Paper 1 Bio-Medical Ethics
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The Ethical Necessity of Rejecting the American Healthcare System

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The American healthcare system is widely considered imperfect, and consistently a topic of political discourse, yet it is rarely considered indefensible. From a bioethical perspective, the debate around this system is not a matter of perspective, but a matter of necessity. There are growing disparities in life expectancy based upon wealth, education, and zipcode– the social determinants of health– that this system continues to accept. From relational, virtue, deontological, pluralist, liberal egalitarianist, and utilitarian lenses, it cannot be defended. To continue to accept this system is to ignore the data against it and to engage in complacency in the face of ethical injustice. Bioethicists have a moral responsibility to reject the American healthcare system.

INTRODUCTION

Despite significant improvements in biomedical innovation, healthcare disparities in the United States continue to harm vulnerable populations at an alarming rate. These differences are evidenced by significant discrepancies in life expectancy, access to preventative care, and mortality between vulnerable and privileged populations.

Is this a system we are ethically compelled to accept? This paper contends with this question through conversation with primary ethical frameworks that are foundational to the field of bioethics, constructing a data-driven argument that the American healthcare system is not simply imperfect– it is indefensible.

To situate this argument, one must understand that the current healthcare system is responsive to social structures and how those structures interact with the principles of bioethics– with an emphasis on justice, nonmaleficience, and autonomy.

The CDC defines the social determinants of health (SDOH), as the non-medical and cumulative factors that affect health outcomes, including education access and quality, healthcare access and quality, built environment, community support, and economic stability.[1] For this work, vulnerable populations can be understood as those who are experiencing poor SDOH, often actualized as one or more of the following: low socioeconomic status, limited access to education, physically difficult and potentially dangerous work, and residency in a rural environment.[2]

A 2025 study from Johns Hopkins found that low educational attainment was associated with significantly higher mortality risks, with adults dying at a rate of 20.90 per 1,000 person-years, compared to 8.16 for those with high educational attainment. This is likely contributed to by factors that serve as a barrier to access, including being over three times as likely to lack health insurance (20.0% vs 6.1%), and nearly twice as likely to report being unable to afford medical care (9.5% vs 4.7%).[3]

Of those with high educational attainment in the same study, only 10.3% are low-income, compared to 43.5% of those with low attainment, and 25.8% with medium attainment– noting the significance of educational attainment as a gradient. This enforces the idea that education is a pathway to avoid poverty, and it is known that poverty is a risk factor for early mortality.

A 2025 study from the National Cancer Institute found that low-income counties had a 58% greater cancer mortality rate than high-income peers, a trend that is also seen in infectious diseases, as demonstrated by data from the COVID-19 pandemic.[4] A 2024 report from the SOA Research Institute found that the life expectancy gap between the most advantaged and most disadvantaged Americans reached 9.9 years for men and 8.1 years for women by 2021, up from 7.3 and 5.8 years respectively in 2019. Similarly to education, this data was also shown over a gradient, with life expectancy increasing with socioeconomic advantage.[5]

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[1] CDC, “Social Determinants of Health,” Public Health Professionals Gateway, May 14, 2024, https://www.cdc.gov/public-health-gateway/php/about/social-determinants-of-health.html.

[2] SDOH are often experienced collectively, making them statistically collinear. Further, race and racism are well-documented SDOH factors, and independent predictors of poor SDOH outcomes. A full discussion of racial health disparities falls outside the scope of this paper.

[3] Ishnaa Gulati et al., “Socioeconomic Disparities in Healthcare Access and Implications for All-Cause Mortality among US Adults: A 2000-2019 Record Linkage Study,” *American Journal of Epidemiology* 194, no. 2 (2025): 432–40, https://doi.org/10.1093/aje/kwae202.

[4] Aleah L. Thomas et al., “County Socioeconomic Status and Premature Mortality from Cancer in the United States,” *Cancer Epidemiology* 95 (April 2025): 102747, https://doi.org/10.1016/j.canep.2025.102747.

[5] Magali Barbieri, *The Impact of Covid-19 on the Socioeconomic Differential in Mortality in the United States*, n.d.

As for rural populations, the access issue is arguably the most tangible. A 2024 study from the USDA found that working-age rural populations have a 43% higher natural cause mortality (NCM) rate than their urban peers, for men and women alike. This is a significant increase from the 6% difference found in 1999, and is reflective of rural areas being left behind in infrastructure upgrades. Access to care is a significant issue, and working rural populations are seemingly more at-risk for exposure to dangerous or life-altering circumstances.[6,7] For these populations, geography alone– a largely unchosen condition– determines exposure to occupational hazard, distance from care, and mortality.

Given the above data, one can ascertain that the educated, wealthy, and urban populations in the United States are those who live longer, healthier lives with earlier and more consistent access to care. The question is once again: is this a system that we are ethically compelled to accept? Or rather, is it a system that we find ourselves ethically compelled to reject?

From a bioethical perspective, these data points closely align with the principle of justice. When there exists a system that allows individuals of equal health and character to receive vastly different healthcare on the basis of their geographical location, relative income, or education, that system is operating unjustly. In this sense, neither life has more value than the other, yet one is clearly extended and treated with care, while the other is seemingly disregarded.

There is also an argument for nonmaleficence. The American system continues to assert that death is a right the people do not have, a sentiment in obvious conflict with the autonomy framework bioethicists rely upon.[8] However, if we are to accept this system, then one must ask: if the people are forced to live, then how come some are forced to live at a lower standard than the rest? Is forcing one to live at a lower quality not an act of maleficence upon the vulnerable? This tension between compelled existence and denied autonomy and justice will be examined across each framework in this paper.

Addressing the structural issues that lead to these differences in healthcare outcomes– differences dependent solely upon the unwilling condition of one's birth– is no longer the sole burden of politicians and social scientists. Rather, it is the burden of ethicists, and bioethicists in particular, to determine the ethics of the existing system. This paper argues that when evaluated against the ethical frameworks most central to bioethical discourse, the existing American healthcare system is not simply imperfect, or in need of reform. Rather, it is ethically indefensible, and we as bioethicists are compelled to reject it.

ETHICAL LENSES

Relational Ethics and Community Responsibility

Carol Gilligan established a framework for understanding the world as a network of relationships between individuals, rather than as a collection of autonomous and isolated individuals who are forced to interact for survival. She asserts that it is within our human nature to care for one another, and that embracing a relational perspective to coincide with justice is essential to understanding the composite disposition of our rationality. This perspective on relationships forces the reader to consider how communities can come together to support one individual, because that individual is cared for by another member of the community.[9] It follows that if a community of care permits the suffering of one individual, on the basis of conditions they cannot control, the system has structurally failed.

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[6] Life-altering and dangerous working conditions are associated with precarious work, an emerging labor classification that's beginning to be documented throughout Europe.

[7] Kelsey L. Thomas, *The Nature of the Rural-Urban Mortality Gap*, n.d.

[8] "Washington v. Glucksberg | Constitution Center," National Constitution Center – Constitutioncenter.Org, accessed March 25, 2026, https://constitutioncenter.org/the-constitution/supreme-court-case-library/washington-v-glucksberg.

[9] Carol Gilligan, *In a Different Voice: Psychological Theory and Women's Development* (Harvard University Press, 2009).

To have an effective community of care, we must not only care-about others, we must recognize that each individual's life has equal value to their peers, and that each peer is cared-for by another. Nel Noddings establishes this, presenting the distinction between caring-for and caring-about, with caring-for someone involving intensive, hands-on engrossment, and caring-about referring to giving thought to an issue, but not becoming compelled to seek resolution for it. Noddings argues that humans are more likely to care-for those close to them, and to care-about, but not for, the plight of those to whom they are unfamiliar.[10] This idea is already acted upon in our society, demonstrated by the efforts of advocates and the media to build empathy between populations as a means for rallying support to a given cause.

Relational ethics in this way is a compelling mechanism– we are inclined to care-for, or care more strongly about, people and battles that we possess empathy for. Yet, empathy alone is not enough to compel universal care. Empathy enables us to understand one another, but it does not assert that we must participate in a community of care as a result of knowing one another’s struggles. However, collectively, Gilligan and Noddings establish a system that is more structurally binding than community.

They synthesize a framework for community as a system of collective and just care. If we acknowledge that all human lives have the same value, and that it is likely that every individual is cared-for by at least one other individual, a moral individual would find themselves compelled to participate in a community that supports all individuals. They would acknowledge that the suffering of one member of the community carries the same moral weight as the suffering of the individuals they care-for, creating an inherent obligation to ensure every member has access to care. Institutions– including national healthcare systems– are an expression of collective community, and therefore inherit the same obligations for care as the theorized communities in this framework.

Virtuous Rejection

A virtuous individual would certainly agree. A virtuous individual is one who fully embodies their values, who can assert with no inner conflict the correct moral pathway, even when doing so may result in harm upon themselves.[11] Then, how would a virtuous person respond to a community that ensures some members receive care, whilst others are left aside to fend for themselves?

The answer is, fortunately, unambiguous. If a virtuous person participated in a community that permitted unequal suffering, they would certainly be unable to avoid inner conflict, effectively prevented from reaching *eudaimonia*, and unable to live according to their moral framework. As such, the answer is simple– a community that extends selective care to its members is one that a virtuous individual could not accept, and accepting it would require a rejection of *eudaimonia*.[12]

Then, we have established that from a relational perspective, communities have a moral obligation to care equally for all members, largely by recognizing the equal value that each life possesses, and the cared-for nature that exists for all members of the community. Further, a virtuous person would reject a community that selectively extends care, acknowledging that such a community would not be just, and that supporting unequal suffering would leave them unable to fully support themselves. Given this, we must now consider: if there exists a system that selectively extends care to individuals, individuals whom we’ve established all have an equal right to life, then is that system morally acceptable?

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[10] Nel Noddings, *Caring, a Feminine Approach to Ethics & Moral Education*, with Internet Archive (Berkeley : University of California Press, 1986), http://archive.org/details/caringfeminineap00nodd.

[11] Rosalind Hursthouse and Glen Pettigrove, “Virtue Ethics,” in *The Stanford Encyclopedia of Philosophy*, Fall 2023, ed. Edward N. Zalta and Uri Nodelman (Metaphysics Research Lab, Stanford University, 2023), https://plato.stanford.edu/archives/fall2023/entries/ethics-virtue/.

[12] Hursthouse and Pettigrove, “Virtue Ethics.”

From a relational and virtuous perspective, the answer is clearly that it is not. Yet, moral intuition alone is insufficient to compel the rejection of a national system. To understand why we must reject the American healthcare system, we must understand the issues considered from a bioethical perspective, using the foundational works of the same ethicists cited by Beauchamp and Childress in their formulation of the four principles.

On Universalizability

Kant's Formula of Universalizability argues that if a maxim cannot be universalized, it must not be a moral maxim. A system that permits preventable suffering on the basis of one's birth, zipcode, education, or income– the SDOH– is not one that any rational agent would universally will.[13] Willing such a framework would require the belief that individuals have varying worth upon birth, which contradicts the foundation of many major ethical schools.[14]

Ross's pluralistic *prima facie* duties require ethical healthcare systems to both benefit (beneficence) those who take part in them, and simultaneously prevent harm (non-maleficence) upon such parties.[15,16] The *prima facie* duties, whatever they may be, are the foremost duties of a system– meant to protect the rights of those within it above all else– and they can only be in conflict with each other. They can never be overruled by another obligation– economic, social, or political– meaning any system that fails to meet *prima facie* duties as a result of other obligations is a system failing its members.

In the American system, there is a 58% difference in cancer mortality and a 9.9 year difference in life-expectancy between the richest and poorest members of the *same* society. It is statistically undeniable that economic duties are competing with the *prima facie* duties established by Beauchamp and Childress, resulting in low-income individuals experiencing the lowest quality of life.[17] This is not a system that any rational being would will to be universal, as it requires human life to be valued unequally.

Deontological and pluralist frameworks converging independently on the same verdict is the first of many indications that the case against the American healthcare system is not one of perspective, but one of ethical necessity.

Non-Maleficence and Compelled Poor Quality of Life

Washington v. Glucksberg establishes that the right to death is not protected under the 14th amendment, and has been used as a basis for legislation outlawing suicide, including that which is physician-assisted. The state compels life, yet that compelled life does not guarantee its quality, instead it permits preventable suffering for those without resources. In this way, external obligations– the aforementioned economic, social, and political– compete with and win over *prima facie* duties, resulting in an act of maleficence upon vulnerable populations. It is maleficent to force individuals to exist with potentially painful, chronic conditions that they cannot afford treatment for. The American healthcare

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[13] Strictly interpreted, the Kantian Formula of Universalizability is based on the concept of free will, which can be understood as a collective agreement between individuals on what is right and wrong. No rational and free agent would will potential suffering against those who also possess the free will.

[14] Immanuel Kant, "Morality and Rationality," in *Ethics : Essential Readings in Moral Theory* (2012).

[15] W. D. Ross and Philip Stratton-Lake, *The Right and the Good*, Reprinted, British Moral Philosophers (Clarendon Press, 2007).

[16] Tom L. Beauchamp, "The 'Four Principles' Approach to Health Care Ethics," in *Principles of Health Care Ethics*, 1st ed., ed. Richard E. Ashcroft et al. (Wiley, 2006), https://doi.org/10.1002/9780470510544.ch1.

[17] Beauchamp, "The 'Four Principles' Approach to Health Care Ethics."

system is unequipped to treat individuals with non-maleficence, because it is by maleficent design that vulnerable individuals cannot access it.

Currently, vulnerable individuals are treated as acceptable losses because of these obligations, resulting in human life being treated as a tool of convenience. This violates Kant's Formula of the End Itself, which stipulates that all humans must be treated as an end in themselves, never as merely a means to another's purpose. The current system functions on allowing the poor to die– through an inability to access preventative, regular, or specialty care– instrumentalizing their lives as a means to fuel the for-profit system. This is not a system that any deontologist would support, and not one that any rational individual would consent to participation in if they were unsure of where they'd fall within it.[18]

In its current state, the American healthcare system exists such that your income, education, and zipcode directly contribute to whether you experience a decade-long deficit in your life expectancy. If rational individuals were told this information– but not which side of the line they are to be positioned on– how many would willingly consent? From behind the Veil of Ignorance, the American system is a promise that none would agree to, as it is unjust. An unjust system would not be supported by Beauchamp and Childress– it violates the principle of justice– and is incoherent in the modern understanding of ethical healthcare systems.

A system that treats individuals as unequal uses the vulnerable as a means to sustain itself, but not to sustain *prima facie* duties. Rather, it is to sustain systems that should not be prioritized over human life, such as economic and political prosperity. Given this reality, no rational agent would consent to the utilization of human life in this way, and no rational agent would choose to participate in this system without knowing which role they would play. Yet another indication that the American healthcare system is ethically indefensible is converged upon, on the principle notion that such large disparities cannot be accepted via any of the frameworks presented.

A Kingdom of Minimized Happiness

Behind the Veil of Ignorance, no rational person would consent to human life being treated as expendable, even if for the sake of preserving their own life, or that of those close to them, as demonstrated by relational ethics.[19] Further, in a Kingdom of Ends, the maxims that permit the existence of the American system would be utterly irrelevant, as the Formula of the End Itself has previously failed.[20] As such, deontologists would have no ability to will this society to exist, and would be ethically compelled to reject such a system.

A utilitarian perspective arrives at the same conclusion. In a nation where the wealthiest 10% of individuals own 68.3% of the country's resources, and income status is the determining factor in adequate access to healthcare, 90% of the population is experiencing minimized access to vital resources in a way that is predictable, calculatable, and systematic.[21] This results in the minimization of happiness for a significant portion of the population, and is in conflict with the foundations of utilitarian frameworks.[22] As such, the American healthcare system has resulted in a kingdom of minimized happiness that cannot be defended by any major ethical school used to formulate the modern framework for bioethics.

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[18] Kant, "Morality and Rationality."

[19] John Rawls, "A Theory of Justice," in *Ethics : Essential Readings in Moral Theory* (2012).

[20] Kant, "Morality and Rationality."

[21] "The Fed - Distribution: Distribution of Household Wealth in the U.S. since 1989," accessed April 1, 2026, https://www.federalreserve.gov/releases/z1/dataviz/dfa/distribute/chart/#quarter:145;series:Net%20worth;demographic:networth;population:1,3,5,7,9;units:shares.

[22] John Stuart Mill, "Utilitarianism," in *Ethics : Essential Readings in Moral Theory* (2012).

DISCUSSION

This paper has intentionally engaged with primary sources to develop a deeper understanding of whether any of the foundational ethical schools can support the American healthcare system in its current state. This engagement has built an argument of convergence across schools, however, it is also worthwhile to acknowledge the secondary works which hold relevance to the ideas presented.

For the argument of universalizability: Dorothy Roberts and Sandra Harding present perspectives on how history has shaped inequalities in medicine, and how knowledge and lived experiences are unequally valued in this field.[23,24]

For non-maleficience: Achille Mbembe presents arguments around necropolitics and whose deaths society chooses to deem acceptable.[25]

When considering utilitarianism: Norman Daniels approaches healthcare from a justice perspective, and views its provision as a special moral duty willed upon members of a modern society. He most notably engages with global scholars to better understand and address the role that SDOH play in the American healthcare system while taking a Rawlsian approach, making his work directly relevant to the discussion presented herein.[26]

Counterarguments and Rebuttals

Some may argue that healthcare outcomes are reflective of lifestyle choices and individual decisions. From a libertarian perspective, one cannot force another to take any action, even if that action is to serve their own personal good.[27] While this point is valid in ethical discourse, it cannot be reliably applied to the issue of public health. The statistics show undeniable correlations between SDOH– once again income, education, and zipcode– and the survival of vulnerable populations. To ignore this data as a matter of individuals choosing against their own health– in a time when information is widely accessible and the statistics are disproportionately affecting those without resources– would be attributing the cause to the symptoms, and failing to acknowledge that experiencing poor SDOH is overwhelmingly unchosen.

Another argument may be made for preference utilitarianism. Perhaps, an individual prefers not to receive healthcare or that they prefer to enable the suffering of others. In this instance, would the American healthcare system not be morally permissible? First, it is worth noting that a decision made with incorrect or incomplete information– better defined as a decision made under conditions of misinformation or inequality– is not a decision made freely. And no decision made without freedom can be considered in an ethical conversation. To assert that those without access to education or wealth may choose not to engage in healthcare is a fallacy, as they possess not the education or know-how to assert otherwise. This is not a failure upon the individual, rather, it is a failure of a series of systems to enable the individual to make a rational and well-informed decision about their own health.

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[23] Dorothy Roberts, *The Problem with Race-Based Medicine*, 2016, 14:50, https://www.youtube.com/watch?v=tx2j_nMubX4.

[24] Sandra Harding, *Whose Science? Whose Knowledge?: Thinking from Women's Lives* (Cornell University Press, 1991), https://www.jstor.org/stable/10.7591/j.ctt1hhfnmg.

[25] Achille Mbembe and Steven Corcoran, *Necropolitics* (Duke University Press, 2019), https://doi.org/10.2307/j.ctv1131298.

[26] *Norman Daniels | Harvard T.H. Chan School of Public Health*, n.d., accessed April 2, 2026, https://hsph.harvard.edu/profile/norman-daniels/.

[27] Bas van der Vossen and Billy Christmas, "Libertarianism," in *The Stanford Encyclopedia of Philosophy*, Fall 2025, ed. Edward N. Zalta and Uri Nodelman (Metaphysics Research Lab, Stanford University, 2025), https://plato.stanford.edu/archives/fall2025/entries/libertarianism/.

Second, if an individual prefers to enable the suffering of others, then that individual is already operating outside the self-defined bounds of preference utilitarianism. This framework is meant to allow for autonomy within utilitarianism, not to permit behavior which society has mutually agreed is harmful.[28]

It is no secret that public health and dissatisfaction with the American healthcare system is at the center of political debates. It is true that this paper could be used to argue for universal healthcare, but that is not the intention. Rather, it is argued that the current American healthcare system is ethically indefensible, a bipartisan concern shared by 61% of Americans.[29] Asserting that this is a system that must change is far from partisan, and evaluating systems is a cornerstone of bioethics, regardless of the political implications of any works the field produces.

CONCLUSION

To claim that a system is ethically indefensible is certainly bold. Some may argue that the system is rather imperfect, but certainly not indefensible. Yet, in an evaluation of all of the frameworks presented, not a single school can defend the American healthcare system against the ethical implications of the data presented in the introduction of this work. No rational agent would consent to participation in a system that fails to value human life, and treats individuals as expendable on the grounds of unchosen conditions.

What is unique about this rejection is that ethical schools that typically disagree have converged. Relational ethics asserts that we must care-for those around us, but virtue ethics expands this to caring-for communities, given the equal value of human life. Deontology is of a separate mind, and approaches ethics as a moral obligation where all individuals are equal, and no one above the other. Moral pluralism embraces the fluidity of ethical obligation– something that irks even the most practiced deontologist– yet they arrive at the same conclusion. Liberal egalitarianism asserts that no rational individual would agree to participate in this system, regardless of any view on duty to relationships or community. Even a utilitarian framework fails to support the system, as it requires the minimization of happiness for the majority of the population. What is critical here is that in places where the most foundational ethical frameworks find great conflict with one another, even then they cannot defend it. So then, if one truly wanted to ethically defend the American healthcare system, they find themselves challenged to do so without the support of relational, virtue, deontological, pluralistic, liberal egalitarian, or utilitarian tools.

Then, is it not the responsibility of the conscientious bioethicist to reject the American healthcare system? If it cannot be supported by the aforementioned schools– the schools that Beauchamp and Childress built their framework upon– then how can we as a field accept it? Rejecting this system is no longer a matter of perspective, it is a matter of ethical necessity. We cannot continue to call ourselves practitioners of ethics when we are complacent in the suffering of the vulnerable, and we are complacent so long as we refuse to reject the system which inflicts unchosen suffering upon them.

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[28] Walter Sinnott-Armstrong, “Consequentialism,” in *The Stanford Encyclopedia of Philosophy*, Winter 2023, ed. Edward N. Zalta and Uri Nodelman (Metaphysics Research Lab, Stanford University, 2023), https://plato.stanford.edu/archives/win2023/entries/consequentialism/.

[29] Holliday Woodard, “Most Americans Now Worry More About Healthcare Than the Economy,” US News & World Report, March 31, 2026, //www.usnews.com/news/national-news/articles/2026-03-31/healthcare-costs-top-list-of-american-concerns-in-2026-gallup-poll.

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