

Catholic Health Care

The Ministry's Future in a Turbulent World

BY FR. J. BRYAN HEHIR, M.Div., Th.D.

Allow me to begin by expressing my appreciation for the invitation to address the Catholic Health Association Assembly. This is the third plenary address I have been invited to offer, and I regard each of them as a great privilege in light of the ministry you fulfill each day.

Your theme this year, “Forging the Future in Turbulent Times,” is just right for this time. The country, the health care community and the church have been through an exhausting, intense debate. Understanding the significance of that debate — its process and its product — is a necessary task, but far more urgent is the need to answer the question of how to move from where we are to where we need to go to provide health care for all that is morally grounded, legally guaranteed and delivered with competence and compassion. I have entitled my address “Catholic Health Care: A New Moment, an Ancient Tradition and a Challenging Future.” It is my attempt to contribute to the overall design of this assembly.

The address will move through three stages:

- A new moment: the setting of American health care
- Locating Catholic health care: the relationship of traditions and institutions
- Reviewing the recent past and forging the immediate future: the work ahead

A NEW MOMENT: THE SETTING OF AMERICAN HEALTH CARE

My purpose in this section is to offer a synthetic statement of the changed context in which Catho-

lic health care must plan and fulfill its ministry. It is useful to begin my remarks with some reference to Tom Friedman’s talk, which opened this assembly. Tom [a *New York Times* columnist and author], is the classic big-picture person: the analyst who draws connections others miss, who combines perspectives others don’t notice and who keeps pressing the country to focus on the macro-challenges we face.

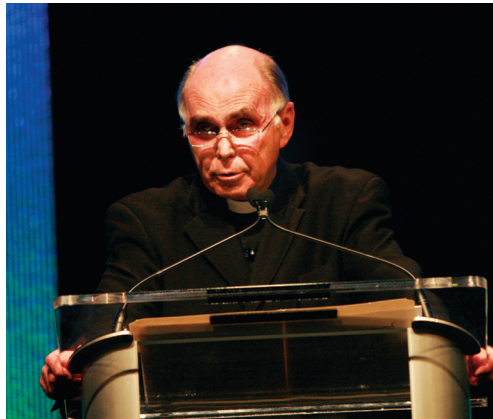
I draw two conclusions from his stimulating presentation. First, both the economy and the environment are iconic examples of the process of globalization, which he has written about in such detail. They highlight that none of our major issues can be addressed without understanding the wider focus, which can shape and at times constrain our decisions as a country. Health care reform seems like a prototypical domestic policy issue. In many ways it is, but it cannot escape the impact of the global market and the global environment. Second, while Tom Friedman’s analysis was filled with facts and hard data, in the end he focused on the values that we need to confront a turbulent world. This is the perfect assembly to stress values; it is Catholic health care’s stock in trade. It emphasizes again that this community belongs in and can contribute to the wider health care debate.

The debate and the decisions of 2010 have given us “the new moment” in health care. The dominant task of the moment is assessing and understanding the Patient Protection and Affordable Care Act of 2010. Like all major social legislation, it is an imperfect product. It is a collage of bold convictions and debatable compromises, of long-term objectives and short-term choices. Its dominant characteristic is that it has survived a complex, conflicted process and is now law.

I note this fact as primary because of the historical background of other efforts of systematic health care reform in this country. The bipartisan record of presidents who have attempted reform reaches from Roosevelt to Truman, to Nixon, to Carter and to Clinton. In the political world, the challenge of passing *any* systematic reform had taken on epic proportions. In their 2009 book, *The Heart of Power: Health and Politics in the Oval Office*, Professors David Blumenthal and James A. Morone described the challenge this way:

Major health reform is virtually impossible; difficult to understand, swarming with interests, powered by money and resonating with popular anxiety ... It costs time, energy and political capital. This is no arena for half-hearted efforts.

I doubt that anyone — in the professional community or the popular debate — thinks that the legislation has solved the Rubik’s Cube of the American health system. But the new moment has been decisively shaped by the new legislation. We are now in a different setting, a threshold has been crossed and a new policy context now exists. Perhaps the best way to understand that policy



Fr. J. Bryan Hehir at the 2010 CHA Assembly.

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context is to compare it with other moments of major, substantial change in American social policy. The Patient Protection and Affordable Care Act of 2010 has the proportions and the potential of the Social Security Act of the 1930s, the Civil Rights Act of the 1960s and the Welfare Reform Act of the 1990s.

In each of these cases, major systemic changes were introduced into American law, policy and life. But it is also true that in each case, later modifications were added by new legislation, succeeding court decisions and new policy initiatives. Undoubtedly, as of March 23, 2010, we have begun an innovative chapter of health care policy in the United States. The real narrative lies ahead of us.

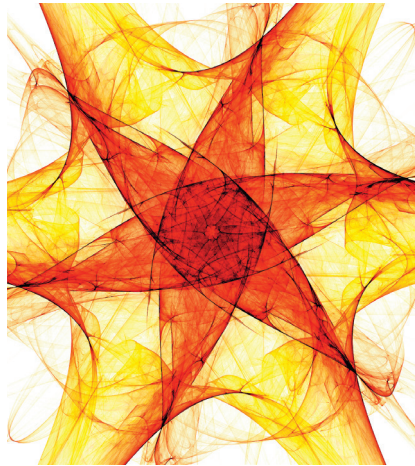
The conviction that a major threshold has been passed is broadly shared; the assessment of the potential consequences of the legislation is divided — and divisive. The consensual definition of the policy problem of health care reform has been in possession since the 1990s. It consists of three factors: coverage, cost and quality. While most agreed with the definition, proposed remedies varied widely across the last 20 years.

Indeed the debate about health care surfaced issues deeply rooted in American culture and politics. The various policy proposals were offered in light of these broad themes: First, the fact of religious pluralism — this is a defining dimension of American society. Pluralism in this sense means that in one civil society there exists multiple communities of faith that differ in their interpretations of the ultimate questions of life. The double challenge of religious pluralism involves: (1) protecting the religious freedom of each individual and every community; and (2) fashioning from pluralism sufficiently shared moral agreement to be the

foundation of law and policy for civil society. This challenge has been part of American constitutional history for over two centuries. What has changed is that moral pluralism is more pervasive in the United States than in earlier ages. Both religious and moral pluralism made consensus on health reform more difficult to debate and to achieve.

The second conclusion I draw from Tom Friedman's talk, the role of government in the economy and in civil society, was intensely debated during the past year. At one level the question seems clear-cut: What does the government do well and what does it do poorly? This descriptive account of government, however, does not exhaust the policy debate. The normative question of the responsibilities and duties of the state must be part of the policy discussion. Catholic social thought, for example, rejects the notion of a purely neutral "umpire" state whose duties are restricted to defense and law enforcement. Beyond these functions lies the moral role of the state to protect and promote human dignity and human rights. The specific duty of the state to protect and foster human life along the spectrum of human existence shapes the answer one gives to the role of the state in health care. John XXIII observed in *Pacem In Terris* (1963) that the common good is best preserved where the rights and duties of each member of society are protected. Such a concept provides a positive role for the state in social policy. Health care policy is an example of this principle.

Third, the correlative idea to the state is the understanding of the role of the market in health care. One of the dividing lines in the policy debate has been how heavily one depends on the market as an agent of health policy. To invoke Catholic social teaching again, John Paul II in *Centesimus Annus* (1991) provided helpful distinctions. Having known from experience the record of a command



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economy, he brought to the papacy a positive sense of the role of a market economy. The market, he argued, protected freedom and promoted innovation. Equally firmly, he specified the moral limits of the market. First, for those without resources, the best functioning market is of no help; they can't enter the market. Second, the market does not distinguish the intrinsic value of different goods. The latter point is directly relevant to the health care debate. A pure supply-and-demand calculus is inadequate in assessing health care policy. It is a necessary good, essential for human well-being. Hence, it cannot be treated as other goods that may be desirable but are not essential for human well-being.

Each of these elements of the health care debate illustrates how moral and religious factors are woven into the argument. Because Catholic health care ministry is rooted in a moral-religious commitment, our voice was and continues to be a potentially powerful one in the larger public arena.

It is neither my mandate nor my purpose in this address to engage in a detailed policy analysis of the Patient Protection and Affordable Care Act of 2010. I have spent some time on the *context* of the next stage of health care reform because I am proposing two recommendations. First, the scope and substance of the legislation requires that all actors in the American health care community now have to review and assess where they are located in this new policy environment. Second, I now want to focus on the intersection of American health care and Catholic health care in the new setting established by health reform.

LOCATING CATHOLIC HEALTH CARE: THE RELATIONSHIP OF TRADITIONS AND INSTITUTIONS

The concept of a "new moment," the image of crossing a threshold, does not, of course, mean

that everything has changed. But many things have and will change. The context of care has been reshaped, even if the daily duties of care remain constant. As the largest nonprofit providers of health care in the United States, the Catholic health care community's understanding of its role and place in health care is of interest not only to the church but to American society. In many ways we share similar concerns with our secular colleagues, both for profit and nonprofit systems. In addition, however, Catholic systems and institutions answer to an older tradition of care whose role I seek to summarize.

For Catholics, traditions (religious, moral and legal) shape institutions. In his book *The Vindication of Tradition*, the late Jaroslav Pelikan of Yale quoted Edmund Burke's definition of tradition as a "partnership in all science, art, every virtue." Burke went on: "As the ends of such a partnership cannot be obtained in many generations, it becomes a partnership not only between those who are living, but between those who are dead, and those who are to be born."

The Burke quotation stresses tradition as a continuity of thought and practice. In a more content-oriented description, I would say traditions are a mix of convictions, ideas, customs, practices and moral and intellectual principles that guide individuals and institutions across time and space. Peter Steinfels, in his book *A People Adrift: The Crisis of the Roman Catholic Church in America*, makes the point that the prevailing model of medicine in the United States is deeply indebted to the Enlightenment tradition's commitment to reason, modern science, and, I would add, secularity as a worldview.

In the Catholic community of care, we certainly share some of those convictions, but we combine them with layers of tradition tightly woven into a conception of health care and moral responsibility for life that has a distinctive character to it. I would argue that three distinct traditions shape Catholic health care today.

First is the *Christian tradition of care*. The elements of this broadest and oldest tradition, which guides our work and service, combines biblical, ecclesial and moral ideas. The poles of the biblical narrative which ground our conception of care lie between the Good Samaritan and the Hebrew prophets. Luke's account of the Good Samaritan permanently captures our conscience because of his compassion and generosity, a compassion that

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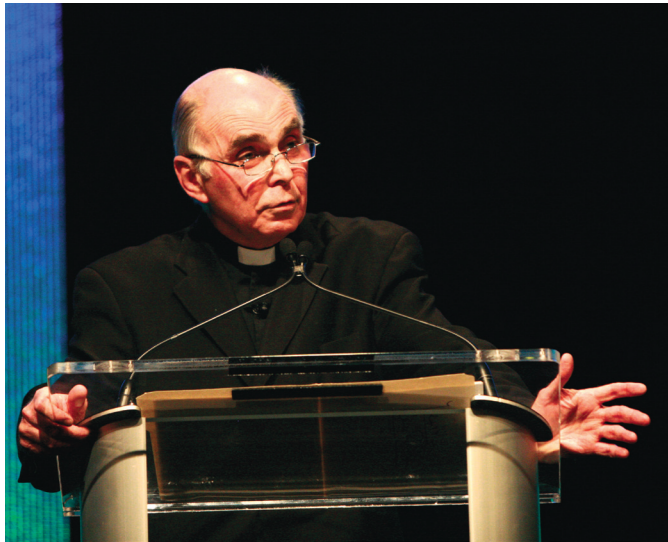
transcends boundaries of faith and ethnicity, and a generosity which reflects the lavish goodness of God. In one of the most religiously, ethnically and racially pluralistic societies in the world, the Good Samaritan's example sets the daily standard for our ministry. The prophets of the Old Testament address our role in advocacy for they focus on the structural questions in society. They complement issues of generosity and compassion with searing mandates about justice, fairness and public choices.

The passage from biblical narrative to ecclesiology illustrates how the biblical mandate of care becomes, in time, a ministry, a permanent expression of the life of the church. Ministry in this sense means extending the substance and spirit of the Gospels and the prophets across the ages, the times and the places where the church lives and serves.

Second is the tradition of *the charism of care*. The biblical mandate and the ecclesial ministry have been the possession primarily of communities of women and men religious. The spirit of these communities in the United States has been nicely captured by Peter Steinfels:

In the United States the men and women of religious orders played a central role in creating the vast network of religious institutions. In some ways, while bishops and diocesan priests kept the existing parishes going, the priests and sisters in religious orders were the entrepreneurs, the adventurers, the experimenters who broke new ground, founding hospitals and colleges, staffing primary schools, launching missionary efforts, starting publications and guiding new organizations for lay people.

Steinfels' canvas is broader than mine, but it highlights how communities of religious charisms



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adapted and shaped the ancient legacy of Christian care in this nation of pluralism, secularity, the market and modern science. My gloss on the Steinfelds text is simply to say that one cannot write the history of American Catholicism without these communities and their various charisms of care. They have been at the heart of the preservation of faith in this country.

I would also add at this point in the lecture that it would be a major omission not to assert in this assembly how powerfully Sr. Carol Keehan's leadership embodies the characteristics of experienced care, service of the poor and intelligent, courageous ministry.

The third tradition is the *Catholic health care record* in this society. By this I mean the role it plays across the country, the status it has in the eyes of others, and the transitions it has made in adapting to new realities in the church and in the arena of modern medicine. The big story here is the modern complement to the role of religious communities, namely the transition to lay leadership on boards, in senior management and through the diversity of the Catholic health care community. In a narrative which is paralleled in Catholic schools and social service agencies, it is both possible and necessary to say that if this transition in competence and leadership had not occurred, an erosion of Catholic presence and influence in American society would have been the outcome.

How do these multiple traditions shape Cath-

olic health care today? What is the visible, tangible product they yield? In my view, they help us with the following questions: the way we see, the way we stand and the way we judge.

The way we see is the product of a fundamental theme in Catholicism: the complementarity of faith and reason. This idea — that faith can take us beyond reason, but it never should fall beneath reason — was forged in the earliest centuries of the church and has been sustained — with more or less creativity — throughout the centuries. The theme applies to diverse areas of knowledge: faith and politics, economics, law and culture. Catholic health care stands at a unique inter-

section — faith and reason embodied as religion and science. In a culture where this relationship is cast in doubt on both sides, it is very important to demonstrate fruitful complementarity. The task is not simple; the dynamics of modern science challenge the linkage in diverse ways. Two fundamental ideas of the Catholic tradition are tied to this intersection: the sacredness of the person, and our stewardship of all the resources God has given us. Protecting sacredness is a requirement when it can be threatened or enhanced by the relentless dynamics of scientific discovery. Honoring stewardship as a human responsibility stretches today from the inner secrets of nature to the expanding concepts of environmental policy.

The way we stand is the legacy of a tradition as old as the Gospels. How should communities of faith engage the world, the state and civil society? Historically the choices have ranged from flight from the world to trying to control it. The preferred path is one that acknowledges the rightful independence and status of world-state-society and then seeks a collaborative relationship with them. Such a view — reflected in Vatican II's texts (*Gaudium et Spes* and *Dignitatis Humanae*) — resists a secularist vision of life and care; it also recognizes the limits of religious claims in secular arenas. Such a conception stands behind the contemporary Catholic stance for our institutions of education, social service and health care. They are rooted in the Catholic tradition, they are expressions of ministry for the church and they

act as bridge institutions to the wider American society, open to serving all and collaborating with secular institutions. We should be neither overwhelmed by them, afraid of them nor dismissive of their value and role.

The way we judge takes us back to the moral dimension of the Christian view of care. The moral dimension is integrally related to the religion and science theme. In our health care institutions, we daily lay hands on life. It is at the heart of medicine in any tradition. In Catholicism, a recognition of the abiding intrinsic moral significance of this profession has produced over the centuries a distinct subfield of moral analysis. In the United States, Catholic moral theology sustained the field when it had been marginalized in other traditions. Beginning in the 1970s, the broader world of science, the academy and health care returned to an interest in what is now called bioethics. For the Catholic tradition of judging, this opened new challenges and new partners in the pursuit of moral clarity. Today the moral universe in bioethics is as deeply pluralistic as our religious discourse. Precisely because we come to this conversation with a broad spectrum of positions taken over many centuries, we find ourselves in theory and in practice engaged on multiple fronts. The engagement requires a clear sense of what we hold, and an equally clear insight into what we can share and when we may have to judge and stand alone on issues. Laying

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hands on life today means we can enhance or diminish human dignity; we can cure and change. At other times, we need the humility to recognize that we have exhausted every effective effort and can do no more than accompany someone in their final passage to eternity.

REVIEWING THE RECENT PAST AND FORGING THE IMMEDIATE FUTURE: THE WORK AHEAD

At this transition I wish to state my intentions in this final section. Specifically I want to say something about what I seek to do, why I am doing it, and how I will proceed.

My purpose is to recognize explicitly the debate that occurred within the Catholic health care community this past year. I do this because I believe addressing the debate is the best way to move beyond it; finally, I want to state why I believe the differences of judgment occurred and how to evaluate them.

Let me begin with a brief comparison between the wider secular debate and the Catholic place in it. As I have acknowledged earlier, the wider debate produced a very important product. But the tone, style and content of much of the debate must leave one with a diminished sense of our public conversation. This sense is due to the way this crucial piece of legislation reflected the wider condition of the American political process, particularly its polarization, intellectually and politically. I have no unique remedies for the problem, but a convergence of views from [commentators] David Gergen, E.J. Dionne, David Brooks, Tom Friedman, James Q. Wilson and others highlights the seriousness of the question. Polarization made an intrinsically complex policy discussion infinitely harder to carry on.

The Catholic debate was intense and at times conflicted, but more focused and more moderate in tone. Indeed, there were multiple Catholic voices in the discussion. While the dominant ones were the U.S. Conference of Catholic Bishops and CHA, there was a range of commentary in Catholic institutions and publications.

What was the character of the Catholic contribution to health care reform? It was defined at the outset by four broad objectives: (1) support for basic health care for all, describing this goal as a public good and a moral imperative; (2) opposition to federal funding for abortion, described as maintaining an abortion-neutral position for the bill; (3) a call for access for immigrants (of whatever status) to health care — this position made the Catholic voice almost unique in its scope; and (4) advocacy for conscience-clause protection for professionals and institutions based on religious conviction.

These four objectives, broad, substantial and significant, should not be surprising to anyone familiar with Catholic social teaching and Catholic bioethics. They did, however, locate the Catholic voice of advocacy in a singular position in the de-

bate. We had many ad hoc alliances, but few if any absolute allies. Moreover, *post factum*, the final legislation requires improvement in all four areas.

As the legislative process moved forward, and particularly in the final days before passage, the Catholic debate moved from discussion to signs of division. As I read it, the division was primarily about *methods* of achieving the objectives, not the *objectives* themselves. This distinction is not meant to minimize the differences; they were real and serious on both sides. As noted, the primary voices were USCCB and CHA. Beyond differences of *method*, there was also a clear difference about what kind of *certitude* was needed about the future consequences of the bill to provide support for it.

Beyond method/means as well as certitude about outcomes, another major fault line in the Catholic debate might be described as “follow the money.” At stake here was the objective of preventing federal funding for abortion and insulating tax dollars from payments of health plans cov-

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ering abortion. The USCCB has long seen the best guarantee in this area in the Hyde Amendment. This provision amended to appropriation bills has had the status of a gold standard in the complex debates about abortion funding. Hence there was clearly an understandable desire led by USCCB to translate its content into any health care reform legislation. Debate about the degree to which this was achieved or not became the ultimate fault line in the Catholic debate. The USCCB argued that the final bill and the President’s executive order did not adequately guarantee conscience protection or prohibition of expanded abortion funding by the federal government. On this basis, USCCB did not support the Patient Protection and Affordable Care Act of 2010, and CHA did.

Sorting out the contending positions requires a two-step process, reminiscent of a distinction [Fr.] John Courtney Murray, SJ, once made about moral analysis. He distinguished the as-

essment of the *quaestio facti* and the *quaestio juris*. The first refers to the empirical realities of a moral problem; the second to the actual moral judgment made. Speaking of the moralist’s role, Murray comments, “He can give no answer at all to the *quaestio juris* until the *quaestio facti* has been answered” (*We Hold These Truths: Catholic Reflections on the American Proposition*, p. 272). This distinction, originally used by Murray in a discussion of war, has relevance when parsing the recent Catholic debate. Both inside and outside the church there were differing views on how extensively and effectively the health-reform legislation would prevent federal funding of abortion. The issue was worth a real struggle with the facts, and one occurred. While definite positions were taken about the *factual* character of the bill, divisions persisted. Recognition of this persistence of legal debate and analysis is important since the *moral* judgment (*quaestio juris*) hangs from and is dependent upon the prior description of the question of fact. In a more detailed analysis, one could compare the contrasting conceptions of the *quaestio facti*, but that is not possible here.

Rather, I would make two summary judgments about the Catholic debate. Both sides supported the objective of preventing federal funding of abortion. The division lay at the level of factual analysis, and that difference yielded divergent conclusions of whether the legislation should be supported or not. Based on this reading, I would argue that both conclusions about a decision to support the bill or not can be sustained within the context of Catholic moral argument precisely because the differences are rooted in divergent judgments about the *quaestio facti*. Where one comes down on the final judgment of support or opposition to the bill is not the kind of choice which distinguishes being inside or outside the church. This conclusion is reinforced, in my view, by the issue of what kind of certitude about one’s objectives is necessary for support of the bill. Admittedly, Hyde is the gold standard, but failure to achieve the exact certitude which Hyde language guarantees need not require opposition to the bill.

This assessment about positions in the Catholic debate will continue. Serious issues are at stake, and complicated judgments of fact and principle were made on both sides. But review

of the past must also yield to your theme at this conference, "Forging the Future." A sense of proportion is needed on all sides. The legislation is a fact of life. Moreover, the broad challenges that Catholic health care faces would exist if the legislation never passed. All sides in the secular and Catholic communities recognize that the bill has made a real advance in terms of coverage. This has been a social justice objective for Catholic teaching and advocacy for decades. More remains to be done on this objective, as well as on the others espoused by the bishops and CHA together. The USCCB has already joined an effort to clarify and strengthen the protection of life; this legislative effort should be supported by all. A similar effort is needed, focusing on conscience clauses. This topic, in my view, is of the highest urgency for it cuts across multiple issues for Catholic institutions. Perhaps the most challenging political issue will be protection of the health care of immigrants. In brief, it is time to face the future, not to continually replay the past.

As we move forward, recognition of the complexity of the issues American health care faces, and Catholic health care must decide upon, underscores the need for a coherent strategy. This will require more dialogue, not less. It also will require a sense of tolerance among multiple voices in the church. This is not about subordinating principles or eroding the truth of moral analysis. But it is about how our dialogues and debates are conducted.

Again I turn to Murray, a theologian well acquainted with tough debates in the church. He once distinguished between *mistakes* and *errors* in the church. Mistakes, he argued, are the result of deficient intelligence; errors, on the other hand, are the result of bad will. His point was that the two should not be confused. He then went on to offer advice for our future debates in the church, applicable to health care and much else.

There will be lots of "mistakes," but they are readily dealt with, since they involve no will to error. The latter thing is the danger. How

to avoid it? I think the corrective is a will to community — of thought and love. The Christian community is not in error, whatever mistakes it may make.

As the CHA and the wider Catholic community face a turbulent future, as we debate and decide policies and practices, let us not forget why we are in Catholic health care, what catalyzed our ministry and what will sustain it over time. Catholic identity in health care requires that we say no at times, firmly and with confidence. Correlatively, the much broader reality is the way we say yes to care for the poor and the stranger, comfort to the grieving and dying, commitment to quality for all who pass our way.

The positive posture of Catholic identity is grounded in a recent liturgical feast we have celebrated. The feast is Corpus Christi, the Body of Christ; the theme is pervasive in Catholic faith. Indeed, we can distinguish the physical body of Christ, the sacramental body of Christ and the social body of Christ. The first, the Jesus of the Gospels, forever stands as the model of healing we pursue. The second, the Eucharist, sustains us in our pursuit of discipleship. The third, the social Christ, can be understood precisely as the church and more broadly as the human community. This distinction usefully summarizes our ministry — the social Christ, which is the church at work, heals and comforts the humanity of Christ in our clinics, hospitals and nursing facilities throughout this country.

Christ healing Christ. A good way to think about our future ministry in a turbulent world.

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