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Health Care Rationing: A Theologian's Perspective

An Address By

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It is a pleasure and an honor for me to address this meeting of the New England Chapter of the Catholic Health Association (CHA) on a theologian's perspective on the topic of health care rationing. It is a very rare occurrence to find a priest, especially a theologian, to be at a loss of words; however, I confess that from the moment this hot potato was tossed to me, I have been stunned — and numbed by the complexity of the problem, the avalanche of statistics, and the staggering figures. I am greatly indebted to several individuals and groups whose research has been invaluable to me. I must make special mention of Professor John O'Connor of Worcester Polytechnic Institute has provided me with invaluable, if often opaque, information on health care financing.

Introduction

This talk will incorporate and partially repeat facts repeatedly discussed by health care managers and other bioethicists. But here, from the perspective of a theologian, the setting of those facts will take on a different cast. The present clinical, administrative and financial realities of health care have a history, and in

terms of Catholic health care, this is a long history. It is important to recall parts of that history in order to highlight the perennial, enduring, foundational elements that faith provides and theology analyzes when bringing these to bear on the present problems and challenges. My talk is theological: theology is defined as faith seeking understanding. What we are trying to understand is the practical question of what the Lord expects us to do as responsible Catholics in the current health care situation.

Health Care in the Catholic Tradition

Christians' concern for the sick derived primarily from the example of Christ. He healed the sick, he restored their physical health — even their life — as well as healing their moral lives and immortal souls. A full third of Mark's Gospel is devoted to Christ's concern for the sick. His compassion is spontaneous and immediate. In fact, the adverb "immediately" is used 42 times in the Gospel of Mark. In sending out the 12 in chapter 9 of Luke's gospel and in sending out the 72 in chapter 10, Christ tells them to do two things: to heal and to teach. I think this mandate is beautifully reflected in His Church today.

Jesus' example and His compassion for the sick, widowed, orphaned and neglected was emulated in every age of history. The deacons and pious laypersons, especially widows, took care of the sick in the first centuries of Christianity. St. Benedict, the father of Latin monasticism wrote in his Benedictine rule that "the care of the sick is to be placed above and before every other duty." His Order's monasteries were to offer temporary "hospitality" to pilgrims and more permanent hospitality to those whose earthly pilgrimage was about to end. Hospitality and hospital both derive from the Latin word *hospes*, guest. This guest who sought comfort or care in sickness was never to be a stranger. In fact, for the monks, as for all Christians, those whom one serves in the sick, is the one whom Christians are to love above all things, the one who said, "When I was hungry you gave me food, when I was thirsty you gave me drink, when I was naked, or sick or in prison you attended to my needs. Whatever you do to the least in this world, that you do to me." It was to serve Christ who is loved above all, that others were served with love and joy. By doing so, Christians will hear their beloved say, "Well done, good and faithful servant, faithful in little things, enter into the joy of your Lord."

This concern for the sick on the part of Christians led to reflection upon the sorts of medical decisions that must be made, that is to a line of *substantive* questions about the morality of certain forms of intervention: when does one have a soul?, should we baptize monstrosities?, is one obligated to undergo an amputation (without anesthesia) or is that "extraordinary" means, must a doctor treat everyone, should physicians be paid by individuals or by the state?, etc. There also arose a line of *institutional* concerns, should we run our own hospitals, should we do major cost shifting to support uncompensated care *and* to support our clinics in missionary lands?, why should we operate a Catholic hospital in a non-Catholic area or one already served by non-Catholic health care? These institutional concerns were often based on financial concerns, desire for charity

work and to spread the faith by good works and example. It is interesting to watch these heretofore understudied institutional concerns of the past. We see a change in the financial landscape as well as the structural elements which inspired the original mission and identity of the religious congregations.

My point here, however, is this: there have always been daunting challenges and always in institutionalized health care ministry, based on the Lord's example of love and the loving response of Christians to His love. In this sense, our contemporary challenges should not be intimidating. We should not be paralyzed by the fast-paced changes or enormous statistics. In no period has it been easy to respond to the issues faced by Catholic health care.

Today's Challenge

It is difficult to briefly delineate the salient features of today's challenge of the allocation of health care resources. When I took my first course in medical ethics in the mid-1970s, the question of rationing had to do with the limited supply of transplantable organs (viz. kidneys) and the limited number of new wonder machines (viz. dialysis). The tough question of the day was: Who gets what and why? It was often resolved by examining medical criteria and then by random selection because social considerations would compromise appreciation of the transcendent value of each human being. The method of resolving the problem was "microethics." Today, the focus is not so much on the machine or the organ, but on the cash flow. It is now a "macro-concern." True, the micro question has not disappeared. If anything, it has become exacerbated by technological development which permits almost any organ's transplantation, and pharmaceutical development which overcomes immune-response rejection with increasing effectiveness. Today, an estimated 17,000 Americans await an organ transplant, so the short supply has gotten more acute in light of the promise of greater clinical success.

The question today comes from a different direction. It is not a matter of how or when to provide an exotic treatment. It is how can we provide basic health care. This is not a question — as I understand it — of having someone's gunshot wound or heart attack treated. Rather it is a question of making health care (generally meaning hospital, day surgery or long term care) available to all those who need it. The terms of the question are financial. How can we afford not to bankrupt the near poor, serve the already poor and pay for a spiraling health care bill that performs spectacular feats with good results for a limited number of patients, but which does not dramatically improve morbidity in general? In fact, the structure of health care is responsible for increasing morbidity by discouraging preventative care and thereby encouraging people to get sicker before they come for help. Also we hear of studies that say we spend the largest single portion of our personal health care dollar (up to 50%) within the last three months of life. This imbalance arises from the cultural and systemic imperative of the "911 mentality." (David Thomasma has suggested that in addition to DNR orders, we need DNLH orders: Do Not Leave Home.)

The litany of statistics is staggering and well rehearsed. 37 million people

uninsured in the USA. We will spend \$733 billion on health care this year (\$2 billion a day, \$23,000 per second). Of the \$733 billion total, about \$160 billion or 21.9% goes to unnecessary services and fraud. Fraud alone accounts for 10 cents of every health care dollar. Health care is now about 13% of the GNP. This compares with 4% of the GNP in the early 1950s and 9.4% in 1980. (11.2% in 1988 and 11.6% in 1989 — Helen C. Lazenby and Suzanne W. Letsch). Medicaid (which cost \$2.3 billion in its first year, 1967) now costs 69 times as much and serves only 40% of the poor, as opposed to 65% of them in 1980. If you are interested in the goings and comings of the national health care dollar: In 1989, 42% came from the US government (Medicare, Medicaid, et.al.) 37% from private health insurers and 21% out of pocket. 39% went to hospitals, 8% to nursing homes, 19% to physicians, 22% to personal health care (e.g., dental, other professional services, home health care, drugs and other non-durable medical products, and vision and other durable medical products) and 12% to other spending (e.g. administration and the net cost of private health insurance, government public health and research and construction). [*Health Care Financing Review*, Winter, 1990, 12, 2]. According to the fixed weight price index, the cost of health care nearly doubled between 1980 and 1989.

Last year, CHA released a working document "With Justice for All? The Ethics of Health Care Rationing" which succinctly formulates the problem this way: "A combination of choices by private industry and the federal government has created a pattern of employment-linked health insurance that has dramatic rationing effects. Nearly 37 million Americans have no insurance at all, and as many as 60-70 million are underinsured As a result of these choices, the health insurance market has seriously deteriorated. Many Americans who are most in need of health care are being denied coverage, thus creating the category of the 'uninsurable' Increasingly, health insurance coverage, and thus financial access to medical care, is becoming a benefit available only to the healthy and the economically advantaged."

The challenge today is this: to have a view comprehensive enough to see and to analyze the pertinent data yet specific enough to be practically useful or suggestive of actual solutions beyond the mere statement of the problems.

Catholic Proposals

Recent Catholic social teaching — at the level of the papal magisterium — has taught that health care services are a basic right of human beings. Pope John XXIII and Pope John Paul II have mentioned this — but without much elaboration. The "rights" the pontiffs enumerate are analogous, not univocal realities, i.e., the lists are a mixed bag of things some of which should be provided by society, others which should be protected from coercion or made freely accessible (as opposed to specifically provided) by legal protection.

The bishops of the United States directly addressed this problem in their statement "Health and Health Care" of November 19, 1981. They listed six principles for public policy: (1) Every person has a basic right to adequate health care. (This right derives from the sanctity and dignity of human life which is

created in the image of God.) Consequently, "attention should be given to meeting the basic health needs of the poor." (2) In our pluralistic society, "provision should be made for the protection of conscience in the delivery of health care" — the relevant consciences being those of the individual and institutional providers, and of the consumers. (3) Emphasis in any national health care policy "should be placed on the promotion of health, the prevention of disease and the protection against environmental and other hazards to physical and mental health Toward this end, public policy should provide incentives for preventative care, early intervention and alternative delivery systems." (This would call for alteration of the operative philosophy of medicine.) (4) Consumers should be allowed a reasonable choice of providers whether they be individual providers, groups, clinics or institutions." (5) "Public policy should ensure that uniform standards are part of the health care delivery system." And (6) "methods of containing and controlling costs are an essential element of national health policy." The bishops conclude as follows: "Following on these principles and on our belief in health care as a basic human right, we call for the development of a national health insurance program. It is the responsibility of the federal government to establish a comprehensive health care system that will ensure a basic level of health care for all Americans."

The 1991 CHA document mentioned earlier defines health care rationing as "the withholding of potentially beneficial healthcare services because policies and practices establish limits on the resources available for healthcare." Eight ethical criteria are enumerated to guide any reformulation of health care delivery: (1) There must be a demonstrable need for rationing, apart from administrative and other systemic cost wastes which should be eliminated. (2) "Healthcare is a social good belonging to all people, not only because a basic level of healthcare is a right, but also because our healthcare system has been developed through the collaborative efforts of many individuals and institutions and with considerable public funding." The focus of clinical medicine is the best interest of the individual patient, but "public policy choices governing the distribution of healthcare services beyond the level determined to be each person's right must consider the common good." (3) A basic level of health care must be available to all. Basic health care is "a fundamental right." (4) "Rationing should apply to all." The task force explains that "two important values are in conflict here. One is cultural allegiance to the concept of individual rights which, for some, means, they have the right to choose whatever healthcare they can afford. The other is a commitment to social justice and equity. Equity would be comprised if a significant number of Americans obtained their healthcare outside a rationed system while acquiescing to the withholding of potentially beneficial healthcare services from others." (5) Rationing must result from an open, participatory process. Catholic health care should help to be a political voice for the politically voiceless. (6) The health care of disadvantaged persons has an ethical priority. (7) Rationing must be free of wrongful discrimination. And (8) the social and economic effects of rationing must be carefully monitored.

Analysis: Critique and Suggestions

Neither time nor the topic permit a detailed analysis of this important document. Its many other points and proposals must regrettably go unmentioned. I would, however, like to mention several problematical aspects of the "Catholic side" of the discussion, particularly as articulated by CHA. First, the definition of rationing has several ambiguities that compromise its usefulness. "Potentially beneficial healthcare services" which are the objects of rationing is vague. "Healthcare services" are not univocal terms. Health care is not a single item but a collection of services of varying complexity and varying effectiveness. Any process of rationing cannot practice medicine, cannot replace the prudence of situational judgment or the responsibility of professional care with politically arranged formulas. Also, the definition is formulated in a way that places the onus of blame for rationing on the government (policies). Other cost driving entities are not addressed. Technological and pharmaceutical companies play a large part in driving health care costs higher. Here, I think, investigative reporting may find a fertile field of examination.

The participatory process is also a touchy issue. Perhaps another approach to settle the question of rationing might concentrate less on politically active groups and concentrate on the decision trends (and clinical results) of broadly studied patient cohorts. These are the groups who have lived and died with their clinical choices, often times being inappropriately overtreated in ways most say did them no good, and in the end racked up half of their lifetime health care dollar.

Finally, the language of rights is confusing. This is alluded to in the CHA document, and more fully treated in an article in *Health Progress* (June, 1990) by Fr. Dennis Brodeur. Here Brodeur delineates the broad differences between the understanding of rights in Catholic social teaching on the one hand, and the American legal understanding on the other. He says, in its broadest sense, the Catholic social understanding has a more societal, communitarian connotation. Rights in this sense involve the ability to participate fully in the goods of society. The American legal notion of rights is based on individualism which should be as free as possible from government constraint.

From the reign of Pope Leo XIII, Catholic social teaching has employed the language of rights. While it is true that the Roman law and its two millennia of students understand the concept of "right" differently than post-Enlightenment social philosophers in non-Latin countries, it is also true that Popes and other organs of the Magisterium generally propose Catholic teaching using language in common parlance, but generally prescinding from the specific philosophical contexts in which certain words are used in technically precise ways. For example, doctrine is cast in language using such philosophically derived words as "person," "substance" and "accident," and "human rights" without at the same time adopting the technical meaning forged in the thought of a particular theologian. Hence, the confusion remains about the meaning of the word "right." Is it something we may freely pursue, like a right to have a family? Or is it something to which one has a claim, that one is entitled to and which society has a corresponding responsibility to provide? Or is it a mixture of the two, like

education: society provides the basics, the individual is responsible for any education after high school. Clearly CHA advocates the second and rejects the first and last understandings. Where is the line to be drawn between basic health care and rationed health care?

Why is spiraling cost being accepted as a given? Fraud and inappropriate treatment account for a substantial portion of the health care bill. This figure would rise if one factors in the management of end stage conditions in acute care facilities according to the technological imperative and the 911 mentality. Again, other cost driving entities should be thoroughly scrutinized, particularly technological and pharmaceutical research and development. And the specter of outrageous malpractice settlements needs to be addressed by the legislature.

Two other items about cost control deserve attention as well. First, which is the more effective form of cost containment: single entity pressure (from government regulation) or competition generated by private health management organizations which one may not be excluded from joining? Can the government manage this process? The experience of medicaid tells us no. The most benign implication would be that we should exercise great caution before saying yes. Second, the life expectancy has increased, interestingly, not so much because of technology as because of more mundane public health developments. When Social Security was instituted, retirement benefits were retrievable at age 65, the average life expectancy in America. At that time, 15 workers were paying into S.S. for every one receiver. Now, life expectancy is in the 70s. Only four pay for every one receiving benefits. Should the age delineation be moved to, say, 70 years old? This would vastly expand both the work force and the tax base.

Concluding Theological Reminders

I would like to conclude by placing all this back within its theological context, or better, within the experience of the faith that has inspired the health care mission in the Church through the ages. The whole point of health care ministry in the Church is not precisely humanitarian. It is only "humanitarian", for us, in so far as it is primarily an activity of faith expressed in good works. As the Popes, the bishops and CHA repeatedly assert: we believe that human persons are created to the image of God. They are the recipients of His love and His invitation to enjoy a destiny with Him, a destiny larger than their created natures, and larger than their wildest dreams of peace and love. Being the object of God's love from the beginning, human beings' lives are sacred and inviolable, gifts of incommensurable value, goods that are never to be treated as evils. The fullness of life is made available freely by baptism and is cultivated by a life of faithful discipleship.

The Lord Jesus is the very incarnation of God in His complete divinity and He is the way of salvation and the teacher of fidelity in His Passion and Death, and in His complete humanity. He taught that the ratification of His friendship on our part is not simply a matter of saying "Lord, Lord," but is *doing* the will of our heavenly Father. "If you love me, keep my commandments" was one of the last things He impressed upon His followers. He taught that love for Him would

take concrete shape in love for the least esteemed in the world — with whom the Master identified Himself when He taught “whatsoever you do to the least of my brethren, that you do unto me.” It is the Lord Himself whom we serve in others and it is His love that we are privileged, blessed and called to embody and share when we do the serving. This is the *real* world, the *real* bottom line. The most important thing in life is to embody, foster and share the love of God, to be lucid beacons of His love and to find it in those whom we serve, His images. This is the most basic identity of human beings even when it is not their most obvious identity.

This dramatically affects, I would say “constitutes,” the identity of Catholic health care. “When I was sick, naked and imprisoned you cared for my needs. When did we see you hungry, thirsty, far from home, ill or imprisoned? When you reached out to help another for love of me.” We cannot help being in Catholic health care. Most fundamentally, through it we serve Christ and give glory to God not only with our lips but in our lives. And we activate responsible stewardship to those whom Providence puts in our path. And in facing any daunting question in the 1990s or in any time, we hear the Master’s wise counsel: “Be as cunning as serpents, while being as innocent as doves.”

We see, then, the essentially religious character of our most clinical or administrative actions. In Catholic health care, it is all for love of Him who was the *victim of love* for us. It is for this reason that CHA has been so emphatic on leadership formation. Catholic health care is a matter of the heart, where faith in and love for Christ animate and inspire the total mission. It is this inspiring and animating love of and for Christ that is the essence and reality of Christian *charity*. Charity is no *pro bono* work on the red side of the ledger. It is rather the soul of Christian discipleship, communion with and in Trinitarian love. The word “charity” needs rehabilitation in our vocabulary by contact with its pristine meaning, not some quaint 19th century virtue. Also, realistically speaking, even if we Catholic health care providers lived in financial and medical utopia, we would still find an extra mile to walk with someone. And we would feel compelled to do it.

This fundamental charity (the soul of Christian discipleship) will animate the other virtues needed to effect necessary change and to maintain necessary *continuity in this mission*. The virtues of fortitude, justice and prudence will be the life force of the collaborative effort needed in health care reform. Creative financing of health care will involve changes in the whole spectrum of medicine and cultural expectations of health. The philosophy of medicine will change from the symptomatic to the preventative — in harmony with the conviction of responsible stewardship throughout the life-cycle. The lifestyle of our culture in general, and of caregivers should reflect this less costly approach.

Finally, as a theologian I must bring up a point that is rarely if ever, highlighted. It is best seen in this brief, true story. On May 3, 1992, I had the honor of celebrating Holy Mass and preaching on the occasion of the 40th anniversary of Mary Immaculate Hospital in Newport News, Virginia. It is a study in the tenacity of Catholic health care. In 1952, a private physician sold his 120 bed facility to the Bernardine Franciscan Sisters. They appeared in an

area at the time when Catholics constituted less than 4% of the population. They faced difficulty in locating property for a convent, deteriorating building structures, and they have been refused every certificate of need they ever submitted to the Commonwealth, at least on the first try. They have survived a declining inner city census, a change of campus, a highly competitive health care market (in the public and private sectors) and a less than friendly political environment. Yet on the two occasions when their governing board decided to call it quits, the local people whom the hospital had served, mostly poor minorities (some wealthy, however) raised over a million dollars. People rave about the care and write to government officials. Their present campus of about 20 acres houses a 110-bed acute care facility, day surgery, physician offices, a host of clinics, a convalescent center and quarters for the dozen or so Sisters. I recently asked a group of the nuns how Mary Immaculate had survived. With one voice the answer came, "Prayer and sacrifice."

Not every Catholic hospital has had its prayers answered the way Mary Immaculate has. But prayer and sacrifice have been constants in the mission. As providers and participants in Catholic health care, faith is absolutely essential for its continuation and necessary adaptation. Faith, prayer, the sacraments, meditation are *essential*. And I think we must engage in this as integral to the health care mission as well . . . as a whole hospital community . . . To be places of healing, we should also be places of prayer (and *non-medical* fasting). This is important for balance of vision, the nourishing of our compassion and the deepening of our wisdom, courage and prudence to face the challenges of the day. It will impart a sense of peace and serenity which so easily dissipates in the rush of the moment.

When St. Bonaventure was asked what textbook he studied to become so wise, he pointed to the crucifix and said wisdom is learned here, on one's knees. In confronting the problem of making basic health care available to everyone, we must always keep our mind's eye on the patient in whom the suffering Christ whom we love above all is served. And we must remember love for them is the condition and embodiment of love for Him. And let us keep in mind the words of St. Bonaventure who said, "the day you no longer burn with love, many others will die of the cold."

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