EQUITY IN HEALTH AND WELLNESS: HEALING AND TRANSFORMING THE SYSTEM TO DELIVER A SINGLE STANDARD OF CARE

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The changes that society has undergone in the Western world have led us to reflect more deeply on the task of medicine and on the way it deals with disease and the promotion of health. The dizzying increase in scientific knowledge and in the technological developments that we have witnessed in the medical field have resulted in a significant economic impact on healthcare treatments and facilities. We have recently seen more clearly, due partially to the pandemic, the urgent need for ethical reflection, followed by the implementation of relevant criteria, on how to ensure a fair distribution of the burdens related to legitimate healthcare expectations and of the advantages of the new health-related discoveries that are being made.

1. Different dimensions of healthcare inequalities

The work of social sciences in the field of healthcare has allowed us to understand better that health and disease are not solely natural phenomena but are also constructed and produced in a social context. We realize more clearly how living conditions, which are in turn the result of social and environmental policy choices, have an impact on the health and life of human beings, and of the other living creatures, all of which are in relation with us. If we examine healthy life expectancies in different countries and in different social groups, we see obvious inequalities. These depend on variables such as salary levels, education, residential locations (even within the same city). It is said that the most reliable indicator of a person's life expectancy is his or her postal code. How can we say that life and health are fundamental values for everyone if we disregard the conditions that produce inequalities? Such an approach actually reveals that not all lives are the same and that healthcare is not available to everyone in the same way.

These healthcare issues must be examined more fully, not only in the light of clinical practice at the patient's bedside, but also in the light of public health, so as to highlight these connections and understand how we can become responsible for them. In this way, we will be able to turn our focus and our actions toward greater justice, following the fundamental principles of the Social Doctrine of the Church, which considers the human person, with his or her inherent dignity, and the search for relationships based on solidarity and justice, as central to all social activity.

We need therefore to consider how the question of inequalities in medicine is expressed on different levels, the political and the clinical. With respect to policy, it is necessary to find the right balance between prevention-oriented health education, location considerations, and hospital structures, all in support of continuity and integration in healthcare. As for clinical concerns, it is in

the context of the doctor-patient relationship that the General Practioner will be able to reduce waste prudently and help the patient to make those lifestyle and health management choices that reduce risks, and to accept responsibility for his or her own health and that of the community. The doctor must certainly bear in mind the economic importance of the treatments he or she prescribes, but the trust that is necessary for a good doctor-patient relationship would be lost if treatment were provided only on the basis of economic considerations, especially if the doctor can derive direct or indirect personal advantages (incentives, vouchers, participation in profits) from his or her prescription choices.

2. Social and organizational justice in healthcare systems

The issue of justice lies at the heart of the issues that I am discussing. In common usage, justice is interpreted as impartial, fair, and appropriate behavior that takes into account what is due to the individual. An injustice involves an act or omission that deprives individuals of the benefits to which they are entitled or that does not distribute burdens equitably. In particular, "distributive" justice, in the context of public health, refers to an impartial, equitable and society-appropriate distribution of care and facilities that is based on justified norms that underlie social cooperation. Problems of "distributive" justice arise in situations that reflect scarcity and competition. This was clearly seen during the Covid-19 pandemic.

In fact, in his February 11, 2019 Letter to the President of the Pontifical Academy for Life, *Humana Communitas*, Pope Francis wrote, "…the many and extraordinary resources made available to human beings by scientific and technological research could overshadow the joy of fraternal sharing and the beauty of common undertakings, unless they find their meaning in advancing that joy and beauty. We should keep in mind that fraternity remains the unkept promise of modernity. The universal spirit of fraternity that grows by mutual trust—within modern civil society and between peoples and nations—appears much weakened. The strengthening of fraternity, generated in the human family by the worship of God in spirit and truth, is the new frontier of Christianity." In these days of globalization, the re-discovery of our all being part of a universal and supportive fraternity offers a valuable insight. Solidarity is an aspect of the Gospel message that reappears constantly, but that has been overshadowed by the excessive and unbridled individualism that characterizes our times.

If we want to offer some suggestions based on the foregoing, the first would be to make better use of scarce resources. Given the important consequences that healthcare policy has on the people, we need to examine the several roles of healthcare professionals, administrators, patients, and the general population, and to require that healthcare decisions themselves be rational and solidly based.

In relation to the cost/benefit binomial, the first thing to ensure is that this calculation have a clear definition and ethical consistency. What is the value according to which the relationship between cost and benefit is determined? Is it economics? Is it health? Are both cost and benefit calculated in relation to the same factor? If not, problems arise. If we put economic cost on one side of the scale and human life on the other, every possible cost can be justified. It is therefore necessary, even in the field of economics, to have a clear understanding of the transcendent value

of the human person. It is true that the resources of a State are not infinite, but this fact requires a hierarchy of choices, starting from the primacy of the human person, to which economic considerations must be subordinated. In practice, before a public authority can say that funds are not available, it must be able to show how existing funds are being used.

In addition to "cost/benefit" terminology, in which the economic aspect tends to prevail, there is also the "risk/benefit" calculation. This approach is very suitable in a healthcare context. Likewise, the "cost/effectiveness" formula refers to the use of therapeutic means, and of technical equipment and structures, so we want to emphasize that between the economic costs of these tools and the therapeutic results of such use it is necessary to require a certain consistency and proportionality. The requirement of proportionality applies not only to diagnostic and therapeutic measures, but to ethical concerns as well. Taken into account are the characteristics of a given treatment (costs, availability, difficulties in application, and so forth), its diagnostic / therapeutic effectiveness, and the emotional, psychological burdens the treatment imposes on the patient and those close to the patient, as well as on the treating healthcare professionals.

With reference to the allocation of resources, we must distinguish between a macro-allocation, which determines the amount of allocable national resources, micro-allocation, which concerns the decision process adopted by a healthcare provider to determine the needs of a given patient in specific circumstances. Economists evaluate the general "convenience" of a given course of treatment as it relates to the costs and benefits affecting all of society, not just the patient. On the other hand, an individual treating physician concentrates on the needs of the individual patient and adopts a protocol that includes all means available to restore health or save life (subject to the general criteria of proportionality).

The Church has always been attentive to considerations of justice, human rights, and common fraternity, as the Apostle Paul writes, "There is neither Jew nor Greek, there is neither slave nor free person, there is not male and female, you are all one in Christ Jesus." (Gal 3:28) This is a Gospel that sounds like good news for our times. and it is closely linked to the Gospel words of Matthew, "…I was hungry, and you gave me food, I was thirsty, and you gave me drink, a stranger and you welcomed me ... whatever you did for one of these least brothers of mine, you did for me." (Matt 25:35-40). The fraternity indicated by the Gospel appears in many other passages and direct messages of Jesus. For us, it is time to take a step forward: we are interconnected; the world is interconnected, and the sooner we can understand it, the sooner we will be a true global community united in fraternity. Barriers do not exist; it is we who erect them, and they are destined to prove pitiful and useless, even foolish, in the face of global emergencies.

We can describe this Gospel message as an instance of the principle of subsidiarity, which in turn is based on the principle of social solidarity and on a personalistic vision of the economy and society. This principle becomes a moral criterion for dealing with patients' rights—and society's corresponding duties—to the protection of health, even when healthcare needs arise from lifestyle risks, voluntarily chosen. It is precisely the principle of subsidiarity that must govern the theoretical development and practical application of healthcare protocols that are truly just and consistent with human rights.

A place where ethics and healthcare economics can come together positively is in the need for the ongoing training of healthcare personnel. If it is well-planned and effectively carried out,

this continuing training has a threefold benefit: scientific-professional updating, ethical training, and the maintenance of personnel motivation and qualification. All this can benefit not only the humanization of healthcare but also the efficiency and cost-effectiveness that healthcare institutions are pursuing appropriately.

3. Justice and solidarity in times of pandemic

On the issues of justice and inequality, the recent pandemic has been both a test and a time of reflection and learning. The Covid-19 pandemic has shown that, in all countries, the benefits of public health programs must be balanced with economic concerns. During the early stages of the pandemic, many countries focused on saving as many lives as possible. Hospitals and especially intensive care units were not equal to the challenge and were brought up to speed only with great difficulty. Clearly, healthcare facilities have survived, thanks to the generous sacrifices of doctors, nurses, and other healthcare professionals, more than to investments in technology. The focus on hospital care, however, has drawn attention away from other institutions. Nursing homes, for example, were hit hard by the pandemic, and personal protective equipment and tests became available in sufficient quantities only at a later stage. Ethical discussions on resource allocation have been mainly based on utilitarian considerations, without paying attention to the most vulnerable and those exposed to the most serious risks. In most countries, the role of primary care physicians has been ignored, even though for many they are the first point of contact with the healthcare system. The result was an increase in deaths and disabilities caused by conditions other than Covid-19. Widespread vulnerability required international cooperation and coordination, in the knowledge that it was not possible to confront a pandemic without adequate healthcare infrastructures that are accessible to all globally.

Universal access to the best opportunities for prevention, diagnosis and treatment must not be reserved for the few. The distribution of the Covid-19 vaccines is a case in point. The only acceptable goal, consistent with fair distribution of the vaccine, is access for all, without exception. And the reason for this universal availability cannot be (only) one's personal interest in protection from virus variants.

I would like to note that a central issue at present is the moral, and not just strategic, significance of solidarity. Solidarity implies responsibility towards the other who lives in need, and it is rooted in a recognition that, as a human being endowed with dignity, each person is an end in him or herself, not a means. Solidarity as a principle of social ethics is based on the concrete reality represented by some person in need who cries out to be recognized. The response required of us is not simply an expression of sympathy. The only response that is consistent with the dignity of the other who cries out to us is an ethical openness arising from our internalized acceptance of the intrinsic value of every human being.

We therefore need an alliance between science and humanism, which must be integrated and not separated, nor, even worse, opposed. An emergency like that of Covid-19 is defeated first of all with the antibodies of solidarity. The technical and clinical means of containment must be integrated within a vast and profound search for the common good, which will have to counteract the tendency to select advantages for the privileged and to separate the vulnerable on the basis of

citizenship, income, politics, or age. This also applies to all "care policy" choices, including those most closely related to clinical practice.

4. The drama of choices in emergency situations: what criteria?

The pandemic emergency conditions in many countries forced doctors to make dramatic and painful *triage* decisions because resources were not at once available to everyone. In such circumstances, after having done everything possible on an organizational level to avoid rationing, it must always be borne in mind that decisions cannot be based on differences in the value of human life and the dignity of every person. These are always equal and priceless. Decisions are rather to be made on the basis of a patient's needs, *i.e*., the severity of a disease, the medically appropriate level of care, the expected clinical benefits, and the longer-term prognosis. Age cannot be a single and automatic criterion for choices; otherwise, a discriminatory attitude towards the elderly and the most fragile could result.

Moreover, as disaster medicine has taught us, to avoid arbitrariness or improvisation in emergency situations it is necessary to formulate criteria that are as shared and well-founded as possible. Of course, it must be repeated, rationing is to be the last option. The search for equivalent treatments, the sharing of resources, and the transfer of patients to other facilities are alternatives that must be carefully considered, in the search for healthcare justice. As well, adverse conditions have produced imaginative solutions, such as the use of the same ventilator for several patients.

In any case, we must never abandon the patient, even when there are no more treatments to consider. Palliative care, pain management and accompaniment are always to be available. At the level of public health, the pandemic experience shows the need for a general re-consideration, particularly of the balance between a preventive approach and a therapeutic approach, and between medicine for the individual and medicine that concentrates on the collectivity (given the serious concern in healthcare for the interplay between personal rights and public health).

These are concerns that arise out of profound questions with respect to the goals that medicine can pursue in the context of the overall structure of society and societal activities such as education and environmental concerns. Here we can see the fruitfulness of a global bioethical perspective which takes into account the multiplicity and global scope of healthcare issues, and which overcomes an individualistic and reductive vision of the issues that concern human life, health, and care. Allow me to quote the words of Pope Francis at the Plenary Assembly of the Pontifical Academy of Life in 2018, "Global bioethics calls us to the wisdom of a profound and objective discernment of the value of individual and community life, which must be preserved and promoted, even in the most difficult circumstances. We also state strongly that, without the adequate support of responsible human closeness, purely legal regulation and technical assistance cannot, on their own, guarantee conditions and relationships consonant with the dignity of the person. The vision of globalization that, left to its own devices, tends to increase and deepen inequalities, invites an ethical response that favors justice. Attention to social, economic, cultural, and environmental factors that affect health is part of this commitment."

I know that I am speaking to doctors, so I conclude my reflections with the story of an Italian writer, an atheist, Ennio Flaiano, whose daughter Luisa was stricken 1942 with an illness related to

epilepsy. Lovingly cared for by her family, she died in 1992. In the sixties, Flaiano considered making a movie about the situation but only a first draft of the script remains. In it Jesus returns to earth where he is besieged by reporters and paparazzi but is concerned only for the sick. At a certain point, a man brings his sick daughter to Jesus saying, "I don't want you to heal her. I want you to love her." Jesus gives the daughter a kiss and says, "Amen, this man has asked for what I can truly give." When he said this, he disappeared in a brilliant light, leaving the crowd to speak about his miracles and leaving the reporters to describe them.

Dear friends, dear friends, it is love – only love – that saves.