Preserving Our Tradition Of Community Service

BY SR. BERNICE COREIL, DC

Few issues are more important to the leaders of Catholic healthcare facilities than our tradition of service to our communities. Our institutions were established often at great sacrifice and not as an end in themselves, but always in response to pressing community healthcare needs. This tradition is more relevant than ever. We must continue to demonstrate that we care *about* our communities, as well as *for* them. We must seek out unmet needs and, to the best of our ability, fill in the gaps—especially for the poor and least fortunate in our society.

An important characteristic of our facilities is their tax-exempt status. They were established for the public benefit, to serve the communities that helped create them. On September 14, 1990, in introducing legislation favorable to not-for-profit institutions, Sen. Daniel P. Moynihan, D-NY, said, "A distinguishing feature of American society is the singular degree to which we maintain an independent sector—private institutions in the public service. This is no longer true in most of the democratic world; it was never so in the rest. It is a treasure; a distinguishing feature of the American democracy."

As healthcare leaders, we must foster this rich tradition of private voluntary healthcare institutions serving the public interest. But I am concerned that this tradition is at risk. Preserving it is up to each of us.

Distancing Forces

Two historical forces have distanced our facilities from their communities. First, the adoption of the Hill-Burton Act, establishment of Medicare and Medicaid, and the rapid expansion of private health insurance—although a blessing for the elderly, the poor, and religious institutes involved in healthcare—substantially reduced our facilities' need for philanthropy. As we came to rely less on philanthropy, we relied less on our communities. Public and private health insurance relieved us of the burden of constantly organizing volunteers for fund-raising. As a result, our communities gradually became less familiar with us and our mission and took less ownership in our programs and activities.

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The second force jeopardizing our voluntary tradition is the increasingly competitive environment, exacerbated by growing financial pressures. Hospitals' resources have been constricted as Medicare and Medicaid payments have failed to keep pace with hospital costs. The shift from cost-based reimbursement to prospective payment has substantially increased hospitals' risk. Before 1983 a hospital could have a zero margin and still know that its costs would be covered. Today's hospitals do not enjoy that certainty. A recent Catholic Health Association (CHA) analysis showed that in 1991 more than 62 percent of all our hospitals lost money on Medicare (Lewin/ICF, *Payment Simulation Model*, 1991), and Medicare in many places is our best payer. For a small percentage of our facilities the loss was so great it threatened their continued existence. The outlook for future years is equally grim.

Meanwhile, private payers have adopted cost-control techniques, and competition from other entities, such as ambulatory surgical centers, has intensified. Thus, to survive economically so they can carry out their public missions, many not-for-profit hospitals have become increasingly price competitive and commercial.

As a result of at least the appearance of competitive and commercial behavior, many not-for-profit facilities are viewed more as business entities than as traditional community institutions dedicated to public service. They are under greater scrutiny at all levels of government and, as never before, are being asked to justify their tax-exempt status.

What has distinguished American voluntary organizations is the absence of the profit motive as an end in itself and the realization—both by us and the communities we serve—that our primary purpose is to respond to the community's health-

care needs. The debate on tax exemption represents an accusation by the government that we have neither the ability nor the will to identify and meet our communities' needs because we are too preoccupied with the business of healthcare.

When we look and act too entrepreneurial, government officials are likely to ask us to pay taxes or dictate the services we provide as a condition of tax-exempt status. But these challenges to our tax exemption are symptoms of a much larger problem. They are evidence that our communities believe we are absorbed with our own success and have lost our capacity to respond to their real needs. They also suggest that we no longer allow our original values to guide and instruct our operations.

Sustaining a Commitment

It is difficult but not impossible to sustain a commitment to mission in a competitive marketplace. To do so, we must adopt a position that runs counter to the conditions and environment in which we operate. This is essential, since the most damaging side effect of competition is not what it has done to us and our image, but how it has affected access to healthcare. Our country is experiencing a serious problem of access to healthcare by the poor, the near poor, and, increasingly, those not traditionally thought of as poor. The healthcare system's ability to serve our communities has taken a step backward because no one competes to take care of the poor. Marketing directors are not looking for new product lines most needed by those for whom our institutions were originally founded: the poor, the homeless, those persons marginalized by society.

Of course, the problem of the poor's healthcare needs cannot be solved by hospitals alone. We need fundamental reform of the entire healthcare system to deal with this growing public policy crisis. However, until the access problem is resolved, not-for-profit hospitals have a special responsibility to care for the needs of the poor and to respond in the same way our founders would have responded.

Our challenge is to respond to community needs and to maintain our tradition of service despite fiscal and competitive pressures. This can *only* be done by intentionally planning and budgeting services for our communities, especially the poor, just as we plan and budget for our other programs and activities. Using CHA's *Social Accountability Budget: A Process for Planning and Reporting Community Benefits in a Time of Fiscal Constraint* (1989), we can inventory current services, assess unmet community needs, integrate services to the poor and other community benefits into strategic plans and budgets, and, finally, report the benefits of these services to interested groups.

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CHA developed this program because of fears that, without a specific method for planning and budgeting community services, mounting financial constraints on Catholic hospitals would prevent them from providing such services. The religious institutes that sponsor these facilities also wanted reassurance that competition in healthcare had not forced their facilities to abandon their ministry commitments to the poor and to their communities. CHA also developed this program to force us to ask ourselves if our charitable tax-exempt purpose was being served.

The Catholic Response

Two years after publishing the *Social Accountability Budget*, CHA conducted a study to examine how it was being used and to take stock of how Catholic facilities were responding to community need (*A Community Benefits Report on Catholic Healthcare Providers*, 1991). What have we learned?

First, most hospitals provide more community benefits and services to the poor than even those persons heavily involved with their daily operation ever imagined. Nevertheless, some hospitals provide very little, and these facilities might not withstand an Internal Revenue Service challenge to their tax exemptions based on the federal community benefit standard.

Second, the scope of community services our facilities provide varies, depending on community needs. Together these services make up a rich tapestry that shows our tradition of service is being sustained. Examples include:

- Starting an adolescent maternity clinic to address the problems of low-birthweight babies among teenage mothers
- Sending nurses from hospital trauma units to high school drivers' education classes to talk about the horrible consequences of drinking and driving
- Maintaining a pediatric unit because the community needs it, even though it consistently loses revenue
- Being a clinical site for students in nursing, social work, physical therapy, and other health professions
- Donating beds, linens, and food to shelters for the homeless
- Setting up a primary care clinic in a poor neighborhood, staffed in part by volunteers from the hospital's medical and nursing staffs

The third lesson is that hospital policies make a difference in whether a facility behaves like a com-

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munity service organization. For example, when an explicit charity policy is in place—one that everyone from the chief executive officer to the billing clerk understands—the hospital is more charitable. It treats poor people who cannot pay in a much kinder and more caring way than does a hospital with less clear charity policies.

Fourth, we learned that many important programs are not necessarily costly. For example, health promotion and screening programs may be low cost but provide terribly important benefits to all populations in our communities.

Finally, we learned that in spite of fiscal constraints, we can protect important community services and services to the poor, and even enhance them, by including them in strategic plans and budgets. Members of our communities, especially the poor, the uninsured, and other special populations, need us as much now as at any time in our history, and we can serve them if we plan to meet their needs.

Reinforcing the Tradition

I believe that we can and must address pressing healthcare needs in our communities. If we maintain and reinforce this tradition of community service and response to the poor, the results will be rewarding:

- Through CHA's *Social Accountability Budget* and other planning processes, we can sustain and increase our commitment to providing community benefits in response to needs.
- We will be seen as part of the solution to the current healthcare crisis, allowing us to take a leadership role in the design of policy solutions.
- We will maintain our tax-exempt status and the public trust exemption represents.
- We will relieve some of the human distress inherent in a healthcare system that denies service to people in need.
- We will preserve the tradition, started years ago by those who established our fine institutions, by galvanizing community resources to respond to community needs. □

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The Catholic tradition does not insist on the prolongation of dying.

not hold that all means must be employed to prolong and preserve biological life. Assisted suicide and mercy killing are prohibited by a negative command (Thou shalt not kill), which binds absolutely. The command to prolong and preserve biological life, on the other hand, is a type of affirmative command that always allows for reasonable exceptions (similar to the command to participate at mass on Sundays). Thus the Catholic Church teaches that people are only obliged to use *reasonable* means to prolong and preserve life and health, but not every means available in this age of high-technology medicine.

Specifically, papal teachings[4] and other official Church documents[5] make it clear that medical interventions may be refused or removed when the person (or if the person is incompetent, the family or authorized surrogate) considers them unusual, burdensome, or futile. A treatment is unusual when the person believes that it does not fit well in the context of his or her life right now. For example, a Third World missionary who gets seriously ill might legitimately choose not to return home for more advanced medical care, even though this decision might seriously shorten life or impair health. Burdensome treatment is any that causes disproportionate pain, suffering, psychological duress, economic hardship, or other dislocation. A treatment is considered futile when it will not restore well-being within a reasonable amount of time.

Persons may refuse or remove these kinds of interventions because they are extraordinary or disproportionate, even if natural death occurs more quickly as a result of this decision. Thus the Catholic tradition does not insist on the prolongation of dying, but does teach that the compassion and care we render to dying persons should not include the willingness to assist in the direct ending of their lives. Revisionist theologians generally accept this line of reasoning, although they would, as mentioned earlier, accept assisted suicide and mercy killing in some limited situations.

Need for Perspective

Whatever their own position, those who wish to contribute to the debate on euthanasia should be familiar with changing attitudes on the issue, as well as the principles on which persons base their views. Persons familiar with Church teaching on euthanasia will have a valuable perspective on an issue that often creates tension between the dictates of compassion and a fundamental commitment to the sanctity of life. □

For a more detailed analysis of euthanasia, see Principled and Virtuous Care of the Dying: A Catholic Response to Euthanasia, *by Rev. Richard M. Gula, SS—available for $3 from the Catholic Health Association of the United States, 4455 Woodson Road, St. Louis, MO 63134-3797, or call 314-427-2500, ext. 258.*

NOTES

1. Derek Humphry, *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide*, National Hemlock Society, Eugene, OR, 1991.
2. See Daniel C. Maguire, *Death by Choice*, Doubleday, Garden City, NJ, 1984, especially pp. 118-122; Joseph Fletcher, "Ethics and Euthanasia," in Robert H. Williams, ed., *To Live and to Die: When, Why and How*, Springer-Verlag, New York City, 1973.
3. Lawrence J. Nelson, "Ethics of Intentionally Killing the Innocent," paper presented at Controversies in the Care of Dying Patients, sponsored by the University of Florida, Orlando, February 16, 1991.
4. Pope Pius XII, "The Prolongation of Life," *The Pope Speaks*, vol. 4, 1958, pp. 393-398.
5. Congregation for the Doctrine of the Faith, *Jura et Bona* (Document on Euthanasia), *The Pope Speaks*, vol. 26, 1980, pp. 289-296.