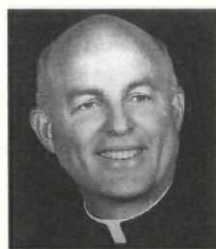


AN OPPORTUNITY FOR POSITIVE CHANGE

*We Have the History, Experience, and Will
To Preserve a Catholic Presence in Healthcare*

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The origins of Catholic healthcare in the United States are without a doubt the response of faith-filled, pioneering women to the readily discernible healthcare needs of their communities. The absence of public health measures; the concentration of poor immigrants in substandard housing; inadequate nutrition; the physical and mental fatigue of men, women, and children working interminable hours in factories under unsafe conditions; the epidemics of flu, typhoid, cholera, and scarlet fever; alcoholism; tuberculosis; and men wounded in battle generated the need for Catholic healthcare services. The lack of government response created a vacuum into which many of the 254 religious communities still active in healthcare entered. The charitable, heroic acts of women religious in response to the needs of the communities in which they set-

tled constitute one of the great chapters in the history of the Church in America (see **Box**).

A TIME OF CHANGE

The past 30 to 40 years have seen extraordinary change in the Catholic healthcare ministry. The Hill-Burton Act and the passage of Medicare and Medicaid legislation created new opportunities for the development of facilities and services to serve the aging and the poor. Catholic healthcare providers rebuilt acute care facilities, expanded services to their communities, and developed long-term care nursing homes. Public policy made it possible for Catholic providers to fulfill their mission to a previously unserved population.

In the past two decades, however, government has moved into a strong regulatory role and has experimented with various reimbursement

Summary The charitable acts of women religious in response to the needs of the communities in which they settled is one of the great chapters in the history of the Church in America. But in the past two decades providers have had to contend with extraordinary changes in the healthcare environment.

The Catholic healthcare mission was rooted in concern for the poor. Should Catholic healthcare providers withdraw from this field in which they have had such a significant presence and have contributed so much, or be driven from healthcare by the fiscal consequences of fidelity to mission? Instead, through its reform proposal, the Catholic Health Association has recommended that Catholic providers become advocates of change.

However, even if change, such as universal access to healthcare, is achieved, we shall still have a society in which there will be many poor peo-

ple. The challenge will be to see that healthcare for the poor does not become poor healthcare.

Although the changing urban environment presents enormous challenges to providers, the Catholic healthcare ministry is a significant presence in urban areas. Widespread poverty accompanied by behavioral problems and social breakdowns are significant factors affecting healthcare and healthcare costs. Drug addiction; AIDS; teenage pregnancy; homelessness; the deterioration of the family; and generations of unemployment, anomie, abuse, and violence, which are often most acute in concentrated neighborhoods of poverty, challenge the ability of Catholic hospitals to meet their community's needs.

Catholic providers today have a real opportunity to bring about positive changes in healthcare. They have the history, experience, and will to preserve a Catholic presence in the provision of healthcare.

methodologies. And in the past decade government has created a marketplace environment that, from a Catholic perspective of social justice, has had disastrous consequences.

The Catholic Health Association (CHA), St. Louis, has exercised outstanding leadership in calling attention to the inequities in the U.S. system of healthcare. In *No Room in the Marketplace: The Health Care of the Poor* (1986), CHA raised serious questions about Catholic participation in a system that marginalizes the poor. Can we be true to our Catholic identity in a healthcare marketplace that effectively limits or excludes so many citizens from access to healthcare? Should we withdraw from this field in which we have had such a significant presence and have contributed so much, or be driven from healthcare by the fiscal consequences of fidelity to mission?

CATHOLIC PROVIDERS' MISSION

During this past decade, not-for-profit, voluntary hospitals have wrestled with their missions and with their concerns for institutional identity and integrity. Catholic providers have become acutely aware of the contradictions inherent in their mission statements and the environment in which they operate. Many hours of prayerful reflection have raised questions around issues of social justice, concern for the poor, access to care, collaboration, the dignity of person, the transcendent value of human life, institutional integrity, workers' rights, and the need for advocacy to effect

changes in healthcare.

CHA has initiated studies to review the theological roots of our identity, to explore the ethical questions challenging Catholic values, and to probe our responsibility to the poor and frail elderly. The following collaborative efforts were established to create a vision for the future: the Commission on Catholic Health Care Ministry's *Catholic Healthcare Ministry: A New Vision for a New Century* (1988), the CHA 2000 Task Force, and the establishment of the Leadership Task Force on National Health Policy Reform.

Instead of leaving the healthcare field, CHA decided Catholic providers had to be advocates for change. I believe CHA has developed one of the most sound proposals for healthcare reform, grounded in the Catholic value system and focused on the primary need to reform the healthcare delivery system. The proposal promotes collaboration (rather than competition); citizen participation in the renewal of healthcare; a national commitment to the allocation of resources; and an appropriate role for government in determining needs, setting standards of quality, and measuring outcomes.

CHA's reform proposal is paradoxical: As a CHA board member commented, "We may be advocates for change, but we are also the targets of change." We stand on the brink of unprecedented change in which the very nature of healthcare may be radically altered from a disease-oriented system to a health-preservation system. Although I believe we are theologically and philo-

THE CATHOLIC RESPONSE

For hundreds of years religious congregations in the United States have responded to the healthcare needs of the communities where they settled. A few vignettes exemplify this response:

- St. Vincent's Medical Center was founded in 1855 in Toledo, then a disease-infested area known as the Black Swamp. Cholera plagued residents. In response to the local pastor's request, the Sisters of Charity Grey Nuns of Montreal established a mission to care for the sick and help raise the children orphaned in the plague.

- St. Vincent Charity Hospital and Health Center, sponsored by the Sisters of Charity of St. Augustine, opened its

doors in Cleveland in 1865 to care for sick and wounded soldiers returning from the Civil War. It was the city's first general hospital. In 1872 the hospital constructed Cleveland's first amphitheater for teaching medical students. St. Vincent opened a school of nursing in 1898. The city's first open heart surgery was successfully performed at St. Vincent in 1956.

- In 1852 the Sisters of Mercy obtained a charter for Chicago's first hospital. Chicago had serious sanitation problems, compounded by outbreaks of typhoid fever, smallpox, and cholera. Mercy Hospital cared for the sick and the orphans and was the only Chicago

hospital to survive the fire of 1871.

- Cholera broke out in St. Paul, MN, in 1852. The Sisters of St. Joseph of Carondelet converted a log cabin chapel to a hospital to nurse persons who contracted the disease. It was the first hospital in the state. In 1894 the sisters founded the first school of nursing in Minnesota.

- In 1869 officials in Scott County, IA, asked the Sisters of Mercy to find a solution to the county's growing health problems. The sisters obtained a building and land and opened a hospital for the sick, poor, and insane. The sisters' agreement with county officials was to relieve "suffering in all its forms."

sophically prepared to participate in a reformed healthcare system, our capacity for entrepreneurial initiatives and timely action will be severely tested.

Some might argue that once we have achieved universal access to healthcare, we will have accomplished a major part of our mission and perhaps our presence in healthcare will no longer be necessary. It is an interesting proposition, but not persuasive. No matter what system is devised, we shall still have a society

in which there are many poor people. It remains to be seen if any reform will or can eliminate a multitiered system of healthcare. Even if this were possible, the many barriers to obtaining healthcare that go beyond the financial will still exist.

Furthermore, *how* people are treated in the system entails more than technical competence and skill. Catholic healthcare providers do not claim exclusive concern for the dignity of the human person, but it is a driving force for our participation. We value life as God given, having transcendent value. This conviction in faith inspires us to provide compassionate care and service to the sick and sustains our preferential concern for the poor.

THE URBAN SCENE

The Catholic healthcare ministry is a significant presence in urban areas: 71 percent of Catholic hospitals are located in urban areas—25 percent (143 hospitals) in the largest cities and 46 percent (265 hospitals) in smaller urban communities.

These urban communities experienced significant changes between 1980 and 1990. Widespread poverty accompanied by behavioral problems and social breakdowns are significant factors affecting healthcare and healthcare costs. Drug addiction; AIDS; teenage pregnancy; homelessness; the deterioration of the family; and generations of unemployment, anomie, abuse, and violence, which are often most acute in concentrated neighborhoods of poverty, challenge the ability of Catholic hospitals to meet their community's

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Between 1980 and 1990, 40 percent of the nation's population growth was the result of the immigration of 8.6 million people, most of whom settled in central cities. Since 1980, 42.7 percent of all immigrants came from Latin America and the Caribbean (22.5 percent from Mexico alone), and 38 percent from Asia, largely the Philippines, Vietnam, and Korea. In general, there was a decline in cities' white population and an increase of all other

ethnic and racial groups.

Epidemiological studies indicate a correlation between poverty and ethnicity. In 1991, 14.2 percent of the U.S. population lived in poverty. The poverty rate was 32.7 percent for African Americans, 28.7 percent for Hispanics, and 11.3 percent for whites. A similar correlation is seen when comparing the poverty rate among children under age 18. In 1991 the poverty rate for children under 18 was 21.8 percent; for African-American children, 45.9 percent; for Hispanic children, 40.4 percent; and for white children, 16.8 percent.

In 1991 Americans' per capita income as adjusted for inflation shrank. The national poverty rate rose from 12.8 percent in 1989 to 14.2 percent in 1991. In families where women were the heads of the household, 57.4 percent were poor. In 1991 such families accounted for nearly two-thirds of all poor families.

In 1990, 44 percent of African-American children under age five were poor. In New York City 40 percent of children were poor. In 1992 welfare rolls in New York City soared to more than 1 million for the first time since 1970. Even though welfare dependency has reached record levels, 44 states cut or froze fringe benefits in 1992. And purchasing power of welfare recipients has declined 43 percent in the past two decades. More than 10 percent of the U.S. population (26.6 million persons) use food stamps, up 36 percent in the past three years.

Although there are no agreed-on figures for the number of homeless, estimates range from

250,000 to 3 million.

Medicaid costs averaged about 17 percent of state budgets from 1989 to 1991 and rose 25 percent in 1992. In 1992 federal Medicaid dollars exceeded federal dollars for education. Federal and state governments spent 31 percent more on Medicaid in 1991 than in 1990. Still, Medicaid covers only about 47 percent of people below the poverty level.

Medicare covered 35.6 million Americans in fiscal year 1992, at a cost of \$132.3 billion, or \$3,624 to each beneficiary. In 2003, 2.2 million persons will turn 65, and between 2003 and 2027 it is estimated that 75.9 million people will be covered by Medicare—more than double the present number.

URBAN CATHOLIC HOSPITALS

The changing urban environment presents enormous challenges to healthcare providers. Currently the fiscal health of hospitals is related to location. According to *A Profile of the Catholic Healthcare Ministry, 1992* (CHA, 1992), Catholic hospitals located in large urban areas serve an average population of about 185,000. The population under 32 years of age is large in urban areas compared with rural areas (40.4 percent versus 14 percent). Compared with financially sound hospitals, adversely affected Catholic hospitals are located in areas with higher unemployment, lower per capita income, and a larger population in poverty.

In 1980 Catholic hospitals and long-term care facilities served more than two dozen communities in which 35 percent or more of the population lived in poverty. In 1990 nearly 100 communities served by one or more Catholic hospitals or long-term care facilities had African-American populations in excess of 50 percent. Communities in south Texas had concentrations of Hispanic residents ranging from 60 percent to 95 percent. Nearly a dozen communities in California had Hispanic populations ranging from 25 percent to 80 percent.

As shown in *A Profile of the Catholic Healthcare Ministry, 1992*, margins of 89 adversely affected Catholic hospitals have decreased since 1985. In 1990, 80 hospitals had average margins of -7.05 percent. Twenty-six of these hospitals had 4 consecutive years of negative margins. The subgroup of adversely affected hospitals grew by 12 between 1989 and 1990. In CHA's study of 497 Catholic hospitals, 21 percent of the study group was characterized as consistently sound and 17.9 percent as adversely affected.

In 1990 the average total expenses per admission for all Catholic hospitals (\$5,025) for the first time exceeded average net patient revenue per admission (\$4,946). Catholic hospitals allocated an average of 14.2 percent of their gross patient revenues (\$5 billion plus) to care for the poor. Forty-nine hospitals spent an average of 33 percent of gross patient revenues on the care of the poor. At the Catholic Medical Center of Brooklyn and Queens, which serves an urban area, bad debts, charity care expenses, and Medicaid costs totaled \$233 million, or 50 percent of gross expenditures.

CATHOLIC PROVIDERS' CHALLENGES

We are on the brink of major changes in the U.S. healthcare system. Catholic healthcare providers have been active participants in the debate and have advanced one of the most highly respected proposals for reform. We have advanced a series of criteria that focus on social justice values, ethical concerns, and persons' right to choose their providers. We are deeply concerned about the unsustainable increases in healthcare costs and believe it is possible to eliminate many inefficiencies in the present system of care. We advocate a positive but less-intrusive role for government in healthcare. We believe it is possible to change the direction of healthcare to a wellness approach from its present preoccupation with disease and rehabilitation.

It will take a number of years to revamp the healthcare system, but there will be enough flexibility to allow for state and regional initiatives to create locally responsive systems of care. Our challenge is to take the initiative to forge local relationships among providers to create networks of care and service. I believe this presents a significant test to multi-institutional systems' ability to empower local boards and staff to act in a timely fashion to establish local agreements. While this must reach beyond Catholic institutions, we do have a unique opportunity to initiate and strengthen relationships with parishes and Catholic institutions of social services and education.

Healthcare reform may make service and care available irrespective of ability to pay, but it will not eliminate poverty in our society. There will continue to be poor people, and our challenge will be to see that healthcare for the poor does not become poor healthcare. Many of our institutions that serve large, impoverished populations may benefit from a reformed system of financing, but they will face the challenge of recruiting and

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HOLISTIC RETREATS

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lives. Many say they are improving their physical health by exercising, losing weight, coping with stress in more positive ways, and integrating prayer into their lives.

Finally, the recent offshoot from participants of the holistic spirituality retreats is Lourdes Associate Ministry Process (LAMP). LAMP members are persons who have participated in retreats and are now sharing their experiences with others. For example, LAMP members have given presentations on a variety of holistic topics to Mercy Corps (a group of volunteers who work with the Sisters of Mercy), to a bereavement group, and to several other groups.

LIFE AS GIFT

Lourdes wellness retreats have a bright future. More and more people are turning to spirituality, preventive care, and alternative ways of healing in our high-stress and environmentally threatened society.

In addition, the medical center's constituents appreciate that it seeks creative ways to take its mission seriously.

Lourdes, through its holistic retreat program, can provide a caring experience for an individual, enabling him or her to achieve wellness. It can cooperate in forming communities that attend to the whole person—body, mind, and spirit—and that care for the environment. It can influence the Christian theology of wellness, of living life to the fullest, no matter what limitations the individual faces.

The Scriptures say, "I have come so that you may have life, and have it in abundance." The holistic retreats at Lourdes Wellness Center help people to know and name life as gift and to commit to living it more fully for themselves and, ultimately, for their society and their world. □

ANTITRUST

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petition. On the one hand, this allows broad freedom for developing efficient IDN structures, even without any antitrust exemptions. On the other hand, no specific legal structure offers more or less antitrust protection under current rules.

An IDN could raise all the classic antitrust concerns such as horizontal arrangements between like providers, vertical arrangements between different types of providers, and even per se violations that fix prices. Antitrust enforcers' interest in these arrangements will vary according to their effect on competition. Coordination of services among providers who do not compete because of differences in service area or product will raise less concern than plans involving the same kinds of providers or price fixing.

If an IDN can remain focused on the patient and efficiently deliver services to the community, as is proposed, this would minimize antitrust concern. Unfortunately, some features integral to IDNs (especially pricing and arrangements among like providers) could raise serious antitrust problems.

Another antitrust challenge common in healthcare is the private use of antitrust laws to fight a hospital's denial of physician's privileges, bid to provide medical services, or medical staff membership based on the quality of his or her medical care. Providers who are shut out of IDNs for similar reasons could sue the IDN, alleging antitrust violations. And some healthcare providers, motivated by politics or self-interest, doubtless will harm the consumer and merit antitrust enforcement.

Any attempts to establish IDNs will need to also ensure clear language exists regarding the reach of antitrust laws. Healthcare providers will need support to act without being tied up by those who oppose change or believe they have lost some economic benefits. No one needs a valid reason to sue, but clear, coordinated government healthcare and antitrust policies will help ensure a successful defense and timely IDN development. □

POSITIVE CHANGE

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retaining qualified medical and allied health professionals.

If managed care is at the heart of reform, we will become part of a network or a continuum of care. Our external relationships will require considerable interaction, dialogue, and mutual accountability. We shall have less autonomy and more interdependent relations. This will challenge us to determine what specific roles we want to play in the network, and it will raise delicate ethical questions about cooperation with other organizations. Boards of directors of Catholic healthcare organizations will be driven to review mission and constantly evaluate participation in a pluralistic network.

As we cope with external realities, we must also attend to internal concerns. Sponsorship of Catholic healthcare providers will change in the next two decades. We shall have to identify and recruit lay leaders to exercise governance of our institutions, and we will have to establish stronger ties with local Churches. The maintenance of Catholic identity and integrity will be more difficult in a reformed delivery system, but we have educated and capable lay leaders to sustain our distinctive presence. Religious sponsors, along with CHA, are already developing educational institutes to focus on training our lay leaders. In urban areas we shall have to give greater attention to identifying, recruiting, and training minority lay leaders.

WE CAN MEET OUR CHALLENGES

These are exciting times, providing real opportunity to bring about positive changes in healthcare. I believe we have the history, the experience, and the will to preserve a Catholic presence in the provision of healthcare. CHA has positioned itself strategically to be an active and influential player in the reformed system. The challenges may be more complex but are not more daring than the efforts made by the pioneers of Catholic healthcare. □