



This is the edited text of a presentation at the “Is a For-Profit Structure a Viable Alternative for Catholic Health Care Ministry?” symposium in March 2012 hosted by Seton Hall Law’s Center for Religiously Affiliated Nonprofit Corporations and its Center for Health & Pharmaceutical Law & Policy, in collaboration with the University of St. Thomas, John A. Ryan Institute for Catholic Social Thought, the Terrence J. Murphy Institute for Catholic Thought, Law and Public Policy and the Veritas Institute.

For-profit and Catholic: How Would the Ministry Fare?

BY SR. DORIS GOTTEMOELLER, RSM, Ph.D.

As trustees and leaders ponder the future of the ministry they guide, there are questions that go to the very core of its identity. The hundreds of hospitals and care sites they lead now may still be here and flourishing a generation from now, but will they still be Catholic? If so, what accommodations will have to be made to the changing landscape of health care in the United States? In particular, what about the new for-profit models of Catholic health care? Are they a viable alternative for capital-starved facilities?

Let’s begin with Catholic identity. When is something entitled to be called Catholic in any official sense? I would suggest that there are three requirements. First of all, the entity must assert and claim its identity as Catholic by some sort of public declaration. By way of counter-example, in early 2012, a major West Coast health system renamed itself Dignity Health and asserted that it is no longer Catholic. According to Dignity Health’s Jan. 23 press release, it is a “not-for-profit organization, rooted in the Catholic tradition, but is not an official ministry of the Catholic Church.”

Secondly, this Catholic identity has to be validated by Catholic Church authority, usually the bishop of the place, but sometimes by a dicastery in Rome. There is not really a formal procedure for this. Typically, a religious congregation founds an organizational ministry with the implicit, if not explicit, consent of the bishop and has it listed in the Catholic directory of

the diocese. The diocese, in turn, adds it to its listing in the *Official Catholic Directory* for the United States. Most of these designations occurred generations — even a century or more — ago. The bishop’s confidence in allowing such an organization to be designated as Catholic usually rested on the fact that it was founded by and remains under the direction of a religious congregation which is presumed to be about the work of the church. Again, we had an unhappy example a year ago when the bishop of Phoenix declared that a Catholic hospital no longer could be so identified.

Now we come to the third requirement for a Catholic organization. Unlike the first two, it is multifaceted and requires discerning judgment. But I would argue that it is at the heart of identity. It is the requirement that the organization embody in its culture and performance behaviors compatible with Catholic Church teachings. What are those teachings? For the sake

of simplicity (and at the risk of caricature), I have created a Top Ten list for health care services:¹

1. The organization’s mission statement affirms its Catholic identity and declares its intention to provide essential human services expressive of Gospel teachings.

2. It has a special concern for the poor and disadvantaged, as evidenced by its proactive efforts to meet their needs and by its expenditures for community benefit.

3. It promotes wages and benefits and working conditions that honor the dignity of each employee, including participation in workplace decisions as well as the right to be represented by a union.

4. There is a commitment to excellence in spiritual care, including for persons of diverse faith traditions.

5. Prenatal, obstetrical and postnatal services are provided for mothers and their children in a manner consonant with the mission.

6. End-of-life care, including palliative and hospice services, is provided with reverence for the dignity of the individual and care for the family.

7. There are formation programs for trustees, senior leaders, employees and



physicians that build understanding of and commitment to the mission.

8. There is a well-developed ethics function that guides decision-making in the clinical and organizational spheres.

9. The organization uses its public voice to advocate for policies that promote the common good and a more compassionate and just society.

10. Cooperative arrangements with organizations whose mission is incompatible with ours are limited to remote mediate material cooperation.

In addition to these “Catholic” requirements, of course, are those of all health care — superior quality, honest and transparent business arrangements, compliance with the innumerable federal and state regulations for health care today. All of the qualifications on the Top Ten list are tangible and admit of observation and measurement. They are also aspirational, in the sense that improvement is always a possibility. This is where the element of discerning judgment comes in. No Catholic organization has maximized the opportunity embedded in each of the Top Ten, but we all want to be known for our efforts and challenged to do more. The consistent effort to excel in all of them creates a culture that is distinctive.

You’ll recognize in the Top Ten list references to the *Ethical and Religious Directives for Catholic Health Care Services*, a publication of the United States Conference of Catholic Bishops. Also found

One cause for hope is that we are asking the right questions. May our work strengthen that shared purpose.

dational to the list is Catholic social teaching, a body of teachings beginning in the late 19th century and coming up to the present, largely articulated in papal encyclicals and episcopal letters. These are practical implications of the Gospel for our age. Here we find concepts like human dignity, sacredness of life, the common good, a preferential option for the poor and respect for the rights of workers. A fuller explication of Catholic identity would require a deeper dive into these core teachings. However, for our purposes here, it is enough to affirm that identity is more than a superficial veneer, easily altered. It pertains to the DNA of an organization, its *raison d’être* and its characteristic activities, both internal and external.

Note that “not-for-profit” did not appear on

the Top Ten list. However, it has long been understood that the not-for-profit structure best facilitated the requirements listed there.

We can sum up this first part, then, by saying that the three requirements for Catholic identity that I have described — assertion, validation and integration — represent a progression from “thin” to “thick” Catholic identity. I want to assume that the latter is really what we are looking for. We sometimes hear the pejorative phrase “Catholic lite” used to describe some arrangements. I would assert that a genuine Catholic identity is not something contractually negotiated; it permeates the culture of an organization.

Let’s go now to the second key word: ministry. It is common to speak of health care as a ministry of the church. What does that mean? Until a few decades ago, ministry was a word associated by Catholics with the work of Protestant clergy: we had priests, they had ministers. Since then, it has come into widespread use to mean the public work of a Catholic organization in fulfillment of its mission, or the work of an individual specifically commissioned by the church. For our purposes, the first meaning applies. It is the public service rendered by an organization that bears Catholic identity, e.g. a school, a university, a hospital, a residence for the elderly, etc. It is an official Catholic work, not just the work of Catholics. It’s not necessarily everything the Catholic organization does, but that which enacts its mission.

The Catholic Church has long been known for its institutional ministries in the United States — the largest not-for-profit health care sector, the largest social service agency (Catholic Charities), and the largest private education system. As Fr. Bryan Hehir, SJ, Ph.D., wrote more than 15 years ago, “The Catholic Church is institutional by instinct and by nature. ... Size never proved anything, but there is something to presence. If one seeks to influence, shape, direct, heal, elevate and enrich a complex industrial democracy, it cannot be done simply by the integrity of individual witness. It is done by institutions that lay hands on life at the critical points where life can be injured or fostered, where people are born and die, where they learn and teach, where they are cured and healed, and where they are assisted when in trouble.”²²

Bringing the testimony closer to home, the constitutions of my religious congregation, the Sisters of Mercy, stated in #5, “We sponsor institutions to address our enduring concerns and to witness to Christ’s mission.” Generations come and go, gifted leaders pass from the scene and oth-



ers take their place, but the work goes on, largely because the institution provides a continuity of witness and service. The institution or health system is held accountable to its mission by its sponsors, historically a religious congregation or a diocese, more recently a group of co-sponsors or a public juridic person.

For centuries these institutional ministries have been organized on a not-for-profit basis. In fact, the not-for-profit model has prevailed across the United States in virtually all faith-based and community hospitals. Now we are seeing some of them translated into for-profit models. Is there a theological principle at stake? Or some doctrinal proviso that needs to be observed? Let me respond by asserting that there is no authoritative doctrinal teaching on the matter. It is a matter of practical and historical experience that the not-for-profit model has been especially amenable to the nature and purpose of institutional ministries. It has facilitated clarity of purpose and accountability to the church. Could a for-profit model accommodate the same ends?

There is an oft-cited speech by the late Cardinal Joseph Bernardin to the Harvard Business School Club in which he makes the case for not-for-profit health care.

Health care — like education and social services — is special, he says. It is fundamentally different from most other goods because it is essential to human dignity and the character of our communities. It is, to repeat, one of those “goods which by their nature are not and cannot be mere commodities.” Given this special status, the primary end or essential purpose of medical care delivery should be a cured patient, a comforted patient and a healthier community, *not* to earn a profit or a return on capital for shareholders.³ This understanding has long been a central ethical tenet of medicine. The [World Medical Association’s] International Code, for example, states that doctors must practice their profession “uninfluenced by motives of profit.”

However, one of the qualities that mark the church as a living community is its ability to change in response to the signs of the times. There are numerous examples of practices once deemed incompatible with fidelity to the Gospel, such as borrowing money at interest, that have become acceptable. And other practices long tolerated, such as slavery, have been condemned. Bringing the matter closer to hand in 2009, Pope Benedict XVI wrote in *Caritas in Veritate*:

“When we consider the issues involved in the *relationship between business and ethics*, as well as the evolution currently taking place in methods of production, it would appear that the traditionally

Other consequences to be avoided are ... a loss of distinctive identity which entitles us to speak on behalf of the poor, the vulnerable and the disenfranchised.

valid distinction between profit-based companies and non-profit organizations can no longer do full justice to reality, or offer practical direction for the future. In recent decades a broad intermediate area has emerged between the two types of enterprise.”

What the pope envisions is ... “a broad new composite reality embracing the private and public spheres, one which does not exclude profit, but instead considers it a means for achieving human and social ends. Whether such companies distribute dividends or not, whether their juridical structures correspond to one or another of the established forms, becomes secondary in relation to their willingness to view profit as a means of achieving the goal of a more humane market and society.”⁴

Pope Benedict’s predecessor, Pope John Paul II, gave some helpful distinctions about the role of the market in regulating access to public goods such as health care. He notes that the market protects freedom and promotes innovation. But at the same time it is subject to moral limits. First, for those without resources, the best functioning market is of no help; they can’t enter the market. Second the market does not distinguish the intrinsic value of different goods. This latter point is directly relevant to health care. A pure supply-and-demand calculus is inadequate in assessing health care policy. Health care is a necessary good, essential for human well-being. Hence, it cannot be treated as other goods that may be desirable but are not essential for human well-being.⁵ It is true that both for-profit and not-for-profit institutions vigorously compete for market share; can we say that each is equally motivated by a desire to improve the health of the community, with emphasis on the poor and underserved? I would suggest that a comparison of their community benefit expenditures might give the answer.

TOWARD A SOLUTION

Given that there is no authoritative teaching prohibiting for-profit health care — and an implicit openness to change in such matters — I think the answer to our question about the compatibility of for-profit health care with Catholic identity comes down to a prudential judgment in specific instances. Lest we think that this conclusion constitutes a cowardly evasion, prudence sets a high standard. It is “the virtue that disposes practical reason to discern the true good in every circumstance and to choose the right means of achieving it.”⁶ Going back to my earlier list of 10 key characteristics of the Catholic health care institution, the question becomes, can they be maintained and even optimized while discharging the required legal and fiduciary duties to bondholders and shareholders? What is the true good in this circumstance and what may be considered the right means? In making that prudential judgment — which may vary from one example to another and which may require uncommon wisdom and courage — I would suggest two considerations that should guide the discernment: the integrity of the ministry itself and provisions for its continuity. Both of these considerations call for attention to the possible unintended consequences of any choice.

By integrity I mean a consistent and good-faith effort to maintain and optimize the 10 requirements I listed at the beginning of these remarks. Note that they begin with a public statement that asserts the Catholic identity and declares an intention to act in ways compatible with that identity. It goes without saying that there are tensions among the various requirements. For example, the commitment to a preferential option for the poor requires outreach programs to meet their needs and a generous commitment to charity care. At the same time, we want to provide wages and benefits which contribute to the dignity of the workers and their families and reinvest in the ministry in order to provide excellent care. It is not always an easy balancing act, but neither imperative can be sacrificed. Recall Pope Benedict’s words that profit, rightly used, must be a means of achieving a more humane market and society.

Furthermore, operating in a secular *milieu* where we assume responsibility for the health

of a community, many or most of whose members are not Catholic, automatically subjects us to pressures to act in ways contrary to our mission. Integrity also requires guarding against cooperation in practices inimical to Catholic identity and teachings. As the *Ethical and Religious Directives* indicate, the provision of health care in most communities today involves new partnerships with other institutional providers and with payers and physicians. “Any partnership that will affect the mission or religious and ethical identity of Catholic health care institutional services must respect church teaching and discipline.”⁷ Parsing the precise distinctions between the various modes of cooperation could occupy us for hours, but, in practice, the final arbiter of whether a proposed cooperative agreement is acceptable is the local bishop, who will take into consideration the possibility of scandal. Can we expect shareholders to be respectful of these distinctions? These challenges to our integrity are not, strictly speaking, a consequence of a for-profit structure, but they are part of the world in which we operate.

An unintended consequence of a transition to for-profit status may be to jeopardize the tax exemption of our not-for-profit facilities. Presumably, for-profit Catholic hospitals will be taxed. This might prompt public officials to suggest that, since we are “all alike,” all Catholic hospitals should be taxed. To give an example of the implication: the system for which I work, Catholic Health Partners, spent \$365 million in 2010 for community benefit, as defined by the IRS. It’s hard to imagine that we could maintain that level of charity care and outreach if we lost our tax-exempt status.

Turning to the second consideration, continuity of the ministry requires that the commitments made at its inception endure over time. Will covenants entered into at the time of transition to for-profit status endure when it is sold to another owner? According to the materials we received from Ascension Health Care Network, Ascension Health Alliance, headquartered in St. Louis, has sole authority over all elements of Catholic identity in perpetuity (subject to the rights of the diocesan bishop). Moreover, Ascension Health Alliance has set in place provisions to insure that, for any acquired Catholic hospital, its operations,





programs, policies, characteristics and services remain in conformity with that identity. However, if there isn't a legally enforceable way to do this in some of the new models, transition to Catholic for-profits will just be an interim step along the way to eventual loss of Catholic identity.

One of the factors in ensuring continuity of mission is the strength of formation programs for trustees, senior executives and employees throughout the organization. From my experience, ongoing development in understanding and appropriating the mission and values and the principles of Catholic social teaching and ethical standards can be incorporated into the workplace in a way that respects the religious diversity of the workforce and which contributes to a distinctive culture. A related issue is whether or not any of the trustees or executives are members of the Catholic Church. A traditional way in which communication has been maintained with the church is through the sponsors and the senior executives. If there are no sponsors in the traditional sense, and few or none of the senior executives and/or trustees are Catholic, there can be a credibility problem. It's my impression that very few, if any, of the new models have addressed this issue.

Mentioned above is the need to be alert to unintended consequences in whatever path we choose. Will the new option of sale to a for-profit investor cause some Catholic hospitals to hold on to the point of near failure without making some necessary but hard choices, such as seeking a Catholic system with which to align, or perhaps closing and converting the resources to other community needs? Other consequences to be avoided are the diminishment of the church's witness in the public square through the gradual erosion of our institutional presence, a loss of distinctive identity which entitles us to speak on behalf of the poor, the vulnerable and the disenfranchised.

To return to the question with which we began, is for-profit health care compatible with our Catholic identity? Can it be a ministry of the Catholic Church? I would suggest that the jury is still out. The judgments involved with regard to "true good" and "right means" — the goal of prudence — will take time and experience to discern. Simultaneous with the movement to for-profit models is the development of hybridized models — Catholic systems with significant non-Catholic divisions. How much of this can we do without diluting the Catholic identity beyond recognition? Maintaining the integrity of the mission and pre-

serving it through time will take dedicated leaders who see the vision and who have the requisite talent to enact it. It will also take collaboration among Catholic lay leaders and the bishops, because the prudential judgments involved will not reside solely with the hierarchy. Venues for these trusting and mutually respectful conversations are not very common at the present time.

In closing, let me cite again some words of the late Cardinal Bernardin, this time from an Oct. 18, 1995, pastoral letter entitled "A Sign of Hope." It was written after he had been diagnosed and treated for pancreatic cancer, when his views on institutional health care were more than theoretical. He wrote, "Although illness brings chaos and undermines hope in life, we seek to comfort those who are ill, whether or not they can be physically cured. We do so by being a sign of hope so that others might live and die in hope. In this we find the Christian vocation that makes our health care truly distinctive. It is the reason we are present to believers and nonbelievers alike. This is the heart of Christian health care: caring for people in such a way that they have hope."

One cause for hope is that we are asking the right questions. May our work strengthen that shared purpose.

Sr. DORIS GOTTEMOELLER, RSM, is senior vice president, mission and values integration, at Catholic Health Partners, Cincinnati.

NOTES

1. Comparable examples of such a list include the Catholic Health Association's "Statement of Shared Identity" and the statements of some Catholic systems, for example, Catholic Health Partners' "Thirteen Foundational Standards" or the Sisters of Charity of St. Augustine Health System's "Statement of Faith Obligations."
2. J. Bryan Hehir, "Identity and Institutions," *Health Progress* (Nov.-Dec.1995): 76-8.
3. Joseph Bernardin, "Making the Case for Not-for-Profit Healthcare," Archdiocese of Chicago, January 12, 1995.
4. Pope Benedict XVI, *Caritas in Veritate*, no. 46.
5. Pope John Paul II, *Centesimus Annus* (May 1, 1991), summarized by J. Bryan Hehir in "The Ministry's Future in a Turbulent World," *Health Progress* (Sept.-Oct. 2010): 74.
6. *Catechism of the Catholic Church*, no. 1806.
7. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, Fifth Edition, Part Six, no. 68.

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, July-August 2012
Copyright © 2012 by The Catholic Health Association of the United States
