The Ethics of Health Disparities

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Introduction

The ethical implications of health inequalities among racial, ethnic socio-economic groups and along gender and age lines have been gaining increasing attention over the last several years. Much of this attention has focused on the question of when do inequalities in health care and health status become inequities that must be addressed from an ethics perspective? A great deal of data are now available documenting extensive inequalities in terms of access to appropriate health care services and in terms of relative health status (morbidity and mortality rates), especially along racial, ethnic and social class lines. Much of this information on health disparities is included in several articles in this issue of Generations and is readily available in the growing body of literature on health disparities. This literature describes a long history of disparities in the U.S. and the currently extensive scope of disparities even with the steady expansion of privately and publicly funded systems of health care insurance over the last 50 years. Access to appropriate health care has increased very substantially since the 1960s and the advent of Medicare and Medicaid and the health status of most Americans has improved as measured by increased longevity. At the same time, however, inequalities, especially among racial, ethnic and socio-economic groups persist and in some cases appear to have gotten worse in recent years, especially among women without a high school degree (Olshansky, Antonucci, Berkman, Binstock, Boersch-Supan, Cacioppo, Carnes, Carstensen, Fried, Goldman, Jackson, Kohli, Rother, Zheng, and Rowe, 2012).

The key questions from an ethics perspective is, to what extent do these inequalities in our health care system and the larger society constitute inequities (unjust inequalities) and to what extent are we (society) responsible for actions designed to reduce, or even eliminate these gaps in health care and health status if they are understood to be inequitable?

The initial criterion for determining whether a health inequality is also an inequity is the extent to which it is potentially remediable through some form of collective action, most often a public policy initiative. If the inequality is the product of biological differences or any other source that cannot be feasibly addressed and reduced through collective action, then it cannot plausibly be considered an injustice that should be remedied. In point of fact, few if any health inequalities cannot be effectively addressed through collective efforts to reduce discriminatory practices or compensate for differential access to appropriate and effective services through such material interventions as publicly funded health care. The dispropriate prevalence of a few genetically influenced diseases among racial and ethnic groups should not obscure the fact that the vast majority of health inequalities are a product of inequitable (unfair) access to health care services and a range of social determinants (education, income, discrimination, exposure to polluted environments) that appear to influence morbidity and mortality rates more than health care services alone.

Beyond this initial criterion, however, for determining if an inequality rises to the level of being a potential inequity, more theoretical considerations must be addressed before deciding the ethical status of an inequality.

Ethical Perspective on Health Inequalities

Within the western, or more specifically the U.S. context, two broad theories have tended to dominate the debate over the proper ethical framework for understanding health inequalities and guiding policy responses to them. These theories are also relied on frequently in debates over policy in other domains of public policy.

Libertarianism – This ethical perspective is closely associated with the emergence of capitalist economies in the west beginning about 500 years and is based on the principle that markets are the arbiters of true value as long as they are unrestrained and are not influenced by the exercise of political power. This "free market" perspective holds that the only defensible functions of the state (public sector) are to ensure the right to property, to enforce formal contracts and to protect national interests against foreign threats. Neither the state nor individual citizens are under any obligation for the provision of assistance to individuals without the means to meet basic needs, including for food, housing, education, income, or health care. In the absence of any biding moral obligations on the state to collectively meet the needs of destitute individuals or families, people are free to respond through individual or organized charity to help needy others on a purely voluntary basis (Nozick, 1974).

Part of the rationale for this very limited role of the state and the absence of any moral obligation for the more advantaged to assist those with fewer resources is that it protects the "natural" operations of the market and keeps it from being distorted by misguided acts of benevolence, which almost invariably generate less than optimal market outcomes and outcomes that provide a true measure of a products value. This process is often referred to the "hidden hand" of the unfettered market, a concept first formulated by Adam Smith in his classic book *The Wealth of Nations* (Smith, 1982).

Libertarian economics and ethics have been strongly supported during several periods in U.S. history since the mid to late 19th century, including the last 30 years, which have been dominated by neoliberalism and its prioritization of reduced taxes and public spending, deregulation, and privatization of public services. Neoliberalism has tightened its grip on economic policy across the west as several countries, including the U.S. have adopted austerity policies designed primarily to reduce public spending and public debt (Stiglitz, 2012).

Disparities in health care and health status are not significant ethical concerns from the Libertarian perspective. In fact, the concern runs the other way in that Libertarians fear that efforts through public policy to reduce disparities would interfere with individual rights and responsibilities and the efficient functioning of the market by imposing laws and taxes that diminish the value of personal property and undermine individual choice. These concerns are precisely why Libertarians are critical of universal health care systems administered in several

European countries and are opposed to variants of this model, such as the Affordable Care Act (ACA) being implemented in the U.S.

Holding this perspective does not mean that one is opposed to public support for health care in all circumstances. Many Libertarians recognize something of a right to emergency care and to minimal interventions in life threatening situations. Most, however, would prefer that these services be organized and provided through private, charitable initiatives that in no way implies a

right to all the health care an individual may need and a comprehensive role for the public financing and provision of health care services. Libertarianism recognizes, at most, a very limited role for the public or common good in any domain of human need or condition that others might consider necessary for human flourishing, such as health care (Nozick, 1974).

For this philosophy of ethics, the essential unit of analysis and ethical concern is the individual and her right to use her property in whatever way she chooses as long as she does not interfere with the freedom of others to use their property as they choose. In this view, collective efforts through the public sector to reduce health disparities by broadly increasing access to appropriate and effective care represents coercion by the state. Coercion in this context is defined as the taking of personal property (taxes) that only the individual has a right to and using it for collective purposes outside of the market, which, in its pure form undistorted by state intervention, is the foundation of individual freedom. In this view, taxes collected for the purpose of reducing health inequalities (inequities) is essentially a form of theft by the state and a fundamental violation of individual rights and freedom, however lofty the rationale for the taxes may be (Nozick, 1974).

In this "night watchman" notion of the proper role of the state, health disparities, as well as many other kinds of inequalities, may be unfortunate, but efforts to reduce them will almost invariably cause even greater harm to individuals and society, mainly the loss of freedom and the crippling of market efficiency leading to even greater disparities and social dysfunction (Friedman and Friedman, 1990 and Hayek, 2014).

The fundamental concerns for Libertarians are the ethical standard of individual autonomy and what they consider to be the essential role for the market, free of state intervention or monopoly power, in protecting this standard and ensuring its primacy in the pantheon of universal values (Friedman and Friedman, 1990 and Hayek, 2014). From this perspective, public policy initiatives designed to reduce health inequalities in either health care or health status cannot be ethically defended, at least not effectively. Equalitarianism approaches health disparities from the opposite perspective that the failure to intervene in an effort to reduce inequalities that have reached the level of becoming inequities, are unjust (unfair) and cannot be ethically justified.

Equalitarianism

Daniels and others have developed an ethics of health care based on the principle of fair equality of opportunity for individuals to flourish as human beings. This principle is an essential part of

the notion that health care, like education, is a fundamental human right and not just a privilege. According to Daniels, et al., the fair equality of opportunity standard means that;

> Inequalities cannot be justified through some utilitarian calculus that allows advantages to the better-off to balance out or outweigh the disadvantages to the least well-off as some economists do in focusing only on GNP growth rates or per-capita wealth and ignoring increasing levels of inequality or impoverishment among the worst-off members of a society. In the utilitarian calculus, the needs and interests of the least well-off disappear as the distinction between persons is ignored in calculating total benefits for society as a whole. Instead…priority should be given to improving the condition of the least well-off before considering benefits for a whole society (Daniels, Light, and Caplan, p. 20, 1996).

In application, the fair equality of opportunity principle would make the elimination of health disparities an essential policy priority. The equality of opportunity based right to health care and, by extension, a right to not be disadvantaged by disparities in access to appropriate and competent care, is largely drawn from John Rawls theory of justice as fairness (Nagel, 1999).

According to Nagel (1999), Rawls position;

> …is a direct challenge to the utilitarian answer and its modern version, cost-benefit analysis, according to which we should add up the pulses and the minuses and try to choose policies that produce the maximum amount of total benefit, aggregated from the advantages and the disadvantages to all person affected. This method, Rawls has famously said, does not take seriously the distinction between persons. Tradeoffs across lives should be avoided, and replaced by a system of priorities for the most serious needs and interests, even if this means improving the condition of a less fortunate minority before that of a more fortunate minority…Rawls's idea of justice would minimize the disadvantage to members of a society caused through the social structure by factors that are not their fault. (Nagel, 1999, p. 39).

For Daniels, and other proponents of equalitarian ethics, health care equality protects our opportunities to function normally (or to flourish) by protecting our functional physical and mental capabilities. The lack of access to adequate health care erodes our capacity (equality of opportunity to flourish) to use our talents and skills to take advantage of opportunities available to those able to function normally according to Daniels, et al.:

> A commitment to fair quality of opportunity thus recognizes that we should not allow people's prospects in life to be governed by correctable, morally arbitrary, or irrelevant differences between them, including those that result from disease and disability. By designing a health care system that keeps all people as close as possible to normal functioning, given reasonable resource constraints, we can in one important way fulfill our moral and legal obligations to protect equality of opportunity (Daniels, p. 20).

The fair equality of opportunity principle does not mandate that individuals receive all of the health care they may want or could benefit from in some marginal fashion. The principle recognizes the need for limits on the use of resources (tax revenues) that are also needed to pay for other common goods that are essential for ensuring fair equality of opportunity, including education and public safety. The principle does require, however, that sufficient resources be provided to ensure that everyone, regardless of ability to pay, have equal access to all health services commonly recognized as necessary to maintain normal physical and mental functioning. For Daniels, this provision of the principle includes many services, such as long-term care, that are only partially covered for those who are eligible in the current Medicare and Medicaid programs.

In describing the effort to create an adequate balance between fair access and resource limitations, Daniels et al. note the following:

> The primary social obligation is to assure everyone access to a tier of services that effectively promotes normal functioning and thus protects equality of opportunity… Because of their high "opportunity costs," there will be some beneficial medical services that it will be reasonable not to provide in the basic tier, or to provide only on a limited basis, for example with queuing. To say that these services have "high opportunity costs" means that providing them consumes resources that would produce greater health benefits and protect opportunity more if used in other ways (Daniels, p. 370).

These limitations on the right to health care and the moral commitment to reducing health care disparities mean that not every medical need can be met through an entitlement to services.

The Ethics of Health Care Policy

It is not difficult to see that the U.S. health care system has been shaped by and very much remains under the influence of both ethical perspectives (theories) described here. The U.S. health care system is Libertarian in nature to the extent that it does not include a comprehensive right to health care or a right to the same kind of access to appropriate and effective care for everyone regardless of race, ethnicity, socio-economic status, or economic class, gender, age or any other possible source of social division. On the other hand, our health care system does operate under a formal obligation to provide everyone with necessary emergency care and the federal and state governments fund universal (Medicare for the elderly and disabled) and means tested (Medicaid for the low income) health care programs, which reflect the influence of the equalitarian ethics of equality of opportunity.

The equalitarian model of health care has played a major role in reducing class and race/ethnicity based inequalities and inequalities in access to health care. Medicaid has very substantially increased access to care among the poor of all ages who are dispropiately African American and Hispanic. Medicare has greatly reduced inequities in access to care for everyone over age 65

regardless of race/ethnicity or socio-economic status and raised the standard of living of low to moderate income beneficiaries as they age (Finkelstein, et al, 2004). Without these programs, poor and low income individuals would have far less access to health care than they have had for almost 50 years and would be more victimized by the processes of cumulative disadvantage that operate across the life course.

Medicare seems to have been especially important in protecting individuals from the downside risks of cumulative disadvantage by providing more equal access to appropriate and high quality care than is generally available in Medicaid, at a period in life (old age) when much greater levels of care are likely to be needed. From an equalitarian perspective Medicare, or some similar version of the program, should be extended to the entire population in order to maximize the programs full potential to reduce health inequalities and inequities for everyone regardless of age, class or race/ethnicity (Fein, 2010).

Proponents of Libertarian policies, on the other hand, oppose an extension of Medicare to the non-elderly population. Furthermore, many Libertarians support the conversion of the Medicare program to a premium support program designed to move Medicare into the private, mostly for profit insurance market and requiring beneficiaries to bear a greater share of their health care

expenses out of pocket (Van de Water, 2013). This would have a major financial impact on beneficiaries who already pay, on average, 15% of their income to cover out-of-pocket expenses in the current Medicare programs, which is twice the percentage paid by the under age 65 population (Noel-Miller, 2012). These additional expenses would, in all likelihood, reduce access to health care in the Medicare program, especially for lower income beneficiaries who are dispropiately women and minorities (Van de Water, 2013).

For Libertarians these differences in health care access outcomes would be compensated for by greater market efficiencies, an enlarged role for personal responsibility and reduced dependency on public budgets. For equalitarians, however, achieving these Libertarian priorities is not worth the price of reducing health care access for beneficiaries especially those with the fewest resources to cover their own costs for care. They would, in fact, take exactly the opposite tack by expanding Medicare to the entire population and capping out of pocket expenses at a much lower level than 15%. In this view, Medicare expansion would substantially enhance the chances that low to moderate income individuals would enter old age in better health than they do now and be in a better position to experience an active old age with fewer chronic illnesses and impairments.

The Affordable Care Act (ACA) includes several equalitarian provisions, including the expansion of coverage for several million previously uninsured individuals, new regulations designed to prevent the use of pre-existing health conditions to either exclude coverage or require abnormally high out-of-pocket costs, community rating for all premium charges and the removal of caps on insurable expenses to prevent insurers from dropping members (recession) with especially high expenses (Kaiser, 2013). The ACA also reflects Libertarian priorities in that

the non-Medicaid part of expanded coverage is largely administered by proprietary companies in the private insurance market.

Conclusion

Conflicting ethical tendencies in the U.S. health care system have greatly influenced perspectives on health disparities and the uneven responses of policymakers to them. The tacit resolution of these tensions in health care policy and politics at this point seems to be that we are willing to slowly reduce the magnitude of existing disparities that are clearly evident among racial and ethnic groups and social classes, but we are not yet willing to take comprehensive and decisive steps toward their elimination. The fact, however, that even slow progress has been made over the last several years in reducing disparities is remarkable given the powerful influence of Libertarian ethics among our policy elites in both the public and private sectors.

Libertarian ethics is far more consistent than equalitarian ethics with the neoliberal policies of relatively low taxes, reduced spending, deregulation and privatization that have dominated the economic agenda for most of the last 35 years and that are currently reflected in the bipartisan austerity policies enacted after 2010. The ACA, however, which clearly reflects a commitment to the fair equality of opportunity principle in health care policy, passed when a narrow window of opportunity was available in 2009 and 2010. This equalitarian model of health care will in all likelihood substantially reduce inequitable health disparities, at least in terms of access to care, over the next several years even if Neoliberalism and Libertarian ethics continue to dominate the rest of the public policy agenda including aspects of the ACA. Such are the anomalies of policy and politics in contemporary America.

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