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How Individualism Undermines Our Health Care

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This *PJR* series begins with the principle that all persons are formed in the image of God and are part of the human community. In the [first article](#), Michelle Kirtley argued that justice in health care embraces community responsibility for the well-being of our brothers and sisters through ensuring access to health care, as well as personal responsibility for stewarding one's own health. We contribute to the common good and uphold human flourishing by ensuring that all members of the community have the resources needed to contribute to that good.

American culture, though rich in the communal value of patriotism, is weak in its commitment to, or even recognition of, the *common* good. From the perspective of the political right, persons have a right to the goods they individually lawfully accumulate. Social assistance is grudgingly reserved for and given to *deserving* people (children, elderly, disabled persons, and so forth), not as a matter of right, but of charity, which they should work to avoid whenever possible. From the perspective of the political left, everyone has the personal right to basic goods, as a human right, not based on individual achievement. Public assistance is thus a matter of human right and should seldom, if ever, require personal responsibility in return.

This “rights” language, grounded in individualism, dominates policy debates, including health care. The language of justice, common good, community, and solidarity are largely absent.

American culture's commitment to individualism is incurably blind to the reality of community in health care. Our individualism obscures the communal foundations of health care and hinders creative ways to transform a broken and deeply unjust health care system. Individualism is particularly problematic in health care, which is *essentially* communal, not simply as a value or preference, but as a matter of fundamental fact.

Why Health Care Is Essentially Communal

Let us look at some of the practical ways that health care's communal foundation plays out in reality.

1. Consider the unfortunately named "herd immunity," central to vaccination against infectious diseases. Better termed "community immunity," it demonstrates how an individual vaccination against mumps protects not only the person vaccinated, but also helps to prevent mumps in the whole community. When approximately 90 percent of a community is vaccinated, the virus is greatly suppressed. Following a mumps outbreak in Texas during Spring 2017, one infectious disease physician put vaccination this way, "It really goes beyond individual choice by affecting people around you and people you come into contact with. That's the scary part. You make the choice not only for you and your child, but you're making the choice for people around you."ⁱ The good of the person and the community are essentially, not accidentally, intertwined.

2. What is true of vaccination is true of public health generally. Clean water and air, smoking cessation, and collective efforts to reduce addictions do not simply protect discrete individuals; they make entire communities stronger. Communities are webs of relationships rooted in common work, mutual aid, common memories, and shared joys and sorrows. Addiction, for example, diminishes not only the capacities of the addict, but fractures families, friendships, and workplaces. Addiction also undermines neighborhoods and social trust. Successful public health measures to prevent and treat addiction thus restore community. Yet our individualist, rights-focused culture focuses responsibility for addiction, smoking, and clean air on individual persons and businesses, leaving our public health initiatives chronically underfunded.

3. The social determinants of health tell the same story. Poverty, income inequality, and substandard housing touch not only the health of lower income individuals, but make entire communities less healthy compared to communities with better measures on these variables.ⁱⁱ Health is highly correlated with income, education, race and ethnicity, and place of residence. When persons are disadvantaged in their social, economic, and cultural spaces, this profoundly impacts their health and their ability to contribute to the common good of their communities.

4. We believe enough in community to require emergency departments to treat all persons regardless of their ability to pay. We fail, however, to realize that their care is paid for by the entire community through taxes and higher premiums on insured persons. Public hospitals and not-for-profit, faith-based health facilities treat a disproportionate share of lower income patients unable to pay for their

care. These facilities depend on community support in the form of tax exemptions and Medicaid spending. Since all health facilities need a positive bottom line in order to survive, unreimbursed expenses incurred treating the uninsured are partially made up by higher prices paid by insured persons, which in turn generate higher premiums for their insurance.

5. Although Americans tend to see it in terms of individual benefit, health insurance is essentially communal. The essence of fire insurance, for example, is that many people pay relatively small amounts so that the few people with fire losses are covered for large amounts. Insurance expresses a solidarity that American culture has difficulty recognizing, “Why should I have to pay higher auto insurance rates? I’m a safe driver.” “I’m a man. Why should I have to buy an insurance policy that covers pregnancy?” “I’m a woman. Why should my policy have to cover prostate treatment?” Insurance, however, cannot function if everyone in every year (or even over a period of years) pays only for his own risks or her own losses. The essence of health insurance is that the healthy at a given time subsidize the sick. The young subsidize the old. Males subsidize females for some diseases, and vice versa. Shared risk is not only the definition of insurance, but also one of the purposes of community.

6. Medical research is a cooperative endeavor. When research study participants sign up for clinical trials, they affirm that the research may not benefit them personally, but potentially improves the future health of the community. Similarly, medical knowledge is held in community. Knowledge generated over generations of research and practice resides in the collective creation of medical training, textbooks, journals, reference materials, and collaboration/consultations with colleagues from multiple fields of medicine. Medicine as a communal enterprise stewards this knowledge in trust for the health and human flourishing of the community.

But Personal Stewardship Also Matters

Stewardship of personal resources is the flip side of community benefit. Containing the costs of health care and keeping them in balance with other community needs requires attention to the impact of personal decisions on the good of the community, whether one is a patient consuming or a practitioner allocating medical resources. For example, the latest chemotherapy drug may cost hundreds of thousands of dollars but provide limited benefits over existing drugs. Care for the common good should give patients and physicians pause about beginning such treatment. One reason that US health care spending is ruinously inflationary and far higher than spending in other nations is the mistaken, often unconscious, notion that “I” have a right to all the resources that I need for my own well-being. This notion fails to recognize that, while the insurance pool is indeed common, it is neither unlimited, nor does it necessarily have higher priority than other common resources, such as education, infrastructure, and clean air. Dollars unreasonably sucked into health care are not available for other community needs. This is not to say that other goods always trump health care, only that an individualistic culture fails to see the connection.

Stewardship also extends to personal responsibility for behaviors that prevent disease and maintain health. The common pool of health care resources and the insurance that pays for them would not need to be as large if individuals took better care of their own health where they are able. This calls for a balance of personal responsibility and the public health measures discussed above. Even abundant addiction treatment resources, for example, will remain unused if individual persons do not take the steps to access them. Balance is always a matter of prudential decision making, yet it cannot happen without recognition of both person and community.

Divisions Over Health Care Reform

Although there are innumerable technical issues in the debate over health care reform, at its heart, the highly contentious, partisan, and emotional dispute flows from our entrenched individualism. Until recent months, the ACA was viewed unfavorably by roughly half of the population, primarily because of the “individual mandate,” the legal requirement for most individuals to purchase insurance or pay a fine. Instead of seeing universal coverage as a matter of communal solidarity and common good, most saw it as an imposition on individual freedom. Resistance to the individual mandate undermined the individual insurance exchanges in some states, as older and sicker persons tended to enroll in the ACA, while younger and healthier persons did so less frequently. This feature, plus the refusal of Congress to fund risk adjustments for insurance companies, led to many companies withdrawing from the ACA marketplaces.

It would be unfair and inaccurate to claim that the ACA completely reflects community and the Republican American Health Care Act (AHCA) embodies individualism. Each approach builds flaws into a historically unjust and largely individualistic American health care system.

But one of the deepest divisions in our debate is about justice. For individualism, justice is about *my* fair share, *my* rights versus others, and *my* responsibility for health care. A public justice perspective is oriented to the proper allocation of responsibilities to sustain common life among individuals, communities, and institutions, upheld by government. The division reflects the insight of Deborah A. Stoneⁱⁱⁱ nearly a quarter century ago, that the “struggle for the soul of health insurance” is a struggle between two competing visions of fairness: actuarial fairness (in which persons pay premiums related to their individual risk of filing claims -- largely related to age, past illness history, and gender) and solidarity (in which persons pay community-rated premiums – based on the average risk of claims within a specified community of persons). Community rating reflects common membership and shared responsibility; actuarial fairness reflects individualist assumptions.

Where the ACA relies on community rating of insurance premiums, allowing only narrow differences related to age and none to health status, the AHCA allows a wider range of premiums related to age and allows medical underwriting to price policies more closely to individual, actuarial risk. The AHCA also allows states to establish “high-risk” insurance pools for persons with pre-existing health conditions, thus dividing the community into the sick and the well. Historically, healthy taxpayers fail

to fund adequate risk pools for the sick. By reducing Medicaid spending (which will lead to fewer recipients and/or reduced benefits) and cutting subsidies for the purchase of policies on the individual market, the AHCA reduces support for low-income individuals who have difficulty affording insurance (that is, difficulty being part of the community of risk). In this, it manifests a deeply individualist ideology.

Ways Forward

Considering this entrenched individualism around health care, what are some ways that Christian citizens can offer a different narrative?

Self-Examination. As citizens of a republic devoted to celebrating the primacy of the individual, we must examine our own assumptions. Is our primary language when we speak of health care expressive of individual responsibility? “It’s my body and my responsibility.” “Health care would be better and cheaper if government stopped messing with my health care.” Or do we use the language of community, solidarity, common good, and justice? Is our approach to health care policy reflective of an understanding of the Gospel or more attuned to ideological currents?

Prophetic Resistance. Our preaching and teaching and public speech should have a countercultural voice. During our engagement in everyday conversation, as well as on more formal occasions, we must challenge individualistic assumptions, statements, or policy positions-- even of our friends and families.

Faith-Based Institutions. The American health care system abounds in hospitals, nursing and rehabilitation facilities, clinics, and outreach programs founded and operated by churches, religious orders, and denominations. Sustained and shaped by faith, these institutions must continue to be free to serve the common good, to assure care for the most marginalized, and to advocate for health reform that advances human flourishing, community well-being, and personal responsibility.

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ⁱ *Lubbock Avalanche-Journal*, April 30, 2017, A9.

ⁱⁱ See, for example, the Centers for Disease Control discussion at <https://www.cdc.gov/nchhstp/socialdeterminants/faq.html>

ⁱⁱⁱ *Journal of Health Politics, Policy, and Law* 1993 Summer; 18(2): 287-317.