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CHAPTER SIX

THE ETHICS OF THE JUST COMMUNITY AND THE REFORM OF HEALTH CARE

We turn now to the most substantive questions in this book, the questions about the moral obligation of the just community to bring about health care reform. For me it was very important not to treat these questions without first setting up the context of the theology of the person and the community. But the justice questions are crucially significant, and it is time to try to address them directly. Many sources will be called upon as we look at the justice questions, but there will be a special emphasis on the social teaching of the Catholic Church since 1891.

This chapter will consider five main issues about the just community and health care: first, human rights and health care; second, the common good as the basis for health care delivery; third, distributive justice and the delivery of health care; fourth, the ethics of health care rationing; and fifth, the relationship between government action and private action in the delivery of health care, with particular emphasis on the question of how the principles of

subsidiarity and socialization interact in the field of health care.

In terms of the logic of Roman Catholic theology, it might have been more coherent to place the treatment of human rights after the sections on the common good and the meaning of distributive justice. However, since so much the twentieth century debate about just health care has focused on the notion of a human right to health care, it seemed most useful to treat this issue first and then to critically develop our understanding of health care rights as we consider the subsequent and even more foundational material on the common good and on justice.

Human Rights and Health Care

To address the issue of human rights and health care, we will look at three themes: the historical development of the human rights tradition, some of the current critiques of human rights thinking, and the specific question of whether persons have a right to a basic level of health care.

The Modern History of Human Rights

Secular Political Developments

Historically, human rights thinking has developed on both a secular political track and a religious or theological track. In the secular or political arena, we usually think of the major emphasis on human rights as having begun with the French Declaration of the Rights of Man (1789) and the U.S. Bill of Rights (1790). These two documents espouse what is often called the liberal theory of human rights, i.e., the right of persons not to be interfered with as they pursue their goals in life. This level of human rights thinking fits in well with the individualistic thinking of the philosopher John Locke, and with the laissez faire economics of Adam Smith. Sometimes we call the rights of our Bill of Rights civil rights or political rights. Whatever the exact language, the thinking behind the liberal theory of human rights has a certain negative quality about it. These rights are rights to be left on one's own, rights to immunity from harm. Government's tasks are to pass laws guaranteeing these rights and to be sure that no one acts against us to take these rights away. But beyond these tasks, government does not have to organize any programs to provide these rights to people.

Hidden within the liberal theory of human rights is a fairly high awareness of the problem of human sin.[1] No one ought to be allowed to interfere with our liberty. Because with our common sinfulness, none of us is wise enough to place limits on the liberty of others. If government tries to do more than protect us from one another and from outsiders, government will inevitably mess things up. It is ironic that this viewpoint historically has been called the liberal view. Today we tend to call persons with this rights outlook conservative, and we use the word liberal in very different contexts.

Surely we can make some criticisms of the classic liberal view of human rights. We might argue for example that the classic liberal view offers little basis for any assertion of a right to health care. However, when we stop to consider that, before the time of the French and American revolutions, many persons' lives were rigidly controlled by repressive political regimes, it is clear that the emphasis on personal freedom did much to advance our awareness of the dignity and worth of each human person. This emphasis on dignity and freedom is an important part of the overall human rights tradition, with significant links to the issue of why all people should have access to basic health care.

In the mid-nineteenth century, another level of human rights thinking began to emerge in the secular political sphere. This level was not so much concerned with protecting our freedom from outside interference. Instead this level was concerned with what steps government and society might be able to take to positively enhance our condition as human persons. Unlike the earlier liberal tradition with its concern for civil rights, this later political tradition began to speak about social and economic rights. Today we sometimes use the terms "entitlements" or "welfare rights" to describe the social and economic rights which are at issue. Marxist and socialist thinkers were prominent in the early thinking about economic and social rights, but the concern for socioeconomic rights is by no means limited to Marxists and socialists. Anyone who advocates some kind of "mixed economy" (in which capitalism operates under certain social controls) is concerned about social rights.[2]

When we stop to think about it we can easily see that there is a tension between the liberal theory of civil rights and the emphasis on socioeconomic rights. Those who would emphasize socioeconomic rights sometimes argue in favor of limiting certain civil rights (e.g., the right

to free enterprise) in order to provide basic economic rights to all people. Public life in the United States is currently based on a compromise between the two theories of human rights, with one side stressing liberty and the other equality. The differing proposals for health care reform which we reviewed in Chapter Two have different slants on human rights. Some of them are more interested in keeping free enterprise and the liberal view of rights in the primary position, while other proposals are more convinced of the need to limit individual rights so as to advance social rights in the area of health care.

Roman Catholic Thinking on Rights

Earlier we saw that, in following Aristotle, Thomas Aquinas had a fairly positive notion of the responsibility of government to enhance human dignity. In addition, during the 19th century Catholic leaders were becoming very much aware of the growing social problems caused by the industrial revolution. For these reasons, it is not surprising that when modern Catholic social teaching began with Pope Leo XIII's Rerum Novarum (1891), there was a significant emphasis on the social side of human rights. Probably the most famous section of Rerum Novarum is Pope

Leo's call for all working persons to be paid a living wage.[3] While Pope Leo does speak very briefly about human rights, he places greater stress on the duties and responsibilities which are correlative to human rights. None of this however means that Pope Leo endorsed socialism or Marxism. His arguments in Rerum Novarum in favor of private property are very conservative from an economic point of view.[4] He manages to combine a concern for socioeconomic rights with a rather traditional view of economics.

Pope Leo XIII's conservative outlook gave him a mistrust of 19th century liberalism, especially in France. He believed in the importance of stable governments, and he worried that too much stress on individual civil liberties might serve to undermine governments. Thus it seems fair to say that, unlike modern secular political thought which began with liberal rights and then moved to social rights, modern Catholic social thought began with a greater emphasis on social rights and only later moved to a stronger emphasis on civil rights.

With Pope Leo's encyclical as a benchmark, I think it can be said that twentieth century Roman Catholic thought on

human rights has seen three important developments beyond Pope Leo's teaching. First, and most important, there has been a reassessment of the types of economic policies which might be used to assure human rights. Private ownership, which Pope Leo saw as critically necessary, is no longer the only acceptable means to bring about the delivery of human rights. In 1931, Pope Pius XI continued the Church's clear rejection of the atheism and materialism which is often part of the socialist approach to life. But at the same time, Pius XI began to assert that, at some times in history, the economic power of some businesses and groups in society may need to be regulated by government in order to bring about human rights.[5] This sort of thinking became even more explicit in later Popes such as Paul VI with his call for the break up of the great landed estates in Latin America.[6] In his encyclical Solicitudo Rei Socialis (1988), Pope John Paul II seems to be quite even-handed in his criticism of both capitalism and socialism as economic systems.[7] In view of this trend in Roman Catholic thought, it would seem that, whatever their pros and cons, none of the major proposals for health care reform can be stated to be in clear opposition to Catholic social teaching.

A second trend in 20th century Roman Catholic rights thinking has been the growing emphasis on the dignity of the human person, so that individual rights such as freedom, participation, and self-expression have become substantially more present in Catholic teaching. This concern, which was seen as early as Pope Pius XII, became especially prominent in Pope John XXIII's famous encyclical Pacem in Terris[8] and in Vatican II's Declaration on Religious Liberty.[9] Through the writing of these Popes, Catholicism has become gradually less hierarchical in its view of society, and more accepting of the ethos of many of the modern democratic states. The themes of personal freedom and participation may have significant potential for helping us shape contemporary approaches to health care reform. These themes can help us be more aware of the dignity of the poor and the sick. In addition, the clearer Catholic emphasis on the civil and political side of human rights may help Catholic hospitals maintain their legitimate autonomy.

Finally and briefly, in the 20th century, Roman Catholic rights thinking can be said to have become more theological in its focus and less based on philosophy and ethics alone. In this context it is hard not to think of World

Synod of Bishops' famous 1971 assertion that action in behalf of social justice is a constitutive dimension of preaching the gospel.[10] There are important debates about how to interpret this statement,[11] but its focus clearly makes the human rights debate more of a religious issue than it once was.

Current Critiques of Human Rights

On the whole, the human rights tradition has a very important history both politically and religiously. Recently however I have begun to notice in some of my students a level of dissatisfaction with human rights as an ethical issue. These students are saying that they think human rights has become too much of an individualistic, me-against-you, category of thought. Statements such as "I demand my rights" seem not to suggest a wholistic or communal approach to who we are for one another as a community of persons. In the context of health care delivery too much insistence on what someone thinks is his or hers by right may obscure efforts to establish a common framework about what we can and cannot do in the health care arena. We saw earlier that most of the accomplishments of the progressive and rather successful Canadian health care

system have been due to the efficiency of the system's design. But so far Canada's use of global budgeting has meant that the harder questions about Canada's health priorities as a nation have not yet been asked in the deepest sense, i.e., the questions of which health care services Canada should and should not offer all its citizens based on a common set of moral principles. Such questions may not be able to be asked exclusively on the basis of the human rights tradition, especially when this tradition is construed in its more individualistic forms.

Some recent scholarship has helped point out the limitations of the human rights model of ethical thinking. In her book Rights Talk: The Impoverishment of Political Discourse, Harvard law professor Mary Anne Glendon argues that an over-concern for individual rights can serve to rob us of a strong sense of the common good.[12] Listening to her critique it is hard not to think back to Pope Leo XIII a century ago with his fears about human rights thinking. Of course no one today would want to endorse the very static and hierarchical view of society which marked Pope Leo's thought. But his concern for the excess of individualism which can mark human rights thinking has a clear relevance today.

I would not argue that these critiques should cause us to abandon the human rights tradition, particularly in the area of health care. There is a positive and necessary importance in our reflecting on the claims or expectations which each of us has from one another and from society. But it is increasingly clear that rights language needs to be balanced with the language of duties, responsibilities, and communal concerns. It is also clear that idea of rights as immunities or protections from harm needs to be balanced with the idea of rights as welfare rights or entitlements.

A Right to Health Care

Based on the human rights tradition can we say that persons have a right to health care? To begin our answer, several clarifications must be made, both linguistic and historical. Linguistically, it is to be emphasized that we are not speaking about a right to health, because so much of our health is dependent on our genetic make-up and other similar factors over which society has no control. Some would say that we do have a right not to have our health interfered with by environmental pollution or other similar influences, but even this kind of protection will not assure that everyone will be in good health. No one

can guarantee this, even though some in our society seem to expect it and even though some facets of today's medicine (such as the defensiveness in medicine due to fear of lawsuits) exist because of the false expectations of a right to health. Also, in speaking of a right to health care, it is not adequate to speak about a right to any sort of health care whatsoever. Rather we are speaking about a right to a basic standard of health care.[13] Thus the precise rights question is whether persons can claim from society a basic standard of health care.

From the point of view of history, some might ask why health care has not been an issue for as long as human rights have been discussed. We saw earlier that when rights thinking first became politically prominent at the end of the eighteenth century, the focus was largely on civil rights, rights not to be interfered with. It is no surprise that health care was not considered among these non-interference rights. When social rights began to come to the fore in the mid-nineteenth century, medicine was still in a rather primitive state with relatively little good to offer. So here too it is not surprising that the early thinking about social rights did not place a high focus on health care as a human right. It was only in the

last quarter of the nineteenth century that medicine (with the development of effective antiseptics and anesthetics by doctors such as Joseph Lister and Crawford Long) began to be able to offer the great goods which are so much a part of our consciousness today.[14] For this reason, the question of a basic standard of health care as a human right is largely a twentieth century question. Some countries such as Great Britain began to focus on this question in the early twentieth century, and many other countries faced the question in the middle part of the twentieth century. For the United States, the question remains very pressing as the twentieth century ends.[15]

But do all people have a right to basic access to health care at this time in human history? Ethically, I would argue yes for two main reasons. First, unlike earlier historical times, in our era basic access to health care can be a very great human good. Thus, if we accept the idea of social rights, it seems unthinkable not to include health care within those rights. Secondly, crises in health can happen to persons of all ages, economic conditions, degrees of social usefulness, etc. In other words, crises in health are part of our common humanity. We cannot tie these crises to any particular facet of our human-

ity so as to find a reasonable basis for limiting health care access to persons with non-medical human qualities such as virtue, usefulness, and wealth. It seems most just to see the need for health care as part of our common humanity, and thus to state that all persons, as human, have a right to an adequate level of health care. Rights language does have its limitations, but it still seems morally and religiously proper to speak of a human right to health care. Later in this chapter, our reflections on the common good and distributive justice will help further establish the notion of a basic or adequate level of health care as a human right.

The case that all persons have a right to a basic standard of health care seems to be coherent with recent official Roman Catholic teaching. In his famous encyclical Pacem in Terris, Pope John XXIII lists both medical care and security during sickness as elements in his listing of human rights.[16] In Laborem Exercens, Pope John Paul II speaks about the right of working people to health care which is cheap or even free.[17] I think it would be reasonable to extend the Holy Father's notion of cheap or free health care from working people to all people. In 1981, the Catholic Bishops of the United States spoke of health care

as "a basic human right which flows from the sanctity of human life."[18] In the Protestant world, the earlier General Assemblies of the World Council of Churches worked out of the notion of the "responsible society", a term with some Lockean roots which may not have been as strongly open to a social right such as health care.[19] However the more recent General Assemblies, beginning with Nairobi's emphasis on a "just, participatory, and sustainable society," have moved towards a more social focus on rights, a focus which appears open to the idea of a right to health care.[20] We should also note that Article 25 of the famous United Nations' Universal Declaration of Human Rights (1948) explicity speaks both about a right to medical care and about a right to a standard of living adequate for the health and well being of self and family.

In asserting the claim that all people have a right to an adequate level of health care, I have not addressed the issue of exactly what specific services should be included in this basic right. In Chapter Two our review of current health care reform proposals showed a fair diversity on the specifics of what should be included. Certainly history will have its impact on the matter of the specifics because different services will be possible in different

eras. Economics and medicine also have a lot to say about the specifics in terms of what it is feasible and beneficial to provide. In Chapter Eight, I will present my own general outline of which types of services ought to be included in a just system of health care delivery. Here the point is more fundamental: to make the case that a basic standard of health care is in fact a human right for all people.

The Tradition of the Common Good

Before I began the section on human rights and health care, I mentioned that the topic of health care as a right would need to be grounded in two key themes from the Catholic moral tradition, the common good and the meaning of justice. The Catholic tradition's teaching on the common good is rooted in the works of Aristotle and Aquinas. In our times, an understanding of the common good is especially important for U.S. society with its strong tendency towards individualism. The fundamental definition of the common good is that there exists a good for society as whole which is ultimately more important than the good of any individual.[21] Earlier, when speaking about the natural law tradition, we emphasized natural law's belief in

the possibilty of good government and good society. It was these themes which generated the strong role of the common good in Catholic thought. Today, in the context of health care reform, it may be that an awareness of which health services most truly foster the common good will be able to stand as a basis for some of the difficult policy decisions which will have to be made as part of health care reform.

Two important cautions are necessary in speaking about the common good. First, we cannot limit our notion of the common good to a focus on material goods alone. The great Neo-Thomist Jacques Maritain pointed out in the 1940's that the spiritual good of the individual person transcends the common material good of society.[22] Thus a notion of the common good which denies the existence of God and the spiritual nature of human life is unacceptable, as is any rationale which concentrates on economic productivity to the exclusion of other values. Maritain's concern about Marxist notions of community is obvious, but it also seems that he would be critical of themes such as the famous statement that what is good for General Motors is good for the country. Pope John Paul II's 1991 encyclical Centesimus Annus raises a concern very similar to

Maritain's when the Holy Father asserts that socialism's error is that it considers the individual person simply as a molecule within the social organism so that the good of the individual is completely subordinated to the socio-economic mechanism.[23]

In response to Maritain's concerns, what we need is a wholistic notion of the common good which considers all facets of who we are as human persons. For instance, how much will a new health care system give all people a true sense of participation and partnership in the direction of their health care? How much will a new health care system enhance the quality of life and the character of relationships between persons? Will a new health care system foster values like realism about our human limits, peace-making, care for the environment, acceptance of the meaning of death, etc.? These questions are not easy, but if we only ask the more material questions (how much will a new system cost? what number of people can it help?), we will not be working from a sufficiently human grasp of the common good.

The second caution about the common good is that we should not think that the common good relates only to matters of

law and public policy. Catholic scholarship makes a distinction between the common good and the public order.[24] The public order refers to that aspect of the common good which is appropriately dealt with through laws and government actions. But the common good itself is a larger notion. Insititutions such as hospitals, universities, and drug companies can and should be working for the common good. So should private individuals. In the end, the best system of health care will probably come about through a number of different individuals and groups working together with government for the good.

When I was a young student of theology, the common good was a very frequent theme in Catholic thought. I first learned the term in Latin, since it was such a standard part of Catholic thinking about law and public policy. Thus while I was doing research for this book, I was rather surprised to find that since Vatican II relatively little has been written in Catholic circles about the common good.[25] In the past few years, the University of Notre Dame has sponsored some important new work on the common good, but before that there was almost nothing for a twenty year period.

Charles Curran suggests several reasons why Catholic philosophers and theologians have shown little recent interest in the common good.[26] The teachings of the Popes have not stressed the common good as much as in the past. The natural law tradition, on which the concept of the common good rests, is still important but not as central in Catholic moral theology as it once was, now that we are emphasizing things like scripture as sources of moral wisdom. The static, somewhat a-historical view of society in which earlier common good thinking was rooted has been replaced by a more dynamic and historical understanding, an understanding attentive to the signs of the times. The scholar Dennis McCann thinks that the change to a more historical worldview means that we should avoid the traditional notion of the common good, although McCann does suggest a similar but clearly more dynamic and processive phrase, "the good to be pursued in common."[27]

Curran wrote his comments about the decline of Catholic writing about the common good before the publication of Pope John Paul II's Centesimus Annus which does bemoan the growing inability--even in the democracies--to situate particular interests within a coherent vision of the common good.[28] So it may be that the common good theme

will make a comeback in Catholic thought, and in Protestant thought as well.[29]. I think that Curran is generally correct in his summary of reasons for the decline of interest in the common good. But in addition to Curran's list of reasons, I also think that there may be another factor, namely that some Catholic thinkers--like so many others in our society--may have unconsciously adopted many of the individualistic assumptions which mark present day life in the U.S. At this time in our history, we may well need more accurate and carefully nuanced terms instead of the traditional term common good. But whatever the terms, I think it is critically necessary for us to recover the heart of the common good tradition, for health care reform and for a whole host of other issues as well.

One of the most fascinating contemporary efforts to restore something of the common good tradition can be found in the book The Good Society,[30] written by Robert Bellah and those who were his co-authors in the earlier book Habits of the Heart.[31] While Bellah and his groups are working principally as sociologists, is it remarkable how many theological resources they draw upon, including authors like the two Niebuhrs and John Courtney Murray, as well as the Catholic social encyclicals. The title of

their book The Good Society, borrowed from a 1937 work by Walter Lippmann, is deliberately chosen in distinction from the possible title "The Great Society." I think the title they choose very helpfully avoids generating any kind of false optimism about what we can accomplish and instead helps us think more about the quality of the community which it is possible for us to have together.

The Good Society focuses in particular on social institutions such as the economic establishment, the government, structures to provide education, and the Churches. The decision to call the book "The Good Society" instead of "The Good Community" flows precisely from the authors' intention to highlight the importance of structures, rather than trusting all community building efforts in the realm of personal relationships.[32] The Good Society affirms the value of government, education, church, etc., and stresses the role of these institutions in helping break down the individualism which marks so much of today's life. While the background of The Good Society is somewhat different, it is hard not to feel a strong sense of continuity between the book's main premise and the arguments offered by Aristotle and Aquinas centuries ago.

Of special importance are some of the qualities which the Bellah group thinks are essential for the working of the good society. They mention themes such as attentiveness, generativity, responsibility, trust, sustainability.[33] To me, all these themes re-echo the concern that the common good not be limited to what is economically or numerically most efficient, but that rather the pursuit of the common good serve to create a society in which all people have a genuine sense of participation rather than alienation.

In the area of health care, I realize that common good judgments will need to ask some of the hard questions which seem to have more quantifiable answers. How much will it cost to develop and/or provide such a technology? How many or how few people will the technology benefit? What sort of benefit does a given technology bring? Does a technology actually save lives, or does it have the worthwhile objective of helping chronic but not life threatening conditions? Will the technology benefit a group such as children who may gain a very long lifespan through the use of the technology? Or will it benefit persons whose earthly lives, even under the best conditions, will end within a few years anyway? These are fair questions, and it is reasonable to consider them.

What the common good tradition shows us, however, is that for true health care reform we must be willing to move beyond the quantifiable questions and move towards a more complete vision of the meaning of human life, towards a vision in which issues like participation, attentiveness, and creativity are an inherent part of the decision making process. If society can recapture a sense of these latter issues, the quantifiable issues can be approached with true justice, so that genuine health care reform becomes a possibility. Without the presence of these broader common good issues, my judgment is that an "every person for himself or herself" outlook about health care will continue to predominate so that real health care reform will be difficult if not impossible.

Justice and Health Care

Justice is a crucial moral notion for us to reflect upon in the context of health care reform, a notion which can help us ground human rights including the right to an adequate level of health care. Justice can also help us move beyond the individualist orientation which can mark some rights thinking. In classic Catholic thought justice is understood as a virtue, as one of those stable ongoing

habits which mark all aspects of human relationships. The object or purpose of the virtue of justice is that we give each person his or her due, give each person those goods and services which he or she rightfully expects from us. Even from this basic definition it can be seen that justice shifts our thinking from what we can claim from each other to what we owe to each other. In other words, justice is about duties and responsibilities, about building the good community. Justice is not simply a question of what we might like to do for other people, not a question of how we might be generous to others. Rather it is a question of what we simply must do for others on the basis of our common humanity. This is not to say that voluntary charitable efforts to better society are unimportant. But such efforts are not enough. They do not meet the demands of justice.

This section on justice will have four parts: first, an outline of the classic Catholic concepts of justice; second, a review of some of the more recent concepts of justice; third, some summary comments on the centrality of distributive justice; and fourth, a reflection on which specific principle or canon of justice ought to apply in terms of supplying people with access to health care.

The Classic Catholic Teaching on Justice

Commutative Justice

Historically, Roman Catholicism has spoken about three aspects of the claim which justice makes upon us, three types of justice.[34] The first of these, commutative justice, is perhaps the easiest to understand. Commutative justice describes the obligations which exist between two individual people, the obligations which one specific person owes to another person. For instance, if I agree to pay someone $40 to dig a certain size ditch and he digs the ditch exactly to my specifications, I must in commutative justice pay him the $40. If it were a hot day and he did the job very quickly and well, I might also be generous and give him a cold beer, but I must in justice give him the $40.

Commutative justice brings to mind previously set contracts, but there can be other commutative justice relationships as well. The individual employer surely has an obligation to provide just wages, even when economic conditions shift so as to make a previous agreement about wages inadequate. In general, commutative justice is not

the major focus in the larger social issue of health care reform since we are speaking about the need for a global system of health care reform, rather than about relationships between specific individuals. However, there are aspects of health care delivery in which commutative justice has a high importance. Consider for instance the relationship between an individual hospital and its nurses, housekeepers, maintenance personnel, etc. Consider also the relationship between the caregivers and specific patients. In relationships such as these, the traditional notion of commutative justice surely applies.[35]

Commutative justice is also important because it can serve as a paradigm for some of the larger notions of justice which we are about to consider. At the level of imagination, it can be hard to develop a vision of what we as a country owe to our citizens in terms of health care. The issue can seem too big to get a hold on. If we can think of the U.S. as a person relating to each one of us as persons, possibly we can begin to activate our creative imaginations about the justice issues. In this context it is interesting to recall that the word "corporation" originally applied to governments as well as to businesses, and that part of the idea behind corporation was that both

governments and businesses should be understood as corporate persons having clear public responsibilities to other persons.[36]

Legal Justice

The second traditional notion of justice is legal justice, sometimes called general justice. This type of justice has to do with what we as individuals owe to the community. If, as Aristotle and Thomas argued, the community was created and exists for our good, then surely we as individuals are responsible for providing the community with the means which it needs to serve the good of all of us. The requirement of military service is seen by many as an example of legal justice, even though there are continuing debates about pacifism and the nature of just wars.[37] Taxes are another example of legal justice. We can debate the specifics of tax policy, but even in a era when taxes are unpopular, the principle of some taxation so that government can serve the good is unquestionable in the judgment of most people. Still another example of legal justice is the requirement that everyone take appropriate care of the environment. In general, legal justice is very much dependent on the theme of the common good which we considered in the last section of this chapter.

Legal or general justice has important implications in the area of health care. If we agree that an adequate level of health care is a human right, then the citizenry clearly has an obligation to supply society with the goods which it needs to assure that all people in fact have access to adequate health care. This supplying of society with the goods it needs to accomplish health care can take place in various ways, ways which involve both private and public systems of health care delivery. Inevitably, in differing historical circumstances there will be changes in just what goods society needs to deliver health care as well as changes in the means which society uses to assure health care delivery. My view is that today the United States needs a more active government role in assuring access to health care, so that the obligation of legal justice will center more strongly on the obligation of citizens to supply government (not simply society in general) with the ability to assure adequate access to health care.

I am sure it is clear that we cannot address the exact specifics of what we owe society and government as a matter of legal justice in the area of health care, unless we are clear as to the exact specifics of what society and government ought to supply all people in the area of

health care. No doubt many of the current frustrations about tax policy in the U.S. come from uncertainty as to how tax monies will be spent and from uncertainty about whether the goals of some government programs are truly reasonable and just. This is true in health care and in many other areas. Thus we cannot speak effectively about legal justice without also considering the third of the traditional Catholic concepts of justice, the concept of distributive justice.

Distributive Justice

Distributive justice is the obligation which falls on society as a whole in relationship to individual persons. Based on distributive justice, society must meet the reasonable claims of its citizens. As with the other types of justice, distributive justice can be executed differently in different historical settings and with respect to different specific issues. Both private social entities and governments can be involved in the effort to meet the claims of distributive justice. In my view, distributive justice is the most crucial and central of all the justice questions, especially in health care, and especially for the purposes of this book. In the first part of this

chapter, we argued that a basic standard of care is a human right for all people. This immediately raises the question of society's responsibility for health care , i.e., the question of distributive justice. Unless we can come up with an adequate understanding of just what society owes to its people in the area of health care, all our other questions about just health care delivery become quite empty.

As a Catholic thinking about distributive justice, it is impossible not to reflect on the pioneering work of the social activist priest, Msgr. John A. Ryan, a moral theologian who did so much to turn Catholic America's attention towards the issues of justice and rights. His classic book, Distributive Justice, first published in 1916, stands as a major treatise on the make-up of human community and on the responsibility of the community to share its benefits with all those who are part of the community.[38] With particular emphasis on the field of economics, Ryan writes about the four sources which contribute to the worth of any product: the providers of the raw materials from which the product is made, the providers of the capital to develop the raw materials, the managers who oversee the production of the product, and the laborers

who make the product. Ryan insists that each of these groups, especially the laborers, must be justly compensated in a measure which respects the radical human dignity of all. He searches probingly for canons or principles on which the distribution of justice should be based.[39] Clearly much in Ryan's work is dated today, but his central thesis on distributive justice remains crucially important, as does his confidence in the feasibility of a mixed economy, i.e., an economy which retains private enterprise, but with enough social controls to insure true justice. Ryan died in 1945, long before today's health care crisis, but there is little doubt that his methodology would cause him to be a major advocate of health care reform, if he were on the scene for today's debates about health care.

These comments on distributive justice conclude our summary of the traditional threefold Catholic approach to justice. We will return to the precise question of a canon or norm for distributing health care, but we first need to consider two other notions of justice which are prominent today.

Two Modern Notions of Justice

Egalitarian Justice

Much of the contemporary discussion about justice focuses on the radical equality of all human beings, leading some authors to speak about egalitarian justice, a term which echoes the famous liberte, egalite, fraternite slogan of the French Revolution and the "all men are created equal" language of the U.S. Declaration of Independence. It is true that all human persons are radically equal and that any sound theory of justice must respect this fact. There are however certain philosophical problems about the egalitarian notion of justice. While we are all equal as human, we do as individuals have different abilities and talents, all of which can work together for the building of the human community. It may well be just for society, acting for the sake of the whole, to give individuals opportunities to develop their differing gifts, even if this means that not every individual is treated in exactly the same way. Similarly, as individuals we can bear different kinds of burdens, especially in an area like health. Some persons with chronic diseases, physical handicaps, developmental disabilities, and other complicated health condi-

tions, may very reasonably expect a level of support from the community which other persons should not expect.[40] In addition, there is the whole question of the preferential option for the poor as well as other types of affirmative action programs in which something other than equal treatment seems to be the most just.[41] For all these reasons, I believe that the distribution question--how society allocates benefits and burdens through the entire community--is ultimately more central to justice than the equality question, even though equality remains hugely important. In this I agree with what Charles E. Curran has written in another context.[42]

Social Justice

Another concept of justice which occurs a great deal in contemporary thought is the concept of social justice. Today many people use the term social justice in a broad general sense to cover any justice issue which relates to society as a whole. However in its origin in Catholic thought, especially under Pope Pius XI, social justice referred specifically to institutions (governments, corporations, international trade structures, etc.) and to the impact which these institutions can have on the just qual-

ity of life for all peoples.[43] Such a notion of social justice has opened the way to a significant critique of institutions and to a significant challenge to institutions to be more just. To the extent that modern health care facilities are institutions and are part of today's economic system with its concern about the "bottom line," the critiques from the Catholic approach to social justice ought to be applied to them. But here again, reform of the structures of society so that society can more effectively deliver health care still depends on society's having a clearer focus on just what health care goods it ought to be delivering to people. Thus, while the social structures question, like the equality question, is a pivotal aspect of all justice including health care justice, my judgment is that the distribution question (i.e., what health care benefits must we provide?) is the most central of all the justice questions which relate to health care.

Some Summary Comments on Distributive Justice

At the beginning of this book I stated that the concept of distributive justice would be the most synthetic of all the moral notions addressed in the book. Just now, in describing five categories or types of justice, I have again

indicated the centrality of distributive justice. In many respects, the case for distributive justice can stand quite well on its own merits. It simply makes the most sense to begin by asking what it is we must do for all people in terms of supplying them with access to health care. How can we say anything else about justice in the delivery of health care, unless we conceive of society as having responsibilities to its citizens, and unless we see reasonable access to health care as one of these social responsibilities? If we do feel a sense of moral outrage about the thirty-seven million uninsured persons in the U.S., is not the outrage due to our country's failure to meet the demands of distributive justice? As noted earlier, these comments do not resolve the issues of exactly how health care should be distributed, or exactly what level of health care should be supplied. But there is no doubt that the fundamental claim is a claim of distributive justice.

It is also helpful to note that each of the other categories of justice, while valid and important, falls well short of establishing a sufficiently wholistic basis for approaching the question of justice and health care. If we focus too strongly on commutative justice, we are too

likely to understand health care in terms of a market economy, with all the problems noted earlier about an overly market-oriented approach to health care.[44] If we focus too much on legal justice, we are very likely to get so preoccupied with the tax burdens involved in just health care that we fail to focus on the core issue of what we owe one another with regard to health care. It is true that there are complex questions about how to levy taxes and about the need to build an economy which is productive enough to sustain just tax burdens in an area such as health care. But these are not the most pivotal questions about health care justice.

If we focus too much on egalitarian notions of justice, we may become overly concerned about how to justify affirmative action for health and about access for some persons to health care services which go beyond the minimum which we must supply to all. If we focus too much on social justice, the risk is that we will emphazise the structures necessary to furnish health care instead of first focusing on the human need of real persons to have real health care crises adequately addressed. Such emphasis on structures without a prior commitment to genuine human needs can raise all the fears of complex bureaucracies without

really substantial goals. Once we consider all these limits of the other categories, the case for distributive justice as the central notion of health care justice becomes even clearer.

Toward a Canon of Distributive Justice For Health Care Delivery

If distributive justice is so central to health care reform, we need to come up with some kind of canon or principle for distributive justice in health care. In general, apart from health care, theologians and philosophers engage in an ongoing effort to come up with a suitable norm or theory of distributive justice. One well known modern effort at a norm for justice can be found in John Rawls' A Theory of Justice, published in 1971.[45] Rawls argues that distribution of benefits in a society must be equal for all except when it can be shown that giving more benefits to some people enables those who have less to have more than they would have had otherwise. Thus if a policy which makes rich people richer serves to make the poor less poor it is a just policy. Many criticisms are made of Rawls, both in terms of whether his theory actually works, and in terms of whether the poor, even if they

have a little more materially, are not even more alienated personally under Rawls' approach so that the overall human condition of society is actually worsened.

In terms of the specific question of distributive justice in health care, my view is that the work of the Protestant theologian Gene Outka in the mid-1970's is the most significant single contribution to the modern effort to work out a theory of distributive justice for the health care field.[46] Later, we will be talking about the work of Daniel Callahan (with his notion of limits) and about the Catholic Health Association's working group on rationing.[47] To me it seems that these very notable efforts all have roots in Outka's notion of distributive justice.

Outka considers five possible canons or maxims of distributive justice for health care. First is the distribution of health care benefits based on people's merit. Such a meritarian approach to justice ignores the fact that health care needs can occur completely independently of merit. In addition how can we humans, with our weaknesses and biases, really assess the merit or virtue of one person against another? There may be a few narrow cases where meritarian notions could be used in health care dis-

tribution, such as giving non-smokers slightly lower insurance rates. But on the whole, merit is surely an inadequate canon for distributing health care justly.

Outka's second possible canon is the distribution of health care benefits to persons based on their social usefulness, i.e., the more useful persons are the better health care they get. Here again, health care needs can be very much disconnected from social usefulness, especially when we consider that health care needs tend to be particularly prominent in children and even more so in older persons. Also, how can we really tell who is more useful? Do we understand enough about the human good to make such a judgment? In this context it is hard not to think about Paul Ramsey's account of the early efforts of the Swedish Hospital in Seattle to decide who should get kidney dialysis. Noting that the hospital committee which made these decisions tended to pick out persons whose social status was much like their own, Ramsey ended up by quoting the famous remark that the Pacific Northwest would be a very bad place in which to be a Henry David Thoreau with bad kidneys.[48]

There may be some very rare circumstances in which the focus of all society of or a specific social group is clear enough that health care benefits might be distributed to the society or the group on the basis of social worth. One thinks for instance of battlefield triage which aims to quickly attend to those who can continue the fight so that even more people will not end up being killed, captured or wounded by the enemy. Another example, not directly connected to health care, comes from the famous Holmes case in which it was decided that after a ship sank in the North Atlantic, at least some sailors had to be saved to handle the lifeboats, or in the end no one would be saved. In the end, I think the very character of these exceptions shows that in ordinary circumstances, we cannot use social worth as a principle for the just distribution of health care.

Outka's third possible canon of distribution is a system of providing people with health care based on their ability to pay for it. Outka argued against this position in 1974, noting particularly that in view of the overall human importance of health care crises, it seems out of place to force people to consider how much they can afford to pay for their health care.[49] Outka took his position

on this issue before the crisis in U.S. health care delivery reached the proportions which we are aware of today. If anything, his arguments against the ability to pay as the principle for delivering health care are even clearer than when he first proposed them.

In saying this, I would not deny that there may be certain health care services which go beyond the basic needed minimum and that these services might be made available on the basis of ability to pay. But this would only be true if the assured minimum were clearly adequate and in place for all people. Also, not every conceivable service beyond the basic package should be available to those who can pay. If a proposed service involved an undue risk, or drained away resources needed for other goods, I think society could bar such a health care service, even from those who could pay for it on an optional basis.

After having dealt with merit, usefulness, and economic ability, Outka turns to the two canons of just health care delivery which he thinks have the highest potential for turning out to be correct. The first of these (fourth overall) rests in the famous maxim "To each according to his needs." Even though this maxim has a Marxist tone, it

immediately strikes us as attractive. After all health care is about sick and therefore needy people. Meeting these needs seems to be a basic goal. Once we get rid of the false notions found in the first three canons, why should we not make the meeting of health care needs our basic canon for the just distribution of health care services?

Surely, the human need for health care must always be part of our consciousness when we seek to develop a just system of health care. We should always want to do whatever we can to meet people's legitimate health care needs. Thus the canon "To each according to her needs" stands as an energy behind our approach to health care and as at least a partial answer in the quest for justice. It must always be part of our thinking about health care justice.

But can the canon based on need be the final answer? Once we grant some of the facts we discussed earlier, i.e., that sickness and death are inevitable, we realize that as finite human beings it will not be possible for us to make available every conceivable service in the area of health care. This leads Outka to his fifth and ultimately most correct canon of health care justice which is "similar

treatment for similar cases."[50] In other words, with careful reflection and dialogue, we should determine those health care needs which we as a society must meet as a minimum standard, and then provide these needs for everyone, regardless of merit, usefulness, economic ability, etc. Such an approach means that there will be some possible health services which will not be provided because they are not truly needs or because they are beyond our capacity as a society of mortals who must face the fact of death. To use Callahan's phrase, similar treatment for similar cases will involve us in setting limits.[51]

It is interesting to consider how classic Catholic thought relates to this theme of establishing a decent minimum standard for health care and then assuring that everyone has access to the minimum standard. In classic Catholic thought about the living wage, it was assumed that if all persons could live in reasonable and frugal comfort, their true needs (as opposed to wants) were being met and that distributive justice was being achieved. Classic Catholic thought held that our understanding of the nature and dignity of the humam person was such that we could know which goods and services were necessary for a person to live in reasonable and frugal comfort.

In health care, if we decide that the development of one life-extending technology will deny us the opportunity to develop another life-extending technology which has even more potential to extend lives, it may well be that persons who are hoping for the first technology will assert that they are being denied a true health care need. If we accept the fact that death is intrinsic to human existence and that the goodness of life is an instrumental good, it can be argued that the extension of life is not always an absolute need, especially if the common good ultimately outranks the individual good. Such an approach would make the "similar treatment/minimum standard" approach to health care justice very close to classic Catholic thought, but the tension remains around the issue of not developing every possible life-extending technology. Clearly, the theology of death which we reviewed in Chapter Three has a crucial importance in the debate about distributive justice and health care. We can only hope to focus a minimum standard of care which society must provide to everyone after we have accepted the idea that death is a part of life.

We will consider many of these issues further in a section about health care rationing, but for now the point is that

the canon about setting a basic minimum standard of similar treatment for similar cases stands is the best approach to distributive justice in health care. As soon as we say this, the matter of legal justice also comes to the fore, i.e., the responsibility of all of us (through taxes, other funding mechanisms, and creative private health services) to be sure that society has the resources it needs to provide a basic set of health care services to all people.

In contexts other than health care some scholars have raised questions about the theme of disinterested love which underlies Outka's appeal to the theme of similar treatment for similar cases. It is argued for instance that we owe more to our parents than we do to other people.[52] I agree that in some kinds of situations we do owe more to some people than to others. But in terms of a nation setting a policy on how to deliver health care justly, it is clear that the setting up of a basic standard of similar treatment for similar cases makes the most sense. The one area in which we might wonder about the adequacy of the similar treatment for similar cases approach has to do with the poor and other groups in society about whom it is said that we should make a preferential

option. My view is that the option for the poor involves a requirement that we take the necessary procedural steps to be sure that the poor, cultural minorities, etc., are fully aware that they have access to just health care as a matter of right. However, the actual level of health care services to be made available to the poor need not be different from what we provide to everyone else.

What About Health Care Rationing?

In our survey of current developments and proposals in Chapter Two, we mentioned some of the pros and cons of the Oregon plan of health care rationing. Now, in light of all the ethical reflection of the past few chapters, it is time to inquire more directly about whether health care rationing can ever be a moral option. For the purposes of our inquiry, health care rationing can be defined as the decision not to develop or not to provide people with potentially beneficial medical treatments.

As a moral theologian, my view is that health care rationing can in fact be justifiable. As soon as we consider that we are finite human beings and that, as a matter of both philosophy and faith, death is inevitable, it becomes

clear that in the nature of things there are limits as to how much we should and ought to do to prolong life and to prevent death. In some historical eras such as ours, it may seem necessary for the sake of the common good to use public policy to help us recognize the natural limits of life in the first place. No ultimate moral objection need be lodged against such a use of public policy, even if there is a need for careful moral scrutiny of any specific rationing plan.

In asserting the moral possibility of health care rationing, it is hard not to think about how health care relates to other crucial common good issues such as education. To put it simply, if we spend every conceivable dollar to develop and furnish potentially beneficial health care services, we will take so much money away from education that we could very quickly become a nation of illiterates (a tragegy which is already happening in some places).[53] In another generation, it might happen that no one will have the educational abilities to use all of our wonderful medical technologies. If so, then the last situation would be worst than the first.

In Chapter One I mentioned that by the very fact of the many millions of uninsured persons in our country, the United States already has a health care rationing plan in effect. The current plan works against the poor, against those who work for small employers, and against some racial and ethnic minorities. It is clearly an unjust approach to rationing because similar health care needs are not treated in a similar way for all persons and there is no assured basic level of access to health care. In the real world therefore the question is not whether or not we ought to have health care rationing. The real question is how to come up with an appropriately just plan of health care rationing.

My own position is to argue that the rationing of potentially beneficial health care services can be justified under the following seven conditions. First, a move towards rationing of health care services must be a last resort, i.e., all other efforts to deliver a reasonable level of health care must be tried and found to fall short of the goals of a just health care policy. More efficient approaches to delivery, alternative delivery settings, etc., must all be employed to their maximum potential before rationing is considered. Our review of these prior

steps earlier in the book has suggested that they are not sufficient, so that rationing is fact justifiable. In stating this last-resort condition, it seems like I am making the case for rationing sound similar to the case for a just war. But due to the enormous moral importance of just health care delivery, it may not be inappropriate to use language which makes us think about an issue as sobering as war.

Second, before it begins any program of health care rationing, our society needs to develop a clear consensus on the question of medical futility, using the kind of principles I outlined in Chapter Four. Based on this clear consensus, patients as a matter of medical policy should not be provided with any futile treatments. It seems unconscionable for us to speak about withholding beneficial treatments if at the same time we are continuing to furnish some people with futile treatments. Obviously there are questions about framing the concept of futility correctly, and about leaving patients with appropriate discretion in borderline cases. But addressing the futility question is an essential preliminary to any just rationing program.

Third, a program of health care rationing must be set up so that in the long run it requires involvement in the program by all members of U.S. society, not just involvement by some groups within a society such as the poor. To be effective, a rationing program designed for the whole of society must furnish a high enough standard of care that most people are quite satisfied to participate in the program and accept what it provides.[54] It must be clear that the rationing program does a good job in meeting people's essential health care needs. Otherwise there would be constant complaints about the program, and a general level of instability.

The assertion that a health care rationing program must be designed so as to require involvement by all people does not mean that we can do without a special concern about the health care needs of the poor. Especially as a health care rationing program is starting up, there will need to be an emphasis on the poor because of all the health care they have lacked in the past. But to be fully just, a rationing program must be designed for society as a whole so that it is taken for granted that the poor have access to the same basic package of services which is available to everyone else. This is what the fundamental notion of

human dignity requires of us. To my way of thinking, this is the point of Outka's "similar treatment for similar cases" criterion, i.e., that a basic level of services must be made available to all persons.

Fourth, a program whose focus on human dignity provides a decent or reasonable level of rationed care to every citizen need not exclude all seeking of additional optional health related services by those who can pay for them. However, if any type of optional access to health care becomes so consumptive of health care resources that it threatens basic access to health care services or threatens our ability to provide other social goods such as education, housing, or defense, this type of optional health care ought to be excluded.

Fifth, while a just program of health care rationing must be aware of the needs of every individual person, its ultimate focus must be on the common good in the wholistic sense of common good which I described earlier. Among the many common good issues which must be part of any just rationing program, I would especially stress two issues: participation and non-discrimination. In terms of participation, decisions on how to ration heath care services

should be made on the basis of dialogue with as large a segment of the human community as possible. Health care professionals, economists, political leaders, religious leaders, philosophers and theologians, business and labor leaders, media representatives, and spokespersons for public interest groups should all be part of the dialogue. Very especially persons with different kinds of diseases should have a chance to be part of the dialogue and to state their needs. Also it is crucially necessary that advocates for the poor be part of the dialogue process in working out any plan for health care rationing.

In terms of non-discrimination, the common good requires that factors such as religion, race, economic status, and talent ought never to be the basis for deciding who is eligible for what in a basic package of health care services. If we discriminated for these reasons, how could we be said to have a health care policy which is committed to the common good?

Gender works a little differently as a discrimination factor since there can be kinds of medical services which members one or the other sex need precisely because of their differing physiology. For these kinds of services

the standard should be that the needed service be available to all members of the pertinent sex regardless of any other factors. Beyond these specifically sexually related services, there should be no difference in basic services because of one's sex. Age is also a tricky factor in terms of the common good and health care delivery. I think there can be no discrimination in excluding age-appropriate medical services from any person from the infant to the centenarian. But I also think there is room for reasonable debate on just which services are appropriate for persons in given age brackets. Very complex surgeries, with lengthy recovery periods, and only limited prospects for success may sometimes be appropriate for young persons but not for persons whose age is quite advanced. Other countries have worked out policies on such issues and the U.S. might do well to see what it can learn from the experience of such countries.

Sixth, a rationing policy can only be just in withholding a potentially beneficial medical treatment when the burden connected with that treatment is a burden which is found in the treatment itself, rather than a burden based on a societal judgment that the life of the person from whom the treatment is withheld would be too burdensome even if

the treatment were provided. If a treatment is very costly (a classic issue in Catholic medical ethics), is hard to acquire, has uncertain results, or threatens our ability to provide more basic services, society may have a reasonable case for choosing not to provide such a treatment. But if it is not too difficult for society to provide the treatment, and if the treatment itself does not cause the patient undue burden, I do not believe there is a ground for a social policy which excludes such a treatment. Earlier we argued that a patient or those entitled to speak for him or her might refuse non-burdensome treatment because the treatment will result in a burdensome life. My point now is that to respect patient autonomy, these kinds of delicate borderline decisions ought to be left in the hands of patients rather than becoming part of a rationing policy. This does not mean that patients can demand futile treatments or treatments which can only be furnished with great prejudice to the common good. But I do think it is important to preserve a zone of patient autonomy in addressing some of these very delicate issues.

Seventh, because medicine and socioeconomic conditions change so rapidly, a health care rationing policy can only be just if it undergoes frequent periodic review to be

sure that it is providing the maximum level of effective services. This review ought to include the same kind of broad dialogue which the development of a rationing policy should involve in the first place.

Among the growing array of very useful resource materials on the rationing question, I find Daniel Callahan's What Kind of Life: The Limits of Medical Progress to be the most helpful contribution.[55] Also very helpful is the Catholic Health Association (CHA)'s pamphlet With Justice For All: The Ethics of Health Care Rationing? which was prepared by a group of distinguished scholars.[56] Like my own summary just above, the CHA pamphlet lists a set of criteria for health care rationing. Our two lists are quite similar but not exactly the same. In my summary, besides many of the issues addressed by the CHA group, I have tried to show how issues like medical futility, burdensome quality of life, and optional treatments might relate to a rationing program.

Health Care Reform:
Government Involvement vs. Private Initiative

The final social/moral issue for our consideration in this chapter has to do with a theme we have mentioned several times, namely that there seems to be an important place in health care delivery for both private initiative and government involvement. But how do we balance the private and the governmental aspects of health care delivery? Is there any Catholic social teaching which can add to our perspective on this issue? To answer we need to consider the well known discussion of subsidiarity and socialization which has occurred in the papal social encyclicals of the twentieth century.

One of the most interesting parts of Pope Pius XI's 1931, encyclical Quadragesimo Anno was the Holy Father's discussion of the principle of subsidiarity.[57] According to this principle, things which can be handled effectively by private initiative ought to be handled that way. Similarly, matters which can be handled effectively by a lower level of government (i.e., a city government instead of a state government, a state government instead of a national government) ought to be handled by the lower government.

The role of the higher levels of government is to provide help (this is the meaning of the word subsidy from which the principle of subsidiarity takes its name) for those matters which the lower groups cannot handle by themselves. The end result of the principle of subsidiarity is that there will be a healthy pluralism of approaches present as society seeks to address various social problems.[58]

Historically it is clear that Pius XI was making a greater opening to government involvement in social and ecomonic issues. But he wanted to do this very cautiously, and thus generated the idea of subsidiarity which makes it clear that only that level of government involvement which is truly necessary ought to take place. Pius XI's ghostwriter for Quadragesimo Anno, the Jesuit Oswald von Nell-Bruening, lived to be more than 100 and died only in 1991, so that even in recent years Catholic scholars have been able to have a pipeline into the thought world of Quadragesimo Anno.

None of the Popes since Pius XI have disputed the principle of subsidiarity. Beginning however with Pope John XXIII's encyclical Mater et Magistra, there has been a

tendency for the Popes to say that the world is growing ever more complex and that therefore more government involvement is in fact necessary to meet the demands of social justice. In Mater et Magistra, John XXIII summed up this line of thinking with the famous term "socialization," a term repeated in a similar context by Pope John Paul II in Laborem Exercens.[59] Since the publication of Mater et Magistra, many Catholic thinkers have used the two terms subsidiarity and socialization to describe the tension between private or local government initiatives and the social programs of state or national governments. In the decades after Mater et Magistra, several of the social encyclicals have had a "north-south" focus (stressing relations between the developed and the underdeveloped countries) while other encyclicals have had more of an "east-west" focus (stressing relations between capitalism and communism). Especially in the north-south encyclicals (such as Populorum Progressio and Solicitudo Rei Socialis) there has been a continuing emphasis on John XXIII's theme of the need for more government activities to help bring about a more just world.

It should be no surprise that some conservative Roman Catholics have not been happy with John XXIII's emphasis

on socialization and with some of the other more recent social teaching. William F. Buckley's famous phrase "mater, si, magistra, no," sums up much of this conservative critique. Sometimes also, this conservative critique will interpret the social encyclicals as having a stronger pro-capitalist tone than is actually the case.[60] It is important that we not twist the careful balance of Catholic teaching towards socialism. But at the same time we should not underemphasize the place of socialization in Catholic social teaching.

In terms of health care, the Catholic social teaching on subsidiarity/socialization can tell us two important things. First, we really do need to find a health care system which offers us some balance between private management and public management. In this context, it will remain very hard to justify something like the British system in which the public sector has such a dominant role in both access and delivery. Second, in view of the increasingly complex character of health care delivery, it is only to be expected (and clearly "catholic") that more and more government management of health care will in fact be necessary. Thus we ought not to be afraid on religious/moral grounds of the fact that many of the major

health care reform proposals which are being discussed in the United States today are calling for a significantly increased level of government involvement, at least in the financing of health care. In the end, Catholic social teaching may well help us decide which of the current reform proposals seems best, by challenging us to consider carefully which proposal best mixes subsidiarity and socialization in our current health care context.

These comments bring us to the end of the second part of this book. In this part we have sought to review the major theological and moral resources which might help us move towards meaningful health care reform. What remains for Part Three will be an effort to assess what that health care reform might look like in practice.