Why Should We Eliminate Health Disparities?

The Moral Problem of Health Disparities

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Health disparities exist along lines of race/ethnicity and socioeconomic class in US society. I argue that we should work to eliminate these health disparities because their existence is a moral wrong that needs to be addressed.

Health disparities are morally wrong because they exemplify historical injustices. Contractarian ethics, Kantian ethics, and utilitarian ethics all provide theoretical justification for viewing health disparities as a moral wrong, as do several ethical principles of primary importance in bioethics. The moral consequences of health disparities are also troubling and further support the claim that these disparities are a moral wrong. The *Universal Declaration of Human Rights* provides additional support that health disparities are a moral wrong, as does an analogy with the generally accepted duty to provide equal access to education.

In this article, I also consider and respond to 3 objections to my thesis. (*Am J Public Health.* 2010;100:S47–S51. doi:10.2105/AJPH.2009.171181)

ARE HEALTH DISPARITIES morally problematic, and is there a moral obligation to address such disparities? Despite the affluence of US society, health disparities exist along lines of race/ethnicity and socioeconomic class. I argue that we should strive to eliminate these disparities because their existence is a moral wrong that requires addressing. My thesis comprises 2 tenets: (1) The existence of health disparities is a moral wrong, and (2) health disparities are a moral wrong that should be addressed. I will demonstrate that the existence of health disparities is morally problematic by applying several ethical theories as well as moral principles. I will also consider the significant ethical implications of the persistence of health disparities in the United States, as these offer additional support for the claim that health disparities are morally problematic. To demonstrate that the moral wrong of health disparities is a problem that requires addressing, I will appeal to rights and correlative duties, and I will draw an analogy between the right to reasonably equal access to health care and the right to reasonably equal access to education. Finally, I will consider and critically respond to several objections that can be offered against my thesis.

THE MORAL BASIS FOR ELIMINATING HEALTH DISPARITIES

To establish that health disparities are a moral wrong that should be eliminated, I must first demonstrate that the existence of health disparities is morally problematic. I suggest that the most compelling argument for judging health disparities to be morally wrong is based on viewing these disparities as exemplifications of historical injustices. The health disparities that exist in the United States are morally problematic because they exemplify and aid in perpetuating a centuries-old system of injustices based on race/ethnicity and class. This system of injustices is clearly an ethical problem; thus, states of affairs that exemplify or perpetuate these injustices are likely ethically problematic as well. I will assume that it is unnecessary to offer arguments in support of the claim that it is a moral wrong to impose injustices upon groups or individuals based upon race/ethnicity or class, or to allow such injustices to continue. (In other words, I will not offer an argument demonstrating that racially based oppression is wrong.) I will also assume that perpetuating past injustices, even if done unintentionally, is likely de facto racism and therefore morally problematic as well. It is, however, necessary to demonstrate here that health disparities are a contemporary instantiation of these kinds of injustices. There are a number of ethical theories and principles that can be applied to show that health disparities are in a category of injustices generally deemed to be morally problematic.

Contractarian ethics (based on social-contract theory) affords a simple way to argue that health disparities exemplify morally problematic injustices. Rawlsian "natural duties" to promote just institutions, condemn unjust institutions, and avoid doing harm to others offer a direct way to argue against health disparities.[1] The existence of health disparities along racial/ethnic and class lines, in the absence of any evidence that people of those groups are biologically determined to be less healthy because of their group membership, is a violation of the basic liberties of those individuals on contractarian grounds. An analogy can be drawn with the oft-cited argument contractarianism offers for civil disobedience and against the injustices that led to the Civil Rights Act of 1964: it is morally problematic that there are members of our society who bear the societal burdens that everyone else bears but who do not

receive some of society's basic benefits.[2]

Social-contract theories and contractarian ethical theories generally claim that social institutions and laws are necessary and that members of a society receive societal benefits in exchange for burdens, such as paying taxes and following the law. When a specific group is subject to the burdens of a society but does not receive the basic benefits of that society or fair legal representation within it, a serious wrong is committed on contractarian grounds. This was clearly the case for many African Americans in the 1950s, for example, who paid taxes and followed the law without really being able to vote, fully utilize public transportation, or receive adequate medical care. When examining the health disparities that currently exist in the United States, we see that many groups of people do not experience reasonably equivalent health outcomes when compared with the majority of White Americans.[3] Health disparities along racial/ethnic and class lines thus unfairly disadvantage certain members of our society who are nevertheless still subject to the same societal burdens borne by the majority. This situation places health disparities in a category of injustices deemed morally problematic on contractarian grounds.

Kantian ethics, as a duty-based ethical theory, would argue that we have a moral duty to address health disparities because the required basic respect for all persons is violated by the presence of significant differences in health for some. The Kantian categorical imperative has 2 significant formulations; the formulation that prohibits us from treating individuals merely as means to our ends is the one most relevant in bioethics.[1] The force of this universal moral maxim derives from the notion that rational individuals are inherently deserving of respect. This maxim is undoubtedly violated by the presence of health disparities. People who are considerably less healthy than the average White American are not being treated with the requisite respect owed to rational individuals. That is, on Kantian grounds, health disparities are a significant moral wrong because they violate a basic respect for persons that is universally owed to rational individuals. Thus, we have a moral duty to avoid perpetuating this violation of respect for individuals.

Even utilitarian ethics, which relies on consequences to judge the rightness or wrongness of a practice (along with the rule of maximizing the greatest good for the greatest number), can be employed to argue that health disparities are morally wrong.[2] According to utilitarianism, the good of the many can outweigh the good of an individual if the balance of happiness gained by the many easily outweighs the comparable unhappiness of the single individual. Health disparities, however, involve harm to a reasonably large group of individuals that is not outweighed by a corresponding significant benefit. The fact that certain minority groups are on average less healthy than are Whites does not make Whites any better off in the long run. Instead, health disparities appear to be a significant long-term detriment to society as a whole. The consequences of health disparities thus point to utilitarian reasons to consider them morally problematic.

In addition to ethical theories, there are numerous moral principles—including the principles of beneficence (we should act to benefit others), nonmaleficence (we should act so as to avoid harming others), and distributive justice—that we can apply to offer further support for the claim that health disparities are a moral wrong. Health disparities surely do not benefit the individuals on the losing side of the disparities, nor do they benefit any other individuals, violating the principle of beneficence. Health disparities instead can be said to be a significant harm in the form of poorer health, pain and suffering, and shorter life spans, violating the principle of nonmaleficence. Further, most conceptions of principles of distributive justice involve the notion of equity or equal access. Health disparities violate equity in that many citizens of our affluent country—a country that spends more than any other per capita on health care—suffer from significantly lower health outcomes on the basis of their race/ethnicity or class.

THE MORAL IMPLICATIONS OF HEALTH DISPARITIES

A significant problematic consequence of the existence of health disparities in the United States is that these differences perpetuate substantive inequities. Those who suffer from these inequities are thereby less able to enjoy their rights to life, liberty, and the pursuit of happiness. Health disparities thus amount to de facto racism and classism because they perpetuate preexisting inequities suffered by vulnerable members of our population.

Notably, several of the groups that are disadvantaged by health disparities have been historically disenfranchised by past laws and medical practices. In this era of ever-improving medical technology, it is embarrassing for the United States that hard-won equality rights have yet to be extended to the very basic area of health care. In addition, health disparities can fuel a deep-seated mistrust of the medical establishment based on past injustices, discouraging minorities from seeking care and leading to a further widening of health disparities.

Another significant implication of health disparities is that these inequities may be impeding access to quality care in many areas, as well as impairing the quality of the care available to everyone, including the insured. When resources are diverted to cover the increased cost of treating patients who have more serious conditions because they are less healthy, everyone suffers. For instance, it has been argued that uninsurance, the rates of which are significantly higher than average for Mexican Americans and somewhat higher than average for African Americans, leads to problematic consequences for many insured citizens as well as for those on the losing end of health disparities.[4]

Thus, it seems that the mere existence of health disparities is a moral wrong, as are their

consequences, especially given that: (1) the United States is an affluent country that should have the resources to offer at least a minimal amount of health care to its citizens, and (2) the United States spends a disproportionately large amount of its gross domestic product on health care, in comparison with all other countries.

THE DUTY TO ADDRESS HEALTH DISPARITIES

Ethical theories and moral principles are typically construed to entail duties to act or not to act on the basis of whether an action is found to be right or wrong. That is, if we judge health disparities to be a moral wrong, then we are obligated to work to prevent or address this wrong. Of course there are moral wrongs that I may be powerless to fix on my own, such as the prevalence of child abuse, domestic violence, or homelessness. But larger organizations such as our government, which have considerably greater power to address such wrongs, may therefore have a stronger duty to address them than any individual has.

Another way to look at this is to notice that rights and duties *correspond.* If I have a *right,* then someone must have a corresponding *duty* to provide for the exercise of that right; otherwise the right is meaningless. The issue of whether there is a duty to address health disparities can be approached via the contemporary debate over whether access to health care is a right. The existence of a right to health care would seem to make the second step in my overall argument much easier. That is, if there is a right to health care, then there would seem to be a duty to provide for this right; thus, the existence of serious health disparities must be addressed. However, even though it is undoubtedly an easier logical move from the claim that health care is a right to the claim that someone has a duty to address health disparities, there is currently no legally recognized right to health care in the United States. Nevertheless, the existence of both "anti-dumping" laws and the Medicaid and Medicare systems are evidence of legal recognition of some basic rights to receive medical treatment if an individual is in an emergency situation, and to receive certain minimal kinds of treatment if an individual cannot afford to pay and is uninsured or underinsured.

But is there a moral right to health care? Such a right may be established by the application of ethical theories and principles. Additional support can be drawn from statements such as article 25 of the *Universal Declaration of Human Rights* and from documents such as *Healthy People 2000* and *Healthy People 2010.* And, as already mentioned, our legally established rights to life, liberty, and the pursuit of happiness are rendered moot if we do not possess the basic health required to exercise these rights, a basic level of which can more easily be obtained by the White, middle-class majority in the United States than by members of racial/ethnic minority groups. It seems, then, that a moral right to health care can be established on the basis of these distinct sources.

There still remains a gap in the argument, however, because there is a distinction between the right to health care and the duty to address health disparities. Even if a moral right to health care can be established, that right would not necessarily entail a duty to address health disparities; a moral right to health care only entails the duty to ensure that all people have access to health care. Such a measure is likely insufficient for eliminating health disparities in the United States.[5] An argument from analogy relying on the legally recognized right to equal access to education in the United States can fill this gap and can link a moral right to health care to a moral duty to ensure not only minimal access to health care but also reasonably equal access to health care. When a right to education was established early in the 20th century, it was the first step in ensuring equal access to education and equal opportunity for all citizens, but it took additional legislation and court decisions, such as *Brown v. Board of Education*, to complete the picture. A moral right to health care is only the first step. Equal opportunity and access require that we desegregate health care as well.

OBJECTIONS AND RESPONSES

What objections can be made against the thesis that health disparities are a moral wrong that requires addressing? I will consider and respond to 3 objections that can be raised against this thesis. The first objection is that it is not *necessarily* wrong that some people are "less healthy" than others. The second objection holds that different cultural groups may exhibit cultural habits that perpetuate health disparities; thus, suggesting that these groups modify their habits is at least insensitive to (and at worst intolerant of) differences between cultures. The third objection is that addressing health disparities is a waste of resources, as substantial resources have already been spent studying the problem of health disparities, yet the disparities persist.

Objection 1: People Make Unhealthy Choices

The moral wrongness of health disparities may depend upon the specific causes of poorer health in people who are less healthy. Given our country's keen interest in protecting individual autonomy and privacy, we might be less responsible for addressing health disparities if those who are less healthy are somewhat responsible for their conditions. If individuals, in exercising their autonomy, engage in activities that pose significant risks to their own health, such as smoking, excessive drinking, or daily fast-food consumption, one might argue that these individuals are primarily responsible for their poorer health. And if individuals are primarily responsible for their own poorer health, then we might not be responsible for addressing those disparities. For example, we may feel less obligated to provide a liver transplant to an alcoholic than to someone who was born with a defective liver or to ameliorate the lack of mobility of a morbidly obese person as

opposed to that of someone disabled by a drunk driver.

This is not to say that these comparisons carry equal moral weight or that it is fair to discount the medical needs of the alcoholic or of the morbidly obese patient because they bear some responsibility for their medical conditions. This objection does suggest, however, that a duty to address these patients' poorer health may be mitigated if the patients bear responsibility for their conditions. In other words, this objection to the thesis that health disparities are a moral wrong that requires addressing asserts that whomever has the purported duty to address health disparities may be less responsible for "fixing" health conditions that are under the control of the affected individuals.

I would argue, however, that this objection misses the point. Even if some individuals bear some responsibility for their own poorer health, it's difficult to imagine that people who are less healthy are, as a group, entirely or predominantly responsible for their deviation from the norm. For example, alcoholics typically report compulsions to drink that most nonalcoholics do not report, and many morbidly obese people were raised with poor eating and nutrition habits and are enabled in their condition by those around them.

But, more importantly, the health disparities with which we are concerned are disparities that follow racial/ethnic lines and socioeconomic distinctions. It would be a strange leap to suppose that the members of a particular ethnic group are responsible for their lower health outcomes or that the poor are responsible for their lack of access to adequate medical care. Even if we assume, for the sake of argument, that this is indeed the case, we may still argue that the high rate of diabetes and heart disease in minority populations, for example, is a problem that should be addressed through education, even if the population as a whole exhibits habits that are unhealthy and are somewhat within their control. Public health programs designed to educate the public about the dangers of smoking are an example of this logic at work.

Objection 2: It Is Insensitive to Try to Address Disparities Caused by Unhealthy Cultural Habits

This objection claims that addressing health disparities based on race/ethnicity and class inevitably entails condemning cultural practices. There may be evidence that ethnic groups practice cultural habits that perpetuate health disparities, such as the high-fat and high-starch diets eaten in some Mexican American communities, for example. Therefore, isn't it wrong to suggest that ethnic or cultural groups need to modify these habits to achieve better health outcomes? This is a deeper worry than it may appear, as addressing health disparities may entail judging certain ethnic practices as inferior. Doesn't tolerance require that we accept cultural differences?

In response to this objection, I would argue that cultural practices that result in significant health risks should be addressed, albeit as sensitively as possible. If a cultural practice results in harm to the individual or to others, then it would be morally problematic to ignore such harm. It may be that we can educate individuals about potential harm while presenting healthier alternatives that are not antithetical to a group's ethnic and cultural practices. We should not ignore the fact that race and ethnicity are factors in health disparities.[6] We can, however, embrace uniqueness and healthfulness in our efforts to address health disparities.[5]

Objection 3: We Are Not Obligated to Try to Solve an Unsolvable Problem

The third objection is that substantial resources have already been spent studying the problem of health disparities, to no avail. To quote the National Center for Health Statistics: "despite decades of effort, disparities persist."[3(p1)] Why should the government waste resources on an unsolvable problem, even if the presence of health disparities is accepted as morally problematic? There is no duty to fix the unfixable.

A simple response is possible here. We shouldn't abandon efforts to address a problem because past efforts have been unsuccessful. Efforts to address diseases like Alzheimer's and breast cancer, and social problems like domestic violence and poverty, shouldn't be curtailed because these diseases and problems persist. There is also no clear evidence that the problem is indeed "unfixable." At best, this objection points to the need to rethink approaches to addressing health disparities.

CONCLUSIONS

A common theme repeated many times at the 2008 NIH Summit dedicated to the science of eliminating health disparities was the need to "look upstream for social determinants of health." Numerous factors, such as health literacy, housing, environmental toxins, mistrust of health care professionals, and uninsurance affect health and can perpetuate or increase health disparities. Clearly a complex tangle of factors is at work to affect health and contribute to significant health disparities in the United States. We need to develop creative, broad-based approaches to address these inequities. Rather than pulling health disparities out of the social context in which they are entrenched and attempting to address them narrowly, it was suggested at the summit that researchers should find ways to address health disparities within the social context, which may require "fixing" more than just the health disparities. Perhaps increasing public awareness of health disparities as a moral issue can contribute to addressing this problem.

My arguments here rely on an analogy to other moral problems in our society's history, for example, the absence of women and racial minorities in many workplaces and positions of power, and the egregiously inferior education that was available in the past to non-Whites. Affirmative action was enacted to address the former moral wrong, and desegregation was an attempt to address the latter. Whether or not we accept affirmative action and

desegregation to be ideal solutions for these moral issues in our society, it is at least generally accepted that vast discrepancies in job availability and access to education based on race and gender were moral problems that required addressing. I argue that health disparities are yet another manifestation of the history of racism in the United States, a history from which we as a society should learn. Recognizing that health disparities are a moral wrong that needs to be addressed is another step in the moral evolution toward fairness and equality of opportunity in our society. ■

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