VALUES AND VISION

CHA's Plan for Healthcare Reform Is Based on Two Unique Perspectives

BY SR. BERNICE COREIL, DC

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Members of the Catholic Health Association (CHA) Leadership Task Force on National Health Policy Reform are encouraged and excited about the many possibilities contained in the association's plan for healthcare reform. We believe it is a forward-looking plan that would accomplish many worthwhile goals, such as:

- Providing real access to needed healthcare for the growing millions of uninsured Americans
- Controlling healthcare costs effectively and in a manner that will improve the quality of care while retaining the best features of the current pluralistic system
- Providing new opportunities for a fuller expression of the Catholic healthcare ministry

The task force recognizes that the implementation of CHA's plan would result in profound changes in the way providers deliver healthcare in the United States. CHA's plan would:

- Result in fewer acute healthcare facilities
- Challenge some acute care facilities to refocus their missions and to begin providing additional healthcare services needed by the community
- Require each Catholic healthcare provider to engage in meaningful collaboration with Catholic providers and others to maintain a strong presence for the Catholic healthcare ministry

THE PREEMINENCE OF MISSION

One of the first questions the task force asked was, Should CHA's reform effort focus primarily on the needs of healthcare facilities, or should it first consider the needs of patients, clients, and families? The task force decided that providers must focus first on doing a better job of meeting people's healthcare needs.

The task force believes this approach recognizes the primacy of mission without diminishing the important and legitimate needs of healthcare facilities. It also accords favorably with the religious origins of Catholic healthcare facilities, all

Summary The Catholic Health Association (CHA) Leadership Task Force on National Health Policy Reform has offered a proposal that, if enacted by Congress, would result in profound changes in the way providers deliver healthcare in the United States. The proposal would result in fewer acute healthcare facilities, challenge some acute care facilities to provide additional services, and require each Catholic healthcare provider to collaborate with Catholic providers and others.

Two features distinguish CHA's plan from the many other healthcare proposals that have been offered. First, CHA's plan is rooted in six tenets of Catholic healthcare. Second, the plan primarily focuses on client-centered delivery reform rather than on financing issues as other proposals have done. The task force believed it first had to create a vision of what the nation's future healthcare delivery system should look like.

The task force decided that providers must do a better job of meeting clients' healthcare needs. To be a credible leader in the healthcare reform debate, the task force believes that CHA must offer a plan that primarily focuses on the needs of people and, second, controls costs effectively.

of which were established in response to community need and were "sustained in faith often under difficult circumstances and at considerable personal, material, and financial sacrifice" (CHA, *A Time to Be Old, a Time to Flourish: The Special Needs of the Elderly-at-Risk*, 1988).

Once the task force decided it would take a mission perspective, other questions followed: How well is the current healthcare system delivering services? How could it be organized in a manner that would better meet the needs and preferences of clients and their families? Catholic healthcare providers have a wealth of knowledge and experience and can and should mobilize to help the task force answer the tough questions that remain.

The Faces of the Healthcare Poor

CHA's plan, which responds to the nation's healthcare crisis, is essentially economic, social, and statistical—that is, conceptual. The nature of this task does not obscure the fact that the U.S. healthcare crisis and CHA's attempt to address it have real consequences for real people.

The following stories, about uninsured people who needed healthcare but did not receive it, remind us that these situations are not unique, that they occur daily in the current healthcare system:

- A woman enters a private hospital to give birth. In the delivery room she mentions to her physician that her husband recently lost his job and his health insurance. Although she is in labor, the physician then sends her to the county hospital that caters to the area's poorer residents.
- A public clinic refers a desperately ill baby to a regional medical center for treatment. The baby's parents are indigents and have no family physician. After waiting in the center's emergency room for four hours, the baby is finally admitted. The pediatrician on call had refused to treat the baby because he did not want to serve as a backup for a "free clinic." The baby dies a few hours after admission.

As CHA's *No Room in the Marketplace* (1986) reminds us, "These stories are not mere anecdotes; they are paradigms for the nation's suffering poor who are uninsured and require healthcare." We must keep them in our minds and hearts as we discuss how our healthcare system might better serve them.

A Unique Approach

Two features distinguish CHA's plan from the many other healthcare reform proposals that have been offered to date. First, the task force clearly and precisely articulated its values (see **Box**). The task force derived these values from Catholic social teaching and employed them in two ways: to develop a social critique of the existing healthcare system and to form the foundation of the task force's approach to reform.

The task force modeled its vision of healthcare reform on the biblical notion of Jubilee. Sr. Juliana Casey, IHM, PhD, STD, explains Jubilee in the January-February 1992 issue of *Health Progress* ("The Vision of Jubilee," pp. 29-31). Jubilee represents a new vision for society, a profound reform that would reverse the wrongs of previous times—and set relationships aright. The Jewish people developed the concept during one of their Babylonian exiles.

Jubilee is most of all an expression of *hope*. Although most scholars believe that the actual Jubilee never took place, what is important is that hope prevailed in a time that encouraged despair. The vision of Jubilee reminds Catholic healthcare providers that faith will not allow us to give up on the one who goes with us. It urges us to dream and to believe the dream will become real. Jubilee challenges us to make the dream come true.

Vaclav Havel also helped the task force in its understanding of hope. Currently president of Czechoslovakia, this courageous poet was once in prison behind the Iron Curtain. He says, "Hope is definitely not the same as optimism. It is not the conviction that something will turn out well, but the certainty that something makes sense regardless of how it turns out."

The second unique element of the task force's approach is its emphasis on client-centered *delivery* reform. Other reform proposals begin with the financing issue. The task force believes that before addressing the *means* to achieving reform, it had to create a *vision* of the nation's future healthcare delivery system.

SIX TENETS OF CATHOLIC HEALTHCARE

- Catholic healthcare is a ministry.
- Every person is sacred and the subject of human dignity.
- Public policy must serve the common good.
- There must be responsible stewardship of resources.
- The needs of the poor have a special moral priority.
- Tasks should be performed at appropriate levels of organization.

A Leadership Plan

CHA's Leadership Task Force on National Health Policy Reform has taken very seriously the association's Vision 2000 statement, which asserts that CHA should be a "leader in the movement toward a redesigned U.S. healthcare system that is just and equitable." Leadership requires many things, but most of all it requires *credibility*. To be a credible leader in the healthcare reform debate, CHA must offer a plan that primarily focuses on the needs of people and, second, controls costs effectively.

As a representative of both the Catholic

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OVERVIEW OF CHA'S WORKING PROPOSAL

CHA's comprehensive reform plan responds to the needs of millions of uninsured or underinsured Americans by providing for universal access to healthcare under a modified single-payer plan. All individuals would be included in a national health program covering primary and preventive care, acute care, and long-term care.

The plan creates integrated delivery networks (IDNs), which would link various types of providers in a community to provide a broad range of services. By treating patients in the setting that is the most appropriate to respond to their particular needs, IDNs would ensure a healthcare system that is client centered. The IDN system would contain costs by reducing duplicative services and excess hospital capacity.

State health organizations (SHOs) would charter the IDNs and distribute to them a risk-adjusted capitated payment for each person they serve. To ensure a one-tier system, IDNs would be required to offer the comprehensive benefit package to all persons.

A national health board (NHB), functioning independently of the executive and legislative branches, would administer the system. Since the NHB would establish national health expenditure levels and the basic comprehensive benefit package for IDN clients, its independence from political pressures is a crucial aspect of the plan.

The program would be financed through a payroll tax, funds currently devoted to state and federal health benefits programs, and additional revenues.

The Plan's Development

CHA's Leadership Task Force on National Health Policy Reform developed the final plan and presented a preliminary proposal to CHA members last October. In response to members' suggestions and to concerns raised by recent legislative proposals that mandate employer-based insurance, the task force considered the implications of many funding arrangements, especially the pros and cons of including employer financing in its plan.

After looking at possible options in which employers could either "pay" (be assessed a payroll tax to fund employees' insurance) or "play" (provide insurance plans directly to their employees), the task force decided against including employer-based financing in its final proposal. Task force members feared that, although all people would have the same basic comprehensive package of benefits, such a system would likely perpetuate two tiers of care. Task force members were also concerned that continuing to link access to healthcare with employment would perpetuate the funding, regulatory, and bureaucratic problems that plague the nation's current system.

The task force considered the disadvantages of disrupting existing financing streams and relationships among the current system's various stakeholders. The group determined, however, that the reorganization contained in its plan would be the most effective means to address service fragmentation and escalating costs, as well as to substantially improve Americans' health status.

CHA members responding to a survey about the preliminary proposal last fall agreed that the plan would increase opportunities for their institutions to fulfill their mission. Of 116 respondents, almost half were CEOs. A large majority (more than 65 percent) supported the plan's tax-based financing. More than half said their facilities could easily become part of an IDN.

CHA Board Adopts Proposal

At its February meeting, the CHA Board of Trustees voted to adopt the task force's report. The board identified its recommendation for U.S. healthcare as "one working proposal for systemic reform that embodies the values of the Catholic healthcare ministry."

The task force will continue to report to the board concerning members' concerns and recommendations for change. Sr. Coreil noted that this "will enable our members who may disagree with one or more aspects of the proposal to make formal presentations suggesting changes or modifications that are consistent with our values.

"Where such recommendations make good sense and are agreed to by the board, they could be incorporated into the advocacy strategy," she continued. She said the task force should develop programs "to help members better understand the forces driving the healthcare reform debate, the various reform proposals, the values underlying the CHA proposal, and the proposal itself."

THE MEDICAL WASTE AUDIT

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studies being planned for the laboratory, the emergency room, radiology, standard patient rooms, intensive care units, and other areas.

PREPARING FOR THE FUTURE

Increasing levels of public concern are focusing attention on the hospital as a source of medical wastes. The EPA is now directed to uncover the true health hazards associated with infectious medical wastes. More stringent documentation, disclosure requirements, and regulation are sure to follow. Hospital managers can prepare for future regulation and manage their medical waste generation, handling, and disposal activities more cost-effectively. The hospital medical waste audit is the first step in this process. □

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NOTES

1. U.S. Environmental Protection Agency, *Characterization of Medical Waste Generation and Treatment and Disposal Practices in New York and New Jersey*, draft report submitted to Air and Waste Management Division, Region II, and Office of Solid Waste, January 30, 1989.
2. U.S. General Accounting Office, *Medical Waste Regulation: Health and Environmental Risks Need to Be Fully Assessed*, report to the chairman, Subcommittee on Regulation, Business Opportunities and Energy, Committee on Small Business, House of Representatives, March 1990.
3. U.S. Environmental Protection Agency, *Medical Waste Management in the United States: First Interim Report to Congress*, May 1990, pp. 2-7.
4. P. Layne, W. Westbrook, K. Hendry, and T. Pierson, *Review and Evaluation of Existing Literature on Generation, Management, and Potential Health Effects of Medical Waste*, Contract No. 68-01-7075, U.S. Environmental Protection Agency, November 1988.

A MOVEMENT GAINS MOMENTUM

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liabilities, hospital waste handling, and future issues and developments in waste management. Almost 400 persons participated. Representatives from 28 DCNHS facilities viewed the teleconference live via on-site equipment. Eight member facilities from the Sisters of Charity Health Care Systems, Cincinnati, participated in the conference as well. Tapes of the conference were made available to six other DCNHS members.

ENVIRONMENTAL CHECKLIST

As awareness of the importance of preserving planetary resources grows, providers will become increasingly interested in developing recycling and waste management programs. Hospitals just beginning such programs may find some of the following suggestions helpful:

- Contact other hospitals or systems with established recycling programs for suggestions on getting started and estimates of the potential net income recycling may generate.
- Arrange for a staff member involved with a successful program at another hospital to give a presentation to managers and other employees explaining how the program was set up and what it has accomplished.
- Determine whether a full- or part-time position should be established to coordinate recycling efforts, or specify which existing manager should coordinate the program.
- Contact local recyclers to find out what materials can be recycled.
- Have the communications staff publicize the program, give it a name, and create a logo.
- Explore possibilities for working with business or community groups to increase recycling options, educate community members, and develop a community-wide campaign.
- Ask employees who are enthusiastic about recycling to help coordinate the program.
- Contact a medical waste management firm for information about disposal and recycling options and their costs.

—Phil Rheinecker

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healthcare ministry and dues-paying membership organizations, the task force has had to consider many competing interests and claims in the development of its approach to national health policy reform. The task force believes this plan is a good starting point for balancing those interests while retaining its credibility. However, the task force has certainly not answered every specific question.

In the final analysis, however, Catholic healthcare providers must recognize that, because we are talking about the *future*, we will never be able to address *all* of the *possible* obstacles that might arise. At some point, Catholic healthcare providers will have to press forward—much as our founders did—in faith, in charity, and in hope, with the certainty that what we are proposing makes sense "regardless of how it turns out."

Direction can be found in these words by Sr. Joan Gallagher, CSA, from her foreword to *Pioneer Healers* (Sr. Ursula Stepsis, CSA, and Sr. Dolores Liptak, RSM, eds., Crossroad Publishing, New York City, 1989):

> Today the healing mission and ministry requires new linkages, new forms of involvement and dialogue, to build trust, to enable all of us to move beyond our security to address the needs of the medically indigent, the lonely, the homeless, the abused, and the displaced. All of us have been created to share in the divine life through a destiny that goes far beyond our human capabilities. God now asks us to sacrifice and to reflect on our reverence for human dignity and on our service and discipleship, so that the divine healing for the human family and this earth can be fulfilled. □