

PRESERVING THE CATHOLIC VISION OF CARE

*Ministry Leaders Must Not Be Intimidated
By Managed Care or Market Pressures*

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What do we mean when we talk about managed care?

On one hand, we have a conceptual model, introduced more than 25 years ago, in which the healthcare interests of patients, physicians, providers, and third-party payers are not only compatible but mutually reinforcing. In this model the physician-patient relationship is primary, healthcare is delivered in the most appropriate low-cost setting, preventive and primary care are emphasized, and the patient's needs are served in an efficient, cost-effective way.

On the other hand, managed care also means a reordering of the healthcare marketplace. Insurers, who receive and distribute the health insurance premium, are now in a position to control healthcare resources. Providers and physicians, presumably the patient's advocates, may in fact be in a conflicted position because they earn more money when patients do not use their services than when they do. As for patients, in choosing a managed care entity—a decision typically made when they are not ill—they limit the healthcare services they can receive to those provided by the entity. Clearly voice, choice, and access are managed.

PROBLEMS WITH THE PROFIT MOTIVE

Although this control could be employed to greatly improve healthcare in this country, investor-owned managed care entities function primarily to increase private profits. Every year, employers and consumers pay hundreds of millions of dollars that might be used to fund medical research, or educate physicians, or underwrite free clinics—but are in fact paid as dividends to corporate stockholders. The profit motive operates in healthcare like a black hole: the money that goes into it disappears.

The profit motive is the single most disruptive, threatening element in the delivery of healthcare today. Fortunately, nine out of ten acute care hospitals are organized as not-for-profit, tax-exempt entities. Their leaders want to focus solely on providing high-quality healthcare to the public. They do not want a shareholder-imposed profit motive to distract them from that goal.

Healthcare, whether provided in a managed care or fee-for-service environment, is not a commodity like any other.¹ Society puts a great value on healthcare precisely because it puts a great value on human life and welfare; reducing healthcare to a mere commodity means discounting the value of human beings. An industry whose entire purpose was to make money treating sick people would be one that profited from human misfortune.

We are asked to accept the supposition, under certain managed-care approaches, that "less is better." This is not necessarily so. Although reducing healthcare expenditures globally may indeed be a desirable social goal, reducing expenditures for an individual patient may not be good for the patient. Herein lies the ethical dilemma. As members of society, we want healthcare costs controlled. As patients, however, we simply want the best treatment available, no matter how much it costs. As healthcare professionals, we try to behave as advocates for our patients. But as representatives of an insurer—a role many professionals will be relegated to under managed care—we may find ourselves rewarded by the financial performance of the managed-care entity. Our professional judgment could become clouded by our personal interests.

Consider the physician's role, for example. Under some managed-care models, physicians are paid according to the number of patients they see per hour. Such a system could be, in one sense, more efficient because it encourages doctors to

care for more patients than they did previously. But providers can maximize patient encounters only by spending less time with each patient—which could be worrisome for some patients, particularly those with complex or unusual health problems.

Ethical dilemmas like this are a direct result of the movement to interpose market and business forces between the caregiver and the patient. As managed care becomes ever more prevalent, we must all take care that our responsibilities as healthcare providers are not compromised by business practices.

MARKET FORCES' IMPACT ON THE MINISTRY

Let me, as an administrator of a Catholic healthcare system, describe the impact market forces are having on our ministry. There are, as I see it, six elements.

Care In discussing managed care, we must remember that what sets excellent healthcare apart from mediocre healthcare is the *care*, not the management. The important relationship is that which exists between the patient and the caregiver. This is particularly true of the care provided by Catholic organizations, because they tend to attract staff committed to the art of caring. But if managed care is allowed to replace the patient-caregiver relationship with a customer-merchant relationship, then caring will become a lost art.

Capitation Under capitation, healthcare providers share financial risks with insurers. What are the implications of such an arrangement?

Imagine a member of a capitated healthcare plan, an 18-year-old man who is found to have acute leukemia. His illness requires frequent hospitalizations and extensive home care. The young man's healthcare provider, who had expected him to remain healthy (thus fitting the actuarial profile of most 18-year-olds), discovers that the patient has instead become a drain on the provider's capitated dollars. Then the illness grows worse. Depressed, the young man asks the provider to help him kill himself (he lives in a state where assisted suicide is legal). By doing so, the provider can both save money and obey the patient's wishes. On the other hand, the Hippocratic Oath says the provider may not harm a patient. What is the provider to do?

I do not believe that the principles of capita-

tion are inherently unethical. It is true that under fee-for-service healthcare, providers were reimbursed for whatever efforts they made caring for patients, and thus had no financial incentive to withhold treatment. But providers have always been encouraged to follow the dictates of conscience and acceptable medical practice in serving the healthcare needs of the patient. This is still true. The provider must make the *patient's* needs, not the provider's, the prime concern.

Coverage According to one survey, 85 percent of Americans have some kind of health insurance.² Those of us who do have such coverage should try to imagine what life is like for the millions who do not. For instance, if I had no insurance, would I allow my children to play sports and be exposed to potential injuries? Would I perhaps have to forgo a career opportunity because a family member's preexisting condition was excluded by my new employer's insurance?

This situation also poses an ethical dilemma for the healthcare provider. For centuries, providers have been ethically bound to treat any person who was ill or injured—thus providing “universal access” to healthcare. Today, however, managed care entities pay for the treatment of only those ill and injured people who have coverage, threatening to replace the healthcare professional's traditional service ethos with business and profit imperatives.

Consolidation Healthcare in this country has traditionally been a community-based service. When we Americans got sick, we went to a local hospital where we were treated by physicians, nurses, and technicians who also happened to be our

ADDITIONAL RESOURCES

Readers may find the following books on related themes to be helpful:

- Catholic Health Association and Catholic Managed Care Consortium, *A Workbook for Understanding Capitation*, St. Louis, 1994.
- *Guidelines for Values-Based Managed Care*, Catholic Health Association, St. Louis (forthcoming).
- Lisa J. Gildea and Jean deBlois, *Mission in Action: Integrating Hospitals and Physicians*, Catholic Health Association, St. Louis (forthcoming).
- The Coalition for Accountable Managed Care, *Principles for Accountable Managed Care*, Washington, DC, 1997.

neighbors. But all that is changing now.

Like the banking and airline businesses, health-care is being forced by the market to consolidate. In order to gain access to managed care contracts, large health-care organizations are acquiring smaller ones. In some cases, this consolidation is good because it will result in a better use of the community resources needed to serve patients. In other instances, however, consolidation is bringing about unnatural alliances that threaten the essence of community-based care. These new healthcare organizations may no longer be as responsive to local communities and the patients who live in them. And since Catholic healthcare is not immune to market forces, it is being affected by the drive toward consolidation, too.

Conscience The coming of managed care also affects matters of conscience. In purchasing a managed care health insurance policy, one is usually contracting to receive comprehensive services. But what if the purchaser is, say, a Catholic who not only does not want but morally disapproves of one of these services, for instance, abortion? Is the purchaser still obligated to pay for it? Is this fair? What if the healthcare provider disapproves of the service? Must it still provide it? What if, in refusing to provide the service, the hospital risks business failure? Is that fair?

Church Although healthcare is now a big business, the Catholic Church has always seen its health ministry as a calling from God. As such, the Church has always derived its healthcare imperatives from the Gospel, thereby making financial considerations secondary. Can it continue to do this under managed care and intense market pressures? Can it, for example, care for uninsured AIDS patients or for homeless pregnant women? Can it minister to the dying elderly? If ministry is subordinated to business, who will do the caring?

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MINISTRY MUST REMAIN PATIENT-FOCUSED

Investor-owned health-care organizations see healthcare as a commodity that is to be delivered to consumers in return for a profit. Because satisfying investors' desires is the main incentive of such organizations, they can be described as *investor focused*.

In contrast, Catholic healthcare organizations are *patient focused*. They are charita-

ble organizations that deliver healthcare according to patients' need, not their ability to render investment returns.

It is true that Catholic healthcare entities are large businesses in the sense that, like investor-owned entities, they must respond to market forces. Indeed, for several reasons—because managed care will continue to penetrate the insurance market; because capitation will continue to become the primary payment mode; and because government support for medical research, medical education, and actual healthcare services will continue to dwindle—the Catholic health ministry must become more efficient and businesslike in the way it manages its organizations and services.

Despite that fact, the leaders of Catholic healthcare organizations should not let themselves be intimidated by the market into making decisions contrary to ministry values. Our Catholic healthcare tradition is value driven, not profit driven. This tradition must be preserved. □

The Pope John Center, Braintree, MA, has given Health Progress its permission to print this edited version of a talk Dr. Collins gave at "The Gospel of Life and the Vision of Health Care," the center's 15th Workshop for Bishops, in Dallas in the winter of 1996.

NOTES

1. Joseph Bernardin, *Making the Case for Not-for-Profit Healthcare*, Catholic Health Association, St. Louis, 1995, p. 6.
2. 1993 *National Health Interview Survey*, National Center for Health Statistics.