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**Catholic Social Teaching,  
the Common Good, and Health Care  
in the United States:  
Seeking A Universal Model  
of Health Care Coverage**

by

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**Introduction**

Currently in the United States, estimates reveal that around 43 million Americans are uninsured and several million more are underinsured, and the numbers continue to rise.<sup>1</sup> In the most powerful, wealthiest, and medically-technologically advanced country in the world, this situation is deplorable. This paper will investigate the social teachings of the Catholic Church as a foundation for universal health care in the United States. Focusing in particular on the principle of the common good, we will investigate a universal model of health care coverage proposed by Alain Enthoven and Richard Kronick.<sup>2</sup> These authors “propose a set of public policies and institutions designed to give everyone access to a subsidized but responsible choice of efficient managed care....”<sup>3</sup> Given the socio-economic political structures in the United States, we will argue that their proposal defends the common good as developed in Catholic social teaching and is a plausible solution to the crisis of health care coverage in the United States.

## Principles of Catholic Social Teaching

Catholic social teaching, though implicit throughout Catholic tradition, was explicitly formulated in Leo XIII's encyclical *Rerum Novarum*, the fountainhead of modern Catholic social teaching. In this document and all subsequent social teachings, the common good is a central theme. Just as society has evolved and changed socially, economically and politically, so too, has the principle of the common good in light of these evolving and changing circumstances.<sup>4</sup> While the common good and its implementation must adopt and change to particular cultural-historical political economic systems, it must always stand in judgment of these systems and evaluate them in light of the Gospel message. Thus, the common good is not a static, homogenous principle, but a dynamic, heterogeneous principle depending on the historical-cultural situation in which its incarnation is sought. As such, it is sometimes difficult to get a firm grasp not only on a conceptual understanding of the common good, but also its practical implementation. While some normative principles rooted in the common good are universals, such as the call for respecting and protecting human dignity, other considerations such as its practical implementation are dependent upon existing political and economic structures. What unites all perceptions of the common good is its search for justice. In this section, we will seek a clearer conceptual understanding of the common good. In the following section, we will investigate how this conceptual understanding can be brought to fruition in a particular historical-cultural milieu—the United States—with regard to a particular ethical issue—universal health care.

The U.S. Bishops' 1986 pastoral letter "Economic Justice for All" set forth six imperatives that pertain to the common good. These imperatives will serve as our point of departure in exploring the conceptual meaning of the common good not only because this document is directed toward the specific socio-economic situation in the United States, but also, since it is rather recent, it synthesizes much of the Catholic Church's social teaching.

The first imperative of the common good asserts that "human dignity can be realized and protected only in community...and requires a broader social commitment to the common good."<sup>5</sup> There are two important assertions in this statement. The first entails what may be referred to as an anthropological assumption of the common good.<sup>6</sup> Beginning with Pope John XXIII, the common good has emphasized the intrinsic worth and dignity of each human being.<sup>7</sup> This human dignity is grounded in the belief that the human person is transcendent and naturally oriented towards God and is made in the image and likeness of God. It is in light of this anthropological assumption that the United States' Bishops assert that



“every person has a right to adequate health care. This right flows from the sanctity of human life and the dignity that belongs to all human persons, who are made in the image of God.”<sup>8</sup> Furthermore, and this explains the second assertion of the first imperative, the human person is integrally communal and directed towards life with others.<sup>9</sup> The common good, then, is rooted in a basic anthropological understanding of the inherent dignity of each individual and this dignity is protected, respected and prospers only in community.

Second, “the common good demands justice for all, the protection of human rights for all.”<sup>10</sup> Justice is the very essence of the common good and entails a social and distributive dimension as well as the protection of human rights. The social and distributive dimensions of justice can be summed up in a principle of Karl Marx borrowed from the Acts of the Apostles<sup>11</sup>: “from each according to his ability, to each according to his needs.” Social justice demands that all contribute to the good of the whole on the basis of their capacities and capabilities; distributive justice demands that all benefit from those goods to insure human dignity. Human rights entail corresponding duties. Just what are specific human rights? Though lists vary as to what does or does not constitute a legitimate human right, most lists would include health care as a basic human right.<sup>12</sup> With this right comes a corresponding duty of both the individual and the community. The individual has a duty to protect, sustain and nurture one’s health to the greatest extent possible. This duty, however, must be protected and insured by the community’s duty to insure individual health care when the individual either fails in one’s duty or, for reasons beyond one’s control, is unable to, or prevented from, fulfilling one’s duty. Granted, the human condition necessarily entails an eventual deterioration of one’s health, in which case, ultimately the community has a duty to care for individuals to whom it is responsible. However, preventive care and health maintenance is largely the responsibility of the individual with the support of the community.

The third imperative is that “the obligation to provide justice for all means that the poor have the single most urgent economic claim on the conscience of the nation.”<sup>13</sup> This imperative expands on the notion of distributive justice and prioritizes those who have the greatest claim on the goods of society, the poor. Precisely because the poor are powerless, their needs must be prioritized otherwise, as is clear from the disparity between the rich and poor in our own country, their basic needs will not be met, their human dignity will be violated. The poor include, but are not limited to, those who are economically needy. It entails a much wider spectrum including those who are most vulnerable in society: the embryo, aged, mentally handicapped, non-indigenous persons, etc. The “economic claim”

of these people "on the conscience of the nation" implies that medical programs and reform measures should be structured in light of, not in spite of, these people with their specific needs and vulnerabilities in mind. Not only must we make the poor a primary concern of social policy and the common good, but also "as individuals and as a nation...we are called to make a fundamental option for the poor."<sup>14</sup> That is, a conscious imperative of social policy "to speak for the voiceless, to defend the defenseless, to assess life styles, policies, and social institutions in terms of their impact on the poor."<sup>15</sup>

Both imperatives three and four illustrate the virtue of solidarity first linked to the common good in the writings of Pope Paul VI.<sup>16</sup> Solidarity asserts the mutual interdependence of nations, communities and individuals and entails the mandate that we are our brothers' and sisters' keepers. Solidarity implies both rights and duties. It is the right of the poor to exist in human dignity, and the duty of the wealthy and those in power to provide for them. John Paul II later identifies the virtue of solidarity as "a firm and persevering determination to commit oneself to the common good."<sup>17</sup>

The virtue of solidarity and the provisions which it entails, however, must be tempered by the principle of subsidiarity, the fifth imperative. "The prime purpose of this special commitment to the poor is to enable them to become active participants in the life of society. It is to enable all persons to share in and contribute to the common good."<sup>18</sup> For if concern for the poor amounts to mere "handouts" then paternalism results and unjust structures remain intact. True solidarity entails not only providing for the poor, but also making them active participants in their own destiny, participants in the attainment and fulfillment of human dignity. The principle of subsidiarity or subsidiary function first found expression in the social encyclical of Pope Pius XI in *Quadragesimo Anno*. According to Pius, it

is a most weighty principle, which cannot be set aside or changed, [and] remains fixed and unshaken in social philosophy: Just as it is gravely wrong to take from individuals what they can accomplish by their own initiative and industry and give it to the community, so also it is an injustice and at the same time a grave evil and disturbance of right order to assign to a greater and higher association what lesser and subordinate organizations can do. For every social activity ought of its very nature to furnish help to the members of the body social, and never destroy and absorb them.<sup>19</sup>

The principle of subsidiarity is equivalent to participatory justice. Certainly people participate on various levels, within various capacities in



society on the basis of their talents and abilities. In many socio-economic political structures it is not possible for all to participate directly in formulating policy. However, to deny the possibility for indirect participation (e.g., through voting) or to actively silence such participation is a basic violation of subsidiarity and human dignity.

The sixth imperative entails stewardship or a responsible use of resources.<sup>20</sup> As the world population grows and the disparity between first and third world expands, and between the rich and poor of first world countries, we are called to utilize our resources more responsibly and equitably. For health care, stewardship entails eliminating duplication and frivolous waste of technological and medical resources as well as the talents of physicians. For example, in a time when specializations in such areas as cosmetic surgery or orthopedics are ever increasing, there is a greater need for primary care physicians. Economic incentives are frequently the motivation for specialization, though it ignores the basic needs and common good of society since only a small minority of the population can afford these treatments, while the vast majority requires minimal, basic health care that a primary care physician provides. Thus, the Catholic Health Association asserts under the auspice of stewardship: "Responsible health care reform requires the introduction of economic discipline into the health care delivery system and the creation of credible expenditure controls to hold overall spending within realistic financial and political limits."<sup>21</sup>

Catholic social teaching based on the common good, then, is founded on the intrinsic dignity of each human person, living in community, directed towards social, distributive, and participatory justice, in solidarity with the poor. With regard to health care reform, the Church herself has distinguished between delivery reform and financing issues, focusing on the former since many other proposals have focused on the latter.<sup>22</sup> The guiding principle for this proposal is the common good and its dimensions that we have discussed. What is lacking in the Bishops' proposal, however, is a specific plan for financing universal coverage. Alain Enthoven and Richard Kronick's concrete proposal for universal health care coverage is an attempt to incarnate the common good based on the United States' unique socio-economic political structure.

### **Enthoven and Kronick: "Managed Competition" to Serve the Common Good**

In his address to the 81st Catholic Health Assembly, Alain Enthoven praised the role and function of Religious health care in today's health care system. Much like the Bishops themselves, he distinguishes between

health care as a commodity and as a service.<sup>23</sup> He maintains that "we must not lose the values of charity, justice, caring, honesty, and support of essential community services." Furthermore, he supports the Church's preferential option for the poor that provides services for the poor and advocates for the disadvantaged. Projecting that the United States is about twelve years away from "wall-to-wall HMO's," echoing the words of the late Cardinal Joseph Bernardine, Enthoven asserts that "managed care must be managed." According to Enthoven, this system of health care must have "a framework of rules and incentives to do the right thing. I call it 'managed competition.'"<sup>24</sup> Enthoven and Kronick propose a model of managed competition that is based on an inculturated principle of the common good adjusted to the socio-economic political structures of the United States.<sup>25</sup> In this section, we will present their analysis of the current "health care crisis," the goals they seek in managed competition, and the financial proposal for attaining those goals.

That over 43 million Americans lack health care "is the sort of thing that happens when people are left to a free market."<sup>26</sup> Enthoven and Kronick pinpoint four reasons for the current crisis of health care. First, there is the "cost-unconscious demand" factor; that is, "our health care financing and delivery system contains more incentives to spend than to not spend."<sup>27</sup> Though there are several levels at which these incentives to spend occur, the greatest expenditures are in Medicare, Medicaid and the non-taxable subsidies to employer-provided health care coverage. The latter accounted for 46 billion dollars of lost revenue for the government in 1990, a health care expenditure second only to the Medicare program.<sup>28</sup> Second, health care financing and delivery systems are not organized for quality and economy due to a lack of data on outcomes, treatments, and resource use, which create duplicate resource and treatment expenditures.<sup>29</sup> "Market failure" is a third major problem. Competition, without being managed, is neither fair nor efficient. The market incentive is to deny coverage for those who need it most through, for example, unfair risk selection. Fourth, "public funds are not distributed equitably or effectively to motivate widespread coverage." In the words of Catholic social teaching, there is not a "preferential option for the poor." Rather, there is a "preferential option for the rich" whereby "the most powerful incentives to insure go to those in the highest income tax brackets."<sup>30</sup> In summary, powerful incentives provide too costly treatments for those who are covered by health insurance and exclude millions who have no coverage at all.

To remedy this imbalance, Enthoven and Kronick propose a comprehensive strategy promoting efficiency and equity. The goal of this strategy is universal health coverage. The means of attaining this goal are



through mixed public/private sponsorship, economic incentive reform, and developing "managed competition" based on the HMO model of healthcare.

One myth about the health care crisis is that it is only the unemployed who are not covered by health insurance. In fact, of those 43 million a large percentage are part-time or full-time employees. The reason that they are not covered is either that the law does not require full benefits for part-time or full-time employees, or full-time employees cannot afford, or choose not to provide a benefits package. In any case, the cause is economically driven. To correct this, Enthoven and Kronick propose establishing a "Public Sponsor"—a quasi-public agency—that would contract with private health care financing and delivery plans offering subsidized health care packages to those employed but without coverage similar to those employed with health care packages. The public sponsor would cover 80% of the cost of an average plan that meets federal standards and the person covered would pay the remaining 20%. Those at or below the poverty line would have their coverage fully subsidized, and those between 100% and 150% of the poverty line would share the premium contribution depending on income. In addition, small businesses could purchase health care plans for their employees through the Public Sponsorship. Their expense would entail 8% of their payroll.<sup>31</sup>

While the above proposal covers the employed but uninsured, the poor, and allows small businesses to provide coverage, what incentive would there be for employment-based systems of health insurance to participate in such a plan? This is where incentive reform enters into the proposal. As mentioned earlier, currently businesses and corporations receive tax-free employer contributions for health care. Enthoven and Kronick propose that this exemption be reduced to 80% of the average price of a comprehensive health care plan. By adjusting tax-law in this way, the incentive to provide more costly and oftentimes inefficient health care would be curbed, since the additional expense for more expensive plans would come out of the employer or employees own pocket. In addition, to prevent employers from dropping health care coverage altogether and allowing the Public Sponsor to provide coverage (the "free-ride" clause), a federal mandate would require that employers provide health care coverage. Furthermore, in order to insure the competitive dimension of a free market system that would guarantee both quality and economical care, "managed competition" would be the goal. To create managed competition would entail large employers working in conjunction with the public sponsors to "structure and manage the demand side of the market." To accomplish this "they must act as intelligent, active, collective purchasing agents and manage a process of informed cost-conscious



consumer choice of 'managed care' plans to reward providers of high-quality economical care.<sup>32</sup> In this way, health care providers are forced to compete with each other for large-scale health care plans by maintaining quality care at a quality price.

The final group of those who would not be covered by either full-time employment or a fully and/or partially subsidized program for the poor are those who are part-time employees, self-employed, seasonal workers, or retired and under 65 without coverage. For those who are employed but are not covered by a plan, the employer would pay an 8% payroll tax on the first \$22,500 of wages and salaries. An 8% tax on adjusted gross income would be levied on all those who are self-employed, early retirees and anyone else not covered by an employer umbrella plan. Again, a sliding scale would be utilized to determine the exact amount each subscriber would pay depending on income and family size.

Enthoven and Kronick's plan is comprehensive and is dependent upon all components of the reform for success: public and private sponsors working in conjunction, payroll tax on uninsured employees, and limits on tax-free incentives for employer health plan contributions. To finance their model they have come up with an expense-income proposal whose plausibility has been confirmed by the Congressional Budget Office.

First, under this proposal the government needs money for five purposes:

- (1) To subsidize 80 percent (50 percent from the federal government) of the cost of an average health plan for households in which no member is a full-time worker;
- (2) to subsidize small businesses arranging coverage through the public sponsor, whose unsubsidized costs exceed 8 percent of the payroll;
- (3) to subsidize the individual's share of the premiums when family income is less than 150 percent of the poverty level;
- (4) to cover the increased cost to the federal employee's health benefits program;
- and (5) to cover the revenue lost from the reduction in taxable wages when employers contribute to the health insurance of previously uninsured employees.<sup>33</sup>

Second, the money to cover these governmental expenditures would be raised in three ways: first, through the 8 percent tax on noninsured workers, the self-employed, retirees and others; second, by limiting the tax-exemption for employer contributions to the employee's health plan; and third, states would fund part of the program through money saved on publicly sponsored or uncompensated hospital care.<sup>34</sup> Both the income and expenditure estimates are "tunable dials" that can be adjusted to attain "deficit neutrality."<sup>35</sup> Though the figures have certainly changed since their initial proposal, Enthoven and Kronick estimated that while federal

expenditures would amount to 12.8 billion, additional revenue would tally 12.4 billion, resulting in a net difference of 400 million dollars to provide universal coverage.<sup>36</sup> To put this amount into perspective, the Washington Redskins, a professional football team, was recently sold for 600 million dollars. The amount for universal coverage under this proposal is fiscally miniscule, and is a moral imperative.

### **“Managed Competition” in Light of Catholic Social Teaching and the Common Good**

Given Enthoven and Kronick’s proposal, how does it measure up to Catholic social teaching and the common good? First of all, one essential component to promoting and protecting human dignity is access to health care. Through “managed competition” each individual in the United States would have access to health care. Public Sponsors, working in conjunction with private employers, would both support this system and guarantee its maintenance. Second, it would be a system advocating social, distributive and participatory justice for each individual in society, especially the poor. Distributive justice would facilitate a more equitable and inclusive sharing of society’s wealth. Though participatory justice would be limited, members would retain the power of choice between different medical plans through the Public Sponsor or private employer. This power of choice provides economic pressure, which is the determining principle in a free-market system, whereby a health care system provides care that is both economically competitive and of high quality, or is replaced by a competing system. Third, managed competition entails a fundamental option for the poor by providing a basic need, health care, and giving the poor a voice, through choice. Finally, through “management” this system would practice stewardship by eliminating unnecessary duplication of health care services and expensive and unnecessary treatment that was the hallmark of a fee-for-service health care system. In addition, through “competition” it would stem current abuses in HMO’s whereby care is sacrificed to save on costs (e.g., the physician as gatekeeper). Competition would guarantee a certain standard of quality care. Those who do not meet this standard would not survive in a competitive market.

Managed competition is one way of incarnating the common good within a free-market economy where competition provides cost control and encourages efficiency and a responsible use of resources avoiding duplication of services and waste while providing universal health coverage. Given that the goal of the common good is never fully reached, there is a basic tension in its incarnation. While being implemented within a particular socio-economic political structure, thereby depending upon that



structure to a certain extent it must, nonetheless, remain critical of that structure as well. Perhaps the weakest link in Enthoven and Kronick's proposal of managed competition in relation to the common good is its implementation of the principle of subsidiarity, what we have called participatory justice. Certainly choice is a means in which the voice of the individual can be heard in a free-market economy, but to what extent does individual choice actually shape the type of health care available, as compared to providing an opportunity to merely choose from those systems already intact? From a Christian perspective, just as there is a tension between the already and not yet of the Kingdom of God, so too, in establishing the common good. Certainly "managed competition" is a step in the right direction. While unjust structures are in place that frustrate the implementation of this model and work to frustrate its realization based on economical greed and a lack of social, distributive, and participatory justice, the attainment of the common good is still not yet and remains a goal to be striven for. On the tenth anniversary of the U.S. Bishops' pastoral, "Economic Justice for All," the Bishops call "for a 'New American Experiment' of participation and collaboration for the common good that has yet to be really tried in our land."<sup>37</sup> Enthoven and Kronick's model of managed competition is a credible proposal to implement the common good in one very important dimension of our society, health care.<sup>38</sup>

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