CATHOLIC IDENTITY, ETHICS NEED FOCUS IN NEW ERA

"Whither Catholic Health Care?" is the title of an article by John Coleman, SJ, that was published in the Nov. 30, 2012, issue of *America*. It's a great question! Where *is* Catholic health care headed? It is clearly undergoing profound changes and doing so quite rapidly. Catholic health care systems are merging with other Catholic, other faith-based and, increasingly, with secular health care systems. They are partnering with physician groups and increasingly employing physicians. They are purchasing or partnering with secular not-for-profit and for-profit entities that provide health care services such as home health, occupational and ambulatory care, surgical centers and imaging.

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There are increasing numbers of for-profit Catholic health care entities. One Catholic system has created a for-profit subsidiary that aims at purchasing financially challenged Catholic hospitals which will in turn become for-profit. One formerly Catholic system has restructured in such a way that it is no longer formally Catholic so it can better accommodate its secular hospitals and better facilitate partnering with or the acquisition of additional secular health care entities. Other Catholic systems are studying the advantages and disadvantages of such restructuring for themselves. And all of this is not to mention ongoing hospital mergers and acquisitions, some with secular community hospitals and even university medical centers.

Much of this activity is, in large part, an attempt to provide more effective and efficient health care to particular populations. Such a focus, often referred to as a shift in approach to population health, can be described as "managing the care of a discrete group of individuals in a coordinated way that achieves improved outcomes at lower cost. The group can be an entire community, a segment of that community, a base of employees or people who simply are categorized by demographics or condition. The key is focusing on the entire population — how does it access care, and how can its needs be better met through a more integrated approach to health care delivery?"[1]

In order to achieve a more integrated approach to health care delivery, new and different kinds of partnerships are required. One such type of structure is the accountable care organization (ACO) which is described as "groups of providers who are willing and able to take responsibility for improving the overall health status, care efficiency, and health care experience for a defined population."[2]

At the pace and the extent to which these new partnerships and structures are occurring, as well as the shift in emphasis in health care delivery, what will Catholic health care look like 10 years — even five years — from now and, more importantly, will it have become stronger or weaker in carrying out the healing ministry of Jesus? That, after all, is the bottom line. In a 1994 address to Catholic health care of Illinois, Cardinal Joseph Bernardin stated: "While the manner in which this ministry is exercised has changed, and will change even more, the ministry itself must continue."

Ultimately, all the changes that Catholic health care is undergoing should contribute not only to surviving or flourishing in the health care marketplace, or to facilitating more effective and efficient care to ever-increasing numbers of persons, or to reducing the costs of health care — but they also should contribute to whom and what Catholic health care is all about.

The matter of Catholic identity is chief among the challenges all of these mergers, acquisitions, partnerships, affiliations and new structures bring. It can be watered down deliberately, as when an organization doesn't want to appear "too Catholic" out of fear of offending partners who are other than Catholic. A more likely danger, however, is an inadvertent weakening, possibly due to mixing different organizational cultures (i.e., the assemblage of prevailing and formative beliefs, values, intentions, motives, practices and behaviors) without sufficient deliberate and ongoing efforts of various kinds to nurture and strengthen Catholic identity.

Paramount in considerations of possible partnerships are these two questions: How will the issue of different cultures be negotiated? And how will it be negotiated in such a way that the Catholic culture of an organization is not dissipated?

The very nature of Catholic identity also comes into play. Do we have a common understanding of what it is? What happens if we don't? Already, we see thin and thick notions at work. Some seem to reduce Catholic identity to observance of a couple of the *Ethical and Religious Directives for Catholic Health Care Services*, particularly the church's prohibition of direct sterilization. Thus, the reasoning is, if a Catholic organization does not perform sterilizations and prohibited reproductive procedures and, needless to say, direct abortions and physician-assisted suicide, it can be considered Catholic.

Others seem to sum up Catholic identity as not performing prohibited procedures, having religious symbols in lobbies, hallways and patient rooms, supporting a pastoral care department and recognition by the local diocesan bishop. These practices are not unimportant and they are certainly a part of Catholic identity, but they miss the deeper reality: Catholic health care is fundamentally about carrying on the healing ministry of Jesus and advancing the reign of God, and all that these imply for Catholic health care's defining beliefs, values, practices and behaviors.

Speaking of sterilizations, these, too, are becoming an increasing challenge. The days of "pastoral exceptions" for serious medical reasons are basically over. There is a sense in which, in the context of partnerships with secular organizations, pastoral exceptions have been replaced with carve-outs, namely, creating firewalls between the Catholic partner and the secular partner performing sterilizations. Ownership, governance, management, financial benefit and elements essential to the performance of sterilizations have been carved out of the relationships.

But creating carve-outs is becoming much more difficult with the formation of ACOs, an emphasis on population health and medical homes, partnerships with physician practices and the hiring of physicians. Some potential partners are offended by the suggestion that they are engaged in wrongdoing. Others believe that their professional integrity is being compromised because they are being required to practice in a way that is inconsistent with the standard of care, thus they are providing poor care to their patients. Still others believe that their personal and professional conscience is being violated.

In maintaining the church's prohibition of sterilization, Catholic health care organizations might well find themselves having to pass up some partnerships, some new modes of health care delivery or find themselves restructuring in a manner they would not otherwise choose in order to avoid these kinds of difficulties.

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It may give rise to a new focus on different sets of issues than those we typically deal with in an acute care setting, with almost exclusive concern for the individual patient. This area is ripe for further thought and work. There are undoubtedly many reasons why Catholic health care (and other) organizations are moving in the direction of population health, restructuring their delivery of care to better achieve this goal. Hopefully, one of the reasons is to promote mission — to carry on the healing mission of Jesus and advance the reign of God.

The many challenges stand in sharp contrast to the numerous opportunities afforded by these new partnerships, new structures and new modes of delivery. The shift to population health and the development of delivery structures to enact this shift actually begin to embody some of the fundamental commitments of Catholic health care. Therefore they have the potential for strengthening and realizing Catholic identity.

It would seem that, from a theological/ethical perspective, one of the grounding convictions of population health — because it seeks to address the health needs of everyone in a given population

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— is a belief in the inherent dignity of all persons and the importance of health care for meeting a basic human need, thus respecting and promoting *human dignity*.

A focus on population health also suggests an implicit commitment to *solidarity*. In the words of Pope John Paul II, solidarity "is not a feeling of vague compassion or shallow distress at the misfortune of so many people… . On the contrary, it is a firm and persevering determination to commit oneself to the common good; that is to say, to the good of all and of each individual because we are all really responsible for all."[3]

The attempt to meet the health needs of a defined population is at once a recognition of our responsibility for the good of each and our responsibility for the good of all, which is nothing less than a pursuit of the *common good*. What we are seeing in the development of ACOs and medical homes is the creation of structures that promote the good of individuals as well as the well-being of an entire given population.[4]

But this is not all. Population health also promotes good *stewardship* of health care resources by seeking to provide quality care at lower costs and by addressing the physical and social determinants of health that are known to have a greater impact on health status both positively and negatively than medical interventions and medical technology. Prevention, a major goal in population health, is intimately linked to good stewardship as are efforts at better coordination and integration of care.

A focus on population health also fosters *justice* in that it seeks to reduce health inequities within and among population groups by addressing the health needs of the underinsured and uninsured as well as the insured. In so doing, population health promotes Catholic health care's *commitment to the poor, the vulnerable and the marginalized*. And, finally, an emphasis on population health fosters *participation* in that it consults with community residents and leaders of community organizations about matters relating to the health needs of the given population.

From a mission perspective, there is much to be said for a shift in emphasis in our health care delivery system to population health and for the development of those structures that can facilitate implementing this shift. Because it is such a change from our current delivery system, this effort is going to be difficult, and it is not without significant challenges to and for Catholic health care. The enormous potential benefits, however, are worth the effort. The challenges are not insurmountable and may, in fact, lead to very positive results in the long run.

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NOTES

1. Mark Crawford, "Catholic Health Systems Steer the New Course," *Health Progress* 94, no. 1 (January-February 2013): 27.
2. Susan DeVore and R. Wesley Champion, "Driving Population Health through Accountable Care Organizations," *Health Affairs* 30, no. 1 (January 2011): 41.
3. John Paul II, *Sollicitudo Rei Socialis*, no. 38.
4. DeVore and Champion, "Driving Population Health." On page 42, DeVore and Champion suggest that the goals of ACOs "are to empower people to take charge of their health and engage in shared decision-making with providers; eliminate waste and unnecessary spending while also meeting patients' preferences for care; increase preventive care and other strategies that could help keep people well; and increase overall satisfaction with care …"

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