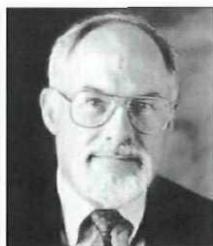


A TIME TO CHOOSE

The Ministry Should Throw Its Resources into Health Care Reform

BY JOHN W. GLASER, STD, & BRIAN B. GLASER, PhD



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How does one criticize care of the poor without sounding like a Charles Dickens novel? Very carefully!

The approach of the U.S. Catholic health ministry to care of the poor is generous but shortsighted and too narrowly conceived. The ministry's current practice primarily treats symptoms, even though its social justice tradition points it toward root causes—the systems and structures of health policy. If the ministry were to address root causes, it would find itself plunged into health care reform.

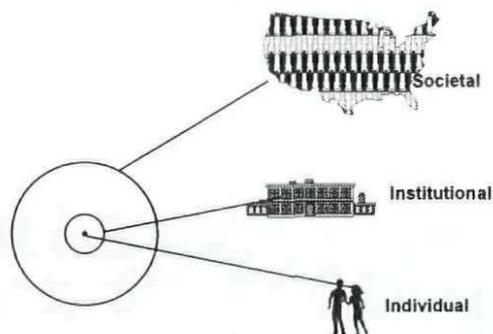
We believe that the relationship between care of the poor and health care reform has received far less recognition—both conceptually and practically—than it deserves. On one hand, most people involved in Catholic health care agree that service to the health care poor is essential to the ministry. For the delivery of that care, the ministry is equipped with a vision, a philosophy, and concepts for understanding. It also possesses a detailed infrastructure with which to implement this care: committees, goals, budgets, and systems of accountability. On the other hand, however, the ministry has nothing similar to help it deal with health care reform.

We believe that care of the poor and health care reform are two dimensions of the same issue. The former has to do with symptoms, the latter with root causes. In fact, long-term, “upstream” service to the health care poor requires reform of the U.S. health care system. If the nation were to reform its unjust system, the need for care of the poor would disappear.

THREE REALMS OF MORALITY

A paradigm from Catholic moral theology can help us explore this thesis. Our theological tradi-

tion recognizes three realms of morality, two of them nested within the third:



Societal morality concerns the extent to which human dignity is promoted and protected by society at large.

Institutional morality concerns the extent to which human dignity is promoted and protected by particular institutions.

Individual morality concerns the extent to which human dignity is promoted and protected by individual behavior.

Many relationships exist among these three realms. Important for our discussion here is society's enormous power to shape life at the institutional and personal levels. Because this is true, we believe, the root cause of health care poverty is the health care system itself. To put the case a bit differently, 39.3 million Americans lack access to care because of the unjust way the system (and its subsystems) has developed.

The United States is alone among first-world countries in this unconscionable situation. Germany, for example, recognized more than a century ago that health care was an issue of the highest importance where the well-being of the nation and justice for its citizens were concerned. As a result, the Germans developed an integrated national system for financing and delivering care,

one that tied access and basic need tightly together.

The United States created a very different system. Indeed, we did not so much *create* a system as allow a rabbit warren of subsystems to spread. We did this because we lacked a vision concerning the importance of health care for our nation and its citizens. As a result, health care in this nation tied access not to need, but to a broad array of factors, often bizarre ones. Some of these inconsistent factors are: being rich, being poor, suffering from end-stage kidney failure (but not from cardiac or respiratory failure), having a good job, being over 65, and living in Mississippi rather than Connecticut.

Characteristic of how our nation's fragmented situation developed is the way we instituted the centerpiece of our system—employment-based insurance, which today accounts for 66 percent of insurance coverage. During World War II, the United States saw a freeze on wage increases but not on benefits. Employers therefore began using health insurance to woo scarce workers. Because this often occurred in unionized workplaces, the simultaneous growth of unionism in those years helped to spread the practice rapidly and to embed it deeply in the ethos of the American workplace.¹

Although the practice demonstrated employer ingenuity at the institutional level, it helped to fragment health care at the societal level—thereby generating injustices. Consequently, 20 years later, the United States was forced to develop Medicare and Medicaid to try to fill the gaps created by this shortsighted wartime maneuver. As other inadequacies emerged, the nation created still newer programs to deal with them. But the criteria, funding, and infrastructure of these programs were almost never integrated. Indeed, they often worked at cross-purposes.

Researchers have provided a detailed look at one state's subsystem for attending to health care for children. In 1990 California had 160 child health programs, with 25 different eligibility criteria, situated in seven different departments of state government, administered by 37 different government programs.² It would be hard to imagine a more child-hostile approach to the problem.

Health care should be an organic societal reality. When a health care system is put it together in ad hoc, fragmented ways, it cannot help but produce injustice. (The health care poor are one of this nation's more egregious injustices.) In fact, fragmentation seems to produce ballooning

injustice. During the last decade—one of overall prosperity—the number of uninsured in the United States increased by 40 percent. Compare this with the situation of Germany, which, in the same years, combined total coverage of its population—one significantly older on average than that of the United States—with freedom of choice of provider, a rich benefit package, and outcomes that match or exceed ours nation's, all while spending about 30 percent less of its gross domestic product on health care than we do.³ The difference is in systems at the societal level. The United States is the only first-world nation that tolerates a societal system that produces an ever-growing number of health care poor.

THE CATHOLIC BIAS FOR INDIVIDUAL SERVICE

In an unjust societal system, the victims of injustice can be served in several ways. One can choose to:

- Help the victims directly
- Reform the system, thereby helping the victims indirectly
- Try to do both, in varying doses

Faced with this choice, the Catholic community in the United States has almost universally chosen to provide direct service and to leave reform of the system to others. This is not unusual. During two great reform movements of U.S. history—abolition of slavery and female suffrage—we Catholics, as a community, chose to stand on the sidelines while others changed the world.⁴

Bishop Joseph Sullivan, DD, commenting on this phenomenon, notes that despite the 1971 Bishops' synod recognizing that working for a more just society is constitutive of the Church, "we have not captured the hearts and minds of ordinary Catholics with the church's social teaching. . . . A fair criticism is that we have a paper trail that attests to our teaching, but not necessarily an action agenda consonant with our proclamation."⁵

THE LIMITS OF DIRECT SERVICE

Here it is important to note another principle of the three-realm model: Fundamental, widespread dysfunction at the societal level can never be compensated for by increased activity at the institutional and individual levels. If those who wish to end injustice concentrate their activity on its victims, two things happen: First, only a fraction of the victims are served (and currently, in terms of U.S. health care, an ever-diminishing fraction); second, the root cause of injustice is left

unchanged. When the injustice is societal, the remedy must be societal as well.

The contemporary U.S. Catholic health ministry puts most of its resources into direct service to the victims of injustice—and many fewer into trying to rectify injustice's root causes. This ratio should be reversed. We believe that the Catholic health care community should become preeminent in the community of health care reformers for as long as it takes to change the system.

Changing the system will demand time, energy, and financial resources. The reallocation of resources should not be additive, a totally new and additional burden on already hard-pressed institutions. We suggest that the allocation of resources for the care of the poor, on one hand, and the allocation of resources for advocacy programs, on the other, be reconceptualized along the lines we have sketched in this article. The ministry's approach to advocacy should, moreover, expand significantly beyond its present understanding and practice.

TWO EXTRAORDINARY MEN

Let us consider two extraordinary men, both of whom dedicated most of their adult lives to serving the victims of injustice.

THE SAINT

St. Peter Claver, SJ (1580-1654), spent 33 years of his life in direct and immediate service to slaves, providing care to ravaged, terror-stricken Africans who arrived in Cartagena (in modern Columbia) aboard slave ships. Every day he plunged into the loathsome holds of newly arrived ships to quiet the slaves' terror, nurse their sick, bury their dead, and minister to their spiritual needs. He himself longed for the abolition of slavery, but that was culturally and politically impossible in his historical era. So he relieved the horrors of slavery as best he could—through direct care to its victims.

THE ADVOCATE

William Lloyd Garrison (1805-1879), on the other hand, served slaves in a less direct but more enduring way. He was arguably the single most important force in the abolition of slavery in the United States. Mario Cuomo has said that Garrison "stirred the conscience of millions and—more than anyone else—helped move the issues of slavery to the top of the political agenda. Without him, Lincoln might not have had his chance for greatness."⁶

Each of these men was heroic. Fr. Claver brought love to those crushed by the injustice of slavery. Garrison changed the world, ensuring that never again would a child be born into the cruelty of slavery. Christian witness calls for both kinds of work, and the historical era in which Christians happen to find themselves prescribes the dosage of the two elements to be applied. Claver longed for abolition but did not live in an era in which that was possible. Garrison found himself in an era in which abolition was highly improbable—it was on few people's agenda—but its elements, scattered like Ezekiel's dry bones, were only waiting for a prophet to gather them and call them into a powerful dance. Garrison spent 30 years successfully choreographing that dance.

We believe that we live in a time that needs a Garrison more than it needs a Claver. We believe that, within the next generation, we can create a world of respect for dignity, in which no one again need be born into the primitive and cruel world of current U.S. health policy and practice; in which no newborn, no working poor person need dwell in the world of the health care poor. But, like Garrison, we of the Catholic health ministry need to bring vision, passion and long-term commitment to the abolition of the health care poor. We Catholics, in and outside of health care, must become indefatigable advocates of health care reform—therein lies the upstream, long-term service to the poor.

RELIGIOUS SPONSORS MUST LEAD THE WAY

A final parallel can be traced between reform and care of the poor regarding the religious congregations that sponsor Catholic health care. Religious women are the reason that care of the poor is so solidly anchored in the Catholic health care community. Without the clarity and unshakable character of their commitment, the storms that have raged in health care over the past two decades would have caused care of the poor to be jettisoned from our institutions in the name of fiscal responsibility.

We believe that only religious sponsors can make health care reform an essential priority of Catholic health care systems and institutions. For many of us in the ministry, the very urgency of need for direct care for the poor keeps us from working for the reform that will finally end health care poverty. Reform, to us, usually seems too far away. It is far more complex than any single issue we have faced; it will involve far more work than

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Health care leaders need to converse in theological language as comfortably as in the language of business.

(sometimes verging on scandal), high status, and clear job descriptions. Their professionalism is not in question. What they lack is theological formation, which would enable them to think creatively about how to run the business of health care *as a ministry*.

A mission leader in Catholic health care once said to me, "We don't need theology. What we need is more spirituality!" This remark betrayed a shocking anti-intellectualism and a lack of awareness that Catholic spirituality cannot exist without theology. We like to think of spirituality as soft, comforting, inclusive, and noninstitutional, whereas theology tends to be seen as abstract, sharp-edged, and irrelevant to everyday concerns. The New Age movement has seduced us into thinking that "spirituality" is whatever we want it to be and that it conforms itself to our own subjective needs. The fact is that Catholic spirituality, although broad and multifaceted, is still rooted in basic theological convictions about God and how God acts in our personal and corporate lives. Ronald Rohlheiser's recent book *The Holy Longing* is an excellent summary of what those convictions are.²

If our sponsored institutions are to survive as ministries, leaders need significant theological education to help them understand what christology, ecclesiology, Scripture, and moral theology have to do with health care. What difference does it make to health care, for example, if we see the church as the Body of Christ or the People of God? How can Jesus' one saving act be salvific for all persons, even those

who are not Christian? Why don't Catholics describe their religious experience in terms of "choosing Jesus Christ as their personal Savior?" Why aren't Catholics biblical fundamentalists, and what difference does that make in health care? Why is the notion of sacrament at the root of what the physician or nurse does in the operating room? Unless our health care leaders have some idea of the answers to these questions, they cannot effectively direct the mission of health care. They need to be able to converse in this theological language just as comfortably as they converse in the language of business and finance.

Dr. Grant is correct when she says that leadership development is not remedial. Spiritual and theological formation are not just frosting on the health administration cake, but entirely new competencies required by the massive ecclesial changes that have taken place in the last 30 years. □

NOTES

1. Zeni Fox, *New Ecclesial Ministry: Lay Professionals Serving the Church*, Theological Book Service, 1997.
2. Ronald Rohlheiser, *The Holy Longing: The Search for a Christian Spirituality*, Doubleday, 1999.

This column addresses issues related to ministry leadership development for sponsors, executives, trustees, and physicians. Reactions to this column—both positive and negative—are welcomed and invited, as are topics for further consideration. Please address all correspondence to the editor at hpeditor@chausa.org.

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merely extending the current, distorted system to everyone. The assumptions and attitudes that resist reform sit deeply in American institutions and American souls. Nothing short of fervid religious dedication and deep spiritual vision can prevail against such adversaries, in our society and in ourselves.

If religious congregations come to recognize that the long-term, root-cause moral and ministerial challenge concerning the poor is not direct service to the poor, but rather reform of the health care system—nothing will stop such reform. If, on the other hand, the relationship between care of the poor and reform is not recognized for what it is by religious sponsors, Catholic health care will continue to behave admirably, like Peter Claver, a saint—but in an era that calls for the saintly work of William Lloyd Garrison. □

NOTES

1. J. K. Igleheart, "The American Health Care System: Employer-Sponsored Health Coverage," *New England Journal of Medicine*, vol. 340, no. 3, pp. 248-252; Robert Kuttner, *Everything for Sale*, University of Chicago Press, Chicago, 1996, pp. 117-120.
2. B. Harvey, "Toward a National Child Health Policy," *JAMA*, vol. 264, no. 2, 1990, pp. 252-253.
3. U. Reinhardt, "Germany's Health Care System: It's Not the American Way," *Health Affairs*, vol. 13, no. 4, pp. 22-24.
4. See, for example, the *New Dictionary of Catholic Social Thought*, Liturgical Press, Collegeville, MN, 1994; M. Fiedler and L. Rabben, eds., *Rome Has Spoken: A Guide to Forgotten Papal Statements and How They Have Changed through the Centuries*, Crossroad, New York City, 1998; and Henry Mayer, *All on Fire: William Lloyd Garrison and the Abolition of Slavery*, St. Martin's Press, New York City, 1998.
5. Joseph Sullivan, "Church Social Teaching: Proud Heritage, Neglected Treasure," *Origins*, vol. 27, no. 35.
6. Mario Cuomo's remarks about Garrison can be found on the dust jacket of Henry Mayer, *All on Fire: William Lloyd Garrison and the Abolition of Slavery*.

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