Health-Care Reform

Too Much of a Good Thing?*

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Abstract

Approaching health-care reform from a philosophical and theological perspective, the author calls into question the assumption that more health care is better health care. He points out that the high cost of the technological advances that have improved health care in the developed world raises a moral issue, for most other people in the world have no comparable health security. The right to basic health care must be defined in a realistic way. Otherwise, the author warns, the ever increasing call for more health care will lead to the rationing of benefits for those that technology can no longer help: the very old and the terminally ill.

When I was providing pastoral care for a small nursing home run by Catholic sisters in St. Petersburg, Russia, they came to me for advice on the following matter. One of their employees, a much beloved man in his sixties, had a heart condition that was likely to bring about his demise in a short time. Apparently, there was an experimental drug in use in Switzerland that offered some hope for a significantly longer life.

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The sisters were inquiring whether I thought there was any chance of raising the ten thousand dollars that would be required to begin this treatment. A difficult quandary....

This was the first time that I, an American, had ever been confronted with the uncomfortable reality that modern medicine forces us to face: a person's health, and even life, must be weighed against money. We must ask what seems to be an absurd question: If the value of the human person is infinite, what finite sum is his life worth to us? Is it, as this case suggests, as little as ten thousand dollars? If the question is accepted as legitimate, or rather unavoidable, then how does one answer it? And who answers it? Doctors? Bureaucrats? The market? Or moral theologians?

This is, in the main, a new problem. Certainly, in the not-so-very-distant past, a man of means could afford to call down specialists from the big city. He could afford to travel to a warm place to take the waters. He could, above all, afford to rest, stay warm, and stay well fed, while poorer folk died younger for lack of such things. Nonetheless, for the most part, treatments were not expensive; society in general and no individual in particular ever regularly spent 15 percent of his income on health care.

Most of the health-care reform debate focuses upon *who* pays. Given the extraordinarily high cost of health care, the question becomes "How do we spread the risk?" Shall it be through purchases from private insurers (mandated or voluntary), or should it be from payroll taxes and public insurance?¹ The question of *why* these expenditures are so high is indeed part of the debate, but a small part. There is, to be sure, a concern to make the high cost more manageable, yet still most everyone accepts that it must be a high cost. For instance, there are calls for less waste, more competition, tort reform, and so forth. Nonetheless, it would seem that these debates are often technical, partisan, and missing the bigger question. It is assumed that the highest level of health care that is technologically possible is a *desideratum*, is attainable, and is even a human right. But is this the case?

Presenting the perspective of a moral theologian, I would not presume to trespass into the complex thicket of questions regarding how best to spread the expense of health care, or how best to reduce the costs to some degree. It would, however, be my role to raise uncomfortable questions at the root of why health-care costs are so high in the first place. What has happened—or better, is happening—that a nation should be willing to spend so much money on its physical well-being? Is it right that one nation's citizens should spend so much on their health while other peoples in the world can afford so little? How is it that this debate, which usually is conducted without looking beyond our nation's borders, has failed to include the fact that Americans spend *twice* as much per capita on their health as even Canadians, Swedes, Germans, or Australians?²

The philosophical and theological perspective is often an unpopular one. The questions that I would like to ask are questions that politicians on both sides of the aisle would not consider asking. Indeed, for most Americans we have gradually grown accustomed to the idea that we *deserve* the best care that technology can provide and that money can buy. It must be convenient and effective, backed up by studies, controlled by regulations, guaranteed by the threat of law suits. We are supposed to have our own doctor, who will respond to our every whim. Most of all, we expect this, no matter who we are, at a very low cost. The growing expectations, which have much to do with an exaggerated sense of rights, a fear of suffering and death, an almost religious faith in technology, and an understandable wish to have poor Americans share the same benefits, are placing us in a genuine crisis.

The philosophical and theological perspective should recall us to first principles, which is genuine wisdom. As the ancients asked in a different context, have we, for the sake of life, ignored the reasons for living?³ Philosophers and theologians have often been mocked and killed, because their perspective is unpopular. Their contrarian bent would lead them to point out, just as medical science is celebrating a new cure that the patient will still die in a little while of some other cause—perhaps a worse one. Now, clearly there is a great service provided by those who fight against disease, but we must not lose sight of the fact that there is also an aspect of futility in all that medical science can do. We will all die and with some degree of suffering. The effort to conquer every kind of human misery needs to be tempered by recalling that it is ultimately a battle that cannot be won. There remains some of the hubris of the followers of Descartes, who thought that the application of reason and science to human health would enable man soon to live to the age of the Patriarchs.

The approach of Catholic ethics is, on the other hand, eminently realistic and practical. Not long ago, on the occasion of the twenty-fifth annual conference organized by the Pontifical Council for Health Care Workers, Pope Benedict XVI reiterated the right of every human being to “basic health care.”⁴ The word *basic* is very important here. We could say that the point of my remarks today is really to ask: What is basic health care? There must be some care that is not basic and no longer a right. Certainly, everyone will agree that much cosmetic surgery should not be covered by public insurance, but the line surely is not to be drawn there. We must ask: If too many people seek an excessive degree of health care, will it be possible to see that *all* men, or even all Americans, have access to care that is basic? In his speech, the pope lamented “the fact that still today many of the world’s populations have no access to the resources they need to satisfy their basic needs, particularly with regard to health care.” This is because in some places, he added, “we are witnessing an attention to health that borders on pharmacological, medical, and surgical consumerism, almost a cult of the

body.”⁵ The Holy Father was discreet enough to leave specific countries unnamed.

We can find some inspiration for this aspect of Catholic social teaching in that document that has been immortalized as the formal entrance of the magisterium into social doctrine: *Rerum novarum*.⁶ Although Pope Leo XIII was treating the plight of laborers whose lot in the industrial revolution was little better than slavery, he made some general observations that we could do well to recall in the present context. We can find three points of great relevance, which reveal the realism of Christian social thought.

Pope Leo noted, “It must be first of all recognized that the condition of things inherent in human affairs must be borne with.”⁷ In other words, the consequences of original sin, including sickness and death, will always be with us. He continued:

In like manner [to the burden of work], the other pains and hardships of life will have no end or cessation on earth; for the consequences of sin are bitter and hard to bear, and they must accompany man so long as life lasts. To suffer and to endure, therefore, is the lot of humanity; let them strive as they may, no strength and no artifice will ever succeed in banishing from human life the ills and troubles which beset it.⁸

The pope did not deny, of course, that Christians should do all they can to alleviate suffering, but such efforts should not become, as they can become, an obsession born of forgetting where our true happiness lies. We cannot imagine that constructing a civilization of justice and love will be the same as building a utopia. The pope continued:

If any there are who pretend differently—who hold out to a hard-pressed people the boon of freedom from pain and trouble, an undisturbed repose, and constant enjoyment—they delude the people and impose upon them, and their lying promises will only one day bring forth evils worse than the present. Nothing is more useful than to look upon the world as it really is, and at the same time to seek elsewhere, as we have said, for the solace to its troubles.⁹

Indeed, recalling our theological perspective, it must be pointed out that suffering, pain, and death are not only inevitable, but that they have a positive purpose in restoring man to friendship with God. Every man, whether he recognizes it or not, has a “vocation” to suffer to some degree. The Apostles “exhort[ed] them to continue in the faith, saying that through many tribulations we must enter the kingdom of God” (Acts 14:22). Our Lord, too, asked, “And what shall I say? ‘Father, save me from this hour’? No, for this purpose I have come to this hour” (Jn. 12:27). The very human and Christian desire to alleviate pain must coexist with the equally Christian attitude toward suffering that anticipates it without fear and accepts it without complaint, finding the strength to do so in human virtues elevated by the grace of Jesus Christ.

A second point that Pope Leo made is that this suffering will inevitably be born in unequal measures. Regarding the inherent inequality of life on earth, he wrote, "Socialists may in that intent do their utmost, but all striving against nature is in vain. There naturally exist among mankind manifold differences of the most important kind; people differ in capacity, skill, health, strength; and unequal fortune is a necessary result of unequal condition."¹⁰ Some people will always be able to afford the highest standard of care, but this cannot mean that all people can be made able to afford it. This would be naught but a utopian, socialist dream.

In fact, as a third point, Pope Leo seemed content to set at a rather low height the bar delineating when the state should intervene to ameliorate the plight of the poor. He wrote, "True, if a family finds itself in exceeding distress, utterly deprived of the counsel of friends, and without any prospect of extricating itself, it is right that extreme necessity be met by public aid, since each family is a part of the commonwealth."¹¹ Again, we recall our essential question: What is *basic* health care? To this everyone has a right, surely, every man, woman, and child on the face of the earth, but can basic health care be over seven thousand dollars per person per year? This is what we are spending in the United States, and people are not yet satisfied. Let us remember that about two and a half billion people in the world survive on a mean income of less than one thousand dollars per year.¹² Their entire livelihood is one-seventh of our average personal health expenditure, and some 70 percent of their income must be spent on food.

Even if one is open to the idea—rather radical, I think, in the context of our health-care reform debate—that American citizens should get used to the idea of a greatly reduced reliance upon doctors, pills, and surgeries, the question will still arise: Who should define what constitutes this basic health care? Part of the answer—not the whole but part—is that the individual would himself decide what degree of health care he really *needs* and what is more of a luxury, if the cost of each health-care decision were truly linked to his own pocket book.

Let us take an example which is both extreme and yet all too commonplace: One of my parishioners, a veteran, who is extremely unstable walking, must use a wheelchair for most of his excursions outside the home. It is not motorized but the sort that can be picked up and put in a car. He and his wife wanted a lighter one that the wife could put into the car trunk more easily. He applied for a new wheelchair (he already had one, remember) and was given one that cost—he told me because he was so surprised—seven thousand dollars. Of course, he did not pay even one-tenth of that cost himself. And if he had had to, he would have made do without the new chair. We must not confuse the unacceptable notion that we should abandon those who cannot afford what they need with the legitimate claim that each person should pay for what he needs himself. Here we might recall that a major principle of Catholic social

doctrine—subsidiarity—is not irrelevant. If a person can take care of himself, he should be left to do so. Otherwise, what begins as welcome help will soon become most unwelcome interference.

We easily forget that there are grave unforeseen consequences to ideas that seem superficially attractive, such as free wheelchairs for veterans. While resisting entrance into the concrete details of health-care reform, for which, again, I claim no qualifications, I could mention, as an example of such consequences, in the opinion of many, the destruction of the doctor-patient relationship of years gone by. The “integrity of the physician-patient relationship” is one of the main goals of health-care reform listed by the Catholic Medical Association.¹³ Yet, a piece in the *Wall Street Journal* titled “How Medicare Killed the Family Doctor” blames the fact that “patients who used to pay the bill themselves [now] no longer [care] about the cost” with making “the primary care doctor ... a piece-rate worker focused on the volume of patients seen every day.”¹⁴ The point might be refined, but we must all admit that the house calls have ended. Indeed, not only the family doctor, but the Catholic hospital system as well could end up a victim of current trends.

There are other unforeseen consequences of excessive health care, which, while less easy to trace and quantify, nonetheless, must be recognized. For instance, proper care should enable people to feel more secure as they age. The availability of advanced medical know-how should help them face inevitable disease and death with *greater* serenity, not less. Yet, do we not find most older people living precariously, thinking of their health constantly, and visiting doctors weekly? Some older people are now actually afraid to move in with their children in their declining years because they would feel more secure in an assisted-living facility with a doctor down the hall. To most denizens of the world, we have become a nation of hypochondriacs.

Much good has come from the technological development of health care. Do not think that I propose that we do away with all advances, which truly are lauded as blessings by the Church, as examples of man answering the noble call to cooperate with the provident and merciful Creator. Nonetheless, it is undoubtedly technology that is a primary cause of rising health-care costs. It is always a danger of the technological mindset to think that if it can be done, it must be done. And then, if it must be done, it must be done at the drop of a hat by anyone who wishes. Neil Postman, in his 1993 book *Technopoly*, provides ample evidence to support the claim that Americans are particularly vulnerable to the siren song of technology. He notes that “although the U.S. and England have equivalent life-expectancy rates, American doctors perform six times as many cardiac bypass operations *per capita* as English doctors do.”¹⁵ He lists similar facts regarding hysterectomies and prostate surgery, before noting that American doctors also prescribe more drugs at higher doses and far more X-rays.¹⁶

Moreover, there is a paradoxical aspect to technology in general: We find that we are busier despite time-saving devices and that we communicate less well despite having more means to do so. We should not be surprised if we are less secure in regard to our physical weaknesses despite so many more means to analyze and alleviate them. In the case of medical technology, is it not obvious that as human beings are enabled to live longer, they will have to rely on technology *exponentially more*, as their frail bodies begin to break down on a variety of fronts? I do not wish to be interpreted as saying that older people deserve less care—just the opposite, as you will see. However, I do wish to perform what George Orwell called the first duty of intelligent men—the restatement of the obvious. In this case, technology cannot bring immortality. The challenges facing medical science only increase with the longevity of the patient. Witness, for instance, the precipitous rise in hip replacements and spinal surgery (indicative of an ageing population).

As Americans have grown accustomed to solving all of their difficulties with technology, they have begun to distort the very nature of medicine. Contraception is now a mandated part of health insurance in many states. Abortion and artificial reproductive techniques could follow. Such things are far beyond “basic health care” and even beyond the “[medical] consumerism and cult of the body” decried by Pope Benedict. Such evil uses of medical technology, and the claim of a right to have them funded, serve to signal the greatest danger lurking in excessive health-care. As the population ages, propelled by an exaggerated attention to health, people will nonetheless begin to fall apart. The ultimate impotence of man against death will not go away. People will be more afraid of suffering than ever, as health resources will become increasingly scarce. The temptation to use so-called “medicine” to cut short the lives that technology can no longer extend will be enormous. It will appear as the only option and as a “right.” Ironically, the habit of intemperate consumption of health care will lead to a voluntary, or even involuntary, denial of the very health care, the “basic” health care, to which all men really do have a right. Euthanasia is the deprivation of a patient of basic health care. Health-care consumerism is producing a crisis that will appear to have no other solution.

In this light, we must welcome the fact that the government is making some cuts now. Arizona Medicaid has cut funding for some transplants of lungs, hearts, and livers.¹⁷ The Food and Drug Administration has banned Avastin, a cancer drug, ostensibly for “significant risks to the patient,” but more likely for its astronomical price tag: up to ninety thousand dollars per year.¹⁸ Such decisions amount to no more than the one that I was asked to make at the nursing home in St. Petersburg, as I mentioned at the outset of this talk. This is, perhaps, some tiny step toward a return to an attitude toward health-care policy that would be genuinely moral. It would be moral and virtuous because it would be

reasonable. Not every effort to save life or limb is reasonable. Spending hundreds of thousands of dollars to avoid an amputation, for instance, might seem virtuous, but this will be a vice mimicking a virtue, just as prodigality mimics generosity.

Such a reasonable, virtuous attitude would, in conclusion, include the following elements. It will, first of all, seek to provide care that is truly basic and truly universal. If medical care cannot be reasonably extended to all, it cannot be basic. Secondly, more complete kinds of coverage will be dependent, to some degree, on the patient's ability to pay. Like education or housing or food, to which all are entitled in some basic degree, one receives better education, housing, or food if one has the ability to pay for it. Such inequalities are not unjust but natural and inevitable. In the third place and consequently, it will no longer be seen as a right or even as a good thing to eliminate all physical defects, dependency on others, pain, or discomfort. This is part of life. Indeed it is related to the most beautiful part of life. Charity, compassion, and sacrifice are the best things in life. We must not view illness and suffering purely as problems to be solved. If we seek to flee from the Cross, be we Christians or not, we will have nowhere to go but an ultimately futile flight from reality, ending in a sinful surrender—euthanasia, when technology is of no further avail.

The perspective of wisdom, of philosophy and theology, then, is not so complicated, but it is paradoxical. By providing truly *basic* health care, we will be able to care for not only all men throughout the whole world, but also the *whole* man. We are more than our bodies; we have a destiny beyond this life. Paradoxically, if medicine forgets this, it will fail in its noble mission, which is to sustain us on our way there.

Notes

¹ Cf. Robert B. Reich, "ObamaCare Repeal: GOP Should Be Careful What It Wishes For," *Wall Street Journal*, January 7, 2011.

² Kaiser Family Foundation, *Health Care Costs: A Primer* (Menlo Park, CA: Henry J. Kaiser Family Foundation, 2009), 7, http://www.kff.org/insurance/upload/7670_02.pdf.

³ Juvenal, *Satirae*, VIII, ll. 83–84: "Summum crede nefas animam praeferre pudori et propter vitam vivendi perdere causas."

⁴ Pope Benedict XVI, address to participants in the Twenty-Fifth International Conference organized by the Pontifical Council for Health Care Workers, Rome, November 18–19, 2010, http://www.vatican.va/holy_father/benedict_xvi/letters/2010/documents/hf_ben-xvi_let_20101115_op-sanitari_en.html.

⁵ *Ibid.*

⁶ Pope Leo XIII, encyclical *Rerum novarum* (On Capital and Labor), http://www.vatican.va/holy_father/leo_xiii/encyclicals/documents/hf_l-xiii_enc_1505_1891_rerum-novarum_en.html.

⁷ Ibid., n. 17.

⁸ Ibid., n. 18.

⁹ Ibid.

¹⁰ Ibid., n. 17.

¹¹ Ibid., n. 14.

¹² UC Atlas of Global Inequality, "Income Inequality," <http://ucatlas.ucsc.edu/income.php>. This seems to be based upon data from 1997.

¹³ See Catholic Medical Association, "Overview of Health Care Reform," http://www.cathmed.org/issues_resources/health_care_reform/overview.

¹⁴ Richard M. Hannon, "How Medicare Killed the Family Doctor," *Wall Street Journal*, November 8, 2010.

¹⁵ Neil Postman, *Technopoly* (New York: Vintage, 1993), 94.

¹⁶ He cites Charles B. Inlander, Lowell S Levin, and Ed Weiner, *Medicine on Trial: The Appalling Story of Medical Ineptitude and the Arrogance that Overlooks It* (New York: Pantheon, 1988); L. Payer, *Medicine and Culture: Varieties of Treatment in the United States, England, West Germany, and France* (New York: Penguin, 1988); S. Reiser, *Medicine and the Reign of Technology* (Cambridge: Cambridge University Press, 1978).

¹⁷ Carl Bialik, "Health Studies Cited for Transplant Cuts Put Under the Knife," *Wall Street Journal*, December 18, 2010.

¹⁸ David B. Rivkin Jr. and Elizabeth Price Foley, "'Death Panels' Come Back to Life," *Wall Street Journal*, December 20, 2010.