Encyclopedia of Global Bioethics
DOI 10.1007/978-3-319-05544-2_106-1
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Commodification

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Abstract

Commodification is a challenge that deals not only with the payment for health care but also with the price of the human body. Commodification is somewhat a new concern in bioethics since money and markets have been traditionally ruled out of medicine in order to favor an extra-patrimonial approach to healing the ill. In the last 60 years, the amazing surge of medical technologies has further forged the relationship of health care with money, contributing to an ever-growing market of medical insurance. The need for new goods (mainly biotechnologies and insurance) in health care has clearly begun its commodification. The current commodification of health care is described as a social involution based on individual egoism and is deplored for its lack of social solidarity. Certainly, the market is an unequal factor for welfare distribution – the amount of money we hold is never the same among us nor even the same as time goes by. The commodification of medical care is backed by a neo-utilitarian/libertarian ethics that considers any issue to be seen not only as an individual situation but as a possibility to help all people live better, thanks to the market.

Keywords

Price; Body; Dignity; Freedom; Allocation of health resources; Justice; Market

Introduction

The word "commodification" is an economic term, first coined by Marx in the opening chapters of his famous work, *Capital: Critique of Political Economy* (1867), to condemn the reduction of human beings as mere goods, thus allowing for the possibility of placing a price on human life across all fields. Since Marxist studies on commodification (particularly in relation to labor to support his theory of social alienation), the term "commodification" has been used to describe a widespread trend that identifies human actions as subject to economic values rather than moral or social values. The dividing line is that where moral or social considerations emphasize an ideal, economic values are underpinned by the importance of an exchange of goods. In this latter context, human deeds can be steered by economic values, leading us to treat humans as tradable goods. The consequence here is to take into account only production costs and monetary value, key contributors to establishing trade conditions. Moral intent or the social significance of human actions is discarded. It then follows that applying current market rules to all human activities goes beyond the traditional notion of commodity pricing (as with bread or to wood) but is extended to everything regarding our needs such as paying for air (i.e., carbon tax) or for water (a paid good in our urbanized world).

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DOI 10.1007/978-3-319-05544-2_106-1
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History and Development

As regards medicine, commodification is a challenge that deals not only with the payment for health care but also with the price of the human body (such as sperm or even the heart). Generally speaking, commodification refers to extending all aspects of economics to humans. Nowadays, the word "commoditization" is used in business theory to add a positive connotation to what has been transformed into simple commodities in market perspectives. Actually, the two terms are interchangeable. They both aim to analyze the process of making commodities out of things not previously available for trade – of rendering "salable" what was not for sale.

Commodification is thus a growing global phenomenon that makes money the paragon of everything. Simply put, this means that we can do something only if we have enough capital to afford it or if there is some money to be made from doing it. At this point then, there is no right to freedom if one does not have the money to complete a free action (I am free to travel but I need the money to do it). For this reason, Marx criticized human rights as being only formal assertions disconnected from economic realities. Where Marxism seeks the emancipation of economic inequalities, the new theory of commodification takes the individual will as the reference to act in a way or another – a will only limited by the amount of money one has. Inequality among individuals is not a major point to consider in this perspective. As a result, all moral values (freedom, love, charity, etc.) end up depending on their own commodification, that is, once they are put into action, they can be defined.

For bioethics, commodification is used to focus on the possibility of either paying for access to a medical care or placing a price on the human body. Commodification is somewhat a new concern in bioethics since money and markets have been traditionally ruled out of medicine in order to favor an extra-patrimonial approach to healing the ill. Besides, medicine has been perceived as primarily a public matter as medicine is used not only to cure individuals but to prevent epidemics that are liable to threaten everybody as well. Nevertheless, apart from a few exceptions of global medical threats (i.e., the Ebola epidemic now), at present health care is considered more and more a private concern, open therefore to market rules.

Questioning the role of money in the relationship between a doctor and patient is traditionally perceived of little importance. Thanks to the Hippocratic Oath, medical deontology does not refer to the cost of health care but rather to the nobleness of the art of medicine; being a physician also means healing the poor and even the enemy! And, as included in the Hippocratic Oath, medical knowledge is to be kept secret, therefore not a merchandise to be exchanged for money or goods. In Europe, the hospital as a public institution was developed with reference to the Holy Bible in the early Middle Ages. Doctors were taught to act in the spirit of Jesus who cured the ill, and the King was to guarantee free access to hospitals (named *Hostel Dieu* – or God's hospitality – in France). At the time, medical knowledge was transmitted by mystical Muslim circles (especially Sufism) in Africa and India, which was certainly not a commercial business. Historically, the close link between religion and health care can be found in many other cultures as many diseases were thought to be instigated by divinities or God (such as the jinni in the Sunna). In some African cultures, the close ties between religion and medicine created a context in which there were no set fees for healing, such that patients gave what they could afford, hence either completely exempting the poor from payment or giving them the liberty to pay upon recovery. However, issues of poor patients absconding following healing sometimes occurred (Wall 1988) Nevertheless, these sets of examples generally show that the physician – across diverse cultures – was never considered a merchant but as someone to be considered almost priestlike (or a wizard in Amerindian cultures). Money was not the issue, although there could be offerings dedicated to God.

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DOI 10.1007/978-3-319-05544-2_106-1
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Conceptual Clarification

Even if the development of modern medicine secularized the social function of the physician, the medical profession remained rooted in the idea that money is not a crucial element of health care as physicians generally remained committed to a public service to save lives at whatever cost. In the nineteenth century, the *birth of the clinic* was inspired, as Foucault noted, by the ideal of having a noble public mission to observe illness and disease. The creation of the Red Cross (and then the Red Croissant) accomplished this financially unmotivated quest for curing the ill. Furthermore, the use of the word "patient" (and not the economic term "client") to indicate the ill is another obvious element to understand the long-standing reluctance of using economic expressions in medicine. An even more apparent fact is the legal status of the relationship between a physician and patient that was only referred as a contract at the beginning of the twentieth century. A contract designates an exchange (in this case, money for medical skills). Initially, this legal concept damaged the tradition of the medical profession as autonomy from money. For centuries, it was argued that the criteria for a contractual exchange could not be respected since medicine is not a predictable science (implying the uncertainty of the object of the contract) and that the patient could not understand the medical knowledge (no exchange of wills). Although these arguments are still valid today, these points were overcome with the development of medical biotechnologies that enable physicians to assess a patient's risk.

The notion of risk in contemporary medicine was the turning point that enabled doctors to accept legal liability by acquiring the consent of a patient informed on medical risks and the coverage of those risks through insurance, constituting the object of the contract. The idea of risk relies less on the physician's knowledge but rather on the predictability of using recent biomedical techniques. The advent of our biotechnological society after World War II has also profoundly transformed the medical profession. Since medical techniques play a greater determinant role in curing the sick, their costs have radically influenced the financial burden of health care. The doctor-patient relationship is no longer a pact accepted by the physician (which today would be seen as paternalism) but as a contract in which money plays an important part.

Ethical Dimension

In the last 60 years, the amazing surge of medical technologies has further forged this relationship with money, contributing to an ever-growing market of medical insurance. The need for new goods (mainly biotechnologies and insurance) in health care has clearly begun its commodification. The costly allocation of medical resources is another element to bear in mind in order to understand the process of commodification. Indeed, the need to provide medical care to all citizens (health welfare) has been driven by cost and funding possibilities. After World War II, many European countries opted for a partial public financing of health care. In order to provide medical care for all, many European countries, as well as some Latin American countries (such as Costa Rica and Mexico), decided to give health-care control to the State. In the following decades, this model was adopted by many African and Asian countries.

It is also important to note that well before World War II public control of medicine was already established in as much as there was on so far as the legal monopoly of doctors able to practice medicine was guaranteed by the State. The reason was for public health and safety. This dual public control of medicine (access to the title of medical doctor and access to health care) in most countries of the world has enabled the State to define what can be accepted in medicine. Private money could not bypass the State's control of health care. This State power over public health was dubbed "biopolitics" by Foucault. Nevertheless, biopolitics is not a genuine commodification of medicine since it is defined as a public

good controlled by the State. However, the current debt crisis has recently forced many countries to abandon part of their public aid, and an emerging insurance market focused on medical goods is gaining ground. This is however a general reflection of the sociological notion of the smaller facets of society responding to the larger influences and realities embedded within the larger society.

It is worth adding that the USA has always readily accepted a strong commodification of medicine. For instance, at the beginning of the twenty-first century, while medical research on human embryos was forbidden, the ban did not apply to privately funded research. And in 2014, the USA forced its citizens to subscribe to State-supported medical insurance. Today, the global commodification in the distribution of health-care resources and medical resources has taken a new twist based on the insurance market. Even the State's monopoly on granting medical titles (which also have obvious positive economic consequences for medical doctors) has been challenged with the uptake of alternative medicine which is totally market dependent and driven. The transnational competition among physicians, made possible with the Internet and low-cost travel, has created the so-called medical tourism, reinforcing the commodification of health care. Ethically speaking, it is obvious that judgment of the commodification of health care is mainly twofold: it can either be seen as an unfair practice that favors the rich and neglects moral values or as a way to give incentives to talent and freedom.

As in all discussion on bioethical issues, one's own ethics will be the starting point directing answers on the commodification of health care. For instance, people who share the Kantian idea of human dignity are likely to condemn it. As it was previously seen, the concept of basing access to health care solely on the availability of money appears to be in flagrant contradiction with the universal right to health. Since the commodification of the medical profession opens up the possibility to place a price on the human body, it would be repugnant to Kant's followers: the human body can never be a simple means (a good for something) but should always be considered as an end outside all markets. On the European continent and in many South American and African countries, the legal code has reflected this Kantian principle and confirmed that the human body is a protectionist issue. From this viewpoint, the selling and buying of any part of the human body is strictly forbidden by civil and criminal laws. To give some specific examples, it is not allowed to market blood, sperm, oocytes, embryos, surrogate pregnancy, or human organs for transplantation. Even participants in clinical trials cannot be paid in these countries (only a compensation for associated costs can be considered). The Kantian approach is very influenced by a secularized Christian idea of the sanctity of human life that is now called "dignity."

This is also a holistic approach to bioethical issues which are always analyzed in an abstract, general, and legal way. Dignity is a word quite often used in bioethics. One strong example is found in the aim of the Universal Declaration of Bioethics and Human Rights (2005): "to promote respect for human dignity" (art.2.c). Here, dignity refers to an ontological dimension of the human being. A clear illustration of ontology can be shown with the case of slavery: owning a human is against human dignity. Human beings are not goods by nature and, as a result, they cannot be owned. Nevertheless, one could object that slavery has had a legal status for centuries! From this example, we see that dignity is to be defined as a meta-legal principle to which we are bound regardless of the law. However, things are more complicated when it comes to medical care.

Even if it is easy to agree that buying human beings is against human dignity, such an assertion runs into difficulty when extended to human body parts. It is possible to strictly maintain the prohibition and, as Kant wrote, always refuse to pay for human body parts – not even for human hair! On the contrary, one can affirm that you can price hair or sperm or even a human heart! At this point, even if the exact domain of human dignity remains a hard issue in medical care, dignity has an ontological limitation to the commodification of medical care: the right to health cannot depend just on money – that would be against human dignity. This is based on the egalitarian vision of human dignity which cannot accept health care that cures people only on the basis of money. Those who oppose the commodification of medical care

Encyclopedia of Global Bioethics
DOI 10.1007/978-3-319-05544-2_106-1
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ought then to do it as a defense of human dignity. On the other hand, those who deny this can develop the fact that health care cannot insure everyone and forever as part of a right to health.

Dignity appears to be a word that can heuristically justify public health assistance (health welfare) as it can indicate the State as a chief stakeholder in health-care system to distribute medical resources (biopolitics) and it can point out market-controlled health care (commodification) as social discrimination. Dignity is a term that compels us to look at the egalitarian right to health as being a mark of social progress (as was understood in the Enlightenment philosophy). As a result, the current commodification of health care is described as a social involution based on individual egoism and is deplored for its lack of social solidarity. Furthermore, the word dignity can also be taken up to refuse specific medical acts (such as selling your blood in France) or to prevent the rise of new medical biotechnologies (such as paying for research on human cloning). In this Kantian egalitarian perspective, dignity is the totem of human life which no one dares to attack.

Opposite to this, individual merit is a strong argument for favoring the commodification of medical care. Certainly, the market is an unequal factor for welfare distribution – the amount of money we hold is never the same among us nor even the same as time goes by. With this point of view, the egalitarian definition of dignity is challenged in order to find a definition of dignity based on one's individual merit.

Even if the word "commodification" has a negative connotation, it can be accepted as a way for individual merit to flourish. Far from trying to radically change humans, a positive outlook of commodification can be accompanied with the respect of personhood (or dignity). First of all, recalling that commodification is the synonym of reification, which literally means turning a person into a good or a "res" if we stick to the Latin etymology of reification, and bearing in mind that Roman law was founded on the difference between the person (*persona*) and goods (*res*), many civil codes throughout the world are heirs of the Roman law, and, as part of that heritage, Roman law cleared the way for any confusion between the person and goods, *persona* and *res*. Nevertheless, Roman law lays the emphasis on the freedom of the person in order to establish what dignity (*dignitas*) is, whereas goods have no will and have no dignity. Here is the strong metaphysical difference between an egalitarian dignity based on an anonymous approach and a utilitarian dignity founded on an eponymous approach.

Certainly, the common point between the Roman law, Kant, and Marx is to refuse to treat human beings as goods. Nevertheless, in Roman law, the word *dignitas* was used as a synonym for the current English word "merit" (taken from *axia* in Greek). As a result, dignity was to be acquired, not granted. Whereas modern philosophy gives dignity and freedom an egalitarian anonymous definition, Roman law sought an elitist eponymous explanation of dignity based on one's merit. Merit was the mark of the free citizen; therefore, he could never be obliged to be treated like a good. In the wake of Roman law, libertarian authors (like Tristram Engelhardt) today insist on the notions of merit and freedom to support the commodification of medical care. The libertarian statement is that from the moment an individual has the will and the money to undertake medical act, he cannot be prevented from doing it. From this standpoint, the State has no public fundamental right to impose on individuals as long as the whole community is not threatened. The State ought to be a simple coordinator of individual needs in daily life. The notion of merit is not a formal right; it has to be rooted in reality. One deserves to do something from the moment he has the means to do so. Following the utilitarian philosophers Bentham and Mill, the correct understanding of freedom for the advocates of commodification of medical care is based on the individual's consciousness. There is no universal reason but an unassuming recognition that individual experiences will frame perceptions, appreciate feelings, and motivate the will of individuals. A few illustrations from bioethical case studies can be useful to understand the utilitarian point of view on the commodification of medical care.

The rapid development of medical biotechnologies in the last 40 years has provoked new moral cases that implied a certain commodification of health care. The first bioethical milestone was the birth of the

DOI 10.1007/978-3-319-05544-2_106-1
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first baby after an in vitro fertilization in 1978. The first critique laid against this medically assisted reproductive procreation was that life is a gift and not a good; as a result you cannot plan to reproduce artificially. This argument is still upheld today by the Catholic Church (Bauzon 2011). But in many countries now, the in vitro fertilization technique has been legally accepted on the premise that everyone deserves to have a baby. People who cannot have children suffer, their feelings are strongly hurt, and their freedom is violated. The question of financing this medical technology is another interesting issue. In order to have it accepted, some countries have favored the public financing of in vitro fertilization in the name of an equal right to all sterile couples. Other countries have maintained that this technique is liable to destroy human embryos and thus prefer private funding in order not to have citizens/taxpayers criticize public choices. In most developed countries, in vitro fertilization is perceived as a private matter (in which the idea of suffering takes over any other arguments to the point of accepting, e.g., the third donor of gametes in in vitro fertilization in order to avoid hereditary genetics disease). The main question remains, however, about the high cost of this medical biotechnology (a reason for which it is not quite an issue in poor countries). In the end, the utilitarian perspective has prevailed on this polemic issue: the medically assisted reproduction of human life is seen as a good, and the cost of it is mainly left to the private insurance market. In 40 years, even if the ritual words about the respect of human dignity have been pronounced, in vitro fertilization has become a market affair.

The prevalence of individual choice over public decision in the medical field as a factor of its commodification can also be illustrated in a rather old case: cosmetic surgery. After the disgraceful atrocities of World War I, many injured soldiers were so maimed that cosmetic surgery was the only way to restore devastated faces. The success of cosmetic surgery in the 1920s caused an intense legal dispute. The debate was whether it was acceptable to undertake cosmetic surgery only after an injury or even when an individual resented a natural deformation. The suffering of the person (e.g., an ugly nose) was finally legally accepted. In the 1950s, cosmetic surgery was also accepted in cases of psychological suffering (i.e., a disgraceful nose) and in the 1980s for any kind of suffering (simply wanting another type of nose). In this case, the process was to allow individual choice to prevail. However, cosmetic surgery soon evolved into a business.

The word dignity as an individual worth triumphed: the modification of your body can be performed as you please; it is after all your own good (Bauzon 2006) . Again, the costs are very high and mainly financed by private funding (and now mentioned in many medical insurance policies). The dignity of the individual implies being able to refuse suffering where anyone deserves to feel good about his/her body. Cosmetic surgery is now a massive worldwide medical business and hence a good example on the process of the commodification of medical care.

Cosmetic surgery – and just about all kinds of medical treatments – also demonstrates the advent of medical tourism which is bolstered by the global use of the Internet. For instance, there are many advertisements on the Web for European customers willing to go to Turkey or North Africa or for North Americans to go to Brazil, Mexico, or Costa Rica to receive cheaper medical goods they could not afford at home. Medical tourism is a strong motor in the commodification of health care. Here the deal is clearly about the business of medical goods that one finds too expensive in a domestic market or for which access is illegal.

The case of surrogate mothers, who “rent” their uterus to carry someone else’s pregnancy, is another case of the commodification of health care. A few minutes browsing the Internet leads to a barrage of information on various clinics, prices, and procedures (almost as easy as renting a flat). The countries where the practice is forbidden, often inspired by Kant’s philosophy, must now legally manage newborn babies of their citizens who used surrogate pregnancy abroad. Sterility has always been seen as a tragic situation, where it is difficult to accept not having offspring in the name of the Kantian interpretation of human dignity that bans placing a price on the human body. In fact, the payments given to surrogate

DOI 10.1007/978-3-319-05544-2_106-1
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mothers are the reason that led some countries to prohibit it. But actually, it would probably be even forbidden in the case of a surrogate who would do it for free since this could be seen as a form of exploiting women and violating human dignity. It should be noted that surrogate mothers are often not desperate poor women whose economic distress is being exploited. American sociological surveys show that most are women who want to improve their standard of living, such as obtaining money for a car. On the other hand, those who seek to "rent" a woman's womb are desperate for they suffer from not having a child. The ethical debate on the legitimacy of paying for a surrogate mother will likely follow the path of cosmetic surgery, as seen by the growing number of countries that have accepted it. Perhaps, the bioethical issue about selling specific human organs might also be accepted, as it is already in countries like Iran (where kidneys can be sold) and Singapore. Today, the major problem deals with the global shortage of human organs needed for transplants. The prohibition of buying human organs is being challenged since it seems that the commodification of health care could help provide human organs. The individual free choice of selling his/her organ can be understood; it is, for example, a way to leave money to relatives after death. The price of human organs would influence the cost of transplants since the good would no longer be free but more human organs would be available. Commodification of medical care can be positively seen as a way to increase the amount of human organs on the market. The commodification of human organs is still out of the political agenda in most countries, and the mere mention is often rejected by a majority of people.

Nevertheless, libertarian and utilitarian scholars support the idea due to the lack of human organs. Their approach will not be easily accepted since it appears to be a brazen violation of the egalitarian tradition of human dignity. On the other hand, the suffering (not to say the death) of thousands of people could be avoided if the freedom of selling one's organ were implemented. Once again, the utilitarian vision of avoiding suffering and of freeing an individual will enter into conflict with all the current legislations based on the Kantian notion of dignity. Perhaps when new biotechnologies can replace body parts, a determining argument against the commodification of health care will disappear. For instance, in the case of human transplants, the lack of human organs would no longer be a problem when biotechnologies could substitute human organs. Nobody ever condemned the South African athlete Pistorius for having artificial limbs! Apart from some futuristic outlooks on the advent of transhumanism, there is little evidence for the time being to imagine that the problem of the access to human organs will soon disappear. In both cases, the cost of human organ transplants is and will remain high.

The commodification of medical care is backed by a neo-utilitarian/libertarian ethics that considers any issue to be seen not only as an individual situation but as a possibility to help all people live better, thanks to the market. Nevertheless, it does not mean to give an absolute power to private property, but public affairs are still considered. Another specific example is the case of protecting medical patents. Until now, the possibility to patent drugs has been defended as a way to protect investments that would otherwise diminish. The creation of new elements – and not just the mere discovery of natural components – is meant to be entitled as private property. As a result, the patent holder of a pharmaceutical treatment is authorized to ask for money each time the invention is used. The protection of the property of the drug is declared in a general and abstract way. Now, as it occurred in India in 2007, if the cost of the patent is too high to save people from suffering from AIDS and at the same time the possibility to duplicate the drug is possible, the application of utilitarian ethics (individual case and suffering of a great number of people) justifies the refusal to pay the patent. The already-commoditized medical drug (private property of invention) turns here to be challenged by the technical possibility to duplicate the good to sell it at another price for the sake of the majority. Patenting drugs then not only prevents the diffusion of pharmaceutical treatments but also blocks the inventor by producing a similar drug at lesser cost and/or of better quality. People learn from imitating others and competing with one another. Here, the dynamic view on the commodification of medical care contradicts the current static defense of the private property of pharmaceutical patent.

DOI 10.1007/978-3-319-05544-2_106-1
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Conclusion

Seen from a global perspective, the commodification of medical care partly reflects the development of new medicine based on biotechnologies and partly echoes the way societal values and ideologies shape the principles and laws that guide medical practice. These determine the kinds of tensions that arise to the increasing commodification of health care in particular countries and climates. The cost of medicines has become much too dependent upon all the biotechnological innovations that are redefining the medical infrastructure. The defense of human dignity is placed as a structural ethical value that leads humans to respect one another. Nevertheless, dignity cannot be a term used to deny people free choice in the way they want to be cured. Since being cured nowadays implies paying a lot of money for the medical infrastructure, it is realistic to say that the process of the commodification of medical care is set to continue.

Cross-References

► Commercialism and Health Care
► Consent: Informed
► Health Insurance
► Law and Bioethics
► Life, Value of
► Medical Tourism
► Organ Trade
► Professional-Patient Relationship
► Quality of Care
► Risk
► Welfare

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Further Readings

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