



The Affordable Care Act And Rationing

By CLARKE E. COCHRAN, PhD

Catholic social teaching's attention to the common good has potential for disentangling some of health care's knottiest paradoxes: American health care is both abundant and scarce. Although the U.S. appears to have the least medical-care rationing of any similar country, we legitimately can be described as having more. It's just that our kind of rationing isn't so obvious.

The United States spends far and away the most money on health care of any advanced nation, yet most people find substantial barriers to access. For some, the barrier is financial; for others, it is the system's extreme complexity, or it is the convoluted structure of insurance coverage.

The publication more than 30 years ago of *The Painful Prescription: Rationing Hospital Care*, by Henry J. Aaron and William B. Schwartz, signaled the principal paradox of rationing — namely, all health systems ration care, but they do so in different ways.¹ In the U.S. system, practices that amount to rationing are so indirect or even hidden that most citizens and political leaders don't believe rationing exists — yet it is pervasive.

Strictly speaking, “rationing” refers to the denial of beneficial medical care for nonmedical reasons. Thus, denying a medical intervention to a patient would not be rationing if that intervention provides no medical benefit. Example: A physician who refuses to perform an appendectomy on a person without appendicitis would not be rationing the care. However, denying an appendectomy to a person with appendicitis because she could not afford to pay for the procedure would be both rationing and unjust.

Those examples, of course, are extreme. More common examples are not hard to find. Drug shortages sometimes mean that physicians can-

not prescribe the most effective medicine, for reasons unrelated to the medical condition of patients. We tend to believe that such occurrences are rare and remediable if only more resources were devoted to, for example, drug production. They are, however, endemic.

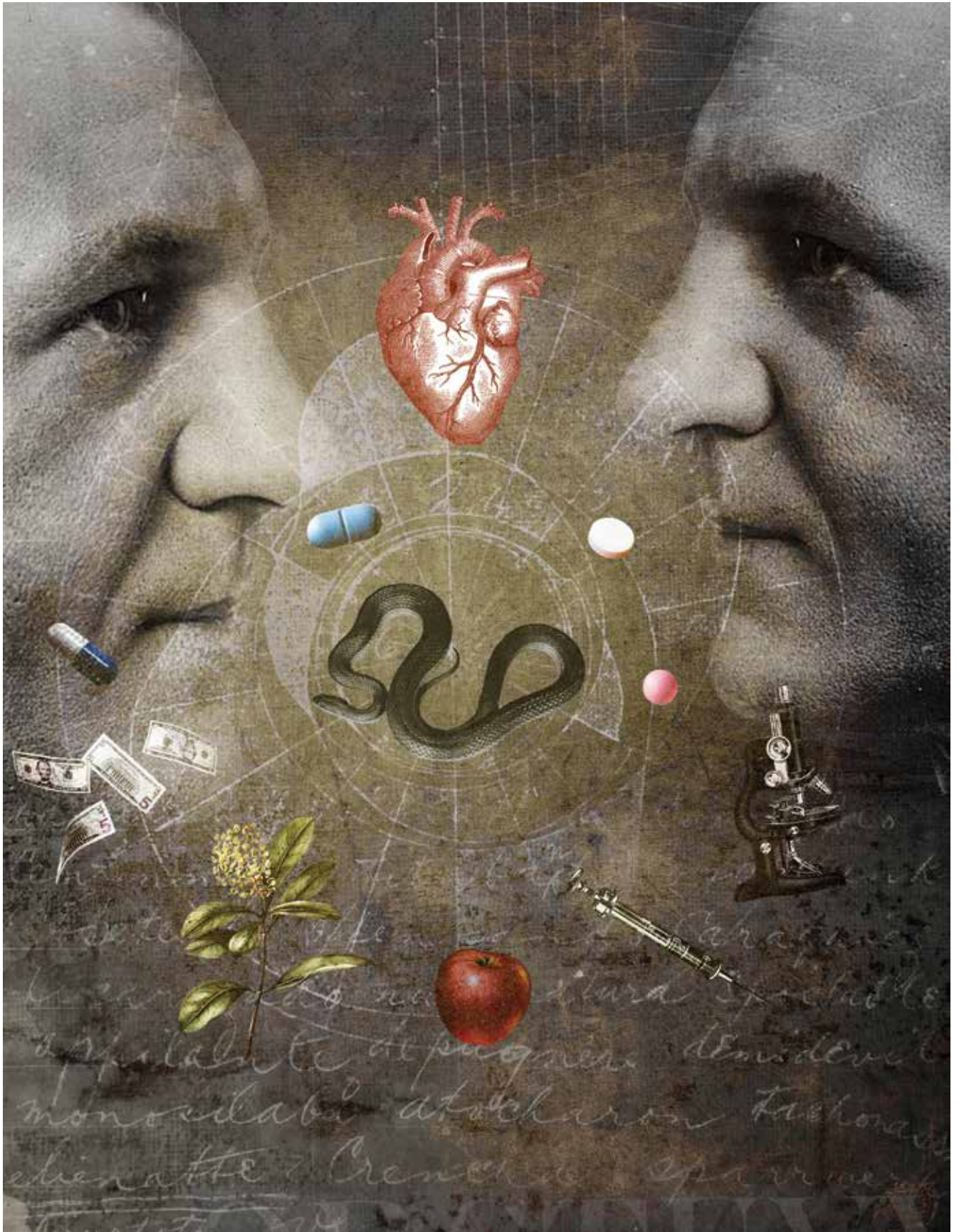
DIRECT VERSUS INDIRECT RATIONING

Direct rationing means that beneficial treatments are denied or made unavailable by conscious decisions. Rationing is explicit and direct when the decisions are public and transparent. In many nations, for example, there are boards or commissions that make public decisions not to cover certain medications, even if beneficial, because they are too expensive for the benefit conferred. This

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form of rationing occurs relatively infrequently in the United States.

Rationing is indirect when beneficial care is not explicitly denied, but nevertheless is unavailable or difficult to access. This occurs so frequently in the U.S. as to be characteristic. Thus, many persons are unable to access care because they cannot afford it, or because they cannot afford health



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insurance, or because public subsidies are unavailable. There is no person or commission or board that explicitly denies care. The denial is hidden and impersonal, but it is altogether real.²

Rationing happens when the different forms of insurance available to people because of age, employment or other status offer different coverage (Medicare versus Medicaid versus veterans' health care programs versus private insurance). Rationing also happens because the U.S. health care system is too complex to navigate for people of limited ability or financial resources. Thus, rationing is widely practiced in the U.S.; however, Americans perceive it not as rationing, but the unfortunate, unavoidable nature of a modern, individually oriented, free enterprise system.

PARADOX OF RATIONING

Paradoxically, the United States is evolving rapidly both toward and away from rationing. Evolving health care delivery systems, such as account-

able care organizations and health maintenance organizations, both within Medicare (Medicare Advantage) and outside it, are forms of direct rationing, as are individual and employer-based insurance policies that include high deductibles, or "narrow networks" of providers, or both. So, too, are drug formularies with limited choices or higher co-pays for certain pharmaceuticals. So are pre-approvals for medical devices or procedures. Each example involves direct rationing, because it restricts or delays access to actual or potentially beneficial providers, procedures or drugs.

This evolution toward more explicit rationing, though it never is called such, began prior to the Affordable Care Act, but the ACA incorporated many of the developments or encouraged their more rapid deployment. Yet explicit policy decisions by Congress and by the Centers for Medicare and Medicaid Services also moved away from direct rationing. Examples are: decisions to increase access to experimental drugs by patients with advanced stages

ON THE COMMON GOOD

Me personally, I suspect the secret of the common good is a roaring mortifying teeth-rattling humility. The more we remember that we are small and fragile and brief, that we understand a mere jot and tittle of the miracle of What Is, the less we would be arrogant and violent and racist and sneering and so bloody fearful of the Other. The common good is the word mercy. The common good is each reaching for each. The common good is food on the table and a job and not getting shot at. The common good might be the whole point of human evolution. Could we evolve into a species characterized by mercy and humility, creativity and humor, imagination and innovation? Could we outwit violence? Is that so unthinkable? Could we evolve to a thorough and delighted reverence? Why not? Really and truly: why not? Why settle for savagery?

— *Brian Doyle, poet*

A WAY FORWARD

Physicians, health policy analysts, academicians and politicians have considered health care rationing for at least 40 years. The recommendations below represent one approach derived from a focus on the common good.¹ They aim to change health care culture from “more is better” and “the latest is greatest.” They encourage patients, families, medical professionals and ordinary people to adopt “voluntary rationing” — limiting expectations and demands on the health care system, accepting more personal responsibility and acting for the common good.

Each relies on slowing access to new drugs and treatments, for two reasons. First, new technological innovation in medicine (drugs, devices and procedures) is the principal driver of health care cost inflation. That inflation in turn drives unfair forms of rationing. Second, until all have fair access to standard and proven forms of medical care, it is a violation of the common good to drive demand and resources toward newer and less-proven forms of care.

1. Comparative effectiveness research with teeth. New drugs, devices and procedures are introduced constantly into the American health care system, sometimes with minimal evaluation. Moreover, even pharmaceutical regulation focuses on safety, with barely a marginal change in efficacy over current standards sufficient to allow its introduction into the market. Comparative-effectiveness research that explicitly considers the cost of new treatments, as well as safety and efficacy, could change that pattern, especially when combined with #2.

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New technologies with high costs and marginal improvement in outcomes should meet a high barrier. The beneficial effects should substantially outweigh any harms. The standard for acceptance should include the common good by maximizing the health of the population served, not only the individual patient, subject to available resources.

2. Reduce diffusion of insurance coverage for new technologies. This strategy is anticipated by #1 above. Medicare, which often leads the way in covering new technologies, should be slower to approve them. More time for research on effectiveness and cost as actually represented in the field should be required even after comparative effectiveness research based on experimental environments. Medicaid and private insurance should follow Medicare’s lead on this.

3. Slowing medical research and development. This recommendation is deeply heretical in the current environment. However, allocation of fewer, rather than more, federal research dollars to medical innovation would allow more robust comparative effectiveness research on current modalities and slow the

diffusion of new technologies.

4. Capping the tax exclusion of medical expenses for businesses and individuals. This conservative policy recommendation also would slow diffusion of new technologies. The current tax treatment of health insurance and, to a lesser extent, of medical expenditures encourages purchasing the most generous coverage an individual or company can afford. The ACA’s “Cadillac Tax” goes some way in this direction. The fact that it is unpopular and under attack by both Republicans and Democrats is instructive about the challenge of fair allocation.

Insurance policies could include “value-based” coverage in which copayments would be higher for more uncertain or limited efficacy technologies compared to the current standard of care (which would have little or no copayment).

5. Attend to the social determinants of health. When choices among social resources must be made (as they always do), the social and behavioral determinants of population health have a claim on health care resources. Examples of these determinants are: smoking, substance abuse, clean air and water, good wages and availability of healthy foods and safe housing. Reducing the pace of health spending allows more investment in other dimensions of the common good.

NOTE

1. The principles here owe a debt to a series of articles by physician David M. Eddy in the 1990s. Especially helpful is “Principles for Making Difficult Decisions in Difficult Times,” *JAMA* 271, no. 22 (June 8, 1994): 1792-96.



of cancer; rapid coverage of new technologies and drugs by Medicare and private insurance; and fast-track approval of new drugs.³

Moreover, the evolution of the delivery and insurance systems toward patients having more economic “skin in the game,” in the form of increased deductibles and copayments, increases the proportion of health care costs covered out of pocket. The result imposes indirect rationing on insured persons of limited means who, previously, had few such costs.

SCARCITY, ABUNDANCE, IMPERATIVES

When it is justified, rationing reflects both the scarcity of a resource and a fair method of allocating it. For example, the presence of lead in municipal water supplies makes safe water a scarce commodity and justifies forms of rationing (queuing for bottled water) and fair procedures (allocating safe water by family need, not by income or race or gender).

Health care in the United States is both scarce (justifying rationing) and abundant (making rationing unnecessary). Our system spends the most money on health care of any similar nation, whether in absolute dollar terms, per capita or as a percent of gross domestic product. Resources for health care are so abundant that we can “afford” to waste billions of dollars in excess medical equipment, unnecessary tests and procedures and administrative paper/electron shuffling.

To justify rationing, there must be a real, not artificially created, scarcity of a resource; a real, not artificially created, conflict between resources needed for health care and those needed for other important social and personal goods. Some areas of health care are resource-starved — primary care, mental health and public health, for example. In response, there are substantial movements to put some parts of health care on a diet to release resources for other priorities. Examples: campaigns for “parsimonious care” and “choosing wisely.”⁴

Effective rationing schemes require trust that allocation procedures are fair and transparent.⁵ Because we are in an era of pervasive mistrust of public and private institutions, recovery of the common good is an indispensable founda-

tion for restoring trust and living with health care tensions.

Catholic health care knows that God demands social justice in health care. Current structures of rationing, direct and indirect, violate justice. Therefore, it is incumbent upon followers of Jesus the healer to ensure that such illness and injury as exist this side of paradise are not the fault of injustices we create or tolerate.

But why ration at all? Do not abundant resources guarantee that all needs can be met so long as resources go fairly to all? Would not that satisfy justice?

It might, if justice were the only consideration. Trustworthy and fair rationing requires justice; however, justice focuses only on specific trade-offs among health care resources. The common good directs us to the larger social context of

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health care, moving us beyond the limitations of justice. The common good balances all the realms of personal and social necessity, not simply health care. Moreover, specifically in the American context, the common good points to solidarity, which is too frequently neglected in our focus on individual autonomy. When the individual — whether patient or provider — is the touchstone for justice claims, the result too often is competing absolutist claims about “my right” to the latest pharmaceutical versus “your right” to long-term chronic care. The common good moves beyond rights and individualism to furnish the foundation for trust.

PUBLIC POLICIES

Catholic social teaching demands that public policies and officials have as their aim the formation of the common good, which is not an aggregation of individual goods or interests, but, rather, a flourishing common life among citizens.⁶ The common good is the web of personal goods, social structures, institutions, organizations and re-

relationships that constitute the community itself. When these are healthy and interconnected, persons in community relate to one another in mutual support and protection.

Health care is a foundational constituent of the common good, because healthy persons are more able to build the institutions and structures of common life. Robust attention to public health affirms that all are valuable members of the community. Similarly, universal access to curative and preventive health services upholds the dignity of each person and his or her equal membership in the community.

The common good requires that health care be in balance with other vital social needs — education, transportation infrastructure, public safety and so forth. However, the abundance of resources devoted to health care means competition for public and private resources available for education, roads and bridges, job training and many other worthy areas of society. Health care's bloat contributes to the common good's deprivation.

The balance of health care and other social needs entails that individuals and groups live within limits. If society needs safe water treatment and structurally sound bridges, it should be ready to accept fewer new and expensive medical treatments. Both medicine and bridges are important goods, but we cannot have all we might want of each. Thus, the common good directs persons and society to live within the creative tensions among goods. Members of a community owe it to each other to take responsibility, to the degree that it is within their capability, to care for their own well-being by adopting healthy patterns of living. In doing so, they do not unfairly absorb resources from the common pool. That means particular persons or groups may not receive *all* the medical care (or education or recreation or transportation alternatives) that they prefer or need.

Thus, health care is *part* of the common good; that is, the ensemble of goods required for a flourishing community. In addition to being part of the common good, health care also is a means to the common good. When members of society become ill or injured, access to health care becomes one of the corporal works of mercy, affirming again common humanity and common human dignity, even in the indignities of illness. In these cases, health care becomes a sacrament of companionship and accompaniment in the midst of suffer-

ing, affirming again the sick person's continuing membership in common life and restoring ability to contribute to the common good to the fullest extent possible.⁷

Health care providers rightly see much of their own effort, creativity, caring and entrepreneurship as a major part of the health care system. They sometimes resent submerging their individuality to the common enterprise. ACOs, patient-centered medical homes, bundled payment methodologies and other experimental delivery structures feature teamwork, cooperation and solidarity as cultural and institutional cement for creating successful models of delivery. These models implicitly recognize health care as a part of a common good and also as a means to the common good. The controversies swirling around their creation and the evaluation of their successes and failures testify to the essential tension between a culture of individualism and the requirements of the common good.

The ACA recognizes the common good's insistence on universal health insurance and therefore access to health care for all citizens. Its primary goal and chief accomplishment has been to reduce the number of uninsured and underinsured persons.

Moreover, the ACA nods toward recognizing limits and embraces experiments toward eliminating wasteful or marginally useful care, experimenting with ACOs and patient-centered medical homes.

HURDLES REMAIN

Though the health reform act begins to pull down the vast U.S. network of indirect rationing by income and insurance status, it does not altogether eliminate that network and its enormous and complex hurdles for the less adept and less affluent. The ACA is so cumbersome in execution that it has not realized its enrollment goals on the individual and small business markets. In some ways, the ACA has increased complexity barriers.

Unfortunately, the ACA's commitment to solidarity and the common good stops at undocumented immigrants, and the U.S. Supreme Court's limitation of the ACA's Medicaid provisions unjustly declares that the common good in many states does not include the working poor.

The ACA's success has come primarily by reducing the number of uninsured. Its mecha-



nisms for reducing costs and waste (reliance on prevention, value-based purchasing, changes in payment and delivery models and greater reliance on electronic health records) have had mixed results and point to an uncertain future for sustainable spending levels. Yet, if health care spending doesn't come under control, hidden forms of rationing will remain in the system.

Democrats principally focus on the successes of the ACA and Republicans on its failures. Neither political party is willing to touch rationing; both prefer individual interests to the common good. They fail to understand different forms of rationing and the bearing of common good on fair allocation of risk, responsibility and reward.

Reviving a robust understanding of and commitment to the common good facilitates preservation of the best parts of the ACA and allows for reform of its inefficiencies and shortcomings. The common good also suggests an approach to rationing that improves the ACA and the restraint necessary for sustainable health care in balance with other essential social goods.

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NOTES

1. Henry J. Aaron and William B. Schwartz, *The Painful Prescription: Rationing Hospital Care* (Washington, D.C.:

Brookings Institution, 1984). See also Norman Daniels, "Why Saying No to Patients in the United States Is So Hard," *New England Journal of Medicine* 314, no. 21 (May 22, 1986): 1380-83.

2. For a dramatic example, see the description of queuing for health care described in Jeff Tieman, "Health Reform Initiatives — Will Your Number Be Drawn? Welcome to the Health Care Lottery," *Health Progress* 90, no. 3 (May-June 2009): 4-5.

3. See, for example, "James D. Chambers and Peter J. Neumann, "Listening to Provenge — What a Costly Cancer Treatment Says about Future Medicare Policy," *New England Journal of Medicine* 364, no. 18 (May 5, 2011): 1687-89.

4. See the debate over "financial stewardship," "parsimonious care," and "choosing wisely." For example, Jon C. Tilburt and Christine K. Cassel, "Why the Ethics of Parsimonious Medicine Is Not the Ethics of Rationing," *JAMA* 309, no. 8 (Feb. 27, 2013): 773-74, and Leonard M. Fleck, "Choosing Wisely: Is Parsimonious Care Just Rationing?" *Cambridge Quarterly of Healthcare Ethics* 25, no. 3 (July 2016): 366-76.

5. For more on trust and rationing, see Clarke E. Cochran, Joel Kupersmith and Thomas McGovern, "Justice, Allocation, and Managed Care," *Health Progress* 81, no. 4 (July-August, 2000): 34-37, 41.

6. Clarke E. Cochran, "The Common Good and Healthcare Policy," *Health Progress* 80, no. 3 (May-June, 1999): 41-44, 47. See David M. Craig, *Health Care as a Social Good: Religious Values and American Democracy* (Washington, D.C.: Georgetown University Press, 2014).

7. I owe some of this language to conversations with M. Cathleen Kaveny in the late 1990s; accompaniment is a major theme of Pope Francis.

QUESTIONS FOR DISCUSSION

Clarke Cochran observes that the American health care system is riddled with practices that amount to rationing of care, but the practices are so indirect or hidden that most citizens and political leaders don't believe rationing exists.

Indirect rationing, Cochran explains, means beneficial care is not explicitly denied by a commission or panel, but nevertheless it is unavailable or difficult for people to access. Examples: people who can't get care because they can't afford it, or they have no health insurance or public subsidy that will help them gain access. Or, a health care system that is so complex that some individuals can't figure out how to go about getting the care they need.

- Can you think of everyday practices in your ministry that could be seen as indirect rationing?
- Consider Catholic social teaching. How is access to health care a fundamental aspect of the common good? What are the balances and trade-offs? How might health care practices sharpen their focus on the common good?

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