

SYSTEMIC REFORM IS VITAL TO OUR MINISTRY

Without Reform, Catholic Health Care Cannot Practice Biblical Values

BY JOHN W. GLASER,
STD, & BRIAN B.
GLASER, PhD



John W. Glaser is senior vice president, theology and ethics, St. Joseph's Health System, Orange, CA; Brian B. Glaser is a poet and faculty fellow at the University of California at Berkeley.

For many years, those of us who serve Catholic health care believed that the primary place to work on the ministry's moral identity was the institutions themselves. The authors of this article have come to view that notion as mistaken; the institutions constitute a secondary arena. The authors now believe that the *primary* moral identity of Catholic health care is determined by U.S. health care policy and practice. Without reform of U.S. health care, the ministry's intra-institutional efforts will merely tinker at the edges of its moral identity, leaving its substance deeply flawed.

Put concretely, a nonreligious hospital in Germany has a far better chance of making biblical priorities present in German society than does a religious hospital in the United States. That is because the public policies shaping hospitals in Germany are significantly closer to biblical priorities than are similar parallel policies in this country. As Uwe Reinhardt wrote in 1994, "The ethical principles driving German health policy just do not square with the American way."¹ For the authors, this thesis and the evidence supporting it have been sobering and motivating.

In developing the thesis, we will trace it through five steps. We will:

- Identify respect for human dignity as the heart and foundation of moral identity.
- Develop a moral paradigm that distinguishes three different, but related, realms of respect for human dignity: individual, institutional, and societal.
- Focus on a critical law of this three-realm model: Society shapes and limits an institution's ability to respond to human dignity by setting the rules according to which the institution will survive and succeed.
- Identify some major biblical priorities that

should shape Catholic health care institutions, and contrast them with priorities-in-practice that, in fact, shape U.S. health care institutions.

- Conclude that reform of U.S. health care is essential for improving the moral integrity of, and presence of biblical priorities in, Catholic health care institutions.

MORAL IDENTITY AND HUMAN DIGNITY

What language does Catholic tradition use to measure moral character? That depends. The dominant language varies at different points in the tradition. A few examples will illustrate this tendency.

In the New Testament, the dominant parables, images, and language concern love of neighbor. Romans 13 captures this idiom: "If you love your neighbor you have carried out your obligations. All the commandments: You shall not commit adultery, you shall not kill, you shall not steal, you shall not covet, and so on, are summed up in this single command: You must love your neighbor as yourself."

Later, during the centuries when Catholic morality found its center revolving around the tribunal of confession, the manuals of moral theology cast moral character in terms of obedience to the Ten Commandments.

More recently, as the church applied the commandment of love to "the social question"—to society and its structures—the dominant language came to concern human dignity and the respect it deserves. For example, the U.S. bishops' pastoral letter on the economy says, "The dignity of the human person, realized in community with others, is the criterion against which all aspects of economic life must be measured."²

Although history shows that evolving pastoral emphases have tended to develop their own preferred languages and conceptual systems, Jesus'

great double commandment of love underlies all these languages and conceptual systems.

Because our topic concerns institutional ministry and social morality, the recent language of Catholic social teaching—respect for dignity of persons—suggests itself as the preferred way to discuss moral excellence and moral identity.

THREE REALMS OF RESPECT FOR DIGNITY

Scattered throughout the Catholic moral tradition—though often concealed in language that sometimes obscures its contours and basic coherence—is a model of three different, but related, realms of respect for dignity/love of neighbor. Raising this paradigm to an explicit level and developing its structures and implications can be very fruitful for Catholic moral thought.³ The following line of thought is one example of the light it can shine on issues (see **Figure** below). Only a few of the paradigm's elements are relevant to our present discussion. The paradigm emphasizes:

- The fact that the human person is both indivisibly individual *and* social. Whether we humans realize it or not, we constantly live as individuals in interdependence with mediating social communities that are in turn interdependent with the larger society.

- The fact that there are three “nested” realms of love of neighbor and respect for his or her dignity: societal, institutional, individual, each of which is essentially interdependent with the others but also significantly different from them.

- The growing complexity and magnitude of these realms as one moves from individual to institution to society.

- The fact that—and this point is the most germane to what follows—the larger realms have enormous power to shape the moral possibilities of those they encompass.

SOCIAL STRUCTURES AND MORAL POSSIBILITIES

A major principle of the three-realm paradigm is this: A society's systems and structures (financial, legal, scientific, cultural, etc.) so firmly set the moral parameters of successful mainstream institutions that those institutions can differ only marginally from this socially defined moral level. Not all institutions are equally imbedded in the larger society. But the more *mainstream* an institution is—that is, deeply interdependent with society's major dimensions—the more it will be shaped by society's forces. The more marginal an institution is to society, the more it will be shaped by its *own* inner vision and goals. Compare, for example, the defining influence of society on a national hotel chain, on one hand, and on a vol-

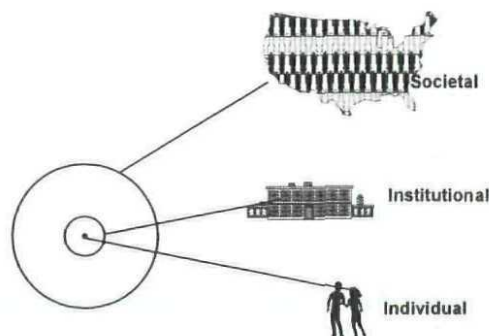
unteer-based hostel for domestic violence victims, on the other.

It would be hard to imagine more mainstream institutions than U.S. health care facilities. They are bonded in every way imaginable with the major forces of U.S. society—banks, rating agencies, the job market, state and federal laws and regulations, unions, professional licensing agencies, government budgets and crises, social programs, the business community, the pharmaceutical and insurance industries, all forms of media, and public expectations and demands.

The three-realm model says that such mainstream institutions are inexorably mirrors of societal priorities. Therefore health care organizations will serve those persons defined as worthy of service by society. Such organizations will be rewarded for providing services that society prizes and punished for providing those that the culture does not esteem. Such organizations will staff and pay at levels determined by society. They will manage their finances under the scrutiny of their state capitals; Washington, DC; and Wall Street. Their boards of trustees and executives will spend the preponderance of their time and energy dealing with issues generated by the systems and structures of society rather than those generated by their mission and values.

As for respecting human dignity, a successful U.S. hospital can differ only marginally from the way society at large respects it. *An organization that attempts to deviate significantly and consistently from these societal priorities will, in due time, be destroyed.* To be a “provider of preference” is to substantially conform to the priorities of the society.

Robert Kuttner's observation offers empirical confirmation of this ethical dynamic: “All segments of the health care industry and profession, even those with a sense of mission very different from that of for-profit enterprises, found themselves in a new world where the pursuit of market share, the development of referral networks, the



search for profitable admissions and subscribers, relentless cost cutting, and other practices pioneered by shareholder-owned firms came to predominate."⁴

One might conclude that such hostile pressures give Catholic organizations a reason to exit American health care. But flight into sectarian isolation runs counter to Catholic tradition. We Catholics are called to change the system, not flee from it. In 1984 the U.S. Catholic Conference summarized this growing conviction thusly:

It is appropriate in this context to offer our own reflections on the role of the Church in the political order. Christians believe that Jesus' commandment to love one's neighbor should extend beyond individual relationships to infuse and transform all human relations from the family to the entire human community. Jesus came to "bring good news to the poor, to proclaim liberty to captives, new sight to the blind and to set the downtrodden free" (Lk 4, 18). He called us to feed the hungry, clothe the naked, care for the sick and afflicted and to comfort the victims of injustice (Mt 25). His example and words require individual acts of charity and concern from each of us. Yet they also require understanding and action on a broader scale in pursuit of peace and in opposition to poverty, hunger and injustice. Such action necessarily involves the institutions and structures of society, the economy and politics.⁵

BIBLICAL PRIORITIES AND OTHER PRIORITIES

The Bible does not speak explicitly about health policy, of course. But Catholic societal teaching provides conceptual tools that enable one to translate biblical priorities into some elements of a biblically just health care system.

Unlike other "first-world" nations, the United States has not developed an overarching theory and policy for health care. We have preferred to allow our health care delivery and financing to evolve in its own way, driven by various independent social forces. But a nation that spends over \$1.5 trillion annually for health care certainly can be said to have *priorities-in-practice*, however unarticulated these may be.

Let us compare biblical priorities in health care, on one hand, with U.S. priorities-in-practice, on the other (see Box, p. 19). Of course, biblical and U.S. priorities are identical or at least harmonious in many areas. U.S. health care is, in many ways, a splendid and compassionate effort. But from a biblical perspective, it is also deeply

unjust, gravely flawed, and—in its impact if not in intent—extensively cruel.

If we stop and examine a single aspect of our system, we see that this claim is not hyperbole. U.S. health care spends prodigiously—now more than \$1.5 trillion, multiples of most other developed countries' per capita spending. But we systematically exclude about 11 million children from this prodigal outpouring. When we look at the potential consequences of such policy neglect—stunted neurological development; immune system compromise; impairment of the child's capacity to become a self-confident adult as worker, partner, parent, and citizen—the characterization of our system as "extensively cruel" seems merited.

REFORM IS MORALLY VITAL

The logic of our argument so far brings us to the following conclusion: The most significant factors in a health care institution's *primary identity* are the systems and structures on the societal level that define success for such institutions. Catholic health facilities are like all others in this regard.

Thus the path to deep and abiding improvement of the moral integrity of Catholic health facilities leads to reform of the larger system. We must work to build a system that moves significantly away from the current priorities-in-practice and toward one that more robustly honors human dignity and expresses biblical priorities.

The main lines of the agenda, though not obvious in every detail, are clear enough. But the agenda itself is daunting because the current situation involves more than programs, funding, and political maneuvering. Health care today is rooted in deep and abiding attitudes and assumptions of U.S. culture. Some of these attitudes and assumptions can fairly be described as cultural addictions—patterns of dysfunction that Americans cannot relinquish despite irrational and punishing consequences. These addictive patterns have, in turn, resulted in kingdoms and constituencies that benefit from the status quo. The ranks of those resisting reform are long and deep—and we who work in Catholic health care ourselves can be recognized in that crowd.

Rooting out deeply imbedded injustice is always a project that takes decades, sometimes generations. This was true of the abolition of slavery and the achievement of women's suffrage. But we Americans did finally accomplish both goals, making our societal systems more deeply respectful of the dignity of all persons. We should also take hope from the fact that that every other first-world nation has a health care system significantly closer than ours to biblical priorities. So there are solid reasons—to be found in history, in

the example set by other nations, in biblical faith—for us to hope for success in this effort. But we need to begin this long journey now, rather than postponing it until crises involving the Balanced Budget Act of 1997, seismic retrofitting, and other problems have been dealt with. If we who serve the Catholic health ministry do not find a way to deal, at one and the same time, with both short-term crises and this long-term moral challenge, our own essential moral character will continue to be gravely compromised. As unlikely as it may seem, the reform of U.S. health policy is the reform of our own moral identity. □

NOTES

1. Uwe E. Reinhardt, "Germany's Health Care System: It's Not the American Way," *Health Affairs*, Fall 1994, p. 24.
2. National Conference of Catholic Bishops, *Economic Justice for All: A Pastoral Letter on Catholic Social Teaching and the U.S. Economy*, U.S. Catholic Conference, Washington, DC, 1986, para. 28.
3. See John W. Glaser, *Three Realms of Ethics*, Sheed & Ward, Kansas City, MO, 1994, which the author is currently expanding.
4. Robert Kuttner, "The American Health Care System: Wall Street and Health Care," *New England Journal of Medicine*, February 25, 1999, pp. 664-668.
5. U.S. Catholic Conference, "Political Responsibility: Choices for the '80s," *Origins*, April 12, 1984, pp. 732-736.

BIBLICAL PRIORITIES VS. U.S. PRIORITIES-IN-PRACTICE

BIBLICAL PRIORITIES

Common Good Context Health care is seen as part of the common good—that network of basic social goods (education, employment, housing, health care, etc.) needed for individuals and society to flourish with consistency over the long haul. This network is the foundation and context for understanding and making decisions about health care.

Sustainable Growth Progress and growth are highly valued. But progress is the servant of the common good, not its master. To serve the common good, individual conscience, cultural awareness, and societal structures will have to restrain the virtually endless possibilities of health care.

Health as a Right/Responsibility for All As a social good, required by society and individuals for long-term flourishing, health care must be equitably accessible to everyone. For the individual, this grounds the right to access; for society, it grounds the duty of provision.

Explicit Hard Choices Because health needs are virtually infinite but resources are finite, hard choices cannot be avoided. Such sacrifices should be made explicitly and in a way that permits examination. Hard choices made implicitly unavoidably hide and empower bias and injustice. Infrastructure is needed for explicit decision making.

Priority to Basics Keenly aware that many potential goods must be sacrificed, biblical allocation demands explicit priorities. The most fundamental priority is resources for universal basic health care.

Pursuit of Explicit Integration and Oversight Like national defense, national health care has an organic integrity, but also enormous complexity requiring explicit attention and systematic, identified responsibility. Scattering responsibility (and incentives) can be compared to assigning the care of an ICU patient to a gang of subspecialists who refuse to talk to each other. The forces of entropy and dysfunction must be harnessed to serve the individual and common good.

U.S. PRIORITIES-IN-PRACTICE

Individual Context Health care is seen primarily as an individual good. Its predominant relationship is that between individual physicians and individual patients. Bioethics sees personal autonomy as its first principle. Treatments providing no more than modest benefits are fought for as medically justified, regardless of their aggregate impact.

Maximum Tolerated Growth U.S. practice promotes maximum growth in quantity and pace. Newer forms of care and ever-larger amounts of it are assumed to be better care. Limits tend to be set in a crisis-management mode by major payers with narrow criteria lacking a larger context or long-term perspective.

Health Care as a Commodity for Most Only for some—for example, those 65 and older, members of the military, penitentiary inmates, patients in end-stage renal failure—is health care an established right. For most people, access to health care is a commodity, directly related to wealth and power. At present, at least 40 million Americans cannot afford this commodity.

Implicit Hard Choices U.S. practice prefers to make hard choices implicitly, nurturing the illusion that we do not ration health care. Deeply punishing results—children constitute more than 11 million of the 40 million uninsured Americans—flow from diffuse decisions for which no one owns responsibility.

Priority to Frontiers Pursuit of innovation and a dream of a disease-free future tend to divert attention and resources from universal basic care. Rescue/research/technology imperatives overwhelm the basics/prevention/promotion imperative.

Strong Resistance to Integration and Oversight Because health care is seen as care for individuals; because personal freedom is highly prized by both professionals and patients; because maximum, unfettered growth is valued; because the free play of market forces are viewed as the answer to social problems—for all these reasons, society rejects efforts to integrate and rationalize health care as "inappropriate."