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HEALTHCARE REFORM'S MORAL, SPIRITUAL ISSUES

The Problems Are Not Just Political

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Some people were relieved by the collapse of the Clinton healthcare reform proposal in late 1994 because they think that healthcare delivery in the United States is not broken and does not need fixing. But most of us know the issue will not go away. Clearly, the problem is not just political; it is deeply rooted in morality and spirituality.

FUNDAMENTAL DIFFICULTIES

A number of fundamental difficulties plague healthcare reform. No real progress in reform can be achieved until they are adequately acknowledged.

Good Medicine Many people say that the healthcare system must be reformed because it has failed. Paradoxically, the opposite is true: Our system needs reform because it has been so successful. Medical specialists and researchers have done their jobs so well and made healthcare so good that we have an embarrassment of riches and no clear idea of how to distribute them equitably.

One of the problems this has created is an expanded definition of disease. As Willard Gaylin, MD, notes, "It is often difficult to appreciate that good medicine does not reduce the percentage of people with illnesses in our population. It increases that percentage. There are proportionately more people in the US with arteriosclerotic heart disease, diabetes, essential hypertension and other expensive chronic diseases than in Iraq, Nigeria, or Colombia. Good medicine keeps sick people alive."[1]

Gaylin notes that, in the past, conditions such as presbyopia (a common visual deterioration easily corrected with eyeglasses) were not recognized as disease. Diabetes, hypertension, and glaucoma were not even diagnosed, much less treated; diminished sight, hearing, mental capacity, and mobility were just signs of "old age," not correctable by medical science. Today all these infirmities are recognized as treatable diseases.

Gaylin says that people often ask how nations like Canada and England can provide universal access for far less money than the United States spends. He answers that our healthcare crisis is

Summary Although President Clinton's proposals were defeated in 1994, healthcare reform is an issue that will not go away. But it is an especially complex issue because it is moral and spiritual as well as political. Catholic social teaching could help free us Americans from our confusion on the topic.

For example, the Catholic ideas of justice, subsidiarity, and the common good could help us address the crux of the healthcare reform debate, which questions the fairness of forcing more fortunate people to provide healthcare for those who are sick and poor. Catholic social teaching tells us that our healthcare decisions must be made not only on the basis of what is good for me but what is good for us as a community.

By the same token, we might find that several specifically spiritual ideas are helpful. Christianity says, for example, that sickness can be a gift because it is a window on immortality for us; that we should not prize life above all other values; and that friendship—including the civic friendship involved in healthcare—is a way we can enter full friendship with God.

These moral and spiritual ideas lead us to certain political conclusions: Healthcare reform should be politically realistic, relatively simple, and inclusive. Because healthcare is a good like no other, it can be a powerful occasion for realizing God's own compassion, healing, and justice.

severe "not only because we are the preeminent high-technology culture but because of the nature of the American character. Americans [in contrast to Europeans and Canadians] refuse to believe that there are limits to anything—let alone to life itself."[2]

This, says Gaylin, has led to an ever expanding definition of health. "Death with dignity" and "growing old gracefully" have, he writes, come to mean "dying in one's sleep at 92 after having won three sets of tennis from one's 40-year-old grandson that afternoon and having made love to one's wife twice that same evening."

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These changes are in part the result of Americans' pragmatic "can-do" attitude—the same attitude that enables us to engage in humanitarian and military interventions on numerous different fronts at once. But the shadow side of this is a spiritual sickness that denies disability and death and repudiates the eschatological dimension of Christian faith.

Conflicting Goals of Reform A second major problem is that reform is not a univocal term. Those advocating reform have diverse and not necessarily compatible goals, and the differences among them are not acknowledged frequently enough. Ethicist H. Tristram Engelhardt cites four:

- The best possible care for everyone
- Equal, though not necessarily the best, care for all
- Freedom of choice, allowing maximum autonomy and minimum restrictions on the use of private resources
- Cost containment[3]

Depending on our priorities, political affiliation, economic position, and health, we may favor one of these goals over another. But all of these are human goods that true reform must balance.

Allocation Assuming that society has finite resources to devote to all its needs, some choices will have to be made about what general, broad categories to support.

No one disputes that health, education, military security, domestic safety, and a number of other things are worthy of promotion and funding. But how do we decide on their relative importance? And who makes the decision? In 1991 we spent about 13 percent of our gross national product (GNP) on healthcare (compared with 9.9 percent for Canada, 6.8 percent for Japan, and 6.6 percent for the United Kingdom). Is that percentage appropriate? If not, what kind of process will enable us to arrive at a better one? Or should we let market forces decide? These questions are at the heart of the debate, but we have not yet mustered the will to look at them rationally.

Microallocation and Outcomes Assessment Even if we could decide what percentage of our GNP to devote to healthcare, we would still have to decide which particular kinds of healthcare would receive those dollars. Do we devote one-third to prenatal care, one-third to mental health, and one-third to long-term care of the elderly? Or are some other proportions appropriate? Once we determine what percentage goes to the elderly, how do we decide whether it should be spent on heart/lung transplants, palliative care, or kidney dialysis?

Several possible criteria suggest themselves. Healthcare should be given:

1. Equally to all in need, distributing limited resources by lottery
2. To all who can pay, or who have someone who will pay for them
3. To those who are most likely to benefit medically
4. To those who are most likely to benefit society in the future
5. To those who have most benefited society in the past

Most of us would rule out 1 as irrational and 4 and 5 as too utilitarian. As for 2, we are reluctant to base allocation solely on the ability to pay. That leaves 3, which involves complicated evaluations of the patient's total condition and the outcomes of various technologies. Good choices concerning who gets what treatment must be based on more than hunches or emotion.

Healthcare and Catholic Social Teaching

A number of ideas from Catholic social teaching might help us out of this morass and enable us to reform the healthcare system.

Subsidiarity Several years ago Rev. Andrew Greeley lamented the fact that the notion of subsidiarity, a "bias in favor of maximization of participation,"

once so central to Catholic social teaching, had all but disappeared from the lexicon.[4] But the importance of the concept is obvious when we recall the difficult questions I just raised about allocation of resources. Assuming that society as a whole "owns" medical knowledge and resources, then society as a whole must find a viable, public way of making decisions about how they are to be allocated. Our egalitarianism makes these kinds of choices and criteria repellent, but we will eventually have to develop some kind of rational allocation mechanism. To reach consensus, our deliberations will have to take place in the bright light of public scrutiny. As Gaylin notes, "Limited resources will force us to make tragic choices—if not now, under whatever plan Congress finally adopts, then very soon. These may look like medical choices, best made by medical professionals. But in fact, they are decisions that are best made by all of us, struggling toward consensus."[5]

Subsidiarity also means "small is beautiful," so that "a community of higher order should not interfere in the internal life of a community of lower order, depriving the latter of its functions, but rather should support it in case of need and help to co-ordinate its activities with the activities of the rest of society, always with a view to the common good."[6] This leads us to solve problems at the lowest level of social organization possible. On the personal level, this means that healthcare reform must start with individual responsibility. I cannot expect the physician, much less the government, to keep me healthy if I myself do not have a significant investment in doing so. It means learning about prevention (such as obeying speed limits and using seatbelts), reasonably complying with directives from healthcare professionals, and carefully weighing the dangers of high-risk activities, whether they be smoking, drinking, or skydiving.

Setting Limits All of us must begin to ask ourselves, How much healthcare is too much? We have all seen statistics about the percentage of healthcare dollars expended on patients in the last months or even weeks of their lives. Advance directives and durable powers of attorney are small steps toward ending inappropriate treatments, but

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beyond that we need to reshape our presuppositions about life.

Ethicist Daniel Callahan has proposed thinking of this in terms of "biographical age."[7] Is there a point, he asks, when our natural life is pretty much drawing to a close, even though we may be in relatively good health? Is there a point when our attitude should shift away from life-prolonging technology and toward gracious acceptance of death? He writes:

> There are large and growing numbers of elderly who are not imminently dying, but who are feeble and declining, for whom curative medicine has little to offer. For many, old age is a reason in itself to think about medical care in a different way, whether in forgoing its lifesaving powers when death is clearly imminent, or in forgoing its use even when death may be distant but life has become a blight rather than a blessing.[8]

He also cites the heavy bias of the Medicare program toward saving and extending life rather than providing primary care, comfort, and palliation. He asks why we do not allow the elderly to choose their own balance between high-technology curative medicine and low-technology care and social support. "At a specified age, say 75 or 80, elderly people could choose restricted hospital benefits and receive enhanced quality-of-life benefits in return," Callahan suggests. Despite the risks of such a proposal, "rationing is inevitable and we must allow people to make as many of the difficult choices themselves as possible."[9]

Such a proposal should be carefully distinguished from others having to do with euthanasia or assisted suicide. Allowing people to choose the way in which their final illnesses will be managed is ethically distinct from neglecting them, killing them, or helping them kill themselves. In fact, there is good evidence that many people consider suicide or euthanasia because they are afraid of overtreatment. In many cases, bias toward high-technology, lifesaving measures is so strong that choices for comfort and pain relief only are made with difficulty. Norman Paradis wrote recently of just such a case in the treatment of his own father:

When I finally got my father's physicians on the phone, I insisted that he be cared for only by internists who had no incentive to do anything but make him comfortable. Yet my father had been in the hospital two weeks and had spent most of that time receiving "billable" high tech therapy that could not possible cure him or relieve his pain. We had to forbid them to do anything that was not directly related to relieving his pain.[10]

> We are reluctant to obligate people to do something for others.

We should begin by educating ourselves about the burdens (including cost) of a treatment relative to its ultimate benefit. This is really nothing more than learning about the old "ordinary/extraordinary" distinction in Catholic medical ethics and redefining "futility" so that it takes more account of *ultimate* benefit to the patient. As we grow older, we should ask not only whether this treatment will prolong life, but also whether it will enhance our ability to participate in life.

Justice and the Common Good Justice is "the will that each receive his or her due,"[11] but its achievement is much more difficult than this simple definition suggests.

Justice is a flexible, proportional calculation of responsibilities and claims in an organic society composed of individuals with private interests and common goals. Two kinds of justice are central to the healthcare debate. The first is *contributive justice*, which concerns what the parts owe to the whole. The most obvious example is taxes, which we pay to provide for common needs such as education and police and fire protection. The second kind is *distributive justice*, which deals with the relationship of the whole to the parts: Once society has amassed a certain amount of wealth from its citizens, it must decide how to return these resources to individuals or groups to preserve the common good.

Because of our tenacious individualism, Americans are reluctant to part with our economic resources, and this—coupled with a pervasive cynicism about the effectiveness of political institutions—has made it increasingly difficult for us to either collect or distribute resources for the common good. Indeed, the call for privatization of healthcare, education, and public safety is growing. Most of us are willing to pay for services that directly benefit us, but we resist paying higher taxes for services benefiting other groups or the public as a whole.[12] Under what circumstances should the government or some other agency *mandate* this transfer of wealth for the sake of the common good?

A particularly vivid judgment on this matter appeared in a letter to the editor of the *New York Times*. The author criticized an editorial that had advocated a more "caring and compassionate" form of government. The writer objected: "The forceful taking of property from citizens, in order to transfer that property to other citizens for whom you may feel sorry is not a moral act. There can be no morality without freedom. Acts of the state are acts of coercion and, by definition, are a negation of free will."[13]

The question really comes down to whether the things I own (including cash, property, and knowledge) are radically mine, and cannot be taken from me for any reason, or whether they are mine only "in a sense," or relatively, and may be claimed by society or government for the common good or for those who are in greater need. In the first case, my private wealth may be transferred only with my consent. In the second, my hold on wealth is tempered by the society's understanding of the needs of those around me.

Our society has tended to favor what Engelhardt calls "obligations of forbearance" rather than "obligations of beneficence." This means that we are more than willing to leave others alone, restraining ourselves from interfering in others' activity (such as buying firearms), and we are reluctant to obligate people to do something for others. This is the appeal of a "free-market" approach to healthcare. We are guaranteed freedom to pay or not pay for healthcare as we see fit, but no one is compelled to do anything positive. Such an approach is rooted in a "freedom-based" notion of justice that, in Engelhardt's words, "maximizes free choice . . . [by] minimizing interventions in the free associations of individuals and in the disposition of private property."[14]

This tension between obligations of forbearance—which leave me maximum freedom—and obligations of beneficence—by which I am obligated to do good—has fueled the healthcare reform debate and led to Clinton's "managed competition" proposal, which tried to maximize freedom and com-

petition and increase access at the same time. Congress, apparently, was not convinced this was possible.

Engelhardt makes a helpful distinction between things that are *unfair* and those which are merely *unfortunate*. Unfortunate things happen to all of us. These may occur either through a "natural lottery" (e.g., when a hurricane destroys my house or my child becomes chronically ill), or through a "social lottery" that makes some rich and some poor, some well educated and others not. *The crux of the debate about healthcare is fixed at exactly this point*: Given that illness (and let us assume here it is illness that does *not* result from a voluntary health risk) is an *unfortunate occurrence, to what extent is it also unfair*, so that others are obliged to share their resources to relive my suffering? At what point am I obliged to part with my hard-earned resources to provide medical care (or education of safety) for another, even though I myself an not ill or in need of treatment?

A "freedom-based" understanding of justice prizes noninterference above all else and would probably answer that we are never obliged to share our resources for the safety or security of another. The Catholic notion of justice, on the other hand, is rooted in what Engelhardt calls "goals-based justice," which is concerned with "the achievement of the good of individuals in society, where the pursuit of beneficence is not constrained by a strong principle of autonomy." The "goal" that Catholic social teaching has in mind is the common good—not merely the sum of individual wants and desires, but "the sum total of social conditions which allow people, either as groups or as individuals, to reach their fulfillment more fully and more easily. The common good concerns the life of all."[15] This means that our healthcare decisions must be made not only on the basis of what is good for me but on the basis of what is good for us as a community.

Healthcare and Spirituality

Justice, subsidiarity, and the common good flow from social philosophy or natural law and are not specifically religious concepts. A number of specifically religious and spiritual themes are also helpful in shaping the future of healthcare.

Sickness and Suffering A purely scientific view of sickness sees it as a mechanical failure to be repaired. But the Christian view of sickness is much richer. No one welcomes sickness, but Christians should see it as a window on immortality. When we are sick, we are forced to face our finiteness and limitations. Rather than frustrating obstacles, these can be moments of grace, encounters with Christ, whose own suffering makes ours redemptive. This is why the movement toward hospice care and greater contact with death and the dying process is entirely appropriate for Catholics. These events help us enter more fully into the paschal mystery and point us toward the resurrection. The purifying and clarifying nature of illness is also something we can share with a pluralistic society.

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Asceticism Philip Keane speaks about the importance of cultivating asceticism as we look toward healthcare reform. He writes:

> When talking about asceticism we need to be careful not to glorify suffering so that we end up embracing some sort of spiritual masochism. . . . But the ascetic tradition [does] tell us that we need to grasp life lightly, that we sometimes need to be willing to let go of our own personal interests and priorities for the sake of higher values and for the sake of other people. Such a theology of letting go may be a crucial step in the movement toward healthcare reform.[16]

This also reminds us that, although physical life is great good, it is not the ultimate good. As the *Baltimore Catechism* taught us, God created us to "know him, love him, and serve him in this world, and to *be with him forever in the next.*" That is the ultimate purpose. Overly "successful" healthcare can obscure that.

Friendship and Community For St. Thomas Aquinas, *friendship was a major paradigm for the moral* life. The notion of friendship rounds out ethics and makes it pleasant and rewarding. It saves justice from being a cold, economic calculation and

rescues our moral choices from the uncertainty of isolation and loneliness. Friendships, Paul Waddell reminds us in his wonderful book *The Primacy of Love: An Introduction to the Ethics of Thomas Aquinas*, are "schools of virtue" in which friends "practice their love on us and thus bring us into being in a way we could never have accomplished ourselves. . . . A good friend is someone who draws the best out of us, someone who creates us in the most promising way."[17]

> Healthcare is not just a commodity; it is a personal service.

Friendship is a "conversation for the good," which can take place on an intimate, personal level or on a public level in civic and political community. It involves mutuality and benevolence, and this is true even of our relationship with God. Waddell quotes Etty Hillesum, a young Jewish woman who lived in Amsterdam during World War II and eventually died at Auschwitz. She describes this mutual benevolence vividly in her diary:

> One thing is becoming increasingly clear to me: That You cannot help us, that we must help You to help ourselves. And that is all we can manage these days and also all that really matters, that we safeguard that little piece of You, God, in ourselves, and perhaps in others as well. Alas, there doesn't seem to be much You yourself can do about our circumstances. You cannot help us but we must help You and defend your dwelling place inside us to the last.

This is a marvelous description of the spirit that must animate healthcare reform. We must treasure that bit of God within ourselves and others, because all of us are truly "sacraments" of God's own self. This means that people of faith must make their healthcare decisions not only on the basis of what is "good for me," but also on what is "good for us," as we contribute to the common good.

We must seek this civic friendship through mutual care, benevolence, and a public conversation aimed at providing the kind of healthcare that will lead each of us through life's inevitable pain to full friendship with God.

Healthcare and Political Life

I have discussed a number of moral and spiritual ideas that I believe should animate our thinking on healthcare reform. What political goals do these ideas suggest?

Participation One of the problems with our attempts at reform thus far is the dominance of too many special interests that speak loudly only for themselves. Keeping in mind the importance of subsidiarity, we should try to maximize participation so that everyone's best interests are considered. Although the initial plan, shaped by Hillary Rodham Clinton and her advisers, was, I believe, formulated in relative secrecy to avoid the influence of special interests groups, it also excluded the vast majority of citizens who have the greatest personal stake in the future of healthcare.

Inclusivity I strongly favor universal coverage, and I support the notion of a "right to healthcare." Rights language is tricky, however, and means many different things to different people. We must remember that rights are related to justice and are based on a reciprocal relationship between at least two parties. When we claim a right, there must be both something claimed and *someone upon whom to make that claim.* That someone need not be the federal government. Because healthcare is the result of cooperation among generations of physicians, scientists, patients, and other private and public concerns, it is not private property; it "belongs" to all of us, to society as a whole. Society may, however, choose to use the government as a means of equitable distribution.[18]

A right to healthcare is based first of all on the fact that natural and social lotteries subject all of us to misfortunes. Prudent persons will realize they could be the ones suffering illness or injury. Simple self-interest will move them to try to guarantee that they have access to help in case they need it.

But health is not a purely private matter. When one of us is sick, we all suffer because of lost productivity, the possibility of contagion, and use of limited resources for treatment. The current AIDS epidemic is a graphic example of all three of these things. It is in all of our best interests to see that healthcare—preventive and curative—is as widely available as possible. The right to healthcare is not unlimited. It can be honored only within the constraints of available resources. But we should strive to allow each sick person the greatest possible amount of healthcare while

maintaining enough in reserve to provide equivalent care to everyone else, should that become necessary.

Simplicity Overhead costs for healthcare in the United States are nearly 25 percent; in Canada, they are 10 percent. The average overhead for American insurance companies is 14 percent, nearly three times the overhead for Medicare and Medicaid, our much maligned government healthcare programs for the poor, elderly, and disabled.[19] Sponsors of managed care maintain that it will reduce overhead costs by stimulating competition, but managed care often places an intermediary between the patient and the healthcare provider, and many plans are so complicated that *they are incomprehensible to the average citizen.*

We must preserve self-interest and initiative, but we must bear in mind that healthcare is not just a commodity like any other; it is a personal service that touches us at the core of who we are. We should be prudent about allowing profit on healthcare, and we should take care to ensure that the relationship between the healthcare provider and the patient is as unencumbered as possible.

Political Realism Few Americans favor a system of socialized medicine like that found in Britain, where all healthcare resources are government owned. Although such a system provides universal coverage, it weakens initiative by controlling salaries and profits, an idea which will probably never satisfy Americans. I personally favor universal access to basic healthcare through a single-payer system (which, in the interest of efficiency, would effectively eliminate health insurance companies as we know them).

But, like Engelhardt, I believe there has to be room in the system for a second tier, one that would make more extensive care available to those able and willing to pay for it. As he says:

> It is better to harness human passions than to suppress them. A two-tier health care system is a compromise. On the one hand, it provides at least some amount of health care for all, while on the other hand it allows those with resources to purchase additional health care. It can endorse the provision of communal resources for the provision of a decent minimal amount of health care for all, while acknowledging the existence of private resources.[20]

Healthcare is a good like no other. It is intensely personal, yet it requires extraordinary resources and the generous cooperation of thousands of different experts; it must be highly empirical and technical, yet sensitive to patients' moral and spiritual capacities. It can cause fear, greed, and hubris, but it can also be a powerful occasion for realizing God's own compassion, healing, and justice. □

NOTES

1. Willard Gaylin, "Faulty Diagnosis," *New York Times*, *June 12, 1994, section 4a, p. 1.*
2. Gaylin, p. 15.
3. H. Tristam Engelhardt, *The Foundations of Bioethics*, Oxford University Press, New York City, 1986, p. 354. See also Philip Keane, *Health Care Reform: A Catholic View*, Paulist Press, Mahwah, NJ, 1992, pp. 140-143, in which Keane cites Gene Outka's "Canons or maxims of distributive justice for health care: merit, social usefulness, ability to pay, need, and similar treatment for similar cases."
4. Andrew Greeley, "What Is Subsidiarity? A Voice from Sleepy Hollow," *America*, November 9, 1985, p. 292ff.
5. Gaylin, p. 1.
6. *Catechism of the Catholic Church*, Liguori Publications, Liguori, MO, 1994, n. 1,883.
7. Daniel Callahan, "Setting Limits: Medical Goals in an Aging Society," *Hastings Center Report*, October-November 1987.
8. Daniel Callahan, "Terminating Treatment: Age as a Standard," *Hastings Center Report*, October-November 1987, pp. 21-25 (excerpted from *Setting Limits: Medical Goals in an Aging Society*, Simon & Schuster, New York City, 1987).
9. Daniel Callahan, "High-Tech or Long-Term Care? Let the Elderly Decide," *New York Times*, June 12, 1994, p. 15; and "Aging and the Goals of Medicine," *Hastings Center Report*, September-October 1994, pp. 39-40.
10. Norman Paradis, "Making a Living Off the Dying," *New York Times*, June 12, 1994, section 4a, p. 4.
11. Thomas Aquinas, *Summa Theologica*, Benziger Bros., New York City, 1947, 2-2, q. 58, a. 1, citing Aristotle's *Ethics*, 8.11.
12. For a chilling description of the social consequences of this attitude, see Adam Walinsky, "The Crisis of Public Order," *Atlantic Monthly*, July 1995, pp. 39-54.
13. Charles M. Freeland, letter to the editor, *New York Times*, January 8, 1995, p. 22.
14. Engelhardt, p. 357.
15. *Catechism of the Catholic Church*, n. 1,906. See also Dennis McCann, "The Good to Be Pursued in Common," in Oliver Williams and John W. Houck, eds., *To Enhance the Common Good: An Introduction*, University Press of American, Lanham, MD, 1987, pp. 158-178.
16. Keane, p. 66.
17. Paul Waddell, *The Primacy of Love: An Introduction to the Ethics of Thomas Aquinas*, Paulist Press, Mahwah, NJ, 1992, p. 70.
18. See the U.S. bishops' "Resolution on Health Care Reform" of June 18, 1993: "We believe government, an instrument of our common purpose called to pursue the common good, has an essential role to play in assuring that the rights of all people to adequate health care are respected" (*Origins*, July 1, 1993, p. 100).
19. Paul Spector, "Failure, by the Numbers," *New York Times*, September 24, 1994, p. 18.
20. Engelhardt, p. 361.