

The Right to Health Care: Social Responsibility and the Health Care Issue

“Animated by and united in the spirit of Christ, we extend our hands to all who are sick and to all who have dedicated their lives to the work of healing. May the faith and goodness of all Christians be the light by which they heal, the light in which they live and work.”

National Conference of Catholic Bishops, *Health and Health Care* 1981).

In November 1994, the National Conference of Catholic Bishops [now the United States Conference of Catholic Bishops (USCCB)] approved the third revised edition of the *Ethical and Religious Directives for Catholic Health Services* [Hereafter, ERDs].

More than 20 years had passed since the original guidelines had been published in 1971. Since that time, technological advances, along with rapid social change, had raised fresh moral quandaries that include issues such as abortion, physician-assisted suicide, reproductive technologies, the fair allocation of resources, and for-profit enterprises in health care.

But the first section of 1994 edition of the *Ethical and Religious Directives for Catholic Health Services* [ERDs] was striking inasmuch as this updated version of the Directives had explicitly incorporated social justice concerns into the religious and ethical teaching. The demands for social justice in health care define the mission of the Church in health care in terms of the Catholic moral tradition. On June 15, 2001, the United States Conference of Bishops released the fourth edition of the *Ethical and Religious Directives*. The current directives retain the emphasis on social responsibility as it was articulated in the 1994. [Catholic Bishops of the United States, “Ethical and Religious Directives for Health Care Services,” *Origins* 31:9 (July 19, 2001): 153, 155-163 at 156-157.]

“Part One” succinctly identifies the normative principles which are constitutive of the Church’s healing ministry. The principles are fivefold:

- ◆ First, Catholic health care ministry is rooted in a commitment to promote and defend human dignity
- ◆ Second, the biblical mandate to care for the poor requires us to express this in concrete action at all levels of Catholic health care.
- ◆ Third, Catholic health care ministry seeks to contribute to the common good.
- ◆ Fourth, Catholic health care ministry exercises responsible stewardship of available health care resources.
- ◆ Fifth, within a pluralistic society, Catholic health care services will encounter requests for medical procedures contrary to the moral teaching of the Church. (Emphasis added.)

All of these principles are integral to the mission of Catholic health care and stand interrelated with one another. The ERDs specify the applications of these principles in nine directives. Directive 2 addresses the second principle --- "biblical mandate to care for the poor." Providing health care for the poor has been historically significant in the origins of Catholic health care services in the United States.

"The Social Responsibility of Catholic Health Care Services," the title of "Part One" of the ERDs, is a noteworthy feature in the revised directives. Although the social responsibility for health care has been "a given" in the tradition of the Catholic ministry in health care, conditions in the field of hi-tech medicine and the influence of secular bioethics have undergone rapid change. Consequently, at this moment, the distinctive Catholic identity of Church-sponsored institutions and health care services continues to call for sustaining a fully religious vision of the Church's core values in the health care apostolate. In particular, in the milieu marked by a growing dominance of the business ethos in medicine and health care, universal access to health care is a prime ethical concern.

In this regard, the second principle --- "the biblical mandate to care for the poor"--- spells out the obligation of Catholic health care ministries to care for the poor. This principle clearly widens the focus on the needs of the poor, as well as the claims of the uninsured, and the underinsured. Thus, the ERDS acknowledge that certain groups in society are vulnerable by their social condition.

Directive 3 of the ERDs identifies service of and advocacy for the marginalized as an integral component of the Catholic mission in the health care field. The directive reads:

In accord with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination: the poor, the uninsured and the underinsured; children and the unborn; single parents; the elderly; those with incurable diseases and chemical dependencies; racial minorities; immigrants and refugees. In particular, the person with mental or physical disabilities, regardless of the cause or severity must be treated as a unique person of incomparable worth, with the same right to life and to adequate health care as all other persons.

There is a forceful accent on the harsh reality that certain groups in society are vulnerable to neglect on account of their social condition.

Moreover, Directive 3 embodies a view of health care as a basic social good subject to the demands of distributive and social justice.

According to *Economic Justice for All*, the bishops' 1986 pastoral letter on the economy, the plight of the poor in the U.S. economy warrants an urgent and focused claim on the conscience of the nation. Such a claim emanates from the obligation of society to provide justice for all. [NCCB. *Economic Justice for All: Pastoral Letter on Catholic Social Teaching and the U.S. Economy* (National Conference of Catholic Bishops, 1986).

In June 1993, a year before the release of the third edition of the ERDs, the USCCB issued a resolution on health care reform --- "A Framework for

Comprehensive Health Care Reform: Protecting Human Life, Promoting Human Dignity, Pursuing the Common Good." The fundamental principle that anchors the Church's approach to health care can be summed up in the following declaration of a right to health care:

Every person has a right to adequate health care. This right flows from the sanctity of human life and the dignity that belongs to all human persons who are made in the image of God. [NCCB / USCC, "A Framework for Comprehensive Health Care Reform: Protecting Human Life, Promoting Human Dignity, Pursuing the Common Good," *Pastoral Letters and Statements of the United States Catholic Bishops, Volume VI -1989-1997* (1998): 519-526.]

The NCCB resolution firmly asserts that health care is "a basic human right, an essential safeguard of human life and dignity." Access to adequate health care cannot be reduced to "commodity" to be sold on the premise of supply and demand subject to market forces.

A fuller treatment of health care as a right was set forth in "Health and Health Care," a statement issued by the National Conference of Catholic Bishops on November 19, 1981. In the section concerning "Principles for Public Policy," the bishops affirm a basic right to adequate health care first. The text reads:

Every person has a basic right to adequate health care. This right flows from the sanctity of human life and the dignity that belongs to all human persons, who are made in the image of God. It implies that access to that health care which is necessary and suitable for the proper development and maintenance of life must be provided for all people, regardless of economic, social, or legal status. With increasingly limited resources in the economy it is the basic rights of the poor that are frequently threatened first. The Church should work with government to avoid this danger. [USCC / NCCB. *Pastoral Letters of the U.S. Catholic Bishops --- Volume IV 1975-1983* (Washington, D.C., 1983): 469-485 at 483-484.]

The national conference of bishops adopted the position that the right to health care and other related principles should be reflected in a national health policy.

At the national level, the statements of the Catholic bishops of the U.S. on health care apply the common Church teaching on human rights and social justice to the conditions of health care systems indigenous to the United States. Not only at the national level but also at the regional and diocesan levels, statewide Catholic conferences have issued statements dealing with problems in the specific milieu of their respective regions.

In Kentucky, the Catholic Conference of Kentucky had assumed a prominent role of leadership in advocating universal coverage and cost containment in health care during the 1994 state legislative sessions. In the early 1990s health care reform was emerging as a key issue in public discussions both on the national political scene and on the agendas of state politics. Despite a waning of concern for realistic health care reform proposals at the present compared with a decade ago, advocacy for that cause remains a continuing agenda item for implementing justice in health care.

In the Fall of 1992, the Catholic bishops of Kentucky had issued a "Statement on Health Care Reform." The CCK statement declared the bishops' commitment to work for reform in health care on the premises of the moral principles adopted by the National Conference of Catholic Bishops. [*Messenger* (Diocesan newspaper of the Diocese of Covington, October 11, 1992): 2.]

The Center for Business and Economic Research, located at the University of Kentucky's Gatton College of Business and Economics, has published "Market Responses to Kentucky's Insurance Reforms. Michael Clark and Ginny Wilson, the authors of the study, reviewed the major revisions of Kentucky's health care laws in 1994, 1996, and 1998. [<http://www.gatton.uky.edu/CBER/Downloads/health99.htm>]

Clark and Wilson explained the distinction between two "pure" ratings structures to price policies --- "experience rating" and "community rating." The distinction revolves around two criteria, either the pooling of risks or the segmenting of risks:

Under an experienced-rated pricing system for health insurance, the health risks associated with particular policyholders are segmented. This means that those with similarly low expected claims are placed in one category and charged a low price reflecting a low level of risk, with those with higher expected claims are placed in another category and charged a higher price, reflecting their similar level of risk. [Ibid. 1-2. Emphasis added.]

The projected risk factor for a given policyholder is subject to re-evaluation when a policy is renewed.

The pooling of risks in terms of community rating would stipulate that premiums of all policyholders pay "a premium closer to the average for the whole group and those who move into a different risk category do not see a parallel increase in premiums."

The revisions of the 1994 laws centered on several principal concerns. Clark and Wilson explain:

The first revision was designed to provide relief for all policyholders facing unaffordable premiums because they are judged by insurance carriers to pose greater risk of large claims. ...Supporters of the measure generally expected that this change would substantially lower premiums for individuals with a high probability of filing larger and numerous claims, and somewhat increase the premiums for those with low probability of filing large and numerous claims.

The 1994 Kentucky General Assembly did enact a major achievement for equity in health care insurance by passing HB 250. HB 250 protected Kentuckians who were at risk of being denied insurance coverage, i.e., purchasers of insurance in the small-group and individual markets. Guaranteed issuance and guaranteed renewal were key facets of the 1994 legislation.

The 1994 legislation began to be impacted by the withdrawal of 57 health care insurance carriers from the Kentucky scene. The 1998 General Assembly again reverted to adopting "experience rating" as the criterion for the insurance market.

The Catholic Health Association drew up a proposal on health care reform in 1992. An executive summary of the proposal interprets the health care reform to be "essentially a debate about values." The CHA proposal reflects "distinctive value

tradition, and much of that tradition makes an important appeal to a broad cross section of contemporary Americans.

The proposal enumerated six values which are embodied in the Catholic health care tradition:

- ◆ Health care is a service ...Health care must be more than a business. It is an essential social good, a service to persons in need and should never be reduced to a mere commodity exchanged for profit.
- ◆ Health care and human dignity ... Every person is the subject of human dignity. ... the importance of health care to human dignity insists on universality, that is, all persons have a right to basic and comprehensive health care.
- ◆ Health care and the common good ... Dignity is realized only in association with others. The human person is inherently social, an entails an obligation to serve the common good.
- ◆ Health care and the poor ... The wealthy and the well should care for the poor and the sick. This conviction, the original premise of community-rated health insurance, is strongly reflected in many American movements that have been driven by concern for those who are less well-off.
- ◆ Health care and stewardship ... Responsible health care reform requires the introduction of economic discipline into the health care system and the creation of credible expenditure controls to hold the overall spending within realistic financial and political limits.
- ◆ Health care and government ... This wisdom is reflected in American political traditions and suggests that a politically prudent reform must use federal authority to create a national health care community, respond to local diversity through state government, preserve pluralism in delivery, and protect a range of choice by clients and patients. [Catholic Health Association, "Health Care Reform Proposal." *Origins* 22:4 (June 4, 1992): 60-63. Emphasis added.]

The value-driven reform proposal of the Catholic Health Association represented a project for implementing the principles taken from the vision in Church social teaching on justice in health care.

In light of the development of culture and society in the 20th century, Church social teaching upholds a right to health care. In the encyclical *Pacem in Terris* (*Peace on Earth*, 1963) Pope John XXIII posited a comprehensive and integral development of a theory of human rights based on a natural law concept of rights and reciprocal duties. A right to health care, a social right, appears under the heading of a primary right, namely, "the right to life":

Man has the right to live. He has a right to bodily integrity, and to the means necessary for the proper

development of life, particularly food, clothing, shelter, medical care, rest, and finally the necessary social services. In consequence, he has the right to be looked after in the event of ill-health; disability stemming from his work; widowhood; old age; enforced unemployment; or whenever through no fault of his own he is deprived of the means to livelihood. (PT n. 11)

Medical care is placed under the right to the means necessary for the proper development of life.

Under "Respect for Health," the *Catechism of the Catholic Church* associates the need for medical care with other correlative needs: "*Concern for the health* of its citizens requires that society help in the attainment of living conditions that allow them to grow and reach maturity: food and clothing, housing, health care, basic education, employment, and social assistance." (CCC n. 2288)

In *Health Care Reform: A Catholic View*, Philip S. Keane, S.S., discussed the ethics of a just community in relation to health care reform. Father Keane clarified the ethical meaning of a right to health care. The right to health care in the strict sense is a claim "to a basic standard of health care." Over against the 19th century notion of rights which tended to conflate the notion of civil rights with "a right not to be interfered with," Father Keane unpacked the rationale for the changed consciousness about health care as a social good. From an ethical standpoint, he offers two reasons for the shift away from understanding a right to health care merely under the rubric of "negative freedom." He explains at length:

First, unlike earlier historical times, in our era basic access to health care can be a very great good. Thus, if we accept the idea of social rights, it seems unthinkable not to include health care within those rights. Second, crises in health care can happen to persons of all ages, economic conditions, degrees of social usefulness, etc. In other words, crises in health care are part of our common humanity. We cannot tie these crises to any particular facet of our humanity so as to find a reasonable basis for limiting health care access to persons with non-medical human qualities such as virtue, usefulness, and wealth. ... [Philip S. Keane, *Health Care Reform: A Catholic View* (New York: Paulist Press, 1993): 128.]

Father Keane concludes that the demands of justice acknowledge the need for health care as a component of our "common humanity."

Later, Father Keane published a second work on the question of health care justice where he again discussed the establishment of "a *reasonable standard* of health care." To determine that "reasonable standard" of health care, a consensus should emerge from "an ongoing debate with a host of responsible figures in the human community."

Time and location dictate “what is truly possible at a given time and place.” [Philip S. Keane, *Catholicism & Health- Care Justice: Problems, Potential and Solutions* (New York: Paulist Press, 2002): 11.]

Within the perspective of health care justice, the N.C.C.B.’s resolution on health care reform stipulated a framework of eight criteria to assess measures of health care reform on moral grounds:

- Respect Life. Whether it preserves and enhances the sanctity and dignity of human life from conception to death.
- Priority Concern for the Poor. Whether it gives special priority to meet the most pressing health care needs of the poor and underserved, insuring they receive quality health services.
- Universal Access. Whether it provides ready universal access to comprehensive health care for every person living in the United States.
- Comprehensive Benefits. Whether it provides comprehensive benefits sufficient to maintain and promote good health, to provide preventative care, to treat disease, injury and disability appropriately, and to care for persons who are ill or dying.
- Pluralism. Whether it allows and encourages the involvement of the public and private sectors, including the voluntary, religious, and non-profit sectors, in the delivery of care and services; and consumers and for individual and institutional providers.
- Quality. Whether it promotes the development of processes and standards that will help to achieve quality and equity in health services, in the training of providers, and in the informed participation of consumers in decision-making on health care.
- Cost Containment and Controls. Whether it creates effective cost containment measures, reduce waste, inefficiency, and unnecessary care; measures that control rising costs of competition, commercialism, and administration; and measures that provide incentives to individuals and providers for effective and economical use of limited resources.
- Equitable Financing. Whether it assures society’s obligation to finance universal access to comprehensive health care in an equitable fashion, based on the ability to pay; and whether proposed cost-sharing arrangements are designed to avoid creating barriers to effective care of the poor and the vulnerable.

The criteria as a whole overlap and bear an interrelationship with one another. Yet two of the above criteria, namely, a priority for the poor and the securing of universal access for all, are especially germane to a discussion of social responsibility in the field of health care.

First, there must be recognition of “a special priority to meeting the most pressing health care needs of the poor and underserved.” The second criterion raises the question about the provision of universal access: “Whether it [the health care system] provides universal access to comprehensive health care for every person living in the United States.”

In that 1993 resolution on health care reform, the bishops criticized the existing pattern of health care delivery for failing to “meet the minimal standards of social justice and the common good.” The NCCB judged that the present state of the health care system “serves too few and costs too much.” The national conference of bishops candidly assessed the current system in the U.S. to be “so inequitable, and the disparities between the rich and the poor and those with access and those without are so great that is clearly unjust.” A just health care system must respond to the basic needs of the poor, the uninsured, and the underinsured.

On April 20, 1999, the Reverend Michael Place, president of the Catholic Health Association of the U.S., delivered the Joseph B. Brennan Lecture at the Kennedy Institute of Ethics at Georgetown University. In his address, Father Place, who is also a moral theologian, expounded on the need for building “a national consensus for on the need for and desirability of accessible and affordable health care for all.” [Rev. Michael Place. “Health Care: Essential Building Block of a Free Society,” *Origins* 29:4 (June 10, 1999): 49, 51-57.]

The introductory section of Father Place’s lecture summed up the state of the question on access to adequate health care in the late 1990s:

First, because our health care system remains seriously, even dangerously dysfunctional and is getting worse:

Despite falling unemployment and a record-breaking stock market, the number of Americans without health care reached 43.4 million in 1997, growing from 14.2 percent of our citizens in 1995 to 16.1 percent. Between 1996 and 1997 alone, 1.7 million more Americans were denied access to adequate health care.

The percent of employees who receive health insurance from their employers has dropped from 69.2 percent in 1987 to 64.2 percent in 1997. Similarly, the percentage of persons in the small-business work force who are covered by employer health insurance declined to 47 percent --- the first time since the Henry J. Kaiser Family Foundation began tracking trends eight years ago.

Total national health care costs have climbed to \$1.1 trillion annually, yet despite some recent gains, the United States continues to have the highest mortality infant rate mortality rate of any industrialized country and fares poorly on other comparative measures such as life expectancy and childhood immunization rates. [Ibid. 49, 51.]

Besides the strong commitment of the CHA to advocate health care reform, Father Place cited an additional reason for selecting his topic. It was the inspiration that he drew from the thought of the deceased Cardinal Bernardin. In the national debate on this issue, Cardinal Bernardin had consistently challenged the nation to review the condition of the health care system as well to seek a resolution to its failure to enact "basic standards of responsible policy."

Coverage by health care insurance is a crucial component in health care reform. Current statistics on the uninsured still depict an unacceptable situation. The U.S.C.C.B.'s Department of Social Development and World Peace (SDWP) provided the following data in February 2000:

- About 11 million of the underinsured are children under age 18.
- Most adults who lack health care insurance work for small and medium size firms, work part-time or are self-employed.
- The majority of the uninsured live in households with an annual income under \$30,000; and are disproportionately young.

Although the economy and employment have improved, the percentage of citizens without health care insurance has not. In 1987, 15% of Americans were uninsured; by 1996, 17.7% had joined the ranks of the uninsured.

Over and above the prospects of seeking routine care, being uninsured is associated with several other negative outcomes:

- Studies show they [the uninsured] delay seeking care even when in need of medical attention, do not fill prescriptions and have trouble paying medical bills.
- They are generally in poorer health, in part because they lack access to proper care.
- While every day thousands of people who lack insurance receive medical care and cannot pay, managed care is making it increasingly difficult for providers to offer 'free' care [achieved by shifting costs to those who can pay] to the uninsured.

The increasing numbers of the underinsured must be added into these calculations. Skyrocketing health care costs, rising levels of employee contributions, the strain on the budgets of small businesses, and the growing numbers of part-time or contract workers complicate access to adequate health care coverage.

In a communiqué dated February 2002, the Department of Social Development and World Peace (SDWP) called attention again to the probability that the

accelerated numbers of uninsured Americans is and will continue to soar. A Census Bureau Report (September 2001) recorded that 14% of U.S. citizens, approximately 38.7 million, were without health insurance in the year 2000. The SDWP's statement pointed out that "as many as 2 million people have lost health care coverage since January 2001, increasing the number of uninsured in the country to over 40 million."

Above all, two factors contribute to that alarming trend:

Health insurance premiums increased an average of 11 percent in 2000 and 2001, far beyond the rate of inflation. It is estimated that premium increases may be as high as 15 percent in 2002. As a result, some employers --- particularly small employers --- will discontinue providing health care coverage to their workers entirely, while others will face the increased costs on to their employees, causing many workers to forego coverage. At the same time, if unemployment continues to rise, additional workers may be expected to lose health care coverage.

Runaway health care costs combined with a current upward spiral in unemployment are contributing significantly to the decline of health care coverage.

The Department of Social Development and World Peace has also been monitoring the Medicare Program in the broader context of Social Security reform. In a brief statement dated February 2000, the SDWP declared its resolve to call for ongoing support of both programs. ["Social Security and Medicare," February 2000.]

The Medicare issue raises growing concerns since Medicare spending has decelerated and payments have been reduced to providers. The SDWP's statement recalls the special importance of Medicare for responding to the needs of low-income citizens:

Medicare provides health care not just to the elderly but also to the disabled and low-income individuals. In 1999, 39 million Americans relied on the Medicare program for their health care, with 12% under age 65 and 12% 85 or older. Nearly half of all beneficiaries have incomes below 200% of the poverty level [\$15,480 for individuals]. Some of the nation's most vulnerable -- - the oldest-old [those 85 and over], the under 65 disabled, racial and ethnic minorities, and women --- are disproportionately represented among the low-income segment of Medicare payments. ["Social Security and Medicare," February, 2000.]

The issue of providing "genuine health coverage to the elderly and the disabled." In a more recent advisory, "Alert on Medicare" (June 2003), the SDWP once more strongly accented the need to restore the Medicare funds which were cut in the 1997 Balanced Budget Act.

The U.S.C.C.B.'s Administrative Committee's statement for the 2004 political campaign on political responsibility supports "measures to strengthen Medicaid and Medicare as well as measures that extend health care coverage to children, pregnant women, workers, immigrants and other vulnerable people." ["Faithful Citizenship: A Catholic Call to Political Responsibility," *Origins* 33:20 (October 23, 2003): 321, 323-330 at 328.)

In "A Comprehensive Framework for Health Care Reform," a 1993 resolution the Catholic bishops of the United States committed the national conference to a stand espousing strong support for "measures to ensure true universal access and rapid steps to improve health care of the poor and unserved." Otherwise, the bishops reason that the postponing of universal access will exacerbate an already bleak outlook on the delivery of adequate health care coverage to all "since coverage delayed may well be coverage denied."

With clarity and candor, the late Cardinal Joseph Bernardin (d. 1996) had phrased the negative outcome of inaction:

Being without insurance means being without care when you need it, delaying care until an illness or injury may require more costly intervention or be beyond treatment. [*Origins* 24 (June 9, 1994): 60 ff.]

During his life, Cardinal Bernardin was indefatigable in his advocacy of the necessity for implementing justice in the field of health care. [See, for example, one of his last addresses, "Managing a Managed Care Health System," *Origins* 26:2 (May 30, 1996): 20-25.]

In an early lecture on a consistent ethic of life, Cardinal Bernardin identified a right to health care as an immediate corollary of the foundational moral truths about the human person as both sacred and social. Because men and women are inherently social, there is a moral basis for sustaining a "human ecology" to protect the sacredness of human life from conception to death. He noted:

The protection, defense and nurture of human life involve the whole spectrum of life from conception to death., cutting across such issues as genetics, abortion, capital punishment, modern warfare and the care of the terminally ill. ["The Consistent Ethic of Life and Health Care Systems," in *Consistent Ethic of Life*, edited by Thomas G. Fuechtmann (Kansas City, Mo.: Sheed & Ward, 1988):49-58 at 51.]

In this lecture, Cardinal Bernardin targeted the inner relationship of “quality of life” issues with concerns for “the right to life.” The crux of his position was clear: “We must defend the *right to life* of the weakest among us; we must also be supportive of the *quality of life* of the powerless among us.” [Ibid., 52. See the collection of Cardinal Bernardin’s lectures in *A Moral Vision for America* edited by John P. Langan, S.J. (Washington, DC.: Georgetown University Press, 1998.)

More than a decade later, in his 1996 lecture on the managed care approach to health care, Cardinal Bernardin again singled out the ethical crux of the problem: “(t)he paramount health care issue of our time is the affront to human dignity that is occasioned by the lack of universal insurance coverage for even basic care.” He questioned whether “managed care savings from public programs will be recycled to expand coverage.” [Bernardin, op. cit., (1996); 24-25.]

Returning to the N.C.C.B.’s 1993 statement on health care reform, a second point in that resolution was well taken. In the last analysis, failure to enact a broad and minimal health care package for all Americans sanctions an unacceptable two-tiered system of health care with inadequate or no coverage of the poor and uninsured. Inaction on health care reform realistically becomes “a de facto” version of rationing.

The justification for a basic package of health care services is grounded in a right to health care. Although Catholic social teaching affirms that right, the United States is alone among comparable industrial democracies in not fully recognizing such a right.

A right to health care is derived from the dignity of human persons who enjoy a fundamental right to life. The basic good of human life entails access to the means for proper development. This rationale is compatible with the first systematic ordering of human rights which was developed in *Pacem in Terris*, the last encyclical by Pope John XXIII issued in 1963 shortly before his death. This right has been reaffirmed in all recent Church social teaching.

In addition, *the preferential love for the poor*, a moral responsibility integral to biblical religion, inspires advocacy on the side of the poor and the marginalized of society. The preferential option for the poor intersects with the demands of a consistent ethic of life.

As mentioned above, Cardinal Joseph Bernardin, the architect of “the consistent ethic of life,” had explored the relationship of a consistent ethic of life to the right to health care precisely as a “quality of life” issue.

Again, in his 1985 lecture on the consistent ethic and health care systems, Cardinal Bernardin raised several provocative scenarios about the ramifications of the consistent ethic of life framework for health care services.

Cardinal Bernardin crafted several ethical dilemmas which have to be faced in the light of the distinctive Catholic mission in health care services. Is it acceptable for Catholic hospitals to transfer an indigent patient, except for superior treatment elsewhere? Or, is it acceptable for a Catholic nursing home to transfer patients when their insurance runs out? And, lastly, should staff privileges in Catholic hospitals be

given to physicians who do not accept Medicaid or uninsured patients? [Bernardin, op. cit. (1985), 57]

Obviously such frank questions raised in the abstract do not immediately lend themselves to facile answers that render specific concrete solutions. Cardinal Bernardin explicitly granted that it was not his point to recommend “simplistic answers to complex and difficult questions.” He was well aware of the tough reality confronting Catholic institutions in health care. After all, realism often surfaces conflicts whose resolution would perplex the best-intentioned consciences. But, at least, these and similar quandaries can act as a catalyst in defining the values and ideals distinctive of Catholic health services.

As a matter of fact, in some circumstances, societal and cultural barriers can strain and hamper the capacity of Catholic health services to implement these ideals. Sadly, pressures brought on by financial exigency have forced some Catholic institutions to close. Inadequate reimbursement or lack of compensation for services to the needy has taken its toll. The societal responsibility to view health care as a social good rather than as a market commodity is being significantly undermined by the dominant trends of surrendering access to health care to the free play of markets. In the words of Cardinal Bernardin, markets in themselves can be “ethically blind and humanly insensitive.”

Lester Thurow, the MIT professor of economics, once referred to markets as “the black hole of capitalism.” In a sense, if Thurow’s observation is accurate, the economics of the health care system tend to be a microcosm of the ethical challenges of the U.S. economy as a whole. Consistent with its impact on many areas of the overall economy, the dynamics of the market tends to widen the gap between the rich and the poor and unravels the safety net for the vulnerable members of society. The gravitational pull of unbridled markets across the economic spectrum continues to benefit the advantaged and disenfranchise the disadvantaged. That dynamic is no kinder in regard to access to health care.

Health care services and markets can be assessed within the broader framework of free markets and the overall economy. Accordingly, the analysis of free markets by Pope John Paul II in *Centesimus Annus (On the Hundredth Anniversary of Rerum Novarum, 1991)* is instructive.

In that centennial encyclical of Church social teaching, the Holy Father judged that the free market is “the most efficient instrument for utilizing resources and effectively responding to needs.” But he states the free market approach is valid “only for those needs that are ‘solvent’, insofar as they are endowed with purchasing power and for those resources which are ‘marketable’, insofar as they are capable of obtaining a satisfactory price.” (CA n. 34)

From a moral standpoint, however, Pope John Paul II warns: “... there are many human needs which find no place on the market. It is a strict duty of justice and truth not to allow fundamental human needs to remain unsatisfied, and not to allow those burdened by such needs to perish.” (Ibid. Emphasis added.)

Further on in the encyclical, the Holy Father speaks of the task of the State and of “the idolatry of the market”:

It is the task of the State to provide for the defense and the preservation of common goods such as natural and human environments, which cannot be safeguarded simply by market forces.

Here we find a new limit on the market: there are collective and qualitative needs which cannot be satisfied by market mechanisms. There are important human needs that escape its logic. Certainly the mechanisms of the market offer secure advantages. ... Nevertheless, these mechanisms carry the risk of an 'idolatry' of the market, an idolatry which ignores the existence of goods which by their nature are not and cannot be mere commodities. [Ibid. n.40. Emphasis added.]

The Catholic bishops of the United States insistence on health care being a basic right and not a commodity accords with the Catholic tradition of social justice.

Without advocacy on their behalf, the non-voting poor especially will not gain equitable access to a basic social good. If a good society is judged by its treatment of its weakest and most powerless members, then "health care beggars" stand as an indictment unveiling the structural injustice of the health care system.

Among the key policy priorities in proposals for health care reform, the bishops list "*Priority Concern for the Poor / Universal Access*." The bishops write: "We look at health care from the bottom up, how it touches the unserved and underserved."

In their resolution, the bishops endorse new public policy as an essential response to the health care crisis. Yet they acknowledge that more than the enactment of fair and just public policies is in order. They express the need for a new awareness:

Each of us must examine how we contribute to this crisis - -- how our own attitudes and behavior demonstrate a lack of respect for our own health and the dignity of all. Are we prepared to make changes, address the neglect, accept the sacrifices, and practice the discipline that can lead to better health care for all Americans? In our own lives and in this vital health care debate, we are called to protect human life, promote human dignity, and pursue the common good. In particular, we call on all Catholics involved in the health care system to play leadership roles in shaping health care reform that respects human life and enhances human dignity. ["A Framework for Comprehensive Health Care Reform," June 1993.]

In conclusion, the resolution on health care reform stresses the urgency of the issue - -- "Now is the time for real health care reform." It calls the need for health care reform a literal "matter of life and death, of lives cut short and dignity denied."

The need for health care reform continues to be a moral priority in public life. "Faithful Citizenship: A Catholic Call to Political Responsibility," was issued by the Bishops' Administrative Committee of the U.S.C.C.B. The statement, a set of guidelines for the upcoming 2004 elections, summarizes the moral elements entailed in public policy proposals concerning health care reform:

Affordable and accessible health care is an essential safeguard of human life, a fundamental human right and an urgent national priority. We need to reform the nation's health care system and this reform must be rooted in values that respect human dignity, protect human life and meet the needs of the poor and uninsured. With tens of millions of Americans lacking basic health insurance we support measures to ensure that decent health care is available to all as a moral imperative. ["Faithful Citizenship: A Catholic Call to Political Responsibility," *Origins* 33:20 (October 23, 2003): 321, 323-330 at 328.]

In line with previous statements on "faithful citizenship" prior to the presidential elections, the 2004 guidelines once again renew the call for justice in health care reform.

As the U.S. Conference of Catholic Bishops stressed in "Health and Health Care" (1981), the bishops in their role of pastors and teachers "feel it is opportune to issues these reflections on health and the Catholic community." The statement carried their hope of promoting "a continuing dialogue on health and health care, a dialogue that takes its starting point from some of the issues we have raised." All proposed solutions to health care access point up the need for society to make tough choices in a world of limited medical resources. But, a just society will not allow the marginalization of the poor and the exclusion of the disenfranchised from access to health care to be that choice.

Competition for survival --- "Your money or your life" --- is not a moral option.

The Right to Health Care

--- Safeguard of Human Life and Dignity

The Catholic News Service recently reported on a newly formed coalition to address the social needs of the more than 40 million Americans without health care insurance.

The Catholic Health Association has allied itself with a diverse spectrum of advocates on behalf of access to health care, including the American Hospital Association, American Nurses Association along with the U.S. Chamber of Commerce and the Health Insurance Association of America. The sponsoring agencies often represent such diverse public interests that Father Michael Place, president of the CHA, has nicknamed this unlikely confederation the "Strange Bedfellows" coalition.

On the occasion of the 2004 "Cover the Uninsured Week, Cardinal Francis George, the archbishop of Chicago, issued a statement on access to health care dated May 14, 1994. After a brief survey of the state of the question, Cardinal George stressed that "God's commandment to protect human life calls us to develop a vision of care for the sick throughout all of life." That responsibility is incumbent on society as a whole including health care institutions and business as well as individual citizens.

Moreover, Cardinal George called on legislators at all levels of government to attempt once more to "fashion policies and legislation access to basic health care for all people." He urged health care institutions "to keep the safety net available until such a change occurs."

The fact that over 40 million Americans are uninsured appears to be a singular unifying force for creating this unlikely partnership for approaching a vexing social problem.

For background in preparation for "Covered the Uninsured Week" 2004, the Alliance for Health Care Reform collated statistics highlighting the need for renewed interest in health care reform:

- ◆ Almost one in every six in the U.S. lacks health care --- 46.6 million in 2002, according to the Census Bureau.
- ◆ The percentage of the U.S. population without coverage is growing, reaching 15.2 percent in 2002 vs. 14.2 percent in 2000.
- ◆ Eight out of ten uninsured are in working families.
- ◆ The uninsured don't fit any stereotype. They come from every community, every walk of life, every race and ethnic group, every income level.
- ◆ People who have coverage can't necessarily count on keeping it. A person could have good coverage today, none at all in six months from now, then regain coverage a few months later. Nearly 85 million people lacked coverage at some point between January 1, 1996 and December 31, 1999. [Alliance for Health Reform, *Health Care Coverage in America: Understanding the Issue & Proposed Solutions*, 2004 (www.CoverTheUninsured.org/Materials)]

While the majority of Americans have health care coverage, the report concludes that "far too many are left without any help at all." In other words, a persistent problem remains despite attempts spanning over decades years to resolve an inequitable system.

The State Health Access Data Center (SHADAC) presented the following data for the State of Kentucky:

- ◆ In Kentucky, 541,466 adults between the ages of 18 and 64 or 21% are uninsured.
- ◆ Among adults with a child in the household, 277,757 Kentuckians or 51.3% are uninsured. By contrast, the number of insured adults in the same category stands at 48.8%.
- ◆ Statistics on the uninsured within racial and ethnic minorities identify 29,459 or 23.2% of adult African-Americans and 10,780 or 27.2% of the adult Hispanic population.
- ◆ The uninsured include 285,869 employed and self-employed workers; 17% of working adults are uninsured.

Fuller data tables from the State Health Care Data Assistance Center can be reviewed at SHADAC's website, www.shadac.org

The national and statewide impasse on health care reform persists as an unresolved moral challenge. The state of the question has shifted away from talk about rights and the common good to matters of supply and demand and markets of an ethically neutral business ethos.

In 1993, the Catholic Bishops of United States issued a resolution entitled "A Framework for Comprehensive Health Care Reform." Its subtitle reflected the key elements of the church's social justice perspective --- "Protecting Human Life, Promoting Human Dignity, Pursuing the Common Good."

The statement opened with a summary judgment, namely, that the nation's health care system "serves too few and costs too much." It identified reform efforts as steps towards reshaping a societal "response to a basic human need." The response to that need is a moral imperative which cannot be reduced to the economics of a "market fundamentalism."

The bishops identified the universal right to adequate health care as the fundamental moral principle supporting the structure of values, criteria, and priorities involved in a moral analysis.

In Catholic social teaching health care cannot be commodified. Rather health care is "a basic human right, an essential safeguard of human life and dignity."

Pope John XXIII formulated the first integral charter of human rights and correlative duties based on natural law presuppositions in *Peace on Earth (Pacem in Terris, 1963)*. The "Right to Life and a Worthy Standard of Living" stands first in the ordering of these universal rights and obligations.

Peace on Earth defended every person's "right to life, to bodily integrity, and to the means which are suitable for the proper development of life." Section 11, then, specifies the means required to proper human development in relation to the right to

life and integrity as "primarily food, clothing, shelter, rest, medical care, and finally the necessary social services." (PT n.11)

The 1993 resolution of the National Conference of Catholic Bishops (now the United States Conference of Catholic Bishops) repeats the bishops' "constant teaching that each human life must be protected and human dignity promoted" and their insistence that all people have a right to health care.

There can be no doubt that the church's advocacy for health care reform is premised on that right.

Large numbers of men, women, and families remain uninsured. Additional millions have insufficient health care coverage. Skyrocketing health care costs pose a threat to adequate care for all. Such alarming indicators focus on the need for fundamental reforms in the nation's health care system.

The church's health care ministry is rooted in the biblical vision to heal the sick, with special protection of the poor and the needy, as well as the demands of social justice and the principle of the common good.

The N.C.C.B.'s 1993 resolution on health care reform issued criticized existing patterns of health care for failing to "meet the minimal standard of social justice and the common good." The document concluded with the morally tough judgment: "The current health care system is so inequitable, and the disparities between rich and poor and those with access and those without are so great that it is clearly unjust." (Emphasis added.)

In this regard, Directive 3 of the "Ethical and Religious Directive for Health Care Services" (2001) confirms service of and advocacy on behalf of the marginalized as integral to the mission of Catholic institutions in the field of health care ministry.

Directive 3 reads:

In accord with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination: the poor, the uninsured and the underinsured; children and the unborn; single parents; the elderly; those with incurable diseases and chemical dependencies; racial minorities; immigrants and refugees. In particular, the person with mental and physical disabilities, regardless of cause or severity, must be treated as a unique person of incomparable worth, with the same right to life and to adequate health care as all other persons.

The hope for a vital inclusion of a "moral perspective and intensely political debate" remained alive in the year 2001. Health care reform remains a major issue in social justice in the first decade of the new millennium.

In an analysis of markets and Christian ethics, Dr. Edmund D. Pellegrino, physician and philosopher of medicine, has pointed out that "healing and curing can never be

primarily a commercial enterprise." In other words, health care cannot be conceived as a commodity. [Edmund J. Pellegrino, "The Good Samaritan in the Marketplace," in *The Changing Face of Health Care: A Christian Appraisal of Managed Care*, edited by John F. Kilner et al. (Grand Rapids, Mi.: William B. Eerdmans, 1998): 103-118 at 105.]

Dr. Pellegrino rejects a "provider-consumer" relationship since the commercial model of health care delivery is incompatible with Christian values. As an operational model, the commercial approach displaces "the vulnerable, the marginalized, the poor, the persons who have neglected their health, the uninformed, or the uneducated." Consonant with Catholic social teaching, the noted Catholic thinker argues that "these are the 'non-players' who cannot even enter the market." [Ibid.]

From the standpoint of a Christian ethics of health care, Dr. Pellegrino is critical of "successes" in a managed care system if its profitability is produced,

by the denial of claims, cutting payments to physicians and hospitals, erecting new barriers to care, disenrolling patients and physicians who cost too much, and refusing grievances and appeals by redefining medical necessity and experimental therapy in terms of favorable to managed care organizations. [Ibid., 106]

Ethical questions also arise as to whether assets and surpluses in profit can be appropriated by the organization "to be used as capital and counters in the frenetic game of mergers and buyouts."

By contrast, Dr. Pellegrino points out that "nominally not-for-profit managed care organizations like Blue Cross were chartered for the benefit of the public they are presumed to serve."

Dr. Pellegrino excludes the compatibility of managed care with a system accountable to Christian ethics when managed care is construed as a commercial undertaking. However, he judges that managed care can be consistent with a Christian ethic of care "when its aim is to improve the quality, availability, and quantity of health care and when the means employed to this end are in themselves just." [Ibid., 106]

Finally, Dr. Pellegrino affirms the congruence of a Christian ethic of care "with the idea of a good society built on the conception of human solidarity and the dignity of all humans as children of the same Creator." [Ibid.] After referring to a 1997 statement from the National Conference of Catholic Bishops on the pastoral role of diocesan bishops, the Director of the Center for Bioethics at Georgetown University, sums up a rationale for Christian health care services:

In a Christian social order, economics serves as a means of satisfying human need in accordance with the Gospel principle of charity. Ethics precedes economics; it does not deny the reality of economics, but it locates it in proper relationship to the good for humans. [Ibid. Emphasis added.]

The Catholic Health Association (CHA) has consistently been addressing and supporting health care reform in the United States. The CHA views its role as "a catalyst for accessible and affordable health care for all in a just and compassionate health care system" as a corollary of its mission.

Father Michael D. Place, the president and CEO of the CHA, "The Health Care Reform Equation" in 2001. [*America* 184:10 (March 26, 2001): 8-13.] Place, a moral theologian, conjectured that the national dialogue about expansion of health care insurance coverage would again appear on center stage. A factor which signaled the likelihood of a renewed discussion on the question was the emergence of "recent proposals for sequential, rather than wholesale reforms --- including those developed by C.H.A. --- have greater viability." (Ibid., 9)

Father Place summed up the guiding principles that mark the CHA's call for health care reform. A reformed system will be one which ...

- ◆ makes health care available to all, regardless of employment, age, income or health status;
- ◆ makes a defined set of basic benefits available to all;
- ◆ shares responsibility for health care all --- individuals, families, health care providers, employers and government;
- ◆ bases health care spending on appropriate and efficient uses of resources;
- ◆ shares responsibility for financing among government, employers and individuals;
- ◆ promotes the continuous improvement of health care services;
- ◆ encourages effective participation in decision making by patients and their families.

In addition, Father Place identifies an eighth principle, the adoption of "the concept of a sequential strategy for transforming the health care system." Realism would anticipate that "systemic change is likely to be a gradual rather than a sudden process." [Ibid., 10. Emphasis added.]

The CHA proposal embraces five essential components:

- ◆ An expansion of Medicaid and the State Children's Health Insurance Fund (S-CHIP).
- ◆ A program of premium subsidies.
- ◆ An expansion of the Federal Employee Health Benefits Program.
- ◆ An outreach and enrollment initiative for Medicaid/S-CHIP coverage.
- ◆ An initiative to strengthen the health safety net.

The CHA's strategy is one that is working towards the ultimate goal of universal coverage but "in deliberate and sequential steps." [Ibid., 10-12]

["Faithful Citizenship: A Catholic Call to Political Responsibility \(2003\),"](#) prepared by the United States Conference of Catholic Bishops for the 2004 elections, includes the issue of health care as a moral priority. The current statement on political responsibility reaffirms a basic moral premise: "Affordable and accessible health care is an essential safeguard of human life, a fundamental human life, and an urgent national priority." [USCCB, op. cit., 2003]

The NCCB's 1993 resolution on health care reform offers several distinctive contributions to constructive dialogue: "an ethical framework in an arena dominated

by powerful economic interests" and a human perspective in an often overly technical discussion."

As the Catholic bishops admonished in "Health and Health Care" (1981), "Christian people have a responsibility to actively participate in the shaping and executing of public policy that relates to health care." Since a right to health care is an integral component of a theory of human rights, the Church has a responsibility to witness to gospel values in the public order. It is incumbent on the lay faithful "to fulfill their political responsibility in the area of health care policy by educating themselves on the issues and by making their views known." [NCCB, op. cit. (1981): 483.]