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Health Care with a Conscience

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Catholic hospitals have a long and rich history in the United States. By 1872, there were already seventy-five such hospitals in operation around the country, founded and staffed mainly by women's religious congregations—the Sisters of Charity, the Benedictine Sisters, the Daughters of Charity, the Sisters of Mercy, the Ursulines, and many others. These women were motivated by a vocational call to care for the sick, which they did with distinction despite considerable hardship, earning along the way the deep and lasting gratitude of the varied constituencies they served.

The institutions they founded have since undergone massive transformation, mainly in the last forty years, as the demands of the modern era of medicine and plummeting numbers of young Catholic women entering religious vocations have forced significant structural changes in how the hospitals are run. Most Catholic hospitals in the United States are now no longer standalone facilities. Rather, they are part of regional "systems"—such as Catholic Health East, with thirty-three hospitals in eleven states—and governed by boards that include ample numbers of lay experts in addition to representatives from the original sponsoring congregations. As fewer and fewer women have joined the orders which had traditionally been active sponsors of health care services, the older sisters in those orders have had to pull back from their day-to-day involvement in the operations of the institutions their predecessors founded.

Still, by and large, Catholic hospitals have remained Catholic—which is to say their governance structures leave no doubt that they are accountable to the operational and ethical demands of a genuinely Catholic vision for health care. And they continue, in the main, to thrive. Today, about 615 hospitals in the United States—or about one of every nine—are sponsored by the Catholic Church. These facilities employ 725,000 workers and serve 5.5 million overnight patients annually, and many millions more on an outpatient basis. The Catholic Church is the single largest provider of not-for-profit health care in our country.

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What explains this staying power in an era of technology-intensive medicine and ultra-specialization? Part of the explanation is simply incumbency. Catholic hospitals were often the first to open in fledgling communities needing better access to health care. Once established, there has been a strong tendency for patients and resources to flow toward what's already there, with new entrants facing significant financial and regulatory hurdles.

But there is also an intangible element to the enduring appeal of these institutions. Patients, especially when they are very sick and vulnerable, would prefer—all else being equal—to be cared for in settings that bring to mind compassion and human concern as well as professionalism. Hospitals named Providence and Holy Cross and St. Vincent's communicate through their very names and histories a sense that they understand human beings as more than human bodies, and that inherent dignity is not dependent on physical health.

And yet, despite this long history of service to communities in every region of the country, as well as continued financial strength, the future of Catholic health care in the United States is far from assured because of the wide cultural divide between secular elites and those motivated by religious conviction. The same principles and ideals that move Catholic hospitals to care for the weakest and neediest also move them to oppose abortion, sterilization, and other practices at the juncture of medicine and morality. And at that juncture, Catholic hospitals are running into an increasingly hostile public health establishment with very different values. It is simply incomprehensible to many people in positions of power in both the public and private sectors that the same vision that inspires widely-respected compassionate care would also compel closure or sale of a facility to avoid complicity in providing abortions—yet that is just the difficult choice some Catholic health facilities have faced.

The main sources of trouble for Catholic hospitals on this front have been the institutions overseeing the flow of financial resources in health care, both public and private. In some instances, they want to impose a homogenous, secularist vision on all health care service regulation—a vision that runs directly counter to that held by sponsors of most religiously-affiliated facilities. The resulting conflict of worldviews has appeared in the news periodically for more than a decade. In 1995, the Accreditation Council for Graduate Medical Education moved to include abortion training among the services needed for medical school accreditation. In California in 1999, a bill was actively considered in the state assembly to require all hospitals, including Catholic hospitals, to provide

abortion services. Regulators in several states have been under pressure from the ACLU and others to block Catholic mergers with non-Catholic hospitals on the grounds of reduced access to "reproductive services." In 2007, the American College of Obstetricians and Gynecologists issued an ethics opinion suggesting it is the duty of physicians opposed to abortion and other services to at least make referrals of patients to providers who do not have such moral objections. And, in early 2008, Denver Archbishop Charles Chaput had to publicly defend the purchase of two Denver-area hospitals by the Sisters of Charity of Leavenworth Health System as state politicians attempted to pressure the parties into scuttling the deal or coerce the Catholic facilities into performing services contrary to their principles.

All of this has increased the nervousness among sponsors of Catholic hospitals as well as some physicians, pharmacists, and others that cultural trends may put them out of business. Indeed, in some instances, weak administrators in Catholic facilities have sought to avoid further confrontation by essentially capitulating to the demands of their opponents, generating a different kind of controversy inside the Church. In recent years, several bishops have had to step into the fray and remind hospital administrators of their duty to adhere to Catholic ethical directives despite mounting pressure to abandon them.

The U.S. Department of Health and Human Services (HHS) recently entered the debate with a proposed regulation to extend and solidify existing legal conscience protections for health care providers. On the surface, the regulation seems mainly innocuous, as it largely clarifies how existing conscience protection laws passed by Congress in previous years will be implemented. Among other things, the regulation would make it clear that conscience protections apply to *facilities* and not just *individual practitioners*, and it would require states to certify their compliance with federal law in this regard.

But the immediate reaction of the opponents of the proposed regulation highlights just how controversial this whole area of public policy can be. Twenty-eight Democratic U.S. Senators, led by Barack Obama, Joe Biden, and Hillary Clinton, sent a letter to HHS denouncing the rule and demanding its immediate withdrawal. They declared that protecting Catholic hospitals from participating in services contrary to their moral convictions would damage "the health care needs of women." More than a hundred House Democrats penned a similar letter.

Of course, HHS is not only hearing from opponents. Representatives of Catholic facilities, including the Catholic Health Association, voiced

strong approval of the proposed regulation. Still, the acerbic volleys from the opponents of the rule have served to remind Catholic-sponsored facilities of how vulnerable they are to political currents.

Power and Financial Control

Even if the HHS regulation is put into final form and upheld by the next administration—a *big* if—it won't solve the larger problem of financial control and sufficient independence to resist outside pressure. Indeed, as long as Catholic-sponsored health care providers and individual practitioners sharing the same point of view are financially dependent on insurance payments from those who fundamentally oppose their vision of human dignity, they will be at considerable risk.

Today, the federal government and the human resource departments of large employers make the key decisions in this regard. Government-run Medicare and Medicaid programs do not require coverage for abortion services, but they do pay for many services, including sterilizations, which fall outside acceptable boundaries for Catholic facilities. In most cases, patients generally have to go someplace other than a Catholic hospital if they want access to such services, but there is constant pressure for the Catholic facilities and physicians to conform to the cultural norm. Moreover, because government insurance programs are such a large and important source of hospital and physician revenue, there is great fear of doing anything to jeopardize continued funding, making these facilities and practitioners much less willing to stand up for their point of view.

Conscience protections face even greater difficulties with large employer health insurance plans. According to the Kaiser Family Foundation, 46 percent of all employer-sponsored health insurance firms offer abortion coverage, 87 percent cover sterilization services, and 86 percent offer full contraceptive coverage. In most instances, the employer-based plans pay for services by organizing a network of preferred hospitals and physicians to whom they send their employees and families for care. To stay in business, Catholic hospitals and physicians need to be able to see patients covered by such plans, which means they are under tremendous pressure to find ways to "work around" their objections to providing the services covered by such insurance.

The situation is in some ways worse for workers who may not want their premium payments to finance objectionable services. In most cases, the employer's human resources department picks a health insurance plan for all employees. Workers really only have the option to take it or leave it,

and leaving the plan is often not a serious alternative because insurance in the individual market can be far more expensive. Since only employer-paid premiums enjoy full exemption from federal taxes at this point, if a worker rejects job-based coverage and shops for insurance on his own, he must pay the full premium with no tax break. This makes individually-owned insurance an unrealistic option for most working families.

It follows that the kinds of reforms that would really make a difference are those which transfer power and financial control from government bureaucracies and employers to households and consumers. That's what would happen under proposals like the one offered by Senator John McCain in this fall's election to convert today's tax preference for job-based coverage into a universal tax credit ($5,000 for couples, $2,500 for individuals) so families could choose their own insurance. Similar reforms have been proposed over the years for Medicare and Medicaid, allowing beneficiaries of those programs to take their entitlement and get insurance of their choosing instead of forced enrollment in the government-run plans.

These reforms would unlock demand, which, in time, would make it viable for insurers to offer coverage that would be attractive to Catholics and others who may not want to pay for services that violate their views of right and wrong. Moreover, these kinds of products would find it only natural to build their preferred networks of hospitals and physicians using those who share the same understanding of health care and human dignity.

Unfortunately, we are almost certainly years away from congressional enactment of reforms of this type. Proponents of market-based reform have been building the intellectual and political case for putting consumers in the driver's seat in health care, but it seems most likely that more incremental reforms will be considered in the short term, given the deep divisions among policymakers about the philosophical direction for health care reform.

But that does not mean that nothing can be done right now. Indeed, in recent years, there have been two promising efforts to bring into the marketplace insurance arrangements that could demonstrate the viability and appeal of what might be called "values-based insurance."

In 2002, President George W. Bush signed an executive order to kick-start his initiative to bring faith-based and community organizations more directly into the provision of government-funded services. This effort opened up new possibilities in the government's program, known as the Federal Employees Health Benefits program (FEHB), to provide health insurance for federal employees.

Beginning in 2004, the FEHB program began offering to workers in selected regions of the country insurance products sponsored by Catholic, not-for-profit health systems. The program began in Peoria, Illinois, with an insurance product offered by OSF Health, owned by the Sisters of the Third Order of Saint Francis (this product has subsequently been bought by a commercial insurer). Similar options have been introduced for federal workers in Missouri, South Dakota, Texas, Wisconsin, and Illinois. Workers selecting coverage through these plans can reduce their premiums somewhat as they do not have to pay for services, such as sterilizations, covered by other FEHB offerings.

Another approach to tackling the problem of financial control over insurance payments was pioneered in the late 1990s by Robert F. Vasa, an enterprising priest (now bishop) who was the vicar general for the diocese of Lincoln, Nebraska. In that capacity, he was in charge of organizing health insurance coverage for diocesan workers. After studying the insurance then in place, Vasa was horrified to discover that parishioner donations to the church were effectively paying insurance premiums to finance abortion and other objectionable services—and nobody knew it. The diocese was simply purchasing insurance the same way other employers of similar size were doing it. Unfortunately for the diocese, that meant coverage of many services it would rather not pay for.

Vasa took it upon himself to investigate alternatives. He chose to pull as many people as he could into a single, church-sponsored plan, which would self-insure. The church, not an insurer, would decide what was and was not covered. With full control, the diocese was able to design an insurance plan fully consistent with its principles. The plan covered about five hundred people, including teachers, administrators, and staff at the local parochial schools, as well as their families. Five hundred is far too few people to ensure long-term premium stability, but it was enough for the diocese to make a switch it considered crucial to its integrity.

Vasa launched a similar effort when he was installed Bishop of Baker, Oregon. His initiative may point to a way forward.

The Untapped Potential of Catholic Employees

Philip F. Lawler, the former editor of *Catholic World Report* magazine, has written several times about the problem that Vasa and others have uncovered: Catholics, including employees working directly for Church institutions, sending their health care premium dollars to insurers who use those premiums to pay for abortion and other problematic services.

Lawler argues that an enterprising institution or individual should begin selling insurance directly to Catholics that adheres to the Church's understanding of human dignity and sexuality.

Lawler is right about the urgent need, but the problem to be confronted first is that there will be no supplier of such insurance as long as the potential enrollees are all locked up in employer-based insurance from which they cannot easily escape.

A better way to proceed is to look to the example of Vasa's initiatives in Nebraska and Oregon, looking for ways to scale up that idea so that tens of thousands, not hundreds, of workers are covered. It can be done. All that is needed to jump-start a movement toward morally-sound insurance is a clear vision, better organization, and will.

Consider, for instance, the Archdiocese of Chicago. There are 2.3 million Catholics in Cook and Lake Counties, in and around the city of Chicago. There are 363 parishes, 217 parochial schools, and 39 secondary schools. There are six colleges and universities with a combined faculty of about 3,500, not including staff. The Archdiocese has 818 diocesan priests, six bishops, one cardinal, 844 religious priests, 298 religious brothers, 2,151 religious sisters, 637 permanent deacons, and 5,552 teachers and administrators in the school system. All in all, the archdiocese directly employs around 14,000 people. And these figures do not take into account the twenty-one Catholic hospitals in the archdiocese and their staff.

These institutions employ more than enough workers to form an attractive insurance pool that could be pulled out of the current marketplace and placed in an insurance arrangement consistent with Catholic moral principles. Moreover, with control over the premiums, the archdiocese could also build a network of preferred providers that steers patients to the various Catholic-sponsored facilities found all around the city and suburbs. It would be a win-win proposition. The archdiocese would gain control over premiums, and Catholic hospitals and physicians would gain access to insurance payments without the pressure to provide services they consider unacceptable.

And, of course, the Archdiocese of Chicago is not the only jurisdiction with this potential. So too are the Archdioceses of Boston, New York, Philadelphia, and perhaps many others. What's needed is someone with the entrepreneurial skills to bring a fragmented and diverse array of Church-sponsored organizations into one health insurance arrangement and show them how their workers will be better off for the effort.

Dr. Edmund Pellegrino, the chairman of the President's Council on Bioethics, likes to remind listeners when discussing health care policy that

we will all one day find ourselves "on the gurney." One way or another, we are all eventually in that position of ultimate vulnerability: unwell and entirely dependent on the professional skills of people we may not even know. It's a bracing reminder—especially coming as it does from someone with six decades of experience as a practicing physician. It is easy to think in terms of efficiency and economy when the patient in question is an anonymous statistic, but not easy when it's you or a family member. It's also why many Americans would like to see institutions and individuals with a reputation for compassion and no other interests but the patients'—traits for which Catholic health care providers are widely admired—survive and even thrive. To ensure such institutions and practitioners are around a generation from now, it is crucial that they have the freedom to deliver services in a way that protects their moral integrity. As matters stand, that is far from certain.