The value of dignity: health insurance, ethics and court cases in Brazil

Bähre, E.

Article

CRITIQUE of ANTHROPOLOGY

Critique of Anthropology
2023, Vol. 43(3) 289–310

DOI: 10.1177/0308275X231192308
journals.sagepub.com/home/coa
Sage

The value of dignity: Health insurance, ethics and court cases in Brazil

Erik Bähre
Leiden University, Leiden, The Netherlands

Abstract

This article examines court cases brought by clients against private health insurance companies and against Brazil's public health system. When clients take private health insurers to court, they successfully claim that the insurer violated their dignity, which entitles them to a moral damage payment. Similar cases against the state did not include moral damage claims. In relation to public healthcare, it is somehow not possible to equate dignity with economic value. One might conclude that the dignity of consumers in the market is worth more than that of citizens vis-à-vis the state. Instead, I argue for a more subtle approach by concentrating on the ethics of incommensurability. What legal and ethical considerations lead to such a fundamental incommensurability between personhood and economic value? How do the actors involved in court proceedings (claimants, prosecutors, judges, and insurers) perceive the differences between cases against insurance companies and against public health authorities? What can we make of the differences between the legal and everyday understandings of dignity and morality?

Keywords

Brazil, commensurability, economic anthropology, ethics, health insurance, personhood, value

Diana was about to give birth, but before doing so she needed medication for herself and her new baby. She had an autoimmune disease and giving birth without the medication would threaten both their lives, the doctor told her. Diana went to the public pharmacy that is part of Brazil's public health system. There they told her that they had run out of their

Corresponding author:
Erik Bähre, Institute of Cultural Anthropology and Development Sociology, Leiden University, Postbus 9555, Leiden 2300 RA, The Netherlands.
Email: ebaehre@fsw.leidenuniv.nl

annual stock. Diana contacted her private health insurer, who told her that her policy did not cover this medication. Diana and her husband could not afford to buy the R$7,800 medicine.

Diana and I met at the Public Defender's Office where she went for legal support and where I did fieldwork. The Public Defender initiated two lawsuits; one against the state and one against the private health insurer. The lawsuits had to ensure that Diana would get access to healthcare and were very similar in their demands. But there was one crucial difference. The lawsuit against the private insurer included a moral damage claim. The Public Defender argued that the private insurer had violated Diana's constitutional right to 'the dignity of the human person' (*dignidade da pessoa humana*). Therefore, the insurer had to pay Diana for moral damages (*danos morais*). The judge agreed. The lawsuit against the state responsible for public health did *not* include a moral damage claim; it did *not* claim that the state had to pay moral damages to Diana for having violated her dignity.

The difference between these two lawsuits is not unique to Diana's case. Of the 16 health-related lawsuits in the private health insurance system that I examined, 15 included a moral damage claim to compensate for the violation of the client's dignity. The hundreds of lawsuits that the Public Defender in Brasília each year initiated against the state responsible for public health did not include such a moral damage claim. This seems to be typical for Brazil. A national study by Biehl et al. (2012: 46) showed that the constitutional right to dignity was mentioned in only 16% of court cases against public health authorities. In these 16% dignity seems to be only mentioned in order to convince the judge that the claimant has the right to public healthcare and not to substantiate moral damage claims.

In the private healthcare cases I examined, the moral damage claims were all because the insurer had unlawfully refused to authorize a treatment. In these cases, insurers had denied surgeries to treat appendicitis, kidney stones, ovarian cancer, as well as a breast reduction surgery to treat spinal problems. They denied, or only partially authorized, medication to treat life-threatening illnesses; had refused to admit a patient to a psychiatric institution; denied autism treatment for an infant; and denied medical homecare, which means that patients receive professional healthcare at home. All cases were accompanied by a statement from a physician that the health and even lives of the patients were at great risk.[1] In 4 of the 16 cases, clients accused their insurance company, and in some instances also the broker, of fraud.

In their petitions to the courts, the clients argued that they had a constitutional right to the 'dignity of the human person' and that violations of this dignity required compensation. Moral damage claims ranged from R$5,000 to R$25,000. From 13 cases, I could find what the preliminary or final ruling was.[2] Decisions about moral damage were made only in the final ruling. Judges always granted moral damage but often awarded less than was asked for.[3]

These judicial processes and outcomes reveal and establish that dignity is something different in relation to a private health insurer than in relation to the state. Within this legal context, differentiated treatment is deeply rooted in the hierarchical relations that permeate Brazilian society. Taken together, petitions, lawsuits, verdicts, narratives of claimants, and legal professionals offer a lens through which I analyse the political, legal,

and social divisions that permeate Brazilian society. Dignity is central to disputes about moral personhood across Brazil's racial, gendered, and economic inequalities.[4] Brazil's social and political struggles are after all about dignity, morality, and care, as well as the expectations that people have of the state and the market. These issues are all central to court cases where people often desperately try to get the healthcare they need. How did legal processes distinguish between the dignity in the market vis-à-vis the state? How do clients who need healthcare experience the violation of dignity at the hands of the health insurers? This article explores the distinctions that exist between legal, professional and everyday understandings of dignity in relation to health and value.

One might argue that people who do not receive a financial compensation for their suffering have less dignity, or that their dignity is not recognized. It is tempting to argue that Brazilians who have access to private insurance have more dignity because the violation of their dignity is compensated. When people with private insurance receive moral damage payments they are financially better off, and one could argue that their dignity is therefore recognized. I suggest a more subtle analysis that focuses also on the incommensurability between personhood and economic value. Personhood cannot be captured by numbers and prices alone and this too points to an ethics. When Brazilians do not receive moral damage compensations it means that their dignity has no equivalent in numbers. It suggests that a conversion of personhood into economic value is illegitimate (on this see Guyer, 2004, 2009; Henig, 2019; Lambek, 2008, 2015; Maurer, 2005; van Berkel, 2019).

When one *only* examines how personhood and economic value are commensurable, one could conclude that moral values are increasingly eroded (see, for example, Fourcade, 2021). Yet even under global capitalism, not everyone or everything can be priced. Sometimes things, people, identities or beliefs are so valuable that they cannot be expressed in economic value; they remain priceless. These incommensurabilities are important because they show social and cultural differences as well as the creativity that exists in societies (Lambek, 2008). Incommensurabilities draw our attention to virtue ethics that 'asks not how we can acquire objects of value nor how we can do what is absolutely right, but how we should live and what kind of person we want to *be*' (Lambek, 2008: 134, italics in original).

Both virtue and value are at stake in court proceedings. They are at stake in people's narratives at the Public Defender's Office, when they seek recognition of their suffering and the indignity they experienced when healthcare treatments were refused.[5] They are at stake when public defenders are confronted with the question: when is it right, in the legal and moral sense, to argue that the violation of 'the dignity of the human person' must be financially compensated? Value and virtue are an integral part of the judges' verdicts: how do judges substantiate and 'price' the violation of dignity?

These insights are based on ethnographic research in the office of the Public Defender, open interviews with claimants, their families, and with legal experts. Research took place over several periods, ranging from a few weeks to two months, from 2017 to 2019, during which I was assisted by Fabíola Gomes. At the Public Defender's Office, we interviewed somewhere between 50 and 100 people and examined dozens of legal processes. Some of the court proceedings, verdicts, and judge's motivations could be accessed through the

electronic repository, as well as the on-site archive of the Tribunal de Justiça do Distrito Federal e dos Territórios.

I will first examine how legal resources and institutional arrangements are interpreted and used in the office of the Public Defender. I will then present three court proceedings that I found particularly salient for understanding the nexus of dignity and value.

Dignity in legal and healthcare arrangements

Since 1989, Brazil has had the Unified Health System (*Sistema Única de Saúde*) or SUS. Today, public health consists of a national network of hospitals and other public health institutions that offer basic and specialized healthcare (Castro et al., 2019; Paim et al., 2011). Dignity was crucial to the history of public health in Brazil. The SUS was established after the military dictatorship. The 1988 Constitution made a clear break with the military dictatorship that had ruled the country from 1964 to 1985 and that had grossly violated human rights (Biehl, 2013; Biehl et al., 2009; Paim et al., 2011; Sant'ana, 2017a). The Constitution defined the right to health and the right to dignity. It stipulated that 'health is the right of every individual' and that the state was required to provide 'access to services designed to promote, protect and recover health'. The SUS was established to meet these constitutional duties, but in practice it often falls short (Biehl et al., 2009; Jurca, 2020; Sant'ana, 2017a). The Temer administration (2016–18) passed several austerity laws that restricted the SUS budget further (Doniec et al., 2016). Increasingly, patients who depend on public health have to wait months for a medical examinations, surgeries and other treatments. During fieldwork people told me that it is becoming more common that hospitals cannot admit any more patients, even when their life is at risk.

In addition to public healthcare, Brazil has private health insurance, with a network of private clinics, doctors, and other medical services. Private health insurance precedes the SUS and is rooted in Brazilian private companies and other social organizations dating back to the beginning of the 20th century (Carvalho and de Oliveira Cecílio, 2007; Paim et al., 2011). A quarter of the Brazilian population is covered by private health insurance. Relatively prosperous regions like Brasília have a higher uptake of insurance. Here, more than 30% of the population has private health insurance (ANS, 2021: 14). In practice, it is very common for people to combine public and private healthcare. Relatively poor people buy certain forms of health care or private insurance throughout their lives, even if they rely primarily on SUS.

The 1988 Constitution defined the right to health and guaranteed the 'dignity of the human person as the essence of all rights'. From the beginning of the Constitution, in Article 5, it is clear that dignity is a fundamental right and that its violation gives 'the right to compensation for … moral damages'. The phrase 'the dignity of the human person' (*dignidade da pessoa humana*), seems somewhat tautological, in the Portuguese language as well, but accentuates the importance of humanity.

All but one of the cases presented in this article were collected during fieldwork at the Public Defender of the Federal District (Defensoria Pública DF). The Public Defender is an independent government organization that ensures that people who cannot afford a private lawyer receive free legal support. The Constitution states that Brazilians must have

the opportunity to claim their rights. The Defensoria Pública plays an important role in that it provides free legal support in situations where a person's income is less than five times the minimum wage or when the claim or legal costs meet certain criteria. The Public Defender of the Federal District has 33 offices, including a mobile office. It provides legal support in adoption procedures, in relation to child maintenance payments, domestic violence, crime, human rights violations, lawsuits against businesses, and also against the Federal District.

When people have difficulty accessing healthcare, they can visit the office, which is only a short walk from the main bus station of Brasília. During opening hours, it was always very busy, with dozens of people waiting to be seen. They often carried medical reports, price quotes from private hospitals or pharmacies, insurance contracts, proof of income, or powers of attorney to act on behalf of patients unable to go there themselves. The public defenders were assisted by student interns, volunteers, and junior colleagues, all with legal training or a degree in law. The staff and volunteers called visitors 'users' (*usuários*), a term that is commonly used to refer to people who make use of public services and which avoids labelling them as consumers.

The users were directed to the 'health nucleo' or 'consumer nucleo'. The 'health nucleo' was for people who had difficulty accessing the public healthcare system (SUS). The Public Defender kept a detailed record of public health cases and, in 2017, assisted in approximately 28,000 cases. Users mostly wanted access to medication, medical exams or surgeries, and many had several cases running at the same time, such as lack of medication and also a need for physical therapy. About 10% of these cases ended up in court, most of them relating to access to medication (719 cases), admission to intensive care (709 cases), and surgeries (379 cases).[6] Judges generally ruled in favour of the plaintiff. If the public health system could not offer healthcare, the Federal District had to pay for a patient's treatment in a private hospital, clinic, or pharmacy.

Patients or their representatives who needed help with private healthcare were directed to the 'consumer nucleo' that was specialized in consumer law. The number of cases that passed through the 'consumer nucleo' was not systematically registered, but it was far fewer than in the 'health nucleo'. However, the amount of work that needed to be done in this 'nucleo' was substantial. Hence users of the 'consumer nucleo' spent more time in the office, because insurance company cases were more complex and took longer to prepare.

The public defenders had given Fabíola Gomes and me permission to do fieldwork. We met with users in the waiting area or in one of the dozens of cubicles where they were seen by staff or volunteers. Users almost always welcomed the opportunity to talk to us and share the problems that they were experiencing. These conversations took place while staff members and volunteers inspected documents and proceedings, wrote petitions, and prepared the case in other ways.

The Constitution allows people to make claims of moral damage against the state, but such claims were only made against private health insurers.[7] Their petitions to judges routinely included claims to compensation for moral damages (*danos morais*). In these court cases, clients accused insurance companies, and sometimes brokers, of damaging their dignity, acting in bad faith, and inflicting other forms of emotional and moral distress.

Conversations with legal experts revealed an important ethical consideration. Pedro, an experienced lawyer who worked at the Public Defender, had given this extensive thought. Pedro said that it was not only legal considerations that mattered when claiming moral damage to companies only. Moral damage payments had to discipline companies and not just compensate for the suffering of the client. Moral damage payments had to stimulate insurance companies to behave better in the future, towards all clients, including those who were not represented in the lawsuit.

I asked Pedro if the state could not be disciplined in the same way for not meeting people's constitutional rights to health and for causing suffering. Pedro argued that it would be unethical to claim moral damages from the state. He, as well as many other lawyers I met, argued that moral damage payments would cut public healthcare budgets. Therefore, such payments would deprive others of badly needed healthcare and would undermine an already strained public health budget. He also explained that he saw no pedagogical function: doctors, nurses, and other healthcare professionals were already doing their utmost to take care of patients, and such a punishment would be unhelpful and immoral. Such claims would not recognize the effort that medical professionals and public servants were putting in to make the best of an underfunded system.[8] Moral damage payments would actually undermine these efforts.

This means that public healthcare lawsuits consider healthcare as a collective responsibility which concerns the dignity of the population at large (see also Biehl et al., 2012). What Pedro said made sense to me: that moral damage payments would be at the expense of the public healthcare – a fundamental right under the Brazilian Constitution – of the general population who were not represented in court. Pedro, like other legal experts I spoke with, argued that moral damage payments work differently in the private sector. In the market, these can improve the way insurers treat their clients. I asked if moral damage payments would not undermine the solidarity on which insurance was based, similar to moral damages against the state. Pedro argued that an important difference was that moral damage claims reduced the company's profit. Every day, he could see how insurance companies were making profit while refusing to pay for treatments that their clients are entitled to. Witnessing the injustices and suffering of people at the hands of private insurers was part of Pedro's work.

Actuaries and other professionals working in the private health insurance sector told me that they were acutely aware of this view and explained that this was based on a misconception. Moral damage payments, as well as other legal costs, led to an increase in the premium for policy holders, or meant that insurers could only offer cheaper healthcare services provided by less reputable doctors, clinics, and hospitals. These professionals explained to me that moral damage payments – and legal processes in general – threatened the sustainability of healthcare.

This means that actuaries and other professionals working in the insurance sector had a different perspective than lawyers. With Holmes (2014) I agree that we need to take the metaphors and views of experts seriously, as they affect the way in which financial systems work and how professionals come up with solutions to the problems that they encounter in finance (see also Leins, 2018; Ortiz, 2014). Pedro and other lawyers represented their clients, but also considered that the right to health and dignity can be seen

from a collective point of view. Moral damage claims were seen to weaken the solidarity on which public healthcare was based, as they would be at the expense of others in need of healthcare. The ethical considerations in relation to the market were different. Here, moral damage claims had to compensate for the violation of dignity by the insurer and, at the same time, promote justice for the general population who were not legally represented in court.

As a consequence of the ethical considerations on the part of the public defenders, people who can afford private healthcare often end up financially better off than people who depend on public healthcare. Awarding moral damage to clients only reinforces the sharp health inequalities that permeate Brazilian society.

At the same time, I take these ethical considerations also as a critique of the relationship between capitalism and healthcare. Capitalism means investing in companies to make a profit. Pedro and other lawyers see on a daily basis how profit is made at the expense of the health, well-being, and dignity of clients. As I will show, they see how this leads to all kinds of suffering and even puts people's lives at risk. Lawyers reason – perhaps incorrectly – that moral damage payments cut the company's profit. This implies an ethics that disapproves of how profit, the core of capitalism, prevails at the expense of the health and dignity of clients. Moreover, a detailed examination of court cases shows that it is not only these more personal ethical considerations that matter. The laws that lawyers, public defenders and judges can use also create a distinction between public and private healthcare lawsuits. I will show how healthcare lawsuits can draw on a set of laws and regulations that facilitate the commensurability of dignity and money in the market only.

'I don't want to ask for moral damage'

Maria came to the Public Defender after her insurance company turned down a surgery that her doctor had prescribed. She suffered from severe back pain and had reached a point where the pain is so bad that she was unable to do the physiotherapy that was necessary to relieve the pain. She was diagnosed with thoracic kyphosis and chronic cervical pain caused by her large breasts. The doctor prescribed breast reduction surgery, after which she could resume physical exercises that would strengthen her back. Maria's insurance company did not authorize the surgery. The reason they gave was that this particular surgery was not explicitly mentioned in her insurance contract and was also not listed by the Agência Nacional de Saúde Suplementar (ANS). Since 2000, the ANS has been under the Ministry of Health and is the regulatory agency responsible for controlling the health insurance sector. The ANS established a list of treatments that every health insurance policy needs to cover, and this particular treatment was not on the ANS list.

Maria was angry that the surgery was denied, but at the Public Defender's Office she said that she hoped to find a solution. Before arriving, she had already called the insurance company and offered to pay the surgery herself if they would pay for the anaesthetist, the necessary surgical materials, and post-surgery medical costs. The company rejected her proposal, and these conversations left her with a bad feeling. She had the impression that they did not believe that there was a medical reason for the surgery. She said that the company implied that she wanted them to pay for an aesthetic surgery. While being

attended in one of the cubicles she jokingly said: 'If what I really wanted was aesthetic surgery, I would ask for an increase in the size of my breasts, not to reduce them!'

Maria was upset that the insurance company was not honouring the contract, especially because she had always been responsible, had modest expectations, and had always been a reliable client. She highlighted her loyalty by saying that she had the policy for nearly ten years when she started her current job as a financial advisor. She always paid the premium on time, but now, when she needed them, they let her down: 'It's a matter of disregard for the client. They deny authorization to see if people will give up.'

From her bag, Maria took several newspaper articles she had found online and printed to show us. The articles reported on lawsuits against health insurance companies, and she added:

> You see, insurance companies know that they have to do this [treatment], but they don't care. My doctor also complained about this and about the low fee that the insurance company would pay him for doing the surgery. They charge me 800 per month [insurance premium] and then pay him only 700 for a risky surgery.

She continued: 'My intention is not to harm the insurer or anything like that…. If they propose to pay for surgery instead of starting legal action, it's okay.'

Daniella, the intern at the Defensoria Pública who assisted Maria advised her to ask the judge for moral damage compensation and explained that she would be entitled to this as the insurer violated her dignity. At first, Maria objected, saying that she was not trying to hurt the company. She only wanted them to authorize the surgery, nothing more. Daniella explained that they routinely included moral damage claims, also as a negotiation strategy in a conciliation hearing.[9] Maria agreed and the moral damage was placed at R$10,000. I asked Daniella how she came to this amount. She said that this was approximately the amount that Maria needed for surgery. In this instance, the medical costs, and not Maria's personal experience, demonstrated the moral damage payment. The motivation for the moral damages that Daniella included in the petition depended little on Maria's personal experiences. The petition did not relay the words Maria had used to describe how she felt humiliated by the company and how the company's behaviour had angered her. Instead, the petition argued in great detail why it was unlawful to deny this surgery, even though it was not included in the contract and was not part of the ANS regulations. This was supported by documentation, such as the insurance policy, the doctor's medical report, and references to Maria's constitutional and consumer rights.

During conversations, the public defenders explained to me that it was very difficult to demonstrate the violation of dignity by using personal experiences and narratives. It was legally problematic to establish personal experiences as facts, especially with regard to dignity.[10] Although experiences mattered a great deal to the users, the evidence for the violation of human dignity came from the insurance contract, consumer laws and ANS regulations regarding private health, and, last but not least, constitutional rights to health. To prove the violation of dignity, the petition had to focus on these contractual and legal obligations.

What became clear was that Maria's contract stated that only treatments listed by the ANS were covered. The insurer denied breast reduction surgery because it was not on the ANS list and was also not included as an additional treatment in the contract. The Public Defender argued that this contract was abusive because it covered *only* treatments that the ANS listed. This meant that the contract was not in line with what a client could expect in light of constitutional rights to health. The contract complied with the Consumer Protection Code and ANS regulations, but, as the petition to the judge pointed out, the constitutional right to health *always* prevails over other laws, codes and regulations. Therefore, the fact that the insurance company presented the client with a contract that did not honour her constitutional right to health was a violation of her human dignity, a violation that required a payment moral damages.

It took some time for me to understand all this, which I am sure is at least partly because I am not a lawyer. The violation of human dignity was *not* because the insurance company dishonoured the contract. In fact, the company *did* comply with the contract, as well as the Consumer Protection Code and ANS regulations. Instead, the claims for human dignity and moral damages were based on the client's constitutional right to health that the contract did not honour. What took some time for me to comprehend was an important aspect of the constitutional right to health. The Constitution explicitly defined the right to health in relation to the state, but this right had become the foundation for the right to health in the market, as well as the dignity and moral damage claims vis-à-vis insurance companies. Maria's petition went on to argue that her doctor was responsible for defining the best treatment and that, by denying this treatment, the insurer abused her constitutional and right to health and dignity. The staff and volunteers of the Public Defender believed it was important to evoke the judge's empathy. At the same time, it was clear that this did not mean that the claims of the violation of human dignity and moral damage could be based on the suffering that Maria and other clients like her expressed. The proof of the violation of dignity was in presenting the client with a contract that was abusive. The contract was abusive because it did not provide the same rights to health as the Federal Constitution of 1988, irrespective of the fact that the contract complied with consumer legislation and ANS regulation.

This particular use of constitutional rights to health and dignity was not seen as unusual; it only appeared unusual to me as the anthropological outsider and a novice in the field of law. In conversations with Brazilian lawyers, public defenders, and even clients of insurance companies, it was seen as normal. When I expressed my surprise at this interpretation, a lawyer recalled a meeting he attended with the vice-president of a large US health insurance company. The vice-president was considering expansion into the market in Brazil, but the legal processes puzzled him and held his company back. He failed to understand why Brazilian judges ruled that insurance companies had to compensate for the violation of dignity and authorize treatments even when these treatments were not included in the contract, were not listed by the ANS, and when the Consumer Protection Code was not violated.

The lawyer laughed when he recalled this event. He understood that this might not make sense to foreigners who were not familiar with Brazil's legal intricacies, but also pointed to another more political aspect. Lawyers and healthcare professionals told me

that they did not see the ANS as a legitimate institution. They argued that the ANS was supposed to regulate the healthcare market and protect clients, but was in fact more a lobby organization catering to the interests of the insurance sector. It was a commonly held view that the ANS did not prioritize the interests of patients or medical professionals and therefore violated fundamental human rights. As Carvalho and de Oliveira Cecílio (2007) show, over the past 25 years, the federal government repeatedly sided with insurance companies against the interests of clients and medical professionals. Disputes over government regulations, insurance coverage, exclusionary clauses, the autonomy of medical professionals, and the responsibilities of public and private healthcare systematically ended in favour of the insurance sector (Carvalho and de Oliveira Cecílio, 2007; see also Daros et al., 2016).[11] Many lawyers and medical experts did not see the ANS as a legitimate institution, and this was reflected in the petitions in which judges were asked to give precedence to the constitutional right to health and dignity over and above ANS regulation.

Maria waited five months for the court's final verdict. The judge ruled that the insurance company had to pay for the treatment prescribed by the doctor, pay all legal costs, and that Maria was entitled to R$7,000 for moral damages. The judge stated that the insurance contract was intended to provide complete and integral protection of the right to health. Maria's contract was abusive because it did not provide this. The contract was instead 'frustrating the legitimate expectation of the consumer', and ANS regulations and the Consumer Protection Code could not be used to deny her treatment. The contract was abusive, as the Public Defender had argued. The payment of moral damage was based on the 'sacred dignity of the human person as the foundation of the Federative Republic of Brazil (art.1, III, and 6°, caput of CF/88)'. Although constitutional rights to health and dignity refer to the state, they were used to claim access to healthcare and compensate for the violation of dignity in the market. The legal experts that I spoke to presented this as a consequence of legal resources: the contract was evidence of suffering. At the same time, this distinction also suggests a virtue ethics that distinguishes personhood in relation to the market from personhood in relation to the state. The next case will shed more light on this distinction.

'It made us look like swindlers'

Rosa and Gilermo visited the Public Defender on behalf of Alexa. They are Alexa's mother (Rosa) and brother (Gilermo). Alexa had to stay home to take care of her newborn baby and because she was struggling with some health issues. Rosa and Gilermo wanted to take the insurance company and their insurance broker to court. They said that when Alexa was in hospital to deliver her baby, the insurer refused to pay the hospital bills. They said that the insurer or the broker had forged Alexa's signature.

When they were seen by Raquel, it was Rosa who did most of the talking. She explained that Alexa decided to review her health insurance policy when she was pregnant. A health insurance policy often only pays for healthcare when it is done by a clinic or hospital that they include in the contract. When Alexa reviewed the hospitals she

could go to, she decided to change her policy. A new policy would be more expensive, but would include hospitals that were closer to her home and that had a better reputation.

Alexa's insurance broker advised her to 'migrate' to a new policy from another company. He assured her that the new policy would go into effect immediately and that the usual six-month waiting period (*carência*) that were normally required would not apply. Alexa signed the contract but never received a copy. She proceeded with prenatal care, routine check-ups and exams, all at the hospital of her choice and that was covered by her new policy. They also planned a caesarian section delivery. In Brazil, it is common to have a caesarian section, at least in private hospitals. In some cities, the prevalence of caesarian sections in private hospitals exceeds 90% (de Almeida et al., 2008). When Alexa arrived for the planned delivery, she was told that the insurance company did not authorize the treatment. The insurer had informed the hospital that the treatment was not covered because the policy was within the six-month waiting period (*carência*).

Gilermo and Rosa spoke about how terrible the situation had been. Clearly agitated, Gilermo said: 'They [hospital staff] told me to call an ambulance to take my sister to a public hospital!' He found the idea to be preposterous. Gilermo and Rosa told the hospital staff that Alexa was not going anywhere and insisted that the insurer authorize the treatment. The hospital staff told them that they would only treat her when they paid the bill upfront. Faced with having to travel to a public hospital, Rosa charged paid R$15,000 with her credit card, after which the hospital proceeded with the delivery.

Alexa, Rosa, and Gilermo were not poor, but also told us that they could not easily afford to pay such a large sum of money. The prospect of Alexa having to deliver her baby at a public hospital had worried them. Public hospitals are often overcrowded, caesarean sections are not performed as often, and they expected that the care that Alexa would receive would be inferior. They had been upset about the prospect of having to put Alexa in an ambulance.

During the conversation, it became clear that their concern also had to do with dignity. They were worried that the medical staff or onlookers might think that they had planned to deceive the hospital. Rosa explained how being seen as dishonest had humiliated them:

> The nurses were commenting: 'This is the patient who had a negative from the health insurance.' We were so embarrassed!

This concern was voiced several times, and in response Raquel explained that they would claim moral damages from the insurer. Rosa agreed, sharing once more what she experienced that day:

> The horror of arriving for a delivery and finding out that they wanted to send my daughter to the SUS! … The hospital staff told me: 'We have to put your daughter in an ambulance and take her to SUS.' As if SUS would work out! We see on television people giving birth in the corridors of SUS hospitals. Not to mention the embarrassment! We pay for private health insurance and then receive a negative [from the insurer]. It made us look like swindlers (*caloteiros*).

Nobody had accused them of being swindlers, but the prospect of people gossiping that they were, Rosa explained, was an indignity.

The embarrassment that Rosa voiced referred not only to being suspected of fraud, but also to popular notions regarding class, race, and crime in Brazil. Right-wing discourses persistently equate being poor with being criminal. In Brazil, it is not uncommon to refer to the poor as criminals who have no right to visit shopping malls, airports, private hospitals. In Brazil, these places of consumption symbolically mark spatial and class boundaries that distinguish the 'middle class' from the poor (Pinheiro-Machado and Scalco, 2013, 2014). When people draw on these discourses, they self-identify as virtuous and hard-working 'good people'. This sets them apart from the poor, who are seen as free riders who use public institutions without paying for them through taxes (Cesarino, 2020; Pinheiro-Machado and Scalco, 2020).

These ideas were not new, but have become more prevalent during President Bolsonaro's administration. They were declared at political rallies, in public speeches and social media, and played a growing role the hatred directed towards the poor (see Bähre and Diniz, 2020; Bähre and Gomes, 2018; see also Cesarino, 2020; Pinheiro-Machado and Scalco, 2020).

Alexa, Rosa and Gilermo live in Sudoeste, which is one of the wealthier parts of Brasília, and health insurance and private hospitals seemed to be important not only for health reasons, but also as a symbolic marker of their middle-class identity. Being seen as swindlers seemed to be at the core of the violation of human dignity that centres around middle classness. At one point during the conversation, Rosa and Gilermo talked quite loudly about their suffering. Some of the users of the 'health nucleo', which is in the same room as the 'consumer nucleo', became involuntary witnesses to how a well-dressed and carefully made-up *dona* despised the public healthcare system. They could hear how Rosa fiercely argued that the dignity of her family was violated by the prospect of depending on a public health system that they themselves were struggling to access.

Gilermo and Rosa suspected that the insurance broker had forged Alexa's signature and filed a complaint at the police station. The police told them that this broker had a bad track record. They informed the insurer who did nothing about it. They were angry about many things that the insurer only cared about money; that the Superintendência de Seguros Privados (SUSEP) did nothing with their complaints and had not revoked the broker's licence.[12] Gilermo said he felt abandoned by these and other regulatory bodies: 'SUSEP, ANS, PROCON, they don't solve anything. Things get resolved only when you go to court.'[13] Rosa agreed: 'It seems that they know all the manoeuvres for conning people', after which Gilermo explained how he saw the heavy aura and negative energy of insurers and the public institutions that were supposed to regulate them.

Raquel carefully drafted the petition to the judge and included the insurance contract, the police report, and other reports. The petition was approved by the Public Defender and sent to the court. The petition included a claim for the hospital bill of almost R$15,000, an allegation of fraud, as well as a moral damage claim of R$15,000.

Through the electronic database of the court, I could find out what happened with the petition. First, the judge called in an expert who established that the signature on the contract was forged. The judge called a hearing where the insurance company argued that

Alexa was not entitled to the treatment. This was not due to the waiting period, as Alexa was told in hospital, but because she did not pay her premium in time. Almost a year after receiving the petition, the judge ruled that the insurance company had no grounds to refuse the treatment. The insurance company had to pay the hospital bill, all legal costs, and award Alexa R$7,000 as indemnity for moral damage. The judge wrote that the key element of moral damage is an offence against 'personality rights' (*direito da personalidade*). These were 'offences against honour, decorum, inner peace, in short, personality projections of the human person'. The judge argued that a breach of contract was in itself not sufficient to cause moral damage, but that in this case, where a mother who was about to deliver a baby was denied healthcare, the beneficiary's 'dissatisfaction and stress … go far beyond mere daily nuisances'. He reasoned that refusing to authorize medical assistance during childbirth was a breach of contract. This breach of contract caused a mother psychological distress and anguish and the R$7,000 moral damage compensated for this. The judge argued that moral damage compensation also had 'an important pedagogical function': it encouraged the insurance company to improve its behaviour.

A public and private lawsuit

Let us return to Diana, who, with the help of the Public Defender, initiated a lawsuit against her health insurance company *and* the state. Only the suit against the insurer had a moral damage claim, which was set at R$20,000. Diana's autoimmune disease had caused her to partially lose her eyesight. She could easily fall and hurt the baby. It was also for this reason that Diana's husband took a day off as an Uber driver. He wanted to accompany his wife, gently holding her hand. The intern who attended Diana could clearly see that Diana was pregnant and jokingly said: 'Please do not deliver here!' Diana laughed: 'I hear that a lot these days. People at work also tell me: "You have to go home, you could have this baby at any moment! Don't have it here!"' We all laughed.

Diana told us that her pregnancy was not planned, but that the baby was very wanted. Only later did Diana find out that the medication she took could be dangerous to the baby. Diana was relieved when tests revealed that the baby was fine. She said: 'When I found out, I could only cry. I thought I could have killed or damaged the baby.' Diana's anxiety was amplified by feelings of guilt and she explained that she might be seen as an irresponsible or uncaring mother.

The doctor had prescribed another type of medication to Diana, which she had to take in two doses. The first dose had to be taken within 24 hours after delivery, and the second dose six months later. The doctor said that Diana's health also requires her to have a caesarean section, for which they had set a date. But now, without medication, they had to postpone childbirth as much as possible.

When Diana and her husband visited the Public Defender for the first time, they were directed to the 'health nucleo'. They drafted a petition against the Federal District of Brasília, which is responsible for public health. The petition stated that Diana's constitutional right to health must be honoured, that it was the constitutional duty of the state to provide healthcare and that the doctor's prescription had to be followed. The state had to provide the medication or otherwise purchase it from a commercial pharmacy. The

petition did not explicitly mention the distress and suffering that Diana was feeling, but it was clear that the life of Diana and her baby was at risk if the medication was not available very soon. For that reason, the judge was asked to make a decision as quickly as possible. This petition did not include a moral damage claim.

During this first visit to the Public Defender, it became clear that Diana had health insurance through her work. This was with a so-called self-managed health insurance company (*empresa de autogestão*). Self-managed health insurance companies were created by and for groups of workers; some of them date back to the 1930s, long before Brazil developed an extensive public healthcare system. They were common among civil servants like Diana, and today self-managed health companies make up about 6% of the health insurance market. Although these insurers are non-profit they are regulated in the same way as other private insurers (Carvalho and de Oliveira Cecílio, 2007; Paim et al., 2011: 1786). Diana's health insurer said that the ANS, the national regulator of private healthcare, did not require the insurer to cover this policy and that her medication would not be provided.

The Public Defender then decided to sue both the state *and* the insurer in the hopes of getting a fast positive verdict. Given that the delivery date had already been postponed and given the severity of the health risks to Diana, a few days would already make a difference. It was best to take both the public and private routes at the same time. Another reason for suing the insurance company, the Public Defender explained, had to do with a Supreme Court ruling. The ruling stated that a health insurer cannot pass on its responsibility to the public healthcare system. If Diana won the case against the state, which they were certain of, she would still have to sue her insurer and force them to reimburse the state.

Four days later, Diana returned to the office to find out about the ruling. The judge had ruled that the Federal District had to purchase Diana's medication at a commercial pharmacy. But there was a setback. Diana needed to take a court order that proved the judge's ruling to the private pharmacy. The court order was not there yet and nobody knew how long Diana could wait. Initiating a lawsuit against Diana's insurance company would, hopefully, be a faster route.

Here, also, the claim was that Diana was entitled to this medication, but now a moral damage claim of R$20,000 was included. Marieta drafted a petition that was more than twenty pages long and explained that it was so long in order to convince the judge. From experience, they knew that it helps to be as specific as possible about the health threat. Marieta was clearly concerned about the well-being of Diana and her baby. Diana was concerned that her autoimmune disease could worsen. When her vision deteriorated further, there could be massive consequences extending to her work, social life, the ability to take care of herself and of her baby. The fact that the delivery had already been cancelled, and that she could have the baby at any moment without having the proper medication, weighed heavily on her.

Diana told us about her financial worries. She and her husband could not afford to buy the medicine and her husband earned less as he had to accompany her. These experiences and stories mattered a great deal to Diana, and Marieta was very concerned too. Marieta tried to include as much as possible in the petition, but could only indirectly relate Diana's

experiences. The petition gave a detailed overview of Diana's health, the urgency of her situation, the doctor's diagnosis and treatment, her insurance policy and her communications with the insurance company. It presented a detailed legal motivation for why Diana was constitutionally entitled to the medication prescribed by the doctor.

Marieta said that, like her colleagues at the Public Defender, she found it difficult to explain why experiences were only marginally included in the petition. Users wanted to share their fears and other emotions. They talked passionately about how they were humiliated, brushed off, or lied to. It was frustrating for clients to politely listen to the insurer's veiled accusations that they were trying to cheat. Some of the staff of the Public Defender said that these stories were a distraction from the work they had to do. Others, mainly new staff members, told me that they were disturbed by these stories and found it difficult to deal with the emotions and injustices. Some had sleepless nights over this.

Diana's petition did not explicitly mention these emotions and experiences. To back up the violation of dignity claim, it referred to texts written by legal professionals. The petition stated that Diana's dignity was violated when the company denied authorization in an attempt to 'win by tiring the consumer', which had put the client's life at risk. It argued that the value of life was protected by law and that dignity was a fundamental constitutional right in a democratic state. It quoted numerous legal experts who argued that human dignity was the very basis of all moral values and the essence of all personal rights, including the right to honour, a name, intimacy, privacy, and freedom of the human person. The company had violated this human dignity by acting in bad faith; by not approving the treatment, it caused anguish and distress. The petition declared that non-authorization clearly proved 'damage to the right to dignity of the human person and damage to her physical health as a whole and damage to the greatest value of all, life itself'.

The moral damage payment had to compensate for the embarrassment, distress, and humiliation that the patient experienced, but also served to punish the insurer:

> We can see that in order to quantify moral damage, it is necessary to analyse how badly the company conducted itself. Based on this, the compensation must be enough to punish and prevent the continuation of these practices…. [T]he compensation established by the judge should be severe to discourage the defendant from doing this again and harming the lives of other people.

The same day, the judge made the preliminary ruling that the insurer had to provide the medication the doctor had prescribed. The final ruling was issued six months later and could be read in the online database of the court. It confirmed the preliminary ruling. Furthermore, the company had to pay R$5,000 for moral damage, which was substantially lower than the R$20,000 asked for in the petition. The judge supported her ruling, stating that, although this case concerned a non-profit company, it could be understood that there was 'abusive conduct … established by virtue of the business entered into'. Diana's insurer had been abusive by denying treatment and, therefore, did not act in good faith. The ruling stated that the moral damage compensation was based on the extent of the damage, the socioeconomic conditions of the parties, as well as 'the pedagogical function

of moral damage'. The judge argued that she hoped that penalizing the insurer would lead to better behaviour in the future. The moral damage payment was also based on the 'prohibition against illicit enrichment and the principle of proportionality'. In other words, the judge argued that by denying Diana the medication, by not including it in her contract, they had violated her dignity. Additionally, by doing so, the company was acting as a for-profit company that was illicitly enriching itself at the immediate risk of the client's life. The judge explained that the fact that the insurer was actually a non-profit organization did not mitigate this violation. The moral damage claim was based on the abuse of a market relation – between a consumer and a company – even though the contract that Diana had was with a non-profit organization. The judge made it clear that non-profit insurers had the same obligations towards clients as for-profit companies. A consequence of this ruling is that the state does not have to provide Diana's medication.

Paying attention to incommensurability

What was at stake in the court proceedings was far from trivial. People's health and even lives were compromised by not having access to healthcare. Their dignity was also in danger. According to the Brazilian Constitution, 'the dignity of the human person' is the essence of all personal rights. The judges ruled that health insurers had to pay for moral damages and compensate for the violation of dignity, while such claims were not included in lawsuits against the state that was responsible for public health.

This lack of commensurability of dignity needs to be contextualized within Brazil's deep-seated configuration of inequalities where 'citizens may not have the same rights in all circumstances, depending on social standing and position' (Cardoso de Oliveira, 2013: 132). Court proceedings established that people who entered the market, as consumers of healthcare, had a kind of dignity that was different from those who depended on public healthcare. The violation of their dignity was commensurable to economic value, at least to the extent that dignity could be proven by the discrepancy that existed between contractual obligations and constitutional rights.

One could conclude that marketization and financialization increasingly quantify personhood by equating dignity to economic value. Court procedures might lead to the conclusion that the dignity of consumers was worth more or that courts could only recognize the dignity of consumers as a function of the contract. After all, privatization of services reinforced the separation of Brazilians with access to the market from those who depend on the state, reflecting high levels of inequality (Biehl et al., 2012; Biehl, 2013). The individual experiences with financial markets that clients expressed fit within a moral and political discourse that celebrated consumer identities and delegitimized the state and its public services (Pinheiro-Machado and Scalco, 2020). This discourse was prominently present among Bolsonaro supporters during the 2018 and 2022 election campaigns, which presented poor people as immoral people who abuse public resources, an image that was contrasted with 'us', the good people who found dignity as entrepreneurs and consumers in the market (Bähre and Gomes, 2018; Cesarino, 2020). For some, the prospect of having to rely on public healthcare not only posed health risks, but also threatened notions of self

that were defined by market relations that shored up distinctions between the good people and the scroungers.

At first, I considered it unfair that compensation should be paid only for violation of dignity at the hands of the market (see Bähre, 2022). The incommensurability of dignity and economic value vis-à-vis the state suggested to me that Brazilians who rely on public healthcare have less dignity than people with private health insurance. Moral damage payments in the private sector only reinforce Brazil's sharp economic inequalities. However, such a view would imply an embrace of a political and ideological discourse that only recognizes personhood when it is commensurable to economic value. Such a view would misrepresent markets as totalizing and universalizing forces, where, in the end, not even personhood escapes economic values. But a close examination of court proceedings reveals a more complex and diverse reality. Values are created within social and institutional networks that create and reflect particular worldviews.[14] When people take part in particular exchanges they gain recognition and prestige but also develop other aspects of moral personhood (Bähre, 2020; Brites, 2014; Guyer, 2004; Kusimba, 2020, 2021; Zelizer, 1995, 2005). For example, Diana experiences empathy for her physical, financial and emotional problems on the part of the staff at the office of the Public Defender, and that they treat her with dignity. Moreover, both public and private healthcare are possible because of exchanges. Public health is financed through a tax-based system and this affects moral personhood. In public health, moral personhood does not 'translate' into moral damage payments as it does in market exchanges. At the same time, moral personhood is the outcome of a tax-based system that not only considers the constitutional right to health of a patient but also the responsibility to have healthcare as a collective quality.

The incommensurabilities are, as Lambek (2008) importantly argued, crucial to a theory of value that takes seriously cultural change, human creativity, and the tensions that exist over morality, personhood, and ethics. Beyond the insights that this study provides into legal procedures in Brazil, the proceedings highlight how important it is to pay attention to the existence of 'a partial barrier, a lack of clear or complete equivalence' (Lambek, 2008: 139).

Court proceedings establish that the violation of dignity can be priced in the market only because it needs evidence to prove the violation of dignity. Personal experience does matter, but is not sufficient. Instead, it is the contract between the client and the company that proves the violation of dignity. Personal experiences and contractual obligations thus offer different perspectives on moral personhood, each with far-reaching consequences for what can be equated with economic value. To prove moral damage one needs a contract between a client and a company, and that exists only in the market. This specific legal context has a technical side (private lawsuits can draw on legal resources to prove violation of dignity via the contract) that, at the same time, represents an institutionalized justification of unequal treatment.

By taking an ethnographic look at what precisely happens in court proceedings, one notices all kinds of moral evaluations, some of them represented through legal resources and considerations, where dignity and morality are considered but at the same time not made commensurable to economic value in the form of a moral damage payment. An

ethnographic approach to court proceedings reveals those ethical considerations that have escaped monetization and reveals an ethic that establishes a boundary between dignity and economic value; where legal professionals are not ignorant of personal experiences but need to have the legal resources to express them; and where not only the suffering and dignity of the claimant are considered, but also of other Brazilians in need of healthcare; and where moral damage claims are a fundamental critique of the nexus of capitalism and healthcare. For Rosa and Gilermo, dignity means avoiding public healthcare. They find dignity when they are compensated financially for possibly being seen as swindlers. For some legal experts, dignity is a feature of the contractual obligations between clients and companies. Public defenders like Pedro have a different view again, when they do not make moral damage claims as they consider dignity and the right to health as a collective responsibility that would be threatened by such claims against the state. Legal practices, professional evaluations and personal experiences reveal the complex and diverse ethical perspectives on personhood in a divided Brazilian society where personhood is sometimes priceless.

Acknowledgements

I would like to express my gratitude to the Defensoria Pública DF for its support and help. I am very grateful to Fabíola Gomes for her generous assistance to this study. I would like to thank in particular Nikkie Buskermolen, Luís Roberto Cardoso de Oliveira, Deborah Fromm, and Irene Moretti for their helpful and constructive feedback as well as the anonymous reviewers and editors of *Critique of Anthropology* for their generous and considered comments.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was supported by the Moralising Misfortune project funded by the European Research Council (ERC) under the Horizon 2020 Research and Innovation Programme (Grant Agreement No. 682467).

ORCID iD

Erik Bähre https://orcid.org/0000-0001-5695-1719

Notes

1. See Daros et al. (2016) for an analysis of complaints that were sent to the Supplemental Health National Agency (ANS). It shows that problems with access to services and care were the most prominent complaints.
2. Preliminary rulings were only made in cases of medical emergencies. These rulings were sometimes made within a few hours and would not take longer than a few days.

3. For example, a claim of R$15,000 was reduced to R$5,000; R$20,000 reduced to R$3,000; R$20,000 reduced to R$5,000; R$10,000 reduced to R$7,000; R$15,000 reduced to R$7,000.
4. See Biehl (2013) and Cardoso de Oliveira (2020) on dignity and inequalities in Brazil.
5. See Das (1998) on the communicability of pain. See also Robbins (2013: 456) on suffering, empathy and the mobilization of social change.
6. See also Biehl et al. (2012) and Sant'ana (2017b).
7. A moral damage claim was included in all but one of the 16 cases.
8. In a conversation, Aleksandar Bošković pointed out to me that this might relate to the sanctity of the state: the state cannot be punished because of its sovereign status.
9. In one of the 16 cases, the judge ruled that the company had to pay for a surgery to remove an inflamed appendix and awarded the moral damage claim. After the verdict, the insurance company informed the client that they would appeal the ruling, unless the client accepted that the company would pay for the surgery but not for moral damage. The insurer emphasized that such an appeal would take a very long time and would be risky for the client. Although the client and her lawyer were convinced that she would win the appeal, she agreed to the proposal. She realized that the appeal would lead to frustration and anxiety, and possibly financial problems. She decided to accept this and move on with her life.
10. See also Cardoso de Oliveira (2020) on civic sensibilities in Brazil's legal context.
11. See Fromm (2019) on how insurance companies influence national laws and policies regarding car insurance.
12. SUSEP falls under the Ministry of Economy and is the inspectorate of the insurance, private pension, capitalization and re-insurance market.
13. PROCON is the Institute of Consumer Protection (Instituto de Defesa do Consumidor).
14. See Bähre (2011), Graeber (2001), Guyer (2004, 2009), Lambek (2008), and Otto and Willerslev (2013). Studies of life insurance show how these moralities are at the forefront when people receive financial compensation for the loss of life. See Bähre (2020, 2022), Chan (2012), Golomski (2018), Moretti (2021), Mulder (2020) and Zelizer (1995).

References

ANS (2021) Dados Consolidados da Saúde Suplementar. ANS. Available at: http://ftp.dadosabertos.ans.gov.br (accessed 21 January 2021).

Bähre E (2011) Liberation and redistribution: Social grants, commercial insurance, and religious riches in South Africa. *Comparative Studies in Society and History* 53(2): 371–392.

Bähre E (2020) *Ironies of Solidarity: Insurance and Financialization of Kinship in South Africa*. London: Zed Books.

Bähre E (2022) Precificando a dignidade humana no tribunal: Os planos de saúde e as indenizações por danos morais. *Antropolítica* 54(1): 350–374.

Bähre E and Diniz D (2020) Women's rights and misogyny in Brazil: An interview with Debora Diniz. *Anthropology Today* 36(2): 17–20.

Bähre E and Gomes F (2018) Humiliating the Brazilian poor: The iconoclasm of former President Lula. *Anthropology Today* 34(5): 10–15.

Biehl J (2013) *Vita: Life in a Zone of Social Abandonment*. Berkeley, CA: University of California Press.

Biehl J, Petryna A, Gertner A, Amon J and Picon P (2009) Judicialisation of the right to health in Brazil. *The Lancet* 373(9682): 2182–2184.

Biehl J, Amon JJ, Cocal MP and Petryna A (2012) Between the court and the clinic: Lawsuits for medicines and the right to health in Brazil. *Health and Human Rights: An International Journal* 14(1): 1–17.

Brites J (2014) Domestic service, affection and inequality: Elements of subalternity. *Women's Studies International Forum* 46(Sept.–Oct.): 63–71.

Cardoso de Oliveira LR (2013) Equality, dignity and fairness: Brazilian citizenship in comparative perspective. *Critique of Anthropology* 33(2): 131–145.

Cardoso de Oliveira LR (2020) Civic sensibilities and civil rights in a comparative perspective: Demands of respect, considerateness and recognition. *Ius Fugit* 23: 195–219.

Carvalho EB and de Oliveira Cecílio LC (2007) A regulamentação do setor de saúde suplementar no Brasil: A reconstrução de uma história de disputas. *Cadernos Saúde Pública* 23(9): 2167–2177.

Castro MC, Massuda A, Almeida G, Menezes-Filho NA, Andrade MV, de Souza Noronha KVM et al. (2019) Brazil's unified health system: The first 30 years and prospects for the future. *The Lancet* 394(10195): 345–356.

Cesarino L (2020) Como vencer uma eleição sem sair de casa: a ascensão do populismo digital no Brasil. *Internet & Sociedade* 1(1): 91–120.

Chan C (2012) *Marketing Death: Culture and the Making of a Life Insurance Market in China*. Oxford: Oxford University Press.

Daros RF, Gomes RS, Silva FH and Lopes TC (2016) A satisfação do beneficiário da saúde suplementar sob a perspectiva da qualidade e integralidade. *Physis* 26(2): 525–547.

Das V (1998) Wittgenstein and anthropology. *Annual Review of Anthropology* 27: 171–195.

de Almeida S, Bettiol H, Barbieri MA, Silva AAM and Ribeiro VS (2008) Diferença notável nas taxas de parto cesariano em hospital público e hospital privado no Brasil. *Cadernos Saúde Pública* 24(12): 2909–2918.

Doniec K, Dall'Alba R and King L (2016) Austerity threatens universal health coverage in Brazil. *The Lancet* 388(10047): 867–868.

Fourcade M (2021) Ordinal citizenship. *British Journal of Sociology* 72(2): 154–173.

Fromm D (2019) Creating (il)legal markets: An ethnography of the insurance market in Brazil. *Journal of Illicit Economies and Development* 1(2): 155–163.

Golomski C (2018) Elder care and private health insurance in South Africa: The pathos of race–class. *Medical Anthropology* 37(4): 311–326.

Graeber D (2001) *Toward an Anthropological Theory of Value*. New York: Palgrave.

Guyer JI (2004) *Marginal Gains: Monetary Transactions in Atlantic Africa*. Chicago: University of Chicago Press.

Guyer JI (2009) Composites, fictions, and risk: Toward an ethnography of price. In: Hart K and Hann C (eds) *Market and Society: The Great Transformation Today*. Cambridge: Cambridge University Press: 160–174.

Henig D (2019) Economic theologies of abundance: Halal exchange and the limits of neoliberal effects in post-war Bosnia-Herzegovina. *Ethnos* 84(2): 223–240.

Holmes DR (2014) *Economy of Words: Communicative Imperatives in Central Banks*. Chicago: University of Chicago Press.

Jurca R de L (2020) Neoliberalismo e individualização nas políticas de saúde na periferia sul de São Paulo. *Caderno CRH* 33: 1–17.

Kusimba S (2020) Embodied value: Wealth-in-people. *Economic Anthropology* 7(2): 166–175.

Kusimba S (2021) *Reimagining Money: Kenya in the Digital Financial Revolution.* Stanford, CA: Stanford University Press.

Lambek M (2008) Value and virtue. *Anthropological Theory* 8(2): 133–157.

Lambek M (2015) *The Ethical Condition: Essays on Action, Person and Value*. Chicago: University of Chicago Press.

Leins S (2018) *Stories of Capitalism: Inside the Role of Financial Analysts*. Chicago: University of Chicago Press.

Maurer B (2005) *Mutual Life, Limited: Islamic Banking, Alternative Currencies, Lateral Reason*. Princeton, NJ: Princeton University Press.

Moretti I (2021) Kin enough: Measuring closeness for insurance payouts in Italy. *Social Analysis* 65(4): 90–110.

Mulder N (2020) Bad deaths, good funerals: The values of life insurance in New Orleans. *Economic Anthropology* 7(2): 241–252.

Ortiz H (2014) The limits of financial imagination: Free investors, efficient markets, and crisis. *American Anthropologist* 116(1): 38–50.

Otto T and Willerslev R (2013) Prologue. Value as theory Value, action, and critique. *HAU Journal of Ethnographic Theory* 3(2): 1–10.

Paim J, Travassos C, Bahia L and Macinko J (2011) The Brazilian health system: History, advances, and challenges. *The Lancet* 377(9779): 1778–1797.

Pinheiro-Machado R and Scalco L (2013) Sobre bondes de marca: Consumo e rituais entre jovens de baixa renda na cidade de Porto Alegre. In: Rial C and Silva SR (eds) *Consumo e Cultura Material: Perspectivas Etnográficas*. Florianópolis: Editora da UFSC, pp. 131–154.

Pinheiro-Machado R and Scalco L (2014) Rolezinhos: Marcas, consumo e segregação no Brasil. *Revista de Estudos Culturais* 1(1): 1–21.

Pinheiro-Machado R and Scalco L (2020) From hope to hate: The rise of conservative subjectivity in Brazil. *HAU: Journal of Ethnographic Theory* 10(1): 21–31.

Robbins J (2013) Beyond the suffering subject: Toward an anthropology of the good. *Journal of the Royal Anthropological Institute* 19(3): 447–462.

Sant'ana RN (2017a) *A Judicialização como Instrumento de Acesso à Saúde: Propostas de Enfretamento da Injustiça na Saúde Pública*. PhD Thesis, Centro Universitário de Brasília, Brazil.

Sant'ana RN (2017b) Judicialização e promoção da justiça no acesso à saúde: Estudo do perfil das demandas dos cidadãos atendidos na defensoria pública. In: Neto JP, Avanza CS and Schulman G (eds) *Direito da Saúde em Perspectiva: Judicialização, Gestão e Acesso*, vol. 2. Vitória: Abrages, pp. 53–71.

van Berkel T (2019) *The Economics of Friendship: Conceptions of Reciprocity in Classical Greece*. Leiden: Brill.

Zelizer VA (1995) *Pricing the Priceless Child: The Changing Social Value of Children.* Princeton, NJ: Princeton University Press.

Zelizer VA (2005) *The Purchase of Intimacy.* Princeton, NJ: Princeton University Press.

Author Biography

Erik Bähre is an associate professor at the Institute of Cultural Anthropology and Development Sociology, Leiden University, the Netherlands. His research interests include economic anthropology, conflict and care. He has done extensive fieldwork in South Africa and Brazil. He is an ERC Consolidator Grant laureate with a project on the morality of insurance. His most recent book is *Ironies of Solidarity: Insurance and Financialization of Kinship in South Africa* (Zed Books, 2020).