Commentary

Health Equity in a Trump Administration

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Abstract Donald Trump's rhetoric and leadership are destroying the "culture of community" necessary for progress on health equity. His one-line promises to provide "quality health care at a fraction of the cost" smack of neoliberal nostrums that shifted ever more costs onto patients, thereby preventing many people from getting care. The dangers of Trump go far beyond health policy, however; Trump's presidency threatens the political and cultural institutions that make any good policy possible.

Keywords Trump, health equity, health care

The authors of this special issue on health equity wrote their articles at a time when a Trump victory was unthinkable. Although they were able to make some revisions after the election, the editors thought the issue needed at least a short piece written with the knowledge of a Trump administration as a *fait accompli*, and that is the charge they gave me: What might a Trump administration mean for health equity?

I accepted the charge reluctantly, partly because prognostication one month into a cataclysmic political shift is a fool's errand, but mostly because I knew that having to write about this nightmare would force me out of denial and my own self-imposed news ban. When I shared those reasons with Colleen Grogan, the journal's outgoing editor, she said, "I hear you, but I find it helps to write." I don't know whether the pen is mightier than the Tweet or whether reason can triumph over rage, but Colleen reminded me that the antidote to despair is fighting back.

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In that spirit, I will discuss health care in this commentary, because this is a journal about health policy, but I can't emphasize enough that Americans will lose the war for survival as a political community if we allow Trump to pick us off one policy battle at a time—now health care, now education, now work and wages, now climate change, now science, now media. Thus, I try to frame health care in the context of the bigger questions of what we're fighting for and what we're fighting against. We are fighting for equity in health care, yes, but far more urgently for the ideal of equality for all people and for repair of our broken constitutional democracy. We're fighting against a president and a servile Republican Party bent on fomenting hatred and conflict in order to destroy the American social compact and the rule of law. Trump's behavior during the campaign and since his inauguration have violated not only the norms and rules of American politics, but even the pretense of caring about norms and rules. While we all continue to fight for health equity, let's keep foremost in our minds that we're fighting to preserve equality as a political aspiration and rule of law as our way of conducting public life.

Why use the term "health equity" instead of "equality"? We use the term equity to mean, loosely, treating everyone fairly, and, in this loose sense, it differs from how people generally understand equality. Equality denotes sameness. Intuitively, equal opportunity suggests that everyone has exactly the same chance to fulfill their goals. The dilemma of equality is that giving everyone their fair share or an equal crack at personal success often means—and *should* mean—giving people unequal shares or treating them differently on account of differences among them that seem important. Equity, then, denotes a distribution that treats people differently for good reasons, reasons people agree are legitimate. Nowhere is this idea more obvious than in health. Equal access to care or equal medical treatment does not mean "one person, one hip replacement." It means each person should get the medical procedures appropriate, necessary, and effective for his or her illnesses.

Without saying so explicitly, most health policy scholars assume this principle of distribution according to medical need. They assume that no standard other than medical need—not race, gender, age, national origin, sexual orientation, or religion—ought to influence whether people receive medical care or what kinds of care they get. When distribution of medical care seems to be correlated with these nonmedical factors, the apparent deviation from a medical need standard is often taken as evidence of discrimination. The medical need standard also dictates that place of residence should not have a strong influence on whether people receive

adequate care. Even though public health and welfare are matters of state responsibility, the medical need standard would seem to be violated when there are large differences in access to care across states or across smaller areas within states. Equity in health also means that in so far as the burdens of illness and disability are preventable or can be lessened through medical care and other human interventions, they should not be correlated with race, gender, age, national origin, sexual orientation, or religion.

Importantly, equity is a political aspiration even more than it is a philosophical or technical standard for evaluating distributive justice. As a political aspiration, equity can be sustained only by a culture of community. Donald Trump threatens equity most gravely not by the specific policies his government will likely enact, but by his vigorous attacks on the culture of community.

What is a culture of community? First, in a culture of community, people are disposed to see the similarities among members of the community more than the differences. Or, put another way, the members believe they share some kind of abiding sameness, a sameness that has overarching importance to how the polity treats its individual members. In the case of health, it goes without saying that there is huge variation in health status and therefore medical need, but the abiding sameness resides in an understanding that we are all biological creatures, vulnerable to disease and disability, and that good health is a prerequisite to every other kind of opportunity and pursuit that people desire.

Second, a culture of community means that people are willing—and actively want—to help other members of their community because they understand that individuals sometimes encounter problems they can't overcome themselves, and they understand the power of collective action and mutual aid. This is the cultural attitude that underlies risk-sharing and insurance.

Third, a culture of community means that people are willing to differentiate among members of the community for all kinds of purposes, yet they have some shared understanding of what they consider legitimate bases and purposes for differentiating. Thus, for example, hiring and promotion decisions, college admissions, and yes, selection for political office, should be based on merit, not on a lottery that gives everyone a strictly equal statistical chance of success. And access to medical care should be based on the need for care, not on ability to pay, and not (as in the Oregon Medicaid program) on a lottery.

Presidents lead with rhetoric as much as they lead with their policy goals. Make no mistake: Donald Trump intends his poisonous rhetoric to

change what will be considered the legitimate bases for differentiating among people in public policies. Trump campaigned by strategically cultivating division and resentment. He deliberately nurtured animosity based on race, religion, immigration status, and nationality as a way to gain the political support of groups whose agendas, if not also motives, are to denigrate and suppress women, blacks, Jews, Muslims, immigrants, and LGBT people. As president, he continues to portray the world in terms of "them versus us": immigrants versus natives, terrorists versus Americans, other countries—including our trading partners and NATO allies—versus America, Muslims versus Christians, and his enemies versus him. By accepting the endorsements of White Nationalists and other members and supporters of hate groups, and by appointing high officials who share his hostilities, Trump has all but declared racism, misogyny, homophobia, anti-Semitism, nativism, and xenophobia to be national policy. He has appointed a secretary of education who will do everything in her power to further destroy public schools as vehicles for common socialization and integration. This overall attack on the culture of community will undermine support for universal health insurance, but before I turn to describing how, let me come back to Ground Zero: everyone should be fighting for the larger culture of equity, not merely equity in specific policy areas.

In the United States, the idea of a right to health care never put down enough roots to grow the strong institutions that sustain universal health insurance elsewhere. I've always been mystified why some people think that having government guarantee them access to medical care *diminishes* their personal well-being, while owning a gun increases it. Of course I know the answer, but it's still a mystery. Such people understand all too well that most of what people pay in insurance premiums or taxes goes to pay for people who need medical care more than they do. In other words, when you buy insurance, until you wind up in a hospital you can tell yourself that you're paying for other people. In a culture that nourishes a sense of them versus us and preaches responsibility for oneself, insurance is a hard sell. So is the concept of medical need. "They wouldn't need medical care if they were more responsible and behaved better."

Along comes a president who espouses the self-made man as reality rather than image and believes he is one. A president who can't fathom that everyone gets to where they are thanks to help from family and friends, and from the schools, hospitals, stable banking systems, and legal protections that their society provides for them. A president who gains his political support from people who believe, as one man at a Trump rally said, "The white working class [are] the ones paying for all the others." The man

continued, "Finally, we're getting someone who'll do something about it" (quoted in Danner 2016: 8). Trump gives voice to—or rather, shrieks to—the racial, class, nativist, and sexist resentments that make risk-pooling appear wrong and harmful, and that make it morally imperative (so his supporters believe) to dismantle the Affordable Care Act (ACA), Medicare, and Medicaid as much as politically possible.

Arguably, the ACA's most important achievement was to prohibit insurers from denying coverage to people who have "preexisting conditions." In plain English, that clunky phrase means people who are sick or might get sick (woe to them and their families), and thereby cause their insurer to have to pay big medical bills on their behalf (woe to the insurer's profit). Until President Bill Clinton's drive for national health insurance, *preexisting condition* was a piece of technical insurance jargon that commercial insurers used to disguise their core business strategy of refusing to insure sick people (Stone 1993). By now, though, politicians, media, and ordinary people use this once-arcane term as a synonym for sickness or disability. Underneath all the talk of repealing Obamacare, there remains almost universal support for keeping its prohibition on preexisting conditions—by which people don't mean banning sickness itself, but prohibiting insurers from refusing to insure sick people or charging them significantly higher premiums.

This ambiguity of the term *preexisting condition* in popular discourse might actually help the cause of broad risk-pooling. Because *preexisting condition* makes no mention of illness, it takes the focus away from a causal story that holds sick people to blame for their illness, and instead points the finger at insurers who deny sick people coverage. A preexisting condition sounds more like a fact of nature or an act of God than a behavior or character trait for which individuals can be held responsible. The same people who oppose "paying for all the others" want to preserve the ban on preexisting condition denials, yet they don't understand that such a ban promotes precisely the risk-pooling they abhor.

What a delicious irony: a piece of insurance industry jargon meant to disguise discrimination against sick people has become the weapon sick people use to force insurers to do what they're supposed to do—help sick people get medical care. When I told friends I was writing about health care under Trump, a few asked me if I could give them a ray of hope. Well, here's a small one. But it's only small, and it's very fragile. Even if a federal legislative brake on outright coverage denials remains in place, we should scrutinize how insurers continue to squeeze out sick people by manipulating provider networks, benefit packages, and drug formularies, and by strategic marketing.

As I write this commentary, so far Trump's only proposal for health reform smells and tastes like snake oil: "We're going to have great health care at a fraction of the cost, and you watch. It'll happen." That's a line he repeated nearly verbatim at rallies, and again in his speech announcing Tom Price as his choice for secretary of the Department of Health and Human Services (HHS). We can deride his fatuous promises or the gullible people taken in by them, but it's a sobering thought that Trump's oil is only a less refined version of the neoliberal nostrums both parties have peddled for the last forty years.

Consider how Alain Enthoven, the intellectual godfather of managed care, summarized his blueprint for health reform in 1978: "Cutting Cost without Cutting the Quality of Care." That was the title of his "Shattuck Lecture" featured in the prestigious *New England Journal of Medicine* (Enthoven 1978). Enthoven and others elaborated this menu for a free lunch in a series of articles and policy documents, all promising people more freedom to purchase exactly the care they needed and wanted, while in fact reducing their choices and their benefits. To take one example, Medicare Advantage plans indeed reduce up-front premiums compared to traditional Medicare, but people in the Advantage plans pay much higher cost-sharing if they actually use care, and their choice of providers is far more restricted.

Thus, Trump's populist sleight-of-hand is nothing new, but his crass packaging of what has become the essential direction of American health policy does expose the hypocrisy at the center of it all. To the extent that liberals have been acquiescing in this neoliberal fantasy in hopes of achieving some incremental advances in equity, they might have gained a bit of ground here and there, but, on the whole, they bought a pig in a poke. Managed care cuts costs by churning people in and out of plans, disrupting doctor-patient relationships, and forcing people with limited means to choose between medical care and other life necessities. Reductions in government spending indeed reduce the cost of medical care *to government*, but no matter how you slice it, they also reduce the volume and quality of care for individuals. The one form of spending reduction that might improve quality and equitable distribution would be price controls on drugs and hospitals. That is not on Trump's or Congress's menu.

What about policies that disproportionately harm—and some would say discriminate against—blacks, women, people with disabilities, and people with low incomes? As Mark Hall points out in his article in this issue, most of the major advances against discrimination in health care over the last sixty years have not resulted from court decisions, but rather from

regulations issued by administrative agencies and from administrative interpretations of statutes and regulations. In all areas of discrimination law, courts have moved away from the standard of "disparate impact," the potent legal tool developed in the early 1970s to attack actions and policies that might not be explicitly discriminatory—"no blacks, women, etc., allowed"—but that exclude and harm particular categories of people nonetheless. More and more, however, courts require plaintiffs in antidiscrimination cases to prove that a policy maker *intended* to discriminate against them. Here's another ray of hope: normally, proving intentional discrimination is next-to-impossible, but Trump, thanks to his lack of filters, may be making it easier.

The Affordable Care Act includes the strongest antidiscrimination provisions of any health legislation (in Section 1557). Under President Obama's administration, the HHS implementing regulations went a long way toward restoring the disparate impact standard by specifically authorizing private plaintiffs to bring disparate impact claims (see Hall, this issue). Given the Trump administration's intent to dismantle the ACA and all of its regulations, we can expect it to undo much of what progress has been made in restraining the actions of medical providers and insurers that disproportionately harm blacks, women, people with disabilities, and people with low incomes.

There's a lot more to be said about the future of health equity, and think tanks and scholars are already saying it in detailed analyses of Republican proposals, for example, to convert Medicaid to a state block grant program and to replace comprehensive insurance with catastrophic coverage only. Women's advocacy groups such as the Center for Reproductive Rights have carefully calculated what overturning *Roe v. Wade* and defunding Planned Parenthood will mean. The health equity terrain looks mighty rough, but the general political terrain looks even more devastated.

Despite the media's best efforts to portray Trump's inauguration as a "smooth and peaceful transition of power," his administration launched in explosive chaos, with an executive order on immigration that three appellate court judges politely laughed out of court, and with the president seeking to discredit judges who rule against him. It's clear that Trump will continue to use his bully pulpit to undermine the legitimacy of all American political institutions except the presidency he now holds. Trump's targets may include elections, courts, regulatory agencies within the executive branch, and perhaps Congress if, at some point, one or both houses do not buckle to his will. He will continue to undermine the legitimacy of the cultural institutions on which progress and democracy depend—science,

news media, and reasoned debate. And he will continue to undermine the rule of law—the one institution that distinguishes the so-called advanced countries from places where violence, coercion, and corruption are the everyday means of conducting collective life.

All of us concerned for the future of American government, prosperity, and well-being, not to mention the well-being of people everywhere in the world and of Planet Earth, had best broaden our concerns for specific policy areas to attend to the survival of US democracy. Yes, we need to put up resistance in every policy corner where Trump and his policies are going to cause havoc and suffering. We need to resist in small places and small ways everywhere. But let's also keep our minds and our energies on the political and cultural institutions that make good policy possible at all.

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