Article

Health care's ills: A Catholic diagnosis

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Catholic teaching is emphatic on the need to “guarantee adequate [health] care to all,” as Pope Benedict XVI has stated. America has been slower than other advanced countries in progressing towards this goal. Reasons for this delay can be found in certain attitudes that have long been present in American culture, and have been reinforced by the wave of libertarianism (free-market ideology) that swept the world in the late twentieth century. Catholic theology and social/economic teaching can help us understand the flaws in these attitudes, which involve fundamental philosophical and theological principles, but which are far from academic, since they have serious and very practical consequences. In the light of Catholic teaching, we can look towards a sounder understanding of healthcare needs and effective ways of meeting them.

Lay Summary: This article argues that access to healthcare, at least up to the level of basic necessity, falls under the heading of distributive justice. It is a human right owed by the community to each of its citizens. And since rights entail obligations, this right entails an obligation upon each citizen to contribute, as circumstances permit, to the costs, which need to be shared equitably; they cannot be met simply by each individual providing solely for oneself. Also discussed are the problems of excessive costs in healthcare administration and in pharmacological research, as well as harmful tendencies in private-sector firms to over-reward top management and to target maximum (rather than adequate) profits.

Keywords: Catholic social teaching, Catholic economic teaching, Healthcare reform, Universal health coverage, Solidarity

INTRODUCTION

It is necessary to work with greater commitment at all levels to ensure that the right to health care is rendered effective ... to establish a real distributive justice which, on the basis of objective needs, guarantees adequate care to all.

Pope Benedict XVI (2010)

The paradox of American health care is well-known. By comparison with other advanced countries, American healthcare spending, whether we measure it *per capita* or in proportion to GDP, has for many years been much higher; yet American

health outcomes have been in many ways clearly worse (Commonwealth Fund 2015). And the American system, despite its exorbitant costs, still does not “guarantee adequate care to all.” The “Obamacare” Act (*Patient Protection and Affordable Care Act* of 2010, hereinafter ACA) has enabled a sharp cutback in numbers of uninsured, from 45.5 million in 2012 to 28.6 million in 2015. But coverage is still not universal; and there should arguably be wider exemptions from covering contraceptive and related services.

Passage of the ACA required long and bitter struggles against fierce opposition in

federal and state congresses, in the insurance industry, and in the courts. Indeed, America has a long history, reaching back to Theodore Roosevelt's 1912 presidential election campaign, of failed attempts to establish nationwide universal health insurance. Yet the practice of mandatory health insurance for all has long been accepted as normal, and largely uncontroversial, in many other advanced, and advancing, countries (Klingen 2013). This American exception calls for critical examination.

Historical and continuing problems in the US health system apparently reflect certain deeply rooted, widely held ideological positions, notably:

- (a) overemphasis on self-reliance, as opposed to solidarity;
- (b) a too narrow conception (libertarianism) of freedom as "absence of restraint and constraint";
- (c) belief in near-absolute rights to private property;
- (d) exaggerated distrust of government, even though democratically elected;
- (e) obsession with the supposed need to maximize, paradoxically, both business competition and "shareholder value".

From the standpoint of Catholic social teaching, all these positions are challengeable.

IS UNIVERSAL HEALTHCARE A "HUMAN RIGHT"?

The Universal Declaration of Human Rights states that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family including . . . medical care," thus recognizing, in general terms, access to healthcare as a human right (United Nations 1948, art. 25).

Catholic teaching agrees, as we see from Pope Benedict's remark above. Elsewhere, Benedict states that "hospitals and structures for assistance must rethink their role to prevent health, first and foremost a universal good to be guaranteed and defended, from becoming a mere 'product' subjected to the laws of the market, hence accessible to few" (Benedict XVI 2012). In the *Catechism* we read that "*Concern for the health* of its citizens requires that society help in the attainment of living conditions that allow them to grow and reach maturity: food and clothing, housing, health care, basic education, employment and social assistance" (CCC 1997, no. 2288).

Moreover, Catholic teaching insists on the importance of "*distributive justice*, which regulates what the community owes its citizens in proportion to their contributions and needs" (CCC 1997, no. 2411). Since medical treatment is clearly something that from time to time is vitally necessary, it follows that healthcare, like food, clothing, housing etc. is a need that falls within the ambit of distributive justice. It is thus a good that, at least at the level of basic necessity, the community owes its citizens, a good that we owe each other, in accordance with the Catholic principle of *the universal destination of earthly goods*. This is defined in the Vatican II pastoral constitution *Gaudium et spes*: "the right of having a share of earthly goods sufficient for oneself and one's family belongs to everyone" (Vatican Council II 1965b, no. 69).

THE GOAL OF UNIVERSAL HEALTH COVERAGE

It would be erroneous to see *health insurance* as a human right; such a notion would confuse means with ends. The right is to *health care*, which is the end or goal; *health insurance* is the normal practical means of

achieving it for everyone. In fact, in accordance with the principle that rights entail obligations, the universal right to health care entails a universal obligation to contribute, insofar as one is able, to its costs.

Universal health coverage means a system that enables every citizen of a country to have access to medical care, at least for essential health needs, without having to pay substantial charges for such care at the time of use. It is thus a form of insurance that is based on *prepayment* and on *solidarity*. Prepayment, because, as with any insurance, one pays a premium today for protection against what might go wrong tomorrow. Solidarity, because the cost of medical treatment is unpredictable at the individual level. One cannot foresee when one will need it, or what it will cost. Therefore, if we are all to have access to the treatments we need, without facing potentially ruinous unpredictable costs, *there must be a pooling of risks*, otherwise called insurance.

Effective pooling requires the participation of a large group of people in a fund to which every member of the group contributes, in accordance with one's means, and from which every member can draw benefits when necessary. In effect, the costs of the sick are paid largely by the healthy. This is a manifestation of the Christian virtue of *solidarity*, which may be defined very briefly as *practical and effectual recognition of our mutual dependence upon one another*.

Catholic teaching lays great stress on solidarity, based on (for example) St. Paul's dictum: "we, being many, are one body in Christ, and individually members one of another" (Rom 12:5).¹ In the words of Pope Pius XII,

for two thousand years this sentiment has lived and endured in the soul of the Church . . . for the sake of creating the social conditions capable of offering to

everyone possible a life worthy of a man and of a Christian. (Pius XII 1941, no. 26)

Pope John Paul II explained that "solidarity is a firm and persevering determination to commit oneself to the common good; that is to say to the good of all and of each individual, because we are all really responsible for all" (John Paul II 1987, no. 38).

In Europe, as in Canada, group solidarity in health care has been achieved by setting up national health insurance regimes, financed mainly by taxes.² This means that everyone (unless too poor to pay taxes) is obliged to contribute, and that everyone is eligible for benefits. The inclusion of everyone in a national system ensures that risks are spread as widely as possible. The structure of such a system, as a nationwide entity managed by the state, avoids the involvement of private-sector insurance companies. This makes for simpler, cheaper administration than is usual in America.

By contrast, American health insurance has developed as an adjunct of employment. A large firm buys an insurance plan covering all its employees, thus creating an extensive "risk pool" with a good spread of risks. But this practice is growing less feasible, as medical costs rise faster than inflation, and as big firms reduce their headcount. They contract out many of their operations to smaller firms, for which group insurance is more difficult and expensive, since the spread of risks is narrower. And today, more people are working independently, rather than within corporations. Moreover, under increasingly competitive business conditions, it grows harder even for large firms to afford adequate cover for their employees. The growing burden of insurance costs undermines the competitiveness of American firms in world markets. Therefore, many

firms are cutting back their health insurance coverage, or even dropping it altogether.

The American employment-based model, which even at its best left many uncovered, is running out of steam. Our present mix of systems is incomplete, over-complex, and over-costly. So there is a need to consider publicly funded models, such as those employed in Europe and Canada, and already in America with Medicaid and Medicare. However, generalizing such models raises difficulties, because of the long-standing American aversion to public-sector based solutions.

OBLIGATORY CONTRIBUTION

If you have a right to something, but do not obtain it, you suffer an injustice. So the doctrine of a right to health care implies that the community has an *obligation in justice* to provide care to whomever needs it, even if the recipient cannot pay for it. Contributions for this purpose should therefore be obligatory (or mandatory) rather than voluntary. In the past, relatives, neighbors, and friends often *voluntarily* helped each other out when they had difficulties in paying for health care. This could involve paying a doctor's or hospital bill for one's relative, neighbor, or friend; alternatively, an altruistic doctor or local charity hospital might provide treatment without charge, or for a less-than-normal charge.

That, of course, did not always work out in practice; not every poor and sick person was in a position to rely on voluntary help from others. And today, medical technology is far more developed and treatments are often far more expensive; it is therefore all the more difficult for them to be covered by voluntary charity. As long ago as 1931, Pope Pius XI inveighed against those in the richer classes who

“wanted the whole care of the supporting the poor committed to charity alone” (Pius XI 1931, no. 4).

“ABSOLUTE RIGHTS” TO PROPERTY

Those who reject the concept of obligatory contribution typically hold that no one “owes” anything to anybody, except in payment for some good or service at full market value. For them, there cannot be an obligation in justice to pay for something without personally receiving it, and thus a right in justice to receive something without paying for it. This argument rhymes with the belief that we have *absolute rights* to our property; therefore, any obligation to pay away (in taxes or mandatory insurance premiums) a part of our property, without personally receiving equivalent benefits, constitutes theft. Thus, economics professor Paul Cleveland argues that people who favor mandatory payments for universal health cover “would rather steal health care from others than to work hard and purchase it for themselves” (Cleveland 2002).

But Catholicism teaches that property rights are not absolute; on the contrary, the property owner has a certain debt to society; while *ownership* can be private, *use* should be shareable with others. This principle dates back to Aristotle, who stated that “it is clearly better that property should be private, but the use of it common” (Aristotle 1895, 1263a); and, still further, to the Old Testament, where the Law of Moses imposes various obligations upon landowners. In sabbatical years (one year in seven), fields and vineyards must lie fallow, whatever grows there being available to the poor (Ex 23:11). The first fruits of crops and the first shearings of sheep must be given to the priests (Deut 18:4). A classic statement on this subject in modern Catholic teaching appears in *Sollicitudo rei*

socialis: “The right to private property is valid and necessary, but . . . private property is, in fact, under a ‘social mortgage’. . . based upon and justified precisely by the principle of the universal destination of goods” (John Paul II 1987, no. 42).

THE OBSESSION WITH SELF-RELIANCE

Rejection of communal obligations and rights in the field of healthcare also reflects the traditional American obsession with *self-reliance*. It is argued that every individual must “stand on one’s own feet”. Extreme examples of the cult of self-reliance are found in the writings of Ayn Rand; thus Hank Rearden, hero of *Atlas Shrugged*, claims that “I held it as my honor that I would never need anyone” (Rand [1957] 1996, 238). From a Catholic standpoint, such a claim is absurd; the Church’s teaching, as we have noted, strongly emphasizes our need of each other. In his encyclical *Graves de communi re*, Pope Leo XIII observed that “no-one is so rich that he does not need another’s help” (Leo XIII 1901, no. 16).

Clearly, a certain degree of individual self-reliance or independence is necessary. Can one imagine a society in which every individual is, like a small child, totally dependent on others? And yet, Jesus says, “unless you turn and become like children, you will never enter the kingdom of heaven” (Matt 18:3). Thus, though limited independence is possible and necessary, there is equally a need to recognize our fundamental condition of dependence, upon other people and ultimately upon God.

AN ANALOGY BETWEEN SICKNESS AND POVERTY

The non-obligatory view on health care has its counterpart in the libertarian

attitude to poverty, which rejects the idea that the poor can have a right, an *entitlement in justice* to help from the community. It also disfavors the idea that we should strive for an economic system that prevents the emergence of severe poverty. For that might well mean interfering with the sacrosanct freedom of the markets. It is argued that we must accept that the free-market economy may leave some people destitute, and that their poverty can be relieved only by voluntary gifts.

The Catholic view is quite different. The Church rejects outright the notion that social justice and charity are opposing alternative principles, one favored by the Left, the other by the Right, each derided by proponents of the other. On the contrary, justice and charity are inseparable. In *Caritas in veritate*, Benedict XVI states that “I cannot ‘give’ what is mine to the other without first giving him what pertains to him in justice. . . justice is the primary way of charity . . . charity transcends justice and completes it” (Benedict XVI 2009, no. 6). The Vatican II decree *Apostolicam actuositatem* asserts that “The demands of justice must be satisfied first of all; that which is due in justice is not to be offered as a gift of charity” (Vatican Council II 1965a, no. 8).

Thus, divine law imposes a *legal obligation* upon the rich to assist the poor, though that does not eliminate the need for voluntary gifts as well. The Law of Moses decrees tithes (Deut 14:22–29), partly for the support of the poor, as well as various practices such as the rule of *pe’ah* or “corners” (Lev 19:9): a farmer must not reap all the way to the corners or edges of his fields, but must leave part of his crop standing, so that poor people may gather it. These rules are not recommendations for voluntary giving; they form part of the Law, so they (or their modern equivalents) are obligatory for observant

Jews. But Jewish tradition also stresses the value of gifts of “loving-kindness” (*gemiluth hasadim*), over and above what is due in strict justice.

Libertarians argue that the Old Testament principle of obligatory transfers to the poor does not apply to Christians. Jesus told the Pharisees that they should not neglect the duty of paying tithes (Matt 23:23, Luke 11:42); but it is argued that his words here apply only to Jews, that the earliest Christian churches did not demand tithes. Yet the Church Fathers, from St Ambrose (340–397) onward, insisted that tithes must be paid. An earlier Father, St Irenaeus (c. 130–200), bishop of Lyons, wrote that Jesus “taught . . . in place of the rules of tithing, that we should share all things with the poor” (Irenaeus 1857, col. 1008), and this text is sometimes quoted today in support of the view that obligatory contribution is not Christian. But those words are preceded by: “in place of ‘You shall not commit adultery’, that we should also avoid concupiscence; and in place of ‘You shall not kill’, that we should not even be angry.” In the Latin text, as in this translation, the form of words is exactly the same in all three places. Irenaeus clearly did not mean to suggest that the rules against adultery and murder do not apply to us, so we must surely draw the same conclusion concerning the rules imposing tithes. It appears, then, that he was not rejecting the principle of obligatory contribution, but simply pointing out the importance of charity that complements justice.

THE INDIVIDUAL MANDATE AND FREEDOM

The *individual mandate* in the ACA raises hackles because it *obliges* individuals resident in the USA to take out health insurance, unless they are already covered

by Medicare, Medicaid, or a company plan (and with certain other exceptions). According to Michael Tanner, a senior fellow at the Cato Institute, this obligation amounts to “an unprecedented assault on individual liberty” (Tanner 2010). In holding it to be constitutional, the Supreme Court tied itself in knots, resorting to the bizarre device of declaring the penalty for not insuring to be a tax, which may legitimately be avoided by paying one’s insurance premiums (*National Federation of Independent Business v. Sebelius* 567 US 2012).

The libertarians’ objection derives from their view of private property, but also from their negative conception of freedom. This was neatly summarized by the Austrian free-market economist Friedrich von Hayek, who wrote that liberty is the “absence of restraint and constraint” imposed by other people, especially the people who govern us (Hayek 1960, 17). Hayek’s teacher, Ludwig von Mises, put the matter even more bluntly: “liberty is always freedom from the government” (von Mises 1958, chap. 5). This kind of freedom is called *negative freedom*, because it means that, so far as possible, we are *not* prohibited from doing things and *not* obliged to do things.³

We all want to be “free”, and many people apparently think, like Mises, that “freedom” is a simple, easily defined concept. But it is not, for the word “freedom” has countless meanings. We talk of political freedom, national freedom, religious freedom, freedom of expression, freedom of conscience, and many other freedoms, including that of the free market.

Negative freedom, which includes such conditions as not being enslaved or imprisoned, is clearly an essential element of freedom, but in itself it is a narrow and inadequate conception thereof. The released prisoner, after all, is not truly free

if he remains a slave to his own vices. Freedom from enslavement or arbitrary imprisonment is clearly very important; so is freedom from hunger. Yet one “does not live by bread alone” (Deut 8:3; Matt 4:4). Likewise, one does not thrive simply by not being wrongfully detained.

Moreover, the libertarian conception of freedom is often *amoral*. Thus, Hayek observed that “philosophers have sometimes defined freedom as action in conformity with moral rules. But this . . . is a denial of that freedom with which we are concerned” (Hayek 1960, 79). Another free-market economist, Milton Friedman, insisted that “freedom has nothing to say about what an individual does with his freedom” (Friedman 2002, 12). Anarcho-capitalist Murray Rothbard asserted that “the libertarian stands foursquare for the freedom . . . to engage in such ‘victimless crimes’ as pornography, sexual deviation and prostitution” ([1973] 2006, 9).

THE CATHOLIC UNDERSTANDING OF FREEDOM

By contrast, Catholic theology favors a positive and moral conception of freedom: “there is no true freedom except in the service of what is good and just” (CCC, no. 1733). The eminent Catholic theologian Bernhard Häring gave us another helpful description: “in essence freedom is the power to do good . . . the power to do evil is not of its essence” (Häring [1951] 1961, 99). This reflects the biblical doctrine that sin is equivalent to slavery, the opposite of freedom; the word *redemption*, which originally meant buying a slave out of bondage, is used metaphorically to mean pardon and purification. “He will redeem Israel from all his iniquities” (Ps 130:8); “we have redemption through his blood, the forgiveness of our trespasses”

(Eph 1:7). In his encyclical *Libertas praesantissimum* Leo XIII wrote that “the possibility of sinning is not freedom, but slavery” (Leo XIII 1888, no. 6). On this view, the concept of *amoral freedom* is self-contradictory.

Thus, we should think of freedom not just as a negative absence of constraints, but as a positive, creative power to do good. And we should recognize that certain constraints can help us to do good, and thus make us more free, in the positive sense. Paradoxically, a reduction in Hayek’s *negative freedom* can mean an increase in Häring’s *positive freedom*. The constraints imposed by divine or human laws can prevent us from deranging and damaging, even destroying our own lives, thus curtailing or losing our power to do good. We find resonances with this view in Judaism and in classical philosophy. “I shall walk at liberty, for I have sought thy precepts” (Ps 119:45). Rabbi Joshua ben Levi (third century AD) insisted that no man is free unless he studies Torah,⁴ i.e., learns God’s laws and strives to abide by them. Aristotle argued in his *Politics* that “men should not think it slavery to live according to the rule of the constitution; for it is their salvation” (Aristotle 1895, 1310a).

If we are obliged by law to make provision for medical treatment when we need it, we are enabled to stay in better health by preventing avoidable illness, treating contagious diseases (which if untreated may infect others) and mitigating disabling conditions. We thus give ourselves more *power to do good*, more freedom. In the words of John Paul II (1999), “considered in its entirety, human health thus becomes an attribute of life, a resource for the service of one’s neighbor and openness to salvation” (John Paul II 1999, no. 14). Good health is itself a power to do good, and thus a freedom.

THE OBSTACLE OF ANTI-STATISM

Many of the excessive costs of US health care appear to stem from its dependence on over-powerful, profit-maximizing, private-sector corporations. Yet many Americans abhor the idea of a state-sponsored insurance system; they consider this to be “socialist” or “statist”, and therefore inherently objectionable.

It is understandable that America, a nation built largely by people emigrating from states that they found oppressive, should have a tradition of anti-statism. This has often manifested itself in deeply negative attitudes to the whole concept of state governance. Thus Emerson wrote that “the less government we have, the better” (Emerson 1844, par. 15), while for Thoreau, “That government is best which governs not at all” (Thoreau 1849, par. 1). In our own times, Harvard philosopher Robert Nozick argued that “the most extensive state that can be justified” is the “minimal state . . . limited to the function of protecting all its citizens against violence, theft, and fraud, and to the enforcement of contracts” (Nozick 1974, 149, 26). Rothbard urged us to “simply think of the state as a criminal band” (Rothbard [1973] 2006, 57).

Against these negative views of the state stands a tradition rooted in Holy Scripture, in classical philosophy, and in Church teaching; a tradition that calls for good government, believes in its possibility, and celebrates its benefits. King David told us how “The God of Israel . . . has said to me: When one rules justly over men, ruling in the fear of God, he dawns on them like the morning light, like the sun shining forth on a cloudless morning” (2 Sam 23:3–4). Aristotle wrote of the state “originating in the bare needs of life, and continuing in existence for the sake of a good life” (Aristotle 1895, 1252b). According to St. John Chrysostom, “For

that there should be rulers, and some rule and others be ruled, and that all things should not just be carried on in confusion . . . this, I say, is a work of God’s wisdom” (John Chrysostom 1861, 393). St Thomas Aquinas argued that “There must exist something which impels toward the common good of the many over and above that which impels toward the particular good of each individual” (Aquinas 1949, chap. 1). Benedict XVI tells us that “A just society must be the achievement of politics” (Benedict XVI 2005, no. 28).

Anti-statism holds that the proper alternative to bad government is minimal government, or even none at all. By contrast, the tradition I have just described holds that the proper alternative to bad government is good government. It insists that the achievement of good government, though difficult, is possible, and that this is a challenge that we must take up. Catholic social and economic teaching clearly sides with this tradition. We cannot dispense with the state, so we must do our best to make it work well for the benefit of all its citizens. And that, surely, was the view of the Founders of the American republic, who took great pains to devise a constitution that would work well.

Anti-government sentiment may be understandable, and in some circumstances even laudable, but in many ways it is a thoroughly unhelpful mentality. For people who despise or detest the very idea of the state are unlikely to be able or willing to strive for a better state. And they resist reforms or innovations that need the state’s help. It appears that universal access to adequate health care cannot well be achieved by the private sector alone; it needs the participation of an efficient state.

Some argue that state involvement in health care offends against the Catholic principle of *subsidiarity*, thought in certain

circles to imply minimal government. But Pius XI, in his classic discussion of subsidiarity, did not envisage a disempowered state. He argued that the state must “freely, powerfully and effectively do all those things that belong to it alone because it alone can do them” (Pius XI 1931, nos. 78ff), without, however, attempting to micro-manage everything (Miller 2012). Opponents claim that, under a state-sponsored health system, one loses the freedom to consult the doctor of one’s choice. That is not the case in the two systems (British and French) with which I am personally familiar.

A necessary step towards effective healthcare reform is to overcome the exaggerated distrust of government that has become endemic in recent times, especially in America but also in Europe and elsewhere. As leading British economic commentator Martin Wolf has observed, “no democracy can thrive if its citizens view their own government as their greatest enemy” (Wolf 2012).

WHY ARE WE SO MISTRUSTFUL OF GOVERNMENT?

Today, governments support economic strategies from which majorities of citizens do not benefit. Gains from technological progress and economic growth flow mainly to small minorities of entrepreneurs, executives, and investors. Good jobs disappear and are replaced by short-term, poorly paid employments. Not surprisingly, neglected citizens feel frustrated and discontented, and are apt to turn to eccentric or incompetent politicians who offer specious promises, the political equivalents of medical “quacks”. From a Catholic standpoint, it is possible to make a diagnosis that goes some way to explain this unhappy situation.

Current economic policies are based on the orthodox (mainly neo-classical) economic doctrines that have been dominant since the latter part of the last century. These doctrines contain many problematic elements, in particular:

- (a) the notion that “the markets know best”, and therefore that private enterprise is always better than state-sponsored operations;
- (b) the belief that competition should not be restrained;
- (c) the belief that the state should regulate private-sector activities as little as possible.

The “markets know best” theory, promoted notably by Mises and Hayek in the last century, posits that the various markets within the economy “know” the supplies of every commodity and service and the demands for them. This knowledge is a vast mass of dispersed data that could not be gathered together by government planning offices. So it is futile to attempt central planning or regulation of the economy; we should leave the markets free to determine its workings, since they are the sole possessors of all the relevant information.

However, this plausible argument is defective. For though markets are indeed “knowledgeable”, there is also much that they do not know, or behave as if they do not know. In the healthcare sector, the market “knows” the demand for various treatments, but *demand in the economic sense simply means ability and willingness to pay*. It does not necessarily reflect patients’ needs. The market, in itself, does not “know” about those needs. It only knows how much patients are able and willing to pay for various treatments. So a market-based healthcare system often fails to deliver the *distributive justice* that Catholic teaching demands.

UNRESTRAINED COMPETITION

Economic orthodoxy holds that competition should not be restricted. This reflects the doctrine of negative freedom; businesses should be “free” from restraint by anti-competitive agreements or regulations. In practical terms, free competition motivates each firm to cut its costs, and thus its prices, so as to gain market share. Lower prices mean that we can afford to consume more, to have “higher standards of living”. Cost-cutting very often means generating the same quantities of goods or services with fewer employees; to offset this job-destroying trend, we need continual growth in output.

However, today the human race as a whole is overconsuming many of the earth’s resources, even though many people are still miserably poor, unable to consume enough for a decent way of life. Therefore, overall consumption needs to be restrained; the richer countries cannot persist in consuming more and more of everything. John Paul II warned, that “man consumes the resources of the earth and his own life in an excessive and disordered way” (John Paul II 1991, no. 37); Pope Francis, in *Laudato si’*, observes that the pursuit of unlimited growth “is based on the lie that there is an infinite supply of the earth’s goods, and this leads to the planet being squeezed dry beyond every limit” (Francis 2015, no. 106).

But stable (sustainable) production and consumption, under unrestrained cost-cutting competition, is likely to mean ever-rising unemployment, of which Catholic teaching strongly disapproves: “*Full employment* remains a mandatory objective for every economic system oriented towards justice and the common good” (Pontifical Council for Justice and Peace 2006, no. 288). Indeed the Church tells us, not only that “work is a duty” (CCC, no. 2427), but that opportunity to work is a right: “the

fundamental right to employment should not be dismantled” (Francis 2014).

“HYPERTHYROID” COMPETITION

The dogma of free competition is therefore obsolescent. Indeed, its merits have always been doubtful. I have argued elsewhere that competition plays a role in the economy remarkably like that of the thyroid hormones in the human body (Sibley 1995, 305–6). Just as these hormones stimulate metabolism and growth, so competition promotes economic activity and growth. And, just as hyperthyroidism can cause serious illness, so excessive competition can cause grave economic problems (Sibley 2015, 53–74). It can also cause medical problems, such as excessive stresses in the workplace. In the world of sports, too fierce competition calls for hyperintensive training regimes, which can cause physical and psychological harm.

In health insurance, free competition has perverse consequences. As explained above, the way to make insurance affordable for everyone is to charge premiums based on average costs per person, so that the healthy subsidize the sick. This practice is called *community rating* because premium rates are based on average costs over the whole insured community. The system imposed by the ACA is a form of partial community rating, since it allows premiums to vary, within limits, according to age and place of residence, but not according to medical condition or gender.

Conversely, in a fully competitive health insurance market, insurers are free to compete for the business of the young and healthy by offering cheap premium rates based on their lower costs. This practice leads to segmentation of the market, eliminating the cross-subsidy that makes insurance more affordable for those who need it most, the old and the unhealthy.

These persons then have to pay premiums based on their full costs, which are likely to be prohibitively high. They may indeed be refused coverage altogether. For this reason the ACA rules out unrestricted competition on rates. We have here a practical example of the principle enunciated in 1931 by Pius XI : “the right ordering of economic life cannot be left to a free competition of forces” (Pius XI, no. 88).

REGULATION OF THE ECONOMY

Orthodox economics, in keeping with the doctrine of negative freedom, disapproves of state regulation of economic activities. But we know from painful experience that deregulation can get us into terrible trouble. After the horrifying banking crisis of the early 1930s, American banks were placed under very tight regulation, which kept them on the rails for several decades. The financial crisis of 2007–2008 could hardly have happened without the extensive deregulation of financial systems, from the 1970s onward, that was encouraged by the worldwide spread of free-market dogma.

In health insurance, the ACA imposes stringent regulations on insurance companies that participate in the new health insurance exchanges. They are forbidden to discriminate against customers with pre-existing medical conditions, to impose annual or lifetime caps on benefits, or to rescind policies in the event of illness. They are also required to keep their administrative costs and profits within 20% of premium income, or 15% when insuring large groups. These rules are designed to prevent malpractices by insurers more concerned to maximize their profits than to provide a good public service. Thus the ACA clearly challenges the ideology of orthodox economics.

The aim of this digression on economic theory is to explain, in part, why so many

people are disillusioned with current political leadership, and deeply distrustful of government as they know it. Our mainstream politicians, whether center-left or center-right, basically go along with economic orthodoxy. And, for many years, economists have succeeded in persuading most of us that their orthodoxy is the only possible way. But today, it is becoming clear that this kind of economics treats ourselves as workers with scant respect, makes it impossible to secure affordable health care for everyone, generates exorbitant inequalities, encourages excessive, wasteful consumption, and is promoting the ruin of our environment and climate. People are coming to see that the reigning economic emperor has very few clothes. So they have little confidence in politicians who genuflect to the emperor.

THE PROBLEM OF CORRUPTION

John Paul II commented severely on the consequences of corruption in political life: “the right [of all citizens] to participate in the life of their community . . . means nothing when the democratic process breaks down because of corruption and favoritism, which . . . prevent people from benefiting equally from community assets and services” (John Paul II 1998, no. 6). The problem of inordinate corporate influence on American political decision making has become very serious in recent times, especially since the Supreme Court’s decision in *Citizens United v. Federal Election Commission* (558 US 2010). From a European standpoint, it seems odd to hold that “freedom of speech” can extend to the “freedom” of wealthy corporations to spend without restraint on influencing the political process.

In Britain, the *Communications Act* of 2003 prohibits paid political advertising

on radio and television, and there are similar restrictions in most western European countries. The decision in *Citizens United* seems to reflect the negative concept of freedom criticized above (freedom = absence of restraint and constraint), in contrast to the Catholic concept of freedom “in the service of what is good and just.” A business that spends heavily on persuading politicians to make laws favorable to itself, is likely to be serving its own private interests rather than the common good.

The healthcare sector spends substantial amounts on lobbying legislators and regulators. In recent years this expenditure has been running at around \$480 million annually, more than double the prevailing level at the turn of the century (Center for Responsive Politics 2016). In addition, the sector makes large federal campaign contributions, “a record \$260.4 million to federal candidates during the 2012 election cycle” (Center for Responsive Politics 2016). The result is that healthcare law and regulation tends to be biased toward the interests of businesses and professionals involved in health care, rather than those of patients and the general public.

Trust in government is unlikely to return until governments take a firm stand against excessive corporate lobbying, disengage from current economic orthodoxy, and adopt economic philosophies and strategies better suited to the needs of our times.

WHY ARE PHARMA PRICES SO HIGH?

Technical progress is the basic reason that medical costs worldwide tend to rise faster than overall inflation. More and more new treatments are developed and put to use, but the costs of developing and using them can be very high. An offsetting factor is that techniques permitting prevention or early diagnosis of diseases may

avoid the need for expensive treatments, and may thus reduce overall costs.

The cost problem is especially controversial in pharmacy. The costs of developing and testing new drugs can be huge, largely because the process is so lengthy. A note issued by the FDA indicated that the standard testing and approval process in the 1990s could take up to twelve years (USFDA 2006); PhRMA gives a timescale of “on average ten to fifteen years” (PhRMA 2016, 46). Since new drugs have occasionally been found, after approval, to have disastrous side effects, there can only be limited scope for abridging the approval process.

Pharma companies justify their very high prices for patented drugs by the need to finance continuing R&D. The estimate published by DiMasi et al. (2003) showed the average cost of developing a new drug, including the costs of related drugs that fail in testing and have to be written off, as \$802 million in 2000. A study by Paul et al. (2010) gives a figure of \$1.8 billion; Mestre-Fernandez et al. (2012, 38) show \$1.5 billion; PhRMA (2016) claims that the average cost has reached \$2.6 billion. Thus R&D costs appear to have more than tripled, over a period in which overall US inflation was less than 40%. According to PhRMA (2016, 47), the main causes of cost inflation are the increasing size and complexity of clinical trials, an increased focus on drugs for chronic and degenerative diseases, and higher failure rates in the early stages of testing.

THE DECLINE OF “RESEARCH PRODUCTIVITY”

PhRMA (2016) reports that American R&D spending has swollen from \$2.0 billion in 1980 (\$4.8 billion in 2015 dollars) to \$58.8 billion in 2015, thus expanding *more than twelvefold* in real

terms. Yet the number of “novel drugs”⁵ approved by the FDA averaged only about twenty-eight per annum between 2006 and 2014 (USFDA 2015), a level seen as long ago as the 1950s; between 1980 and 1995, the average was about twenty-five (Light and Lexchin 2012, figure 1). Significant innovation has not accelerated much, despite vastly greater spending.

Moreover, various studies covering the past several decades show that only 10–15% of all new approvals have provided significant improvements, as compared with existing therapies. And many new drugs, barely more effective than older ones, present higher risks of serious adverse reactions.

Obsessed by fear of revenue losses following patent expirations, manufacturers concentrate on developing new drugs to replace those that “fall off the cliff”. These are often minor variations on existing products, but they can be patented and sold at high prices. This requires that massive marketing be spent to convince doctors, pharmacists, and patients that the new products are superior to their predecessors. According to Gagnon and Lexchin (2008), “as a percentage of US domestic sales . . . promotion consumes 24.4% of the sales dollar, versus 13.4% for R&D.” The scope of marketing has widened since direct-to-customer (DTCA) television advertising of prescription drugs became legal in the USA in 1997. This practice is prohibited in practically all advanced countries, apart from the USA and New Zealand.

Manufacturers argue that direct-to-customer advertising is beneficial, since it makes people more aware of treatable health problems and encourages them to seek treatment. On the other hand, it appears that this type of advertising is often misleading, and that it encourages patients to demand prescriptions for drugs that may be unsuitable or unnecessary. Mintzes

observes that, with new drugs, “new serious risks are often discovered in the early post-marketing period. From a public-health perspective, caution, not rapid uptake, is needed”; and she considers that “Any benefits [of DTCA] could be better achieved through public health campaigns” (Mintzes 2009, 131–133).

Catholic teaching is not opposed to advertising in principle; “the Catholic Church has been engaged in advertising since the time of Jesus; we call it evangelization” (Foley 2003). But the Vatican gives clear guidelines: “Advertising may not deliberately seek to deceive, whether it does that by what it says, by what it implies, or by what it fails to say” (Pontifical Council on Social Communications 1997, no. 15).

A STRATEGY FOR BETTER RESEARCH

Jean-Pierre Garnier, on his retirement as CEO of GlaxoSmithKline, published a striking article in which he describes reforms that he initiated in this company. He argued that “The way to solve the productivity problem . . . is to return power to the scientists by reorganizing R&D into small, highly focused groups” (Garnier 2008). In his view, R&D loses much of its effectiveness when carried out in huge research departments under complex bureaucratic hierarchy; the work needs to be decentralized into much smaller, specialized, autonomous units. This approach seems to accord with the principle of subsidiarity, which “calls for respect (and for support when needed) by larger and more distant entities, for the initiative, freedom, and responsibility of the smaller and more local entities” (Turkson 2014). Thus, groups of researchers can benefit from the facilities that a large organization can provide, while being free to pursue their ideas as though in a dynamic small enterprise.

HUGE COSTS FOR LITTLE BENEFITS

Certain very costly drugs provide only marginal benefits. For example, [Fojo and Grady \(2009, 1044–48\)](#) report that clinical trials of cetuximab (Erbix), in the treatment of non-small cell lung cancer, found that the addition of this agent gave an overall survival advantage of 1.2 months with, however, increased frequency of various unpleasant side-effects. They also remark that the FDA approved bevacizumab (Avastin) for the treatment of non-squamous non-small cell lung cancer, based on an overall survival advantage of two months. These treatments are reported to cost \$80,000 and \$90,000 respectively. No one claims that they have the potential to cure the disease.

From a Catholic standpoint, it seems bizarre indeed that people are prepared to disburse (or have their insurers disburse) such large sums merely to linger a few weeks longer *gementes et flentes in hac lacrimarum valle*.⁶ Such behavior seems to reflect a culture that has little or no faith in the life of the world to come, and prefers therefore to hang on to life in the present world for as long as possible, whatever the cost and the discomfort. The *Catechism* tells us that “Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate; it is the refusal of ‘over-zealous’ treatment. Here one does not will to cause death; one’s inability to impede it is merely accepted” ([CCC 1997](#), no. 2278).

AN ALTERNATIVE WAY TO FINANCE R&D

While much effort is put into developing new drugs that resemble existing drugs and are little better, urgently needed research is neglected, such as the quest for

new antibiotics to replace those to which microbes become resistant. A new antibiotic should be introduced well before resistance to existing treatments has become a major problem. But doctors use new antibiotics as sparingly as possible, so as to minimize the development of resistance; they are also dissuaded by the high prices of new, patented antibiotics. Therefore, the developer’s return on investment in such drugs may be very slow in coming; so this is an area of research that attracts little private-sector investment. Here we have an example of what economists call *market failure*; the market fails to motivate us to do what needs to be done.

A new report, sponsored by the Wellcome Foundation and the British government, suggests an alternative method (*Market Entry Rewards*) of financing this type of R&D: an international fund, supported by many governments, could award prizes, sufficient to cover the full upfront costs plus an adequate margin of profit, to developers of new drugs that successfully meet “acute unmet medical needs” ([Review on Antimicrobial Resistance 2016](#)). A prize-winning firm, having earned a fair return on its investment, would be in a position to sell its new drug at no more than the cost of manufacture plus a reasonable profit margin. This would eliminate the need for patent protection and the problems of selling drugs at discounted prices in poor countries, with the risk of diversion back into the rich countries by unscrupulous traders. Since there would be no prizes for new drugs that offered only marginal improvements, much costly and superfluous R&D might thus be avoided.

REGULATION OF DRUG PRICES

Patent protection allows manufacturers to sell new drugs, for limited periods, under

conditions of monopoly. Yet, in America, they are allowed to sell at unregulated prices, which can be extraordinarily high, leading inevitably to accusations of profiteering.

By contrast, in European countries, prescription drug prices are normally regulated, by a variety of methods. Golec and Vernon (2006, 8), in a study covering the period 1986–2004, show that European prices moved in line with consumer prices, while in the USA, drug prices showed almost 50% higher inflation than the consumer price index.

However, this and other studies show that, in relation to business volume, the level of R&D spending has generally been lower in Europe than in the USA. Thus it is argued that, while Europeans benefit from lower current prices, they may suffer in the longer term from slower development of new drugs. Yet, given that the large majority of US “innovations” provide little advantage over existing therapies, one may wonder whether there is really much to be gained from the higher US level of research. Eger and Mahlich suggest that “regulation may not only decrease R&D spending but lead to a more efficient use. . . . regulation could in principle reduce the development of so-called ‘me-too’ drugs. . . . while maintaining or even increasing the number of break-through innovations” (Eger and Mahlich 2014).

ADMINISTRATIVE COSTS

Himmelstein et al. (2014, 1590, 1593) confirm that administrative costs are far higher in US hospitals than in those of other advanced countries. A 2010 average of 25.3% of total hospital expenses in the USA compares with 19.8% in the next highest country (the Netherlands), 12.4% in Canada and 11.6% in Scotland. These researchers argue that the high US level is

due largely to the complexity of the payments systems. They think these should preferably be “less market-oriented”. According to an earlier congressional study, “It appears that only by a dramatic change to a single-payer system can great savings be realized” (USCOTA 1994, 6).

Recent British experience is relevant here. The National Health Service (NHS), dating from 1948, was a single-payer system where the government owned and directly funded most hospitals. The Thatcher government initiated drastic changes, legislated by the *NHS and Community Care Act* of 1990, which transferred the hospitals to independent trusts and required them to compete with each other, thus setting up an “internal market” for healthcare services. Paton, in a report published by an independent group of academics and doctors, argues that “market structures in the NHS. . . have cost a lot and delivered little (if indeed anything) positive” (Paton 2014, 5).

Following devolution in 1999, the Scottish government reversed these market-based reforms, reverting to a single-payer system. Under this regime, hospital administration costs, as noted above, are a little lower than Canada’s; while in England, which retains its internal market, the ratio is significantly higher at 15.4%. Moreover, the Scottish government has provided a substantial increase in funding. Steel and Cylus, in a report sponsored by the WHO and the European Union, observe “marked improvements [over the previous decade] in population health and in the quality and effectiveness of NHS care and treatment” (Steel and Cylus 2012, 133).

EXECUTIVE OVERPAYMENT

Another contributor to high medical costs is the remuneration of senior executives in

hospital, health insurance, and pharma companies. Should the CEOs of such firms be paid many times more than the best-paid specialist doctors? In 2015, the compensation of the twenty highest-paid CEOs (in S&P 500 health-sector firms) ranged from \$46.46 million to \$14.84 million (Ellison 2016).⁷ By contrast, orthopedic surgeons (the highest-paid specialists) earn on average \$443,000 (Peckham 2016).

In America and internationally, top executive pay has expanded enormously in recent decades. It is reported that the ratio of average CEO pay in large firms to the pay of “typical” US workers has soared from 20 in 1965 to 303 in 2014 (Mishel and Davis 2015). This report argues that the increase reflects in part “the increased value of highly paid professionals in a competitive race for skills,” but also “the power of CEOs to extract concessions” from their employers.

Gabaix and Landier observe that, in some cases, “Stock-option plans are viewed as a means by which CEOs can . . . increase their own compensation under the camouflage of . . . improving incentives, and thus without encountering shareholder resistance” (Gabaix and Landier 2008, 52). Thomas Piketty, renowned for his studies on inequality, has harsher words for this kind of behavior: “top managers take advantage . . . by putting their hands in the till” (Piketty 2009). Some executives become very rich, “earning” far more than they can reasonably need and sometimes hoarding their surpluses in tax havens. We read in the *Compendium* that “evil is seen in the immoderate attachment to riches and the desire to hoard . . . he who retains riches only for himself is not innocent; giving to those in need means paying a debt” (Pontifical Council for Justice and Peace 2006, no. 329). Overpaid executives in health companies could perhaps “give to those in

need” by accepting more reasonable remuneration, thus helping to reduce costs and make treatment more affordable.

The rationale for paying business leaders extravagantly is that, if a more capable (or ruthless) CEO can enhance a firm’s profitability, and thus increase its market capitalization by (say) \$25 million, then it makes sense for the firm to employ this person, even if he or she demands a remuneration package of \$20 million.

This argument is faulty. For any real improvement in a firm’s performance is normally the work of many people. A good leader may indeed act as a catalyst, showing the way to better performance and inspiring greater enthusiasm and effort. But since the achievement of better performance is a joint undertaking, logically the benefits should be shared by all those who take part, not monopolized by the leader. As long ago as 1931, in *Quadragesimo anno*, Pius XI recommended that “workers and other employees . . . become sharers in ownership and management or participate in some fashion in the profits received” (Pius XI 1931, no. 65).

MAXIMIZATION OF PROFITS

Pharma companies, like many other businesses, appear to have become inordinately fixated on marketing and on maximizing their profits. It is still widely thought that the sole duty of business management is to maximize returns to stockholders (“shareholder value”). This view found its classic expression in the case of *Dodge v. Ford Motor Company* (170 NW 668 [Mich 1919]), where the Michigan Supreme Court ruled that

a business corporation is organized and carried on primarily for the profit of the stockholders . . . The discretion of the directors does not extend . . . to the

reduction of profits, or to the nondistribution of profits among stockholders in order to devote them to other purposes.

In the mid-twentieth century, a broader view of the duties of directors came to be recognized. Berle and Means, in their classic text on management, argued that it is unreasonable for stockholders, who generally play no part in running a business, to claim exclusive rights to its profits. Neither should management claim all the profits remaining after allowing a fair return to the stockholders; that could encourage “corporate plundering.” These authors argued for a third alternative: “a program comprising fair wages, security to employees, reasonable service to the public, and stabilization of business, all of which would divert a portion of the profits from the owners of passive property” (Berle and Means [1932] 1968, 299–313).

This civilized concept of management did indeed become quite widespread for a time. However, more recently America has reverted to the older mentality, popularized notably by the Chicago economist Milton Friedman. He wrote that business managers have no social responsibility “other than to make as much money for their stockholders as possible” (Friedman 2002, 133) and that “a corporate executive is an employee of the owners of the business” (Friedman 1970), implying that executives must always bow to stockholders’ wishes. But Friedman’s arguments are open to serious legal, moral, practical, and theological objections.

As a matter of law, it is simply wrong to state that corporate executives are employed by the stockholders. They are in fact employed by the corporation, which is a legal personality in its own right, distinct from the persons who own it. The duty of executives is therefore primarily to the

corporation itself, and only indirectly to its stockholders.

In theory, stockholders’ interests should accord with the corporation’s. But in practice, these interests may well diverge, especially where the stockholders are transitory. Too many stockholders just want quick gains and are unconcerned with the corporation’s long-term welfare. And the pursuit of short-term gains can indeed damage the corporation. Asset-stripping, skimping on research, short-changing and overstressing workers, gouging customers . . . executives who indulge in such practices are pandering to the demands of transient stockholders, or to their own greed, but neglecting their basic duty to promote the welfare of the corporation that employs them. In practical terms, such behavior can lead to the degradation of important businesses and damage to the societies within which they operate. Morally as well as legally, it should be condemned as a dereliction of duty.

Theologically, Catholic teaching holds that private property rights are by no means absolute. “To Yahweh belong the earth and all it contains” (Psa 24:1 NJB), so all earthly property basically belongs to God; we are God’s tenants or stewards, not outright owners. So, are stockholders entitled to expect management to pursue stockholder interests exclusively? Clearly they are not, for that would imply the un-Catholic libertarian view, that owners of property have absolute rights to it, and are entitled to use it exclusively for their own private benefit. In Catholic terms, management and workers in a business firm have a duty to serve the common good, not merely the firm’s proprietors. John Paul II gave us a good description of the firm as “a *community of persons* . . . who form a particular group at the service of the whole of society” (John Paul II 1991, no. 35).

CONCLUSION

To achieve effective reform of American health care, we need to accept wholeheartedly the need for solidarity; to rebuild a medical ethos that is intolerant of personal and corporate greed; to rely less on market mechanisms. For, in this field, these mechanisms too often fail to motivate us to steer our efforts towards achieving the most valuable real advances, and towards making them available as widely as possible. Catholic teaching, which deals explicitly with all these matters, can be of much help to us in our endeavors to create a health system that truly serves the common good.

NOTES

- 1 Biblical citations (unless otherwise noted) are from the Revised Standard Version (Catholic edition).
- 2 A European study shows public expenditure on health as percent of total health spending (2010) varying between 71.7% in Poland and 83.2% in the United Kingdom. See Pavolini and Guellén (2013), 242.
- 3 For fuller discussion of the ideology of these Austrian economists, see Sibley (2011).
- 4 Talmud, Mishna *Avoth* 6:2.
- 5 “Novel drugs” are new molecular entities or new therapeutic biologics.
- 6 “Groaning and weeping in this vale of tears,” a phrase from the hymn *Salve Regina*.
- 7 Figures from the *Equilar/Associated Press S&P 500 CEO Pay Study* 2016.

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