

# The Good of Health Care: Justice and Health Reform

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Following World War II, most developed nations provided systems of universal public health care coverage for their populations. These were rooted in various notions of equity, solidarity, rights, and health care as a public good or as an element of the common good. The United States has been the notable exception in maintaining health care as a private, market good, privileging choice and competition. Today, health care systems in all industrialized countries are challenged by increasing costs, threats to equitable access, and public demands. The reasons for the challenges are many and complex including: unprecedented advances in medical science and technology, rising costs of medical interventions, patient expectations of unlimited benefit in a consumer society, the medicalization of life, and the widespread and rapid diffusion of and dependence on technology. At the same time, developing nations struggle to provide even the minimum health care for their peoples.

Enthusiasm for market solutions to the challenges of health care dominates the health policy landscape. This enthusiasm prevails despite widespread market failure and rising inequities in health within countries and across the globe. Indeed, the market and its mechanisms are so deeply embedded in contemporary culture in all developed nations that it is difficult to assess the market critically.<sup>1</sup> As the recent U.S. health reform experience demonstrates vividly, we know how to think and function as individual consumers. However, we have lost any notion of being socially interdependent members of society with skills for civil discourse about the goals of common projects such as health system reform. Sadly, Catholics appear to be buyers and sellers with the best of them, having lost connection to our traditions of justice, health care as service to persons, *and* commitment to the common good.<sup>2</sup>

In a review of international health reform, Callahan and Wasunna<sup>3</sup> have shown clearly that nations choose to privilege either individual choice or equity in their

design and reform of health systems. International health system reform presents a unique opportunity for Catholic bioethics to take up Lisa Cahill's challenge to assess

...critically the connections among individual decisions and social practices, with the aim of showing how practices that favor the privileged and enable their free choices and access to resources carry a negative impact for global health patterns and the resources and choices of the poor.<sup>4</sup>

Despite the American reluctance to learn from other nations, a much-needed critical reflection on the social practices of the market in promoting justice and the common good can be informed by emerging empirical evidence from international health reform. Some foundational notions from Catholic theology can challenge us to reflect on how our individual health care decisions and our support for health policy options appear to be shaped more by our consumer society than by our faith.

### **Health Equity and the Market: Lessons from International Experience**

In the clinical situation, we know that we must have detailed and accurate information on the patient's condition as a basis for ethical reflection. In health policy ethics, the condition of the system is equally important. The financing of health care systems—private or public;

their delivery—for-profit or non-profit; and their focus on health or health care—affect both equitable access to necessary health care services and equitable health outcomes.

Health equity can be defined as “the absence of systematic disparities in health (or in the major social determinants of health such as poverty, education, employment, nurturance in early life, etc.) between groups with different levels of underlying social advantage/disadvantage – that is, wealth, power, prestige”.<sup>5</sup> Health and wealth are clearly related: the higher the socio-economic class, the longer the life expectancy, and the better the health state at every stage of life.<sup>6</sup> Health inequities further disadvantage those who are already socially disadvantaged on the basis of wealth, power or prestige.

Those in greatest need of health care are in the worst place to buy it in the marketplace. So, access to necessary health care is one of the socio-economic determinants of health. There is broad agreement that governments have obligations to develop health systems that promote equity and that these include notions of fair access and fair financing for the full continuum of health needs.<sup>7</sup> Historically, most systems in the developed world have incorporated a range of public-private options into their organization while protecting the goal of equity. Today, the major factors driving privatization and increasing use of market mechanisms in countries with established public systems have been identified: beliefs regarding privatization as a mechanism for

increasing productivity and empowering consumers; budgetary strain; public failures especially with access; affluence and consumerism; medical technology; and wider political and social developments especially regarding the role of the market in society.<sup>8</sup> Market mechanisms include consumer choice, competition, and its concomitant advertising, specialization (and creation of niche markets), a focus on technology and interventions, and the use of financial incentives (e.g. positive and negative gate-keeping and co-pays).

International experience demonstrates some of the consequences for health equity from the increasing use of market mechanisms in formerly “public,” i.e., not-for-profit, health care systems:

- The mechanisms bring medicine into the realm of commerce where commodities are sold for profit;
- They separate health care into discrete, saleable units creating buyers and sellers who are forced to compete, creating winners and losers;
- Providers can gain market share by separating medical commodities according to different patient needs; and
- Profitable providers attract investors and power to expand; unprofitable ones are driven from the market.<sup>9,7</sup>

Europe-wide attempts to improve health system efficiency by introducing consumer choice through market competition have

demonstrated that decentralized competitive markets do not provide equitable access to health care, do not control costs, and show no better quality than integrated systems.<sup>10, 11</sup> In reality, competition increases longstanding inequities in health outcomes between advantaged (high socioeconomic status, whites) and disadvantaged (chronically ill, low socioeconomic status, racial minorities) populations and supports the general conclusion that “...competition will likely further expand disparities that already exist in health care access and health outcomes.”<sup>12</sup>

Clearly, there is a wide range of market practices in health care and many of these are morally neutral.<sup>13</sup> For instance, in delivering health care, we use commodities such as IV tubing and medical devices and contract laundry and food services. However, certain market practices in health care are not morally neutral. Treating clinical need and care of patients as commodities, for example, is morally problematic. The empirical evidence seems clear: as market mechanisms are increasingly inserted into systems built on notions of solidarity and equity, the focus shifts to individual choice, and the lucrative technological fixes of acute care (and away from the full continuum of health needs). The more health is understood as a commodity and health care is operationalized as a market good rather than as a public good or an element of the common good, the less it will be funded and delivered in a manner compatible with justice and equity. Significantly, it will be less likely that any

serious attention will be given to the other crucial determinants of health, such as poverty and meaningful employment, in public policy or health care practice.

### Theological Bioethics and Critical Connections

Theological bioethics, rooted in the healing and reconciling ministry of Jesus Christ, cannot be inattentive to issues of health policy. Our foundational beliefs should influence our health policies not only because health is of moral import but also because health policy itself is a moral endeavor. In a very real sense, policy shapes the nature and scope of the moral/ethical dilemmas experienced by individuals. Who gets coverage, for which health needs, and where and how care is delivered are all issues of policy. The worldwide enthusiasm for market mechanisms as solutions to crises in health systems brings us an unprecedented opportunity to assess critically the connections between our own individual health decisions and our support for social practices with consequences for justice and the common good. Just one example from the *Catechism of the Catholic Church* can serve to illustrate how theological reflection informed by this empirical evidence can challenge us. The teaching of the church is very clear: “Life and physical health are precious gifts entrusted to us by God. We must take *reasonable care* of them, taking into account *the needs of others and the common good* (emphasis added).”<sup>14</sup>

We certainly accept that life and health are precious. But how many Catholics know that our obligation is to take “*reasonable care*” of life and health and to take “*into account the needs of others and the common good*”? How many accept it? In our death-denying, death-defying world dominated by rampant individualism and a consumer mentality, “reasonable” care seems to be totally inadequate, even for a Resurrection people. While Catholics have a long and strong tradition regarding prudent decision-making in health and illness, there seems to be a radical disconnect today between the tradition and the way we approach medical decisions for ourselves and our loved ones. We all have been seduced by notions of the market and now behave as consumers of health care rather than a community of faith committed to the common good.

Contemporary medical advances, focused on individuals, and secular bioethics, dominated by autonomy, practiced in an increasingly consumer society, have encouraged demands for unlimited potential individual benefit. Commodities are goods designed to satisfy individual desires, not needs. For persons of faith, health care is not a commodity; it is a service to persons who are body, mind and spirit. There are deep limitations to the notion of sick and dependent persons as “customers.” Not surprisingly then, there are serious moral effects of understanding health care as a commodity including:

- Depersonalization of the patient
- Challenges to trust

- Erosion of the moral agency of the health care practitioner
- Loss of the need for any calculus of benefit/harm; what the patient (customer) want is central.<sup>15</sup>

Commodification also affects the way in which we view the good of organized health care.<sup>16</sup> As Pope Paul VI said: “Regulating (the economy) solely by the law of the marketplace fails social justice, for there are many human needs which cannot be satisfied by the market.”<sup>17</sup> Health need is one such human need. Health care is an element of the common good; not a market good. The common good in Catholic tradition “is the sum total of those conditions of social life which allow social groups and their individual members, relatively thorough and ready access to their own fulfillment....”<sup>18</sup> All conditions for human flourishing are important. In this teaching on the sum total of conditions of social life, we find some powerful motivations for addressing issues of primary prevention with attention to the reduction of risk factors related to poverty, lifestyle and the environment. We also see the importance of the full continuum of care including those areas of health need for the most vulnerable and marginalized where it is difficult or impossible to make money.

## Making Critical Connections

The United States is grappling with rectifying important inequities through recent health reform in the context of a strong market ethos and domination of market practices. Canada and other industrialized nations with systems based on notions of equity and the common good are pressured to incorporate more market practices into systems. International experience presents some powerful cautionary tales about unthinking enthusiasm for the market and justice.

Catholics must use health system reform as an opportunity to test our real identity. Are we simply consumers demanding all for ourselves and our own, or are we brothers and sisters sharing a commitment to notions of justice and the common good that are so starkly counter-cultural in our time?

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## References

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