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FOREWORD

THE COST-FACTOR IN HEALTH CARE

RICHARD A. McCORMICK, S.J.*

A simple case taken from the Hastings Center Report¹ can serve to introduce my concerns in this foreword to the essays in this volume.

An automobile crashes into a motorcyclist one block from a for-profit hospital. The unconscious motorcyclist is rushed to the emergency room where a neurosurgeon diagnoses an epidural hematoma that requires immediate surgery. But a hospital administrator is unable to determine whether the patient has health insurance and wants to transfer him to a public hospital, on the opposite side of town. Should the physician agree to the request for a transfer?

Here in microcosm is the cost-factor working its way into the clinical setting and potentially affecting the life and well being of an individual patient. In a sense, the physician is caught between serving the patient and serving the common good by reducing or limiting care. I say “microcosm” because at present, health care facilities are being asked — or forced — into policies (macrocosm) that have an eye on both constituencies, the patient and the common (economic) good.

That this situation is loaded with ethical problems is clear from the studies in this volume. I will neither rehearse nor attempt to answer such problems here. Rather I want to provide an optique, a general ethical perspective on such problems. I am convinced that ethics is much less about answer-giving than it is about value-raising. In this sense it may be described as “corrective vision,” an attempt to expose the value-dimensions present in human conflicts and dilemmas —

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especially those we are likely, in our often short-sighted enthusiasms, to overlook or downplay.

The Catholic moral tradition, from which I come and in which I frankly revel, has approached these situations in a somewhat unique way. It takes seriously the radical transformation of perspectives that has occurred in God's intervention into history through His Son, Jesus Christ. For the Catholic Christian this radical transformation is "The way things are in this world." Thus Vatican II stated: "[F]aith throws a new light on everything, manifests God's design for man's total vocation, and thus directs the mind to solutions which are fully human."

The Catholic moral tradition, however, refuses to view such faith-sources as dispensations from human responsibility. As St. Thomas stated: "He [human person] participates in providence by providing for himself and others." This means, of course, that we are charged with the responsibility of human intelligence and creativity.

Catholic tradition has attempted to combine these twin sources of moral insight in the phrase reason informed by faith. That is neither reason replaced by faith (a kind of fideism) nor reason without faith (a kind of dreary rationalism). Reason informed by faith means that faith provides the context or background for the exercise of human reflection. In this sense it yields general perspectives that influence our insights but do not preprogram our judgments.

There are many components of the Catholic moral vision as this vision is at play in health care delivery. For instance, in this vision life is a basic good — as the condition for all other experiences — but not an absolute one. It is not absolute because there are higher goods for which life can be sacrificed (glory of God, salvation of souls, service to one's brethren, etc.). Thus, "[t]here is no greater love than this: to lay down one's life for one's friend." Laying down one's life is, after Jesus' example, life's greatest fulfillment, even though it is the end of life as we know it. We could word this judgment as follows: death is an evil but not an unconditioned or absolute one.

This value judgment has immediate relevance for care of the ill and dying. It issues in a basic attitude or policy: not all means must be used to preserve life. I do not wish to pursue

2. SECOND VATICAN COUNCIL, Gaudium et Spes no. 11 (1965).
3. ST. THOMAS AQUINAS, SUMMA THEOLOGIAE, I-II, Q.91, A.2c.
the further casuistic details of this judgment here. My sole point is that Catholicism, in its religious sources, yields a perspective that forms the basis of a moral vision. It informs our reasoning.

Let me address another component of this vision. In a 1953 address to the International Congress of Anesthesiologists Pius XII stated: “Life, health, all temporal activities are in fact subordinated to spiritual ends.” In other words, there are higher values than life in the living of it. There are also higher values in the dying of it.

What are these “ends?” What is this “higher, more important good” to which Pius XII referred? One answer can be given in terms of love of God and neighbor. Such love sums up briefly the meaning, substance and consummation of life. As Matthew puts it on the lips of Jesus: “On these two commandments the whole law is based, and the prophets as well.” One scarcely needs to belabor the point in the biblical accounts. Charity is the epitome of the entire law. It is more elevated than all charisms. It is the bond of perfection.

What can easily be missed is that these two goods are not separable. Our love of neighbor is in some real sense our love of God. The good our love wants to do Him and to which He enables us, can be done only for the neighbor. It is in others that God demands to be recognized and loved. If this is true, it means that in Christian perspective, the meaning, substance and consummation of life are found in human relationships.

The primacy of human relationships in the Christian moral vision does not solve concrete problems. But it does shape our reason as we go about the messy work of problem-solving. It reminds us that welfare values (having things), important as they are, are subordinate to dignity values (being regarded and treated justly, fairly, with respect, etc.). That is why, for the Christian, “quality of life” refers primarily (not exclusively) to dignity values.

Another component of the Catholic moral vision is our essential sociality. In the Judeo-Christian story God relates to and covenants with a people. As Christians, we live, move and have our being as a group, an ecclesia. Our being in

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7. See, e.g., Galatians 5:14.
8. See, 1 Corinthians 13.
Christ is a shared being. We are branches of the same vine, sheep of the same shepherd.

This vision underscores our radical sociality and within it, our essential equality regardless of functional importance. These dimensions of our being powerfully suggest (faith informing reason) that our well being and the rights that protect this flourishing cannot be conceived in isolation from others. Furthermore, our radical equality should exercise a steadying and restraining influence as we deliberate about the problems of a just health care system.

More particularly the above dimensions that I have lifted from the Christian story mean that beneficence must be tempered by autonomy (the good of the patient is not defined by medical beneficence alone) and that efficiency must be tempered by justice (the good of patients is not defined by efficiency alone).

I have lifted out three components of the Christian story to indicate how they can and should influence our insights, shape our reasoning. I have done so in order to lay the groundwork for a brief consideration of three contemporary threats to this vision. These threats can have the effect of blurring the Christian vision of who we are, where we come from, what constitutes our good. In other words they can replace faith’s shaping of reason with infecting elements.

I. DEPERSONALIZATION

There are three factors at work in the way we perceive and respond to health care problems. First, there is the growth of technology. Everything from diagnosis through acute care to billing is done by computer. Check the advertisements in any medical journal and it becomes clear that medicine and the machine are wed. This gives efficiency but inevitably some impersonality.

Second, there is cost and cost-containment. Spiraling costs are due to many factors (e.g., sophistication of services, higher wages, more personnel, cost pass-along systems, inflation). In 1976, for example, expenditures for health constituted 11.4 percent of the gross national product. Of this sum, 91 percent went into health care systems, 3 percent to human biology, 1 percent to life style, 5 percent to environmental factors. Obviously, the cost factor will force difficult decisions. Shall we rescind federal coverage of end-stage renal disease? Must we eventually exclude some classes of infants from neonatal intensive care?
The third factor is the multiplication of what I will call "public entities" in health care delivery. I mean attorneys, courts, and legislatures. Thus we have legislated living wills; we have had a series of trial cases: Quinlan, Saikewicz, Fox, Spring, Severns, Perlmutter, Conroy. We have the *Roe v. Wade*\(^{10}\) and *Doe v. Bolton*\(^{11}\) decisions of the Supreme Court. These are but the protruding tips of the icebergs.

Together these factors affect the very matrix of the healing profession. This matrix roots in the conviction that patient-management decisions must be tailor-made to the individual, to the individual's condition and values. They are *personal* decisions that must fit the individual like a glove to a hand. Yet the three factors mentioned above are rather *impersonal* factors. When they begin to pre-program our treatment, they tend to depersonalize that treatment. There are those who argue that "fixing" occurs in hospitals but that genuine healing occurs elsewhere. This drift touches every problem area and limits the available responses by framing the questions one-sidedly. Adverting to this problem may be half its solution, just as inadvertence will only compound it.

II. THE MARKET-DRIVEN SYSTEM

By "market-driven," I mean institutions whose existence and policies are heavily controlled by the economic factor. The environment of the contemporary Catholic health care facility is competitive. The signs of this are multiple. Hospitals have marketing officers. They experience pressure from Health Maintenance Organizations (HMOs), which will increasingly feel pressure from Preferred Provider Organizations (PPOs). They have a keen eye on Diagnosis-Related Groups (DRGs). They are increasingly all but forced into joint ventures. Essential services do not support themselves. The dumping syndrome is alive and well. Acquisition decisions, hiring practices and incentive proposals are often straightforwardly market-related, etc.

At present, hospitals are literally slopping around in the glare of three unanswered questions:

- What resources (time, energy, money) should be put into health care and into other social goods (education, defense, environment, poverty elimination, etc.)?

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Within health care, how much time, energy, money should go to preventive vs. crisis or rescue medicine?

Within either category (prevention, rescue) who should receive resources when we cannot meet all needs?

Until such questions are answered, hospitals will continue to struggle as triage agents for Medicare, Medicaid, DRGs, third-party payers, physicians, government pressures. And of course, struggle means preoccupation and preoccupation means the subordination of mission to the economic factors that are its condition of possibility. “No margin, no mission.” In such an atmosphere what is likely to inform or shape reasoning?

III. Secularization of the Medical Profession

By “secularization” I mean the divorce of the profession from a value tradition. Concretely, I refer to an increasing independence from the values that make health care a human service, one altruistically conceived and delivered. The factors I have already discussed (depersonalization, market-driven system) mean that physicians are enormously preoccupied with factors peripheral to and distracting from holistic human care. One fears that the result of this will be the gradual transformation of medicine from a profession to a business. We are already seeing this happening. This transformation (already lodged in our language: provider, consumer) means that medical judgments will increasingly be penetrated by and even controlled by business principles. When this happens we will be the sad witnesses to the loss of soul by a noble profession. And from my perspective in these remarks we will witness the transformation of a notion ("the Christian physician") into an oxymoron.

In this issue of the Journal, Dr. William Roper, the administrator of the Health Care Financing Administration which oversees the vast Medicare and Medicaid programs, documents the increasing cost of medical care. Dr. Roper’s prescription for curing this malady is market-based, believing that competition not only contains costs, but also preserves quality. Moving the discussion to questions of ethics, law professor Barry Furrow posits the need for a new "advocacy beneficence" which would strengthen the moral, fiduciary obligations of doctor to patient in light of new methods of delivering health care. Authors Sharkey and Buckle from Johns Hopkins are especially concerned with the impact of the prospective payment system on the frail elderly. Building on recent Pennsylvania legislation, these authors would re-
calibrate the prospective payment system to make it sensitive not just to the cost, but also the effectiveness of the services rendered. The essay by former Colorado Governor Lamm provokes a re-examination of whether extraordinary health expenditures can be justified in light of scarce resources. Lamm is skeptical of what he calls the “mindless” pursuit of medical technology at any cost. James Schepers, a present third year student, addresses costs associated with a particular form of malpractice. Finally, recent law school graduate Nancy Burke attempts to apply the religious obligation of being a “healing force” to evaluate the sufficiency of Health Maintenance Organizations for providing assistance to the poor.

The articles and essays included in this issue are thus quite diverse. These prefacing remarks, therefore, are a kind of plea: that as readers study the rich and provocative studies in this volume they never lose sight of the fact that reason can be informed by many influences, but that from the Catholic Christian Ethical perspective it ought to be informed by faith. When it is not, we have something other than Christian ethics. And that “something other” erodes not only faith, but — if Catholic tradition is correct, as I firmly believe it is — our humanity.