HEALTH CARE DELIVERY AND VALUE COMMITMENTS

Several years ago, those involved in Catholic health care articulated the mission and values of the ministry in what has come to be known as the "Shared Statement of Identity for the Catholic Health Ministry" (see facing page). Appended to the statement are seven value commitments. As this month's *Health Progress* investigates new models of health care delivery, it might be appropriate to discuss how some of these models can either enhance or detract from the seven value commitments.

FR. THOMAS NAIRN

Among the models that have become part of the new landscape of health care are accountable care organizations, clinically integrated networks, patient-centered medical homes, palliative care and movements toward population health, to name only a few. Some of these models are based on the framework developed by Donald Berwick, former president of the Institute for Healthcare Improvement in Cambridge, Massachusetts. Known as the Triple Aim, Berwick's framework is based on these goals: to improve the quality of the health care experience for the patient, to improve population health and to reduce total cost of health care by reducing unnecessary procedures, utilizing better care coordination and avoiding duplication.[1] Berwick and his co-authors explain that the Triple Aim is an "exercise in balance," in which the improvement in any of the three aims must not come at the expense of either of the other two.[2]

Looking at the seven value commitments shows both opportunities to live by our expressed values and raises some concerns:

1 Promote and Defend Human Dignity

Many of the new models in one way or another show respect for the dignity of the person. The Triple Aim's focus on care improvement, for example, emphasizes safety, patient-centeredness, timeliness and effectiveness.[3] Each of these factors ultimately can promote human dignity. The movement to population health also is grounded in a belief in the inherent dignity of all persons and the importance of health care in meeting basic human needs.

On the other hand, U.S. health care often has equated respect for the dignity of the person with personal autonomy. With the shift to population heath, clinically integrated networks and patient-centered medical homes, there likely will be a need for health care to move beyond a simplistic understanding of patient autonomy and choice. Here, the moral tradition that grounds Catholic health care can be of help, with its emphases on the social dimension of the individual-in-community and on solidarity. Similarly, the commitment of the Catholic social tradition to the dignity of the person can stand as a counterpoint to those elements in contemporary American life that threaten true dignity — for example, recent attempts by several states toward the legalization of assisted suicide.

2 Attend to the Whole Person

Many of the newer models of health care delivery emphasize the fact that they are holistic. The Agency for Healthcare Research and Quality of the U.S. Department of Health and Human Services, for example, describes the patient-centered medical home as delivering primary health care in a way that is comprehensive, patient-centered, coordinated, accessible and committed to quality and safety.[4] These core functions can relate well to Catholic health care's commitment to care for the whole person.

Similarly, the emphases of palliative care are holistic. At its best, palliative care employs an interdisciplinary team approach, which includes

pain and other symptom management, emotional support and spiritual care. It thus addresses the comprehensive needs of the patient.

3 Care for Poor and Vulnerable Persons

In several emerging models, one of the goals is that of caring for vulnerable populations. Population health especially seeks to reduce disparities and inequities among population groups. Looking at the other models, there is nothing inherent in any of these structures that would exclude care for poor populations. It seems that patient-centered medical homes especially might be in a position to provide quality care for the poor and vulnerable.

A concern remains, however, that the very structures created to deal with greater equity may themselves create greater disparities. In a recent article in *JAMA*, Craig Pollack and Katrina Armstrong, physicians associated with Johns Hopkins School of Medicine, questioned whether the creation of ACOs and similar organizations actually might increase racial and class disparities.[5] They argue that, though it is not intentional, the cherry-picking practices in ACO formation and the process of owning panels of patients may concentrate more well-off patients within certain systems and create a scenario that "leaves lower-income patients ... more concentrated in hospital systems that have relatively fewer financial resources and less ability to compete in a new world of accountable care."[6]

4 Promote the Common Good

The individualism and growing libertarianism of contemporary American society have made discussion of the common good and solidarity (which Pope John Paul II identified as "a firm and persevering determination to commit oneself to the common good"[7]) extremely difficult. Nevertheless, there are rays of hope in the new structures. Especially in population health, there exists an implicit commitment to the common good and to solidarity. Similarly, since part of the Triple Aim is, in fact, population health management, those structures also are able to contribute positively to the common good.

Problems definitely remain, however, as the debate around the Affordable Care Act's "individual mandate" has shown. Action on behalf of the common good often is characterized as socialism. Solidarity often is rejected because it impinges upon a particular understanding of choice which does not take into account one's responsibility for one's fellow citizens — one's neighbors. Of all the articulated value commitments of the "Statement of Shared Identity," this may be the most difficult to share with those outside of — and even sometimes within — the ministry.

5 Act On Behalf of Justice

The value commitment to act on behalf of justice characterizes many aspects that have already been discussed. Justice, in its many forms, relates to respect for the dignity of persons, care for the poor and vulnerable, and promoting the common good. Of particular interest when discussing justice is the fair allocation of health care resources across the population. Berwick summarizes the need for justice in emerging structures when he explains that "the gain in health in one subpopulation ought not to be achieved at the expense of another subpopulation."[8] Simply put, these structures must remain equitable. Going even further, Norman Daniels, professor of ethics and population health at Harvard's School of Public Health, says simply that "social justice is good for our health."[9] Emerging health care structures must enhance not only distributive justice, but also social justice.

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6 Steward Resources

Stewardship should not be seen exclusively in monetary terms. The emphases on coordination, prevention, management of chronic conditions, the following of patients when they leave the acute-care facility, quality and safety all embody good stewardship. Yet, because health care costs in the United States remain much higher than in any other industrialized nation, emerging health care structures also need to address costs. The movement from pay-for-performance to outcomes and evidence-based medicine, which characterizes

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many of the new health care delivery models, will inevitably become an important factor in the future of the nation's health care. Appropriate stewardship also will help guarantee that our health care system serves all members of the population in a manner that ensures sustainability.

7 Act in Communion with the Church

The delivery models under discussion will call for greater collaboration between Catholic health care institutions and entities that may not share some or all of our basic values. This in itself is not a problem. Pope Benedict XVI has suggested, "The solidarity shown by civil society thus significantly surpasses that shown by individuals. This situation has led to the birth and the growth of many forms of cooperation between State and Church agencies, which have borne fruit. Church agencies, with their transparent operation and their faithfulness to the duty of witnessing to love, are able to give a Christian quality to the civil agencies too, favoring a mutual coordination that can only redound to the effectiveness of charitable service."[10]

Elsewhere, however, he has warned, "We must of course exercise critical vigilance and, at times, refuse funding and partnerships that, directly or indirectly, foster actions and projects that are contrary to Christian anthropology."[11] Catholic health care may increasingly need to negotiate the tension between "mutual coordination" and ensuring that it does not foster projects contrary to our Catholic faith. This tension will not go away any time soon. In fact, last year the Congregation for the Doctrine of the Faith issued "Principles for Collaboration with Non-Catholic Entities in the Provision of Health Care Services" in an attempt to deal with the tension.[12]

From the point of view of the value commitments articulated in the "Shared Statement of Identity," there are many elements of the current trends that are consistent with the mission and values of Catholic health care. Ethical issues nevertheless remain and will continue to call for vigilance on the part of Catholic health care ethicists and others involved in the ministry.

FR. THOMAS NAIRN OFM, PhD, is senior director, ethics, at the Catholic Health Association, St. Louis.

NOTES

1. See, for example, Donald M. Berwick, Thomas W. Nolan and John Whittington, "The Triple Aim: Care, Health, and Cost," *Health Affairs* 27, no. 3 (May-June 2008): 759-69.
2. Berwick et al., 760.
3. See Berwick et al., 760.
4. See pcmh.ahrq.gov/page/defining-pcmh (accessed March 4, 2015).
5. Craig Evan Pollack and Katrina Armstrong, "Accountable Care Organizations and Health Care Disparities," *JAMA* 305, no. 16 (April 27, 2011): 1706-07.
6. Pollack and Armstrong, 1707.
7. Pope John Paul II, *Sollicitudo Rei Socialis*, par 38.
8. Berwick et al., 760.
9. Norman Daniels, *Just Health: Meeting Health Needs Fairly* (New York: Cambridge University Press, 2008), 6.
10. Pope Benedict XVI, *Deus Caritas Est*, par 30.
11. Pope Benedict XVI, "Address to the Pontifical Council Cor Unum," Jan. 19, 2013.
12. See Congregation for the Doctrine of the Faith, "Some Principles for Collaboration with Non-Catholic Entities in the Provision of Health Care Services," *The National Catholic Bioethics Quarterly* 14, no. 2 (Summer 2014): 337-40.

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