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Abstract: Standard health economics concentrates on the provision of care by medical professionals. Yet 'care' receives scant analysis; it is portrayed as a spillover effect or externality in the form of interdependent utility functions. This conceptualisation is subject to considerable problems, stemming from its reliance on a reductionist social model that centres on instrumental rationality and consequentialism with its subsequent disregard for the deontological (moral rules and duties) and compassionate aspects of behaviour. Care as an externality is a second-order concern relative to self-interested utility maximization, and is crowded out by the parameters of the standard model. We explore an alternative approach to conceptualising care based on the social embeddedness of the individual that emphasises the deontological properties of care.

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Health economics concentrates on the provision of care by medical professionals (Mooney, 2009), although its boundaries extend beyond this (Jones, 2006). Health care is explained in terms of externalities; specifically through interdependent utility functions between clinicians and patients within principal-agent relationships (McGuire, et al, 1982), and/or between “significant others” and the patient (Bobinac, et al, 2010), or between the wider population and those who are ill (Culyer, 1976); or in terms of dual utility functions (Wiseman, 1997; Mooney, 2009). Care is treated as homogenous across those distinctive sets of relationships, although there is some recognition of differences in the intensity of care as a set of practices (Lilly, et al, 2010). Within this framework care can be conceived as altruism and/or social capital. In these ways health economists’ understanding of care draws from Gary Becker’s work in extending the “economic approach” to the social domain (for example, Bobinac, et al, 2010; see also, Fine, 1999).

We believe that health economics’ consequentialist character (Forget, 2004) offers an inadequate view of care qua care. We believe this is partly rooted in the standard health economic conception of the individual as a bundle of preferences. This presents the individual as socially disembodied (Davis, 2003; 2011). Our view shares sociological, communitarian, feminist, institutional and social economic critiques of Cartesian mechanical thinking about care, and emphasizes how individuals are socially embedded and situated in social roles and relationships. On our view, a more thorough appreciation and understanding of care must recognise it is relational, instinctive, socially constructed, and deontological in character; something that is beyond the scope of the mainstream approach.

This is not to suppose that theories of care are not contested. Nonetheless, for our purposes we emphasise that the scope of our analysis reflects that of health economics, i.e., it primarily focuses on medical care provided by medical care institutions and professionals, although we stress that our approach, emphasising social embeddedness, encompasses diverse forms of care that transcend disciplinary boundaries. Our aim is to demonstrate the inadequacy of health economics in its ‘own territory’, and that its approach cannot readily apprehend the diversity, nuances and value of care and caring. We emphasise that we do not establish an alternative approach – this is beyond a single paper. Given the growing influence of health economics (Culyer and Newhouse, 2000); indeed, given the fiscal challenges authorities
are endeavouring to address, health economics may become yet powerful in its influence. Therefore, we feel it is highly appropriate to scrutinise its conception of “health care”.

The remainder of the paper adopts the following structure. In the next section, we discuss health economics’ conceptualisation of care. The following section critically evaluates this standard analysis. The next presents our understanding of the relational nature of clinical-medical care, and advances the concept of the socially embedded individual. We then use this alternative framework to consider a broader more detailed understanding of the concept of care in health emphasising the different dimensions and grammar of care.

2. Mainstream health economics: care as an externality

Mainstream health economics’ entry point for its analysis of care is the delivery of health services through markets. Thus, medical care is at one level analogous to the transaction for any good or service, subject to information asymmetries in a principal (patient)-agent (physician) relationship (Mooney and Ryan, 1993). Yet standard health economics acknowledges a potential contradiction between a clinician’s self-interest, via demand inducement (for example, McGuire, 2000), and acting in ways that promote the patient’s welfare (see Rice, 2001). Indeed, Alan Williams (1988) argued that the physician-patient relation was a “perfect” agency relationship. Yet what constrains the physician from inducing demand for their services, and lowering their quality? This tension requires the standard health economics approach to explain care as an externality (see references to this in, for example, Bobanic, et al, 2010; Culyer, 1976; McGuire, et al, 1982), or as an unintended spillover effect of production or consumption not reflected in the price of the activity, i.e. as a market failure. From this perspective, we argue mainstream health economics’ conception is further manifest as two overlapping approaches: care as altruism and/or social capital.

2.1 Care as altruism: interdependent utility functions

Since Arrow (1963), medical ethics has been acknowledged in standard health economics as intended to temper “consumer exploitation”. The most prominent interpretation has medical ethics as both an assurance and insurance against both moral hazard and adverse selection (see Mooney and Ryan, 1993; A. Williams, 1988). McGuire (2000: 521) argues:

“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 ethic, 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” (emphasis added).

McGuire’s summation makes explicit that nature of the physician utility function as consisting of net income accruing to the clinician and the benefits/utility received by the patient. Similarly, standard microeconomic accounts of altruism view the benefits accruing to another as an argument in the individual’s utility function, a special type of preference of the form: agent X’s preference for satisfying agent Y’s preferences (Folbre and Goodin, 2004). As Khalil (2003: 116) expresses, the altruist (qua charity) lowers, “his interest in order to buttress the recipient’s interest”. More generally, the standard framework can be seen as distinguishing three approaches to altruism: “ego-istic”, where altruism revolves around the expectation of future benefits accruing to the benefactor; “egocentric” (which resonates with Becker’s [1976] approach) where the donor’s utility reflects the utility of beneficiaries, and “altercentric”, where altruistic actions are associated with a personality trait (Khalil, 2003).

Health economic accounts of “humanitarian spillovers” between the wider population and those who are ill (Culyer, 1976), or care interventions as “spillovers” on “significant others” (Bobanic, et al, 2010) fall in the Becker-inspired “egocentric” orientation. A “caring externality” in the representative agent’s utility function generates a benefit flow to this agent (Mooney and Ryan, 1993) from the knowledge that other members of the population have the ability to access health care regardless of their ability to pay.

A variation on the foregoing is presented by Wiseman (1997), who associates process utility with care in arguing that utility may be derived from the act of caring or giving, as well as the consequences of care-giving. Drawing from Margolis’ (1982) fair shares model, Wiseman notes that individuals may be conceived as possessing two utility functions: one deriving “selfish utility” and the other from group or social activities. In supporting this approach, Mooney (2009) invokes Sen’s (1977) reference to “commitment” in
articulating a social welfare function “independent” of an individual’s utility functions, so that the social welfare function is no longer the aggregation of individual utility functions. This dual utility function approach may be viewed as a heuristic device to account for how seemingly irrational acts seen from a strictly selfish perspective – such as altruistic care giving at personal cost – can be reconciled as rational acts consistent with utility derived socially. This contrasts with other analyses where the process of care-giving is modelled as burdensome (Bobanic, et al, 2010).

In effect, two interpretations are offered: care as an argument in the standard physician utility function, and care as a component in a separate “collective” or “social welfare function”. Mooney and Wiseman associate the latter with commitment, and say it thereby goes beyond the standard case, which they believe can only accommodate “sympathy” in the form of interdependent functions (Mooney, 2009: 22). Mooney also argues health economists have “ignored” the contextual element of caring: caring that takes place in a community, which carries some resonance with a process perspective, and thereby identifies a potential distinction between processes and outcomes of care. We agree with Mooney’s assessment and commend his emphasis. However, we feel the dual utility function approach does not capture all the relevant dimensions of care, as we argue below, in recognising there can be care without commitment. Moreover, in the dual utility case it remains theoretically plausible for a meta-function to serve as the appropriate maximand with all the resulting trade-offs (see also Brennan’s 1993 critique). Indeed, the dual function approach does not depart from the standard frame in its reliance on other-regarding behaviour, but limitedly so. As the quotation from McGuire, above, makes explicit, arguments (or utility functions) in the individual’s (meta) utility function may be traded off against one another.

2.2 Care as social capital

The health economics literature consistently refers to health care as a “special commodity” (see for example, Becker, 2007; Culyer and Newhouse, 2000; Jones, et al, 2006, and McGuire, et al, 1982, see also, and Mooney’s, 2009, advocacy of a “community” health care commodity).

Treating care as an externality makes it as an aspect of social capital, since most define social capital in terms of non-rivalrous public goods (Folland, 2006), or as an externality (Portes, 1998). The social capital literature supposes that caring social relationships have powerful beneficial effects on health. A considerable literature also recognizes the potential for the indirect effects of social capital on health through its associations with politico-economic and environmental variables that influence health, such as access to resources (for example, Dahl and Malmberg-Heimonen, 2010).

Although they do not refer explicitly to social capital, Bobinac et al’s (2010) model of informal care is informative in that it seeks to expand health economics beyond its principal focus on the physician-as-carer by using the standard externality account. Those close to an ill individual benefit from improvements to this individual’s health status by virtue of their relationship to that individual – “the significant other(s)”. By contrast, Bobinac et al’s “caregiver effect” refers to the welfare effects of providing care as a set of activities. Their hypothesis reflects the standard assumption of the disutility of work in that the greater the caregiving activities involved the greater the adverse impact of the care provider’s welfare, through for instance, emotional stress and opportunity costs in time commitment. The authors claim the two effects are difficult to disentangle due to the common providers of informal care – the family.

Bobinac et al also argue that the family effect of informal care offers an important insight: care provision has welfare effects beyond the care provider-recipient relationship, and therefore that their research ultimately shows: “patients should not be seen as isolated individuals” (Bobinac et al, 2010: 555). Their claim echoes Culyer’s (1976) “humanitarian spillovers” and represents the social dimension as interdependent utility functions. We agree with Bobinac et al’s advocacy: the patient should not be viewed as an isolated individual. Indeed, their allusion to the social hints at relations nested in further relations, and thus departs from the standard view of social capital as a
“plausible” economic concept when it is reformulated at the individual level (Folland, 2006). Nonetheless, Bobanic, et al and Folland share their analytical grounding in Becker’s individualist model of altruism within the family.

3. Problems: an inadequate treatment of care?

Care, we believe, has not been explained adequately in the mainstream health economics framework, because the interaction between the individual patient and clinician is one solely between individuals who are instrumentally rational utility maximizers. This is also the case in those models that seek to account for welfare beyond the physician-patient relation (for example, Bobinac, et al, 2010; Burge, et al, 2010; Lilly, et al, 2010).

We do not deny that individuals in many walks of life are instrumentally rational. We do deny that this form of behaviour fully describes patient-clinician relationships nested in other relations. We also believe modelling relations other than that between patient and physician in the same way as the interaction between patient and physician does not furnish an adequate account of the many social dimensions of care. 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, by for example, confining care to a set of definable, standardized – instrumental or functional – acts, while crowding out its less tangible and measurable therapeutic, compassionate, and deontological dimensions.

3.1 Care as altruism

The orthodox analysis of altruism has been heavily criticised, and by extension much of this criticism may be applied to health economics’ view of care as altruism. Recall Khalil’s (2003) egocentric account of altruism: on this view, altruists can identify with health care, and so would be willing to fund health care provision. However, Khalil argues, altruism thus understood has a paradoxical quality in that it can be equivalent to masochism as the altruist gains more the more wretched the state of the parties cared about. This is logically consistent with Culyer’s idea of “humanitarian spillover” and the interdependence of clinician-patient utility functions. However, it seems hardly humanitarian or caring in a positive sense that others’ misery sustains a vicarious sort of utility for the altruistic/caring agent. More specifically, in extremis, under this conception medical cures are the last thing physicians want: therapeutic treatments are ruled out, and medical procedures are reduced to some form of intermittent palliative episodes of “care” followed by periods of tolerating the patient’s worsening medical condition (a source of disutility), to be followed by the patient’s improvement as a consequence of further episodes of palliative “care” (as a source of utility), and so on. Thus, a process of infinite regress is entered as Khalil’s masochist mutates 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 the physician is motivated to behave in the manner outlined above.

Moreover, the idea of a ‘caring externality’ is problematic in itself in that the spillover is not on a third-party, as in standard microeconomics, but on one of the parties to the transaction, namely, the patient. In clinical-medical encounters, should we say, then, that health care providers exhibit caring externalities toward their patients, because they gain utility when their patients gain utility, their care for those individuals would constitute a feature additional to those factors that explain the interaction over whatever health care services are being delivered? Caring externalities might then be thought to counterbalance the negative effects of moral hazard in that the incentives that asymmetric information creates for physicians to pursue individual gain, such as supplier-induced demand, could be offset by the special regard for the well-being of the patient that comes from this caring preference.

However, on the standard view, caring, when defined as an externality, still acts as a secondary type of factor in explaining the operation of health care since interactions can be explained whether or not clinicians exhibit caring preferences. Indeed, the same may be said of informal care. Whether or not, then, supplier-induced demand does play a significant role in health care markets, on the standard view it must still have a greater weight than physicians having a caring preference, seen as a secondary factor. Thus depending on the degree to which individual incentives operate in health care, there should generally be a tendency for caring attitudes, such as compassion, and hence some activities, such as therapeutic care, to be crowded out, or at least become peripheral. Ethical motives, as it were, are always at risk when economic ones dominate. This conclusion is reinforced by the standard view in microeconomics that externalities are
only addressed through the intervention of government in the market system. In the case of clinician caring preferences, this implies that unless government or some other public authority (medical associations, codes of ethics, etc.) weighs in on the side of patients, one should expect caring preferences to be continually under pressure to be crowded out of health care markets.

The view of care as altruism is subject to a further problem: how does the altruist know what another agent’s preferences are, especially assuming the standard view that preferences are understood to be revealed preferences? Drawing from Bourdieu (1977), Dewey (1922) and Veblen (1994 [1899]), altruism, we suggest, is more appropriately seen as a disposition, in effect a habit, in that it is more suitably conceptualised as a cause of an individual’s actions and practices. Habit (habitus) can be either dynamically reinforced or weakened through changes in the patterns of social interaction.

As 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 …”.

What we take from this is that treating “care” as a preference in an agent’s utility function makes the level of care something determined through an algorithm of utility maximisation. But this framing makes care a highly mechanical affair, and imposes an instrumentalist interpretation on the concept of care. This in turn suggests the body ought to be understood as a machine, and that ethical values, particularly non-consequentialist deontological ones, have no place in the analysis of care. Drawing from Bernard Williams (1985), we say that instrumentalism removes care from the realm of ethical consideration. For Williams, the outcomes of actions certainly warrant classification as ethical considerations, but so to do obligations and duties, as do character dispositions (virtues), given that they affect how individuals deliberate in undertaking or avoiding actions of certain types. Williams’ arguments stress deontological value and the social embeddedness of the individual. In contrast, a health economics based on socially disembedded individuals imparts, at best, a thin notion of care. It is well recognised in various literatures that therapeutic care, for example, can provide beneficial health outcomes (Adams and Nelson, 2009; Armstrong et al., 2008; Kontos and Naglie, 2009; Watson and Smith, 2002) – this seems beyond standard health economics.

3.2 Care as social capital

As noted, health economists consider health care a “special” type of commodity – one exhibiting external benefits. We believe there are sufficient grounds for saying that health economists do not appreciate the implications of this narrative. Commodities are things that are tradable, therefore monetizable, produced for sale in a market, and therefore where property rights may be identified and transferred (Barr-David and Darr, 2009; Fine, 2001; Jessop, 2002). Culyer (1990) is one of the few health economists to seriously reflect on this conceptualisation of health care. He describes commodities as:

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

This is appealing, but Culyer goes on to compare the “characteristics” of health care; timeliness, clinical efficacy, and readmission rates, with those of a steak; juiciness, tenderness, and flavour. The implication is that care is solely instrumental in producing its special characteristics, and that the social relations involved in health care provision are essentially the same as those governing other commodity exchanges, including those involving principal-agent relations. In the extreme, this would seem to suggest that the nature of dependency, as typified by the principal-agent relationship, is reducible to one of the distribution of information between two parties.

Culyer’s analogy can be elucidated through Radin’s (1996) insightful work on commodification. Complete commodification, she argues, involves the conjunction
of four dimensions: commensurability, fungibility, monetisation, and objectification. Commensurability relates to the valuation of entities, such that they are on a continuous scale. Fungibility concerns the exchangeability of entities whilst maintaining their value for the proprietor. Monetization is the property of ease of convertibility to money. For us, objectification is of particular interest.

Nussbaum (1995) expands on what is involved in treating something as an object by distinguishing seven further dimensions: instrumentalisation, where the object is treated as a tool for the purposes of another; denial of autonomy, where the object is treated as lacking in autonomy and self-determination; inertness, where the object is treated as lacking in agency; fungibility, see above; violability, where the object is treated as lacking in boundary-integrity; ownership, or property rights to the object, and denial of subjectivity, where the object can be treated as if devoid of experience or feelings, or they need not be considered. Applying these ideas to the concept of care, we seem to be working with a socially disembedded entity lacking in any relational attributes. But this seems the very antithesis of the nature of care and caring.

Note that commodification is neither necessary nor sufficient for objectification, but that health economics’ Cartesian foundations as well as its commodity rhetoric resonates with objectification. This is further buttressed by health economics’ reification of the patient as an individual through its conceptualisation of the patient as an argument in a physician’s utility function (Davis and McMaster, 2007).

It is interesting, then, that much of the feminist literature, in particular since the 1980s explains care in general as profoundly relational, thus not something that can be objectified, whilst still recognising the market as an important provider of care (see Folbre and Nelson, 2000).

“Caring because it is the development of a relationship, is manifestly an activity … in which the output is the care itself … This means that it is hard to raise the productivity of caring” (Himmelweit, 2007: 585).

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

In the context of nursing and gender, Adams and Nelson (2009) similarly note that many desirable activities focused on therapeutic care are necessarily time costly and attempts to impose codified, standardised procedures are likely to diminish important aspects of caring, such as in the development of relations that potentially elicit more effective diagnoses (see also, Armstrong et al, 2008; Groopman, 2007; van Staveren, 2001). This is consistent with Kontis and Naglie’s (2009) argument that caring does not develop through theoretical learning, and involves experience (tacit knowledge) and “embodied selfhood”, i.e. a synthesis of primordial and social being.

4. The relational nature of clinical-medical care and the socially embedded individual

The medical literature is replete with references to care as profoundly relational in character (for example, Aasland, 2001; Groopman, 2007; Lipman, 2004; Sulmasy, 1993; Watson and Smith, 2002). Given this, we believe that patients and clinicians should be treated as socially embedded individuals where this reflects their membership of patient social groups (family and community) and clinician social groups (professional associations), which are jointly responsible for individuals’ care. This is, it seems to us, consistent with the tenor of Bourdieu’s social capital approach (see for instance, Fine 2001). These social groups are in turn nested in various other social relationships and interact with other social groups indirectly connected to the patient-clinician relationship. Social groups are defined as collections of individuals with shared characteristics that specify membership in those groups, which creates sets of rights and responsibilities that are supported by individuals’ collective intentions (Davis, 2003; 2011). 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 enabling and constraining behaviour, and in partly constituting the individual (Hodgson, 2008). Countries’ health care systems are then taken to be networks of institutions built up around the interaction between these social groups involved in patient-clinician relationships.
Thus, our framework explains the provisioning of care socially through how many individuals as members of many social groups interact both directly and indirectly in the social provision of care. Markets indeed operate for health care, but do so in community and national networks structured around social groups. Central to this view is the idea that care thus understood is not between instrumentally rational atomistic individuals linked through (clinician) externalities, but between socially linked individuals for whom it is rational to act on shared goals.

One way, then, in which this social interaction between individuals can be understood is in terms of their expression of shared, or ‘we’ intentions both within groups and between groups. Shared intentions provide the basis for reciprocal obligations, as when clinicians and patients commit to courses of treatment as a package of care to which they have agreed. These mutual obligations are rational in virtue of individuals freely binding themselves by them when in interaction they come to the point of expressing shared intentions as the outcome of their deliberation over the course of care (Davis and McMaster, 2007; see also Mol, 2006). Thus, their rational character does not derive from the particular ends they promote – a consequentialist view – but from the individuals’ shared commitment regarding care – a deontological view. In effect, the constraints which shared intentions produce are ‘internal’ to the clinician-patient relationship, rather than ‘external’ to the two atomistic individuals’ interdependent utility functions in the standard analysis. The simple difference between first person singular, or ‘I’ intentions, and first person plural, or ‘we’ intentions individually expressed points to fundamental differences in individual behaviour. With the former, atomistic individuals express intentions that apply only to themselves and their choices are instrumental to maximizing individual utility – there is no social or impersonal referent. With the latter, individuals express intentions that apply to themselves via the relations they have to others. Care relationships between patients and clinicians are thus socially embedding, because patients and clinicians share intentions which they implicitly or explicitly represent in ‘we’ language. This is even the case in circumstances where a patient is incapable of decision-making, such as in comatose or related conditions, as then individuals from the patient’s social group (family or friends) stand in on behalf of the patient in virtue of their shared intentions. Thus, pace Wiseman and Mooney a more appropriate model for explaining care is, in our view, based on a deontological rather than an instrumental rationality. Care has important unconditioned, non-instrumental qualities.\footnote{5}

5. Towards a richer conceptualisation of care in health economics: a discussion

We find Blustein’s (1991) analysis of care to be highly instructive and reinforcing of our argument. Blustein’s philosophical approach, which partially draws from works of Baier (1982), Frankfurt (1982), and Williams (1985), further demonstrates the significance of the grammar of care. In this Blustein is by no means unique – for instance, the grammar of care underpins Bobinac, et al.’s (2010) delineation between family and caregiving effects, and is also evident in the work of Carse and Lindemann Nelson (1996), Noddings (2003), and Tronto (1993), for example.

Bobinac, et al distinguish between ‘caring for’ and ‘caring about’. The former concerns the set of activities inherent in a particular individual’s care, whereas the latter relates to family ties. Both, as noted, are conceptualised as externalities. Tronto (1993) and Carse and Lindemann Nelson (1996) also identify ‘caring for’ and ‘caring about’ as distinctive types of care and caring, but offer rather different definitions. ‘Caring for’ is discussed in terms of the exercise of a “moral skill” on the part of the individual in regard to how to they position themselves to act in a fashion that “best” cares for what the individual cares about. ‘Caring about’, thus presupposes some valuation regarding what makes ‘x’ worth caring about (Carse and Lindemann Nelson, 1996). This, according to the authors, need not be directed to a particular person; it may also be relevant in the abstract, as, for example the future or the situation of persons unknown.

While Tronto’s (1993) and Carse and Lindemann Nelson’s (1996) definitions are insightful they do not recognise the importance of an individual’s
situatedness. Blustein’s description does. Thus, for Blustein four (overlapping) forms need to be distinguished:

“\textit{To care for}” refers to having some affection for another, as in a loving or other intimate relationship. “\textit{To have care of}” refers to having some responsibility, or duty for supervising or managing, providing for, or attending to the needs of another. Thus, care in this category is dependent upon an individual’s social position and the consequent range of activities inherent in this position, e.g. the functional or instrumental acts of care, such as a physician examining a patient or a nurse dressing a wound (see also Mol, 2006). “\textit{To care about}” is the most complex and nuanced of four forms. It involves some commitment of interest by the individual, which Frankfurt (1982: 260) describes as: “a person who cares about something is, as it were, invested in it”. The fourth form, “\textit{to care that}” is discussed, below.

Yet there are tensions in theorising care, reflecting its ontological diversity and value ladeness (Noddings, 2002). Care, for some, is heavily influenced by gender, such that women display more “natural caring”, which is considered to be a moral attitude founded in the experience of being cared for (Noddings, 2003). Without becoming embroiled in a contested domain, Noddings’ argument raises issues with care as a duty (to have care of) and dimensions of social situatedness.

For Blustein, the notion of “interest” is critical in clarifying “to care about”. There is a “stake” for the individual in caring about something – as with Carse and Lindemann Nelson and Tronto there is valuation in caring. This may be positive or negative. With a positive disposition the individual may gain if the nature or condition of ‘x’ is enhanced; the reverse applies to a negative perspective. Thus, with a positive disposition if the condition of ‘x’ is diminished then the individual will experience some degree of distress. There is some correspondence with the interdependent utility function account in standard health economics. However, importantly, caring-about may benefit the recipient without benefiting the provider. Caring-about is described as “disinterested” by Frankfurt, and can be manifest in such behaviours and inclinations as, loyalty, benevolence, and unselfishness (Blustein, 1991). Mainstream health economics’ interdependent utility functions are ultimately only able to account for what Frankfurt describes as “interested” caring-about, where the care may only be given so long as it remains advantageous to the care-giver.

Different manifestations of care and caring acts reveal incongruities. Indeed, there is some recognition of this in Folvere’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 exhibit the binding qualities of the membership of her group – in terms of medical norms, as a network of beliefs, encapsulated by the Hippocratic ethos – in that the motivation of care is manifest as \textit{caring about} and \textit{having care of}, but her or his individual predilections do not lend themselves to \textit{caring for} the child. The nurse in accepting a particular role within her group is \textit{obliged} to undertake certain functions as part of the shared intention (s)he has with other members of her/his (clinical) group (through having care of) in the context of some pertinent medical dependency; the scope of this obligation need not extend to \textit{caring for}, as a process of therapeutic care. In this case the nurse may demonstrate limited empathy for the child, and be attentive to her/his medical needs, but there is no altruism (\textit{quåá} charity). For some, notably Noddings (2002), this may represent an absence of care due to the lack of sympathy, and indeed, may thus question the association of medical procedures with the conception of care. Yet, for us, the social embeddedness of individuals means that 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 profession, shares an intention with the child’s family, and is hence obligated in certain ways (see also Hochschild’s, 1983, account of emotional labour).

The example further demonstrates how standard health economics conflation of care with altruism is reductionist and flawed. It implies that the ill-humour of the nurse could be interpreted as a lack of care (i.e., independent utility functions) and a symptom of an underlying agency problem; potentially associated with job mismatch, where the disutility of work is not compensated by relatively low wages (cf. Nelson, 1999).

According to Baier (1982) a measure of an individual’s intensity of caring can be determined by the “intolerance of ignorance” concerning the state of what is cared about. This reveals further nuances – care may become peripheral, by Baier’s test where an individual will tolerate ignorance of the state of x. It also signals the potential for an overly intensive, or invasive, approach to caring.\textsuperscript{2} Carse and Lindemann Nelson (1996) discuss the possibilities of care imposition that leads to the loss of autonomy (see also, Mol, 2006; Sybylla, 2001; Tronto, 1993). They write (1996: 22-23):
Again there is some correspondence here with the notion of supplier-induced demand, but the "arrogance" of the clinician is reduced to an exercise of consumer exploitation as part of utility maximisation. Moreover, the objectification of the individual would seem to foster such attitudes. Indeed, standardised curative care may be seen to resemble this. The nuances of professional position and underlying philosophy are ignored. The foregoing thus engages with the difficulty in assessing the quality of care provided, which is recognised by health economists (for example, McGuire, 2000). Insufficient “caring about” signals the potential for sub-standard quality even in the administration of instrumental acts of care (“to have care of”).

Blustein’s final category is “to care that”. Care in this case is not focussed on a particular person; it is more abstract and less concrete and has some situation as its object. For instance, it is possible for us to care that people are suffering from the effects of conflict in parts of the world. While this indicates that an individual is interested, or “invested” in Blustein’s terminology, there is no action to affect a process or outcome. There may be limitations on the ability or disposition to act. An absence of individuation, or a Cartesian orientation in viewing the body as analogous to a machine, and the egocentric reference of mainstream notions of altruism (Khalil, 2003) all resemble Blustein’s “to care that”, as it appears do biomedical interpretations of curative care. For Blustein (1991: 11) observes, “Though there cannot be commitment without care, there can be care without commitment”. In effect, an ethic demonstrating an overtly caring orientation is more likely to engender a shared intention among group members that encourages a dedication, or motivation and habit, to “care about”, to be attentive than a group or institution where this ethic is absent or attenuated. The attrition of such an orientation could entail a further erosion of the system of beliefs or norms, and hence a dilution of motivations and commitments to care, which may change care as an activity; for instance, where “caring about” becomes “caring that”. The intensity of care can also be considered to be diluted. Our references to the crowding out of care mean precisely that – care becomes peripheral and commitment is eroded.

Again we refer to the deontological nature of role relationships. The way people interact and act is influenced by their relationships with one another in specific social roles in particular contexts, as is discernible in the ill-humoured nurse example above. Hence, personal care of this nature is not focussed and any intimacy is (usually) associated with the demands of the role as expressed by the rules and norms associated with the role, such as standards of “good conduct” (Runick, 2001). Moreover, the contextual nature of such relationships reflects their social embeddedness and that of care itself. Indeed, for some it is possible to speak of a “care ethic” (Adams and Nelson, 2009; Carse and Lindemann Nelson, 1996; Folbre, 1995; Noddings, 2002, 2003; Sybylla, 2001; Watson and Smith, 2002; van Staveren, 2001, 2005), and a “logic” of care (Mol, 2006). Again, this demonstrates the importance of shared intentions since, 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 an ethic accenting care can impact on individuals’ motivation of “caring about”, “care of” and “caring that”.

Shared 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 (see also Sen, 1977). As Blustein (1991: 11) observes, “Though there cannot be commitment without care, there can be care without commitment”. In effect, an ethic demonstrating an overtly caring orientation is more likely to engender a shared intention among group members that encourages a dedication, or motivation and habit, to “care about”, to be attentive than a group or institution where this ethic is absent or attenuated. The attrition of such an orientation could entail a further erosion of the system of beliefs or norms, and hence a dilution of motivations and commitments to care, which may change care as an activity; for instance, where “caring about” becomes “caring that”. The intensity of care can also be considered to be diluted. Our references to the crowding out of care mean precisely that – care becomes peripheral and commitment is eroded.

Dispositions to care are sensitive to patterns of social interaction (see also, Mol, 2006). This highlights care and caring as emergent properties of interactions between clinicians and patients and the importance of the institutional architecture in which these individuals are embedded. Given the individualistic orientation of
standard health economics, it is beyond its scope to recognise care as emergent upon these relationships.

What then is to be made of health economics notion of care as a spillover or externality? We believe it implies the marginalisation of care in health economics. In the extreme, the disregard of social relations embodied in Culyer’s contrast of the characteristics of medical care and a steak echoes the objectification of humans and disregard for the profoundly relational nature of care, confining standard health economics to “care that”. There are grounds for saying that the standard approach allows for care as caring-about interpreted as other regarding via interdependent utility functions. But this is only partially the case as it is constructed on a consequentialist and self-interested rendering of value, which ignores or dismisses the deontological aspects of care and caring. Blustein’s (1991: 48) emphasis on the importance of commitment in this respect is illuminating:

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

Institutions matter and point to the social embeddedness of individuals. The reductionist tenor of the standard health economics approach points to a chronic undervaluation of care and caring in health care. Accordingly, policy informed by this approach is likely to concentrate resources on measurable standardised procedures and outcomes. Caring about (health) care then becomes peripheral. Following Blustein’s quote above, associating care, commitment and meaning, the standard health economics framing of care divorces it from commitment as a significant deontological dimension, and thereby weakens the rationale for medicine as a normative endeavour. Indeed, we are left with the unfortunate conclusion that mainstream health economics cannot furnish an account for the appearance of care – only its disappearance.

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Notes

1 The distribution of power in medical relationships has been the subject of extensive discussion (see for example, Heritage and Maynard, 2006; Karniel-Miller and Eisdikovitz, 2009; Kennedy, 1981; Groopman, 2007). We also recognise shared intentions do not always pertain – patients may defy physician advice, refuse treatment, and even where intentions are shared outcomes may diverge from intent due to errors and practices (see for example, Cramer, 2011). Given space limitations, we leave aside issues of power.

2 Overly intensive caring poses potentially profound problems in terms of the loss of the care-giver’s integrity and autonomy with the potential for “moral wrongdoing” (Baier, 1982). The position of the “ageing” butler – Stevens – in Kazuo Ishiguro’s The Remains of the Day is a potent case in point. This also resonates with the notion of “helper’s syndrome”, where an individual will be helpful, or other regarding to the point of mantrum. In this case dependency does not necessarily lie with the cared for, but with the party providing care.