

ADDRESS

"THE CONSISTENT ETHIC OF LIFE AND HEALTH CARE REFORM"

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As many of you may know, in the last year I have experienced a significant amount of press coverage for reasons that are happily behind me. There is a temptation in this prestigious forum to share some of my reactions and reflections based on that experience, but I am going to resist that temptation. At another time and after more reflection on my part, I might share some thoughts about what I learned about the news media and related topics. But today I address a more important and more timely topic -- the moral dimensions of health care reform.

For the last decade as a pastor, a bishop, and a leader of our National Conference of Catholic Bishops, I have had the opportunity to address a series of vital moral challenges. I chaired the committee that produced the pastoral letter on war and peace a decade ago. I have served as chair of our bishops' committees on pro-life matters and family-life concerns. As a bishop, I have also seen the crime, injustice, and violence in our neighborhoods and the loss of roots and responsibility in our cities, the loss of the sense of family and caring in our communities that is undermining millions of lives.

I believe that at the heart of so many of our problems -- in Chicago and Washington, in Bosnia and Rwanda -- there is a fundamental lack of

respect for human life and human dignity. Over the past ten years I have articulated a "Consistent Ethic of Life" as a moral framework to address the growing violence in our midst.

The purpose of the consistent life ethic is to provide a moral framework for analysis and motivation for action on a wide range of human life-issues with important ethical dimensions. The consistent life ethic, by design, provides for a public discourse that respects the separation of church and state, and also recognizes the proper role of religious perspectives and ethical convictions in the public life of a pluralistic society.

Over the past years I have addressed many issues in the light of the consistent ethic. In addition to the central question of abortion, I have spoken about euthanasia and assisted suicide, capital punishment, the newer technologies used to assist human reproduction, and war and peace, to name a few. The foundation for all of these discussions is a deep conviction about the nature of human life, namely, that human life is sacred, which means that all human life has an inalienable dignity that must be protected and respected from conception to natural death. For the Christian believer and many others, the source of this dignity is the creative action of God in whose "image and likeness" we are made. Still others are aware that life is a precious gift which must be protected and nurtured.

For advocates of a consistent life ethic, the national debate about health care reform represents both an opportunity and a test. It is an opportunity to address issues and policies that are often matters of life

and death, such as, who is covered and who is not; which services are included and which are not; will reform protect human life and enhance dignity, or will it threaten or undermine life and dignity? It is a test in the sense that we will be measured by the comprehensiveness of our concerns and the consistency of our principles in this area.

In this current debate, a consistent life ethic approach to health care requires us to stand up for both the unserved and the unborn, to insist on the inclusion of real universal coverage and the exclusion of abortion coverage, to support efforts to restrain rising health costs, and to oppose the denial of needed care to the poor and vulnerable. In standing with the unserved and the unborn, the uninsured and the undocumented, we bring together our pro-life and social justice values. They are the starting points for a consistent life agenda for health-care reform.

In these remarks I speak as a pastor of a diverse local church. In Chicago we see both the strengths and the difficulties of our current system. We experience the remarkable dedication, professionalism, and caring of the people and the amazing contributions of the institutions that make up our health care system. I also see the children without care, the sick without options, the communities without adequate health services, the families and businesses strained and broken by health care costs. We see the hurts and pick up the pieces of a failing system -- in our hospitals and clinics, our shelters and agencies, our parishes and schools. We look at health care reform from the bottom up, not who wins or loses politically, not how it impacts powerful institutions and

professions, but how it touches the poor and vulnerable, the unserved and the unborn, the very young and the very old.

As I indicated earlier, I am also a member of the National Conference of Catholic Bishops, an organization deeply involved in this debate. Our principles and priorities are summarized in a resolution unanimously adopted by the Conference last year (a copy of which is at your tables). A unanimous vote of our bishops is an unusual accomplishment, as those of you who have ever seen us discuss holy days or liturgical texts can attest! But we found unity in embracing a consistent life ethic approach to health care reform.

The broader health care debate is driven by many factors. For the sake of time, I will list only five without discussing them at any length.

- 1) The amount of money spent on health care is escalating at an unsustainable rate. It surpassed 14 percent of the gross domestic product (GDP) last year, and it is reasonable to assume that, without effective intervention, it could reach 18% of the GDP by the year 2000.

- 2) This uncontrolled growth is creating economic hardships for many of our fellow citizens, especially working families.

- 3) Private insurance programs are deteriorating through risk segmentation into programs that more and more serve those who have the least need for health insurance -- the healthy.

4) Cost shifting -- that is, the passing on of unreimbursed expenses by health providers to employer premiums -- has become a "hidden tax" that no longer is sustainable.

5) Finally, and most significantly, the number of uninsured in the United States continues, now approaching nearly 40 million, a large portion of whom are people who work. Ten million are children. This lack of coverage touches African-American and Hispanic families most directly.

I join the many who have concluded that the United States needs profound systemic change in its health care system. We cannot rely on the system to correct itself. Without intervention, things are getting worse, not better.

I hasten to add that my advocacy is not partisan. Neither do I argue on behalf of any particular proposal before the Congress. I do, however, take exception with those who say that there is no serious systemic problem or that what we merely face is an insurance or a health care delivery problem. On the contrary, there is a fundamental health care problem in our nation today. I share this judgment with many leaders of the Catholic community whose outlook and convictions have been shaped by the experience of Catholic religious communities and dioceses that operate 600 hospitals and 300 long-term care facilities, constituting the largest non-profit group of health care providers in the United States: by the experience of the Catholic Church in the United States, which purchases health coverage for hundreds of thousands of employees and their families; by the experience of Catholic Charities, the largest private deliverer of

social services in the nation; by our experience as a community of faith, caring for those who "fall through the cracks" of our current system.

It is this broad range of experience that led the U.S. Catholic bishops to say last June:

Now is the time for real health care reform. It is a matter of fundamental justice. For so many it is literally a matter of life and death, of lives cut short and dignity denied. We urge our national leaders to look beyond special interest claims and partisan differences to unite our nation in a new commitment to meet the health care needs of our people, especially the poor and the vulnerable. This is a major political task, a significant policy challenge and a moral imperative.

Before addressing some of the more specific issues associated with health care reform, it is important that we consider some even more profound issues. I say this because President Clinton's health care reform proposal and the alternatives to it, like any significant government initiatives that would reorder social relationships and responsibilities, have drawn us into a discussion of fundamental values and social convictions. Several important convictions, which serve as a kind of bedrock for the consistent life ethic, can assist us in this broader discussion. They are:

1. There are basic goods and values which we human beings share because we share the gift of human life; these goods and values serve as the common ground for a public morality that guides our actions as a nation and as a society.

2. Within the individual, these common goods and values express themselves in an inalienable human dignity, with consequent rights and duties.
3. One of the ways these rights and duties are expressed in the human community is through the recognition and pursuit of the common good; or, to say it differently, through a good that is to be pursued in common with all of society; a good that ultimately is more important than the good of any individual.
4. This common good is realized in the context of a living community, which is nurtured by the virtues and shared values of individuals. Such a community protects the basic rights of individuals.
5. As part of this community, both individuals and institutions (including government, business, education, labor, and other mediating structures) have an obligation, which is rooted in distributive justice, to work to secure this common good; this is how we go about meeting the reasonable claims of citizens striving to realize and experience their fundamental human dignity.

These convictions find their origin in a vision of the human person as someone who is grounded in community, and in an understanding of society and government as being largely responsible for the realization of the common good. As Catholics we share this vision with many others. It is consistent with fundamental American values, though grounded differently. For example, our Declaration of Independence and our Constitution reflect a profound insight that has guided the development of our nation; namely, that there are certain fundamental human rights that exist before the

creation of any social contract (such as the constitution of a sovereign nation), and that these must be protected by society and government. There is an objective order to *which* we are held accountable and to which we, in turn, hold others accountable in our many relationships and activities. The Catholic tradition also affirms such rights but sees them emerging from the organic relationship between the individual and the community.

As a nation, we also have had a sense of a common good which is greater than the agenda of any individual. Alexis de Tocqueville noted this when he commented on the American penchant for volunteering. We also have been a nation of communities. Whether in the small towns of the Plains or the ethnic communities of the large cities, U.S. citizens had a sense of being bonded together and being mutually responsible. We also recognized that our individual and collective existence is best protected by virtuous living -- balancing the demands of personhood and social responsibility. In more recent years, as our social order has become more complex, we have come to see that a proper sense of mutual responsibility requires a greater presence of the state in helping individuals to realize their human potential and social responsibility. Public education and social security are but two examples of this presence.

Without being overly pessimistic, I suggest that these fundamental convictions, which are essential both to a consistent life ethic and to our well-being as a nation and a society, are being challenged today. There is abroad a certain tendency which would suggest that law and public order are accountable only to the subjective convictions of individuals or

pressure groups, not to any objective, albeit imperfectly perceived, moral order. Robert Bellah and his associates have convincingly shown how a sense of the common good, the role of community, and the value of virtuous living have been compromised, if not lost, in recent years. I am convinced that the violence that plagues our nation is a symptom of this loss of an overarching social order. We are a nation that is increasingly overly individualistic at the very time when the problems we face require greater common effort and collective responses.

All of this needs to be taken into consideration in any substantive discussion of health care reform. If we are not attentive to issues such as these, then our dialogues and debates will go nowhere because of disagreements -- unknown and unacknowledged -- on basic principles.

First, there is the issue of universal access. In the June 1993 statement I cited earlier, the U.S. Catholic bishops outlined key principles and priorities for initiating and executing reform. Our third principle was universal access to comprehensive health care for every person living in the United States.

We believe that health care -- including preventive and primary care -- is not only a commodity; it is an essential safeguard of human life and dignity. In 1981, the bishops spoke of health care as a "basic human right which flows from the sanctity of human life." In declaring this, the bishops were not saying that a person had a right to health, but that, since the common good is the sum of those conditions necessary to preserve human dignity, one must have a right of access, insofar as it is possible, to those goods and services which will allow a person to maintain or

regain health. And if one views this right within the context of the convictions I have just discussed, then it is the responsibility of society as a whole and government to ensure that there is a common social order that makes the realization of this good possible. Whether we have health care should not depend on whom we work for, how much our parents earn, or where we live.

So far, so good. Most would agree, at least in theory. Where the disagreement comes is in regard to the last of the convictions I noted in discussing the consistent ethic. Allow me to rephrase it.

Under the title of distributive justice, society has the obligation to meet the reasonable claims of its citizens so that they can realize and exercise their fundamental human rights.

When many of us Americans think of justice, we tend to think of what we can claim from one another. This is an individualistic understanding of justice. But there is another American instinct which has a broader understanding of justice. It has been summarized by Father Philip Keane, a moral theologian, who wrote: "...justice shifts our thinking from what we claim from each other to what we owe to each other. Justice is about duties and responsibilities, about building the good community." In this perspective, distributive justice is the obligation which falls upon society to meet the reasonable expectations of its citizens so that they can realize and exercise their fundamental human rights. And, in this instance, the right is that of access to those goods and services that make it possible for persons to maintain their health and thus broaden

health care beyond what is provided by a hospital, a clinic, or a physician.

So far I have argued that health care is an essential safeguard of human life and dignity and that there is an obligation for society to ensure that a person be able to realize this right. I now want to go a step further. I believe that the only way this obligation can be effectively met by society is for our nation to make universal health care coverage a reality. Universal access is not enough. We can no longer tolerate being the only Western nation that leaves millions of persons uncovered. For many, this will be a "hard saying." The cry of political expediency and the maneuvering of special interest groups already are working either to provide a program of access that maintains a two-tiered health care system (which marginalizes large portions of our society) or to limit coverage. When I speak of universal coverage, I do not mean a vague promise or a rhetorical preamble to legislation, but the practical means and sufficient investment to permit all to obtain decent health care on a regular basis.

If justice is a hallmark of our national community, then we must fulfill our obligations in justice to the poor and the unserved first and not last. Similarly, we cannot ignore the millions of undocumented immigrants. Even if the demands of justice were set aside, reasons of public health would necessitate their being included. The undocumented will continue to need medical assistance, and hospitals will continue to be required to provide medical care for those who present themselves for treatment. In a reformed system, which should contain, if not eliminate,

the cost-shifting that previously had paid for their care, the medical expenses of the undocumented must be covered for both policy and moral reasons.

Unfortunately, as the national debate on health care reform has evolved, and as legislation has been proposed, an important fact has been lost: namely, that it is not enough simply to expand coverage. If real reform is to be achieved -- that is, reform that will ensure quality and cost-effective care -- then we must do what is necessary in order to ensure that our health care delivery system is person-centered and has a community focus. Health care cannot be successfully reformed if it is considered only an economic matter. This reform will be morally blighted if the nature of care -- something profoundly human, not easily measured, yet that which, far more than technology, remains the heart and breath of the art of healing -- is not preserved and expanded along with health coverage itself. The challenge is to provide universal coverage without seriously disrupting the doctor / patient relationship which is so central to good medical care.

After a long period of research and discussion, the Catholic Health Association (CHA) developed a proposal for health care reform that seeks to meet this and other challenges. It is called "Setting Relationships Right." I hope that the values CHA has proposed and the strategies it has developed in this regard will not be lost sight of our objective must be a healthy nation where the mental and physical health of the individual is addressed through collaborative efforts at the local level.

Let me summarize my major points so far. First, we need a profound systemic reform of our health care system. Second, justice and the common good demand that this reform include universal coverage. Third, justice at this time requires a program of effective universal coverage that is person-centered and community-based. This leads us to two thorny questions: How is the program to be funded, and how are costs to be contained?

As you know, these two questions are essentially interrelated. It is clear that the rate of cost increases in health care cannot be sustained even if there is no systemic reform. It also is clear that the demands of a more fiscally responsible use of federal monies must be taken into account. We cannot spend what we do not have.

Our episcopal conference has insisted that health care reform must also include effective mechanisms to restrain rising health care costs. Without cost containment, we cannot make health care affordable and direct scarce national resources to other pressing national problems. Containing costs is crucial if we are to avoid dangerous pressures toward the kind of rationing that raises fundamental ethical and equity questions. The poor, vulnerable, and uninsured persons cannot be denied needed care because the health system refuses to eliminate waste, duplication, and bureaucratic costs.

But we may also have to consider other steps to restrain costs and distribute health care more justly. For example, we may have to recognize that basic and preventive care, and health care to preserve and protect life, should be a higher priority than purely elective procedures. This

raises the often explosive concept of "rationing." I prefer a different word and a different concept -- "stewardship." How do we best protect human life and enhance human dignity in a situation of limited health resources? How do we ensure that the lives and health of the poor and vulnerable are not less valuable or less a priority than the lives and health of the rest of us?

This is not an abstract discussion. Rationing health care is a regular, if unacknowledged, feature of our current health care system. Nearly 40 million are uninsured; 50 million more are underinsured. In 1992, nearly 10 million children were without medical coverage, 400,000 more than in 1991. In my own state of Illinois, 86,000 persons lose their health insurance each month. Being without insurance means being without care when you need it, delaying care until an illness or injury may require more costly intervention or be beyond any treatment.

We now have an insurance model that requires individuals to pay for the items and services which their health care needs require -- some without limitations and others with enormous constraints. We have been rationing health care in recent years by squeezing people out of the system through insurance marketing techniques like medical underwriting, pre-existing condition exclusion, and insurance red-lining. Actuarial pricing designed to protect insurance company assets pits one group against another -- the old against the young, the sick against the healthy -- thus undermining the solidarity of the whole community. We can see this tension playing itself out in the disturbing debates around this country about assisted suicide.

In light of these concerns, the nation must undertake a broad-based and inclusive consideration of how we will choose to allocate and share our health care dollars. We are stewards, not sole owners, of all our resources, human and material; thus, goods and services must be shared. This is not a task for government alone. Institutions and individuals must be involved in reaching a shared moral consensus, which will allow us to reassert the essential value of the person as an individual and as a member of the community. From that moral consensus must come a process of decision-making and resource allocation which preserves the dignity of all persons, in particular the most vulnerable. It is proper for society to establish limits on what it can reasonably provide in one area of the commonweal so that it can address other legitimate responsibilities to the community. But in establishing such limits, the inalienable life and dignity of every person, in particular the vulnerable, must be protected.

The Catholic Health Association has addressed the ethics of rationing and offered some moral criteria. These demand that any acceptable plan must meet a demonstrable need, be oriented to the common good, apply to all, result from an open and participatory process, give priority to disadvantaged persons, be free of wrongful discrimination, and be monitored in its social and economic effects.

This kind of framework offers far better guidance than the moral bankruptcy of assisted suicide and the ethically unacceptable withholding of care based on "quality of life" criteria. We will measure any cost containment initiative by two values: Does it distribute resources more

justly? And does it protect the lives and dignity of the poor and vulnerable.

But the problem of rationed access to necessary medical care is only one aspect of the cost containment debate. What of the issue of funding? Obviously I cannot offer a detailed analysis of the specific proposals which are on the table. But I can say this: If systemic reform addresses in a substantive manner issues of quality care and cost effectiveness, then justice will demand that all sectors of our society contribute to the support of these efforts. And this support takes two forms. First, each individual must assume appropriate responsibility for the costs associated with health care, and must assume responsibility to do all that is possible not to put his or her health at risk. Second, those segments of our economic order, which have been able to avoid an appropriate level of responsibility for the health care of their employees, must begin to assume their fair share, just as the rest of society must. In other words, we all must be willing to help meet this demand of justice. We must share the sacrifices that will have to be made.

Thus far, I have insisted that a consistent life ethic requires a commitment to genuine universal coverage, because lack of coverage threatens the lives and diminishes the dignity of millions of men, women, and children. I must also say clearly and emphatically that a consistent life ethic requires us to lift the burden of mandated abortion coverage from needed health care reform. I say this for several important reasons:

- 1) It is morally wrong to coerce millions of people into paying for the destruction of unborn children against their consciences and

convictions. How ironic it would be if advocates of "choice," as they call themselves, require me and millions like me to obtain and pay for abortion coverage, which we abhor. It is a denial of "choice," a violation of conscience, and a serious blow to the common good.

2) It is politically destructive. Needed national health care reform must not be burdened by abortion coverage, which neither the country nor the Congress supports. Public opinion polls and recent Congressional action clearly indicate that, whatever their views on the morality or legality of abortion, the American people and their representatives do not wish to coerce all citizens into paying for procedures that so divide our nation. University of Cincinnati poll in January of this year indicated that only 30% favor the inclusion of abortion as a basic benefit even if it could be included at no cost at all. Only 14% wanted abortion coverage if it would add to the cost of health premiums.

3) Abortion mandates would undermine the participation of Catholic and other religious providers of health care, who now provide essential care in many of the nation's most underserved communities. I fear our hospitals will be unable to fulfill their mission and meet their responsibilities in a system where abortion is a mandated benefit. Strong conscience clauses are necessary to deal with a variety of medical / moral issues, but are not sufficient to protect Catholic and other providers who find abortion morally objectionable. The only remedy is not to link needed reform to abortion mandates.

The sooner the burden of abortion mandates is lifted, the better for the cause of reform. We continue to insist that it would be a grave moral tragedy, a serious policy mistake, and a major political error to link health care reform to abortion. An insistence on abortion coverage will turn millions of advocates of reform into adversaries of health care legislation.

We cannot and will not support reform that fails to offer universal coverage or that insists on abortion mandates. While this offers moral consistency, it can place us in conflicting political alliances. For example, we concur with the position of the President and Mrs. Clinton in calling real universal coverage essential. We concur with Representative Henry Hyde and the pro-life caucus in insisting that abortion coverage must be abandoned. We concur with the Hispanic Caucus in our commitment that universal coverage must be truly "universal coverage."

This is our consistent ethic message to the White House, the Congress, and the country. We are advocates of these key principles and priorities, not any particular plan. We will not choose between our key priorities. We will work with the leaders of our land to pass health care reform, reform that reflects a true commitment to human life and human dignity. As I noted above, the polls indicate that most Americans join us in support for both authentic universal coverage and the exclusion of abortion coverage in health care reform. We will carry this message forward with civility and consistency. We offer our moral convictions and practical experience, not political contributions and endorsements. We have no "attack ads" or PAC funds. But we can be a valuable partner for

reform, and we will work tirelessly for real reform without abortion mandates.

For defenders of human life, there is no more important or timely task than offering an ethical and effective contribution to the health care debate. The discussions and decisions over the next months will tell us a lot about what kind of society we are and will become. We must ask ourselves: What are the choices, investments, and sacrifices we are willing to make in order to protect and enhance the life and dignity of all, especially the poor and vulnerable? In the nation's Capital, health care reform is seen primarily as a Political challenge -- the task of developing attractive and workable proposals, assembling supportive coalitions, and securing the votes needed to pass a bill. But fundamentally, health care reform is a moral challenge -- finding the values and vision to reshape a major part of national life to protect better the life and dignity of all.

Ultimately, this debate is not simply about politics -- about which party or interest group prevails. It is about children, who die because of the lack of prenatal care or the violence of abortion. About people who have no health care because of where they work or where they come from. About communities without care, and workers without coverage.

Health care reform is both a political task and a moral test. As a religious community with much at stake and much to contribute to this debate, we are working for health care reform that truly reaches out to the unserved, protects the unborn, and advances the common good.