Commodity or Public Work? Two Perspectives on Health Care

by Bruce Jennings and Mark J. Hanson

Much of today's debate over health care reform implicitly views health care services as commodities. This economic point of view obscures morally important features of health care and of the medical profession. By viewing health care service instead as a public work—a civic activity—we recapture its true purposes and are better prepared to debate health policy, health reform, and ethical medical practice meaningfully.

Bioethics is sometimes defined as the academic study of ethical issues arising in biomedicine and the life sciences. That definition is accurate, but too narrow. Bioethics is also a form of civic discourse, an essential component of what John Dewey called "social intelligence," particularly regarding our practical grasp of value issues inherent in medicine, biomedical technology, and health care. So conceived, the task of bioethics is to make arguments in public about the social goals of medicine and how medicine should serve both individuals and the common good.

The purpose of this essay is to discuss two ways of understanding health care as a culturally defined activity: health care as a *commodity* (the commodity conception) and health care as *civic or public work* (the civic conception). Distinguishing between health care as a commodity and as a public work is one way to address the place of medicine in society and the place of bioethics in civic discourse. These two notions lead discussions of system reform in different directions. Neither notion is new; both have historical roots in Western medicine and in the politics and economics of the modern era.

These two rival conceptions underlie much of the current normative debate about the health care system and the profession of medicine. Recently, the commodity conception has been winning. As it waxes in our discourse, concern for the community wanes, and we neglect the civic dimensions of health and of caring. Future work in bioethics of the sort that we ourselves are engaged in will be devoted to preserving and nurturing a civic conception of health care, although bioethicists of a conservative or libertarian bent will disagree with this approach. But all those who work in bioethics, regardless of political orientation, must be aware of what is at stake in this struggle and the implications for the shape of the moral imagination in America. It is important to be explicit about presuppositions underlying the goals of health care that inform health policy and bioethics (Annas 1995).

The dominant role of the commodity conception is evident throughout the United States health care system. It leaves its mark in the explicitly market-oriented proposals being circulated by the Republican leadership in Congress and among conservative think tanks. Liberals who favor single-payor plans and those who support some version of "managed competition," such as the ill-fated Clinton plan, also view health care as a commodity (a service) that should be equitably

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distributed among, and privately consumed by, individuals. The commodity conception cuts across public or private sector financing mechanisms, and it also cuts across the spectrum of egalitarian to libertarian theories of distributive justice and equity. One reason why we have had such a narrow and unsatisfying health reform debate is because both liberals and conservatives take a commodity conception for granted. We believe that seeing health care as public work—as an activity that is fundamentally civic in its nature and purpose—provides a richer normative foundation and guiding vision for health policy and ethical medical practice.

This discussion will proceed in three steps. First, we pose some general questions about the nature of health care and why these questions should be brought into public debate. Next we contrast the commodity and public work conceptions, arguing that the commodity concept obscures morally important features of health care, while the public work concept places those same features squarely in view. Finally, we turn to the role these notions play in health care reform, with particular reference to the fate of the Clinton plan. Lessons of the recent past illustrate an urgent need to recapture and reassert fundamental features and commitments of health care as public work.

What is Health Care?

Two things are striking about the situation of American medicine today. First, the American way of conducting public policy debate and civic discourse has failed to cope with the challenge of health system reform. The Great Health Reform debate of 1994 was, in Daniel Yankelovich's apt phrase, "the debate that wasn't" (Yankelovich 1995). The public was misinformed and frightened by the debate and finally estranged from it. A large majority of Americans saw serious flaws in the health care system, but their sense of "personal trouble" was never translated into the comprehension of a "public issue" (Mills 1959). The proper language and imagination were lacking to make that translation. Now that the political moment for comprehensive governmental reform has passed and policy makers are frantically returning to the cost-shifting maneuvers that make up business-as-usual in the federal and state health policy arena, the private sector has taken over. A remarkably rapid and far-reaching structural transformation is taking place as the private sector restructures health care financing and delivery through vertical integration and capitated managed care. This may be happening with even less public understanding and meaningful debate than the Clinton plan called forth.

At the same time, the profession of medicine is adrift and demoralized, sensing that doctors individually, and the profession collectively, are losing control over the conditions of medical practice. Much as Paul Starr predicted in *The Social Transformation of American Medicine* (1982), the medical profession is beginning to succumb to the process that sociologists refer to as "proletarianization," that is, doctors are better understood as sellers of their labor in a so-called labor market (like other workers and occupations) than as autonomous professionals dedicated to an ancient tradition and to a special ethical calling. The same could be said about other professions in America today; medicine has simply been the last and most powerful profession to see its hegemony challenged.

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These trends are disturbing. We believe the confusion over health policy and the crisis of professionalism in medicine are linked: they flow from the same source. Health reform debate is confused because those engaged in that debate–political leaders, special interest groups, the citizenry at large–literally do not know what they are talking and arguing about. These are fairly sweeping

claims, and we obviously do not mean to deny the expertise and enormous body of data and information at the disposal of both health policy makers and health care professionals. The confusion in the discourse surrounding American medicine today exists because we have not addressed the question of what health care is and what it should be. What kind of human activity is it fundamentally? How does it fit into other forms of life and other practices that make up the fabric of our society and culture? What is the most coherent and normatively appropriate way of characterizing health care?

The problem with questions such as these is not that they are vague and unanswerable, but that they are answered tacitly and through acquiescence or presupposition rather than openly and critically. Confusion comes from the fact that culturally and historically, American medicine is undergoing a significant shift in what we understand the fundamental nature and purpose of health care to be. We are straining to adjust older conceptions to emerging institutional and economic realities: torn between competing ways of understanding health care; daunted by the prospect of bringing into the open assumptions and conceptions normally at work beneath the surface.

This presents both a challenge and an opportunity for the field of bioethics in the coming years. Bioethics performs few social or intellectual functions more important than that of critically analyzing our presuppositions about the nature of health care that shape public discourse, policy approaches, and institutional practices. To do this, however, bioethicists may have to concentrate on more than simply "ethics." They may also need to examine the *philosophy* of medicine and the social and cultural underpinnings of medicine's goals.

In the past, bioethics has been reactive and ameliorative rather than fundamental and critical. Bioethicists have responded to issues and dilemmas that were artifacts of biomedical technology and fee-for-service, sub-specialized medicine. Bioethicists have rarely questioned the institutional structures that were background and context for ethical dilemmas resulting from competing moral principles. Bioethics also has lent an important voice in support of human rights and patients' rights. But rarely has it examined the implications of undermining professional discretion in medicine, assuming that if doctors didn't have power, then patients would have it. It is only now becoming clear to bioethicists that empowerment of patients does not necessarily follow from disempowerment of physicians.

The Idea of a Commodity

How do we now focus and sharpen our understanding of the fundamental nature of health care? What is it exactly that our society is attempting to organize (or reorganize) when governmental and corporate leaders restructure the "health care system"? If we can't answer this question, how can we tell whether our leaders are doing a good job? And what are doctors and other health professionals doing when they deliver "health care" to patients? If we can't answer this question, then how can we tell the difference between taking away arbitrary power from physicians that society ought not grant them, versus destroying a moral identity and calling in medicine that society ought to protect and preserve?

As we have said, the dominant way of conceptualizing health care in policy and even in bioethics discussions today is to see it as a commodity. To conceive of any good or service as a "commodity" involves three constitutive ideas: (1) commodities exist in exchange relationships; (2) the value of commodities and exchange relationships is instrumental; and (3) commodities can only be privately or individually consumed.

A commodity is something that is traded or exchanged between distinct parties whose relationship is created by the exchange. Commodities don't exist apart from distinct relationships based on exchange; and, conversely, exchange relationships don't exist unless and until the objects or services involved in the transaction are understood as commodities. Commodities are not the same as gifts and they are not the same as acts

of love, fealty, honor, or service. We note these distinctions because these terms are appropriate in different kinds of contexts and relationships. Commodities are thus what philosophers have called "institutional facts." That is, they are potent social realities and not just illusions, but they only make sense within a particular social context. To ask if health care should be seen as a commodity is to ask, in part, whether we want the dominant relationship in health care giving to be an exchange relationship between providers and consumers. Is that really all there is or should be to the relationship between physicians and patients. Or between health care givers and citizens?

Moreover, in commodity exchange, both the good or service exchanged and the exchange relationship itself are of only instrumental value to the parties involved. They are means to an end. The provider is interested only in the relationship with the consumer insofar as the consumer has something of value to the provider (usually money). The consumer is interested in the relationship only because it is a means to gain access to the commodity or service he wants or needs. The interests, wants, and needs of both parties exist prior to the relationship and the commodity exchange. They are instrumentally served (or not) by the relationship, and they will persist through time to create the need for future exchange relationships of the same type. In other words, the exchange relationship is something extrinsic to the self — one passes through it, uses it as a means to some other end, and then moves on. Again, to ask if the commodity conception is appropriate for health care is to ask if health caring as a practice or as a human activity is adequately described as an extrinsic and instrumental relationship of this kind.

Third, the notion of a commodity carries with it the notion of private consumption. By that we mean that commodities are not simply used, they are used up. Commodities exist to be consumed, to be individualistically appropriated. To the extent that one person consumes a commodity, someone else cannot. The concept of a commodity fits naturally in a situation of natural or artificial scarcity where resources are to be broken into discrete units and distributed across the members of a group or population for consumption. A commodity is something that ceases to exist as it is consumed.

Health Care as Public Work

The conception of public work or civic practice contrasts with the concept of commodity on each of these three points. Public work and commodity are different lenses for viewing the activities of healing and caring. But then again, the metaphor of a lens is too passive and static; it does not capture the dynamic, constitutive quality of these conceptions. Better to say that these conceptions are alternative interpretations of practices that have the cultural power to transform the practices they interpret. As we convince ourselves that medicine is a commodity, it will eventually turn it into a commodity because it will elicit the cultural and social responses that commodities typically elicit. A knight is a knight in chess because competent players move and counter it like a knight. A verb is a verb in a natural language because competent speakers use it grammatically like a verb; a noun becomes a verb when it is treated like a verb. (To be "tasked" with a task, tasks us.) The same dynamic of transformation can apply to the notion of medicine as public work as well. Caring can be a public work if we make it so. This is not about naming or labeling; it is about ways of living and ways of world making.

The distinction we wish to draw can be introduced by an example. Consider something that typically would be understood as a commodity, and conversely something that most definitely would not. A bag of cookies that one divides among a group of eager children contains commodities—the more one child gets, the less another will get. The relationship the cookies have created among the children (and the adult dispensing them) will cease to exist as the cookies disappear. When they are gone, the children will cease being consumers and go back to being playmates.

By contrast, how should the sacramental

wafers and wine used in Christian churches at Holy Communion be understood? Communion is one of the major liturgies in the Christian tradition, and liturgy (Gr. *laos*-people + *ergon*-work) means the work of the people. This is not the place to discuss the theological doctrine of transubstantiation. However, considering only the material reality of the wafers and wine and what they symbolize in the liturgy (the public work) of the church, they are not commodities; and it would be fundamentally misleading, theologically and sociologically, to think of them as such (Price and Weil 1979). What they symbolize and what they are believed to do in and through the community of people who share them, is just the opposite of the three notions associated with the concept of a commodity.

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First, the Eucharist does not create exchange relationships among the people taking part or an exchange relationship with God. It is a mutual sharing in and a joining with a larger dimension of being than any of the participants, acting alone and without the liturgy, could attain to by themselves.

Second, it is not an instrumental transaction or relationship; its purpose and value are not defined in terms of the satisfaction of preferences or a *quid pro quo.* One is not "buying" forgiveness when one takes part in the liturgy, and neither God nor the church is "selling" anything.

Third, while the material supply of wafers and wine might conceivably be used up, what is really being shared and dispensed in the Eucharist (call it love, grace, forgiveness, or redemption) cannot be. Its abundance is not diminished incrementally by each communicant because that abundance is not consumed. Indeed, it grows the more it is shared.

Now, to be sure, this liturgical example is tendentious in the sense that it draws from a centuries-old religious tradition that places it in the sharpest contrast to the modern notion of commodity and economic exchange. Nonetheless, there remain secular practices that resemble more closely the liturgical understanding of sharing, community, and relationship than they do the commodity conception. These are the secular practices that are called civic practices or public works.

Public works establish relationships among individuals that are not transactional or consumptive but involve a cooperative and participatory effort to *produce* something of common value. This value is not appropriated exclusively by one of the parties to its creation, no one is simply a "provider" or a "consumer," and the value is realized by communities as much as by individuals. In fact, a "community" is nothing more nor less than a fabric of relationships formed by public work. That is why it is appropriate to call them *public* or *civic* works. Moreover, these cooperative practices are productive, not exchange, activities, and they require intentional, intelligent effort on the part of all those involved in order to produce something of public value or significance. Therefore it is appropriate to call them public work (Dietz 1994).

In health care, examples of these facets of public work are more widely manifest than simply in the area traditionally known as "public health," where the collective goods of controlling infectious disease and eliminating environmental sources of illness are central goals. Of course, these traditional functions of public health are instances of important public work, as are the more recent

public health strategies in response to infections, such as HIV and STDs, that can only be controlled by modifying individual behavioral risk factors (Beauchamp 1988). Beyond public health, though, the dimensions of public work we have in mind also extend into areas of primary and preventive medicine, where maintaining wellness enhances the quality of life of both individuals and entire communities. Chronic and long-term care are also primarily public works since the main purpose is not the technical one of curing disease or eliminating biologic dysfunction, but rather the shared enterprise of rehabilitation, making a new life lived with and in spite of the chronic disabling or debilitating condition (Jennings et al. 1988; Jennings 1993).

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What kind of communities will we have in an aging society if we forget the ways in which mutual vulnerability and dependency can bring us together rather than drive us apart? If aging and disability are treated as "enemies" and "stigmas" only, then the commodity counter of medicine will never be able to provide us with enough ammunition to fight them off. Dependency and limitations can also be symbols of a common fate and a shared mortal humanity; rising to their moral challenge is public work of the most significant kind. A metaphor for medicine and health care that obscures these moral and human realities is worse than philosophically inadequate; it is socially pernicious. We maintain that the commodity conception is dangerous in exactly this way.

Asking the Right Moral Questions

Which model best addresses the things we want to say about health care and medical practice? The commodity conception certainly fits the mainstream framework of today's public policy debates. Health care is routinely characterized as a marketplace good, subject to economic valuations, utility calculations, and the market and regulatory mechanisms of commodity exchange. Individual consumers (rather than patients) are viewed in relation to health care providers (rather than to physicians or care givers). Within this framework, consumers think of health care in terms of economic free choice, product quality, and individual entitlement. Ethically, this conceptualization has focused attention on distributive justice—emphasizing fair procedures and outcomes, resource utilization and allocation, and financial incentives.

Viewing health care as a commodity, however, blinds one to what is distinctive ethically about organized medical response to illness in a social context and to the practice of caring in a community. Providing care for another person is taking part in a shared endeavor, one that would not be possible without drawing upon broader resources. These include the technological, educational, and infrastructural resources of the society, certainly, but also the cultural and symbolic resources of the community that invest healing and caregiving activities with meaning. In this sense, giving and receiving care are no more private or individualistic than playing in a symphony orchestra or running for elective office. The sick rely upon a community that offers—through medicine—caring, healing, dignity, and the assurance that they have not been excluded. This is more than pain relief, more than the application of technology to treat pathologies. While this point is understood in Europe, we have difficulty grasping it in the United States. This, more than details of financing, is what distinguishes our health care system from theirs.

When viewed as secular liturgy or public work, health care represents a commitment of the healthy to care for the sick. The political and moral

will to support such a public work comes about not simply because people fear they one day may be sick, but because they sense their human connection to others. We engage in public works because we are a part of one another. Untreated disease, uncompensated disability, and untended suffering in a community diminishes not only the individuals who suffer, but the community as a whole. According to this view, health is a state of individual and communal wellness and well-being, a state attained both through actions one takes in life and through relationships, structures, and communal fabric that connect people. Unlike the commodity conception, the public work conception makes it impossible to be healthy (or sick) all by yourself. We can only be healthy or sick together. This conception is vital for acute care, but even more important for the coming realities of an aging society: chronic illness and long-term care. Thus, when individuals are healed the entire community partakes in that healing.

The relationship between caregiver and patient is a response to human needs that extends beyond the individuals involved. It nurtures morally significant ties between those who suffer illnesses and those who care for them. This relationship has an impact on the health of the entire community as it carries out the hard work of healing (making whole)—both morally and physically—those who share in it.

Heading Health Care Reform Off at the Impasse

The Clinton administration's efforts to reform the United States health care system attempted to change the way American health care is financed and delivered. It expressed a social commitment to provide universal access to health care. Moral dimensions of the issue were not ignored. Hillary Rodham Clinton's health care reform task force included an ethics working group, assigned the task of articulating moral principles to inform the new health care system.

These principles were carefully thought out, intended to describe the ethical properties of the system the Health Security Act was aiming for (White House Domestic Policy Council 1993; Brock and Daniels 1994). However, they were simply tacked onto a system built upon the notion of managed competition within a global budget. This system presupposed the commodity conception of health care. Clinton's reformers never seriously attempted to articulate alternatives. Consequently, bioethics was put in the position of devising a normative framework for evaluating alternative distributive schemes within a commodity-based system. Here bioethics became a servant of the commodity conception rather than its critic. The question of whether or not the American people wanted to start from an economist's vision of health care as a commodity never was posed.

The Clinton plan was a mixed system that relied upon a combination of market mechanisms and government regulatory systems to deliver health care. Universal coverage was to be achieved through mandates upon employers to provide care through contracts with regional health care alliances. These alliances would have introduced price controls and some consumer choices through competition for provision of attractive and affordable benefit packages. The government also would have provided subsidies for small businesses, coverage for the unemployed, and continuation of Medicare. Although this mixture of government and private sector mechanisms seemed to mean less government control and restriction of choice than single-payer options, it nevertheless relied upon new regulatory institutions, mandates on business, and government controls on spending.

The Health Security Act perished in Congress during the summer of 1994. The Republican victory in November meant an end to comprehensive health reform via federal legislation for the foreseeable future. Reasons for the failure of the Clinton plan were many. The plan involved complex, new institutions untried elsewhere. Employer mandates were perceived as a threat by small business owners, and spurred fear of increased unemployment. Health care budget caps invoked fears of waiting periods and limits on

treatment availability. Proponents and critics alike concede that mistakes were made in the political handling of the plan, from secrecy of the task force to delivery of a 1,342–page proposal to Congress. The plan's breadth and complexity made it a target for interest groups that opposed any part. In the end, interest group politics succeeded in convincing people that they would end up paying more for less.

When public revolutions fail, private revolutions often arise to respond both to the need for, and to the fear of, social change. The private revolution in American medicine is comprised of financing through capitated fees and pre-paid group practice, and increased control by payors of patient access to providers and services.

Managed care has become a major focus of attention in bioethics. Too often it is assumed that managed care is synonymous with treating health care as a commodity. This need not be the case. Managed care, as one way of organizing health care financing and delivery is compatible with understanding and valuing health care as public work. If we set priorities and goals for medicine in these terms, bioethicists would have something constructive to say about the organization of managed care institutions. The purchasing power and economies of scale of large organizations could be coupled with HMOs dedicated to comprehensive care and rooted in the communities they serve. "Publics" need not always be defined geographically; communities of shared risk and coverage form new publics with common interests, and these mini-publics are what HMO and point-of-service managed care plans create. We have not yet treated them as publics with work of their own to do; we have treated them as individual consumers. We shouldn't conclude that it has to be this way, however, until we have tried to make it otherwise. Moving from the individualism of the fee-for-service, the indemnity insurance environment poses civic opportunities as well as civic dangers.

It is too early to judge the effects of private managed care. Further change will be needed to alleviate the economic burdens that continued growth in the health care sector will lay on the overall economy. But what these recent reform attempts do indicate is that taking the commodity conception for granted as the presupposed starting point for all reform proposals does not work. It does not engage the full range of concerns that people have about the place of health care in communities and in their lives. Americans care about efficiency and cost in health care, but that is not all Americans care about. The evolution of managed care will have to rely on both conceptions of health care to be at least sustainable and satisfying.

We believe that the fundamental questions about health care that philosophical integrity, moral responsibility, and political prudence compel us to ask are best facilitated by the civic conception. These are not too esoteric or technical to be addressed by bioethicists as civic discourse, broadly conceived. It is the civic questions that people listened for, but did not hear, in 1994. They are still waiting and if these questions are posed by our society's leadership and by the medical profession, people at the grass-roots level will engage and respond. It is in communities, after all, where people actually do get sick and get well, where they care and are cared for.

The moral future of American medicine will depend, we are convinced, not on how clever we are at efficiently managing and distributing health care as a commodity, but on how creatively medicine and health care institutions can reclaim and exercise their civic imagination. It will depend on how ably they can carry out the essential public work of creating communities through healing diseases, compensating for disabilities, and promoting the health of the individuals who compose them.

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