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The Great Divide: Catholic Social Teaching and American Health Care

Drew Christiansen, S.J.

This speech was given by Drew Christiansen S.J. of Santa Clara University, at the annual meeting of the National Federation of Catholic Physicians' Guilds held at Notre Dame in October, 1990.

All of us have heard the story many times. It still remains one of the best told stories in the New Testament and perhaps in the whole bible. It is the story of the Rich Man and Lazarus. Since the text is so familiar, allow me to read to you a contemporary paraphrase by the Episcopalian priest and spiritual writer, Robert Farrar Capon, in *Parables of Grace*, pp. 155-157).

Now there are two details of the story that we need to note, details which point to one another. I mean the gate and the chasm. Lazarus lies at the rich man's gate. In the Old Testament, "the gate" was where the elders of the city rendered justice. So, Luke implies by including this bit of architectural information that Lazarus was waiting for justice from the rich man. Justice which never came. There is good reason to think that the duty to do justice to the poor is what Luke had in mind because one theme running through this chapter, as through the rest of Luke's gospel, is the rejection of the Law and the Prophets which made justice *for the poor a primary way of showing one's devotion to God*.

Besides this allusion, the evangelist makes a quite deliberate contrast between "the gate" in the first part of the story and "the unbridgeable chasm fixed between [the two men]" in eternity. It is as if he said, here was an opportunity irrevocably lost. The rich man might have passed through the gate and given alms to Lazarus; he might even have invited him in to share his table. But he never even saw him, not until he sought relief for himself and his family. In hell, the evangelist says, he looked up and saw Abraham far away and Lazarus at his side. With hindsight, then, Jesus' listeners can appreciate the tragedy of Dives, the Rich Man, as a case of missed opportunity. Under the covenant what mattered was whether a Jew gave justice to the poor, to widows, orphans and strangers in the land. But distracted by his conspicuous consumption, Dives never grasped the need of his neighbor.

PART I

The Parable in Papal Teaching

Why, you may be asking, is he talking about a gospel parable in a speech on contemporary Catholic social teaching? Well, I do so because contemporary Catholic social teaching has done so. If there is one biblical text which not only marks, but also guides, Catholic social teaching in the last 30 years, it is the story of the Rich Man and Lazarus. The Second Vatican Council asked that Catholic moral theology renew itself with greater study of scripture. Ironically, the area which has been most affected by that scripture renewal is not moral theology properly so-called, but the one field where we would have thought it most difficult to apply biblical reasoning, namely, Catholic social thought. Interestingly, the person who has appealed to this parable more often than any other is Pope John Paul II.

In 1976, John Paul, then Cardinal Karol Wojtyla, gave the papal household its annual retreat at the Vatican. During that retreat, he appealed to the parable as a reflection on the state of the world. In his 1980 encyclical, "Rich in Mercy", he lamented the indifference of affluent nations to the plight of the world's poor. "We live against the background of gigantic remorse", he wrote, "because 'wealthy surfeited people', indeed whole societies, (live) side by side with shortage and destitution, real and growing hunger, caused by the 'defective machinery of the world' which produces 'radical injustice' ". For John Paul, the contemporary world is a re-enactment of the parable on a gigantic scale. In his most recent social encyclical, "On Social Concern", he appealed once more to the parable of the Rich Man and Lazarus as a parable of our time, capsulizing the relation between the affluent nations of the North and the impoverished peoples of the South. "It is essential," he wrote, "to recognize each people's right 'to sit at the table of the common banquet' ", instead of lying outside the door like Lazarus while "the dogs come to lick his sores". (Also see No. 28). More important for you and me, in two visits to the United States, he utilized the parable to make a direct appeal for action to American Catholics. In his address at Detroit, during his 1987 pilgrimage, he went so far as to chide his American audience for thinking that the parable did not speak to them. "You are all familiar with this marvelous lesson in social responsibility which Jesus left us," he told his listeners. "Knowing your faith and your openness to challenge, I ask you today: What have you done with that parable? How many times in the last eight years have you turned to that parable to find inspiration for your Christian lives? Or have you put it aside thinking that it was no longer relevant to the situation in your country?"

For the Holy Father, the Rich Man and Lazarus is meant for us because, above all, it is a description of the kind of world we live in where growing affluence dwells unmoved alongside worsening poverty. For John Paul, writes Ronald Modras, "Christ stands as a sign of contradiction to all, including Christians, who are indifferent to the oppression of the poor." In

"On Social Concern", John Paul notes that the pattern of indifference may be found not only in the so-called developing world, but within the industrial democracies themselves. There is mounting evidence that, in the case of the United States, John Paul was on the mark. We are more and more a divided society.

A Society Divided

The American bishops in their 1985 pastoral letter, "Economic Justice for All", noted that in the course of their discussions across the country, they too had grown increasingly alarmed over the distance which Americans keep from one another. They reported finding an alarming sense of fragmentation among the American people. So great are our divisions that the oral historian and columnist Studs Terkel entitled a recent book about American society *The Great Divide*. According to Robert Bellah and the co-authors of the sociological best seller *Habits of the Heart*, we live in "a culture of separation" in which classic American individualism erodes the last vestiges of civic responsibility. "As we unthinkingly use the oxymoron 'private citizen,'" they write, "the very meaning of citizenship escapes us. And with Ronald Reagan's assertion that 'we the people' are a 'special interest group', our concern for the economy being the only thing that holds us together, we have reached a kind of end of the line. The citizen has been swallowed up in economic man." (271) The dominance of economic life over all the other fields of human activity, as physicians know all too well, separates us from one another and forces us more and more into an isolated concern for our own narrow self-interest.

The Growth of Inequality

In recent months, a spate of statistics shows how the fragmentation of American society has progressed. Republican analyst Kevin Phillips, in his recent book *The Politics of Rich and Poor*, cites an Urban Institute study which shows that between 1977 and 1988, the average yearly income of the poorest American family has declined by 14.8%, while that of the richest has increased by 16.5%. While "the average family income" has increased by 2.2% in the same period, 80 per cent of families experienced a loss of income over the same period. In other words, only the top 20 per cent actually made any gains, and even among the well to do, it is only the top 10 per cent of families with incomes in excess of \$100,000 who have made any serious gains over the last decade. Phillips, as you know, has predicted that inequality will be the great political issue of the 1990s, anticipating, as it were, the Democratic demand for tax equity in the stalled negotiations over the national budget.

During the 1980s, according to a report due out next month from the Economic Policy Institute, the bottom 40 per cent of the population has actually lost income, while the income of the richest 80 per cent grew by

nearly 30 per cent, nearly eight times that of the rest of the nation. At the end of the '80s, a male high school graduate with less than five years of work experience was earning 18 per cent less than his counterpart a decade ago. Young black men earned 21.6 per cent less. The fraction of the workforce earning poverty level wages increased by 25 per cent in the last 10 years. The working poor are caught in a vise, therefore, between declining job opportunities, on the one hand, and the decrease in government services, along with a higher tax burden, on the other. We have, once again, an economy which makes people poor. Thus, the intensification of poverty and the aggravation of inequality which Catholic social teaching has repeatedly viewed as the primary "sign of the times" to which Christians and all men and women of good will are called to respond, are increasing the trends we witness in American society as well. We are a country divided: between rich and poor, the upwardly mobile and the downwardly destined, between malnourished and chronically ill ghetto children and affluent leisure village retirees whose every health problem is cared for by HMOs. We are a house divided.

The trends in society at large are reflected in American healthcare as well. The facts are well-known to you. Thirty million Americans are without health insurance. Caught in a squeeze between technological innovation and the spiraling costs of healthcare, hospitals refuse uninsured patients and those on Medicaid. Institutions committed to care of the poor totter on the edge of insolvency. According to Lawrence Brandt, writing in a recent *America*, up to 60 million Americans are at risk for lack of any or at least adequate health insurance. Healthcare, as much as any force in American life, is cleft by a yawning chasm. Pope John Paul is correct. The parable of the Rich Man and Lazarus is re-enacted in our midst.

One use of the story is to point out what is wrong with the world, and to remind those with power and resources that they have failed to exercise their capacity to change the situation. But another use we find in papal statements is to appeal to another favorite image of Luke, namely, that of the banquet, and to dream of a time when the Rich Man walks through the gate and embraces Lazarus as his brother.

The Table of Fellowship

Table-fellowship is an attractive image and a powerful one as well. [Avalon; *Family History*] I am surprised at how evocative it remains even for today's supposedly worldly-wise students. Here at Notre Dame, I taught a course for undergraduates called *Love and Justice*. Three years running, I was astounded to read in student evaluations that table-fellowship as a symbol of the just society was the single most important idea they had taken from the course.

Paul VI was the first to re-imagine the story with a happy ending in *Development of Peoples*. And especially in recent years, Pope John Paul, who is much more a realist than his predecessor, has projected the common

banquet as a symbol of the just society.

Part II

In Search of the Common Good

The old-fashioned Catholic term for speaking about table-fellowship as a social ideal is “the common good”. As the fragmentation of American society has grown more and more evident, the common good has suddenly become a popular phrase among philosophers, political commentators and social critics. It is an ancient concept, with its roots in the life of the Greek city-states, which became the center of Catholic political thought in the Middle Ages, and in the 19th and 20th centuries, it has been one of those concepts which sets Catholic thought apart from the liberal individualism of the American political tradition. The Common Good is a way of saying that everyone ought to share in the benefits and burdens of living in a society. It is opposed to the notion of possessive individualism: the notion that all good things are the private property of individuals and that they ought to be privately enjoyed. Possessive individualism assumes that the only way to act is out of self-interest. The Common Good holds that people can act out of concern for the good of the whole society, and that they ought to do so.

A Common Quality of Life

Since the time of Pope John XXIII, the concept of the Common Good has taken on an egalitarian aspect. In Roman social teaching, at least, the common good requires that every person and group share in improving quality of life. As John Paul II wrote in “*Sollicitudo*,” the common good requires that others “live *on a par* with ourselves”. As a result, Roman teaching has been sensitive to the fact that accelerating inequality undermines even the possibility of protecting people against the worst ravages of society. And so, one of the conclusions that Roman teaching has drawn — long in advance of Kevin Phillips — is that holding inequality in check is the key to providing basic needs for everyone. On that ground, Paul VI and more recently John Paul II have argued that privileged groups need to sacrifice not just their interests, but even some of their rights, so that everyone can enjoy the possibilities of a humane quality of life.

Now, this notion of sacrificing one’s rights is strange to American politics and political philosophy. But it derives from an experience that entitlements create privilege which ultimately disenfranchise other people. The customary hobbyhorse for this kind of excess is the labor movement. Roman teaching has always supported the rights of labor, but has likewise warned against privileged groups forming workers. And, though management is also at fault, it is clear that unions have served to create a privileged elite among working people to the neglect of the welfare of young workers, minorities and the unemployed. [SF Story]

But no development better illustrates the need to balance rights by consideration of the common good than the current debates over justice in healthcare. Two cases stand out. The first is Medicare and the grey lobby and the other is the AIDS lobby and public policies relating to HIV. As you know, last year Congress rescinded the Catastrophic Healthcare bill because of a taxpayers' revolt on the part of wealthier old people who had been required to pay a tax surcharge to defray the cost of this expensive program. Catastrophic healthcare, though one might quibble with the detailed provisions, was a social service which served the common good. Its defeat by a privileged minority depicts clearly the pernicious effects of a rights-based theory of justice in a culture of self-interest.

The AIDS lobby is yet another instance of an interest group which acts without apparent concern for the common good out of the conviction that self-restraint and self-sacrifice are virtues for political naifs (the politically naive). Lacking is any sense that national health policy must respond to many needs of diverse groups, some of whom are utterly deprived and whose small voice is drowned out by chants in the street and sophisticated lobbying and media programming. But having learned that the U.S. political system responds most readily to vocal, organized pressure, the AIDS lobby has pursued its aims as if no other victims were in need of care and support. An AIDS policy developed out of response to the common good would not occupy acute care beds when hospice services would suffice. It would not allow demand for exotic and expensive treatments of unknown worth when others still need basic health care. In short, the common good would require not that special interest groups not put forward their needs, but that they would enter the political arena recognizing that it is a right to decline special considerations when others are still denied basic care.

A Shared Obligation

One point which is frequently misunderstood with respect to the common good is that it is an obligation which falls on everyone. It is not, as Michael Novak and others have argued, a statist concept. It does not appeal, in the first instance, for government action. It insists that all groups attend to the common good. Management and labor, professional associations and voluntary organizations, local and national groups are all urged to work so that all sectors of society can share in the advancing quality of life. Government is asked to coordinate diverse views, and it must act as an agent of last resort in situations where other groups either cannot or will not do so. But, according to official Catholic teaching, everyone and every group bears responsibility to see that no one is excluded from "the banquet of life."

When it comes to healthcare, many of us may feel a certain despair that action, governmental or otherwise, can solve the problems facing the nation. We may be skeptical that rationing programs like those proposed in

Oregon or articulated by ethicists like Daniel Callahan can work. It may seem that the only alternative is the market, in which case one must become reconciled to the growing disparities between rich and poor. In that case, however, we will have despaired of Christian ethics and thrown in our lot with the Rich Man. The logic of despair guarantees that the gate of opportunity will become an unbridgeable abyss.

The Grassroots Health Decisions Movement

For my part, I find reason for hope in the grassroots health decisions movement which is spreading across the country under official, semi-official and private sponsorship. That movement has shown that people of diverse backgrounds can come to agreement on the basic outlines of health policies in their region. In an assessment of several such programs in the current *Hastings Center Report*, Bruce Jennings reports that "the philosophical argument about the justness or rightness of equitable access to health care for all has pretty much been won." Now he says, "it is necessary to define specifically the components of the health care floor below which no one will be allowed to fall. In several states," he continues, "it is precisely this debate in which the community health decisions groups now find themselves caught up."

According to Michael Garland and Romana Hastain, the principles governing the Oregon discussions included prevention, quality of life, cost-effectiveness, ability to function, and above all, equity. They write, "The theme of equity was displayed in discussions appealing to a premise that persons should not be excluded from health care when they need it." The repeated emphasis in these reports on equity in health care delivery, it seems to me, is a sign that, given an atmosphere in which there can be genuine and serious exchange, men and women can agree on a health care program in which all sectors of the society share in the advances of medicine as a common good.

The decisions movement also exemplifies another aspect of the common good which is frequently overlooked. Sharing in the life of a society entails not only enjoying its benefits, but also exercising a role in guiding and directing it. This active dimension of the common good is known by the term "participation". Dennis McCann and others, including myself, have argued that public dialogue on policy may well be a constitutive dimension of the common good. In any case, the grassroots health decisions movement appears to me to be a sign, like many of the people interviewed by Studs Terkel or the Bellah team, that even in individualist America, people can work for the common good.

Subsidiarity and Federal Action

Another dimension of the common good which is relevant to healthcare in America is the principle of subsidiarity, the notion that responsibility is

rightly exercised at the smallest appropriate level. Given the costs and the scale of contemporary healthcare problems, of course, some very basic decisions must be taken at the national level: decisions on research, national health insurance and macro-allocation, for example. This is a traditional feature of the common good frequently overlooked by conservatives in their appeal to subsidiarity. There are conditions under which national government is the most appropriate place to deal with issues, for one of three reasons: either (1) the federal level is the only level at which effective action can be taken, or (2) local, regional and state activities fail to extend assistance to certain groups, or (3) coordination is required for the work being done by smaller units. With so many ethicists addressing issues of macro-allocation, rationing and national health insurance, I don't feel I can add anything helpful to those discussions. What I would like to do, however, is to point up some of the ways in which, as physicians, you might be able to take action on a corporate, local or even individual level on behalf of the common good.

Subsidiarity: Some Examples

What would action on behalf of the common good look like in American health care today? How might you yourselves act on behalf of the common good — as professional men and women, as staff members in healthcare institutions, as members of medical organizations?

Recall that before it counts as a principle of political justice the common good is essentially a principle of social justice. It requires that every person and every group take account of the ways in which its action has an impact on others' sharing in a common quality of life. In that sense, the common good is a prescription for inclusion. That, for example, is how the U.S. bishops interpreted the principle in their 1985 pastoral letter "Economic Justice for All" with relevance for extending benefits to the poor and minorities.

(1) Personal Responsibility. One of the potential deceptions in an affluent society or for advantaged people in any society is to believe they have no power to make a difference. Individuals can make a difference. Let me tell you the story of one health care professional. A psychologist, he began with an interest in the dying and grieving, and then helped found a hospice. Later, as experience pointed to lacunae in the caregiving system, he focused his work on terminally-ill children and ultimately founded a hospice for dying children and their families. Subsequently, realizing that this was a population overlooked by the health care system generally, he helped organize a foundation directed to meeting their needs. Now, that is a pattern of action which shows not just awareness of the common good, but especially the exercise of responsibility, within his own professional practice, to see that the common good is served. His story can be duplicated by medical personnel serving the homeless, the rural poor, refugees, and so on.

Two things are especially worth noting about the psychologist's story. First, acting on behalf of a forgotten population did not marginalize him from his practice. Secondly, it involved a societal solution as well as a personal response.

Often, we fear, I think wrongly, that ethical action involves unacceptable costs. There are costs, but, as a matter of fact, they seldom are impossible to bear. It is our projection which makes the price seem ruinous. In the professions, we think that if we act out of ethical responsibility, we'll lose standing among our peers, or that we'll cease to be on the cutting edge in our discipline. In this case the man's professional standing actually grew with each advance in commitment. So the exercise of personal responsibility for the common good does not necessarily entail the kind of severe sacrifice which brings on moral paralysis. To imagine it does usually means we are engaged in self-deception and moral evasion.

Secondly, the psychologist's work on behalf of dying children was not restricted simply to personal service in the *pro bono* mode. He took initiatives to see that a wider population was served, model organizations were founded, and means invented to extend the care beyond one hospital and one city. There is an important place for humanitarian service on the part of physicians and other health care professionals, for example, as modeled by Physicians without Borders. The common good is promoted by direct service, and many helpful solutions can be found through local action. Nonetheless, systemic solutions are needed in as complicated and costly a field as American medicine, and so the common good is better served, where possible, by solutions which serve a wider public.

(2) Institutional Responsibility. One of the characteristics of American society today, as management guru Peter Drucker has said for many years, is that we are a society of organizations. The implications of that insight have still to bear fruit in the way most of us treat ethical issues. Even ethicists tend to focus on problems as if they are decisions for individual decisionmakers in crisis situations. But the big ethical issues in all our lives are seldom any longer individual decisions. They are institutional decisions determining the policies of the organizations to which we belong: a university, a hospital, a business conglomerate, a research lab. Because of the pervasive influence of the institutions in which we work, we also bear a responsibility to see that they work for the common good. It does no good to lament government inefficiency and yearn for local initiative, and then neglect to share in the formation of policies in the institutions in which we live.

Of course, the degree to which one can influence the direction of one's institution will vary with one's role, the ethos of the institution, and the channels for open communication. I like to tell the story of a physician friend who worked for years in large medical bureaucracies. He was fond of saying it cost little or nothing to ask an ethical question every day. And that was the practice he employed with his staff. Sometimes directly, sometimes in a roundabout way, they would discuss the ethical dimensions of the

actions they were taking. Over time the outcomes of that office were different, and my friend was different. At the end of his career, he finally was passed over for a major political appointment because he had stood against his boss on two decisions affecting the delivery of healthcare to urban ghettos. As it turned out, he won both fights, and then retired to a comfortable and adventurous retirement.

So, I would urge that one implication of the principle of subsidiarity is that we work within our institutions to see that their policies provide the benefits of their activities to all Americans.

I should also add that subsidiarity also entails some self-denying decisions. By that I mean, decisions made by light of the common good, despite the assertions of some that the common good and self-interest will coincide, will demand that we sacrifice some institutional interests. Some years ago, a medical center with which I was associated made a major financial investment in an independent hospice. The original plan was that a certain number of beds in the hospice would be reserved for terminally ill patients from the medical center. But for a number of years, the hospital transferred very few patients to the hospice. The result, of course, was an increase in expenses for hospice patients and for insurance policyholders generally. Furthermore in many cases patients were denied appropriate terminal care. Institutional self-interest had undermined a program which was genuinely in the common good. Meeting the institutional costs of such decisions is not always easy, but with imagination and ingenuity, it can be done.

(3) Professional Societies. One last arena in which we all can work for the common good is in voluntary associations, especially professional societies. All too often, professional societies are simply the sources of that sort of privileged right of which Catholic social teaching has been rightfully critical. They work primarily to insure our advantages as physicians, as older Americans, or as university professors. But professional societies can also be instruments of the common good. State bar associations, for instance, are now debating whether lawyers and law firms should be required to do a certain amount of pro bono work for the indigent. Can you imagine medical societies demanding a certain standard of service to the poor as a requirement for membership? How about funding scholarships for medical students willing to spend a certain number of years in service of deprived populations? The possibilities are too numerous to exhaust. What about sponsoring voter initiatives for bond issues to upgrade medical facilities in underserved parts of the community?

In any case, I want to suggest that we ought not let our sense of possibility be limited to federal government action or individual humanitarian service. We can make important contributions to the common good through institutional and organizational initiatives as well, and the avoidance of large scale government intervention will be possibly only to the degree that we participate actively and effectively in the intermediary groups of which we are a part.

Conclusion:

A Gospel for Middle Class Professionals

Contemporary Catholic social teaching takes the two images with which it understands the common good — the story of the Rich Man and Lazarus, and the image of table-fellowship — from the gospel of Luke. While Luke's gospel is commonly called "a gospel of the poor" because of its special concern for society's rejects, it is quintessentially a gospel for middle class professionals. Parable after parable is told with a view to influencing people who have money, power and influence. Luke writes of builders, managers, generals, wealthy farmers and highliving arbitragers, with a sensitivity to their everyday expectations of the world. He is a pragmatist, who values action. He wants results. His characters — and his God — look for big payoffs. His Jesus admires decisive people of action, who can seize an opportunity and make the most of it. He appeals to the fact that his audience knows how to wield authority, and that it is used to demanding a lot of its employees. He even understands the principle of success, namely, that to those who have much responsibility, still more will be given. And that is the point with which I would like to close.

Whatever the stresses on the medical profession today, physicians are still a tremendously privileged group. The responsibility for bridging the great divide in American healthcare lies with you. From those to whom much has been given, much is expected. Luke is stark in this demand. He concludes the parable of the Profitless Servant, a parable addressed to people who are used to others working for them, this way: "When you have done everything you were told to do, you should say, 'We are unworthy servants; we have only done our duty (17:7-10).'" Our duty today is to see that all Americans can share in the benefits of modern medicine and up-to-date health care.

But perhaps in the spirit of Luke, we ought to think of ourselves as men and women of action who know how to get things done, who see a need and meet it. They tell a story of Sargent Shriver, who when other people say "It is impossible", responds, "Oh, it's just a little more difficult. We'll have to try harder." Bridging the Great Divide is not impossible; it is just a little more difficult than we would like it to be. Catholic social teaching challenges you as physicians and as citizens to seize the opportunity, to make things happen, so that rich and poor may be able to sit down together at the banquet of life.