AGENDA FOR THE STRONG AT HEART

Facing the Challenges Ahead Will Require Recommitment to our Right to Serve in a Manner Faithful to our Identity

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This article is a companion piece to my standard “Reflections” column, which appears on p. 6 of this issue of Health Progress. Whereas that column reflects on some aspects of our 275-year history as a healing ministry, this article engages some of the challenges we are currently encountering and will likely continue to experience over the next years. Those challenges will be considered in light of three concepts: social good, ecclesial ministry, and public actor.

SOCIAL GOOD

One of the more significant items found in the archives of the New Orleans Ursuline community is a letter from President Thomas Jefferson to Sr. Therese de St. Xavier Farjon, Superior, dated May 15, 1804. After the Louisiana Purchase the previous year, the Ursuline community had written the president; its members were concerned whether they would be able to continue their service after the treaty made New Orleans no longer part of a Catholic country. The president’s reply remains one of the most significant commentaries on the role of religion in the still young country.

I have received, holy sisters, the letter you have written me wherein you express anxiety for the property vested in your institution by the former governments of Louisiana. The principles of the constitution and government of the United States are a sure guarantee to you that it will be preserved to you sacred and inviolate, and that your institution will be permitted to govern itself according to its own voluntary rules, without interference from the civil authority. Whatever diversity or shade may appear in the religious opinions of our fellow citizens, the charitable objects of your institution cannot be indifferent to any; and its furtherance of the wholesome purposes of society by training up its younger members in the way they should go, cannot fail to ensure it the patronage of the government it is under. Be assured it will meet all the protection which my office can give it. I salute you, holy sisters, with friendship and respect.

As comforting as the president’s words were, even a casual student of history knows that there often has been a significant disparity between theory and practice vis-à-vis the Catholic experience. Nonetheless, over the centuries, an implicit understanding did develop about what might be called a distribution of social responsibilities within our nation. The provision of many social goods and services was left to private associations and religiously sponsored charitable services. The role of local and state government by and large was confined to what today would be considered a rather narrow definition of preserving public order. It was in this area of the charitable provision of social services that Catholic women and men religious served so many people. Although in many instances the recipients of these services were fellow Catholics, more often than not the services were explicitly requested by public or private officials as a solution to an existing social need. For example:
• In October 1861, the governor of Indiana, Oliver P. Morton, asked the Sisters of the Holy Cross to serve as nurses in Union hospitals. Within hours, a group of sisters was on its way from the sisters’ home at St. Mary’s Academy in Notre Dame, IN, to a military hospital in Paducah, KY. In the following months, additional groups of sisters were sent to manage hospitals in Mound City and Cairo, IL, where they served with distinction.

• The Daughters of Charity of St. Vincent de Paul, whose convent is located in Emittsburg, MD, just 10 miles from Gettysburg, PA, tended both Union and Confederate casualties of this most horrific battle. The sisters served for weeks in one of the fields, tending the wounded in tents until they could be moved.

• During the New York City smallpox epidemic of 1875, people refused to go to the smallpox hospital on Blackwell’s Island (now Roosevelt Island) because of conditions there. The city asked the Sisters of Charity at St. Vincent Hospital to take over the management of the smallpox hospital. Their impact was summarized in a report by the city government: “Since the change in management has been effected, the hospital has been steadily growing in popularity, and it is not at all unusual for us to be gratified with the sincere thanks of returned patients for the kindness and tender care which they received…”

• Mother Marianne of Molokai, a sister of St. Francis, traveled from Syracuse, NY, in 1883 to take over a hospital for lepers in Honolulu. From there she moved to Molokai Island, an isolated leper settlement, where she and her other Franciscan Sisters found 1,000 people suffering from leprosy and living in chaos and degradation. From 1889 until 1916, she turned Molokai into a model facility for addressing a public health problem that civil authorities had left primarily to voluntary efforts.

Implicit in these requests and the generous responses were a cluster of assumptions about how society was to be ordered. In other words, concomitant with the American commitment to individual responsibility, there was a recognition that some situations call for collective or communal responsibility in addition to individual responsibility. At times that responsibility was best exercised by private religious/charitable entities of their own volition; at other times, by those entities at the request of or in an informal partnership with the government. In these instances, the role of government was to provide the “space” needed for these activities (e.g., exemption from taxation) or a degree of financial support.

Reflection on that precedent has given rise to some helpful categories that allow us to organize and better understand this experience. The late Cardinal Joseph Bernardin discussed them in his 1995 address to the Harvard Business School Club of Chicago, entitled “Making the Case for Not-For-Profit Healthcare.” He noted that our society has come to be divided into three zones or spheres: business, government, and voluntary (not-for-profit). One of the functions or purposes of the voluntary sphere is to provide what he called “social goods”: “In other words, the purpose of not-for-profit organizations is to improve the human condition, that is, to advance important non-economic, non-regulatory functions that cannot as well be served by either the business corporation or government.”

He went on to argue that the provision of health care is one of those social goods most appropriately provided in the voluntary sector.

So healthcare—like the family, education, and social services—is special. It is fundamentally different from most other goods because it is essential to human dignity and the character of our communities. It is…[in the words of Pope John Paul II] one of those “goods which by their nature are not and cannot be mere commodities.” Given this special status, the primary end or essential purpose of medical care delivery should be a cured patient, a comforted patient, and a healthier community, not to earn a profit or a return on capital for shareholders.

History and theory support the critically important role Catholic health care and social services have played in our country.

Evolution of Health Care Delivery First, there has been significant qualitative evolution in the nature of health care delivery over the course of our nearly three-century presence to it in this country. It is clear that the early experience of providing basic nursing care while an illness ran its course, or palliative care and comfort to the dying, has been complemented by the ability to intervene and alter the course of an illness or eradicate it altogether. These developments were made possible by surgical procedures that depended on anesthesia and sterile environments; the discovery of antibiotics such as penicillin; vaccines that target the source of disease or illness; tools and technology facilitated, in part, by space exploration; and advances in...
diagnostic techniques. These previous transformations are but a prologue to a new era of change being driven by the knowledge of genetics.

So although at its heart health care is a human reality involving art and touch, it also involves science and technology. And, as such, it is increasingly an interdependent rather than an independent reality. Its very complexity requires both greater expertise and financial resources.

Group Health Insurance Second, as the nature of health care changed and became more expensive, it made sense for groups of people to share the risk of the cost of medical treatment through the mechanism of insurance. Although health insurance coverage as a widespread employment benefit could be described as an accident of history, it was also an expression of the concept of sharing responsibility for some social needs. In fact, history has recorded that the Benedictine Sisters were among the first to implement the creative concept of health insurance as an additional source of income. They offered to cowboys in North Dakota and lumberjacks in Minnesota a ticket costing $1 to $5 that entitled the holder to care at one of their hospitals. As helpful as insurance was in providing increased access to health care, it did begin to change the "social landscape" of health care by introducing a third party to the previous two-party system of patient and provider.

Expanding the Formal Role of Government Although government had previously been present to health care, chiefly by sponsoring public health measures and biomedical research, its role changed significantly with the introduction of Medicare and Medicaid. These two programs were another response to the fact that we recognize health care is a social good, a good so essential that the well-being of society will be compromised if the aged (Medicare), the poor (Medicaid), or the young (State Children's Health Insurance Program) are systematically denied access to it. At the same time, the introduction of state and federal government as health care actors also significantly changed the landscape.

Commodification of Health Care Not surprisingly, but somewhat ironically, even as a consensus about the social nature of health care as exemplified by the expansion of private and government-sponsored insurance grew, the focus of that delivery in the U.S. social scene began to shift. Although one could argue over the reasons for the shift (economic forces or shifting social/political philosophy, such as "Reaganomics"), the fact is that the delivery of health care has taken on a more commercial character. This is true both in the growing investor-owned sector and in the voluntary sector, which has too often responded to economic pressures by adopting practices associated with investor-owned organizations.

Increasingly, though somewhat uncomfortably, health care is treated as a commodity—albeit a distinctive commodity—that can be the source of monetary gain.

As we look to the next 25 years and the 300th anniversary of Catholic health and social services in the United States, what is the significance of these forces, in particular for the health care ministry? Allow me to address them one at a time.

Growing Capacity Although our history has some rather significant examples to the contrary, the Catholic imagination is not afraid of science or technology. Both can be examples of divinely given creativity to humankind:

In fact, high tech and "high touch" are not fundamentally incompatible. What is at issue is setting priorities. Is technology an end in itself or a means to a higher end: enabling human dignity? Although we do not have many equivalent models to assist us, there is no reason we cannot embrace the increasing complexity of health care as an opportunity to aggressively model the complementary contributions of faith and knowledge, art and science, touch and technology.

Outside Actors Just as challenging as the increasing complexity of health care is the presence of many third parties, such as private insurance payers, in their various forms. Their many and often inconsistent rules and cost-control efforts present a daunting challenge to both patients and health care providers. We can ask, however, whether the difficulties they bring are more symptomatic than causal. In itself there is nothing wrong with managing costs to bring about efficiency or seeking to bring outcomes and expenditures into a reasonable relationship. Indeed, a central tenet of Catholic health care values is the prudent stewardship of resources. Without cost containment, Cardinal Bernardin noted, "We cannot make health care

*In response to World War II controls on wages but not on benefits, many employers gave health insurance benefits instead of wage increases.
Commodification Of all the challenges, commodification troubles me the most. I do not believe it is an exaggeration to say that not-for-profit acute care delivery is one of the last bastions of the institutional dimension of voluntary sector health care. For example, a large percentage of long-term care facilities are investor owned, Blue Cross/Blue Shield plans are increasingly “going public,” and publicly traded hospital firms such as HCA and Tenet are here to stay. But even as these forces of commodification grow, there also is disquiet heard that suggests an increasing realization that health care delivery is not the same as widget making. In the midst of what might seem to be an insurmountable momentum, perhaps our challenge is to remain steadfastly prophetic in our belief that as a social good, the promise of health care, is fundamental to human dignity. As suggested by the respected management expert Peter Drucker, not-for-profits understand this as part of their role in improving the human condition. Our organizations do this by:

- Taking a leadership role in our communities
- Responding to the needs of the poor and vulnerable and urging others to do so as well
- Identifying unmet needs and working with others to meet those needs
- Advocating, both locally and nationally, just and equitable health care policies that will lead to improved health for all
- Attending to the future of health care by preparing practitioners and leading the way in clinical and health delivery research

In doing this we are being faithful to a vision of not-for-profit health care in which the service that is an essential dimension of health care delivery is both a means and our ultimate goal. This is unlike investor-owned health care, for which service is a means to its ultimate end of financial return to owners or shareholders.

Ecclesial Ministry

Much has already been written about the challenges we face as a ministry: evolving new forms of sponsorship; ensuring necessary leadership in the areas of sponsorship, governance, and management; and sustaining and enhancing ecclesial relationships. In light of the considerations touched on so far, I would like to make note of what perhaps is an even more significant challenge: whether the ministry of healing and contemporary institutional health care delivery are compatible.

We all know that what we are about is carrying forward the mission of Jesus Christ and the church. It is in response to that mission that we are constituted as a ministry of the church.

Our ministry finds itself compelled both by mission imperative and financial necessity to become a more assertive actor in the public sphere.
I am optimistic that those who gather to celebrate our 300th anniversary in 2027 will be able to recount the stories of how, with God’s grace, we turned these opportunities into successes.

Mission and ministry are the what and why of who we are. There is an essential element to what we are about that transcends time and ultimately is eschatological in nature: witnessing to the radical healing that is found in the coming of the kingdom. The how of that ministry is the contemporary modality of institutional health care delivery along the continuum of care as experienced in our country. In a sense, these current modalities become the form of mission/ministry or, to put it differently, the outward sign used to communicate/mediate the inner mystery of Christ’s healing presence. The question we face is whether it is possible that the forces I described earlier could converge in a “perfect storm” scenario, with the result that contemporary institutional health care delivery would not be an apt sign or an appropriate “how” for carrying on the what/why of mission/ministry. Although I personally believe the storm has yet to occur, humility requires that we not ignore the possibility. Our current efforts at defining our identity and benchmarking our commitments will provide us with helpful reference points for what should be a process of continuous reflection. Unlike some who have already concluded that a radical incompatibility already exists, I believe that by embracing the question with candor and creativity, we can ensure the continuing presence of an institutional expression of the healing ministry.

**Public Actor**

In the first part of this article, I reflected on our role as the provider of social goods. I noted that from the earliest times (the Ursuline Sisters came at the request of the French governor of Louisiana), while providing these services in what has come to be known as the voluntary sector, we have been in a variety of relationships with local, state, and federal government. While serving our own, we have also participated with others in addressing critical social needs, often partnering with the public sector in formal and informal ways. Contrary to the positions of some contemporary adversaries, this partnership involved at least an implicit accommodation in that the terms of the partnership honored our right to serve in a manner faithful to our identity.

Two realities have called that historic partnership into question. First, as noted above, the terms of the partnership have changed, with the public sector becoming a significant source of health care financing (Medicare/Medicaid) and not just a somewhat distant partner. Although we are only reimbursed (and at times, inadequately) for services rendered, clearly we are in a new relationship when 40 to 60 percent of a hospital’s or long-term care facility’s revenues come from government sources. Second, because of Roe v. Wade, our national public policy has placed into the arena of health-related services access to abortion services. In other words, within the sphere of the social good of access to health care, an activity we consider inimical to the common good—the taking of the innocent life of the unborn—now exists as a so-called right. The convergence of these two realities has not unexpectedly resulted in a call by those who advocate this so-called right that all who receive government reimbursement provide access to abortion and other “reproductive services.”

If this view were to prevail, it would call into question our historical relationship within our nation’s social compact in which we have been able to contribute to the fulfillment of social goods on which there is broad agreement while remaining true to our core values. I believe that such an eventuality can be avoided, but it will require an honest dialogue in the context of the fundamental principles of the American experiment that recognizes the centrality of accommodation and mutual respect to the success of our society. In the long run, our ability to heal the tear in the social fabric that has resulted from Roe v. Wade may be critical to the continuing our healing mission through the institutional forms we know today. Consequently, we must recommit ourselves to working for a consistent ethic of life that is grounded in the inviolable dignity of human life from conception to natural death as both a moral imperative for our country and an ethical vision that sustains our very identity. Even if in the short term Roe v. Wade is not overturned, we must effectively defeat the pro-choice campaign to eliminate Catholic health care and other social services as a partner in the provision of health care. To avoid this confrontation is to guarantee our opponents success and deprive countless communities of the compassionate care that is unique to our ministry.

As we celebrate the richness of a history whose origin and destiny is the Lord Jesus, the Alpha and the Omega, we have many opportunities facing us:

- Navigating the growing complexity of health care as an art and a science
- Serving as an active partner in public discourse about the proper allocation of health care resources across the continuum of care and the adoption of coherent national policy that guarantees access to all and just payment for all providers

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• Witnessing to the distinctive character of health care as a social good
• Confronting honestly the tensions arising from being an institutional ministry in today's health care environment
• Preserving our very freedom to serve

I am optimistic that those who gather to celebrate our 300th anniversary in 2027 will be able to recount the stories of how, with God's grace, we turned these opportunities into successes just as those who came before us shaped and sustained not only their destiny, but ours and that of those who will follow us.

NOTES
1. Letter from Thomas Jefferson to Sr. Marie Therese Farjon of St. Xavier, May 15, 1804, courtesy The Ursulines of New Orleans.
5. Farren, pp. 97-103.
8. Bernardin, "Making the Case for Not-for-Profit Healthcare," pp. 139-140.