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Ethics and Economics of the COVID-19 Pandemic in the United States

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Abstract

The Covid-19 experience provides a natural experiment in personal and social ethics. Difficult decisions are routinely made to optimize lives and livelihoods. This commentary provides background and insight into the ethical and economic foundations underpinning dilemmas of this historic pandemic.

Keywords

COVID 19, economics, ethics, philosophy, policy, utilitarianism, Kant, pandemic, public health, quality-adjusted life year

Introduction

The COVID 19 epidemic is a watershed event. It has exposed severe weaknesses in public health preparedness and governance. It also underscores social ills such as disparities and inadequate safety nets. These shortcomings are generally widely understood. Less obvious and perhaps more consequential are the philosophical and ethical responses we observe in the United States and elsewhere. What are the rights of individuals to social protection from the virus? And what are the rights of economic participants to their livelihoods in the face of this biological threat? A common refrain is that there is no tradeoff, that what is best for public health is best for the economy. There is some truth to this. Economies are more likely to prosper the less the biological threat. But there are tradeoffs and in practice many decisions are made seeking to optimize between lives and livelihoods.

On the economic side of the ledger unemployment jumped to near Great Depression levels. Trillions of dollars of economic welfare were lost to delay infections and boost hospital and intensive care capacity for the expected surge that did indeed overwhelm parts of Italy and New York City. Once the curve turned down, authorities around the world opened economies instead of extinguishing the epidemic.

In the United States, infection rates have since resurged, especially in sunbelt states. Authorities are reluctant to reimpose lockdown conditions. Social patience is a factor. The initial shutdown to save lives was applauded as noble and perhaps even the heroic thing to do. But eventually the “heroics” began to look ill-advised to many and protests emerged to open the economy. Economies were subsequently partially opened with a tradeoff:

willingness to accept some level of infection and fatality rates for the greater good of the economy and social welfare.

Philosophers have debated ethics for thousands of years. Many of our public health, medical and economic experts hold the Ph.D. That stands for Doctor of Philosophy. One would expect widespread discourse on what the current crisis tells us about our ethics instead of the dearth of reflection in the academic literature and the media. One way to evaluate this issue is to view relevant perspectives from the standpoint of two schools: the first is the utilitarian school identified with the 19th-century political economist John Stuart Mill and foundational for mainstream business and economics. It emphasizes the greatest utility or happiness for the population subject to basic human rights. A pragmatism and emphasis on maximizing social welfare is part of this perspective. The second focuses on rights and duties of the individual. This school is identified with the 18th-century German philosopher Immanuel Kant. It emphasizes the dignity of individual humans and the obligation to respect rights of others. Both philosophical perspectives have antecedents in antiquity. The Epicureans provide foundation for utilitarianism and some argue Stoicism

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underpins Kant and deontological ethics. Deontological ethics posits moral right and wrong regardless of consequence. It emphasizes duties and rights of the individual.

Philosophy and Economics

Putting a price on life is anathema for politicians and society more broadly. We shun such decisions. Yet widespread opening of the economy with implicit acceptance of additional fatalities makes for such a decision. There are limits to the economic burden societies are willing to bear for health. This is consistent with use of cost per quality-adjusted life-year criteria to allocate scarce resources to and within the health sector. Health economists have increasingly used such tools over the last several decades. And even the World Health Organization, recognizing the importance of efficient resource allocation, recommends thresholds for cost per quality-adjusted life year, or its cousin, cost per disability-adjusted life year.¹ Utilitarians, even those who strongly support human rights, can argue that the greater interests of society are best served by drawing a line, accepting a certain level of morbidity and mortality, and allowing the economy to move forward. Those more concerned with absolute rights of the individual from social harm are uneasy with our collective choices.

The obfuscation of tradeoffs between health and economic welfare does not serve a clear-thinking society confident of its ethical foundations. It is time for cost-effectiveness analysis to be more widely embraced, understood and discussed for decisions related to epidemics, such as COVID 19, or more routine coverage decisions such as for Medicare. This will advance transparency and better frame decision making considering the utilitarian impulse to optimize social welfare, even at significant human cost. Realistic thresholds must be identified.

A prominently cited University of Chicago study concluded that lockdowns were efficient using an \$11.5-million threshold for the age-adjusted statistical value of human life.² This was derived from willingness to pay studies that are notoriously inconsistent and sometimes inadmissible in court. Such thresholds seem high to many. They may work for relatively rare occurrences. But dislocating millions of dollars per afflicted person for an event that could directly affect many millions of people over a short period of time is more problematic. The total cost is measured in trillions of dollars.

Research has improved to better identify mortality associated with COVID 19. In the United States, the case-fatality rate is under 4 percent. But the infection-fatality rate is much lower because of unidentified cases. This rate is estimated at approximately 0.6 percent, albeit with considerable variation by age and other socioeconomic factors.³ Consider what would occur were there no public health response to the virus. Perhaps 70 percent of the population would become infected.⁴ This implies about 232 million infections and 1,392,000 deaths. But an estimated 295,000 people are projected to have died anyway by December 1st 2020, suggesting public measures will save no more than approximately 1.1 million lives.⁵ The Congressional Budget Office (CBO) estimated that the COVID

response will incur a cumulative economic cost of 7.9 trillion dollars.⁶ This works out to \$7.2 million a life saved (unadjusted). The University of Chicago study concluded public health measures to prevent COVID were worth \$8 trillion. The CBO cost estimate falls within the Chicago study limits of being worthwhile, but not by much. Minor changes in assumptions could easily lead to the conclusion that our public health distancing measures are not worthwhile.

Historians, with the benefit of hindsight, will look back on this episode and better pass judgment on the wisdom of our decisions. It is incumbent for an honest, rational and deliberate society to address such crises in a sober and informed manner. Let us hope that next time we can be more judicious about how best to improve pandemic public health measures with both costs and benefits in clear view. More targeted use of the most cost-effective measures is essential for optimization between lives and livelihoods. We can surely generate more output with less morbidity and mortality. Authorities can start with clear guidance about masks, therapies such as hydroxychloroquine, and other sources of confused messaging.⁷ And when choices must be made, explicit information concerning tradeoffs about how much the utilitarian greater good should triumph over the unfortunate minority is vital for the next pandemic.

Public health and medical experts tend to focus on health outcomes, such as mortality rates, while ignoring economic costs. One explanation for this one-sided focus lies in the lack of emphasis on health economics in traditional health professional training programs. Public health schools sometimes offer elective courses on health economics that introduce cost-effectiveness, but like medical schools they do not require that all students be exposed to key health economics concepts. Going forward, health professional education would benefit from curriculum reforms that include coursework about how to assess the economic benefits as well as the costs of health-related policies including for pandemic events. This will help ease discord between health and business communities. It will also underscore the dilemma between utilitarian objectives and the sanctity of human life.

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