

Catholic Identity And the Shape of Reform

BY MARY KATHRYN GRANT, PhD

Guaranteeing access to care is clearly one of the critical challenges we face in healthcare reform. But in changing the system to ensure universal access, Catholic providers will also be changing themselves. The shape reform takes will have a major impact on our core identity as providers and sponsors.

What will be the shape and the consequences of systemic reform? First, I believe the government will mandate integrated health networks in most markets, requiring us to form partnerships with other providers and in some instances with insurers. Second, I believe advances in technology, disease prevention, and treatment will bring about fundamental changes in healthcare delivery. Finally, these two developments will cause us to reshape and redefine sponsorship because what we sponsor will no longer be only hospitals, long-term care facilities, and clinics, but a true health and healing ministry.

THE QUESTION OF ACCESS

But how will these changes in the delivery system help us address the issue of access? The fundamental question of access leads us to a host of others: Access to what? By whom? How?

Access to What? The *what* of access will undoubtedly include the following elements:

- Prevention, wellness, and education services
- Ambulatory and outpatient centers
- Acute care
- Long-term care
- Rehabilitation services
- Home healthcare
- Hospice

To ensure such services are included in an integrated system, we will need to create new incentives for hospitals, physicians, insurers, and the insured that promote personal responsibility for one's health. And healthcare providers will have new partners—the government, schools, social service agencies, parishes, and churches.

Integrated health systems have as a goal the



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development of seamless continuums of services, often linked to financing. Such systems alone will not guarantee access, but they should remediate some of the injustices inherent in the current system. This paradigm shift will require providers to form new alliances and invest considerable capital in information resources. Access will most likely not be to "Catholic hospitals" in the traditional sense, nor even to "Catholic health networks." In many markets, Catholic healthcare providers will not be able to form "Catholic networks." Networks and systems will be forged with other not-for-profit and for-profit providers, often with us playing a minority role.

Access by Whom? The simplest answer to this question is, By everyone. It is *how* to ensure everyone has access that concerns so many self-interest groups. Physicians advertise that they do not accept Medicare assignment. Employers and employees cannot afford escalating healthcare premiums. The insurance-employment link is a woefully inadequate means of ensuring access today. We all know of individuals in "job-lock" who cannot change jobs because they would lose insurance. Insurers cherry pick to avoid risk, excluding those in high-risk jobs, persons with preexisting conditions, and the sick. The elderly fail to comply with drug protocols because they cannot purchase the needed prescriptions. Our emergency rooms become departments of convenient medicine for people too ill to wait any longer.

How? We are told that within the next decade almost 80 percent of what is done in hospitals today will be performed in homes, physicians' offices, outpatient centers, and the like. Hospital buildings will become intensive care and long-term care centers, and we will need fewer of them. These developments will also create the need for vast computer networks that link laboratories, offices, outreach centers, and other sites and are accessible to appropriate healthcare providers.

This shift in the points of access will oblige us

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to change how we allocate resources and capital. We will also have to alter some of our fundamental premises concerning sponsorship, reserved powers, and "Church property." In the future, a large percentage of our assets will no longer be buildings and property but these complex computer systems, insurance programs and products to cover potentially thousands of lives or persons, and pieces of ventures and partnerships.

One result of these paradigm shifts and partnerships will be that we become responsible for people, not property. People will access networks or systems of services, where and when they need them. Our responsibility will be to ensure a seamless connection to services. This in turn will require systems that facilitate access to medical records, patient histories, diagnostic results, and insurance and payer information. The resulting networks will be responsible not only for providing services but also for maintaining the health status of a defined population. If providing access has been a challenge, think of the radical redirection of energy, resources, and capital that will be required to ensure access to an integrated network—and the tremendous potential before us to transform healthcare.

CATHOLIC IDENTITY AND SPONSORSHIP

As we become "stewards" of the health status of communities, we must find a new way of looking at healthcare. These three developments—integrated health systems, technological advances, and a new definition of our asset base—will call us to write a new definition of sponsorship, to articulate clearly the meaning of Catholic healthcare, and to create new ministerial responses.

What will be the concrete expressions of these changes? As patients receive healthcare, what do we want them to experience? What should distinguish our services from those of other providers?

Consider for a moment the potential of moving our pastoral ministry to points of service in the hospital-without-walls paradigm. In the past, patients and their loved ones usually awaited the results of surgery in hospitals. Today this news is provided in medical office buildings or sometimes even at the other end of a phone. We will need to find creative ways to ensure that pastoral services are available where patients and families need them most.

From Intramural to Intermural Issues In the first phase of our reality, we were concerned with *intramural issues of Catholic identity*. We endeavored to be faithful to our sponsor's heritage and our Catholic identity. In this model our role has been to provide health services, and we enjoyed control in part as employers and owners of property.

But now we are moving toward *intermural*

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integrated delivery systems or networks. Our role will be to provide, to participate in, or to promote the development of integrated continuums of care. To be effective, we will need to develop skills in influencing without control.

Sociopolitical Responsibilities Let me take this one step further and ask what our role is in American society. What do our Catholic identity and values call us to in the *sociopolitical arena*? What kind of role as moral agent must we and should we bring to the transformation of American healthcare?

Recently, California-based Healthcare Forum identified in its study "Bridging the Leadership Gap in Healthcare" six skills providers will need to thrive in a reformed healthcare system: systems thinking, shared vision, mastering change, continuous quality improvement, redefining healthcare, and serving the public.

I believe we in Catholic healthcare will need these, as well as a complementary set of competencies. First, we will need a clear, well-articulated vision of Catholic identity. This will require an understanding of both the "legal" requirements for Catholic identity in complex organizational relationships and the "affective" dimensions embodied in the values and the culture of the organization. Armed with this understanding, we will know clearly what we stand for and why.

It will also be important to develop the skills to work with others in situations where we have less control than we typically have had in the past. This will require us to be discerning when we consider where and with whom we collaborate and how compatible our corporate culture is with that of potential partners. We must also become adept at assessing risk and have the courage to respond to promising opportunities.

As we endeavor to create communities of service comprising providers committed to the same mission, we will need our own personal, integrated spirituality that centers us and keeps us faithful to our values. Without this, we will be unable to change, much less transform, healthcare.

Lastly, we will need to be passionate for justice. We must believe we can make a better world, create healthier communities, and enhance the quality of life. We must believe we can be and bring God's mercy to our world.

A NEW FUTURE

Providing access is a part of our challenge. From the perspective of the provider and the user, the changes on the horizon seem radical. Yet from the perspective of our core Catholic identity and the responsibility of sponsorship, this dimension of systemic reform pales in comparison with the opportunity to create a whole new future for our ministry—if we are willing to transform it. □