

## IS THERE A MORAL RIGHT TO HEALTH CARE?

Bioethics: Course Notes | Brendan Shea, PhD ([Brendan.Shea@rctc.edu](mailto:Brendan.Shea@rctc.edu))

**Learning Outcomes.** In this lesson, you'll learn to:

1. Explain how the “fair opportunity rule” applies to the rationing and distribution of healthcare.
2. Explain arguments for a “right to a decent minimum of healthcare.”
3. Use principles of justice to analyze issues related to biomedical research and medical treatment.

**Why Does Fair Opportunity Matter?** Nearly all theories of justice require that everyone be given a “fair opportunity” to get access to goods and services. The **fair opportunity rule** asserts that “individuals should not receive social benefits on the basis of undeserved advantageous properties and should not be denied social benefits on the basis of undeserved disadvantageous properties, because they are not responsible for these properties.” The idea is that a *just* society is one in which goods and services are NOT distributed according to *luck* (for example, it should not matter “how rich your parents are” or “how good of genes you have”). Of course, it is not possible to eliminate the role of luck entirely (at least if we want to respect peoples’ rights); however, we ought to try to distribute benefits and costs in a way that *minimizes* the effects of luck (e.g., by helping those who have been unlucky).<sup>1</sup>

**What Does this Mean for Health Care?** Before the beginning of the Affordable Care Act (“Obamacare”) in 2013, nearly 20% (1 in 5) of the U.S. population was uninsured (no health insurance), and nearly as many were underinsured (they had to pay large portions of their income in out-of-pocket health care expenses). In 2016, Obamacare had reduced the uninsured rate to slightly above 10%, but there are still substantial numbers of uninsured and (especially) underinsured. This is markedly different from nearly every other developed country, where nearly *all* citizens are guaranteed health care. Over the last 30 years, opinion polls have consistently shown that most Americans agree that the health care access should be more “equitable” and “fair”; however, there are large disagreements on how to do this. Until the debate over Obamacare that started in 2010, most scholars of bioethics (including left-wing liberals, right-wing libertarians, and religious thinkers of all types) have argued for a right to a **decent minimum of health care** (where a basic universal plan would cover a set range of preventive measures, surgeries, and treatments; and people could pay more for additional treatments) and NOT for “equal health care for all” (where the government would try to ensure that *\*all\** health care was distributed equally). The main arguments for this idea are as follows:

- **Argument 1: Analogy with other public services.** Health problems are relevantly similar to the sorts of threats posed by crime, fire, food and drug safety, and pollution. Everyone agrees that these latter sorts of problems should be addressed by government action (and not left entirely to the individual). Consistency requires that we treat health care the same way. So, the government should ensure that each citizen has a decent minimum of health care.
- **Argument 2: Society’s past investment argument.** Society as a whole has made huge investments in health care—it subsidizes the training of medical staff, pays for biomedical research, and pays for hospitals and clinics. The common morality thus demands that *\*all\** members of society receive a proportional return on this investment.

In contrast to most other theorists, some libertarians have emphasized that it is essentially *impossible* to ensure perfect equality of opportunity, at least if we care about preserving people’s rights to make their own decisions (and so, we shouldn’t try). Nevertheless, most participants in the health care debate have agreed that *something* needs to be done to ensure that “unlucky” people (especially those who incur massive medical bills for conditions that they could not prevent) have access to a reasonable level of medical care.

## HOW SHOULD WE ALLOCATE SCARCE HEALTH RESOURCES?

Many health care resources (such as organs, hospital beds, and time and attention from medical staff) are **scarce**, in the sense that there are not enough of them to meet everyone’s needs. This raises the question: How should we distribute these resources?

- **Is it fair for the rich to get better health care than the poor?** In the U.S., many scarce health care resources (including many surgeries, drugs, and time with specialists) are allocated on *ability to pay*. This raises questions of fairness of opportunity, since (1) people’s medical problems are often entirely out of their control and (2) people’s wealth is at least somewhat out of their control. In most other rich, capitalist countries (such as Canada, the UK, Germany, and Japan), ability to pay plays far less of a role.

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<sup>1</sup> For more details on the healthcare debate as it relates to justice, see Norman Daniels, “Justice and Access to Health Care,” in *The Stanford Encyclopedia of Philosophy*, ed. Edward N. Zalta, Winter 2017 (Metaphysics Research Lab, Stanford University, 2017), <https://plato.stanford.edu/archives/win2017/entries/justice-healthcareaccess/>. Another good (though slightly older) source is Richard Cookson and Paul Dolan, “Principles of Justice in Health Care Rationing,” *Journal of Medical Ethics* 26, no. 5 (October 1, 2000): 323–29, <https://doi.org/10.1136/jme.26.5.323>.

- **Can you forfeit your right to health care by making poor lifestyle choices?** Some ethicists have argued that those who knowingly engage in risky behavior should be treated differently than those who do not. So, for example, they have argued that it would be reasonable for smokers to (1) pay more for their insurance and (2) to be put LOWER on transplant lists for lungs or hearts. The same thing has been argued for liver transplants for heavy drinkers. A problem case: What about *former* smokers or drinkers (e.g., those who quit years ago, but now have health problems because of this).
- **Does citizenship matter?** Some people have argued that health care should be left to *nations* and *states*, and that it is perfectly fair for each political unit to favor its own citizens. So, for example, they argue that U.S. hospitals should give transplant organs to U.S. citizens instead of foreigners (if they are forced to choose). Others (sometimes called **cosmopolitans**) have argued that justice requires we treat *everyone* fairly, and not just those in our country.

B-C argue that purely formal principles of justice commits us to the following goals: (1) provide “unobstructed access to a decent minimum of health care through some form of universal insurance coverage”, (2) “develop an acceptable incentives for physicians and consumer-patients” to constrain costs, (3) “construct a fair system of rationing that does not violate the decent minimum standard” and (4) “implement a system that can be put into effect incrementally, without drastic disruption of basic institutions that finance and deliver health care.”

### HOW CAN WE ALLOCATE, SET PRIORITIES, AND RATION IN A JUST MANNER?

Here are three common scenarios in which the principle of justice comes into play:

- **How should we ALLOCATE resources?** This includes questions of how to (1) spend on health care, given that we need to spend money on other things (education, defense, etc.) as well? (2) divide up our health care budget (public health, hospitals, training, research, etc.), (3) allocate treatment dollars (Which hospitals get funding? Which research projects are worthwhile?) and (4) make decisions about individual cases (Which patient gets the ICU bed? Who gets referred to the specialist?)
- **How do we set PRIORITIES?** It is impossible for the government (or for private insurance) to cover every treatment that might be helpful to a patient. Some governments (the U.K., Oregon) have come up with ranked lists of procedures based on (1) expected cost-benefit and (2) citizen preference. In general, research has shown that **preventive care** and **public health measures** are have much better cost-benefit ratios; however, citizens often prefer to have their dollars spent on expensive, low-success procedures (open heart surgery, second-line chemotherapy, etc.). If we are forced to choose, what should we do?
- **How do we RATION scarce treatment?** B-C argue that, in order to decide who gets treatment, we need to (1) determine criteria for a person being *eligible* for this treatment, and (2) figure out how to rank those who are eligible.
  - ELIGIBILITY includes **constituency** (is the person a member of the relevant social “group?”), **progress of science** (do researchers need to exclude certain sorts of patients?), and **prospect of success** (scarce resources should be given to people that actually be helped).
  - RANKING requires sorting by **medical need** (who “needs the treatment the most?”). In some cases, we may also consider **social utility** (for example, if there is an epidemic, medical professionals should be vaccinated first, since this is the “best action for society as a whole”). This final criterion should be used only when the person’s contribution “is indispensable to attaining a major social goal.”

### SOME OTHER ISSUES WITH “FAIR OPPORTUNITY”

The fair opportunity rule (and the principle of justice more generally) also affects other areas of health care policy:

- Historically, there have been large disparities in health care based on gender, race, ethnicity (and language), and social status (none of which people “choose”). For example, such people may live in neighborhoods with poorer health care facilities, may lack employer-based health insurance, and may not benefit as much from medical research as other groups. Because of differences in education, they may also be unaware about how to access health care services, and more likely to distrust health care providers.
- Differences in inherited income, primary and secondary education, home environment (second-hand smoke, violence, exposure to toxic chemicals, etc.) and genetics also contribute to poor health outcomes, and all of these are out of people’s control. For example, because of difference in blood types, people of certain ethnicities been less likely to receive donor organs (because organ-sharing networks have prioritized “having the same blood type” on the grounds that this maximized chance of success). In this case, this policy seems justified on utilitarianism (since it “saved the most lives”) but NOT justified according to “fair opportunity.”
- The use of (paid) **human research subjects** has also raised concerns. Such people are often poor, and many come from so-called “vulnerable groups” (this term is misleading, since individuals within a group will have varying degrees of vulnerability). On the one hand, if researchers pay these people too little, this amounts to **undue profit**, since it’s unfair to ask people to participate in painful, risky research for too little money. However, if too *much* money is offered, this raises issues of **undue inducement**, since such

individuals may feel “forced” to take risks they otherwise wouldn’t, because of their need for the money. B-C suggest that medical research should pay close to minimum wage, to ensure that vulnerable individuals are actually choosing to participate in the research.

## REVIEW QUESTIONS

1. What is the fair opportunity rule? Why do many bioethicists think that this rule requires that this entails a right to a “decent minimum of health care”? Do you agree with their reasons?
2. Do you think it is OK for (government subsidized) health insurance to charge people more based on “life style conditions” (such as smoking and obesity)? Why or why not?
3. Suppose that you are put in charge of determining what counts as a “decent minimum” of health care (remember—this will at least partially be paid for with tax dollars!). Which of the following services would you include? Why?
  - a. Annual check-ups including physicals and blood tests
  - b. Preventive care (cholesterol and blood pressure tests and meds, immunizations and flu shots, etc.)
  - c. Prescription drugs
  - d. “Normal” hospital services, including surgery, cancer treatment, ER visits, and so on (assume a medium to high benefit-cost ratio).
  - e. “Extraordinary” hospital services, including surgery, cancer treatment, and so on (assume a low to very low benefit-cost ratio)
  - f. Transportation (Ambulances, etc.)
  - g. Prosthetics (artificial limbs)
  - h. Psychiatric care
  - i. Experimental treatments, surgeries and drugs
  - j. Prenatal care and birthing
  - k. Visits to specialists \*without\* referrals
  - l. Fertility treatments (IVF, artificial insemination)
  - m. Reproductive healthcare *other* than abortion (condoms, birth control drugs)
  - n. Abortion in the case of rape or threats to the mother’s life
  - o. “Elective” abortions
4. Why is it so difficult to determine how much to pay research subjects? What is the problem with paying them too little? Too much?

## WHAT SHOULD BE THE SCOPE OF A HEALTH NETWORK’S OBLIGATION TO RESPOND AFTER A HOSPITAL CLOSURE? (AMA JOURNAL OF ETHICS)<sup>2</sup>

**Background:** In recent years, many rural hospital have closed (including some in SE Minnesota), which has made it more difficult for residents of these areas to access healthcare. This case study raises questions about how we should respond to this, both at the institutional and personal level.

“N Health Network recently announced the closure of one of its institutions, S Medical Center. In a rural location, the medical center is the area’s only full-service, inpatient hospital, providing primary, emergency, and specialist care to over 20 000 residents since its opening 40 years ago. Reasons given by N Health Network for the medical center’s closure include decreasing revenue, decreased patient volume, and burdensome building maintenance costs. The medical center’s patients and staff of local clinicians will be consolidated and transitioned to N Health Network’s main campus about 30 miles away.

Beyond medical care, S Medical Center has served as an economic anchor for this town, employing residents in a wide variety of professions and consistently contracting with local businesses. Unsurprisingly, there has been considerable public outcry since the announcement. Many residents feel that S Medical Center has become a way of life for their town and express great concern over its impending departure. Generally, the community feels unprepared for the ramifications of this decision.

The medical center’s clinicians, including Dr P, acknowledge that the reasons given by N Health Network administrators are good ones, but they are concerned about the closure’s impact on their and their community’s livelihood. Because the medical center is one of the main employers in the community, its closure will mean job losses and reduced economic prosperity in the community and make it harder for many long-time community members to access the clinicians they’ve been used to seeing when they have health problems. Dr P wonders how he should respond to his colleagues’ and patients’ concerns during the consolidation and transition.

Many of Dr P’s long-term patients have asked for more information regarding S Medical Center’s closure. Mr H, a 63-year-old man with diabetes and fatty liver disease, expresses his concern. “After all these years, I can’t believe S is leaving, and that you’re leaving! You’re still going to be my doctor, right?” Dr P tries to reassure Mr H that everything will work out and that he will continue to care for him. Mr H responds, “How do they expect me to travel so far to see you?”

Dr P apologizes to Mr H for the distressing situation. Dr P feels frustrated, too, and wonders how the collective distress of the closure could be hurting patient-clinician relationships all over the town. Dr P wonders what to say and do.”

<sup>2</sup> George M. Holmes and Sharita R. Thomas, “What Should Be the Scope of a Health Network’s Obligation to Respond After a Hospital Closure?” *AMA Journal of Ethics* 21, no. 3 (March 1, 2019): 215–22, <https://doi.org/10.1001/amajethics.2019.215>.