Everybody Ought to Have Health Care

Stephen A. Wilson, MD, MPH

(Fam Med. 2017;49(8):654-5.)

The main thing is to remember to keep the main thing the main thing, so start with the end in mind: Every American should be able to access the US health care system to meet acute, chronic, and preventive health care needs.

Sometimes we can become more wedded to how the main thing is achieved than to actually achieving the main thing. The focus becomes so much on the tool, or its associated ideology, that the main thing becomes a means to justify the tool or ideology. This means either the main thing was displaced or it was actually never truly the main thing. Some examples related to approaches to US health care include: centralized vs decentralized, federal administered vs state administered, single payer vs multipayer, Obamacare vs not-Obamacare.

Losing focus on the main thing can result in focusing on the means to the end instead of on the end. The Patient Protection and Affordable Care Act (ACA, also known as Obamacare) of 2010 had some positive results: expanded insurance access to the working poor, allowed children <26 years of age to be covered by their parents’ health insurance, and removed pre-existing conditions from being considered in insurance premium costs. Many uninsured benefitted.

At the same time, there were negative economic and health care realities for some in the US middle class: cost for health care rose significantly, and some were disconnected from their physicians. The increased cost of health care was not a significant issue for the wealthy and for many with large employer-based health insurance. However, many of the effected started to feel misled, unheard, or ignored.

Some struggled philosophically with the idea of being required by the government to buy something, in this case health insurance, either all together or in a manner that did not allow some adjustment for ethical or religious reasons. The optics of the US government suing the Little Sisters of the Poor to force them to buy a certain type of health insurance plan was a clash of ends and means. That the US government needed to penalize people whose mission is to manifest the love of God by providing care for the neediest elderly was a means at odds with the stated ends of Obamacare.

Was organized family medicine so enamored and aligned with the ends that it was blind or mute to inconsistent or distracting means, such as the severing of doctor-patient relationships, and inattention to the cost of medications?

To be in favor of Obamacare does not equate with being a socialist or communist. Not being in favor of Obamacare does not equate with greed or indifference to, or hatred of the poor. When two different approaches or positions on the same problem are at odds, they may at times be well served by reasoning through a Hegelian dialectic—contradictions between two positions, a thesis and antithesis, are resolved with a third position (synthesis). Maybe health care could be funded by a set percentage of each person’s income going into a health care fund that would serve as a de facto budget from which the most valuable services are prioritized.

Another example of goal obfuscation by a philosophical or ideological position is the argument that health care is either a right or privilege. It is neither.
Amongst those who reason that all should have access to health care, those who see health care as a right are not more generous, moral, or sensitive; and those who do not see it as a right are not less generous, virtuous, or kind. They can simply have the same end goal with a differing rationale.

Framing the argument that all Americans should have health care as one of right vs privilege inaccurately sets up a false dichotomy that is incomplete, requires some suppositions, and diminishes the higher reason for achieving the goal of health care for all.

Can something be an actual right if it has to be explicitly paid for with the resources–effort, work, and money–of others?

A right is something a person has by merit of existence, by being alive. Some examples include: rights to life, liberty, and pursuit of happiness; and rights to freedom of religion, speech, and press. “Happiness” in the 18th century was not the happiness of the 21st century, an ephemeral moment of gladness or satisfaction. It was seen as a state of well-being or contentment; closer to what today might be considered fulfillment or joy. Happiness is to joy as weather is to climate. While rights require safeguarding (from being taken away or infringed upon) and balancing with responsibilities, they are inherent to being human.

Although calling health care a right for all adds gravitas to this logical and necessary moral conclusion, claims a moral high ground, and even shames impeders, intuitively, health care does not seem to be an inherent right. At the same time, we intuitively know it should not be a privilege. Both ethical (systematic rules of external conduct) and moral (internal principles of right and wrong) sensibilities inform that conclusion.

If each human being should have health care, yet does not have the right to others’ resources, what is the rationale for health care for all if it is neither a right nor a privilege? It is a sense of moral obligation to our neighbors, our fellow human beings. Health care is an ought: everyone ought to have it.

We take care of the needy, suffering, unfortunate, and downtrodden not because it is their right to have us do so, but because we ought to do so. It is our expressions of love and kindness–loving-kindness–to each other: human to human, human for human. In our hearts and souls we know that caring for our neighbors, for each other, is what we ought to do. This is compelling, convincing rationale.

Every one ought to have health care. “We give to each other from what we have because it is right” has a different tone, appeal, and impetus than, “Give to others from what you have because they have a right to it.”

A just end accomplished forcefully or by any means necessary may achieve transient success and happiness for some. A just end achieved by just, moral, equitable means has a better chance for longevity and joy for all.

Love for one another, loving our neighbors as ourselves, is realized when we do what we ought, when we fan the flame of the ought to do what is right.

Though there may be different means and reasons to the same end, the populace is better served when we remember to keep the main thing the main thing: Every American should have equal access to the US health care system, regardless of income or station, because it is the right thing to do. It is how we ought to treat each other.

CORRESPONDENCE: Address correspondence to Dr Wilson, Director, Faculty Development Fellowship and Medical Decision Making, Education, University of Pittsburgh UPMC St Margaret Family Medicine Residency, 3937 Butler St, Pittsburgh, PA 15201. 412-784-7672. Fax: 412-621-8235. wilsons2@upmc.edu.

Reference