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Health Equity and the Circle of Human Concern

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Abstract
Using the inequality exposed by the COVID-19 pandemic as a vivid example, this article focuses on health equity from the standpoint of structural marginalization—here, described as being marked as an "other" outside of the circle of human concern. This process leads to tension between the principles of liberty and equality and contributes to the creation of systemic disadvantage as manifested in health disparities. Creating an equitable health system must begin with this root understanding and generate greater belonging through the policy process of targeted universalism. Targeted universalism replaces a disparities framework with one in which a universal goal is identified but targeted strategies to meet each population group's needs are employed.

Locating Inequities in the Structural

The US health care system has always had deep flaws and inequities.[1] Critics have pointed to its siloed structure in which care is separate from public health and coverage is tied to employment.[1] Furthermore, our approach to health, common among Western nations, tends to isolate health outcomes from the systems that produce them and to promote a narrow biological model that often ignores the social determinants of health. Health policy is segregated from environmental policy even though the placement of refineries and polluting facilities contributes to the levels and distribution of respiratory illnesses.[2] Access to nutrition, among other influences, determines which populations have higher rates of stroke, diabetes, and heart disease, but policymaking rarely links health care reform and access to healthy food.[3]

A growing movement within public health is making these connections and urging a recognition and centering of systemic marginalization to drive reform and health care processes. Specifically, researchers are drawing connections between the racialized structure of the economy and negative health outcomes.[4] Public health professionals have registered public support for grassroots efforts aimed at fair and affordable housing, citing the racially inflected systemic inequality in the housing system.[5] A growing list of cities and states have declared racism a public health issue.[6] Despite this progress, there is still significant work to be done to extend this understanding to mainstream health professionals.

At the same time, the scope of the problem demands a deeper analysis. Although we have begun to better understand the social determinants of health, we have been slow to understand the social construction of those determinants. Health outcomes are one expression of inequality. But that inequality is an expression of a lack of power among marginalized groups; marginalization is a function of some groups being perceived as undeserving or unworthy. In other words, structural marginalization can be understood in terms of groups' relationship to the circle of human concern, or the social arena within whose ambit people are fully valued, supported, and cared for. This concern extends beyond the interpersonal to how groups are institutionally regarded. The boundary of the circle of human concern is shaped by those within via the lens of othering and belonging. Interactions and contestations around this boundary have bearing on the ontological self. This article examines these concepts and their implications for health equity and then proposes a path forward to a just and equitable health care system through the framework of targeted universalism.

COVID-19 and Racial Inequities

Health care-related decisions currently unfold from a starting position of a restricted circle of human concern. At the time this article was written in late April 2020, the world was in the depths of the first of potentially several waves of an outbreak of COVID-19 at a pandemic scale. A common refrain at the outset of the crisis was that "we are all in this together" or that the virus is the "great equalizer." But as data started to come in on the virus' widespread impact, it became clear that certain populations bore the brunt of the disease more than others. Black communities, it became clear, were facing particularly severe outbreaks. In places like Detroit, Milwaukee, and New Orleans, Black people were becoming infected and dying at rates higher than other segments of the population.[7] In 4 hospitals in Georgia accounting for two-thirds of cases, 80% of hospitalized patients in March 2020 were Black.[8] The Latinx population faced similarly staggering figures.[2] Ravages exacted on the Indigenous population were also stark. The Navajo Nation, as an indication, had the third highest number of cases per 100 000 population behind New York and New Jersey in late April 2020.[9]

These disparities and the marginality they're based on take shape through social structures and occur throughout the health care system. In most cases, the groups that are most isolated and marginalized have more preexisting conditions and comorbidities, are more physically segregated, have fewer financial resources, and have less access to healthy food and clean water. The more vulnerable the community, the fewer resources it has access to, and the weaker the response is to its needs and vulnerabilities. All of this is tied to a functional, if not an explicit, othering and lack of concern.[10]

Meanwhile, as everyday life ground to a halt to slow the spread of the virus, a majority of knowledge economy workers—engaged in what Robert Reich terms "symbolic analytic services"[11]—settled into working from home. Those deemed essential workers, who are disproportionately people of color (service workers, delivery workers, grocery store employees, janitorial staff, health care workers), had no such option and remained at high risk of exposure to ensure the continued functioning of society.[12] At the same time, people of color and women were more likely to lose employment, as many industries that could not shift to at-home work were forced to shut down.[13] This situation stranded many without health insurance or means to pay for housing and other basic needs, adding to negative stress-related health effects.

These disturbing scenarios have been treated by policymakers as if they call for after-the-fact fixes. Of course, as data on racial and ethnic disparities related to COVID-19 emerge and it becomes increasingly clear how strongly these disparities and the impact of COVID-19 track marginality across race and other vectors, it is imperative that swift action be taken to mitigate these harms as part of a strategy to combat the virus in general. But the post-hoc reaction appears to stem from a general perspective that these inequities are an unpreventable and even unexpected outcome in the aftermath of catastrophe and that the best we can hope for is to address them when they occur. In other words, from this perspective, racial and other marginalized groups' inequality is seen as residing not within the fabric of society itself but more likely within the group. Even the inadequacy and undercollection of racially disaggregated data can be read as a part of this larger problem of structural neglect. Early failures to report this data and recognize its importance are indicative of an assumption that population groups are situated equally within society even as racial and gender-based disparities persist. Without the efforts of activists, health professionals, and researchers from communities of color demanding better data recording, the public wouldn't know as much about the alarming disparities as it does now. The effort to mitigate inequities comes after the fact because the social structure is seen as unalterable or without need of alteration—in essence, as a more or less just arrangement.

Liberty, Equality, the Self, and the Circle of Human Concern

This perspective of the inevitability of racial and ethnic disparities derives from a narrow delineation of the circle of human concern.[7] Placement within the circle determines the status of belonging. Those within the circle are cared for, seen as one with the social self, and seen as part of an integrated ecosphere. Those outside the circle are othered—devalued, degraded, scapegoated, and marginalized. What is meant by othering is, in the words of the first author and colleagues, a "set of dynamics, processes, and structures that engender marginality and persistent inequality across any of the full range of human differences based on group identities."[14] In contrast, the process of belonging involves the story crafting that demarcates those whose full humanity is recognized and who will receive the concern and attention of society.[14] Belonging also involves having a claim to co-create whatever it is one belongs to. This calls for the right not only to participate in the ordering of society and its rules but also to co-create who we are as a people.

Ideally, the circle of human concern would be wide and encompassing enough to hold all people within its boundaries, as well as all forms of life and nature. But social formations around the globe and throughout human history have been constructed by carving out a narrow domain for those deemed the true people, those valued above others and who are served by society's institutions at the expense of those labeled inferior. In the United States, the terrain within the circle of human concern was etched through the concept of whiteness. Whiteness is a social force through which people who are eligible to receive its privileges are invited to construct their sense of self. As a social contrivance, whiteness must be refashioned, reaffirmed, and secured. This process happens through the dynamics of othering—the rote mechanisms that assert a hierarchy of value between peoples, the ritualistic violence visited upon population groups to reinforce difference, the calcified prejudices and institutional arrangements that channel resources, concern, and investment away from the disfavored and toward the *herrenvolk*. These mechanisms in general form describe othering but should be recognizable by their specificities in the US context as the component parts that contribute to the structuralizing of racism.

Population groups are held outside of the circle of human concern based on a number of ascriptive qualities. Yet, the main driver of othering is not these qualities but the disposition and ideology of the dominant group. Each society tends to have processes of othering critical for the dominant group's identity. In the United States, anti-Black racism serves this function. It should be noted that the importance of Blackness and even the concept of race itself does not exist without the process of racism that is doing work to constitute and benefit the dominant group. As whiteness interacts with other forms of dominance, such as patriarchy and heteronormativity, the exclusionary sphere within which one's full humanity is recognized is constituted through the embedding of others within layers of marginalization, producing intersectional social positionalities. The imperative is thus to trace out the circle of human concern without any commitment to identities secured through domination.

The members of the dominant group not only exert an outsize force on the boundary of the circle, but also are influenced by how they draw the line in terms of their conceptions of self. When one's identity is predicated on whom one can exclude and exert a degree of control over, an expansion of the circle comes to be interpreted as a threat to one's identity. Losing the ability to control and subordinate is understood as a violation of liberty, since one's freedom of action was filtered through the perspective of an exclusive social locale. Equality thus becomes a threatening prospect. Since achieving equality would necessarily be a public effort—that is, it must include a collective redrawing of the circle with input from the formerly excluded and the redistribution of maldistributed resources—the private sphere becomes not only an escape from social responsibility and commitment to community, but also a safe haven for an exclusive, dominating "we."

While this phenomenon is happening all over the world, in the United States, this exclusive "we" is expressed in terms of a narrow conception of whiteness.[15] Thus, the rugged individual, as a project of whiteness, demands complete detachment from society, from collective destiny, from nature. As a result, demonstrations have abounded across the nation calling for—as an expression of liberty—an end to a collective effort to end a virus disproportionately impacting people of color.[16] This is public health's fundamental challenge: achieving health equity in a society where self-actualization is conflated with entitlement to domination. It should be clear that the majority of Whites reject domination as the basis of liberty and the self, but there is a powerful minority that presses this project forward, with the backing of well-resourced and powerful shadow groups.[17]

This drawing of the boundary of the circle of human concern and the self that it produces informs and is informed by society's institutions. Those excluded from the circle are systemically conscripted to a devalued position, hence their overrepresentation in underpaid, benefit-barren, and risky occupations euphemized as the "essential workforce"; in quarantine-induced employment loss; and among those in harm's way of social health risks. COVID-19 hasn't produced post-hoc questions about racial inequities as much as it's pulled back the curtain on business as usual within the society we've constructed. It should be clear that White-identifying people fall within this category as othered and disposable and that many Whites identify with the project of equality over domination. Yet, resolving these social issues depends on more than just how people self-identify. The role of institutional arrangements and the work they do must also be considered. To belong requires the ability to interact with and be supported

by institutions in a manner that reflects being fully valued by the community. The pandemic and the health care crisis reflect institutional disregard for those considered outside the circle. And it is within this context and institutional constraints that doctors must decide how to ration care, whom to admit to hospitals, who will have access to the limited supply of ventilators, whose life they will attempt to save and who's on the other side of that decision. When the circle is drawn in an exclusionary manner, these decisions are inherently unjust. Critical intervention requires that we go beyond identity and rework our collective narrative and institutions.

Targeted Universalism—Expanding the Circle of Human Concern

A radical expansion of the circle of human concern would make the background condition from which our institutions follow and from which our medical decisions are made a just point of departure. It would also require a transformation of our medical system and approach to public health. Because the process of othering has placed those who are marginalized in different social positions within a stratified society, the project of expanding the circle of human concern will also be a process. After generations of subordination and systemic oppression, society, to be just, must do more than simply name everyone equal. Populations that have faced particular patterns of exclusion will need specific and tailored strategies to fulfill the demands of substantive equality. A society of genuine belonging calls for such a strategy, known as *targeted universalism*.[18]

Targeted universalism sets a universal goal but proposes specific and varying strategies targeted to every population group based on their positionality to the issue. In regard to health care, this means that treatments, outcomes, and strategies for providing access will differ across population groups if the universal goal is a certain level of desirable healthiness for all groups measured by frequency of contact with the health care system, life expectancy, or a number of other indicators. This approach differs from proposing a universal strategy and assuming that it will produce similar results for all. If, for instance, treatment is administered without due attention to situatedness, outcomes will still be unequal. If a patient with influenza and a patient with cancer are provided the same level of treatment, they will likely not have even remotely similar outcomes in relation to health status following care. While this may be an overly simplistic example, it illustrates why it is a mistake to act as if every social group is situated similarly within the structure of society. Some populations have drastically higher exposure to risk than others based on their positionality. Because social determinants reflect different risk levels, universal strategies will not produce equal outcomes. This misstep was made in the context of health insurance reform in Massachusetts. The state set a goal of universal insurance coverage, and though it did make a conscious effort to address disparities between population groups, it for the most part relied on universal strategies to achieve this goal and did not take into account structural situatedness to an adequate extent.[18] For instance, while the proportion of insured Latinx residents increased by 15.2%, a disparity remained between the proportion of insured White and Latinx residents (96% vs 78.9%, respectively) following the reform.[19] Researchers were able to identify a number of reasons for the persistence of this disparity, including a shortage of Spanish-speaking physicians, a mistrust of interpreters, language barriers during the enrollment process, and the unaffordability of copayments and premiums.[19]

Targeted universalism also shifts the narrative of othering and belonging away from a disparities-based strategy for extending the boundary of human concern. When a disparities-based approach is taken, groups are measured against a normalized group—

generally Whites in the US context. A disparities-based approach also tends to stigmatize othered groups because the underlying issue of a lack of belonging for certain populations goes unaddressed. When groups do not belong and are seen as the other, a sense of undeservingness is associated with them. Disparities can be closed by conditions worsening for the normalized group that others are measured against. In this case, bringing every other group into parity with this group would not be desirable. For instance, research shows that in the United States, White life expectancy has fallen in recent years as a result of higher rates of suicide, alcohol abuse, and other unnatural causes, mostly among the working class.[20] This trend in fact represents a narrowing of the life expectancy disparity between racial groups, but it is far from the goal of closing the gap by elevating all groups to a universally set target. Targeted universalism allows for a universal goal to be collectively set irrespective of where the most well-off group is currently situated and then for targeted goals to be deployed to meet each group's specific needs. In this sense, targeted universalism makes clear that population groups aren't pitted against each other but that all stand to benefit.

A Place for All Within the Circle of Human Concern

While targeted universalism aids all, it needs to be made clear that the current arrangement, although it may not seem so, is detrimental even to those within the exclusively drawn circle. Revisiting the above discussion about liberty and equality—when liberty is defined as the right to dominate, control, and exploit—it is apparent that any assertion of these "rights" becomes a distorted expression of freedom. Exercise of these "rights" is how corporate entities gain inclusion and the power to act at will within the circle of human concern while people of color are excluded.[21] In health care, the outcome is the consolidation of hospitals and the closure of "unprofitable" wards, leading to a dearth of care in rural areas and for communities of color and to a shortage of intensive care unit beds during the COVID-19 crisis. The exercise of corporate prerogatives has also led to mergers of medical device companies in an acquiescence to corporate greed, resulting in an undersupply of ventilators when they're most needed.[22,23]

A targeted universalism approach would likely lead to stronger checks on corporate power and greater restrictions on acquisitions and mergers and less leniency in patenting.[22] The targeted universalism framework would help orient policymakers and public opinion toward viewing such concentrated power as a barrier to all people reaching democratically determined universal health outcome goals. Understanding how population groups are positioned differently with respect to public health will underscore the importance of addressing anti-Blackness head on and of confronting elements of structural racism, such as police brutality, as a public health issue.[24] Violations of Indigenous rights and the persistence of settler-colonial governance would also have to be considered, as infractions on Native sovereignty and issues like substandard water infrastructure have placed additional burdens on Indigenous communities' ability to respond to Covid-19.[25] Additionally, even as the Affordable Care Act and Medicaid expansion enter a new phase of deeper precarity with the new composition of the Supreme Court, it becomes even more urgent to place tremendous political and grassroots energy behind legislatively expanding publicly covered health care.

The invitation to corporate dominance within a circle welcoming of liberty as dominance ultimately harms all. The alternative, however, gives reason to be hopeful. A circle that welcomes all people on the basis of belonging sets the path toward a just society and is the foundation upon which an equitable health care system will be built.

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