

HEALTH CARE IN AMERICA: A CATHOLIC PROPOSAL FOR RENEWAL
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The Light Obscured: Mis-insurance and a Missing Relationship

A crisis exists in American health care. This crisis transcends, indeed it explains, the crisis of coverage. In the United States in 2002, an estimated 43.6 million people lacked health insurance coverage during some part of the year, 60 percent of them for the entire year.¹ However, the number of Americans who are mis-insured -- who work but cannot obtain coverage, who cannot obtain coverage that matches the varying needs of the life cycle, or, most important, who cannot obtain coverage that accords with their fundamental moral beliefs -- is far larger. Indeed, it can be said that the mis-insurance of America, defined as the systematic, inequitable and unjust allocation of public and private resources for health purposes, is a near-universal phenomenon.²

Just as cogently, the crisis in American health care is more than the crisis of the insured and uninsured. It is a crisis afflicting the patient-physician relationship, which has been eroded by factors that include the financing of health care, but that are more properly understood as having their root in the loss of a common understanding, within and without the medical profession, of the sanctity and inviolability of each human life.

In the United States, this erosion is now decades-advanced, and in key respects it is deepening. For millennia, the guiding ethic of the physician was captured in the Hippocratic Oath, a statement of both positive obligation and moral proscription, epitomized by its strict injunctions against acts of abortion and euthanasia. More than this, the Oath carried with it notions of both justice and charity in the care of the sick.³ Secular in its underpinnings, it nonetheless reflected in thought and form a sense of medicine, much as the Charter for Health Care Workers expresses it, as “a meeting between trust and conscience.”⁴

Since 1964 the clarity of the classical Oath has been gradually displaced, in many U.S. medical schools, by the subjective terms of a modern restatement.⁵ Omitting all reference to the moral proscriptions, the restatement, for example, acknowledges the physician’s “power to take a life” but describes it only as an “awesome responsibility [that] must be faced with great humbleness and awareness of [the physician’s] frailty.” By 1993 displacement of the classical Oath and the unbroken tradition it represented was nearly complete. In that year only 8 percent of new physicians swore not to commit abortions, and only 14 percent forswore the practice of euthanasia.⁶ There is little reason to believe that the numbers have changed markedly since, though it should be acknowledged that many physicians who did not take the Oath do observe its precepts.

The institutional collapse of the Hippocratic ethic, accelerated by decisions of legislatures and courts, affects not only the patient-physician relationship, but also the entire health care system and the thickening nexus of laws and regulations that govern it. In modern society, medical expertise is deployed throughout not only health institutions

but also health policy-making bodies, including accrediting organizations, institutional review boards, health management organizations, federal, state and local agencies, insurance companies, medical associations, and task forces. The compromised conscience of individuals quickly becomes the compromised standards of law, public policy, and private practice. The evidence of this revolution in ethics is now daily news:

- The number of governmental mandates requiring health insurers to provide coverage for contraceptives, including abortifacient drugs and devices, is growing. In 1999 the U.S. Congress adopted an Equity in Prescription Insurance Contraceptive Coverage (EPICC) law requiring all insurers participating in the Federal Employees Health Benefits Program (FEHBP) to cover all FDA-approved contraceptives. The law exempts only religious organizations, illegitimizing the exercise of moral conviction by private insurers.⁷ Some 21 states now have similar EPICC mandates. As a consequence, according to a new study released by Planned Parenthood's research arm on June 15, 2004, the percentage of employer-sponsored health plans covering these drugs and devices grew from 28 percent in 1993 to 86 percent in 2002.⁸ Pressure is mounting for passage of an expanded EPICC statute at the federal level to require coverage for women in the 29 states without mandates and in self-insured plans. Avenues of escape from these intrusions on conscience are closing.
- On March 1, 2004, the California Supreme Court, applying, in part, the Supreme Court decision in *Employment Division v. Smith*, voted 6-1 to uphold a state law that has had the effect of requiring Catholic Charities and other church agencies in the state to provide contraceptive and abortifacient coverage to their employees. In dissent, Justice Janice Rogers Brown wrote accurately that the statute reflected "such a crabbed and restrictive view of religion that it would define the ministry of Jesus Christ as a secular activity."⁹ As a consequence of the decision, Catholic agencies face an intolerable choice between 1) abrogating conscience by providing for birth control injections, pills, IUDs, and "morning-after" pills to children without parental consent and/or knowledge; or 2) subverting the common good of the insured by dropping prescription coverage altogether.
- Mandatory and often preferential taxpayer support of contraception, sterilization, genetic screening and abortion permeates federal and, to a lesser extent, state programs, entangling Catholic workers and families in support of policies, directed even against their own children, that violate their conscience. Federal programs that subsidize and extend such practices number in the dozens, and funding for them has grown under Administrations of both major political parties. At the state level, while 45 states allow some health care entities to decline to provide abortions, only 11 states afford the same protection regarding contraception and only 16 regarding sterilization.¹⁰
- The federal-state Medicaid program obliges coverage of abortions in the cases of endangerment to the life of the mother, rape and incest, essentially establishing national policy. Seventeen states go further and provide taxpayer funds for virtually all abortions for women enrolled in these state medical assistance plans. Thirteen of these 17 states do so under court orders imposed under interpretations of state constitutional

provisions, rendering them immune to any potential changes in federal law to make them more protective of poor mothers and their unborn children. Taxpayers have thereby been traduced into paying for an estimated one of every seven abortions performed in the United States today.¹¹

- The State Child Health Insurance Program, enacted in 1997, allocated \$48 billion in federal money to the provision of health insurance coverage for the children of working families. Although not required to do so by Congress, most states allow S-CHIP programs for children to pay for birth control injections, pills, IUDs, “morning-after” pills, and abortion in the case of rape, incest or life of the mother, without parental knowledge. In this context, as in the context of surgical abortion, where the law is similarly intrusive by judicial decree, the family, the “sanctuary of life”¹² is doubly invaded.
- With increasing frequency, pharmacists are facing charges of unprofessional conduct or being dismissed for acting on their convictions by refusing to fill birth control prescriptions or distribute the “morning after” pill. Some pharmacy chains have striven to accommodate the moral beliefs of their personnel, while others have expressed their determination to ensure that their customers “promptly receive all medications for which they have a lawfully written prescription.”¹³ To date, only two states have passed laws affirmatively protecting the right of pharmacists not to dispense birth control on grounds of conscience. Ten more are considering such laws.¹⁴ At the same time, aggressive marketers of birth control and abortion are promoting legislation that would mandate that all hospitals provide “morning-after” drugs.¹⁵
- The absence of comprehensive and widely accepted conscience protection runs athwart an ever-growing panoply of techniques that challenge or contradict moral norms. In vitro fertilization, cloning, postulated embryonic stem cell therapies, assisted suicide, lethal withholding of ordinary care for the dying – all of these developments, nurtured in the humus of decaying absolutes, confront the Christian health care worker with profound dilemmas. Transplant medicine and genetic engineering pose an array of difficult issues as well. The infant science of genomic medicine, which offers new horizons of therapy and cure, particularly carries with it the temptation to conflate disease with the person diseased, with consequences that deal in discrimination and even death.
- Lacking statutory protection that applies comprehensively and with equal force to institutions as well as individuals, some Catholic hospitals have been forced to “choose between governmental accreditation and training residents in abortion procedures.”¹⁶ As a result of concerted efforts by abortion agencies and advocates, the refusal to engage in, promote, refer or train for abortions has been used effectively as a basis for such unjust and punitive measures as denying hospital mergers, threatening to remove state contracts for medical services, and forcing a hospital to leave a cost-saving consortium.¹⁷

- The regulatory thicket that has grown around the provision of health care has formed an unbreakable “Gordian knot” that, according to one health insurance expert, “greatly increases healthcare overhead and seeks to reduce costs by reducing or standardizing care.”¹⁸ The results directly impinge on the physician and the patient’s “freedom and responsibility in healthcare decisions.” The burden imposed by the Medicare program alone now encompasses more than 110,000 pages of regulation, virtually ensuring that any decision under the program violates some provision of law.¹⁹

This regulation is far more than a roster of intrusive requirements. It is a vain attempt rather to substitute for the judgment of the physician and the responsibility of the patient a regime of omniscient rules. A thousand laws are needed wherever a single virtue declines. In the context of health care, self-government is inextricably tied with the idea of the fee. The aims of massive regulation are better served by a system of fee-based payments that acknowledge the skill and care of the physician and betoken the gratitude of the patient. The fee is both an enabling and conserving principle that encourages the patient to discipline his wants, practice prevention, and comply with treatment. Likewise, the fee stimulates the physician to do only what is medically necessary, avoid waste, practice informed consent, and act with conscious and effective charity.

- The final rule governing patient privacy protections under the Health Insurance Portability and Accountability Act (HIPAA) of 1997 abrogates “the natural right to privacy inherent in the relationship between patient and physician,” striking at the very heart of medicine. In the name of the efficiency and effectiveness of the health care system, this rule essentially eliminated the longstanding requirement for patient consent and transferred control of personal health care information to the federal government.²⁰

Most of these developments troubling to the mission and vocation of health care workers are the result of deliberate policy making by private corporations, human resource departments, legislatures or, increasingly, judicial bodies. In other instances, deleterious features of the current American health care system are accidents of history. None of these is more significant than the rise since the mid-20th century of the system of employer-provided health insurance. Employer-provided health coverage was offered to attract and retain scarce workers during the Second World War. In 1943, the National War Labor Board ruled that employers’ contributions to health insurance for their employees would not violate wartime wage controls and the benefit was not calculated as taxable income for employees.²¹ Congress codified this interpretation in 1954.

While this provision of law was advantageous to workers at companies that offered health benefits, one of its unintended effects was to channel tax benefits away from lower-income workers, the self-employed, and smaller companies unable to afford or to negotiate health coverage for their workers. The estimated value of the tax exclusion for employer-provided health benefits in 2004 is \$188.5 billion. Most of these benefits accrue to employees with high income; by one estimate the average annual value of the exclusion for those earning less than \$10,000 a year is \$102, while for those earning more than \$100,000

it is \$2,780.²² This regression in reverse in the tax code is a serious affront to the requirements of justice.

In all of these developments, the most negative impact is felt in the core transaction of medicine, the encounter of the sick patient with the physician. In the scheme of Christian, and particularly Catholic, health care, this encounter is much more than a meeting of need and skill. No advance in technology, no deprivation in finance, can alter the fact that the patient-physician relationship is grounded in the meeting of whole persons, operating under presumptions of virtue, seeking the restoration of well-being, benefiting the individual and serving the common good.²³

In this regard, the level of dissatisfaction among patients with their interaction with physicians is compelling. In many ways, for example, the Federal Employee Health Benefits Program (FEHBP) represents the best that employer-sponsored health care can achieve under current circumstances. It is employer-subsidized (72 percent on average in 2003) and maximizes, for the more than 8,000,000 workers, retirees and their dependents²⁴ who have access to it, choice among a variety of eligible plans, including 11 national fee-for-service plans and some 279 health maintenance organization options in the states.

Patient-satisfaction ratings for the health maintenance organizations were disturbingly low. Of the 179 HMOs for which the quality of communication with doctors was surveyed, members of 126 plans rated them average or below average. Only for the national fee-for-service plans, which operate on the more traditional model of patient choice of physician, were the doctor satisfaction numbers high. For 10 of the 11 plans surveyed, nearly half (5) were rated as above average in communication with the physician.²⁵

Dissatisfaction with and disruption of the patient-physician relationship are manifested in other ways as well. The evidence can be discerned in the steady decline in the esteem in which physicians are held, as reflected in opinion polls, in the flight of patients to alternative therapies, in the steady increase in the frequency and severity of malpractice litigation and jury awards, and in the alienation physicians feel from their own patients and the medical profession itself. It is the height of irony that these phenomena should arise at the very time that medicine is at the pinnacle of its physically therapeutic power.

As Catholic physicians dedicated to both the well-being of our patients and the common good of our society²⁶, we are distressed by these realities of the modern practice of medicine. Our patients seek something more, and so too do we. We take as the model of our vocation *Christus Medicus*, *Christus Patiens*, the God-made-man whom we strive to imitate as the divine “guardian and servant of life.”²⁷ In the institutions of medicine that Catholics have long built and maintained – from hospitals to hospices, well-equipped offices to threadbare mission clinics – Christ as Divine Healer, Christ as the Suffering Servant has been the foundation.

Healer and Sufferer, Jesus Christ is the epitome of both physician and patient. He who extends his hand to the patient in therapy must act as Jesus would, and he who reaches out

for relief of his suffering must know in a special way that his Lord is with him in his cry for aid. Jesus taught that even the righteous will ask, “When did we see you ill or in prison, and visit you?” (Matthew 25:39) “And the king will say to them in reply: ‘Amen, I say to you whatever you did for one of these least brothers of mine, you did for me.’” (Matthew 25:40)²⁸ To those who did not do for these least ones, who did not do for Christ, eternal punishment awaits. (Matthew 25:45, Luke 16:19-31) This injunction is personal and specific. The preferential option for the poor, the sick and the imprisoned is not optional.

The key to the crisis in American health care today is that it violates essential norms of justice and charity on both sides of the physician-patient relationship. It impairs the ability of the physician to decide and act as Jesus would, and it ignores the dignity of the poor in countless ways. Government policies have denied persons of little or no income the means to direct their own families’ health care; have saturated poor neighborhoods with “reproductive health” facilities and philosophies that have resulted in abandoned children, extraordinarily high rates of abortion and sexually transmitted disease; and have undermined husband-and-wife and parent-child relationships.

As a subset of the mis-insurance of all Americans, the mis-insurance of the poor is a particularly scandalous affront to the requirements of genuine justice, charity and solidarity. “History teaches us that in the field of service to health as well, every commitment to achieve justice has been shown to be insufficient because of the fragility and selfishness of man. Without the support of charity there has not been either a sufficient or an increasing upholding of justice . . . The figure of the Good Samaritan is the point of reference for a full interpretation of the relationship between justice and charity, of a justice that receives from charity the connotations of sensitivity, sharing and solidarity.”²⁹

The Light of Experience

By the evidence of Scripture and tradition, Luke the Evangelist has been known as a medical doctor. St. Paul in his Letter to the Colossians refers to Luke as “the beloved physician.” (Col. 4:14)³⁰ Consonant with the other Gospel writers, Luke writes of the specific miracles that filled the healing ministry of Jesus, “the resplendent sign that ‘God has visited His people’ and that the Kingdom of God is close at hand.”³¹

Significantly for the entirety of the patient-physician relationship, the first healing miracle that Luke records was spiritual in nature. A man possessed by a demon in the town of Capernaum asked Jesus, “Have you come to destroy us?” When the demon was cast out, all were amazed and asked with what “power and authority” Jesus had commanded the unclean spirit (Luke 4:34-36). In succession thereafter, this healing power and authority, the manifestation of divine love, cured a woman with a severe fever (Luke 4:39), a leper (Luke 5:14), and a paralytic (Luke 5: 24). This remarkable sequence ends with Jesus’s response to the Pharisees who asked Him why He ate and drank with sinners (Luke 5:30).

Jesus said, “Those who are healthy do not need a physician, but the sick do. I have not come to call the righteous to repentance but sinners.” (Luke 5:31-32).

From the beginning, therefore, Scripture called forth an understanding of the healing arts, modeled in Christ Himself, that addressed the sick person in every dimension: spiritual, physical, social and psychological. This understanding has been present throughout the history of the Church, embodied in corporal works of mercy that became signs of the individual Christian, hallmarks of numerous religious orders, and the focus of patristic and papal teaching. It became a means by which the power of all healing was revealed as having its origin in the creative, corrective and curative authority of God.

For more than two millennia, those who hold and teach the Catholic faith have gone forth with a determination to “be doers of the word and not hearers only” (James 1:22). In so doing, as the apostle wrote, they peer into and persevere in the “perfect law of freedom.” (James 1:25) The idea of freedom as law emanates from the recognition that there is no freedom without truth, and that conformity to the truth, the freedom to do what one ought to do, is obedience to the law of love. As John Paul II phrased it in *Centesimus Annus*, the freedom of the world “is detached from obedience to the truth, and consequently from the duty to respect the rights of others.” (*Centesimus Annus*, 17)

This truth is Christ Himself. “I am the way, the truth, and the life.” (John 14:6) In this manner, the cornerstone of Catholic health care has been a freedom to serve a patient in truth. “The truth shall set you free.” (John 8:32) In the context of the American experience, to an even greater degree than in Europe where there existed Catholic nation-states, this freedom to build Catholic health institutions was expressed in the actions of religious orders and private benefactors who saw needs and met them, cooperating with institutions of government but not awaiting their summons to service. Catholic health and social institutions flourished under the inspiration of the Holy Spirit, breathing in word and deed the Gospel of Life.

The history of Catholic health care is co-extensive with Church history. As early as 436 the Council of Carthage enjoined bishops to offer hospice, which included care for the traveler and the sick. This injunction echoed the words of Paul in First Timothy 3:2 that the bishop must be “temperate, self-controlled, decent, hospitable.” In the early Church, the bishop’s own care for the sick was supplemented by the charity of the wealthy, many of whom maintained *valetudinaria*, places of respite, on their lands.³² These practices, limited as they were, were precursors of the more organized institutions of health care the Church established.

Under the influence of great saints and religious orders of both men and women, institutions, both large and small, for the care of the sick were created across Europe. The institution built by St. Basil at Caesarea in Cappadocia had the character of a city in its scope. The first Catholic hospital in Rome was founded in 400; the first in France, at Lyons, came in the 6th century. In 580 Bishop Masona at Merida gave orders to that locale’s physicians and nurses, telling them “that wherever they found a sick man, ‘slave or

free, Christian or Jew,' they should bring him in their arms to the hospital and provide him with bed and proper nourishment."³³

In the Middle Ages, aided by the growth of monasteries and the multiplication of religious orders and their rules of poverty and obedience³⁴, Catholic hospitals grew even more dynamically and, with the onset of the Age of Exploration, accompanied adventurers to the New World. Throughout France the Benedictines, most famously at Cluny, and the Cistercians established hospitals. Between 1207 and the early 1500s, 155 hospitals were founded in Germany. In Rome alone in the Middle Ages, the papacy directed the establishment of 30 hospitals. Some 600 hospitals were established in England during this period, and 77 in Scotland.³⁵

For the expiation of his sins, Cortez provided in his will for the establishment of what became the first hospital in the Americas, in Mexico, in 1524. Continuing the tradition of the Hotel-Dieu or Maison-Dieu, Jeanne Mance established the first Catholic hospital in Montreal in 1644. The first in the United States came two decades later on the island of Manhattan. With the same inspiration that brought a practical Gospel of Life to the Church in Europe, Catholic evangelization and Catholic health care were virtually congruent in the United States. By 1910, over 100 different religious orders of women had been established worldwide to care for the sick. By that same year, the United States had more than 400 Catholic hospitals, which saw an estimated 500,000 patients per year.

The articulation of Catholic social teaching, elaborated in the wealth of papal encyclicals that coincided with the development of modern economies with all of their lasting accomplishments and lingering disparities, followed centuries of accumulated works of charity. The Church spoke with increasing specificity about questions touching upon the organization of social goods, matters in which it had significant practical experience. This, too, was the experience of Catholic families, whose debt to charity was often paid most generously in the openness of parents both to the transmission of life and the fostering of vocations among their children.

From the smallest medical office to the largest hospital, the metaphysical symmetry of Catholic medicine can be glimpsed, just as it is present in cathedrals and basilicas. Jesus Christ is its cornerstone. The pillars are those of subsidiarity, solidarity, the sanctity of human life, and virtue³⁶. The floor is justice, and the light that fills its space is charity, by which all that occurs there is illuminated. The whole of the structure gives rise to the common good. In the many such structures that have been and are yet to be built, subsidiarity has a hand in their framing and dispersion. Solidarity is found in the doors that are open to all, the sanctity of life in the inestimable value that is recognized in all.

Far from being Utopian, this vision of Catholic medicine roots the civilization of love in a locus of love. It is a conception that is valid always and everywhere, even as it admits of differences in the size and shape of institutions. Nonetheless, at the dawn of the 21st century, the character and shape of Catholic medical institutions are under severe stress, as we have outlined. It can be said that this stress upon Catholic medicine in 2004 parallels the stress imposed upon the Catholic working family in the late 1800s. The

industrialization of medicine challenges the social mission of the Church today just as the industrialization of labor challenged its social mission more than a century ago.

In *Rerum Novarum*, Pope Leo XIII addressed the twin dangers posed by the industrialization of work: the radical *laissez-faire* that places the laborer at the mercy of the employer, and the radical demand for state intrusion that establishes in government a monopoly of ownership. Against these polar monopolies, *Rerum Novarum* established as Catholic social doctrine the idea of the “just wage.” In the words of Pope John XXIII, the just wage is that recompense “in proportion to the available resources, to provide for the worker and his family a manner of living in keeping with the dignity of the human person.”³⁷ Even as the language of the “just wage” has ripened into the idea of an adequate income in more recent papal writings, it has retained its fundamental character as remuneration “that will suffice for establishing and properly maintaining a family and for providing security for its future.”³⁸

Ennobled and strengthened by its grounding in the “obligations of family,”³⁹ this just remuneration, or adequate income, represents an equitable transfer of property to the worker, whose demand for justice includes the right “to dispose of [his wage] as he sees fit.”⁴⁰ Duty exists on both sides of this transfer, first in the personal duty to work, to leave the gift of the laborer’s talents from God unburied (Matthew 25:25), and the corresponding duty of the worker, as Pius XII framed it, “to provide for his own life and the lives of his children, so profoundly is the empire of nature ordained for the preservation of man.”⁴¹

In the neglect of industry to recognize and provide for income adequate for the family to live commensurate with human dignity, there arose the temptation of the unitary, the nascent socialist and communist movements of Leo XIII’s era. With equal clarity, he condemned this temptation as a “remedy openly in conflict with justice.”⁴² “The family,” he wrote, “like the State is by the same token a society in the strictest sense of the term.” Thus, “the family assuredly possesses rights, at least equal with those of civil society, in respect to choosing and employing the things necessary for its protection and its just liberty.” These rights inhere in the family because “its rights and duties are also prior [to] and more in conformity with nature” than those of the State.⁴³

These reflections prompted Leo XIII to observe that “State benevolence”⁴⁴ cannot replace charity. To meet the demands of justice there are needed “associations of workers” that can “be adapted to meet the present need,”⁴⁵ and the aim of these associations must be the “increase in the goods of body, of soul, and of prosperity.”⁴⁶ In this context, both the family and associations of workers, specifically labor unions, served the virtues of solidarity and subsidiarity. They both asserted natural rights and supported the discharge of natural obligations, and they did so by redressing imbalances that left the family exposed to the naked power of both industry and government.

The moral and economic crisis in medicine in the United States today has produced a new set of imbalances. The vast majority of workers have no choice among the means of health insurance they provide to their families. They exercise little or no control over what that insurance does or does not cover. Their health policies are not portable; a change of

employment to improve the worker's long-term opportunity may carry with it an unacceptable loss of current benefits. Tax policy advantages the best-compensated workers in the arena of health, and the decision to access those tax preferences is most often the employer's alone.

The traditional associations of workers functioned well in expanding health benefits throughout most of the 20th century, and it is surely noteworthy that they have had the greatest success in promoting worker choice of health plans only in government, one of the few sectors of the American economy where the share of the unionized work force is high and growing.⁴⁷ Overall, however, the share of the U.S. work force that has union membership declined once again in 2003, shrinking from 20.1 percent in 1983 to 12.9 percent two decades later.⁴⁸

In this environment, and with the continued growth in the number of uninsured (but not uncared-for⁴⁹) poor, the temptation of the unitary, of the complete socialization of medical practice, is persistent. In addition to the inherent violation of subsidiarity such socialization would entail, the clear historical experience in the United States assures that a unitary, or single-payer, system of health care financing and administration would profoundly subvert the sanctity of human life. In national policy, imposed and enforced by juridical means that have proven impervious to reform, unitarian financing would carry with it universal and compulsory cooperation in abortion and other procedures that epitomize a culture of death. For advocates of such a system, this inversion of culture is non-negotiable.⁵⁰

A culture of death inherently and profoundly maximizes discrimination against the poor, who already struggle on the margins of economic opportunity. For example, a 2003 study found that 57 percent of women having abortions in the United States in 2000 were poor or low-income.⁵¹ This is no mere accident of social conditions, but at least in part a result of deliberate marketing strategies by abortion agencies whose mission is depopulation, not health care.

Important as these facts of the contemporary national situation are, they must not obscure the inherently flawed structure a unitary system would represent. The temple of medicine envisioned in this statement rests its universality on an understanding of the patient-physician relationship that is holy, catholic, apostolic, and covenantal. It is no mere physical transaction, but instead an embodiment of the relationship that should exist between man and God and between two persons created in His image.⁵² Its close connection with self-governance is therefore inescapable. The physician is not an automaton, a mere instrument of patient autonomy. Conscience compels him to act virtuously, not merely to do what the patient asks⁵³ or as regulations command. The patient in turn has a corresponding duty to recognize and reward the service that has been rendered him, even when, in charity, that reward has been voluntarily waived.

In this vital sense, the right to health care, the floor of justice in the temple, is a claim upon virtue that must not extinguish the other virtues that surround it. This "right" is first and foremost a demand, forged by divine command, upon the person of the physician to

act, as we have said, with conscious charity. It is far from, and even alien to, the erection and perpetuation of bureaucracies, certainly an all-encompassing bureaucracy, in which the medical and personal virtues of the physician cannot be exercised and may even be punished. Moreover, because the “right to health care” is necessarily a companion of rights to other necessities – among them food, clothing and shelter – it is properly understood as a right to acquire the means of procuring for one’s self and one’s family these goods, and, concomitantly, a duty to exercise virtue (diligence, thrift, charity) in every aspect of their acquisition and discharge. This language of rights, coupled with duties toward those who “through no fault of their own” are unable to work, is present throughout papal teaching, and only reinforces the idea that, in its proper perspective, the goal is to live and to work and “to be looked after” only in the event of real necessity.⁵⁴

One commentator has put the distinction particularly well:

We can, therefore, say with certainty that, as the term is usually construed today and under ordinary [i.e., non-emergency] circumstances, there is no right to universal health care. There is, of course, a serious moral obligation to see that our fellow men are taken care of in a manner befitting human dignity. That, however, is an obligation that comes under charity, not justice, and cannot and must not be enforced by the coercive power of the State (civil society). It is only enforceable by the moral authority of faith (religious society).⁵⁵

In this regard, Pius XI, in *Quadragesimo Anno*, repeated the words of Leo XIII and reminded us that “if human society is to be healed, only a return to Christian life and institutions will heal it.”⁵⁶ The care to be expected from such institutions and their personnel is personal and proximate. In the case of medical institutions and medical personnel, it is care that sees the “serious moral obligation” to attend to the needs of the poor as a call to serve the eternal destiny of both body and soul. It is care that recognizes, with Pius XI, the error of a socialized system that, “wholly ignoring and indifferent to this sublime end of both man and society, affirms that human association has been instituted for the sake of material advantage alone.”⁵⁷

It is a testament to the thorough secularization of the contemporary mind that the strictures of the State, enforced by fines or professional penalties, are viewed by many as more imposing and portentous than the strictures of faith, represented by the fate of Dives. (Luke 16: 19-31)

When the “right to health care” is improperly understood, when it lapses into radical autonomy, the triumph of relativism, the mere instrumentality of the healer, or a culture of entitlement for the healed, it ceases to be just and it ceases to be of Christ. The raw language of rights, divorced from moral truth, leads, in the memorable formulation of Mary Ann Glendon, to the “impoverishment of political discourse.”⁵⁸ Again, in the Gospel of Luke, we read of Jesus’s encounter with the ten lepers. He commands them to show themselves to the high priest and along the way they are cured. Only one returns to give

thanks. Jesus asks, “Ten were cleansed, were they not? Where are the other nine? Has none but this foreigner returned to give thanks to God?” (Luke 17: 17-18).

Throughout history, Catholic medicine has been modeled on the parable of the Good Samaritan. Great institutions of Catholic health care have borne this name, symbols of compassion and mercy (Luke 10:33, 10:37). The Good Samaritan is one to whom no person is a stranger or foreigner. He goes out of his way, lays his hands upon the sick person, sacrifices of his substance, and stays with him until he is healed. If the cost to him is greater than at first it seemed, he makes new provision. “Man cannot ‘fully find himself except through a sincere gift of himself.’ A Good Samaritan is the person capable of exactly such a gift of self.”⁵⁹ Catholic health care must preserve, above all, the capacity to give, receive and understand such gifts.

The Lamp of Progress: Proposals for the Renewal of Health Care

“Not only the world, however, but also man himself has been entrusted to his own care and responsibility. God left man “in the power of his own counsel,” that he might seek his Creator and freely attain perfection. Attaining such perfection means personally building up that perfection in himself. Indeed, just as man in exercising his dominion over the world shapes it in accordance with his own intelligence and will, so too in performing morally good acts, man strengthens, develops and consolidates within himself his likeness to God.”

- John Paul II, Encyclical Letter *Veritatis Splendor*⁶⁰

Technology, bureaucracy, the revolution in genomic medicine, the advance of relativism in ethics and bioethics – all of these present Catholic medicine with “new things” that require fresh discernment and innovative application. The Health Care Task Force of the Catholic Medical Association was formed in 2003 with the express goal of examining options for renewal of the traditional Catholic teaching and practice of medicine. In the first section of this statement, we outlined, and redefined, the crisis of American medicine as we see it in our work and in our communities. In the second section, we set forth the “doing and hearing of the word” that have characterized the Catholic response to the ministry of healing established by Jesus Christ.

In this section we set forth proposals and applications that, in the first years of this new millennium, will extend and strengthen this ministry. We have no hubris that what we propose represents a complete and overarching solution; indeed, we doubt that such solutions exist, and that the perfection of the human condition in this life is within the reach of fallen mankind. Instead, we offer and endorse ideas that address current needs and that are in accord with Catholic teaching. We welcome comments and criticism directed at refining these ideas. We aim not for the idealism of the impossible, but for the good of the achievable.

We begin with the imperative to maintain the connection between the expectation of work and the means to live, while ending those features of current policy that hurt the

working poor. Current tax policy clearly discriminates against those who most need help in purchasing health insurance, forcing millions to go without coverage and robbing them of the security of knowing they can get the health care they need, especially in the event of a major accident or illness.

The challenge is to create new incentives that drive the power and responsibility for purchasing health insurance away from specific employers and government bureaucracies and toward the individual worker and family. Changes in public policy are needed to foster a renewed climate in which individuals and families are free to make decisions about their health care and its source based upon conscience. This will serve the principle of subsidiarity, confirming the right and the ability of the worker to dispose of his wages to serve his own basic needs and that of his family, while mitigating barriers that interfere with the patient-physician relationship.

1. Individual ownership of health insurance

Every American should be able to obtain needed medical care. Reforming the tax treatment of health insurance is indispensable to achieving that goal. Congress could begin by providing a new set of incentives for Americans to purchase their own health insurance directly. These incentives should be properly structured to create an opportunity for people to purchase coverage that conforms to the dictates of their conscience and moral convictions. This assistance could be in the form of tax credits or other incentives to be used to purchase medical services or health coverage.

We recommend creation of refundable⁶¹ tax credits to provide resources to those who now lack the means to purchase health insurance that they would own and control. The money could be used to obtain health coverage in a variety of ways, either individually or through participation in groups, such as health plans sponsored by faith-based associations. This would ensure millions of Americans a new freedom to purchase health insurance in keeping with their conscience and family priorities. They would own and control the policy, not be subject to the dictates of other purchasers or negotiators, and enjoy the same portability they have with life insurance and other instruments they use to ensure family security. Protections can and must be put into place that assures these plans are designed and managed by people with comprehensive knowledge of insurance.

Refundability ensures that the credit retains its incentive for the poor to work, and for the non-working but able poor to obtain and hold jobs where the employer does not offer health benefits. The credit cannot be claimed if a tax return is not filed on at least some income, and for the poor that will be earned income.⁶² The Fair Care for the Uninsured Act of 2003 (S.1570/H.R. 583) embodies this concept. It has attracted the bipartisan support of 129 members of the House and seven senators.⁶³ This legislation would also protect higher-risk and harder-to-insure people by keeping premiums affordable through the encouragement of safety-net policies at the state level. Fair Care would build on the \$100 million grant program for Qualified High-Risk Pools established under the Trade Act of 2002.⁶⁴

In order to maximize their usefulness and to ease some of the burden of the upfront cost of health care until deductibles are met, this tax credit should also be advanceable; that is, taxpayers should be able to receive the credit in the year it is authorized and not be required to wait until the following April 15 when they file their tax return with the Internal Revenue Service. In May 2004 the outgoing president of the American Medical Association, Dr. Donald J. Palmisano, renewed and updated the AMA's reform agenda, affirming its support for replacing "the tax exclusion of employment-based health insurance with tax credits that are inversely related to income, refundable, and advanceable." Palmisano and his coauthors estimate that this and related reforms will result in a gain of 16.2 million to 26.2 million in newly insured individuals at a cost ranging from \$39-\$65 billion in new federal spending.⁶⁵

Tax reform, and the measures described below, should lead to a restoration of the confidentiality of medical records, but changes in federal law may also be needed, particularly to the privacy rules in the Health Insurance Portability and Accessibility Act of 1997. Privacy that is designed as a one-size-fits-all commodity dispensed by government regulators will very likely suit no one and will interfere with the ability of patients and physicians to make the best and most informed decisions.

2. Freedom from health insurance mandates

Individuals and families need more than equal tax treatment in order to be able to purchase a health plan of their choice. They must be able to purchase insurance that is free of restrictions and bureaucratic dictates, especially state health insurance mandates. States have enacted more than 1,500 health insurance mandates over the last several decades, including everything from toupees to in vitro fertilization procedures,⁶⁶ dictating the shape and structure of health plans for small businesses, individuals, and anyone else purchasing state-regulated policies. Only those who "self-insure," usually medium-sized and large companies, are able to offer coverage that isn't governed by these mandates.

The federal government also is moving into the health insurance mandate arena, further robbing individuals of control over the benefits their health insurance policy will cover. Many states are realizing that mandates and other insurance regulations are driving up the cost of health insurance, in addition to denying individuals and families' freedom of choice. Some states are requiring economic analyses of the mandates before they can take effect, and more should do so.

3. Choice of private insurance policies

As we have noted, a wide choice of affordable health care policies exists for government employees and few others. For decades, Catholic social policy has endorsed and supported the formation of various kinds of worker and family organizations, from labor unions to fraternal benefit societies, to promote and protect the well being of spouses and children and the security of the family unit. At the time of the formation of such societies in 19th century America, the lack of social insurance in the form of unemployment compensation and disability, combined with the high rate of mortality among working

men, exposed families to the risk of ruin. The Knights of Columbus and other denominational organizations came into being to foster solidarity among Christian families facing these dire circumstances.

More than a century later, the invaluable work of these organizations continues. The needs of the family have continued to evolve, however. Improvements in workplace safety, the development of penicillin and other antibiotics, advances in medical diagnostics and treatments, and improved sanitation and housing have dramatically reduced worker mortality. Longer lives have in turn increased the likelihood that families will, at some point, be forced to deal with a debilitating and expensive illness. Today a 45-year-old man can purchase a typical \$500,000 life insurance policy for \$150 per month or less. If that man is a head-of-household and seeks to purchase health insurance for his family in the market, his monthly burden approaches \$900. One estimate is that the average monthly cost of family coverage in 2006 will reach more than \$1,200.⁶⁷

New associations, including faith-based groups, would be welcome, even essential, additions to the array of health care options for families. We endorse the enactment of legislation to allow the creation of voluntary groups that sponsor health insurance coverage, such as association health plans (AHPs) or voluntary purchasing coalitions. New health plans could be created through faith-based groups or other affiliations of like-minded individuals that meet the moral, spiritual, and health care needs of individuals and families. We recognize the need for appropriate regulatory protections to ensure the financial integrity of these new institutions.

Legislation of this kind, which has passed in the U.S. House of Representatives, would be a significant step forward in meeting the needs of the uninsured. The Congressional Budget Office (CBO) has estimated that 330,000 working Americans would gain coverage under AHPs. CBO's high-end estimate is that 2,000,000 people might access coverage through AHPs. A separate study by the CONSAD Research Corporation found that as many as 8.5 million uninsured workers and dependents would participate in AHPs.⁶⁸ By freeing these plans from expensive state-benefit mandates, the number of small businesses that offer insurance will increase. This is important because 85 percent of the nation's uninsured are workers and their families.⁶⁹

At the same time, the federal government must do more to end the active discrimination against faith-based health providers that has caused many of them to forego public funding because of valid fears about interference with their religious missions. From Christian Medical and Dental Association clinics to the network of 1,500 health professionals nationwide who constitute the Christian Community Health Fellowship, the desire to "live out the Gospel through health care among the poor"⁷⁰ is a mighty force that public policy should only encourage.

4. Health Savings Accounts

The interests of the family are also served by public policy that allows them to finance and control more of their discretionary and routine health spending through tax-preferred

Health Savings Accounts (HSA). Families who open an HSA must also purchase a high-deductible health insurance policy that functions as real insurance,⁷¹ protecting the family against the risk of major medical expenses. This approach will require states to relax restrictions on the purchase of health policies with high deductibles for catastrophic medical costs. Paired together, HSAs and high-deductible catastrophic coverage operate to preserve the cost-sensitivity that can promote responsibility and eliminate waste, while protecting families from calamitous expense.

In its purest sense, insurance has operated on the principle of the common good, distributing risk and conserving resources for the most medically needy. Under existing health policies, laden with mandates, bureaucracy, claims disputes and delays, insurance directed at helping families with routine or first-dollar expenses imposes massive costs and fosters inappropriate uses of the health system.

We note with approval the inclusion of new Health Savings Accounts designed along these principles in the Medicare Modernization Act of 2003, adopted late last year. The statute requires that funds may be withdrawn tax- and penalty-free from HSAs only for qualified medical expenses, but exceptions for such purposes as purchasing health insurance while unemployed or for long-term care increase the flexibility of this option for the general population. HSAs continue and broaden a trend that was already established through employers, who have been able to offer Flexible Spending Accounts and Health Reimbursement Arrangements. It is vital that government policy makers at all levels continue to enhance the utility of HSAs.⁷²

One key step in this regard would be the establishment of an HSA Faith-Based Health Plan as an option within the Federal Employee Health Benefits Program. Since state mandates can be pre-empted under federal law and a conscience exemption is available, this option would offer a model health plan that helps to ease the moral and economic crisis we face today in health care. Such a plan would:

- Enhance the physician-patient relationship by ensuring a congruence of values
- Provide employees with a conscientious choice
- Make patients more discerning about utilization of the health care system
- Promote trust and minimize malpractice
- Improve member satisfaction through improved communications

If HSAs, which became a legal option for all 250 million non-elderly Americans on January 1, 2004, follow the pattern of the MSAs they supplanted, these savings accounts will also draw many of the uninsured into coverage plans subject to their own control. The IRS calculates that between 23% and 25% of HSAs are being established by people who were previously uninsured. The most recent data from companies that market HSA plans, including Assurant Health, shows that as many as 43% of those who are buying HSA plans did not previously have coverage.⁷³ Moreover, data compiled by Golden Rule Insurance, the largest provider of HSAs in the country, shows that 77 percent of new policyholders are self-employed and 10 percent are single parents.

We applaud those members of Congress, in both parties, who have steadily promoted reform of the American health system that moves further in the direction of these reforms. We note with particular appreciation the adoption by the House of Representatives, by margins of as many as 120 votes, of three bills that advance Health Savings Accounts, malpractice reform, and Association Health Plans (AHPs). H.R. 4279 would strengthen HSAs by allowing employees to roll over as much as \$500 in unspent deposits from their Flexible Spending Accounts at the end of the tax year. H.R. 4280 would cap the non-economic portion of malpractice awards at \$250,000, allowing injured patients substantial recovery but limiting excessive awards that contribute to exploding health insurance and malpractice insurance costs. Finally, we are encouraged by House passage of H.R. 4281, legislation to allow clusters of small businesses to form AHPs.⁷⁴ We urge the U.S. Senate to follow through on these reforms with the speed and seriousness they deserve.

5. Comprehensive Protection of Conscience

No reform of the American health care system will restore the patient-physician relationship if health care workers are not afforded comprehensive protection of conscience. The nation's patchwork of laws and private sector policies has woven a fabric of doubt among health professionals. In 1997 the State of Illinois adopted expansive conscience legislation designed to protect individuals, medical offices, hospitals and other institutions. This law, alone among the states in its scope, honors the "ethical, moral or religious grounds" on which these providers decline to "counsel, refer, perform, administer, prescribe, dispense, treat, withhold, withdraw, diagnose, test, evaluate, train, research, prepare or provide medical advice or material or physical assistance in a health care service." This detailed enumeration is necessary to counter the vagueness of existing statutes and the penchant of courts for puncturing the veneer of protection those statutes have offered.

This past April, the Michigan House adopted, by large margins, HB 5006, titled the Health Care Right of Conscience, protecting health care providers; HB 5277 and 5278, protecting health care payers; and HB 5276, protecting health care facilities⁷⁵. This legislation will be introduced in the Michigan Senate in the fall session of 2004. Michigan's effort is notable because it reflects the need for legislation that is simultaneously more comprehensive and more flexible than existing law, which typically applies only to certain health care personnel and particular procedures. The pace of medical developments, particularly in the realm of genetic medicine with potential therapeutic and reproductive applications, makes it essential that new statutes be swiftly enacted that place the medical practitioner's right of conscience foremost and that shift the prospect of economic sanctions to those who would trample on this right.⁷⁶

Congress should also act with dispatch and adopt the Abortion Non-Discrimination Act of 2003 (ANDA) to extend the protection of federal law to any federally funded health entity that refuses to provide or pay for induced abortions. As introduced in the U.S. Senate, the definition of "entity" is broad and includes physicians, hospitals, provider-sponsored organizations, health maintenance organizations, health insurers, and any other

kind of health care facility, organization, or plan. In the absence of such legislation covering abortion and other objectionable practices, changes in the financing of health care will maintain a shell of reform that destroys the pearl within. We note with encouragement the inclusion of ANDA's key language in the committee version of the Fiscal Year 2005 appropriations bill for the Department of Health and Human Services and other agencies, and we urge the full U.S. House of Representatives and Senate to retain this language as a good first step.

6. Experiments in Diocesan Self-Insurance

Finally, we take note of the noble experiment in self-insurance undertaken by the Diocese of Lincoln, Nebraska, and now extended under the visionary wisdom of Bishop Robert Vasa in the Diocese of Baker, Oregon. Both dioceses changed their employee insurance schemes from a private carrier to self-insurance. Although an opt-out provision was available with the private carrier to avoid coverage of abortion and contraception, these dioceses did not wish to see Church funds transferred to a company that routinely covered these practices for other customers. We commend these efforts, even as we recognize the difficulty of maintaining them in the face of rising costs to which no plan has immunity.⁷⁷

Conscience means much more than the refusal to participate in or in any way cooperate with practices contrary to the moral teaching of the Church. Conscience in its proper scope in medicine is a decision to recognize and treat the whole person. The Lincoln and Baker plans provided affirmative support for natural family planning and marriage and family counseling. They became powerful tools of evangelization for the Culture of Life.

More such experiments are urgently needed. The reforms in the law cited in this statement can fuel such experiments, by eliminating wasteful mandates, lifting rules that impinge on conscience, preserving the freedom of health care workers to serve "the least of these" as Jesus would have them do, and strengthening the ability of families to select and finance care consonant with their Christian faith. We call upon our sisters and brothers, within the Roman Catholic Church and without, to dedicate themselves anew to the ingenuity and sacrifice that have characterized authentically Christian health care through the centuries.

A Beacon Forward: Imploring the Lord of Light

Our vision is wide-ranging and, we pray, far-seeing. We look to a day, not far off, when a National Catholic Health Plan will offer to the faithful an opportunity to act in full service to life. We foresee entities of such character and scope that those whose working contributions support the Plan will give freely of their substance to provide for those who cannot help themselves. We urge the institution of new Temples of Medicine, authentically Catholic clinics like the Sacred Heart Medical Centre of Livonia, Michigan.⁷⁸ We embrace the need for evermore insightful and comprehensive study of models of Catholic health care, and we support significant new investments in scholarship and public policy research to stimulate and advance the dialogue.

Our reflection on the past, the long, unbroken history of the Church's ministry to the sick, reminds us that the work of transformation is both gradual and individual. Steps must be taken one by one to reform existing structures and to allay the fears of change that tighten the gridlock of politics and the grip of bureaucracy. Increments of patient-physician-centered, value-driven health care reform can and should be applied to every existing program. We hold that no individual or family, of whatever means, fortified in the fellowship of the Holy Spirit, is incompetent to direct and guide its own acquisition and use of health care.

We began this statement with cautionary words about the crisis we face, and we conclude with hopeful words about the changes we seek. We write with full consciousness of the fact that of all peoples, Americans have enjoyed levels of health and life expectancy that are the envy of the world. Our fallen nature ever renders us unlikely to be that tenth leper who faithfully returned to the Savior to offer Him praise and thanks. We do so now, asking Our Father His grace and His love and rededicating ourselves to be the work of His hands, knowing with His Holiness John Paul II, that only in this direction will we find "justice, development, true freedom, peace and happiness."⁷⁹

¹ Facts and Figures on the Uninsured, The Heritage Foundation, Washington, D.C., April 25, 2004 at www.heritage.org/Research/Features/Issues/2004/uninsured.cfm. The number of Americans who went without health insurance for all of 2002 is estimated at 26 million. Some articles that emphasize the lack of insurance coverage use only the higher figure for those who were without insurance for part of a year, ignoring the fact, implied by these figures, that at least a third of these individuals reacquire insurance in less than 12 months (See Hillary Rodham Clinton, "Now Can We Talk About Health Care?" *The New York Times Magazine*, April 18, 2004, at www.nytimes.com/2004/04/18/MAGAZINE). See also, "The Uninsured and Their Access to Health Care," Fact Sheet, The Kaiser Family Foundation, December 2003.

² Ibid. The prime misallocation of health resources lies in the tax subsidies that have, for several decades, tied health insurance benefits not to work but to specific employment. Under Section 106(a) of the Internal Revenue Code, employers are permitted to exclude from taxation benefits they provide to their employees in the form of health insurance. In 2004 the value of this tax exclusion is estimated at \$188.5 billion, but most of this benefit goes to employees with higher incomes.

³ A modern translation of the Oath, faithful to its substance but avoiding its archaic language and references to Greek deities, was prepared and ascribed to by a group of distinguished physicians led by Edmund Pellegrino, M.D., the late Joseph Stanton, M.D., and others. It reads as follows: "I swear in the presence of the Almighty and before my family, my teachers and my peers that according to my ability and judgment I will keep this Oath and Stipulation: to reckon all who have taught me this art equally dear to me as my parents and in the same spirit and dedication to impart a knowledge of the art of medicine to others. I will continue with diligence to keep abreast of advances in medicine. I will treat without exception all who seek my ministrations, so long as the treatment of others is not compromised thereby, and I will seek the counsel of particularly skilled physicians where indicated for the benefit of my patient.

"I will follow that method of treatment which according to my ability and judgment, I consider for the benefit of my patient and abstain from whatever is harmful or mischievous. I will neither prescribe nor administer a lethal dose of medicine to any patient even if asked nor counsel any such thing nor perform act or omission with direct intent deliberately to end a human life. I will maintain the utmost respect for every human life from fertilization to natural death and reject abortion that deliberately takes a unique human life.

“With purity, holiness and beneficence I will pass my life and practice my art. Except for the prudent correction of an imminent danger, I will neither treat any patient nor carry out any research on any human being without the valid informed consent of the subject or the appropriate legal protector thereof, understanding that research must have as its purpose the furtherance of the health of that individual. Into whatever patient setting I enter, I will go for the benefit of the sick and will abstain from every voluntary act of mischief or corruption and further from the seduction of any patient.

“Whatever in connection with my professional practice or not in connection with it I may see or hear in the lives of my patients which ought not be spoken abroad I will not divulge, reckoning that all such should be kept secret.

“While I continue to keep this Oath unviolated may it be granted to me to enjoy life and the practice of the art and science of medicine with the blessing of the Almighty and respected by my peers and society, but should I trespass and violate this Oath, may the reverse be my lot.”

⁴ “The Charter for Health Care Workers,” Pontifical Council for Pastoral Assistance to Health Care Workers, Vatican City, 1995, 2.

⁵ Louis Lasagna, “Hippocratic Oath – Modern Version,” NOVA Online, at www.pbs.org/wgbh/nova/doctors/oath_modern.html. This version of the oath was written in 1964 by the then Academic Dean of the School of Medicine at Tufts University.

⁶ Wesley J. Smith, *The Culture of Death: The Assault on Medical Ethics in America* (Encounter Books, San Francisco, California 2000), p. 20, citing Robert D. Orr, MD, Norman Pang, MD, Edmund D. Pellegrino, MD, and Mark Siegler, MD, “Use of the Hippocratic Oath: A Review of Twentieth Century Practice and a Content Analysis of Oaths Administered in Medical Schools in the U.S. and Canada in 1993,” *Journal of Clinical Ethics* 8, no. 4 (Winter 1997), p. 377-387.

⁷ As of July 2004, no health insurer participating in the FEHBP had yet claimed the religious exemption from this mandate. This fact illustrates another facet of the modern American system, its tendency to deaden the conscience of providers by habituating them to moral compromises. Ultimately, it is the responsibility of individual Catholic physicians and health care administrators to recognize and resolutely resist such compromises, even if the magnitude of the effort needed seems overwhelming.

⁸ Mark Kaufman, “More Health Plans Cover Birth Control,” *The Washington Post*, June 14, 2004, A2. The new study traces 30 to 40 percent of the coverage increase to state mandates and an unspecified amount to lawsuits and a 2000 finding by the Equal Employment Opportunity Commission that non-coverage of birth control constitutes sex discrimination.

⁹ “Weblog: California Supreme Court Orders Catholic Charities to Pay for Birth Control,” Compiled by Ted Olson for *Christianity Today*, March 2, 2004, at www.christianitytoday.com/ct2004/109/22.0.html.

¹⁰ “Refusing to Provide Health Services,” *State Policies in Brief*, The Alan Guttmacher Institute, April 1, 2004. The title of the Guttmacher fact sheet suggests the gulf that separates the Catholic view of informed conscience and more utilitarian theories. In Catholic thought, abortion and contraception are not health services but acts that, respectively, “contradict the full truth of the sexual act as the proper expression of conjugal love” and that “destroy the life of a human being.” (*Evangelium Vitae*, 13)

¹¹ J.D. Forrest and R. Samara, “Impact of publicly funded contraceptive services on unintended pregnancies and implications for Medicaid expenditures,” *Family Planning Perspectives*, 1996, 28 (5): 188-195; cited in “Facts in Brief: Induced Abortion,” The Alan Guttmacher Institute, at http://www.guttmacher.org/pubs/fb_induced_abortion.html#ref33.

¹² *Evangelium Vitae*, 59.

¹³ The CVS pharmacy chain, which operates 4,100 drugstores in 34 states, announced that it would “address the situation” of a suburban Dallas, Texas pharmacist who declined to fill a prescription for birth control pills. The American Pharmacists Association supports, in general, a right of conscience for pharmacists and encourages accommodations that require another non-objecting pharmacist to fill the prescription without making the customer aware of the objection. Activist organizations like the Planned Parenthood Federation of America actively oppose such accommodations and resist laws that embody them. See Marilyn Gardner, “Pharmacist’s Moral Beliefs v. Women’s Legal Rights,” *The Christian Science Monitor*, April 26, 2004.

¹⁴ Ibid. The states are South Dakota and Arkansas. The pressure exerted on health professionals to engage in practices contrary to their moral beliefs affects every sector of health care, from physicians and insurers, to pharmacists, nurses and even employers.

¹⁵ See Francis J. Manion and Geoffrey R. Surtees, "Health Care and Conscientious Objection: Ethical and Legal Perspectives," unpublished paper, circa 2003. Both authors are attorneys associated with the American Center for Law and Justice.

¹⁶ Testimony of Steven T. McFarland, The Christian Legal Society, Before the Judiciary Subcommittee on the Constitution, U.S. House of Representatives, March 26, 1998, citing *St. Agnes Hospital of the City of Baltimore, Inc. v. Riddick*, 478 F.Supp. 319 (Sept. 10, 1990).

¹⁷ "Backgrounder: Hyde Conscience Protection Amendment," Secretariat for Pro-Life Activities, U.S. Conference of Catholic Bishops, July 2004, at <http://www.usccb.org/prolife/issues/abortion/h-backgrounder.pdf>.

¹⁸ Robert J. Hanten, "Freedom in Healthcare," *Social Justice Review*, January/February 2003, pp. 3-7. Mr. Hanten works in health insurance with the firm of Solidarity International in Golden Valley, Minnesota.

¹⁹ Robert Waller, "Administration of the Medicare Program." Testimony before the National Bipartisan Commission on the Future of Medicare, August 10, 1998; Washington, D.C.

²⁰ R. Steven White, M.D., "The Privacy Rule: An Abrogation of Patient-Physician Confidentiality," *Social Justice Review*, November-December 2003, p. 181.

²¹ For a fuller discussion of this history, see Grace-Marie Turner, "Health Care: Avoiding the Achilles Heel of Tax Reform," IPI Center for Tax Analysis, Institute for Policy Innovation, Policy Report 167, February 2002, p. 2ff.

²² "Facts and Figures on the Uninsured," The Heritage Foundation, Washington, D.C., April 25, 2004 at www.heritage.org/Research/Features/Issues/2004/uninsured.cfm.

²³ The "common good" as understood here in the context of Catholic teaching (See *Catechism of the Catholic Church*, Libreria Editrice Vaticana, translated from the Latin, St. Paul Books and Media, Boston: 1994, 1906-1909, p. 465) is contradistinct from the schemes of "public health" that subordinate the individual's good to the needs of the community through such mechanisms as rationing of care based on a "quality of life" analysis. The Catholic idea of the common good serves the fulfillment of the community by means of the fulfillment of the individual's well-being. (*Catechism*, 1906)

²⁴ "Union Members Summary," Bureau of Labor Statistics, U.S. Department of Labor, Table 3, "Union Affiliation of Employed Wage and Salary Workers by Occupation and Industry," at www.bls.gov/news.release/union2.t03.htm, January 21, 2004.

²⁵ Patients' dissatisfaction with their personal interaction with physicians seems to be endemic in Western medicine today, irrespective of the system in which that care occurs. A June 2003 article in the *British Medical Journal* underscored what patients desire from their medical providers. None of them, interestingly enough, was a certain cure. Patients desired eye contact, partnership, communication, time, with the doctor, and timely appointments (*British Medical Journal*, 326:1294, June 14, 2003).

²⁶ *Catechism of the Catholic Church*, 1906 et seq. Again, the common good and the good of the individual are not antagonistic in Catholic teaching, but rather complementary precepts. This is not to assert that what is achievable for both the common good and for the individual is unlimited, nor is it to defend any particular current limit. It is, however, to deny any form of "lifeboat ethics" that limits achievable care for the individual because of some presumed benefit to others outside the patient-physician interaction.

²⁷ *Evangelium Vitae*, 89.

²⁸ New American Bible, World Bible Publishers, Iowa Falls, Iowa, p. 1054.

²⁹ Fiorenzo Angelini, "The Theological Dimension, the Word of God, Health and Power," Official Publication of the Pontifical Proceedings of the XVIth International Conference, No. 49, 2002, No. 1 *Dolentium Hominum*, p.16. Cardinal Angelini is president emeritus of the Pontifical Council for Pastoral Assistance to Health Care Workers.

³⁰ While this designation of Luke has been disputed and scholars have questioned whether the medical references in the Gospel of Luke signify the vocation of its author, there is insufficient evidence to overturn the traditional view. A scholarly study of the question by Joseph A. Fitzmyer, S.J., while concluding that the importance of the gospel message in no way depends on accepting the medical vocation of Luke, found that "some of the modern objections to the traditional identification are not all that cogent." Fitzmyer, *The Gospel According to Luke I-IX: A New Translation with Introduction and Commentary* (Doubleday & Co.: Garden City, New York), p. 51-53.

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- ³¹ *Catechism of the Catholic Church*, 1503, citing Luke 7:13, p. 376.
- ³² *The Catholic Encyclopedia: An International Work of Reference on the Constitution, Doctrine, Discipline, and History of the Catholic Church*, Volume VII, "Hospitals," (Robert Appleton Co., New York: 1910), p. 481.
- ³³ *Idem*, p. 482.
- ³⁴ The Christian tradition of hospitality to the stranger, the idea that we may at any moment be "entertaining angels unaware," benefited from the productive labor and personal poverty of the monastics, who, as the author of the item on hospitality in the 1910 *Catholic Encyclopedia* framed it, "having made their renunciation of the goods of this world" are the better able "to perform the works of mercy toward others." (*Catholic Encyclopedia*, Vol. VII, p. 476)
- ³⁵ *Idem*, p. 484.
- ³⁶ *Catechism of the Catholic Church*, 1883, 1939 ff., 2258 ff. and 1804 ff.
- ³⁷ *Pacem in Terris*, 20.
- ³⁸ *Laborem Exercens*, Encyclical Letter of John Paul II Issued on the 90th Anniversary of *Rerum Novarum*, September 14, 1981, 19. While contemporary encyclicals speak with increasing specificity about the nature of remuneration in modern economies, including such benefits as workmen's compensation and pensions, they insist on the need for due respect for the maternal role in the rearing of children. (*See Quadragesimo Anno*, Encyclical Letter of Pius XI on the 40th Anniversary of *Rerum Novarum*, May 15, 1931, 28, 71.) Just as insistently, they speak of remuneration in such a manner that it is clear that the family receives wages or income "as a practical means" whereby it "can have access to those goods which are intended for common use[.]" (*Laborem Exercens*, 19) In this sense, remuneration is recognition that it is the worker's labor that provides, not the largesse of the employer or the state.
- ³⁹ *Rerum Novarum*, 18.
- ⁴⁰ *Rerum Novarum*, 9.
- ⁴¹ Pius XII, Pentecost Address, June 1, 1941.
- ⁴² *Rerum Novarum*, 10.
- ⁴³ *Rerum Novarum*, 20.
- ⁴⁴ *Rerum Novarum*, 45.
- ⁴⁵ *Rerum Novarum*, 69.
- ⁴⁶ *Rerum Novarum*, 76.
- ⁴⁷ Union Members Summary, Bureau of Labor Statistics, January 21, 2004.
- ⁴⁸ *Ibid.*
- ⁴⁹ Estimates of the dollar value of free care provided yearly to the nation's uninsured population range up to \$35 billion.
- ⁵⁰ The national health plan advanced by the Clinton Administration in the early 1990s would have made abortion "part of a mandatory national health insurance 'benefit package,' forcing all taxpayers to pay for virtually all abortions." (The Presidential Record on Life: President William Clinton 1993-2001, National Right to Life Committee, Washington, D.C.). The same administration urged Congress to repeal the Hyde Amendment, which has, since the 1970s, barred federal funding of most abortions under the Medicaid program. The NRLC also notes that the Clinton Administration declared abortion to be a "fundamental right of all women." The same idea is retained in the 2000 Democratic Party Platform, where the abortion right is upheld "regardless of the ability to pay," a euphemism for compulsory taxpayer support.
- ⁵¹ "An Overview of Abortion in the United States," Developed by Physicians for Reproductive Choice and Health (PRCH) and the Alan Guttmacher Institute (AGI), © January 2003, at www.agi-usa.org/pubs/abslides/abort_slides.pdf.
- ⁵² This vertical and horizontal representation of the physician-patient relationship epitomizes the two great commandments that constitute "the whole of the law." (Matthew 22: 37-40) The Catholic physician strives for holiness, a right relationship with the Father, in the conduct of his profession. Moreover, his practice is both catholic (universal) and apostolic (seeking out the patient in need). Each dimension of the relationship is covenantal, in that love for God cannot be real if His image, reflected in each of His human creations, is ignored or defiled.
- ⁵³ In this regard, it is interesting to note that the classical Hippocratic Oath obliged the physician neither to "give a deadly drug to anybody *who asked for it*," nor to "make a suggestion to this effect." In one concise phrase, the Oath condemns both euthanasia and assisted suicide. In so doing, the autonomy of both patient and physician is subjected to a higher law.

⁵⁴ *Pacem in Terris*, 11. Pope John XXIII was a passionate advocate of labor, human rights, justice and charity. He wrote: “Man has the right to live. He has the right to bodily integrity *and to the means necessary* [emphasis added] for the proper development of life, particularly food, clothing, shelter, medical care, rest, and, finally, the necessary social services. In consequence, he has the right to be looked after in the event of ill health; disability stemming from his work; widowhood; old age; enforced unemployment; or whenever through no fault of his own he is deprived of the means of livelihood. “

⁵⁵ Michael D. Greaney, C.P.A., M.B.A., “Universal Health Care – Justice or Charity?” *Social Justice Review*, September/October 2003, p. 132.

⁵⁶ *Quadragesimo Anno*, Encyclical Letter of Pius XI on the 40th Anniversary of *Rerum Novarum*, May 15, 1931, 129, citing *Rerum Novarum*, 63.

⁵⁷ *Quadragesimo Anno*, 118.

⁵⁸ Mary Ann Glendon, *Rights Talk: The Impoverishment of Political Discourse* (The Free Press: New York, 1991). The proliferation of evermore-expansive rights, never regarded as being in tension with or even opposition to one another, always to be enforced by evermore-remote levels of civil society, harms the achievement of the very goals “rights talk” aims to serve. Glendon deplores this talk, “its penchant for absolute, extravagant formulations, its near-aphasia concerning responsibility, its excessive homage to individual independence and self-sufficiency, its habitual concentration on the individual and the state at the expense of the intermediate groups of civil society, and its unapologetic insularity. Not only does each of these traits make it difficult to give voice to common sense or moral intuitions, they also impede development of the sort of rational political discourse that is appropriate to the needs of a mature, complex, liberal, pluralistic republic.”

⁵⁹ *Salvifici Doloris*, 28, Encyclical Letter of John Paul II, February 11, 1984, “On the Christian Meaning of Human Suffering,” quoting *Gaudium et Spes*, No 24.

⁶⁰ *Veritatis Splendor*, Encyclical Letter of John Paul II, August 6, 1993, “The Splendor of Truth,” 39.

⁶¹ A “refundable tax credit” is one in which an eligible taxpayer receives the full amount of the credit as cash returned even if he or she doesn’t owe taxes or doesn’t owe taxes equivalent to the full amount of the credit. Also, the credit would be assigned to the purchase of health insurance and could only be used to help finance the coverage. In order to be of real assistance in today’s expensive health care market, the credit would have to be substantial. One current proposal pegs the credit amount at \$1,500 for individuals and \$4,000 for families. As with some existing tax credits and exemptions, the value of the credit could be maintained by adjusting it annually for inflation.

⁶² A refundable tax credit can be structured in different ways, but the general notion of refundability is that the credit is not limited by the amount of tax owed. If the value of the credit exceeds the taxpayer’s liability in a given year, the balance of the credit, or some portion of it, is paid back to the taxpayer in cash. The classic example is the Earned Income Credit, or EIC, formerly known as the EITC. The federal government, 15 states, and the District of Columbia offer various forms of the EIC. The credit is refundable in 12 of the 15 states, and it is designed to encourage working families with children to stay in the workforce and not fall back on public benefits. See www.taxcreditsources.org.

⁶³ Robert Deposada, “Fair Care would cure uninsured epidemic,” *The Hill News*, April 6, 2004. Mr. Deposada is the president of The Latino Coalition, a nonpartisan, nonprofit organization that addresses policy issues affecting Hispanic Americans, one third of whom lack health insurance.

⁶⁴ “Santorum Introduces Fair Care for the Uninsured Act,” press release, Office of U.S. Senator Rick Santorum, Washington, D.C., August 1, 2003, at <http://santorum.senate.gov/pressreleases/record.cfm?id=207191>.

⁶⁵ Donald J. Palmisano, M.D., J.D., David W. Emmons, Ph.D., and Gregory D. Wozniak, Ph.D., “Expanding Insurance Coverage Through Tax Credits, Consumer Choice, and Market Enhancements: The American Medical Association Proposal for Health Insurance Reform,” *Journal of the American Medical Association*, May 12, 2004, 2237-2242.

⁶⁶ Conrad F. Maier, “‘Stealth Health’ Care Reform Looks Like Clinton Care,” A Heartland Perspective, The Heartland Institute, at www.heartland.org/archives/perspective/stealth.htm. This essay was originally published in the May/June 1998 issue of *Medical Sentinel*, published by the Association of American Physicians and Surgeons. The Institute estimates that state mandates cost insured parties \$60 billion per year.

⁶⁷ “Facts About Health Care: Health Insurance Cost,” National Coalition on Health Care at www.nchc.org/facts/cost.shtml.

⁶⁸ “Association Health Plans: Improving Access to Affordable Quality Health Care for Small Business,” U.S. Department of Labor, undated, circa 2002, p. 9.

⁶⁹ *Ibid.*, p. 4

⁷⁰ See www.cchf.org. CCHF founded its first clinic to serve the poor in rural Mississippi, under the guidance of John Perkins. Today it has begun to expand its reach through participation in the Compassion Capital Fund established by the Bush Administration in 2002.

⁷¹ Although a detailed discussion of the philosophy of insurance is beyond the scope of this paper, the idea of “real” insurance is one key to restoring both family management of and balance to the American health care system. Historically, insurance has operated as a means of pooling risk against the most significant and costly of life’s unexpected events. Life insurance operates in a highly competitive and largely uncontroversial manner based on this principle. Health insurance, however, has increasingly become a tool for both managing smaller health expenses and, in our time, attempting by bureaucratic means to ration care. While both impulses may have benevolent purposes, they have weakened the self-management of both patients and physicians while doing little to ease the concerns of families that a truly major health expense will destroy them financially. Put another way, the existing health care system is involved in far too many medical decisions to be either efficient or beneficent.

⁷² Nina Owcharenko, “Health Savings Accounts: How to Broaden Health Coverage for Working Families,” Web Memo, The Heritage Foundation, April 16, 2004, at www.heritage.org/Research/HealthCare/wm481.cfm?renderforprint=1.

⁷³ “U.S. House Speaker Hastert joins business leaders to review latest data on success of Health Savings Accounts,” *Business Wire*, June 21, 2004, Chicago, Ill.

⁷⁴ “House Passes Three Controversial Health Care Bills,” *Weekly Washington Wire on Health Care Issues*, Issue 15, May 14, 2004, at www.ppsv.com/wire/health/20040514.htm.

⁷⁵ House Bills 5277, 5278, 5006 and 5276 (H-2), as amended April 21, 2004.

⁷⁶ Nikolas T. Nikas, “Law and Public Policy to Protect Health-Care Rights of Conscience,” *The National Catholic Bioethics Quarterly*, Vol. 4, No. 1, Spring 2004, 41-52.

⁷⁷ The Diocese of Lincoln resumed its association with a private carrier, United Health Care, effective January 1, 2004.

⁷⁸ The Sacred Heart Medical Centre offers families an alternative in medical care that is faithful to the Magisterium and dedicated to the Gospel of Life. Its physicians advocate chastity, offer comprehensive family medicine for all ages, address alcohol and drug addiction, obstetrical care and natural family planning. Its motto is “Proclaiming the Kingdom of God Through Ministry to the Sick.”

⁷⁹ *Evangelium Vitae*, 5.