

Health-Care Counter-Reform

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Abstract

The debate preceding passage of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, of 2010, was divisive amongst United States Catholics. Supporters of this flawed legislation dissented from the United States Conference of Catholic Bishops. Threats to human dignity persist for the most vulnerable, including the unborn, elderly, immigrants, and poor. Third parties will increase intrusion upon the doctor-patient relationship. Unsustainable spending trends portend health-care rationing. Catholic social teaching offers clear, and universal, principles for citizens of good will to guide amelioration of these fundamental health-care policy concerns.

I. Introduction

United States Catholic bishops have advocated for health-care reform for nearly a century, continuing a two-thousand-year tradition of responding to Christ's summons to care for the sick (Mt 10:1).¹ The bishops' prerequisite for supporting legislation was defense of human dignity. Their 2007 "Forming Consciences for Faithful Citizenship" quotes Pope John Paul II's explanation of this critical foundation in *Christifideles laici* (no. 38)²:

The common outcry, which is justly made on behalf of human rights—for example, the right to health, to home, to work, to family, to culture—is false and illusory if the right to life, the most basic and

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fundamental right and the condition for all other personal rights, is not defended with maximum determination.³

Yet in the tumultuous week prior to passage of the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act (H.R. 4872) of 2010 (hereafter described together as “the Patient Protection Act”) public—and ostensibly Catholic—dissent from the bishops “resulted in confusion and a wound to Catholic unity.”⁴ The United States Conference of Catholic Bishops (USCCB) would not support the legislation without clear language preventing taxpayer funding of abortion and protection of provider conscience. Democratic politicians, pressured by their Congressional leaders to pass this controversial legislation, were provided false moral comfort when the Catholic Health Association defiantly endorsed the Patient Protection Act.⁵ A group of sisters egregiously claiming to represent fifty-nine thousand religious women weighed in in favor of these bills, yet they were promptly reproached by numerous cries of misrepresentation.⁶

Since President Obama signed the Patient Protection Act into law on March 23, 2010, the acrimonious debate on this far-reaching legislation persists. Despite a March 24, 2010, executive order elaborating the Patient Protection Act’s “Consistency with Longstanding Restrictions on the Use of Federal Funds for Abortion,” many pro-life advocates fear a judicial order could reverse long-standing Hyde amendment restrictions on the use of federal tax dollars for abortion.⁷ Impending Medicare insolvency and the Patient Protection Act’s establishment of an “independent payment advisory board” to address treatment effectiveness and cost suggest bureaucratic restrictions on the horizon for medical care of the elderly and disabled. Prior to the 2008 presidential election, Barack Obama voiced concern for forty-seven million Americans without health insurance. More recently supporters of this legislation focused on thirty-two million Americans, with fifteen million immigrants⁸ and others left out of the equation, yet still requiring care in United States emergency rooms. The Patient Protection Act increases eligibility for Medicaid recipients, yet state budgets are severely strained with their current underfunded medical obligations. Moreover, doctors struggle to provide health-care access to Medicaid patients when reimbursed below the overhead costs of delivering care.

The perception of third-party responsibility for health, including payment for health-care resource consumption, is the major factor for unsustainable escalation of medical spending in the United States.⁹ Yet the Patient Protection Act augments third-party authority and threatens doctor-patient relationship autonomy, by increasing responsibility of government and employers for health care. Patients and physicians will face increasing involvement of third parties in decision making in exam rooms and at the bedside.

Physicians and patients might be inclined toward despair when considering these circumstances. However, Pope Benedict XVI, in his 2007 encyclical letter propitiously titled *Spe salvi* (Hope Saves), provides inspiration. “What this means is that every generation has the task of engaging anew in the arduous search for the right way to order human affairs; this task is never simply completed.”¹⁰ To address exigencies of our time, like health-care reform, the Catholic tradition provides a most beneficent patrimony.

Catholic social teaching provides guidelines, consistent with faith and reason, for responding to the imperative of improving health care for all those in the United States while respecting human dignity. This article will initially review Catholic social teaching in the context of health care. Secondly, contemporary challenges facing patients, physicians, and the greater community will be explored following passage of the Patient Protection Act in 2010. Finally, the universal principles of Catholic social teaching will be applied to guide those of good will in confronting these concerns.

II. Catholic Social Teaching

Pope Benedict XVI guides us forward in times of confusion, uneasiness, and unrest:

Four fundamental principles of Catholic social teaching: dignity of the human person, the common good, subsidiarity and solidarity ... offer a framework for viewing and addressing the imperatives facing mankind at the dawn of the 21st century.... How can solidarity and subsidiarity work together in the pursuit of the common good in a way that not only respects human dignity, but allows it to flourish? This is the heart of the matter which concerns you.¹¹

Respecting these four Catholic social teaching principles can help this country achieve consensus on critically necessary health-care reform.

Respect for the Dignity of the Human Person

The first principle—*respect for the dignity of the human person*—is absolutely fundamental for health-care reform. Otherwise, health-care reform is meaningless; why bother? “Indeed, the failure to protect and defend life in its most vulnerable stages renders suspect any claims to the ‘rightness’ of positions in other matters affecting the poorest and least powerful of the human community.”¹² Assent on this priority can be achieved by reason considering laws of nature, and also by faith. Pope John Paul II in his 1991 encyclical letter *Centesimus annus* summarized the principle this way:

The guiding principle of ... all of the Church’s social doctrine, is a correct view of the human person and of his unique value, inasmuch as “man ... is the only creature on earth which God willed for itself.”

God has imprinted his own image and likeness on man (cf. Gen 1:26), conferring upon him an incomparable dignity.¹³

This principle of respect for the human person can be agreed upon by all people of good will. The right to life is a premise of this country's founding fathers in the Declaration of Independence. Life must be safeguarded from conception to natural death. Suggesting human rights begin at any other chronologic point of a human being's life is arbitrary and capricious. Archbishop Charles J. Chaput admonishes:

Deliberately killing the innocent is always, inexcusably wrong. It sets a pattern of contempt for every other aspect of human dignity. In redefining when human life begins and what is and isn't a human person, the logic behind permissive abortion makes all human rights politically contingent.¹⁴

This principle must apply on both ends of the stethoscope in respect for both provider and patient. Health-care providers must have freedom to follow their conscience in prescribing and providing treatment. Furthermore, the dignity of the greater community must be respected; premium payers and taxpayers must not be complicit in procedures or treatments which violate human dignity.

The Common Good

The second principle concerns the *common good*, which the *Catechism of the Catholic Church* defines as "the sum total of social conditions which allow people, either as groups or as individuals, to reach their fulfillment more fully and more easily."¹⁵ This principle prompts consideration of how scarce resources ought to be allocated in society. Discussion naturally follows concerning human rights, the role of government, and that of markets.

The *Compendium of the Social Doctrine of the Church* instructs: "The demands of the common good are dependent on the social conditions of each historical period and are strictly connected to respect for and the integral promotion of the person and his fundamental rights."¹⁶ While there is no question of room for improvement in this historical period, United States citizens should be very concerned about advocacy for greater government intervention in health care. The face of the United States government is the Federal Emergency Management Agency (FEMA), Amtrak, the Internal Revenue Service (IRS), and more recently the federal response to the tragic oil crisis in the Gulf of Mexico. Our administration funds abortions, finances embryonic stem cell research, and threatens conscience protection. Medicare is heading toward insolvency. States cannot fulfill their present Medicaid obligations. Shall we really increase this government's role in health care, when it presently is failing at many essential elements of the common good?

Some recall Pope John XXIII's 1963 encyclical letter *Pacem in terris* (Peace on Earth) discussing "the right to live ... the right to bodily integrity and to the means necessary for the proper development of life, particularly food, clothing, shelter, medical care, rest, and, finally, the necessary social services."¹⁷ In this document, the Holy Father speaks of health care as a natural right, with corresponding responsibilities, not as a direct obligation of the state. The government is not assigned accountability for food, clothing, shelter, or health care in *Pacem in terris*.

More recently, Archbishop Charles J. Chaput reiterated the Church's understanding of health care as a right. "At a minimum, it certainly is the duty of a just society. If we see ourselves as a civilized people, then we have an obligation to serve the basic medical needs of all people, including the poor, the elderly and the disabled to the best of our ability."¹⁸ Yet there are options for society to meet this duty apart from the federal government. All persons by virtue of their inherent dignity deserve some level of basic health care. But, moral theologian Fr. Thomas Williams makes a helpful observation in his book *Who Is My Neighbor?* He distinguishes between moral and civil rights. These differ with respect to their demands upon the government.¹⁹ We might agree upon a moral duty to make health care accessible to all citizens and work toward that goal, while challenging the presumption that our government should assume greater responsibility for health care (civil duty).

The appropriate balance between market-oriented and government-controlled medical resource allocation belongs in the realm of prudential discussion. On the one hand, "A truly competitive market is an effective instrument for attaining important objectives of justice."²⁰ On the other hand, as the *Catechism of the Catholic Church* exhorts, quoting Pope John Paul II's 1991 encyclical letter *Centesimus annus*, "Regulating the economy solely by centralized planning perverts the basis of social bonds; regulating it solely by the law of the marketplace fails social justice, for 'there are many human needs which cannot be satisfied by the market.'"²¹

Subsidiarity

The third principle of Catholic social teaching—subsidiarity—emphasizes that those with "closeness to those in need"²² provide care for them. The *Catechism of the Catholic Church* describes the principle of subsidiarity: "A community of a higher order should not assume the task belonging to a community of a lower order and deprive it of its authority. It should rather support it in case of need"; and it cautions: "Excessive intervention by the state can threaten personal freedom and initiative."²³

As Pope Benedict XVI wrote in his 2005 encyclical *Deus caritas est*, "We do not need a State which regulates and controls everything, but a State which, in accordance with the principles of subsidiarity, generously

acknowledges and supports initiatives arising from the different social forces and combines spontaneity with closeness to those in need.”²⁴

This principle argues for health-care reform solutions which fortify individual and family responsibility for health-related decisions. The doctor-patient relationship should be strengthened and protected rather than threatened by distant bureaucratic panels. Local, or community-level, initiatives should receive priority over increasing the role of more distant employers and the government. Amendment 10 of the United States Constitution incorporates this conviction: “The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.”

Pope John Paul II in *Centesimus annus* was explicit:

By intervening directly and depriving society of its responsibility, the Social Assistance State leads to a loss of human energies and an inordinate increase of public agencies, which are dominated more by bureaucratic ways of thinking than by concern for serving their clients, and which are accompanied by an enormous increase in spending. In fact, it would appear that needs are best understood and satisfied by people who are closest to them and who act as neighbors to those in need.²⁵

Solidarity

The fourth principle, solidarity, obliges us to maintain a “preferential option for the poor and vulnerable” in confronting socio-economic problems. Pope John Paul II, in the 1987 encyclical letter *Sollicitudo rei socialis*, when reflecting upon the interdependence of humanity, defines solidarity as a virtue: “It 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.”²⁶ Herein he speaks of “a commitment to the good of one’s neighbor.” Furthermore, the late Pontiff refers to “many points of contact between solidarity and charity, which is the distinguishing mark of Christ’s disciples.”²⁷

Solidarity motivates us to fulfill our duty to the poor and vulnerable, in the spirit of loving our neighbor, feeding the poor, and caring for the sick.²⁸ Health-care reform must address the needs of immigrants within our borders, the chronically ill, the disabled, the economically marginalized, and human beings who are particularly vulnerable at the chronological extremes of life.

With these four complementary, fundamental, and universal principles, we are prepared to address contemporary challenges of health care in the United States. However, Pope Benedict XVI counsels:

Love—*caritas*—will always prove necessary, even in the most just society. There is no ordering of the State so just that it can eliminate the need for a service of love. Whoever wants to eliminate love

is preparing to eliminate man as such. There will always be suffering which cries out for consolation and help. There will always be loneliness. There will always be situations of material need where help in the form of concrete love of neighbor is indispensable. The State which would provide everything, absorbing everything into itself, would ultimately become a mere bureaucracy incapable of guaranteeing the very thing which the suffering person—every person—needs: namely, loving personal concern.²⁹

III. Contemporary Challenges

The Patient Protection Act compromises each of these foundational principles of Catholic social teaching. After considering these challenges, a coherent response is prescribed.

The Principle of Dignity of Human Person

Providing health insurance coverage to thirty-two million more Americans is not atonement for the threats to human dignity presented in the Patient Protection Act. Concerning abortion funding and health-care provider conscience protection, the United States Conference of Catholic Bishops (USCCB) Office of the General Counsel concluded that the Patient Protection Act “poses serious problems in these two areas, and that the executive order does not correct those problems,” and that this act “violates both principles of the Hyde Amendment.”³⁰

The elderly and chronically ill should be concerned about threats to their dignity as well. Ezekiel J. Emanuel, M.D., Ph.D., presidential health-care advisor and National Institutes of Health bioethicist, mischaracterizes the Hippocratic Oath as “imperative to do everything for the patient regardless of cost or effect on others.”³¹ He implicates physician culture as driving overutilization of health-care resources. In effect, he advocates for changing the physician’s primary responsibility from the good of the patient to one’s duty to society, in order “to move toward more socially sustainable, cost-effective care.”³²

Dr. Jeffrey Mirus asks: “At what point does it become too dangerous to put health care in the hands of a government which, over the past generation, has consistently allied itself with the culture of death?”³³

Bureaucrats are well aware that considerable medical spending occurs during the last years of a person’s life, leading to particular vulnerability for the elderly and chronically ill. Mandates for health care may sound attractive until one begins to consider what is included, or what may be denied, with tax-payer funded and politically determined entitlements. The chief Medicare actuary, Richard S. Foster, in an April 22, 2010, analysis of the Patient Protection Act, predicted that decreased Medicare spending by \$575 billion over ten years will delay insolvency of the Medicare trust fund by twelve years. Given the aging demographic distribution of United States citizens, Medicare benefits cannot be main-

tained at the present level.³⁴ Cost effectiveness research, calculations of quality-adjusted life-years (QALY), and other utilitarian allocation mechanisms threaten human dignity as methods for rationing medical care.³⁵

Pope Benedict XVI, in his encyclical letter *Caritas in veritate*, re-emphasized his predecessor John Paul II's *Evangelium vitae* exhortation that

a society lacks solid foundations when, on the one hand, it asserts values such as the dignity of the person, justice and peace, but then, on the other hand, radically acts to the contrary by allowing or tolerating a variety of ways in which human life is devalued and violated, especially where it is weak or marginalized.³⁶

The Principle of the Common Good

The common good is not promoted by legislation likely to disrupt the socio-economic stability necessary to improve the human condition in the United States. Despite ostensibly good intentions, the Patient Protection Act is fiscally unsound, threatens the practice of medicine, and propagates medical resource overconsumption.

The Congressional Budget Office (CBO) director Douglas W. Elmendorf predicted: "The rising costs of health care will put tremendous pressure on the federal budget during the next few decades and beyond." Furthermore, in the

CBO's judgment, the health legislation enacted earlier this year does not substantially diminish that pressure. In fact, CBO estimated that the health legislation will increase the federal budgetary commitment to health care ... by nearly four hundred billion dollars during the 2010–2019 period.

He concluded, on May 28, 2010, that "efforts to reduce costs substantially would increase the risk that people would not get some health care they need or would like to receive."³⁷

The Congressional Budget Office estimated that the gross cost of the Patient Protection Act's expanded health-care coverage provisions is \$938 billion between 2010 and 2019.³⁸

Rather than protecting seniors, Medicare remains on track for insolvency. Instead of increasing access to care for the indigent and disabled, expanding access to Medicaid will overwhelm states that cannot afford their current Medicaid liability. Furthermore, physicians and hospitals are presently unable to cover the costs in caring for established Medicaid patients, much less more of them. Neither access nor quality will be enhanced for the poor and disabled.

Many others may have greater difficulty affording health insurance. The United States Chamber of Commerce, under director Joel White, concludes:

While the law makes a number of changes to reduce spending, particularly in the Medicare program, several more provisions will actually increase health care costs over and above costs that would have happened without enactment of health reform. Therefore, at least from the perspective of controlling costs, the law is likely worse than doing nothing at all.³⁹

Through mid-2010, physicians have faced three episodes of 21 percent cuts in Medicare reimbursement, and delays in payment, for patient care due to Congressional inability to meet deadlines for correction of “sustainable growth rate” (SGR) methodology. (The sustainable growth rate is a component of a formula used to regulate government spending on physician services under Medicare, compared to growth of the United States gross domestic product.) Currently under consideration, the American Jobs and Closing Tax Loopholes Act of 2010 (H.R. 4213) would defer resolution until 2012, when doctors would face a 33 percent reduction in reimbursement.⁴⁰ Frustration with this type of bureaucratic mismanagement, the pressures of practicing defensive medicine, and pessimism with the future prompt earlier physician retirement and resultant provider shortages. Nationally, nearly one fourth (24.7 percent) of the active physician workforce is age sixty or older.⁴¹ The American Medical Association predicts: “The nation likely will see a shortage of about 160,000 physicians by 2025—leaving too few to keep up with the flood of newly insured patients seeking care for long-neglected health problems.”⁴²

Furthermore, the Patient Protection Act propagates the third-party responsibility for health care, which is the primary reason for medical spending escalating out of control. This legislation increases the role of employers and government in health care. Employers confronted with more costly regulation and mandates will be less likely to employ more workers. The algorithm for small businesses to receive government subsidies for providing health-care benefits defies comprehension. Many large employers will see paying a fine preferable to providing insurance. Therefore more workers will be reliant upon subsidized state exchanges for health insurance. The United States Chamber of Commerce has concluded that “the combination of reduced flexibility, new taxes, new penalties, new benefit mandates, new reporting requirements and uncertainty about implementation far outweighs the potential benefits to employers of the new law.”⁴³

The mandate for individuals to carry health insurance is likely to be ineffective as guaranteed issue requirements, combined with relatively inexpensive fines for non-compliance, allow individuals to purchase insurance only when needed. Insurance premiums are likely to continue to increase relative to the cost of other goods and services. Many who have studied the Patient Protection and Affordable Care Act

conclude it really makes patients more vulnerable and insurance less affordable.

The Principle of Subsidiarity

The Patient Protection Act transgresses the principle of subsidiarity: government authority for health care increases, the doctor-patient relationship is threatened, and personal responsibility for health is not sufficiently promoted.

The Congressional Budget Office summarized the Patient Protection Act, stating that it

would establish a mandate for most residents of the United States to obtain health insurance, set up insurance “exchanges” through which certain individuals could receive federal subsidies to reduce the cost of purchasing that coverage, and make numerous other changes in the health insurance system, in federal health care programs, and in the federal tax code.⁴⁴

Twenty-four million citizens would receive federal subsidies to purchase health insurance through exchanges by 2019.⁴⁵ Government authority is also increased by adding sixteen million more residents to state Medicaid and the Children’s Health Insurance Program (CHIP) by 2019, and state spending on these programs would subsequently increase by about twenty billion dollars.⁴⁶ In contrast, Acton Institute founder Fr. Robert A. Sirico observes that “other key institutions—the family, the Church, local civic associations—might also have a role to play in shaping reform” rather than our nation simply socializing health care.⁴⁷

In addition to threats to providers who ought to be able to follow their conscience, the doctor-patient relationship faces greater difficulty as a result of this legislation. Establishment of the “Independent Payment Advisory Board” (IPAB) predicts greater third-party responsibility and intrusion, by administrative appointees, for those taking care of Medicare patients. This fifteen-member panel, appointed by the president, will have authority “to extend Medicare solvency and reduce spending growth through the use of a spending target system and fast-track legislative approval process.”⁴⁸ Further evidence of greater government control is the Patient Protection Act’s promotion of “accountable care organizations,” pilot programs for bundling payments to hospitals and providers, and more experimentation with Medicare “gainsharing.”

Dr. William White has lamented about erosion on both sides of the doctor-patient relationship by third party intrusion. Physicians yield to the influence of government and corporations; patients feel entitled to care with pre-paid insurance plans and perceive medical providers as agents of insurers.⁴⁹ The 2008 Catholic Medical Association’s report “Health Care in America: A Catholic Proposal for Renewal” states,

The key to understanding the crisis in American health care today is that it violates essential norms of justice and charity on both sides of the physician-patient relationship. It impairs the ability of the physician to decide and act as Jesus would, and it ignores the dignity of the poor in countless ways. This results from government policies that dictate the financing and delivery of health care services in America.⁵⁰

As more and more physicians are employed by hospitals, join very large practices, or become members of accountable care organizations, greater conflicts can be expected between the doctor's duty to the patient and pressures on doctors as agents of a firm.

Also contrary to the principle of subsidiarity is the diminishing perception of personal responsibility to care for self and family, not only in life-style decisions affecting health, but also in financial participation in health-care resource consumption.

The Principle of Solidarity

The Patient Protection Act also fails to sufficiently follow the fourth principle, solidarity, when measuring reform efforts from the perspective of the poor and vulnerable, including immigrants. To wit, instead of universal coverage, fifteen million people will not gain coverage from this legislation. It seems the United States Conference of Catholic Bishops is the only national voice speaking for immigrants⁵¹ who become sick or sustain injury within our borders. Millions of citizens will be added to state Medicaid rosters, which will not improve access to care. Elderly and disabled Americans face considerable uncertainty with impending Medicare insolvency.

IV. Prescription for Reformation

We share a duty in the United States to care for all those within our borders, and improve health-care affordability and quality. Nearly fifty million uninsured, and millions more who are precariously insured, required health care reform in the United States. However, the Patient Protection Act does not fulfill the criteria required by the fundamental Catholic social teaching principles. Catholic social teaching guides us to a universal—that is, for all those of good will—prescription for further health-care reform.

1. The dignity of the human person, which follows from human beings' creation in the "imago Dei" (Gen 1:27), must be safeguarded from conception to natural death. Tax dollars or mandated premiums must not subsidize abortion or abortifacient contraception. Furthermore, health-care providers must have freedom to follow their conscience in prescribing and providing treatment. "When a society moves towards the denial or suppression of life, it ends up no longer finding the necessary motivation and energy to strive for man's true good."⁵²

The Church also defends human dignity in the final days of life. The United States Conference of Catholic Bishops' *Ethical and Religious Directives* provide guidelines for care of terminally ill with compassion and without extreme measures, or costly defensive medical testing or procedures. They promote respect for the person as he or she approaches a natural death.⁵³ Archbishop Nicholas DiMarzio observed:

We also welcome the call to provide more effective palliative care, hospice care and end-of-life care.... [P]atients and families facing the reality of death are entitled to respect, love and support. Our health care system must be structured to provide care when a cure is no longer possible. Effective management of pain in all its forms is critical in the appropriate care of the dying. In the use of life-sustaining technology, two extremes are to be avoided. Insistence on useless or burdensome technology even when a patient may legitimately wish to forgo it is not appropriate. But intentional efforts to cause death, whether by overt action or omission of basic health needs, are not acceptable.⁵⁴

The dignity of the human person also includes the responsibility to care for oneself, and one's family. Many medical problems arise from personal decisions affecting health, and health-care resources are over-consumed when perceived as free. Therefore reform must not abrogate personal responsibility for decisions which affect health, or financial participation in consumption of medical goods and services.

Pope John XXIII was very clear: "Every basic human right draws its authoritative force from the natural law, which confers it and attaches to it its respective duty. Hence, to claim one's rights and ignore one's duties, or only half fulfill them, is like building a house with one hand and tearing it down with the other."⁵⁵ Yet government health-care programs encourage people to believe that someone else is responsible for their health; they seldom have a choice over what medical care is available to them, and decisions are made for them from afar, by bureaucrats. This is contrary to human dignity, promoted by Catholic social teaching. Pope John Paul II exhorted:

Not only the world, however, but also man himself has been entrusted to his own care and responsibility. God left man "in the power of his own counsel" (Sir 15:14), that he might seek his Creator and freely attain perfection. Attaining such perfection means personally building up that perfection in himself. Indeed, just as man in exercising his dominion over the world shapes it in accordance with his own intelligence and will, so too in performing morally good acts, man strengthens, develops and consolidates within himself his likeness to God.⁵⁶

2. The second principle, the *common good*, requires us to seek policy changes that will improve "social conditions which allow people ... to reach their [proper] fulfillment."⁵⁷ Given the pending insolvency in Medi-

care, and annual increases in medical spending exceeding the growth of the nation's gross domestic product, another major financial crisis is inevitable. The Patient Protection Act fails to correct this outcome, without substantial amendment. The financial burden that has been placed on the young and future generations is unconscionable.

Sound economic reasoning identifies opportunities to improve the plight of the poor and vulnerable through competitive health-care market reforms.⁵⁸ Innovation in medical care, improvement in quality, and increasing affordability are fostered when medical market forces are not overly constrained by government.

Efforts to educate patients about costs, outcomes, and quality of medical goods and services to empower them, rather than "independent panels," will enhance resource allocation for the common good, while respecting human dignity. Patients must be financially involved in their care decisions for significant control of health-care inflation. Subsidies can assist those unable to access the health-care marketplace with their own resources.

Allowing insurance purchase across state lines would offset the near monopolistic dominance many insurance companies possess in the individual insurance markets, further increasing health insurance affordability and portability. The American Medical Association reported nearly all health insurance markets "highly concentrated." A study by the American Medical Association that examines insurer competition in markets across the country found that "in 92 percent of the 313 metropolitan areas studied, one or more insurers had a share of 30 percent or greater, while 54 percent of the metropolitan areas had an insurer with a share of at least 50 percent."⁵⁹ Increasing competitive pressures on insurance companies could improve the common good by making health insurance more affordable and portable. Proposals that provide opportunity for the chronically ill to obtain medical coverage should not be coupled with guaranteed issue provisions that are likely to make insurance too expensive for the younger and healthier. New models of risk dispersion for catastrophic medical expenses could be developed which respect the dignity and conscience of patient, provider, and subscriber.

Defensive medical practices, particularly in emergency rooms and critical care circumstances, result in unnecessary expense as well as compromising compassionate patient care. Mitigating malpractice risks deserves a place in health-care reform.

3. The principle of subsidiarity argues for efforts to strengthen and protect the doctor-patient relationship. Individuals and families with health savings accounts (HSAs) would be better able to prioritize health-care resource allocation through the marketplace rather than distant bureaucratic panels assigning mandated benefit components. Since 70

percent of medical spending is for conditions directly influenced by personal behavior, the potential for improved wellness and resource allocation is considerable. The Patient Protection Act threatens Health Savings Accounts rather than encouraging their development. Preference for health-care reform solutions at the family and local community level (for example, through churches, unions, fraternal, and other community organizations) should receive priority over increasing the responsibility of more distant government and employers.

4. The principle of solidarity calls for confirmation that our efforts have maintained a “preferential option for the poor and vulnerable.” Neighbors who become sick or injured within our borders cannot be left out of the health-care reform equation. Doctors and hospitals are required by law, and conscience, to care for those who come to emergency rooms. Our society should cover the costs in providing this care and facilitate charitable organizations in their efforts to provide primary care for all those in the United States. The debate over immigration reform has no place at a patient’s bedside. Those with chronic disease, the poor, and the elderly are particularly vulnerable, and vigilance must be maintained to ensure a safety net for their care.

5. Prior to the conclusion of this essay, the dissent and divisiveness amongst Catholics and others of good will prior to the passage of the Patient Protection Act requires attention.

Archbishop Charles Chaput provides the proper perspective and helps calm the erosive winds of infidelity and disobedience:

National statements by the American bishops have often given good guidance to the faithful on issues ranging from economic justice to immigration reform. But the church has no special claim to policy competence. Her task is offering basic principles for her people to apply to daily life.⁶⁰

It is the role of the faithful laity to use these principles in the public square to advance the common good. Dr. Jeffrey Mirus calls on the laity to learn the relevant moral principles from the bishops and “to do their own proper job, which is the implementation of specific public policies.”⁶¹ The *Catechism* instructs:

By reason of their special vocation it belongs to the laity to seek the kingdom of God by engaging in temporal affairs and directing them according to God’s will.... It pertains to them in a special way so to illuminate and order all temporal things with which they are closely associated that these may always be effected and grow according to Christ and may be to the glory of the Creator and Redeemer.⁶²

Furthermore, Kenneth Whitehead asks his readers whether they “listen to the teachings of the successors of the apostles—the bishops in union with and under the successor of the apostle Peter, the pope—as if these teachings were the words of Christ himself.”⁶³ Those professing the

Nicene Creed recite the four marks of the Catholic Church: one, holy, catholic, and apostolic. Just as “any entity claiming to be the Church of Christ [as the Catholic Church does] ... must demonstrate its apostolicity, its organic link with the original apostles, on whom Christ manifestly established his Church,” so any entity claiming to be *of* the Catholic Church must demonstrate its fidelity to the Catholic Church.⁶⁴ Catholic debate on health-care reform requires fidelity with the Church on foundational issues, but prudential judgment and charitable discussion on policy in pursuit of justice. Catholic social teaching offers a remedy for those who mistakenly depart, or divisively dissent, from the Church’s teaching authority.

V. Conclusion

Health-care reform is absolutely necessary in the United States. The demographic silver tsunami of aging baby boomers, ever increasingly expensive advances in medical technology, anticipated Medicare trust fund insolvency, and millions of persons in the United States with limited medical access provide witness to this necessity. However, the Patient Protection and Affordable Care Act, and the Health Care and Education Reconciliation Act, of 2010, threaten human dignity and do not adequately address these problems. The Patient Protection Act neither sufficiently protects patients nor sustains long-term affordability.

Catholic social teaching provides guidelines for amendment with universal principles for all those of good will concerned about the common good.

Human dignity must be defended at the most vulnerable stages, from conception to natural death. Medical providers’ freedom of conscience must be protected. Health care ought to be considered as a scarce resource and allocated with competitive market-oriented reforms rather than further increasing third-party responsibility for medical care. The principle of subsidiarity leads to increasing responsibility for health care at the patient, family, doctor-patient, and local levels of society rather than at distant bureaucratic plateaus. Finally, the principle of solidarity requires us to confirm that our policy initiatives have benefited the most poor and vulnerable.

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