HEALTH CARE CAPITAL:
AN ACCOUNT OF HEALTH CARE PRODUCTION
AS A CRITIQUE OF HEALTH CARE ETHICS

By

Alex Benjamin Neitzke

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ABSTRACT

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My dissertation is foremost a critique of traditional normative approaches to health care ethics. I argue that many health care ethicists presuppose an idealized conceptual schema where moral values, justifications, or principles are the primary driving force in health care practices and thus should be the primary focus for normative consideration. On the contrary, social and economic structures shape and constrain health care practices and in many instances undermine or preclude attempts to alter practices by altering moral justifications or normative stances.

In my dissertation I argue that accounting for the functions of economic and social structures in health care helps reveal the ways that individual concepts, moral dilemmas, or actions are *mediated* by their relations to those structures. Examining social practices and the actual functions of profit-driven health care production is necessary for health care ethics because those social functions help constitute moral concepts and practices. Marxian social theory contributes to addressing this problem in that it accounts for the role of social relations in determining conceptual categories and related practices. By accounting for the social relations and economic practices that produce health care, health care ethicists can theorize from a better starting point and offer better normative argument for social change.

The first chapter details and defends my overall methodology and critique of what I call "idealized moral frameworks" in health care ethics, arguing that an explanatory model of social relational structures is a necessary contextual grounding for stronger, more informed moral and

political theorizing. The chapter grapples with the role of symbolic discourse in influencing social, political, and economic changes to deeply rooted structures. The chapter also situates my project amid existing literature.

The second chapter analyzes the concept of the commodity as it relates to health care ethics. I argue that health care functions as a commodity in the United States in that it is subject to the value form through ideational and actual exchange. Further, health care fits the commodity form in that it functions as a vehicle for the production of surplus value and profit—despite the fact that the earnest motivating ethos of individual practitioners and regulators is likely health promotion.

In the third chapter I turn to medical labor and its relation to profit production. Health care ethicists tend to depict physicians and medical practitioners in a largely separate sphere from ordinary economic, market, or commercial relations. Yet such depictions interfere with understanding medical labor as a part of the totality of processes that reproduce the material conditions of society, which is to say capitalist economic production. I explicate Marx's account of labor and value-production in order to explain how capitalist production creates value and surplus value by manipulating labor power, time, and wages.

In the fourth and final chapter, I offer more explicit directions for translating my project into normative health care ethics. I utilize Marx's ethical politics in dissolving the tensions between ethical and critical analytic frames in theory by focusing attention on the task of health care ethics: effecting change in health care praxis. I offer a concept of social pathologies of health care, which emerges from my project, and lends normative and epistemic motivation to ethical politics aimed at transforming and de-alienating health care practices, institutions, and structures.

For Leiann, Fred, Nina, and Ian.

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TABLE OF CONTENTS

Chapter 1

Between Ethics and Critique:

Marxian Challenges to the Practice of Health Care Ethics

In this chapter's first section, I offer an extended introduction and illustration of tensions that I perceive in the task of health care ethics as self-understood by ethicists and theorists amid a complex social context that may undermine that task. This chapter explicates and defends my project's methodological commitments in arguing that critical analytic accounts of social-relational structures that concretely produce health care in the United States provide a necessary descriptive model for understanding underlying pathologies of health care delivery, which largely determine and interact with the ethical issues identified in health care ethics. Such analytic models offer an alternative, but potentially complementary, way of understanding normative deficits identified in health care practices by the field of health care ethics or bioethics more broadly. That understanding, in turn, offers to transform ways of doing health care ethics that better contribute to the actual change or transformation of the social order of health care.

The central motivating force behind this dissertation is the tension that arises between, on one hand, attempts to give normative arguments for what ought to be (or what individual or collective actors ought to do) in some area of health care practice and, on the other hand, understanding social determinants and limitations to individual actors that are the result of social and economic relations. Those social relations refer to the patterns and forces that materially produce health care for individuals and populations, as opposed to ethical interpersonal relations that ordinarily frame ethical approaches in applied philosophy. Put another way, these are the

tensions between doing contemporary English-speaking health care ethics while also accepting (especially Marxian)[1] understandings of social-relational structures that reproduce our capitalist social formations, as well as dominating social structures like racial and gendered oppression.

The effects of social-relational structures often undermine or disrupt health care ethicists' attempts to address moral dysfunction in health care practice, or to try to bring about good or right action. Some Marxian models of social reality depict a limited role for agents' moral understandings and intended actions in what ultimately creates and reproduces overarching social structures that constitute or surround those actions subjected to ethical analysis and normativity. Marxian accounts of social relations, however, threaten to lead to befuddled inaction, apoliticism (at best), or cynicism (at worst) because of this very tendency to discount the efficacy of individual agents in altering social relations that create moral problems.[2]

Many straightforwardly moral authors in health care ethics presuppose an underlying transitive efficacy whereby—because social institutions are a reflection of social moral obligations and widely held socio-cultural orientations—alterations in our moral commitments or beliefs on the basis of reasoned argument can effect change to those institutions and practices that make up their reflection. I see this underlying transitive efficacy from moral belief to actions and institutions as akin to liberal understandings of the "challenge of pluralism" as the incongruity between diverse "reasonable doctrines" (Rawls 2005, 4) or "rational plans" regarding notions of the good (Rawls 1971, 93). That is, social and political activity is

[1] I generally use the term "Marxian" to refer to theory that comes directly from Marx, while I generally use "Marxist" to refer more to the theorists who follow Marx and attempt to elaborate and develop his ideas.

[2] This criticism applies generally to economic determinism of orthodox Marxism. It is also applied to structuralist thinkers following Marx, like Louise Althusser and Michel Foucault—whose theorizations of social relations inform this project immensely. Foucault in particular is often accused of focusing solely on the internal logic of structures in a way that both discounts individual agency and also leaves direct normative evaluation of structures largely unstated. I return to this tension and the critique of Foucault in more detail in the final chapter. See also Benton (1984, especially 1-31).

understood primarily as the enactment of ideas and justificatory beliefs. This seems similar to—if not inspired by—John Stuart Mill's (1978) depiction of social existence as largely in search of truth, and thus like the work of scientists or philosophers rejecting and accepting hypotheses. Different lifestyles are depicted as "experiments of living" (54) representing hypothesis-like truth claims about notions of the good, and it is from this experimental mode of sociality that pluralism derives its value for Mill. Thus by affecting individual moral belief through normative argument, ethicists see their work as the first step toward affecting practice.

More politically focused thinkers in the field of health care justice also see their normative transformation of moral belief as a means of transforming institutional and political policy. Theorists like Norman Daniels (1985) justify their ideal, principles-first approach as offering moral guidance to policymakers in transformative times for policy design and implementation by offering responses to broad normative questions like, "How much equity should there be?" (x). But such approaches simply presuppose, first, a kind of efficacy on the part of government policy as the actualization of basic principles and, second, a primacy of ideas and moral belief that Daniels arguably carries over from John Rawls. And third, such authors tend to emphasize only one direction in the efficacy of ideas in shaping practices without recognizing influences in the opposite direction. Mark Hansen (1999), for instance, argues that "rhetoric both derives from and shapes moral commitments, *which in turn direct behavior*" (273; emphasis mine). Yet this does not recognize the ways that behaviors and patterns of behaviors influence and constrain moral commitments.

Such a social and political depiction is continued in contemporary ethics and health care ethics with the notion of common morality found in Tom Beauchamp and James Childress (2013). Common morality is "the set of universal moral norms shared by all persons committed

to morality" and includes a virtue component of shared moral character traits (3). Beauchamp and Childress make clear that "common morality comprises moral *beliefs* (what all morally committed persons believe)" (4). By identifying and weighing those beliefs in reference to a given context, common morality can guide action and thereby affect or transform practice. However, this quote continues: "common morality comprises moral *beliefs*… not standards that exist prior to moral belief" (Beauchamp and Childress 2013, 4). So it should be noted that this emphasis on belief is likely meant to identify the authors' metaethical commitments to moral cognitivism, to argue that moral claims are descriptive claims with truth content, and not necessarily about moral motivation or the relation of morals to action. I instead claim that this latter component is implied in their methodological approach to medical ethics.

These variations of presupposed transitive efficacy from moral belief to practice largely belie certain social and historical realities, particularly in the US health care context. Historical accounts like those of Paul Starr (1982, 2011) offer an understanding of the development of institutional health care practice and policies that are forged at least as much if not more through relations of power in the professional authority of physicians and political and economic influence from health industries and organized groups in the elderly and veterans versus underlying governing principles.

Marxian theoretical frameworks help to challenge the supposed transitive efficacy from morals to action, or from ideals to practice. While Marxian frameworks share something like the premise that social institutions are a reflection of social moral obligations and widely held socio-cultural orientations, this picture is complicated or qualified by the idea that much of the social structure is made up of capitalist social relations and practices that operate by a largely self-moving logic that is not consciously executed or carried out by individual social actors who

nonetheless take part in those relations, and thereby reproduce them (see for instance Marx 1993, 712; Reichelt 2007, 5). Social structures can influence actors in ways that prevent or undermine their moral beliefs being translated into action and from transforming practice over the long term. In addition, structures are often implicated in the forces that create ethical dilemmas and health care ethics cases, yet those determinants themselves are less often the object of ethicists' scrutiny. While the realm of politics largely bridges the theoretical gap between the individual and structures, that realm is less often the focus of health care ethicists normative claims.

Allow me to suppose an example to illustrate my misgivings with what I call "straightforwardly moral" frames. A health care ethicist argues that a more holistic conception of patients should be taken up in health care practices in order to reverse the ongoing dehumanization of technologized and specialized medical care. This is a general form of a rather common criticism of biomedical practice (see for instance Mead and Bower 2000; Todres, Galvin, and Dahlberg 2007; Entwistle and Watt 2013). Indeed, even countless hospitals themselves have taken up such criticisms by promising "personalized medicine" or "person-centered care" in their advertisements.

Suppose that an individual physician named Dr. Moral is convinced by this argument and attempts to integrate a more holistic model of the patient as a person into her everyday medical practice. If Dr. Moral is a general practitioner, she might make a point of committing more time in each visit to counseling patients on treatment options, or advising patients on how to achieve healthier lifestyles. Based still on her medical judgment, these person-oriented practices would be instead-of, or in-addition-to, more technological tests and interventions, diagnostic procedures, or pharmaceutical prescriptions that critics argue dehumanize medical practice. For example, Dr. Moral is aware of evidence showing that the benefits of cholesterol-lowering statin

drugs, in terms of mortality, are similar to those of exercise as a secondary prevention of cardiovascular disease (Naci and Ioannidis 2013). So she decides to spend more time counseling her patients with early or mild heart disease indicators instead of immediately prescribing statin drugs. The goal would be to better inform patients of the limited benefits of statins for their condition and to encourage lifestyle changes, including exercise, that will prevent their death as effectively as statins while also having broader benefits outside of cholesterol indicators, therein treating her patients more as persons than as numerical cholesterol indicators. Dr. Moral here is accepting the broader premise that routinized pharmacological prescriptions act to reduce persons to mere calculable numbers derived from blood work rather than a workup for a whole patient, which accounts for a patient's individuality—his or her environment and lifestyle, including family and work relations and everyday habits.

Now what are the likely results of Dr. Moral enacting the ethical prescriptions regarding patient-centeredness? Among the more obvious results is likely to be more time spent with each patient, and thus an overall decrease in the number of patients seen per day. This alone can have a ripple effect in a few other areas. Of course, if she is a member of an HMO, or if her hospital or medical group also has contracts with PPO insurance plans, then it is likely that she will receive pressure from a manager to reverse her increased time-per-visit. This is because, from the standpoint of the manager, this physician is not maximizing the hospital or group's efficiency.

In addition to this immediate pressure, there are other ways that Dr. Moral's decisions can work against her. If she does in fact forgo pharmaceutical prescriptions for some marginal patients, who perhaps have a diagnosis like pre-diabetes or high blood pressure in favor of nutritional consultations or more holistic means, then she may find herself going against an established standard of care. Authoritative councils, often with industry-employed physicians

sitting on them, establish standards of care for what is to be done in the event of given indicators or diagnoses. For instance, a set level for both blood sugar and insulin in combination will be set for the diagnosis of pre-diabetes. The standard of care for that diagnosis is then established as prescribing the drug metformin. When such standards are set, a physician's failure to adhere to them, while within the grounds of professional autonomy, could subject that physician to penalty in the form of lowered physician grades from both hospitals and insurers. Those grades then influence a physician's ability to continue accessing hospitals, working with insurers, and staying in medical groups, and may be seen by patients choosing a physician through insurer websites. Because these standards can be influenced by the pharmaceutical industry, standards of care themselves—initially intended as a patient protection mechanism—are influenced by the powers of capital and profit-production. And in this instance, the standard can act to push down Dr. Moral's grades and thus influence her own standing in the profession and her ability to continue working, earning, and attracting new patients.

In this example we see an individual's attempt to realize moral norms from an ethical concept like person-centered care lead to serious frictions from social-structural constraints that hamper, if not eventually prevent, the realization of that moral norm. While it is not necessarily my claim that all health care ethicists should become trained in the minutiae of health care policy, economics, and institutional practices, I argue that a set of basic critical concepts that I borrow largely from Marx offer a framework for a different approach to health care ethics. This is part of a larger claim that greater attention should be paid to analytically mapping out and modeling social relational structures in conceptual philosophical analysis in order to account for their influence in the matters and practices at hand in health care ethics.

In this chapter I pull together three intersecting thinkers in Seyla Benhabib (1986), Iris Marion Young (2011), and Charles W. Mills (2005, 2007a-c) in order to theorize and defend the methodological commitments of the remainder of my project—and to critique certain approaches and commitments in mainstream health care ethics discourse. I argue that my generally critical-theoretical approach offers a defetishizing explanatory model of the social objects of health care ethics, which fills in aspects of a contextual background that is necessary for doing better-informed moral and political theorizing. The result of my project is a theoretical account of capitalist relations and their functions through health care, which informs and motivates different ways of doing health care ethics. That approach to ethics can better bridge the space between moral belief and social-relational structures. I conclude this chapter by explaining why a social-relational account of health care practices is significant for the moral problems and discourses of health care ethics.

Benhabib and the Methods of Critical Theory

Seyla Benhabib's (1986) overarching project is conveyed in its subtitle: *A Study of the Foundations of Critical Theory*. Her work identifies several key concepts in Marxian critical theory and their development from Kant and Hegel, through to Marx, then Frankfurt School Critical Theory, and later Jürgen Habermas. Her book focuses most on the Marxian philosophy of the subject, which she argues begins in Hegel and is adopted by Marx and is thus held over through the Frankfurt School (242). Benhabib argues that the classical Marxian philosophy of the subject as self-actualization through objectification has a major shortcoming in that it precludes consideration of morality—disputes about what is right, good, desirable, and just—which Habermas's theory focuses on (200-1).

Benhabib's project obviously weaves in and out of direct relevance to my concerns regarding Marxian critical theory and its relation to ethics and morality. I only select a few germane concepts for explication that cluster around the theme of the *task* of critical theory as it pertains to its methods. I utilize Benhabib's broader analysis of Critical Theoretical methodology drawn from its central Marxian authors; I do not, however, engage Benhabib's substantive claims about the preferred philosophy of the subject because they are mostly intra-Marxian and somewhat tangential to my project (even if the alleged resulting preclusion of morality has merit).

One more procedural note: while Critical Theory—especially when capitalized—usually refers to the intellectual work stemming from the Frankfurt School, I use Benhabib to argue that, at the broader level of my largely methodological analysis, critical theory can be understood as a family of approaches that includes feminism, critical race theory, and disability theory.[3] I see the creation of such alliances in discourse as both theoretically and politically justified in an attempt to form a unified bloc among liberation theories and movements. I make a point of drawing such connections when possible, and have in mind this broader concept when referring to "critical theory" unless otherwise denoted with capital letters.

In its broadest terms, Max Horkheimer identifies the goal of critical theory as human beings' emancipation from relationships that enslave them (qtd. in Benhabib 1986, 3). This leads critical theory first to elucidate and emphasize the human role in creating and maintaining systems and relations that determine and shape individuals' lives. This is at the origins of much *relational* theorizing that is most visible in feminist philosophy and in the theorizations of race, gender, and disability. These theories and thinkers argue that social categories like race and

[3] This broader understanding of critical theory reflects Maeve Cooke's (2006) similar category of *critical social theory*.

gender are relational practices that limit certain individuals' freedom. It is for this reason that critical theory is so closely associated with social science and the empirical investigation of social limitations and influences. A result of this emancipatory aim and the elucidation of human influence over broad social forces is that critical theory constantly challenges universalist, essentialist, or naturalist assumptions. For Marxian theory, the central universalizing assumption that critical theorists challenge is that the conceptual subcategories of capitalism have existed in some form for as long as humans have lived: calling the shaping of a primitive spear "labor" or the trading of symbolic seashells an "exchange of money," etc. Critical theory insists that, no matter how totalizing a system like gender, race, or capitalism may be in its reach over specific conditions of human reality, such systems cannot elude careful conceptual analysis when they are de-centered and not taken for granted—taken as existing neither in a natural nor universal ideal realm and instead understood in a specific set of historical social relations.[4] By analytically accounting for the ways that categories gain their reality from specific social relations in history, critical theorists show that dominating systems like capital, race, or gender are contingent and limited, and can thus be fundamentally transformed into something distinct.

I begin with what Benhabib calls the "two dimensions of critical theory" (225) in order to establish the scope for how critical theoretical work is done. These dimensions are roughly the social-critical and the normative, and in Benhabib's more precise language the *explanatory-diagnostic* and the *anticipatory-utopian* aspects of critical theory. The explanatory-diagnostic aspect uses the findings and methods of social science to diagnose social and systemic crises (226). Such work identifies and analyzes internal contradictions, limitations, and dysfunctions in the present social order to make sense of the "protests and pathologies" that these manifest in the

[4] See for instance Marx (1993, 105, 247-50).

population (226). As is clear in the *explanatory* term in its name, the task is largely descriptive and expository—the goal is to make sense of some aspect of society in a way that makes it intelligible in reference to relational practices. While this is descriptive work, this does not mean it is not theoretical or conceptual in nature, or that it is necessarily what we would call "empirical." While Marx or Foucault largely describe social practices and discourses of knowledge production, their results are highly critical *analytic* accounts of capitalism and relations of power that draw important conceptual distinctions that can have normative ramifications.

Explanatory-diagnostics relate to the methods of historical materialism that emphasize the relational and material manifestations of traceable forces behind present social phenomena: present institutions, norms, knowledge systems, and practices can be made sense of in terms of a series of human decisions and reactions leading up to the present that are materialized in physical structures, bodily comportments, altered environments, and material reproduction of a society. Social formations manifest themselves in material and symbolic existence within these formations. Finally, the standpoint is usually that of the generalized observer, which draws connections across theoretical space, as opposed to a particular individual or an exceedingly narrow focus (142).

Outside of directly Marxian work, Paul Farmer's (2003) language of "pathologies of power," and the school of critical medical anthropology that he comes from, is one example of explanatory-diagnostic work. What Farmer does is descriptive anthropological work that traces major health problems like poverty and violence back to certain causes in economic and political systems and forces.[5] Farmer's work is both critical and relational because it situates the pathologies or crises that it diagnoses within a set of social relations of power and dependence,

[5] See for instance Farmer's (2003) chapter "On Suffering and Structural Violence."

thus making sense of crises in terms of direct or indirect human agency in political, social, and economic forms (Farmer 2003, 40). This makes specific occurrences like an individual's brutal beating and murder intelligible in a larger context of economic and political neocolonialism. The philosophical problem that this leads to is one that many discussing global poverty, capitalism, and gender seem to wind up at: when making sense of individual lived crises in terms of structural factors or systemic crisis (via critical explanatory-diagnosis), how can normative theory *mediate* between these two?[6] I address this question in the course of the present chapter.

The second dimension of critical theory for Benhabib (1986) is the anticipatory-utopian. Beginning with what makes this anticipatory, Benhabib argues that critical theorists taking part in this second dimension evaluate present protests and movements by their perceived emancipatory potential. She argues that critical theory looks primarily to present social actors and "addresses the lived needs and experiences of social agents in order to interpret them and render them meaningful in light of a future normative ideal" (142). This dimension leads the critical theorist to the lived experiences of human suffering and injustice that then can lead to resistance and organized struggle and is clearly "the more properly normative aspect of critique" (226). So where the explanatory-diagnostic aspect explicates the roots of crisis in the present *system* the focus of the anticipatory-utopian aspect is in the *lived experiences* of crisis in individuals and groups (226-7). As a result, the work of those occupying this dimension of critical theory looks much less descriptive and more often takes part in future-oriented work; it constructs a normative future from what is present in some (often inchoate) form. One can be clued into this work most easily when authors take their cues—whether explicitly or implicitly—from activism, struggle, or group and individual lived experience. This not only includes a great

[6] This problem of mediation is posed in Benhabib (1986, 225); the language of lived crisis and systemic crisis, and of mediating between the two, also comes from Benhabib (141-2, 350-1).

deal of feminist philosophy, but other theories from struggle like Black feminism, critical race, postcolonial or decolonial, Queer, and disability theories. Theorists take part in anticipatory-utopian work in these instances because they look to the present practices of groups and individuals who are responding to social crises and use these immediate responses and tactics as a basis for normative work that supposes a radical future on that basis. But the orientation of this dimension toward *lived experience* and crisis is also important for Benhabib. I take this to be critical because it relates functionalist or structural ideas to the experiential vocabularies of injustice, silencing, and humiliation (142) but also takes its normative beginnings from those very social actors.

Even though human social relations reproduce their corresponding systems, they nonetheless dominate individuals in ways that defy their individual and often also their limited collective control. This would appear to be a hindrance to ethical and political transformations in social relations. Social power takes an objective form:

> Production is not *directly* social, is not 'the offspring of association'… Individuals are subsumed under social production; social production exists outside them as their fate; but social production is not subsumed under individuals, manageable by them as their common wealth. There can therefore be nothing more erroneous and absurd than to postulate the control by the united individuals of their total production. (Marx 1993, 158-9)[7]

Production under capital is the result of a collective process, but that process and its interconnections take on a form that works externally upon individual actors, it seems, by its own momentum. So while it may seem that, because collective labor power is the source of wealth production in capitalism, the total upheaval of capitalist production cannot be achieved simply through a collective decision for things to be otherwise. This idea, too, can be illustrated through

[7] I believe that it is important to understand that this passage in Marx refers to *capitalist* production, and not necessarily production as such. As has been established, Marx is skeptical about the latter sort of essential, universal claim about economic categories. It may be the case that post-capitalist forms of social production can be mediated in equally collective and social ways.

analogy with race or gender. These systems are socially manifested and reproduced through practices, yet the idea that all people might simply make the conscious decision to obliterate gender or race from individual and social practices is "erroneous and absurd."[8]

But Marxist theory insists that dominant systems in a materialist framework must also create the forms that will overcome that system. The anticipatory-utopian dimension analyzes the frictions and reactions to contradictory forms in our social relations and in that way performs a kind of Marxian Minesweeping: "Within bourgeois society, the society that rests on *exchange value*, there arise relations of circulation as well as of production which are so many mines to explode it" (Marx 1993, 159).[9] Marx's notion of the "mines" to explode bourgeois society signals to what I see in Benhabib's notion of the anticipatory-utopian: that the seeds of a radical future order are present in the current system—the norms for what ought to be can and should be derived from present political practices and formal crises. By "formal crises" I mean to protect against the claim that every normative argument or prescription must *necessarily* come from current political or social upheaval or resistance. I argue that normative philosophy can also come from the conceptual analysis of contradictory relational forms like those found in capitalist production. While it is always the case that there must be some observable manifestation of contradictions, I argue that those manifestations are not necessarily identified—or for political movements, self-identified—as reacting to a given contradictory form. For instance, while the ongoing climate of political populism has (especially in the US) focused on the departure, return, and creation of "jobs" as the central concept of economic discontent, the critical theorist may

[8] And so the meaning of "social relations" for a Marxian account is generally less personal than in the sense that Nel Noddings (1984) discusses caring relations, which have to do with "the affect—or subjective experience—of the members" of the relation (4). For a better sense, still, of the concept of social relations for a Marxian account, see the next chapter's discussion of social form.
[9] Marx (1993) later claims that the original historical forms of capital appear at first in small ways alongside old modes of productions "while exploding them little by little everywhere" (520).

argue that other less recognized formal crises can be at work. These include structural forces keeping wages relatively stagnant for decades, or undermining critical functions of the welfare state, such as public education. So part of the task of Marxian projects is identifying the possible "mines" with which to radically transform the present order, and that process need not necessarily be grounded in individual or collective self-understandings though it is likely to take its cue from actual experiences and dissatisfactions.

These two sources of anticipatory-utopian influence (political practices and formal crises) are similar to the *social* and *systemic* limits to capitalism that Benhabib (1986) identifies in Marx (108-9). Social limits arise as class conflicts and struggles in the face of a dominating force of capital, for example "the struggles against the lengthening of the working day, the intensification of production, and child labor" (109). Where systematic limits are dysfunctionalities in the economic sphere, social limits are struggles and conflicts between social groups (109).

This anticipatory-utopian dimension is the corollary to the explanatory-diagnostic commitments of critical theory in an important way. Because critical theory denies universalist or essentialist understandings of categories in specific social formations (like gender, capitalism or religion), then it seems that critical theory cannot rely on universalist or essentialist methodologies for moral theorizing. Because the universalist theories of Kantian ethics, for instance, make no reference to the relational derivatives of moral obligation and responsibility, and conceive of a morality with no reference to history or context, then those theories cannot form the basis for normative theory and prescription. A normative methodology that relies on human relational practices of struggle and an analysis of social relational forms in an existing

social world is consistent with critical theoretical commitments to the social contingency of structures and institutions and their corresponding modes of knowledge.[10]

I see Jackie Leach Scully's (2008) *Disability Bioethics* as one example of anticipatory-utopian work. Scully looks to build a set of normative bioethical concepts by beginning with both lived experiences of individuals with disabilities navigating a world not made for their anomalous bodies, and with the group struggles that have arisen historically from persons with disabilities mobilizing together for political action. Scully uses these insights—these reactions to social dysfunctions—as a means to normative theorizing for a better future and better bioethical theory. Disability theory is a good example, too, because it offers a model for the mediation between social and individual worlds, where the social organization and physical structure has significant influence on an individual's lived experiences and understandings.

I should note that it is not the case that authors are always working within one or the other of these two dimensions; authors—and especially those doing philosophy—are often working in both. The explanatory-diagnostic aspect can look most like crude Marxian structuralism—understood as determinist or "scientific"—and the often descriptive appearance of much Marxian work. But critical theory does not adhere to such caricatured structuralism. Benhabib and others identify these two dimensions of critical theory in order to interpret and understand the work of Marx and past critical theorists, and presumably also to guide future work.

Before moving on, I feel the need to explicate a few more concepts from Benhabib (1986) that are necessary to understand the methodological commitments and motivations of my

[10] See Cooke (2006) for an elaboration and philosophical treatment of the tension between context-transcending validity and situated rationality in critical social theory, which roughly maps onto my distinction here between universalist and contextualist ethical theory. See also Blackledge (2012, 21-33) for an extended explication of Marx's critique of modern moral theories, including Kant, utilitarianism, and social contract theories.

project. These concepts are immanent critique, defetishizing critique, and crisis diagnosis. Benhabib identifies each as differing procedural forms found in Marxian critical theory. First, immanent critique is differentiated from mere criticism. Immanent critique "refuses to stand outside its object" (33) and looks to hold the social order to its own promises (328)[11] by working with its own categories and assumptions (106):

> The task of the [immanent] critic is not to juxtapose an ideal, eternal standard to the existent, but through a "ruthless critique of the existent" to reveal that what is, already contains within itself what "ought" to be as a possibility. (34)

So mere criticism formulates a set of ideal moral principles that stands outside of and opposed to the social order it is criticizing—it derives its ideals from essential, universal, or a priori methods of normativity. Marxian immanent critique takes the concepts and relations of a given social order and shows how those concepts lead to their opposites, to their contradiction.[12] Marxian critique must also show how the "struggles and wishes" that arise from such contradictions also anticipate society's radical transformation (60). Benhabib argues that immanent critique is not criteriological—as in saying, *here are the ideal criteria and here's how* x *does not meet them*—in the way that mere criticism is (33).

So what does immanent critique look like and how does it reveal such potentiality in the present forms of society? A famous example from volume one of *Capital* is in Marx's argument that, by starting at the Lockean foundations of property in bodily labor, society winds up at a place where property largely takes the form of capital to which workers have no ownership rights. So "the separation of property from labour," where the capitalist comes to own the

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[11] This aspect of immanent critique is reflected in Black philosophy and politics, as Charles Mills (1998) argues: "A lot of black thought has simply revolved around the insistent demand that whites *live up to their own (ostensibly universalist) principles*" (5).

[12] For an extended analysis of the strengths and challenges of immanentism in social philosophy, see Maeve Cooke (2006), especially "The Instability of Radical Contextualism" (25-36) and "Dialectics of Immanence and Transcendence" (37-72).

product of the worker's bodily labor power, "thus becomes the necessary consequence of a law that apparently originated in their identity" (Marx 1990, 730).[13] In Benhabib's (1986) words, "through an internal exposition and deepening of the available results of political economy, he shows that these concepts are self-contradictory" (154).

Immanent critique is nonetheless a somewhat controversial concept within Marxian discourse. It is difficult to tap a source of true critique without supposing some kind of "discursive 'exterior'" (Laclau and Mouffe 2001, 154) from which critical concepts arise. Laclau and Mouffe (2001), for instance, argue that the subject positions of *serf* or *slave* do not designate themselves as antagonistic without a different discursive formation, like "the rights inherent to every human being," that subverts these categories and constructs *oppression* from a relation of subordination (154). This is to say that subordinated identities need this exterior in order to subvert the unquestioned positivity of *'this is how it is'* and *'this is where I fit into this mode of social reproduction.'* It would thus seem that something like criteriological criticism must be the source of this subversive category from some external standpoint. If immanent critique refuses to stand outside its subject, it would seem that it cannot achieve the exteriority necessary for the construction of oppression from subordination, and thus its subversion.

I argue that the source of critique within immanent critique—since it cannot come from purely exterior ideal principles—comes from the interplay between structural relational elements and their discursive articulation and understanding. There is a complex interplay between our discursive understandings and practices that construct knowledge and identities on the one hand and practices that reproduce our material existence within a given societal group on the other. This interplay is one that has proven impossible to completely or precisely parse out—a task that is made even harder if one supposes that discursive meanings and material practices are unfixed

[13] See also Blackledge (2012, 61-3) for an explication of this passage in *Capital*.

and capable of shifting and reshaping over time. Those relational practices that reproduce our material existence are understood through discursive practices that formulate knowledge and identities. But these practices can also give rise to certain "elements" that are not discursively articulated (Laclau and Mouffe 2001, 105), that is, there are no constructed discursive concepts to anchor the meanings of a given set of experiences (112-3). I argue that structural relational practices give rise to elements that provide a discursive exterior from which to begin critique. The analysis of social relations can reveal and articulate patterns and forms that are subjected, then, to political and ethical discursive forms like democratic equality. Because these relational practices occur on the same ontological field for all persons and practices, but are subject only to exteriority with regard to discourses, the elements are transformed into an intelligible moment or nodal point. So it is through the discursive act of examining structural relations, which are themselves discursive because they "do not arise from a necessity external to the system structuring them" (107), that these moments can be subject to other discursive exterior concepts like equality and contradiction.[14] Structures are made intelligible to social and political actors, through philosophical analysis, for the sake of subjecting them to immanent normative expectations.

It is in this vein of immanent critique that I stop short in this project of offering ethical criteria against which to assess some situational dilemma or systemic reform. Such criteriological criticisms tend to work from a foundation of a priori essentialism, which supposes a fixed set of meanings from which to make sweeping claims, that goes against the theoretical commitments laid out here. I insist that my project can be no less critical, however, in that it looks to provide health care ethics discourse with a set of articulations of the relational

[14] An additional source of discursive exteriority consistent with immanent critique is in the discussion of *overdetermination* in the final section of this chapter.

contradictions and antagonisms that arise from the capitalist production of health care and how these can undermine the practice of health care ethics as it is currently practiced. I indicate when possible how certain critical concepts may act to subvert these contradictions in order to move toward a new social order. I do not take up the detailed articulation of such a new social order's normative characteristics as the primary domain of my project, though I recognize the need for such a vision in ethical and political praxis. I return to the relations between normative vision and critical understanding below in discussing ideal theory.

Returning to Benhabib (1986), defetishizing critique looks "to show that the social reality of capitalism necessarily presents itself to individuals in a mystified form" (154). This task emerges from the fetishism of the commodity in the first volume of *Capital* where Marx (1990) argues that the commodity "is nothing but the definite social relation between men[sic] themselves which assumes here, for them, the fantastic form of a relation between things" (165). The basic idea is that persons tend to take their social world as objective and natural—that the present social order and ways of doing things derive from some natural, essential, or necessary basis—and critical analysis can show how this is not the case. Defetishizing critique looks to reveal the human influence and social relations that create the social order, that the mode of production is a complex of "individuals in mutual relationships, which they equally reproduce and produce anew" (Marx 1993, 712). By explaining the actual social processes and structures that produce and maintain the social order, defetishizing critique entails that that order could be otherwise and is a part of changing those processes and structures.

Critical theories of feminism, race, and disability help to illustrate this form of critique outside of political economy. One foundational contribution of feminism is the defetishizing critique of gender: the social order, and most individuals, take gender to be a natural distinction

grounded in an objective reality while it is in fact something that is maintained through social relations between persons. A good deal of feminist work illustrates the social relational structures that create, reproduce, and reinforce gender in order to challenge naturalizing conclusions or norms made on the basis of gender.

Michel Foucault's methodological concept of "eventalization" can also be understood as taking part in defetishizing critique. For Foucault (2001a) this means first refusing to take some historical event or development as a necessary historical development (226), and second to rediscover the human elements of power that create and establish what counted (or counts) as true or self-evident (227). It is by refusing to accept the necessity, universality, or naturalness of systems of practice like the penal system or madness, and instead to reveal their human elements of maintenance and reproduction, that leads me to argue for a defetishizing understanding of eventalization.

The nature of defetishizing critique can cause some difficulty since it sometimes appears that critique is identical with its object. For Marx this may lead some to conclude that he is merely doing political economy. For feminism this can lead some first-time readers (perhaps an undergraduate student) to feel that feminist scholars treat women as weak or inferior—that in critiquing women's social roles, norms, and interactions feminist authors are in fact taking part in or reproducing the patriarchy that they are attempting to illustrate. The emancipatory ideal for defetishizing critique is for people to reappropriate social reality and alter it to fit desired human potentials (Benhabib 1986, 154). This often requires some self-clarification of the concepts and social relations that create new struggles and wishes that anticipate radical transformation (60). To make sense of a social-relational system for critique requires close analysis that is to some

extent in its own terms. Yet the critical step is to draw attention to the contingent nature of those aspects of the social order to de-naturalize those social categories.

Crisis diagnosis is rather straightforward. In revealing the contradictions and dysfunctions of capitalism, the struggles and needs that these cause cannot be addressed by the present order. Benhabib argues that crisis diagnosis should "explicate the protests or pathologies" that arise from these contradictions (226) in order to "enable and encourage future social transformation" (155). So social dysfunctions are identified for their underlying causes in a way that makes them conceivable for their transformation. This latter aspect may seem quite straightforward, but I argue that the centrality of transformation as a goal in critical theory motivates the most important critical divergences with traditional normative ethics and health care ethics.

I see this project to be taking part primarily in defetishizing critique because my primary goal is to make the US health care system more intelligible for health care ethicists and policy-minded thinkers by applying the categories and methods of critical theory and Marx's critique of political economy. By theorizing capitalism itself as it relates to health care, I offer a critique of dominant portrayals of health care in bioethics and also reveal inroads for sociopolitical intervention or influence, if only in preliminary forms. This can transform the ways that we do bioethics and think about ethical concepts in relation to the social world. For instance, in the next chapter I apply the concept of the commodity to health care in arguing that health care functions as a commodity in our social relations of health care. In so doing I am attempting to reveal avenues for the reappropriation of health care, which is motivated by moral ends, by indicating the ways that we construct and maintain the systems that come to dominate our lives. My defetishizing critique is related to a project of crisis diagnosis in that, while applying a Marxian

analysis of health care as a capital-driven venture of value production, I am identifying a set of contradictions or limitations in this capitalist health care system. In doing this I identify some sources of dysfunction, dissatisfaction, and struggle that one sees emerging in health care in the UNITED STATES. These limits can also be understood in terms of systemic and social limits in health care similar to Marx's systemic and social limits in the capitalist mode of production (Benhabib 1986, 108-9). Systemic limits include the rising price of health care despite serious underperformance in measurable statistics, while social limits include dissatisfaction among patients and communities that person-centered care or community health care organizations are attempting to address. This work looks to explicate aspects of these health care crises to make them more comprehensible for health care ethics and for social transformation.

In summary, Benhabib's analysis offers five crucial and interrelated methodological concepts from critical theory that inform my project: two dimensions in explanatory-diagnostic and anticipatory-utopian analysis, and three forms of critique in immanent critique, defetishizing critique, and crisis-diagnosis. The explanatory-diagnostic dimension offers descriptive models of social relations, systems and forces, particularly in order to illustrate the material manifestations of social input in their reproduction. This dimension is the setting for both defetishizing critique and crisis diagnosis. The former looks to reveal those categories, which are taken as natural or given, as being instead of an underlying social fabrication reproduced through relational practices. Crisis diagnosis is the descriptive task of identifying the dissatisfaction, dysfunction, or internal contradictions of social systems like capitalism—it identifies those problems that arise for populations or social actors when a system nonetheless works the way that it ought to work (in a nonmoral sense), while this often runs counter to the intentions and interests of social actors.

Benhabib's second dimension of critical theory is in the anticipatory-utopian, which provides the grounds for critical normative theory. Such analysis is both anticipatory and utopian in the sense that present crises and dissatisfactions—identified through crisis diagnosis—are considered for their emancipatory potential, whether through formal analysis or through considering social movements already underway. Finally, immanent critique seems to bridge these two dimensions in that it looks to hold social systems of practice to their own standards in order to reveal their internal contradictions and the potentials for subversion thereof.

I now turn to Iris Marion Young for additional methodological theory, which I understand as intersecting with and expanding some of the concepts that Benhabib identifies in critical theory.

Young and Social-Relational Structure

Iris Marion Young's (2011) posthumously published *Responsibility for Justice* offers an alternative to legalistic or juridical concepts of moral responsibility (blame/fault) in reference to some wrong or injustice. Young perceives a need for this alternative in a social landscape where harms often come from multifactorial and complex interactions of alienated social relations. For instance, harms to an individual worker in a textile factory in Bangladesh are not sufficiently accounted for in terms of legalistic responsibility—especially when such accounts tend to leave out Western corporations, policies, and consumers. The factory owner, manager, Western contractor, and consumer can all operate within accepted rules or norms while nonetheless taking part in the structural processes that create structural injustice. The practice of blaming only a handful of people in the face of wrongdoing tends to let countless others off the hook for their part. Young therefore offers an alternative to this liability model with the concept of social-

structural processes to account for social-relational injustice, and therein to move toward a corresponding social connection model for responsibility shared across a web of social relations and processes. It is Young's theorizing of social-relational structures that is key to my project.

For Young, offering an account of structural relations is to depict the general conditions that produce a set of circumstances that social actors work through and within, including how these circumstances came about through several factors and processes (19). Young notes that nothing in this structural account prevents one from also considering the individual desires, motivations, and actions of individual actors or to hold individuals responsible for their actions (19). But accounting for structural relations indicates the *opportunity set* that similarly positioned persons have available (19-20). An account of structural relations does better to recognize the impact of systems of economic, racial, and gendered oppression because it takes a broader view that allows patterns to become visible amid a series of individual interactions.

A structural focus for Young results in a view of moral responsibility—and thus also of justice and moral normativity—that differs from traditional accounts. In critiquing luck egalitarians, Young argues that rectifying injustice, when using a structural approach, calls for restructuring institutions and relations in order to prevent harm and injustice rather than redistributing resources to rectify the harms of social processes (34). This highlights a difficulty in critical theoretical methodology that motivates this chapter. The tools of critical theory lend themselves more to *preventative* normative arguments, which tend to be broader and future-oriented, versus ethical alternatives that lend themselves well to the case study and individualized application in some immediate circumstance.

Young builds an account of structure by describing social-structural processes through four related aspects:

> (1) as objective social facts experienced by individuals as constraining and enabling; (2) as a macro social space in which positions are related to one another; (3) as existing, however, only in actions; and (4) as commonly involving the unintended consequences of the combination of the actions of many people. (53)

Starting with point (1), Young refers to the ways that social relations and systems create "channels" that direct and shape the actions and opportunities for individuals without fully impeding their flow (53). Such processes can take material form in the shape of our physical world as a result of policies, decisions, and actions of the past society (54), and also in the immaterial form of institutional and social rules (55). Young notes that individuals often experience structural constraints as reified and thing-like and thus treat them as operating outside of human agency (56); here we see especially where Young's work fits with regard to defetishizing critique and critical theory. Young refers to Marilyn Frye's (1983) analogy between gendered oppression and a bird cage to describe the way that structures interact with notions of freedom: a careful analysis of the *individual elements* of oppressive structures do not account for the restrictive results that become apparent from considering the same elements in the context of a *larger structure* (4). In this vein Young (2011) argues that "to say structures constrain does not mean that they eliminate freedom; rather, social-structural processes produce differentials in the kinds and range of options that individuals have for their choices" (55). I understand this point to be that social-structural processes influence our actions in diffuse yet significant ways that are sometimes lost in social philosophical analyses (including many ethical case studies). In addition, these influences are often cumulative over one's lifetime, across generations, and over historical time.

This leads directly to point (2) above. Understanding social relations from a social-structural point of view means "taking a broad macro point of view on the society that identifies its major social positions—general categories that define these constraints and opportunities—

and how the positions relate to one another systematically" (56). Young argues that one must understand where individuals are situated within a multidimensional schema in order to account for structural constraints, opportunities, or enablings. For instance, "the social positions of the owner of capital and owner of nothing but labor power are key to explaining the outcomes of [the production of surplus value in capitalist accumulation]" (58). One's position within a social structure—whether that be the capitalist mode of production or a system of race or gender—is significant because her or his position often relates to that of others in the form of oppression or inequality, privilege or disadvantage. Using highly abstract or idealized models tends to bracket out the situatedness of social actors, which overlooks important realities for philosophical and ethical considerations. Broader, contextualized approaches need to be employed in combination with narrower analytic tools in order to do good normative philosophical work.

Young's third point (3) is that structures are produced and maintained by actions, though not reducible to actions in their descriptions (60).[15] Individual social actors internalize and act within the rules of a certain institution—they come to know the expectations, patterns, and sanctions and come to act habitually within them. This is the aspect of structure that deals enormously in examining power relations, both in terms of individual capability and in power over others through threats of sanctions or offering desirable goods (61). Young employs Pierre Bourdieu's concept of *habitus* in building out this aspect of social-structural relations, where our individual actions, perceptions, and preferences reproduce and fit within a schema that correspondingly reproduces social position (61). This is to say that the ways that we comport ourselves in our bodies is influenced by our position within a social system, and that our tastes or

[15] This point regarding irreducibility to inter-subjective relations is one that comes from Marx (1993, 158-9, quoted above), and is a central point for Althusser (1997, 174, 180). Young does not cite Althusser in any of the footnotes, yet it seems that an Althusserian reading of her concept of structure is a fruitful one for understanding and application (see Althusser 1997, especially 165-193).

preferences are similarly influenced.[16] I understand this third point to be highlighting the social relational elements of structure, where social categories and systems are the result of individual actions and decisions while simultaneously proving to seem impervious to manipulation through conscious individual action. Social practices of capitalism, race, class, and gender reproduce their respective systems, and make them in-principle changeable; this also means that such systems or their effects should not be treated as eternal, natural, or given in theoretical accounts.

Another important implication here is that, even though Young's language of "opportunity sets" (20) and one's "range of options" (55) implies an idealized decisional framework, constraining or enabling social-relational structures formed through practices can nonetheless have *material* and behavioral consequences on environments and individuals' bodies. Young is, after all, still the author of "Throwing Like a Girl," which argues that gendered oppression creates a set of constraining norms and expectations that influence the ways that women experience and comport their physical bodies (Young 1980). Thus references to Bourdieu and Foucault help to illustrate that the conditions that create limited or expanded *opportunity sets* for different persons or groups can also generate, maintain, and enact important *material* differences between persons and groups, which then take on their own kind of momentum or force. Framing the effects of social structures in terms of the former need not preclude the latter. While it may be the case that Robyn, a 22 year-old working class Black woman from the south side of Chicago, has a diminished opportunity set relative to a wealthy white male from the suburbs, it is also the case that the forces that constitute whiteness, white supremacy, and gender also constitute the material disadvantages that ghettoize certain neighborhoods of a city like Chicago and drive wealthy people to certain suburbs or

[16] This idea also motivates Michel Foucault's work in examining those ways that the capitalist mode of production shapes bodies and populations in such a way that is conducive to capitalist production and labor (see for instance Foucault 1995).

neighborhoods. These forces then go on to influence individual bodies in measurable terms of health disparities from social determinants of health, while also conditioning individuals' embodied existence from a phenomenological perspective in practices (throwing like a girl) and the social *habitus*.

The fourth (4) and final aspect that Young highlights to build out an account of social-structural relations is that individual actions taking place over large groups of people often lead to unintended consequences—consequences that are sometimes even counter to the interests and intentions of actors (62-3). Young includes the tragedy of the commons, many financial crises (especially market-based runs like currency crises), and affordable housing shortage in urban areas among examples of such unintended unjust consequences (63-4). Here again Young notes that people often play by accepted laws, rules, or norms that prevent outright censure for most individual actors (64). This final aspect is somewhat unique to our present times in that people can participate in a system or series of social processes that create or perpetuate injustice while not intending or knowing about such harms.

Young clarifies the idea of structure that takes shape in her account by differentiating it from the notion of basic structures for Rawls. Young argues contrary to a Rawlsian framework that "structures" as the subject of justice do not refer to some *part* or *parts* of the society; "instead they involve, or become visible in, a certain *way of looking* at the whole society, one that sees *patterns in relations among people* and the positions they occupy relative to one another" (70; latter emphasis mine). It is in this way that Young sees her account as including personal interactions in addition to broad institutional processes because personal interactions are

to be considered in light of those broader networks in order to look for some pattern of oppression or injustice.[17]

It is helpful to note how the notion of structure fits within a Marxian framework. All four of these aspects cluster around a set of concepts that we see in Marx, namely fetishism/alienation/reification as a set of interrelated concepts, but also the notion of social relations determining a person or thing's conceptual significance. Young argues that the largely descriptive analysis of social-relational structures can help to elucidate new forms of shared responsibility for social injustices that plague advanced capitalist societies and the global community. In Benhabib's terms, Young can be understood as offering an analytical method for largely explanatory-diagnostic defetishizing critique: rendering intelligible a set of social relations that produce injustices and harms that are often conceived of as natural, given, and thus unavoidable, in order to offer a critical account of those social structures. Further, structural analysis broadens the scope beyond merely individual questions of autonomy and responsibility—whether a person freely chooses to enter relations that critics deem oppressive. Young brings this social and political project into the realm of moral responsibility in her social connection model for responsibility, which can be seen as amenable to existing ethical frameworks from feminist authors, especially Margaret Walker (2007).

What the concept of social-relational structure offers my project is a framework that both informs and motivates my attempts to offer critical accounts of social relations that constitute health care interactions and practices. The doctor-patient relationship, for instance, is predicated

[17] We can relate this point in Young to Margaret Walker (2007) who argues that we need a "story of connection" for individuals or groups to be connected to vulnerable others to generate *responsibility* and thus a moral *need for action* (92). Walker argues that "specific causal histories (of colonialism, exploitation, or discrimination, for instance)" may provide those salient stories of connection (92). Given its relational component, the moral problems in unintended harms of diffuse collective action is identified and addressed by many authors doing feminist care theory. These include Walker (2007), Joan Tronto (1993) and Sara Ruddick (1995).

on a vast social and economic framework that *produces* health care for its delivery to an individual patient—and is deeply (and increasingly) driven by capitalist wealth production. Marxian analytical concepts help reveal social-relational structures that produce and reproduce health care in ways that are significant to their ethical consideration. And yet this very concept of the doctor-patient relation often functions in literature as an idealized reduction of two choosers taking part in communicative action and making collective decisions in a context where occasional challenges can be explained through conflicting moral principles. Structural considerations render more intelligible the practices that make possible an individualized model of doctor-patient, and also have contributed to the problems of rationing in an American system that insists on a certain sacred picture of this dualistic relation. When structures are not accounted for, there is something missing in normative considerations of shortages, triage, or fairness. Yet structures often have a hand in constituting certain scenarios that later become paradigm cases discussed in principlist ethical terms.

I further motivate what makes this largely descriptive and often materialist endeavor nonetheless relevant, and indeed vital, for normative ethical theory concerning health care by calling on the notion of nonideal theory offered by Charles Mills.

Mills on Ideal and Nonideal Theory

Charles Mills has focused much of his work in political philosophy on theorizing nonideal revisions to Rawlsian liberalism in an attempt to use the imagery of the social contract for identifying and rectifying injustice, especially regarding race, gender, and class. Mills's major break with Rawls is in the former's largely forgoing the methodology of ideal theory. Ideal theorizing conceives of the principles of justice for a perfectly just society amid favorable

conditions of cooperation where all persons comply with those principles (Mills 2007a, 112-13). All classical contract theorists like Locke, Hobbes, or Rousseau do not necessarily presuppose strict compliance and cooperation, but they are all concerned with the theorization of perfect justice in an idealized (non-actual) world. Ideal theory ordinarily begins from some kind of "ground zero"—the state of nature for classical contract theorists, and the original position for Rawls (Mills 2007a, 112-13). That ground zero provides the axioms from which to derive logically entailed principles of justice in the form of a hypothetical imperative: if these original conditions hold, then the principles of justice are *x*, *y*, and *z*.[18]

On the other hand, nonideal theory deals in what is to be done in instances of injustice. This is largely the concern of our actual world, especially in what we normally call the justice system. Mills (2005) attempts to adjudicate in greater detail the distinctions between ideal and nonideal theory in order to argue that the latter is preferable for the actual achievement of egalitarian ends, especially with regard to addressing racial injustice. Mills first notes that all normative social and ethical theory takes part in both abstraction and idealization. That is, all such theory abstracts from reality for the sake of generalization and it appeals to some desirable goal or ideal that we ought to aspire to and attempt to realize. He calls this kind of idealization ideal-as-normative and considers it uncontroversial for social theory (166). Mills's critique of

[18] Compare Rawls's method to that of axiomatic logic where formal proofs, utilizing the various methods of subproof in a realm of pure logic, produce authoritative axioms that one may apply in other logical proofs or arguments. The original position acts like a subproof: unfettered by given premises, one may suppose whatever one likes in order to derive some conclusion based on those premises already in force. Upon completing this subproof (applying only the laws of logic and valid premises already in force), one may then treat the result or conclusion of the subproof itself as a true premise. In the original position, by supposing one does not know the particular facts of one's life, Rawls makes the initial suppositions of his own liberal subproof (mostly negations of what those in the original position do *not* know), and then applies laws of logic and minimal suppositions about reasonable human beings in order to derive binding principles for justice as fairness. Axioms in logic have been rigorously proven, taken to be true on the merits of their initial proof, and are thus defined as "a proposition (or claim) that is accepted as true about some domain and used to establish other truths about that domain" (Barker-Plummer et al. 2011, 579).

ideal theory instead isolates critical distinctions as taking place within a type of idealization that he calls *ideal-as-model*, where a theoretical model is meant to represent some other thing existing in the natural or social world, *P* (166).

Mills identifies two types of idealized modeling: ideal-as-descriptive model and ideal-as-idealized-model. The first form of modeling offers a description of *P* that "purports to be descriptive of *P*'s crucial aspects (its essential nature) and how it actually works (its basic dynamic)" and will thus abstract away some non-vital aspects (166). This ideal-as-descriptive-model abstracts from the actual world in order to draw our attention to what is of interest for the matter of theorizing. So for instance, a railway map may omit roads from its representation in order to simplify and more effectively convey what its modeler takes to be important, namely railways. The second type of idealized model (ideal-as-idealized model) represents an exemplar of what the best possible *P* should[19] be like (167). In our same example, one might generate a map of an ideal railway system that is unrestrained by the existing infrastructure and designed to maximize the values of optimal railroading (likely various iterations of efficiency). The relations and comparisons between ideal-as-descriptive and ideal-as-idealized models for a given slice of social reality will be central to Mills's critique of ideal theory in social philosophy. Notice that both forms are in fact idealizations in so far as they both abstract away details of actuality in order to draw attention to some essential characteristic(s) of interest. Ideal-as-descriptive-models "abstract without idealizing" (168), while ideal-as-idealized both abstract and idealize.

Mills then considers what might be called the "distance" between the descriptive and the idealized model. Mills asks: "in trying to understand the workings of an actual *P*, how useful will it be to start from an ideal-as-idealized-model of *P*?" (167). In trying to understand the actual

[19] Mills notes that this is not necessarily a moral "should" and can be applied to purely functional descriptions of, say, ideal vacuum cleaners, or to simple limiting assumptions for calculations in the way that an ideal gas or a frictionless plane are ideal (167).

workings, then, one must generate a descriptive model of an actual *P*. Mills argues that the answer to this question "how useful will it be…?" depends on the extent to which that ideal-as-descriptive-model for *P* is similar to the ideal-as-idealized. If a working *descriptive* model of *P* were only slightly deviant from the *idealized* model (the exemplar), then starting with the idealized model as a way of understanding or discussing the workings of *P* could plausibly be useful. However, if a descriptive model representing *P* were vastly different from the idealized model, then the latter would be an absurd starting point for understanding *P*, much less making good normative statements for *P* (167). If one wants to change *P* to conform more closely to the ideal, then one would instead have to start by considering the actual properties of *P*, and thus with descriptive modeling, in order to determine what features of *P* prevent it from reaching the ideal (167). Returning again to our example, if we wish to travel on the railways, using the idealized map to get there would be absurd. And if we wish to make the actual rail system conform more closely with the ideal, then we will need to start with the actual system and not simply the ideal. We would need a reliable descriptive-model map.

Beginning at the ideal-as-idealized-model is only useful in understanding or altering some social order when it approximates that order. For many instances of ideal theory, especially those of Rawls and subsequent Rawlsians like Norman Daniels, this is not the case. Western liberal societies do not resemble the ideal-as-idealized model governed by the principles of justice. Mills adds the intermediary concept of the ideal-as-descriptive-model to bridge the space between perfected ideals and the actual thing, a space to which good theory must be attentive. The ideal-as-descriptive-model is central to the work of nonideal theory, which takes social change as a central goal. The question for a critical social theory then becomes: To what extent does this theory formulate a conceptual space that brings descriptive approximations of the

actual into relation with ideals? Is that formulation conducive to bringing about the ideal in the reality that the description is representing? The distinction between ideal and nonideal theory as methodological approaches turns on the role—if any—given to descriptive models of actuality. "What distinguishes ideal theory" from nonideal, Mills argues, "is the reliance on idealization [ideal-as-idealized] to the exclusion, or at least marginalization, of the actual" (168). Ideal theory does this by either representing idealizations as approximate to the actual or by claiming that dealing only with the ideal-as-idealized-model is the best way to actualize the ideal (168). So ideal theory actively forgoes consideration of the actual in its theory. Nonideal theory starts instead "from an *already existing* unjust society, and then asks what measures of justice would be necessary to correct for them" (Mills 2007b, 95). Descriptive models are the means of understanding that already existing social order.

Mills is largely dubious of the value of ideal theory for achieving the aims of justice in applications to contemporary society. Mills (2007a) argues that doing ideal theory is a practice in ideology, or "the adoption of a set of ideas/values/approaches/framing assumptions that reflect and reproduce the perspectives of the privileged," and is thus a part of the conservative momentum of the dominant status quo (108; see also Mills 2005, 172). Margaret Walker (2007), too, argues that the decontextualized universalities of ideal moral theory uncritically reproduce the specific position of a white male aristocracy (or later bureaucracy) as the norm—which is to say the *ideal*—and in so doing both *exercise* and *reinforce* their privilege (60). Ideal theory and its willful ignorance of actual injustice is clearly a non-starter for feminist theory, which Joan Tronto (1993) argues "grows out of the attempt to end women's marginal status in society," which is to say actual gendered injustices (15). The same goes for other critical theories of race, ability, and class. Mills argues that it is clearly not in the interest of women, the poor and

working class, or persons of color to simply ignore a past of repeated domination or structures still expressing it. Such ignorance-through-abstraction can only possibly work in favor of those already benefitting from all that they abstract away from: privileged bourgeois white men. By not engaging directly with instances of oppression and domination in gender, white supremacy, or global capitalism, ideal theory gives space for the obscured underbelly of the status quo to continue theoretically unchecked by ignoring it altogether. Because critical theories take emancipatory social transformation as a key end to their work, such political ramifications are of theoretical import as well.

What these critiques from Mills, Walker, and Tronto share is the insistence that the ways that thinkers do theory, and the subsequent discursive forms that take shape and that these plug into or build upon, are themselves part of a constructive political process. Laclau and Mouffe (2001) argue that the individualist and idealized subjects of neo-conservative liberal political theory—including their corresponding concepts in contemporary ethics—are not merely given philosophical forms, nor are they purely constructed from the development of philosophical ideas alone, but that these constructions are themselves the result of political formation and material practices (171-6; 168). Concepts like the atomist individual, rational chooser, or idealized interlocutor, which center certain philosophies, only become "organic ideology" as a result of political discourse and action that constructs and cements these forms as nodal points. So while Mills's notion of ideology is of one that contributes to the reproduction of privileged positions and the systems that contain and legitimize them, it can be the case that discursive concepts of ethics and politics are constructed around discursive forms of emancipatory politics. A part of doing (socially and epistemically) responsible theory is recognizing the political elements of doing that theory and accounting for them.

In this vein, Laclau and Mouffe argue that, "in order for a philosophy to become 'organic ideology', certain analogies must exist between the type of subject which it constructs and the subject positions which are constituted at the level of other social relations" (175). So in their example, the theme of individual liberty can only be mobilized in conservative political discourse because it bears on other understandings of social relations, including theorizations of individual rights taken to exist prior to society (175). I understand this to mean that discursive forms must in some way bear on or mesh with social actualities in order to get taken up in "organic ideology" or the ways of knowing that come to be at hand and institutionalized. But even before becoming organic ideology, subversive or disruptive social and ethical concepts must have these "certain analogies" to the present relations of their background in order to have transformational leverage. I therefore see my project as filling out some of the structural components that codetermine the complex discourses through which we in the United States and English speaking health care ethics come to make sense of health care. These structural contributions to social understanding can then be better employed in social and political attempts to subvert dominating concepts and to transform present orders and practices.

One objection to critiques of ideal theory accepts that ideal theory has its limitations, especially in its political application, but argues that ideal theory is foundational or is necessarily prior to nonideal considerations. The claim is that the ultimate end of social and political theory is to bring about a closer approximation of a perfectly just society, but in order to do so, we need some kind of reference point at which to steer our ship (or whatever other travelling metaphor you prefer—perhaps a compass if we wish to avoid strong teleology). That reference point is our ideal and it is prior to—or *more important than* and thus needing to be done prior to—any immediate political actions that would attempt to bring about a more just society. And in order to

lend that necessary guidance, an ideal reference point should be fairly robust, well-thought out, justified, and coherent or non-contradictory. This claim is articulated by, among others following Rawls, A. John Simmons (2010):

> The shape of our political ideal must be reasonably precisely specified before nonideal policies can be endorsed by a theory of justice. The requirement that nonideal policies be "likely to be successful" requires that we know how to measure success; and that measure makes essential reference to the ultimate target, the ideal of perfect justice. (34)

Simmons argues further that "even most nonphilosophers who are active in the cause of justice do in fact have in mind, however vaguely, an ideal of justice toward which they take their campaigns to be ultimately directed" (36). Simply put, the claim is that folks need a sense of where they are going prior to setting out if they truly want to reach that destination (see Rawls 2005, 281-5; see also Gledhill 2012, 77ff for a reply to Simmons 2010).

This is undoubtedly true, and I think that the consideration of real political activism is a helpful frame of reference. Yet such activist ideals are likely to be much more grounded than the ideal theories of Rawls and others. Most activist ideals, I believe, are arduously sought but still achievable ends like "clean public drinking water for all communities" or "greater access to voting [or quality in public education] for the poor, working class, and people of color." Such ideals of justice hardly seem to require lengthy justifications or appeals to the logical epicycles of a philosophical justification of ideal principles of justice. Instead, they come more as a reaction to the actual challenges to a community's capacity to flourish and rely on largely shared notions of broader concepts. Activism often appeals more to notions of what is *better* than to notions of what is perfect.

The insistence that ideal theory permits *greater understanding* of actual problems of injustice simply does not seem plausible given the methodological bracketing-off of the real.

Among early nonideal theorists, Karl Marx (1990) poses the following analogical question in a footnote of the first volume of *Capital*:

> What would one think of a chemist who, instead of studying the actual laws governing molecular interactions, and on that basis solving definite problems, claimed to regulate those interactions by means of the 'eternal ideas' of *'naturalité'* and *'affinité'*? (178-9n2)

With this question Marx asks what good it would do in a pursuit of knowledge for the purpose of addressing real practical problems to try to alter or control those workings by applying idealized eternal laws derived from logical moral truths—instead of careful empirical study of their actual interactions and the manipulation of those.[20] When the object of knowledge is something like the properties of atomic particles this is clearly absurd. Marx then continues the passage above to ask: "Do we really know any more about 'usury', when we say it contradicts *'justice éternelle'*, *'mutualité éternellé'*, and other *'vérites éternelles'* [eternal truths] than the fathers of the church did when they said it was incompatible with [their eternal laws]?" (179). We do not gain any knowledge of the actual workings of an economic social order (needed to try to change it) when we draw attention to the fact that it conflicts with ideal moral laws. Yet this seems to be the very case made by ideal theory. Consider Rawls (1971): "The reason for beginning with ideal theory is that it provides, I believe, the only basis for the systematic grasp of these more pressing problems," referring to the everyday problems of how to deal with injustice (9). That is, a well-argued and comprehensive theory of perfect justice is the only basis for a sound understanding of unjust happenings in actual life. If we attempt to slough off our acquaintances with philosophical traditions and disciplines, should we ever really accept this rationale for the complexities of

[20] This of course is an interesting analogy to come from Marx, as he would be among the first to call attention to the tendency for natural sciences to increasingly become an arm of capitalist production. So the actual "definite problems" of chemistry are increasingly the chemical barriers to greater production or surplus and not the barriers to greater justice, self-determination, or knowledge. That said, I do not think that Marx would endorse an idealized or essential notion of knowledge and would have to accept that it is to meet human ends—but those ends should be determined more deliberately than they are in a capitalist social formation.

human society? I think that Marx's analogy gives us a hint. It is not clear why the subject matter of human society should be treated much differently than that of the natural world in Marx's analogy, where governing laws might be identified by actively ignoring actual phenomena and social interactions. Thus I endorse a critical theoretical methodology that takes explanatory and diagnostic accounts of actual social interactions as a central part of philosophical and ethical discourses.[21]

Another line of response to the claim that ideal theory is necessarily prior to nonideal projects of addressing injustice in the existing world is to take up a broad historical frame for the beginnings of ideal theory as Rawls conceives of it, namely in social contract theories of Hobbes, Rousseau, Locke, and Kant. These theorists, and the enlightenment project in general, was largely grappling with overcoming the divine right of kings. From this frame, social contract theorists were attempting to conceive of a rational justification for a new social order that would supplant divine right. Rather than deriving political power from God alone, these theorists sought to derive it from some natural state or ground zero. In this way one can understand social contract theory—including its ideal methodology—as itself a reaction to the practical historical demands of an actual and nonideal challenge: how to justify a state apparatus without the notion that a supreme God bestowed that right on one person or familial line. This understands the very plausibility of the ideal project as itself a product of a material history rather than a universal and logical discovery of philosophers. The actually *nonideal* nature of their past endeavors, then, might even be proven in their less-than-perfect results, which created a normative moral apparatus to covertly justify the subordination of women (Pateman 1988), slaves and people of color (Mills 1997; Mills 1998), and the poor and working class (Marx 1990).

[21] "Critical social theories… aim to enlighten them [i.e., human subjects] as to the social obstacles that impede their flourishing as human subjects and as to the concrete ways in which these obstacles are actualized and produced" (Cooke 2006, 208).

Some of the plausibility of this argument for the priority of ideal theories of justice may actually come from a philosophical problem that nonideal theory, I argue, actually addresses. The apparent need for prioritizing the ideal comes from the need for holistic theories that can account for broader concerns, social phenomena, and descriptive frames. In many ways, when one asks the activist or supporter of a narrow political action or reform, "What kind of principled notion of justice is this action appealing to or moving toward?" one might be understood as simultaneously asking, "How do the underlying justifications of this activist end address or relate to other pressing concerns, perhaps especially of a broader scope?" While the former would appear to lead one to the construction of idealizing models through the consideration of perfect justice, the latter question seems to lend itself to a collaborative venture grounded in the actual social and political challenges for society.

In this vein, there is some reason to think that the priority question—particularly in the form of which theorizing must be done prior to the other—is itself not very consequential. This idea comes from Norman Daniels's (2008) account of adapting his Benchmarks of Fairness—a measure for the fairness of health reforms that follows Rawlsian justice as fairness—for international application in countries at different levels of so-called development. Daniels notes that in his initial development of the Benchmarks, his thinking "clearly went from theory to practice" (255). In terms of the present discussion, he proceeded first from the ideal theory of his previous project (Daniels 1985), extending Rawlsian accounts of justice to include fair equality of opportunity in health, to then consider measurements for the incremental achievement of those ideals through public policy. This clearly follows the image of steering a nonideal political ship toward the reference point of ideal justice.

In contrast to a theory-to-practice or ideal-as-prior approach, Daniels (2008) argues that the adaptation of the Benchmarks for international use followed different methods and yet arrived at similar normative ends or ideals. Collaborators from Colombia, Mexico, Pakistan, and Thailand reached consensus around central concepts of fairness by proceeding first from considering the success and failure of various reform attempts in order to identify their common features, including with regard to fairness (255). The collaborators started from descriptive accounts of actual policy practices in order to get to criteria of fairness, "not from abstract theoretical issues to concrete instances of them" (256). This mapping of common features even sounds like approaches that Mills in particular is calling for in nonideal work to provide "a corrective mapping of, an expository device for grasping, the *real* 'basic structure'" (Mills 2007a, 117).[22]

The use of descriptive accounts for Mills and Daniels both act to identify the actual workings of social phenomena and hindrances to fairness. What both theorists are asking is, "How did instances of inequality/unfairness come about?" For those in Daniels's case, this question is more technocratic and seems somewhat disinterested, while the theorists that Mills is drawing attention to consider also how (racial) inequalities were/are maintained through the very moral frameworks that proclaim equality. But these projects share their beginning at nonideal, descriptively-oriented starting points in the project of a more just alternative.

Daniels goes on to argue that their practice-first method "avoided debate … about competing theoretical frameworks for talking about justice that might have sparked complaints about cultural bias" among the different regional collaborators or from outside critics (256). But he claims that the two different approaches—Daniels's own theory-to-practice formulation of the Benchmarks and the international practice-to-mid-level criteria of fairness adaptation—

[22] See also Mills (2005, 174-6) on nonideal work as descriptive mapping concepts.

"converged on very similar structures" (256). I take this example from Daniels and the prior considerations of political activism's relation to broad ideals of justice to support the claim that arguments about the priority of ideal theory—that it must be done first as a foundation for activism—to be mostly inconsequential. Instead it seems that the import of the critique of ideal theory comes from the source of ideal theory and whether that is in essentializing a priori principles or from grounding in actual social formations and practices. And the temporal language of what needs priority simply does not have any plausible referent in the social historical reality. While aspects of governance do sometimes call on research organizations and think tanks to perform policy-related tasks of knowledge gathering and production, the history of social change is more accurately described as always already ongoing—with no start to be "prior to" some second step. The ongoing movements in politics and the already-present knowledge formations in the social imagination will help contribute to social change and reactions to crises.

Thus I argue to reject altogether dichotomous philosophical argument that creates endless fodder for philosophical theses and instead move to accept common ground around prudential claims about our priorities as a society—and as a discipline within philosophy. I argue that nonideal theory should be a priority, not in a temporal sense of what must be done first, but in that it should be the focus of philosophical efforts over ideal theory. This is primarily because I am convinced by the arguments of those like Mills and Marx who claim that ideal theory by design is not adequately suited to address the instances of injustice and domination that are most pressing because of its inherent interest in counterfactuals over actual states. However, I recognize that the kind of philosophical imagination necessary to conceive of better states requires the kinds of counterfactual thinking in asking "What if this world were not this way?" My claim is simply that various projects of emancipation do not benefit in any justifiable

proportion from even more coherently articulated justifications of perfect justice when compared instead to the nonideal considerations of correctives that are "just enough," to borrow a phrase from Leonard Fleck (2009).

Simmons ends his article by supposing simply that we have sufficient ideal grounds "to affirm that enough of ideal theory is settled" that activists (and likely also theorists) might forge ahead in nonideal projects without considerably more ideal refinement. That, Simmons argues, is "only to insist that we be careful with our political sledgehammers and seek justice thoughtfully" (36). This to me seems like an acceptable claim and one that can be consistent with a call to focus greater efforts on critical nonideal projects, and need not be anti-revolutionary. It also fits within the overall project of reflective equilibrium to simply claim that perhaps more efforts are needed at present to respond to new challenges in the world rather than redouble efforts to refine our ideal principles even further. Political arguments can motivate this emphasis.

This may still leave open the question of how new ideals or reformulations of existing ones are to come into existence without more ideal theory. Following Banhabib's concept of anticipatory-utopian aims of critical theory, I argue that looking to present nonideal conditions and political movements are a better starting point for the (re)formulation of ideals than ideal theoretical methods that elect to ignore real present conditions and phenomena. I understand the tradition of historical materialism to, in part, claim that ideal theories of previous historical eras were in fact formulated as an effect of the material conditions and challenges of the thinkers' times.

In the remainder of this project, it will not be so important to adjudicate whether or to what extent a given author is taking part in ideal or nonideal theory. What I take to be important instead is whether or to what extent an author is working with adequate descriptive accounts of

the basic social relational structures relevant to their subject matter in doing normative theorizing. Thus my arguments will not be made in order to conclude that a given author is doing ideal theory and is thus not as good as nonideal forms. Instead, my critiques revolve around considering whether a given author is accounting for descriptive actualities relevant to the realization of their proclaimed normative ends. In this dissertation, I argue that critical Marxian accounts of social-relational forms at work in the basic structure of United States health care apparatuses provide one such descriptive model. I attempt throughout to show how such an account is helpful to ongoing normative considerations of health care ethics. In the final chapter, I return to some of these themes in order to illustrate in a more applied way how my project can contribute to ongoing normative health care ethics and to social praxis in pursuit of transformation.

Critical Health Care Ethics

In this final section, I bring these three discourses together—Benhabib and Marxian critical theory, Young, and Mills—in order to chart out a methodological justification of my project, that is, to chart out what my project is doing in relation to health care ethics discourses and how I attempt to address the tension between discursive ethical frames and more functionalist structural-relational frames. Above I argue that Mills provides convincing reasons to reject ideal theory as a normative method for correcting unjust social structures, and thus motivates a turn toward nonideal theory that operates from descriptive models or accounts of what is dysfunctional or wrong with an institution or society. I take this to be a largely explanatory-diagnostic endeavor. Benhabib's defetishizing critique identifies one sort of descriptive model (in Mills's terms) and explains its function for social understanding: to challenge the

presupposed necessity of social forms in favor of models that account for their bases in concrete practices and processes of production. Descriptive modeling as it pertains to normative theory can also be related to the critical theoretic method of immanent critique, which describes the ideals inherent to a system at work and shows how those ideals are betrayed by its very functioning. In constructing defetishizing descriptive models, I wish to utilize Young's notion of social-relational structures. Young offers a bridge between two discourses of applied normative social philosophy and its critical examination from a structural standpoint.

I see Mills as shifting the emphasis for normative social philosophy to the generation and use of descriptive discursive models for the sake of understanding and addressing injustice or social pathologies. His work redirects philosophical focus away from how we generate ideals and instead insists that the ways that we understand social realities conceptually are themselves of normative philosophical import. This is where Benhabib's generalized methodological theorizations of critical theoretical work fills out this picture of what normatively motivated descriptive work looks like with the explanatory-diagnostic dimension of critical theory. Benhabib and critical theory offer a set of concepts that show what descriptive modeling can do for normative philosophy and the generation of new ideals from the tension between ethical discourse and relational structures. Mills motivates the use of critical theoretical concepts and methods for the preliminary work of identifying and theorizing social normative problems and questions. And what Young brings to the table is a set of tools by which to identify the work of social relations in the social and political sphere and relate it to ethical notions of responsibility.

The central critical claim of my project is that many authors in health care ethics explicitly or implicitly operate with inaccurate, undertheorized, or fully idealized descriptive models of health care practice that insufficiently account for the highly influential and often

constraining role of capitalism and economic social relations. Such theorists therefore arrive at normative arguments and models that are of little use in the ultimate aims of *applied* philosophy and ethics because they are derived from essentialized, universalized, or a priori criteriological sources. In the chapters that follow I therefore attempt to fill in an account of capitalist structural relations as they pertain to concrete practices of health care production. This claim is in the spirit of Foucault (2015) in addressing the shared aspects of the prison-form and the capitalist wage-form. He argues that they share their use of time not because the one served as a (discursive/normative) model for the other. Instead he argues that they share these similarities because the prison and the wage *connect to the same apparatus of power* "that ensures the real extraction of time and introduces this into a system of exchanges and measures" (83). My project looks primarily to reveal and analyze the capitalist apparatuses at work in health care rather than presupposing the primacy of normative discursive models in shaping and propelling health care practices and normative change.

It must be noted, however, that my justification for an account of social relational structures of capitalist health care is not intended to replace or entirely exclude normative ethical argument. I argue to *deprioritize* or perhaps *decenter* normative arguments that emphasize ethical discourse and ideas (and especially principles) as the source of moral problems and thus also the source of their solutions. I must maintain some role for ethical discourse in order to avoid performative contradiction. On one hand it seems that I claim that merely giving ethical reasons to transform beliefs in an appeal to individual agency is unnecessary or ineffectual because of structural limitations of capitalism. But on the other hand, I nonetheless do so *by employing (if only implicitly) normatively justified reasons to individual readers in an appeal to*

their moral and theoretical belief. The former claim seems to be contradicted in the very form of my project.

Rather than rejecting the influence of philosophical discourse regarding ethical belief, I reject its primacy or attempts to reduce society and social systems to communicative understanding and moral discourse alone. By accounting for capitalism and by filling in its influences I look to begin a mapping of communicative action and moral discourses' potencies in a material-linguistic sense of discourse generally.[23]

This is an area where I think that the Marxian concepts of fetishism and alienation, and defetishizing critique, are key. A Marxian critique of ethical discourse does not necessarily have to insist that, because it arguably has little to no bearing on largely structural social relations, communicative action is altogether a fool's errand, to put it uncharitably. Instead, the idea of fetishism offers the argument that such ethical discourse alone is ineffectual because of misguided presuppositions about the nature of the problems it looks to address. By assuming that ideas and moral understandings are the fundamental driving force, or the primary "stuff" of the social world, such authors fetishize the present (incidentally, capitalist) social order by leaving unquestioned basic social categories that determine that order like distribution, legal systems, markets, etc. But a critical Marxian frame expands focus to the elements of a mode of production, or the ways that a society reproduces its material existence. Jason Read (2003) argues that this is what distinguished Marxian philosophy from mere moralism:

> Without a thought of the mode of production as the material and historical ground of practice (including theoretical practice), Marx's philosophy and political work collapses into moralism (capitalism is bad) and (incorrect) prophecy. (5)

[23] Again, I return to the ways that my project relates to ethics in the final chapter, after the actual content of my project is presented.

The Marxian claim is that many authors in ethics take too much of the "moral world" at face value rather than asking critical questions about *how moral quandaries are constituted in the interplay between discourse and material structures and modes of production*. It is indeed this set of questions that seems more in line with the primary self-proclaimed functions of philosophy. While it may seem that one is asking probing "critical" philosophical questions when asking "What kind of good is health care?" or "What is equity with regard to the distribution of health resources?", doing so in the practice of applied philosophy—which aims to be relevant and effectual to the real social world—appears precisely *uncritical* through a Marxian frame.

It is in this way that my project is a critique of health care ethics discourse more than a mere critique of capitalist health care itself. My critiques are aimed at the ways that many bioethicists theorize social reality in their moral argumentation. The kinds of health care ethics arguments that I take issue with tend to occur between the poles of system and lifeworld, public and personal, institutions and individuals. Many moral problems in medical ethics (I try to draw attention to such issues through examples) are the result of the contradictions in a capitalist system of health care. Yet by treating these problems or dilemmas as purely moral problems, and failing to account for social-relational practices and structures, bioethicists reify these structural/relational components and thus construct an idealized model that is critically incompatible with the reality it seeks to address. In each chapter I illustrate what my alternative approach offers bioethics through critique of contemporary health care ethics literature.

Yet my project is not solely negative or critical. I have a positive project wherein I draw connections between the conceptual nodal points that I identify and analyze in the relational structures of health care and current and potential ethical and political discourses. I look to plug

into positive projects for transformative social change and not just take part in a "strategy of opposition" or pure negation (Laclau and Mouffe 2001, 189). A motivating goal of my structural mapping is thus to offer a set of concepts that lend themselves to better ethical and political normativity and understanding.

The apparent dichotomy or tension that I am drawing attention to between the two poles of (ethical) discourse and (Marxian) structures clearly cannot be adjudicated wholly on the side of one or the other. Instead I argue that those working in either of these frames should do so in ways that readily integrate and share some awareness of the other component. Discursive ethical approaches should account for the structural landscape of the social relations upon which they comment. This is likely to be done through the "mapping" projects of nonideal theory for which Mills calls. Meanwhile structuralist projects should account for the ethical-political concepts at play in the discourses pertaining to and co-determining aspects of the social, political, and economic structures being analyzed. This can be done through the political-conceptual relations made between structural analyses and ethical-political discourses. By this I mean that structural projects should contribute to the conceptual content of subject positions, identities, and theorizations of subordination, oppression, and domination that are utilized in ethical and political discourse. They can do this by submitting some of the ethical-epistemological content available to normative discourses.

Where my project differs from some ethical projects is in the latter's a priori, essentialist, or universalist tendencies. Instead I follow the theorization of Laclau and Mouffe (2001) (which is basically Marxian) that untethers ethical and political discourse from essentialist or foundationalist claims where concepts of traditional analyses like "power" or "autonomy" are reintroduced with redefined status:

> All of them are contingent *social logics* which, as such, acquire their meaning in precise conjunctural and relational contexts, where they will always be limited by other—frequently contradictory—logics; but none of them have absolute validity in the sense of defining a space or structural moment which could not in its turn be subverted. (142-3)

I understand their claim to be that the concepts employed in what I am calling more traditional ethical discourses—which in addition to power and autonomy I might include ethical concepts like reciprocity, vulnerability, or even commodification—derive their meaning as a part of ongoing social structural processes, and not necessarily from the reasoned declarations of ethical argument alone. Such structural and relational contexts that Laclau and Mouffe point to are revealed in part through the largely economic analyses from a Marxian framework. Ethicists who appeal to autonomy or person-centered care, for example, as normative ideals in the absence of structural and relational reflection regarding how these concepts and their objects are constituted through practices and discourses, but instead only through philosophical moral reflection on pure ideas, are failing to reflect on the real meanings of these forms.[24]

Structural and relational analyses reveal the lived meaning of ethical and political concepts and can thus contribute to the efficacy of these concepts as political concepts employed in organizing and mobilizing political action. Through mapping social and political space, such projects plug into a larger discourse and can articulate an alliance between one form of subordination or antagonism between health care practice and a population of subject-patients (or health care practitioners) and a corresponding framework of anti-capitalist and liberation discourse and politics. The practice of discourse-based projects like mine, which may appear largely descriptive, are themselves *critical* in that they perform this articulation—they illustrate

[24] It is in this light that I understand such feminist concepts as relational autonomy (Mackenzie and Stoljar 2000) to be satisfying structural and relational considerations in ethical and political work because the concept accounts for the structural-relational practices that constitute autonomy within society and history. I return to this fundamental Marxist notion of ideal concepts as lived social and historical categories in the final chapter.

and analyze connections between structural and relational forms and their antagonistic relation to a subordinated group of people. Such groups might include patients, patients with a particular chronic illness, physicians, nurses, persons with disabilities—relevant communities formed around shared struggle.

Further, Laclau and Mouffe argue that the autonomy of certain spheres or institutions from the economic base—such as the state—are not the necessary structural effect of anything inherent to those social forms or institutions (140). They argue that the autonomization of certain spheres is instead "the result of precise articulatory practices constructing that autonomy" (140). By this they mean that certain institutions can come to operate separately from underlying economic influences because of historical discursive practices that separate and insulate those institutions from economic forces. It was the result of a series of discussions, decisions, and actions that a certain set of institutional structures is capable of operating relatively unchecked by economic forces. Such instances challenge Marxist thought because it generally holds that social categories and structures are increasingly subjected to the control of capital, and so Laclau and Mouffe offer this argument as a partial explanation for some apparent counterexamples. Health care delivery may appear to be such an area where specific historical practices and decisions constructed its relative autonomy from economic capitalist influence. That is, there may be constructed social and political structures that make it independent.

Some authors suppose the relative autonomy of health care delivery from the general economic activity of society—especially in its interpersonal practices between doctor and patient. Regulations like the Emergency Medical Treatment and Active Labor Act (EMTALA), for example, came about from explicit discursive political action to separate access to emergency care from an individual's ability to pay. Many individual physicians continue their health care

practices without consideration or extensive knowledge of procedures' costs or of health insurance coverage plans. Some are even outwardly hostile toward attempts to make physicians know and share prices of medical procedures with their patients in an attempt to assert patient-consumer rights and to curb spending through microeconomic consumer-based approaches.

This apparent autonomization of health care, I argue, contributes to ethical discourse that essentializes or abstracts away from structural, relational, and especially *economic* contexts in order to do moral philosophical analysis. Part of what my project does is challenge the supposed autonomy of health care from economic or political bases by mapping out ways that capitalist relations constitute health care practices and institutions.

With the move away from universalist theories in ethics and toward more contextualist theories comes, obviously, the importance of social contexts for moral life. Thus perceptions and interpretations of the social world largely determine the ways that contextual information is accounted for in ethical theory. The influence of contexts in ethics is navigated through a set of background knowledge and presuppositions from culture and social norms,[25] and these are shaped by the social and political discourses of the past and present. As a result of this, social and political discourses—and the systemic factors that influence political existence—influence the identification and interpretation of moral data in doing contemporary ethics. A ready example of this is the transformed treatment of women, gender, and caring labor in ethical discourse as feminist political movements influenced philosophical research.

In contextualist ethics, discursive space must in some way be opened up or made possible by articulation through social and political discourse. With universalist theory, any individual action can be subject to ethical analysis. In contextualist ethics, any individual action must be

[25] Something like a Habermasian lifeworld: "the horizon of unthematized, intuitive, and 'always already' assumed expectations, definitions, and modes of orientation" against which social action occurs (Benhabib 1986, 238).

analyzed on the basis of relatively diverse and specific norms or criteria in order to determine the influence of contextual data on ethical prescription. I argue that, because of this added layer of contextual analysis in contemporary ethics, social and political discourses and understandings of structural relations take on an important, co-determinant role; first in determining the set of action potentials and efficacy of an individual moral agent by also theorizing social phenomena that determine the former, and second in simply opening up the social space to moral discourse about a given subset of our lives by contributing to the articulation of concepts at work in relational praxis. Because of the role of context, social and political discourses play a substantive role if ethical and political discourse is to take any sort of hold and lead to action.[26]

I argue that an explanatory-diagnostic model of social relational structures of capitalist health care practices provides a better framework from which to understand the nature of, and genesis of dysfunctions in, health care that are the target of bioethical discourse, and that this is a necessary step in better understanding the interactions between social-material structure and ethical discourse. In addition to those aspects already covered above, I argue that this project provides several missing elements to the discourses of health care ethics.

The first missing element that this project provides is a sense of context regarding the relational structures that determine ethical dilemmas. By this I mean that the dysfunctions that those in health care ethics call dilemmas arise from a specific mode or way of *producing* health care

[26] I see this and the preceding paragraph as largely overlapping with Laclau and Mouffe's (2001) political philosophy and the notions of *hegemony* and the *articulation* of *nodal points*. Hegemony, very briefly, refers to coalitions built among people and groups around common bonds of identity or equivalence for the sake of political formation (134-43). Hegemony is formed in part through the discursive act of articulation, which is the construction of partially fixed centers of meaning, or nodal points, in the face of a shifting discursive space (112-4). These nodal points then anchor the social imaginary and political discourses, like the democratic principles of liberty and equality "constitute a fundamental nodal point in the construction of the political" and this logic of equivalence was increasingly employed in social discourse of equivalence between genders, races, and other social groups (154-5).

services. By offering a model for understanding this mode of production, my account offers insights into how some ethical issues or systemic dysfunctions comes to be and thus offers some guidance as to how such dilemmas may be addressed through social-relational means, and potentially through more local reformist means. In addition, such accounts serve a defetishizing function that refuses to treat such dilemmas as inherent or natural to health care practices—and thereby reify them. I instead look to illustrate those ways that moral questions in health care arise amid the contingent ways that we go about producing health care in capitalist relations. This has the benefit of accounting for both "the structural contradictions of the whole and the felt experience of individuals" and to "think their unity, not to emphasize one at the expense of the other" (Benhabib 1986, 349-50). By this Benhabib means for critical theory to theorize individual moral lives and dilemmas as related to greater structural frames rather than to a universal space of ethical reasons, reasonable doctrines, or competing theories of the good. Doing the former, I argue, starts health care ethics out on stronger epistemological footing than the uncritical naturalization of capitalist modes of producing health care.

The second and related element that an account of capitalism in health care provides is a better sense of individual and institutional agency with regard to realizing normative goals. A central concept of Marxian structural theory is the individual as a "bearer" (*Träger*) of a given role within a set of capitalist relations (see Marx 1990, 179, especially translator's footnote). Marx also sometimes uses the language of an actor wearing a character mask. The idea of the bearer or actor of a role is first that the individual is playing her or his part in a coordinated production that limits the options of that individual. Even the capitalist experiences the laws of capitalist production as a coercive external force (Marx 1990, 381) and is in that way also merely a "cog" in the machinery (Marx 1990, 739). He is just a cog for whom the system is a benefit.

The implications of this include that an individual abandoning her role will only make way for an understudy to take over. And leaving the production altogether is not an option and thus she must merely take on another role or mask in the same drama.[27] The result is a largely downplayed role of individual actors (the predominant topic of ethics) in favor of structures and forces of social relations.[28] Marx (1990) writes that he does not intend to consider whether or in what ways the immanent laws of capitalist production "enter into the consciousness of the individual capitalist as the motives which drive him forward" (433). Marx looks to identify the internal logic of capital as it functions, not necessarily as they appear to individuals enacting them.

For the sake of ethics, however, I argue that explanatory descriptive models of capitalism also help to map out the space in which an actor might work within while also pointing the way to structural transformation.[29] So this project deals more in the concepts and formulations of knowledge that we employ in moral and political thought than it does in making moral and political normative argument or traditional looking moral "critique" of capitalist health care. The act of theorizing descriptive models could, however, contribute to ethical and political articulation of new concepts that can serve as concepts from which to critique capitalist health care. Structural frames in health care ethics permit understandings and critique of capitalist mechanisms in health care that go beyond mere conflicts of interest among individual actors to reveal deeper structural pathologies. Rather than merely arguing that one set of options for a practitioner or institution is morally preferable to another, an author can offer a more realizable

[27] Something like this point could likely be made in a Wittgensteinian framework of language-games and the moves available to one therein.

[28] "Marx presents the humans themselves only insofar as they have intercourse with one another as character-masks. Insofar as they come into relation with one another as individuals, they are not the object of theory" (Reichelt 1982, 168).

[29] "The only way to the essence of the economic is to construct its concept, i.e., to reveal the *site* occupied in the structure of the whole by the region of the economic, therefore to reveal the articulation of this region with other regions (legal-political and ideological superstructure), and the degree of *presence* (or effectivity) of the other regions in the economic region itself" (Althusser 1968 [1997], 179).

and action-guiding normative argument that also raises new ethical and political potentials. Politically, this also avoids making moral villains of individual persons (like overpaid CEOs or "bad apples") and instead draws attention to structural workings in relation to one another.

A third element that my project provides is a Marxian framework that relates to biopower and biopolitics of Foucauldian theory, but that I argue makes better sense of health care practices. Foucault (2001b) breaks somewhat with classical Marxism regarding the goals of the state by claiming that its objective is not necessarily wealth but *health* and well-being (334, see also Foucault 2008, 317). Yet this claim does not seem to apply well to a US context where major indicators of population health are miserable when compared to other so-called developed OECD countries (Woolf and Aron 2013). While a plausible argument could be made that the US government is simply very bad at this Foucauldian state function, I argue that there is a Marxian understanding of US health care in relation to the state-capital apparatus that understands its apparent weaknesses instead as its hidden strengths.

From the standpoint of a policymaker or ethicist with some idea of what a fair and well-functioning system of health care would look like, the present system appears like an irrational and chaotic free for all. This is especially the case for those with the intention of rendering the US health care system more fair or just through new policies or institutions. What my project presupposes, however, is that there is in fact some kind of underlying rationality to the way that health care functions in the US—that the system is rationally and efficiently serving some ends. The key to understanding this rationality, I argue, is a concept of capital. When the mechanisms of health care are so intimately entwined with capitalist wealth production as they are in the United States, then the general ill health of a nation can be tolerated (if not promoted) by the logic of capitalism. General trends in US health care practices better fit a conceptual

understanding as contributing to the production and accumulation of wealth wherein the runaway spending on health care—bemoaned by politicians, policy wonks, and bioethicists—is in fact no more than the spiraling effect of accumulating health care capital. The driving force of health care in the United States is not primarily the health of the working population as Foucault would have it; by such measures it is clearly failing. By modeling US health care practices as a part of capitalist social relations, I argue that taking wealth as a driving force produces a more coherent conceptual picture for making sense of its development.

The fourth element is an alternative source for new normative ideals and normative motivation. The challenge must nonetheless be answered by all those doing political work in the face of individual ethical challenges, and that is that something must pragmatically *be done right now*. Rather than having merely future-oriented political aims of overcoming dominant systems of capital, patriarchy, or white supremacy, this Marxian—and more specifically critical theoretical—framework does offer some guidance for present moral problems but reorients attention to sources of resistance and emancipation within existing political movements or in response to existing contradictions of dominant systems. Rather than an appeal to neutral liberal principles, ideal suppositions of an original position, or of ideal speech situations, a critical theoretical framework that I argue for can offer normative ideals from nonideal standpoints and emancipatory theories from struggle. Benhabib's explanatory-diagnostic and anticipatory-utopian goals for critical theory (226) generally map onto descriptive and normative goals. These also map on roughly, I think, to what Benhabib identifies as "*norm* and *utopia*, justice and the good life," which she calls two poles "between which the discourse of a critical social theory unfolds" (328). I think that it is becoming apparent what the explanatory-diagnostic work of critical theory looks like. What is distinctive and interesting for this project are the ways that

critical theoretical normativity differs from traditional ethics. I think that the important distinction is in the relation to the present. Critical social theory grounds its normativity in the existing potentials of the present in a way that motivates theory much more than mere "implementation" concerns.[30]

The fifth element that this project provides (having brought with it from a Marxian background) is the concept of *overdetermination*, which I think captures the complex interplay between social, political, and ethical discourses and the social relational structures often conceived of in more material and institutional terms. For the sake of this project, it helps draw attention to the idea that structural-material relations in society and the discursive realm of ideas and the "social imaginary" contribute in diffuse and complex ways to social transformation through time.

The term originates in Freud and subsequent theory. Laclau and Mouffe (2001) argue that overdetermination for Freud "is no ordinary process of 'fusion' or 'merger,'" which at least has some analogy in the physical world, "on the contrary, it is a very precise type of fusion entailing a symbolic dimension and a plurality of meanings" (97). Freud (1953) understands a dream's content as a condensation of a litany of dream-thoughts that contribute to the various aspects of a dream's content (279). This means that one can analyze a dream along a nearly infinite set of meanings because each aspect of the dream has a fractured set of influences and connections to other thoughts and memories (279). Yet the dream cannot be interpreted along distinct causal lines between one aspect of content and the underlying unconscious thought or memory. Freud argues: "the dream is not a faithful translation or a point-for-point projection of the dream-thoughts, but a highly incomplete and fragmentary version of them" (282). Instead a multitude of elements in dream-thoughts converge upon a certain aspect, object, or theme in the

[30] There is more on this theme in the final chapter.

dream's content;[31] the dream content is thus said to be overdetermined because it is represented in the dream-thoughts many times over—though perhaps at times only partially—and converges to be presented in a unified form in the dream content (284).

Althusser then takes the concept of overdetermination into the realm of social and political theory, and the concept is taken up in subsequent Marxist thought, including Laclau and Mouffe (2001). For Althusser (1967), overdetermination refers to the ability for a multitude of social and political forces and antagonisms to converge into one moment, which leads to the rupture of one social form and its transformation into another. He argues:

> A vast accumulation of 'contradictions' come into play in the same court, some of which are radically heterogeneous—of different origins, different sense, different *levels* and *points* of application—but which nevertheless 'group themselves' into a ruptural unity. (23)

The result is a revolutionary moment. What is important is that the varied sources of influence in overdetermination can come both from fields of discourse (referred to as *superstructure* in some Marxist discourse) and also from "external historical" sources in a national or social past, which is to say the material corollaries to discursive systems of meaning—"the *existing world* context" (27). The ways that these forces converge defies simple causal frameworks of one-to-one influence, what Freud called "point-for-point projection," not only because the causes are plural and varied, but also because in their convergence they transform and fuse in novel ways.

Laclau and Mouffe (2001) take up this concept and transform it only slightly. Their first transformation is in a revised notion of revolution, where a political rupture can have affects ripple across varied fibers of the social fabric and not only through political upheaval and a new state form (177). Their second transformation is in their rejection of Althusser's claim that, despite overdetermination, superstructural forms are "determined in the last instance" by an

[31] Freud (1953) calls these points of convergence materialized in dream-content "nodal points" (284)—an indication of the Freudian influences of Laclau and Mouffe's (2001) political ideas.

economic base (98). A detailed explication of these debates goes beyond the bounds of this project, but the important point is that Laclau and Mouffe look to shift the emphasis of overdetermination toward discourse and the field of the symbolic (98, 111, 121-2) and away from Althusserian-Marxist structuralism (113). Yet *discourse* for Laclau and Mouffe takes on a distinctly material character in addition to the symbolic, and thus encompasses both directly linguistic and non-linguistic elements (107-9). Discourse is not merely mental—material occurrences only gain meaning or intelligibility as objects from the structuring of a discursive field—and its language-games have material elements and consequences (108). Thus the interplay between discursive constructions of meaning and social-material relations that include state apparatuses and the social practices and institutions like health care takes place under the umbrella of discourse; and both are in the field of overdetermination.

What this means for my project is that both the social-structural-material aspects of our discursive world and the directly discursive-symbolic aspects of ethical discourse contribute to the overdetermination of social change, identities and subject positions, and social relational practices and institutions. In these terms we can understand my critique of "straightforwardly moral" arguments as insufficiently accounting for the structural, relational, or material elements in the overdetermination of social practices and social and political change. By attempting to make sense of these structural elements through discursive approaches of largely Marxian philosophical analysis, I look to offer a preferable means to understand and transform the relational practices of health care without resorting to oversimplification of a complex social praxis. The revised notion of revolution, moreover, allows for a normative framework that can aspire to ruptural effects in the understandings and practices of social relations (like aspects of health care) and not rely *only* on the hope of major revolutionary social transformation. I think it

is in this vein that the very rise of health care ethics and "patients' rights" could be understood as a revolutionary extension of a democratic logic to an expanded set of social relations.

And in one last note, I feel the need to explain my choice to focus on the United States system of health care production as opposed to offering theory that can be applied to any location or system. By now, perhaps, part of this explanation is obvious. In rejecting a priori essentialism and turning to structural and contextual analyses, I align myself with nonideal theorists, contextualist ethicists, and historical-materialist Marxists in insisting that existing networks of social relations codetermine what is at stake for ethical and political discourse. As a result, the turn to context is often localized in some way. It is necessary to place boundaries on structural analysis for the sake of saying something that is plausible or truth-tracking. My examples and arguments come from the health care practices in the United States because I am most familiar with that complex set of practices. I argue in this project that certain *specific means of health care production* are such that they conform predominantly to the forms, tendencies, and ends of capital. This is often based on nuts-and-bolts types of considerations of how health care is actually socially produced. To try to both *achieve* and *incorporate* that level of familiarity with the intricacies of other national health care systems, I believe, would be a truly daunting task for a single author attempting to also engage philosophical and health care ethics literature.

While much of my analysis could be applied to other locations in order to examine the influences of capital on *those* systems and practices, I simply cannot take on that broad of a scope in a single project. Those connections cannot be made directly without knowledge of other health care practices and systems at a level that I cannot claim. My project can, however, be considered on a more global conceptual level to some extent in the connections made to broader normative, political, and philosophical concepts. One central goal in my project is to offer an

example of an alternative way to approach health care as an object of knowledge for moral and political engagement. Such a methodological approach can doubtless be brought to other systems of health care production, or even in examining the interactions between nations and economies in terms of health care production.

Conclusion

This chapter provides an explanation and justification of my methodological approach in this project. That methodological approach is largely one of explanatory-diagnostic critique that formulates a descriptive model of the social-structural relations that enact health care production in the United States. This approach is a critical alternative to ethical theorizing that depicts ideas, moral belief, and discourse as the sole foundation of social practices like health care. I understand my critical approach as nonetheless formulating concepts for health care ethics from the very tensions between ethical discourse and concrete structural practices in treating each as a part of *discourse* proper in a joining of theory with praxis. In this way my project might be understood as attempting to critique and reverse the neglect of the structural side of this dichotomy by modeling it conceptually in a way that brings it into dialogue with ethical discourse.

Chapter 2

The Commodity Question for Health Care in the United States

Contemporary social philosophy—and especially bioethics—has dealt in critical discussions of the commodity, often in terms of the phenomenon of "commodification." The objects of commodification include organs, tissues, genetic material and sequences, sex work, and health care. In this chapter I focus on the commodity question for health care—and specifically in the United States as an instance of a "mixed" health care system that blends public and private influences through some "competitive market forces," some regulation, and state provision. Because of this heterogeneity, addressing the commodity question for health care in the *unsystematic* US system presents a challenge.

In this chapter I argue that health care functions as a commodity in the United States in that it is subject to the value form in its social relations through ideational and actual exchange. Further, Health care functions as a vehicle for the capitalist production of value despite the fact that the proclaimed motivating ethos of individual practitioners and regulators is generally health promotion. I begin by explicating philosophical and ethical treatments of the commodity concept and its application to health care. I then explicate Marxian concepts of social form and a Marxian account of the commodity and contrast the latter with those that emphasize markets. Finally, I use these Marxian frameworks to address the commodity question for health care in the United States and defend this answer against claims that health care is "incompletely commodified" in Margaret Radin's (1996) terms. By considering the social relations that make up health care as a process of production amid a larger capitalist social formation, one can gain better understandings of health care as it exists in order then to consider it in ethical and political terms.

A Brief Review of the Commodity in (Health Care) Ethics

In the philosophy and ethics of health care, the commodity question is most often raised in distributive questions of health care justice and in professional ethics. It is seen as a preliminary step in considering how to treat health care in overarching policies and ethical decision-making. It usually takes the form of asking, "Is health care a market good?" This question is the present form of the commodity question for many, as theoretical talk of the commodity is now seldom far from that of "the market."

Norman Daniels (2008) frames part of *Just Health* as addressing the commodity question by considering the kind of good that health is, and thus the level of importance health care deserves in its distribution (16). Daniels defines commodities as "things we agree to buy and sell in a market" (16).[1] In a special issue of *The Journal of Medicine and Philosophy* devoted to the commodity question for health care, Daniel Callahan's (1999) focal question is "Are the institutions and traditions of medicine and health care morally compatible with market theory, thinking and practice?" (225). In that same issue, Edmund Pellegrino (1999) characterizes what it means to treat health care like a commodity as such: "its cost, price, availability, and distribution should be left to the free workings of a free marketplace constrained by a minimum of governmental regulation" (244). Paul Starr (1982) describes the commodification of medicine as the point at which the market became the dominant institution in caring for the sick (22). Indeed, many authors rely almost exclusively on the market in their conceptual definitions of a commodity (see also Caplan 1989, 1139; Radin 1996, 12-3). Further, M. Cathleen Kaveny (1999) portrays a common treatment of the commodity question in professional medical ethics in

[1] Daniels focuses the commodity question on *health* rather than health care—a choice that I think has negative consequences in overlooking aspects of health care production as a *social relational function or process* in favor of idealized notions of health as a state of being.

understanding a commodity as an on-demand good where the consumer-patient's desires alone motivate the procedures performed without mediation through the professional's expert opinion (213-4). For a "market good," mere consumer demand is sufficient justification for meeting it, while for a professional service the client or patient cannot simply demand it but must work jointly with the professional. That professional's conduct is governed by a professional code of ethics while the profession collectively bears a socially sanctioned monopoly for providing the services in question.

Such discussions take their cue from neoliberal economic theory, like that of Gary Becker and Richard Posner, where markets are the central conceptual component in discussing would-be commodities, and indeed the entire social world. This then leads to talk of sellers and consumers, rational self-interest and needs satisfaction, trade-offs and externalities, opportunity costs and demand curves (the list of economics jargon clearly goes on). This discourse, in turn, is an extension of classical political economy, as contemporary economics still calls on concepts from classical thinkers like Adam Smith. Classical political economy was, of course, the subject of Karl's Marx's *A Critique of Political Economy*, the subtitle to his *Capital* series. Thus Marxist perspectives may help to shed some critical light on the commodity question. However many of the Marxist treatments of health care available tend to utilize a more orthodox frame of class struggle, commenting on the ways that ruling class power is expressed through health care institutions and access to them (Waitzkin 1981, 1983, 1989; Navarro 1985, 1989, 1993; Caplan 1989; Chernomas and Hudson 2013).[2] These fall in line with a more orthodox Marxism inspired mostly by Marx's earlier work, including the *Communist Manifesto* and the notion of alienation

[2] There are exceptions to this class focus among Marxist authors writing about health care. See Waitzkin (1979), which makes and illustrates an argument, similar to the present project, that the early adoption of coronary care units (CCUs) was governed more by profit interest and valorization than by medical benefit. See also Waitzkin (2011).

from his *Economic and Philosophical Manuscripts of 1844*. Included in this orthodox form is the category of "worldview Marxism" that largely dominated the twentieth century (on worldview Marxism, see Heinrich 2012, 20-7).

As opposed to the criticism of underlying class power in health care, a second set of Marxist (or at least Marx-inspired) treatments of health care in contemporary literature comes from the criticism of commodification. Commodification is often identified as a critical Marxist concept (see for instance Caplan 1989, 1139; Timmermans and Almeling 2009, 23), and stems from humanist Marxism and an ethical critique of alienation and reification. This is to say that critics of commodification are often seen as working in a Marxist vein or continuing one avenue of critique that started largely with Marx. Margaret Radin (1996) is among the most prominent authors who theorize commodification and its critique. In what follows I briefly explicate Radin's concept of commodification and offer some preliminary critical remarks; I respond to Radin more fully in a section below.

Radin's (1996) *Contested Commodities* attempts to apply what Radin calls pragmatic methodology to adjudicate between instances where commodified understandings seep into previously noncommodified understandings of social interactions (xii). In her theorization of commodification, Radin rejects two claims that she attributes to Marxism (though not necessarily Marx): the first is that commodification is always wrong and the second is "that commodified understandings of social interactions cannot coexist with noncommodified ones" (xii). Instead Radin looks to map out a middle way between the poles of universal commodification, exemplified in theorists like Gary Becker and Richard Posner, and universal noncommodification attributed to Marx (xiii). Radin's middle way takes shape in the concept of "incomplete commodification" and the idea that commodification is a matter of degrees.

Radin begins her analysis of commodification by noting its treatment in predominant discourse and claims that there are narrow and broad senses of the term. The narrow refers to the actual act of buying and selling goods as commodities in a market and the broad refers to the application of market rhetoric to objects that are not necessarily subject to actual market exchange (12-3). So the distinction is between actual acts (narrow) and discursive social meanings (broad). Radin makes this distinction in order to claim that critics often employ a slippery slope argument against the application of economic discourse to traditionally noncommodified subjects (broad commodification) by claiming that this will lead to their actual (narrow) commodification (13-4). While Radin denies the inevitability of this slippery slope, she does wish to theorize the connections between literal and metaphorical markets. Radin argues that "there is no sharp distinction between the nature of an interaction and the terms in which we conceive it" (14).[3] So her theoretical approach to commodification attempts to look at the interrelation between these interactions and the meanings we employ to understand them.

The key point of concern for Radin (1993; 1996) is the potential effect that increasingly market-driven economic interactions and the discursive meanings assigned to them have on notions and practices of personhood. In those instances where commodified understandings of a thing or practice may erode the notion of persons as ends in themselves, Radin is likely to argue to maintain at most an incompletely commodified understanding of that thing or practice as opposed to a fully commodified one. Radin (1996) claims: "The way to a less commodified society is to see and foster the nonmarket aspect of much of what we buy and sell, to honor our internally plural understandings, rather than to erect a wall to keep a certain few things

[3] Later in Radin (1996): "Actions and discourse (the thought structures giving meaning to action) are not completely disjunct, so that literal market exchanges and market rhetoric are interdependent in whatever way(s) action in general and discourse in general are interdependent" (115). Radin's project clearly connects to the discussions of the first chapter of this work.

completely off the market and abandon everything else to market rationality" (107). Radin thus argues that commodification can be, and often is, incomplete or a matter of degree.

The analytic structure of Radin's concept of commodification takes shape as follows:

> Literal complete commodification is characterized by (1) exchanges of things in the world (2) for money, (3) in the social context of markets, and (4) in conjunction with four indicia of commodification in conceptualization. Those four conceptual indicia characterize complete commodification in rhetoric. They are (i) objectification, (ii) fungibility, (iii) commensurability, and (iv) money equivalence. Literal commodification and commodification in conceptualization need not be coextensive in practice, but they are loosely interdependent. (118)

So in this definition and Radin's notion of incomplete commodification, commodification includes both the set of practices involved (literal markets) and also how we conceive of and talk about the things in question (metaphorical markets or market rhetoric). For Radin, widely held moral convictions regarding the noncommodified nature of a good like health care is an important aspect of the ultimate degree of commodification of health care in a given social context.

Radin's project can be aligned with humanist Marxism in that it takes a normative framework in order to make ethical arguments for the reaffirmation of essential human personhood in the face of increasing commodification in practice and rhetoric. Radin does not characterize the process as easily reduced to class conflict or political clashes and instead emphasizes the role of meaning, discourse, and shared understandings that underlie social practices. Radin identifies these primarily in *how we justify actions and practices*, including how we justify limitations and regulations of action, and argues that "something important to humanity is lost if market rhetoric becomes (or is considered to be) the sole rhetoric of human affairs, excluding other kinds of understanding" (122). Radin's category of incomplete commodification relies on the ways persons in a given society understand and discuss objects and less on the tangible function of those things in social relations. Radin addresses and appears

to align herself more with humanist Marxism. Her treatment of reification and fetishism is mostly through Marxist scholar Georg Lukács. Via Lukács, Radin characterizes the Marxist position that "commodification in discourse and practice are inseparable and all-pervasive" (83), and thus Radin sees the concept of incomplete commodification as a break with Marxism because it maintains a distinction between literal and metaphorical markets and denies commodification's ubiquity on the basis of that distinction. Radin also references an earlier essay on alienation that lays out the beginnings of her views on the importance of effects on personhood in theorizing commodification. In that essay, Radin (1993) is largely working from the early *Economic Manuscripts* notion of alienation and its interpretations as a more psychologized critique focused on the harm to the individual on the basis of notions of humanity ("species being") and personhood.[4]

However, ongoing movements in Marx scholarship, following various contemporary European authors, emphasize the later work of Marx, including the three volumes of *Capital* and the long unpublished draft *Grundrisse*. These new readings analyze the structural components of capital and tend to deemphasize humanist or moralist concepts as analytical frames for critically understanding society. A more class-based orthodox/worldview frame looks to identify the interests of a ruling class at work in health care and explain how these form an antagonistic relationship with an oppressed or working class in order to motivate and inform class politics. A humanist approach looks to illustrate how a set of practices and resulting conceptual understandings degrade or threaten the humanity or personhood of individuals, and usually make moral condemnations of those practices on that basis. But from a more structural perspective,

[4] For an instance of this psychologized notion of what "creates alienation between" persons, see Radin (1996, 93). See also Radin (1993, 200-202) for her preliminary thoughts about personhood and community as the basis for noncommodification, which develops into her theories of incomplete commodification in Radin (1996).

one is more likely to identify the *formal mechanisms of capital*—the tendencies and functions of capitalism that work to direct or contort practices—at work in health care systems and to explain how these contribute to the continued accumulation of wealth. In the previous chapter I attempt to flesh out the conceptual components of structural Marxism and critical theory in dialogue with normative and political perspectives. In order to address the commodity question for health care from a Marxian perspective, I would like to go back to the texts of Marx himself in this chapter in order to explain his notion of social form, which relates to this notion of structure.

Marxian Philosophy and Social Form

Marx's choice to begin the first volume of *Capital* with the chapter on the commodity is in some ways saying a lot and in other ways saying only a little. Some understand the chapter on the commodity as the main source of *Capital*'s insights, however in many ways the category of the commodity is just a necessary first step in a series of examinations that fill in a picture of the totality of capitalist social reproduction. The commodity is, after all, among the most common mediums with which individuals interact with a capitalist mode of production and is thus as good a place as any to start. In reading beyond just the chapter on the commodity, the role of *social forms* starts to become even more apparent in understanding capital systematically.

There are two senses of the term "social form" that come from Marx. One is social form in terms of a specific social form, and the other is in terms of a social totality or the relational organization that allows one to refer to one intelligible social totality. The first sense of social form is a concept to identify how a specific thing like a commodity or wage functions as a part of a larger set of relations, wherein the thing comes to be understood categorically—as in the commodity form or the wage form. Form is a unit of abstraction for understanding a relevant

piece of a larger system like capital; Marx compares social forms, like the commodity form or value form, to the "cell-form" of biology that allows for understanding the cell in relation to the entire organism (1990, 90).[5] Form in this sense is an abstraction for the sake of understanding how a given categorical unit fits within a total set of concrete relations. The correspondence of forms to the reality described are historically relative and therefore in motion and active within the set of social relations.[6] The social form of the commodity is determined through analyzing how it stands in a functioning relation with other economic categories in a larger perspective (CI, 955). Social form for Marx, then, draws attention to the fact that categories gain their meaning from historically specific social relations; by referring to the social form of a component part of that society, like the commodity-form or the labor-form, one is drawing attention to its specific social determination.

The second sense refers to something like capital as "social form" in the sense of an organizing principle of society. This takes the capitalist epoch to be

> a historically *specific* form of social totality and social integration that needs to be understood via a specific relation between social productivity (wealth) and the form under which this social productivity appears (value, money, capital). (Lotz 2015, 376-7)

[5] Hereafter Marx's major works are cited as abbreviations. *Capital*, volume I (1990) is cited as "CI," volume II (1992) as "CII," and *Grundrisse* (1993) as "G." I include under the citation "CI" material from a previously unpublished Part Seven to the first volume of *Capital* entitled "Results of the Immediate Process of Production." This was included as an appendix in the 1990 Penguin edition of the first volume of *Capital*, pages 948-1084. All pages cited are from Penguin editions. See final References for full author-date source citations.

[6] "[I]t is not possible to regard any *fact*, any *practice* apparently unrelated to the 'economy'…*as rigorously economic*, without first having constructed the concept of the differentiation of the structure of the social whole into these different practices or levels, without having *discovered* their peculiar meaning in the structure of the whole, without having identified in the disconcerting diversity of these practices the *region* of economic practice, its configuration and its modalities" (Althusser 1997, 179). This quote reflects on Marx's critique of political economists for treating things or practices of pre-capitalist or "primitive" societies as adhering to natural economic concepts like markets, labor, or commodities without situating each within given relations of production. Marx's claim is that in fact these categories stem from the specific relations of capitalist production and should not be applied universally to any human social formation.

Here social form refers to a broader theory of society—a theoretical conception of the unifying social relations that parse out one social whole from another—within which a given category is understood as mediated by its place and relations within a totality. In this sense the totality of social relations is what constitutes the social form of a specific thing or category within those relations.

Marx argues that some socialist economists of his time make a mistake by losing sight of the social formation: "they do not conceive capital in its *specific character as form*, as a *relation of production* reflected into itself" (G, 309). Yet, Marx argues, concepts only "possess their full validity for and within" their historical social relations, or their social formation (G, 105). In order to try to avoid confusion, I tend to use "social *formation*" to refer to this second sense of social form. Marxian formal analysis in general looks to identify how a specific concrete practice stands within a larger set of social relations that influence and determine that practice. For Marx, to understand something as social form is to understand it in relation to those other things that it presupposes or relies on—the social formation.

It is possible here to connect the ideas of social form and social formation with some of the notions of social-relational structures introduced in the first chapter. Social relational structures for Young are the general conditions that produce a set of circumstances that social actors work through and within, including how those circumstances came about through several factors and processes (Young 2011, 19). These become visible by considering those patterns of actions and reactions as a part of the larger whole. Just as Frye (1983) argues that oppression's influence in particular instances is best recognized by considering them in context within a system, the Marxian notion of social form calls for considering individual categories as determined by the larger system of social relations. For this reason Patrick Murray (2000) argues

that Marx's *Capital* "is largely a study of the nature, inner connections, and powers of *value-forms* (commodity, money, capital, wages, etc.), that is, the specific social forms constitutive of the capitalist mode of production" (28). The means of recognizing social-relational structure in Young's terms can in part be taken as a means of recognizing the social form of an individual category as operating within a specific social formation or mode of production in Marx's terms.

The Commodity Form

This section explicates Marx's notion of the commodity form as a specific and significant instance of social form. I explain how commodities come to be the bearers of exchange value, and how this leads persons in capitalist societies to misattribute *social* characteristics of value to *material* commodities before them. This introduces the important Marxian concepts of fetishism and alienation. I provide this account in order to highlight the most important properties of commodities for Marx: (1) that they are the objects of actual and ideational exchange, and (2) that they are the basic formal unit by which capital produces surplus-value, profit, and wealth. The social nature of commodities is important for addressing the commodity question for health care.

The commodity form is identifiable by its dual characteristic: first, its usefulness in how it serves some purpose, which is derived from its substance and realized in its consumption, and second its value form (exchange-value) derived from its social relation (CI, 138). There is no specific material basis for a thing's exchange value (CI, 138), as exchange value comes purely from its standing in quantitative equation with a certain number of other commodities. A thing gains its commodity form when it is placed in a relation of equivalence with another number of objects, e.g. *x* commodity A = *y* commodity B. (Notice, however, that this relation does

presuppose the quality of exchangeability within a social formation.) This is a purely quantitative relation of equivalence—it is made without regard to the qualitative characteristics of the things in question (CI, 128, 136; G, 165). This already differs from contemporary economic definitions that consider commodities as possessing value simply because they satisfy a person's needs or interests.[7] This only represents one half of what is at stake in the commodity for Marx, namely use value. Whereas the social form of a commodity is in its exchange-value. This for Marx is a relation between commodity and commodity[8] (as it derives from the move to equivalence above), *not* between a person and a commodity. Marx claims that a thing's being a commodity is not simply entailed in its being useful to humans, but instead it comes from how a things stands within a larger set of social relations. Commodities, then, are a social form rather than a natural or essential category.

The act of equivalence has another important implication: if the respective quantities of commodity A and B are equal to one another in a relation of exchange (1 table = 15 shirts), then there must exist in this relation "a common element of identical magnitude" in some third thing, which allows the two commodities to be placed in an equal exchange relation (CI, 127; G, 143, 846). Marx argues that the equivalence of commodities entails the equivalence of the objectified labor-power expended to produce them, yielding the notion of *abstract labor* as the determining substance of the form of value (CI, 128, 137). So the reason that the two sums of commodities can be placed in an exchange equivalence is because they are both the product of human labor. Abstract labor is thus "abstract" not so much in the sense of being opposed to "material" but in the sense of extraction or removal; in the performance of equivalence between objectified labor

[7] See footnote 12 below for an indication of how Marx might respond to this claim (G, 156-7).
[8] "In exchange-value, the social connection between persons is transformed into a social relation between things" (G, 157). "A product posited as exchange value is in its essence no longer a simple thing; it is posited in a quality differing from its natural quality; it is posited as a *relation*, more precisely as a relation in general, not to one commodity but to every commodity" (G, 205).

power, one is *extracting* that labor from its physiological source through an idealizing move and treating it as a unified and purely quantitative substance shared among all labor. We will see that this simple relation of equivalence leads to all commodities being fungible in relation to some universal equivalent form represented in the money-commodity, which takes on the money form (CI, 183). The character of money within a capitalist social formation is such that things placed in an exchange relation become fungible with one another. But it is important that even in a simple commodity exchange, where one sum of commodities is equated with another sum of some other commodities, this equivalence exists and thus bears the basic value form (CI, 155, 162).

The notion of social form that emerges in *Capital* is as follows: that which takes its shape from being in a set of social relations. While the substance of the commodity is wood in the shape of a table, the social form of the commodity is in its value form determined through its standing in relation to all other commodities in an exchange relation.[9] The commodity form of the table is not derived from anything about its substance, instead, "as an equivalent, all its natural properties are extinguished" (G, 141; G, 157); its commodity form is a characteristic of the society in which it exists and not its natural properties (Heinrich 2012, 40). Marx notes, however, that commodities "must stand the test as use-values before they can be realized as values" and use value is often derived from a thing's material properties (CI, 179).[10] So a thing's

[9] This distinction between substance and form applies to money, too, where money operates as the physical medium of exchange in substance and the relational measure of value in its social form (G, 667).
[10] I say "almost always" here because there are exceptions in some immaterial labor or immaterial use values. For example, the use value of a vitamin supplement that does not actually create its claimed/intended material physiological effect is not derived from its material properties but from the affective results that its consumption produces in its consumer. They feel healthier, but only accidentally from the material supplement. While this could be reduced to a series of material processes of brain chemistry, the effect is still derived from the supplement's meaning for the consumer and not the material properties of the supplement itself. One may argue that this is an instance of something with price but no value (CI, 197), though I would argue that there is a use value here.

material properties in the form of its use value are a necessary condition for something to become exchange value, but its value in capital is not derived from those material properties directly; its formal value is determined instead by abstract relations to other commodities in a social order of commodity exchange.

It is in this dual nature—as a social form with a material use value—that the commodity is a "sensuous extrasensory thing" (CI, 163; modified translation from Heinrich 2012, 72). What is perceptible in the commodity is a carrier or placeholder for what escapes the senses in its relation to other commodities, value, and money; the commodity form must represent "both the unity and the duality of use-value and exchange-value" (CI, 955). There is unity in the single thing before me but it has another form like a soul, animating it and placing it in relation to something greater, because the particular thing experienced as a use value is also experienced as a member of the community of commodities.

Marx's chapter on the commodity can potentially leave its reader with an exclusively discrete or alienable sense of what can count as a commodity. However, it becomes clearer from the nature of use value and later discussions of labor that *services* can also be commodities. Because the social relations entailed in the usefulness of a thing are the basis of the commodity form, the act of exchange is the primary determining factor in whether something is a commodity and not that it is an alienable material thing. Michael Heinrich (2012) clarifies that the difference between material and service products is in "a different temporal relationship between production and consumption" (44). A material product like a bread roll at a bakery is baked before it is consumed some time later, while a taxi ride or theater performance is consumed simultaneously in its production (Heinrich 2012, 44). So long as there is an act of exchange

involved between producer and consumer, the bread role and the performance are both commodities despite the lack of a discrete, alienable thing consumed in the latter.

The commodity's being both sensuous and extrasensory, which stems from its *formal* properties, leads to what Marx calls commodity fetishism, that is, treating the formal properties of the commodity—those determined by a set of social relations—as the properties of the commodity itself as a material use value.[11] The characteristics that determine the commodity form are (a) objectified human labor power *abstracted as exchangeable* with the objectifications of any other human labor power, and (b) that the products of labor take on a *magnitude of value* from being abstract labor, (c) that value also stands in *relation to other bearers of value*, and (d) through the nature of wages, labor power, and the working day the commodity empowers the capitalist to *produce more value* from the process of commodity production than was put into the process in equal exchanges. The fetishizing move is to attribute all of (a)-(d) to the product of labor itself, to the material in its sensuous and/or useful characteristics. One's senses perceive a thing, yet that thing gestures to the commodity form and the value-relation, which "have absolutely no connection with the physical nature of the commodity and the material relations arising out of this" (CI, 165). Yet the sensuous character leads one to see the value-relation and commodity form as the result of these physical objects, in the relations between *things* before her or him (CI, 165). In this way the sensuous commodity comes to appear autonomous and imbued with powers of its own. Marx is thus arguing for a middle ground between idealist and physicalist notions of commodities. The commodity is a social concept but is not simply the

[11] The term "fetish" is often applied in ordinary language to mean deviant sexual desires. Thus one may be prone to understand commodity fetishism in this metaphorical way as an inordinate love of commodities to the point of sexualization, where their purchase and/or consumption is an inordinate or deviant source of sexual pleasure. This can be misleading, I think, and it helps initially to defamiliarize oneself with this common contemporary usage for understanding Marxian commodity fetishism in its perhaps less common use associated with animism.

result of what people believe (idealist), and it is a perceptible thing that serves a purpose but its commodity status does not come only from the material thing but instead from it functions within a larger structure of social relations. Thus it seems that commodities for Marx are based in the interplay between beliefs and material actions.

Fetishism in this sense may be understood merely as false consciousness, and thus in subjective terms. But it becomes much more. Heinrich (2012) argues that fetishism has important *objective* implications because, for instance, one's prosperity or misfortune in life actually depends on the magnitudes of value given to my labor power and its products (75). Thus persons in a commodity-producing society are in fact controlled by the movement of things and that movement is the result of external, not personal, relations (75). Heinrich concludes:

> This impersonal, objective domination, submission to "inherent necessities," does not exist because things themselves possess characteristics that generate such domination, or because social activity necessitates this mediation through things, but only because *people relate to things in a particular way—as commodities*. (75)

The objective results of the fetishism of commodities, the misidentification of social form in its substance (or of essence in appearance), permit a kind of domination by those very commodities—where one's life prospects depend on the workings of a vast and volatile market and system of production.

In considering money, we see that "the riddle of the money fetish is therefore the riddle of the commodity fetish" (CI, 187). Money as the bearer of value appears to take on its own powers housed in my pocket. Fetishism also provides the groundwork for understanding the formal or structural concept of alienation and alien labor in Marx's later work that is quite unlike a "phenomenological," experiential, or psychologized understandings of alienation that is often read in his *Economic and Philosophical Manuscripts of 1844*. Instead alienation is characterized by the products of human labor coming to dominate human beings through a vast structure of

value and capitalist wealth (G, 453, 831). In alienation, human activities are subjected to the logic of capital rather than human values and desires. Much like commodification can be understood as a complex process that admits of degrees, so too can alienation, I think, be a process and thus admit of degrees. Certain activities or areas of life can be more or less alienated than others, and can also be in an ongoing process of becoming more alienated. In such instances those areas of life directed by cultural or ethical values become increasingly controlled by the forces and logic of capital.

The significance of fetishism as it originates in the value form can be further understood from Marx's own analogy in calling the commodity a "social hieroglyphic" (CI, 167). By this he means that, while the commodity has its own material existence much like the printed ink on a piece of paper, the value cannot be found in that material itself—much like the meaning of words cannot be found in the material that they are printed on. This is not to discount the significance of value, however, as we can easily see how the implications of language and meaning condition and influence the ways that human beings navigate and understand the world. These similarities between the commodity and value on one hand and language and meaning on the other further illustrate one philosophical puzzle in this project. The processes of social change—seriously reshaping social relations—cannot occur quickly in the same ways that we cannot simply make concepts mean what we want them to mean through theoretical discourse. Of the philosophical work of deep conceptual analysis, Anne Phillips (2013) notes that "concepts tend to resume the shape they had before their theoretical refinement" (131), and institutional or political changes tend to takes steps backward in the historical process of (r)evolutionary scoial development.

To conclude on the commodity for Marx, by far the most important conceptual aspect of the commodity is that it is the unit or medium by which labor power, the nature of the working

day, exchange, circulation, and accumulation combine to produce surplus value for capital. Yet this function is largely grounded in commodities being set in equivalent exchange relations to one another. The remaining chapters (and volumes) of *Capital* schematize the totality of the organism of which the commodity is just one type of cell.

A Market Objection

Because I wish to utilize Marx's concept of the commodity, as well as his underlying critical methodology, it is necessary to defend both against possible objections that come from contemporary economic frameworks. This section substantively takes up arguing in favor of the Marxian commodity form and critical methodology against such objections, and differentiates both from market-centered approaches.

In response to the Marxian claim that the commodity relies on social relations with regard to exchange and circulation, one might wonder: How does this differ from the contemporary claim that commodities are that which rely on the conventions of markets? After all, the market seems to be a set of social relations predicated on a relation of exchange between various people. Marx argues that exchange value "is posited as a *relation*, more precisely as a relation in general, not to one commodity but to every commodity" (G, 205). It would seem that it is precisely in a market that a commodity is put in relation to others. So how does a Marxian account of the commodity form's reliance on exchange differ from the standard economic treatment that relies more simply on markets?

Taking this objection further, a market-based notion of commodities better lends itself to normative arguments regarding health care. Recall Pellegrino's (1999) functioning notion of the commodity (or what it means to treat health care like a commodity) is that "its cost, price,

availability, and distribution *should be left to the free workings of a free marketplace* constrained by a minimum of governmental regulation" (244; emphasis mine). One could argue that health care is not or ought not to be a commodity because it is not a straightforward market good on the basis of standard economics; it may be market-like in ways, but it is not a *free* market. Individual patients, especially in emergency care situations or already in the hospital, do not have the kind of agency and choice that contemporary economic models of rational choice assume in theorizing. Patients do not know prices ahead of time, nor are they easily obtainable; those insured through their employers do not choose their health insurance, which in turn often limits their choice of hospitals, doctors, and drugs; and they cannot easily discern what is at stake medically in a given choice set without the advice of professional expertise. An economist might even chime in here to argue that much of what economics does is to determine and conceptualize those ways that actual markets *deviate* from an idealized free market, and so the absence of that free market does not preclude economic analysis on the basis of markets. The brunt of this objection is that a market-based concept of commodities could arguably do the same work as the Marxian notions of social relations and the commodity form's reliance on exchange.

I have three lines of response to this objection. The first is a more methodological or prudential claim that a market focus tends to distract or distort commodity-question discourse, especially in health care; the second is that focusing on markets privileges only one set of social relations over a more totalizing picture; and the third response comes from Marx's general critique of political economy in that market-based accounts fail to conceive of capitalist social relations as a limited historical, material, social form and instead treat its relations and categories as universal logical concepts.

First, this approach to commodities shifts the focus of analysis away from the *formal* properties of value and exchange and instead toward the substantive nature of exchanges themselves. Following this objection's line of reasoning, it becomes an empirical question whether there is or could be an actual market in a given thing, which includes looking to the set of rules that govern, or should govern, such a market. This line of thought leads those considering health care to pursue what I believe are shallow questions about whether it fits standard economic models, and this often leads to a quick dismissal of the commodity question for health care on the bases outlined above. Yet such topical analyses deeper considerations of the extent to which health care practices nonetheless take part in capitalist relations and contribute enormously to wealth production in ways functionally identical or at least similar to commodity production—and thus how this may affect normative matters of health care practices.

The commodity question too often shifts immediately to the *market question*, which are often taken to be synonymous. But these questions are not identical. The act of exchange—which realizes the commodity form—is broader in Marx's terms and seems to rely on the ideational act of abstraction and equivalence and the actual exchange of commodities. Marx does not necessarily emphasize the market nature of that decision, which stresses information, alternatives, formal equality of buyer and seller, etc. Exchange value and its realization in actual exchange—and thus the realization of the commodity form—relies more on the participation of *money* for Marx than on the participation of a market. Thus I argue below, in line with Marx's account, that money equivalence and wealth production are more important for considering the commodity question for health care than the nature of markets in health care.

Further, the tendency to focus on markets as the sole or even primary determinant of the commodity only captures one aspect of the Marxian idea of social relations and only one of the

three phases of capital, which are production, circulation (markets), and consumption. Neoclassical accounts privilege one set of social relations, the market, over all others. Yet this is a typical tendency to attribute powers to the market when a mode of production depends on exchange:

> As the producers become more dependent on exchange, exchange appears to become more independent of them, and the gap between the product as product and the product as exchange value appears to widen. (G, 146)

This is what lies behind economists' desire to emphasize the market and exchange over production. When exchange becomes more complex and developed, it begins to appear as though it acts on its own accord like some kind of monster (like bears and bulls!). But for Marx this creates the problems of fetishism for markets and leaves a lot out of consideration—the production process in particular—for the commodity question or other social analyses (CII, 179).[12] Production and consumption combine with exchange in the larger capitalist social formation to maintain the social conditions that market analyses presuppose. Rational self-interest and "the market" are conditioned by a capitalist social formation that needs to be accounted for, examined, and *not taken for granted or natural*. Marx argues that the mode of production "produces the object of consumption, the manner of consumption and the motive of consumption" (G, 92). It is only under capital that human social existence must be understood in terms of individual interests in competition with all others.

[12] Marx addresses market language and individual self-interest (invisible hand) as fetishizing. He argues that the real point to take from individuals' pursuit of private interest is that "private interest is itself already a socially determined interest, which can be achieved only within the conditions laid down by society and with the means provided by society; hence it is bound to the reproduction of these conditions and means. It is the interest of private persons; but its content, as well as the form and means of its realization, is given by social conditions independent of all" (G, 156, see also G, 92). "The social character of activity, as well as the social form of the product, and the share of individuals in production here [in exchange value, money, self-interest] appear as something alien and objective, confronting the individuals, not as their relation to one another, but as their subordination to relations which subsist independently of them and which arise out of collisions between mutually indifferent individuals" (G, 157).

We can call on Althusser's (1997) Marxist notion of structural causality here to understand something like health care as conditioned by a complex set of social relations and influences that defy simple causal analysis. Asking only if markets drive health care exchanges takes part in simpler causal analysis without considering more complex structural factors. By considering health care *production* within a social whole, as I do in this project, one can conceptualize a greater part of those relations that condition the social form of health care.[13]

My third line of response to the market objection brings us to Marx's fundamental critique of (classical) political economy and the Marxian critique of contemporary neoclassical economics. I explicate this to some extent in the first chapter, so the current treatment will be brief. Neoclassical economic categories come from the presupposition of pure, ahistorical, a priori forms of economic concepts like commodities, money, or capital, which are treated as independent from their larger social formation. Neoclassical economists identify the instruments of labor that constitute capital for a factory owner as conceptually "that which helps shape and create things we use." This means for economics that capital has always existed in that essential form. Economists similarly look back in time and call traders' pelts commodities, the semi-standardized clamshells of precapitalist societies money, and even the volcanic glass of an early primate ancestor raw material. This naturalizing move takes for granted that the entirety of the ways we understand economic categories today is immediate, obvious, and cemented in nature, and thus the economic laws of markets are equally natural laws.

Yet I am reminded by Marilyn Frye (1983) that "for efficient subordination, what's wanted is that the structure not appear to be a cultural artifact kept in place by human decision or custom, but that it appear *natural*" (34). The presupposition and universalization of the relatively

[13] For this reason, the next chapter looks at labor and valorization in health care. "The circulation of capital *realizes value*, while living labour *creates value*" (G, 543).

recent appearances of the present economic experience does not interrogate their deeper existence. This in turn empowers the exploitative and destructive structure of capitalism to trundle on unquestioned. For health care ethicists, adopting such presuppositions from economists repeats their fetishism and prevents the ethical and political consideration of social relations that actually situate health care practices. A Marxian frame permits, on the other hand, that "the rule of value over humans is not a natural law of society, but the result of a very specific behavior by humans, and this behavior can—at least in principle—be changed" (Heinrich 2012, 77). "Capital is not a thing, but a social relation between persons which is mediated through things" (CI, 932). Means of production and subsistence only become capital and wage when they are the means of exploitation and domination over the worker or wage-laborer (CI, 933). While we see determinism most often attributed to Marxism, neoclassical economics looks to be the determinist theory in this light. When persons look around at global economic inequality and the effects of globalizing capital, even economists who see recognize these issues as a problem fail to adequately question them if they assume that they occur from natural human tendencies. Instead, Marx offers critical theoretical tools to call the social order that creates urban slums in India and Brazil, megafactories in China, toxic air and water, and global climate change a fundamental corruption of human social potential.

In the next section, we will see how this critical Marxian approach plays out when applied to health care.

Health Care as Commodity-in-Question

The systematic understandings that come from Marx's first volume of *Capital* can shed significant light on the commodity-status of health care in the United States. From this Marxian

frame, whether health care is a commodity is not a matter to be addressed through moral arguments regarding the qualitative characteristics of health care practices because this deals only in the substance of health care, in how it is useful to human beings. Because commodities represent an economic form that is determined by its relations to the larger social formation or structure, examinations of whether it ought to be a commodity on its moral bases does not get at the commodity question—or seem to grasp the concept of commodities. I argue, however, that this tends to be the way that many health care ethicists treat the commodity question. Edmund Pellegrino (1999), for instance, argues that "the special nature of illness and healing" entails that health care is not a commodity (249). I take Pellegrino as an example in this discussion because his work as a whole is generally well respected in the field of health care ethics and because his article is also representative of a fairly standard argument that one sees made in some form by various others dealing in the commodity question of health care (especially as it pertains to professional ethics).[14]

Pellegrino (1999) argues that health care is not a commodity because of (a) health care's unique moral character in having to do with life, death, and suffering, (b) health's fundamental role in well-being, (c) the unparalleled intimacy of the doctor-patient relationship (248), (d) "the sheer totality of engagement with the biological as well as the psycho-social and spiritual" in medicine (249), and (e) the non-proprietary nature of medicine and medical knowledge on the part of the physician (249-51). With the partial exception of (e), all of these reasons share in evaluating the characteristics of the moral and physical, which is to say "sensuous," content of the health care interaction and accounts for little in terms of how health care services fit into the entire social formation.

[14] See for instance Dyer (1985), Heubel (2000), Relman (2007), and, in a slightly different way, Daniels (2008).

I argue that this sort of argument falls victim to fetishizing treatments of the commodity, that is to say, an attentiveness to the *substance* of the commodity-in-question—in examining its use value or the characteristics that make it useful to human beings—to the exclusion of its *social-formal* properties—like whether it is an objectification of exchange-value. Such arguments attribute the social-relational nature of the commodity form to the objects or services themselves. That health services ought not to be treated as commodities due to their inherent moral implications does not affect whether or not they *are* commodities because the latter is determined by whether health care interactions fit the dual nature or double form of the commodity, thus how they fit into a larger system of social relations. This system encompasses even more than the physical, psychosocial, and spiritual qualities of an object or practice that Pellegrino notes (249), but also the relation to the form of *value* in a society, which is determined by production, labor, and exchange and together constitute the commodity form.

This illustrates the analytic value of dealing with the social commodity form as described above. Even though Marx indeed argues that the double form that constitutes the commodity relies on social relations, this does not imply that some contingent of society may simply deem certain things to be noncommodified because we as social actors may determine the social relationship that we have with objects. That social-relational determination comes directly from how those objects or services move through the circulating social framework of production, circulation, and consumption—how they concretely function *in motion* as part of a social whole. Thus I argue that whether health care is a commodity is not to be determined by qualitative analyses of its moral character but by looking to the social-relational form of medical interactions, specifically whether health care is exchanged (not necessarily in a "market") and part of a mode of production that creates surplus value from the activity of productive labor. (I

take these two criteria from the four main characteristics of the commodity highlighted in the commodity section above.)

First off, for the sake of consistency I share (with some exception) what Pellegrino means by health care:

> The provision of assistance to persons in need of care, cure, education, prevention, or help related to trauma, illness, disease, disability or dysfunction by other persons knowledgeable and skillful in providing such assistance. (247)

I do not wish to share the second aspect of Pellegrino's use of health care where he argues that "the central feature of health care is the personal relationship between a health professional and a person seeking help" (247). I forgo this emphasis mostly in order to avoid a kind of myopia common in bioethics that lionizes the doctor-patient relationship to the detriment of theorizing beyond that limited interaction. While one primary health interaction will be that between a doctor and a patient, the provision of health care is a complex set of labors that includes technicians, custodians, materials management and linens staff, transport, information technology services, food services, clerical staff, hospital managers, nurses and nurses' assistants, pharmacists, anesthesiologists, and biotechnology and medical equipment manufacturers to name only a few.[15]

Pellegrino, however, argues to ignore the material aspects of medical practices as "means to the end of healing and helping sick persons" (247). It is for this reason that Kevin Wildes (1999) claims that "Pellegrino assumes that there is a fundamental nature to medicine" and on the qualitative basis of that assumption argues that commodification is an inappropriate means to

[15] It is also worth considering whether or to what extent public health fits into health care as it is ordinarily used in most philosophical and health justice discourse. I do not generally include public health within the category of health care for this project because it forms a separable process or set of practices and labors performed by different individuals and institutions. However contrasting public health with health care in the United States in light of the commodity question can yield some interesting considerations.

the ends of medicine (309). But purposely ignoring the *means* of delivery and production does not seem to make much intuitive sense in determining whether something is a commodity, before even any Marxian critique is applied. Applying a social-economic category like the commodity to health care must include the reality of a vast economic apparatus that surrounds and constitutes its provision. In order to address the commodity question one must consider the material and relational processes that go about producing the thing in question because these are precisely what is at stake in economic questions. One cannot simply ignore the means in favor of ideal, decontextualized ends—particularly if such theorizing is intended to contribute to *affecting* or *transforming* the practices or social order that it examines.

Now, it should be clear from this definition that, if health care were a commodity, it would not be an alienable physical object like an iPad or a grande mocha latté. However, as noted above, services may take part in the commodity form as well. The relevant Marxian questions for health care services, then, are (1) whether there is an act of exchange, and (2) whether the service contributes to the production of surplus value.[16] For the former, Marx defines an act of exchange as "an act which constitutes the positing as well as the proving of the exchange values and the subjects as exchangers" (G, 242). That is to say that the act must have that ideal equation of commodities to one another as instances of abstract labor, and also the actual purchase that acts to *realize* the exchange value of a commodity. The first of these ideational acts arguably occurs when Medicare makes its elaborate fee schedule, hospitals establish their chargemaster prices, or when hospitals and insurers negotiate the particular prices to be paid for specific services. In fee-for-service physician payment of Medicare, for instance, a

[16] The first consideration corresponds to characteristics (a) through (c) of the commodity from "The Commodity Form" section above, and the second corresponds to characteristic (d).

> Current Procedural Terminology (CPT) code assigns a unique identifier to (almost) every clinical task and the Resource-Based Relative Value Scale (RBRVS) permits indexing and conversion into dollar units. (Robinson 2001, 151)

Thus almost every clinical task in American medicine is subject to a relation of equivalence with the universal commodity in money. The fact that health care services are regularly rendered into a certain magnitude of value in the form of a dollar-amount is indicative of the positing of an exchange-value. And the fixation on health costs in health care policy discourse also illustrates the extent to which policy makers and individual patients recognize health care in a background of exchange relations with regard to the value form, that is, as money.

Exchange values for health care are realized or "proved" when money actually changes hands in exchange for health care services. Experientially speaking, the commodity nature of health care is blunted for patients by third party payment by insurers. The patient does not necessarily experience the health care exchange as a commodity exchange in the same way as when she buys groceries or a new pair of jeans. But the exchanges are nonetheless realized in monetary payment. Even this blunting effect is becoming increasingly less potent in the UNITED STATES. Patient out-of-pocket payments—for those commercially insured—increased by 37% from 2009 to 2013 (Adrion et al. 2016). And the United States as a nation already spends more out-of-pocket for health care than other rich democracies (Starr 2011, 157). Individuals in the United States enact the relations between health care and the value form to a significant extent through positing ideational exchange through monetization and in proving through direct payment.

One might argue that, even if patients, policy makers, and hospital managers subject health care to the value form, the *physician* does not make this ideational exchange. Thus the

ethical practice of individual physicians could be separated from commodification.[17] But there is reason to believe from the effects of reimbursement patterns that physicians are in fact performing this exchange too. Economists Jon Christianson and Douglas Conrad (2011) argue that

> the relatively large number of published studies that assess the impact of provider financial incentives on medical care utilization and cost have found, with very few exceptions, that providers will take steps to reduce utilization or cost when rewarded to do so. (634)

The fact that providers do respond to financial incentives, often times in the form of altered payment schemes, would imply that they are taking part in an ideational exchange in the performance of health care services.[18] From a Marxian perspective, the way that physicians perform such exchange need not even be conscious. Helmut Reichelt (2007) argues that in value "the act of equating takes place in a manner which remains obscure to the participants themselves" (20; see also 24). Individual actors "simultaneously constitute and discover value in a process which is to be conceived… as a unity of positing and external reflection" (20). Recall Marx's notion of positing and proving exchange value. This dialectical process of positing and actually exchanging creates a system of value, and I argue that both sides of this dialectic are present in US health care production. In their being equated with money, medical services are treated as a mass of exchangeable commodities from the standpoint of capital (CII, 128).

Question (2), whether health care services contribute to surplus value production, is much more important as it emphasizes the formal properties of the commodity by asking how health care fits into a set of social relations with regard to surplus value. After all, Marx argues that "capitalist production is not merely the production of commodities, it is, by its very essence, the

[17] Those within the profession calling for an increase in reimbursement to encourage certain services would seem to belie this argument. See for instance Belluck (2014).
[18] On the import of the act of exchange and the "exchange principle" for capital, see Reichelt (2007, 4-6).

production of surplus-value" (CI, 644). In this frame, health care is strikingly capitalist and ought to be considered a set of commodities. The entire next chapter is devoted to analyzing the ways that health care contributes to valorization, so I only offer a brief justification for this claim here.

On a more general level, health care plays a role in maintaining the capacity for labor among the working population, which in turn produces value in a Marxian schema: "*Living labour capacity belongs just as much among capital's conditions of existence as do raw material and instrument*" (G, 676). By this Marx is claiming that the means of subsistence for workers, which wages provide, contributes an often-downplayed necessity in the labor process by maintaining the very ability for the worker to provide her labor power. One way or another, it is in the interest of capital to maintain the labor capacity of workers and populations, and in this health care plays an important role. Wages paid in the form of health insurance target this need, and even state-provided health insurance or direct care provision fill this role in a time of advanced capitalism where the state acts in tandem with capital to further the interests of production. This leads some Marxian authors to refer to the combined "state-capital apparatus."

All of this is to say that health care is "an organ of the collective labourer" (CI, 644), that the immediate contributions of a physician need not be or produce individual commodities per se but need only to contribute to the production of surplus value and the valorization of labor. And in a consumer economy like the US, maintaining the capacity to *consume*, in addition to provide labor, becomes an important component of health care's contribution to valorization. It is largely for the sake of consumption that I believe Medicare for the elderly, a relatively unproductive population from the standpoint of capital, can be rendered more productive.[19] Further, the

[19] Susan Wendell (1999) observes how expectations and ideologies of aging gracefully correspond to a series of consumptive practices to pursue that goal. Speaking for the aged and retired, Wendell argues "we are offered, for a price, many products and services to reverse our hatred and assuage our fear,

employer provision of health insurance in the United States fosters "the social dependence of the worker on the capitalist, which is indispensable" to keep wages in a satisfactory range for capital (CI, 935).[20] When workers depend on their employers for aspects of their sustenance beyond just direct wage income, they are more likely to be beholden to their job and more willing to accept less pay or sustain certain abuses and overwork.[21] But health care as a totality also contributes enormously to the production of surplus value in nearly all of its sub-industries.

Health care contributes to the valorization of capital in another sense, which is illustrated in the so-called medical industrial complex. For contemporary health care, commodity production is, in Marx's words, "a particular ether which determines the specific gravity of every being which has materialized within it" (G, 107). Even if we were to grant that health care services are not commodities, the doctor would take part in capitalist production. Here I duplicate Marx's example of the schoolmaster in *Capital* (CI, 644) but instead for the physician:

> The physician is a productive worker when she, in addition to belaboring the bodies of ill persons, works herself into the ground to enrich the owners of the hospital. That the owners of the hospital laid out their capital in a health care factory instead of a sausage factory makes no difference to the relation.

This of course is the case for shareholders and executives[22] of hospitals, biotech companies, pharmaceuticals, and all of the other enterprises attracted by health care spending. The relation of the physician to the surplus-earning mechanisms of health care, including biotechnologies and pharmaceuticals, is scarcely different in social form from other capitalist and surplus-oriented

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including dietary supplements, hormones, drugs, surgery, and an incredible array of therapies—physical, psychological, and spiritual" (136-7). See also Joyce and Mamo (2006).

[20] This can be seen at work in Starr (1982) where capitalists saw insurance as a source of "worker loyalty" (251, 312), which translates from Capitalist to ordinary language to mean, "willingness to get paid less."

[21] One sees this at work in China where industrial workers preface talk of pollution with a desire to keep their job more than breath cleaner air. See *BBC Newshour* (2014).

[22] Heinrich (2012) argues that ownership of the means of production is not the only determinant of class position, as CEOs and suchlike executives are "functioning capitalists," dispensing with the means of production, organizing exploitation, and getting compensated at the rate of profits produced instead of for the value of her or his labor power (193).

ventures. That health care is a desirable source of surpluses for capital is well known. As Daniel Callahan (1998) argues, medicine offers capital an ideal situation: "powerful and potentially unlimited demand combined with constant scientific progress and technological innovation" (58). And in familiar fashion for capital, it has appropriated previously existing organizations of labor and production in nonprofit, charitable, often Catholic and otherwise religious hospitals that are becoming extremely profitable despite their tax-oriented designation to the contrary (Brill 2013, 10-1; Starr 1982, 328). In capitalist fashion, too, hospitals across the country invest their surpluses in fixed capital in the form of expensive diagnostic machines, subsequently going to work paying them off by ordering additional diagnostic scans and tests.

By pouring money into medical research, hospital expansion, and Medicare, the state-capital apparatus precipitated an end-around to bypass the guild-like authority of physicians. When the AMA and the conservative bent of physicians staved off the creep of capital into medical practice, it (capital), like an amoeba, engulfed the practice of medicine completely—through pharmaceuticals, biotechnologies, medical equipment, hospitals, health insurance, and research and development.

This brings us to perhaps the least controversial representation of commodified health care in pharmaceutical drugs. Even though one needs special social sanction in the form of a prescription from a physician (a possible distraction for a market oriented commodity-questioner), pharmaceuticals have the other trappings of traditional commodities. You go to a store and often times (depending on your drug plan) must hand over money in exchange for a product that you consume later to fulfill some useful function for you. Companies spend millions of dollars on advertisements asking you to "talk to your doctor" about their product. We know from images in television news reports that thousands of the tiny pills come rolling down

industrial conveyor belts to be sorted and counted by workers. The pharmaceutical wing that relies on doctors' prescriptions as recently as 2009 was ranked third in profitability of sectors by *Fortune* magazine (Elliott 2010, xi). And while it is difficult to calculate for several reasons, there is some evidence that pharmaceutical R&D investments earn a roughly similar rate of return compared to other industries (Danzon 2011, 537-8).

By the commodification measure of pharmaceutical drug utilization, the United States may be ahead of the rest of the world. North America accounted for 45.9 percent of global pharmaceutical sales in 2007 compared to 31.1 percent for Europe, and the United States is home to the largest number of multinational pharmaceutical and smaller biotechnology companies (Danzon 2011, 522). So for pharmaceutical drugs we have (1) an act of exchange for patients or for insurance (a dollar amount that, if paid in full by insurance, is usually still made known to the patient), and (2) their consumption contributes to the production of surplus value. Here again we see the physician acting as a mediator of further commodity consumption through medical services.

However, it is not the case that critical theoretical scholars agree that health care takes part in the commodity form, or is subject to the form of value. Peter Kennedy (2015) argues the opposite:

> In both systems [US and UK] the law of value does not govern the inner relations between the main agents; both systems are transitional to the law of value; both resist the full sway of commodity form; and both present a hostile environment for the transformation of concrete labour into abstract labour and social need into value. (212)

Kennedy draws this conclusion largely on the basis of the political and decision-making structures of US and UK health systems, specifically that public funding makes up a large portion of overall spending (50 percent in the United States, though that is well below the OECD average of 70 percent), and that the state is the final arbitrator in health care pricing (212-3). In

his key claim that health care is not subject to the commodity form, Kennedy takes what could be considered a more political frame like that of Paul Starr (1982; 2011), who looks at historical political development and professional authority as the main drivers of health care.[23] Kennedy argues that although the market plays a larger role in the United States than elsewhere, "this market is not one in which the law of value has an internal grip" (213). (Kennedy does not elaborate on what is meant by "internal grip.") By this it seems Kennedy claims that health care can be separated off from the greater market or capitalist economy on the basis of its internal decision and management mechanisms. He argues that "politics, power, genuine care for patients (which cannot be extinguished), fraud and corruption are the main drivers" for health care instead of the external economy (213).

First, the positing of an inside and outside demarcation between health care on the one hand and capitalism, the market, or the economy on the other is problematic, as this boundary is not easy to make when looking at health care production and its results. Hospitals themselves are an admixture of private contractors, biotech and material commodities employed in care, skilled and unskilled labor, capitalist management, and government funding and regulation. Within those operations, it is not clear where one could draw a line over which influences of economics or capital do not cross.

The bulk of Kennedy's support for the key claim that "the law of value has a very tenuous hold over the medical and healthcare system" (214) comes in his argument from the specific structures of the United Kingdom's National Health Service (NHS) system, which is much more bureaucratic than the United States.[24] After several paragraphs explaining NHS

[23] Much of the remainder of Kennedy's (2015) paper focuses on the ideological role of biomedicine relative to state and capital control.

[24] It might be the case that this dual focus was motivated by the extra-argumentative *professional* interest of broader readership appeal in order to get a paper accepted and published—something that is likely to

structures, Kennedy points to bureaucratic management, fiat pricing and budget constraints, and state administration to conclude *for both the United Kingdom and United States* that "the production of health and medical care has not been taken over completely by the commodity form of capitalist production" (214).[25] However, these same forces, while certainly influential in the United States, do not weigh nearly as heavily on the operations of health care production. Arguably much of what hospital systems do in the United States is attempt to overcome the limitations of state regulation and price controls, for instance by drawing additional revenues from privately insured patients through standard consumer-capitalist mechanisms like advertising, technological improvements, branch expansion, or mergers. In a *New York* Times article, a former Rhode Island health commissioner claims: "hospitals see where they're making money and try to do more of that" (David Gifford, quoted in Rosenthal 2013, A16). And the author adds: "like any business, many hospitals try to do fewer services that are not well paid," which has included outsourcing kidney dialysis and closing an acute psychiatric unit (Rosenthal 2013, A17).

Fiat pricing in the United States arguably comes in the form of CMS reimbursement amounts and those negotiated with (often private, capital-driven) insurance providers. Yet these are only loose constraints that are not widely adhered to for all patients' billing; and the underlying motive for insurance negotiations is precisely the maximization of value for their enterprise against the hospital or provider's interest to do the same for their enterprise. Further, it

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be greater when a paper addresses both academic audiences. Early in the paper there is a predominant focus on the United Kingdom with an occasional paragraph suturing the United States into the discussion (see for instance Kennedy 2015, 212, 215). But then even these attempts peter out for the most part as the paper continues.

[25] Michael Keaney (2001) may disagree even for NHS. Keaney (2001) focuses on the United Kingdom and argues that the adoption of neoliberal ideology, which emphasizes efficiency and effectiveness, has undermined goals of equity and justice in favor of calculable monetization—arguably subjection to the value form.

is certainly not the case that the US government places budget constraints on hospitals in ways similar to the fixed state allotments of the NHS (Kennedy 2015, 213). While state administration is loosely in place in the United States in the form of compliance standards from the Department of Health and Human Services, these still allow for considerable autonomous management in individual institutions and they do not have a large monetary component.

Kennedy argues that "the meaning and practice of modern medicine hover unstably between commodity form and meeting social needs as use values" (214), but I argue that the US failure in delivering on those social needs as use values in proportion to the resource expenditures is evidence that this is not the case. The "product" for most agents in US health care is not health, outcomes, or benefits. For many, including hospitals, insurance, and to some extent physicians, it is profit. In biotechnology, medical materials, and pharmaceuticals, physicians act as a mediator of commodity consumption where exchanges are veiled somewhat by added layers of insurance and nonprofit status. Kennedy gets distracted by political and decision-making structures—especially those in the United Kingdom—and inadequately accounts for the relational structure and functional results more particular to the United States.

Yet there are a variety of mechanisms whereby one can see the form of value and the commodity at work in US health care when one looks behind decisional structures. Indeed, Clare Bambra (2005) created a "health care decommodification" index in order to measure the extent to which health care access depends on individual financial resources or the market (201). Bambra concludes that access to health care is much more market dependent in the United States than in other countries (203, 208) and thus makes access to health care more subject to the value form in the United States than in other industrialized countries. So even if it may not be the case that health care is *entirely* subordinated to the capitalist regime and the form of value, it is more

likely the case that capital "has at least indirect control" of medicine as one of "those social layers which, although they belong to the antiquated mode of production, still continue to exist side by side with it in a state of decay" (CI, 931). The development of health care since at least the 1950s it would seem has seen the increasing decay of one less- or non-commodified mode of health care production and the increasing takeover of a commodified capitalist one.

One important result of treating health care as a kind of commodity is that it allows for greater clarity regarding what the relevant "product" of health care is *in terms of use value*—what is the useful quality that patients consume in their heath care services. Because of the large role for the value form and capital in the delivery of health care in the United States, it cannot be said that use value alone drives health care. The utility of health preservation and promotion is not the predominant "product" of health care. This much is clear from the dismal performance of the US system in comparison to wealthy peer countries (see Wolf and Aron 2013). Instead it seems the product that health care centers around is simply the service itself—health care is driven by the mere delivery of a service. Indeed, among standard economists the predominant measure of health system outputs in calculating productivity is simply an episode of treatment (Triplett 2011, 711). The form that an individual treatment episode takes is variable but it is the pursuit of selling the most health care services relative to expenditures that drives health care production.

Health care does not adhere strictly to the usual patterns of capitalist production because the commodity that orients health care is a mere service that adapts to whatever contemporary form that that takes. What was done with an inexpensive stethoscope yesterday is done with an EKG machine today. In ordinary industry, a new machine becomes a necessary technology because competition forces the capitalist to take on its capacity to produce commodities at

cheaper per-unit rates, to produce more per working day. However, in health care, a new machine becomes a necessary technology because competition forces the hospital or physician-capitalist to take on its capacity to deliver the most up to date procedures and diagnostics in order to attract patients and increase treatment-services. What the machine produces is demand for *this* technological service instead of *that* outmoded one.

For these reasons health care might be what contemporary Marxist scholars call affective labor. That is, "all forms of labor that produce and circulate states of being, feelings of well-being, desire, ease, and passion" (Read 2003, 128). The medical service commodity is that which produces a feeling of well being, of being cared for or looked after. It is for this reason that hospitals renovate their entrance halls for grandiosity and luxurious swank, and why they pursue top ranks from US News and World Report.[26] These considerations of the kind of labor that health care is and where that labor is situated in a process of value creation or valorization will be the focus of the next chapter.

Responding to Radin and "Incomplete Commodification"

Finally, one might object that, rather than accept the Marxian picture of health care as largely taking part in the commodity form, Radin's (1996) concept of incomplete commodification is a better fit. This line of reasoning argues that the variety of medical practices and regulations that prevent health care from being an object of market exchange show that it is not completely commodified. Moreover, from Radin's perspective, the fact that those like Pellegrino have

[26] I add to these examples an anecdotal one from my brother and sister-in-law recounting the extensive security apparatuses in place in a contemporary labor and delivery ward. These included a Lo-Jack-style tracker and alarm attached to the baby's ankle that sounds when it leaves the room. Security measures are boasted by hospitals on the Internet and talked about a good deal, this despite the fact that nonfamily infant abductions are extremely rare (Burgess et al. 2008; Bonifield 2011). What are sold here are feelings of security among expecting parents and mothers.

strongly held moral commitments about the noncommodified nature of health care show that its commodity status is at least *contested*, in Radin's language. This means that both commodified and noncommodified understandings of various health care transactions coexist (Radin 1996, 102)—no matter observations of literal exchanges. Recall that for Radin both *literal markets* and *market rhetoric in shared understandings* contribute to the degree to which a thing is commodified. Thus it seems that Radin would bolster Pellegrino's claims because the latter represents an adamantly noncommodified understanding of health care transactions that contests any commodified markets or understandings. The concept of incomplete commodification also has the benefit of motivating normative arguments to protect noncommodified moral commitments and enact limitations and regulations on their basis to protect practices of personhood. Applying Radin's incomplete commodification to health care is indeed popular in philosophical and ethical treatments of the topic (Kaveny 1999, 220; Hanson 1999, 269). It may be claimed, then, that employing Radin's frame of incomplete commodification to US health care offers a better basis for action and normative argument than a Marxian frame.

In response, I argue that Radin's concept of incomplete commodification, while appearing to offer a compromise between the spheres of economic practices (literal markets) and social discourse (market rhetoric), does not sufficiently conceive of the interrelations between those two spheres. I do agree with Radin that there are degrees of commodification because commodification is ultimately a social-historical process in which a thing's commodification can be more or less developed. Thus one thing can be more commodified than another. But Radin remains in an overly idealized sphere of meaning while discounting the practices that create and enact those meanings in her theorization of incomplete commodification.[27] Radin seems to

[27] Radin's account of incompleteness allows her to draw attention to contested commodities that she wishes to protect, but it may have logical implications for the other side of the commodity spectrum. It

privilege understandings over concrete praxis. In the chapter before incomplete commodification is explained, Radin does some theoretical groundwork to set up her approach. The themes of that discussion bear a great deal on those of the first chapter of this project, namely the extent to which discursive understandings should be the target of normative philosophical work, or should be granted primacy in philosophical argument, against more descriptive accounts of what is. Radin argues:

> If we accept the gist of antifoundationalist theories, facts are not "out there" waiting to be described by a discourse. Facts are theory-dependent and value-dependent. Theories are formed in words. Commitments to facts and values are present in the language we use to reason and describe, and they shape our reasoning, our description, and the shape (for us) of reality itself. (89)

Here Radin claims that the distinction between objective facts and values is dubious because of the ultimately discursive systems of meaning that we use to make sense of the world of facts and objects. Radin comes to this conclusion in part from engaging the orthodox Marxist scholar Georg Lukács on the linkages between thought and reality. Lukács argues: "It is true that reality is the criterion for the correctness of thought. But reality is not, it becomes—and to become the participation of thought is needed" (Lukács 1971, 204). So it seems from this basis that Radin takes this claim to its conclusion regarding how we conceive of things and observed processes with regard to their properties as objectified, fungible, commensurable, or equivalent with money (Radin's four conceptual indicia of commodification; see Radin 1996, 118). For contested commodities, our thoughts participate in their becoming reality, and therefore widely held

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threatens to render everything short of money itself incompletely commodified and making money the only *complete* commodity. This could then be used to dismiss contestations on the basis that "nearly all commodities are incomplete."

thoughts about the noncommodified nature of something contribute to its becoming a contested incomplete commodity.[28]

But I argue that Radin does not fully embody the truth and spirit of Lukács and Marxian historical materialism from which she draws. Specifically, Radin downplays the *historical* and *material* aspects of that process of reality's becoming, yet these practical and concrete elements of social change, including structural *processes*, are vital for Lukács (1971, 197-209). Lukács's treatment of these elements helps to further explicate the concepts of Marxian social form and its philosophical role in understanding social phenomena. In the same passage quoted above (also quoted in Radin), Lukács (1971) claims that the identity of thought and existence "is that they are aspects of one and the same real historical and dialectical process" (204). I take this in part to place importance on the idea of knowledge *production* as opposed to mere discovery of facts, meaning that the institutional and social apparatuses that drive creative and scientific endeavors are intertwined with their products. Lukács dismisses both versions of a "theory of reflection," or correspondence theory, that either regards things as reflections of concepts or concepts as reflections of things because "in both cases the duality [of thought and existence] is firmly established" (200). Lukács argues to dissolve this duality. Yet it seems that Radin is taking part in it still when arguing that "commitments to facts and values… shape our reasoning, our

[28] This view may run aground on more traditionally philosophical (or sophistical?) objections. One may ask: How many peoples' understandings about an object or transaction are sufficient to make a commodity incomplete? If one person decides to adopt a noncommodified understanding of money or oil, perhaps on the basis of these things' incredible capacity to connect individuals across the world in a cooperative global trade community, can we intelligibly say that their commodity nature is truly contested? It appears not. But if one person's strange belief is not sufficient, what about two people, (etc.)? This would seem to force Radin to establish some kind of minimal standard whereby a certain number or quality of understandings can be taken as sufficient for truly contesting a commodity. This, then, may appear arbitrary (why n people and not $n + 1$?) and thus challenge the credibility of Radin's emphasis on understandings. For money, oil, and other commodities it would seem that we must look to the *social relations that these things stand in—how they function within a set of capitalist social relations*—to determine whether they are rightly subject to commodified understandings.

description, and the shape (for us) of reality itself" (89). In arguing that values and meaning (i.e., thought) shape our existence, Radin echoes the claim that things are reflections of concepts rather than a true dissolution of the duality in reality as becoming. Radin may arguably be working with a somewhat perceptual or cognitive notion of how thought "shapes" existence, like the way that the eye "shapes" light passing through it to be perceived. This is opposed to a notion where the "shaping" is much more material in terms of a historical process in which the individual is just a part.

For Lukács this process of becoming has two components corresponding to space (material) and time (historical). The first is understanding thought as a form of reality that is always an ongoing process and not separable in pure logic because as soon as it is so separated it is "ossified" (203). By plucking concepts from the social processes that spawn and maintain them in order to posit pure logical concepts, one removes them from the processes that lend them their reality. Arguably this first component correlates to an understanding of thought and reality as occupying the same concrete dimension of *space*. Meanwhile, the second component of understanding reality as a process of becoming regards the dimension of *time*. When considering the historical past or what Lukács calls the equally concrete "historical future," he argues that a focus on the past *or* the future necessarily takes the similarly ossifying form of a thing as given, and thus "between the subject and the object lies the unbridgeable 'pernicious chasm' of the present" (204). I understand this to mean that any conceptual understanding of an object by a subject must be understood in terms of the *present process* of understanding rather than one that attempts to separate one's understanding out from the flow of processes in time that condition that understanding.

Lukács continues: "Man[sic] must be able to comprehend the present as a becoming. He[sic] can do this by seeing in it the tendencies out of whose dialectical opposition he[sic] can *make* the future" (204). We can call on Althusser's concepts of structural causality and overdetermination to shed light on what this might mean. In order to understand present social phenomena as concrete historical processes culminating in the present, it is necessary to conceive of a set of social-structural relations at work that culminate in it. Given the nature of overdetermination, however, this could never be understood *in its totality*—this is not likely to be a problem for Lukács given the ossifying effects of such a logical isolation, however. (Yet there is nonetheless a *posited* totality at work.) The second aspect regarding the present and the human influence on the future relates to the project of defetishizing critique and the understanding of structural functions that appear as an "objective economic evolution" (208) as instead the development of forces in which human beings have a constitutive role.[29] By understanding the present as the culmination of historical and material processes maintained and made intelligible through human social relations, one can posit that human social-relational process and where one stands within it into the future to conceive of sociopolitical change. By understanding the present and its categories of understanding as the result of specific social relations, one can conceive of the collective human agency capable of altering those relations through struggle. Adopting a distinctly *political* stance is thus key for Lukács (and Marx), calling to mobilize in opposition to the structural understandings gained about the functions of capitalist social relations.

[29] It is worth noting here that Lukács arguably holds a largely economistic base/superstructure notion, where a society's economic base determines the superstructural forms of moral ideology and culture—including the revolutionary potential of the proletariat. This is an aspect of orthodox Marxism that is increasingly abandoned or at least highly qualified or modified. For more on the conceptual development on the relation of economic base to ideological superstructure, see Laclau and Mouffe (2001), especially "Hegemony: The Difficult Emergence of a New Political Logic" (47-91; and 75-85 to get even more particular).

Allow me to bring this distinction between Radin and Lukács on reality-as-becoming a bit closer to earth. I take the historical materialist perspective to give considerable importance to the material and relational processes that go about producing knowledge and influencing conceptual understandings. This importance is such that separating out our *logical moral justifications* (such as those for why sex or babies ought not to be commodified) from the concrete relational practices (such as literal markets for either) is something that cannot be done in its entirety without becoming "ossified" in Lukács's language. Here the *concrete processes* by which a society *enacts* its conceptual schema regarding the potential commodity status of a given type of thing are a part of the way we conceive of things rather than just a distinct "literal market." Actions, practices, and social relations make up a corresponding logic to discursive moral justifications that can be the object of critique on the basis of contradiction, but neither moral understandings nor social material practices are definitive. An example of this comes from a popular example for Radin in housing. Radin (1996) argues that the regulation of housing reflects its incomplete commodification: "Rent control, habitability requirements, restrictions upon termination of tenancies, and antidiscrimination requirements can all be seen as indicia of incomplete commodification" (108). However, there is an alternative set of practices that tell a different story, and the increasing practice of eviction is one. Since the housing crisis there have been some policies that would appear to embrace the noncommodified nature of housing because they allow foreclosed-on residents to remain in their homes. But this was arguably driven mainly by the need to protect the houses' value. Allowing residents to stay was the best way for banks to do that, so the policy actually *protected* or *affirmed* the commodity nature of the house by protecting its value. Meanwhile rental evictions continue at an alarming rate among some poor communities in the United States and continue to maintain the logic of private property that

undergirds capitalism and commodity production over noncommodified understandings of home, dwelling, and belonging (see Desmond 2016).

Radin concludes that "the critique of market rhetoric tells us that the way we conceive of things matters to who we are" (93), but I argue that Radin has an overly mentalistic or idealistic notion of what "the way we conceive of things" means. This is to argue that Radin is insufficiently heeding the arguments of Lukács and Marxian historical materialism, that the way we conceive of things is a process of becoming rather than merely a set of moral justifications to be refined and submitted to logical analysis by philosophers. Radin seems to prioritize conceptual schema over structural or relational ones. In considering contested commodities, Radin's method is as follows: "for each case of contested commodification I believe we should look and see how powerful the market conceptualization is in context" (104). Now, this could be interpreted as looking primarily at the "contexts" of social relations and material processes over time, but Radin continues in a way that reveals a primacy for idealized conceptualization over hybrid notions of becoming: "We should consider whether under some circumstances market understandings and nonmarket understandings can stably coexist, either as contested concepts or as internally conflicted (plural) meanings" (104). Radin goes on to argue that by *starting from* these conceptualizations and moral justifications, then "a broad range of policy alternatives becomes available" to realize those ideals (104). I therefore take Radin as taking part mostly in an ideals/morals/principles-first methodology that I critique at length in the first chapter. Though she claims that "there is no sharp distinction between the nature of an interaction and the terms in which we conceive it" (14), she seems to prioritize the latter over the former. While there is a sense in which shared understandings and moral commitments regarding health care can and should be mobilized in (political) action to change practices, Radin errs in focusing to heavily on

understandings—both descriptively in looking to our *justifications* rather than social relations and practices, and also normatively in focusing on fostering understandings as the key rather than the alteration of social relations and practices.

It is worth noting briefly that Radin is a professor of law and is therefore theorizing in an intellectual context where interpretations of meaning have a clear influence on actual practices. An individual's understanding of the nature of property and its relationship to an individual's personhood can potentially have significant consequences when it bears on a judge's ruling that in turn is based on the understood meaning of a word, concept, practice, or norm.[30]

Further, we might understand Radin to be considering how to theorize the individual effects of reification and alienation because Radin is considering how individuals in capitalist societies might stave off the tendency to consider previously humanist or non-economic or capitalist sectors of life in newly commodified language. Radin's claims regarding incomplete commodification and maintaining incompletely commodified conceptions in order to protect personhood could be understood as a cognitive-behavioral political tactic for preventing total reification in thought. I believe that with added emphasis on social relations and a more political normative focus Radin's theorizing of incomplete commodification can be of greater use. But the concrete structural realities of health care that become apparent when considering it as a historical-material process of production weigh too heavily to deprioritize in favor of a focus on meanings, understanding, and conceptualizations. By looking at both conceptual justifications/understandings and social relational structures as taking part in the same process of becoming, health care ethicists and philosophers can gain better understandings with greater political and normative potential.

[30] This line of thought comes from Radin (1993, 191-202).

Conclusion

In this chapter I argue that health care is a commodity in the United States in the sense that it is subject to the form of value through acts of exchange and that it contributes to capitalist surplus value production. Where many contemporary authors adopt the conceptual schema of neoclassical economics to ask the commodity question for health care, I argue that Marx's critical philosophies of social form offer a preferable alternative to the universalist categories of contemporary economics and the emphasis on "markets" that often accompany them. By considering the way that health care interactions take place in relation to a larger ensemble of social relations, rather than its instrumental or moral characteristics, I argue that health care is one increasingly commodified part in a process of capitalist production. Finally, I argue that health care should not be considered "incompletely commodified" in Radin's terms because that conceptual account relies too heavily on idealized notions of discourse and meaning while insufficiently accounting for historical and material processes—for Marxian social form.

Chapter 3

The Relation of Medical Labor to Capitalist Valorization

The predominant assumption in health care ethics is that physicians perform a different kind of labor than an "ordinary" worker. In this account the work of physicians differs even from the cognitive labor of advanced capitalism and many of the highly skilled labors of those who most would call "professionals." Professional ethics literature tends to deny that physician payment does or should operate like normal worker wages. Politically, the United States has largely avoided salaries or direct time-wage payment for physicians in favor of systems of variable pay that grant doctors some control over their income. For some ethicists, it is precisely because of the perceived special nature of physicians' labor that they appeal to moral principles to govern their behavior. The special nature of professions is the basis of professional ethics as a theoretical approach.

However, there is a parallel account of physicians' labor that comes from considering how it relates to the social formation within which it occurs. Physicians' labor and their payment has increasingly become a part of capitalist processes oriented toward producing and accumulating surplus value and wealth. The independent medical practitioner once operated like a small-business owner, whose above-average income was still relatively modest compared to the capitalist class's wealth accumulation or to contemporary corporations. But the relation of a physician's labor to the capitalist production of value in the United States has grown stronger over the latter part of the twentieth century—and even more so into the twenty-first. Like the move from small-scale manufacture, to large-scale manufacture, to the mechanized factory, this brings with it important developments; and we can trace similar developments in medicine when

moving from independent practice, to medical groups and hospitals, to large hospital systems. Meanwhile a host of ancillary industries have multiplied around health care delivery in order to produce profits from its activities.

Health care ethicists and physicians often assume that by protecting the covenant nature of the physician-patient relationship, by rejecting any shifts toward a "market" relationship, its moral nature can be preserved. The American Medical Association (1997), for instance, warned of the following in the decades of managed care: "Mounting shadows darken our calling and threaten to transform healing from a covenant into a business contract" (1733). I argue that this is an oversimplified view that fails to account for the extent to which physicians and health care as a whole already serve a major role in productive capitalist apparatuses. I argue that Marxian social-relational accounts of medical labor illustrate that the US physician or medical worker is a "productive worker" from the perspective of capital. This means that she or he contributes to the production of surplus value (valorization) through her or his labor. This is to say that within the social formation of capitalist health care in the US, medical labor takes part in the social form of productive labor. With this alternative understanding, the scope of concern for bioethicists and its epistemic grounding is better suited to realities and thus more likely to contribute to social and political change.

I begin this chapter with a review of accounts of medical labor—mostly in terms of physicians—as they are utilized in health care ethics. In the next section I explicate Marx's account of labor as the basis of the capitalist production process, and in particular valorization, or the production of surplus value. I then give an account of the ways that productivity for capital can be applied to medical labor; that is, I argue that health care increasingly contributes to the

overall process of capitalist production and I indicate what this means for health care ethics and practice.

Medical Labor in Health Care Ethics

The argument in this chapter is not terribly novel. Karl Marx and Friedrich Engels (2012) as early as the *Communist Manifesto* argue that capitalism and the bourgeoisie "converted the physician, the lawyer, the priest, the poet, the man of science, into its paid wage labourers" (76). But a part of their argument, too, is that those forms of capitalist exploitation are veiled by political and social ideologies that cover up those labors' role in capitalist valorization (76). This leads one to ask what covers up medical labor's relation to value production. In this section I give a brief review of the treatments of medical labor in health care ethics; I argue that it is largely the ethically special nature of medicine—often lionized by health care ethicists—that provides an ideological cover for the workings of valorization in medical labor. Medical and physician labor is often afforded special moral standing on the basis of its qualitative characteristics. In addition, the nature of professions is often contrasted with ordinary economic or "market" activity and is used to ground special moral obligations for professionals like physicians or nurses. Finally, I consider medical labor in terms of the concept of caring labor developed in feminist care ethics, and argue that this is not an appropriate application for medical labor.

I do not necessarily wish to falsify the substantive arguments about the morally special nature of medicine. Health care does seem to be special, particularly on the grounds of the seemingly universal need for healing within and across cultures. What I would contend on this front is first that the shape that healing labor takes in a given society, whether "special" or not, is

determined in some ways by the social formation that it takes place within. Second, any special nature of health care does not preclude medical labor from being considered in an economic, social-relational light. The conclusions from such economic considerations, however, should also not be applied haphazardly to moral considerations, as could be done in applying certain conclusions from health economics to medical ethics.

Before continuing, I must explain what I mean by medical labor and distinguish it from a few other categories of labor in this project. I use medical labor in most instances to refer to labor that deals directly with a human patient, or in some cases (like a radiologist looking only at images) representations of- or placeholders for patients. Medical labor for me has to do with more direct care, or the types of occupations that one ordinarily considers among the jobs one does in health care. Medical labor, then, includes the work of nurses, nursing assistants, and similar non-physicians—although I have tended to emphasize physicians up to now. I therefore use the term physician labor to refer to the specific labor of a medical doctor, including what would traditionally be the subject of the doctor-patient relationship. This being said, a central claim in my project is that health care ethics needs to open its moral universe to the expanding army of workers that contribute to the industrial scale of contemporary health care production. This distinction bears on different portions of my project, and I draw attention to this when necessary.

Medical labor is afforded special standing in the philosophy of medicine and health care ethics. Eric Cassell (2004), for instance, argues that the nature of human suffering, which drives the patient to seek out a healer, makes the physician's relationship to the patient a highly personal one. On this basis he argues explicitly against accounts that take health care as a service commodity. He argues that "current depictions of physician and patient as adversaries struggling

over a commodity called medical care bear no relation to the actual care of sick persons because of this special connection" (62). Cassell appeals to "the nature of sickness and the bond between patient and doctor" as something that makes the healer role special (62). Healing labor is special because through that relationship it is possible "to heal the sick, to make whole the cured, to bring the chronically ill back within the fold, to relieve suffering, and to lift the burden of illness;" this takes more than just curing patients of their diseases (65). So Cassell is arguing that the personal-relational nature of healing differentiates it from merely curing physiological diseases. Healing when viewed as a social-cultural practice is shown to reintegrate an individual into the community. The latter is aligned with medical anthropology's notion of healing, which identifies the healer role as existing in varying culturally specific forms across societies.

Cassell goes on to claim a kind of relational foundationalism in that "all other possible relationships between doctors and their patients" such as economic, political, community, social, personal, private "derive from this foundation," referring to the special bond that forms from the "basic relationship between doctor and patient" (62-3). Cassell does not elaborate exactly what this means for those other considerations of physicians' labor. It would seem that Cassell is arguing that one considering those other possible relationships between physician and patient must in some way account for its foundational personal nature. In this same passage Cassell appears to be saying (by analogy with the parent-child relationship) that when we refer to the doctor-patient relationship, "we generally mean something more basic than the economic, political, community, social, personal, or private relationships in which they…may enter" (63). Here it appears that Cassell does not preclude other considerations but perhaps wants to emphasize this basic relation over those others as morally important. But Cassell may be claiming that the nature of suffering creates a bond that *does preclude* or override alternative

relational frames or conclusions drawn from them. This appears to be at work when Cassell denies that health care is a commodity above. Although here he appears to be making a factual claim based on "the actual care of sick persons" (62) rather than a theoretical claim for medicine's formal consideration.

I do not challenge or doubt that there are unique qualities in health care that make it distinct from most other services and thus even morally special. But these are considerations that are largely outside of the social form that medical labor takes on within a capitalist mode of production. Focusing too much on an exclusive "special" relationship in theorizing health care blocks out possible influences of an economic social formation in that relationship. So long as one interprets Cassell to be making the more reasonable claim that one can still examine other relationships between doctor and patient (like the economic and political), then it is consistent with Cassell to simply draw attention to some specific relation *outside the intimate doctor-patient relationship* for a project like mine. This extends considerations to the *institutions and economic relations* within which the physician-healer works, thus forming a context for the doctor-patient relationship. Approaches like Cassell's have the potential to overlook a great deal of social relational components in the production and delivery of health care in favor of romanticizing health care beyond the point of recognition in a delivery system with an enormous capitalist component. I hope to push beyond moralized appearances in order to consider the physician as a part of an ensemble of social relations.

Another source of the specialness of health care comes from the fact that much of it is performed by members of a profession. Many health care ethicists use a professional ethics approach, which seems to appeal especially to physicians themselves. Professional ethics holds that the nature of the professional role and the relationships that follow require that the

professional conduct herself according to a set of moral norms shared among the profession. The professions are usually identified by a cluster of characteristics including: an extensive knowledge base and skillset, similarly extensive training for new practitioners, a socially sanctioned monopoly to deliver a specific service, and relative self-regulation (see Smith and Churchill 1986, 25-6; Kittay 1999, 38-9; Ozar and Sokol 2002, 14; Pellegrino 2002, 378; Beauchamp and Childress 2013, 7). Harmon Smith and Larry Churchill (1986) argue that the "internal characteristics of a profession" like those above "derive originally from a social mandate to provide a particular service" (26). Because a profession is granted both monopolistic power over that particular service and relative autonomy within society, the profession has certain obligations to the society that grants such powers. A profession here is depicted as a variety of hypothetical social contract. For these reasons, professional labor is often contrasted with non-professional sorts. These special characteristics that distinguish professions from a social perspective often lead theorists to conclude that professions are distinct in an *economic* sense.

Medical professionals are, then, seldom considered from the viewpoint of their contributions to capital. Paul Starr (1982) notes that "medicine and other professions have historically distinguished themselves from business and trade by claiming to be above the market and pure commercialism" (23). And some argue that understanding professionals to be like other sellers of services or labor is a category mistake (Ozar and Sokol 2002, 48-51). Edmund Pellegrino (2002) argues that the medical profession (in addition to law, ministry, and teaching) is set apart from other occupations categorized as professions by "a certain degree of altruism, or suppression of self-interest when the welfare of those they serve requires it" (378). By differentiating medicine through its altruism, it appears that Pellegrino separates it from an

economic sphere that is itself defined by the neoclassical principle of self-interest. Professional ethics emphasize the relationship between doctor and patient and the moral obligations derived thereof. Unlike commercial models where the customer is always right, professional ethics insists on the need for sovereign professional judgment of the patient's best interests, which may override or conflict with a patient's wishes. Ethical principles of beneficence and non-maleficence are among the obligations derived from this basic professional healing relationship.

Another possible treatment of medical labor is from the perspective of caring labor. This refers to care as the central activity of interest in feminist care ethics. Care itself is approached and defined in varying ways within care ethics. Sara Ruddick (1995) includes among the many caring activities:

> maintaining a shelter in which children, among others, are safe (housework); sustaining a circle of connections—of kin and friends—on whom children, among others, depend (kin work); securing, preparing, and serving food to a household or community, including its children; attending to the needs of the vulnerable, children as well as the elderly; and teaching the very young or the previously untaught. (46)

Medical labor as it is provided by a physician pertains mostly to attending to the vulnerable (and perhaps also teaching) and would thus appear to be caring labor.[1] For Eva Kittay (1999) care takes a back seat to *dependency work*, which responds to dependence caused by infancy and early childhood, illness, and disability (29). Dependence is the central concept for Kittay, and it would seem that her inclusion of illness in the sources of dependency would place much medical labor under the umbrella of dependency work and caring labor.

Joan Tronto (1993) defines care much more broadly as, on the most general level,

> a *species of activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible*. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web. (103)

[1] Ruddick (1995) elects to focus her project on theorizing the specific act of *mothering* rather than generalized care (47).

This is obviously an expansive conception of care, which would appear to include most things that fit within the concept of reproduction in Marxian theory—or that which is necessary to reproduce the material conditions of production in a society (see Althusser 2014, especially 232-7). This includes most economic activity, and also includes the reproduction of labor power, which is to say the biological and social reproduction of a labor force in human beings. However, Tronto argues later that "production" and economic activities like marketing a new product are not care (104), and she limits her use of care to instances where "both the activity and the disposition of care are present" (105). It would seem from a Marxian standpoint, therefore, that Tronto's notion of care actually narrows on a more specific realm of what persons do to reproduce our world—or that Tronto is operating with a particular definition of our "world." In an example Tronto does include the care for a patient within the fold of caring (107), and so would appear to include health care in caring labor.

But there are reasons to think that care is not an appropriate conceptual approach for medical labor, and especially for that of physicians. The first is because it emphasizes individual dispositions or motivations over structural relations or consequences. Depending on the author, care has varying degrees of reliance or emphasis on an individual's conscious disposition and attitudes. Kittay (1999) argues that dependency work relies on care, connection, and concern (31), and Tronto (1993) as noted above includes disposition in determining care (105). Some authors recognize that unpaid care work performed in the family or community can be done at times with little love for the work on the part of the care worker or affection for the receiver of care. This focus on individual attitudes through care has clearly yielded significant work in the field of ethics. However, in this project I emphasize instead the ways that medical labor fits into a larger system. This requires considering the structural consequences and functions of medical

labor more than the dispositions and conscious goals of the individual practitioner or worker—particularly because part of my project's claim is that medical labor's relations to a capitalist social formation can unconsciously or unwillingly subvert or contradict a practitioners conscious goals or moral motivations.

The second reason that I do not employ care in my approach to medical labor has largely to do with the material, political, and intellectual history of feminist care ethics. Doctoring and healing were professional practices for many years before care was employed as a feminist category for critiquing traditional ethics. It was largely *in reaction to* philosophical models of principled ethical decision-making that some feminists first theorized a concept of care (Gilligan 1982; Noddings 1984). Yet these traditional models were often applied to the physician in the "language of the father," to use Nel Noddings term (1984, 1). To now apply the category of caring to physician labor would thus seem inappropriate. Care was theorized from the margins, which is a space that physicians cannot be said to occupy as a group.

Indeed, Kittay (1999) makes this basic argument that dependency work is distinct from professional work. Kittay argues that what distinguishes professional activities from dependency work (as a subcategory of care) "are features associated with status" (39). Professions, it seems by their nature, afford a level of social status to their practitioners that is also accompanied by means of payment—which can be taken as the social acknowledgment of their benefiting the community. Dependency and care workers have, on the other hand, been historically marginalized in their being largely excluded from wage work, and the impact is highly gendered and racialized. So both professions and dependency workers for Kittay occupy a space outside of the "the self-interested competition for goods" (39). But, Kittay argues,

> when the professional stands outside the fray, he stands above it. Rather than being seriously disadvantaged, he is exempt from its vicissitudes and is amply rewarded for his

> efforts. Of the two categories of labor in which devotion to the well-being of another is at stake, the status and remuneration goes to the professional. (39)

Kittay argues here that the social status afforded professionals is also reflected in the monetary compensation afforded their labor and not afforded to most forms of dependency work. Kittay also claims that formal mechanisms exist to insulate physicians from the challenges and insecurities that come from economic fluctuations and volatility. The marginalization of dependency and care work is even reflected *among and within* the professions. Kittay argues that women are so identified with dependency work that the professions that they do enter in the greatest numbers ("social work and early childhood education rather than law or medicine") are themselves thought to be closer to dependency work and care—and are less compensated (40). I would add to this that the specializations within a profession like medicine also reflect this tendency. Most women physicians are in primary care specialties (Lindemann 2012, 42), where overall compensation is much lower relative to specialty care (Bodenheimer, Berenson, and Rudolf 2007).

It seems that the holistic nature of reproductive caring labor, which Silvia Federici (2012a) argues differentiates it from commodity production (123), may also separate it from the specialized labor that Kittay (1999) argues gets compensated—specifically because it is specialized and interventionist as opposed to holistic and sustaining (39-40). It seems as though the social significance lent to specialized labor gains its meaning in part from being contrasted with care work. This deserves to be critiqued, and has been by Tronto, Kittay, Lindemann, Federici, and many others. But such is not the immediate task of my project. This observation does become relevant to my project, however, when the social value of caring labor or women's labor becomes a mechanism for capital to increase surpluses and cheapen labor. The increasing feminization and injection of women into primary care roles—including among nurse

practitioners and physicians assistants—which are the most needed roles from a standpoint of good health and US demand, thus takes on particular significance from the standpoint of capital and Marxian theory. It would seem that the multiplication of such workers ultimately acts to drive down the cost of medical labor, the proceeds of which predominantly become profits for capitalist health care producers.

This section briefly accounts the approaches to medical labor in professional medical ethics and the theorization of the doctor-patient relationship. These treatments have in common a tendency to differentiate medical labor in a special moral sphere from ordinary non-medical labor in a strictly economic or commercial sphere. The result of this is a corresponding tendency to ignore the relation that medical labor plays in the production of surplus value through capitalist health care production, and how these relations might affect ethical and political discussions of health care. It may seem that the category of caring labor from feminist care ethics has some bearing on medical labor. While there is certainly a good deal of overlap, care is not an appropriate frame for my project. In the next section I explicate Marxian conceptual accounts of labor and its relation to capitalist production.

Labor, Valorization, and the Wage Form

Much of Marx's treatment of labor comes alongside his analysis of the commodity in the first chapter of the first volume of *Capital* because there he argues that labor is what lends commodities their value within capitalist social relations. Because labor, commodities, and value are tangled up in one another they can be hard to separate in theoretical explication. I try not to repeat too much from the previous chapter here. In addition to the claim that labor quantified in a commodity gives it its value, Marx argues that the characteristics of labor power (defined below)

in capitalist relations of production are such that they enable the creation of surplus value for the capitalist. In this section I explicate Marx's claim that the social form of labor in capitalism has a material component and a social component. Labor's social relation as abstract labor in capitalism means that it produces value, and in the production process living labor power in the worker can create more value over time than it costs for the capitalist. This process of valorization increases the magnitude of wealth for all of capital. Finally I explain Marx's account of wages in terms of paying for the reproduction of the worker, and the historical presuppositions of the "wage-form."

Marx begins his analysis by arguing that labor is the creation of use values, of things that fulfill some purpose (CI, 131). If one's labor produces something that is useless, then it is of no value from the standpoint of capital, and thus the labor that created it is also considered useless and of no value (CI, 131). I argued in the last chapter that health care is primarily a set of service commodities, where its consumption occurs in the act of producing it. In this chapter I focus mostly on the physician's labor that produces these service commodities, and medical labor to a lesser extent. This is slightly different from the highly material notion of commodities and labor that assumes the creation of a physically alienable product that can be packaged, shipped off, or put in a pocket or shopping bag to be consumed later.

Like the commodity, labor within a capitalist social formation has a dual form. The first comes from its material or useful quality and the second from how it stands in relation within a social formation (CI, 137). For labor, its social-relational quality is that it creates and maintains value in capitalist production. When two quantities of products of labor are equated to one another, then what is being equated must be a characteristic that they share in common; Marx argues that in capitalism this comes to be the human labor embedded in them or used to produce

them (CI, 142, 159, 166, 296). But labor itself is not value—it must be objectified in something in order to actually be value (CI, 142). Through commodity production and exchange, human labor comes to be equated as sharing a fundamental form: "the equality of the kinds of human labour takes on a physical form in the equal objectivity of the products of labour as values" (CI, 164). Labor itself comes to be exchangeable and thus equally capable of lending itself to capitalist production. Under capitalism,

> activity, regardless of its individual manifestation, and the product of activity, regardless of its peculiar make-up, are always *exchange value*, and exchange value is a generality, in which all individuality and peculiarity are negated and extinguished. (G, 157)

The exchangeability of labor creates a link between abstract labor and money as the universal equivalent. The exchangeability of labor becomes embodied in the money form because the abstract labor that determines exchange value is expressed and realized through exchange in a quantity of money.

If you are picking up on Marxian themes, you may anticipate that this dual form in labor opens up the potential to fetishize labor. Individual workers tend to take their labor at its face value and fail to see how it functions in the larger social formation. To workers, Marx argues,

> the social relations between their private labours appear as what they are; i.e. they do not appear as direct social relations between persons in their work, but rather as material relations between persons and social relations between things. (CI, 166)

Here Marx claims that to the individual worker her labor appears as mere material work that contributes to a product that is purchased by another person to be put to use. She attributes the characteristics that give those commodities value—their social "power"—to the things themselves and their workings against one another in mysterious markets. She is a mere contributor to an external and self-moving economy. Yet it is workers' contributions—and that they are equated to one another as abstract labor—that lend capitalism value as its sole end-in-itself.

This brings us to Marx's response to a question that political economists before him set out to answer, namely, what is the source of surplus value that drives capitalist production and allows the capitalist to reap profit? Capitalist exchange takes place in a series of equivalent values, so it is not clear why more value comes out of the process in the form of surplus or profit than went into it in what is paid in materials, rent, and wages.[2] Marx contends that this increase must come from the consumption of a commodity paid for in full, that is to say that it comes from some commodity's use value. Marx argues that *labor power* is that commodity (CI, 270). The distinction between labor and labor power is important. Labor is that human activity that gets objectified in the commodity through the process of production.[3] Labor power or labor capacity, on the other hand, exists in the worker. Labor power is:

> the aggregate of those mental and physical capabilities existing in the physical form, the living personality, of a human being, capabilities which [that human being] sets in motion whenever he[sic] produces a use-value of any kind. (CI, 270)

So labor power is the embodied capacity to perform work, to objectify one's labor in the production of commodities. Labor power—not labor—is the actual commodity that a capitalist purchases for a period of time when agreeing to pay a worker a wage (CI, 270; G, 282).

Since labor power is a commodity, it must have a value. And also because labor power is a commodity, its exchange value is not determined directly by its use value. Marx argues that "the value of labour-power is determined, as in the case of every other commodity, by the labour-time necessary for the production, and consequently also reproduction, of this specific article" (CI, 274; see also G, 307). Because labor power exists in the human body, one with money who wishes to purchase it must do so at the value necessary for the worker to maintain

[2] Surplus value and profit are not identical, just as exchange value and price are not either. This is simply worth noting, and I think it would be tangential to explicate these distinctions fully. For present purposes these can be *roughly* equated.

[3] And if machines produce or assemble a commodity, then the objectified labor is that of the machine's designers, operators, and that preserved in the raw material.

and reproduce him or herself. "The only thing that is sure is that the price of labour, wages, must always express the quantity of labour which the labourers want in order to keep soul and body together" (G, 570). Like all values this is a socially average amount, so it is not determined on an individual basis (CI, 274, 434, 655). Now we get to the basis of a worker's wage. The magnitude of value in wages is an exchange value and is therefore unrelated to its use value. So regardless of the magnitude of value produced, labor is sold for the cost of its production and supply and demand for such workers (G, 306). Because the purchaser on the labor market is purchasing *labor power* in the human being, rather than objectified labor itself, he must pay for the cost of producing that labor power. For a human being these are the costs of living or the costs of sustenance. In more advanced capitalist economies salaried workers seem to do well for themselves. Their income is not what one would call mere "subsistence wages" in ordinary language, and yet those salaries are much more in the realm of subsistence in that they do not create *wealth* as valorization does for the capitalist (G, 284).[4]

The distinction between labor and labor power is important because it helps illustrate why, in fact, "the value of a commodity is determined not by the quantity of labor actually objectified in it, but by the quantity of living labour necessary to produce it" (CI, 677). Marx clarifies this with an example: "A commodity represents, say, 6 working hours. If an invention is made by which it can be produced in 3 hours, the value, even of the commodity already produced, falls by half" (CI, 677). The invention changes the amount of *socially necessary labor time* for the commodity's production—and that is what influences its value (CI, 295-6). The fact that I spent four days crafting a plastic novelty keychain of the Grand Canyon does not make it more expensive than a similar keychain mass produced and imported from China. The mass

[4] This touches on the difference between income and wealth, which is important for understanding present discussions of economic inequality within countries and across the globe.

production, cheaper labor in China, and trade between China and the United States mean that my keychain is valued as equal to the social average influenced by China. The fact that more labor is objectified in my keychain does not matter when it is placed in that relation as abstract labor. This is what Marx means when he argues that "labour is the substance, and the immanent measure of value, but it has no value itself" (CI, 677). Time is actually the measure of labor's value-lending powers, and objectified labor is placed in a value relation to all similar labor.

Time, then, becomes the primary subject of manipulation and exploitation on the part of the capitalist. The function of labor power, which the worker sells, is such that it can create more value than it costs to pay for the worker's subsistence (G, 674). That is the use value of labor power for the capitalist. Because this function over time is purchased and not the labor itself—and because the use of a commodity belongs to its purchaser (CI, 292), then the capitalist can use labor to produce more value in commodities over a working day than the worker is paid in wages for that day (CI, 300-1). Marx argues that the worker only spends a portion of the day creating the value necessary for subsistence that he earns in a wage (necessary labor) and the rest of the day is spent creating value for the capitalist (surplus labor). That excess labor then creates surplus value, which belongs to the capitalist given the nature of the wage contract. "If such a thing as the value of labour really existed, and [the capitalist] really paid this value, no capital would exist, and [the capitalist's] money would never be transformed into capital" (CI, 682; see also G, 570). The conceptual distinction between labor and labor power helps explain what empowers the foundational element of capitalist production of surplus value (valorization) that drives the entire mode of production, or social formation (CI, 304).

Finally, in order for a capitalist to even find labor power on the market for purchase, Marx argues that a set of conditions must first be met. The first is that the worker is a free

proprietor of her body (CI, 271) and that she cannot simply make commodities to sell or consume herself, nor does she possess land by which to sustain herself and others, but is instead compelled to sell her embodied labor power as a commodity (CI, 272; G, 471). Finally, other means of sustenance as commodities must be appropriable through exchange of her labor capacity (G, 502-3; CII, 138). In order to sell commodities rather than labor power, one must possess means of commodity production. Marx argues that these prior conditions of the wage form are not natural or self-evident—one class of people possesses commodities (means of production) and the other possesses nothing but their labor power (CI, 273; CII, 115). This relation is instead "the result of a past historical development, the product of many economic revolutions, of the extinction of a whole series of older formations of social production" (CI, 273). It presupposes that people are rendered wage workers by appropriating their lands or means of subsistence, forcing them from the land, and then forcing them to work (G, 502-3). Their "liberation" historically is from a prior means of social reproduction. Marx calls this "primitive accumulation," meaning "an accumulation which is not the result of the capitalist mode of production but is its point of departure" (CI, 873). After such (often violent) appropriation of land and expulsion of now landless populations, Marx argues that forms of *discipline* are needed for wage labor and that "the rising bourgeoisie needs the power of the state" (CI, 899).[5] The conditions created through primitive accumulation must be maintained and expanded to further empower capital. This is in the conceptual territory of the state-capital apparatus.

In the next section I apply these concepts to medical labor from Marx in order to consider how it contributes to the valorization process of health care capital.

[5] Michel Foucault clearly expands on this idea in much of his work.

The Physician as Productive Wage Laborer

My claim in this project is that the practice of health care is a part of relations of capital to the point that health care itself is a mode of capitalist production. This is not readily apparent, and is likely to be denied by some, because of health care's care-orientation and the philosophical treatments of physicians' labor outlined above. People ordinarily want to differentiate physicians from salespersons, factory workers, CEOs, or regular capitalists. But those authors must admit that there is an economic dimension to medical services simply because of the interventions of money (in addition to economic variants of social determinants of health, which often contribute to making patients ill). An account of the physician as a kind of wage laborer who contributes to valorization generally runs counter to accounts that characterize them as special. The former account should not necessarily supplant the latter. Physicians' social relations to capital should simply alter the ways that physicians and medical labor are treated in health care ethics and politics.

In this section I first explicate a standard economic account of health productivity and contrast that to a Marxian notion of productive labor. I then analyze health care and medical labor in terms of four categories of productive labor that I identify in Marx's discussions of productive labor. These four categories occupy two dimensions: direct/indirect and relative/absolute. My conclusion from considering health care in these categories is that health care labor in the United States stands in a productive relation to the capitalist process of wealth (value) production as a whole.

Productivity can have different meanings depending on the discourse. Contemporary health economics defines productivity in measurable terms of the ratio of health care's outputs to its inputs (Triplett 2011, 707). By this measure, productivity in health care has behaved

differently than in other economic sectors: while economic productivity is generally increasing in advanced capitalist economies, productivity growth has typically been negative for health care. This finding is not limited to the obviously wasteful US, as data also finds the same in Sweden and the United Kingdom (Triplett 2011, 707). This fact would appear to run counter to my Marxian claim that health care is rendered increasingly productive from the standpoint of capital. Responding to this puzzle requires considering first (briefly) how exactly productivity is measured as an economic ratio, and then contrasting this to Marxian theoretical accounts of productivity.

As mentioned, health economists measure productivity as a ratio of inputs to outputs. Inputs in economic jargon go by the acronym KLEMS:

> [K] capital services, [L] labor services (the vector of all labor inputs, from surgeons to janitors), [E] energy, [M] intermediate or purchased materials (which in this sector includes pharmaceuticals used in hospitals and clinics, stents, and so forth), and [S] purchased services. (Triplett 2011, 708)

This seems pretty straightforward, as these are the immediate resources necessary to provide a health care service. Health care outputs, however, are both more controversial and harder to quantify and measure, and so there are competing accounts (Triplett 2011, 710-5). But the widest-used unit of output is simply an episode of treatment for an illness or disease (Triplett 2011, 711).[6] The theoretical ideal would be to measure as outputs the economic impact of actual health outcomes brought about by treatment. Indeed, this approach reflects a standard for *theoretical* economic thinking about health production developed from Michael Grossman

[6] For the sake of data gathering and analysis, these episodes of treatment (and some other proposed outputs) conveniently correspond to medical coding data like Current Procedural Terminology (CPT), Resource-Based Relative Value Scale (RBRVS), and Diagnosis-Related Groups (DRGs), which themselves often correlate with International Classification of Diseases (ICD) codes used in epidemiological and clinical statistics. I am not clear on how exactly these become quantified in relation to inputs, and it seems like the quantifying determination would differ depending on the type of output chosen.

(1972a; 1972b). But economist Jack Triplett (2011) claims that Grossman's models have yielded few attempts to actually implement them empirically (724). Measuring the actual economic impact of medical procedures would be difficult to predict or quantify for any given case, let alone for a large data set. Some procedures are more successful than others, while patients' economic impacts differ due to factors like age, occupation, previous health, etc. The treatments themselves are presumably easier to assign uniform values for the sake of economic data analysis.

It is perhaps because of the challenges in applying economic theory to health care outputs that productivity appears to be negative, and generally confuses attempts at empirical translation and measurement. Triplett (2011) argues that industrialized countries "have very little information on what their medical expenditures buy" (727). When there is such ambiguity in health care's outputs, it is difficult to measure its productivity. In addition, when a measure of productivity focuses on the use value of health care, that is, its actual health outcomes, it is not surprising that it shows decline. The United States is an excellent example of the possibility for diminishing returns from health spending in terms of actual health outcomes. Many already argue that inherent mechanisms of human biology and medicine would seem to keep health care spending soaring while medical benefits get asymptotically smaller (see, for instance, Callahan 1998).

Marx's distinction between use value and exchange value helps to clarify by lending *two separate ways of considering health care outputs*. Marx argues that practices that appear unproductive from a standpoint of use value can be rendered productive for capital:

> production for unproductive consumption [like consuming tobacco (his example), or needless medical procedures (my example)] is quite as productive as that for productive consumption; always assuming that it produces capital. (G, 306n)

The production of surplus value is the most relevant measure of productivity from the view of capital, and so something that is not terribly useful can still be productive for capital.

A Marxian approach to productivity focuses primarily on exchange value and the production of surplus exchange value, which drives capitalist production and growth. My claim is that health care practices are subjected to the social form of value (exchange value), and that therefore the functional output that predominantly motivates health care is surplus value production, or valorization. I do not claim that that this is necessarily a conscious goal on the part of physicians, nurses, other health care practitioners, or policymakers. I am instead claiming that there is an "inner logic" that, if truth-tracking, can explain and anticipate certain trends visible in health care practice today. I see this increasing control over health care by capitalist logic (i.e., alienation) as a normative problem, which will be addressed in the final chapter. I now explicate productivity for Marx and consider those ways medical labor is productive for capital.

Ernest Mandel (1992) reminds readers that "when Marx classifies certain forms of labour as productive and others as unproductive, he is not passing moral judgment or employing criteria of social (or human) usefulness" (42). Productivity here is from the viewpoint of capital, or specific to a capitalist social formation. While use value can be a subject of output considerations for analysis, it is not the primary concern *from the standpoint of capital*. What is at stake in determining whether medical labor is productive is determining whether or in what ways it contributes to capitalist production—and the production of surplus value in particular. Determining the One Definition for productive labor is an intra-Marxian debate that does not pertain to this project. I wish to only explicate what is at stake in the discussion to set up an analysis of medical labor that places it in relation to capital and not merely professional codes or health outcomes. The result will be several possible understandings of what might make any

particular labor productive for capital. In doing so I apply those categories and possible understandings to health care practice. Without arguing for just one correct definition of productive labor, I use Marx's distinctions to shed light on health care as a process of production and medical labor as its basis.

Marx's notion of productive labor evolved somewhat over his economic writings. Mandel (1992) claims that the second volume of *Capital* presents Marx's definitive views on productive labor (42).[7] The evolution from Marx's earlier considerations to those in the second volume of *Capital* seem to come down to two dimensions: (1) whether the worker contributes *directly* or *indirectly* to the production of surplus value, and (2) whether productivity is considered in terms *relative* to a particular instance or process of production or in *absolute* terms regarding an entire social formation or mode of production.[8] The (1) direct/indirect dimension of productivity corresponds, in Mandel's (1992) words, to a specific labor's "participation in the process of commodity production (which involves the unity-and-contradiction of the labour process and the valorization process, use-value and exchange-value, concrete and abstract labour)" (43n48). Direct contribution to surplus value refers to labor that *itself creates commodities* that go on to realize surplus labor in the form of surplus value contained in exchange value (Mandel 1992, 43; CI, 1038; CII, 225-6). Indirect contributions refer to those labors that *contribute some part*

[7] Mandel (1992) bases this Marxological claim on the fact that the material on productive labor in volume two is taken from manuscripts written after other sources where Marx works out the concept (42). This claim might be challenged from two directions. The first is that Marx took part in new editions of the first volume and, being multilingual, also helped edit French translations of the first volume that contains a slightly different notion of productive labor. Marx would have been editing French translations after Mandel's "most definitive" 1870 manuscripts, given the 1872 publication of the first French edition (CI, 104). But the second line of objection is simply to challenge that what is definitive is only what is published last. It may be the case that an earlier Marx had it more right. It is also the case that, *for purposes of application like my project*, what matters most is what tracks the truth rather than simply what Marx wrote.

[8] This distinction is inspired by that between absolute and relative surplus value for Marx (CI, 429-38, 643-54).

(perhaps itself unproductive, or a pure cost to capital) of an overall process that results in surplus value production (see CI, 643-4).

The (2) relative/absolute dimension of productivity refers to whether the value generated from a surplus-producing process is merely revenue (money moved from one source to another) or if it increases the *total magnitude of capital* within a social formation. Relative productive labor has to do with the relation between labor power purchased and the value created by it. So it refers to labor that produces surplus value *for the specific capitalist entity* that purchased the labor power. For example, insurance is only a relatively productive industry because it simply redistributes money paid to it from other value-creating sources (CII, 215). When done well, it produces "surplus" in the form of profits—which can pay workers, executives, or shareholders—but from the viewpoint of capital as a whole this is mere revenue and not real surplus value in new wealth. Absolute productive labor processes create surplus value that increases the *total amount of wealth* within the social formation or society (Mandel 1992, 42). So the latter is determined from the standpoint of capital as a whole as opposed to a specific capital.[9] The bottom line is that all categories of productivity are spurred on by various overlapping forces of capital and contribute to capital's expansion and domination. Whether direct/indirect or relative/absolute, all productive labors are subject to underlying laws of capital.

Social relations determine the productivity categories for specific instances of medical labor from the viewpoint of capital. For a given process of production, if one wishes to calculate productivity, the process would in fact be similar to the standard health economics ratio above. But the quantified calculation of productivity is not necessary to consider it theoretically or analytically (as the difficulty in applying Grossman's theories to health care shows). The major

[9] Relative and absolute productivity are not mutually exclusive, as relative productivity is a minimal requirement for all forms of productivity from the standpoint of capital. In order to even be absolutely productive, a production process must be relatively productive.

difference in a Marxian approach is that outputs are differentiated in terms of use value on the one hand and exchange value and surplus on the other.[10] But this difference has important consequences. In what follows I consider medical labor in light of these four categories of productivity—direct/indirect and relative/absolute—in order to examine the various ways that medical labor and the health care industry is rendered productive from the view of capital. For both of these dimensions, considerations include: the nature of labor itself (e.g., whether its objectified in anything), its relation to time within repeated cycles of service provision, its own value (what is paid for the labor), how it is purchased (e.g., for an amount of time or a piece-rate), how work stands in relation to their production process and to others, and finally to the social formation in its entirety. Each category of productivity is addressed in a subsection below.

Direct Productivity

As a baseline claim, it seems safe to argue that whatever value is created in health care industries is at base the result of human labor. If all physicians stopped working, then the engines that create profit for hospitals, pharmaceuticals, insurance, and the like would seize up. And if *all* medical workers were to simultaneously stop working, then the entire health care industry would come to a total halt. However, from a Marxian perspective, it is not immediately clear whether physician and medical labor is directly productive because the product is not a physical commodity of objectified labor. The contributions of medical labor are mostly embodied quite literally *in bodies* because they are the object of medical services and cannot be said to be the product of health care alone. And while there are material components to the provision (or

[10] In much of the second volume of *Capital* Marx analyzes the political economy of the process of circulation in like terms of inputs and outputs, see for instance the chapter "Fixed Capital and Circulating Capital" (CII, 237-62). Marx's *Capital* project is nonetheless *critical* of economics for the reasons discussed in the first chapter of this project.

production process) of medical care—like medical records, equipment, tools, materials, etc.—these are not the product of health care either.

Marx himself claims that physicians are not productive workers (G, 310, 465, 468). Given their production of service commodities and their small scale, independent medical practitioners would seem to operate in the category Marx calls (unproductive) simple circulation:[11] "One exchanges necessaries, the other labour, a service which the other wants to consume… For example… if I give money to a doctor to patch up my health" (G, 465). In a relation of simple circulation, one party exchanges commodities or money for another to render a service. The money or commodities do not become capital in the hands of the service worker. They do not become, nor are exchanged for, means of production of surplus value and cannot therefore be called capital (CI, 976). Instead the payment for service labor acts only as revenue or income for the service worker's sustenance and costs of living. In addition, the purchaser of the service receives only a use value, a useful service, in return. The use value of a service also is not rendered an exchange value for resale in the fashion of commodity production (G, 465-7). At most, health care could be construed to produce a commodity in living labor power in the worker's person, but this too does not appear to produce surplus and wealth but only revenue and subsistence. The physician provides *useful* labor but not *productive* labor from the standpoint of capital. This form of circulation is *simple* in that it need not extend far beyond the two poles of service-seller and purchaser. No other parties immediately benefit or are even affected by this exchange and it does not do much for the total production within a social formation. This narrow focus also reflects that this is *direct* productivity under consideration.

[11] "Circulation" for Marx ordinarily refers to the processes outside of production itself; these are the exchange of money capital for materials of production and—after production—exchange of commodity capital (the products of a production process) with money. This includes necessary activities for exchange like transport and communication. The circulation of capital is the subject of volume two of *Capital*.

Particularly before health insurance was widespread, Marx's simple circulation model seems to fit the independent practitioner or "community doctor." Here an individual exchanges money (or perhaps even a commodity) for a physician's medical service. Because neither the physician nor patient is producing commodities, surplus value, or capital, Marx's concept of labor-as-valorization does not really apply. Use value motivates these exchanges—the usefulness of the physician's service is central. For much of the twentieth century the typical physician was an independent practitioner. He (—yes, usually he) would leave medical school to open his own practice, or perhaps join a family member or small group of physicians. In the twentieth century independent practitioners could still gain admitting privileges at local hospitals and provide care for their patients who needed inpatient care. Such independent practitioners and small groups functioned for the most part like small business owners. But they even differed given that they did not generally advance their startup money to produce more value, which would fit the ordinary form of money capital (CII, 137). Physicians generally lived well, but surpluses were relatively modest and not reinvested to grow the magnitude of capital driving the practice.

This model, however, is vastly outdated. Marx's specific claims regarding doctors are easy to dismiss given how much health care practices have changed since the 19th century. In addition to having significantly more effective remedies than tonics or bloodletting, physicians are part of entire institutional apparatuses of health care (rather than the individual doctor with a black bag) and a complex set of organizations contribute to monetized transactions in exchange for their services. More than ever in US society and health care

> exchange has already acquired a sufficient extension and importance to allow useful things to be produced for the purpose of being exchanged, so that their character as values has already to be taken into consideration during production. (CI, 166)

Health care is not inherently a source of capitalist production, but the latter has developed to a point of consuming the former. One cannot help but navigate the world in terms of exchange

value and money. Thus medical labor seems to contribute *indirectly* to productive endeavors in ways that I outline in the next subsection.

Finally, there is a way to consider medical labor directly productive without considerable conceptual cartwheeling. I stated above that Mandel (1992) argues for a strict objectified-commodity understanding of a product for labor to be considered directly productive. Mandel explicitly objects to the productivity of immaterial service labors, asking:

> What is the 'immaterial good' produced by a wage-earning teacher which could be conceptually contrasted with the 'immaterial service' produced by a wage-earning cleaner (working for a capitalist cleaning firm) or by a wage-earning clerk of a department store? (43n48)

Mandel seems to think there is no reasonable answer to this question. But one line of response comes from Marx himself, and also from Louis Althusser's and Michel Foucault's elaborations of Marxian ideas.[12] Foucault and Althusser particularly work out the material and ideological demands of maintaining labor capacity in individuals and populations that can address the immaterial contributions of teachers and, I argue, medical labor.

In response to Mandel's challenge, the immaterial good that a teacher produces is a set of students suited to the labors that capital demands. Althusser (2014) argues that an educational state apparatus has the ideological function of ensuring that labor power is competent, diversified (235), adaptable, and "virtuous" in the ways that capital demands (250-3). *The student-as-living-labor is the immaterial good that a teacher produces.* This, then, can be contrasted with the service of a cleaner or clerk who does not produce greater total value but instead serves unproductive secondary functions from the viewpoint of capital. Money paid for their labor is subtracted from the surplus value created in the production process without increasing that surplus. Althusser and Foucault can be understood in part as elaborating and extending Marx's

[12] See Althusser (2014) and Foucault (1978, especially 141-3; 1995, especially 220-1; 2008, especially 223-33).

claims that capital must stockpile and manage a vast population of workers as living labor on hand for capital (G, 508; CI, 450, 716, 781-802, 899). Health care's function within capital helps differentiate education as directly (and absolutely) productive while certain service labors can only be relatively productive. The fact that medicine and public health management have become so much more effective and formidable parts of the society since Marx's 1883 death might indicate why he did not label the physician as productive in the eyes of capital.

Above I explicate in Marx that *a worker's labor power is her commodity*, which she must sell to a capitalist enterprise in order to receive wages for subsistence. In a similar function for capital, health care *contributes to the production and maintenance of commodities in living labor itself*. Marx argues that "the worker, in order to continue to exist on the market as exploitable material for the capitalist, must before all else be kept alive, and therefore maintain himself[sic] by individual consumption" (CII, 138). In order to be on hand for capital, workers must be minimally healthy and have the physical and mental capacities for whatever labor is required. On a larger scale, the population of workers must reproduce themselves biologically in order to reproduce the reserves of labor power necessary for capital. Health care's shift to treating industrialized nations' problems—which come from advanced capitalist economies and corresponding shifts in labor—arguably reflects this function. Health care is increasingly asked to deal with challenges of psychological stress from cognitive labors rather than just physical stress from manual labors and physical workplace hazards. Diabetes and heart disease have to do with sedentary lifestyles that correspond to sitting at desks in front of screens and a commodity food economy that delivers addictive calories more efficiently than ever. What makes health care directly productive for capital is that it helps maintain its living labor and addresses various pathologies that arise from relations of production themselves.

This account of health in relation to capital and productivity is not merely cynical Marxist rhetoric, but it actually dovetails with contemporary economic treatments of "human capital." Foucault (2008) describes human capital as the idea that

> the wage is nothing other than the remuneration, the income allocated to a certain capital, a capital that we will call human capital inasmuch as the ability-machine of which it is the income cannot be separated from the human individual who is its bearer. (226)

The individual worker is considered as her own capitalist enterprise where every contribution to her capacities is an investment in her earning potential. One result of this is that "all the problems of health care and public hygiene… can be rethought as elements which may or may not improve human capital" (230). The theory of human capital is indeed the point of departure for contemporary economic treatments of what health care produces (Bolin 2011, 96). And from the human capital frame, health plays a distinctive role because "its main impact is on the total amount of time a person can spend producing money earnings and commodities rather than on his or her wage rate" (98). Given the importance of time in economic analysis and capitalist production, this makes the use value of health quite important from the viewpoint of capital. In the same way that lengthening the working day increases labor productivity, increasing the number of working days and years of living labor increases overall productive capacity for capital. Health care contributes to the production and maintenance of individual workers and their labor capacities, which form the backbone of capitalist production itself.

Indirect Productivity

Foucault and Althusser present a challenge, however, to my argument regarding health care capital in the UNITED STATES. Notions of discipline, biopower, and ideology pertain to health care's use value as it relates to capitalist production—that is, the *qualitative* contribution health maintenance makes to a capitalist mode of production, or what makes it useful. Much like labor

power's usefulness for capital is its capacity to create more value than it costs to reproduce, health care's useful quality is the ability to maintain the *potential for productive labor* in society. Yet by such qualitative[13] measures the United States performs abysmally compared to other industrialized nations, especially when considered in relation to US spending. And consider again health economists' findings that health care productivity is actually declining (Triplett 2011). In order for my argument to hold, something about the US health care system must be productive, or otherwise advantageous to capital, in order to explain why capitalist influences have not asserted themselves more to alter the system to become more directly productive.

I argue that this capitalist advantage is the valorization to which health care has come to contribute indirectly. If the direct objectification of medical labor in the labor capacity of populations and individual workers is lacking in productivity (use value) when compared to its considerable inputs, then it must make up for that in productivity in its indirect value-based outputs and profit potential (exchange value). This also arguably helps explain capital's interests in privatizing health care in relatively state-oriented nations like Canada and the United Kingdom that perform better than the United States in health outcomes. Uncoupling the health care industry from its *qualitative* performance through privatization liberates its potential for *value* performance.

It is thus insightful to look beyond just the immediate labor of an individual physician and grasp where she stands in a vast technology of hospitalized biomedicine, the extent to which that is productive, and the role it plays for other valorizing industries. Jason Read (2003) notes

[13] While I say "qualitative" here, I do not mean that it is measured "qualitatively" in the sense of social scientific research that is contrasted with quantitative data analysis. In *Capital* and *Grundrisse*, Marx uses the qualitative/quantitative contrast as primarily corresponding, respectively, to the use-value/exchange-value distinction. One can still use quantified units to measure how well a thing is performing its useful function, and so in this way a quantitative study or measure can nonetheless be qualitative in this Marxian sense when it assesses the use value of a thing.

that "once the machine replaces the tool it is no longer possible to think of labor as the activity of an isolated individual on an object" (129). Increasing complexity, interconnectedness, and cooperation between various labors requires a broader frame of reference to identify its contributions to capital. Volume one of *Capital* presents Marx's indirect notion of productive labor, which contrasts with the direct notion in his second volume. In the former Marx argues: "with the progressive accentuation of the co-operative character of the labour process, there necessarily occurs a progressive extension of the concept of productive labour" (CI, 643). That extension for Marx means that the productive worker "is one who produces surplus-value for the capitalist, or in other words *contributes towards the self-valorization of capital*" (CI, 644; emphasis mine). The standard of mere contribution to valorization allows more labors to be considered productive than more stringent definitions based on direct surplus value creation. This is the source of the indirect/direct productivity distinction. Health care production and medical labor contribute indirectly in several significant ways to production processes that ultimately create surplus value, or valorization. In the subsection on absolute productivity below, I argue at greater length regarding those ways that health care contributes to valorization overall. In this subsection I provide a brief overview.

Health insurance, pharmaceuticals, and medical technologies represent three of the major industries for which medical labor produces indirectly. Even though, as noted above, insurance industries are not absolutely productive, they nonetheless produce surplus values that serve an important purpose within capital. Insurance also served an important historical function by injecting extra money into health care. This had a "cushioning" effect in that individuals felt less of the cost because they were not paying out-of-pocket, which permitted hospitals and physicians to increase their prices for greater profits (Starr 1982, 319). Medical labor contributes services

that are ultimately necessary for insurance to produce surpluses. In a familiar capitalist fashion, it is in an insurance company's interest as the payer to get the maximum amount of production output from medical labor power in a given service for as little money as possible. This is why insurance companies commit so many resources to finding ways to deny coverage and adjust claims made by physicians and hospitals.

Pharmaceutical drugs are a major source of wealth production, and their consumption, and thus realization of value, relies on medical labor to contribute. Physicians in particular are so important for the pharmaceutical industry that major companies employ sales representatives whose primary job is to increase physician prescriptions of their company's drugs through a variety of means (see especially Elliott 2010, 51-73; Oldani 2004). Medical technologies have a similar relation to medical labor in that they rely on physicians and hospitals to provide the services that require their commodities, or recommend them to be covered by Medicare or Medicaid as durable medical equipment. These ordinary commodity producers rely on the indirect contribution of medical labor. Among other surplus producers to which medical labor contributes are hospitals themselves, management companies, various medical contractors, and even independent firms that supply "outsourced" hospitalist physicians for hospitals (Scheiber 2016).

One may claim that many hospitals and other health care entities are not actually health care capital because they are not-for-profit. Because of such non-profit status, those institutions cannot be considered a part of capitalist structures because they are not driven by profit and wealth production. In response to this claim, I argue that nonprofit hospitals should be included among health care capital because they still contribute indirectly to capital, many compete directly with for-profit entities, and they tend to operate in similar ways to for-profits because

they are subject to the same laws and mechanisms.[14] Nonprofit hospitals still purchase and prescribe drugs that produce surplus values for pharmaceutical producers, and they similarly must purchase medical materials and services that produce wealth for capital. In part because many nonprofit hospitals are near for-profit hospitals and must attract and retain physicians against for-profits, nonprofits are in direct competition with for-profits. Competition within capitalism compels all actors to behave like capitalists. This leads Joseph Schumpeter (1950)—a conservative economist writing over 60 years ago—to conclude that

> although the modern hospital is not as a rule operated for profit, it is nonetheless the product of capitalism not only . . . because the capitalist process supplies the means and the will, but much more fundamentally because capitalist rationality supplied the habits of mind that evolved the methods used in these hospitals. (125-6)

In what arguably (and perhaps ironically) amounts to an Althusserian/Foucauldian insight, Schumpeter points out the ways that ideologies and habits of capital shape hospital practices. The purpose for both is maximizing surpluses using familiar capitalist mechanisms. Further, Paul Starr (1982) argues that it is only the law that says hospitals and insurers are not for profit, and not other compelling distinction (328). Nonprofit insurers historically operated to increase the income of the physicians that ran them, and the nonprofit legal status had added advantages like tax exemption and increased control without the influence of shareholders (Starr 1982, 328). As large hospital systems become increasingly influential in health care provision one might expect those ideologies and habits to have even greater influence.

It seems clear that medical labor contributes indirectly to a variety of productive industries. Other such industries are covered in terms of relative and absolute productivity below.

[14] The US National Football League (NFL), for instance, had a not-for-profit designation until only recently—despite bringing in and distributing millions of dollars in revenues and coordinating the production of much more by individual teams and corporations. To claim the NFL is not productive or capitalist because it is a nonprofit seems absurd.

Relative Productivity

The relation of *time* to the value paid for labor and the value created by it is central in determining relative productivity. Marx argues that all economy ultimately reduces to *economy of time*: the distribution of time in a purposeful way in order to achieve production adequate to satisfy overall needs (G, 173). A production process is relatively productive from the standpoint of a specific capital if it creates value at a magnitude greater than the value expended in labor, materials, and circulation. As explained above, a worker must provide labor power for an amount of time that surpasses her own exchange value paid in wages in order to begin producing a relative surplus for the specific capital that employs her. Marx argues that this distinguishes the creation of value from valorization:[15]

> If the [production] process is not carried beyond the point where the value paid by the capitalist for the labour-power is replaced by an exact equivalent, it is simply a process of creating value; but if it is continued beyond that point, it becomes a process of valorization. (CI, 302)

So even value-creating ventures do not become productive until they take part in valorization, and in order to do this they must create more value than is expended in labor, which Marx illustrates in terms of the working day (necessary labor and surplus labor). The question, then, is whether health care labor continues beyond the point of value creation and into valorizing surplus labor for capital, and thus into *relative* productivity. Answering this question for health care relies on specific health care entities and on considering the payment of workers as wages in order to consider their value against the value produced. In this subsection I consider those ways that physician payment operates like wages.

Recall above that Marx argues that there were historical prerequisites for wage labor to take hold within a capitalist social formation. A worker must be free in the dual sense that they

[15] "Valorization" here seems to correspond to *relative* productivity in my schema because it looks only at a specific process of production and not the size of the entirety of social wealth.

are in possession of themselves and their bodily labor to sell, but they do not possess means of production themselves. In addition, a worker must be in a social-economic context where commodities are the primary medium of production and consumption. Beginning with the third precondition, it seems obvious that the physician and medical laborer has existed in a thoroughly commodified context of social reproduction beginning at least with the twentieth century. Everyday survival for the average person in the United States relies on the purchase and consumption of commodities, and they must therefore take part in the production of commodities in order to sustain themselves. Further, the first two presuppositions are found in the workforce in general. If we pluck an individual at random from the 300-some million people in the United States and call her Sandra, it is exceedingly likely that Sandra will *not* possess the means to produce commodities in order to sustain herself. She will likely lack both the material means and the wealth to purchase such means of production.

However, physicians arguably have access to means of production in that many still take part in private practice where they own the practice either partially or entirely.[16] The American Medical Association (AMA), which arguably has its own political agenda and interests, offers a 2012 survey that shows that "53.2 percent of physicians were full or part owners of their practices," though this is down eight percent from 2007/2008 (Kane and Emmons 2013, 4). A US Congressional research report corroborates that "the majority of the approximately 972,376 doctors and residents in the United States work mainly from smaller, office-based practices" (Kirchhoff 2013, 1).

[16] As of 2003, the cost of launching a small primary care practice was estimated at $70,000 to over $100,000, including rent, insurance, payroll, and living expenses for the first few months (Terry 2003). More recently another author estimates about $100,000 as average for a start-up (Borglum 2014). These are considerable amounts that require wealth on-hand for a physician seeking to open a private practice. Credit is always an option, however, and "a few of the big banks have specialty departments that only lend to doctors" (Borglum 2014). This latter fact makes me suspect that there are reliable returns on such investments.

In response to physicians' apparent position as the predominant owners of the means of health care production, I argue that the development of indirect sources of valorization in hospitals, insurance, and pharmaceuticals subverts their position as capitalists and still subjects the provision of health care to the capitalist logic of productivity. Although the independent practitioner is a small business capitalist in that he owns his practice, he becomes the free laborer when hospitals nonetheless become the necessary place for the most critical and up-to-date care, and when medical commodities become the primary medium of its provision. Paul Starr (1982) argues that "acknowledged skills and cultural authority are to the professional classes what land and capital are to the propertied. They are the means of securing income and power" (80). Yet this is an imprecise analogy from a Marxian perspective because Starr assumes that the professional classes themselves are the sole or at least primary beneficiaries of the productive capacities of cultural authority that he compares to land and capital. But the financial success of physicians (especially specialists) makes up only a small portion of the total wealth created in the medical-industrial complex.

I contend that, while it is the case that the medical profession does produce and maintain some wealth and power for its own ranks, physicians increasingly contribute to the production of wealth overall for capital. My claim parallels Michael Heinrich's (2012) contention that class affiliation cannot be determined simply from formal properties like wage payment or ownership of means of production. Instead, Heinrich contends that it can only be determined when looking at the process of capitalist production as a whole (193). "At this level," Heinrich continues, "it is clear that the ownership or non-ownership of means of production is not the only decisive criterion concerning class affiliation" (193). A wider-angle view looks at the social relations of an individual, group, or institution in context. Thus a CEO, who is paid a wage-like salary, is

nonetheless a capitalist in that she or he directs capital like the capitalist (Heinrich 2012, 193). Historically, access to hospitals became crucial for medical professionals in the modern US medical system beginning around 1870 (Starr 1982, 146-7). What then follows historically maps onto the tendencies of capital to appropriate the labor of spread-out, independent workers and put them to work under one roof (see G, 586-7; CI, 439), including the division of labor (CI, 455-8) and hierarchization of labor (CI, 469; CI, 481) and the development of the specialist out of general practice (CI, 456). Physicians working in hospitals become workers contributing to the various indirectly productive ventures.

Further, when physicians do take on the apparent position of capitalist, their independent practice nonetheless (like nonprofit hospitals) must function as a capitalist enterprise and thus any medical labor that the practice employs must become relatively productive. If non-charity-based medical practices do not at least cover costs, they cannot persist in providing care. So while physicians in this position are not taking part in wage labor, they are employing ordinary wage labor in their staff and purchasing commodities as inputs to a production process. This entrepreneurial role of the independent practitioner is reflected in advice about launching and running a private practice. Like ordinary capitalists, would-be solo practitioners are told that "location is key," to "prepare a marketing strategy," and to "get a good accountant" (Girgis 2015). When a physician is not in a wage labor position for capital, she or he must render all medical labor in the practice productive and thus function as a capitalist.

Furthermore, I argue that the visible trends in health care practice affirm that the forces of capital are increasingly at work in health care because those trends fit the tendencies of capital. The forces of capital make it increasingly difficult for one capitalist to enter production because increasingly large magnitudes of capital are necessary (CI, 777). This tendency corresponds to

the fact that the number of physicians in solo practice is decreasing while they are increasingly members of group practices, and the average size of those groups is increasing (Welch et al. 2013, 1664; Kirchhoff 2013, 9). Arguably, each additional owner in a group practice increases its capital-like functions because the collective financial interest holds greater sway over individual practitioner interests or ethical determination. Marx argues further that capital requires an army of managers to discipline and direct labor (CI, 450). While in health care "activity by for-profit practice management companies, which buy and run physician practices, has been growing, particularly those that contract with hospitals" (Kirchhoff 2013, 9-10). The demands of health care production are such that individual physician-capitalists' capacity for meeting them is diminishing. Various management ventures—themselves relatively productive—arise to increase the productivity of medical labor. Increasing sizes of group practice also appears to be a transition toward the sale of such practices to centralized hospital systems. And private equity firms like Bain & Co. are predicting increasing profit potential in health care providers, saying they expect "significant strategic interest in accountable-care oriented investments, including investments that stretch across traditional boundaries (such as UnitedHealth Group's acquisition of Monarch Care)" (qtd. in Kirchhoff 2013, 15). So smaller health care providers themselves are becoming attractive areas of value-production for the contemporary venture capitalist.

Health care is also familiar with the capitalist tendency for supply to create demand, so to speak. Paul Starr (1982) argues that the period of hospitalization of US medicine, roughly 1870-1910, followed the example of ongoing urbanization and industrialization (146). Starr also notes what is known as Roemer's Law, which observes that hospital beds are used to the extent that they are available (399). This reflects the tendency of capital to lay claim to labor and surplus labor in order to render an idle furnace or workshop productive (CI, 425). That is, the

expenditure on physical means of production becomes for the capitalist a mandate for its maximal use. And so the idle furnace creates a claim for night labor so that operations need never stop. Similarly, the hospital's operation room manager ensures that the room is never left empty longer than needed, and instead has a well-orchestrated series of procedures planned so the surgery workshop is never idle. Thus I contend that most of the ways that physician labor appears to be different from wage labor is only because health care and medical practice are part of an antiquated social mode of production that is in a transition process of capital takeover. Capital has surrounded it at all points and rendered the activities of physicians and medical labor productive.

Marx argues that capital does not create its components but works with what is already at hand (G, 675). Like the unmoored free laborers created by mass expropriation, the US hospital system, when combined with existing capital, found a multitude of unmoored and independent practitioners that could be put to work for capital. The hospitalization of medicine is akin to the real appropriation of land in that it rendered most doctors free-laborers in the sense that they lacked the ability to turn their labor power into value or livelihood without association with a hospital. So physicians can be considered wage laborers to some extent for various productive capitals, which will seek to render their labor at least productive in a relative sense. I now consider the ways that a physician's payment can be considered a wage. One result of this supposition offers a clue regarding one reason that health care prices are so high.

Physician payment can take different wage-like forms. The three predominant methods of physician payment are fee-for-service, capitation, and salary.[17] But the predominant theme in physician payment is that *the more services one performs the more one is paid*. Despite varying

[17] Although James Robinson (2001) argues that, from a cost-containment and health-maximization standpoint, these are also the three worst payment mechanisms for physicians. Robinson claims that US payment schemes tend to blend various aspects of these three methods (149).

and mixed payment schemes "health care payments are still mainly based on volume of services rather than quality improvements" (Kirchhoff 2013, 18). In similar fashion to commodity production, the exchange value paid for medical services can be separated into wages paid to the doctor and costs collected by the owner of the means of production. When dealing with HMO or PPO plans (capitation), the contract between health care providers and insurance companies is even more like a labor contract in that the insurance company exchanges one amount of money for the services of a medical group or hospital over a period of time in order to produce a surplus over the course of a year. HMO and similar managed care regimes, which dictate the time allotment and number of patient visits, represent classic versions of labor intensification. Intensification has the effect of a lengthened workday without actually making the day longer by increasing relative surplus labor.[18] Meanwhile, an increasing number of physicians are working as salaried hospitalists in the United States (about 50,000 in 2015 up from 11,000 in 2003), who then operate in obviously wage-like roles for hospitals. They attempt to maximize the number of patients serviced in a day in order to increase productivity, and their salaried work tends to increase hospital profits (Scheiber 2016).

For any hospital services under fee-for-service, the physician(s) is paid a fee separately from fees paid to the facility. So when an independent physician works in a hospital, she or he provides services for which the hospital bills separately and, through repeated cycles of medical services, produces surplus value. When doctors are paid in fee-for-service or something like it, then this can fall under the category of piece-wages, which while being different in content tend to operate in similarly to time-wages in capital (CI, 694). But Marx claims:

> the wider scope that piece-wages give to individuality tends to develop both that individuality, and with it the worker's sense of liberty, independence and self-control, and also the competition of workers with each other. (CI, 697)

[18] See Heinrich (2012, 104) and Marx (CI, 340-416).

Piece wages give workers a sense of freedom and individuality within a production process and can also spur more production from those working beside that worker. I contend that these tendencies toward independence in piece-wages help maintain conceptions of the physician as a special kind of worker. And the perceived independence of physicians as a professional group may militate against their potential as political actors. Much of the resistance to health care reforms in the past, especially managed care, has been from physicians resisting any kind of salary payment in favor of liberty and independence. If physicians can be convinced that they already stand in wage-like relations to productive entities around them, then it may help to shift their roles as political actors.

So how are physician reimbursement amounts determined? The ways that we pay for health care services, and physicians' payment, is not determined in the usual capitalist ways. I believe that analyzing these mechanisms can point in one direction to moderately lower health care costs, which is certain to face resistance from the medical profession but I believe nonetheless to be politically plausible. Adjustments to physician payments, especially if part of broader transformations in health care production structures, could have implications for overall health care spending in the US—and yet it is also one of the most contested and loathsome possibilities among the medical profession.[19]

And while it may be the case that physician payment itself does not make up a large portion of health care expenditures, the connections between physician payment schemes and other aspects of health care, like the prices of services, may conceal its influence. Evidence from the 1970s supports predictions of a "medical arms race," where hospitals compete for patients by offering more services and/or *more expensive* services, indicating that competition leads to

[19] Michael Chernew and Dustin May (2011), for instance, argue that changes to patient incentives and physician payment have the greatest potential for controlling costs (323).

higher costs; and flexible fee-for-service payment schemes, which offer physicians such flexibility, empower and exacerbate such trends (Robinson and Luft 1985, 353-4; Luft et al. 1988). In addition, competition over *physicians* may lead individual hospitals or medical groups to spend more on technologies and facilities to attract them. The payment schemes that make specialized services so lucrative for their providers may contribute to price growth in other ways.

> Larger physician practices, particularly specialty practices, have advantages such as increased leverage in negotiations with insurance companies, greater purchasing power, and efficiencies in overhead and in their ability to use advanced technology and other patient-management tools. (Kirchhoff 2013, 9)

Many of these "advantages" for physicians help to drive up prices and overall spending in health care—and these advantages are themselves made possible initially by the lucrative nature of specialization and fee-for-service. So it need not be the case that direct physician payment alone is the measure of the effects of physicians in driving up health care costs because it may influence other drivers of cost growth that are not immediately associated with physician payment. Thus implementing something like a salary may at least help curb growth, especially if part of other structural changes.

Ordinarily the value of wages is an exchange value and is unrelated to its use value, or the utility it offers the capitalist in the form of producing surplus value. Regardless of the value it actually produces, labor power is sold for the cost of *its* production and supply and demand—for the cost of the worker's subsistence, influenced by the supply and demand for such workers (G, 306). However, the determination of the value of labor-power, which is to say the price given to subsistence for a given type of labor, is not like other commodities because it has an "historical and moral element" (CI, 275). This is an important admission for Marx because it reveals some of the flexibility in the structural logic of capital, which can ultimately be influenced by morally and politically motivated collective action. Wages as exchange value, then, are also influenced

by social evaluations of the value (more broadly speaking) of specific instances of labor power, and thus the workers who perform it. So the social value placed on certain kinds of labor, or kinds of workers, can influence the specific price at which a worker might sell her labor.

We can see both historical and moral elements at work in physicians. Starr (1982), of course, illustrates how a history of professional authority and monopoly allowed for physicians to control and (in combination with inflationary effects of private insurance) increase their own incomes through the prices of services. One moral element at work here seems to be the reverence for the medical profession rampant in the UNITED STATES. Even amid the (figurative) CEO-lynch-mobs of the post-2008 Great Recession calling for lower compensation for executives, fewer people in the concurrent health-care-cost discussions called for physicians to make less money. This was despite the fact that the majority of physicians in the US, like their corporate CEO counterparts, make far more than those in other industrialized countries. I think that the unpopularity of calls for physicians to take a pay cut is in part a reflection of the moral worth afforded physicians and their labor in the UNITED STATES.

But why are they paid so much more? It seems implausible that this is only because of their cultural authority and the corresponding social value. An answer to this question leads to examining the Centers for Medicare and Medicaid Services (CMS) Resource-Based Relative Value Scale (RBRVS) and its influence on fee-for-service physician payment, which in turn influences other payment schemes. The RBRVS attempts to systematically and rationally determine physician fees "by measuring the resource costs required to produce them" with the intended result of determining fees for a hypothetical perfectly functioning market (Hsiao et al. 1992, NS1). While the RBRVS only applies to Medicare reimbursement rates by the federal government, hospitals and insurance companies often use it as a baseline in determining their

own (usually even higher) prices (Bodenheimer, Berenson, and Rudolf 2007, 304). Further, Suzanne Kirchhoff (2013) notes:

> Even though a number of hospitals are now preparing to make the transition to coordinated systems such as accountable care organizations (ACOs), they are still basing physician compensation on a fee-for-service or volume basis—offering new hires a salary with a productivity bonus. (12)

Thus many forms of physician payment have the RBRVS as their foundation, and so physicians' wages are influenced mostly by the number of services they provide.

Designers of the RBRVS identified three main resource inputs required to produce physician services: "1) the total work of the physician (TW); 2) practice costs, including professional liability insurance premiums (PC); and 3) the amortized value of the opportunity costs of postgraduate specialty training (AST)" (Hsiao et al. 1992, NS3). Thus the equation for a service's Resource-Based Relative Value is as follows:

$$RBRV = TW + PC + AST$$

The primary area of concern for my analysis is the total work (TW) portion of this equation. The designers explain:

> We first derived a definition of physicians' total work as encompassing both time and intensity. We found, further, that intensity has several dimensions: 1) mental effort and clinical judgment; 2) technical skill and physical effort; and 3) stress due to risk. (Hsiao et al. 1992, NS3)

They separately measured the total work in pre-, intra-, and post-service periods and summed them to get the total work (Hsiao et al. 1992, NS3). The rating method was magnitude estimation, where physician respondents were asked to give a subjective rating of a service in ratio scale to some reference service deemed basic or uncomplicated (Hsiao et al. 1992, NS4). For general surgery, for example, the designers identified inguinal hernia repair as the reference service and assigned it a value of 100; thus, "a surgeon who judged the work required of a lower

anterior resection for rectal carcinoma to be 4-1/2 times that of an uncomplicated inguinal hernia repair would assign that service a rating of 450" (Hsiao et al. 1992, NS4).

So one third of the value for the Resource-Based Relative Value comes from physicians' subjective accounts of their labor: the mental and physical effort, skill level and clinical judgment, and stress due to riskiness. In combination, these can be considered like the notion of "labor" as the actual substance that is mixed with materials of labor—*and not actually labor power itself*. The physician is estimating the magnitude of efforts expended in the act of producing the service commodity of a medical service. On the face of it, it may seem that this is an embodiment of a Marxian idea: that a use value, or in this case a useful service, "has value only because abstract human labor is objectified or materialized in it;" and therefore the magnitude of value can be measured "by means of the quantity of the 'value-forming substance', the labour, contained in the article [or service]" (CI, 129). The process of determining the total work (TW) of the RBRVS is very much like Marx's notion of abstract labor: a measure that is relativized in comparison to all other labor (CI, 128-9). The TW determination even calculates complex labor (lower anterior resection for rectal carcinoma = 450) as a multiplication of units of simple average labor (inguinal hernia repair = 100), which is a reflection of Marx on abstract labor's relation to value determination (CI, 135). Thus it would seem that an accurate equation of value is determined in RBRVS along the lines of a labor theory of value.[20]

However, the major problem from a health systems standpoint is that the RBRVS ordinarily determines *what we pay physicians* (wage) instead of what we charge buyers (price) or at what quantity we value these services for supply-side accounting (exchange value). The

[20] This is yet another instance of a direct ideational exchange occurring for health care service. Regardless of the fact that what is at issue is not actual dollar amounts, it is significant from a Marxian account that there is such an exchange going on in reducing the *labor* of a service into an exchangeable and generalized unit of quantitative measure.

RBRVS-based fee functions like the piece-wage for the physician-worker. Thus in fee-for-service, physicians are paid for the value of their labor *as objectified in the medical service commodity* and not their *labor power* over a period of time. This in fact turns the very basis of capitalist exploitation—relative productivity—upside down. It is capitalist exploitation, the fact that a capitalist can purchase labor that *produces more value than it costs*, that allows individual commodity prices to decrease for the consumer when combined with circulation, competition, and productive technologies (and also for the production of surplus value, and thus wealth and capital). The very basis of the capitalist's ability to extract surplus value (or "cost savings" in our health care systems vocabulary) is by paying the worker *less than the value that she creates in a given commodity*. From the perspective of the capitalist, "if such a thing as the value of labour really existed, and he really paid this value [in wages], no capital would exist, and his money would never be transformed into capital" (CI, 682). If capitalists paid workers for the value they create, there would be no profit.

United States medical reimbursement is doing precisely the reverse of what undergirds capitalist production, and what would bankrupt a capitalist. From this perspective it is no surprise that health care producers must drive up costs or sell add-on commodities and services in order to make up for what in Marxian terms would be the "relatively unproductive" character of medical labor under fee for service. Health care capital must derive surplus value from other aspects of medical service commodities, with the effect of inflated overall spending. This is one major difference that makes health economists' market-based conclusions problematic when applied to the problem of rising costs—the very foundation is built on a backwards and thus inflationary economic principle of reimbursing the value of *labor* instead of the value of *labor power* (the cost of the worker's subsistence) over a period of time.

Finally, this analysis of medical labor from a view of relative productivity offers an explanation for health care's general avoidance or failure in delivering certain services like long-term care for the elderly and persons with severe disabilities. This perspective offers an explanation for a specific kind of deskilling of labor on the part of health care capital:

> continuing to divert responsibilities for patient well-being from highly trained and experienced professionals (who have tolerably clear role-related limits to the extent of the services they are supposed to provide), to an amateur population, often otherwise employed, and with no clear socially recognized limits to their responsibilities. (Nelson 2012, 434)

This refers to the social tendency for long term care responsibilities to fall on unpaid family members, and usually women. Such "covert rationing" from the standpoint of capital allows for labors that are less productive to be jettisoned from a specific capital's costs. The diversion of responsibilities is in fact a *diversion of labor* that permits health care capital to commit medical labor to more productive activities. Here we see the capitalist mechanisms behind Kittay's (1999) contention that caring labor is not granted the same status and remuneration as professional medical and physician labor (39). Differences in social status and expectations of remuneration allow for increased relative rates of production by medical labor. When family members and close friends have other jobs, their sustaining wage is paid by another source, which amounts to free labor for health care capital.[21] That free labor, in turn, devalues such caring labor when it is of the paid sort. This phenomenon identifies the role of capital both in driving and benefitting from the gendered cycle of vulnerability (Okin 1989; Donchin 2010, 325).

Medical tourism offers another instance of taking advantage of the relation of inputs to outputs that determines relative productivity. Health care services can be cheaper in other countries for many of the same reasons that ordinary commodity production is: because labor is

[21] See Silvia Federici (2012b) for work in such a vein.

cheaper. When persons can be paid less—no matter the reason—the downward force on wages helps increase the productivity of labor. Medical tourism reflects one more way that health care is subject to many of the same capitalist mechanism that drive globalization.

Absolute Productivity

In considering whether health care is productive in an absolute sense, its analogous role to transport is key. As I argue above, health care is necessary to deliver many medical commodities, and thus medical labor is productive in that it enables their purchase and consumption through health care production. Along Marx's notions of productivity that I call absolute productivity, medical "transport" labor therefore creates new value that increases the exchange value of those commodities and is therefore absolutely productive in that it increases the total magnitude of value in the total capitalist formation. I argue that medical labor can be compared to Marx's treatment of transport industries.

Marx claims that among the branches of industry where "the product of the production process is not a new objective product" (so presumably services), the only one that is "economically important" is the communication industry, within which he includes the transport industry (CII, 134). Marx argues that transport is not productive because transporting a commodity to be purchased and consumed does not usefully change the *content* of the commodities to add value (if anything, it detracts) and that its costs must then come out of the surplus value of the commodities (CII, 225-6). Because of this transport costs are simply unproductive overhead (CII, 225-6). But Marx modifies this conclusion by noting that the consumption of some use values may make a change in location *necessary* and that the capital invested in such transport industries "thus adds value to the products transported, partly through

the value carried over from the means of transport, partly through the value added by the work of transport" (CII, 226-7). When the absolute only way that a commodity's value can be realized through exchange is that it must necessarily be transported, then that transport adds value to that commodity and thus to that process of production. Extending this reasoning, the service commodity that medical labor produces is a *necessary* means for the consumption of medical commodities, and thus contributes indirectly to their surplus value. Chief among such medical commodities that medical labor "transports" are pharmaceutical drugs. The physician's prescription power and special authority is necessary to transport pharmaceutical commodities to their consumers, while medical labor contributes indirectly to the process.

With this analogy to transport comes an understanding of the tendencies that come with the industry. Marx argues:

> The capitalist mode of production reduces the transport costs for the individual commodity by developing the means of transport and communication, as well as by concentrating transport—i.e. by increasing its scale. It increases the part of social labour, both living and objectified, that is spent on commodity transport, firstly by transforming the great majority of all products into commodities, and then by replacing local by distant markets. (CII, 228-9)

Capitalism trends toward (a) reducing the magnitude of value added to a product by its transport costs by making means of transport more efficient and by increasing the overall scale of the transport industry. This increase includes (b) an increase in commodities themselves, which can then be subject to transport. And finally, capital will look to (c) put more total labor to work in transporting commodities to all corners of the globe through this multiplication of commodities, their destinations, and consumers. By increasing the breadth and depth of transport and communication, capital can quickly reap the surpluses of commodity production while creating profit from transport itself. One arguably sees these effects at work in health care where hospitals merge, grow, and conglomerate in order to "better serve their patients," and also in the

centralization of hospitals in urban centers. All of these forces streamline the delivery and consumption of medical commodities that produce wealth (though not necessarily lower prices or overall spending, nor improve health-outcome performance).

The quest for new drug treatments is in actuality the quest for new commodities whose consumption will create more value. Michael Chernew and Dustin May (2011) also note a typical capitalist phenomenon where new technologies make the per-unit cost lower but then as a result spawn higher consumption of that unit. The result, then, of lower per-unit cost is higher overall spending and thus also of surplus (Chernew and May 2011, 313). I argue that underlying capitalist forces like these prevent many of the changes made to health care delivery for the sake of "efficiency" from actually curbing the overall growth of health care spending. Capitalist mechanisms push per-unit costs down *but increase the overall value-producing apparatus*.[22] Capitalist mechanisms like competition and efficiency are historically fine-tuned for increasing the overall production of value and consumption of resources—not less overall production or, necessarily, more use values. The US health care context is incredibly illustrative of Marx's contention that the object of capital is not the production of a wealth of use-values, but simply a wealth of *value* (G, 348, 353). Thus even when the medical apparatus produces waste in terms of health outcomes or spending, it still augments capital. This undermines incentives to curb spending and spending growth. If patients and policy makers want to stop the growth of health care spending, then they need to understand these capitalist mechanisms in order to begin to try to counter to them politically.

Paul Starr (1982) claims that Marxists writing about health care "need to account for the success of the [medical] profession in long maintaining its sovereignty" against the capitalist

[22] Daniel Callahan (1998) makes a similar argument about the apparent paradox in claims that markets can control costs while somehow also leading to economic prosperity (226). The latter usually means wealth production, which necessitates consumers spending more overall.

class (17). Starr claims that this success proves that the system of capitalism and a capitalist class has largely not succeeded in rationalizing health care (17). Starr takes aim at, essentially, the central thesis of my project by arguing that, contrary to Marxist claims, it is not the case that "the structure of medicine can be more adequately explained as a mirror of the development of the[sic] capitalism" (16). My first line of response to this claim is that Starr is using a narrow and overly personal level for framing the issue, which I think helps to illustrate some of the shortcomings of class struggle and class interest frames as they are often articulated. My project's commitment to Marxian critical methods that account for the totality of capital as it relates to particular parts helps to respond to Starr's challenge. When classes are reduced to one group of consciously operating individuals against another in a political arena, one can miss how class interest operates in diffuse structural ways that elude conscious political interests and actions. In much the same way that racist structures persist in the United States and abroad despite the utter dearth of actual self-avowing racist individuals, political victories on that further one group's interests can still have structural influences that will prove to work against them. Interpersonal frames have limitations for analytic understandings of what drives persistent social problems and oppressive systems. Structural accounts yield different and preferable understandings.

Capitalist development does not necessarily follow Weberian models of "rationalization" to which Starr appears to be alluding. It instead moves in a series of contradictions and antagonisms that can obfuscate its influence in certain modes of social production. I argue that it is precisely the *irrationality* of US health care that has in various ways been rendered productive from the standpoint of capital, and those ways that physicians have protected authority and autonomy for themselves led capitalism to simply work around them. To say that "capitalist

mechanisms have rendered health care productive" is not the same as saying something like "health care practices are governed by purely capitalist market principles." Capital appears to have simply overcome that authority as a barrier and rendered it a source of profit. Capital can make apparently antagonistic forces productive. The inflationary tendencies of fee-for-service payment proves that the model of the beneficent physician with authority to go to any length necessary for her patient is among the most productive forces that health care has to offer capital because it permits the bundling and sale of various health care commodities. The physician who spurns cost containment and orders one more diagnostic test for her patient just to be sure—because she has the authority—helps to add to the overall productivity of medical labor and health care technologies.

From the standpoint of health care capital, the more services rendered and procedures performed, the more money flows through the system and the more surplus is produced from these processes. The major sources of downward pressure on health care spending do not come from physicians, hospital groups, or capitalist owners, but from insurance companies, (sometimes) patients, and politicians and policymakers—i.e., those who pay for health care. Even insurance companies, it seems, have only a limited incentive to truly decrease overall spending because they gain their profits from the total dollar amount being spent. Health economist Uwe Reinhardt argues something along these lines. Reinhardt (2009) notes that, when competing against other insurance companies it is better to have lower premiums to attract more buyers of their insurance. However, Reinhardt continues, *for the insurance industry as a whole*, their profits depend on how much money "flows through their books" and moves through the system. Somewhere between three and five percent of all money that flows through insurance

books becomes profit (Reinhardt 2009).[23] If prices charged and overall spending for all health care services were magically cut in half overnight—a dream for health policymakers—then profits for insurers would subsequently be cut in half. This is not an attractive scenario from an insurers' perspective. In a similar vein, Chernew and May (2011) argue that "because all expenditures are revenue to some individual or organization, efforts to slow expenditure growth are synonymous with efforts to restrain revenue growth" (323). These health economists are drawing attention to the points at which health care has been made productive for capitalism.

An underlying drive for capital is to expand its size and reach at all points. Marx argues that a precondition of production based on capital is "*the production of a constantly widening sphere of circulation*, whether the sphere itself is directly expanded or whether *more points within it are created as points of production*" (G, 407; see also G, 408fn). The tendency to propagate production based on capital means to propagate the production of *value* foremost—not necessarily use value, which is to say not qualitative products that effectively meet human needs. Medicine, when subjected to production via capital, transitions from the production of direct use values in medical healing and is increasingly rendered a series of multiplying points from which to create value—more nodes of production and more nodes of circulation.

> Firstly, quantitative expansion of existing consumption; secondly: creation of new needs by propagating existing ones in a wide circle; *thirdly*: production of *new* needs and discovery and creation of new use values. (G, 408)

This in turn creates new divisions of labor and new types and needs of labor altogether (G, 408). I argue that one can identify all of these phases of capital expansion in health care, most of which falls under the umbrella term "medicalization." Medicine in particular must be attractive to capital for its capacity to create new needs.

[23] Health insurance is not as profitable as industries like energy or pharmaceuticals, but it ranked second in return to shareholders in 2009 (Kaiser 2009). So it is still an attractive source of wealth investment in capital, if not itself hugely productive in terms of absolute surplus and profit.

With the spread of capital in health care the predominance of use values has given way to the predominance of exchange value; that is, capital's final goal or end-in-itself is not necessarily the efficient creation of use values to effectively service human needs, but to create value, to create wealth (see G, 502, 710). Despite performing poorly in useful healing and efficiently meeting human medical needs, US health care proves quite effective in creating value and wealth for capital. The health care sector[24] has fourteen different companies ranked in the top 100 of the *Fortune* 500 for revenue in 2015 (Fortune 2015), with ten of those in the top 50 (Lorenzetti 2015). According to *Fortune*, drug maker Johnson & Johnson is in the top ten most profitable companies in 2015 (Kell 2015). The labor performed by physicians and health care workers of all kinds by necessity contributes to these companies' productivity from the viewpoint of capital.

Determining the stage or degree of development of "the mode of production based on capital" for Marx is measured by the scope of fixed capital, which is to say the amount of objectified labor to be put to use in creating *new values*—its use value is the creation of new value (G, 715). We could apply this test to the health care sector in an attempt to determine the degree of capital's development within it. We might compare the United States to others on this measure. If my argument is correct, this ought to show a higher degree of value-creation in the United States than in other industrialized countries that perform better. I think that medical labor's various productive relations indicate the extent of that value creation.

Conclusion

In this chapter I argue that health care ethics tends to depict physicians and medical labor in a largely separate sphere from ordinary economic activity. Many professional ethics accounts of a

[24] Included here are health insurance and managed care, medical facilities, pharmacy and other services, pharmaceuticals, and health care wholesalers; see Fortune (2015).

physician's activity explicitly distinguish the profession from market or commercial relations or occupations. I argue that such depictions interfere with considering medical labor as a part of the process of capitalist production as a whole. I explicate Marx's account of labor and valorization in order to explain how capitalist production goes about creating value and surplus value through the manipulation of labor power, time, and wages. In order for living labor power to be at hand for capital, workers must be "liberated" in the sense that they do not possess means of production but do possess property in their person in the form of labor power to exchange. I explicate traditional and Marxian notions of productivity and analyze medical labor in Marxian terms of four categories of productivity along two dimensions in direct/indirect and relative/absolute. Ultimately I argue that health care has come to make up a multiplicity of points by which it contributes (directly and indirectly) to capitalist valorization and production of wealth (relatively and absolutely). Within this context, medical labor stands in relation to capital as productive labor.

What this contention indicates for health care ethics and practice is that those qualitative characteristics of health care are becoming less influential in driving and shaping the overall structures of health care production. The tension between health care as a caring activity of healing versus a productive activity of valorization represents a contradiction in the development of capital (Waitzkin 1981, 340).[25] Yet Marx argues that this in fact drives capital forward: "Capital is the endless and limitless drive to go beyond its limiting barrier" (G, 334). Capital's "production moves in contradictions which are constantly overcome but just as constantly posited" (G, 410). Capital will drive to overcome the moral barriers in health care in order to render them productive.

[25] Peter Kennedy (2015) also notes the forced balance in nursing between Taylorism and the demands of care/compassion/patient-centeredness. Kennedy argues that "the outcome has been to adopt limited forms of Taylorism, while ceding a modicum of work autonomy over decision-making to nurses" (215).

This is a problem for health care ethics because those qualitative moral characteristics are the primary if not sole focus for many ethicists. A normative argument calls on the moral nature of health care activities, which take place within a capitalist social formation that by its nature tends to uncouple its productive forces from those very qualitative characteristics—and sometimes it even renders them productive. If forces of valorization increasingly drive health care instead of human needs and moral obligation, then this dire fact should be accounted for in health care ethics and in political activities. While this project has not entirely committed itself to answering how exactly health care ethicists and activists ought to account for these facts, I offer the next and final chapter to indicate the normative directions in terms of ethical theory and political activity that follow from my project.

Chapter 4

An Ethical Politics for Health Care

(Or: How This Project Is Normative)

In order to draw this project to a close, and try to tie the threads of this critical structural account together somewhat cohesively, it is necessary to return to the tension that I identify in the first chapter. There I explain that this project is motivated by a tension between normative ethical frameworks in health care ethics as opposed to more descriptive analytic accounts of the structures, relations, and processes that actually produce health care. From a Marxian framework, simply providing normative ethical arguments in order to alter health care practices is unlikely to be very effective unless theorists account for the actual workings of social, institutional, and economic structures that produce health care. So my project ultimately promises benefits for those committed to the task of health care ethics; I understand this task to be to effect change in health care practices to make them normatively better. While I frame my critical accounts in chapters two and three in such a way as to inform the ways ethicists theorize health care services and medical labor, this final chapter must offer more in order to make good on that promise of informing better ways of doing normative work. However, because I understand the primary task of health care ethics to be transforming health care practices, and because I focus on the larger social structures of health care, the ways that my project motivates and informs the transformative task of health care ethics is more for collective political change as opposed to clinical ethical guidance for individual physicians or policy prescriptions for health policy

makers. My project, then, has two related purposes: to transform the ways health care ethicists approach theory, and to inform and motivate the ways health care practices are transformed.

However, my task in this is complicated by my project's Marxist commitments because the tension between normative ethics and structural analysis reflects a largely unresolved paradox in Marx's own work, and in subsequent Marxism. That paradox is identified in the fact that Marx generally rejected normative moralistic critique of capitalism, yet his critical analytic accounts of capitalism—much like my own of health care—seem nonetheless normatively motivated and even critical at times on normative grounds. So my attempts to utilize Marxian social theory for normative ends may simply reproduce this paradox, leaving it equally unresolved, by not sufficiently addressing the normative *motivations* and *implications* for my project. The result would not ultimately do enough to inform or contribute to the task of health care ethics.

The first section of this chapter therefore briefly explicates this tension or paradox in Marxist thought and the various pitfalls of falling into scientific functionalism, moralism, and utopianism. The second section, then, offers a concept of Marxian normativity as *ethical politics*. Marxian methodologies produce a different kind of theory that combines normative and descriptive dimensions in a way that is nonetheless potentially productive for affecting social change. Marx argues that in social-historical contexts, certain groups of people can, in their struggle against oppression, come to represent the collective interests of the social whole. This Marxian concept of the "universal class," I argue, has similarities to other political accounts from antiracism, intersectional theory and politics, and the moral foundations of public health. By connecting normativity to political struggles, Marxian social theory joins together theory with

practice in an ethical politics that makes critical analytic accounts like my own normative in their relation to the potential for social transformation.

In the third section, I relate this Marxian connection to social transformation and ethical politics to what I claim to be the self-understood task of health care ethics in affecting change in health care practices that is normatively better. I argue that this task is better achieved through the Marxian methodologies embodied in my project because they are at heart a critique of the alienation of health care from human ends as it is increasingly subjected to the controlling forces of capital. This understanding of both the task of health care ethics and my project as a critical account of alienation lends normative motivation to an ethical politics aimed at achieving real social-normative control over health care production through dereifying and democratizing political struggle. This approach importantly sees what I identify in the first chapter as an "underlying transitive efficacy" from moral belief to health care praxis, which I argue is presupposed by many health care ethicists, as itself the goal to be achieved through an ethical politics. This is because such achievement would represent the reversal of the alienating effects of capital and a new transformative enactment of a historicized notion of freedom.

In the final section I turn to illustrating how my critical Marxian project dissolves the normative/descriptive dichotomy and theorizes the social world in such a way that can contribute to its normative transformation. I propose my own iteration of a category already familiar in Critical Theory, namely *pathologies*. I believe that the concept of social pathologies of health care offers health care ethics (and politics) a theoretical category that bridges the gap between normativity and structure in a way that is analogous to the distinction between disease and illness made in the philosophy of medicine. Critical projects like mine largely point to pathological functions in the structure of health care, which alert social actors and citizens to what also

usually amounts to a normative deficit. By accounting for a structural pathology rather than theorizing or appealing to an ethical principle, my project can better inform and motivate real social transformation. In concluding this final section, I explain some of the most significant social pathologies of health care for which my project accounts. Where possible I indicate the political and class-oriented implications for each pathology, which indicates some normative directions.

A Dilemma Left Over from Marx

At many times in my dissertation I discount or decenter the normative work of health care ethicists in favor of analytic accounts of structures and their functions in health care practices. But these kinds of functionalist or structuralist overtones are subject to the same dilemma or paradox attributed to many projects in Marxism. That is, "scientific" projects of functionalist structural analysis, like those Marx offers in *Capital*, seem to be motivated around every corner by a set of unspecified normative positions.

Twentieth century Marxism largely carried on Marx's own proclaimed aversions to utopianism, moralizing politics, and policy prescriptions or "blueprints" for socialism. This is particularly true for thinkers associated with "structuralist" or "functionalist" labels, whose work looks to simply describe in detail the capitalist social order rather than offer normative critiques against it. (Here I am thinking especially of Michel Foucault and also Louis Althusser.) Yet more recent contributors to Critical Theory, like Jürgen Habermas, Axel Honneth, and Nancy Fraser,

have arguably transitioned Marx-inspired critical social theory away from descriptive analytic critique and toward more ethical normative frameworks.[1]

So while I have mostly avoided taking on intra-Marxist debates in my project, it is necessary here to confront this tension or paradox in Marxist thought, because it has obvious ramifications for my project. In this section, I explicate the normativity paradox in Marxism in order to identify the major challenges and reactions in the development of Marxist thought, and to later carve out a space for my project within this development. Working through this paradox in Marxism helps to clarify how my project relates to normativity—what it can contribute to the task of doing health care ethics (as well as what it cannot).

Those looking to generate normative theory from a Marxian basis tend to find a paradox. Two sets of central Marxian positions appear to generate contradiction when placed side by side: on one hand one finds skepticism toward—and even condemnation of—abstract moral appeals, and on the other hand one finds Marx's obvious normative motivations and overtones. Paul Blackledge (2012) puts the paradox thus: "Marx famously rejected the suggestion that socialism be grounded in some abstract moral principles while simultaneously making ethical criticisms of capitalism" (42). Eugene Kamenka (1969) notes that Marx consistently "would object bitterly to any attempt to base a socialist programme on 'abstract' moral demands embodied in such terms as 'justice', 'equality', etc." (5). Kamenka refers here to the footnote in *Capital* referenced above in the first chapter of this project (CI, 178-9n2). There Marx claims by analogy a need to understand the causal mechanisms at work in the social world rather than just making ideal

[1] These ethical frameworks largely follow Seyla Benhabib (1986) in shifting the Marxist philosophy of the subject away from notions of human self-actualization through objectification (labor and concrete creativity) and toward self-actualization through communicative action oriented toward notions of the good. I believe, however, that Benhabib may lead an overcorrection to one side of this dichotomy. I recognize nonetheless the contributions of a critique of philosophies of self-actualization overemphasizing objective labor and intellectual activity to the detriment of familial, moral, and discursive relations that are not always well recognized or emphasized in Marxism.

moral prescriptions meant to govern it, particularly if one wishes to address and solve problems in that social world. So Marx seems to think that it is more worthwhile for the task of social transformation to analyze the mechanisms at work limiting an individual's freedom than it is to offer a deductive argument about the inviolable moral nature of freedom and justice that are intended to govern those mechanisms. Nonetheless, Marx's analytic accounts of capital seem to be made from a platform of condemnation for its effects on human society. One can thus claim that Marx presupposes some notion of justice despite his rejection of approaches that put them front-and-center.

Steven Lukes (1985) also notes this apparent paradox. Lukes claims that on one hand morality is described in Marxism as mere ideology, social in origin, and simple class interests masquerading as morals, while insisting "that the marxist critique of both capitalism and political economy is not moral but scientific" (3). Yet on the other hand, it seems that Marx's writings also "abound in moral judgments, implicit and explicit," where he condemns capitalism and its exploitation as deeply wrong; and subsequent Marxists follow suit (Lukes 1985, 3). Lukes depicts Marx's work as an all-out assault.

> What Marx offers is a multi-perspectival analysis in which capitalism's self-justifications are portrayed, undermined from within, and criticized from without, and then both justification and criticism are in turn criticized from a standpoint that is held to be beyond justice. (59)

This quote conveys some of the challenges for reading Marx. Lukes draws attention to Marx's immanent critique of capitalism, his willingness at times to take part in outright criticism of capitalism, but then his equal willingness to be *critical of those who critique*.

In Marx's work one sees an attempt to overcome this opposition between simply taking up the categories in the present as natural or deducing eternal principles from ideal theories in order to critique the social order. Marx's critique is an attempt to show that the economic

categories of capitalism are neither natural nor eternal, but are the result of the historical development of a specific mode of production. By analyzing and understanding the social relations that make up that mode of production, Marx looks to reveal that it is *contingent* and *limited*. Understanding capitalism in this way is more amenable, then, to approaches to transform the mode of production. Yet Marx does not seem to explain the normative bases for transformation.

This difficulty in Marx persists in radical and Marxist theory and politics of the twentieth century, and motivates a considerable shift toward ethics and "communicative action" since the 1960s. Jürgen Habermas represents perhaps the most prominent thinker in the Marxist tradition to turn away from structuralism, associated especially with French Marxism, and instead look to the ethical realm of communicative action and the ethical subject. Habermas's critique of Foucault represents his critique of what I have identified here as the lingering paradox in Marxian methodology.

Foucault is almost famously elusive with regard to what individuals or collective movements *ought to do* to oppose the forces of state power and capital in subjecting individuals to their influence. Nor does Foucault offer reasons for why the relations of power he describes in such detail are wrong—yet he seems nonetheless like Marx to presuppose that very conclusion. Foucault instead offers precise descriptive accounts of the development of sets of practices in order, again like Marx, to question their assumed natural or eternal forms. Habermas (1987) describes Foucault's descriptive analyses as seeking "a more rigorous objectivity" in an attempt "to preserve the transcendental moment proper to generative performances in the basic concept of power while driving from it every trace of subjectivity" (294-5). This is to say that Foucault's attentive recounting of the minutia of past practices is meant to reveal power at work in its

capillary-level, and with the same kind of distance and separation that a scientist may have in peering through a microscope at a slide. (We might be reminded of Marxist claims to "scientific" theory.) But Habermas argues that Foucault's work "can give no account of the normative foundations of its own rhetoric," and "presentism, relativism, and cryptonormativism are the consequences" (294). Habermas notes that, like Marx before him, Foucault's work seems suspended in unspecified but still perceptible normative ether, and argues that without being more explicitly normative such projects are left with lacunae. It seems ultimately that such criticisms could be directed at my project as well.

Various Marxist authors have responded to these challenges in different ways, but as noted, these have usually been to side with the need for explicit ethical groundings.[2] Thus Kamenka and Lukes both see the way to overcome this paradox to be to distill a fairly traditional looking ethical doctrine out of Marx, to take pieces of his work and reconstruct it into ethical theory. Kamenka (1969), for instance, claims that Marx emerges from "the formative years of his life, between 1841 and 1845" with a worked-out doctrine of ethical philosophy (11).[3] Kamenka summarizes that doctrine in terms of human freedom as the true end of all human activities, claiming that to Marx "there was something especially monstrous about an alleged type of *self*-abasement" in capitalist alienation, where humans are enslaved by things or institutions of their own creation (11-2). Kamenka argues that Marx's ethical doctrine comes out of his philosophical treatments of alienation and fetishism—and also later Marxist treatments of reification.

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[2] For a fuller account of the major ethical turns in Marxism, see Blackledge (2012; see especially 1-17, 19-44).

[3] It is important to note that it seems Kamenka (1969) subscribes to an (still popular) understanding of Marx's intellectual life where he ceased to write truly "philosophical" works from 1848 to his death in 1883 (6-8). Thus his late work from which thinkers like Althusser and those in the Frankfurt School acquire philosophical insights is downplayed or set aside as more empirical social science. Kamenka does note that this narrative is complicated by the uncovering of *Grundrisse*, which he claims "helped to demonstrate further that Marx took his early philosophical views on economics seriously well after he had become a Communist and a 'materialist'" (8).

Capitalism is morally wrong because it dominates human beings despite being the result of human social relations.

Kamenka argues that human freedom is the counterpoint to alienation:

> Ethics, for Marx, then, was concerned with freedom, and freedom meant human self-determination; it meant that man[sic] was governed by his[sic] own nature and its requirements, and by that alone. Man's[sic] nature consisted of a set of potentialities; freedom allowed him[sic] to go about the task of realising them to the full. (12)

So the central moral concept claimed here for Marx is an individual's freedom of self-determination.

Lukes (1985) seems to arrive at similar conclusions to Kamenka, arguing that Marx operates with some normative ideal in mind, which is based in self-determination. Lukes argues that, despite Marx's dismissal of "utopian socialist" contemporaries, he nonetheless operates with a sobered kind of utopianism. This of course brings to bear another tension within Marxism between utopian and anti-utopian strains. Lukes defines utopias simply as ideal societies, unrealizable within existing parameters, and contrasted with existing evils in order to highlight them (36). He claims that the scientific anti-utopian agendas largely won out in twentieth century Marxism and that this "weakened and subverted its utopianism, to the considerable detriment of marxism itself, both in theory and in practice" (37). So part of Lukes's project sets out to reconstruct Marx's utopianism to correct this perceived misstep. (And thus his project might also be understood as aligned with the late century turn toward ethics.)

Marx's ideal society for Lukes is "one in which, under conditions of abundance, human beings can achieve self-realization in a new, transparent form of social unity, in which nature, both physical and social, comes under their control" (9). Lukes continues, stating that Marx's work "is full of critical judgments that only make sense against the background of this ideal of transparent social unity and individual self-realization" (11). This is all to say that Lukes argues

that Marx was motivated by a utopian vision of an overarching social formation that is a perfect extension of human freedom, where imposing capitalist mechanisms do not determine one's life but instead one navigates a world determined by shared human modes of being.

Marx understood the theories and mechanisms of *rights*, which order social and political life in liberal democracies, as themselves only necessary as a result of conditions that themselves needed to be overcome. Lukes claims that this utopian view was parallel to Marx's view of religion:

> To abolish religion as the *illusory* happiness of the people is to demand their *real* happiness. The demand to give up illusion about the existing state of affairs is the *demand to give up a state of affairs which needs illusions*. (Marx 1975a, 176)

The utopian vision that motivates Marx, according to Lukes, is not aimed at the social mechanisms that govern liberal societies but is instead aimed to transcend the very conditions that require it (more on this below).[4] In the face of the Marxian paradox, Kamenka turns to the concept of self-determination, and Lukes turns to something similar in a normative concept of human emancipation guided by a utopian vision.

Both of these concepts seem highly utopian and/or ideal in the ways that each author expresses them and in their normative force because they rely on what appears to be an abstract moralization of a perfect alternative that is not immediately realizable. Yet Marx was persistently anti-utopian. He criticized Utopian Socialists for drawing up *blueprints*, that is, attempting to map out precise systems of governance and production in the chosen utopia, as this claimed a kind of knowledge in social forecasting that is not possible in any present (Lukes 1985, 40, 45). Because such knowledge of the future could not be justified, and any such utopian blueprint would never be placed before the society in the form of some kind of referendum or vote, Marx

[4] For Marx, "to perceive oneself as an individual in opposition to society is a product of specifically modern social relations" (Blackledge 2012, 23). See also Blackledge (2012, 59-60).

argued that such moral abstractions and blueprints are not worthwhile for theoretical articulation because they are unlikely to affect much change (Blackledge 2012, 46).

However, there is a third way of Marxian normativity that is expressed in the relation of theory to praxis and politics for Marx, which is to understand Marxian normativity as an *ethical politics*. This idea, which I believe is the most compelling, is theorized by Paul Blackledge (2012). I turn to Blackledge now to explicate a different kind of Marxian normativity that I believe avoids the shortfalls of utopianism, abstract moralizing and traditional ethics, and "scientific" Marxist determinism that denies individual agency.

Marxian Normativity as Ethical Politics

Marx's critique of modern moral theory is a reflection of his critique of political economy: moral theorists simply accept as natural and given a state of affairs that is in fact the socially contingent state of affairs of capitalism. In this section I offer a brief explication of Marx's basic critique of modern moral theory in order to then explain an underlying ethics, which is ultimately an *ethical politics*. Marx relies on the notion of the working class as the universal class as the source of normativity in his ethical politics. Yet this has some potential theoretical pitfalls, which I explain below in order to later show how those pitfalls are avoided in Blackledge (2012) and my own project.

Paul Bleckledge (2012), who like Kamenka and Lukes sets out to theorize an ethics from Marx, argues that modern moral theory arose against a contradiction in capitalist society:

> Socialized production means that humans depend for their very existence upon a massive web of connections through each other, whereas individual appropriation implies that these individuals confront each other merely as competitors. (23)

Production under capital is a complex social task where individuals contribute their labor to processes of production that help support and sustain people across the globe. Yet individuals are compelled to take part in a labor market where their labor power is itself already a series of commodities that they must sell in competition against others; and one must earn in order to consume commodifies to survive. That individuation in appropriation required moral theory to account for the valid claims to resources and actions that one could make in an oppositional position of competition with all others. And as a result, Blackledge argues,

> social contract theory, utilitarianism, Kantianism, deconstruction, and even modern virtue ethics can all be understood as attempts to provide an answer to the problem of how to formulate a common good in a world of egoistic individuals. (24)

This is to say that modern moral theories have as their starting place the conditions that Marx looks to illustrate are contingent and limited in capitalism, and not underlying natural conditions of human social existence.

This individuation under capital leads to problems for modern moral theory when applied to action and social practice. Blackledge (2012), following MacIntyre (1985), argues that moral theory based in individual interests leads simply to equal and competing concepts of what morality or justice requires. Blackledge argues of Kant that "if both radicals and conservatives have been able to embrace his formulation of the categorical imperative, it appears that his theory of how we ought to act fails, ironically, to provide a concrete guide to action" (Blackledge 2012, 29). And MacIntyre claims that Marx was "right when he argued against the English trade unionists of the 1860s that appeals to justice were pointless, since there are rival conceptions of justice formed by and informing the life of rival groups" (MacIntyre 1985, 19). And so we can understand liberal theories of "competing notions of the good," reasonable doctrines, and liberal neutrality as themselves theorizing a moral standoff that Marx claims is the coerced condition of capitalist competition rather than any natural condition of societies. It is on this basis that I

understand Blackledge to be corroborating and expanding on Lukes's claim that Marx's normative motivation is emancipation from the underlying conditions of the politics of *Recht*, or liberal rights-based theories of justice, because those conditions are particular to capitalism itself (Lukes 1985, 35).

Marx then turns to the working class itself as the normative source of motivation for the project of emancipation. Blackledge argues: "Marx wagered that the need for solidarity and collective organization amongst workers creates the potential not only to expose but also to overcome the narrow confines of bourgeois society: his was most definitely an ethical politics" (47). Marx's normativity consistently relied on the working class as the most potent vehicle of social change.

Within Marxism, especially in Georg Lukács (1971), this focus on the revolutionary potential in the present working class centered on what is now considered a problematic privileging of proletarian class consciousness. Following Marx, Lukács supposed that the working class is in the best position to become aware of the contradictions and exploitations of capitalism and to subsequently overturn that economic mode of production. Thus Marxists could gain normativity from an immanent source that was inherently opposed to the conditions of capitalism, rather than an ideal transcendent one that takes its basic conditions for granted. This inherent opposition, it seems, makes the added step of ethical justification of the condemnation of capital unnecessary. And the "science" of Marxism offered a means of understanding the nature and tendencies of capital, and thus to understand the inevitable downfall of capitalism at the hands of the working class. It may be apparent here that this highly deterministic theory is of the functionalist orthodox sort. But the proletariat preserved a special role even in post-orthodox Western Marxism. Maeve Cooke (2006) claims that for much of Critical Theory's history "it was

taken for granted that critical social theory's emancipatory perspective was anchored in the proletariat's experiences of alienated labor" (39). However, Marx's wager on the proletariat proved historically flawed, and also bears potential theoretical pitfalls, which must be addressed if I am to nonetheless move forward with a Marxian methodology that privileges a specific class.

It was in part because of the increasing pacification of the working class through the twentieth century welfare state that this political and epistemic reliance on the proletariat had to be replaced in Marxism by a more tempered set of claims. The global proletarian revolution never arrived. Instead workers everywhere in the industrialized West seemed to settle in and accept their lot in wage labor fortified by a welfare state safety net and the promise of economic growth and continued consumption. The turn toward a functionalist analysis of political and economic structures of capitalism is one such redirection on the part of Marxism in the twentieth and twenty-first centuries to deal with this historical shortcoming.

However, Cooke (2006) argues, too, that there are ethical and epistemological dangers in a reliance on the working class that are more troubling than Marxism simply appearing to be wrong in its predictions. Cooke claims that privileging one particular group as an authority on the true nature of social reality "is open to the ethical objection that it is exclusive and antidemocratic" (40). And designating the experiences of one social group as the one authoritative basis for valid knowledge "is open to the epistemological objection that it is finalist and ahistorical—that it denies the finitude of human reason and the influences of history and context of knowledge" (40). Cooke calls these theoretical dangers ethical and epistemological authoritarianism, respectively.

Cooke argues further that even critical theorists' attempts to skirt the substantive reliance on the proletariat for normativity and truth fall into other versions of these authoritarianisms.

Adorno and Horkheimer in *Dialectic of Enlightenment* (first published in 1944) claim that the working class failed to come to consciousness because "instrumental rationality has now penetrated into every aspect of human consciousness" and thus eliminated the possibility for conscious human resistance to capital's oppressive effects (Cooke 2006, 41; see also Adorno and Horkheimer 2016). So Adorno and Horkheimer actually theorize the *failure* of the proletariat to actualize the role afforded to it by Marx. And even though this denies the determinist conclusion of "scientific" orthodox Marxism, that the proletariat will *inevitably* come to realize that they have nothing to lose (but their chains!), it seems to have a similar political consequence in relative inaction or ennui. Thus Cooke claims of Adorno and Horkheimer that "by offering a critical diagnosis and an emancipatory perspective to which no one (except themselves or like-minded social critics) can have epistemic access, they intensify the authoritarian tendencies of their predecessors in the Left-Hegelian tradition" (referring to those like Lukács) (Cooke 2006, 41). But Cooke goes on to claim that this tendency in *Dialectic of Enlightenment* performs a salutary function for critical theory because its authoritarianism is since widely recognized as a potential pitfall to avoid (41-2). It is for this reason that I convey these pitfalls here, in order to ask whether the normative foundations that I endorse below are of an authoritarian sort.

In general, I believe that the notion of praxis and an emphasis on politics and the struggle for social change is what forms the basis for Marxian ethical politics—and this focus includes a notion of class. Even relatively "ethical" critical theorists lend import to the real experiences and struggles of the politically disempowered. Recall Benhabib's (1986) anticipatory-utopian dimension of critical theory that is grounded in lived experiences of suffering that lead to political struggle (142, 226-7). And Cooke (2006), who theorizes political activity in a highly

idealized manner that emphasizes discourse, communicative action, and validity claims more than structural explanation and political struggle, still rejects the idea that theorists' task is to supply political actors with prescriptions for the kinds of action to be undertaken (202).

The turn to praxis and politics manifests in a general hesitance among Marxists and critical theorists for offering outright policy prescriptions or action-plans for political implementation. Instead normative motivation is located in actual politics more than in a theorist's prescriptions. Marxian social theory can overcome "scientific" functionalism and the threat of ethical/epistemic authoritarianism by this turn to politics because the normative concepts are determined in social struggles themselves. For instance, freedom for Marx has a concrete meaning that changes through time as material conditions change and as groups form together to struggle to realize freedom's demands (Blackledge 2012, 57).[5] Blackledge (2012) argues:

> Marx's criticisms of abstract moralizing do not reflect a tendency in his work to dismiss purposeful human agency. Rather, they illuminate the importance of such agency to his model of social transformation. It is because, in Marx's view, the struggle for socialism involves concrete and complex social movements whose outcome cannot be determined in advance that abstract concepts, such as moral abstractions, must be replaced by more concrete categories. (46)

Marx's work does not lead to conclusions that there is nothing to be done—quite the opposite. Marxian hesitance for abstract morals and utopian blueprints comes from its historical materialism—from the claim that the reality and meaning of conceptual categories is determined by particular social relations and historical development rather than universal essentialism.[6] Thus the specific meaning of freedom in a given social context is determined by the struggles for

[5] The changing meanings of freedom also come from changes in human needs, which Marx argues expand with the productivity of labor; thus "as human needs and powers expand through history so does the potential for the realization of human freedom" (Blackledge 2012, 56).

[6] "Marx's historical model of human freedom implies a critique of those superficial viewpoints which either conflate the atomized desires generated within bourgeois society with the good (utilitarianism), or, similarly assuming the existence of desires in this form, posit some universal moral code as a brake on their consequences (Kantianism)" (Blackledge 2012, 59).

freedom that are ongoing within that social context. So too, Marx's notion of human nature, which is at the heart of his notions of freedom and self-determination, is neither static nor substantively universal. While the very notion of human nature is a kind of essentialism, and thus may seem to contradict Marx's critical schema, his is a human nature that is dynamic and historical rather than universal (see Blackledge 2012, 22, 54-6, 82; see especially 55n2).

On this basis, Blackledge looks to preserve an emancipatory and normative role for the working class, the understanding of which bridges the descriptive and normative (45). Because of this claimed link between descriptive critique and normative politics, I believe that Blackledge points to a Marxian normative groundwork that can motivate and ground my project, and need not lead to ethical or epistemological authoritarianism.

Blackledge argues that Marx's alternative to modern moral theory does not try to solve altogether the problem of particular interests but instead claims that "in certain circumstances specific interest groups can act in the universal interest" (43). This is to say that social contexts may position a given group or class as the "universal class," whose particular struggles for emancipation on the basis of self-interest actually function to further liberate all of society. Further, Marx claims that there are verifiable bases for whether an individual class does indeed act as the universal class: "this class liberates the whole of society, but only on condition that the whole of society finds itself in the same situation as this class" (Marx 1975b, 254). Furthermore, it is not necessarily the case for Marx that only one unified and pre-determined class is the universal class. At specific historical junctures different classes or groups can take up this role in attempting to overcome limiting relations, and thus historical progress is where barriers to human freedom are removed piece by piece through the persistent political struggle of a plurality of groups (Blackledge 2012, 54). This latter aspect, which does not necessarily associate the

universal class to any predetermined group, I believe, helps to avoid accusations of authoritarianism because that designation in theory could apply to any group, and because the positionality of the claimed universal class is subject to verifications on the basis of contestable validity claims. Whether a group is fighting for transformation that will benefit the entire society is a validity claim that is subject to verification. But rather than theorists simply determining who that group is, the social context determines that position.

But the claim that there are verifiable bases for determining whether a given class struggle is in the social interest leads one to ask how that is determined. Blackledge argues that this relies on the method of Marx's critique, which connects the individual level to an understanding of the totality of social relations in capital—this is to say, Marx's concept of social form. One of Marx's most significant normative points that motivates his theorizing is that the truth of the process of production only becomes clear when one goes beyond the viewpoint of individuals and conceives of the totality of the capitalist system:

> To be sure, the matter looks quite different if we consider capitalist production in the uninterrupted flow of its renewal, and if, in place of the individual capitalist and the individual worker, we view them in their totality, as the capitalist class and the working class confronting each other. But in so doing we should be applying standards entirely foreign to commodity production. (CI, 732)

This claim, Blackledge (2012) argues, "provides the point of contact between Marx's scientific, explanatory account of the dynamics of the capitalist mode of production, and his normative critique of capitalism" (64). That is, "the labour theory of value conceived from the standpoint of workers' struggles underpins Marxism both as a social science and as a normative critique" (64). Here Blackledge reflects MacIntyre's (2008) claim that the ways one understands the social whole already to some extent commit us to action, and themselves reflect our actions already taken (314). So Marx's critical descriptive analyses hang together with his notion of the potential for particular groups to embody the normative emancipatory capacity of all of society. Thus we

see the role that praxis and politics has for Marx, and we see how Marx's theory of society—that individual categories are determined by the total ensemble of social relations—is reflected in his social theory. Thus Blackledge argues "Marx's critique of political economy, his theory of history, his ethics, and his politics are all aspects of a greater whole which derives from viewing society from the standpoint of the working class" (45).

This again challenges the notion of theory happening prior to politics and being handed over for political implementation. Instead theory and praxis are a part of the same activity. Michael Löwy (2003) argues that in Marxian critique we have "a total human activity, practical-critical activity in which theory is already revolutionary praxis, and practice is loaded with theoretical significance" (109). And Marxian theorists claim that this unification of theory with praxis reflects human social existence, and especially human political practice. Terry Eagleton argues (1990) that "in the critical consciousness of any oppressed group or class, the understanding and the transforming of reality, 'fact' and 'value,' are not separable processes but aspects of the same phenomenon" (225). Blackledge argues, then, that for Marx too the questions of fact and value are joined together: "For Marx, the key moral question is how this situation arose, and what chances there are, if any, that we might overcome it?" (71).[7]

Marx's concept of the universal class, as Blackledge explicates it, has considerable potential, which I believe gains philosophical support from theorists outside the ranks of those discussing Marx and Marxist politics. This support might then lend further credibility to a Marxian idea by showing how it is actually in play in other contemporary oppression theories that do not generally self-identify as Marxist. Further, in understanding theory and praxis as one

[7] This relation of theory to politics should sound familiar to those with a knowledge of feminist theory. Much of feminist philosophy is not easily separable from the political action of second wave feminism in particular. Indeed, Sarah Hoagland's (1992) lesbian (feminist) ethics framework exemplifies something very similar to Marx's moral question: "Moral agency then becomes a question, not of how am I going to stop all the injustice, but rather what is my part, and what are we going to do next?" (204).

process, establishing allegiances between theoretical approaches can be a part of political coalition-building and solidarity between my project for health care, Marxism, and other critical theories and politics.

First, Marx's claim that "the universal interest is embodied in this particular interest" of the universal working class (Blackledge 2012, 53) can be related to legal scholars Lani Guinier and Gerald Torres's (2002) *The Miner's Canary*. Guinier and Torres argue that populations raced as "losers" or as marginalized are sensitive indicators of systematic oppression and are thus central to diagnosing such oppression (11-12). This leads to a specific politics, too, in that Guinier and Torres argue that reversing systemic oppression through coalition with and among marginalized racial groups can have benefits for the whole of society by dismantling those systems (17). Like the canary in a coalmine, oppressed raced classes alert society to systematic wrongs that ultimately affect all of society, and so the pursuit of their particular interests in political struggles, like Marx's universal class, can serve the interest of society.

Second, the notion of the universal class is reflected further in Kimberlé Crenshaw's (1989) theorization of intersectionality and intersectional politics. Crenshaw illustrates the ways that Black women were repeatedly disallowed from being legally recognized as the subjects of discrimination on the basis of being *both* Black *and* women because the legal system only recognized discrimination along either single axis. Crenshaw argues that Black feminism has uniquely productive contributions to make to social theory, law, and emancipatory politics—Black feminism is greater than the sum of its parts in theorizing just race and gender (140). But Crenshaw argues that intersectionality leads to a different approach to feminist and antiracist politics.

Crenshaw argues that antidiscrimination laws tend to be aimed at the most *advantaged* members of *disadvantaged* groups who can claim most convincingly that they would succeed "but for" their race or "but for" their gender (151-2). She calls this a top-down model. Against this she argues for a bottom-up approach to feminist and antiracist politics:

> if their efforts instead began with addressing the needs and problems of those who are most disadvantaged and with restructuring and remaking the world where necessary, then others who are singularly disadvantaged would also benefit. (167)

Crenshaw argues for such a bottom-up approach that relies on the most disadvantaged to further the interests of all other disadvantaged groups "above" them, including those disadvantaged along only a single axis. Crenshaw argues that those engaged in praxis must "develop language which is critical of the dominant view and which provides some basis for unifying activity;" and in a final appeal to something like the universal class, Crenshaw claims that "the goal of this activity should be to facilitate the inclusion of marginalized groups for whom it can be said: 'When they enter, we all enter'" (167).

Corroborating or supporting theories for a Marxian notion of the universal class also exist in the realm of bioethics and health policy. One sees something like Marxian methodology at work in Madison Powers and Ruth Faden's (2006) nonideal theorizations of the moral foundations of public health and health policy. Powers and Faden see their guiding question to be simply which inequalities are the most urgent from the view of justice (9).[8] An understanding of this methodology can be interpreted as drawing normative and epistemic motivation from the most disadvantaged groups. Powers and Faden argue that their understanding of social justice "attaches a special moral urgency to remediating the conditions of those whose life prospects are

[8] This "from the view of justice," again, is of a *nonideal* sort that is less interested in extensive theorization of perfect theories of justice.

poor across multiple dimensions of well-being" (82; see also 88).[9] And this focus leads to a Marxian need to understand the social totality. Powers and Faden explain that in their account, "questions about which inequalities matter most are comprehensible only by examining all of the social determinants having cumulative and interactive effects on human well-being" (5). Quite simply, "inequalities in a nonideal world are interrelated" for Powers and Faden (31). So Powers and Faden understand public health as motivated by the needs of the most disadvantaged, and that prioritizing those groups has positive reverberations across the social order and among other groups because inequalities are structurally related. Helping the most disadvantaged, then, should address the most possible structural means of emancipating those oppressed, and thereby help improve the underlying basic structure of all of society. Understanding those interrelations would also seem to require structural frameworks that comprehend some notion of totality.[10]

I want to add one caution. In my haste to try to make allies of other critical political theories, it is important to differentiate Marx's notion of the universal class from merely the "most disadvantaged." After all, liberal frameworks, including Rawls's difference principle, seem to place the most disadvantaged in a central place for their theories, so Marx's idea of the universal class may not seem so different. My response to this line of argument is to emphasize the second aspect of the universal class in its *strategic significance*. It is not simply because the working class is the most oppressed in society that it is given a privileged theoretical position, but because of "its strategic position in the economic order" (Arthur 1986, 145). Where liberal

[9] Their public health focus may lead them to privilege one class in a way that is less typically Marxian in children (92). In this instance it seems that that privileging is epistemic in that how children fare informs understandings of systemic forces, and normative in that it gives priority to those effects that will help the well-being of children. It is less likely, however, that theory can rely on children for political struggle—though the proxy-politics of *mothers* may provide that instead.

[10] Another, perhaps obvious, corollary to a Marxian universal class comes from disability rights notions of universal access. Removing structural barriers for persons with disabilities, this view argues, ultimately empowers a multiplicity of individuals outside the class of persons with disabilities, thus helping a universal social cause.

frameworks privilege the least well off on the basis of justice or reasonable agreement in the original position, Marx—and I believe the authors above—look to that group *as the vehicle of social change, and the strategic representative of structural injustice*. Where Rawls supposes the position of ideal framers of the basic structure of society, or an ideal situation for persons making political and policy decisions (see Gledhill 2012), Marx focuses on the actual position of those already engaged in political struggle.

In a related caution, this theorization of the universal class also threatens to devolve into merely utilitarian reasoning. The claim that the struggle of the universal class represents the interests of the entire society could be interpreted to mean that the universal class is determined by that struggle that will bring about the most well-being within society. One line of response to this is to emphasize the nature of Marx's notion of social relations and the notion of structure. The universal class's representativeness does not have to do simply with a quantitative measure of maximizing well-being. Instead it has to do with whether a given political struggle will dismantle a contradictory or antagonistic structure of capitalist social relations and realize in part the potential for something better. In this way Marx's reliance on the totality of social relations for understanding the individual or class viewpoint may be construed as an underlying notion of justice that would prevent utilitarian maximizing reasoning for the universal class. I am not sure that this possibility can be fully countered, so I must only draw attention to the different kind of reasoning employed in considering how the emancipatory potential of a class struggle stands to reverberate throughout the totality of a social formation as opposed to mere quantitative maximization. While it might be the case that these tend to overlap, I do not think that it is necessarily the case that the latter can be treated as identical.

It is on this Marxian basis, which joins praxis and politics together with critical theoretical analyses of social-relational structures in their totality, that I believe my project contributes to the normative task of health care ethics. In the next section I explain how I understand this task and then propose a category of social pathologies in health care, which comes out of my project, that I believe can contribute to the normative task of health care ethics and inform political struggles.

The Task of Health Care Ethics and the Critique of Alienation

Health care ethics as a disciplinary field largely came out of an extraordinarily practical set of circumstances where ethicists trained in moral philosophy were asked to weigh in on difficult medical decisions being made in intensive care units, neonatal intensive care units, and in clinical research settings. Many of those ethical dilemmas came about as a result of new technologies creating novel medical scenarios. In those circumstances there was a very clear connection between the moral reasons given to justify a certain course of action and the course of action eventually taken. Thus the underlying transitive efficacy was quite clear between moral justification and action. And for many ethicists engaged in clinical or committee work, this is still very much the case. My critique does not, then, apply much to this kind of clinical schema.

However, with the expansion of the field of bioethics came an expansion of its theoretical apparatus to include a variety of social scientific and philosophical inquiries. Its target practices also expanded beyond just clinical interactions and vexing decisions to include broader social and institutional practices and patterns. It is simply not the case that everything currently published in the field of health care ethics gives immediate guidance for moral decision-making in health care practice. Nonetheless, I believe that those doing health care ethics still generally

perceive themselves as informing health care practices on the basis of reasoned reflection on the underlying moral justifications for those practices. In this project, and in the first chapter in particular, I am critical of the latter methodological emphasis on moral belief and ideal theory. Yet I believe that health care ethicists and bioethics more generally actually share a great deal with Marxian approaches on the basis of the latter's focus on praxis, which I explicate above. I understand the self-understood task for health care ethics to be much in line with Cooke's (2006) Marxist, critical-theoretic notion of praxis: "intentionally guided, rationally based human activity aimed at changing the social order for the better" (190).[11] That is, I understand the task of health care ethics to be the *transformation of social practices for the better*. By this measure, I propose in this section that my project's Marxian methodology and its critique of alienation can contribute to this task of health care ethics in a way that can potentially transform the way that such work is done.

I believe that this task can benefit from greater attention being paid to the relation between health care ethicists' practices of normative theorizing discourse as they relate to social structures and praxis itself. Marx's analogy to the chemist who studies eternal ideals like liberty and equality in order to solve problems of chemistry becomes disanalogous for social problems because there is a vehicle for influence between the objects of study (human beings) and discursive moral ideals. In order to bridge this gap, however, ethicists must be more reflective about *what it is they are doing when they offer moral argument*, and what it is that they wish to do.

[11] Cooke's definition may already beg the question somewhat regarding the role of rational deliberation and moral belief in guiding social change, as Cooke's theorizing gives more weight generally to validity claims and communicative rationality than to structural functions or political struggle. In this way Cooke is more aligned with the traditional approaches to ethics of which I am critical. However, I leave this aspect aside here because (1) I address this emphasis in more detail in the first chapter, and (2) I choose to emphasize the role of social transformation as the focal task at hand.

As illustrated above in Marx's privileging notions of self-determination and freedom in his normative groundings, the critique of *alienation* is central to Marxian theory. The most general meaning of alienation for Marx is that "capital acts as an ever-expanding power over everyone within the capitalist system" (Blackledge 2012, 73). I include among the general Marxian critique of alienation a cluster of alienation concepts that stem from Marx, including Marx's alienation and fetishism, Lukács's reification, and Habermas's notion of colonization of the lifeworld.[12] These concepts share in descriptive and normative critique of capital's tendencies to overtake human moral and deliberative influence over social activity and subject them to the self-moving logic of capital. It is important to note that alienation in the later Marx, the basis for fetishism/reification/colonization, is somewhat different from the understanding of alienation that tends to come from his earlier treatment in the *Economic and Philosophical Manuscripts of 1844* (Marx 1978). The early idea of alienation emphasizes a *subjective experience* of one's relation to one's labor process, while the later notion is associated with the experience of alienated effects of labor as external, self-moving, and objective forces. So the form of alienation that is the focus here is more of the latter sort, which is an objective phenomenon that individuals need not consciously experience in order to nonetheless be subject to it.[13]

In light of alienation concepts, my project can be understood to illustrate alienation/reification/colonization at work in health care in order to challenge the account of society and medicine presupposed by many authors in health care ethics. The link between everyday clinical (micro-)practice and social, economic, and institutional (macro-)structures is

[12] See Marx (CI, 163-177, 716; G, 157); Lukács (1971); Habermas (1987, 332-73). For an explication of Marx's concept of alienation, see Blackledge (2012, 87-91). For an assessment of Habermas's colonization thesis as a reification concept, see Jütten (2011).

[13] Subjective experiences of alienation come back below in discussing the phenomena of "reifying effects," where individuals actually experience dissatisfaction or disillusionment in the face of a reified, alienated social existence.

made evident in alienation critique because alienated/reified macro-structures subvert the aims of microethics and disconnect social consensus or deliberation about what is right from the practices of medicine. For instance, rather than professional judgment in a caring partnership between doctor and patient, we have standards of care with institutionally imposed consequences for physicians. And while it is the case that standards of care were intended to put the best evidence to work in protecting patients, even those mechanisms may be coopted to some extent by physicians with considerable industry ties who help determine clinical standards of care that benefit their industry backers (Choudhry, Stelfox, and Detsky 2002; Greene 2007; Oldani 2010). Those standards then go on to increase the consumption of a variety of pharmaceuticals and technologies that contribute to profits for major corporate entities.

I believe, too, that a part of structural alienation in health care is the reduction of illness to enumerable indicators that correspond to the effects of pharmaceutical interventions. In the US, adults reach the age of 50 in worse health than similarly wealthy, industrialized peer countries. A study that compared the United States to these wealthy peer countries found that:

> The U.S. death rate from ischemic heart disease is the second highest among the 17 peer countries. Americans reach age 50 with a less favorable cardiovascular risk profile than their peers in Europe, and adults over age 50 are more likely to experience and die from cardiovascular disease than are older adults in other high-income countries. (Woolf and Aron 2013, 88)

Despite this fact, however, the United States is among the best in terms of controlling blood pressure and serum lipids (or cholesterol), two significant factors that are often linked to heart disease in the public discourse (Woolf and Aron 2013, 89). These two indicators are also the major targets of decades of pharmaceutical research and development and eventual pharmaceutical products. Here the definitions and clinical standards for certain diseases are themselves influenced by capital. The United States is among the leaders in pharmaceutical consumption (Danzon 2011, 522), and is among the leaders in terms of two major indicators

associated with heart disease that some of those pharmaceuticals target, and yet the intended value in better health is not present. It seems these measurable illness factors are tailored to the pharmaceutical interventions as much as to the underlying physical pathologies that affect health.

For diabetes and hypertension, in particular, the reduction of illness to enumerable indicators for the sake of pharmaceutical intervention (and subsequent profit) means that "the very way practitioners think about these conditions promotes drug sales, by prioritizing abstract hoped-for patient benefits, while downplaying increased risks" (Hunt, Kreiner, and Brody 2012, 457). Here the doctor-patient relationship, professional clinical judgment, and the act of healing in the pursuit of health are all subjected further to the controlling logic of capital.

The authors of one study of underlying influences of pharmaceutical management note that:

> Those interviewed for this study wanted to offer quality care, meet practice standards, and prevent serious downstream complications. But in adhering to authoritative medical guidelines, they are diagnosing and treating test levels closer to normal and prescribing more and more drugs, while unaware of the influence that the pharmaceutical industry may have had on establishing the standards and practices they follow. (Hunt, Kreiner, and Brody 2012, 458)

This study illuminates one instance of the alienating effects of capital at work in health care. Here the very wishes and goals of individual practitioners are—against their will or conscious knowledge—made to increase profitability and production by the workings of capitalist forces.[14]

Indeed, the claim that underlies the two previous chapters on the commodity and labor and valorization is that health care's structural relations to capital increasingly subject its practices to the logic and outcomes of capital rather than the logic of healing and the moral ends

[14] The same authors also note the tendency for "pharmaceutical cascade," where the prescription of one drug leads to the prescription of several others intended to manage the side effects of the first (Hunt, Kreiner, and Brody 2012). One can imagine the incentives at work for pharmaceutical profitability.

of medicine. I understand this as a form of alienation, which ought to be reversed in favor of truly human ends, both ethical and democratic, to influence the practice of health care.

So it is in actuality something like Pellegrino's (1999) essentializing concept of medicine that I would endorse as the normative ideal alternative. However, on the basis of the claim that health care is largely alienated from social control, I see such an uncommodified morally essential form of medicine as *an end to be politically achieved* rather than simply a valid moral claim. I believe that a normative project that identifies the ways that health care is currently commodified in practice, as it relates to individual experiences of dissatisfaction, disempowerment, and illness, better contributes to the task of health care ethics in social transformation than an idealized reminder of medicine's noncommodified moral core.
This still leaves largely unanswered how more precisely my project connects to the normative motivation for decommodifying or dereifying health care practices—particularly because my project has remained largely analytic or descriptive in its critical Marxian methodology rather than being directly normative.

Timo Jütten (2011) addresses this difficulty in reification concepts that are purely functionalist in their descriptive accounts of malfunction without accounting for the normative dimensions of "reifying effects" that come from alienation. Jütten argues that the pacifications of the welfare state have tenuously staved off full-on reification effects of alienation from being widely felt in advanced capitalism (715). That is, workers have managed to stay more or less pleased in a reified existence that is fortified with welfare state securities and the pleasures of consumerism. However, crises can occur when the state-capital apparatus fails to deliver on workers' expectations.[15] In such crises, Jütten argues that functionalist explanations alone will

[15] Jütten (2011) argues that these expectations are: (i) continuous economic growth enabling wage increases and thus increased consumption capabilities, (ii) maintenance and extension of health care,

not suffice, and that "the correct explanation for this resurgence of reification will have to appeal to the normative expectations of the employees as much as to the functional necessities of material reproduction" (715). This is because

> the losses of freedom and meaning that are expressed in reification effects (in alienation from social and political institutions which seem thing-like and immutable, rather than expressing citizens' own values and commitments, for example) can be understood as such only *in comparison to* those legitimate expectations, which serve as the normative standard against which present practices are evaluated. (Jütten 2011, 719)

Feelings of alienation from social practices like health care can only be understood as truly normative deficits in the social system if there is some other justified sense of how things ought to be, what is just, or what is deserved. Reification effects are "a sign of normative disappointment and not only of a social malfunction" (Jütten 2011, 720). Obviously, an account of alienation in the realm of health care is an instance of crisis-diagnosis in that it argues that money and capital have uncoupled medical practice from its normative basis.

If Jütten is correct, and I think that he is, it would seem that a project like mine needs those normative components in order to motivate social, political, and economic changes to medical practices that may reverse reifying effects. Yet much of my methodological arguments in the first chapter were meant to defend a largely descriptive account of structure, and so there would appear to be a serious need for an added normative element—especially since I have made social transformation the motivating benchmark for health care ethics. This combination of an analytic diagnosis of alienation or crisis, on one hand, with the normative motivation and comparison to ethical and political ideals on the other, brings us to a concept from Critical Theory that I think can be adapted for my project's purposes in health care ethics. This is the

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education, and pension systems that guarantee standard of living, and (iii) that the present welfare capitalist state is the best possible social system overall, and its replacement could only come at considerable cost in freedom and material wealth of all social strata (715).

concept of *pathologies* that is associated especially with Jürgen Habermas (1987) and Axel Honneth (1996, 2009, 2010).

Social Pathologies of Health Care

In this final section, I expand the concept of social pathologies of health care that comes out of my critical project in order to relate it to normative motivations in praxis and political struggle. I begin with a general introduction to the term pathology in Critical Theory and explain theorizations of *medical* pathologies in the philosophy of medicine. I argue that an analogy can be made between concepts of (medical) illness and (social) pathology in order to show how the latter concept contains both normative and critical "functionalist" elements, which are brought together in my project. I conclude by briefly identifying prominent social pathologies of health care that my project helps to identify, and I describe where possible how class-based political struggle becomes possible from the diagnosis of these pathologies.

The term "pathology" is applied to the objects of critical social theory's diagnostic task. Authors like Habermas and Honneth set out to analytically identify and explain the origins of societal dysfunctions like alienation. The language of pathology is helpful for explaining my project's role within bioethics because there is a helpful analogy to a well-known discussion within bioethics and the philosophy of medicine. This analogy illustrates my intent to bridge the gaps between methodologies of "functionalist" structural analysis and normative ethical prescription. The analogy to social pathologies is with the distinction between disease and illness. This distinction is represented perhaps most prominently in Christopher Boorse (1975) and is central to debates about the role of medicine and the status of psychiatric disorder and physical and cognitive impairments (especially as the latter relate to disabilities). The distinction

between disease and illness relies on the difference between a functionalist account of physiology and evaluative assessments based on sociocultural norms, respectively. Disease is claimed to be a merely descriptive category for deviation from, or interference with, normal physiological functioning. Illness refers to a somewhat broader, though usually overlapping, category of maladies treated by cultural practitioners of medicine on the basis of normative evaluations.[16] So disease is a functionalist category for abnormality, while illness is a culturally evaluative category from the social task of healing rituals. Granting that we are in an age of scientific medicine, medical anthropologists generally claim that contemporary medical healing addresses both the physiological and cultural elements of its subjects. Anthropological concepts of healing and illness bridge the functional and normative.

Compare this to the distinction between functionalist (structure) and normative (ethical) accounts of social, political, and economic practices. Much like certain Marxists claim to be merely "scientific" in their functionalist assessments of capitalism, Boorse (1975) and others argue that medical theories of physiological function are value-free (49). For the same reasons that functionalist Marxism seems to need a normative dimension, particularly to motivate and orient political action, so too does functionalist medicine need culturally informed evaluative frameworks to deliver adequate healing practices. Extending this to my project, the language of pathology as applied to health care practices offers a concept that bridges the functionalist, structural dimensions of health care production with the normative, ethical dimensions of health care ethics. Structural accounts of health care production thus lend greater balance to politico-normative projects that seek to achieve health care practices that better meet human needs of

[16] The disease/illness distinction is assumed in most medical anthropology and sociology. Indeed it is in part anthropological work that helps draw attention to the culturally determined nature of *healing*, the variation in healer roles across cultures, and the corresponding variations in identifying health and illness, and thus drawing this distinction between the functional and normative/evaluative.

fairness, dignity, and freedom. Accounting for pathologies of health care production through structural analysis offers to play a role in social and political transformations that are motivated and guided by normative ideals. And the concept of social pathologies of health care helps to theorize the combination of structural function and normativity in both the praxis and theory of health care ethics.

In order to be a truly Marxian concept, it seems that social pathologies of health care must relate to *political* praxis and to the struggles of a universal class. It is necessary here to explain how I see structural accounts of pathologies of health care as potentially contributing a normative dimension to political struggles. So far it has been made clear that Marxian approaches generally reject the notion of theorists passing along direct guidance to political groups, and that theory and praxis are seen as two parts of the same activity. But what does this actually look like? For one, I believe that Marxian rejections of simplified theory-to-praxis frameworks, which prioritize theory, do not amount to a rejection of theory itself nor a rejection of theory's potential influence on politics. After all, Marxists cannot deny that aspects of Milton Friedman and such like theorists have become the motivating "organic ideology" of political neoliberalism. And Anna Smith (1998) notes that one of Laclau and Mouffe's central claims is that politicized resistance is *discursively* constructed (7), which is to say that discursive concepts of freedom, justice, or liberation are entwined in the political struggles that Marx so privileges. And because discursive concepts are the stuff of theory, it seems there is at least potential for even the most ideal theory to influence politics. Marxists simply have a more complex account of how and why certain concepts come to be organic ideology, which includes a complex theory of history. I think among the more basic insights of Marx's rejection of simplified theory-to-praxis models is simply to deflate the self-regard of theorists and academics. But Marx obviously sees a

role for theory and discourse to contribute to political struggle, since he never really abandons the former.

Following Marx, as explicated above in discussing Blackledge, the concept of pathologies of health care helps my project connect the viewpoint at the level of individuals with the viewpoint of the totality of relations of health care production as it, in turn, relates to the capitalist mode of production. This project is critical because it reveals the ways that health care is not an eternal or natural practice to be taken for granted, or reduced to the doctor-patient relationship, but instead it is the result of a set of social relations that have *limits* and that can in principle be changed. This specificity should be reflected in the ways health care in capitalist social formations is theorized in health care ethics. Further, we can see the ways that, like Marxian social theory itself, it seems that the pathological forms of health care hang together in ways where individual malfunctions often relate to each other—and where the "resolution" of one through targeted reform alone will not do away with the *overarching* pathology.

Nonetheless I share a Marxian conviction that the possibilities for an alternative social order begin to reveal themselves to political actors engaged in struggle against the forces that dominate, control, and oppress them. And so another function of my project and the concept of pathologies is to help identify the potential in groups to act as a universal class in furthering social interests through their particular struggle. I take guidance from Blackledge's (2012) Marxian contention that for the most part moral abstractions "must be replaced by more concrete categories" (46), of which I believe that the ideal-as-descriptive accounts of this project and the concept of pathologies provide. Pathologies and structural accounts focus more on understanding the present nonideal world, and should take their direction from ongoing struggles and crises in the social order. I think that more concrete categories, like those that analyze the relational

structures that produce health care services, can inform political struggles as to the forces at work against them and their origins. But on the other side of that, the concept of pathologies allows for identifying and verifying potential universal classes and political allies by illustrating the structural interconnections at play and thus how they may be affected by transformation. And thus the pathology concept contributes to answering Blackledge's "key moral question" for Marx: "how this situation arose, and what chances there are, if any, that we might overcome it?" (71).

I would like now to try to get more concrete and briefly explain a handful of social pathologies of health care that I think my project helps to illustrate. Each individual pathology can be analyzed in much greater detail—some of which are in the earlier chapters of this project, and others could be the subject of an entire book. Thus I offer only a sketch here in order to expand on my concept of pathologies and the potential relations to a normative ethical politics.

To begin with, we can understand the subject of my two main chapters—the commodification of health care services and the valorization of medical labor—as two overarching pathologies. Starting at these large categories also illustrates the nature of my concept of pathologies in that, like medical illness categories, certain larger diagnoses can be broken down analytically into more specific pathological functions. So for instance diabetes is an overarching chronic diagnosis, which is made up of more specific pathologies relating to insulin production and metabolism, as well as pathological complications relating to blood circulation and so forth. So too can the broad category of the commodification of health care be understood in structural-normative terms of pathology, and be similarly broken down analytically into component pathological functions.

In my second chapter I argue that the multiplication of acts of exchange surrounding medical services and the mechanisms of profit production that similarly arise at most of these points of exchange contribute to a pathological form of commodification. The normative motivation or grounding for this pathological diagnosis comes from the "ideal" notion of the moral goals of medicine and the concept of alienation/reification in my underlying claim that health care services are progressively decoupled from those moral grounds in favor of the forces of capital. Because these first pathological forms in health care are so broad, it is more difficult to identify a specific class whose political struggle could represent in solidarity the interests of the collective society. Thus the struggle against these larger pathologies are likely to have to either align with other larger economically-based struggles (which are not terribly prominent at present), or they can be broken down analytically into component pathologies for which there may be more identifiable groups who take up the mantle of a universal class in more focused struggles.

One such component pathology is the private and employer-provided insurance system. My project draws attention to the several points at which the underlying productive needs of the insurance industry is antagonistic to the needs and normative motivations of health care. Such underlying antagonisms are precisely many of the "challenges" that needed to be addressed in designing the Affordable Care Act (ACA), as well as prior attempts at reform. Among the policies meant to meet these pathological challenges is eliminating the ability to deny coverage for pre-existing conditions. In more ways that one, insurance is determined to *avoid* having to cover those who need it most, which leads to the other policy change in the individual mandate. When insurance is considered an individual responsibility rather than a collective good for the welfare of all, it undermines its very basis in collective protection of the individual. There are

many other pathological forms that stem from private insurance, or that are made worse by private insurance, which are interwoven with one another.

I think that the private insurance pathology has much more potential in terms of corollaries in political struggle and the potential for a universal class to emerge. There are a multitude of groups who make up the larger class of the Uninsured, who could potentially organize in fighting for universal forms of coverage.[17] Many service sector employees are kept below the weekly hours that would require health benefits, and the ACA's insurance markets also led to some employers to drop their coverage and default their employees to the market. As many health policy scholars and activists know, the concessions made to the insurance industry are among the most glaring weaknesses in the ACA. And those weaknesses are among those most ridiculed by those calling for its repeal and/or replacement. Yet the disempowerment among the ranks of uninsured or underinsured makes for the potential of a political class if those groups could begin to organize around such a class-like identity. (Perhaps a health coverage crisis could actually catalyze such organizing.) Meanwhile, multiple policy analysts line up for cable news and radio spots to explain these underlying challenges, yet few draw attention to how many of those challenge are the result of the specific US system of private insurance. These are not "natural" challenges for any health care system. These are particular challenges for the US private insurance system—which can be changed through struggle. I intend my structural analyses of health care to draw more attention to the various pathologies in this system in order to also draw attention to their historical, contingent, and changeable nature, as well as their connection to the normative deficits in leaving millions uninsured.

[17] Such a class might apply in history to the Saskatchewan farmers who helped push for single-payer health coverage in Saskatchewan before it spread to cover all of Canada. Their particular needs, which relied on farming market goods, led a political struggle which proved to further the interests of all Canadians.

Another pathology of health care that my project helps to analyze is the progressive loss of rural health care facilities and physicians as a result of the accumulating and centralizing forces of capital. For decades hospital-based capital has been centralizing in urban centers as hospitals merge, conglomerate, partner with universities, and purchase physician groups. The number of mergers and acquisitions in the health sector is the highest in a decade (Kirchhoff 2013). Evidence suggests that mergers among hospitals can increase prices, which likely leads to higher expenditures when demand/usage remains the same (Gaynor and Vogt 2003). "This result creates a paradox in the literature: Markets with more providers tend to have higher costs, but mergers among hospitals also seem to increase costs" (Chernew and May 2010, 319). Capital seems to always win, though.

The major losers in this trend have been persons living in the rural United States, where many smaller towns are even seeing hospitals—like the industrial factories decades earlier—close altogether. This has led to some reform movements that try to entice young physicians to move or return to rural locations, often times in return for student loan forgiveness. Such reforms seem to recognize a genuine value on the part of many physicians—especially those who were raised in the rural US—to service those communities. Yet the incentives also recognize that the reifying effects of capital subvert those normative desires. Because the earning potential for young physicians is in those more urban centers where health care capital is centralized, and because medical school graduates are saddled with so much debt, they are subject more to capital's control than to their values for community, human welfare, or for home. An appeal to the freedom and individual values of those physicians is all that is needed to motivate political struggle against such forces, especially if they are identified with larger structural forces through the pathology concept. Thus there is little need to commit theoretical labors to constructing

moral arguments to justify a young physician's virtue or right to become a rural community doctor. There is a need to remove the barriers to her or him acting on that desire.

This pathology, too, has a fairly specific class corollary in rural populations—a class of people who have had recent success in flexing some political muscle in the election of Donald Trump. If rural communities organize around the issue of health care, then there is some potential for the Trump-style class voters—who do not seem as wed to the underlying ideologies of capitalism and neoliberalism as the standard Republican—to represent a universal class so long as their struggle is for changes that truly benefit the social whole. This latter test of social benefit must be determined by analyzing the individual level in relation to the social totality in analytic structural accounts like mine.

Another social pathology in health care is found in the combination of physician payment schemes and specialized health care. As I argued in the previous chapter, the foundation of physician payment schemes in the United States breaks with the capitalist mechanisms that produce surplus value—and thus which form the basis of capitalist production itself. The result of placing part of the determination of payment (and thus prices) on the "intensity and skill" of a procedure has led to a clear monetary privileging and incentivizing of specialists and specialization because those services are reimbursed at the highest rates. This tendency is antagonistic in terms of health needs, however, because the country's most pressing needs are in services and therapies related to basic primary care. So we see how this notion of pathology links the functionalist flaw in rewarding labor intensity rather than labor time with the normative deficit of the resulting distribution in the division of labor that does not meet social needs or legitimate expectations.[18] And one other political result of this is that at least two thirds of

[18] "The physician population is about one-third primary care physicians and two-thirds specialists, a distribution that some experts suggest is not optimal" (Kirchhoff 2013, 4). In addition, there is evidence

physicians are more invested in the present insurance system that is fundamentally to their advantage, feeding into conservative protection of the status quo in health care.

In many ways physicians already operate like a class (see Starr 1982; for examples, see especially 284-5, 288-9). They share a common identity and a common cause of protecting their wages and revenues and will do what is needed to protect them. Class movements, after all, grow "instinctively out of the relations of production themselves" (CI, 415). We see this in most every physician eager to note the meager reimbursement rates of Medicare while nonetheless accepting Medicare patients and complimenting the fast and reliable payout of the federal government.[19] In addressing these private insurance and rural/urban pathologies, it could be the case that primary care physicians can become a class-ally to those in need of more and better primary care, if members of the latter population were able to organize on that basis. The need to construct viable political identities may be necessary here.

Another major social pathology of health care is in the relational complications of technology in health care. It is capital's tendency to engulf the social production of knowledge (i.e., science) and put it to work as a direct force of production (G, 706). In technology, especially, capital manages to render the social production of scientific knowledge productive for its ends. This is well-exemplified in the biomedical sciences and their applications, where observers have for years have argued that the production of knowledge in scientific institutions is increasingly influenced by capital and wealth creation in private grants and laboratories, contract research organizations, and public-private partnerships that lead to new pharmaceuticals and

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showing that increases in primary care physicians as opposed to specialists actually lowers overall spending (Chernew and May 2010, 320).

[19] "The heart of man is a wonderful thing, especially when it is carried in his wallet" (CI, 336). Marx shares this gem when discussing the tendency of capitalists to forecast doom at every turn when their rates of profit appear to be in jeopardy from regulation or state tampering—something familiar to those who follow the politics of the AMA.

technological devices. For most every scientific leap forward in medical knowledge, there is a corresponding application for the creation of wealth.

Technology normally increases productivity of labor in capitalist production because "the same capital creates the same value with less labour," as it creates more surplus labor in the working day (G, 388). Yet this is not the case in medicine for several reasons, in part because technology is more often applied to provide treatments that were not available before, and less often to make a routine procedure more efficient. One possible and significant exception in medicine is the technology of *pharmaceuticals*. Even though they have no gears and require no electricity or fuel, the pharmaceutical tablet, injection, syrup, or ointment is every bit the result of capital's applications of science to the productivity of medial labor. Less of a physician's time is spent in examination and consultation with patients when prescriptions allow her to move on to the next patient's appointment, and thus may create the same value with less labor. In general, however, technological advancements tend to make health care more expensive for consumers, and thus help to drive cost growth (Chernew and May 2011, 313).

For the sake of health care ethics and politics, I see a need to transfer attacks "from the material instruments of production [i.e., machines and technologies] to the form of society which utilizes those instruments" (CI, 554-5). When one considers this contradictory affect in medical technology in a narrow frame, one can miss the place that medical technologies play in the larger system of capital. It is in this larger frame that one sees why the US economy has managed to sustain the growth in health care spending without considerable material crises like shortages or collapsing markets.[20] The typical capitalist phenomenon where new technologies make per-unit costs lower also spawns higher consumption of that unit. The result, then, of lower per-unit cost

[20] Perhaps this has something to do with the fact that rising costs of insurance, as a result of rising costs of care, do not come directly out of corporate employer profits because they represent "wages" in their accounting books (Starr 2011, 118, 126).

is higher overall spending and thus also higher surplus production for capital (Chernew and May 2011, 313). So even if health care technologies functioned in a more typically capitalist way, this would not necessarily drive down the total spending on health care and thus the total rate of growth. Nonetheless, in considering the pathological relations of technology, one can identify various paths for social change. This brings us to the final pathology of health care that I will highlight here, and it is another of the larger overarching sort: growth.

The central challenge for health policymakers today is the expanding growth and *rate of growth* in health care spending.[21]

> The limited evidence on cost growth suggests that even in the most successful settings (significant managed care penetration and hospital competition) the share of GDP devoted to health care still rises, albeit at a somewhat slower rate than in other markets. (Chernew and May 2010, 320)

Health care spending seems almost impervious to attempts to curb growth for many reasons, some of which seem inherent to *medicine* rather than to capitalism.[22] And while health care spending as a percentage of GDP is by far the highest in the US, growth in health care spending is considered a major concern for all industrialized countries. On this basis, spending growth is already considered a major crisis in health policy circles, and has continually caused political strife—especially in countries with nationalized health care systems.

Further, the provision of credit for health care is another pathological form related to growth. Health care credit cards, loans, and debt are not just indicators of the rising costs to health care. These practices perform an expansionary function for the profitability of health care and the ability to pay. Credit functions to allow the circulation of commodities to surpass the bounds of money as the medium of circulation, since one can purchase a commodity without

[21] On this distinction between the growth of cost levels and the *rate of growth* of costs, and its economic/policy significance, see Chernew and May (2011; especially 317).
[22] See for instance Callahan (1998); Reinhardt (2009); Chernew and May (2010); Kennedy (2015).

themselves actually injecting that money into circulation at the time of purchase (CI, 237). The resultant decoupling of commodity and money that results from credit allows again for capital to overcome an obstacle and expand circulation (see also CI, 234; G, 805ff).

What, then, can my project and pathology concept bring to this conversation that it seems already identifies fundamental challenges in the structures of health care? Here, I believe that the Marxist foundations in particular offer new insights. That is, the reliance on social transformation through the political struggle of universal classes, in connection with the totalizing structural viewpoint of Marxian critical methodology, offers some novel ways of framing the challenge of health care growth. Health economist Michael Chernew and Dustin May argue that, "because all expenditures are revenue to some individual or organization, efforts to slow expenditure growth are synonymous with efforts to restrain revenue growth. Thus, such efforts are inherently political" (Chernew and May 2011, 323).[23] We can understand this in the totalizing structural terms of Marxian critique as a central observation of my project: the pathological growth of health care (and especially in the US) is connected at nearly all points to the productive forces of capital. And this fact creates conservative political momentum for protecting the present system.

As a result of this, the "politics of health care" in the United States as understood until now has been predominately led—if not outright dominated—by industries and (perhaps to a lesser extent) physician groups, and less by actual citizens demanding change. It is unlikely that industries will be the drivers of major change when it seems all of the most influential parties stand to profit from ballooning spending. There is a clear need for class-like political organization around these issues, and I believe that a universal class must emerge to lead the charge for universal forms of coverage and fundamental transformations in the ways we produce

[23] Reinhardt (2009) echoes this idea.

health care. While many market-based health economists argue that greater out-of-pocket spending can put more patients' "skin in the game" and drive down costs, I believe that the most effective way to increase patient influence in health care trends would be to *actually achieve patient/citizen influence in health care delivery*. The decommodification and dealienation/dereification of health care goes hand in hand with forms of the democratization of health care.

You cannot rely on the productive relations of capitalism—which inherently require endless growth—to produce health care while simultaneously decrying its unendingly ballooning costs. Health care is thus perhaps the industrialized world's most potent illustration of the fundamental contradiction that Marx illustrates of capitalism: as capital expands the forces of human labor for *social* production, the resulting wealth is increasingly the object of *private* accumulation. With this expansion of capital comes an expansion of its influence over human subjects in alienation. My project is fundamentally critical of alienation in health care, of which it offers an account in terms of structural forces that produce health care and alienate it from its normative human ends. Political struggle that is meant to remove capitalistic influence and systemic malfunction and replace it with more democratic social influence—especially in its *production* as opposed only to its distribution—is a central driver of dereifying and decommodifying health care politics that I ultimately call for in my work. Such a politics will have to rely on actual struggle on the part of a group of people whose interests in democratized, dereified health care embody the potential for a more human mode of health care production that meets the needs of all citizens. It is likely to be the case that these politics will need to find allies in broader struggles for economic and political emancipation in order to be successful.

I believe that my project as a whole better contributes to this transformational goal—which it shares with the task of health care ethics—than does the moralizing philosophical articulation of ideals alone, or the presumption that all of our health care activities are the immediate result of moral belief. The two main chapters of this project illustrate some of the structural relations that challenge this assumption. I argue that a dereified social existence—where one could realistically claim underlying transitive efficacy between social normative beliefs and the social order and practices—is a *political achievement that must be won through struggle* and not a social order to be presupposed in health care ethics. It is as a partial contribution to this potentially inchoate struggle that I submit this project to account for the social pathologies of health care as normative deficits in the social-relational structures that produce health care services in the United States.

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