FEATURE ARTICLE

Catholic Health Ministry: Fruit on the Diseased Tree of U.S. Health Care

The 80/20 Law of Organizational Ethics

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In this article I want to explore the interdependent relationship between the ethics of a society and the ethics of organizations that flourish within that society. Specifically, my focus is on how the ethics of U.S. health care shapes and limits the ethics of Catholic health care institutions.[1] My conclusion: *long-term, Catholic health ministry will be an empty shell, absent radical reform of U.S. health care.*[2]

I share the following thoughts as one immersed in this troubling reality, a beneficiary and agent of its injustices more than others because of my longevity and responsibilities for ethics and mission.

An important qualifier to this reflection concerns how mainstream and successful an organization is within its society. The "mainstream quotient" is measured by the number and intensity of connections the organization has to the major institutions of a society-finance, law, professionals, education, labor, media, government, etc. So, a soup kitchen would be marginal to society and little subject to the moral dynamics that follow; a large health care system, on the other hand, would sit in the bull's-eye of society's mainstream, and the more successful it is, the more the considerations below would apply.

I will view this interdependence of society and organization through three windows—an image; an historical example; a conceptual examination.

An image: fruit on a diseased tree

Like all metaphors, this one is thin and fragile. The one burden I want it to carry is this: fruit on a diseased tree bears the blight of its source; so too, our ministries are infected by the systemic ailments and injustices of U.S. health care. The tree on which we grow is not biblical ministry but American health care. We are, at best, only marginally more just than those systems within which we flourish. Below, I will attempt to spell out some specifics of this concern.

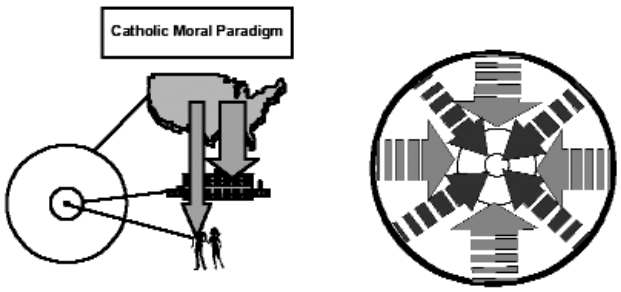
An historical example: the Mennonites in South Carolina
An historical event also illustrates with striking clarity this interdependent relationship between the ethical character of society and the ethical parameters of organizations within that society. It is about a Mennonite group's attempt to run a slaveless plantation in the 17th century South.

> In December 1696, thirty families of Anabaptists arrived (in South Carolina) from Maine. . . . The "dissenters," who protested the ways of the Anglican Church, began to build their community, refused to buy slaves, and relied on their own labor. . . . Their renunciation of the slave business set the New Englanders apart from other white Carolinians—so far apart, evidently, that after ten years the settlement failed. *The dissenters could not build a settlement based on free labor in the midst of a captive society.* (Emphasis added.) In 1708, shunned by their peers, the Anabaptists began to sell off their land, and within a few years they left. With that, the single local pocket of antislavery disappeared.[3]

Their dream of a just organization amid injustice might have succeeded had it been more modest and marginal—for example, a blacksmith shop or a small plantation with only a few, well-treated slaves. But a full-blown plantation without slaves—this degree and magnitude of mainstream counterculture was a formula for failure.

A conceptual examination: the 80/20 law of organizational ethics

We can also look at this reality in some traditional categories of moral thought-principles, systematic constructs, and mental models.



- *For a mainstream, thriving organization 80 percent of its ethical character is beyond its immediate and direct control.*
- *This 80 percent is shaped by the social systems and structures within which it succeeds. This is true of hockey teams, five-star restaurants, hotel chains, and health care institutions.*
- *What we normally identify as the ethics of an organization deals with the other 20 percent within its grasp.*

A framework for clarifying this principle of 80/20 is found in a three-realm model of ethics that I have proposed.[4] The important aspect of this model for our discussion is this: the major institutions of society (law, finance, business, politics, etc.) exert direct, immediate, and powerful pressure on mainstream organizations for conformity to their structures and priorities. A mainstream organization, regardless of its own mission and self-understanding, that is unwilling or unable to substantially conform to these structures and priorities, will be marginalized or eliminated.

To return to our South Carolina example: long-term, these major institutions can indeed be dramatically transformed through arduous social movements—as in abolition, women's suffrage, civil rights. But short-term, a slave society will destroy substantive organizational non-conformity.

Closer to our concern with health care, Rober Kuttner has commented on this phenomenon. "All segments of the health care industry and profession, even those with a sense of mission very different from that of for-profit enterprises, found themselves in a new world where the pursuit of market share, the development of referral networks, the search for profitable admissions and subscribers, relentless cost cutting, and other practices pioneered by shareholder-owned firms came to predominate."[5]

And a press release from a Catholic health system in January 2003 provides a micro example of the kinds of blows (in this case, by the sledge of reimbursement) that inexorably hammer organizations into the shape of society's larger systems and structures:

> Due to major reductions in government reimbursement programs such a Medicare, [name withheld] Health System Home Health Network has announced the elimination of 22 non-direct care positions . . . as part of a financial turn-around of the agency. . . . In addition, it will not fill 14 open positions. . . . Despite these challenges, the [name withheld] Health System is strongly committed to home health as part of our mission. . . . The decision to reduce staff was very difficult, but necessary if we are to preserve our ability to continue providing these essential services to our patients.

U.S. health care as social sin

It seems to me that we too often collapse the disease/injustice of U.S. health care into the issue of "the uninsured."[6] I believe this is like calling a person whose life is riddled with and shattered by addiction a "bad driver." He probably is a bad driver, and we want to help change that! But this narrow, symptom-oriented description misses the broader and deeper pathology that must be recognized and rehabilitated.

Let me offer the barest sketch of this larger social matrix that shapes our organizations of ministry.

- Where we need a clear sense of **purpose and specific priorities** to serve as the foundation for a health care system—we have none. In its place we pile programs atop one another, each trying to patch the torn fabric of past program-cobbling.
- Where we need a **comprehensive, coordinated system** proportionate to the enormity and complexity of U.S. health care (the world's sixth largest economy)—we have thousands of agencies and special interests (including Catholic health facilities) seeking more resources to expand their un-integrated pieces of the action.
- Where **community health leaders should join in collaboration** to assess and strategize about improving the health of the community: assessing needs, establishing priorities, reducing disparities of health, etc.—we have hospital-centric leadership gathering on an institutional basis, in a culture of competition, to strategize about making their individual institutions more successful.
- Where we should **exercise discipline and restraint in**

health care because it accounts for only 10 percent of a community's health,[7] relative to other factors (education, employment, environment, housing, etc.)—we vigorously pursue strategies and programs from a stance of "more."
- Where **rationing should be transparent, accountable and principled** as a constant essential of health care—we chronically bury our rationing, allowing it to be accomplished by blind and brutal social forces, while smugly declaring rationing to be un-American and fit only for foreigners.
- Where **administrative spending should be as small as possible/as large as necessary**—we have a blizzard of bureaucratic and market excess, spending hundreds of billions beyond the requirements of a reasonable system.
- Where a **balanced continuum of body/mind/spirit services is essential**—we fund select areas prodigally while orphaning others of equal or greater need (on any given day, LA County Jail is largest corralling of mentally ill in the U.S.).
- Finally, where the system should provide **sustainable, universal access to a continuum of care**—we see uncontrollably inflated services excluding more and more, with an exclusion preference for the vulnerable.

These are only some of the more obvious elements of U.S. health care that demand our compliance under penalty of extinction. These are a handful of elements that blight the tree on which we grow.

Somehow it doesn't feel that bad!

I have puzzled over why I and my colleagues are not more affronted and outraged by the spread and depth of such injustice. Some reasons for our equanimity amid dense systemic injustice include the following.

- The individual persons in our ministries are so superb. In the presence of such personal goodness it is difficult to see systemic evil.
- Our organizations do so much good.
- We work so effectively and diligently on the 20 percent that is within our reach-organizational ethics, care of the poor, healthy communities, workplace quality, etc.
- Systemic reality, of its very nature, tends to lie beneath explicit consciousness-a given of life, like our breathing or the grammar of our mother tongue. Brining it to the surface is like mining coal-arduous and messy.
- Ours is a world of beleaguered operations and intense action rather than reflection. We have so little time to reflect on the hard-to-get-at systemic infrastructure.
- We have virtually no credible horizon of comparison. What we know of systems in other developed counties tends to be fragmented and distorted.
- But I believe the single most important factor that obstructs our view is our tendency, noted above, *to collapse the injustice of U.S. health care into the problem of the uninsured.* Because we focus on the uninsured as the heart of U.S. health care injustice; because we are such fierce advocates for universal access; because we work so tirelessly to directly serve the victims of "uninsurance"—we experience health care injustice as foreign to us, the enemy-not our image in the mirror.

Hopes and dreams

I have a dream-that I and my colleagues will increasingly recognize the broad, complex, systemic injustice of U.S. health care and the extent to which it shapes the substance of our own ministries. I dream that this will energize us to be leaders in the long-term transformation of U.S. health care. Finally, I hope that the above thoughts will be compelling enough to invite further dialogue and exploration.

NOTES

1. This aspect of organizational ethics was not treated in detail in the recent series of articles on organizational ethics in *Health Progress,* November-December 2006.
2. For an earlier reflection on this theme, see: John W. Glaser and Brian B. Glaser, "Systemic Reform Is Vital to Our Ministry," *Health Progress* 83 (May-June 2002): 16-19.
3. Edward Ball, *Slaves in the Family* (New York: Ballantine, 1999), 92.
   For an account of a more recent medical example, see: Ian Urbina, "Bad Blood: In the Treatment of Diabetes, Success Often Does Not Pay," *New York Times,* 11 January 2006: "With much optimism, Beth Israel Medical Center in Manhattan opened its new diabetes center in March 1999. . . . But seven years later, even as the number of New Yorkers with Type 2 diabetes has nearly doubled, three of the four centers, including Beth Israel's, have closed. . . . They did not shut down because they had failed their patients. They closed because they had failed to make money. They were victims of the Byzantine world of American health care, in which the real profit is made not by controlling chronic diseases like diabetes but by treating their many complications. Insurers, for example, will often refuse to pay $150 for a diabetic to see a podiatrist, who can help prevent foot ailments associated with the disease. Nearly all of them, though, cover amputations, which typically cost more than $30,000."
4. John W. Glaser, *Three Realms of Ethics* (Kansas City: Sheed & Ward, 1994). John W. Glaser and Ronald P. Hamel, *Three Realms of Managed Care,* (Kansas City: Sheed & Ward, 1997). "Three Realms of Ethics: An Integrating Map of Ethics for the Future," in *Educating for Moral Action,* eds. R. Purtilo, G. Jensen, and C. Royeen, (Philadelphia: F.A. Davis, 2005).
5. Robert Kuttner, "The American Health Care System: Wall Street and Health Care," *New England Journal of Medicine* (February 25, 1999): 664-668.
6. Daniel Callahan, *False Hopes* (New York: Simon and Schuster, 1998). John W. Glaser, "'Covering the Uninsured' Is a Flawed Moral Frame," *Health Progress* 87 (March-April 2006): 4-9.
7. 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.