# Literature Review:
## Stewardship or Caritas? On the Economics of Catholic Health Care Ministry

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Increasing economic pressure on Catholic health care ministries in recent decades has inspired renewed conversation regarding the theological bases of our financial decisions. The concept of stewardship has risen to prominence as a foundational commitment guiding our use of limited resources. However, Therese Lysaught argues that an older commitment — *caritas* — is more theologically fruitful. While most agree that a broad array of values is necessary to guide economic decisions in Catholic health care, *caritas* and prudence-infused-by-charity rightly encompass that broad array, and thus, get us much farther in demonstrating our Catholic identity in economic matters than mere stewardship.

**M Therese Lysaught, "Beyond Stewardship: Reordering the Economic Imagination of Catholic Health Care," *Christian Bioethics: Non-Ecumenical Studies in Medical Morality,* Volume 26, Issue 1, April 2020, 31–55, https://doi-org.ezp.slu.edu/10.1093/cb/cbaa002.**

Stewardship has become one of the foundational commitments of the Catholic health care ministry in recent decades. The Catholic Health Association's "Shared Statement of Identity for the Catholic Health Ministry" lists stewardship as a core commitment, as does much of the USCCB's literature, including the *Ethical and Religious Directives for Catholic Health Care Services*.[1] Catholic bioethics literature contains references to stewardship at seemingly every level: patient care, allocation of resources, analysis of novel technologies, organizational ethics, personnel, budgeting, and more. While the USCCB states that stewardship is essential to Christian discipleship, Lysaught is concerned that "Christian discipleship appears to have become yet another form of management, reduced to performing the techniques of accounting, resource management, and maximizing returns."

What's wrong with the concept of stewardship for Catholic health care? Lysaught provides a genealogical analysis of stewardship's rise to prominence in Catholic thought that is quite compelling. From the early days of the Catholic Church, the theologically robust concept of *caritas* — charity, grounded in theological conceptions of the immanent and economic Trinity — was the foundational Christian virtue and the basis of the Christian life. Starting in the thirteenth century, however, the concept of stewardship began to supplant charity as the

model for handling and distributing limited resources. Such a process was furthered as the Roman Catholic Church was dispossessed by the English Reformation in the sixteenth century, concurrent with the rise of modern capitalism. Once the altars were stripped and ecclesial assets seized, the poor were left without large-scale assistance; "stewardship" as an element of good Christian discipleship became a necessary tool to induce individuals to give to the poor. But this is no costly discipleship;[2] rather, stewardship and capitalism are quite natural bedfellows. Unlike charity, stewardship lives comfortably within the bounds of capitalist class structures. It involves unidirectional giving without disturbing the causes and institutional structures behind inequality and poverty. "It is a principle for those with social and economic power," writes Lysaught.

Inherent in Lysaught's project is a desire to attend to the invisible assumptions and structures that distort Catholic theological commitments and contribute to modern dilemmas in the clinic. Putting aside the symptoms, she cuts to the root. Stewardship hinders, rather than enables, the moral imagination of Catholic healthcare. *Charity* is a much more faithfully Christian basis on which to build a just economic structure — but not just "charity care," a legal obligation for tax exemption. What contemporary Catholic healthcare needs in this historical moment is a reconstruction of charity (as solidarity, a charity with teeth) as the basis for our work, Lysaught argues. This reconstruction would employ Scripture, tradition, and magisterial teaching to put charity in its rightful place: as the theological reality underneath all we do. Charity, and prudence infused by charity, must displace stewardship as the guide for economic decision-making. Through prudence-infused-by-charity we participate in the mercy and creativity of God, profligate and abundant, disrupting and transforming existing personal and structural relationships to the benefit of the poor and vulnerable.

**Slosar, J.P., Repenshek, M.F. & Bedford, E. "Catholic Identity and Charity Care in the Era of Health Reform." *HEC Forum* 25, 111–126 (2013). https://doi.org/10.1007/s10730-013-9212-6.**

While Lysaught proposes recovering the theological concept of caritas as the primary lens through which to address economic concerns in Catholic healthcare, Slosar, Repenshek, and Bedford believe the question of if/how/when to limit uncompensated care cannot be addressed by one overriding moral consideration. Rather, it must be tackled using various principles as guides to a holistic understanding of the Church's health ministry. Their article, published 7 years before Lysaught's and shortly after the implementation of the ACA, attends to what they call the "tension between three intersecting primary values, namely, a commitment of service to the poor and vulnerable, promoting the common good for all, and financially sustainability." Within this tension, it is difficult to know whether it is justified to limit charity care. They argue it is justified, but it is vitally important how we do so.

Slosar, Repenshek, and Bedford point out that while Catholic hospital systems have an obligation to charity, and to their identity as part of the Church, they are not excused from their need to operate like a business to remain

economically sustainable. Thus, questions of *limits* on charity care immediately arise, because health ministries are beholden not just to individuals but also to the common good. The authors embrace the theologically considered concept of stewardship as a way of standing in the breach between individuals and the collective; unlike Lysaught, however, they understand stewardship to require both management techniques and a social justice element. Yet it is not clear how they develop this understanding of stewardship — theologically, historically, or otherwise. Their description of stewardship, including allocation of resources to promote human rights, equity, and the common good, seems less like a prophetic voice for social justice and more like something that works toward Catholic values within the current system. It is Lysaught's critique that stewardship-based approaches like this one perpetuate capitalist class structures, instead of subverting them.

But their project, of course, resonates with hers. If the common good requires that healthcare be available to everyone, then no one can have access to *all* healthcare — and this is the basis on which we must build a "theology of limits." By acknowledging limits, and determining where they should lie, we can achieve the common good. For these authors, while caritas requires indiscriminate provision, concern for the common good can help us set limits and thus sustain our health ministries for the long haul. This constrains the proper exercise of charity. In essence, Slosar, Repenshek, and Bedford are saying charity alone does not help us decide where to devote our limited resources. What we have here, as is so often the case, are competing goods; we must balance our obligations such that our charity is sustainable. When conflicts between goods arise, it is crucial that we analyze them from the angle of each obligation, including human dignity, distributive justice, stewardship, participation, the common good, and solidarity. But isn't this just prudence, after all? It seems Lysaught's proposal still stands: caritas and prudence-infused-by-charity can replace stewardship.

Slosar, Repenshek, and Bedford object, saying caritas works well in cases where $n = 1$, but our healthcare institutions are operating at a much larger scale. They believe that caritas and prudence, while important obligations, cannot on their own guide us in large scale economic decisions. So, while Lysaught proposes prudence-infused-by-charity as the basis on which to set limits on spending, Slosar, Repenshek, and Bedford believe only an interplay of various principles can guide us through this complexity.

**Gremmels, Becket. "Can Catholic Hospitals Still Be Catholic? A Virtue Theory Response." *Christian Bioethics*, Volume 25, Issue 1, April 2019, 17-40, https://doi.org/10.1093/cb/cby017.**

Gremmels attends to a question beneath the economic concerns around charity care and limited resources: whether Catholic hospitals can retain their Catholic identity (what Lysaught might call a commitment to caritas, and which Slosar, Repenshek, and Bedford locate in an interplay of principles) amidst the various shifts happening in our country, our institutions, and our Church. He offers virtue ethics as a way of attending to this question, as it provides a framework for understanding the

development of our moral character through our actions and decisions, both as individuals and as organizations.

A Catholic hospital's economic decisions help define it. "Either a hospital's actions, decisions, policies, etc., will lead it toward becoming or maintaining the nature of a Catholic hospital, or they will lead it away from it toward something else ... Every leader's decisions collectively shape who and what the organization is ... " writes Gremmels. Through a virtue ethics lens, we see that Catholic identity is teleological: our final purpose is to be perfected in Christ. As healthcare organizations, just as for individuals, we will fail in our attempts to be "perfect" and yet we continue to strive for increased virtue as we imitate Christ. Shifting factors like consolidation and economic shortfall means the setting for our decision-making and action will look different. And because of their complexity, Catholic organizations may sometimes fail to enact all elements of their identity. From this perspective, Slosar, Repenshek, and Bedford are right to point out the tension between our core values of service to the poor, the common good, and financial sustainability. But is it really fair to pit those against each other?

This is where practical wisdom, or prudence, comes in. Gremmels offers, per virtue theory, that the right action is the one properly tailored to the situation. Lysaught would agree. Prudence entails deliberation and discernment prior to action. The question is not whether Catholic hospitals can live out their identity amidst economic pressures, but how to adapt the expressions of our identity within the bounds of their fundamental tenets. Like Slosar, Repenshek, and Bedford, Gremmels believes that, "An accurate conception of Catholic identity reveals a broad array of values and ideals rather than a narrow vision that focuses primarily on one or two elements." What Lysaught calls us to consider, however, is that caritas might just encompass that broad array of values, and prudence-infused-by-charity may get us much farther in demonstrating our Catholic identity in economic matters than mere stewardship. I think she is right, and a broader moral vision will help us escape the weeds of our economic pressures.

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## ENDNOTES

[1] Catholic Health Association, "Shared Statement of Identity for the Catholic Health Ministry," https://www.chausa.org/mission/a-shared-statement-of-identity.; US Conference of Catholic Bishops, "*Ethical and Religious Directives for Health Care Services*," 2018, Directive 6.
[2] Dietrich Bonhoeffer, The Cost of Discipleship (New York: Touchstone, 1995).