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Equity versus humanity in health care

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Abstract **When the distinction between subjective value judgements and objective scientific analysis becomes blurred, the resulting confusion of values can result in the treatment of economic symptoms rather than causes. Advisors who confuse egalitarianism with humanitarianism may falsely believe they are helping the poor when, instead, they are only promoting equality: the two are not the same. Statistical studies on the distribution of health care provision do not lead to self-evident policy conclusions.**

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Discussions of the economic aspects of health care often blur the distinction between subjective value judgements and objective scientific analysis. A recurring example in the literature is that of 'equality'.[1-11] Scant attention is paid to its value content and to the consequences of equity-based health policies. As a result, much policy analysis degenerates into a preoccupation with the treatment of economic symptoms rather than causes.

One manifestation of this is the use of the notion, the 'maldistribution' of health care expenditure. For example: 'The implication of the maldistribution is that although health care expenditure amounted to approximately 5,7% of the GNP in 1988, the proportion spent on whites was equivalent to 13 - 14% of the GNP . . . while that spent on blacks was equivalent to 3 - 3,5% of the GNP.'[8]

Firstly, the term 'maldistribution' clearly implies a subjective value judgement. There is no single perfect distribution that can be 'discovered' by scientists.[12] Secondly, the groupings across which the judgements are made are also arbitrary.

Given South African history, the comparison of racial groups is understandable but still arbitrary. Such comparisons could also be made within these groupings and would find inequality there also. This is important because our understanding can be confused by a failure to specify the significance of one quantitative measure of equality relative to another.

Further, the *type* of equality should be specified, especially if normative implications are to be drawn. By type, a distinction is made between *equality before the law* and *equality of outcome*; the former refers to a process and the latter to an end-state.[13]

For example, it matters which meaning of the word 'equitable' one intends when calling for 'equitable access to the full range of health care services'.[3,4] Conceptually, the two types of equality are quite separate, and are neither compatible nor morally substitutable. In South Africa, people have been treated equally before the law only *within* each official racial classification. Across groups, such equality has not applied and predictably the groups with greater economic freedom have had higher average incomes. Nevertheless, economic outcomes for individuals within the groups have been unequal and, across groupings, the outcomes have overlapped: some blacks have incomes higher than the average white, while some whites have incomes lower than the average black.

This incompatibility of approaches to equality is of particular importance in the realm of government policy. Equality before the law cannot guarantee any particular income distribution, but it is politically feasible. Equality of outcome is not feasible in practice, but even if it were, the means of achieving it would preclude the existence of equality before the law. The two approaches would also have opposite effects on the average economic situation of the populace.

Redistribution

The question of compensation for past injustices is a separate but related matter. Given the lack of equality before the law in the past, it does not follow that things can be made right by attempts to create an equality of outcomes. Economically, the average member of *all* population groups was hurt by apartheid. And redistribution won't set things right any more than a punch in the back will cure the effects of a punch to the solar plexus. The situation is simply made worse.

Costs and choices

Health care, like any service, requires time, effort and other resources. And when these inputs are devoted to health care, they are no longer available for the provision of other services. People must choose how much is to be spent on which services, which desires to satisfy first and which opportunities to postpone or forego.[14]

The supply of resources is always limited (though not fixed), but the *demand* for health care is open-ended.[15] The lower the price, the greater the quantity of services demanded. If it is free, demand will be unlimited and patients will be less conservative in their use of services (i.e. they will demand top quality regardless of actual resource costs).[15,16]

The central debate in the politics of health care revolves around whether the individual has the right to make these choices and deal with his doctor(s) directly or whether bureaucrats will make those decisions for him. Regardless of who makes the decisions, health care needs cannot be determined independently of the individuals involved. Nor can health decisions be made in isolation from other considerations in an individual's life. Ultimately, no one but the individual patient is in a position to know how much value he or she places on the expected outcome of a particular course of action. If decision-making is separated from cost, then the type of health care (both supplied and demanded) is less likely to be appropriate and the cost in terms of resources will be greater.[14-16]

The broad view

Many factors contribute to one's health: quality and quantity of food, shelter, plumbing, living habits and genetics. What individuals do to themselves and what risks they take determine their relationships with health care professionals and are the foundation of the demand for health care.

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In other words, the whole economy contributes to health. The market for health care is not separate from any of the other sub-markets in the economy. The treatment of one sector (i.e. medical care) in isolation, without recognition of its impact on other sectors, may actually result in reduced levels of health in the population.[17]

Separation of ethics from reality

When equality is proposed as a 'social goal'[4,10,18] it does not follow that everyone agrees or that the value of such a goal is self-evident. An economist, however, is not concerned with the value of the ends chosen, but rather with the means selected to achieve them and with the indirect consequences of that selection.

If 'equality' is chosen as an end, resources must be directed toward its achievement. Thus, some other ends must be forgone. If policy-makers neglect this, the unintended consequences of their policy could produce a worse state of affairs (thereby placing the policy's ethical foundations in question).

The worsening may be due to inappropriate means but also to incompatible ends. In the case of equality, most economists find 'equality of outcomes' to be incompatible with a progressive economy or with 'equality before the law'. If the latter two are valued more, then 'equality of outcomes' is of secondary importance and would be forgone for the greater good.

When writers speak of 'equity as a moral priority' but fail to address the overall costs of such a priority, then their ethical urgings are not realistic.[3,4]

Health care in context

The first victim of equalisation proposals is the doctor-patient relationship. People are individuals, not aggregates. They make decisions as individuals, not as statistical averages. Doctors and patients depend on each other for their continued existence. Neither is more important than the other, and neither is a slave to the other. In essence, they trade services. Doctors deal in life and death, but so do the patients, who may be farmers, policemen, plumbers, machine operators or members of any of the other thousand occupations that contribute to our survival.

The doctor-patient relationship is perpetuated by both parties who contribute to that relationship. They ensure each other's survival. It is, in its purest form, a private bilateral relationship. When the State intervenes to impose arbitrary values, this relationship is upset.

Equality versus humanitarianism

In the literature, there is a tendency to confuse 'equality of outcome' with 'humanitarianism'. But bringing help *to relieve suffering*, and bringing help *to achieve equality* are two different things. Help given on *humanitarian* grounds brings no presumption in favour of continuing the redistribution beyond the point at which distress is relieved.[19]

It is not at all clear that patients in a system of equal outcomes would be better off than the 'worst off'[20] in a system of unequal outcomes. Thus, when these concepts are confused, it is possible for egalitarianism to displace humanitarianism. Taken to its extreme, the equal receipt of zero health care would be chosen over the unequal receipt of positive amounts of health care. This would be a policy of *fiat justitia, pereat mundus* (let justice be done, even if it destroys the world).

Policy-makers must be clear in their minds as to whether they are promoting equality or relieving the suffering of the indigent; the two goals are not necessarily compatible.

Extravagance and progress

If Harry earns more than I earn, he can afford better food, shelter and health care. Does it hurt me if Harry spends more than I can on health care? Some health economists imply that such expenditure is 'extravagance'[10] and that it takes health care away from others — as if there is a fixed amount of care available. This misplaced value judgement comes directly from a methodology of inappropriate aggregation which prevents the analyst from recognising the dynamic relationship between desire and consumption, and between incentive and production.[8,10,18,21-24]

Those who propose to eliminate inequality risk destroying those institutions that promote progress. For example, the rich who pay for expensive new treatments give doctors and researchers experience and resources that will help them develop better and less expensive treatments. By forbidding the wealthy from having these treatments, policy-makers would, in the long run, be hurting the masses of less wealthy potential patients. As the Nobel laureate, Friedrich Hayek[25] explains: 'What today may seem extravagance or even waste, because it is enjoyed by the few and even undreamed of by the masses, is payment for the experimentation with a style of living that will eventually be available to many. The range of what will be tried and later developed, the fund of experience that will become available to all, is greatly extended by the unequal distribution of present benefits; and the rate of advance will be greatly increased if the first steps are taken long before the majority can profit from them. Many of the improvements would indeed never become a possibility for all if they had not long before been available to some. If all had to wait for better things until they could be provided for all, that day would in many instances never come. Even the poorest today owe their relative material well-being to the results of past inequality.'

Skills as liabilities

Putting equality before humanity also hurts patients indirectly by victimising doctors. For example, because salaries are 'the single largest item in the health care budget', Gear[7] proposes that: 'Incomes and salaries of health workers will need to be drastically curtailed, particularly the incomes of professionals who enjoy a lifestyle out of keeping and indeed out of touch with the realities of the country's economy.'

Gear explicitly suggests that these salary reductions be enforced by government power.

At present, any doctor who feels that he can help the world by reducing his fees or salary is free to do so. But to demand that doctors should be forced to do so suggests that their years of hard work and training, instead of being rewarded, should be punished. Instead of treating doctors' skills as something to be valued and respected, advocates of egalitarian medicine subordinate doctors' rights to the demands of anyone who lacks their training. Doctors' skills are no longer assets but liabilities.[26] And basic economics tells us that if you punish an action, you get less of it.

Conclusion

Studies on the distribution of health care provision may be interesting for health care marketers but, for purposes of informing public policy, are of limited value.

Self-evident policy recommendations cannot flow directly from the studies.

Advisors who confuse egalitarianism with humanitarianism fall into the trap of treating economic symptoms rather than causes. If the intention is to promote high-quality health care and to relieve the suffering of the indigent, a policy that focuses on equality of outcomes may bring opposite results. If the root problem is poverty, this is better addressed by an overall liberal economic policy rather than narrow interference in health care.

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