

The Individual in Mainstream Health Economics: A Case of *Persona Non-grata*?¹

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October 2004

First Draft

Comments welcome.

Paper to be presented at the European Association for Evolutionary Political
Economy Annual Conference, University of Crete in Rethymno, October 2004.

Abstract

This paper is motivated by Davis' (2003) recent monograph on the theory of the individual in economics. Davis' analysis is applied to the field of health economics and its conception of the individual. The mainstream literature conceives the individual as generally pursuing utility maximization. Though it allows that individuals need not be entirely selfish or self-regarding, and that others' welfare can be incorporated into individuals' utility functions, the paper argues that this nonetheless involves a restrictive and flawed account of the individual that engenders a narrow and abstract conception of care grounded in Paretian value and Cartesian analytical frames. Instead a richer account of the socially embedded individual is advocated that employs collective intentionality analysis. This generates a fuller understanding of care, and provides a sound

¹ The financial support of the Carnegie Trust for the Universities of Scotland is gratefully acknowledged; all errors and views expressed are the authors' alone.

foundation for further research into an approach to health policy that promotes health as a basic human right ahead of narrow efficiency criteria.

Key words: care, deontology, groups, individual, instrumental rationality, mainstream health economics

Introduction

Health economics has grown remarkably since Arrow's seminal contribution to the area in the early 1960s (see Fuchs, 1996 and Culyer and Newhouse, 2000). Arguably it provides a basis for economists to inform and develop the policy process in health care provision, *inter alia*, particularly since this is viewed as a sphere of increasing significance in light of its seemingly exponential expenditure growth. Indeed, *prima facie* the growth in measured economic activity allocated to health care provision would seem an ideal outlet for mainstream notions of scarcity and opportunity cost. Although the impact that economists make is open to some debate (see Fuchs, 1996, cf. Fine, 2001).

From the outset of the emergence of a distinctive health economics, core tenets of neoclassical economics have been queried. This may be a reflection of the evolution of the mainstream as a whole, but nevertheless, health economists have been prominent in questioning the "validity" of aspects of standard economic theory (Culyer, 1989; Hurley, 1998; Rice, 1998a, 1998b, *et al.*). Specifically, the distinctive features of 'health as a commodity' entail market failure that carries theoretical ramifications. Notable manifestations of this include: Normatively-laden equity concerns in health vex health economists in relation to the overriding pursuit of efficiency. For example, Hutton and Maynard (2000: 92) observe,

"... 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!"

There is extensive recognition in the literature that health care systems are constructed on the "normative" basis of equity or some form of distributional

justice (for example, Fuchs, 1996). Hence, equity questions are of more significance in health relative to the bulk of the mainstream literature.

Moreover, conceptually health economists have observed that informational asymmetries in the market for health care occasion the interdependence of demand and supply, and jeopardize the tenet of individual sovereignty. Indeed, Rice (1998a, b) sardonically considers that the standard theory of demand is Panglossian, and is disparaging of the neoclassical assumption of exogenous preferences. He considers that neither revealed preferences nor the exogeneity of preferences assumption are “valid” in health care. Rice probably goes further than most mainstream health economists in his rejection of the canons of conventional demand theory. Nonetheless, there is some parallel to Rice’s criticisms in the evolution of agency theory in health economics. The agency theory literature has stressed the self-interested orientation of principals and agents, where each exploits potentially different and conflicting benefit flows in circumstances where information imperfections prohibit the perfect monitoring of agents by principals. The outstanding problem to be resolved is the efficient alignment of incentives. By contrast the primary application of agency, i.e., between principal-patients and agent-clinicians, in health care provision expects agents to act in the best of interests of the principal (Mooney and Ryan, 1993). Indeed, a “perfect agency relationship” in health care has even been hypothesized (Williams, 1988), where the clinician reveals all appropriate information to the patient, who then makes the optimizing choice. As with standard agency theory there are extensive economic gains from specialisation.

Yet there are circumstances where this “perfect agency” either fails to appear or is tempered. Mooney and Ryan note that factors contributing to this could include; misperception of patients’ preferences by clinicians, a lack of “perfect” information on clinical effectiveness, coupled with physician tendencies to overstate effectiveness, driven by the “desire to do good”. Also, crucially, the “perfect agency relationship” may be completely undermined with supplier-induced demand, where the agent-clinician manipulates demand for the benefit of clinicians.

In the agency relationship the sensitivity of clinician-agents’ utility functions to external factors is of primary importance (Mooney and Ryan, 1993) in influencing the shape of health policy (for instance, Culyer, 1989).

It is here that the importance of the conception of the individual is of crucial bearing in the economic analysis of health care provision. Following Chick’s (2003) observation that the mode of thought can impact on policy through theory, we argue that this is the case in the context of the provision of health care. Drawing from Davis’ (2003) recent analysis of the individual in economics, the paper contests the mode of thought underpinning mainstream health economists’ application of the agency relationship and, crucially, the conceptualisation of the individual. The agency analogy provides a reductionist and restricted account of complex interactions and human psychology. Instead of the mainstream’s exclusive reliance on one form of rationality, the paper advocates greater cognisance of deontological rationality. This draws on notions of care, which the health economics literature, at best, pays scant regard to, and at worst trivialises or ignores. Further, it engages with a rival conception of the individual as socially embedded as opposed to autonomous. In short, the paper argues that the mainstream mode of thought engenders misconceived and highly limited theoretical models of the individual and subsequently generates potentially insidious policy implications.

Individuals socially embedded in groups cannot be explained solely in instrumentally rational terms. Expressing a shared intention commits an individual to an intention held by others, and introduces an obligation on the individual. This is not of the form of a constraint or an argument in a utility function, as health economists treat medical ethics in modelling clinician behaviour, but is a form of deontological rationality. In effect, the individual voluntarily shares the motivation of the collective entity, and her/his actions are not solely guided instrumentally; certain actions in themselves possess value.

Employing this mode of thought, the paper argues that market-oriented reform has the capacity to reconfigure collective intentionality in the form of changed value systems. Viewing patients as principals can inculcate the patient as consumer and commodify health and medical care. In such circumstances care may be reduced to some homogenised blend of medical procedures and good

customer service. Instrumental rationality drives out deontological considerations. Hence the paper argues that contemporary policy and economic theory potentially germinate an invidious change in notions of care and value that may undermine commitments to the integrity of the individual in the provision of health care. Arguably this is inimical to personal development and well-being.

The paper adopts the following structure: the next section outlines the notion of the individual in health economics, noting flaws in this conceptualisation of individual agency, while the section following advances an alternative notion of the individual as socially embedded. After this we turn to the thin model of care advanced in standard health economics that shapes the nature of the analytical frame and supporting values. The penultimate section advocates a richer conception of care based on the alternative perspective of socially embedded individual agency. The paper closes with discussion of the approach to health care policy we believe follows from serious attention to care.

The Conception of the Individual in Mainstream Health Economics

As with other applied areas mainstream health economics incorporates, augments and borrows from other fields of the discipline. In the introductory chapter to the *Handbook of Health Economics* Culyer and Newhouse (2000), aside from some adulation and description of the vigorous growth of the subject, observe that health economics draws from public finance, labour economics, public choice and welfare economics, *inter alia*. Despite drawing from these areas health economists maintain that health is markedly different from any other object of economists' foci. In particular health economics' texts observe that the distinctiveness of health "as a commodity" lies in the characteristics of health care: it produces externalities (usually presumed to be beneficial), informational asymmetries abound, the demand for health care is derived, and there is "uncertainty" surrounding the need for and effectiveness of health care. The latter suggests, *inter alia*, that there is a strongly normative element in health economic analysis (see Fuchs' (1996) observations on the effects of uncertain outcomes on health economists' recommendations). For Culyer and Newhouse it is the embeddedness of health economics in welfare economics that furnishes the former with any normative content (cf. Hurley, 2000), but "objective" science is still

possible on the basis that economists inform the decision-making process, but do not decide the parameters of this process. Hence within a given frame economists can furnish objective advice (see Culyer, 1998, for a critique see Cohen and Ubel, 2001). In a measured paper Evans (1998) considers that normative positions are sensitive to underlying assumptions. This paper follows Evans in analysing the (unchallenged) conception of the individual in health economics and, *contra* Culyer, how this may bear on policy orientation.

As might be expected health economic commentaries do not afford the conception of the individual any particular emphasis. Instead issues of justice and equity, and efficiency (including economic evaluation) are at the centre of much discussion. There is no overt recognition that the conception of the individual can impact those subjects. As with neoclassical and much of mainstream economics² the individual is generally presumed to be autonomous or atomistic, exogenously conceived – usually in terms of exogenous preferences, and instrumentally rational. Indeed, the focus of economics is not so much on the (*given*) individual, but on individual choice operating according to the metric of instrumental rationality or rational choice. The foregoing, with one possible exception, tends to be incorporated into the corpus of the health economics narrative.

It is possible to discern two approaches to the individual in health economics: the first, earlier approach, embodies all of the foregoing; whereas the latter queries the ability of agents to make informed choices and thereby weakens the atomistic axiom.

The first approach is encapsulated by Grossman's (1972) seminal work on the demand for health. Drawing from the human capital literature, Grossman's model identifies health as an analogue to a commodity possessing both investment and consumption properties. Individuals are endowed with a "stock" of health

² The delineation between neoclassical and mainstream economics follows from the evolution of the latter from the former. This is an area of some debate (see for example, Davis, 2002) as to what constitutes the latter as different from the former. There is commensurability between the two in terms of rationality, individualism, equilibrium and a focus on the domain of exchange.

that they can choose to invest in through demanding health care (where it is deemed appropriate), engaging in activities likely to contribute to their health stock, *inter alia*, subject to constraints including income and, more controversially, educational attainment³. Hence, the individual or the household produces as well as consumes ‘health’. The model distinguishes between the more generic demand for health, as a means of generating utility directly and as a means of enhancing the opportunity to work and accordingly gain utility indirectly through income. In this respect the demand for health care is a derived demand, which a rational individual would consider instrumentally, and only when there was a calculation that the individual’s stock of health had eroded sufficiently subject to constraints.

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 presents the individual in the form of the optimising representative agent facing a time allocation problem. The notion of consumer or individual sovereignty is retained, although there is some latitude for an individual to be relatively uninformed where the level of education is low (see note 2). The model presents the individual as a combination of preferences and human capital, where the individual is recognisable through time despite on-going utility-generating adjustments to the long-run utility algorithm (see Davis, 2003: 56)⁴.

³ For some health economists this is an empirical conundrum as educational attainment is usually presumed to be correlated with income or earnings, thus those with higher earnings/income may be presumed to be better educated. Other interpretations turn on a posited relationship between education levels and information concerning health-promoting activities. In other words, better informed agents are able to fully exercise consumer sovereignty.

⁴ Of course there have been refinements to the basic Grossman model, which attempt to capture “uncertainty”, through Bayesian risk, in the agent’s algorithm.

A more significant departure from the idea of a fully informed agent is embodied in more recent agency models, which can be viewed as an element of a more generic or meta-theoretic evolution within the mainstream that accentuates the role of information asymmetries, and is traceable to Arrow’s (1963) definitive piece on the economics of medicine. Fine (2001) terms this the information-theoretic approach. Certainly it has galvanised the emergence of new fields such as, new institutional economics and public choice economics, and is a central constituent of game theory in economics.

In conventional Fama-Jensen agency-principal models the problem of agency arises from the combination of information asymmetries favouring the agent and misaligned incentive structures. Here the key axioms of instrumental rationality and exogenous preferences tend to be retained. The problem relates to institutional structures preventing principals from being sufficiently informed to monitor the activities of agents to ensure incentive alignment. Thus agents and principals extract potentially conflictual benefit flows in their utility functions. Agents’ unobservable actions can impose costs on the principal, although they are likely to be constrained given that the principal is usually presumed to have information on outcomes. This is a longstanding contention formalised in the managerial discretion models of the 1960s. The resolution to the agency problem is found in the promotion of markets that generate information for principals and suitably ally agents’ incentives to licensing the efficient exploitation of comparative advantages.

As noted, 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.

Agency models in health economics tend to concentrate on the clinician-patient relationship (Scott and Vick, 1999), although there are other applications,

such as Goddard, *et al's* (2000) analysis of agency in the UK's NHS where the principal is the purchaser and the agent is the provider. McGuire's (2000) review of health economists' approaches to agency emphasizes the importance of the analytical role attributed to "uncertainty"⁵. Akin to Mooney and Ryan (1993) noted earlier, "uncertainty" is deemed to arise from doubts concerning the classification of diseases, over the effectiveness of treatment, and patient preferences. This is compounded for the patient-principal relation by the clinician resembling an experience good, implying an adverse selection problem. The distinction between the demand for clinical services and a particular clinician engages with a more general point advanced by Culyer (1998), *et al*, that patients gain utility from the *process* of care. Thus, a patient may demand a particular clinician on the basis of a reputation for example, of a 'caring or sympathetic' attitude. This is presumed to be analogous to brand differentiation, and accordingly can be integrated into the monopolistically competitive model of market structure (see McGuire, 2000).

Unlike the standard agency model there is no presumption that outcomes are known. Moreover, this is coupled with the generally unobservable aspects of clinician-agent actions implying a degree of non-tradability and non-contractibility in physician activities. Far from Williams' (1988) "perfect agency" US health economists in particular (commencing with Evans, 1974) consider some form of supplier-induced demand, where clinicians manipulate patients' demand to the service of the former as opposed to the latter, is endemic (see Evans, 1998, Fuchs, 1996, and McGuire, 2000, *et al.*)⁶. Of course this violates the

⁵ The use of scare quotation marks is a signal that McGuire, and mainstream health economists generally, do not employ the term uncertainty in either a Keynesian or Knightian sense. At best their reference point is Bayesian.

⁶ McGuire (2000: 475) refers to Pauly's argument that patients will be well-informed, and hence less susceptible to supplier-induced demand, in approximately a quarter of "the care they consume", such as routine procedures and care of chronic illness. This resembles the new institutionalist account of the limitations of the potential for opportunistic behaviour through recurrent contracting.

tenet of independence and given, stable preferences, and therefore alters the implicit conception of the individual.

Leaving this aside for the moment; supplier-induced demand may be manifest in quantity and quality dimensions, the latter referring to the diligence of the physician, also the time and effort devoted to the patient. It is in this respect that the context of the interaction between clinician and patient is of crucial bearing on the extent or the incidence of supplier-induced demand, and more general agency associated difficulties. Remuneration schemes appear to be the key here (Mooney and Ryan, 1993). Supplier-induced demand is conceptually more likely where the clinician is remunerated on a fee-for-service basis and in a competitive environment (Ma and McGuire, 1997, Rice, 1998b, see also Goddard, *et al*, 1999). Coincidentally, Williams' "perfect agency" hypothesis appears less Panglossian if medical ethics assuage the potential for supplier-induced demand, although, as noted, most health economists argue that supplier-induced demand is present to some extent.

Since Arrow's (1963) defining piece, medical ethics has, to varying degrees, been acknowledged in the health economics' lexicon as mitigating "consumer exploitation". As McGuire (2000) comments, there are two aspects to medical ethics that have generated differing interpretations within health economics. On the basis of the dictum *primum no nocere* (first, do no harm) medical ethics would enter the clinician's maximising calculation as a constraint to self-interest (Evans, 1974, see also Ma and McGuire, 1997). However, a further expression of the Hippocratic Oath is to consciously act in the patient's best interest, and has been interpreted as a specific element in clinicians' utility function(s) indicating interdependence between agent and principal (Mooney and Ryan, 1993). McGuire (2000: 521) interestingly observes that the latter interpretation is more popular,

"An 'ethic' has the flavor of a dictate or a constraint – once the constraint is binding, other objectives of the physician become irrelevant. Perhaps for this reason, most papers in health economics do not use a constraint to represent ethics, but instead represent physician concern for patients with a utility function including as an argument something valued by the patient ... or the patient's utility itself. In this construction, the

physician's ethically driven concern for patients is subject to being traded off against self-interest"⁷.

Frequently the clinician utility function is represented as consisting of net income accruing to the clinician and the benefits/utility received by the patient. Nonetheless, agency problems, aside from the obvious supplier-induced demand, are not presumed to be negligible. Mooney and Ryan (1993: 134) consider that a "necessary ... condition for an efficient outcome in health care" lies in knowing clinicians' and patients' utility functions. In this respect information may be a source of patient utility by way of reducing the disutility associated with uncertainty concerning the patient's prognosis and condition. On the basis of discrete choice experiments Scott and Vick (1999) advocate the training of enhanced communication skills among physicians as a mechanism for "maximising principal (patient) utility", and improving the basis of choice – the focus of conventional theory⁸.

What does the foregoing imply about the notion of the individual? Is there a reasonable conception of *homo economicus-medicus*?

In essence the individual is delineated according to preferences in both health economics approaches. As noted, under the conditions of the more dynamic Grossman model the individual retains sovereignty and is some form of unchanging entity despite exogenously determined changes in utility. By contrast in health economics' agency approach the atomistic conception of the individual is relaxed somewhat through the interdependence of utility functions argument. This is distinctive from the standard agency conceptualisation, which retains individual autonomy and draws an analogy between the firm and the individual in terms of multiple selves operating to the benefit of the aggregated entity (Davis, 2003, Ch. 4). The presentation of agency in health economics is in a static

⁷ McGuire argues that clinicians may face a steep trade-off since their decisions can have a profound and irreversible effect on their "customers" (sic).

⁸ For an interesting critique of the presumed advantages of enhanced patient choice see Rice (2001).

framework, and so does not presumably invoke similar dynamic properties in individual choice as the Grossman model⁹. Nevertheless, it appears that the individual is still basically defined in terms of preference structures, although a further distinction based on functional roles is introduced.

Davis argues that the standard account of the principal-agent relationship proceeds by conflating individual and firm. He states (2003: 71):

"The main difficulty with pursuing the analogy between the unity of firms and individuals ... is that firms and individuals are different in too many ways".

The differences highlighted include: potential business partners may be said to bargain and negotiate with one another, but this cannot be said in any meaningful way of the multiple selves of an individual. Second, the idea of mutual advantage through specialisation and cooperation only presents a limited analogy as the conventional agency explanation stops there: mutual advantage is the sole basis of cooperation between the multiple selves. As Davis asserts, it is difficult to believe that human psychology is this simple.

Nevertheless, agency introduces functional relationships, and in the health economics agency literature interdependence between individuals. Both, almost tautologically, engage in mutually beneficial activities. This does not imply that individuals are distinguishable from firms. Indeed, health economists articulate the notion of physician-firms, suggesting a conflation. Yet there is a more serious conflation. At the most generic level the ambiguity, vagueness, and *ad hoc* nature of the specification of clinician and patient utility functions implies that patients are subsumed as an argument of the clinician utility function and therefore lose their individuation. The absence of independence entails a loss of identity. Following McGuire, the functional divide between clinician and patient can be reduced to a trade-off in the physician's utility function. There is no

⁹ McGuire (2000) draws attention to a (Roth-Nash) cooperative game theoretic interpretation of the interdependence of utility functions between clinician and patient raising the possibility of a more dynamic account of clinician-patient interaction.

theoretical requirement for the “patient” in health economics *if* patient utility is an argument in the clinician utility function. Everything reduces to exchange or trade-offs.

Even if the foregoing contention is not accepted there are still other potential concerns. The Grossman and agency interpretations of the individual are instrumentally rational¹⁰. This carries profound implications for the notion of care.

There is no requirement for “care” in the Grossman model. However the interdependence of utilities in the agency approach essentially captures the notion of care, and by doing so mirrors the treatment of altruism in mainstream economics, and therefore its flaws. The deficiencies of this view are scrutinised below, but prior to this we advance an alternative conceptualisation of the individual in health care.

Socially Embedded Individuals in Health Care Systems

In this section we explain how we see individuals as socially embedded in order to explain care relationships between patients and clinicians. Patients and clinicians are treated as socially embedded individuals in virtue of their membership in patient and clinician social groups, which come together to receive or provide care to individuals primarily in community clinics. These social groups are in turn linked to various other community social groups indirectly connected to the patient-clinician relationship. Countries’ health care systems are taken to be sets of institutions that influence the interaction between the social groups involved in

¹⁰ Zafirovski (2000) usefully distinguishes between first-order and second-order models of rational choice. The former approach emphasise hyper-rationality or perfect rationality and are ‘hard’ and ‘thin.’ Second-order models are characterised by quasi, pseudo, or imperfect rationality and are ‘soft’ and ‘thick.’ The two differ in terms of their teleological definitions – in identifying actors’ ends and motives – with first-order models practising utilitarianist agnosticism. Hence, in the first-order approach actors’ ends are not specified beyond utility maximization. Arguably the Grossman approach is closer to a first order categorisation and the later agency approach a second order.

patient-clinician relationships in community settings. The standard health economics approach treats health care as a commodity transacted in impersonal markets between autonomous, utility maximizing individuals, and thus ignores how individuals are embedded in social groups. In contrast, our framework explains the provisioning of care as a social exchange involving individuals as members of social groups both directly and indirectly related to the social exchange of care. Markets operate for health care but do so in communities structured around social groups.

Individuals themselves are taken to be socially embedded in social groups specifically in virtue of their capacity to express shared intentions in the use of first person plural ‘we’ language (Davis, 2003). A shared intention is an intention expressed by a single individual which that individual believes others share (Tuomela, 1995; Searle, 1995). When individuals express shared intentions, they effectively speak for all those to whom the ‘we’ language expressing that intention applies. Using ‘we’ language is more demanding than using ‘I’ language, because the individual using it must consider whether those others to whom the ‘we’ applies would accept what the individual has expressed. In this respect individuals are socially embedded – or rather, they socially embed others in themselves by expressing an intention which they believe is held by others as well.

In the patient-clinician relationship, individuals’ expression of ‘we’ intentions may be understood as follows. An individual patient may express a ‘we’ intention regarding her own care when interacting with a clinician who is part of a clinician group. Similarly, an individual clinician may express a ‘we’ intention regarding a patient’s care when interacting with a patient who has family members and others concerned about the patient’s care. From either perspective, the patient-clinician relationship makes each individual’s thinking and decision-making reflect what they each believe they can express in we-intention terms as members of specific social groups.

The implication of this is that when social relationships are seen as embedded in individuals, the expression of a shared intention introduces an element of obligation into an individual’s decision-making in terms of how the individual feels bound by a shared intention. This is not a matter of constraints, as

in the case of instrumentally rational behaviour, but relates to the intrinsic motivation of the individual¹¹. In contrast, when individuals use first person singular speech, and express intentions that essentially apply only to themselves, they are autonomous or atomistic, as in the case of the standard conception of the individual in economics. Our view, however, is that care relationships between patients and clinicians are socially embedding, because patients and clinicians share intentions which implicitly or explicitly can be represented in terms of ‘we’ language they would both express regarding patient care. This implies that those relationships cannot be understood solely in instrumentally rational terms, but need also to be understood in terms of obligations operating on individuals – a deontological rather than instrumental rationality.

These obligations, then, are exercised directly in the patient-clinician relationship that involves the shared intentions both sides express regarding patient care, but also indirectly via shared intentions operating within the social groups of which patients and clinicians are members. Thus shared intentions that patients and their families have and shared intentions that clinicians and related medical professionals have constitute a structure of understanding about care episodes that reflect a view of respective obligations and a deontological rationality. In turn, patient groups and clinician groups are linked to various other community social groups indirectly connected to the patient-clinician relationship, and these further social groups bring additional views of obligation that bear by analogy or general principle to the patient-clinician relationship.

Mainstream models treat the patient-clinician relationship as one that obtains between two isolated individuals. But realistically speaking, more than just two people are almost always involved in the patient-clinician relationship, since at the very least patients have families or are members of households, and clinicians are members of medical teams that staff clinics. Thus while patient-clinician pairs appear to interact on a one-to-one basis, other individuals are also

¹¹ As Davis (2003) explains, this view constitutes an alternative to holism by stressing that only individuals can have intentions. Shared intentions are individual intentions about groups, not *vice versa*.

involved, and this suggests that the patient-clinician relationship is best explained in terms of the interaction between groups of individuals.

Social groups are defined as collections of individuals with shared characteristics that define membership in those groups. Just as shared intentions create obligations, membership in groups creates sets of rights and responsibilities that are supported by individuals’ collective intentions (Davis, 2003). By contrast, institutions may be viewed as durable systems of embedded and established social rules that structure social interactions around groups, and which are manifest in both enabling and constraining behaviour in which individuals engage (Hodgson, 2004). Hodgson draws on Searle’s (1995) argument that institutions and their rules are partly constituted by individuals’ mental representations of those institutions: since institutions can only exist if people possess related beliefs and attitudes. From this perspective, Hodgson’s view is combined with Davis’ emphasis on collective intentionality to represent institutions and groups as structures that influence and are influenced by individuals. Thus, group action is taken to be an intermediate link between individual action and “supra-individual” institutions, rules and social values¹².

Political scientists, sociologists, psychologists, anthropologists, and philosophers have investigated a variety of different types and sizes of social groups (Cartwright and Zander, 1968, p. 48). We emphasize that groups may be termed ‘encompassing’ when they have a common character or culture, involve mutual recognition which promotes self-identification, and membership is typically a matter of belonging rather than individual achievement (Margalit and Raz, 1990). For the health care setting, we particularly emphasize the characteristics and kinds of groups that interact in community clinics. Families and clinicians as two kinds of social groups, then, are both relatively cohesive and well-structured, intermediate in size, exhibit principles of membership, and, importantly, operate by rules and norms, which generally imply sets of rights and obligations for their respective members.

¹² Hodgson delineates organizations as “special institutions” (2004: 425) that embody criteria to institute boundaries and distinguish members from the rest of the population, principles of “sovereignty”, or legitimacy, regarding authority, and hierarchical chains of command.

As noted above, the standard health economics approach, as expounded by Arrow (1963), McGuire (2000), and others overlooks individuals' social group embeddedness, and either ignores rules and norms and their associated rights and obligations, or treats individuals' observance of them in an instrumentally rational way consistent with utility maximizing behavior. We believe this misrepresents the nature of many (though not all) rules and norms, which have a binding quality in virtue of individuals' membership in the groups where they apply. Further, we see the binding quality of certain rules and norms as central to the understanding of care. That is, care generally is guided by a deontological rather than an instrumental rationality. In terms of group membership, one simply follows certain rules and norms because that is what membership involves.

Rules and norms exhibit binding qualities almost by definition. Davis (2003, pp. 134ff), following Tuomela, argues that rules structure the activities and tasks of individuals, and emerge from either explicit or tacit agreement. In contrast, norms arise in networks of mutual beliefs, where beliefs are reciprocally established and reinforced between individuals through constant association and interaction, and are the basis of social values. Both rules and norms are seen as enabling rather than constraining. Thus the shared intentions embodied by rules and norms, albeit to varying degrees, represent what individuals choose to do rather than what they are limited to doing; again highlighting the deontological aspect of behaviour.

Care, like trust, has an unconditional, non-instrumental quality. Indeed its classical meaning in medicine, as expressed in the Hippocratic Oath, has this sense. But rather than treat care thus understood as simply an abstract principle, we explain care as a motivation and activity that arises when individuals socially embedded in groups form shared intentions. Thus, a successful 'we' intention binds the individual who expresses it to care for those individuals to whom that 'we' intention applies. As noted, 'we' intentions have success conditions in terms of whether others agree to what an individual expresses when saying 'we'. When those success conditions are the individual's concern, that individual expresses care for others.

It is important, then, that care relationships between individual patients and clinicians are not just seen as relationships between two individuals, but rather as relationships between two groups associated with those individuals – their family members and professional colleagues. When either the individual patient or clinician asserts that 'we' will follow some program of care, that individual's 'we' intention has a binding, non-instrumental quality in virtue of the fact that it must be consistent with what those individuals indirectly associated with the patient and clinician in the groups to which they belong would agree to, were they reasonably informed. We say 'reasonably informed,' because of course 'we' language, as all human language, is not used with exactitude. Nonetheless, the general way in which 'we' is employed in all languages supports this view.¹³

Care, we believe, has not been explained correctly in the standard health care framework in either the principal-agent or information-theoretic approaches, because both make the interaction between the individual patient and clinician one solely between individuals who are instrumentally rational utility maximizers. We do not deny that individuals in many walks of life are instrumentally rational. We do deny that this form of behavior adequately describes patient-clinician relationships. Moreover, we believe that restricting the analysis and policy thinking of health care systems to populations of instrumentally rational utility maximizers produces incentives for individuals that are inimical to improving patients health and also destructive of clinician well-being. In traditional terms, using a model of autonomous, atomistic individuals rather than one of socially embedded individuals is likely to produce inefficient outcomes in health care systems.

To support our conclusions, we turn in the following two sections to a comparison of the treatment of care in standard health care economics and non-standard health care economics respectively. The standard approach, we suggest, continually runs up against the limitations created by its exclusive attachment to instrumental rationality and the isolated individual conception. The non-standard approach attempts to go beyond this constraint in ways that point toward a richer conception of care, rationality, and the individual.

¹³ Here we put aside the complications associated with deceptive behavior.

A Thin Conception of Care: The Standard Approach

The concept of care has, at best, received limited attention in mainstream economics; despite early recognition of potentially constituting elements of care such as sympathy in the works of David Hume and Adam Smith (Fontaine, 2001, van Staveren, 2001) and more obviously altruism. Most commentary on care tends to be confined to potential trade-offs between caring and income (see Folbre, 1995; Folbre and Nelson, 2000; and Nelson, 1999) or to parental care and the economics of the family (Becker, 1996, cf. Khalil, 2003), but there is little beyond this. Altruism *per se* receives greater attention in the mainstream literature, most notably since Gary Becker's extension of rational choice in examining "non-traditional" areas of economic analysis, such as crime and the family.

Altruism is viewed as an element of 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. Khalil is critical of Becker's conflation of altruism with parental care, claiming that, "While altruism is about charity, parental care stems mainly from non-pathological narcissism" (2003: 111). Thus, Khalil, employing an individualistic orientation¹⁴, suggests that parental care is an extension of the self: this expanded self being an attempt to leave a heritage or some form of immortality. Yet Khalil's account does not consider other forms of care, and altruism *qua* charity seems to conflate care with altruism as part of an individual's (instrumentally rational) voluntary act.

¹⁴ Khalil considers that institutions are a constraint that defines the production possibility frontier, and altruistic acts "stem from the utility function" (2003: 106).

In health economics where "care" is explicitly considered, it is in the same instrumentally rational apparatus deployed by Khalil, but within a Becker-inspired "egocentric" orientation. Health economists have invoked the notion of a "caring externality" (McGuire, *et al.*, 1982), or "the humanitarian spillover" (Culyer, 1976). Here the interdependence of utilities in the agency approach essentially captures the notion of care. A "caring externality" within the representative agent's utility function generates a benefit flow to this agent from the knowledge that other members of the population have the ability to access health care regardless of their ability to pay. The agent "cares" about the health status and consumption of health care of others. 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. Similarly, Posner (cited by Khalil, 2003: 101) explains individuals' resentment when others' rights are infringed, i.e., "caring" for justice as equivalent to altruism towards strangers.

In effect, care is manifest as other-regarding, but 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 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 conception of altruism has been heavily criticised, and by extension much of this criticism may be applied to the (limited) mainstream notions of care. 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 (cf. Simon, 1991). 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 (see 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 is 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 (sic) 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 of a patient's worsening medical condition, to be followed by yet further episodes of palliative "care", and so on. 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.

The treatment of altruism in the mainstream is also subject to another conundrum: how does the altruist know what another agent's preferences are, especially assuming revealed preferences (Folbre and Goodin, 2004)? As noted above, some health economists (Mooney and Ryan, 1993) allude to this problem

in connection with the presumed agency relation between clinician and patient, but cannot pursue this line due to their conflation of knowledge and information. Folbre and Goodin believe that altruism is more appropriately considered to be a disposition, where dispositions are inclinations or capacities to be moved in certain ways under certain circumstances. They may be grounded in habits (cf. Hodgson, 2003), and may be considered to be inclinations to desire something in a more active fashion than is the case with preferences (Folbre and Goodin, 2004: 18). Dispositions, "... can be dynamically reinforced or weakened through different patterns of social interaction" (*Ibid*: 2).

Folbre and Goodin (2004: 19) argue:

"We would get no sense of the way in which professional roles (such as those of a doctor or nurse or teacher) are practised and perfected ... if we were to think purely in terms of specific freestanding preferences and episodic choices emanating from them: we need to think instead in terms of the training and honing of underlying dispositions to act in ways consonant with those roles ...".

Arguably, by treating "care" as a preference in an agent's utility function makes the level of care something determined through an algorithm of utility maximisation. 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 function¹⁵. Utilitarian in that the process of care has no intrinsic value: it is an instrument in the quest for

¹⁵ 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 "fundamental" misconception in the philosophy of medicine: it dehumanises and diminishes the very people medicine seeks to help.

utility maximisation¹⁶. 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 consideration¹⁷. For Williams, the outcomes of actions certainly warrant classification as ethical considerations, but so do obligations and duties as does 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. In contrast, a health economics based on socially *disembedded* individual impacts, at best, a thin notion of care, and moreover, has the potential to generate egregious explanations.

A Richer Conceptualisation of Care

Care is a principal issue in the feminist economics literature (Folbre, 1995; Folbre and Nelson, 2000; Nelson, 1999; van Staveren, 2001, *et al.*), though emphasis is primarily on issues of "caring labour", such as valuation and income, and the "emotional connotations" that distinguish "caring labour" from other forms of labour. There is rather less emphasis on identifying and conceptualising different types of care and how care may change through time and/or through institutional change (Nelson, 1999 and van Staveren, 2001 are exceptions). Nevertheless, prominent feminist contributors assert that care and the process of care is socially embedded, and that institutional change can potentially have an impact on care by changing the motivations to care (Folbre and Nelson, 2000). For Folbre and Nelson there is a dual meaning to care: as an activity and as a motivation.

¹⁶ 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.

¹⁷ 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.

Motives to care are based on altruism, long-run reciprocity (as in the mainstream literature), and the fulfilment of an obligation or responsibility (Folbre, 1995). It is the latter that can be understood in terms of collective intentionality analysis.

Folbre's notion of long-run reciprocity is interesting in that she considers it a "looser form of exchange" than that which occurs in markets (Folbre, 1995: 76). This reciprocity is enforced through *norms* of cooperation, which are fostered by affection and a sense of responsibility. For Folbre the crystallising feature of care is having concern for others, where the activity (or labour) of caring is motivated by affection or a sense of responsibility/obligation for others without expectation of pecuniary reward (Folbre, 1995: 75). The latter part of Folbre's definition may be too limiting in that it would seem to preclude many caring professions where pecuniary reward is expected for engaging caring activities.

van Staveren (2001) furnishes a more comprehensive consideration of care in that she considers care as a value domain distinct from other value domains (justice and freedom). Mainstream economics is analytically confined to the domain of freedom through its concentration on markets and exchange. Drawing from Joan Tronto's work on care, van Staveren argues that the practice of caring (care as an activity) provides the most appropriate starting point in defining care. As a practice care has four distinct "steps": "caring about" (attentiveness), where there is a recognition of urgent and contingent needs, which cannot be addressed in other value domains. "Taking care of" (responsibility) is a response to addressing those needs. van Staveren (2001: 39) considers that this may arise from the unintended consequences of individual behaviour or the "external effects of collective behaviour", in effect we-intentions. Third, "care giving" (competence) refers to the skills and knowledge of those providing care, and fourth, "care receiving" (responsiveness) refers to the interaction between those receiving care and those providing it.

However, van Staveren's delineation between care and justice value domains may be criticised following the earlier contribution of Blustein (1991). Blustein rejects the dichotomisation of care and justice, viewing them as different aspects of morality associated, not disassociated, with each other. For Blustein, a care orientation focuses on the ingredients and conditions "of the good life"

(1991: 7), and demonstrates a commitment to the good of others, and, following Bernard Williams and Max Weber, can act as the formation and maintenance of a sense of self-identity through dedication to projects or principles. A justice orientation relates to matters of right, and focuses on duties, obligations and rights. The two (care and justice) are distinct but not necessarily separate.

Blustein offers four typologies of care: “*To care for*” refers to having some affection for, as in a loving or other intimate relationship; “*to have care of*” refers to some responsibility for supervising or managing, providing for, or attending to the needs of another. “*To care about*” involves some investment of interest by the individual, and can be either in a disinterested or interested fashion, where the former refers to the absence of own advantage. It involves doing something that enhances ‘x’ or prevents the diminution of ‘x’. It can also be negative in that the intention is to diminish ‘x’. Blustein uses an example of a schoolteacher who takes a particular interest in the welfare of a student, is, following van Staveren, attentive; yet does not find the student to be especially appealing or likeable, thereby demonstrating that it is possible to care *about* and not care *for*. Nevertheless, teacher and pupil share an intention. Indeed, there is some recognition of this in Folbre’s (1995) discussion of the scenario of an ill-humoured nurse providing better medical care than a loving parent. In this scenario, the nurse’s actions may be exhibiting the binding qualities of the membership of her group in that the motivation of care is manifest as *caring about*, and *having care of*, in terms of medical norms, as a network of beliefs, encapsulated by the Hippocratic ethos; but her/his individual predilections do not lend themselves to *caring for*, following Blustein’s definition, the child. The nurse in accepting a particular role within her group is *obliged* to undertake certain functions as part of the shared intention (s)he has with other members of her/his (clinical) group: the scope of this obligation need not extend to *caring for*, as a process of care. In this case the nurse may demonstrate some empathy¹⁸ for the child, and be attentive to her/his medical needs, but there is no altruism (qua charity). Moreover, despite differences in care between the nurse (and nursing staff) and the child’s family (especially its parents), the nurse, as a member of a

¹⁸ The nurse need not even demonstrate any sympathy for the child. Following Davis (2004), sympathy involves a concern for other’s well-being that impacts directly on one’s own welfare. A discreet professional distance may limit the degree of sympathy felt.

profession, shares a collective intention with the child’s family, and is hence obligated in certain ways. It may be that the virtues, i.e. the disposition of the individual nurse’s character, that impact on the nurse’s attitude. The example further demonstrates further how the standard health economic conflation of care with altruism is reductionist and flawed. Following the thrust of the mainstream description, the ill-humour of the nurse could be interpreted as a lack of care (i.e., independent utility functions) and the symptom of an underlying agency problem; speculatively potentially associated with job mismatch, where the disutility of work is not compensated by relatively low wages (cf. Nelson, 1999). Alternatively, drawing from McGuire (2000) noted earlier, the ill-humour of the nurse could be a source of brand differentiation!

The final meaning of care Blustein notes is “*to care that*”. Here caring is prepositional and has some situation as its object. For instance, it is possible for us to *care that* people are suffering from the effects of conflict in parts of Sudan. Care in this case is not focussed on a particular person; it is more abstract and less concrete. An absence of individuation, or a Cartesian orientation in viewing the body as analogous to a machine (Kennedy, 1981; Maclean, 1993), and the egocentric reference of mainstream notions of altruism (Khalil, 2003) all resemble Blustein’s “*to care that*”. This is not to say that richer conceptions of the individual cannot adopt this type of care, but that mainstream notions are incapable of accounting for any other type of care. In effect, mainstream health economics’ conception of care is decidedly thin, and is reduced to “*to care that*” in part due to the absence of an adequate notion of the individual: arguably, in the mainstream the individual has no antecedent or consequent.

Of course, caring may be personal or impersonal, where the former focuses on particular persons, such as those that we may “*care for*”, and the latter on an instance of a type that we may “*care that*”. Yet personal care need not be intimate, Blustein focuses on the role relations within some institutional arrangement as examples of personal care without intimacy. Blustein’s invocation of role relations embedded in institutions has a striking resemblance to Lawson’s (2003) notion of realist social theorising, where the way people interact and act is influenced by their relationships with one another in particular social roles in particular contexts, and is discernible in the ill-humoured nurse example above. Hence, personal care of this nature is not unfocussed and any intimacy is (usually)

associated with the demands of the role as expressed by the rules and norms associated with the role. Moreover, the contextual nature of relationships recognises the social embeddedness of these relationships, and of care itself. Indeed, it is possible to speak of a “care ethic” (Folbre, 1995; van Staveren, 2001; cf. Maclean, 1993). Again, this represents an expression of a ‘we’ intention, as, following Williams (1985), an ethical consideration implies an obligation much in the same way as group norms, and such obligations entail duties that are related to an individual’s role or position. More than this though is how the care ethic can impact on individuals’ *motivation* of “caring about”, “care of” and “caring that”.

Collective intentions and obligations entail certain commitments by the individual. For Blustein, 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. As Blustein (1991: 11) observes, “Though there cannot be commitment without care, there can be care without commitment”. In effect, a caring ethic is more likely to engender a shared intention among group members that encourages a dedication, or motivation, to “care about”, to be attentive, as in the case of Blustein’s school teacher noted above, than a group, or institution, where this ethic is either absent or attenuated. The erosion of a care ethic 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, “caring about” changes into “caring that”.

Recent anthropological studies have detected changes in conceptions of care in some Western countries following market-oriented reform (Donald, 2001; Fitzgerald, 2004; Robins, 2001). For instance, Fitzgerald found that concepts of care varied markedly between clinicians and managers: with the former tending to focus on the *person*, although consultants had the potential to view the patient as a scientific object (Kennedy, 1981). This had the potential to invoke feelings of empathy, or “care about”. By contrast managers tended to view care in the abstract, and as a homogenous entity that should be delivered routinely. As with van Staveren, Fitzgerald’s study suggests that as clinical workers experience time shortages, as a result of the rationalisation of medical procedures, they experience disorientation and demotivation. They no longer felt they could fulfil the ethical requirements of their jobs, and conflict with managers was frequently observed

(Fitzgerald, 2004). In other words, the care process, as perceived by care workers, is crowded out by a different and potentially conflicting abstract view of care.

It is important to appreciate that a caring ethic is not some homogenous entity. Recent work in hospital ethnography suggests that hospitals, as an institution, reflect and reinforce social and cultural processes (van der Geest and Finkler, 2004). This is discernible in the process of caring across countries or societies: diagnostics and therapeutic care are culturally influenced. Van der Geest and Finkler note studies of the variations in childbirth procedures across Western societies: chiefly the divergent approaches of the USA and Europe. What is worth highlighting is that reducing care to an argument of an agent’s utility function cannot capture the foregoing: commitment is not a constraint or a preference. Care’s deontological qualities are irrepressible.

The Approach to Health Care Policy

As our criticism of standard health care economics and its understanding of care targets the very foundations in rationality theory and traditional concept of the individual, our view of health care policy necessarily involves a fundamental restructuring of how care ought to be approached. Specific policy recommendations flow from general principles, and thus if we are to create a new set of concrete policy recommendations for modern health care systems, we need to begin by identifying new foundational principles.

Those new principles, we believe, stem from a paradox inherent in the traditional view of care we hope to have set out in this paper. That is, the standard view of care is not really about care at all, but rather about how self-interested utility maximizing individuals – here clinicians – might happen (if we are fortunate) to have positive externalities towards others – here patients. At best, where care does figure, it is identical to an egocentric variation of altruism, which is abstract and conflates all forms of care into “care that”. Further, since patient well-being is only an argument in the clinician utility function, the patient really has no status as a real human individual. Indeed the only individual in the standard health economics conception of care is the isolated, atomistic clinician. Patients are simply the objects of care. Care, then, is not only not a feature of the

traditional health economics view, but those to whom care is to be given are not part of that analysis either. The paradox of care in standard health care economics is that there is no place for care.

Thus if we are to introduce care into health care economics, we need to begin by making care a relationship between individuals. We have seen that a market analysis of atomistic individuals is not sufficient for this purpose, and thus our model of care relationships between individuals treats individuals as socially embedded rather than as atomistic. This in turn makes the practical basis for care principles which are understood to hold as obligations between individuals as members of social groups. We begin, accordingly, by emphasizing the difference between obligations and Pareto efficiency principles.

Pareto efficiency principles always take a general form that is not specific to any particular set of individuals. Whenever some individual's well-being can be improved without sacrifice on the part of others, that situation is recommended. Obligations, in contrast, are generally specific to particular sets of individuals, because they concern relationships between individuals, as when one individual has a responsibility to another. Further, that obligations are specific to particular individuals follows from our treatment of them as arising from shared intentions in social groups. Social groups exist across society, but because they differ in structure, membership, and principles from social location to social location, they almost always reflect their individual histories. Thus as obligations arise in groups, obligations reflect their specific character and individual histories.

What this first implies regarding the general principles guiding health care systems is that policy needs to be tailored to community relationships. Just as the relationship between patients and clinicians is not strictly a relationship between individuals, but also a relationship between social groups, so health care policy needs to be founded on principles that take into account the specific local character of the communities made up of those groups. This local autonomy in health care provision is nonetheless consistent, we should add, with principles of fair allocations of health care resources across communities. While our treatment of social groups emphasizes communities, societies themselves constitute loose social groups constructed around shared histories of nationality and regionality. By virtue of broader inclusion involved in the largest of social groups, the

principles underlying health policy need to favour common objectives, such as fairness. But these broader policy objectives are still compatible with there being a high degree of local autonomy in health care policy that reflects social values and norms that are inherent in particular communities.

The community-specific character of health care policy recommendation dovetails with our view of individuals as socially-embedded in that individuals as the object of care are seen as members of groups. But we wish to emphasize that not only are individuals different from one another in terms of their different memberships in social groups, but that their health care needs also vary according to their social location. For example, family members provide different levels of home care, transportation to health facilities, assistance in interaction with clinicians, etc. Individuals' perceptions and understanding of their health care needs vary according to their social backgrounds. Thus differences in policy recommendation are not well captured by general principles such as efficiency, but depend on the way in which people understand their responsibilities and obligations to one another.

We think these points lay the basis for fairly specific conclusions about how to approach health care policy that we associate with the theory of public deliberation. In standard health care economics, health policy is always the province of experts – for example, health care economists – who make decisions for others without needing to consult them. This reflects the all-purpose character of Pareto efficiency recommendations, which can be made without knowledge of specific local circumstances. In contrast, when community values are the primary focus, the issue of where decision-making is carried out becomes paramount. Clearly, the argument here is that particular health policies need to have a fundamental role in this decision-making. But at the same time, because communities are made up of social groups, this decision-making requires a system of public participation. We thus follow the pragmatist John Dewey's emphasis on the importance of a democratic process of public deliberation rather than a detached role for experts in health care policy making (see also Maclean, 1993).

Democratic systems, of course, operate by well known general principles, such as openness and transparency, full participation, and recurrent deliberation. But the ways in which these general principles are put into action

varies across communities. Moreover, because democratic systems tend to be inclusive rather than excluding, individuals are generally protected and valued. In this respect we see a connection to the principle of care. Care, in all the discussions we have reviewed, has a central component concern for the other. Concern for others, however, becomes tangible when others are not invisible but actively involved in the affairs of the community. Thus open systems of public deliberation are care-supporting.

Moreover, we believe that such issues are vital if “reasonable” health is to become a basic human right (World Health Organization, 2002). It is clear to us that mainstream health economics, with its thin model of care and phantom patients, does not represent a sound basis for advancing this laudable aim. Thus our stance on health care policy demands a revision from the bottom up of how health care is understood. But despite these significant ambitions, we believe that re-thinking individuals and health care has important consequences for the quality of care in modern society. That re-thinking is admittedly only recently begun, but promises to continue, we believe, with the rising concern people have about health care today.

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