Utilitarian Ethics in Healthcare

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Abstract

There are two moral ethical dichotomies in healthcare: consequentialism versus deontology and individualism versus collectivism. When the physician is faced with the dilemma of deciding between one versus many, he often has to resort to the principle of promoting the greatest good for the greatest number, or the principle of maximizing utility. Utilitarianianism is the creed which accepts as the foundation of morals, the greatest happiness principle. It holds that actions are right in proportion as they tend to promote happiness and wrong as they tend to produce the reverse of happiness. It embraces the four component of consequentialism, maximization, aggregation and welfare. This paper analyses the moral implications of applying utilitarian principles in healthcare decisions and illustrate how they relate to the concept of welfarism.

Keywords: Utility, consequentialism, welfarism, morality, well-being.

Introduction

Medicine is a costly science, but of greater concern to the health economist is that it is also a limitless art. Every medical advance created new needs that did not exist until the means of meeting them came into existence. Physicians are reputed to have an infinite capacity to do ever more things, and perform ever more expensive interventions for their patients so long as any of their patients' health needs remain unfulfilled.

The traditional stance of the physician is that each patient is an isolated universe. When confronted with a situation in which his duty involves a competition for scarce medications or treatments, he would plead the patient's cause by all methods, short of deceit. However, when the physician's decision involves more than just his own patient, or has some commitment to public health, other issues have to be considered. He then has to recognise that the unbridled advocacy of the patient may not square with what the economist perceives to be the most advantageous policy to society as a whole.

Medical professionals characteristically deplore scarcities. Many of them are simply not prepared to modify their intransigent principle of unwavering duty to their patients' individual interest. However, in decisions involving multiple patients, making available more medication, labour or expenses for one patient will mean leaving less for another. The physician is then compelled by his competing loyalties to enter into a decision mode of one versus many, where the underlying constraint is one of finiteness of the commodities. Although the medical treatment may be simple and inexpensive in many instances, there are situations such as in renal dialysis, where prioritisation of treatment poses a moral dilemma because some patients will be denied the treatment and perish.

Ethics And Economics

Ethics and economics share areas of overlap. They both deal with how people should behave, what policies the state should pursue and what obligations citizens owe to their governments. The centrality of the human person in both normative economics and normative ethics is pertinent to this discussion. Economics is the study of human action in the marketplace whereas ethics deals with the "rightness" or "wrongness" of human action in general. Both disciplines are rooted in human reason and human nature and the two disciplines intersect at the human person and the analysis of human action.

From the economist's perspective, ethics is identified with the investigation of rationally justifiable bases for resolving conflict among persons with divergent aims and who share a common world. Because of the scarcity of resources, one's success is another person's failure. Therefore ethics search for rationally justifiable standards for the resolution of interpersonal conflict.

While the realities of human life have given rise to the concepts of property, justice and scarcity, the management of scarcity requires the exercise of *choice*, since having more of some goods means having less of others. Exercising choice in turn involves *comparisons*, and comparisons are based on *principles*. As ethicists, the meaning of these principles must be sought in the moral basis that implementing them would require. For instance, if the implementation of distributive justice in healthcare is founded on the basis of *welfare-based* principles, as opposed to say *resource-based* principles, it means that the health system is motivated by the idea that what is of primary moral importance is the *level of welfare* of the people. This means that all distributive questions should be settled according to which distribution maximises welfare.[1]

Understanding Utilitarianism

Utilitarianism is fundamentally welfarist in its philosophy. Application of the principle to healthcare requires a prior understanding of the welfarist theory as expounded by the economist.

Conceptually, welfarist theory is built on four tenets: *utility maximisation*, *consumer sovereignty*, *consequentialism* and *welfarism*. *Utility maximisation* embodies the behavioural proposition that individuals choose rationally, but it does not address the morality of rational choice. *Consumer sovereignty* is the maxim that individuals are the best judge of their own welfare. *Consequentialism* holds that any action or choice must be judged exclusively in terms of outcomes. *Welfarism* is the proposition that the "goodness" of the resource allocation be judged solely on the welfare or utility levels in that situation. Taken together these four tenets require that a policy be judged solely in terms of the resulting utilities achieved by individuals as assessed by the individuals themselves. Issues of who receives the utility, the source of the utility and any non-utility aspects of the situation are ignored.

Healthcare And Welfare Economics

Welfare economics refers to the framework for normative economic analysis that has developed within the neo-classical economic tradition. It studies efficiency and the overall well-being of society based on alternative allocations of scarce resources. It extends the microeconomic analysis of indifference curves to society as a whole. It is concerned with broad efficiency questions and criteria (e.g. Pareto efficiency) as well as the more specific efficiency issues such as those of market failures, externalities, and public goods. Questions which *welfare economics* attempts to address in healthcare would include: "How do we know if

healthcare markets are efficient?", "Is the free market good for healthcare?", "Are people are getting what they need and demand, and how do we know if they are paying too much for health?"

Welfare economics have its roots in the desire of many economists to maintain contact between theoretical analysis and socially relevant themes. A typical characteristic of the "old" welfare economics is the ethical belief that higher material welfare and a better provision of essential goods are desirable targets, even though it is acknowledged that material welfare and utility cannot be equated with general welfare or happiness.

Two elements occupy a central place in "new" or modern welfare economics: the notion of *Pareto-optimality* and the role of *perfect markets* in connection with the Pareto-optimality. The essence of welfare theory is that the performance of economic institutions can and should be judged according to whether they provide economic goods in quantities that accord with people's relative desires for those goods. By "institution" we mean a social structure or arrangement that affects people by affecting how they interact, and it refers to the *market* in this context. In modern welfare economics, economic systems are considered efficient if they display a close fit between the relative terms on which economic goods are made available and people's relative preferences for those goods. The ethical question that is relevant to our discussion is: Why is it a good thing to permit the market mechanism to play a role in generating this close fit?

Moral Perspectives Of The Market Mechanism

The justification in advocating the market as an economic mechanism will have to invoke the language of "*freedom*" and "*value*". The market system is seen as an arrangement through which we are free to choose. The *freedom* here can be seen as either *freedom to act*, such as the autonomy to choose the health services one desires, or as one's *immunity from interference* by others.[2] The achievement in this case is a health state, and the person's *freedom* can come about through his income being high enough to purchase specific health services over and above the "decent minimum" level of healthcare that is provided for him through a system of social security.

Neoclassical welfare theory works on two premises. Firstly, it assumes that individuals know what they want and it is a good thing that they have what they want because they themselves know best what they want. It also assumes that individuals have ends in the same sense that they have tendencies to conduct, and this tendency can be defined and understood. Economics will only ask how their progress towards their objectives is conditioned by the scarcity of means. Whether these ends are noble or base, economics takes them all for granted. In other words, we act as if it is a good thing that individuals have what they want, and as if they know best what they want. The individual's manifest preferences are assumed to be knowable, psychological, verifiable "truths" concerning an aspect of reality that we refer to as "human happiness".

The second premise is the principle of *Pareto optimality*. Put simply, the principle says that the community becomes better off if one individual becomes better off and none becomes worse off. This premise is a good thing, and is a value judgment. The principle is non-controversial but the disadvantage is that it does not provide a complete theory of social choice. The Pareto criterion does not lead to a single best allocation. For a given set of resources, each of many possible allocations of those resources can be Pareto optimal. Furthermore, because nearly all policy changes will hurt someone, an

application of the criterion leads to policy paralysis.

In the area of health policy, it may appear at first glance that most developed countries do believe in the Pareto principle. After all, most countries allow their citizens to spend their own money on additional healthcare services if they wish to go outside of the government sanctioned programme. Yet the reality is such that society has a tendency not to tolerate large differences in access to healthcare. If the Pareto principle were viewed as desirable, insurance companies would be allowed to provide whatever health insurance coverage they wished, but this is not true in real life. An example of health policy operating in conflict with the Pareto principle is when it concerns insurance coverage for new healthcare technologies. Traditionally, when new effective technologies become available, they are viewed as experimental until their safety and efficacy are established. But once established insurers almost always cover them because failure to do so results in strong pressure from the policyholders. If a health policy is such that only well-to-do patients will have access to the new medical technology, it is unlikely that this would enhance overall social welfare. Social envy among the poor and guilt among the well-to-do cannot be assumed to be absent. If public policy were based on the Pareto Principle, then we would see a market-driven gap between the services that are available to the wealthy and those available to the rest of the population. This would result in a reduced social welfare.

The Extra-Welfarist Approach

While the welfare economic framework rests squarely on notions of individual utility and preference as the foundation for analysis, the features of healthcare markets render certain elements of the framework questionable. This is because the role of healthcare in the health production function provides greater scope for third-party judgments of welfare than is the case for many other goods. In the *extra-welfarist* approach, the exclusive focus on utility-based notions of welfare is rejected. Instead, utility is replaced by *health* as the primary outcome of interest for evaluation.[3] For applied analysis, the QALY (quality-adjusted life years) is advocated as a measure of health.

The essence of *extra-welfarism* is that it has substituted "*healthism*" for welfarism. It rejects the principle that the goodness of any resource allocation be judged solely in terms of the associated utilities or welfare levels achieved by individuals. The extra-welfarist framework considers welfarism as inherently limited because utility focuses too much on the emotional responses to commodities and not enough on what these commodities enable one to do. The main problem of focusing on such mental states is *adaptation*. A person suffering from a physical disability can often adjust and live a life full of satisfaction and meaning. An *extra-welfarist* approach can accommodate such concerns in a way that the welfarist approach cannot.

In terms of ethical concerns, the *extra-welfarist* framework shares many weaknesses with the welfarist framework especially in its exclusive focus on outcomes and the unidimensionality of the outcome space. Being consequentialist, any aspect of the healthcare system can have only *instrumental* value for achieving a pre-determined outcome of concern. Actions and processes cannot be valued *intrinsically*. The focus on *instrumental rationality* engenders an overemphasis on efficiency compared to equity. Where equity considerations are included, they are nearly always restricted to distributional equity. In addition, the *extra-welfarist* framework, in which health is the outcome of concern, is severely restricted in its ability to accommodate process utility and individual

values into the analysis. Moral concepts such as *duty*, *fairness*, or *rightness* have value outside their utility effects and are excluded from the range of considerations of the *extra-welfarist* framework.

Concepts of fairness extend to issues other than distributional justice or the distribution of rewards. Concepts of procedural justice also play a prominent role in judging policies and their resulting resource allocation. Procedural justice focuses on process and asks questions like: *How are decisions made? Who is involved in what ways? What factors are considered and what weight do they receive in the allocation process?* Examples in which process considerations come to the fore in health economics are the allocation of organs for transplantation and the rationing of care.

In the allocation of organs for transplant, systems and rules that are perceived as optimal are heavily influenced by procedural justice. This is because the rules do not attempt to maximise the health produced by always giving the organ to the individual who has the highest probability of a successful transplant.

In healthcare rationing a distinction is made between first-order and second-order allocations. In a first-order allocation, the total amount of a resource or service to be provided is first determined. In a second-order allocation, the distribution of the total among those who want a share of it is next decided. It is a feature of market distribution to bring the two orders together under a single institutional framework. Healthcare rationing will however, require different agencies to take the first-order allocations which are concerned with the setting of priorities, separately from the second-order allocations which are concerned with the rationing of care. For the planners and managers who controls the levers of first-order allocations, their job is to get the most from the resources they command, which means that utilitarianism is likely to appeal to them. By contrast, doctors who work the levers of second-order allocations may feel that their professional responsibility is to save the lives of the patients under their immediate care whatever may be the opportunity cost of doing so.

Unidimensionality in the outcome space or "monism" is the other major characteristic of welfarist and extra-welfarist theory. It restricts the consequences considered to a single outcome. In welfarism, that single outcome is welfare, or utility. In extra-welfarism that outcome is health and the extra-welfarist view is that no benefit other than health has a weight in the evaluation. This unfortunately can be at odds with the real life situation. One example is that of genetic screening which has benefits apart from health and such benefits may pertain to the rights of individuals. They provide useful information that helps individuals to make informed decisions about changing their lifestyle and about choosing their marriage partners.

Tenets of Utilitarianism

Apart from welfarism, *utilitarianism* embraces two other concepts. As an ethical theory it gauges the worth of actions by their ends and consequences, and is therefore is said to be *consequentialist.* Consequentialism believes that the right thing to do is to maximise some measure of overall or collective welfare. It specifies a particular structure for ethics in that morally right actions are determined by the non-moral value produced by their performance, be it *health, pleasure,* or *knowledge*, etc. The value is said to be non-moral because it is the general goal of human strivings. The second concept it embraces is that of *aggregation*: the idea that collective welfare consists in the sum of individual welfare.

In its popular usage, the term *utilitarianism* has often been confused or equated with the view that "the end justifies

the means" or that "we ought to promote the greatest good of the greatest number." In this discussion, the term *utilitarianism* refers to the moral theory that there is one and only one basic principle in ethics and that is the *principle of utility*. This principle asserts that we ought in all circumstances to produce the greatest possible balance of value over disvalue for all persons affected. In healthcare, utilitarian thinking would stipulate that whenever there is a choice between different but equally efficacious methods of treatment, patients' benefits should be maximized and the costs and risks minimized. Any other approach would be regarded as an unethical practice.

Strictly speaking, theories about the management of healthcare resources in ways that will maximize the quantity and quality of people's lives are *neo-utilitarian* rather than classically utilitarian. This is because they have substituted "pleasure and happiness" with the "length and quality of life". They may be said to be concerned with maximizing welfare rather than happiness. Nevertheless, the guiding principle is the same. In a situation where resources are insufficient to maximize the health of all individuals, the right and rational course of action is to maximize the health of the group or population as a whole.

In utilitarianism all human actions are to be morally assessed in terms of their production of maximal non-moral value. But how are we to determine what value could and should be produced in any given circumstance? Utilitarians agree that ultimately we ought to look to the production of what is *intrinsically* valuable rather than *extrinsically* valuable.

The intrinsic value of something is said to be the value that the thing has "in itself," or "in its own right." It is a value in life that we wish to possess and enjoy just for its own sake and not for something else which it produces. If one is asked what is good about being healthy and he says "Being healthy is just a good way to be", then he is indicating that he takes health to be non-derivatively good in a way that is intrinsically valuable. Apart from health, examples of intrinsic goods include: life, consciousness and activity, pleasures and satisfaction, happiness, beatitude, contentment, understanding, wisdom, beauty, love, friendship, freedom, peace, esteem, etc.[4]

Intrinsic value is crucial to a variety of moral judgments. In consequentialism, whether an action is morally right or wrong has to do with whether its consequences are intrinsically better than those of any other action one can perform under the circumstances. Since what one is morally responsible for doing is some function of the rightness or wrongness of what one does, then intrinsic value is also relevant to judgments about responsibility. Intrinsic value is also pertinent to judgments about moral justice insofar as it is good that justice is done and bad that justice is denied, in ways that are intimately tied to intrinsic value. Judgments about moral virtue and vice also turn on questions of intrinsic value, inasmuch as virtues are good, and vices bad, again in ways that appear closely connected to such value. For example, undergoing or performing an abortion may not be considered by anyone to be intrinsically good, but many people would occasionally consider it extrinsically valuable as a means to another end, such as the restoration of an ill woman to a state of health. From the utilitarian point of view, this is not what is desired. What we really ought to seek are experiences and conditions in life that are intrinsically good in themselves without reference to their further consequences or extrinsic value.

The Concept of Utility

Utility is a metaphysical and circular concept. It is the quality in commodities that makes individuals want to buy them, and the

fact that individuals want to buy those commodities shows that they have utility. The problem however lies in deciding what counts as utility, and how to objectively aggregate widely different interests in order to determine where maximal value and therefore right action lies. To this end, the question is asked: whether the value-judgment of the utilitarian favour the actual happiness of individuals or does it favour satisfying whatever desires or preferences individuals may have?

Most philosophers incline toward the desire-satisfaction approach. With this approach, the concept of utility refers not to the experiences or mental states, but rather to an individual's actual preferences. This approach is indifferent as regards hedonistic or pluralistic views of intrinsic value. What is intrinsically valuable is what individuals prefer to obtain. Utility is thus translated into the satisfaction of those needs and desires that individuals chose to satisfy. However, the problem of reliance on a metaphysical concept remains. Value judgments must inevitably be made about which preferences should be satisfied, like for instance, drug addicts should be rid of the drug habit, victims of Buerger's disease should stop smoking and patients with liver cirrhosis should abstain from alcohol, etc.

For all utilitarians the *principle of utility* is the ultimate source of appeal for the determination of morally right and wrong actions. Controversy however arises over how this principle is to be applied. Should the principle be applied to particular *acts* in particular circumstances in order to determine which act is right, or should it be applied instead to *rules* of conduct which themselves determine the acts that are right and wrong?

There are two versions of utilitarianism, called *act utilitarianism* and *rule utilitarianism*. Both versions agree that, in some suitable sense, the goal of all morality must be to serve the common interest of society by maximizing social utility. *Act utilitarianism* is the view that a morally right action is simply one that would maximize expected social utility in the existing situation. In contrast, *rule utilitarianism* is the view that a morally right action must be defined in two steps. First we must define the right moral rule as the moral rule whose acceptance would maximize expected social utility in similar situations. Then, we must define a morally right action as one in compliance with this moral rule.

Act utilitarianism calls for the action in each individual case that seems likely to yield the best results on the whole. Each person should act in whatever way that promises to contribute most to the aggregate excess of happiness over misery, taking full account of all effects of all the possible actions compared. In *act utilitarianism*, the morality of an individual's action must be judged only by the overall consequences of a particular action. The only action that is morally justified is that leading to the best overall consequences. The *act utilitarians* is confronted by the question: What should I do now?" and is not guided by what has generally been proved valuable in the past. In *rule utilitarianism* actions are justified by appeal to rules, which in turn are justified by appeal to the principle of utility. In *act utilitarianism* the level of rules is simply skipped and actions are justified directly by appealing to the principle of utility. While the *act utilitarian* considers the consequences of each particular act, the *rule utilitarian* considers the consequences of generally observing a rule.

Using the utilitarian approach in healthcare necessitates an analysis of the situation to enable one to decide what the best overall consequences are. This can be complex. In healthcare, consequences refer to *outcomes of care* and outcomes can be understood in different ways. Firstly, they may be equated as health states that meet individual needs. Secondly they may be seen

in the light of whether they maximise the health gain. Thirdly, outcomes of care may be understood as the extent to which the health gap is narrowed. Of these the commonest interpretation is that of meeting individual needs. This is because physicians work with individuals and are in the business of making them better when they are ill and of helping them to remain well thereafter. Their objective is to improve health of the individual patient by addressing his needs and the effectiveness is measured by the impact the treatment has upon the individual's well-being. Within this core task of medical practice, however, there are other views which move the focus of outcome away from individual patients to groups or populations of patients. Although the broad objective remains meeting the variety of needs that patients present, shifts occur in policy prescriptions of what should be done, to whom, and in what order. Focusing on the health of people en masses may undercut the traditional concerns of physicians in meeting the needs of individual patients. For one thing, individual lives may be accorded a lesser value than statistical lives. Likewise, similar concerns may arise with the parallel objective of narrowing the health gap.

Strictly speaking, an *act utilitarian* should calculate the harms and benefits (e.g. costs and outcomes) of giving or not giving treatment to a patient in every single case to ensure that maximal utility, or health benefit is attained. This would obviously lead to a highly inefficient state of affairs; where a great deal of time will be spent on deciding whether or not to treat individual patients. In many cases it is not possible to make these accurate calculations anyway, because of lack of information. Successfully applying *act utilitarianism* would presuppose an impossibly huge amount of information and foresight about consequences of individual actions – intended and unintended, immediate and delayed. Each physician would have to be impossibly neutral between his own interests and the interests of his patients, his patient's relatives' and friends, and all hospital managers who are involved in the care of the patients, directly or indirectly. In effect, *act utilitarianism* makes each person a law unto himself. It assumes that his moral intuitions were infallible and that he has more factual and theoretical knowledge of many sorts and more prodigious ability to calculate consequences than anyone realistically could have.

Rule utilitarianism does not expect feats of prediction and calculation. Instead, it recommends the following of familiar ethical rules. It values ingrained habits that resist individuals' temptations to deem their own particular cases exceptional. It saves the time and emotional energy that is required for agonizing over each individual case. General observance of ethical rules improves people's abilities to predict and coordinate one another's actions. The logic of *rule utilitarianism* requires people to abide by the rules almost unquestioningly and automatically. Yet the rules themselves are subject to reflective and critical scrutiny by people.

While it is generally agreed that sensible moral norms will promote the interest of individuals and of society, utilitarians go one step further than that. They take the view that the only rational basis for our compliance with various moral norms is the benefit this provides for us and for society as a whole. The assumption is that, in the ultimate analysis, human beings have only two basic concerns – one is their own well-being and the other the well-being of other people. Utilitarianism is based on the assumption that our interests in abstract human values such as freedom, equality, justice, fairness etc. is based on the likely benefits we ourselves and other people are likely to enjoy if these values are widely respected. Accordingly the best moral norms are those that maximise expected social utility.

Whereas *act utilitarianism* focuses on the social utility of our individual actions, *rule utilitarianism* focuses on the social utility of moral rules and codes. Thus *rule utilitarianism* is the view that a morally right action is simply an action in compliance with the optimal moral code. The optimal moral code, on the other hand, is the moral code that would yield the highest expected social utility if it were followed by all members of society. In short, *rule utilitarianism* applies utilitarian tests to rules instead of individual actions and believes that a moral rule is correct if people conforming to it results in more total happiness as compared to non-conformance.

Too Collectivist?

One might accuse utilitarianism of being too collectivist in spirit and that it aims at maximising an aggregate measure of individual utilities without regard to their distribution. Utilitarianism implies readiness to sacrifice the utilities of some individuals for larger increments to the utilities of others. It supposedly calls on each person to work for greatest total utility while at the same time remaining impartial between his own and other persons' aspirations. Many have faulted utilitarianism for taking as its criterion not the diverse welfares of actual individuals as experienced by each but rather some impersonal aggregate utility. As such, utilitarianism is seen to treat the individual only as a unit. In submerging a person's pay-off to an anonymous sum total, it is in effect, inviting him to merge his individuality in a collective whole. Only the aggregate counts, and the individual is a mere cell in a larger organism. Utilitarianism fails to pay attention to the important value of autonomy and fails to articulate a satisfactory conception of justice or respect for persons. It regards each person as a mere processing station for converting goods and experiences into contributions to an impersonal aggregate utility. Individuals are regarded as passively receiving goods rather than as actively engaged in producing them and agreeing on their distribution.

Assessing such charges requires the distinction between *identified lives* and *statistical lives*. The notion that utilitarianism cares only about experiences, not persons become baseless once this distinction is clear. Regarding individuals as *statistical lives* and not according overriding privileges to any of them has a lot to do with the fact that moral philosophers need a detached mental state to develop their ethical arguments in an aura of impartially. Misrepresenting a detached philosophical mood as the stance of a collectivist maximiser is just that misrepresentation. Experiences cannot occur apart from the people having them. Society as such cannot experience satisfaction and frustration. Utilitarians care about experiences because they care about the persons having them. A good society is one that diverse individuals would find it good to live in, one that a person taken at random would find most conducive to his own successful pursuit of happiness.

Almost any action or policy, compared with an alternative, puts some persons at a disadvantage. For instance, a program of vaccination might save millions of lives but harm or even kill a few persons who would have escaped the disease anyway. Policies concerning drug testing necessarily involve trading off greater pleasure, convenience, economy, and even life for many against risk of harm or death for a few. Such programmes and policies are sometimes agonising but necessary choices. Must we consider such policies and actions as immorally sacrificing the interest of a few to the greater interest of the many? It is justified to reject any policy whatsoever that might leave some participants with less attractive prospects than under some alternative policy?

Concluding Remarks

The central thesis of utilitarianism and welfarism is that ethics has ultimately to do with ensuring that lives go well. John Stuart Mill has defended the case of welfarism using a hedonistic approach, by saying that happiness is desirable, and the only thing desirable as an end. All other things are considered desirable as means to that end.[5] We know that this argument is faulty as people are psychologically capable of valuing and pursuing ends other than happiness. Since one can have ends other than one's own well-being, his welfare cannot simply be identified with the achievement of whatever he chooses to aim for.

There is therefore more to welfarism than ensuring that lives go well. Welfarism is a monistic theory of the good, and as such it affirms the foundational unity of ethics and promotes only one kind of value, that of well-being. *Monism* claims that all things, no matter how many or of what variety, can be reduced to one unified thing in time, space, or quality. It asserts uni-dimensionality in the outcome space. We have seen how this single outcome dimension is represented by utility or health depending on the welfarist approach being used.

In conclusion, although economic and moral principles are different, they can and should be converged to guide personal economic interest and goals. Each person is both an economic and a moral agent. The economic person can survive and work out his destiny only by using the resources of the material world and converting them into useful goods and services in collaboration with other persons in his community. As self-knowing and self-judging persons, people use material means and objects also to express their thoughts and feelings and to bond with others. Self-interest is not synonymous with selfishness but reflects the duality of the body and spirit. While economics is essential for making a living, health economics is essential for living itself. The moral economic agent in action is not only individual, but social, wanting not only health but sharing them, not only pricing health services, but valuing them, self-interested but yet bonded to the greater social good.

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