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A WARRANT FOR PAIN: CAVEAT EMPTOR VS. THE DUTY OF CARE IN AMERICAN MEDICINE, C. 1970-2010

Avner Offer

A Warrant for Pain: *Caveat Emptor* vs. the Duty of Care in American Medicine, c. 1970-2010[1]

Avner Offer

avner.offer@all-souls.ox.ac.uk

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Abstract

Bad ethics can make for bad economic outcomes. Bad ethics are defined hedonically as the infliction of pain on others for private advantage. The infliction of pain is often justified by 'Just World Theories', which state that everyone gets what they deserve. Market liberalism (and its theoretical underpinning in neoclassical economics) is one theory of this kind. As an example, the micro and macro underperformance of the American health system c. 1970-2010 is explained in terms of the shift in policy norms from the fiduciary norm "first do no harm" to the neo-liberal market norm of "let the buyer beware" (*caveat emptor*) since the 1970s.

[1] A companion piece to follow Offer, 'Self-Interest, Sympathy and the Invisible Hand '.

The doctrines of economics are indifferent to ethics. This may be disquieting, but it is not easy to pin down what might be wrong about it, and to show that it is harmful. The unfolding financial crisis has left a sense of moral unease, a concern that ethical transgression might be undermining the orderly working of markets. The drift of the American health care system towards market norms, described below, shows more clearly how bad ethics can lead to inferior economic outcomes.

I

Ethics aspires to the Good, but the Good is not easy to identify. Plausible arguments are made for principles which are incompatible with each other. Both Freedom and Justice are compelling, for example, but the two principles are not easy to reconcile. A concept from social psychology may help: it is 'Just World Theory'.[2] The basic idea is simple: a 'Just World Theory' says that everyone gets what they deserve. If the Inquisition burned heretics, that was only what they deserved. If Kulaks were starved and exiled in Soviet Russia, they only got what they deserved. Likewise the Nazis and the Jews. Just World Theories are ubiquitous. The criteria are political, religious, ethnic, gendered, and cultural. They justify the infliction of pain. Classical Liberalism is also a 'Just-World Theory' of this kind. Milton Friedman wrote, 'The ethical principle that would directly justify the distribution of income in a free market society is, "To each according to what he and the instruments he owns produces."' In other words, everyone gets what they deserve.[3] The norm of individual freedom justifies the inequalities of market society.

If there cannot be agreement about the Good, perhaps some can be reached over the Bad? To achieve broad consent, the Bad needs to be defined tightly. One

[2] Rubin and Peplau, 'Who Believes in a Just World?'; Lerner and Miller, 'Just World Research and Attribution Process'; Lerner, *The Belief in a Just World*. In social psychology the 'theory' is informal and attributed to individuals. Here it is applied to social and political doctrines.
[3] Friedman, *Capitalism and Freedom*, 161-2..

such approach would be a narrowly hedonic one that focused exclusively on the harms of pain and death. Physical pain is not good. It provides a warning signal, but otherwise there is little to be said for it. Likewise death is sometimes sought out by individuals for themselves as being the lesser Bad, but has few other mitigations.

I propose an ethical criterion of 'Warranted Pain'. The criterion is: 'No infliction of unwarranted pain or death'. Who would wish to argue the opposite? The infliction of pain or even death is not forbidden by this criterion, but it requires a satisfactory warrant. Pain or death need to be justified. That focuses the argument onto the quality of the warrant. What benefits can justify the infliction of pain or death? How much good can it deliver, and to whom? The principle is not absolute: but it narrows the scope for disagreement. And once the warrant is on the table, we can reach for our ethical intuitions.

For example for the purpose of cost-benefit analysis of regulation, a life is evaluated at about $6 million. This figure is normally arrived at by capitalising the premium required for risky occupations, where the risks are known. If the cost of a protective measure is more than $6 million per life saved, then it will not be implemented. This may be a warrant for somebody's death. But is it a good warrant? To begin with, it assumes identical risk preferences, but the vast majority of workers actually turn down the deals on which this figure is based. Those who accept them are likely to be atypical, both in their appetite for risk, and their economic circumstances. So their lives may be undervalued. The second point is that this figure is not the value of a particular life, but a costing of the risk. It would be the aggregate of 6 million people paying a dollar each to avoid a 1/6-millionth chance of death. People are paid a premium to take on a risk, not to die. A single, particular life is unpriceable. You cannot pay somebody $6 million dollars for permission to kill them. Furthermore, in a

market economy, those who take on the risk, rarely get the benefits. If the repeal of a costly regulation benefits 'the economy', those exposed to the risk are worse off, and those who were previously regulated are better off. Not society 'as a whole'.

The corporate demand for relief from regulation increases death and injury for workers.[4] How much pain and death does laissez-faire warrant? And the gain goes whom? Instead of the supposed value of market and individual freedoms, we can focus on more precise metrics: does privatisation actually increases productivity, who stands to benefit, and can the gain for shareholders and managers justify disease and death for consumers and workers? If the price of competition is inequality, are the benefits worth an expanding gap in life expectation, even if on average, all classes benefit? Or if more gain at the bottom could be had for less at the top? And what if only a few benefit? And if productivity does not actually increase?

There is no simple algorithm for such questions, so this is the point where ethical intuitions can enter. Agreement may still be elusive, but the issues and metrics provide a sharper focus, and show how to make and defend an ethical judgement. In policy, the criterion of warranted pain implies that a bad ethical call has a cost in the currencies of pain and death. And if economic output is all you care for, then pain and death, even of others (as we shall see), can diminish productivity and welfare. The criterion appears to be narrow, but it can do a lot with a little, not only in ethics, but also in policy.

In science, the test of a theory is what grounds it gives for belief ('justification'). A rough and ready test is how well the model fits with experienced reality. When used to derive policy, an economic model not only describes the world, but aspires to change it. For example, the market-liberal model of 'rational

[4] Tombs and Whyte, *Regulatory Surrender: Death, Injury and the Non-enforcement of Law*.

expectations' implies that benign government interventions will be anticipated and thwarted, and are therefore futile. If the model is wrong however, then a policy of non-intervention can well be harmful. In policy, if the model is bad, then reality has to be forcibly aligned with with it by means of coercion. How much coercion is actually used provides a rough measure of a model's validity.

Coercion is a feature of societies that rest on strong Just World doctrines. Such societies have resorted to witch-hunts, secret police, concentration camps and worse. Classical liberalism and its offspring, neo-classical economics, are also such Just World Theories. They accept as legitimate any existing endowments and property rights, and they endorse the market distribution of final rewards. Market-liberal societies make Just-World claims, and also inflict a great deal of coercion, pain, and death. The United States is the most market-oriented of affluent societies, and also leads the developed world, and much of the rest, in the size and severity of its penal system. It continues to inflict the death penalty. It denies secure healthcare to one-sixth of its population, and tolerates hundreds of millions of firearms in private possession. It has troops all over the globe, and uses them readily. It leads the developed world in the proportion of supervisory and coercive 'guard labour'.[5] More than a million people have been killed by guns in the United States since 1968, and more than two million were in prison at any one time during the last decade. How much pain is warranted has been discussed literally with regard to the torture of terrorist suspects, in both the USA and apparently in the UK, and some of it has been found to be acceptable.[6] All this without considering pervasive incidence of poverty, hunger, illness, and early death arising at the lower end of society as a consequence of labour market inequalities and social neglect. Lower income people even suffer pain

[5] Bowles and Jayadev, 'The Enforcement-Equality Trade-Off'.

[6] Cole, 'They did Authorize Torture, but...'

more frequently than those of higher income.[7] These costs can be measured against the tangible and intangible benefits of 'economic freedom', such as they are, and such as it is.

II

The abstractions of ethics come to life in the recent record of health care in the United States. Some ill-health is unavoidable. It exposes everyone to suffering and ultimately to death. Ill-health is a state of dependence on the knowledge and goodwill of others. The entitlements of patients are affected by an enduring tension, between two principles which are as old as economics, on the one side, the individualist principle of 'me-first', on the other the social norm of looking after those who cannot fend for themselves.[8] If the baker serves up stale bread, we may be able to go elsewhere. But the patient cannot be sure how well she is being treated. Her suffering is an urgent matter, while for the doctor, however compassionate, it is all in a day's work. The nurse and the doctor have vital knowledge which is too extensive to convey to the patient. When it comes to payment, the patient's predicament means that doctors can drive a hard bargain. Even a patient who is robustly self-centred himself, does not like to think that those who treat him are in it only for themselves. Nor would any healer wish to convey that impression. But the patient cannot rely entirely on compassion. He hopes that the doctor is also mentally disciplined and morally robust, that she has a sense of duty to the patient and to scientific truth, that she was licensed by impartial assessors, and that the knowledge she uses has been validated by disinterested experts.[9]

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[77] Krueger and Stone, 'Assessment of Pain'; Stone et al., 'The Socioeconomic Gradient'.
[8] Offer, 'Self-interest, Sympathy and the Invisible Hand'; Force, *Self Interest before Adam Smith*.
[9] The doctor is female and the patient male for clarity of exposition.

In his *Theory of Moral Sentiments* Adam Smith's describes the mechanism of ethical validation. The 'impartial spectator' (an inner voice of conscience) is driven by the desire for social approbation, to 'do the right thing'.[10] Even if the doctor cares but little for any particular patient, we trust that she is disciplined by the judgement of her peers. The norm of impartial sympathy is codified as a fiduciary duty, a duty of care, whose first principle is 'do no harm'. Obligations are spelled out in professional codes of practice, backed by the sanction of exclusion, and enforced by the state. These codes can be taken to formalise the norms that the impartial spectator would have us internalise. They restrict the room for discretion, and commit practitioners to the client's interest.[11]

The ethical code of practice binds the profession to refrain from abusing power. The commitment to do no harm has made it easier for society to grant a monopoly of medical practice to certified doctors.[12] Another token of this deal is tax-exempt status for medical schools and teaching hospitals. In return for this power, the healing professions used to promise, implicitly, not to abuse it: 'The organizational culture of medicine used to be dominated by the ideal of professionalism and voluntarism, which softened the underlying acquisitive activity.'[13] The deal with the state assumes that both sides are acting in good faith. The provider takes responsibility for the treatment and for its consequences.

Market liberals do not believe in the good faith of either doctors or the state. Their solution to the problem of unequal power is to 'let the buyer beware' (*caveat emptor*). The duty of care is laid on the patient, with little regard for his ignorance of the relevant information. The standard assumption in market liberalism is that people

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[10] Offer, 'Self-interest, Sympathy and the Invisible Hand'.
[11] Rayner, 'Integrity in Surgical Life'.
[12] Arrow, 'Uncertainty and the Welfare Economics of Medical Care'.
[13] Starr, *Social Transformation of American Medicine*, 448.

are well-informed, and they are at fault if they are not (in the extreme Chicago version, they know everything at no cost). The vendor has a duty only to himself. It is the credo of the strong. As for the others, let the buyer beware.

American anti-trust legislation began in the late 19th century in order to bring more fairness into market competition, as an aspect of the broader Progressive movement. But market advocates after the Second World War (a different group, and hostile to the historical Progressives) cared little about monopoly.[14] Chicago economists are averse to anti-trust.[15] As a rule, however, their partiality to market power does not extend to workers.[16] The Chicago argument is that corporate monopolies, unlike unions, can be challenged by new entrants. The licensing monopoly of the medical profession has also attracted the ire of Chicago. Milton Friedman advocated free entry into medical practice, with the onus of diligence transferred to the patients.[17] These views gained currency with the rise of market liberal influence during the 1970s. In *Goldfarb* vs. *Virginia State Bar* (1975), the United States Supreme Court handed down a judgment that the ethical codes of professional associations were not immune to anti-trust. The case concerned the legal profession, but doctors embraced it too, and their associations accordingly relaxed the anti-competitive elements in their codes.[18] Fees were quick to follow: American doctors are the best paid in the world by far.[19] Competition was not enhanced: the medical professions continued to control education, certification, standards, and

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[14] Van Horn, 'Reinventing Monopoly and the Role of Corporations'; Bork, *The Antitrust Paradox*.

[15] Pitofsky, *How the Chicago School Overshot the* Mark; White, 'The Growing Influence of Economics and Economists on Antitrust'. Henry Simons was the last major Chicago economist to advocate anti-trust.

[16] Friedman, *Capitalism and Freedom*, ch. 8.

[17] Friedman, *Capitalism and Freedom*, ch. 9.

[18] Relman, 'What Market Values Are Doing to Medicine'; Relman, *A Second Opinion: Rescuing America's Health Care* , ch. 1.

[19] Laugesen and Glied, 'Higher Fees Paid to US Physicians Drive Higher Spending for Physician Services'.

numbers. But the duty of care was relaxed. Pricing power was given to impersonal commercial entities, insurance companies that only acted, as Friedman has advocated, in their own interest. In a market where prices are set by corporations, there is little room for obligation or a duty of care. At the point of contact with the patient, however, the unpriceability of human life kicks in, but provides an incentive for indulgent and sometimes futile overtreatment.[20] Doctors and hospitals had financial incentives to treat expansively with little regard for cost. The insurance company's incentive was to maximise net revenue. Unlike the doctors, however, insurance providers retained their immunity from anti-trust, and many of them came to dominate their territories.[21] In consequence, healthcare providers increasingly charged as much as the patient could bear, and often more than that.

III

Increasingly, knowledge in healthcare is embodied in drugs and other medical technology. Doctors have to take drug value on trust, but the vendors have no other duty than to maximise their profits. Drug making is among the most profitable industries in the United States. By the end of the 1990s the ten Fortune 500 drug companies had profits about four times as high as the median corporation, and between 2006 and 2009 the industry was typically the second or third most profitable one in the USA, with profits at between 16 and 19 percent of revenues.[22] This was not the work of the invisible hand, but of monopoly patents. Drug prices are much higher in the United States, with its policy norm of 'free markets', than in the variously socialised medical systems of other countries. When the United States Senate created a Medicare drug benefit for seniors, it specified that the government would not use its

[20] Gawande, 'Letting Go'.

[21] American Medical Association, *Competition in Health Insurance*.

[22] Public Citizen's Congress Watch, *2002 Drug Industry Profits*, fig. 5; CNN Money and *Fortune*, Fortune 500, 'Top Industries: Most Profitable', 2006-2009. It was fifth in 2006.

buying power to negotiate prices. Such was the political heft of Big Pharma. In the recent Congressional debates on healthcare in the United States, the statements of more than a dozen lawmakers were ghost written, in whole or in part, by lobbyists working for Genentech, a large biotechnology company. One statement was prepared for Democrats and another for Republicans. The company, a subsidiary of the Swiss company Roche, estimated that forty-two house members used some of its talking points. Several different statements in the *Congressional Record* matched each other word for word. The boilerplate that appears in the *Congressional Record* even included some conversational touches, as if actually delivered on the congressional floor. A lobbyist close to the company said 'this happens all the time. There's nothing nefarious about it.' [23] One Senator, who has acted successfully to protect health-additive companies from scrutiny of general health claims (of the sort made by patent medicines) has been richly rewarded with financial contributions. [24]

In the United States, drug companies deploy consumer advertising to nudge patients into asking for particular drugs, and also perhaps to reassure the doctors.[25] But this reassurance is often misplaced. A top medical journal editor has written, 'Caveat emptor' may be a reasonable approach for many consumer products, but not for prescription drugs'.[26] Expensive prescription drugs are often little or no better than generic ones, or than over-the-counter remedies. The rheumatism painkiller Vioxx had few clear advantages over aspirin, but made profits for its producer Merck. Evidence began to emerge that it raised the risk of stroke and heart disease. When the

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[23] Pear, 'In House, Many Spoke With One Voice: Lobbyists'.
[24] Lipton, 'Support Is Mutual for Senator and Makers of Supplements'.
[25] Hightower, 'The Great American Medicine Show'.
[26] Angell, 'Your Dangerous Drugstore', 7.

company became aware of those risks, it did not rush to disclose them, and fought to prevent the drug from being banned.[27]

The approval procedure administered by the Federal Drug Administration (FDA) in the United States is no longer slow and thorough, and provides only a flimsy defence for patients. Since the early 1990s, the FDA has been half-funded by drug company 'user fees'.[28] It evaluates drugs partly on the basis of tests submitted to it by the producers. Experts with financial ties to the companies sit on drug approval boards, where it is not uncommon for them to be in the majority. They can look forward to consultancy and speaking fees. The trials are often poorly designed, and investigators frequently fail to report their links with the industry.[29] The figures are dressed up to favour the drugs, and trials are often carried out by investigators with a financial interest in the outcome. Some of the tests are even fraudulent. The standard of efficacy required is low: merely better than placebo. Negative findings tend to be suppressed, and approval not always retracted. The majority of new drugs are variations on old ones, and the industry produces a regular flow of products that are unsafe and ineffective.[30] The drug companies have teams of ghostwriters who write up the research for publication under the names of academic investigators. A study found that 10.9 percent of articles in the *New England Journal of Medicine* were ghost written in this way, 7.9 percent of articles in the *Journal of the American Medical Association*, and 7.6 percent in *The Lancet*.[31] In psychiatry, enterprising doctors seek to define new disorders which are treatable by drugs. Ordinary social

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[27] Ibid.

[28] Angell, *Truth about the Drug Companies*, 208-11.

[29] Angell, *The Truth about the Drug Companies*.

[30] Light, *The Risk of Prescription Drugs*; FDA, 'FDA Notifies Pharmaceutical Companies'; Rosenberg, 'Why Have Medical Journals Not Retracted These Fraudulent Articles?'

[31] Wilson and Singer, 'Ghostwriting is Called Rife in Medical Journals'; Singer, 'Senator Moves to Stop Scientific Ghostwriting'; US Senate Committee on Finance, 'Ghostwriting in Medical Literature'.

attributes, like shyness or sadness, increasingly become medicalized.[32] Richard Horton, editor of *The Lancet*, has defended non-disclosure of conflict-of-interest, on grounds that it has become impossible to prevent. He preferred the term 'dual commitment'. This position was contested by the editor of the *British Medical Journal* .[33] Marcia Angell, for two decades the editor-in-chief of the top medical journal in the United States, *The New England Journal of Medicine*, has written that 'It is simply no longer possible to believe much of the clinical research that is published, or to rely on the judgement of trusted physicians or authoritative medical guidelines. I take no pleasure in this conclusion, which I reached slowly and reluctantly over my two decades as an editor.'[34] In response to public criticism, journals and medical schools are beginning to respond, but slowly: few universities impose a cap on how much a faculty member can be paid by those who make a product they are investigating.[35]

Top doctors get large kickbacks. Ordinary ones benefit too.[36] The companies lay out hospitality at symposia and conferences, often at distant and attractive locations.[37] 'Marketing and administration' is by far the largest cost of drug production. Salesmen press drugs and procedures aggressively, and push them for off-label prescription i.e. for purposes for which they are not tested. There is large divergence in levels of medical costs across United States, with areas in the South tending to prescribe, test, and treat more heavily than in other parts of the country, often at the expense of Medicare. Doctors prescribe tests from labs which they own.

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[32] Healey, *Antidepressant Era*; Lane, *Shyness: How Normal Behavior became an Illness*.

[33] Horton, 'Conflicts of Interest in Clinical Research'; Smith, 'Conflict of Interest'.

[34] Angell, 'Drug Companies and Doctors: a Story of Corruption'. Also Healy, *Pharmageddon*.

[35] Wilson, 'A Tougher Conflict Policy at Harvard Medical School'.

[36] Kassirer, *On the Take*; Nguyen et al., 'Dollars for Docs'; Healy, *Pharmageddon*.

[37] Nguyen, 'Dollars for Doctors'; Pear, 'U.S. to Force Drug Firms to Report Money Paid to Doctors'.

In the medical economy where every service is provided as a commodity, fraud is rife, and antifraud control is also outsourced to private contractors.[38] Drug companies heavily overcharge public health systems.[39] A home care company submits false claims to the federal government.[40] Media and journal sources (which pick up these abuses) depict the medical market as a war of all against all (which is what a competitive market is meant to be, although cheating is left out of the model). Every relationship offers opportunities for deceit: insurance companies and doctors discriminate against different classes of patients, patients resell medicare drugs, doctors overcharge insurance companies and insurance companies undercompensate doctors.[41] Fraudulent billings alone are estimated by the FBI to cost between three and ten percent of total health expenditures, or approximately 0.5-1.7 percent of national income. Healthcare is a "criminogenic" industry.[42]

Adam Smith's norms of sympathy, approbation, reciprocity, and virtue might have protected the integrity of medical treatment and of medical research, if they were not challenged so forcibly by the policy norm of *caveat emptor*.[43] At the point of delivery, healthcare is not a commodity trading impersonally, but is mediated by personal interaction. However, what matters is not compassion, but integrity – the impartial spectator's injunction to do the right thing. Medicine is a vast enterprise, in which everyone has to trust that knowledge is created, validated, and used impartially, and in the interests of the patient. If the authority of scientists and doctors can be

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[38] Gawande, 'The Cost Conundrum'; Dartmouth Atlas Working Group, 'The Dartmouth Atlas of Healthcare' ; Forden, 'Why Medicare Can't Catch the Fraudsters'; Leap, *Phantom Billing, Fake Prescriptions, And the High Cost of Medicine*.

[39] Pope and Selten, 'Public Debt Tipping Point Studies', 19-22.

[40] Lefcourt, 'A Corporate "Culture of Fraud".

[41] Rashbaum, 'A $250 Million Fraud Scheme', and reader comments; Smith, 'Are Cheating Doctors Running Bill Scams'; Terhune, 'Many Hospitals, Doctors Offer Cash Discount For Medical Bills'; Pear, 'Report on Medicare Cites Prescription Drug Abuse'.

[42] Leap, *Phantom Billing*, ix, 3, 11.

[43] Offer, 'Self-interest, Sympathy and the Invisible Hand'.

purchased by interested parties, its quality is no longer secure. Caveat emptor applies. Opportunistic professionals are tempted to cash in the reputation for probity of which they are the transient custodians. The word liquidation has two meanings: destruction, and converting an asset into money. Opportunistic doctors have been doing both: appropriating for their private gain the authority built up by generations of scientists and doctors, and leaving it diminished after they are gone. This ethic of opportunism is pervasive.[44] More medical doctors think like entrepreneurs, and seek to qualify as MBAs.[45] In return for immediate gain, they sacrifice present and future patients, and undermine the work of more selfless colleagues. They are able to exploit a position of authority and knowledge to dismantle the safeguards of knowledge and authority, for what they see as own immediate advantage.

IV

It is not only individuals who were placed at risk. The cost of health care in the United States has risen to a level which threatens macroeconomic stability. Health care costs (at around 17% of GDP) are almost twice as high per head as in comparable countries (figure 1). These expenditures are creating havoc in public expenditures, and dragging down employers, who provide most health insurance. And yet healthcare outcomes (on average) are the worst among the top seven countries (table 1).

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[44] Washington, 'Flacking for Big Pharma'.
[45] Freudnehim, 'Adjusting, More M.D.'s Add M.B.A.'.

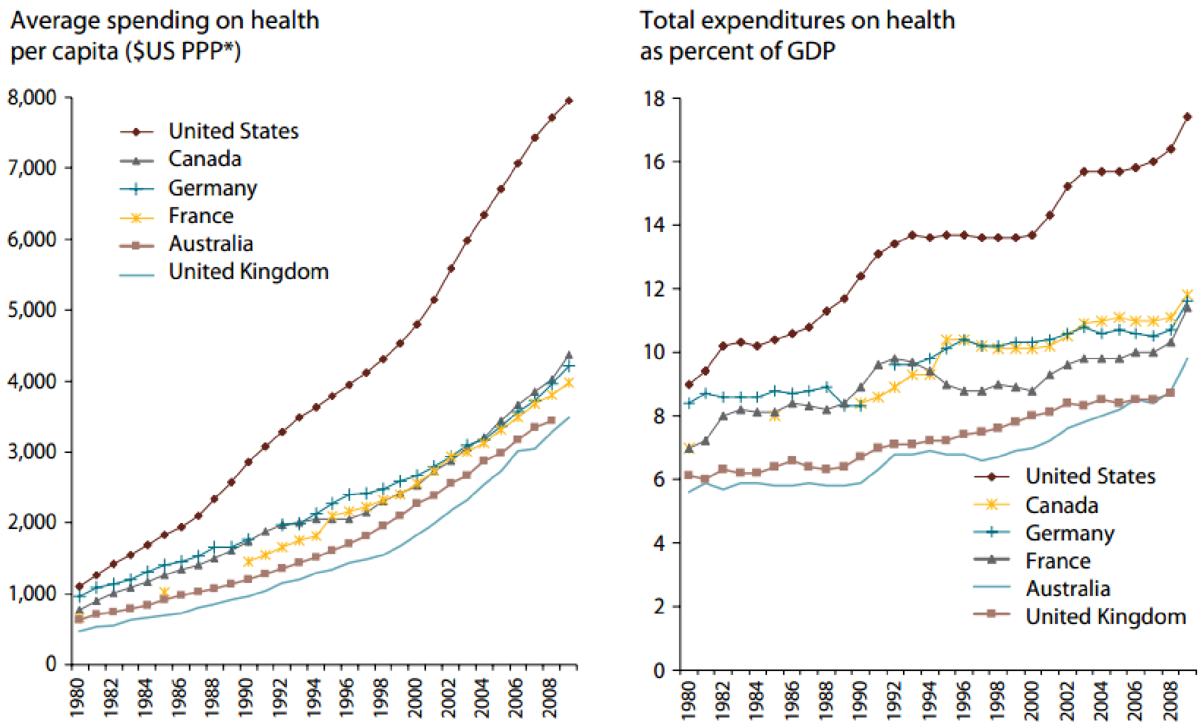

Figure 1. International Comparisons of Spending on Health, 1980-2009. *Source:* Commonwealth Fund, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2011* (New York: Commonwealth Fund, 2011), exhibit 3, 20. Based on OECD Health database.

Table 1. Overall Ranking of Healthcare Performance.

	AUS	CAN	GER	NETH	NZ	UK	US
OVERALL RANKING (2010)	3	6	4	1	5	2	7
Quality Care	4	7	5	2	1	3	6
Effective Care	2	7	6	3	5	1	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	7	2	1	3	6
Patient-Centred Care	2	5	3	6	1	7	4
Access	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, Healthy, Productive Lives	1	2	3	4	5	6	7
Health Expenditures/Capita, 2007	$3357	$3895	$3588	$3837	$2454	$2992	$7290
Rankings 1-2.33							
Rankings 2-34-4.66							
Rankings 4.67-7							

Source: Davis et al., *Mirror, Mirror on the Wall: How the Performance of US Health Care System Compares Internationally, 2010 Update* (Commonwealth Fund: New York, 2010), Exhibit ES-1, v.

A study of mortality reduction in seventeen countries over twenty-five years to 2005 found the United States to have the highest health expenditure per head, and the also the highest mortality rate. It ranked seventeenth in the ratio of expenditure to lives saved, and 11th in the rate of reduced deaths.[46]

Standards of treatment are good, but many people cannot access them. The proportion of uninsured during the last three decades has been typically higher than 15% of the population. It currently stands at almost 17%, or more than 50 million people.[47] Many more are under-insured. In 2010, more than 81 million working age adults, 44 percent of those between the ages of 19 to 64, were uninsured or underinsured during the year. In the economic downturn, nine million working-age

[46] Pritchard and Wallace, 'Comparing the USA, UK and 17 Western Countries'.

[47] U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2009*.

adults lost their health coverage together with their jobs. [48] Medical insurers deny cover for millions with pre-existing conditions.[49] 45,000 excess deaths a year were recently attributed to the absence of medical insurance, comparable to c. 33,000 deaths on the roads.[50] As many as 91,000 fewer people would die prematurely if the US could achieve the leading country's rate in terms of healthcare. The US ranks last among 16 industrialised countries for preventable death. [51] For those without insurance, or with insufficient coverage, a major illness was an economic calamity. Personal bankruptcy in the United States has risen sharply in the last three decades. In 2001, about 1.5 million experienced bankruptcy, more, for example, than heart disease or divorce.[52] Medical costs were implicated in half to two-thirds of all cases of personal bankruptcy.[53] Some couples who would otherwise divorce chose to stay together to benefit from medical coverage, while others separated to protect a partner from medical costs. But assets of divorced spouses can still be seized for medical expenses five years after the break.[54] To keep their health coverage, people stayed in jobs they disliked.

The conflict between the care ethic and the market ethic is exposed in the efforts to make the underinsured pay for their treatment. An entitlement to hospital emergency room attention is the US medical system's ultimate safety net; it is a statutory expression of the duty of care. In law however, it is restricted to the relief of symptoms. But emergency room hospitals still demand payment for treatment, and sign up patients on high-interest credit cards in order to collect their fees. These

[48] Commonwealth Fund, *Why Not the Best*, 9.
[49] Potter, 'Health Insurance Exec Speaks'.
[50] Wilper et al., 'Health Insurance and Mortality in US Adults'.
[51] Commonwealth, *Why not the Best?* 9, 43.
[52] Warren and Tyagi, *Two-Income Trap*, 80-5; Offer, *Challenge of* Affluence, 293-4;
[53] Himmelstein, 'Medical Bankruptcy in United States'.
[54] Kristof, 'Until Medical Bills Do Us Part'; Smartmoney, 'Unhappily Ever after: the 'Nondivorce''.

obligations are pursued, and are ultimately sold at a discount to financial companies. ‘If you go to a veterinarian, you have to pay, one health-care executive notes. Why should a hospital be different?’[55] Patients with assets can have them seized; those without, can lose their credit ratings, and their ability to borrow for a car or a house.[56] This is consistent with the norms of profit-making hospitals, but has caused some heart-searching among nonprofits. ‘In a lucrative new form of fiscal alchemy…a growing number of hospitals, working with a range of financial companies, are squeezing revenue from patients with little or no health insurance.’ Some non-profits were relaxed about charging patients a high rate of interest, but others were uneasy. One medical administrator in Memphis said, ‘If we heal somebody medically, but we break them financially, have we really done what is in the best interest of the patient?’[57] Debt collection companies have stationed agents in emergency rooms and hospital departments to get patients to pay before treatment, and have gained illegal access to personal health records.[58]

A software program widely used in hospitals (‘Conifer’) works out how to maximize cost extraction from indigent patients. “‘One of our main values is to take care of the poor and vulnerable,’ says Mary Jo Gregory, chief operating officer of Sisters of Charity of Leavenworth Health System, which operates 11 hospitals west of the Mississippi and is using Conifer software. ‘How do you fulfil that role and still have a sustainable ministry? Our bad debt is high, and we’re facing the same issues as everyone else in terms of collections.’”[59] The cases described are heart-breaking: pain

[55] Grow and Berner, ‘Fresh Pain for the Uninsured’.
[56] Harney, ‘Debts that Unsettle the Score’.
[57] Grow and Berner, ‘Fresh Pain for the Uninsured’.
[58] Greenberg, ‘Debt Collector Is Faulted for Tough Tactics in Hospitals’. There is rich further testimony in 1159 readers’ comments, the majority indignant, a minority supporting the practices.
[59] Olmos, ‘Getting Patients to Pay before They Go Home’, 22-3.

and death galore. Profits are not as high in health insurance as they are in drug manufacturing. Instead, as in other industries, the surplus is appropriated by the managers.[60] Managers of non-profits also rake it in.[61] Physician-managed hospitals had higher outcome quality scores than those run by managers.[62]

The Obama healthcare reform has given priority to the ethical issue, the denial of medical care, while setting aside the economic one of unsustainably rising costs. The actual form of the Health Care Act is an unwieldy compromise. It has left intact the commercial profit-seeking framework of healthcare provision, protecting insurance company profits and medical overtreatment. In order to achieve its ethical objective of extending healthcare to all, it has resorted to a moderate form of compulsion, and has extended eligibility for subsidized programs. The Act only went through because it did nothing to threaten the revenues of insurance companies and health providers. It became the focus of political unrest, most notably by the so-called Tea Party movement. Inconsistently, these protesters oppose the reduction in Medicare benefits for the old, while objecting to the fiscal cost of extending coverage to other people. In its continued support for Medicare, the Tea Party movement embodies the tension between the 'me-first' ideology that is pervasive in United States, and the contrary intuition that care for the ill is will an obligation and entitlement.

It is revealing to discuss market efficiency in terms of these external costs of pain and death. In the UK, there is more than a decade's difference in life expectation between people at the two ends of socio-economic scale, a gap wider than at any time since 1921.[63] The prevalence of obesity is much higher in the cluster of English-speaking market liberal economies. Statistically, the most important driver appears to

[60] Strauss, 'Outgoing Aetna Chairman gets a $68.7 million Goodbye'.
[61] Buettner, 'Reaping Millions From Medicaid in Nonprofit Care for Disabled'.
[62] Goodall, 'Physician-leaders and Hospital Performance'.
[63] Thomas et al., 'Inequalities in Premature Mortality in Britain', c3639.

be the extent of economic insecurity, and that is affected by the risk of incurring high private medical costs.[64] Obesity is an important risk factor for disease and early death. Economic insecurity has risen sharply in United States during the last three decades.[65] There is a trade-off, then, between opportunity for some and pain and death for others. A market in healthcare is consistent with higher cost and worse outcomes. Even in theory, markets only work if participants are well-informed. That is not the case for health, and indeed, not the case for a great many other purchases, either because information is not readily available, or because it will only be revealed in the future.

We began with the financial crisis. For doctors, write bankers. Do bankers have a duty of care for anything except their private gain? Pain or death are not so directly at stake here, so the issue may not be so clear-cut. But when bankers are bailed out by taxpayers, the pursuit of self-interest affects the access of others to necessities like housing, education, job security, pensions, and healthcare. From the point of view of high finance, its transactions are impersonal. But the marketing departments of retail banking strive to convey the impression of a caring relationship, and the purchase of financial products typically involves a face-to-face interview. The existence of face-to-face interaction, suggests that it would be appropriate to apply the reciprocal norms of the impartial spectator to this type of interaction. Consequently, this aspect of retail banking makes it tempting for reformers to impose a duty of care on bankers, on pain of expulsion. Ed Miliband, current leader of the Labour Party has proposed a duty on bankers of this kind, explicitly modelled on the medical one.[66] But what the medical analogy really shows, is that neither an interpersonal relationship, nor a strict code of professional practice are sufficient. Even in medicine, where the

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[64] Offer et al., 'Obesity under Affluence Varies by Welfare Regimes'.
[65] Hacker et al., *Economic Security at Risk.*
[66] 'Ed Miliband Seeks Banker Disciplinary Code', BBC 11 Sept. 2011, http://www.bbc.co.uk/news/uk-politics-14869650. [accessed 11 Sept. 2011]

norm of care is so powerful, it is inadequate to counteract the ravages of market forces. What is needed in this area of personal service for the duty of care to be effective, is an explicit rejection of the norm of *caveat emptor*, of the license to exploit counterparty ignorance. Even Milton Friedman stressed that an economic exchange is advantageous to both sides, only *'provided the transaction is bi-laterally voluntary and informed*'.[67] If we want to follow Adam Smith, his teaching requires a modicum of virtue on the part of bankers, both individually and in their corporate capacity. The less-demanding 'economy of regard' requires that whatever their real motives, bankers should be able to send an authentic signal, and not a fake one, that they respect their clients' interests, and do not feel entitled to cheat them.[68] For the signal to be authentic, they must genuinely place their clients' interests on a parity with their own.

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[67] Friedman, *Capitalism and Freedom*, 13 (italics in the original).
[68] Offer, 'Self-Interest, Sympathy and the Invisible Hand'.

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