ALL NEEDS ARE NOT CREATED EQUAL

FR. MICHAEL ROZIER, SJ, PhD

A comprehensive community health needs assessment will find genuine need in every corner of our communities, yet these CHNAs focus on the needs that touch our poor and vulnerable. Why is that so? Doesn't diabetes or cardiovascular disease or opioid addiction have the same devastating effect on individuals and families, regardless of their social location or economic status? Why would we focus our attention on one part of our communities over another?

In the field of health care, we all recognize the nearly unlimited needs in our communities and are keenly aware of the limited resources with which we can respond. Prioritization in health care is not a new task, but what is new is the ever-expanding list of medical and social needs with which health care organizations must be concerned. Alternative payment models, better data systems, a disease burden of chronic disease and new community benefit requirements are just some of the reasons why delivery organizations must look beyond their own walls. Issues of prioritization in health care used to focus on matters of care delivery: how to allocate scarce medical interventions;[1] how to triage in an emergency;[2] or who gets pharmaceuticals when drug shortages occur?[3] Yet with health care delivery organizations engaging more with community-level issues, the need for thoughtful prioritization grows.

Community health needs can be prioritized using many methods. The National Association of County and City Health Officials offers five of the most popular methods,[4] all of which are likely used by one or more Catholic health organizations. Still, the more fundamental question for setting priorities is not one of process but one of purpose. The justifications for how we prioritize community needs reveals a great deal about who we are. How might we ensure that the Catholic tradition informs this important task, thus revealing a fundamentally Catholic understanding of this work? One aspect of the answer is to keep our attention focused on the poor and vulnerable. All health needs are real, but all needs are not created equal.

WHY THE VULNERABLE

To further explain the focus on the poor and vulnerable, we can look to three areas of thought.

The law: Nonprofit health care is required not just to be attentive to the community as a whole, but to direct special attention to the poor and vulnerable. The IRS does not specify what process should be used for prioritization, but it does indicate an interest in "ensuring the hospital facilities assess and address the needs of medically underserved, low-income, and minority populations in the areas they serve."[5] We have decided as a matter of policy and law that this is important, similar to means-testing safety net programs, wherein income or disability helps determine whether one is eligible for food assistance or Medicaid.

Social science: Ideally, our society would be organized in such a way that everyone had the same opportunities — safe parks, good education, clean air and water, health insurance — to realize their fullest potential for health. The only differences, then, would arise, aside from genetics and luck, from personal choice. We don't live in that world. We know that social conditions make it more likely for some groups of people to be healthier than others. In addition, those groups that are less healthy are the same people who lack the financial resources or political power to change how society is structured. Therefore, if we want to improve the community's overall health, we must pay special attention to those groups whose social conditions make health more difficult to achieve.

Catholic moral tradition: The third and most fundamental reason for giving priority to the poor and vulnerable is Catholic moral tradition. Human dignity, the idea that every human being is willed by God and imprinted with God's image,[6] is why we are concerned with anyone who is sick and suffering. Any affront to the human person requires our attention, which is why everyone suffering from diabetes or depression deserves our expertise. At the same time, offenses to human dignity are not evenly distributed across society. Some groups — the disabled, the elderly, racial minorities, the undocumented, to name a few — are treated as more disposable than others and, therefore, the efforts to affirm the dignity of these groups must be more concerted.

Human dignity also provides the motivation for our moral tradition's preferential option for the poor. God has a preferential option for the poor "not because they are better than others, morally or religiously, but simply because they are poor and living in an inhuman situation that is contrary to God's will."[7] In part, we draw our care for the poor from the founding congregations who often risked their physical and financial health to respond to their community's greatest needs. But ultimately, this call is from the Gospels and the person of Jesus, who cared for all who crossed his path, but paid special attention to those society tried to marginalize.

Ultimately, the ministry of health care not only affirms each individual's dignity, but also reveals something about how we think society ought to be organized. We seek the common good, or the conditions individuals and groups need to realize a state of fulfillment. The complexity and expense of health care is a perfect example of a good that simply cannot be achieved by an individual acting alone. We pool our resources to educate our physicians and nurses, to build infrastructure, ensure clean air, and much more; we also seek a society where those resources are shared by all.

CONCLUSION

I spend much of my time in the secular world of public health, and it tends to believe all its insights are its own. For example, the general rise in appreciation for meditation and mindfulness rarely points to the religious traditions that have encouraged the practice for millennia. The same is true with the health care community's relatively new emphasis on health disparities and equity. Catholic health care has a rich tradition of grounding its efforts in social analysis and has long found purpose in caring for those the world believes are disposable. We should welcome more voices singing from the hymnal we have been using for centuries, but we must not shy away from claiming our hard-won expertise in this area.

In the Catholic tradition, along with many other faith communities, we do this work because of our core beliefs about the human person and human communities. That is why we are often on the leading edge of these efforts. We do not wait for the law to tell us what to do. We should not need the business case to be conclusive. We are responding to something more fundamental — the belief that our gaze should fall as Jesus' did: on everyone, of course, but with special attention to those from whom society tries to look away.

FR. MICHAEL ROZIER is a Jesuit priest and an assistant professor of health management and policy at Saint Louis University College for Public Health and Social Justice.

NOTES

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