What Makes "Catholic" Managed Care Catholic?

BY THOMAS F. SCHINDLER, PhD

Persons directing or developing Church-related managed care programs face a recurring question: What *distinguishes managed care influenced* by Catholic traditions from other types? In answer, many tend to point to the absence of certain forms of treatment from the benefit package: abortion, sterilization, artificial birth control, euthanasia, and assisted suicide. While that is indeed true, the revised *Ethical and Religious Directives for Catholic Health Care Services (ERD)*, which the U.S. bishops approved at their November meeting, set the basis for some further consideration of the question.

In particular, I believe it important to consider what the *ERD* imply—not only about the services offered (and not offered) by Catholic managed care—but the way such care determines what those services will be.

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The Normative Principles

Of particular significance in this regard are the values of (1) the dignity of the individual; (2) the common good; (3) stewardship of resources; and (4) care for the poor. These are mentioned as "normative principles" in the introduction to Part 1 of the *ERD*. All are fundamental to the Catholic tradition.

This is not to say that the considerations offered here, on how Catholic-influenced managed care determines benefits, are unique to the Catholic tradition. The values that undergird the Catholic approach can be found in other traditions as well. But this does not negate the fact that they are fundamental to the Catholic tradition. And because they are found in that tradition, the implications they have for managed care should be especially apparent in Catholic managed care.

Stewardship of the goods of the earth requires that we use them wisely regardless of their availability. Abundance is not a license for abuse.

But abundance is hardly a word we associate with healthcare at present. And, in fact, managed care can be seen as a means for rationing healthcare (even though the "r" word is not particularly popular in political or marketing circles), as a strategy to use limited resources more effectively and efficiently.

The *ERD* never mention rationing explicitly. It is significant, though, how the authors of the *ERD*, in their discussion of treatment decisions, define "proportionate" and "disproportionate" means of preserving life. "Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community" (Directive 56). "Disproportionate means are those that in the patient's judgment do not offer a reasonable hope of benefit or entail an excessive burden or impose excessive expense on the family or the community" (Directive 57).

The Impact on the Community

In both instances, the treatment's impact on the community is mentioned. And while the patient is said to be the person who must judge when the medical treatment becomes excessive, such judgments are not considered purely subjective within the Catholic tradition. In other words, the patient's decision must be based on an objective assessment of the reality of things. And even if a particular treatment were to hold out "a reasonable hope of benefit," the patient could properly and morally decline the treatment on the basis that it imposed "excessive expense on. . . the community."

If a patient can individually reach such a decision, why cannot a community of potential patients reach a similar decision—namely, that certain types of treatment in certain circumstances excessively burden the limited resources of the community and, as such, should not be available, even if they might offer some level of benefit?

Here is where the values of the dignity of the

Continued on page 54

Continued from page 51

Last year, when Providence merged with General Hospital Medical Center to form Providence General Medical Center, the "Wellness Challenge" was not only maintained through the merger but expanded to all the 1,650 benefit-eligible employees, more than 900 of whom accepted the challenge in 1995, ensuring the program will achieve new standards in savings.

The program has been successful because it addresses employees' actual health risks; anyone, regardless of age or physical condition, can succeed; hospital leaders support it; staffing is adequate; and it allows accurate tracking of results.

Additional Organizations Accept the Challenge

Because of the program's success, other hospitals, businesses, and the media have shown interest in the "Wellness Challenge." Demand for information on the challenge has outstripped the medical center's ability to respond, which has led Wilson and Burt to develop the *Wellness Challenge Resource Guide*, a step-by-step program guide. To date, 23 organizations, such as St. Vincent Hospital and Medical Center, Portland, OR; Mercy Health Center, Oklahoma City; and Genie Industries, Redmond, WA, have purchased the guide.

"The program is structured to be flexible and is equally useful for a senior population as it is for a younger, healthier group," explained Wilson. When combined with aggressive case management and care pathways, he says, it can benefit both and plan enrollees. The program is designed to build loyalty to the provider network and encourage enrollee retention in the managed care plan. □

For additional information on Providence General Medical Center's "Wellness Challenge," call Larry Wilson, 206-261-4575.

Continued from page 52

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individual, of the common good, and of care for the poor come in.

As stated in the *ERD*'s discussion of responsible stewardship, "a just health care system will be concerned both with promoting equity of care—to assure that the right of each person to basic health care is respected—and with promoting the good health of all in the community" (Introduction, Part 1).

Notice that respecting the dignity of the individual does not mean providing each person with every form of treatment he or she might want. Rather, it requires meeting the basic healthcare needs of each individual. This does not stand in opposition to the common good. For, in the words of the directives, "the common good is realized when economic, political and social conditions ensure protection for the fundamental rights of all individuals, and enable all to fulfill their common purpose and reach their common goals."

Thus responsible stewardship requires that we use our limited resources in a way that meets the basic needs of individuals and raises the overall health of the community.

The poor provide the vantage point from which one might judge how well this challenge is met.

The Principle of Subsidiarity

And who is to determine the basic needs and desirable health status of the community? Here the *ERD* appeal to another dimension of the Catholic tradition: the principle of subsidiarity. "The responsible stewardship of health care resources can be accomplished best in dialogue with people from all levels of society, in accordance with the principle of subsidiarity. . . ." The dignity of the individual requires that the individual have a voice in decisions that affect his or her life. Healthcare resources belong to the community as a whole; and that community should make decisions about how to use those resources.

Thus the fact that Catholic-influenced managed care limits the availability of certain types of treatment does not betray its Catholic roots. The real questions are: On what basis is the decision reached to limit those types of treatment? and, Who has a voice in the decision?

There is no simple, one-serves-all recipe for answering these questions. Each situation carries with it its own possibilities, as well as its necessary trade-offs and compromises. Prudential judgments are necessary.

But, at the end of the policy and at the end of the day, what should clearly and strongly mark Catholic managed care is its effectiveness in covering basic healthcare needs; in raising the healthcare status of the community as a whole, especially that of the poor; and in engaging the community as a whole in determining what is needed in both those categories. □