ROOTED IN CHARITY

Catholic Social Thought Has Shaped the Development of Health Care and Social Service Ministries

BY SR. DORIS GOTTEMOELLER, RSM

The Catholic Church in the United States today can boast of a body of social thought and a body of social works unparalleled by any other denomination. Obviously the development of social teachings—beginning with *Rerum Novarum* and continuing through the great social encyclicals up through *Centesimus Annus,* augmented by the documents of the Second Vatican Council, of the synods of bishops, and of the U.S. bishops—is not a distinctively American achievement. But these teachings have been embraced, interpreted, and applied by American bishops and scholars and the faithful in such a way as to make them "our own."

At the same time, the U.S. Catholic Church has founded and continues to oversee a vast array of social service and health care organizations, institutions, agencies, and services. Visits to the Web sites of Catholic Charities USA and the Catholic Health Association (CHA) will reveal the enormous range of services, some of them stretching back into the 19th century, others founded in recent years in response to previously unrecognized or unmet needs.

One might imagine that this evolution of the social teaching tradition, on one hand, and ministerial commitment, on the other, proceeded in a tidy and logical way from principle to practice. In fact, the story is much more complicated. The church launched many of the works that continue to thrive today out of a sense of compassion, with no thought of trying to change the social structures that generated the problems in the first place. At times, the principles enunciated or remedies proposed for social ills were insufficiently in touch with the personal dimensions of human suffering and dysfunction.

We will leave to historians of the U.S. church the task of illuminating all the stages in the rich history of Catholic social thought and ministry development. Today it is probably safe to say that bishops, scholars, ministry leaders, and church members in general—to the extent they think about it—appreciate both the social teachings and the multiple and varied ministries. I would suggest, however, that our appreciation of both dimensions of Catholic life would be enriched enormously by reflecting on five areas of intersection. These are areas in which social principles such as *human dignity, concern for the common good,* and *participation* come to life in both the organization and the care it provides, and in which, conversely, the daily work of ministry is renewed and invigorated through the application of principles of social justice.

Sr. Gottemoeller is senior vice president, mission and values integration, Catholic Healthcare Partners, Cincinnati.

HUMAN WELL-BEING

The first area of intersection is the interpretation of human well-being. The foundation of Catholic social teaching is that every human being has an inherent dignity as created in the image of God. Because this is so, we believe that all people deserve respect and the opportunity to preserve and enhance their well-being and that of their dependents. When we move beyond this principle into practice, the experience of the helping and healing ministries illuminates what well-being entails. We are keenly aware today of the interde-

Our advocacy is most effective when it is not seen as self-serving, but as giving voice to the voiceless.

pendence of health status, education, housing, and public safety. One's health, in turn, has physical, psychological, and spiritual dimensions. Human dignity and well-being can be threatened or eroded in any of these areas.

This awareness prompts collaboration (such as that exemplified by Phase IV of the *New Covenant* initiative; see Bishop Joseph M. Sullivan, "Ministering Together," p. 42) among health care providers, social service agencies, schools, and similar service organizations. In health care settings, pastoral care ministers are being integrated into the care-giving team. The ministry is moving away from "silos" of service toward a more integrated approach to the fostering of well-being—which will, in turn, strengthen our understanding of the basic principle.

Community Benefit

A second area of intersection involves the interpretation of "community benefit." Every health care facility calculates its annual community benefit, using a methodology similar to that promoted by CHA.* The data are then published as an expression of accountability for the tax exemption that not-for-profit institutions enjoy. However, a deeper reason for investment in programs that benefit the community is the desire to live out the principles of human solidarity, participation, and accountability for the common good. *Solidarity* connotes the interdependence of members of the human community; *participation* implies involvement in decisions that affect one's well-being; the *common good* refers to social conditions that allow people to realize their human dignity.

Implementing programs to benefit the community is more difficult than it might seem. It is easy to launch health screening programs that pay a dividend to the hospital in terms of public relations. It is more difficult to involve the community in a needs assessment and design of services—even though needs assessment and design of services, because they require genuine community participation, are likely to be more beneficial in the long run. Helping the needy can be done within a philanthropic, almsgiving framework, without acknowledging or addressing the underlying causes of poverty. Many charitable works were initiated out of benevolent motives that are paternalistic by today's standards. Today we recognize that, to be of lasting benefit to a community, an initiative must take into consideration the social conditions that promote problems—for example, teenage pregnancy, lack of prenatal care, and unemployment—and then address them in partnership with those who experience them.

The Poor and Most Vulnerable

Our ministry's bias for the poor and most vulnerable is another example of social principle and practice coming together. Our country continues to enjoy an unprecedented prosperity, but a significant and growing percentage of people do not share in it. Jesus proclaimed that he was sent "to bring glad tidings to the poor." Therefore, the poor have the first claim on our services. "Whatsoever you do for the least of these, my brothers and sisters, you do for me." Our hospitals and agencies regularly subsidize services for the disadvantaged—Medicaid recipients, people with AIDS, delinquent teenagers, drug abusers, homebound elderly, and others. This daily experience with "the least" among us removes the principle from the realm of romantic generality, thereby ensuring that our services are respectful of the dignity and desires of those served.

In our management sessions we struggle with the question "How much is enough?" We do that because we must maintain a healthy bottom line if we are to continue the mission to the poor and underserved. In such instances, the principles of good stewardship and preferential option for the poor are sometimes in conflict. But these tensions can be salutary. On one hand, investment in plant and personnel ensures that we will be able to meet future needs; on the other, the difficulties we experience in meeting *today's* needs warn us against "empire building."

Design of Work

The church employs hundreds of thousands of people in its work of human service. Its role as employer gives it a significant opportunity to model social justice principles in the design of work. Probably the best-known dimension of the church's social teaching is that concerning the rights and duties of workers and employers.

When the foundation documents of this teaching were published, their focus was on industries

*See *Community Benefit Program: A Revised Resource for Social Accountability*, Catholic Health Association, St. Louis, 2001.

such as manufacturing and mining. Workers in those days usually found unions to be the most effective means of promoting subsidiarity and participation in setting the conditions of their employment. In recent decades, the service industries, including health care, have come to occupy a larger role in the economy. Do unions remain the best way to foster worker participation in these areas? Most dioceses, agencies, and health care systems would maintain that a union is not necessary, and, to the extent that it might promote a disruption of essential services, is an inappropriate vehicle for worker participation. Given that view, the church finds itself challenged to maintain a fair and just workplace with appropriate wages and benefits and participation in designing the conditions of the workplace.

Health insurance is an example of experience illuminating theory in this regard. Most Catholic organizations want to provide affordable health insurance to all their employees, especially the lowest paid. However, workers are free to decline such coverage and may do so for a variety of reasons. The employer is then challenged to somehow promote this benefit without coercing workers or invading their privacy.

Commitment to Advocacy

A commitment to advocacy is a fifth point of intersection between social principle and practice. Human dignity can only be maintained and guaranteed in the context of human society. Society, in turn, is regulated by laws, policies, and institutions designed to promote the common good. Legislators and rule makers need to hear from the broad community, especially from those who are in touch with the interests of the poor and needy. With our vast array of institutions and services, Catholic health care and social service providers have an opportunity and obligation to promote social justice through their public advocacy. Our experience and longevity in ministry give us a credibility that we can then bring to the public debate on issues such as welfare reform and health care reform. Our advocacy is most effective when it is not seen as self-serving (i.e., enhancing Medicare reimbursement), but as giving voice to the voiceless.

Outcomes Measurement Is Needed

These five areas of intersection illustrate how experience can inform reflection, and vice versa. The measurement of outcomes can be a tool for this dialogue. It is tempting to assume that good intentions or large expenditures always guarantee beneficial results, but the evidence for such an assumption may be lacking. In recent years, the continuous quality improvement movement in health care has focused attention on the importance of identifying and measuring the outcomes of specific interventions.

The great principles of Catholic social teaching find their roots in the Gospel, but their application takes different forms in different times and different settings. Applying the techniques of measurement, we might ask whether these applications, these interventions, are achieving the desired results in terms of our guiding principles. For example, what would subsidiarity look like if it were really practiced in this situation? How would it affect a commitment to stewardship or to the common good? Trying to answer these questions in terms of measurable behaviors would be a valuable discipline and contribute to the integrity of a health care or social service agency. Some health care systems routinely use methodologies that integrate the claims of social justice into corporate decision making. A habit of measurement can ensure that the development of social consciousness, as evidenced by both reflection and action, is tested by reality. Measuring the congruity of policies with principles of social justice, as well as service excellence and client and patient outcomes, will create a higher standard for our organizations than that published by any accrediting agency.

At bottom, reflecting on social justice principles and providing social programs are activities that spring from the same source—a belief in God's love for us and a desire to respond in love to our neighbors. Catholic health care and social services constitute a community of moral agency, whose root and foundation is Christian charity. This love, which has its horizon in the future, is never content with what is, but always striving to bring the fullness of God's reign closer to our time and space. □

Catholic-Sponsored LTC Services

CHA's long-term care presence includes:

- Skilled nursing services in more than 670 locations
- Nearly 400 assisted living/residential care programs
- Nearly 500 other housing programs, including senior, low-income, and special need housing
- More than 250 adult day care programs
- Approximately 500 home health programs
- More than 300 hospice programs

CHA
THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES