The Moral Imperative to Population Health
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Objectives

• Discuss how the papacy of Pope Francis and recent developments in the American health care system provides a unique opportunity for Catholic health care to place greater emphasis on public health.

• Explain the limits of medical care in addressing health issues and premature mortality.

• Explain how the Catholic social justice tradition, in particular the notions of common good, preferential option for the poor and subsidiarity provide the moral imperative for involvement in population health.

• Discuss practical challenges to Catholic health care’s involvement in population health.
The Papacy of Jorge Mario Bergoglio

“I want a Church which is poor and for the poor” Pope Francis, *Evangelii Gaudium*

Reclaiming our Christian anthropology that emphasizes the dignity of each person but also the inherent social nature of humanity.

Reemphasis of solidarity and the common good over individualism and personal possessions.

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Trends in the American healthcare system

- Affordable Care Act: Reduction in uninsured (in states that have expanded Medicaid), surpluses for hospitals, community benefit requirements.
- CINs, ACOs, MSSP, Acquisition of insurance companies, risk strategies, population health.
- Physician practice acquisition, continuum of care, Home Health, LTC etc.
The Cost of Healthcare in America

Health care expenditures continue to climb Of the $2.6 trillion spent on health care how much is spent on direct health services? Answer: 95%

Is the amount spent on medical care proportionate to its impact on the health of an individual?

1. Genes and associated biology;
2. Health behaviors such as dietary habits, tobacco, alcohol and drug use, and physical fitness;
3. Medical care- 95%
4. Environment/ecology
5. Social and societal characteristics
Is the amount spent on medical care proportionate to its impact on the health of an individual?

Determinants of Health and Contribution to Premature Death

- Genetic Predisposition: 30%
- Behavioral Patterns: 40%
- Social Circumstances: 15%
- Environmental exposure: 5%
- Medical Care: 10%

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How Does the U.S.A. Rank in the Health Olympics? First Second? Third?

- Japan: 83.4 years
  Per capita spending on health care: $2,879
  Life Expectancy: First Place

- USA: 78.8 years
  Per capita spending on health care: $7,701
  Life Expectancy: 34th Place

We spend twice as much per person on health care. Yet our life expectancy is among the worst compared to other rich countries.


Limited to current data. Data from: 1990 and 2013.
Life expectancy at birth is five years lower for blacks compared with whites.

**Life expectancy in years of life remaining, 2003**

![Bar chart showing life expectancy at birth and at age 65 for whites and blacks.](chart)

**Note:** Based on 1990 post-censal estimates of the United States resident population.


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**Chart 3-1. Minority groups (except Asians) are more likely than whites to report their health status as fair or poor.**

**Percentage of adults age 18 and over, 2005**

![Bar chart showing health status percentages for different groups.](chart)

**AI/AN =** American Indian/Alaska Native.

**Note:** Data are age adjusted.

**Source:** National Center for Health Statistics. National Health Interview Survey. 2005.
Chart 3-2. Blacks are most likely to suffer from a chronic condition or disability

Percentage of adults ages 18 to 64 with any chronic condition or disability, 2005

<table>
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<th></th>
<th>Total</th>
<th>White</th>
<th>Black</th>
<th>Hispanic</th>
<th>Asian</th>
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<td>39</td>
<td>40</td>
<td>48</td>
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<td>25</td>
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Note: Adults are considered to have a chronic condition or disability if they reported that a disability, handicap, or chronic disease kept them from working full-time or limited housework or other daily activities, or if they reported having diabetes or sugar diabetes, high blood pressure, asthma, bronchitis, emphysema, or other lung conditions, heart disease, heart failure, or heart attack.


But how do disparities arise?

Differences in the quality of care received within the health care system

Differences in access to health care, including preventive and curative services

Differences in life opportunities, exposures, and stresses that result in differences in underlying health status
**Ecological Approach to health concerns**

*A Prime Example: Smoking Cessation*

- Smoking rates decreased from over half the adult population in 1955 to 19.3% of the population in 2010. With whites and blacks have almost equal percentages (21% and 20.6)
- Achieved through an “ecological” approach to public health that included tobacco taxation, smoking cessation counseling by physicians, anti-smoking media campaigns, legislative efforts to achieve smoke-free environments, increased education to children and youth, improved cessation methods and drugs.
- Still higher rates among certain groups: Native Americans, mental illness, poor.

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**Catholic Healthcare can impact each of these through Population Health efforts:**

*Why should we? The Moral Imperative*

- Common Good
- Preferential Option for the Poor
- Subsidiarity
• Rooted in our Theological Anthropology: imago Dei and the social nature of the human person. “The human person needs to live in society. Society is not for him (sic) an extraneous addition but a requirement of his nature” (CCC 1879).

• Originally finding expression in the institutional response of the early church to its own members, the church soon reached out beyond its membership to communities struggling through plague and famine.

Growing out of the “Hebrew concept *imago Dei that humans were created* in the image of God, a belief that was taken over from Judaism, . .. early Christians practiced a practical ethics that represented a radical departure from the social ethics of classical paganism” (Ferngren 2009, 98).

• Philosophically and Theologically from the Epistle of Barnabas through Augustine to St. Thomas Aquinas the Catholic concept of the Common Good adopted the Aristotelian notion of Common good as those shared goods which promote human flourishing.

• This notion of the common good in the writings of St. Thomas Aquinas, leads to notions of commutative, distributive and legal justice whereby individuals have duties toward each other and the state and the state has duties to make provision for security and the necessities of life for all its citizens (St. Thomas Aquinas, II, II Q 58,59,61).

• The Second Vatican Council defined the common good as “the sum of those conditions of social life which allow social groups and their individual members relatively thorough and ready access to their own fulfillment.” *Gaudium et Spes* #74
**Common Good (continued)**

• Fraternal relations between people, and cooperation in building a more just society – these are not an idealistic dream, but the fruit of a concerted effort on the part of all, in service of the common good. I encourage you in this commitment to the common good, a commitment which demands of everyone wisdom, prudence and generosity. (pope Francis 7/27/13)

• Every individual and institution must serve the common good.

• Common good compels us in Catholic healthcare to address the causes of poor health and not simply provide care to those who cannot pay.

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**Preferential Option for the Poor**

• The Catholic tradition goes beyond the common good by recognizing that there are those who have no voice who require additional concern.

• Rooted in the Hebrew Prophets and Christian Scriptures and God’s preferential option for the poor, it argues that the church must take special care of the poor.
Its [the Church's] desire is that the poor should rise above poverty and wretchedness, and should better their condition in life; and for this it strives.

*Rerum Novarum* - 'Condition of Labour' (1981), paragraph 23

When there is a question of protecting the rights of individuals, the poor and helpless have a claim to special consideration. The rich population has many ways of protecting themselves, and stands less in need of help.

*Rerum Novarum*, paragraph 29

While an immense mass of people still lack the absolute necessities of life, some, even in less advanced countries, live sumptuously or squander wealth. Luxury and misery rub shoulders. While the few more enjoy very great freedom of choice, the many are deprived of almost all possibility of acting on their own initiative and responsibility, and often subsist in living and working conditions unworthy of human beings.

*Gaudium et Spes* – ‘Joy and Hope’ (1965), paragraph 63
**Preferential Option for the Poor**

“the option or love of preference for the poor. This is an option, or a special form of primacy in the exercise of Christian charity, to which the whole tradition of the Church bears witness. It affects the life of each Christian inasmuch as he or she seeks to imitate the life of Christ, but it applies equally to our social responsibilities and hence to our manner of living, and to the logical decisions to be made concerning the ownership and use of goods” St. John Paul II *On Social Concern* (1987#42).

**Common Good and Preferential option for the Poor**

• “this notion of a preferential option for the poor involves a self-conscious move from a passive understanding that the work of Christians is to provide charity to the poor to an active position that demands justice for the poor” (Nairn 2007).
**Subsidiarity**

Again grows out of a theological anthropology that views human persons in their sacredness but also in their interconnectedness. Primary entities of family and community as the basis for human flourishing. Closely connected with solidarity.

According to the principle of subsidiarity, decisions should be made *at the lowest level possible and the highest level necessary.*

“Just as it is gravely wrong to take from individuals what they can accomplish by their own initiative and industry and give it to the community, so also it is an injustice and at the same time a grave evil and disturbance of right order to assign to a greater and higher association what lesser and subordinate organizations can do. For every social activity ought of its very nature to furnish help to the members of the body social, and never destroy and absorb them.” (Quadregesimo Anno 79)

* Meghan Clark, PhD

**Subsidiarity**

Frequently misunderstood and misused to suggest that government should not take an active role in solving problems. The principle was developed to balance between the extremes of extreme liberalism and totalitarianism. The goal as always is to serve the common good.

Individuals and institutions must be engaged at the community level in addressing the needs of individuals and community.

“...our economy, politics, social programs, our life styles are all measured by how they help or hinder others in participating in the life God has destined for humanity and in experiencing God’s loving encounter.” Bishop Blaise Cupich

* Meghan Clark, PhD
Conclusions/Challenges

In light of the limitations of the medical model to address the social determinants of health, the notions of the common good, preferential option for the poor and subsidiarity compel Catholic healthcare to become engaged in population health esp. in light of disparities in health status that are related to poverty and SES.

“We are all called to be poor, to strip us of ourselves; and to do this we must learn how to be with the poor, to share with those who lack basic necessities, to touch the flesh of Christ! The Christian is not one who speaks about the poor, no! He is one who encounters them, who looks them in the eye, who touches them. I am here not to “make news”, but to indicate that this is the Christian path, the path St Francis followed.” Pope Francis 10/4/13

Challenges

• Hard work, takes a lot of time and no quick fixes.

• Lack of responsibility, focus and expertise (whose job is this anyway?)

• ACOs, MSSP etc focus on particular populations not the population of the community. “Who is my neighbor” to “Who is my population”

• Catholic healthcare becoming more physician-centric and their still exists a wide gap between medicine and public health.