there is no distinction between know-how and know-that, knowledge is codifiable, as well as needs being analytically identical to wants, and hence influenced by price[8].

In short, mainstream health economics' Paretian and utilitarian underpinnings are consistent with a mechanistic tendency that is supportive of a flawed institutional analysis that endorses the notion of universal commodification. It is a short step to presuming that markets are an entirely "natural" provider of health care.

Commodification and quantification

As Marx and Polanyi clearly recognised, commodification by requiring fungibility engenders an increased concentration on potentially quantifiable performance outcomes, usually expressed in the single dimension of money. Porter's (2004) recent references to a "culture of quantification", and Shenav's (1999) and Dupré's (2005) distinctive yet complementary works challenging a mechanistic scientistic approach resonate with this. Broad social changes that institute and legitimize an "objective" status on systems predicated on value-laden assumptions, such as efficiency, maximization, and standardization, can be traced (Shenav, 1999). This is related to increased reliance on quantifiable outcome measures, which Porter (2004: 168) argues:

> "… I [associate] the modern role of calculation, and particularly the spirit of the "bottom line", with democratic *distrust*, and with an ethic that reins in experts even if it assigns important decisions to them" (emphasis added).

Porter's reference to the effective codification of rationality not only signals distrust, but that decision-making out of the defined parameters may be indistinguishable from *ad hocness* or even corruption – it ceases to be legitimate.

[8] Indeed, the separation between patients and clinicians implied by the commodification of health care and the resulting agency relationship may inadvertently undermine any promotion of preventive care activities. The potential patient as consumer may well be motivated differently from the potential patient as a member of a mutualised body exercising a human right. Simply, the former has an emphasis on individual consumption and exclusiveness, as opposed to universality (see also Keaney, 2002).

In economics Georgescu-Roegen (1971), like Dupré, was highly critical of a "mechanistic tendency" that assumed the ubiquity of measurement on a numeric scale. Famously he reproached this trait as an "ordinalist fallacy" where there is,

> "A measure for all uncertainty situations, even though a number, has absolutely no scientific value, for it can be obtained only by an intentionally mutilated representation of reality … It was under the influence of the idea 'there is a number for everything' that we have jumped to the conclusion 'where there is 'more' and 'less' there is also 'quantity', and thus enslaved our thoughts to what I have called 'the ordinalist's error' – which is to hold that wherever there is ordering there is also measure …" (Georgescu-Roegen, 1971: 83).

Economic evaluation techniques in health clearly encompass recourse to quantification. Usefully, this may be viewed as means of enhancing agents' accountability, and of furnishing "objective" evaluations of procedures to produce the greatest net benefit, and hence ration health services in an "efficient" fashion. Nonetheless, the unfettered adoption of economic evaluation techniques must be cautioned against. The more general criticisms of mechanical quantification and scientism are amplified in health care provision. Economic evaluation presumes a relatively straightforward subjective-objective dual, and promotes a particular form of information as more 'scientific' without sufficiently recognising the framing effects involved in measuring, interpreting and judging data (see Hildred and Watkins, 1996). To be sure, quantification relies on certainty and confidence in the processes of measurement, yet many medical activities are profoundly uncertain and heterogeneous[9]. An emphasis on measurable outcomes as the principal, or only, metric has the potential to distort activities in unintentional ways, such as narrowing the focus of behaviour to centring on financial outcomes (Keaney, 2002), and may relegate the process of health *care* (Daniels, 1998).

Where's the 'care' in health (care) economics?

Daniels raises an important issue. As noted, health economics treats "caring" as an externality, which is identical to the more general conceptualisation of altruism in mainstream economics. Comparably, altruism is viewed as an argument in an individual's utility function: a preference. Thus, altruism takes the form of agent X's preference for satisfying agent Y's preferences (Folbre and Goodin, 2004), or, as, for example, Khalil (2003: 116) defines it, the altruist (qua charity) lowers, "… his interest in order to buttress the recipient's interest". Khalil distinguishes three rationalistic approaches to altruism: "egoistic", where altruism revolves around the expectation of future benefits accruing to the benefactor; "egocentric" (associated with Becker) where the donor's utility reflects the utility of beneficiaries, and "altercentric", where altruistic actions are associated with a personality trait.

In health economics where "care" is explicitly considered, it has the properties of the instrumental rational Beckerian "egocentric" orientation (Davis and McMaster, 2005). The employment of medical ethics as a constraint on utility maximisation is a similar methodological device inferring some notion of care by limiting the pursuit of purely self-interested activities. In effect, care is manifest as other-regarding, but, following metaphorical commodification, limitedly so since arguments in the individual's utility function may be traded off against one another following some exogenous change. Thus, an individual, specifically

[9] Obviously the heterodox critique of formalism and unconsidered theoretical closure is of considerable currency here (see Chick and Dow, 2001).

the representative agent, may care less following, for example, an increased flow of information regarding the recipients of care, which the agent finds distasteful. This implies an efficiency loss if the same level of care is maintained despite the preferences of the representative agent. In effect, the "caring externality" is diminished. There are very obvious ethical ramifications following such a scenario that potentially conjure issues of ageism, racism and sexism, to name but a few.

The foregoing notion of altruism has been heavily criticised, and by extension much of this criticism may be applied to the (limited) mainstream notions of care (see Davis and McMaster, 2005, and van Staveren, 2005). For instance, if a caring externality implies a trade-off in terms of lost income to support the provision of health care, then the well-known challenge of individual free-riding surfaces from within the parameters of the model. Indeed, the question arises as to why anything other than free-riding would occur. Khalil further raises empirical and conjectural objections to the egocentric account: the former relates to altruistic donations even in circumstances where the benefactor cannot conceive of the recipients' condition. The egocentric approach presumes that the altruist can engage vicariously in the utility-raising activity: hence, in interpreting the standard health economics approach, altruists can identify with health care, and so are willing to fund health care provision (Culyer, 1976). However, altruistic donations are also forthcoming as a response to events such as famines: a phenomenon unlikely to be encountered by many who donate in western countries. Khalil thus argues that the egocentric account of altruism can be equivalent to masochism! Masochism implies that in order to vicariously gain utility the rational masochist has to appreciate the persistence of the wretched state of the parties (s)he contributes to in order to continue benefiting from her/his donations.

Accepting Khalil's conflation of egocentric altruism and masochism and applying it to the egocentric account of care/altruism in health economics suggests a potential absurdity in Culyer's idea of "humanitarian spillover" and in the interdependence of clinician and patient utility functions. It is hardly humanitarian, or caring in a positive sense, that others' misery continues in order to generate vicarious utility for the (representative) altruistic/caring agent when (s)he has knowledge of how to relieve this misery. Similarly, *in extremis*, a "caring" physician may enter upon an infinite regress in gaining utility from easing a patient's pain, only to desire to establish the *status quo ante* in order to vicariously experience the process again, presumably after calculating the discounted disutility of inducing the initial state! Under this conception medical cures are the last thing physicians wish: therapeutic treatments are ruled out, and medical procedures are reduced to some form of intermittent palliative episodes of "care" followed by periods of a toleration for a patient's worsening medical condition, to be followed by yet further episodes of palliative "care", and so on. Khalil's masochist transforms into a sadomasochist with a stethoscope. Obviously Arrow's "medical ethics" *constrains* a physician's toleration of a patient's deteriorating condition, but it is only a constraint: the logic of the mainstream conception of vicarious utility implies a physician *motivated* to behave in the manner outlined.

This limited conception of care reflects mainstream economics' Cartesian, Utilitarian, and Paretian underpinnings: Cartesian in that care is analogous to a mechanical element in an individual's utility function[10]; Utilitarian in that the process of care has no intrinsic value,

[10] Kennedy (1981) in his influential and highly controversial book, *The Unmasking of Medicine*, argues that the medical profession has extensive power through its ability to diagnose illness and set standards of care. He queries whether this power should rightfully reside within the medical profession, which he contests gains legitimacy by recourse to special expertise. However, this scientific expertise is based on the Cartesian notion of the body as a machine (Kennedy, Ch. 1): humans are reduced to machines. This he considers to be a

and in that it is an instrument in the quest for utility maximisation[11]; Paretian in that there is an inherent default predisposition for the *status quo*. According to Williams (1985) and Maclean (1993), instrumentalism removes care from the realm of ethical consideration[12]. For Williams, the outcomes of actions certainly warrant classification as ethical considerations, but so also do obligations and duties as do character dispositions (virtues), given that they affect how individuals' deliberate in undertaking actions, or avoiding actions, of certain types. Williams' and Maclean's, *et al*. arguments stress deontological value and the social embeddedness of the individual (see Davis, 2003). In contrast, a health economics based on socially *dis*embedded individual imparts, at best, a thin notion of care, and moreover, has the potential to generate egregious explanations.

Towards a heterodox health economics?

Fuchs' (2000) reference to the absences of institutional and historical contexts in standard health economics is, though he may not appreciate it, effectively a plea for a heterodox agenda. Following Davis (2006) the nexus of mainstream economics may be typified as rationality-individualism-equilibrium, with possibly exchange as an adjunct. By contrast heterodox economics may be categorised as an institutions-history-social structure nexus (with production as an additional sphere). This nexus offers the potential for a more lucrative explanation of health care provisioning issues, and in explicitly recognising the importance of social embeddedness and deontology in the provisioning of care. Likewise, such a nexus also affords the opportunity to offer an effective challenge to the reductionist Cartesian, Paretian and utilitarian variants of mainstream health economics. This is not say that important works do not already challenge the standard economic approach. The collection edited by Davis (2001), and the substantive works by Tom Rice; Joshua Cohen and Peter Ubel (2001); Evelyn Forget; Jeremiah Hurley; Michael Keaney; latterly Geoff Hodgson (2006) Gavin Mooney (2001), and Stephen Dunn (forthcoming) and many others offer exciting prospects. Nevertheless, heterodox economics as a whole has not paid sufficient attention to this important area. As far as I am aware there are few references to health care economic issues in many of the main heterodox journals. This needs to be addressed.

Also, heterodox contributions are embryonic in that they mainly offer, like this paper, critiques of the established mainstream. Some coherence in constructing alternative coalitions is required: Mooney's (2001) recent contributions on communitarianism is an initial example. Perhaps Fuchs' (1996: 16) allusion to Adam Smith's definition of a necessity as commodities that are indispensable in the support of life that "… renders it indecent for creditable people, even of the lowest order, to be without" provides a useful initial reference point that emphasises the importance of language and underlying values. Cohen and Ubel (2001) have exhorted that the language of health economics is critically analysed and its framing effects appreciated. Second, Fuch's reference to Adam Smith is only partial. Smith's

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"fundamental" misconception in the philosophy of medicine: it dehumanises and diminishes the very people medicine seeks to help.

[11] Culyer (1998), *et al*., proposes the notion of "process utility", i.e., the patient may gain utility from how care is provided, the *process* of care. In advocating this Culyer presumes that processes are the *consequences* of decisions. This appears to advance a dubious conflation between process and outcome; the former subsumed into the latter.

[12] Williams denotes ethics as a reflection on morality, which he views as a narrower conception of the former, where ethics discusses what constitutes the "good life". Morality refers to particular views on how the individual should live.

(2000) *Theory of Moral Sentiments* furnishes an instructive guide for heterodox health economists. Here Smith expansively investigates the importance of conscience and duties on an individual's conduct. In effect, Smith explores the importance of deontology and context. In language redolent of Thorstein Veblen Smith states:

> "When … general rules … have been formed, when they are universally acknowledged and established, by the concurring sentiments of mankind, we frequently appeal to them as the standards of judgement … Those general rules of conduct, when they have been fixed in our mind by habitual reflection, are of great use in correcting the misrepresentations of all self-love concerning what is fit and proper to be done in our particular situation" (2000: 226).

Smith avoids a solely instrumentally rational account of conduct/action, and his reference to rules as both constraining and enabling is entirely consistent with Veblen. In the context of health economics, Smith's *Theory of Moral Sentiments* stresses the importance of the critique of the mechanistic framework fostered by Cartesian, Paretian and utilitarian influences in mainstream health economics. Hippocrates may yet be influential in shaping a richer economic approach to health, health care and clinical-medical care.

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