FEATURE ARTICLE

Disruptive Germination in Health Care

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> *I tell you the truth, unless a kernel of wheat falls to the ground and dies, it remains only a single seed. But if it dies, it produces many seeds. The man who loves his life will lose it, while the man who hates his life in this world will keep it for eternal life.*
> JOHN 12:24-25

THE SEEDS OF TRANSFORMATION for U.S. health care are in the heart of every health care provider who wants to make a difference in the lives of patients. The only way for these seeds to reach their potential is through the miraculous cycle of death and rebirth.

An apt metaphor

In the previous issue of *Health Care Ethics USA,* John Glaser very aptly describes the financial and ethical dependency of hospitals (fruit) on the blighted, socially sinful tree of U.S. health care.[1] He suggests that our outward focus on the uninsured (as a major source of health care malaise) may prevent us from accurately perceiving how we, despite good works and the best of intentions, are benefiting from and contributing to the immoral state of U.S. health care. Glaser concludes that without radical reform of U.S. health care, long-term Catholic health ministry will be but an empty shell. Rather than reiterating the entire list of social sins in health care that Glaser identifies as shaping the organization of our ministry, I will focus on just one:

> Where we should **exercise discipline and restraint in health care** because it accounts for only 10 percent of a community's health,[2] relative to other factors (education, employment, environment, housing, etc.)—we vigorously pursue strategies and programs from a stance of "more."

More margin = more focus

Every hospital in the country offers a spectrum of services that are both profitable and unprofitable. The only way for hospitals to stay in business, over the long haul, is to offer more money-making than money-losing services. Of course, out of a sense of mission, we continue to provide some important programs at a loss. This ministry is made possible through subsidization by the margin-generating activities. The survival of our health care ministry depends on the wise stewardship of resources, accountability, and rigorous business practices. The pursuit of margin to support ministry is a noble one and we must all become comfortable with this. On the other hand, if our pursuit of margin supports specific ministries but undermines the greater mission, we need to take a step back and reassess what we are doing. What indeed is our mission? Is it not to improve lives and relieve suffering in as many people as possible?

Our current model of reimbursement pays generously for the use of certain tools and interventions that reduce short-term, acute suffering. Examples of activities that are paid for generously (though less so over time as resources become increasingly scarce) include high-tech imaging services, interventional cardiology, and various surgical specialties. Unfortunately, activities that have a far greater impact on improving health and preventing suffering (both acute and chronic) receive meager compensation. Examples of highly beneficial activities that are comparatively under-funded include smoking cessation, health coaching for success in needed behavioral and lifestyle changes, and disease management. Responsible business practices dictate that we will expand the former (profitable) services and limit the latter (unprofitable) services—particularly since the latter reduces the need for the former. Here's the rub. The greater good (the mission) is undermined by the lesser good of pursuing profits via ministering to acute, short-term needs. Otherwise stated, the mission is sacrificed on the altar of perpetuating ministry.

How did we end up in this tangled state of affairs? How is it that mission and ministry can be at odds with each other rather than being completely compatible, if not synergistic? To answer this we must return to the contention by Glaser that we are financially and ethically dependent on a diseased tree. Until society adopts our values, we are put in the

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awkward position of adopting society's values to survive. By values, in this context, I am specifically referring to the valuation of services—the economic value equation that pays pennies for prevention and health promotion compared with thousands of dollars for disease-based interventions. Interestingly, our values and societal values share something in common—the relief of human suffering. The major difference is that U.S. health care providers, because they are competing for limited resources, are continually seeking to maximize profit per unit of suffering relieved. Our mission and values dictate that, in the face of limited resources, the maximum amount of suffering can be relieved if expenses and profits are minimized per unit of suffering.

A new measure of mission?

While human suffering is multidimensional, and the relief thereof is challenging to quantify, the simplest way to measure success may be a function of quantity and quality of life. By combining a longevity factor and a quality factor, researchers have come up with what are referred to as Quality Adjusted Life Years (QALYs).* At the most basic level, our mission is successful if we maximize QALYs. Obviously this doesn't even begin to take into account the impact of pastoral care that lifts the spirits, and the personal touches from multiple interactions that we can't measure. However, if it is true that we manage what we measure, shouldn't we track some global metric like QALYs to manage our ministry? If so, I suspect we would be more effective in achieving our mission and in documenting community benefit. In an environment of increasing regulatory scrutiny, the need for not-for-profit hospitals to persuasively document community benefit has become more important.[3] What better way to document community benefit than QALYs?

Revitalizing the mission through new ministries

As a health care provider, I entered the field to make a difference in the lives of people. It matters not if you are a direct care provider, provide operational support, organizational leadership, ethical guidance, or janitorial support. As part of the health care ministry, we all aspire to have a positive impact in the lives of the people we serve. Each of us, individually and collectively, contributes to the healing ministry of Jesus in the 21st century. However, when we recognize our complicity in a system that indirectly perpetuates human suffering and dependency through superficial fixes, we are faced with an important existential question. The answer to this question has life-changing, career-altering, and society-impacting consequences. Will we cling to the diseased tree that feeds us or will we let go and give the seeds of transformation within us an opportunity to birth a new tree? Germination cannot occur as long as we remain attached to the diseased tree.

Recognizing that the future of our mission as faith-based organizations is trapped in the hearts of our providers, we must find or create opportunities for those seeds to germinate, to sprout, and to grow into new ministries. Even though this can be disruptive and may compete with existing ministries, we must nurture the growth on which the future of our mission depends. Are we ready to do this? How will we do it?

Health assurance before health insurance

Insurance, by definition, provides for the means to handle an adverse outcome. Our mission, in the broadest sense, is to reduce the adverse outcome of human suffering. We can have a much greater impact (with the same resources) through proactive activities that promote health than through reactive interventions that mitigate adverse outcomes. If we are looking for fertile ground for new ministries, we should encourage people to dream more about universal health assurance than universal health insurance. Rather than just thinking of chronic disease and disease management, we should emphasize chronic wellness and wellness management.

Apologies to giants—selfless dreams

Glaser closes his article with hopes and dreams for the role we can play in transforming U.S. health care. With apologies to John F. Kennedy—ask not what health care can do for you; ask what you can do for health care. There's nothing greater you or I can do for health care than to dream. Dream big dreams, and then give them life—your life, your passion, your creativity. With apologies to Martin Luther King Jr., I have a dream, a dream that someday health care interventions will be judged on the basis of their character and their ability to make a difference, not just on their color (as in their contribution to the bottom line). I have a

* Every year of perfect health gained as a result of an intervention constitutes 1.0 QALYs. However, if quality of life is compromised by illness during that additional year lived, the number of QALYs would be some fraction of one depending on the severity of illness. A more detailed explanation of QALYs and cost effectiveness can be found at www.tufts-nemc.org/cearegistry/overview/glossary.asp.

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dream that someday in health care we'll move beyond doing things right to doing the right things. I have a dream that someday soon health assurance will be more important than health insurance and we will promote chronic wellness. I have a dream that the seeds of change will find fertile ground, germinate, sprout, and grow into a tree that touches the sky. ■

NOTES

1. John W. Glaser, "Catholic Health Ministry: Fruit on the Diseased Tree of U.S. Health Care," *Health Care Ethics USA* 15, no. 1 (Winter 2007): 2-4.
2. J. Michael McGinnis, Pamela Williams-Russo, and James Knickman, "The Case for More Active Policy Attention to Health Promotion," *Health Affairs* 21, no. 2 (March-April 2002): 78-93.
3. DM Studdert, MM Mello, CM Jedrey, and TA Brennan, "Regulatory and Judicial Oversight of Nonprofit Hospitals," *New England Journal of Medicine* 356, no. 6 (Feb. 8, 2007): 625-631.

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