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More Questions than Answers: The Commodification of Health Care

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ABSTRACT

The changing world of health care finance has led to a paradigm shift in health care with health care being viewed more and more as a commodity. Many have argued that such a paradigm shift is incompatible with the very nature of medicine and health care. But such arguments raise more questions than they answer. There are important assumptions about basic concepts of health care and markets that frame such arguments.

Key words: commodity, health care, medicine, moral vision.

Cost containment has rolled like a tidal wave over health care in recent years. The delivery of medical care and health care have been reshaped by efforts to control costs. The wave of cost containment knows no national boundaries. Many nations, from the Pacific Rim to the European shores of the Atlantic, have been caught on the turbulent seas of escalating health care costs and the strategies to contain these costs. The problems of escalating health care costs are not simply economic questions nor questions of public policy. The management of health care resources poses moral questions as well. How a society allocates its resources is an indication of the moral commitments it holds and its moral vision.

In a world of limited resources choices must be made about priorities in allocating resources. A society needs a moral vision to guide how resources will be allocated to one priority over another. The moral commitments of a society can be discerned not only in its priorities but also in the mechanisms by which a society manages its resources. The way a nation, an institution, or an individual allocates and stewards resources is a measure of moral commitments and priorities.

There are a variety of strategies for cost containment and the management of resources. One important strategy for both is to create a market

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economy in health care and let market forces develop, distribute, and manage health care resources. Underlying this use of market forces is the assumption that health care can be treated as a commodity. This assumption about the nature of the goods of health care raises as many questions as it answers (Kaveny, 1999; Callahan, 1999; Pellegrino, 1999; Hanson, 1999; Cohen, 1999). Daniel Callahan has clearly laid out important questions and moral issues that must be examined as any move toward a market strategy in health care is undertaken. The questions outlined by Callahan indicate that there are a variety of ways key concepts — like health care, the market, and commodity — can be understood. This is a very important observation, for the current debates and discussions about health care, people often use the same words, but with different meanings, and so they talk past one another.

A key area of confusion and debate, I suspect, is the understanding of health care itself and the different ways in which the term health is used and the different models of health and health care that can be deployed (Kaveny, 1999). Many of the discussions about commodification and markets often make unarticulated assumptions about the very nature of health care itself. The meanings one assumes about such key terms are antecedent to the positions that will be argued for or the conclusions that will be reached. Pellegrino's position, for example, on the commodification of health care is driven by his assumptions, about which he is very clear, about the *nature* of medicine. Pellegrino assumes that there is a fundamental nature to medicine and, armed with this assumption, he argues that markets and commodities are morally inappropriate ways to the ends of medicine. The move toward managed care and different methods of market allocation represent paradigm shifts for health care (Pellegrino, 1999). Models of managed care represent the introduction of market forces as well as a move away from a patient centered model of medicine to a population based model. The cost containment models of managed care rely on conceptual frameworks that see health care delivery as measured against the health care of a population rather than the individual patient.

One indication of the conceptual confusions and changing paradigms that exist in contemporary health care are the mixed metaphors and language that are often used. While speaking of health care in the language of the market place we simultaneously use the metaphor of gift giving in many areas of medicine (Cohen, 1999). The conflicting assumptions in our reasoning are also reflected in other language where those in need are "patients", "consumers", and "covered lives". Each of these terms represents a point of view that has strengths and weaknesses. The language of "patients" assumes a model of health care where the person is ill and weak.

This language recognizes the fiduciary dimension of medicine but it can support subtle forms of paternalism. The language of consumer, in contrast, sees the person as able to choose freely. It does not factor in the phenomena of illness.

Mark Hanson (1999) and Cynthia Cohen (1999) provide interesting examples of how assumptions about health care and medicine color the way moral issues are understood or even identified. Mark Hanson raises important, thoughtful questions about commodification in the biotechnology industry. The development of these technologies raises important ethical questions about the restructuring of human life and whether or not there are moral limits on such intrusive interventions and whether or not knowledge can be sold as a commodity. Furthermore, there are moral questions and concerns about commodification and the drive of self interest which may lead people to cross such moral boundaries. But there are a number of important conceptual issues within Hanson's questions. One question is to know where to draw the moral boundaries that should guide biotechnology. People can have sharply different moral views about what is appropriate and inappropriate behavior in medical practice. But how are we to draw the lines and boundaries? The market provides a mechanism to resolve such differences. People can exercise choice, freely and peacefully, according to their own moral commitments. Furthermore, the market and its incentives provide the resources for important medical innovations. It is not entirely clear how medical interventions in the area of biotechnology differ from other medical interventions.

Concepts of health care are embedded in the moral visions and commitments of men and women. They are part of men and women's vision of the good life. In a secular society, with different moral communities and visions, there will be a range of understandings of health care because there are different views of the good life. A health care system that supports a choice of services will be more appealing than one that does not. One of the appeals of the market model is that it allows for choice.

Another crucial conceptual question that must be asked is what type of markets are being used in health care. The assumptions that are made about markets are crucial to the appropriate or inappropriate way in which we discuss medicine and health care as a commodity. Callahan rightly points out that there are many different ways that markets can operate and commodities can be exchanged. When authors argue that there are insurmountable conflicts of interest between providing health care and the market one has to ask: Why? Many managed care organizations tie physician reimbursement to the treatment of patients and the use of resources and with such ties there is often an incentive to under treat. While such con-

flicts are morally problematic, one ought not assume that such conflicts stem from treating health care as a commodity in a market exchange. The fee-for-service model also tied reimbursement to the treatment of patients. However, in the fee-for-service model the incentives were to over treat patients. It is not sufficient to simply condemn or endorse markets and commodification in health care.

When one takes a position about medicine and commodification one needs to explain what model of market is being used and why. In looking at the realities of managed care in the USA one might argue that managed care is a limited market in that it is limited to employers and the government as purchasers. One can argue that what is really needed is *a more open market* where men and women can choose their own health care. Indeed one response to the question of fungibility of health care services can be responded to by more open and freer markets. No matter which model of health care one uses, it is highly personal in the end. One's view of appropriate and inappropriate health care is tied to a person's vision of the good life and how it ought to be lived. A free, open market allows those who can enter it choice about the type of health care they would like in accord with their views of their lives. In general, markets allow men and women with very different moral frameworks and commitments to collaborate.

A key to understanding the question of the use of "commodification" language in health care is to realize that all of the essential terms — health, medicine, markets, health care — are all social constructions. There may well exist an essential nature to the terms but the epistemological questions of the modern age make one skeptical about our ability to know what these essential natures are. Nevertheless, it is clear that these terms are built upon deeper moral visions about society and the good life. This insight is amplified by Callahan who reviews the social context of medicine and health care delivery. Of course there are important questions about whether or not medicine and health care have an *essential nature* (Pellegrino, 1999) or are socially constructed practices. If medicine is socially constructed and markets are socially constructed, why can't we think through a social construction of a medical market that would be ethically acceptable?

As we think about health care and the market it may be helpful to think of a variety of other social goods and services that are essential and necessary for human life. Roman Catholic moral theology, working out of a tradition that assumes a rich view of the common good and the natural law, argues that there are certain goods that are *basic* to human life. Basic goods often include food, housing, education, and health care. This tradi-

tion has argued that a morally good society ought to provide a basic level of these essential goods. If we think about these other goods, and how they are provided, we can begin to see how a medical market place could emerge. Beyond the basic level a society can use whatever mechanisms it deems best, including markets, for additional and alternative services.

In each of these other goods, societies often try to insure a basic level accessible to all. Even the United States, with its anti-welfare stance, provides public housing, food stamp assistance, and public education. However, beyond the basic levels people are able to purchase more of these goods through some mechanisms of market exchange. These basic goods — food, housing, and education — are provided through a mixture of basic access and a complex, often regulated, market structures. While one may argue successfully that more attention ought to be given to the adequacy of the basic level, the market structures have made the other goods available, at affordable prices, to many.

The question of commodification raises many other questions. It invites a social discussion about the delivery of health care resources which, in turn, invites a discussion of basic issues about the concepts of health and medicine. It strikes me that the most important questions are not about the notion of commodification but about the types of markets, oversight, and regulation that will be used in a society.

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