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Health Care Rationing and Insured Access: Does the Catholic Tradition Have Anything to Say?

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In a recent article in *The New England Journal of Medicine*, Arnold Relman began by saying: "Suddenly everyone is talking about rationing."¹ Indeed, the debate over the restructuring of the Medicaid plan in Oregon has ignited a national discussion about rationing health care services. What reasons are there to even enter into discussion about "rationing" health care? To "ration" something means to have an allotment, or share of something. It implies limits to what one can have. In a broad sense, limiting health care to what one can purchase is a form of rationing: market rationing.

However, "rationing" is more usually employed to identify some constraints, set by others, upon one's access to resources. Here, in particular, the focus is upon limitations on the amount of health care resources one can demand from physicians, health care providers, or third party payers. In particular, fueled by concerns about the rising cost of health care, a national debate is emerging about whether there should be limits to public health care resources and, if so, how such limits should be shaped. We need to be very clear that we are *not* talking about rationing health care as, for example, basic staples were rationed in the United States during the Second World War. In the Oregon discussions, we are talking about rationing the public resources that will be expended for health care. People will continue to be free to use their resources to obtain health care beyond the basic level.

There are three factors that provoke the present dilemma in health care which has, in turn, provoked discussion of rationing. First, there are the questions which arise as we face difficult decisions in making macro-allocational choices about the use of our nation's financial resources. Each time we make such allocation choices about defense or education we are

forced to ask how much, as a nation, we should spend on health care. These macro-allocational choices will limit how much health care we can provide from societal resources. The rising cost of health care and the limits of our national resources are one set of factors that provoke the discussion of rationing.

However, when people are ill, all of the discussion of fiscal realities seems abstract and distant. When we encounter individual cases of illness and disease, we often feel that people should receive whatever treatment they need. In the midst of our compassion, it becomes important to understand the comparative efficacy of our technologies and employ them wisely. We need then, secondly, to decide how to deploy our societal health care resources in light of the comparative effectiveness of medical technologies.

Third, there is a growing national awareness of the number of people without sufficient access to health care and a sense that we need to address that issue. Discussions such as those in Oregon, regarding how to provide insured access, involve policies which put limits on health care. Such limits further contribute to the discussion of rationing. These three elements — the limits of national resources, the differential effectiveness of technologies, and a growing concern for the needs of those who lack insured access to the health care system — translate into a challenge to achieve cost containment, quality of care, and insured access to care.

How are we, as Catholics, especially those working in health care, to respond? Is there anything in our moral tradition which can guide us as we face these difficult issues? The Catholic social and medical-moral traditions offer threads which can be woven together to give us a direction by which to respond to these issues. The first thread is taken from the body of literature which comprises the Catholic social tradition. The second thread is found in the reflections on the distinction between ordinary and extraordinary care. Before explaining these threads, I think it is important to identify clearly the issues at hand. In this way we are better able to grasp the issues so that we can respond adequately from our tradition.

Insured Access, Cost, Effectiveness and the Technological Imperative

The most recent data compiled by the Health Care Finance Administration show that Americans spent 11.1% of the GNP on health care in 1988.² Put another way, Americans spent \$2,124 per capita in 1988 on health care. By either measure Americans spend more on health care than any other nation and health care ranks as the largest industry in the United States. The percentage of the GNP devoted to health care shows a continuing upward trend. This trend has continued even in the last eight years which have been a period of low inflation for the general economy. As the cost of health care continues to increase, we are forced to consider carefully how we will deploy our national resources which are devoted to health care.

In the last 30 years, the structure of health care payments has also been dramatically re-shaped. In 1960, 37% of the hospital bill was paid as an out-of-pocket expense, while in 1988 that percentage was down to 13%. In 1960, patients paid 67% of the bill they received from their physician, while in 1988 they paid only 28% of the physician's bill.³ More people are paying for their health care out of common pools and funds which are either governmental pools or private insurance pools. The public policy debate concerns the discussion of how the societal pools of resources are to be used. Confronted with rising health care costs, the fiduciaries of these pools will have to make choices about the type of coverage that is to be extended to members of these pools. The shift in payment structures often means that the parameters of treatment options will be set within the context of insurance pools.

In the face of interests in controlling the cost of health care, there have been increased efforts to study the effectiveness of different medical treatments.⁴ But even after we have done all that is possible to control and eliminate wasteful spending and increase the efficient use of medical treatments, the upward spiral of health costs will continue. According to Schwartz, the cost of health care will continue to increase as long as new technologies are introduced. "New" technology should be distinguished from replacement technology; that is, technology which more efficiently performs tasks and procedures already being done. New technology, such as the development of mechanical circulatory devices, allows innovative and novel procedures which reshape our understanding of what is possible in medical care. A second concern which emerges from the issue of cost-containment is the relationship between quality of care and the effective, prudent use of technological resources. In a culture which has great attachment to technological developments in all areas of life, the assumption is often made that quality of care can be equated with the employment of sophisticated, often expensive technology. In the effort to control costs, it will be crucial to understand the complex nuances in the relationship of quality of care and the use of technology.⁵ Technology assessment and cost effectiveness analysis will be vital to controlling health care costs.

Addressing a Third Concern

To address a third concern, the provision of some form of insured access to health care for all Americans, one must be careful to distinguish "access" from being "uninsured". It is estimated that 31 million Americans lack health care insurance.⁶ However, within that figure there is a large number, (40% or 12.2 million people) who have access to health care through the mechanisms of the public hospital system.⁷ Of the remaining 20 million who are without insurance, many are young, often self-employed professionals, many of whom could theoretically purchase private health care insurance. Still, there are difficulties of both social and medical cost that result from the existence of a large pool of uninsured individuals.⁸

There are two sets of reasons why we should be concerned with the problem of insured access. From a secular point of view, one can argue that insofar as there are societal resources, drawn from the common wealth, devoted to health care, then all citizens ought to have voice as to how those resources are distributed. Second, as Catholics, we have tradition which understands health care as an element in the dignity of the human person. What that means in concrete terms, however, is not always clear. It is an area which needs to be explored as we respond to these issues.

There are currently, at least eight major proposals to expand insured access.⁹ There are also various estimates as to the cost of expanding access to health care. A Medicaid expansion, at current spending levels, to cover the cost of the uninsured is estimated to cost \$9 billion per year. However, Medicaid varies greatly in its coverage from state to state. If we select a more complete package of care, the cost of extending Medicaid coverage is estimated at \$35 billion. If one used current Medicare levels of reimbursement, the cost of expansion would be about \$40 billion.¹⁰

No matter what policy approach we adopt we must be clear that in a democratic society, with a market economy, there will be two tiers of health care, just as we have a two-tiered system of education. The fortunate will be able to purchase additional (luxury) health care.¹¹ The challenge ahead is to define an adequate and basic health care package that can be provided to all Americans.

Roman Catholic Social Teaching and Access to Health Care

The body of literature identified as Roman Catholic social teaching is now a century old, with the 100th anniversary of the publication of the 1891 encyclical letter, "*Rerum Novarum*", of Pope Leo XIII. The social teaching varies in its content and emphasis, but its foundation is an emphasis on the dignity of the human person. In view of that dignity, Leo XIII articulated and defended the rights of workers. He did express a concern for a negative right to health, in that health was not to be harmed by inhumane working conditions.¹² With scientific development in the last century medicine has become more effective in the control of disease and the improvement of the quality of health care. So it is not surprising that when, in 1963, Pope John XXIII wrote "*Pacem In Terris*", he explicitly addressed a positive right to health care. He said:

Beginning our discussion of the rights of man, we see that every man has the right to life, to bodily integrity, and to the means which are suitable for the proper development of life; these are primarily food, clothing, shelter, rest, medical care, and finally the necessary social services. Therefore a human being has the right to security in cases of sickness, inability to work, widowhood, old age, unemployment, or in any other case in which he is deprived of the means of subsistence through no fault of his own.¹³

In the United States the National Conference of Catholic Bishops wrote a pastoral letter in 1981 which reaffirmed, in even more explicit ways, the right

of men and women to health care and the place of that right in shaping national health care policy.¹⁴ Indeed, like Pope John XXIII, the bishops asserted that health care was a basic human right. This theme was reiterated by Pope John Paul II when he stated that there is a primary right of every one to have what is necessary for the care of his/her health and therefore, a right to adequate health care.¹⁵

The difficulty with this literature is that while it asserts and argues for a right to health care, there is little said about the scope or meaning of this right. The danger is that the encyclical literature can be construed as failing to provide concrete guidance. At a time when we are acutely aware of the limits of our resources, it becomes clear that there will be limits on health care which is commonly provided and available. The Catholic must face the question of whether or not our tradition leaves us at the level of rhetoric, devoid of content.

Another way to frame this problem emerges in the language of rights. There are those rights which are called "negative" rights; that is, a right which protects a person from certain deliberate interferences done by others. For example, I have a right not to be killed and others have a duty not to kill me. There are other rights, "positive" ones, which express my entitlement to something and the duty of others to provide it. A right to health care, like the right to education, is best understood as a positive right. The difficulty with positive rights is that they can seem limitless and impractical. This difficulty affects much of Catholic social teaching in that in its concern for positive rights, the tradition can often seem so Utopian as to be empty. To give it content, one would need to specify the scope of health care services to which individuals have a right. Without such specification, it is impossible to say that all men and women do not have a right to a heart transplant.

However, the Church speaks with different moral voices to different issues. In the case of the social teaching, it speaks of the right to health care, but the voice, by itself, is incomplete. It is a principle devoid of content or with a content that cannot be realized. There is another voice in our tradition which can help us fill in the content of the formal principle expressed in our social tradition: the voice which has influenced so much of our practice toward patient care. This is the distinction between ordinary and extraordinary means.

The Lure of Technology and the Limits of Treatment

The development of technology, in any field, often carries with it the imperative to use the technology. In the medical profession, there is frequently an unspoken imperative to use the latest technological developments, since they offer the hope of a cure. The dynamism of technology carries values which are often unarticulated. The use of medical technology tends to be influenced by a trinity of idols. First, there is the idolatry of "life" as an end in itself. Second, there is the idolatry of our capacity to create and control our own destiny. Third, there is the idolatry of the technology itself as a celebration of our human capacities and as a servant of the prolongation of life.¹⁶

Confronted with medical capacities to prolong life, the Church has a long tradition of moral reflection which asks *why* a treatment—any treatment—should be used in the case of a particular patient. The focus of this tradition has been on the individual patient and the extent of the patient's obligation to seek medical treatment. In a time of significant scientific progress and medical promise, in the 16th and 17th centuries, Catholic theologians set out a distinction between that treatment which was obligatory (ordinary) and that which was not obligatory (extraordinary). At the foundation of this distinction lies the view that the preservation of life is one good among others, and that it receives its proper order from the spiritual end for which all men and women are created.¹⁷ As the distinction has evolved over the centuries, it has not developed as a list of technologies, some of which were ordinary and others which were extraordinary. Rather, the distinction has served to evaluate the burdens and benefits of any proposed treatment. A patient is obliged to use a treatment which offers a reasonable hope of recovery without excessively grave burdens. In judging whether a treatment is obligatory, one has to balance the hope of recovery offered by a treatment against the cost, and other effects of the treatment on the patient's life. This is a *personal* balancing. There is no common metric which weighs benefits and burdens for all of us. Rather, the benefits and burdens of any treatment must be judged within the context of a person's life. The judgment of such means is, as Pius XII noted, relative to the circumstances of "persons, places, times and cultures".¹⁸ We often focus on factors such as pain and psychological issues in order to understand the burden of a treatment. One of the recognized criteria of excessive "burden" has been expense.¹⁹

In general the discussion and use of this distinction has focused on the obligation of the patient to seek treatment; that is, it sets limits on the treatments one must undergo. The distinction can allow us to speak of the extent to which an obligation to provide treatment exists. In talking about the distinction, Pius XII addressed the notion of "burden" as "for oneself or another".²⁰ Indeed the Pope explicated an underlying theme which has been part of the ordinary-extraordinary discussion. The distinction should not be restricted only to those who seek health care but to those who offer such care. The Sacred Congregation for the Doctrine of the Faith wrote, in speaking of the patient's refusal of treatment, that such a refusal may express a desire "not to impose excessive expense on the family or the community".²¹

It may be helpful to recall that the distinction has been used to discern the obligations of families to obtain treatment for family members. In our tradition it has been held that if a treatment occasioned great hardship for a family, then the family is not morally obligated to provide the treatment.²² In following this line of thought, just as a family is not obligated to provide family members treatments that are burdensome to the rest of the family, so, too, our national society should not be held to such a strict moral standard.

Pulling the Threads Together

At the outset it was argued that the problems we face are a matrix of cost containment, insured access for health care, and effective use of technology. In addressing these issues, there will be hard choices to make about rationing health care. How does our tradition guide us? First, we should be concerned, from our social teaching, with creating a safety net of insured access for those who cannot afford insurance or qualify for existing programs. There will, of course, be limits to the type of safety net which can be crafted. However, our first guideline is that we should seek to provide such a net. In this, our tradition accords with the recommendations of the President's Commission in 1983.²³

Our second guideline comes from the distinction between ordinary-extraordinary means. The distinction can help us to think analogously about the extent of our social obligations. There are limits to the care we are obliged to seek and also limits to the care we are obliged to provide. Just as we are obliged to seek basic/ordinary health care, so too one could argue that society is analogously obliged only to provide access to basic/ordinary care. The crucial question becomes, What constitutes a level of basic care?

Little Consensus

There has been little consensus concerning what constitutes "basic" or "adequate" care. The American College of Physicians, in its position paper, "Access to Health Care", calls for a clear determination of "basic" care. Yet, they write: "Despite efforts . . . there is little that does not seem to be either basic or essential".²⁴ The ordinary-extraordinary distinction provides us with yet another guideline to the question of what constitutes "basic" care. The distinction requires a personal balancing of the burdens and benefits of treatment and how the distinction is drawn will vary from person to person. Ordinary care will vary with times, places, customs, benefits and burdens within a person's life. The notion of ordinary care incorporates within it an understanding of the highly personal nature of health and health care which differentiates health care from other common goods. If we seek to fashion a health care system and policy structure shaped by the notion of ordinary care, then the policy structure will need to allow flexibility, so that people can determine their health care within the context of their own lives. One structural way to implement a flexible plan for ordinary health care would be to adopt a voucher system for health care along the same lines which have been proposed for education.²⁵ Rather than talk of "adequate" or "basic" care, we do better to speak of "affordable" care; that is, how much, in light of other macro-allocation decisions, we as a nation can communally spend on basic health care insurance. Here the insurance metaphor may help guide us in deciding what constitutes a minimum societal burden to be borne in creating a basic package of health care services.²⁶ Additional coverage would be extraordinary luxury care.²⁷

In summary, our tradition then gives us at least three guides with which

we enter current discussions: first, a goal of providing a safety net of insured access to health care for all Americans; second, society is not obligated to provide all health care services, and finally, there should be flexibility in the system to allow for personal choices.

Catholic physicians and organizations, like the Guild, are called to participate in the shaping of national health care policy. These issues, and your role in addressing them, are concrete instances of the description of the apostolate of the laity given by the Fathers of the Second Vatican Council. The Council Fathers spoke of the laity as a leaven in the world, shaping the world to the desires of Christ.²⁸ As one addresses these issues, one is able to call upon the intellectual resources of the Church's social and medical traditions in creative ways, as responses to these new dilemmas.

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60th NFCPG Meeting

The 60th annual meeting of the National Federation of Catholic Physicians' Guilds will be held Oct. 10-13 at the Regent Hotel at Domino Farms in Ann Arbor, Michigan. The theme will be "Discussion of Contemporary Medical Issues from a Catholic Moral and Ethical Perspective."

Panel discussions and talks will deal with mercy killing, the formation of a medical conscience, impaired physicians, and chastity. Psychological, emotional and physical sequelae of women who have voluntarily aborted will be discussed. There will be a presentation by agencies which provide assistance to women with problem pregnancies.

For a meeting brochure, please contact: NFCPG, 850 Elm Grove Rd., Suite 11, Elm Grove, WI 53122 or call (414) 774-3435.