AFTER THE SHAKING STOPS

Catholic Healthcare Workers Should Prepare for Seismic Changes

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Summary In an attempt to cap spiraling costs and remain competitive, both providers and insurers are going through a frenzy of consolidation. Experts are predicting these changes:

- The integrated delivery system (IDS) will be the prevailing type of healthcare organization.
- There will be fewer acute care beds and fewer hospitals.
- Hospitals will be subsidiary to IDSs.
- Catholic and non-Catholic providers will join together to form IDSs.
- Regional IDSs will join statewide networks.

The Catholic healthcare ministry can survive in such an era of consolidation if its leaders (1) collaborate with others on a basis of shared values, (2) have a well-defined mission, (3) provide holistic care, and (4) ensure that the organization remains true to its mission and demonstrates core values in its decisions and behaviors.

Sponsors will need to find ways to share management of IDSs with non-Catholic organizations; to collaborate in the formation of regional and statewide IDSs; to urge other Church leaders to support social justice, human dignity, and community service; to be mindful of the stresses these changes will place on physicians and employees; to encourage dialogue about other changes in religious life; and to prepare laypersons to be their successors in the leadership of Catholic healthcare.

Living on the West Coast, one learns quickly that you cannot argue with an earthquake. Something enormous, uncontrollable, and awesome picks up the world and plays with it. We wait and pray that earthquake preparations will be effective and that sound structures will hold up.

The changes in healthcare over the past two years resemble seismic activity. The jolts are strong and sudden, and they relieve stresses that have built over many years: growing numbers of uninsured, insecurity over loss of health insurance, spiraling costs, limited access to services for the poor, and government policies and regulations that are confusing and sometimes contradictory. In 1992 the presidential election added enormous stress, as the push for health reform jacked up the odds of a "big one" occurring within the next four years.

The forces at work in healthcare are larger than any of us, capable of tossing both individual providers and sponsors like lettuce leaves in a salad. Change of this scope cannot be argued away; denial equals self-destruction. When will the shaking stop? And what will be left when it does?

No one knows for sure, and even the boldest and most visionary organizations are maintaining a fresh supply of contingency plans. We do know that, once the current tremors cease, the United States will require new and better structures for organizing, governing, and delivering healthcare. But will the vision and values of the *Catholic* health ministry survive in these new structures?

Forces of Change

In California and many other parts of the country, health reform represents only one of many forces of change. Regardless of the outcome in Washington, DC, powerful trends are reshaping the landscape. Employers and pension plans are exerting increasing pressure on insurers to hold down premium increases. To gain additional negotiating strength, many employers are joining regional buying groups that deal with payers on their behalf. In the last year buying groups in San

Francisco, Cincinnati, and other major cities have registered successes for their clients in containing health insurance costs. Insurers, in turn, are squeezing harder on providers.

But, as health insurers gaze into the future, they understand that providers' capacity to reduce cost is not endless. The threat looms of an inexorable decline in the profitability of health insurance. In defense, insurers are taking shelter in greater size and increased market share. The fastest way to grow is through acquisition. So the insurance companies are gobbling each other up in order to become more cost-efficient and quickly penetrate new geographic areas or new population segments, such as Medicare health maintenance organizations. Consolidation of health plans, on the other hand, is triggering movement among providers: The healthcare ministry begins to reassemble. Hospitals merge. Physicians join groups. Medical groups acquire each other or link themselves to hospital organizations. In turn, some health plans try to build their own delivery system and acquire physician groups.

The change process reveals how interconnected are the major components of the healthcare field. It also demonstrates the power of economic incentives to drive the strategic behavior of all elements of the system. Something is happening here that dwarfs the single organization and calls for a collaborative solution.

After the Shaking Stops

The restructuring of healthcare is expected to run its course over the next three years, leaving the following changes in its wake.

Emergence of the IDS As the Prevailing Type of Healthcare Organization An IDS is characterized by comprehensive services; partnerships between healthcare facilities, other service providers, and physician groups; strategic alliances or partnerships with a few health insurers; collaboration of Catholic and non-Catholic providers; and tight management of the cost and quality of care. Most, if not all, Catholic hospitals will become part of a regional IDS.

Fewer Acute Care Beds and Fewer Hospitals The growth of managed care and advances in technology and pharmaceuticals reduce the need to hospitalize patients. IDSs will respond by staffing fewer beds and closing entire facilities to achieve the cost economies needed to compete.

A Catholic IDS will need strong core values to attract the right partners. Its leaders will need to clearly articulate those values, repeat them frequently, and connect them to specific behaviors.

Hospitals Cast in Supporting Roles In an IDS, the hospital is not the most important or influential component of the system. It takes its place as just one of many services offered to health plan members. The needs of a single institution are subsidiary to those of the broader integrated delivery system.

Mixing of Catholic and Non-Catholic Providers The geographic area that an IDS needs to cover will be determined by the market forces driving the sale of health insurance. In most cases, coverage of a major metropolitan area or a group of cities will be required. Currently, few geographic areas contain enough Catholic hospitals to allow the creation of an IDS solely of Catholic partners. To cover these large regional markets, IDSs will need both Catholic and non-Catholic providers.

Regional IDSs Linked to Statewide Networks Statewide organizations will emerge from the current transformational period. IDSs in one region will link up with IDSs in other regions for payer contracting, quality management, and other purposes. Some futurists, looking at the California market, predict that eventually only three healthcare systems will exist in a state of more than 30 million people: Kaiser Permanente, California Health Network (Sutter, Sharp, Adventist, California Health System, and others), and a Catholic system that includes some non-Catholic partners.

Will Catholic Healthcare Survive?

After all the corporate deals, financial transactions, acquisitions, and alliances—will the important things remain? Can a strong Catholic healthcare ministry rise out of the flux? The answer will depend on the actions we take now. Some keys to success are the following.

Collaboration Founded on Shared Values A Catholic IDS will need strong core values to attract the right partners. To manage such an IDS, its leaders will need to clearly articulate those values, repeat them frequently, and connect them to specific behaviors.

Well-defined and Practiced Mission Successful organizations draw their strength from a well-defined mission reinforced by leadership and demonstrated in practice. This success factor has sustained Catholic healthcare in the past and will continue to be critical in the future.

Adoption of a Comprehensive, Holistic Ministry The emergence of integrated delivery presents us with an opportunity to foster an important but unde-

veloped aspect of the Catholic health ministry: holistic care. Traditionally, the primary focus of the healthcare ministry has been the hospital and the ambulatory and community programs ancillary to it. Under managed care, the primary focus will be on wellness—the maintenance and improvement of people's total health.

Control in the New Organization The developers of new organizational structures need to focus on the fundamental objectives of governance and control. At the most basic level, control ensures that the organization remains true to its mission and demonstrates core values in its decisions and behavior. The traditional control mechanisms of Catholic healthcare derive from obligations of faith and the need to safeguard Church-sponsored hospitals as ecclesiastical property, as expressed in canon law. Controls that address obligations of faith, mission, and values will always be important.

But controls linked to property will not suffice in the new IDS. Because the importance of the hospital will decline, control of this asset will not necessarily lead to significant influence in the IDS. Also, many aspects of an IDS may not be tied to physical assets. For example, many physicians will participate in an IDS through independent practice associations, but their practices will not be owned by the IDS. Insurers may be long-term strategic partners of IDSs, but their health plans will operate under separate ownership.

A Catholic-owned and -governed IDS represents the most straightforward control model. However, market realities and the basic nature of the IDS may place such a clear-cut model beyond reach. In such situations, leaders will need to test alternative models for their potential to influence mission and values. For example, some Catholic facilities may choose to participate in a regional IDS whose assets are controlled by a non-Catholic entity, but which nevertheless has provisions allowing (1) Catholic facilities to maintain their identity and (2) Catholic healthcare leaders to participate on the IDS board or in key management positions. Of course, compatible values and cultures will be essential to the success of this model.

Action Now The long-term viability of Catholic healthcare requires that its leaders take part in the *creation* of integrated delivery systems. They cannot stand on the sidelines watching the restructuring process, since that would pose great risks for their ministry.

A focus on individual identity could undermine the success of collaborative efforts and deter the development of a major Catholic healthcare presence in the nation.

Implications for Sponsors

The shattering changes coming in the next few years will confront sponsors with hard choices. If the Catholic healthcare ministry is to survive, sponsors will need to brave some uncertainties, take some risks, and draw strength from their values and traditions.

Emphasizing the Shared Elements of Catholic Identity Collaboration among Catholic sponsors will be necessary in the formation of regional and statewide IDSs. In the past, emphasis on individual sponsors' charism tended to slow the development of Catholic systems. In the future, a focus on individual identity could undermine the success of collaborative efforts and deter the development of a major Catholic healthcare presence in the nation.

Finding Ways to Share Governance and Management with Non-Catholic Organizations To sustain their influence over the healthcare system, leaders of Catholic hospitals need to become leaders of IDSs. In most cases, this will require partnering with non-Catholic providers. Values provide a powerful base on which to build partnerships. Instead of emphasizing the differences in the values of Catholic and non-Catholic organizations, Catholic leaders should stress those values shared by other organizations.

Urging Church Leaders to Speak Out on Issues of Social Justice, Human Dignity, and Community Service The values of Catholic social teaching on these subjects provide a strong basis for bonding with non-Catholic providers committed to community service. Unfortunately, many potential partners are not aware of the Church's position on social issues. The general public hears mostly about sexual morality and the rights of women, resulting in a skewed public image of the Church. As a consequence, it will be necessary to educate potential partners about the full spectrum of Catholic values. Over the long term, sponsors will need to work with Church leaders to send a strong message on all the moral issues of our times.

Attending to the Painful Human Costs of Massive Change Layoffs, restructured roles, loss of income, and other unsettling changes will have a heavy impact on employees and physicians. During these diffi-

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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. □

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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.