



Training School – Value Based Health Care Model implementation in AFE care services
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Cultural adaptation of VBHC Model

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The purposes

- To critically analyse the value standardization throughout the processes of implementation of the VBHC model
- To offer an alternative way of health care value conceptualization

The main concepts

- political economy of biotechnological promise (Sturdy, 2017)
- material-semiotic structures (Law, 2019)
- discursive purification of science (Latour, 1993)
- critical capacities (Boltanski, 1990, 2011; Boltanski & Thévenot, 1999, 2006)
- political subsystem (Béland et al., 2018; Simons & Voss, 2018)
- assetization (Birch, 2017)
- systems of ideas (Dumont, 1983)
- the voice of lifeworld (Mishler, 1984)
- affordances (Gibson, 2015[1978])
- material hunger (Bloch, 1986[1959])
- technological dramas (Pfaffenberger, 1992)
- ethical value (Lambek (2008)

Locating value-based healthcare (the context)

The political economy of biotechnological promise *iron triangle*

Precision medicine needs the technologies produced by digital health, such as digitization, quantification and imaging technologies to fine-tune its accuracy;

Digital health needs precision medicine to address the real (bio)technological needs as these are diagnosed by technoscience researchers.

Value-based health care which can be applied without either of the other two areas of knowledge, will be more **efficient** if the **effectiveness** of diagnostic methods and associated therapies is high, which is the main goal of the precision medicine – digital health axis.

Digital Health

Precision Medicine



Value-Based Health Care

Precision Medicine

Precision medicine is a set of practices that seek to **adjust medical treatments according to the genetic variability of individuals and the socio-environmental context** in which they live. Due to this genetic-environmental interference, everyone has different organic characteristics that require different clinical and preventive approaches. The goal of precision medicine is therefore “to classify individuals into subpopulations that differ in their susceptibility to a particular disease or their response to a specific treatment.” (The National Research Council, 2011, cited by Ginsburg & Phillips, 2018: 2).

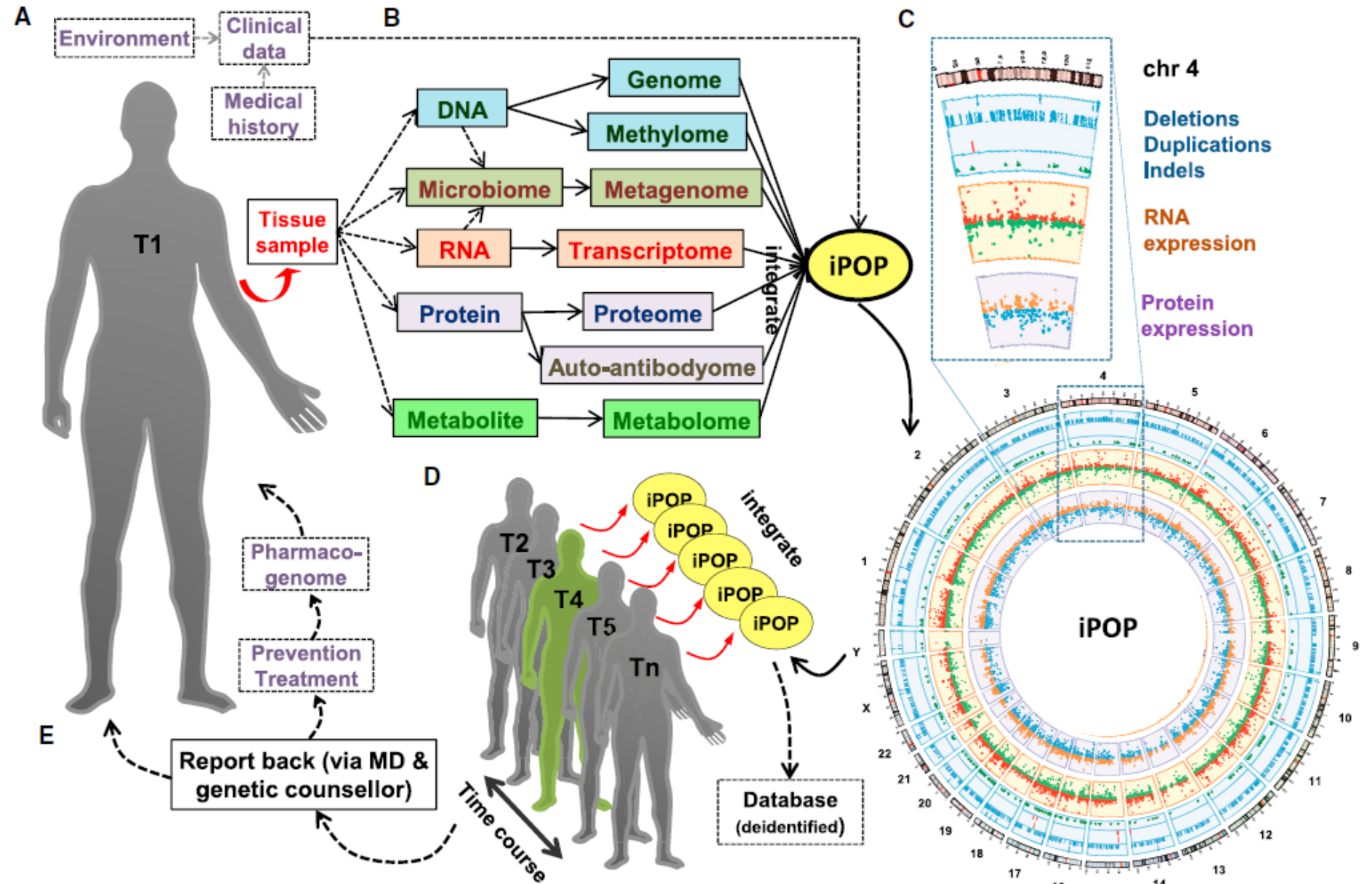
Digital Health

Digital health is supported by the application of biosensors of biometric signals which circulate along informatic infrastructures where they are crossed with other clinical data previously recorded in analogue media in order **to connect** patients and healthcare and/or health education professionals (doctors, personal trainers, physiotherapists, etc.).

The confluence between precision medicine and digital health results in the production of large amounts of data (the **big data**) that will inform clinical practice.

The remote aim is to complete a *panoromic*, or a **panorama of all the omics** that influence the health of individuals and populations (exposome, epigenome, microbiome, metabolome, proteome, transcriptome, genome, image, biosensors, graphs), as if it were a human geographic information system (Topol, 2014), leading to a **personalized medicine**.

The ultimate outcome of such panoramic will be a graphic where the data of all those omics are assembled so that each individual has his own integrative personal omics profile, or iPOP (cf. Li-Pook-Than & Snyder, 2012)



The promise

- “the ability to prevent disease, promote health and reduce health disparities in populations by (1) applying emerging methods and technologies for measuring disease, pathogens, exposures, behaviours and susceptibility in populations; and (2) developing policies and targeted implementation programs to improve health” (Khoury & Galea, 2016: E2).
- One of the cornerstones of this ecosystem’s functioning is that “all stakeholders... are involved in shaping [the] system” (Ginsburg & Phillips, 2018: 3), which makes the health system itself an intelligent, dynamic and continuous learning system (Ginsburg & Phillips, 2018).

The hegemonic contingencies

What is **beyond the technical core** of the system reveals the forces involved in the attempt to establish the **hegemonic contingencies** that shape the sociotechnical systems' practices and outcomes. In this sense, the ramifications of the precision medicine ecosystem are precious indicators for us to analyse its **political economy** as they uncover **the *deep play*** of the new biopolitics (cf. Fischer, 2004). These ramifications include...

“... governments as sponsors of precision medicine research and regulators of precision medicine products, industry as partners in development and commercialization of precision medicine products, professional associations as enablers of the training... of researchers, providers, and policy analysts, and payers who evaluate the appropriateness of precision medicine interventions and the financing that support their use in health care ”(Ginsburg & Phillips, 2018: 3).

The playing field of health care value policy

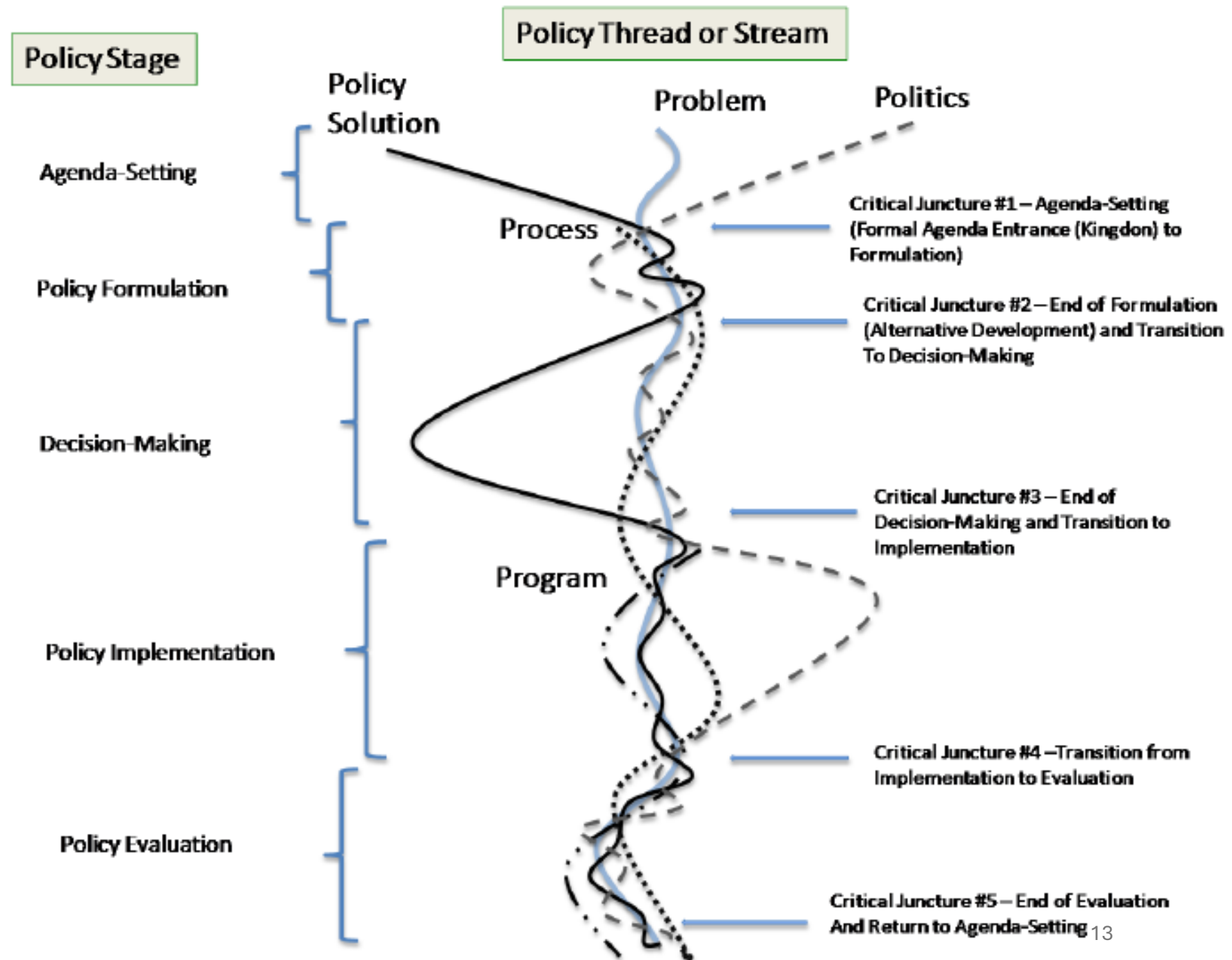
A **political subsystem** is a “mostly undifferentiated group of actors originating in widely different areas of state and society who are united by a mutual concern for, and knowledge of, a specific policy area. They are not necessarily self-interested but share some ideas and knowledge about the policy area in question, which sets them apart from other policy actors” (Béland et al., 2018: 1-2)

The political subsystem is made up of three functional groups of actors, whom by this means, become **policy entrepreneurs**: the **advocacy coalitions**, the **epistemic communities**, and the **instrumental constituencies**. The main actors in the first group are the politicians, in the second are the experts and the technicians, and in the latter are the users or the general population.

Following Kingdon (1984[2011]), the role of political entrepreneurs should be understood “in the context of policy activity involving struggles over problem framing and linking together issues competing for policy attention in non-linear and often contingent decision-making processes.” (Mukherjee & Howlett, 2015:68)

Five policy process
“streams” performed by
policy entrepreneurs

(cf. Mukherjee & Howlett,
2015)



The *deep play* of the health care value construction

- healthcare value is constructed in the context of the *deep play* of the biosciences and biotechnologies
- the development of technologies that assist the political economy of the biotechnological promise is carried out in firms, which are financial entities
- in the logic of finance, the value of technologies is a political-economic attribution, not an attribute of technology

...

...

- the construction of sociotechnical imaginaries, then, greatly depends on the acceptance of the visions of technoscientific vanguards by the financial markets
- as a result, the development of emerging biomedical technologies depends on realizing their ability to be turned into capital, that is, the possibility of them to produce profit in the future. It is this possibility that attracts financial investment.
- most biotechnology firms do not produce any products, but merely develop parts of the process of developing technologies that are then turned into assets and thus transferred to other firms (Birch, 2017)

Birch (2017) argues that bioeconomy is fuelled by the management of value through social practices and evaluation processes that are active, progressive and performative along which an **effort of assigning potentially productive qualities to knowledge** is developed.

This effort seeks **to transform knowledge into assets**, which is substantially different from the value being ascribed through the exchange of products in the marketplace.

For the agents involved in these practices, the important thing is not the effect of the technological products (so the important thing is not the product itself), but the possibility of turning the knowledge that gave rise to them into assets.

Thus, knowledge of technoscientific vanguards is capitalized not based on their output on products that work, but on the criteria used in the evaluation procedures. So, **the value of biotechnologies is more a speculative abstraction than an attribution ascribed to commodities**: “value is constituted primarily by the social practices of political-economic actors who configure the financial value and valuation of firms.” (Birch, 2017: 462).

- Consequently, in order to be funded, research centres need to work in accordance with the criteria of the valuations that financial agents use. Then, “life sciences managers are more attuned to the expectations of financial market actors (e.g., venture capitalists, investors, etc.) than to technoscientific actors (e.g., scientists)” (Birch, 2017: 479).
- Even indirectly, the visionary vanguards end up working for markets rather than to the ultimate recipients of technology applications – patients.

- In this way, “[b]iotechnologies and bio-knowledges represent assets held by firms, which are themselves valued through financial investment practices” (Birch, 2017: 462), making biotechnical companies “financial artefacts”, actually, whose survival is maintained through financial channels rather than through trading products.
- Hence, **in shaping the technoscientific imaginary, the financialization of bioeconomy ends up configuring both the broader socio-technical imaginary and, indirectly, the social imaginary at large (both spatially and temporally).**

- **it is by being able to define reality that value becomes power (Poon, 2012), and then it is by means of determining the criteria of evaluation that power is exerted. So, those who define such criteria are the same who exert the power to design the structures of contingency which will drive and set the limits of a given sociotechnical imaginary.**
- Financialization, assetization and capitalization of knowledge are fundamental features of bioeconomy. **The practice of transforming knowledge into financial assets affirms a tendency for the “normative-interpretive privatization of contingency”** (Rommetveit & Wynne, 2017: 144) in current biopolitics, which shrinks society’s and politics’ roles for leading history.

- As precision medicine gets closer to the cost-benefit models of public health systems' resources management, a strong indicator emerges which reflects **the need for politically controlling the public costs of personalised therapies** – and this is where the adoption of the VBHC model appears as a political measure for costs management within the new biomedicine's political economy
- It is by this means that politics comes to claim its authority over technoscience's tendency to become an instrument to privatize contingencies

In short, **the adoption of VBHC model is not only an imperative to manage public resources but also a strategy to make bioeconomy (with its *dispositifs*) politically manageable and controllable.** This is how the management of the relationships between the *dispositifs* of precision/personalised medicine, digital health and VBHC model configure a same political-economic logic that seeks to reclaim the political control over the forces that produce social history (which, in our technoscientifically driven neoliberal times, are almost entirely detained by the market agents and processes that define the criteria to value health and other services or commodities).

- Notwithstanding the above, it is interesting to notice that the idea behind the VBHC model is to unify the different and often conflicting objectives of different stakeholders into one: “[to] achiev[e] high value for patients” (Porter, 2010: 2477).
- Michael Porter states that value “is neither an abstract ideal nor a code word for cost reduction” (2010: 2477), but instead the measure of the relationship between care outcomes and money spent for the patient to benefit from them (Porter & Teisberg, 2006).

Since it is necessary to continually deliver high value to the patients, who are the ultimate beneficiaries (consumers) of healthcare, the focus seems **to shift from the particular interests of stakeholders to the overall interests of the system.**

The logic is simple: “[i]f value improves, patients, payers, providers, and suppliers can all benefit while the economic sustainability of the health care system increases” (Porter, 2010: 2477)

the **value inside the health system** is no longer **evaluated based on** what it produces (number of consultations, number of hospitalizations, number and type of medical procedures, number of surgeries, etc.) but rather on **the results obtained by the patient from the different means of diagnosis and treatment he benefited from**. In this context, “competing for value [consists in] aligning competition with value for patients” (Porter & Teisberg, 2006: 4)

Given that the VBHC model shifts the focus from measuring production to **measuring outcomes**, value competition revolves around healthcare **results** (Porter & Teisberg, 2006: 4).

Standard Sets and the problem of healthcare value perception

- **“To measure outcomes and costs for every patient” turned into “to measure outcomes and costs calculating the average cost-benefit ratios perceived by specific patient samples”** (definition that governs the methodology for the elaboration of the International Consortium for Health Outcomes Measurement (ICHOM) Standards Sets)
- **Standardization is not consensual** and has mobilized most criticism about VBHC model’s implementation processes (e.g., Riva & Pravettoni, 2016; Nilsson et al., 2017; Bright & Franklin, 2018; Dubois, 2018 Pendleton, 2018; Bright & Linthicum, 2018, 2019).

Prokrustes.



So, the model's value definition/measurement criteria suffer the same pathology as Procrustes – they forcibly adjust the diversity of value perspectives to a same measure for all

(even considering that these 'all' are the elements of a group of patients of a particular health condition, the so-called homogeneous diagnostic groups)

It follows that...

... despite the interdisciplinary effort, the discursiveness proposed by the VBHC continues propagating **the myth of pure ontologies** by adopting a neoliberal discursiveness that understands **health value as the representation of a cost-benefit ratio**

An ethnography on and through stakeholders' **critical capacities** may provide a close reading of **stakeholders' inclinations and disinclinations** and, thus, it may promote the **adjustment of the model to local and national cultural realities** therefore having the potential to contribute to the realization of a realistic **democratic biopolitics**

The initial argument (and a development)

- The initial argument: **the narrative proposed by the VBHC model propagates the myth of pure ontologies by adopting a neoliberal discursiveness that treats value as representing a cost-benefit ratio, neglecting the fact that the value attributed to healthcare outcomes achieved over periods of affliction and infirmity is not limited to such a simple relationship.**
- Going further: **The value of healthcare varies with patients' perceptions, which don't only vary across different health conditions, but are molded by patients' cultures, personalities, and socioeconomic conditionalities, which constrain the relationship between experience and hope, not only in healthcare, but in relation to life in general.**

Value: a substantive account – two empirical examples

- **Value is shaped by substance, not by formalism**; it implies the individuals and their groups of significant others into a consideration (rather than an assessment) of their substantive and existential experiences and dreams which are simultaneously particular and global modes of coping with the contingencies that determine the terms by which the organic and the imaginary should coexist in a unique way of living.
- The attempt to separate perceptions about the value of healthcare from perceptions about the value, for example, of building a house or obtaining a residence visa, is artificial and abstract.
- **Value depends more on who evaluates than on what is evaluated** (Pendleton, 2018), as it always guides (and is guided by) psychosocial and socio-political factors, which are specific to the context in which each patient lives.

- **Differences in perception of the value of healthcare outcomes are observed among all stakeholders involved in health care** (Nilsson et al., 2017; Pendleton, 2018). Even between doctor and patient the differences are significant.
- When treating data from a questionnaire conducted in the state of Utah, U.S., Robert Pendleton and his colleagues found that **45% of the patients considered treatment price as the first measure of value, and only 32% considered it as the improvement of their health condition.**
- The same results also showed that when patients were asked to choose a group of **the five most important characteristics of value in healthcare, in 90% of the cases the response combinations differed from those selected by the doctors.**

- Pendleton concludes that, **“in general, cost and service were far more important in determining value for patients than for physicians”** (2018: 2). This result may lead us to speculate about the difference in living standards and/or income between doctors and patients, but the explanation will certainly not be so simple.
- From this data, Pendleton (2018: 2) realized that **stakeholders “have not communicated with each other effectively, at the macro and micro levels, on what value means to them”**.
- Once again, this is what the problem of healthcare value is about: **value is more an attribution of the subject than an attribute of the object**. The principle we saw earlier when referred to the constitution of value of biotechnologies in bioeconomy is the same that we see here when referring to the constitution of healthcare value.

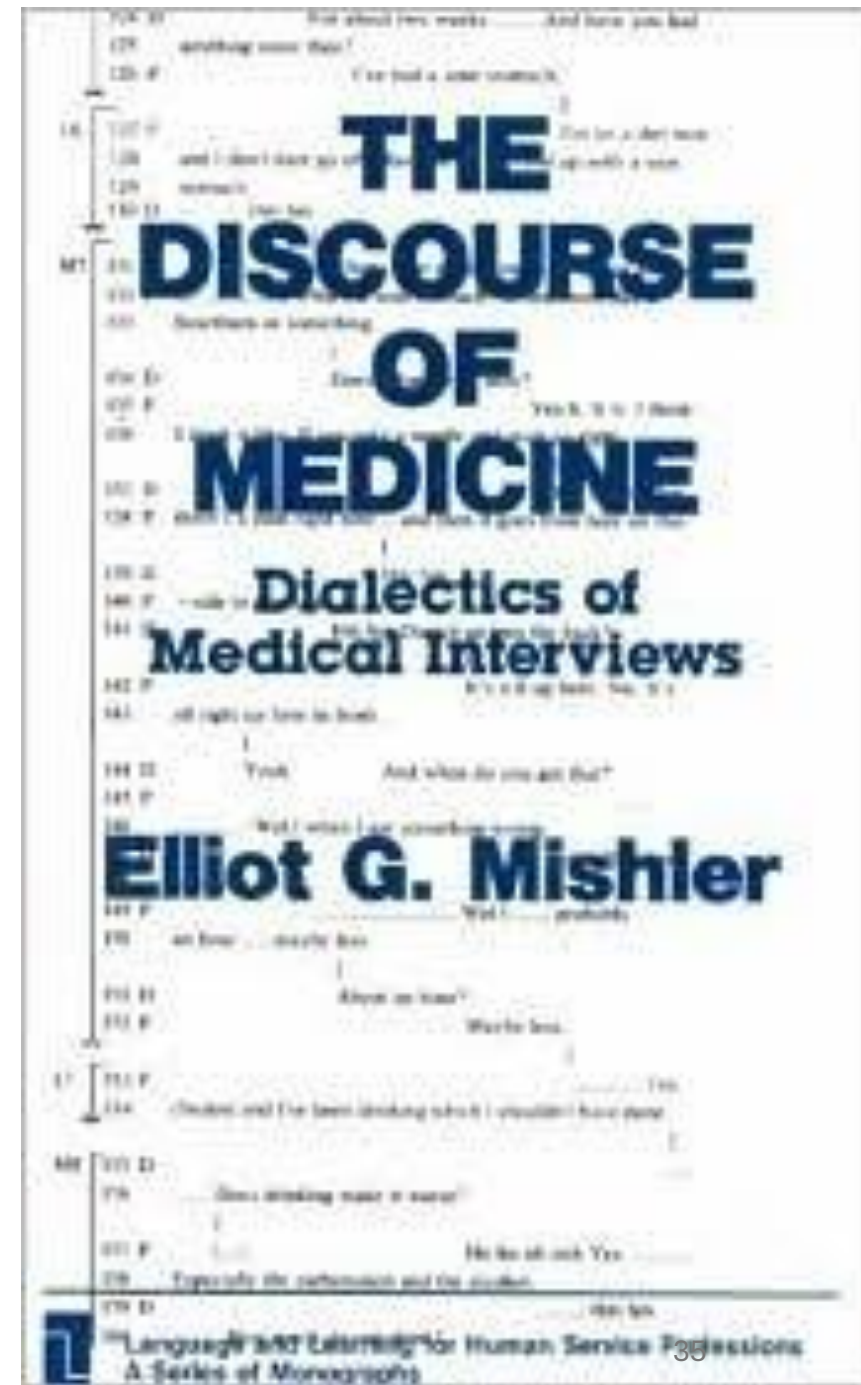
- Similar results were found by Nilsson and his colleagues across their two-year interviews with representatives of the VBHC model pilot implementation projects at a Swedish university hospital. Informants split their opinions between “**we as professionals think we know what value is for the patients but that competence we really don’t always have**” (Nilsson et al., 2017: 5) and “[**patient representatives gave**] **concrete views on patient education and on how to measure what happens to patients**, how patients are doing and so on. Then of course we couldn’t use all their ideas, but they have certainly had an impact on [our] work” (Nilsson et al., 2017: 5).

Jennifer Bright and Mark Linthicum (2018: 2) clearly identify what is at stake here:

Patient characteristics and factors that affect their care choices are highly relevant to the outcomes following a prescribed treatment, and yet such information is often missing from value assessment models because such data are not always recorded in clinical trials. Thus, the neat 'answer' regarding the value of a treatment often overlooks vital information about sub-populations (e.g., ethnicities, age, gender, or disease sub-type). Further, the benefits of expanded patient choice are not considered when high-level models... only measure clinical benefits, risks, and costs for the average patient. ...One step in the right direction is to better incorporate the patient voice into measures of value.

The “voice of lifeworld” and the “voice of medicine”

- This conclusion is shared by Nilsson and colleagues when they point out that “**paying attention to the patient's voice is a most important concern** and is also a key towards increased engagement from physicians and care providers for improvement work” (Nilsson et al. al., 2017: 1).
- Based on Elliot Mishler’s distinction between 'the voice of the lifeworld' (patients’ voice) and 'the voice of medicine' (physicians’ voice), these authors support the idea according to which “**the ‘voice of the lifeworld’ needs to be listened to not just in each encounter between physician and patient but also when managing healthcare**” (id, 2017: 9).



There has been **little understanding of how to develop processes that measure what patients truly value in healthcare** (Bright & Franklin, 2018). To mitigate this problem...

*it's important to have scientific methods and begin to move towards a more inclusive and transparent approach to measuring value – one that acknowledges diversity among patients' characteristics, preferences, and related treatment effects. **While it may be convenient to promote a one-size-fits-all answer, it's not good enough for every patient, every time. That fact should cause all stakeholders to pause and to come together to seek and find a better approach.*** (Bright & Franklin, 2018: 2).

If they address the problem of healthcare value solely based on its standardized definition, healthcare systems' managers do exclude the imminently phenomenological nature of affliction's experiences from health plans, imposing the normative order of biomedicine, and, more significantly, of its political economy, on patients' problems in day-to-day living, as Elliot Mishler concluded (West, 1986).

Anthropological issues require anthropological approaches

If we add to these conclusions the fact that patients involvement is crucial for establishing a trust-based relationship with healthcare providers, and that this involvement is somewhat diminished due to the complexification increasingly settling into health care decision-making in the context of precision/personalised medicine and digital health, we can also conclude that the process of implementing the VBHC model needs to include an anthropological perspective as a way to promote such involvement by crossing the boundaries between epistemic cultures and power practices.

Toward an anthropology of health care value

A double dilemma

By adopting the average as a measure of healthcare value for patients, the first consequence of the VBHC model is to hinder personalised medicine's very purpose: care and therapeutic adequation to the person (Khoury, 2014). In fact, the standardization of value as stated by the VBHC model reveals the existence of an important dilemma.

On the one hand, the political economy of new biopolitics keeps following the principle of care personalisation but fails to break free from the spectrum of *Homme Moyen* norm and the consequent Quetelet's-like moral statistics, which impacts on science and society were enormous (see, for example, Halbwachs, 1912).

On the other hand, and in view of the still little more than incipient capacity to treat, analyse and reduce the immense volume of data produced by the disseminating biometric monitoring practices and the description and interpretation of the functions and effects of biochemical signalling genomes that explain their activity (the epigenome), **the extreme complexity of the ideal interpenetration of precision/personalised medicine and digital health compels the imposition of standard-reducing measures that overlap with the people-centred approach which purportedly constitute their ultimate objective.**

LIFEWORLD VS. STANDARD WORLD

Health Care Personalisation
(the ultimate objective)

Contrasts with the...

Homme Moyen
moral statistics

Aim to...

Leads to...

Precision medicine
+
digital health

Require the...

Standardization

Relies on...

Value-Based Health Care

Champions the...

Therefore, there is a two-way conflict within the biomedical ecosystem that challenges the VBHC model idealizations.

In one sense, the model can prevent the full realization of the potentialities of precision/personalised medicine by, for instance, imposing limits on the number and the variety of therapies by bottlenecking the access to them in order to restrict healthcare due to budget constraints

In another sense, it can annihilate the ideal contained in the expression 'patient outcomes' by tilting the patient's dispositions towards the other stakeholders', notably those producing the standard measures.

Health Care Value as a Lively Quality

- As it's been said, the **tendency for the VBHC model to impose a standard on what value for patient means** is eventually the way the model creators and its succeeding implementers find to reduce the extreme complexity of how people evaluate their organic and mental conditions. It is a **strategy to manage diversity**.
- **It is not reasonable to erase the in-the-bone nature of health conditions, as well as it isn't to deny the principle of payment requirement of healthcare acts** through which outcomes are eventually reached.

What is value?

- The Porter's answer:

“...neither an abstract ideal nor a code word for cost reduction” (2010: 2477)

Michael Porter ends up erasing the very logic of association between help-seeking behaviours (which are triggered by a previous evaluation made by the patient about how his daily life and his self are being changed due to the eventual alteration of their organic or mental condition and formal healthcare providing (which, as an institutionalised way of social organization, is regulated by the principle of payment requirement).

- Apparently, Porter neglects the fact that healthcare value for patients results from an induction of the quality of a certain material-semiotic relationship that in health caring formal contexts always implies to consider both cost-benefit ratios and sociocultural expressions about human condition.
- **The opposition between the forces of homogenization of value in the model and the heterogeneity of individual expressions of the meaning of value is not disconnected, in my view, from the imposition of theory over practice and epistemology over ontology, which is a characteristic of neoliberal ideologies, which seek to normalise and stabilise idiosyncrasies.** This imposition expresses the essential tension between biopolitical imaginary with its hegemonic contingency-producing power and sociocultural imaginary that tries to resist to such power.

- Michel Foucault already had constated that the birth of clinic happened when a new “style of totalisation” (Foucault, 2007:28) was created that emptied the sense of healthcare value of any cultural, collective connotation.
- The centrality of the concept of healthcare value in the VBHC model requires the overcoming of the basic opposition constructed between value as universal anthropological phenomenon and value as modern economic calculation. As Louis Dumont states, that distinction is founded on the fact that modern science “refus[es] all qualities to which physical measurement is not applicable” (1992: 234).

The anthropology of value

Three main lines of theorization

1. **value as a reference for cultural comparability** (Dumont's 1992 [1986]; Kluckhohn & Strodtbeck, 1961)
2. **value as a referent of exchange** (Sahlins, 1972)
3. **value as being produced within action** (Lambek, 2008)

VALUE AS REFERENCE FOR CULTURAL COMPARISON

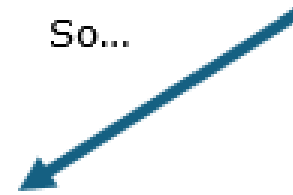
Value is embedded "in the conception of the world [and] in the very configuration of ideas"
(Dumont, 1992: 245,259)

Since...



... "the meaning of a term can only be understood in the context of a total system [of meaning]"
(Graeber, 2005: 447)

So...



healthcare providers, as the other formal stakeholders, will have serious difficulties to define what healthcare value means for patients

Meaning that...



healthcare value for patients does not match healthcare value for healthcare providers and eventually for the rest of the formal stakeholders

Systems of ideas and systems of values

SCIENCE AND SANITY

AN INTRODUCTION TO NON-ARISTOTELIAN
SYSTEMS AND GENERAL SEMANTICS

BY

ALFRED KORZYBSKI

AUTHOR, *Manhood of Humanity*

FOUNDER, INSTITUTE OF GENERAL SEMANTICS

"The progress of science, including the new science of man as a time-binder, has been due uniquely to the freedom of scientists to revise their fundamental assumptions, terminologies, undefined terms, etc., which underlie our reflections, a freedom prohibited in dictatorships, past and present."

From Manhood of Humanity

"General semantics is not any 'philosophy', or 'psychology', or 'logic', in the ordinary sense. It is a new extensional discipline which explains and trains us how to use our nervous systems most efficiently. It is not a medical science, but like bacteriology, it is indispensable for medicine in general, and for psychiatry, mental hygiene, and education in particular. In brief, it is the formulation of a new non-aristotelian system of orientation which affects every branch of science and life. The separate issues involved are not entirely new; their methodological formulation as a system which is workable, teachable and so elementary that it can be applied by children, is entirely new."

From the author's Introduction to the 2nd Edition

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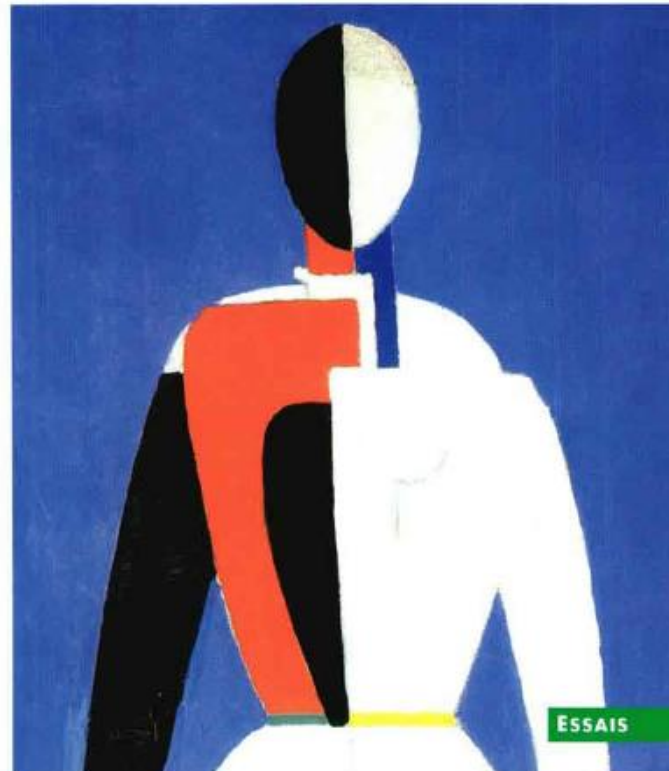


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Louis Dumont Essais sur l'individualisme

*Une perspective anthropologique
sur l'idéologie moderne*

POINTS



ESSAIS

COURSE IN GENERAL LINGUISTICS

FERDINAND DE SAUSSURE

Edited by CHARLES BALLY and
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In collaboration with
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Through Dumont's theory perspective, **patients would not necessarily affiliate their understanding on value to the fact judgment / value judgment distinction in their valuations of healthcare outcomes.** That is a modern distinction, Dumont (1992) says, that lies beneath the "ethical trick of rational action" (Graeber, 2005: 443).

Patients act as common people who, although critical, judge more reflexively than analytically, carrying the criteria to judge value across different regions of practice along their daily activities as a measure of what they accept as being *the desirable* on a wide-ranging plane of judgement devoid of internal epistemological boundaries (Kluckhohn, as quoted by Graeber, 2005: 444).

To our analysis, this important aspect means two apparently opposite considerations:

- Firstly, it means that **the meaning of the value of healthcare outcomes attributed by the patients or by the other stakeholders is only comparable by having the semantic background that underlies them as a term of comparison**, that is, they can only be compared on a plan that dilutes the differences between the several epistemic cultures.
- Secondly, it means that, in order **to understand the meaning of value for each of the agents, it is necessary to place it within each agents' vocabulary technology and its applicable semantics with and through which each of the agents expresses his specific discursiveness, his own idiom.**

The opposition between these two considerations is only apparent, since we observe the same principle applied at different scales.

- **For Dumont, the comparability background is universal;** it is not limited to a particular system of ideas – the separations between systems of ideas are products of Enlightenment, which had promoted both the disciplinary division of reality and the 'discursive purification' of science evoked by Latour (1993).
- Especially important, for Dumont (1992), who adopted Saussure's theory on oppositional linguistic pairs in his theory on value, is that **this semantic background is structured in and by a hierarchy.**
- **So, the way how each of us hierarchizes linguistic oppositions reflects the way our cultures hierarchize value.**

Saussure's structuralism has shown that language (which is both the product and the raw material of ideas) is organized into oppositional pairs, like 'yes/no', good/bad', 'hot/cold', 'high/low', etc.

Dumont realized that **within each of such linguistic structures one of the terms is always more *culturally* valued than the other, and this therefore means that “ideas are always also 'values'”** (Graeber, 2005: 448).

So, both ideas and values are hierarchized. Moreover, **this hierarchy presupposes the existence of a comprehensive term**, as, for example, the entire body comprehends the opposition 'left hand / right hand', and, even within this opposition, the most valued pole, 'the right hand', encompasses the least valued, the 'left hand', and so it is the case of all the other ideas.

Here, the arising question is: “When patients and professionals are from the same place or country are they from the same culture?”

Yes and No, it depends on which scale are we considering

- **When one refers to 'the way cultures hierarchize value', we should keep in mind both the actors' different basic cultural background and their different epistemic cultures.** Specially within a formal/professional context of practices, hierarchizations of value are rooted in both cultural realms.
- This means that **even if the different stakeholders involved in a VBHC model process of implementation belong to a same national or broad culture, they potentially will value healthcare outcomes differently due to their differentiated epistemic cultural backgrounds.**

How is value created?

The way how to access to the environment content is an important aspect we need to address to understand how value is created.

Although classical economists, like Adam Smith and David Ricardo, had already referred to the importance of rarity and utility as factors that form goods' value, it is through James Gibson's affordances theory that, I think, agreeing with Thomas Widlok (2017), we can find some fundamental elements that may help us to think about value creation and sharing practices (within which we may situate the archaic sense of care and one of its special forms: health-related care).



Psychology Press Classic Editions

THE ECOLOGICAL APPROACH TO VISUAL PERCEPTION

James J. Gibson

The affordances

- The affordances “are what [environment] offers..., what it provides or furnishes, either for good or ill”, Gibson (2015: 119) says.
- The affordances are the resources that environment provides as life supports, such as water, land type, shelter, raw materials, etc., as they also are the things that may threaten life. But, to be used by animals, for example, these ones must perceive resources as affordances. This, Gibson adds, refers to “a radical hypothesis, for it implies that the 'values' and 'meanings' of things in the environment can be directly perceived [and, this may suggest that] values and meanings are external to the perceiver” (2015: 119). Moreover, **what each interlinked pair of agencies perceive as affordance is reciprocal, that is, *ego* affords *alter* by using the same 'measure' that *alter* uses to afford *ego*:**

- From this perspective, **what the patient affords the carer is reciprocal to what the carer affords the patient, or what health services and institutions afford the patients is reciprocal to what the patients afford the services and institutions, or, even, what national health systems afford the patients through healthcare institutions is reciprocal to what patients afford the national health systems through healthcare institutions.**
- However, **affordances in human worlds are not as straightforward or naïve as this logic may make us to believe.** As I have stressed earlier, if we want to understand an interaction, we can't exclude from it any of its two main dimensions. **We must look at it as a material-semiotic composite form.** In this regard, Gibson informs, that “the other person, the generalized other, the alter as opposed to the ego, is an ecological object with a skin, even if clothed. It is an object, although it is not merely an object, and we do right to speak of he or she instead of it” (2015: 127). **This material-semiotic compositional work means that agents recognize each other by managing reciprocity through subject-object shifts** (Wagner, 2018).

- That is, **agents are co-constituted as both subject-as-object and object-as-subject forms** through entangled intra-actions, as Karen Barad (2007) would say.
- So, subject-as-object and object-as-subject reciprocally become and evolve. We must mind, then, that **the reciprocal nature of how agents afford each other depends both on their material qualities** (including their clothes, which, in the case of healthcare interactions provoke a special set of expectations, since clothes providers' wear refer to a given socio-professional status and a peculiar epistemic culture that specialize the type of affordance perceived by patients) and their capacities to intertwiningly construct new affordances.

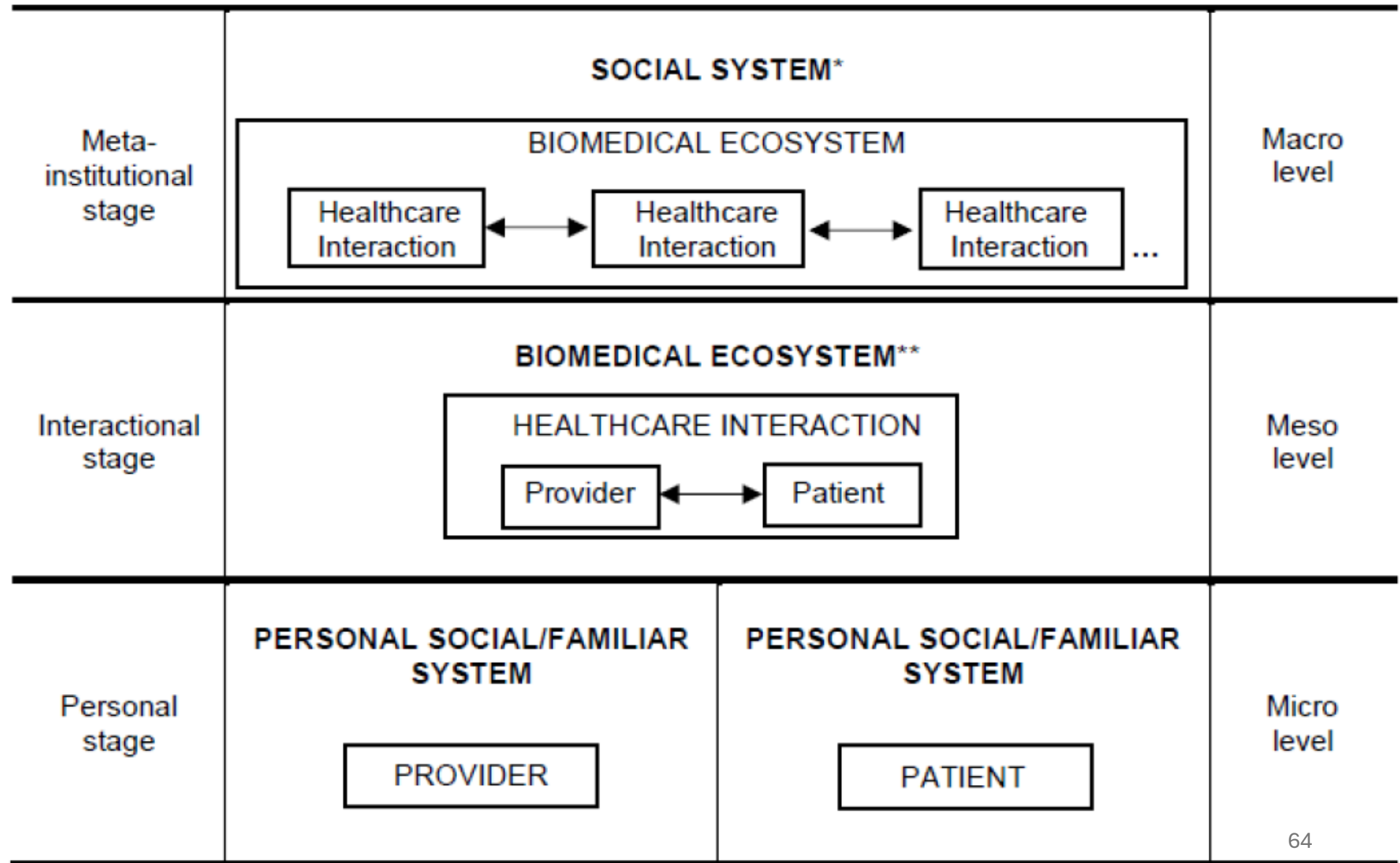
- We must mind, then, that **how agents afford each other depends greatly on their competency to construct, to play the game in an always politically constrained sociocultural milieu**, to which Pierre Bourdieu referred as **the *field*** (Bourdieu, 1991).
- Notably, **interacting actors express their competency to play the game through their mastery of using social reality structuring structures like language** (Bourdieu, 1991).
- This means that **their reciprocal affordances are greatly shaped by their capacities to operationalize systems of ideas, that is, to interpret, to produce, to share and even to manipulate value.**

Healthcare providers and patients reciprocally afford each other by recognizing that each of them elaborates some complementary – that is, unbalanced and not necessarily conforming – representations about the interaction they are involved in.

This results from the complexification of the perceived affordances by agents' culture-bound worldviews and related social statuses and roles they assume and perform, which constrain each's practices and expectations, by contextualizing them into broader upstream levels of social organization.

Within healthcare social interactions, in particular, we are dealing with a formalization of an intersection of **personal material-semiotic stages** (that of professionals and that of patients), which constitutes a second-level, supra-personal or **interactional material-semiotic stage**, from where the first-level personal material-semiotic stages extrapolate their individuality and get their signification in the context of healthcare interaction (which is institutionally mediated and, thus, politically framed). And, by its side, this **supra-personal material-semiotic stage** acquires its meaning in a wider field of sociocultural and political-economic references of signification (the social organization system), which assumes itself as an encompassing third-level **meta-institutional material-semiotic stage**.

Material-semiotic stages involved in valuations of health care in a given social system of ideas



*includes other socially organized ecosystems
 **includes other institutionally organized healthcare-related interactions)

Healthcare, as something that is provided by *human* environment, has an intrinsic value that is both **external** and **internal** to the different agents.

_ External, because none of the involved agents can deny the value of healthcare – and here lies the common ground where all particular perceptions on healthcare value find their similarity, making healthcare practices equivalent insofar they share the same quality as human labour, which is an important characteristic of classical economics' interpretation of value.

_ Internal, because the truth of judgments on healthcare is conditioned by each agent's lives, social function's constraints and cultural competency to play the game. Thus, agents' general (human) condition and specific (sociocultural) conditionalities are both interrelated in the production of healthcare value.

The VBHC model reference to healthcare value as 'the value *for* the patient' means exactly that **there is a value to each of the agents involved in healthcare**. Moreover, it situates the patient in a social position that is inherently relative to the positions of the non-patients. That is, potentially all agents are patients, since a patient is an attribute that physicians confer to a person (McKinlay, 1981), which is then expected to comply a social role – the sick role, in Talcott Parsons' (1951) words. **So, the model itself considers the meaning of value as a social construction which emerges in interactional contexts.**

Additionally to the social construction of patient's persona, **humans are eminently reflexive agents**, i.e., they cumulatively learn from their own and others' experiences, which are transduced across generations (for which purpose exemplary folktales and stories are of paramount importance).

This **continual learning is a way to them algebraically – that is, remotely, without occasions being spatially or temporally necessarily present – prepare to detect the danger**, as, for example, by resisting to be deceived and bite the bait. Algebraic reasoning is acquired from long-lasting observation and is fostered by necessity.

Material hunger and health

Material hunger is the primal urge; it is the whip (Bloch, 1995b) that compels humans (and the other animals) to **take observation seriously**.

As Ernst Bloch refers:

“every implement presupposes exact needs and has the precise aim of satisfying them; otherwise it would not be there. Hunger started everything off at this very point, the earliest implements are those for hunting and fishing ... Hunger forces us to work, but this work wears us out in its own way exactly like hunger.”
(1995b: 658, 886).

The politization of fundamental needs

Arendt referred 'labour' as the kind of human activity that attacks material hunger. **'Labour'** confronts biological needs, and, as these don't have an end, 'labour' never ends. This means that the maintenance of life is a (potentially) never-ending activity. The case is that modernity *socialized* this activity. By integrating 'labour' within political normativity, modern state bio-politicized the human activity that attacks material hunger, concatenating 'labour' and **'work'** (this latter being an activity with a beginning and an end that transforms material forms for a given circumscribed purpose) into a **'social action'** form, invading thus both private and public realms as a way to manage the strategies to fulfil biological needs. Attacking material hunger became a political premise. In this way, **'social action' blurred the frontier between the private (*oikos*) nature of 'labour' and the public (*polis*) nature of 'work' constituting life as an embracing biopolitical resource (Arendt's *vita activa*).**

Approaching this rationale to our discussion, this means that 'labour' (say material hunger) and 'work' (say health care) may seem indistinct to the several healthcare systems' stakeholders from a 'social action' (say healthcare systems management) standpoint. Along with the fact that economy (the regulation of oikos) and politics (the regulation of polis) are blended into 'social action', we may observe a tendency to interpret material hunger and healthcare quality as two facets of the same 'social action', i.e., as two expressions of a same value.

We may understand, then, that 'social action' requires a common meaning of 'value', one that hovers over the value of 'labour' (life needs) and the value of 'work' (the circumscribed work of healthcare). Significantly, we find here, once again, the pertinence of Dumont's theory of value hierarchies. **Modernist bio-politicization of human activities encompassed the values of 'labour' and 'work' into the wider value of 'social action', which, as Hannah Arendt stresses, became the prime value of modern *vita activa*. And this wider value of 'social action' substituted the wider value of 'material hunger' for the purpose of political regulation.**

From affordances to affordability

- The encompassing social action value is, in fact, the value economists reclaim as ***the*** economic value.
- Although “wishful images of **combatting disease** must be the oldest along with those of **combatting hunger**” (Bloch, 1995b: 457), when we think about modern formal healthcare practices, we can’t isolate them from market-like transactions. Payment requirement (cf. Testart, 2013) isolated formal healthcare practices from the wishful image of *human care*. The same happens regarding combatting hunger.

Considering what has been observed from the empirical examples presented above, the phenomenon of value hierarchization implies that between the value of 'health recovery' and 'treatment costs' an opposition emerges in which each agent overvalues one of the poles.

COMBATING HUNGER

Treatment costs
(patient pole)

COMBATING DISEASE

Health Recovery
(professional pole)

- The provider tends to encompass treatment costs in the most *biomedically* important value of health recovery, whereas the patient encompasses the value of health recovery in the most *socioeconomically* important value of treatment costs.
- Considering that each of the agents is focusing on different references of value, the only way to understand the rationality of each position is to contextualize the opposition on a broader plane – that of the total system of values. And this system far exceeds the usefulness of specific goods, projecting itself to what the environment contains and to how humans access its content.

Payment requirement is a pervasive means to people both benefit from healthcare and provide sustenance, and the access to these goods may even possibly be obstructed because of that. **Payment requirement subverts the affordances natural logic by putting abstractions (payment – a representation) before concreteness (goods – the matter).** Payment requirement explains the criteria supporting the design and adoptions of the various national healthcare systems models (see Reid, 2009b:25-39).

- The focus on the value 'treatment costs', which patients elect as their main concern in the Utah survey, recalls precisely that subversion. **Based on the payment requirement primary social action principle (which, as mentioned above, blends politics and economics), the value of goods become measured by their financial affordability rather than by their inherent affordances.** In other words, *affordances became to be perceived through the agent's capability to afford them.*
- And **this perception implies that agents make calculations, that is, that they critically analyse their capability to negotiate.** Agents understand that reaching a measure of optimal negotiation is a complex process that mediates agents' dispositions between collaboration and conflict involving decision-making (Friedman, 2004; Chibnik, 2011).

- Dumont's theory of value hierarchy is especially useful for analysing the difference between the capacities actors have to critically perform negotiations when involved in the technological dramas that potentially arise along the process of implementation of the VBHC model.
- From the empirical examples given, such difference is tested between the whole and the part: the whole, that is, **the material hunger, is the primal leitmotif for organisms and species to maintain vital balance.**

- **Such 'will to power', as Friedrich Nietzsche called it, is a condition of immanence, which overlaps transcendence and historical actualizations (Siebers, 2013), or, rather, encompasses it, by driving the dialectical relationship between potentiality and actualization, which, in the end, resolves the “abstract dualisms, [opening] up a comprehensive viewpoint from which fixed duality disappears” (Bloch, 1983: 304). Articulating this immanence-transcendence dialectical movement to the two main 'wishful images' of the living referred by Bloch – combatting hunger and combatting disease –, we may identify the former with immanence and the latter with transcendence.**

- Indeed, **hunger is constantly problematized**, since it is inherent to the living, while **disease is problematized only when health turns problematic**. Everybody feels hunger from womb to tomb, but not everybody experiences sickness his life all along. Or, still, if one does not fulfil food needs, one may become ill, while if one feels ill, one does not necessarily get hungry.
- **Material hunger is the paramount encompassing value of the living, and it becomes the core of the problematizations about life in situations where it is under scrutiny, as when disease arises.** It is therefore natural that in a situation of vulnerability due to an illness, which, by itself, may not endanger survival, the person who experiences suffering invokes the greatest value of maintaining the balance that allows hunger to be attacked in a durable manner, i.e., sustenance.

- Referring to service costs and quality of care as core values may mean precisely that addressing the biopolitical constraints that the **acceptation of a given health problem mitigation process entails is an exercise that must be performed before proceeding to such an acceptation.** The maintenance of equilibrium that makes possible to sustain life (in its diverse anthropological scales, such as the personal, the familiar, and the social) by controlling socioeconomic contingencies helps to prevent hopelessness – which is the most anti-vital sensation (Bloch, 1995a).

The ethical value of health care and the performative concretization of value

- Ethical value is constituted through **ordinary acts** (cf. Lambek, 2013)
- When patients invoked the quality of care as the second option to measure healthcare value, they were referring to this performative dimension of value. This means that, **while formal stakeholders may understand healthcare value through the logic of the accomplishment – to recover health –, patients, additionally to the payment requirement principle, may understand it through the performative quality of alters' acts, that is, through the capability for these acts to conform with ordinary expressive forms of ethical value.**

- Loaded with meaning, ...

...ordinary acts generate their own forms of value. To the degree that this value becomes objectified, that is, becomes detached from the doing (just as an end – or product – of work becomes detached from the means, that is, from the activity of making it; or as the end and even the very means are alienated from the producer), such objectified values might have their own proprieties, distinct from use value and exchange value of the products of labor or from labor itself considered as an object. (Lambek, 2013: 147)

Acts that perform ethical value (action) are distinguished from acts that produce material value (production). Due to their different nature and results, these two types of acts refer to **different forms of value attribution.** While material value is commensurable, ethical value is incommensurable, and this “leads to two different kinds of valuation, namely **choice in the case of market value,** and **judgment in the case of ethics,** where a **balance** between incommensurable values has to be established” (Otto & Willerslev, 2013b: 5). **Such balance is established through performance in each cultural context.** Thus, ordinary acts potentially become performative acts.

Looking at **healthcare practices as objectifications of ordinary acts** that are socially pervasive and anthropologically omnipresent, patients judge the conformity between the experiences they have during formal healthcare and the expectations which they bring with them from the outside, from the non-technical world of human care. Assuming the role of judges rather than evaluators, patients implicitly refer to this psychological contract to evaluate professional healthcare practices' *ethical value*. **While providers expect to understand what patients have to say about the outcomes of their practices, patients communicate their judgment focusing the very process of realization of such practices.**

Instead of focusing on the product (outcome), patients focus on the process (acts). And this may be one of the reasons why patients respond that care is more valuable than its product. Admittedly, this analysis lacks more empirical observation... But, after all, its aim is precisely to justify the realization of such an observation in order to better understanding why patients *judge* practices rather than *choose* outcomes.

Patients	Professionals
Health care as ordinary act (representation)	Health care as social action (service)
Based on performances	Based on results
Ethical value	Economic value

If the wishful thinking of combatting hunger encompasses the wishful thinking of combatting disease, we can then conclude that the hierarchization of values performed by patients defines 'sustenance' as the encompassing value and 'supervision' and 'looking after' as fundamental encompassed values. So, as argued, if the maintenance of equilibrium that makes possible to sustain life by controlling socioeconomic contingencies helps to prevent hopelessness, then the good care fosters the psychosomatic balance, nourishing, thus, the wish that drives hope.

Conclusions

- The experience of illness shapes the subjects. And this is incorporated into patients' flesh and bone. Whereas researchers *formalize their belief* in healthcare optimal effectiveness, patients *lively perceive* an expectation/experience gap.
- Working on value means doing much more than economists define; it means looking for the common ground between value and values. Investigating this implies “to understand the workings of any system of exchange ... as part of larger systems of meaning, one containing conceptions of what the cosmos is ultimately about and what is worth pursuing in it” (Graeber (2005: 443).

- My meditations on Bloch's philosophy of hope and on Gibson's affordances theory, as well as the reflections on the anthropology of value, appeared as contributions to help thinking about some of the mechanisms humans use to keep a permanent linkage with their conceptions about their place in the cosmos and the function of value to indicate "what is worth pursuing in it".
- These meditations and reflections helped me to ultimately realize that separating the value of health care from this cosmological sense of life is the central issue behind the problem of divergence of notions of value among stakeholders participating in the processes of implementation of VBHC model. After all, **health and life are tightly interlinked**. Thinking through the patient, I would agree with Louis Dumont when he says that "the idea that what man must do has nothing to do with the nature of things, the universe, and its place in the universe, is a bizarre, aberrant, incomprehensible idea" (1992: 242).



Thank you!

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