The Ethics Dispatch

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"Functioning as our better selves leads to better outcomes for patients and everyone."

-- Tarris (Terry) Rosell, PhD, DMin, HEC-C

Hot Topic

Why Rural Healthcare Fails Without Medicaid: An Ethical Analysis

What is Medicaid? According to the U.S. Department of Health and Human Services, "Medicaid is a joint federal and state program that helps cover medical costs for some people with limited income and resources… [It] offers benefits that Medicare doesn't normally cover, like nursing home care and personal care services." (HHS.gov).

In rural communities across the United States, Medicaid is a critical source of healthcare coverage. It supports emergency care, preventive services, maternal health, and mental health treatment – often in places with few or no alternatives. In many rural towns, like the one I grew up in, Medicaid funds up to 50% of all local healthcare. This funding isn't supplemental – it's foundational.

Writing for the National Rural Health Association, Carrie Cochran-McClain explains, "Medicaid serves as a vital source of health insurance coverage for Americans living in rural areas, including children, parents, seniors, individuals with disabilities, and pregnant women." (Cochran-McClain, 2025). These populations represent a significant portion of rural communities, especially in southern and midwestern states, where Medicaid expansion has played a critical role in stabilizing care access.

Justice: Who Gets Care and Who Doesn't

From a bioethics perspective, the principle of justice demands that people receive care based on need – not income or geography. In rural regions, however, the elimination or reduction of Medicaid would create wide disparities in access. This would hit already vulnerable populations the hardest, particularly those in counties without other coverage options or large healthcare systems.

Cochran-McClain warns that "reductions in Medicaid funding of this magnitude

would likely accelerate rural hospital closures and reduce access to care for rural residents." (Cochran-McClain, 2025). These closures wouldn't just eliminate physical infrastructure – they would dismantle critical pathways to care, especially for those managing chronic illness, pregnancy, or disability.

Beneficence: Medicaid Strengthens Community Health

Ethically, healthcare systems should be oriented toward beneficence – improving health and well-being. Medicaid supports this goal directly. It helps rural hospitals offer a full range of services, from primary care to specialty care. Without that funding, hospitals can't keep labor and delivery units open, offer cancer screening, or retain behavioral health staff.

As Cochran-McClain notes, even with proposed supplemental funding ideas, "the latest Senate text establishes a $50 billion fund for a broad range of health care providers, including rural hospitals," but even that "falls short of what is needed." (Cochran-McClain, 2025). If every dollar of such a fund went to rural hospitals, she explains, it would still cover less than half of the projected shortfall from proposed Medicaid reductions.

Nonmaleficence: Preventing Harm

Removing Medicaid from rural healthcare ecosystems is not a neutral policy – it causes direct and predictable harm. This violates the ethical principle of nonmaleficence, or the duty to avoid causing harm to others. Without Medicaid, rural residents will face longer travel distances for care, more delays in treatment, and higher rates of preventable complications.

Cochran-McClain underscores that such funding gaps "would result in significant coverage losses, reduce access to care for rural patients, and threaten the viability of rural facilities." (Cochran-McClain, 2025). In many communities, these changes would represent more than an inconvenience – they would be a matter of life and death.

A Network at Risk

The rural healthcare system depends on Medicaid not just for hospitals but for entire networks of care: clinics, mental health centers, and home-based services. These providers are typically under-resourced to begin with and cannot absorb sudden losses in coverage or reimbursement. When Medicaid shrinks, these services disappear.

In Cochran-McClain's words, "Many of America's states with large rural populations would fare especially poorly," with states that have expanded Medicaid facing "the largest remaining gaps." (Cochran-McClain, 2025). The populations most likely to lose access are the ones who rely on Medicaid the most.

Conclusion: Coverage that Works

Medicaid isn't a luxury. It's an essential structure holding up rural healthcare. It protects hospital solvency, supports frontline providers, and ensures that low-income residents can receive timely, preventive care. In towns like the one I grew up in – a town like many others – removing Medicaid could mean the collapse of half the healthcare system.

As Cochran-McClain and the National Rural Health Association emphasize, it is not enough to acknowledge the challenges rural hospitals face. We must ensure that policy sustains coverage, not cuts it. Medicaid remains one of the most effective tools for ensuring rural Americans can get the care they need, when they need it. Bioethics calls for systems that are fair, effective, and sustainable. Medicaid fulfills those criteria – and without it, rural care fails.

Sources:

What's the difference between Medicare and Medicaid? | HHS.gov

NRHA's Rural Health Voices Blog | National Rural Health Association - NRHA - NRHA

Bioethics in the News

As iconic British Catholic bioethics center closes, fellow academics dub move a 'tragedy'
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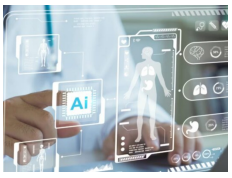

The ethical impact of AI in biomedicine and society
Exaudi News

Sweet Vindication for Stem Cell Research, and American Science
The Hastings Center for Bioethics

The Bioethical Priorities of Pope Leo XIV
The National Catholics Bioethics Center

Case Study: Forced to Choose: Your Money or Your Life

Ms. Essino No Longer Qualifies for Medicaid

Ms. Essino is a 43-year-old mother of two who presented to the hospital with cardiac and respiratory distress. After a month of treatment, she is now medically stable and ready for discharge. However, her discharge plan is complicated by issues related to insurance coverage.

The medical team and case managers believe that transfer to a skilled nursing facility (SNF) or long-term care setting would be most appropriate, with the expectation that she could recover or at least improve her condition. Until recently, Ms. Essino was covered by Medicaid. Due to recent changes at the state and federal levels, she now no longer qualifies and has lost her coverage.

To requalify for Medicaid, she would need to work with the case managers on a "spend down" plan, which would require her to forfeit many of her assets – including her savings, car, and life insurance policy. Ms. Essino is aware that her condition will likely be life-limiting, but she had hoped to improve her quality of life in order to have more good days with her children.

She had also hoped to leave her remaining financial assets to her children, believing that doing so could help support them after her death. Under the spend down plan, that would no longer be possible.

Ms. Essino is now weighing whether to discharge home on hospice – foregoing potential improvement in favor of preserving assets for her children – or to pursue further rehabilitative care at another facility, which may help her live longer and feel better but would require sacrificing her assets. She remains uncertain about which path to choose.

Ethical Musings

Medicaid Cuts: Response to Economic Hurricane or Avoiding Wet Shoes?

There is a concept in philosophy often referred to as *"ought implies can."* What this holds is that for someone to have a moral obligation, that person must have the ability to accomplish said obligation. I cannot create the obligation for someone to drink all the water in the ocean – a person cannot be expected to do that, because a person is not capable of accomplishing it. You cannot have an obligation to do something that someone is not able to accomplish.

In medicine, we apply this principle in situations dealing with non-beneficial and/or futile treatments. Healthcare providers cannot have a moral obligation to provide or accomplish something that cannot reasonably be expected to succeed. A physician has no moral obligation to provide antibiotics to a patient suffering from a viral infection, even if the patient is requesting them, simply because it cannot have the desired benefit. The lack of *can* negates the *ought*.

When Can Creates Ought

But this concept can also be reversed: when does *can* create the *ought*? Life is challenging and complicated, and people often have competing *cans*.

Circumstances can impact our ability to follow through. Imagine you are driving to see your friend. During your drive, you see a young child in a pond, drowning. What is your obligation to that child? Do you have to save them? If you could not swim, then you would not have the obligation to swim out and save them. But imagine you are a lifeguard. Now you have the ability. Do you have the obligation?

Now imagine you arrive at your friend's house and say, "I saw a kid drown on the way here. I could have saved them, but I chose not to." What would your friend think of you? What would you think of yourself?

Now imagine it was during a hurricane, and you would have drowned before reaching the child. That presents a strong justification for not attempting the rescue. But what if you simply did not want to ruin your new shoes? You tell your friend, "I saw a kid drown on the way here. I could have saved them, but I didn't want to get my shoes wet." How does that affect the perceived obligation?

Ethically Defensible Justifications

Some justifications for withholding an action are more ethically defensible than others. It is far more reasonable to not attempt a rescue during a hurricane than to avoid it over concern for footwear.

According to a 2025 paper by the National Bureau of Economic Research,

“expansions increased Medicaid enrollment by 12 percentage points and reduced the mortality of the low-income adult population by 2.5 percent, suggesting a 21 percent reduction in the mortality hazard of new enrollees. Mortality reductions accrued not only to older age cohorts, but also to younger adults, who accounted for nearly half of life-years saved due to their longer remaining lifespans and large share of the low-income adult population” (NBER Working Paper No. 33719).

This study argues that expansion of the Medicaid program saves lives. It can then be argued that reducing Medicaid will harm people and shorten lives. If we follow the logic of *can implies ought*, many believe we are capable of maintaining Medicaid expansions to continue providing these resources to people - and possibly even expanding further. Others argue that we cannot afford continued expansion.

But different justifications rest on different ethical grounds.

The Ultimate Question

As a society, a country, and a people, we need to ask ourselves: Are we reducing Medicaid because we are in an economic hurricane – or simply because some people don’t want to get their shoes wet?

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