

Building Institutions for the Common Good. The Purpose and Practice of Business in an Inclusive Economy; June 21-23, 2018 – University of St. Thomas Minnesota

Abstract: Health and Social Welfare Economy and the Common Good. Responsibilities of Society, Church and State – a Catholic perspective

Catholic Social Teaching offers principles and reflections not only for the realm of the mission of the Church for the common good, but also for social and political order in a secular and pluralistic world. In the health and social welfare mix of public, free and private institutions, which have been the rationale of the *German* social system historically, its development and current situation? What about the basic tenets, strengths and weaknesses as compared to other social systems, e.g. in contrast to the United States with their achievements and struggles towards the common good? Along these questions, I intend to identify the responsibilities of society in general, of the Church and/ or religious communities and of the public order as guaranteed by the State, using and probing the principles of Catholic Social Teaching, of the self-understanding of Catholic social welfare as well as economic principles of health and social welfare: business, public, private, and faith-based.

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Research Interests: Theological and interdisciplinary studies of (Catholic) health care and social welfare systems, the Church's mission in the social and political field; interdisciplinary empirical research on religion and spirituality in illness and various age, social and professional groups.

For Publications cf. https://www.theol.uni-freiburg.de/disciplinae/ccs/personen/Baumann/veroeffentlichungen_general/publikationen

Introduction

Catholic Social Teaching offers principles and reflections not only for the realm of the mission of the Church for the common good, but also for social and political order in a secular and pluralistic world. In following Christ, the Church imitates and continues the privileged attention for the sick and the poor as a necessary focus for contributing to the common good – of all and every single person. Catholic health and social welfare organizations are an integral part of the Church's mission as was repeatedly underpinned by the recent papal magisterium (e.g. Encyclicals *Deus caritas est*, 2005; *Caritas in veritate*, 2009). These Catholic organizations – like public and private organizations in the health and social welfare sectors – do not only face tremendous economic challenges, but they are also significant economic factors in many countries. In the case of Germany, they are employing more than 620.000 persons (2014), rising to more than 1 million employees of *both* Catholic and Protestant organizations (not counting pastoral ministers).

In their self-understanding, the tasks of these faith-based welfare organizations are first of all social services and health care and ongoing professional formation for these services. On a societal level, they want to create solidarity, and in politics, they want to contribute to the improvement of social legislation by political advocacy for the poor and oppressed of any kind (cf. *Gaudium et spes* 1).

1. Solidarity and the common good.

All for the Common Good? The slogan of the University of St. Thomas is compelling and thought provoking. The topic of this conference aligns with this mission statement: "Building institutions for the common good." Although the subtitle shifts attention to business and economy, we may wonder about who is supposed to build institutions. Is it economy? Is it business associations? Is it the State? Does the Church have a role in the play for an "inclusive economy"?

What is the common good? It is one of the four traditional principles of Catholic Social Teaching, in this order (cf. *Compendium of the Social Doctrine of the Church*, N. 160):

- The dignity of the human person
- The common good
- Subsidiarity
- Solidarity

The principle of the common good stems from the dignity, unity and equality of all people (cf. N. 164), without discrimination of whatsoever. The common good means the good of all people and of the whole person (cf. N. 165) – or, in other words, “the sum total of social conditions which allow people, either as groups or as individuals, to reach their fulfilment more fully and more easily” (cf. N. 164, with GS 26). This principle serves the dignity of the individual person as well as of the social groups and of society as a whole.

The principle of the common good is followed by the principle of subsidiarity in order to achieve the common good. This principle is sometimes considered as the most Catholic contribution to social ethics. Interestingly, it is not easily understood. It has much to do with the consequences of the individual person having a social nature and his or her “creative subjectivity” as a citizen. These socially creative citizens constitute the civil society by the many intermediate social realities starting from family to associations and multiple social aggregations. In its classic formulation in Quadragesimo Anno in 1931, the principle of subsidiarity is defined like this: “Just as it is gravely wrong to take from individuals what they can accomplish by their own initiative and industry and give it to the community, so also it is an injustice and at the same time a grave evil and disturbance of right order to assign to a greater and higher association what lesser and subordinate organizations can do. For every social activity ought of its very nature to furnish help to the members of the body social, and never destroy and absorb them.” (N. 186, quoting QA) Underlying this principle is the conviction that every single citizen and the aggregations of citizens are free, responsible and active contributors to the common good. “Their initiative, freedom and responsibility must not be supplanted” by the state, but – where necessary – should be supported by higher social authorities resp. the state.

It is especially with regard to this realization of the initiatives of citizens and their aggregations that the principle of solidarity is paramount. The goal of civil society with all its most diverse initiatives is not collective egoism, but the common good. Therefore, solidarity is needed. In the words of St. John Paul II, solidarity is not “a feeling of vague compassion or shallow distress at the misfortunes of so many people, both near and far. On the contrary, it is *a firm and persevering determination* to commit oneself to the *common good*. That is to say to the good of all and of each individual, because we are *all* really responsible *for all*” (N. 193, quoting SRS [1987] 38).

These social principles in their interconnectedness aim at justice - at the good of every human being as one’s neighbor in the sense of the Gospel. The Compendium of the Social Doctrine of the Church emphasizes this interdependence of these principles also with reference to the universal destination of goods and peace: “*The message of the Church’s social doctrine regarding solidarity clearly shows that there exists an intimate bond between solidarity and the common good, between solidarity and the universal destination of goods, between solidarity and equality among men and peoples, between solidarity and peace in the world.*” (N. 194) It remembers that there is an obligation of private property for the common good.

2. The social system in Germany, starting from Bismarck in the 19th century

In 1878, the German Chancellor Otto von Bismarck had decreed laws against socialists. Three years later, he read “The emperor’s message” to open the 5th German Reichstag on November 17th, 1881.

This message was a further response to the rising social tensions due to the industrialization and the social question in Germany. The message initiated the establishment of three branches of social insurances: Health insurance in 1883, general accident or casualty insurance in 1884, old age pension scheme or social or annuity insurance in 1889. As public statutory insurances, these measures introduced the modern welfare state in Germany. The corresponding laws provided a stable basis for the social policy in Germany and models for other European countries. In 1911, still in the German Kaiserreich, the employees' insurance has been introduced and in 1927, in the Weimar Republic, the unemployment insurance. The latest amendment has been the compulsory long term care insurance in 1995.

In sum, the German social system consists of five columns:

- 1) Statutory old age pension scheme
- 2) Statutory accident insurance
- 3) Statutory health insurance
- 4) Unemployment insurance
- 5) Compulsory long term care insurance.

With the five of these columns, the German social system has become an instrument of a comprehensive system of insurances against grave social risks.

In parliament, Bismarck repeatedly declared that these social reforms are an outgrowth of his Christian ethos; he considered his social legislation as "legal form of Christian faith in practice", as a task of social justice, a guarantee of social peace, assistance to the needy to which they are entitled to. This is the "highest task of any polity [Gemeinwesen], which is grounded on the basement of a Christian people."¹ Actually, he had protestant theologians and political reformers as advisors. Their democratic ideas did not succeed – Bismarck rather favored a "social empire".

The central idea of these statutory insurances has been to establish more social security and sufficient financial support for the needy which they are entitled to get: We see that the idea of doing justice to the needy by the state not as a grace but as a *right of every person to live a dignified life* (principle of personality); and that these insurances constitute a realization of solidarity, a *contribution of all* to guarantee the *common good* in realizing *justice for every and all* citizens.

3. The principle of subsidiarity "ante litteras" in the German social welfare system

In the Weimar Republic after the First World War, the young German democracy had to renew its social order and social legislation. World War I had shown the importance of the various civil welfare associations like the Red Cross, Caritas, of the social-democrats and of the protestants and of the Jewish community; it had become obvious that the emergency aid and social assistance could not be accomplished by state organization, but by such organizations of civil society on which the state could rely as active forces of society. These welfare organizations, in their turn, argued that they realized the citizens' rights and freedom to help and to form associations for social assistance according to their religious and political opinions. The resulting diversity, in addition, would guarantee the right of the needy to choose among the services offered and needed ("Wunsch- und Wahlrecht"). The welfare organizations' lobbying, with a lead of Caritas Germany (Benedict Kreutz), was successful and convincing to the various parties in Berlin.

In consequence, the social legislation of the Weimar Republic (RJWG in 1922) established a "certain precedence" of the social services of free welfare associations over public services; the social welfare system favors and encourages free initiatives of the citizens to realize social welfare within the

¹ Cf. Strohm, Theodor (1993) *Diakonie und Sozialethik. Beiträge zur sozialen Verantwortung der Kirche*, Heidelberg: Heidelberger Verlagsanstalt 1993, 208.

framework of the laws for which they would be reimbursed. It is not the state but the citizens who realize a society of social peace and justice. The state has to facilitate and support and regulate. And the statutory insurance companies have to refund these free social service and health care providers.

Actually, this approach is basically an application of the principle of subsidiarity by 1922, while it was defined by the Catholic magisterium explicitly only in 1931 (Quadragesimo Anno). Basically, this principle has been transferred to the ordering of the German welfare state after World War II, and is working more or less successfully up to now. Nevertheless, it has a special position in the context of other welfare systems. This is especially interesting with regards to the costs of social welfare and health care which the following part is focusing on.

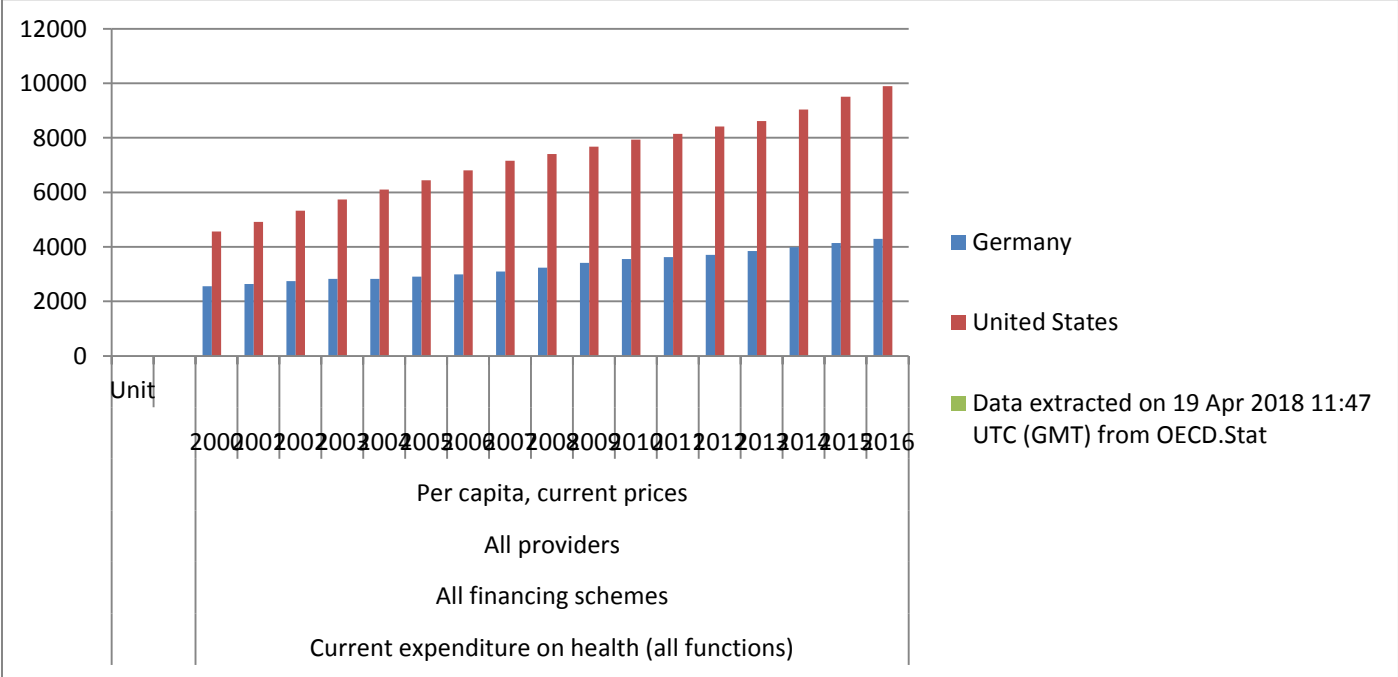
4. Numbers of public health expenditures in Germany, other European countries and USA

A system of social welfare or of health care is basically successful to the degree it is

- providing professional services of high quality as a standard (to be defined, of course)
- to every person as part of what she needs and is entitled to as a human person
- at reasonable costs for the individual and for the public, reducing maximally the risks for the individuals to fall prey to financial ruin due to sickness and treatment.

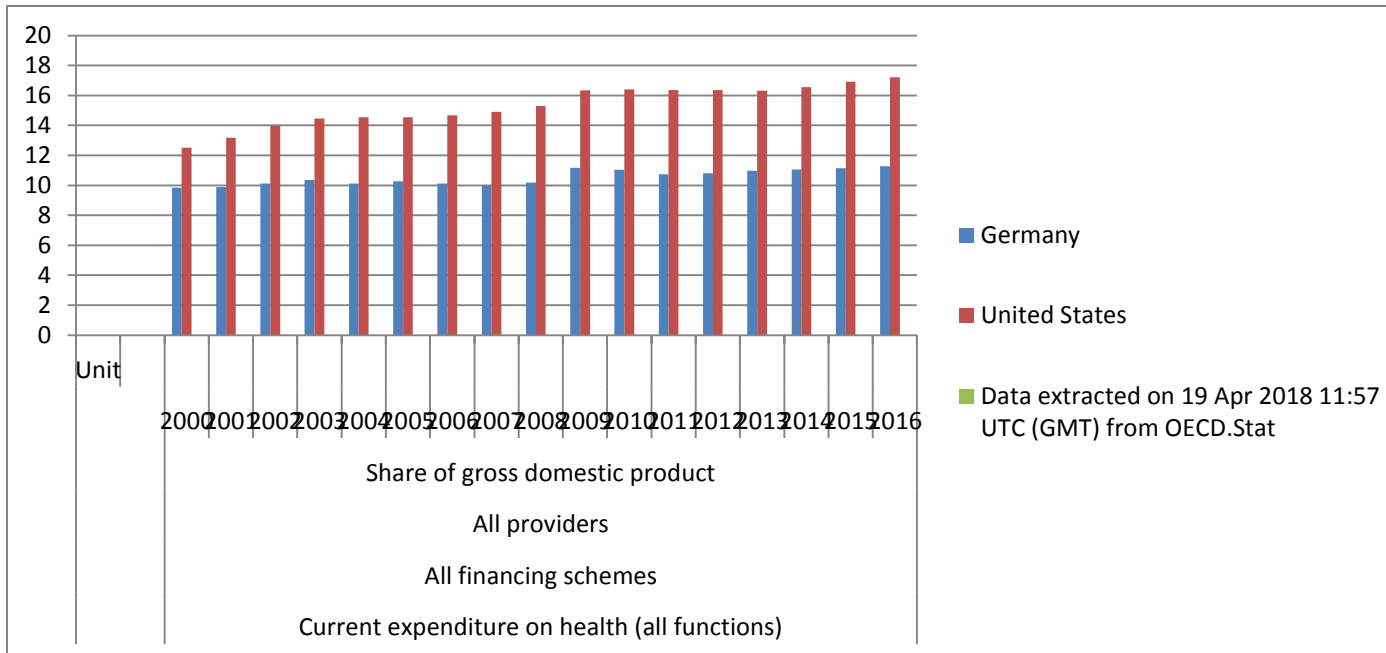
(Further criteria might be added)

The following table shows the costs per capita in Germany and USA for the years from 2000 through 2016:

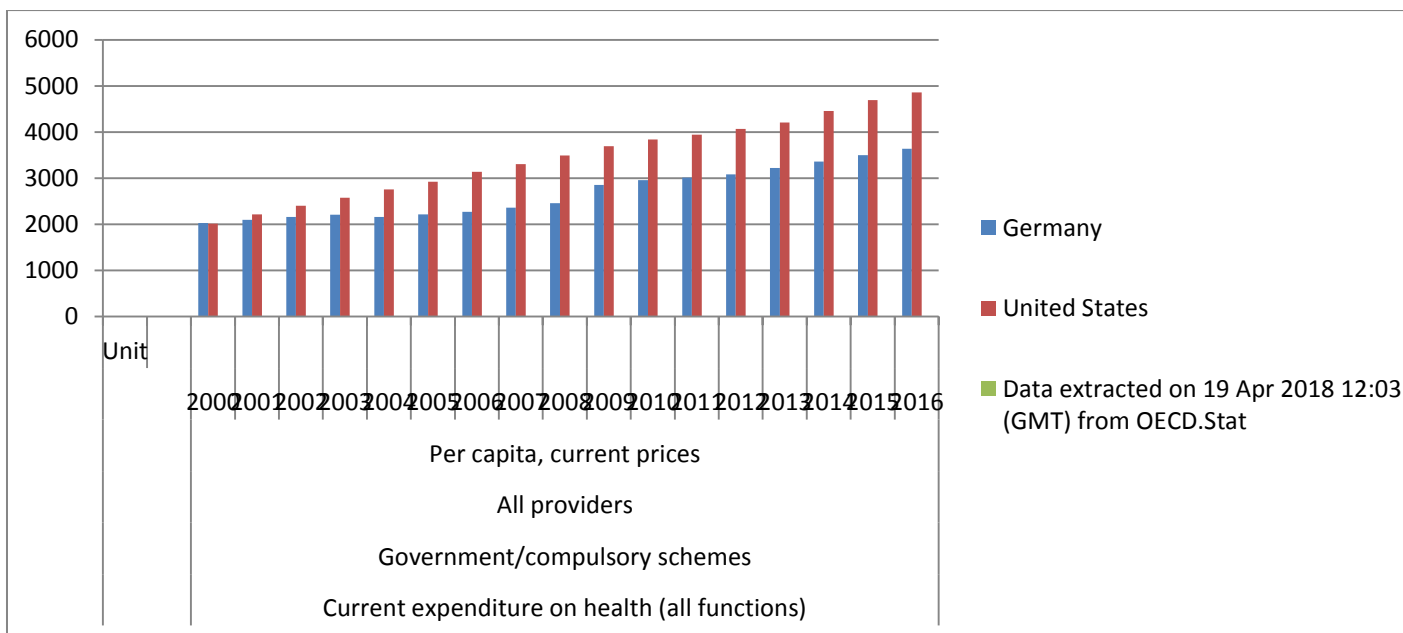


There was an increase from 2.557€ per person in 2000 to almost 4.300€ per person in 2016 in Germany. In the US, the increase amounts from 4.559\$ in 2000 to almost 9.900\$ in 2016.

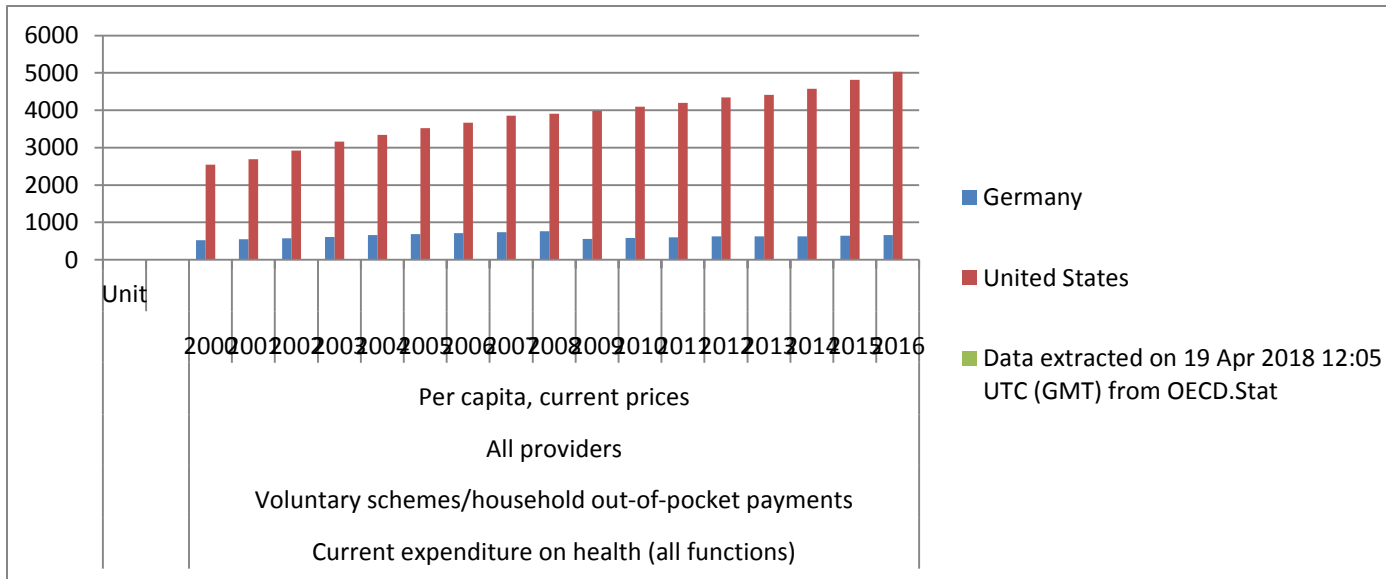
The share of gross domestic product (percentages) in health expenditures shows a significant (and increasing) difference between US and Germany from 2000 (9,8% in Germany, 12,5% in USA) to 2016 (11,3% in Germany to 17,3% in USA).



Per capita, (for USA in \$, for Germany in €), the costs increased in both systems, in 2000 they are close to equal, in the meantime there has developed and increasing gap due to higher costs per capita in USA (without Affordable Care Act).



What is most striking, however, is what the current prices per capita show – the current expenditures on health in both countries in voluntary schemes: there has been a considerable increase of voluntary costs per capita in Germany from 528€ in 2000 to 662€ in 2016. In comparison to the out-of-pocket payments in USA, however, these are negligible numbers. In the US, it was 2.924\$ in 2000 and 5.032\$ in 2016.



The higher costs of health care in the USA do not affect the life expectancy in comparison to Germany, however.

				Year	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Life expectancy	Total population at birth	Years	Germany		78,2	78,5	78,5	78,6	79,2	79,4	79,8	80,1	80,2	80,3	80,5	80,5	80,6	80,6	81,2	80,7
			United States		76,7	76,9	77	77,1	77,6	77,6	77,8	78,1	78,1	78,5	78,6	78,7	78,8	78,8	78,8	78,9

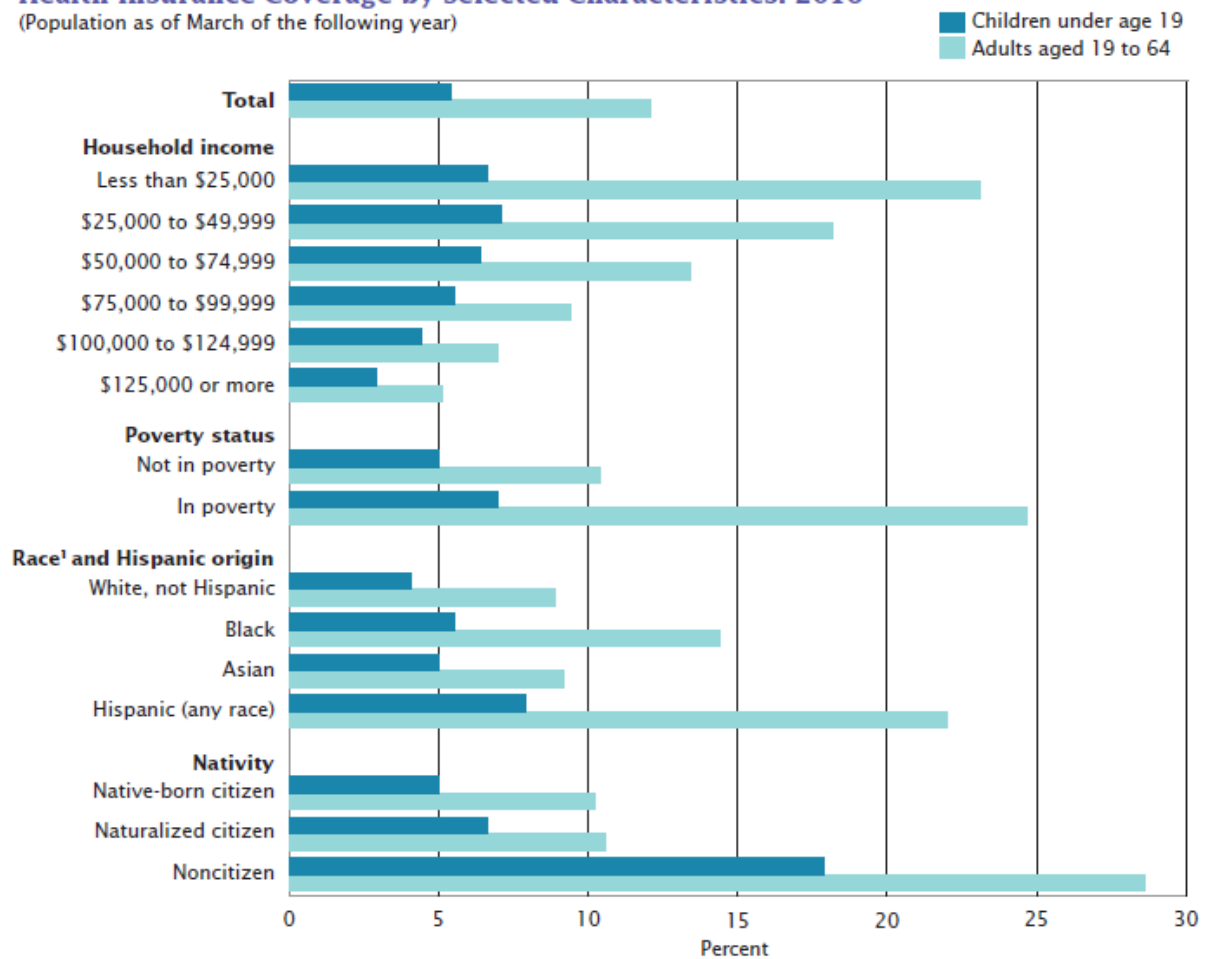
It is true that in Germany, people with less than 60% of average income have a life expectancy which is 10 years less than people with more than 150% of average income. Poor people are less healthy and have other diseases than wealthy people. They die earlier. Presumably, this is the case in the US, too.

A study on the “Health Insurance Coverage in the United States: 2016” (Jessica C. Barnett & Edward R. Berchick; Current Population Reports, US Census Bureau, www.census.gov, issued Sept. 2017) shows a considerable rate of the US population without any coverage. They state: “In 2016, the percentage of people without health insurance coverage for the entire calendar year was 8.8 percent, or 28.1 million, lower than the rate and number of uninsured in 2015 (9.1 percent or 29.0 million). [...]”

In 2016, private health insurance coverage continued to be more prevalent than government coverage, at 67.5 percent and 37.3 percent, respectively. Of the subtypes of health insurance coverage, employer-based insurance covered 55.7 percent of the population for some or all of the calendar year, followed by Medicaid (19.4 percent), Medicare (16.7 percent), direct-purchase (16.2 percent), and military coverage (4.6 percent).” (p. 1) There has been a decrease of uninsured people from 2008 to 2016 (cf. fig. 2 p. 5). It is especially poor people and their children who have no health insurance coverage (cf. Fig. 6 p. 17):

Percentage of Children Under Age 19 and Adults Aged 19 to 64 Without Health Insurance Coverage by Selected Characteristics: 2016

(Population as of March of the following year)



¹ Federal surveys give respondents the option of reporting more than one race. This figure shows data using the race-alone concept.

For example, Asian refers to people who reported Asian and no other race.

Note: For information on confidentiality protection, sampling error, nonsampling error, and definitions in the Current Population Survey, see <www2.census.gov/programs-surveys/cps/techdocs/cpsmar17.pdf>.

Source: U.S. Census Bureau, Current Population Survey, 2017 Annual Social and Economic Supplement.

While people with high incomes might choose not to have a health insurance, for poor people it is not a choice. They cannot afford it for themselves and for their children, in many cases. The system does not take care for every person and all persons.

In Germany, there is only a few 10 thousand people who do not have health insurance coverage. Some of them are “too rich” to fall under the statutory regulations and do not even have private insurance; some of them dropped out of the system due to individual misfortune, esp. homeless people. In general, the total population is under health insurance coverage which is compulsory e.g. for every foreign student, too. After first hesitations, after a few weeks most students are happy with their statutory health insurance to participate in the German health system in a way they did not enjoy at home.

5. All for the common good or all for one’s individual pursuit of happiness or for economic success?

In a leadership program for Catholic Charities USA earlier this year, I discussed with CEO from various caritas organizations here in the US. One of my questions was if people in the US would accept statutory health insurance as a solidarity rule for all. Apart from the interests of private health care services and institutions, these leaders expressed that one of the automatic objections would be: Why should I pay insurance for others? This is in fact a crucial question. Why should I contribute from my property to the common good? Is this part of my pursuit of happiness?

Another question may be closely associated: Is it not a good thing to have high costs in the health sector of economy? Does this not increase incomes and create working places? Does it not generate progress in medicine and treatment options? These questions suggest some truths. Yet they are not convincing if we consider their effectiveness for people who the health system is supposed to care for. Economy is to serve the health services and to the health of people, not vice versa. The exchange of means and ends is one of the valid central critiques of economy by the recent document of the Holy See, *Oeconomicae et pecuniariae quaestiones* (OP Q; 17th May 2018).

These are a basic questions of solidarity as expressed by St. John Paul II: If we have a firm and persevering determination to commit ourselves personally (religiously, culturally, politically, economically, socially) to the common good. That is to say to the good of all and of each individual, because we are all really responsible for all (cf. SRS [1987] 38). The question of health insurance does epitomize this question – and it is also a cornerstone for the credibility of the Church’s political advocacy for justice and for her initiatives to create more solidarity in Church and in societies in the sense of Catholic Social Teaching.