

Good News and Bad

As a Source of Inspiration for Healthcare Reform, the Catholic Tradition Has Both Strengths and Weaknesses

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The American healthcare system is in trouble. It is afflicted by huge disparities in access resulting from long-standing inequities of race and class, galloping costs exacerbated by ever-expanding medical technology, and conflicting aims and obligations on the part of healthcare providers.

In view of these problems, the Catholic Health Association (CHA) decided in February that it must redefine its mission. CHA will work to unify the Catholic health ministry so it will be better positioned to serve as “a catalyst for accessible and affordable care for all in a just and compassionate healthcare system.”¹ (See also p. 10.)

How well can the Catholic tradition meet that challenge? The answer, I think, is mixed. First, we can find many supports for CHA’s program in the social teaching of the Church, which:

- Emphasizes the common good
- Links individual dignity, on one hand, with social interdependence, on the other
- Trusts the reasonableness and moral capacities of human beings and their societies
- Integrates religious faith, moral action, and social responsibility
- Has, in the years since Vatican II, developed a global, multicultural perspective

However, this tradition also has three weaknesses in relation to healthcare:

- *Lack of realism.* The tradition has a tendency to advance broad ideals while downplaying the fact that realizing them in practice may involve conflict and compromise. Society or “the public” may not always be so receptive to these ideals as the justice tradition hopes. Even Catholic providers may have trouble putting these ideals into practice.

- *Top-down approach.* The tradition is inclined to approach social justice and social change in a hierarchical manner, placing key responsibility for defining and achieving the common good in the hands of those already in power.

- *Naïveté about global realities.* The tradition has a belated and still incomplete comprehension of what it means to speak of the “global common good.” Catholic social teaching has not yet begun to seriously confront the ways the U.S. healthcare system is inevitably affected by international realities, nor to address the fact that there is no effective leadership or authority worldwide that might someday ensure health services for all.

The Tradition’s Assets

The modern papal social encyclical tradition, now a little more than 100 years old, is centered in a conception of the common good that includes but is not reducible to the individual good of every single member of society. This tradition is also concerned with the institutions of society and the way they serve the human good. *Peace on Earth*, Pope John XXIII’s 1963 encyclical letter—which affirmed that the common good includes material, social, and spiritual welfare—is a classic statement. The common good, it says, “embraces the sum total of those conditions of social living whereby men [and women] are enabled to achieve their own integral perfection more fully and more easily” (no. 58).

John XXIII and other popes emphasize that it is the government’s responsibility to make sure the mutual rights and duties of all citizens are fulfilled. But, they also say, government regulation should not take from local or more “subsidiary” groups and institutions the right and ability to define the common good at the local level. The principle of subsidiarity cuts both ways. Government and civil society are interdependent agents working to ensure that all members of society contribute to and benefit from shared goods.

More recent documents, especially *Economic Justice for All*, the U.S. bishops’ 1986 pastoral, frequently use the word “participation” to refer to the relationship between the individual and the common good.² In his 1999 World Peace Day

message, Pope John Paul II reiterated that all citizens have the right and the responsibility "to participate in the life of their community."³ If they are deprived of that, he argued, they lose hope (no. 6). Because a decent level of health and well-being is necessary for each person to participate in society, making contributions on one hand and reaping basic benefits on the other, everyone has a right to healthcare.

In recent years, two major improvements—both relevant to the current healthcare debate—have been made in this basic Catholic justice framework.

A Consistent Ethic of Life The first improvement is an enhanced linkage between personal ethics and social ethics (and between individual action and social institutions), as exemplified in Card. Joseph Bernardin's "consistent ethic of life." When the moral theology textbooks of the 1940s, 1950s, and 1960s dealt with issues in medical ethics, they tended to concentrate on individual decision making, developing specific norms to guide those decisions. Today the writers of such books are more likely to recognize that individual choices happen within social patterns and limits. They see that our responsibility extends beyond our own personal actions and involves the social institutions we live in. It is through social institutions, after all, that we fulfill responsibilities to members of society with whom we are not in immediate personal contact. Without such structures of responsibility, we cannot have a meaningful connection to the common good. Today we no longer use the term "medical ethics"—we speak of "healthcare ethics" and "bioethics." We realize that what is involved is far more than personal decision making on reproductive issues, organ transplants, and termination of treatment and mercy killing—the traditional staples of Catholic medical ethics.

To consistently respect and promote life, as Card. Bernardin insisted, it is also necessary "to support efforts to restrain rising health costs, and to oppose the denial of needed care to the poor and vulnerable. In standing with the unserved and the unborn, the uninsured and the undocumented, we bring together our pro-life and social justice values. They are the starting point for a consistent life agenda for health-care reform."⁴

A consistent ethic of life is one improvement in the justice framework.

The Preferential Option for the Poor Contained in Card. Bernardin's statement about social justice and social institutions is the second important development in the recent Catholic social justice tradition—the notion that concern and action should be aimed first at those people and groups who are most marginal and most excluded.

Catholics support "affirmative action" for

all those who have been deprived of participation in the common good, especially those with the least power to remedy their own situation. Catholic ethics, including healthcare ethics, is inextricably bound up in social, political, and economic issues and institutions. It is not enough for individuals to be virtuous or to meet high moral standards; individuals are called to a level of social commitment that is equally, if not more, demanding.

This commitment was the guiding force behind the bishops' 1993 message on healthcare reform.⁵ Reform, the bishops wrote, "is rooted in the biblical call to heal the sick and to serve 'the least of these,' the priorities of social justice and the principle of the common good. . . . The current healthcare 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."

The bishops called for the "virtue of solidarity" and urged Americans to test the healthcare system first and foremost by "how it affects the weak and disadvantaged."⁶ Their ideal for healthcare was both ambitious and confidently stated, combining "universal access to comprehensive quality healthcare with cost control, while ensuring quality care for the poor and preserving human life and dignity."

The revised *Ethical and Religious Directives for Catholic Health Care Services* still maintain a fairly traditional emphasis on caring for the dying while rejecting euthanasia, on the observance of Catholic sexual morality in decisions about reproduction, and on the inviolability of human life from conception to death. But the revised directives also sound some fresh notes, as in their attention to spirituality, their call for holistic care, and their definition of the Catholic healthcare mission in terms of service and "the common good of all human persons."

We can find similar changes in papal teaching,



Justice Is the Theme

Dr. Cahill's article, the fourth in a series, explores an issue of major importance for Catholic healthcare in the new millennium.

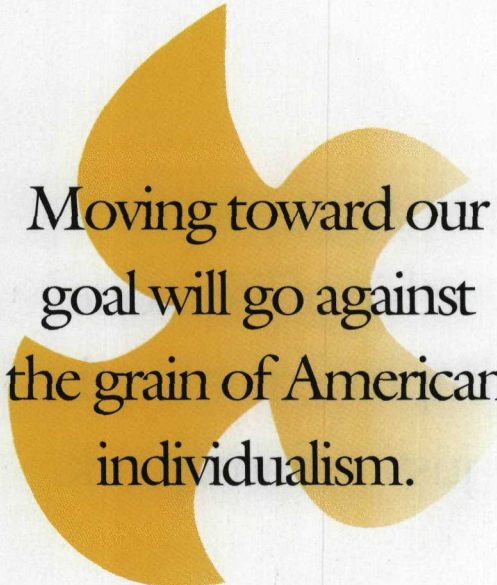
too. For example, Pope Paul VI talks about a "new humanism" (*On the Development of Peoples*, 1967, no. 20) and an integral development of the whole person (no. 14). John Paul II goes even further. He accuses contemporary technological civilization of having neglected a proportionate moral development (*The Redeemer of Man*, 1979, no. 15). He rejects capitalist systems in which unrestricted economic freedom works to the detriment of "human freedom in its totality" (*One Hundredth Year*, 1991, no. 42). John Paul II compares "materialistic consumerism" to Nazism and fascism (*Peace Day Message*, no. 2). He cites Jesus' mission to "the poor" above all (*Gospel of Life*, 1995, no. 32) and highlights the Gospel command to love neighbor, stranger, and enemy (no. 41).

A conviction that the preferential option for the poor must define Catholic healthcare ethics and motivate Catholic policy activism dominates contemporary Catholic bioethics and is the most frequently and loudly sounded note in CHA policy. This notion was reflected in the theme of the 1999 Catholic Health Assembly, in most of the assembly speeches, and in an article by Sr. Maryanna Coyle, SC, which, when it appeared in *Health Progress*, was billed as "a kind of preview" of the assembly.⁷ Sr. Coyle predicted that, since the Catholic health ministry concerns the protection of the weak, its work in the next millennium "may take us from the center of the U.S. healthcare system to its margins," because the market is marginalizing so many people and depriving them of their healthcare rights.

Rev. Michael D. Place, STD, CHA's president and chief executive officer, argued in a later issue of *Health Progress* that the core characteristics of Catholic identity include demonstrating respect and compassion for all persons, focusing on the common good, and providing for the most needy.⁸

The Tradition's Weaknesses

This statement of vital ideals would be prophetic in any society; in today's healthcare climate, it is radically countercultural. Even if it does not specify goals concretely, this kind of announcement of moral obligation is likely to make listeners snap to ethical attention. In fact, this prophetic, counter-



Moving toward our goal will go against the grain of American individualism.

cultural function may be the most important contribution of Catholic social teaching and bioethics.

We must remember, however, that the Catholic social tradition has three important weaknesses.

Lack of Realism Moving even incrementally toward our goal—universal access to healthcare—will go deeply against the grain of American individualism and against the work-

ing of the market. Americans may be far from prepared to accept this vision, even as an ideal. The bioethicist and philosopher Daniel Callahan names some of the obstacles rooted deep in the American psyche and in our cultural traditions, and he argues that they must be taken seriously.⁹ Among these are our infatuation with technological innovation and our desire to use medical technology to completely vanquish death and disease, as well as to resolve problems that are essentially social in nature. We also have an inherently expansionist idea of progress, which makes us unwilling to accept any limits on it. Beyond that, we are intolerant of suffering and fail to find any meaning in what we regard as pointless suffering. Enshrined in our ideology is a market that elevates freedom and autonomy above the humanizing and restraining ethos of a more solidaristic culture. And, finally, we are pessimistic about the possibility of civil public deliberation on the common good.

All this, argues Callahan, makes for a cultural and biomedical ethos in which a sustainable medicine geared simply toward a reasonable chance for all to enjoy healthy functioning over a normal life span is impossible. What we need most is a public conversation, but Callahan is not optimistic that change will occur without coercive measures. For public conversation to actually produce improved well-being (including improved health status) for the millions of Americans now excluded from the common good, some sacrifices will have to be made. It may not be possible to achieve—as the bishops hope—comprehensive coverage, quality care for all, cost control, and a preferential option for the needy, all in one policy.

There will have to be negotiation and cutbacks, reallocation of funds, and curtailment of benefits that some have come to expect or already take for granted. Callahan thinks we have to aim at a

“steady-state” medicine (one without, that is, a constant flow of technological improvements), good overall population outcomes (rather than the best outcome possible for each individual patient), and a readiness to make decisions among competing needs. Limits must be set—both to control the overall cost of healthcare in the face of competing social goods like housing and education, and to redistribute social goods, including healthcare, from the wealthy to the underserved. For many Americans, this will indeed be a bitter pill to swallow. Many can be expected to make sure that any reforms in the system work as far as possible to their own private advantage.

When we move into the concrete, practical, and “short-term” aspects of the CHA advocacy agenda, we will find ourselves right in the thick of this battle. Members are being called, for example, to preserve Medicare coverage for the elderly and disabled, to expand health coverage to vulnerable groups, to expand Children’s Health Improvement Program outreach, and to upgrade families’ options for long-term care. Also on the agenda are even more far-reaching social reforms, such as promoting affordable senior and low-income housing, and improving primary care for low-income clients.¹⁰ But these aims will not be realized unless resources are first taken from other areas of healthcare, or are dedicated to health-related benefits instead of to other social goods.

Top-Down Approach A second weakness of the Catholic justice tradition is its assumption that change can and will occur from the top down. The social encyclicals tend to address their prophetic insights to society’s leaders, proposing, for example, that the world’s “advanced nations” help “undeveloped peoples” (Paul VI, *On the Development of Peoples*, no. 48). But liberation theology—the source of the biblically based preferential option for the poor—turns for leadership to the disadvantaged themselves. This “grassroots” orientation has yet to penetrate deeply into official Catholic teaching on healthcare and healthcare reform, although it is percolating up from the ground in many Catholic-sponsored health initiatives. But the ministry must change its approach to leadership, or it will not be able to overcome the racism and classism so endemic in the current unjust system.

Naïveté about Global Realities The tradition’s backwardness concerning leadership is connected to its failure to develop a strong global, multicultural vision. Although the encyclicals of the 1960s and 1970s have called for such a vision, they have been based on a paradigm—of moral argument, social welfare, political and economic structures, and religion and spirituality—that still derives primarily from Western Europe. This bias can prevent Catholic moral theology and social ethics from

authentically hearing and appropriating the faith experiences, moral values, and social needs of people in other cultures, such as those in Africa, Asia, Latin America, and even parts of North America.

Grassroots Leadership

In her new book, *Breaking the Fine Rain of Death: African American Health Issues and a Womanist Ethic of Care*, Emilie Townes, professor of Christian social ethics, Union Theological Seminary, New York City, develops an approach to healthcare justice that begins with the experience of African Americans and offers an African-American “womanist” theological response.¹¹ Townes suggests some ways in which less privileged members of her race can come to participate in healthcare policy through African-American grassroots leadership in schools, churches, neighborhoods, and in the healthcare setting itself. We should note that Townes goes beyond simply insisting that there be “universal access” or “universal coverage.” She believes that, because of America’s history of slavery and its continuing racism, black people and white people often have different healthcare needs, and that calling for universal coverage obscures these differences. According to Townes:

By 1991, the [U.S. Department of] Health and Human Services’ Annual Report on U.S. health revealed some sobering statistics: the mortality rate for African American and Native American infants was double that of Whites; the life expectancy for Blacks was six years less than Whites; the rate of strokes for Blacks was almost double that for Whites, and within this figure was the alarming statistic that for Blacks between thirty-five and fifty-four, the rate was four times higher; the leading cause of death for African American men between the ages of fifteen and twenty-four was homicide; Native Americans between fifteen and twenty-four had the nation’s highest death rate from accidents—this was closely associated with alcohol consumption; the death rate for Native Americans from liver disease was 327 times higher than for other racial-ethnic groups; the prevalence of obesity was greater among Blacks, especially women, and increased with age—making diabetes, high cholesterol rates, and hypertension in young and middle-aged African Americans increased concerns; and HIV infection spread most rapidly between African Americans and Hispanics/Latinos.

The high rate of poverty for African




Americans (30 percent in 1990 alone) is a violent contributing factor to diseases that could be prevented or cured with commonplace therapy and that end up killing thousands of poor African Americans. Simply put, it is more difficult for the poor to get preventive care.¹²

African-American women have distinctive health problems, including a susceptibility to diabetes—one amounting to epidemic proportions—which is compounded in pregnancy by inadequate prenatal care. Only 64 percent of such women get early care, and “those who received late or no prenatal care were more likely to be poor, adolescent, unmarried, rural residents, or more than forty years old. These are the same categories that are considered high risk for pregnancy.”¹³ Black women are, moreover, disproportionately represented among the uninsured. According to one study, minority women constitute 40 percent of uninsured women in the United States. “Hispanics/Latinas were almost three times less likely to have health insurance than White women, and African American women were twice as unlikely.”¹⁴

To address this dismal scenario, Townes proposes a “cultural-empowerment” model of wellness and healthcare services. Cultural empowerment utilizes strategies such as “consciousness-raising, training health-care professionals in cultural awareness, identifying and building on existing strengths in the social and personal network of persons and communities, analyzing the ways in which feelings of powerlessness are affecting the situation, identifying and using the sources of power present, mobilizing resources, and holding the person’s or the community’s welfare as primary.”¹⁵

Townes gives several examples of local movements for community-based healthcare. One involves five school-based clinics in the Kansas City, MO, school district. A liaison person works between the clinics and five area hospitals. The clinics serve families and the community, as well as schoolchildren. Occasionally they intervene to obtain hospitalization for a suicidal parent. Community members frequently go to a school clinic for care, since the nearest hospital may be as far as 17 miles away. The school clinics bring healthcare into underserved communities, but



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they also provide an opportunity for educators, students, and parents to help shape the healthcare services available to them.

Although the clinics are free for students, they bill insurance companies for those who have insurance. Most of the clinic funding comes from Medicaid. This funding is threatened by, first, the current drive to require Medicaid recipients to enroll in managed care plans and, second,

a lack of broad public support for the idea of maintaining Medicaid funding that provides health services to members of minority groups who live in communities scarred by racism and unemployment.

Another example of community-based healthcare is the Atlanta Interfaith Health Program, which trains lay leaders to show inner-city residents how they can use healthcare services more effectively.

The Atlanta program is reminiscent of the Catholic parish nurse movement that, as it continues to spread across the nation, has become a frequent topic in CHA publications.¹⁶ The parish nurse movement is important not only because it brings healthcare into the community, but also—since it approaches community health holistically, trying to keep residents well and out of the hospital—because it tends to sidestep the profit incentives that increasingly permeate the U.S. healthcare system.

Parish nurses are, in addition, a wonderful way to increase lay participation in a ministry of healing that has traditionally belonged to religious—and a wonderful way to center bioethical discernment in the community, rather than in the academy or the episcopacy. Unfortunately, as Townes points out, parish nurses may be an inaccessible luxury for the communities that need them most, because such communities frequently lack the financial and social infrastructure necessary to support such a program.¹⁷

Grassroots leadership for change has a prominent place in today’s Catholic healthcare mission. This is an important advance for our tradition. Indeed, Carol Tilley, executive director of CHA’s Center for Leadership Excellence, argues that real leadership consists in recognizing, motivating, supporting, and sharing with others.¹⁸ Many Catholic hospitals and healthcare systems are participating as employers in welfare-to-work programs.¹⁹ In these programs the employers learn from former welfare recipients what kind of skills, support, and encour-

agement the latter need to hold a job, and then the employers provide the items needed. CHA, the Catholic Campaign for Human Development, and Catholic Charities USA are collaborating to create home healthcare and day care companies that, first, employ former welfare recipients at wages above average for the industry and, second, foster worker ownership of the new businesses. When these programs involve members of the local community, they also tend to improve health status there.

Global Interdependence

Given the many serious problems Americans face at home, it is easy for us to forget that healthcare prospects for other people are far worse. Rev. James E. Hug, SJ, PhD, of the Center of Concern, Washington, DC, has pointed out that the wealthy industrial nations consume more than 90 percent of the world's health resources.²⁰

In 1990 the United States, with less than 5 percent of the world's population, alone consumed 41 percent of its health resources. As Fr. Hug puts it, "An infant born in Niger has a life expectancy of 38 years. . . . Eleven million [of the world's] children die unnecessarily each year, as well as 7 million adults. . . . In general, the burden of disease is five times higher per capita in the worst-off nations than in the healthiest one."²¹

The great barrier to good health in the undeveloped world is, simply, poverty. What such countries need most is not high-tech medicine, but preventive care, public health services, and basic clinical services.

For \$10 billion, which is less than 1 percent of the amount we spend annually on healthcare in the United States, disease could be reduced by 32 percent among the 3 billion people in the world's 40 poorest countries.²² But the United States cannot become the world's healthcare provider. And CHA and its member institutions certainly cannot change this global picture alone.

Fr. Hug urges Americans to:

- Provide care for undocumented aliens within our own borders
- Join a general movement to diminish our reliance on a technological, curative model of medicine
- Raise consciousness about the interdependence of the global economy

In trying to become more socially responsible, some healthcare organizations have adopted socially responsible, or mission-based, investment strategies, refusing to buy stocks from companies that deal in nuclear weapons or military contracting, or that have poor diversity, labor relations, or environmental track records. Such investment "screens" could also be made internationally sensitive, especially concerning multinational corporations and

the wages and benefits they pay employees.

In the words of John Paul II, there is an "urgent need to establish who is responsible for guaranteeing the global common good and the exercise of economic and social rights," for "the free market by itself cannot do this" (*Peace Day Message*, no. 9). The idea that someone will "establish" an authority to fill this role seems rather naïve, if not downright utopian. But we can at least oppose the market's tendency to restrict healthcare to the wealthy, on both the national and the international level. □

NOTES

1. Susan K. Hume, "Board Crafts New Self-Understanding for CHA," *Catholic Health World*, March 1, 1999, pp. 1 and 8.
2. National Conference of Catholic Bishops, *Economic Justice for All*, in *Pastoral Letters of the United States Bishops*, vol. V: 1983-1988, Hugh J. Nolan, ed., U.S. Catholic Conference, Washington, DC, 1989, pp. 371-492.
3. John Paul II, "Respect for Human Rights: The Secret of True Peace," at www.vatican.va/.
4. Joseph Bernardin, "The Consistent Ethic of Life and Health Care Reform," in John P. Langan, ed., *A Moral Vision for America*, Georgetown University Press, Washington, DC, 1998, p. 106.
5. National Conference of Catholic Bishops, "Resolution on Health Care Reform," *Origins*, July 1, 1993, pp. 97, 99-102.
6. National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, U.S. Catholic Conference, Washington, DC, 1995, pp. 4-5.
7. Maryanna Coyle, "Approaching the Millennium," *Health Progress*, January-February 1999, pp. 24-26, 29.
8. Michael D. Place, "Catholic Identity: A Unifying Force," *Health Progress*, March-April 1999, pp. 10, 14.
9. Daniel Callahan, *False Hopes: Why America's Quest for Perfect Health Is a Recipe for Failure*, Simon & Shuster, New York City, 1998, p. 289.
10. "Affordable Healthcare Tops CHA 1999 Advocacy Agenda," *Catholic Health World*, March 1, 1999, p. 2.
11. A womanist analysis is one that begins specifically from the perspective of African-American women.
12. Emilie M. Townes, *Breaking the Fine Rain of Death: African American Health Issues and a Womanist Ethic of Care*, Continuum, New York City, 1998, p. 61.
13. Townes, p. 116.
14. Townes, p. 117.
15. Townes, p. 156.
16. See, for example, the special section on parish-based nursing in *Health Progress*, March-April 1999, pp. 35-48.
17. Townes, p. 164.
18. Carol Tilley, "Leaders Encourage the Heart," *Health Progress*, November-December 1998, pp. 24-25.
19. See Mary Ann Wilner, "On the Front Lines of Healthcare," *Health Progress*, January-February 1999, pp. 80-79; and Karen Feller and Denise Stiles, "Bridges from Welfare to Work," *Health Progress*, March-April 1999, pp. 50-51, 61.
20. James E. Hug, "Health Care: A Planetary View," *America*, December 11, 1993, p. 8.
21. Hug, p. 8.
22. Hug, p. 9.



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