

Raising Our Voice for Health Reform: A National Priority and Moral Imperative

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A National Priority

Many primers and essays on health care reform begin with this statistic: 47 million people in the United States are uninsured. Disturbing as it is for so many people to lack insurance coverage, it really only skims the surface of what plagues our health care “system.”

In the wealthiest nation on earth, we indeed spend the most money per person on health care – approximately \$6,000, or more than twice what other industrialized nations spend. And, in many measurable and important ways, those nations provide better health care than we do.

According to the Commonwealth Fund, a foundation that conducts research to promote a high-performing health system, the U.S. ranks last among Australia, Canada, Germany, New Zealand and the United Kingdom when it comes to our system’s efficiency, equity and ability to promote long, healthy and productive lives.

This is not to say that those countries do things perfectly, or that we should mimic their systems. It does, however, give us evidence that we can do better—and that if our priorities and our planning were reconfigured, we would do better.

For too many people, the stakes are of the greatest possible magnitude. The Institute of Medicine has concluded that more than 18,000 men, women and children in the U.S. die each year because they lacked health insurance, not because their conditions were untreatable or their disease stages too advanced for intervention. Instead these people died because the lack of coverage prevented them from receiving life-saving treatment before it was too late.

So we spend more and get less for our money. Meanwhile, millions can’t access the system at all, except perhaps when

they show up in the emergency department to receive care for anything from the common flu to a serious condition that should have been addressed much earlier by a primary care physician.

The ED, we know, is the most expensive and least effective place to be treated for anything other than a true emergency or trauma. When we treat people in the ED because they have no other option, we pay more for those encounters than we would have by ensuring access to proper preventive and primary care.

Add to this the health care industry’s poor record on implementing life- and cost-saving information technology. A car owner can get an oil change at Grease Monkey in Dayton, Ohio, then drive to a Grease Monkey in Los Angeles and find that the record reflects everything done to the car in Ohio. That car, in other words, has a mobile record reflecting its “medical” history. The same is not nearly as true in health care, where a patient could visit two hospitals in the same city and neither would have any record of his or her treatment history.

Information technology can expedite bulky and expensive administrative procedures but, even more important, can prevent nurses from administering the wrong dose of a medication or a surgeon from performing an operation on the wrong body part. If we can do it for cars, we can do it for people.

The list of other problems in our health care system is too long to examine here but it includes a host of critical issues we need to confront: health disparities that result in (sometimes vastly) different treatments and outcomes for minorities; a growing shortage of nurses and rural health care professionals; and misaligned incentives that do not reward quality.

From an economic standpoint, the status of our health system is both irrational and unsustainable. In 2005, the United States spent 16 percent of its GDP on health care, while the median for other developed countries was 8.5 percent. In 1960 we spent only 5.2 percent of our GDP on health care. Today we spend more on health care than we do on food.

This puts us at a competitive disadvantage globally. A study by the New America Foundation found that U.S. firms spent twice as much on health care in 2005 than their foreign competitors. For every American worker earning \$18 per hour, U.S. companies spent \$2.38 per hour on health insurance. In contrast, firms in Canada, Japan, Germany, the United Kingdom and France paid an average of \$20 per hour and spent \$0.96 per hour on health insurance.

Meanwhile, the cost of health insurance hugely outpaces the growth in wages – between 2000 and 2007, the net cost of private family health insurance premiums increased 91 percent. Workers’ earnings in that 7-year period grew only 24 percent.

What all these facts and figures add up to is a system that simply cannot sustain itself over the long haul without intervention and change. Some argue that we do not have a health care “system” at all—that it lacks any kind of strategic and integrated coordination. Health care involves so many players and parts that it can easily defy this kind of coordination. Still, reform efforts can and should recognize the need for better planning among all the stakeholders—patients, providers, insurers, employers, government and charity organizations.

With the recent and growing downturn in our economy, many people will argue that health care reform has to wait, that we simply don’t have the money to make real changes. Given the scenario described here, the opposite is actually true: we cannot afford NOT to reform the system.

It is no longer an option to make this a back-burner issue. The economy and health care are too closely correlated to treat them as separate and isolated issues. Fixing health care can and must be part of revitalizing the economy, and a growing number of policy and economic experts are coming around to this viewpoint.

If we do not opt to repair the health care system for economic reasons, we should do it for moral and ethical reasons. Unless and until we act, millions of men, women and children will suffer needlessly and the economic cost will grow.

A Moral Imperative

In a talk on “The Right to Healthcare” delivered in 1993 to the National Conference of Catholic Bishops, Joseph Cardinal Bernardin observed that “the current health care system is so inequitable, the disparity—between rich and poor, between the sick and the well, and between those with access and those without—is so great, that it is clearly unjust.”¹ That was 15 years ago when there were approximately 37 million people in this country uninsured. The situation has only worsened. What led Bernardin to make this claim is the belief, deeply rooted in the Catholic tradition, especially in Catholic social teaching, that health care is not a mere commodity, but “an essential safeguard of human life and dignity.”²

Health care is a fundamental human good. It is one of those necessary conditions for protecting, promoting and enhancing the inherent dignity of all and of furthering human flourishing. It is part of the pro-life commitment of the Catholic community. Here Bernardin is simply echoing the words of John XXIII in his encyclical, *Pacem in Terris*, when he affirms that all have a “right ... to the means necessary and suitable to the proper development of life,” which includes medical care.³ The American bishops, on several occasions, have affirmed this notion that health care is a fundamental human good.⁴

Drawing again on the Catholic social justice tradition, Bernardin also believed that the health care system is unjust because it is a violation of the common good and of distributive justice. The common good speaks to a society’s providing those conditions that are necessary for each person to have the opportunity for full human development.⁵ One of our major social institutions—health care—which ought to provide a fundamental human good fails to deliver for a large portion of American society. Furthermore, distributive justice requires that the goods of society be distributed in an equitable manner to all members of society. That is not the case with health care.

For these and other reasons, the situation of health care in our country is both a moral failure and a moral challenge. It is a moral failure because our nation has lacked the will to pursue reform of the system so that all our people are accorded this fundamental good. It is a moral challenge because every citizen and every lawmaker can no longer rest content with this “clearly unjust” situation. What will likely be required is a brutally honest examination of our hearts and minds to identify those values, beliefs, assumptions and motivations that perpetuate the current situation and that undermine efforts at reform. A fundamental requirement of health care reform is a transformation of hearts and minds — of individuals, communities and society. Short of this, it seems doubtful that we will make any progress, and 15 years from now Cardinal Bernardin’s words will sadly be as applicable as the day he spoke them.

If the existence of profound injustice in our midst is not sufficient reason for us to care about health care reform, then the Gospel should be. Jesus defined his mission in the world as bringing about the Reign of God (Lk 4:18) or, put differently, making God’s way present in the world, making relationships right. And he told his disciples to “Go and do likewise” (Lk 10:37). Working to realize God’s way in the world, to make relationships right, to bring about justice, is not optional for those who claim to be Christian. This is at the heart of what it means to be Christian. For Christians to ignore instances of injustice is to fail at what they should be about.

So why should we care? We cannot not care, because we should be about promoting the Reign of God. And we should be about caring for those on the side of the road. This parable, the Parable of the Good Samaritan (Lk 10:30-37), is often used as a paradigm of Catholic health care. In so many ways, it is. But in at least one way, it falls short. The parable assumes conditions as they are. In fact, what is needed, is to change the road and to alter conditions so as to avoid having people along the side of the road. Working for the Reign of God entails not only caring for the poor and vulnerable, it also entails transforming unjust social structures, those conditions in our communities and in our society that prevent God’s way from being realized.

There is much injustice in American society as recent events in the housing, investment, and stock markets so well illustrate. And there are many fundamental goods essential to human dignity at stake for so many in our society. Health care reform is one among many issues that needs to be addressed. Even though in the weeks and months ahead, other concerns may take priority because of their importance and their immediacy, it would be unwise to lose sight of the need for health care reform. The current economic crisis is likely to leave millions more in this country uninsured. An already unjust situation will be exacerbated precisely because of the structure of our health care system

Catholic health care can play a vital role in “making relationships right” in the area of health care. It can do this, as it so often does, by advocating in various ways for reform. But it can also participate in the desperately needed work of transforming hearts and minds. It can do this in the local community and, perhaps, above all within our organizations. Engaging staff in a series of reflections on health care reform, whether sponsored by administration, advocacy, mission, or the ethicist or ethics committee, can be a further expression and exploration of Catholic identity.

NOTES

1. Joseph Cardinal Bernardin, “The Right to Health Care,” in *Celebrating the Ministry of Healing: Joseph Cardinal Bernardin’s Reflections on Health Care*, St. Louis, MO.: The Catholic Health Association, 1999, pp. 66-67.
2. Bernardin, “The Consistent Ethic of Life and Health Care Reform,” *Celebrating the Ministry of Healing: Joseph Cardinal Bernardin’s Reflections on Health Care*, St. Louis, MO: The Catholic Health Association, 1999, p. 75.
3. John XXIII, *Pacem in Terris*, 1963, par. 11.
4. For example, in their 1981 *Pastoral Letter on Health and Health Care*, the bishops write: “... the Church considers health care to be a basic human right which flows from the sanctity of life” (Introduction). There are other references to health care as a basic right throughout the document, such as in Part V on Public Policy. See also, *Economic Justice for All* (Washington, D.C.: USCCB, 1986), where the bishops include health care in a listing of “fundamental human needs” par. 90).
5. Bernardin, “The Right to Health Care,” p.65.