The Common Good Calls for Balance, Limits

By JOHN W. GLASER, S.T.D.

"Indeed, we must love everyone equally, but since we cannot be of loving service to everyone equally, we should determine where we have greater responsibility."

ST. AUGUSTINE
De Doctrina Christiana

"Every gun that is made, every warship launched, every rocket fired, signifies in the final sense a theft from those who hunger and are not fed, those who are cold and are not clothed."

PRESIDENT DWIGHT D. EISENHOWER
1953 speech before the American Society of Newspaper Editors

These two wise observations, from vastly different eras and experiences, speak to us of an iron law of human existence — we live in a world of limits. Human choices are always hard choices, choices among good options, only some of which can be realized at the cost of forgoing other good options.

Cultures vary greatly in how much they make this harsh law part of their lived assumptions. U.S. culture tends toward mulish denial of this iron law. The author John Updike observed that America is a victim not of limits, but of dreams. He noted that for Americans, "There is no 'enough.' That's one of the words Americans have a very hard time learning — the word enough."[1]

In the interest of the common good, it is time for Catholic health ministry to move "facing limits" high on our agenda until it has become a central, lived element of our consciousness and conscience. Many other key elements of our justice agenda — universal coverage, reducing disparities, providing an adequate continuum of care —are directly related to our taking limits seriously. In the following pages, I look at limits through three windows: restraint on behalf of the common good, making hard choices and re-allocation of abundance. Each of these three windows gives an emphasis to different and complementary aspects of limits.[2]

Central to Catholic social morality is the idea of the common good. Especially in the U.S. context, the common good should always be closely yoked to the concept of human dignity in order to paint the full picture of person as social/individual. In Catholic discussions of health care, the principle of common good is critical but it has tended to be muted and marginal. Our usual starting point of health care analysis is human dignity. That is not sufficient, I believe. Without a balancing emphasis on the common good — the societal context of health care — the focus on dignity of the person can fuel our U.S. proclivities to an individualistic focus

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and an unsustainable set of health care aspirations. Without the social context of the common good, the platform of dignity of person can launch us on a trajectory of "more."

RESTRAINT FOR THE COMMON GOOD[3]

One might summarize the various Catholic descriptions of the common good in these words: the network of social conditions necessary for society itself and those groups and individuals in society to flourish. These social "goods" include: participation as a global citizen in the pursuit of peace and equity, public safety and security, a just legal system, a functioning political system, police and fire protection, maintained infrastructure, basic education, a healthy economy, comprehensive health care, employment, housing, clean air and water, safe products, food and drugs.

The common good requires that everyone in society have equitable access to these social goods. It recognizes that none of these social goods can be exhaustively realized. The goal is a balanced and sustainable presence of all goods at a level that provides an environment for social and individual flourishing.

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Princeton University economics professor Uwe Reinhardt, Ph.D., offers a four-decade historical perspective and further projection of this pattern of health care's prodigal behavior. Health care "spending has outpaced the growth in the rest of gross domestic product by 2.5 percentage points annually throughout the past four decades and has doubled every decade. At that rate, health spending will absorb 40 percent of GDP by 2050."[4]

Traditional health care — insurance, hospitals, doctors, medications, etc. — is far from the only factor determining the nation's health. NEHI, formerly called the New England Healthcare Institute, is an independent, nonprofit research organization based in Cambridge, Mass. In a 2009 report, the group said, "Research indicates that personal behaviors and environmental factors have a much greater impact on health status than access to health care. Indeed, health care alone, while critical at key points of illness or injury, accounts for only about 10 percent of overall health status, while lifestyle and environmental factors together account for about 70 percent."[5]

When health care pushes to the front of society's resource line with its insistent appetite, it causes social and economic disruption and inequity. Studies show that resources used to feed this appetite are drawn away, to a great extent, from other social goods — education, wages, infrastructure, social services and access to health care.[6]

Measured by the criterion of untimely deaths, many social factors have a remarkable impact on community health and a claim to resources for that purpose.

"For the population as a whole, the most consistent predictor of the likelihood of death in any given year is level of education; persons ages 45 to 64 in the highest levels of education have death rates 2.5 times lower than those of persons in the lowest level. Poverty, another strong influence, has been estimated to account for 6 percent of U.S. mortality. The observation also has been made that each 1 percent rise in income inequality (the income differential between rich and poor) is associated with something on the order of a 4 percent increase in deaths among persons on the low end."[7]

Catholic health ministry needs to make the common good much more a part of its self-understanding and self-assessment. We need to see health, health care and its cost in this larger social context. I believe that moral judgment, from the common good perspective, is something like this: Health care has, without intention or attention, been plundering the common good for decades. The time has come to awaken to this abuse of the common good and to hear the moral imperative of *restraint* on behalf of the common good, not *more*.

Possible topics to be explored:

- Deepening our understanding of the common good as an essential of Catholic social teaching
- Yoking the common good with dignity of person in our understanding and discussions of health care justice
- Being familiar with specific ways that U.S. health care has caused harm to the common good
- Seeing the need for policies and social structures that restrain inflation in service of the common good.
- Examining reform legislation in light of its support of the common good.

MAKING HARD CHOICES

Augustine's words at the beginning of this article say, in substance, to be human is to make hard

choices. Hard choices are not between good and evil. The budgeting process where we face a plethora of good options but must forgo many of them in order to realize the more important ones best illustrates hard choices. Augustine sees the basis of this steady diet of hard choices in our finitude. As finite creatures, we can never do all the good there is to be done; we can never avoid all the evil there is to be avoided. Every yes implies a thousand nos.

It is easy to overlook this constant rationing dimension of human existence just as it is easy to overlook our breathing and the grammar of our mother tongue — such givens of life become transparent through their constancy. Further, we have so many different names and settings for making hard choices — budgeting, goal setting, calendaring, agenda setting, long-range planning, rationing, etc. — that we can miss the identical substance common to them all. Every day bristles with hard-choice decisions that focus on a good to be achieved, often overlooking the many goods that must be sacrificed to realize this intended good. Your decision to read (and mine to write) this article rations our time, attention, and energy. This yes says multiple nos.

Though we cannot live without making hard choices, we can live without attending appropriately to them. Donald Berwick, MD, head of the federal Centers for Medicare and Medicaid Services, used the language of rationing to characterize such hard choices: "The decision is not whether or not we will ration care — the decision is whether we will ration with our eyes open. And right now, we are doing it blindly."

Making blind hard choices means saying yes and multiple nos without adequate attention to these trade-offs involved and their long- and short-term consequences. This comment points to a helpful moral distinction between hard choices that are just and those that are unjust.

We make just, hard choices with our eyes open. For example, every chief executive wants her budgeting process to be just — based on a deliberate, systematic process that derives from a larger fundamental vision. It must involve appropriate communities of discernment that can make the essential elements at stake vitally present to the process, but without bias and distortion. It must use decision-making infrastructure that matches the magnitude and complexity of the reality to be decided and is able to integrate centrifugal forces and diversity in service of the mission.

Unjust hard choices lack many or all of the essential elements needed for hard choices that are just. We can trace a major source of U.S. health care's dysfunction to our pattern of making hard choices of enormous proportions without the awareness and infrastructure to match the size and complexity of the task.

While hard choices are a constant of human existence, they fall on a continuum of magnitude and importance. Many of them require little energy and attention. But it is critical that the big, bodacious hard choices of organizations or society get corresponding awareness and infrastructure. It seems to me that Catholic health ministry does this very well on the level of our local ministries and our larger ministry systems. So it is surprising that we are not more aggrieved and advocating in the face of the chaotic approach to hard choices that characterizes the creation of U.S. health policy.

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Possible topics to be explored:

- Recognize the endless fabric of hard choices and its foundation in our reality as finite creatures
- Identify the many hard-choice activities that are involved in running a health care institution and their applicability for shaping policy
- Make essential to our discourse the distinction between just and unjust hard choices
- Deepen our familiarity with U.S. history of unjust hard choices and the severe consequences
- Identify the essential elements of just, hard choices
- Be familiar with those elements of recent reform legislation that move us toward and away from systems of hard choices that are just
- Increase our knowledge of how other developed nations have created structures of hard choices that are just[8]

RE-ALLOCATION OF ABUNDANCE

Reinhardt noted that U.S. health care has, for two generations, enjoyed an extraordinary curve of generous growth. Current pressures to constrain

the culture and habits acquired during these 40 years of feasting are likely to be experienced as the advent of famine and scarcity. Catholic social morality invites us to step back and recognize the abundance we enjoy. In the global framework, we live in extraordinary abundance and will benefit from owning this in our mindset and language.

But the allocation of this abundance occurred through many flawed hard choices and with scant awareness of its impact on the common good. There were multiple agents of these allocation decisions without a shared overarching vision and often with contradictory interests. Hence, we have inherited a network of allocation that often resembles a shelf full of medications prescribed for a chronically ill senior by dozens of non-communicating specialist clinicians.

Our allocation inheritance is a cobbled-together series of institutions and programs that are enormously expensive and often highly irrational and dysfunctional. For instance, instead of providing a health-oriented, full continuum of care that meets needs across a lifetime, we have orphaned prevention, mental health, dental health and long-term care. We have a federal program assuring care for every failing kidney in our nation, but we neglect mental health. We spend far more on administration of our services (our worst health investment) than we do on prevention (our best health investment).[9]

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Catholic social morality cautions us that the solution is not more resources but the re-allocation of our abundance. Health care is only one of many necessary social goods that weave the fabric of the common good, yet health care already consumes its share (many would argue, more than its share) of limited community resources. The social justice imperative is spend differently, not more.

This imperative faces Catholic health ministry with significant challenges. Most of our presence is in the acute, hospital-centric arena of health care. As the gaps in the continuum of care are gradually filled with re-allocated resources, the role of acute care must necessarily experience diminished dominance.

Possible topics to be explored:

- Develop a fundamental vision of health care that can win broad allegiance and guide a coherent system's allocation
- Be aware of the haphazard way our current allocation of health care resources came about
- Recognize how unstable, fragmented and biased our current agents of allocation are
- Apply lessons we learned from our institutional allocation successes to our national challenges of allocation
- Learn from other developed countries' successes in allocation

When Updike observed that "America is a victim not of limits, but of dreams," and that we bridle at the notion of "enough" and "limits," he was talking about more than public policy and legislation. Updike was pointing to our U.S. cultural anchors and our worldview. Priest-sociologist Fr. Andrew Greeley's observation about worldviews can inform our understanding and strategies: "[W]orldviews are not propositional paragraphs that can be explicated and critiqued in discursive fashion. Rather they are, in their origins and in their primal power, tenacious and durable narrative symbols that take possession of the imagination early in the socialization process and provide patterns which shape the rest of life."[10]

Taking up the challenge of limits in U.S. health care is about the evolution of a worldview — a "primal power, a tenacious and durable narrative symbol." Moving from the unrealistic hope of a disease-free future to the reality of a sustainable health system is much like our nation's movement to abolish child labor. This "children's crusade" involved a social movement on two levels. The deepest level was the transformation of community understanding and appreciation of childhood itself. This basic human reality of childhood had to be redefined and re-evaluated in the minds and hearts of the general public, who knew only the inadequate picture they had inherited. From this

transformed new appreciation of childhood could come the second level of social transformation — the dismantling of social structures that violated the new vision and the creation of new structures to support and nourish it. This social movement took five generations to accomplish.

Taking on limits in health care plunges us into an analogous cultural challenge. Bioethicist Daniel Callahan, Ph.D., says about such efforts to transform worldviews: "Trying to change modern scientific medicine and its health care offspring is like trying to shift and channel glaciers. But the effort is worth making, and if one generation fails, then another should take up the task."[11]

I believe that the time has come for Catholic health ministry to begin shifting and channeling the glaciers of limits, restraint, hard choices and re-allocation in health care. This difficult element is the deeper source of many of our other struggles. The vocation of Catholic health ministry, it seems to me, includes the healing of individuals and the healing of the larger culture and its structures, within which we struggle to heal as Jesus healed. I believe that we have the presence, the intelligence and the heart to provide such leadership on the societal and the personal level.

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NOTES

1. Dennis Farney, "Novelist Updike Sees a Nation Frustrated by its Own Dreams," *Wall Street Journal* (Sept. 16, 1992).
2. For a full and trenchant treatment of this issue, nothing compares to the writings of Daniel Callahan. See: *What Kind of Life: The Limits of Medical Progress* (Washington, D.C.: Georgetown University Press, 1995); *False Hopes: Why America's Quest for Perfect Health Is a Recipe for Failure* (New York: Simon and Schuster, 1998).
3. Pope John XXIII, 1963, *Pacem in Terris* No. 11; and David Hollenbach, *The Common Good and Christian Ethics* (Cambridge, U.K.: Cambridge University Press, 2002); and David Hollenbach, "Common Good," in *The New Dictionary of Catholic Social Thought* by Judith Dwyer, (Collegeville, Minn.: The Liturgical Press, 1994) 192-97.
4. Uwe Reinhardt, "A Good Start," *The Wall Street Journal*, (Jan. 20, 2010).
5. NEHI, *Healthy People in a Healthy Economy: A Blueprint for Action in Massachusetts*, June 30, 2009 www.nehi.net/publications/41/healthy_people_in_a_healthy_economy_a_blueprint_for_action_in_massachusetts; J. Michael McGinnis, Pamela Williams-Russo and James R. Knickman, "The Case for More Active Policy Attention to Health Promotion," *Health Affairs* 21, no. 2 (March 2002): 278-93.
6. David Blumenthal, "Controlling Health Care Expenditures," *New England Journal of Medicine* 344 (March 8, 2001):766-69; Ezekiel Emanuel, Victor Fuchs, "Who Really Pays for Health Care? The Myth of Shared Responsibility" *JAMA* 299 no. 9 (2008): 1057-59.
7. McGinnis, "The Case for More Active Policy," 281.
8. The Commonwealth Fund, *Comparative Effectiveness Research and Evidence-Based Decision-Making across Four Countries: The U.K., Germany, France and Australia* (2009).
9. Steffie Woolhandler, Terry Campbell and David U. Himmelstein, "Costs of Health Care Administration in the United States and Canada," *New England Journal of Medicine* 349 (Aug. 21, 2003): 768-75; Uwe Reinhardt, "The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy," *Health Affairs*, 25 (January 2006): 157-69; Uwe Reinhardt, "Indefensible Administrative Costs," New York Times blog http://economix.blogs.nytimes.com/2008/11/21/why-does-us-health-care-cost-so-much-part-ii-indefensible-administrative costs/?scp=2&sq=Uwe%20Reinhardt&st=cse.
10. Andrew Greeley, *The Catholic Imagination* (Berkeley: University of California Press, 1985).
11. Callahan, *False Hopes*: 19.

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