



Ethical Perspectives On Health Care Reform

THE INDIVIDUAL MANDATE

A Rancorous Moral Matter

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More than a year after the passage of the Patient Protection and Affordable Care Act, the nation still seems to be evenly divided, with 41 percent supporting it, 41 percent opposing it and 18 percent undecided.¹ Probably no provision of the act generates more rancor and resistance than the individual mandate.² This particular provision, which is scheduled to go into effect in 2014, requires almost all Americans³ who do not receive health insurance from their employer⁴ to purchase health insurance or pay an annual tax penalty.⁵

Section 1501 of the Affordable Care Act describes the individual mandate in this way: “An applicable individual shall ... ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage.” It goes on to say that if “a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable, fails to meet the requirement ... there is hereby imposed on the taxpayer a penalty with respect to such failures.”

Sentiment against the provision has been so strong that immediately after the legislation’s passage, 13 states filed lawsuits challenging the constitutionality of the requirement. Since then, other states have joined the lawsuit for a total of 26.⁶ At least 41 state legislatures are considering or have considered legislation that would limit, alter or oppose selected state or federal actions related to the Affordable Care Act, including single payer provisions and mandates to purchase insurance.⁷ As of this writing, five courts have ruled on the constitutionality of the act — three in support and two against — and one U.S. court of appeals has agreed that the mandate is constitutional. One other appeals court is still considering the case.

Legal opposition to the mandate centers on its constitutionality, that is, whether the U. S. Constitution’s Commerce Clause grants Congress the power to require people to engage in a commercial act (i.e., purchase health insurance) against their will, as well on its seeming infringement on states’ rights.⁸ Some argue in addition that mandates are

ineffective, inefficient and unenforceable. But perhaps more than anything else, the individual mandate is viewed as an assault on individual liberty, a curtailment by the federal government of autonomy and personal choice, values central to the American political experience. The mandate seems to touch issues that are very deep in the American psyche.

Most discussions of the individual mandate focus on its legal dimensions, and the debate will likely be resolved by the U. S. Supreme Court. But the mandate is not only a legal matter — at its core, it is also a moral matter.

THE WHAT AND WHY

Because a majority of Americans are opposed to a single payer system and because there was so much opposition to a public option, the health care reform initiative is largely built upon the existing structures of our health care system, including private insurance companies. Furthermore, our current health insurance system is purely voluntary. No one is required to purchase health insurance (even though it is offered by most employers). People purchase it only if they want to and can afford to, in the belief that they will benefit from it.

A significant portion of the American public does not carry health insurance, currently approximately 50 million people. These individuals fall into two major groups — those who cannot afford it, and those who can afford it, but decide to put their resources elsewhere.

Among the former are those who are truly poor. They must decide between health insurance and other basic necessities like food, clothing, shelter, transportation and education. Among the latter are those who are young and healthy and simply believe they do not need health insurance. They *choose* not to insure.⁹ This group of “voluntary opt-outs” may believe that the costs of insurance are greater than the benefits they would receive.

There are also those who decide not to spend their resources on health insurance, knowing that if they become ill or injured, they will receive care even if they are uninsured and, quite often, in doing so, they end up transferring costs to others. Society picks up the costs, estimated to be \$49 billion a year, as reported in a Health and Human Services study released in May 2011.¹⁰

Given these two realities — health reform built upon private insurance companies and the health insurance system being purely voluntary — the individual mandate helps achieve at least two major goals. First, it promotes one of the most important objectives of the reform initiative, namely, universal coverage. By requiring almost every American citizen to carry health insurance, approximately 32 million more Americans will be covered. Presumably, this will benefit individuals and communities in a number of ways (better health, increased productivity, etc.), will reduce the costs of insurance for all and will reduce the costs to health care organizations and society of uncompensated care.

MORAL, FINANCIAL FACTORS

While these consequences of the mandate are extremely important drivers, perhaps the most important drivers are ethical in nature. The mandate helps promote justice, (fair distribution of a critical social good), solidarity (the sense that we are in this together and ought to be of assistance to one another in times of need) and, ultimately, the common good (the flourishing of all members of society and of society as a whole).

Second, the mandate helps to protect insurance companies against adverse selection, that is, the disproportionate enrollment in insurance plans of people with higher-than-average health risks. People who think they will need health insurance at some point will typically purchase it if they can afford it. But that means that the insurance pool is made up of high-risk individuals

who could be very costly to insurance companies. This reality contributes to several self-protective practices by the health insurance industry that the Affordable Care Act has prohibited — excluding coverage for pre-existing conditions, dropping coverage for technical reasons, lifetime caps on benefits and the like.

In addition, adverse selection leads to high premiums. The prohibition of these practices, along with requiring insurance companies to continue covering children on their parents’ policy until age 26,¹¹ could, it is believed, put a strain on the insurance industry.

Requiring the uninsured, especially the “voluntary-opt-outs,” to purchase health insurance is necessary for the financial viability of the health insurance market. Young and healthy individuals are needed to balance out higher risk individuals who are likely to become ill and who will be more costly to insurance companies. The presence of

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large numbers of young and healthy individuals in the insurance pool should lower premiums for all and provide funding for various provisions of the Affordable Care Act.

In essence, what the individual mandate effects by converting the uninsured into health insurance policyholders is financing of health care for the sick by those who are healthy, what one author calls “health redistribution.”¹²

“When the mandate compels the 17 million voluntary opt-outs to buy insurance, they not only become consumers of health insurance, many will also become financiers of health care for others,” she writes.¹³ Many if not most of these individuals are likely to pay premiums that are greater than what they will consume in care.¹⁴ Hence, some part of their premiums will pay for others’ medical expenses. However, for a likely majority, their investment may well pay off at a time when they are sick and consume more health care than what they pay in premiums.¹⁵ Ethical considerations again play a role here.

Justice (in the sense of everyone contributing their fair share to society), the common good,

good stewardship of resources and solidarity all provide solid ethical justifications for an individual mandate.

CONSTITUTIONAL FACTORS

A word should be said about the constitutional issue, since that will likely be how this matter is ultimately resolved. The constitutional issue revolves around whether Congress has the authority to require uninsured individuals who can afford health insurance to purchase it, and penalize them through income taxes for failing to buy it.¹⁶

Congress's authority is both determined and limited by the Constitution. The federal government has argued that the individual mandate is supported by three delegated powers — the powers to tax, to regulate interstate commerce and to adopt laws that are “necessary and proper” for effectuating other powers.¹⁷ Article 1, section 8 of the U.S. Constitution gives Congress the power to regulate commerce. Is requiring individuals to purchase health insurance when they otherwise could not or would not to be considered “regu-

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lating commerce”? The administration believes that it is. Choosing not to purchase health insurance for whatever reason is an economic decision that has an economic impact on others — families (dipping into savings, loans, bankruptcies), hospitals (use of emergency departments, uncompensated care), insurance companies (adverse selection, the need for higher premiums, restrictions imposed on those with or needing insurance), people purchasing insurance (higher premiums), and society at large (higher taxes, higher costs for health care, higher premiums).¹⁸ All of these, it is believed, have a cumulative effect on interstate commerce.

With regard to the tax penalty, the Constitution allows Congress to tax, in part, “for the general welfare.” Many constitutional scholars and lawyers believe that the tax levied on those who refuse to purchase health insurance is constitutional for several reasons having to do with the general welfare.¹⁹ First, it helps to pay for the costs of the Affordable Care Act.²⁰ Second, by giving

the uninsured incentive to join the national risk pool, the tax helps lower premiums for all²¹ and helps Congress to more effectively regulate the health insurance industry.²² Whether or not the courts find the administration's legal arguments convincing remains to be seen. However, as a nation, we would fall immeasurably short if we did not also consider the ethical dimensions of the mandate.

AUTONOMY IN CONTEXT

As we move to ethical considerations, we acknowledge the centrality of autonomy. However, contrary to what is often portrayed, the principle of autonomy is a qualified value in American bioethics. The major text used in most medical school and university bioethics courses acknowledges that this principle properly understood “is not excessively individualistic (thereby neglecting the social nature of individuals and the impact of individual choices and actions on others), not excessively focused on reason (thereby neglecting the emotions), and

not unduly legalistic (thereby highlighting legal rights and downplaying social practices and responsibilities).”²³

Similarly, Willard Gaylin and Bruce Jennings, both associ-

ated with the Hastings Center for Bioethics in Garrison, N.Y., have discussed the limits of the principle by suggesting that “autonomy gives individuals a moral liberation from the authority of preexisting rules, roles, and relationships, from inherited and imposed obligations, and from social controls,” but ask “will individuals so liberated neglect the moral relationships that remain essential to the human good?”²⁴

Thus, although some argue that the principle of autonomy does not support the individual mandate, others maintain that the principle itself needs to be placed into a larger context of relevant values. As might be expected, the Catholic social justice tradition is one source of such a more complete understanding. More interestingly, however, is the possibility that a richer understanding of the spectrum of American public values likewise lends support to the individual mandate.

CATHOLIC SOCIAL PRINCIPLES

The Catholic social justice tradition and the un-

derstanding of natural law upon which the tradition is founded affirm that the human person is inherently social. The true good of the person is realized only within community: “The fulfillment of human persons occurs in relationships of love, communion, and solidarity both with God and with other human beings.”²⁵ In the almost 50 years since the Second Vatican Council, the Catholic Church has come to understand the common good as “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.”²⁶ Pursuit of the common good, then, “demands full respect for the many different forms of interrelationship and community in which human beings achieve their good in history.”²⁷ Within this larger context of the common good, certain social principles stand out. Chief among these are the principles of solidarity, subsidiarity and the preferential option for the poor and vulnerable.

Solidarity derives from “the intrinsic social nature of the human person, the equality of all in dignity and rights, and the common path of individuals and peoples towards an ever more committed unity.”²⁸ Pope John Paul II described it as “a firm and persevering determination to commit oneself to the common good,” based on the understanding that “we are all really responsible for all.”²⁹ Solidarity emphasizes the concern for the larger community in which one finds oneself and the sense of mutual responsibility of all members within the larger community.

This understanding of solidarity as commitment to the common good has direct relevance to the issue of the individual mandate. In 1994, Cardinal Joseph Bernardin enunciated several convictions arising from a vision of the human person as “someone who is grounded in community.” Among them are:

- The existence of basic goods and values that we human beings share because we share the gift of human life
- These common goods and values express themselves in an inalienable human dignity, with consequent rights and duties
- One of the ways these rights and duties are expressed is through the recognition and pursuit of the common good, a good that ultimately is more important than the good of any individual

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- This common good is realized in the context of a living community, which is nurtured by the virtues and shared values of individuals

- As part of this community, both individuals and institutions have an obligation, which is rooted in distributive justice, to work to secure this common good.³⁰

A particular form that the principle of solidarity takes is that of the preferential option for the poor and vulnerable. Echoing the 25th chapter of Matthew’s Gospel, the tradition emphasizes that what one does for the least of one’s sisters or brothers one does for Christ — and what one refuses to do for the least in society one refuses to do for Christ. The notion of the “preferential option for the poor” obliges one to acknowledge that care for the poor is “a special form of primacy in the exercise of Christian charity, to which the whole tradition of the Church bears witness.”³¹ It demands that one evaluate alternatives in light of God’s special relationship to the poor and disadvantaged. To ignore this, Pope John Paul II maintained, “would mean becoming like the ‘rich man’ who pretended not to know the beggar Lazarus lying at his gate.”³²

A final principle to analyze is that of subsidiarity. This principle has been used by some within the Catholic community to support a vision that would see the individual mandate as problematic.³³ A deeper understanding of the principle, however, shows that this is not the case. The idea of subsidiarity was developed within the church in the early 20th century to illustrate that the tasks of any society should be accomplished at the lowest possible level, the level as close as possible to the people involved. Larger orderings of society should not take over what is properly the responsibility of more local groupings. Rather, the larger entity should aid and support them.³⁴ Fr. Ken-

neth Himes, OFM, of Boston College has shown however that this principle does not come from a libertarian perspective (“those who govern best govern least”) but rather from a communitarian one. As he suggests, “it would appear that needs

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are best understood and satisfied by people who are closer to them and who act as neighbors to those in need.”³⁵ Subsidiarity acknowledged that various tasks of a society need to be taken up as close to the people involved as possible, but nevertheless at the level large enough to be effective. Again, the principle of subsidiarity properly understood does not necessarily lead to a rejection of the individual mandate.

This is especially true when one takes into consideration what the United States Conference of Catholic Bishops has written regarding the relation between the right to adequate health care and the obligation this brings to others. Two decades ago, during the debate on the Clinton health reform package, the bishops passed a resolution that reiterated that “every person has a right to adequate health care.” They added that “this flows from the sanctity of life and the dignity that belongs to all human persons, who are made in the image of God.”³⁶ Describing the importance of the common good, the bishops emphasized the danger of too much individualism: “We fear the cause of real reform can be undermined by special interest conflict and the resistance of powerful forces who have a major stake in maintaining the *status quo*.”³⁷ Showing the tension between these two poles, they concluded their resolution with the words:

“New public policy is essential to address the health care crisis, but it is not sufficient. Each of us must examine how we contribute to this crisis — how our attitudes and behavior demonstrate a lack of respect for our own health and the dignity of all. Are we prepared to make the changes, address the neglect, accept the sacrifices, and prac-

tice the discipline that can lead to better health care of all Americans? In our own lives and in this vital health care debate, we are all called to protect human life, promote human dignity, and pursue the common good.”³⁸

The Catholic Health Association’s “Vision for U.S. Health Care,” first published in 2007, is itself a product of the Catholic social justice tradition. Its core values include human dignity, concern for the poor and vulnerable, justice, the common good, stewardship and pluralism. CHA used these values to argue for a health care system that is fairly financed. In ana-

lyzing the Affordable Care Act in light of these values, it recognized that the individual mandate was consistent with CHA’s core commitments since it “helps to spread the costs of coverage and care across stakeholders including individuals, employers, providers, insurers, suppliers and government.”³⁹

Although the Catholic social tradition would also acknowledge other appropriate ways to promote the common good in health care, its basic values do support the individual mandate.

UNDERSTANDING AMERICAN VALUES

One can also find support for the individual mandate in the spectrum of basic values that are part of American culture. Even though many discussions regarding the individual mandate devolve into a debate regarding a libertarian understanding of autonomy and choice, professional and civic discussions prior to the passage of the Affordable Care Act articulated a much broader framework of American values. Two such discussions in particular suggested an array of values rather similar to those expressed by the Catholic social tradition. They are the Institute for Ethics at the American Medical Association (AMA) and the Hastings Center.

Several years before the passage of the Affordable Care Act, the members of the Ethical Force Program of the AMA’s Institute for Ethics offered an ethical framework for improving access to health care (or at least health care coverage).⁴⁰ The project articulated four ethical obligations:

- Every member of society must have an adequate array of core health care benefits

■ The contents and limits of health care benefits must be established through an ethical process

- The health care system must be sustainable
- The health care system must ensure that its stakeholders have clear responsibilities for which they are responsible⁴¹

The authors of the report grounded these ethical considerations in equality of opportunity, justice and compassion.⁴² Although the first two values are common in such public policy discussions, the value of compassion is not. The authors justified their inclusion of this value in a report to the AMA:

Although the goals of organizational efficiency and social utility may sometimes compete with the goal of responding to individual needs and values, the moral sensitivity of individuals within health care organizations should foster a corporate sense of obligation to be responsive. Compassion is an innate human emotion, which creates an undeniable “rule of rescue” among us. ... A compassionate health care system can create a sense of security for members of society, who are reassured that special efforts will be made to help any member who falls victim to the extremes of illness.⁴³

They went on to explain that “compassion is especially pertinent because it calls on organizations to focus attention specifically on the needs of vulnerable populations and the ethical obligations that every participant in health care holds towards ensuring their fair treatment,” and concluded that “a system that does not protect its most vulnerable patients is failing medically, ethically, and socially at the most fundamental levels.”

It is instructive that the members of the AMA’s Ethical Force Program found it necessary to ground their argument not only in the traditional principles of equality and justice but also in a value that is based on inter-relationship and to articulate the need for “a corporate sense of obligation.” Clearly these values underlie the individual mandate and move the discussion away from a focus simply on autonomy and individual choice.

Similarly, in 2009 the Hastings Center published a short study demonstrating that the spectrum of core American values supports health care reform.⁴⁴ Although the study pre-dated the current debate concerning the individual mandate, the study’s introduction explained: “The core idea is simple enough: everyone should be responsible for participating in whatever way is appropriate; when anyone needs health care that is reasonably effective and not financially ruinous, the care will be there for them.”⁴⁵ The study consists of 11 short essays, each written by a different ethicist and each analyzing a particular core value.⁴⁶

Eight of the 11 essays address the values involved in the debate around the individual mandate more or less explicitly. We will touch upon five of these values: liberty, fair sharing, solidarity, privacy and stewardship. In his essay on liberty, for example, Bruce Jennings distinguishes negative liberty from positive liberty and suggests that too often we concentrate solely on negative liberty. Rather, he says, “the positive, relational, and enabling side of liberty is what links it to equity.” The essay concludes that “Positive liberty reminds us that no single individual, no matter how wealthy or powerful, can really be free except in a context of social justice and the common good.”⁴⁷ Paul Menzel describes the principle of fair sharing and maintains that “feasible access to insurance for the people who most need it suffers greatly when voluntary insurance that permits the healthiest to go without combines with wide latitude for insurer strategies to recruit optimal subscribers. ... People who want to postpone insurance, thinking

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its expense to be a poor bargain given their current good health, should not be allowed to pick their time to get insured. To receive benefits in times of crisis, people need to pay in all along.”⁴⁸

William Sage addresses the issue head on with his essay on solidarity. He argues that, although the term is currently out of vogue, “many strands of social solidarity exist in American health poli-

cy.” He pleads that “‘medical individualism’ cannot be allowed to paralyze the debate.”⁴⁹ Even Lawrence Gostin’s essay on privacy offers support for the policy regarding the individual mandate. He contends that understanding privacy as synon-

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ymous with strict individual control “defies common sense” and concludes “allowing each person to make her own decisions in ways that disrupt the common good causes a deep social problem.”⁵⁰

The final essay in the study is devoted to stewardship, and in it, Len M. Nichols directly confronts the libertarian basis of much of the opposition to the individual mandate and answers that “nothing ... has ever been more profoundly wrong.”⁵¹ Stewardship, he maintains, challenges political, economic and health care leaders to ensure that our health care system serves all in a manner that will also ensure its long-term sustainability. He urged the government to regulate the insurance industry in much the same manner as what was accomplished by the Affordable Care Act: “We should require all insurers to end discrimination based on health status and all individuals to purchase insurance (or enroll in a public program for which they’re eligible).”⁵²

The above examples demonstrate that the Catholic social tradition and a robust understanding of the values that are the foundation of American culture both offer support for the individual mandate.

CONCLUSION

There is considerably more at stake in the Affordable Care Act’s requirement of an individual mandate than providing a mechanism for achieving universal coverage, funding aspects of the law, maintaining stability in the health insurance market and lowering the costs of health insurance for all. Ethically, what is at stake is also a choice about the values that will contribute to defining American society. A rejection of the individual mandate solely because it impinges on individual freedom and choice would seem to reinforce a caricature

of American individualism and weaken a sense of responsibility for oneself and fellow citizens. It neglects one side of the equation, forgetting that we are not only individuals with the freedom to choose, but also members of a society called to

uphold the common good.

As such, we do have responsibilities to others as well as a responsibility to contribute to shaping our society so that all our fellow citizens can benefit and flourish.

The individual mandate, even though government imposed, can help foster and realize values that are deeply rooted in American culture and the Judeo-Christian tradition. The individual mandate may not be the perfect or the ideal instrument for achieving the goals of health care reform, but, nonetheless, viewed ethically, it seems to resonate with the best of our cultural and religious traditions and seems capable of achieving considerable good for all Americans and for American society. The individual mandate asks “Americans to stand in others’ shoes to recognize a common plight and to help create security for everyone against the costs of poor health.”⁵³

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NOTES

1. Kaiser Family Foundation, “Views on Health Reform Remain Divided,” www.facts.kff.org/chart.aspx?ch=1456.
2. The individual mandate is not unique to the United States. Germany, Israel, the Netherlands and Switzerland also employ it.
3. Native Americans, some religious groups and prisoners do not need to purchase health insurance under the mandate. In addition, it excludes dependents, persons receiving Medicare and Medicaid, military families, persons living overseas, persons with religious objections and, obviously, persons who have insurance.
4. The individual mandate applies to the uninsured that make up approximately 16-17 percent of the non-elderly population. See Allison K. Hoffman, “Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform,” *American Journal of Law and Medicine* 36 (2010): 7-77, at 17-18. This is perhaps one of the most thorough and insightful analyses of the

individual mandate.

5. In 2014, the penalty is either \$95 for every adult and \$47.50 for every child under the age of 18 in the household or 1 percent of taxable income for the household, whichever is larger; in 2015, the penalty is \$325 for every adult and \$162.50 for every child or 2 percent of taxable income, whichever is larger; and in 2016, the penalty is \$695 for every adult and \$347.50 for every child or 2.5 percent of income, whichever is higher. After 2016, the penalty increases annually by the cost-of-living adjustment.

6. "The States' Lawsuit Challenging the Constitutionality of the Health Care Reform Law," at www.healthcarelawsuit.us/.

7. Timothy S. Jost, "State Lawsuits Won't Succeed in Overturning the Individual Mandate," *Health Affairs* 29, no. 6 (2010): 1227. See also, Richard Cauchi, "State Legislation and Actions Challenging Certain Health Reforms, 2011," National Conference of State Legislatures at www.ncsl.org/?tabid=18906. This article provides detailed information regarding the outcomes of these state legislative initiatives. It also offers a summary of the various court cases.

8. At the time of this writing, the 4th U.S. Circuit Court of Appeals is hearing a case brought by the Commonwealth of Virginia and Liberty University of Lynchburg, Va., challenging the 2010 health care law. Virginia filed its own lawsuit rather than join the other 26 states. A panel of three appeals judges from the U.S. Court of Appeals for the 6th District has been named to hear a case filed by the Thomas More Law Center of Ann Arbor, Mich. They were scheduled to begin hearing oral arguments on June 1, 2011, in Cincinnati.

9. Hoffman, p. 19. Hoffman points out that studies estimate as many as 17 million uninsured Americans are "voluntary opt-outs," and that this group is growing faster than the low-income uninsured.

10. U.S. Department of Health and Human Services, "The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Potential Hospital Bills." aspe.hhs.gov/health/reports/2011/ValueofInsurance/rb.shtml.

11. Elizabeth Mendes, "Fewer 18- to 26-Year-Olds in U.S. Uninsured in 2011." A 2011 Gallup poll indicated that 24 percent of Americans aged 18 to 26 were uninsured in January through April of 2011, down from 28 percent in 2010, and fewer than in 2009 and 2008. www.gallup.com/poll/147422/Fewer-Year-Olds-Uninsured-2011.aspx.

12. Hoffman, 11, 32-46.

13. Hoffman, 20.

14. Hoffman, 21.

15. Hoffman, 21.

16. Lawrence O. Gostin, "The National Individual Health Insurance Mandate," *Hastings Center Report* (September-October 2010): 8.

17. Timothy S. Jost, "Can Congress Regulate 'Inactivity' (and Make Americans Buy Health Insurance)?" *New England Journal of Medicine* 364, no. 9 (March 3, 2011): 870.

18. Jost, "State Lawsuits," 1228. See also, Jack M. Balkin, "The Constitutionality of the Individual Mandate for Health Insurance," *New England Journal of Medicine* 362, no. 6 (February 11, 2010): 483 and Gostin, "Individual Mandate," 9.

19. Jost, "State Lawsuits," 1227.

20. Balkin, 482. See also Gostin, "Individual Mandate," 9.

21. Balkin, 482.

22. Balkin, 483.

23. Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, Sixth Edition (New York: Oxford University Press, 2009), 99.

24. Gaylin and Jennings, 81.

25. David Hollenbach, *The Common Good and Christian Ethics* (New York: Cambridge University Press, 2002), 130. Hollenbach bases his analysis on the work of Jacques Maritain.

26. Second Vatican Council, *Gaudium et Spes*, par. 26.

See also Pope John XXIII, *Mater et Magistra*, par 65.

27. Hollenbach, 136.

28. Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church* (Vatican City: Libreria Editrice Vaticana, 2005), par 192.

29. Pope John Paul II, *Sollicitudo Rei Socialis*, par 38.

30. Cardinal Joseph L. Bernardin, *The Seamless Garment: Writings on the Consistent Ethic of Life* (Maryknoll, N.Y.: Orbis books, 2008), 241.

31. *Sollicitudo Rei Socialis*, par 42.

32. *Sollicitudo Rei Socialis*, par 47. See Luke 16:19-31.

33. See, for example, the Catholic Medical Association's statement, "Health Care in America: A Catholic Proposal for Renewal," September, 2004. <http://www.cathmed.org/assets/files/CMA%20Healthcare%20Task%20Force%20Statement%2009.04%20Website.pdf>.

Although the statement was written prior to the debate regarding the individual mandate, it would be an example of what the paper condemns as "socialist" systems.

34. See Pope Pius XI, *Quadragesimo Anno*, par 80.

35. Kenneth Himes, "The New Social Encyclical's Communitarian Vision," *Origins* 21, 10 (August 1, 1991): 168.

36. USCCB, "A Framework for Comprehensive Health Care Reform: Protecting Human Life, Promoting Human Dignity, Pursuing the Common Good," in Patrick W.

- Carey, ed., *Pastoral Letters of the United States Catholic Bishops*, Volume VI, 1989-1997 (Washington DC: USCCB, 1998), 519.
37. USCCB, 524.
38. USCCB, 525.
39. Catholic Health Association, "Realizing Our Vision for U.S. Health Care," (St. Louis: Catholic Health Association, 2010), 9.
40. Mark A. Levine et al., "Improving Access to Health Care: A Consensus Ethical Framework to Guide Proposals for Reform," *The Hastings Center Report* 37, 5 (September-October, 2007): 14-19.
41. Levine et al, 16-17.
42. Levine et al, 15.
43. The Ethical Force Program, "Ensuring Fairness in Health Care Coverage Decisions," www.ama-assn.org/ama1/pub/upload/mm/369/finalbenefitsreport.pdf.
44. Thomas H. Murray et al, *Connecting American Values with Health Reform* (Garrison, NY: The Hastings Center, 2009).
45. Thomas H. Murray, "Values: The Beating Heart of Health Reform," in *Connecting American Values with Health Reform*, iii.
46. The values studied are: liberty, justice and fairness, responsibility, solidarity, medical progress, privacy, physician integrity, quality, efficiency, health, and stewardship.
47. Bruce Jennings, "Liberty: Free and Equal" in *Connecting American Values with Health Reform*, 3.
48. Paul T. Menzel, "Justice and Fairness: Mandating Universal Participation," in *Connecting American Values with Health Reform*, 5.
49. William M. Sage, "Solidarity: Unfashionable, but Still American," in *Connecting American Values with Health Reform*, 12.
50. Lawrence O. Gostin, "Privacy: Rethinking Health Information Technology and Informed Consent," in *Connecting American Values with Health Reform*, 17.
51. Len M. Nichols, "Stewardship: What Kind of Society Do We Want?" in *Connecting American Values with Health Reform*, 30.
52. Nichols, 32.

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