Medicine and the Market

Daniel Callahan

To enter the jungle of medicine and the market is not only to encounter many choking vines and dense undergrowth, but also to move through a climate alternatively marked by cool, technical winds and hot, ideological cyclones. The topic of medicine and the market touches on some of the oldest and deepest human questions--what, for instance, is the appropriate place of self-interest in human communities, and particularly in the health care community? At the same time it forces consideration of a difficult range of technical questions--at what point, for example, does a co-payment for a drug reach a level that it helps control health care costs but is harmful to the health of patients on whom it is imposed?[i]

In my experience, the greatest difficulty in talking about medicine and the market is that, for most people, it seems an either/or choice: either love the market or hate it, either see it as the panacea for troubled health care systems beset by government bureaucracy, or as a mean-spirited devil designed to destroy the very idea of equitable care. Let me put my own general conviction out on the table. I am convinced that a government-run or government-regulated health care system mandating universal health care is the best kind of system--but that there is some room for carefully considered market practices within, or aiming at, and supportive of such care. Moreover, like it or not, it is almost impossible to imagine any universal health plan politically succeeding in any country, and particularly my own, unless it is clever enough to work in some market ingredients in a way that helps such a plan, or at least does no harm to it.

In the European and Canadian health care systems we have, so speak, a long-standing natural experiment with universal care, extending over decades in most

places, and a century in a few. That experiment displays a range of outcomes and qualities that by and large are superior to the jerry-rigged American system that mixes the public and private sectors. The European experience also shows that, if used carefully, there are market practices that can serve the ends of universal health care. It is not necessarily either/or after all. Our problem in the United States is a kind of romantic view of the market that makes it suitable for just about any human activity, and most importantly health care. If there is a clear devil with nasty horns, it is government. As our early President Thomas Jefferson once said, “the best government is the least government.”

There is, moreover, a peculiar feature of the difference between Europe and the United States. When there are tensions and economic difficulties in the American health care system, heavily invested in market practices, the tendency is to look to an increased role for government as a way out. In Europe, heavily dependent upon government, the tendency for over two decades has been to look to the market as a way out.

I want in this lecture to see if some sense can be made of the medicine-market debate, and to ask how the issues are best framed to lead to a fruitful argument--which I do not believe we have at present, at least in the United States. The debate seems to more quieter and more low-key in Europe, but as health care costs continue to rise and more pressure is put on health care systems, more people will advocate for more of a market emphasis to deal with the problem.

A place to start is by distinguishing among three different approaches to the market, one focused on the market and the role of money in medicine and health care, another on the market as a neutral instrument of health policy efficiency, and still another on the market as an important bulwark of democracy in general and of freedom

of choice in health care in particular. While these three approaches can be distinguished, they overlap at many points.

Medical Commercialism and the Market

At the center of a focus on money and commercialism is the tension between the traditional altruistic values of medicine and the centrality of self-interest as a feature of market thinking. Two quotations nicely bring out that tension.

One of them is from Plato, in The Republic: "The physician, as such studies only the patient's interest, not his own….All that he says and does will be with a view to what is good and proper for the subject for whom practices his art."[ii]

The other, better known passage, is from Adam Smith's 1776 book, Wealth of Nations: "It is not from the benevolence of the butcher, the brewer, or baker, that we expect our dinner, but from their regard for their own interest….nobody but a beggar chuses to depend chiefly upon the benevolence of his fellow-citizens."[iii]

A long stream of voices over the years have worried about the impact of commercial values on medicine--the loss of Plato's altruism--most recently the editors of the New England Journal of Medicine (e.g., Arnold S. Relman, Marcia Angell, and Jerome P. Kassirer) as well as such distinguished physician educators as Edmund D. Pellegrino.[iv] They worry about physician entrepreneurs (opening for-profit clinics, referring to patients as "consumers"), the mercenary interests of drug and device manufacturers and their sway over medical research and practice, direct-to-consumer drug ads, and the way a combination of debt and exceedingly good money lure many medical students into medical specialties.

A New York ophthalmologist who advertises on the local New York CBS radio station that he has performed 30,000 laser eye surgeries is vivid exemplar of the crassly commercial model in medicine. Nor is it easy to forget the historical resistance

of the American Medical Association in the late 19th and almost through the end of the 20th century not only at first to group practice of any kind, but later on to a more persistent and effective opposition to universal health care, a.k.a. "socialized medicine." It the medical establishment's way of attempting to maintain economic control over medicine, something they feared government would take from them. Even excessive altruism was treated as a threat.[v]

Yet there is some reason to resist too sharp a line between commercialism and altruism. Plato also recognized in The Republic that, as one commentator put it, the physician was even then "something of a businessman." As long as physicians sell or barter their services to patients as they have always done, commercialism is present (which can run the gamut from benignity to cupidity).[vi] There can be a fine line between a sense of entitlement for hard work and valuable services and sheer greed. For his part, Adam Smith well understood that the market requires a morally supportive culture, one that works to curb excessive self-interest and to instill the virtues of empathy and concern for the welfare of others. That does not always happen.

Of course the problem of money and commercialism goes well beyond doctors and patients. The American health care system as a whole is a combination of for-profit and non-profit hospitals and clinics, insurance companies, the drug and device industry, and companies selling a wide range of ancillary goods and services. The simple fact is that there is money, and good money, to be made in the health care industry, and it serves many purposes other than health: profit, jobs, civic prestige, fine stock market investments. When there is a threat that a community hospital might shut down, there is often as much anxiety about the loss of jobs as about threats to health care. There is not much in American life that is not marked by aggressive

commercialism, and health care is right up there with investment banking as a source of the good (economic) life.

The Market and Efficiency: Instrumentalism

As a profession, health care economists have an important role in health policy, bringing to bear a discipline most commonly oriented to means not ends, efficiency not equity, and empirical research rather than high theory. Now those are generalizations and, in reality, many health care economists do worry about equity.[vii] But the discipline itself nudges economists strongly in what I call an instrumental direction. By that I mean a disavowal of professional competence to serve the inner culture of medicine, to determine the proper political and ethical goals of health care, and to pass judgment on the personal conduct of physicians. Their questions comes to such as these: If one (a nation, a community) has decided on a particular kind of health care system, how might it best work--with what balance between government and market--and which modes of organization are likely to be most efficient? How might financial incentives be used to influence physician and patient behavior for goals of cost or quality?

While there has been a market debate in Europe, it has been far less ideology driven and rhetorically charged than in the U.S. I attribute those traits to a focus by health care economists there on which particular market practice and tactics are most likely to make universal health care systems to work better, whether to control costs or to enhance quality. What contribution could competition make? How much and what kind of price control will be effective in controlling costs without stifling research and innovation?

My impression also is that European health care economists are more willing than their American counterparts to speak out on the need for equity (not understanding that to be outside of their discipline). A European health care economist

who called for a dismantling of a government-run system and turning it over to the private sector would be a striking anomaly; but more than a few with that view can be found in the U.S. On both continents, however, the name of the economic game is the demand for solid empirical evidence to back claims of efficiency, quality, and cost control.

Ideology and the Market: Choice and Democracy

I now come to that group I will call the "politicals." That term characterizes a mixed political and policy group who see the market not just as an instrumental means to achieve efficiency, but even more as a key ingredient of democracy and political freedom. Its economist heroes are Friedrich A. Hayek and Milton Friedman, but it also includes an influential group of neoconservative intellectuals and institutions (e.g., the Wall Street Journal, the American Enterprise Institute, the Heritage Foundation), and most importantly of late President George W. Bush and most Republican politicians.

Their core position (as I read it) is that, in the organization of health care, market and personal freedom are more important than equity (though they never speak that bluntly), and that the private sector will produce better health care than government. Some would add that, if the market is given a full chance, it could eventually lead to de facto universal coverage. Just as the free market is the economic engine of prosperous and productive societies, raising the standard of living for all, so also can it be the foundation of a good health care system. Its main argument is with those who believe that government is the crucial ingredient of a universal health care system, and government bashing--inefficiency, bureaucracy--is a standard refrain of its rhetoric. And that rhetoric, unlike the cool style of health economists, can be hot, sometimes even more than the heat of pro-government advocacy.

My surmise is that because for the politicals the market is seen to play a crucial role in a good society (any good society), its penumbra will affect the culture as a whole and its various political parts. If the market is good for societies in general, it is no less good for its various sub-sectors, including health care. The market as a value is, so to speak, politically and morally supercharged.

Intertwined Values

While the three approaches to the market and medicine I have characterized are distinct, they interact with each other. By and large those worried about the commercialization of medicine and a corruption of its altruistic ideals see market values as the deadly virus. Only a government run, well integrated single payer universal health care system can deal with such a virus; and, preferably, a system where the physician is a salaried employee (as in the Kaiser system or the British National Health Service). That would shut out entrepreneurial physicians, an excessive use of well reimbursed technological procedures of marginal benefit, and a too potent role for pharmaceutical detail men touting the newest and latest drug. Those in this group make some use of economic data, but on the whole rely on clinical information and experience.

It is unclear to what extent the health economists (of the instrumental kind) affect the thinking of those concerned with medical commercialization as a moral concern or those with a political agenda. Some studies in the aftermath of the failed 1964 Clinton health care plan indicated that economists were divided on universal health care and the role of the market.[viii] The distinguished economist Victor Fuchs concluded that, because of their own internal divisions, economists had little influence in that debate.[ix]

While I have not tried to document the influence of health care economists in the market debate, my impression is that those worried about the commercialization of medicine have their own reasons and academic sources, not making use of the mainline instrumentalist economists to buttress their views. For their part, the politicals have their own cadre of economists, using them mainly in support of their own positions. The politicals appear to have little interest in the problem of a commercialized medicine. Indeed, because of their proclivity for a privatized medicine they would not be expected to worry much about it. Actually, neither the instrumentalist economists nor the politicals pay great attention to the impact of market practices on the culture of medicine or medical professionalism.

I have cited these three approaches to the relationship between medicine and the market to make a simple point: there is more than one way to think about the market. While there are some overlaps among them, the problem of the market and medicine can be seen in very different ways. For those concerned with the culture and professionalism of medicine, there is little in a market approach that attracts them; it mainly repels them. While they are prone to support universal health care, it is possible that they would accept some mixed public-private system as long as it supported the traditional values of medicine.

At the other end of the spectrum, the politicals are the most broadly ideological. It is not as if they have examined medicine and health care and then determined that a market approach would be best. They start instead from a belief in the value of the market and then assume that it will be valuable in health care. And for them the market means a rejection of any but the most minimal governmental role (a small, not large, safety net), an embracing of a wide range of market practices, and--most importantly--an embrace of freedom and choice as the highest moral values. By virtue of that last

commitment, there is little anxiety about market failure or a lack of universal coverage. Freedom is a value that trumps all others and the fact that it can create its own problems is no reason to reject it (much as someone committed to democracy would be little swayed to reject it by evidence of the harms that democracy can bring, plentiful though they can be).

The instrumentalists are (at least in principle) ideologically neutral and committed to gathering evidence about the effectiveness of various forms and systems of health care. I have been most influenced by their research, a philosopher who has come to like numbers and data, not just well-honed moral arguments.

Establishing Standards of Judgment

If it is the case that there are three ways of thinking and talking about the market and medicine, does that mean there can be no unified way of doing so? Not necessarily. A full consideration of medicine and the market should encompass each of the three realms I have described: the realm of medical culture and professionalism, of empirical evidence and market theory, and that of ideology and values. Put another way, we should want a health care system that (1) preserves and encourages the traditional values of medicine and the highest standards of professionalism, (2) that in its economic features is based on the most reliable and well-grounded economic theory and evidence, and (3) that its ethical and value foundations works to balance individual good and common good within health care, and no less to balance the well-being of the health care system and all those other collective goods necessary for a decent society (much less commonly considered in health care analysis).

Varieties of Health Care Systems

There are essentially three forms of health care in developed countries:

The American System. The characteristic mark of the American system is its fragmented system of organization, administration, and financing (which many think of as no "system" at all). Its organization encompasses fee-for-service care, for-profit and non-profit group medical practices of many kinds, for-profit and non-profit hospitals and clinics, and government run hospitals and medical services. Its administration can be found at the state level (and within that level at the county and municipal level) and at the federal level, and within the private sector at the corporate level. Its financing comes from the Federal government, state governments, and the private sector (for employee insurance). Lacking any system of universal care, there is no organized effort to guarantee decent health care for all; and, thus, a large number of uninsured. The combination of these ingredients almost guarantrees that the U.S. spends the most money per capita on health care and a larger portion of its GDP on health care than any other nation.

The European and Canadian Systems. While there are a wide range of differences among European and Canadian health care systems, the common thread running through them is a commitment to universal and equitable care and to the value of solidarity as its foundation. No attempt can be made here to summarize the variety of European systems or the Canadian system. However, a few important categories can be noted.

One of them is the difference between the Bismarckian and the Beveridge systems. The former--called social security systems--is traceable to the late 19th century and the regime of German Chancellor Otto von Bismarck.[x] It consists in each country of a number of private insurance plans but plans closely regulated by the government. The plans are funded by mandatory employer and employee contributions, and buttressed by government payment for the health care costs of the

elderly and the unemployed. Some degree of additional private insurance is available in such systems. France, the Netherlands, Switzerland, Belgium, Germany and Israel have social insurance plans.

The Beveridge systems, by contrast, are supported by direct taxation and the systems as a whole are directly run by the government, usually some combination of local and central government management. Private insurance is also available for extra services and avoidance of waiting lists. The tax-based systems include the United Kingdom, Canada, Denmark, Sweden, Italy, and Spain.

If all countries, whatever the system, provide or mandate universal care, they exhibit different attitudes toward the market. In our book Medicine and the Market we discriminate among three such attitudes: a strong, supportive stance toward the market (the United States), strong resistance to market ideas (Canada and the UK), and a permissive attitude (the Netherlands and Switzerland). In the case of the UK, however, "internal markets" have been employed to improve the efficiency of the National Health Service, even though a general resistance to market ideas has remained strong. In the Netherlands market competition among the insurance providers has been encouraged and managed competition pursued in various parts of the system. It is worth noting that two countries, New Zealand and the Czech Republic, embraced a wide range of market practices in the early 1990s, only to decide that they had been a mistake, reverting back to Bismarckian systems.

Though there is a range of responses to market ideas in Europe--mainly centering on its possibilities for increasing efficiency and controlling costs, and not ideologically charged as in the U.S.--some market practices can be found everywhere. No health care system in the world is purely government run or purely market centered; all display a mix. As an aside, outside the scope of this paper, I would note that India

and China, however, provide no safety nets for hundreds of millions of their citizens and thus one can say that, de facto, they are market-based: if one can not pay up front for care, one can not get it. But that neglect seems more a matter of indifference to human suffering than an explicit embrace of market theory.

Evaluating Market Practices

It is useful to divide the impact and value of market ideas into two categories, the tactical and the strategic. The tactical comprises a group of discrete market practices of a kind that are ordinarily used to advance market values. The strategic category is meant to evaluate health care systems as a whole and the relative strength of market-oriented-versus government-oriented systems, each to a greater or lesser extent making use of market practices.

Market Practices

Six market practices are the most commonly employed:

Competition. Competition is at the heart of market theory applied to health care: competition among the providers of care leading to greater freedom of patient choice about the cost and quality of care. While there can be and has been competition on quality of care and the provision of various amenities, its most common use in a market context is that of price competition. In that respect, there can be price competition among physicians for patients (not common anywhere), competition among insurers within universal health care systems (a feature of European Social Health Insurance systems and American health care insurers), competition among providers (such as HMOs), competition among hospitals and clinics, and competition among vendors selling everything from drugs and MRIs to hospital bed sheets.

Cost-Sharing and Co-Payments. While not ordinarily thought of by the public as a market practice, they are, and their use is endemic in all health care systems

(particularly co-payments)--the latter is in fact the most widely used market practice. Their aim is to reduce the costs of health care providers, shifting some of them to patients, and to force patients to take cost into account in deciding on medical treatments. American health care insurers and HMOs make use of deductibles and co-payments, but so also do European systems, even though they frequently waive them for elderly, poor, and other groups of patients. .

Private Health Insurance. There are many things that could be said about private health insurance but I will look at just one. In developing countries it has a special salience: will it suck talent, resources, and political support from government programs--not typically a problem in affluent countries. Canada does not allow parallel private health insurance for the two major tracks of its universal care program (called Medicare), hospital and physician care. Most European countries do allow such insurance and Canada has in recent years undergone a considerable debate on the matter. The Supreme Court of Quebec declared in 2005 a prohibition of parallel private insurance for hospital and physician care to be unconstitutional for that province, but it is not clear whether or when other provinces will follow. In most universal care countries private insurance is used for co-payments, better amenities and faster service and, in Canada, private insurance is allowed for pharmaceuticals, not covered under Medicare in any ample way.

For-Profit vs. Non-Profit, Medical Savings Accounts, Physician Incentives.

I have grouped these last three market practices together because, as a group, they are found mainly, but not entirely, in the United States. For-profit vs. non-profit clinics and hospitals exist in many developed countries but seem to have been studied mainly in the United States. Physician financial incentives for the quality of their care are primarily an American phenomenon. Medical savings accounts are being pushed

by the Bush administration though they have also been used in South Africa and Singapore--though the former eliminated them in 2005.

The Impact and Value of Market Practices

An examination of each of the six listed practices produces mixed results. The evidence on the effectiveness of competition in controlling cost is mixed, working in some places but not in others; its effect on the quality of care is mixed and inconclusive. Cost-sharing and co-payments, but particularly the latter, do reduce health care demand, particularly with low-income patients. The European countries usually exempt the poor and the old from co-payments, reducing any potential health threats, but in general there seems no good body of evidence (except in developing countries) that co-payments directly harm health.

Private health insurance is mainly a serious problem in developing countries where it can lure the best physicians out of the public sector, reduce the interest of the affluent (small in number) in the public system, and gradually weaken that system. It has not proved a serious problem in universal care countries, in great part no doubt because it remains a comparatively small part of the overall systems. As for the last three categories--for-profit/non-profit, medical savings accounts, physician incentives, they display few striking features, other than one. Medical savings accounts will have the most appeal for the affluent, while the other market practices probably do little good or little harm.

The general picture that emerges seems to make clear that the most common market practices have neither great value nor do great harm in controlling costs or improving quality, though they can have some value--but also, depending upon the context, make things worse. Competition has been used with some minor success in the European health care systems but nowhere in a striking way. Co-payments are the

only market practices that are used everywhere. Their ubiquity suggests some consensus on their value, at least for controlling costs.

Market Strategies

By market strategy I refer to the place of market practices in health care systems as a whole and, in particular, the mix of government and market practices in such systems. The basic question is this: which kind of health care systems, market- or government-oriented, provide the best health care for their citizens? Some pertinent standards of judgment are costs, health outcomes, patient satisfaction, and quality. The conclusion I draw from my research is that it is almost a "no contest" competition. By just about every meaningful standard, the European universal health care systems are superior—and, within the European systems, the Social Health Insurance systems are slightly superior to the tax-based systems.

Now it is surely the case that superb medical care can be found in the United States and that those fortunate enough (as I am) to have a good employer provider health care plan are as well off as anyone in the world. But our health care costs are much higher than any other country, a large and growing proportion of people have no health insurance and, by standards of outcome and quality, the U.S. ranks well below most European countries. The Canadian system is not quite as good as the best European systems because of its high costs (second only to the U.S.), it serious waiting list problems, and its poor pharmaceutical coverage. Even so, it is superior to the U.S.

Let me briefly summarize some of the available data. The United States ranks 1st on per capita health care spending;13th among developed countries in life expectancy; many other countries perform better by some standard quality indicators; more Americans believe their system needs a complete rebuilding than citizens of

Australia, Canada, New Zealand, and the United Kingdom; and the U.S. ranks 17th in its citizens' judgment of its healthcare.[xi] Canada and European countries are commonly derided for waiting lists, surely a problem, but they exist in the United States as well, and not all European countries have a serious problem, and at least five have no waiting lists.[xii]

How Do They Do It?

The key to the relative success of the European systems is evident enough: considerable government control and regulation. Physician and other health worker salaries are typically negotiated with the government and are lower than in the U.S. Hospital and clinic charges are no less negotiated, the number of hospital beds controlled, and pharmaceutical prices are usually capped (and, as a result, are considerably lower than in the U.S.). Technological innovations are slower to be accepted, often softly rationed in their use, and their distribution carefully regulated. I have been struck many times by a considerably less driven and enthusiastic drive for improved health and medical technology in Europe, and less media attention devoted to it.

The fact that no European country allows direct-to-consumer advertising as does the U.S., nor does Canada, says much about the difference national attitudes toward the instrument and drug industries. Health care is considered an integral part of European welfare states, and one reason for better health outcomes in Europe is that their welfare systems provide a more solid and capacious safety net, with significantly lower poverty rates--all of which is conducive to good public health. American attitudes toward government-provided health care and welfare have historically been, and remain, different: hostility to government control and regulation, choice taken to be

more important than equity, a love of the market and a rejection of price controls (which is just the beginning of a much longer list of differences).

A note of sobriety is now in order. For all of their past success and continuing good outcomes, the European systems have entered a time of trouble. High unemployment rates, a loss of economic competitiveness, a resistance to still higher taxes, and pressures from a younger generation for more choice and private care, are making market practices more attractive. When European countries find themselves in economic trouble with their health care systems, the only escape valve appears to be an increased market role. That was true in the mid-nineties, during another economic downturn, and is true once again. As noted above, this response is exactly the opposite of that in the United States, where government is more commonly expected to save the economic day. The United States has for years been scratching with its fingernails to move up the mountain to universal care. The Europeans are using their fingernails to hold on to it.

Infinite Technological Innovation

The main force pushing up health care costs in the United States and most developed countries is either new technologies or the intensified use of older ones. The best estimate is that 40%-50% of cost escalation in the United States can be traced to them.[xiii] No comparable figures are available from Europe but there is every likelihood they would be similar or slightly lower. Technological innovations come from research and, while the National Institutes of Health finances much of the American basic research (and thus of the world in great part), the "translation" of that research into clinical application comes from the private, market sector. While there is no doubt gratification in that sector when health-promoting drugs or devices are developed, it is profit and shareholder satisfaction that is the driving force.

The progress being pursued at both the research and clinical level is what I call "infinity" research: the pursuit of more progress and more innovation with no finite, much less, final goals in mind: simply MORE. By virtue of the underlying market drive, its values are utterly relativistic: the market, if left uncontrolled, will develop whatever will satisfy customer preferences and be bought by them. The market, as a set of impersonal techniques aimed at influencing behavior, has no interest in equitable distribution of what it develops; that is someone else's problem, health care systems. The drug companies have only in a lukewarm way pursued the eradication of tropical diseases for one reason only: there are many potential patients but few good commercial prospects.

In considering the market, then, account must be taken of its central place in raising costs, in its unaccountability to few values other than shareholder satisfaction, its bias toward the satisfaction of individual preferences, whatever they may be, and in its attraction to choice as the highest moral value in health care.

At the basis of European and Canadian health care is not a proclaimed individual right to health care (though such language is sometime heard), but that of communal solidarity.[xiv] That notion assumes human interdependence, mutual suffering and threat of illness and death, and the vital role of government in promoting good health care.

By its historical dedication to market theory and practice (not wholly, but heavily), and its individualism, the U.S. has historically made it difficult to enact universal care legislation and has encouraged, through the market, the satisfaction of personal, not community goals. An embrace of the market has no less thwarted any serious attempt to even ask, as a public question, what should count as appropriate, affordable, and economically sustainable medical and health system goals? As a set of

impersonal strategies to manage behavior, the market can not, of its nature, ask such questions, much less answer them.

There is a way to soften the harsh light I have thrown on the market. One can return to Adam Smith to recall the high place he gave virtues instilled by markets: self-discipline, restraint, and prudence, among others, and no doubt such virtues are helpful in health care. One can also recall the empirical work of the instrumentalist economists, showing that the market can, under the right circumstances, foster useful competition and increase efficiency. Nor of course is choice something wrong in itself. Most people want a choice about their physician, some say in the kind of health care they receive; and doctors no less want a considerable degree of choice in the way they medically treat their patients. It is, therefore, hardly out of place to consider possible roles for the market--though it is possible that universal care systems can embody the same values, even if in different ways.

But because of its inability to embody a substantive view of the human good (other than choice and personal preference), or of health, any use of the market must, I believe, be subordinated to universal care systems. It can be used to serve them when possible, but never abandoning the value of solidarity that marks their best practice. Left uncontrolled and unregulated, or allowed to become dominant, the market can be, and often has been, the enemy of solidarity, our human interdependence, and thus indirectly of health as well.

There seems little doubt that, for societies as a whole, the market promotes prosperity, fosters independence and entrepreneurship, and can reinforce democracy. But it is fallacy to conclude that, because the market in general is a beneficent force for societal good, it is therefore equally valid in organizing and running health care systems. I call that the "market fallacy." And I emphasize the word "systems" to

distinguish the use of individual market practices as part of overall systems rather than their dominating feature. There is no evidence anywhere in the world to draw such a conclusion about their system-wide value.

The market rewards strong, knowledgeable individuals, and tolerates the failure of entrepreneurs and commercial enterprises (and the success of others) as a sign of the potency of competition. But the world of the sick is marked by a loss of strength and independence, by a diminishment of self-management, by a painful dependence upon others. Providing the economic and social goods to well manage that combination of human vulnerabilities has not been a mark of the market anywhere, nor is there any reason to suppose they could or would.