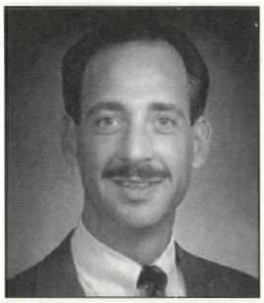
A RENAISSANCE IN HEALTHCARE?

Catholic Healthcare Providers Must Adapt To a New World View

BY PETER J. MURPHY



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In his book *A World Lit Only by Fire* (Little, Brown, Boston, 1992), William Manchester records that on Magellan's voyage around the earth, his first officer kept a log in which he carefully dated each entry, beginning with Tuesday, September 20, 1519, when the ship set sail. The ship returned to Spain, the log noted, on Saturday, September 6, 1522. When the people ashore insisted that it was Sunday, September 7, the officers and crew were left with a mystery they could not solve: Somehow during their voyage around the earth, 24 hours had dropped out of the calendar.

They had just proved that the world was a sphere, Manchester writes, but they were not yet thinking spherically.

This incident is a parable of what may be in store for Catholic healthcare providers as we move from our ingrained way of thinking to an entirely new set of concepts and relationships. As Catholic healthcare providers approach the year 2000, following a half century of revolutionary change in our world and our industry, we may be just as mystified by the realities of the new era as the Medieval-minded sailors on Magellan's voyage were mystified by the Renaissance world they had just helped to open.

Our own journey toward a "spherical" twenty-first century view of Catholic healthcare involves dealing with what I see as the four most pressing concerns facing us: (1) creating a more rational delivery system in which the community's healthcare needs are the driving force, (2) building a solid bridge between physicians and the rest of the healthcare delivery system, (3) ensuring that healthcare reform does not fizzle through our failure to provide universal coverage, and (4) transforming Catholic healthcare from a ministry of religious institutes into a ministry of Christian communities.

Toward a Rational Delivery System

Catholic healthcare, like the rest of the delivery system, suffers from three serious flaws: Its parts are disjointed rather than coordinated, it is driven more by (perverse) marketplace forces than by consumers' needs, and its focus on the individual all but displaces the communitarian dimension of health and healing.

Our challenge is to create out of these disjointed elements a sensible delivery system in which fragmentation and oversupply are replaced by integration and efficiency, in which healthcare needs take precedence over an institution's need for self-preservation, and in which individual healthcare is addressed in the context of an entire community's needs.

It is not just a question of bringing all the pieces of a fragmented and dysfunctional delivery system together in an interrelated network. True reform, especially if it is to be consistent with a Christian ethic, also demands that we eliminate oversupply and streamline the delivery system, that we balance individual good with the common good, and that we integrate healthcare with other ministerial efforts, particularly in education and social service.

Catholic healthcare needs to re-envision its mission by looking beyond the biomedical aspect of Christ's healing ministry and redeploying some of its resources to meet other societal needs. If, for example, we cut back healthcare expenditures from 14 percent to 9 percent of gross domestic product (which is what Canada allocates) and reallocate the remaining 5 percent (about $20 billion in the Catholic hospital sector alone) for schools, job training, and job-generating infrastructure improvements, would the overall health of the nation suffer as a result? Or might it not improve?

Another crucial step toward a more rational

delivery system involves distinguishing between what is good for the individual and what is good for the community. Instead of rationing healthcare services on the basis of an individual's income or job, as we do now, we need to allocate the services in light of the whole community's best interest. Which is better, to spend millions saving 500-gram newborns, or to provide prenatal care to some of the 500,000 women who give birth every year with little or no prenatal care? Which is better, to spend 60 percent of federal social dollars for those nearing the end of their lives, or to reallocate some of those funds to help millions of uninsured children?

Even investor-owned healthcare organizations are beginning to focus their efforts on improving the health of entire communities. We in the Catholic sector need to shed some of our frontier individualism, recognize that the different charisms of the spirit are given for the good of the community, and let our healthcare spending reflect this conviction.

Building Alliances with Physicians

Administrators face the challenge of bridging the moat that has developed over the last 50 years between physicians and hospitals, and of recrafting the hospital-physician relationship to synchronize not only their financial incentives, but also their guiding values.

In the emerging world of integrated delivery networks and capitated payment, the key to an institution's success, whether as the architect of an integrated system or as an attractive partner, will be its ability to dominate the primary care market. A clear strategy for developing an extensive primary care physician network and for linking it to solid subspecialty services will position a Catholic hospital and its physicians to compete aggressively for provider alliances and payer contracts.

Hospitals should encourage physicians to join them in stable and mutually beneficial alliances (which does not mean making them all employees), recognizing that by the end of the decade physician groups, not hospitals, will be at the center of the delivery system. Or, if physicians prove capable of organizing on their own, hospitals can do the twenty-first century thing by seconding the physicians' efforts and keeping them focused on the goal of creating healthier communities.

In short, integrating physicians and hospitals under capitation calls for a partnership mentality along with an entrepreneurial spirit and a long-term commitment that benefits all partners.

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Universal Coverage

We must also ensure that healthcare reform moves forward and does not stop short of universal coverage. For if universal coverage is not enacted, we will be left with essentially the same flawed system in which healthcare is effectively rationed according to one's income or job, in which close to a sixth of the population is without coverage, and in which a staggering proportion of our national wealth continues to be diverted from other, equally important societal priorities, with no discernible return on the additional investment in healthcare.

Healthcare reform has already begun, driven not so much by government legislation as by private-sector purchasers who can command deep discounts and even provide economic incentives to minimize the use of costly resources. Even without a national healthcare law, many will say reform is unstoppable. Perhaps. But the kind of reform we have seen so far has succeeded, at best, only in reducing the cost of healthcare for those already insured. It has done nothing to advance the other equally basic goal of reform: ensuring that everyone has access to needed healthcare.

With the setback in healthcare reform, Catholic providers now face the temptation to acquiesce in a healthcare system marred by injustice and to deal with it through a stewardship of cost-shifting. That kind of stewardship may alleviate the injustice, but it does nothing to correct it. And it is certainly not a very powerful witness either to our preferential option for the poor or to the seamless ethic of life that sees healthcare as a basic human right.

A Ministry of the Christian Community

A fourth and final pressing challenge—particularly for sponsoring religious institutes—is to transform Catholic healthcare ministries into ministries of the larger Christian community. Religious institutes still dominate Catholic healthcare by their control, if not by their numbers; and this model has been extraordinarily well suited to the U.S. Church until recently. The need to adapt this sponsorship model by including the laity is based on both theological and empirical grounds.

The theological basis of lay involvement was

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enunciated 30 years ago in the statements of the Second Vatican Council on the role of the laity in the Church's mission. The more practical pressures for extending sponsorship to the laity have to do with demographics (the declining number of religious women and men), with sociology (among other things, the redirection of religious life away from institutional ministries to more personal involvement in issues of social justice and peace; and the emergence of a qualified and professional Catholic laity), and with economics (especially the need to integrate physicians and purchasers as risk-sharing partners in the Catholic healthcare system of the near future).

Today's ecclesiastical sponsors of healthcare face the challenge of sharing their responsibility with qualified and dedicated lay men and women—parish leaders, educators, health professionals, business leaders, and others—recognizing their right to a voice in the governance of a Church-sponsored health ministry and recognizing the extensive contribution they can make to that effort. Healthcare must be a ministry of the whole Christian community and it must be seen as part of the Church's one ministry of proclaiming the good news and of embodying it, as Jesus did, in expelling the demons of sickness.

A Look Ahead

Less than a century after Magellan proved the earth was a sphere, Galileo proved (or came close to proving) that it also moved around the sun. It remains to be seen whether our view of the role and structure of the U.S. Catholic healthcare system will change as profoundly as did those earlier views of our planetary system. But enough has already changed to challenge our twentieth-century model of Catholic healthcare, and the next few years will be crucial in refashioning this perennial ministry for a new age. □

SHAKING

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cult times, sponsors will need to help people understand why change is necessary and how it relates to the mission.

Examining a Range of Fundamental Changes Jarring Religious Life The restructuring of healthcare coincides with a major transformation of religious life in the developed world. As they grapple with the restructuring of healthcare, congregations are also wondering about the future of religious communities, reexamining their identity, and exploring alternative models of sponsorship. They are testing new ministries and applying new tools to old ones. Women religious, in particular, need to discuss all these changes, placing the changes in healthcare in the broader context of the transformation of religious life.

Developing Lay Leaders During the last decade Catholic healthcare began to move along a path that may eventually lead to lay sponsorship. In collaborative arrangements, laypersons have assumed increasing responsibility for governance and management of the ministry. For this trend to play out successfully—especially in an organization as complex as an IDS—it is vital that we develop lay leaders capable of exerting the influence of Catholic values on their institutions.

Opportunities and Risks

The forces of change in American healthcare are in full swing. The place of Catholic healthcare in the new system will depend on what we do today. The future is appealing because it offers us the opportunity to realize a holistic healing ministry and to achieve broad collaboration with non-Catholics who share our values. It also presents us with significant risks because we will have to share control of our institutions and participate in new services. The future calls us to participate in large organizations, what some might call "big business." Most important, the future calls us to impress on the rock on which the new healthcare system will be built the values of human dignity, stewardship, social justice, collaboration, and excellence. □

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er. Suicides negatively affect their families and all who know of them; won't mercy killings also contribute to a culture of death? Hospice care, by contrast, provides a moral and humane way to live and die a good death. In hospice, persons offer other persons companionship, social support, pain control, and nonintrusive care in a humane environment that respects individual human dignity.

Individuals must surrender to the moral prohibition against killing themselves or others in order to flourish as an interdependent human community of equality and dignity. If this is a truth of the moral order, then it will be shown to be true through the fruit of human experience. The axiom "Truth is great and will prevail" is true, but only in the long run. In the short run, ethical errors and mistaken moral beliefs can create worlds of suffering and misery for society.

In this coming American moral crisis, Catholic healthcare providers will find themselves at the center of great ethical struggles. The outcome of this moral conflict is as uncertain as everything else in the waning twentieth century. But Catholics dedicated to "a civilization of love" must fight against all initiatives that substitute killing for caring, no matter what appeals are made in the name of free choice, individual autonomy, and mercy. □

NOTES

1. Pope John Paul II, *On Human Work: Laborem Exercens*, Daughters of St. Paul, Boston, 1981, pp. 14-15.
2. Herbert Hendin, "Seduced by Death: Doctors, Patients, and the Dutch Cure," *Issues in Law and Medicine*, vol. 10, no. 2, 1994, pp. 123-168; Carlos F. Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands*, Free Press, New York City, 1991.