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EDITORIAL

The business of care

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In his recent book *What money can't buy* Harvard philosopher Michael Sandel examines the role of markets in contemporary democratic society. With the current financial crisis the era of market triumphalism initiated by Reagan and Thatcher has ended with devastation for many. But over the last few decades it has expanded into all domains of public life. We now have for-profit education, healthcare, procreation, security, and environmental protection. The problem with a society in which everything is for sale is twofold: inequality and corruption. These are the two prevailing problems of our times, according to Sandel. With the eclipse of the public domain our society has essentially become a market society. Market values are now ubiquitous in all spheres of life. Sandel argues that we need to rethink the role of markets in human relationships and social practices, in order to articulate the moral limits of market (Sandel 2012).

Initially it was assumed that the free market would provide the ideal context for autonomous individuals who wish to select the best option for healthcare according to their value preferences. For example, the Cato Institute, an American right-wing think tank, argued in 1992 that there are only two ways to solve the crisis of the American health care system: empowering patients so that they can pursue their interests without government bureaucracy, and creating competitive markets in health care (Goodman and Musgrave 1992). Similar arguments have been used by policymakers in many other countries. One example is the Dutch healthcare system that was traditionally based on solidarity and basic public insurance. Since 2006 this system has been transformed into a market-driven system with managed competition between private insurance companies. In accordance with the market ideology it was argued that creating a healthcare market would increase efficiency and decrease costs, provide more freedom of choice to patients, and enhance quality of care. In practice, healthcare expenditures in the Netherlands have skyrocketed since then. With 14.9 percent of the GNP, the country now has the second highest healthcare expenditures in Europe, only topped by Switzerland that has also 'marketized' its healthcare system. Together with the U.S. (17.5 % of GNP) these are now the most expensive healthcare systems in the world (Ten Have et al. 2013: 160 ff). Economists have warned for a long time that the market is not efficient (Stiglitz 2012). Another potential advantage is patient power; but in the practice of the health care industry it is rather limited. With the introduction of the market in healthcare, having insurance is mandatory; one can only choose between different insurance companies. Government as well as insurance companies determine what will be provided. Information concerning insurance packages is highly complicated. In principle, one is free to contact any physician or health facility but in practice the insurance company has made deals with specific health providers. For example in Pittsburgh, the two major insurance companies own most of the health facilities and physician practices. Of course, one is free to visit a medical service that is not affiliated with a specific company; however this might result in an invoice that is seven times more expensive.

The quality argument in favor of creating a healthcare market is even more disputed. In a recent report of the Institute of Medicine an expert panel concluded with surprise that although Americans spend more per person on healthcare than other countries, they live shorter lives and experience more injuries and illnesses than people in other high-income countries (Woolf and Aron 2013). In 27

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countries life expectancy at birth is higher than in the United States. This health disadvantage is not solely due to the inadequate health care 'system' that is often difficult to access for lower income and less educated people. The disadvantage is not confined to socially and economically disadvantaged groups. The problem is more systemic. Even white, insured, college-educated Americans have an inferior health status compared to their peers in Europe. The panel struggled to explain this health disadvantage. Health care is fragmented, a large population is uninsured, the rate of poverty and income inequality is high, the environment is unhealthy, more calories, and prescription and illicit drugs are consumed (Woolf and Aron 2013). Such explanations reflect decades of underinvestment in education, research and infrastructure. Very timidly the panel is asking the question: might certain aspects of life in modern America be part of the explanation? Other countries have a strong societal commitment to the health and welfare of the entire population. Perhaps 'underlying societal factors' may contribute to the problem? But this is as far as the panel wishes to go. It does not want to blame the 'system' and certainly not the fact that healthcare has become a business. Doing so would invoke the blame of 'socialism' and 'European muddling through'.

What is at stake, now more than ever, is the nature of care. This is the focal point of several contributions to this issue of the journal. In her third article on moral attitudes, Petra Gelhaus now analyses the concept of care. Distinguishing virtues from attitudes, she argues that care implies an attitude as well as an activity. The appropriate background for the attitude of care is compassion. The activity of caring requires responsibility, a practical response to the patient's need. The ethics of care introduces us to a framework of values that is completely different from the discourse of the free market (Gelhaus 2013).

This point is underlined and elaborated in the contribution of Charlotte Delmar, though in a slightly different manner. The market discourse justifies itself arguing that it is the best, most efficient way to gratify human needs empowering individuals to follow their own interests and values. However, as Delmar shows, 'being a person with an illness' is no longer associated with the language of power and needs, but brings in phenomena such as hope, doubt, powerlessness, and despair. Patients periodically swing between self-control and loss of control. In a caring relationship trust, respect and mutuality are more basic than autonomy and choice (Charlotte 2013).

The market is furthermore a central theme in the article of Kristin Solum et al. (2013). They tested through focus groups the views of lay persons concerning commercialization in the field of biobanking. Buying and selling of human bodies and body parts is prohibited in the overwhelming majority of countries. This is clearly reflected in the focus groups. Introducing market forces in the sphere of donating human biological materials is strongly rejected by Norwegian lay people. They generally regard it as violation of human dignity. The authors find less resistance against commercial use of already donated materials in a biobank. The focus groups associated this use more with concerns for justice, not dignity. For the authors this implies that regulation rather than prohibition is required. They pessimistically assume that the market is a given.

This is how we currently tend to organize developments in medical practice and research; alternative strategies are not seen as viable options. This conclusion, however, affirms the ideology of market thinking. Market systems are not untouchable; they can be changed and make to work to the benefit of citizens. Although market forces have created growing inequality, government policies have shaped those market forces. The role of political processes therefore has to be re-emphasized. This is what Stiglitz argues in his latest book: markets "are shaped by laws, regulations, and institutions" (Stiglitz 2012, 52). Social norms and institutions should be focused on the common good, on human dignity and justice, instead of on the interests of the relatively few.

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