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Do we have a moral responsibility to compensate for vulnerable groups? A discussion on the right to health for LGBT people

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Abstract

Vulnerability is a broad concept widely addressed in recent scholarly literature. Lesbian, gay, bisexual, and transgender (LGBT) people are among the vulnerable populations with significant disadvantages related to health and the social determinants of health. Medical ethics discourse tackles vulnerability from philosophical and political perspectives. LGBT people experience several disadvantages from both perspectives. This article aims to justify the right to health for LGBT people and their particular claims regarding healthcare because they belong to a vulnerable group. Rawls' theory of justice and Norman Daniels' normal functioning approach will be discussed in this context. Despite the fact that the right to health can be justified by Daniels' normal functioning approach, there is still a theoretical gap in justifying the right to health for particular vulnerable populations such as LGBT people and discussing society's duty to compensate for these disadvantages. In search of solid theoretical grounds for the justification of the right to health for LGBT people, the present author takes the opportunity to utilize Daniels' flexible definition of normal functioning to show that normal functioning not only varies by age but also by different states of human existence, including sexual orientation and gender identity, and to propose replacing the life span approach with normal states of human existence.

Keywords

Vulnerability; Right to health; LGBT; Health; Social determinants of health

Introduction

Vulnerability is a concept that is addressed broadly in scholarly literature. The use of vulnerability in medical science covers a wide spectrum including mental and physical well-being, the physician-patient relationship, human development and phases of life, and recently, social determinants of health (ten Have 2015).

The definition of vulnerability in research ethics discourse focuses on empowering and protecting individuals in the face of science and technology and it is in accordance with the

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philosophical perspective that relates vulnerability to the fragile ontology of mankind (ten Have 2015; UNESCO 2005; Silvers 2008; Hurst 2008), which is that all human beings are vulnerable by nature. This perspective is rejected by some because it defines vulnerability as a normal human characteristic and invalidates any justification for additional protection for particular susceptibilities (ten Have 2015).

On the other hand, there is the political perspective that relates vulnerability to external social, economic, and cultural factors that require affirmative action to protect the dignity and human rights of people belonging to these groups rather than the *intrinsic* incapacity of decision making (ten Have 2015; Silvers 2008). In this context people are *contingently* vulnerable to exploitation “by being a member of a population or a group with special needs or barriers to care from a variety of conditions or circumstances and are less able than others to safeguard their own needs and interests and/or are at high relative risk of suffering poor physical, psychological, and social health” (Silvers 2008; Brock 2002).

LGBT people and vulnerability

The vulnerable nature of lesbian, gay, bisexual, and transgender (LGBT) individuals can be justified both in terms of philosophical and political perspectives. The fragile nature of human beings, which is highlighted by the philosophical perspective, can certainly be applied to LGBT people. Additionally, it is plausible to say that LGBT people are among the vulnerable populations in the context of bioethical discourse because they are susceptible to coercion and exploitation in clinical research trials due to their disadvantages resulting from social exclusion, lack of social support, low self-esteem, high incidence of physical and mental diseases, and lack of access to proper health services (Kertzner et al. 2009). Several protocols and guidelines have been developed for institutional review boards (IRBs) to ethically approve clinical research in order to protect the rights and interests of vulnerable individuals (45 CFR; EU Commission 2013; World Medical Association Declaration of Helsinki 2013; European Commission 2008, 2015).

Despite the positive effects of legislation designed to combat exploitation and coercion towards LGBT people, it can also have an ironic negative impact, that is, researchers may avoid conducting research with LGBT subjects because they may anticipate or have actually experienced difficulty in obtaining IRB approval (Kästner et al. 2015; Mustanski 2011).

The vulnerability of LGBT people from a political perspective is also significant. The disadvantages experienced as a result of being a member of a population with special needs or barriers will vary among countries, depending on the cultural and religious norms. For example, discrimination and social exclusion of LGBT people in Islamic countries are more common relative to most Western countries (Dunne 1990; Adamczyk and Pitt 2009). The criminalization of homosexuality remains valid in 76 countries, primarily in Africa, South Asia, and South America. Homosexuality can still be punished by death in six countries: the Islamic Republic of Iran, Mauritania, Nigeria, Saudi Arabia, Somalia (southern parts), and Sudan (UNAIDS 2014). It is beyond question that in these countries, LGBT people are vulnerable to exploitation contingent on their sexual orientation (Kligerman 2007).

The political vulnerability of LGBT people is not an issue that is hidden in the nooks and crannies of society. On the contrary, stigmatization, criminalization, marginalization, social exclusion, violation of human rights, and violence against LGBT people have been and are still common throughout the world (Council of Europe 2011). Violence against LGBT people often involves hate-motivated crimes and tends to express brutality and a high risk of death even in countries with liberal legislation for LGBT people (Council of Europe 2011; Marzullo and Libman 2009).

Social exclusion and discrimination against LGBT people have devastating consequences to the social determinants of health. Harassment, marginalization, and exclusion lead to relatively low education levels in LGBT teenagers (Williams and Ritch 1994; D'Augelli et al. 2002). Low education levels lead to disadvantages in access to sustainable employment. Furthermore, even well-educated LGBT people with decent jobs are at risk for dismissal if their gender identity is exposed. Employment is particularly important among other social determinants of health because being unemployed comes with a lack of social security and health insurance (Takacs 2006).

Lack of education, marginalization, and social exclusion result in negative feedback and limit the access to health information, health services, and the social determinants of health. Deficiencies in social support, rejection from the family, or homelessness augment the disadvantaged situation of LGBT people (Kertzner et al. 2009). As a result, LGBT people face serious health problems. The incidence of sexually transmitted diseases, HIV AIDS, drug addiction, substance abuse, suicide, and mental health disorders are higher in LGBT populations compared to their heterosexual counterparts (Bagley and Tremblay 2000; Mustanski 2011; Lee 2000; White 1997; Bouris et al. 2016). These negative factors, together with unemployment, can lead LGBT people to prostitution, which brings a high risk of physical abuse and violence (Comstock 1989; Lee 2000).

Justifying the right to health: is there such a right?

The right to health as a fundamental human right in international law

The International Bill of Human Rights, which is the basic instrument for the protection of human rights, consists of the Universal Declaration of Human Rights (UDHR) and the International Covenant on Economic, Social, and Cultural Rights (ICESCR). The UDHR is the universal expression of what humans believe to be the fundamental rights of all human beings and to which they are inherently entitled. The declaration is a constitutive document binding all United Nations (UN) member states and is part of customary international law. Because the declaration is universal and attributed to all humankind, it also establishes ethical standards for governments that should be respected in the context of human rights. In the declaration, the right to health is defined in a broad sense by combining being healthy with having access to major social determinants of health, with particular focus on mother and child health care and social rights (Universal Declaration of Human Rights 1948).

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care, necessary social services, and the right to security in the event of

unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

The ICESCR, a multilateral treaty adopted by the UN in 1966, urges parties to grant economic, social, and cultural rights to individuals. The right to health is defined in Article 12 of the covenant in more detail than in the UDHR (International Covenant on Economic, Social, and Cultural Rights).

Article 12 of the Covenant recognizes the right of everyone to ‘the enjoyment of the highest attainable standard of physical and mental health.’ ‘Health’ is understood not just as a right to be healthy, but as a right to control one’s own health and body (including reproduction), and to be free from interference such as torture or medical experimentation. States must protect this right by ensuring that everyone within their jurisdiction has access to the underlying determinants of health, such as clean water, sanitation, food, nutrition, and housing, through a comprehensive system of healthcare that is available to everyone without discrimination and economically accessible to all.

Article 12.2 requires parties to take specific steps to improve the health of their citizens, including reducing infant mortality and improving child health; improving environmental and workplace health; preventing, controlling, and treating epidemic diseases; and creating conditions to ensure equal and timely access to medical services for all. These are considered to be ‘illustrative, non-exhaustive examples,’ rather than a complete statement of parties’ obligations.

The right to health is interpreted as requiring parties to respect women’s reproductive rights, by not limiting access to contraception or ‘censoring, withholding, or intentionally misrepresenting’ information about sexual health. They must also ensure that women are protected from harmful traditional practices such as female genital mutilation.

The right to health is an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, and healthy occupational and environmental conditions.

The definition of the right to health in the ICESCR is from the perspective of the social determinants of health, recognizing respect for individual autonomy as well as paying particular attention to vulnerable populations such as women and children (ICESCR 1966). However, the major limitation of the ICESCR is that it does not have the universal support that the UDHR has. Twenty-one UN member states have declared reservations, objections, or territorial exclusions to various articles of the covenant including the United States of America who refused to acknowledge social, economic, and cultural rights as fundamental rights, and has not ratified the covenant to this day. The right to health and social determinants of health are not recognized as absolute and assertive as the human rights

voiced in the UDHR. This means that the right to health does not have universal support (Chapman 1996).

Contemporary ethical approaches to the right to health: rawls' theory of justice and Norman Daniels 'normal functioning approach

One of the most well-known justice theories was developed by John Rawls. In his book, *A Theory of Justice*, Rawls follows the path of Locke, Rousseau, and Kant and presents his theory on the basis of the social contract (Rawls 1971). Rawls put forth that individuals have their own definitions of *good* and they are free to make their own life plans in compliance with their concept of what is *good*. The resources that individuals need for their life plans are called *primary resources*. Primary resources are either natural or social. Social primary resources consist of rights, freedoms, income, and welfare. Rawls' theory of justice was developed to establish a system to fairly distribute social primary resources. Natural primary resources are intelligence, health, imagination, and vigor. They are bestowed on or deprived from individuals by the lottery of nature; hence, Rawls left them out of his theory with the claim that societies have no obligation to redistribute these resources based on the principles justice (Rawls 1971).

However, the concept of health has changed since Rawls put forth his theory of justice. Health is no longer a static situation gifted by nature but a dynamic situation very much influenced by social, environmental, economic, and psychological conditions (Hernandez and Blazer 2006; Braveman and Gottlieb 2014). The Whitehall Studies by Marmot endeavored to expose the deterministic role of social factors on the health status of individuals (Marmot et al. 1991, 2003). The recognition of the significant impact of social gradients, stress, early life conditions, social exclusion, working conditions, unemployment, social support, addiction, and nutrition on the health status of human beings changed the paradigm of health and disease from a gift or curse from the lottery of nature to a state that can be achieved or lost due to individual and social factors. This made the subject of health a subject of social justice (Daniels 2008).

Several proposals have been developed to include the subject of health in Rawls' theory of justice as fairness (Daniels 1981; Ekmekci and Arda 2015). Among these proposals, Norman Daniels' normal functioning approach is remarkable. Norman Daniels put forth a concrete argument to defend the moral importance of health with reference to normal functioning and protecting opportunities. He built his ethical reasoning on John Rawls' theory of justice as fairness and started with the argument that a fair and just system requires the protections of opportunities.

Daniels thought that in order to justify the right to health, one must justify that health has a higher ethical value than other social goods or services. His initial question was this: Is there an ethical difference between having access to health care and having access to any other goods or services? (Rawls 1971). Daniels answered this question with reference to Rawls' definition of the normal opportunity range. According to Rawls, a fair and equal opportunity is one of the primary social goods that refers to the fair conditions of the rivalry to have the professional positions in the administrative institutions. The main purpose of a fair and equal opportunity is to diminish the negative impacts and disadvantages of the social and/or

natural lottery. Daniels revised the concept of the normal opportunity range. He redefined it as “the most possible opportunity range that natal abilities and talents of an individual permit in a fair society” and claimed that health and social determinants of health are inalienable requirements to exercise the normal opportunity range and a fair and equal opportunity (Daniels 2008). These requirements formed the grounds to justify a higher ethical value of health and social determinants of health with respect to other social goods and services. Daniels’ argument did not change the original list of primary social goods but made being in good health a pre-condition to the theory. In this context, meeting the health needs of individuals became an obligation to actualize Rawls’ theory of justice.

Daniels’ ethical reasoning is as follows:

1. If health care and access to the social determinants of health promote health, if health is required for normal functioning, and if normal functioning contributes to protecting the normal opportunity range, then health care and the social determinants of health protect fair and equal opportunities.
2. Because Rawls’ theory of justice requires society to protect opportunities—as do other important approaches to distributive justice—then justice gives special ethical value to health care and access to the social determinants of health (Daniels 2008).

Norman Daniels’ approach is indifferent to an individual’s social, economic, ethnic, religious, and gender identity. The roots of this indifference emerge from the hypothetical *original position* of Rawls’ theory of justice.

Rawls’ theory of justice creates a system to fairly distribute primary social goods. This system requires the establishment of institutions that will distribute according to the principles of justice. The original position is the hypothetical place in which these principles are determined (Rawls 1971). There are two *a priori* requirements for the original position. The first is that all individuals are placed behind a veil of ignorance. This veil conceals the individual’s knowledge about his or her own characteristics such as socio-economic status, gender identity, age, ethnic origin, abilities, education level, health status, intelligence capabilities, and his or her own concept of *good*. The second is that all individuals in this original position are capable of making rational decisions. The *ignorance and rationality* of the individual guarantees the *impartiality and reasonableness* of the decisions, respectively. Rawls thought that the original position was the ideal set up to determine the principles of justice in a fair society (Rawls 1971).

Rawls foresaw that in the original position, behind the veil of ignorance, individuals would agree on two basic principles of justice: “the first principle requires equality in the assignment of basic rights and duties, while the second holds that social and economic inequalities are just only if they result in benefits for everyone, in particular, for the least advantaged members of the society” (Rawls 1971). The second principle is known as the *difference principle*. It is reasonable to think that individuals behind the veil of ignorance would make decisions that benefit groups or individuals who are supposed to be in a more disadvantaged position than the rest of the population because in the original position, the

individuals are ignorant of their own position in society; therefore, they are at risk of being members of one of the disadvantaged groups (Rawls 1971; O'Brian 2010).

Daniels stated that these policies should be further developed to embrace the social determinants of health because physical, psychological, and socio-economic well-being are required to enjoy the normal functions of the human species and to enjoy equal and fair opportunity. Hence, access to the social determinants of health is as crucial as access to health care services in terms of maintaining good health status (Daniels 2008).

Analogizing elderly and LGBT individuals to justify the right to health and to replace the life span approach with normal states of human existence

Daniels challenged himself by asking if the normal functioning approach was age biased. Because there are fewer opportunities for elderly individuals than young individuals and because some elderly individuals lose the ability to function like young people, can we say that their rights to health and access to the social determinants of health have less ethical importance? Daniels rejected "the perception of the age group problem as an issue of competition between groups viewed at a moment in time" and developed the lifespan approach (Daniels 2008). The basic idea behind the lifespan approach is that "*because we all age*, we should model what is fair between age groups after what is prudent for us to do for ourselves at each stage of life." With this argument, Daniels connected health, age, and opportunity in a way that avoids age bias (Daniels 2008).

The flexibility that Daniels created with the life span approach can be applied to justify the particular claims and needs of LGBT people in the context of the right to health. Daniels started his reasoning with the phrase "*because we all age*"; however, we do not all age. We *know* that some members of our society will die at a younger age than others. What Daniels meant by this phrase was that ageing is normal in the course of life and it is normal to expect that some members of society will age. His second step was to acknowledge that the definition of normal functioning changes due to age. The normal functions of a baby, a young adolescent, and an elder differ from each other and so do opportunities. However, these variations do not change the core principle that normal functioning should be preserved to protect the normal opportunity range and that it is the duty of a fair society to provide fair and equal opportunity.

The same reasoning applies to LGBT people. Just as we could all age, we could also all be LGBT. It is thus plausible to make an analogy between being LGBT and being elderly and consider both of them as a *state of normal human existence*. Therefore, we propose to change the term *life span* to *state of normal human existence*. By doing so, we can broaden the *frame of normal functioning* to not only cover the elderly but all varieties of human existence including a medically and socially disadvantaged existence. Our sexual orientation and gender identity, like our age, are irrelevant in the face of the right to health. Following Norman Daniels' reasoning, we have an ethical obligation to provide health care services and access to the social determinants of health to all human beings irrespective of their individual and social characteristics. LGBT people, like elderly people, are entitled to the right to protect their fair and equal opportunity range. The hypothetical original position that Rawls defined would also support this argument. In fact, Daniels offers to set up a scene

similar to the original position and places prudent people unaware of their age to determine the fair allocation of resources among age groups. The same reasoning works for resource allocation when LGBT people are the focus. Reasonable people behind the veil of ignorance would presumably agree to recognize the right to health for LGBT people because they are at risk of being one of them.

This argument can be enhanced further to answer the following core question: Are LGBT people entitled to particular rights to health care services or social determinants of health because they belong to a vulnerable population? In the context of the proposal to broaden the *life span approach* to include the *state of normal human existence*, the answer to this question could be both “yes” and “no” depending on the impact of belonging to a particular vulnerable group, the ability to exercise normal functioning, and the ability to sustain a fair and equal opportunity range. Belonging to a vulnerable group does not automatically entitle people to particular rights and services different from their counterparts who do not belong in that vulnerable group. Vulnerability, by definition, carries the risk of being more disadvantaged compared to the rest of the population; however, it is not a *sine qua non*. Therefore, to give an affirmative answer to this question, we must prove that LGBT people are experiencing disadvantages in relation to fair and equal opportunities because of their *state of existence*.

Data from the literature reveals the fact that LGBT people experience various problems because of their sexual orientation and gender identity. The examples given in the previous section regarding the stigmatization, discrimination, criminalization, and harassment of LGBT people together with low access to education, employment, health information, and health care services illustrate the disadvantages of LGBT people when compared to their heterosexual counterparts (Bagley and Tremblay 2000; Mustanski 2011; Lee 2000; White 1997; Bouris et al. 2016; Kertzner et al. 2009). Despite the fact that the aggravation of circumstances varies depending on the cultural, political, and religious features of the societies in which LGBT people live, it is generally accepted that the negative factors of being LGBT are prospective (Council of Europe 2011; Marzullo and Libman 2009; Dunne 1990; Adamczyk and Pitt 2009). This data proves that LGBT people are disadvantaged in terms of a fair and equal opportunity because of their state of existence and that there are risks associated with belonging to *this* vulnerable population. Following this reasoning, for LGBT people, it is plausible to answer “yes” to the core question.

The claim rights correspond to duties on other agent. Because we acknowledge the claims of LGBT people regarding their rights to health care services and access to the social determinants of health, it is plausible to say that members of society have a duty to compensate for the disadvantages of *this* vulnerable population. This duty can be theoretically justified from the original position of impartial, reasonable people behind the veil of ignorance. Rawls’ second principle states that reasonable individuals in the original position will agree that social and economic inequalities are just only if they result in providing benefits for everyone, and in particular, for the least advantaged members of society. As stated above, this is known as the difference principle. Because the disadvantaged situation of LGBT people is explicitly addressed in the literature, it is

plausible to think that a Rawlsian social system would endorse affirmative policies for the reallocation of resources to LGBT people.

This duty also complies with the argument put forth by Daniels to enhance Rawls' theory of justice to embrace health by placing health in an essential prerequisite position for normal functioning and for protecting the normal opportunity range. Furthermore, we can say that our proposition to replace the life span approach with the state of normal human existence would broaden the limits of the ethical duty of society to compensate for the disadvantages because it broadens the frame of normal functioning to embrace not only elderly people but LGBT people and many other forms of human existence including various medical and social entities.

Conclusions

Vast improvements in medical technology have created the need for a just, fair, and sustainable allocation system for the scarce resources in health services and the existence and limits of the right to health for individuals. Although the international declarations of human rights and national legislation serve as a basis for the right to health, they are not sufficient to guide policies for the macro and micro allocation of resources. Additionally, the broadened definition of health and the inclusion of the social determinants of health in the concept of health services complicate the issue. The concept of the right to health extends from a limited claim for health services to a demand for social services and rights. This makes the right to health and the allocation of resources the subject of social justice and bioethics.

The disadvantages of LGBT people in terms of access to health and other social services have been clarified in recent studies. The fact that the right to health is not considered an absolute and universal human right makes it more difficult to justify the rights of LGBT people in affirmative policies for health and social services prioritizing their unique problems. Hence, we need a solid reference point other than total social utility or liberal market rules that may change relative to the consequences of policies or to the supply and demand situation at a given time. Moreover, this solid reference point should be able to guide policy makers to fairly allocate scarce resources in real life.

The theoretical framework of Rawls' theory of justice as fairness provided a departure point for Norman Daniels to develop his argument. The strength of Daniels' normal functioning approach rests on two essential points. The first was proving the particular higher ethical value of health and the social determinants of health among other social goods and services. By doing so, he put the right to health and the social determinants of health in a place that cannot be ethically ignored. The second point is the flexibility of the normal functioning approach. The life span approach of Daniels redefines normal functioning and the fair and equal opportunity concept with regard to age groups. This theoretical approach can be extended to justify the right to health and the social determinants of health for LGBT people. This extension sheds light on the fact that normal functioning not only varies due to age but it also varies due to different states of being human. Sexual orientation and gender identity are among these states as other innate or acquired vulnerabilities. Therefore, the proposal to

extend Daniels' life span approach would not only strengthen the claim of LGBT people in society to be compensated for their disadvantages and vulnerability but would also create theoretical grounds to solidify universal support for the right to health for all vulnerable populations.

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