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# HEALTH CARE REFORM—THE CATHOLIC HEALTH PERSPECTIVE

WILLIAM J. COX\*

## INTRODUCTION

The Catholic Health Association (“CHA”) has developed policy recommendations for healthcare reform to help respond to the current American healthcare crisis.<sup>1</sup> These recommendations are the result of a fifteen-month effort by the Board of Trustees of the CHA to come up with a credible reform proposal that both embodies the ideals of the Catholic tradition and comports with American political traditions. The CHA has proposed a value-driven format that provides comprehensive health-care for all people. This paper will examine the proposal and the forces and values that underlie it.

The task force has three predominant objectives. The first is cost-efficiency. The task force believes that any reform proposal submitted to the American public must convince it that every dollar spent on health-care will be a dollar well spent, i.e., that it will obtain a good return on every dollar invested. A second objective is longevity, i.e., maintaining an adequate flow of capital resources over time into the system. Thus, the proposal does not include elected officials who could subvert the system and allow it to deteriorate over a period of years. Finally, the task force recognizes that providers in any healthcare system must have a strong incentive to balance cost-efficiency with clinical effectiveness. The ultimate goal is value for the patient. Having integrated delivery networks (“IDNs”) compete on the basis of service and quality will offer that kind of incentive.

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\* The author is Vice President of the Catholic Health Association.

<sup>1</sup> See generally Joseph A. Califano, Jr., *Rationing Health Care: America's Self-Inflicted Wound*, 3 STAN. L. & POL'Y REV. 36 (1991) (outlining pitfalls of America's healthcare system).

## I. ECONOMIC AND SOCIAL FORCES

Economic and social forces are driving the healthcare debate in the United States. The CHA has identified these forces and has recognized that any credible proposal for reform must respond to each of them.

### A. *The Rising Cost of Healthcare*

The first force driving the health-care debate is the rising cost of healthcare, an issue with which many Americans are familiar. The United States ("U.S.") is close to spending about fourteen percent of its Gross National Product ("GNP") on healthcare today,<sup>2</sup> and is headed towards spending seventeen percent by the year 2000.<sup>3</sup> However, whatever percentage of the GNP the U.S. is spending on healthcare may not be the determinative issue. For example, it may be appropriate to spend fourteen or seventeen percent of the GNP. The real issue, however, is: What is the U.S. spending on healthcare per capita?

The U.S. is currently spending forty percent more per person on healthcare each year than our leading trade partner, Canada.<sup>4</sup> The U.S. spends fifty percent more than West Germany,<sup>5</sup> fifty percent more than Japan,<sup>6</sup> and seventy-five percent more per person than they do in Great Britain.<sup>7</sup> The question these statistics raise is: What is the U.S. getting back for the additional per capita spending?

Unfortunately, the return is difficult to identify. The longevity rates in the U.S. are comparable to those in Western Europe,<sup>8</sup> but the rates in

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<sup>2</sup> See Janet L. Shikles & Lawrence H. Thompson, *Strategies to Reduce Health Care Spending and Increase Coverage*, 3 STAN. L. & POL'Y REV. 103 (1991) (outlining amount of United States healthcare expenditures and factors contributing to higher costs); see also Gerald L. Musgrave, *Emotions, Politics and Economics: An Introduction to Health Care*, BUS. ECON. Apr. 1993, at 7 (discussing political and economic issues involved in healthcare reform).

<sup>3</sup> Robin Elizabeth Margolis, *Healthtrends*, HEALTHSPAN 28, 30 (Nov. 1992).

<sup>4</sup> Paul B. Ginsburg, *Alternative Approaches to Health Care Cost Containment*, 30 JURIMETRICS J. 447, 449 (1990). See ARNOLD BENNETT & ORRILL ADAMS, *LOOKING FOR HELP: WHAT WE CAN LEARN FROM CANADA'S HEALTH CARE SYSTEM* (1993) (collection of academic essays providing detailed account of Canada's national health insurance system); see also Uwe E. Reinhardt, *Regulated Fees or Regulated Competition? Implications for Young Physicians*, 269 JAMA 1709 (Apr. 7, 1993) (discussing Euro-Canadian model for national healthcare); but see Michael Tanner, *How Not To Fix the Healthcare Crisis* BUS. ECON., Apr. 1993, at 17 (providing critical account of failings of Canadian System).

<sup>5</sup> *Reform of Health Care System Urged by Organized Labor, Business*, 16 BNA Pension Reporter No. 47 1987 (Nov. 20, 1989).

<sup>6</sup> *Id.*

<sup>7</sup> Stephen Conley, *Don't Expect Health-care Reform Any Time Soon*, U.S.A. TODAY, Apr. 6, 1993, at 11A.

<sup>8</sup> See Erin E. Lynch, *Late-Life Crisis: A Comparative Analysis of the Social Insurance Schemes for Retirees of Japan, Germany and the United States*, 14 COMP. LAB. L. J. 339 (1993).

Japan are ahead of the U.S.<sup>9</sup> Moreover, the U.S. lags behind in terms of infant mortality and infant morbidity compared to all of those other countries. Thus, it is not clear what the U.S. is getting in return for its additional per capita healthcare spending.<sup>10</sup> That is why it is difficult today to petition a state general assembly or Capitol Hill for more money for healthcare.

### 1. Burden on the Business Community

The economics of healthcare are becoming a burden for almost every segment of our society, beginning with the business community. In the previous healthcare reform debates in the U.S., the business community always adopted a status quo approach. However, today most major national corporations are spending time, money and effort urging systematic healthcare reform from the perspective that the country, and businesses, cannot afford the cost any longer.

The cost of healthcare has become a competitive issue for many international businesses because these businesses must compete with companies that operate in countries which maintain universal healthcare systems.<sup>11</sup> Healthcare costs in those countries are spread across the population and are not borne solely by the business community.

In addition, competitiveness is an issue within the country because not all businesses in the U.S. provide health insurance to their employees.<sup>12</sup> Those companies which do not, in a sense, get a free ride. When their employees show up for healthcare, the employees often get treated, and the additional costs of treating them getting passed back through providers to the employers that are providing private health insurance.

Moreover, healthcare costs also affect the business community because practically every strike over the past several years in this country has related not to wages, but to healthcare benefits. Thus, these costs are also a labor-management issue. Attempts by companies to cut back benefits, to pass costs through higher co-payments and deductibles, or to

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<sup>9</sup> *Id.* Japan has the highest life expectancy in the world. *Id.* Japanese men and women can expect to live to 75.54 and 80.93 years of age, respectively. *Id.*

<sup>10</sup> See Barbara Bennett Woodhouse, "Who Owns the Child?": *Meyer and Pierce and the Child as Property*, 33 WM. & MARY L. REV. 995, 1059 (1972). The United States has fallen to twentieth place in international infant mortality rates and ranks twenty-sixth in low birth weight babies. *Id.*; see also David M. Frankford, *Privatizing Health Care: Economic Magic to Cure Legal Medicine*, 66 S. CAL. L. REV. 1, 5 (1992) (noting that infant mortality rates in United States are higher than corresponding statistics from almost every other industrialized country).

<sup>11</sup> See generally Leslie Pickering Francis, *Symposium: The Law and Policy of Health Care Rationing: Models and Accountability, Consumer Expectations and Access to Health Care*, 140 U. PA. L. REV. 1881 (1992) (discussing proposals for universal healthcare).

<sup>12</sup> See Gerald L. Musgrave, *Emotions, Politics and Economics: An Introduction to Health Care*, BUS. ECON., Apr. 1993, at 8.

move their union employees into what is called "managed care programs" have created a major issue for the American business community.

## 2. Burden on Federal and State Governments

The cost of healthcare is also a major concern for governments. In 1970, the U.S. federal government spent five percent of its budget on healthcare.<sup>13</sup> Today, it is spending sixteen percent of its budget on healthcare<sup>14</sup> and this figure is projected to reach twenty to twenty-two percent by the year 2000<sup>15</sup> and, by about the year 2010, up to thirty percent. This spending is mandatory, and the amount increases automatically each year and is very difficult for Congress to control. Nevertheless, the amount the federal government budget spends on healthcare must be brought under control.

Similar problems exist at the state level where the Medicaid program is probably the fastest growing component of most state budgets. Governors and state assemblies are having a difficult time coping with it. All of this automatic spending for healthcare creates what economists like to call "opportunity cost." The more the U.S. spends each year on healthcare, the less it has to spend on other important goals that it wants to achieve collectively as a society, i.e., the less the country has for education, transportation, environment and, ironically, healthcare. One of the things that has happened over the past several years is that the more the country spends on acute long-term care, the less it has for public health. And, very often the biggest gains for a society from a health perspective are achieved through public health measures. Immunization rates for children in this country are abysmal.<sup>16</sup> The U.S. is backing away from its historically high goals that it had set and had almost achieved in the area of immunization. Today, children are again contracting polio and measles and are dying from them even though they are preventable. Yet, because the U.S. government does not have the money to dedicate to these areas, the opportunity cost is enormous, not to mention, at the federal level, the \$400 billion deficit which must be addressed.

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<sup>13</sup> See Susan Tedrick, *Legal Issues in Physician Self-Referral and Other Health Care Business Relationships*, 13 J. LEGAL MED. 521 (1992).

<sup>14</sup> *Say Aargh for Reform*, ECONOMIST, Feb. 6, 1993, at 25.

<sup>15</sup> *Id.*

<sup>16</sup> See Timothy M. Smeeding & Barbara B. Torrey, *Poor Children in Rich Countries*, 242 Sci. 873 (1988). Only 70 to 80% of children in the United States are fully immunized, with rates falling much lower in poor communities. *Id.*

### 3. Burden on Individuals

Healthcare costs have also become an issue for individuals. Policy making in this country is essentially driven by middle-income Americans. To the degree that healthcare costs become a burden to these individuals and to the degree that they become insecure about their future health insurance benefits, they will begin to demand change. In fact, this has already begun. Almost every recent public opinion poll taken shows that a substantial percentage of Americans, upwards of eighty percent, believes our healthcare system needs fundamental or radical change.<sup>17</sup> Sixty percent of persons surveyed in a recent Harris Poll said fundamental change—another thirty percent said radical reform—is required.<sup>18</sup> This is going to become a bigger issue for individuals over the next several years as companies push the cost of health insurance premiums back to individuals through higher co-payments and deductibles, through changes or reductions in their benefits, and as some small businesses stop providing health insurance because they cannot afford it.

### 4. Burden on Hospitals and Physicians

Healthcare costs has become an issue for the provider community—hospitals. Today, Medicare and Medicaid are reimbursing healthcare providers, both hospitals and doctors, below the cost incurred by facilities and individuals to provide services to elderly and poor Americans. Today, Medicaid pays approximately seventy-eight cents on a dollar for each dollar of care that is provided to an individual.<sup>19</sup> For hospitals or private employers that can cost-shift this has not been too big of a burden—the employers are picking up the tab. But, this is a big issue for those hospitals and physicians in and around inner-city locations that have high Medicare and Medicaid patient loads, have a large number of what we call “unsponsored patients” with no private or public health insurance and a very small private pay base. Those hospitals and physicians cannot shift costs and as a result they are in financial difficulty today.

Physicians must deal with the rising costs of healthcare. Increasingly, these doctors see private and public regulatory agencies oversee their diagnostic and clinical decisions. Many will tell you that they

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<sup>17</sup> See Steven Mufson, *Clinton Seeks a Health Care Cure; Ending Cost Spiral Is Termed Crucial to Ending Deficit*, THE WASH. POST, Feb. 3, 1993, at F1.

<sup>18</sup> See Celinda Lake & Edward A. Goeas III, *Health Care: The Issue of the Nineties*, 10 YALE L. & POL'Y REV. 211 (1992) (providing detailed analysis of American attitudes regarding U.S. health care system and proposals for innovation); see also Robert J. Blendon & Karen Donelan, *Public Opinion and Efforts to Reform the U.S. Health Care System: Confronting Issues of Cost Containment and Access to Care*, 3 STAN. L. & POL'Y REV. 146 (1991).

<sup>19</sup> See Gerald L. Musgrave, *Emotions, Politics and Economics: An Introduction to Health Care*, BUS. ECON., Apr. 1993, at 8.

spend an hour or more each day on the telephone with an insurance company representative or a representative of the federal government, inquiring whether they may keep a patient in the hospital for two more days or whether they may provide a particular service to a patient. Often, a nurse or another physician a couple of hundred miles away makes this decision, based not on the patient's needs, but on the cost of the care that might be provided.

### *B. Risk Segmentation*

Risk segmentation is deteriorating our private health insurance markets. When private health insurance was first formed during the Depression, it was formed essentially by doctors and hospitals in a not-for-profit setting. It was community-rated on the principle that the healthy and wealthy should take care of the poor and the sick. Underlying this "community-rated" approach was a pragmatic judgment: every one of us has a sense that sooner or later we or a member of our family may become sick. If that event occurs, we do not want to be made bankrupt by the event. We want to be able to obtain affordable healthcare services. The risk of health insurance was spread throughout the entire population.

A community-based approach to private health insurance operated until 1950, when the commercial insurers entered the business by finding a market niche.<sup>20</sup> Their market niche was that they could go to an individual employer and say: "Your employees are healthier on average than the rest of the community. If we insure your employees, we are going to be able to reduce your health insurance premiums. So, get out of your Blue Cross plan, join Aetna and you will have lower premium payments." Many employers began to do that, particularly as health care costs started to rise.

Risk segmentation increased in the 1960s, accelerated in the 1970s and is galloping along presently at a very fast pace. Adding to this heightened pace is society's recent ability to identify people who are potentially high utilizers of healthcare and exclude them from the benefits of private health insurance.<sup>21</sup> The human genome project is just one example.<sup>22</sup> This project concerns the mapping of the entire human genetic structure so that in several years a blood sample from a newborn infant will be tested for maybe 100 genetic defects. If, for example, that infant is

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<sup>20</sup> See generally Terree P. Wasley, *Health Care in the Twentieth Century: A History of Government Interference and Protection*, BUS. ECON. APR. 1993, at 11-12 (outlines history and development of health insurance industry in U.S.).

<sup>21</sup> *Id.* at 12-13.

<sup>22</sup> See Roger J. Bulger, *How the Genome Project Could Destroy Health Insurance; When We Map Out Our Medical Future, Who Will Be Willing to Take the Risk?*, THE WASH. POST, Aug. 4, 1991, at C4.

identified as being a potential alcoholic, drug addict, or exhibiting a potential for breast cancer, diabetes, or some other disease, the potential for that individual to get health insurance during his or her lifetime is remote in our current climate. Therefore, an essential component of any insurance reform initiative is to move away from the casualty insurance model which we have adopted and move back to community-rating.

### C. Cost-Shifting

The process of cost shifting is destabilizing the system.<sup>23</sup> Cost-shifting is the process by which the provider community shifts uncompensated costs to the private sector.<sup>24</sup> We have done that. This has been a principle in our health system since its inception. Until now, it was tolerated because most providers shifted only the costs of healthcare for people who were uninsured. Recently, federal and state governments have been drastically cutting back on what they are willing to pay for the Medicare and Medicaid programs.<sup>25</sup>

In 1989, because of cost shifting, employers paid twenty-five percent more than their actual cost for health insurance premiums. Last year, they paid thirty-eight percent more than their actual cost. This year, these figures may be even higher because providers are becoming better at shifting those costs to the private sector. Cost-shifting is a mechanism that societies have historically used to cover healthcare costs for the poor. It is now out of control and is in a sense a form of a hidden tax on the employer community.<sup>26</sup> In the 1950s and 1960s, costs could be shifted at reasonable levels because only a small group of patients were not covered. Therefore, hospitals and doctors could shift costs to the private side, without an enormous impact on employers.

In this competitive environment, cost-shifting also affects the mission of not-for-profit, mission-driven organizations. For example, if a hospital with a tradition of serving the poor and unsponsored patients in a community must compete with another hospital that does not, in order to make itself more economically attractive to insurers, the not-for-profit institution must begin to engage in the same sort of cost-shifting behavior for survival purposes. This corrodes the mission of these organizations, and it is one of the reasons that we have such a vigorous debate about whether not-for-profit healthcare institutions should be tax ex-

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<sup>23</sup> See Robert G. Knowles, *Execs Clash on Prospectus for Workable Reform*, LIFE & HEALTH/FIN. SERV. ED. (Nat'l Underwriter), at 12 (Apr. 12, 1993).

<sup>24</sup> See Charles Fenyvesi, *Washington Whispers-Amputated Health Care*, U.S. NEWS & WORLD REP. June 28, 1993, at 18.

<sup>25</sup> See *id.*; *Hospital Groups Adopt Wait-And-See Attitude to Clinton's Proposed Cuts*, 20 PENS. REP. (BNA) No. 9, at 515 (Mar. 1, 1993).

<sup>26</sup> See *Execs Clash on Prospectus for Workable Reform*, *supra* note 23, at 12.

empt.<sup>27</sup> Many policymakers argue that the not-for-profit organizations no longer fulfill their traditional service of providing community benefits because they are under this kind of economic pressure. Consequently, the social safety net is shredded.

One of the results of this shredding is that the number of uninsured individuals is growing.<sup>28</sup> Prior to 1980, every year since World War II, more people in the United States were insured for healthcare, either publicly or privately,<sup>29</sup> to the point that about ninety-two percent of the population was covered. Beginning in 1980, however, this tradition began to reverse itself. Now, each year, we have fewer people insured for healthcare. The number of uninsured grew in the 1980s by twenty-four percent and is continuing to grow.<sup>30</sup> After the 1982-1983 recession, many people who returned to work did not receive health insurance because small employers could not afford to provide it. Unfortunately, the same may happen after the recent recession.<sup>31</sup>

## II. VALUES

Debate about values is also driving the healthcare debate. The CHA has suggested that the healthcare reform debate should reflect, at a minimum, the following six values. Although anchored in Catholic social teaching, they are not parochial values, but appeal potentially to a cross-section of the American people.

### A. *Healthcare as a Service*

First, healthcare is a service. In Catholic circles, we say that healthcare is a ministry. In secular terms, we say healthcare is a service. This means caring for the sick whether or not they are going to get better and whether or not they are going to turn a profit for our healthcare institutions. This also means understanding that the moral character of a society is judged by how it takes care of the poor and the sick. Healthcare cannot be reduced to a simple commodity nor can the end of healthcare be a desire for profit.<sup>32</sup>

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<sup>27</sup> See Terese Hudson, *Not-for-Profit Hospitals Fight Tax-Exempt Challenges*, 64 J. AM. HOSP. ASS'N 32 (1990).

<sup>28</sup> See *Families USA Calls for Bold Action, Provides State-by-State Cost Breakdown*, 17 PENS. REP. (BNA) No. 45 at 1898 (Nov. 5, 1990).

<sup>29</sup> See *Why America's Health Care System is in Trouble*, HERITAGE FOUND. REP., 1989, at 1.

<sup>30</sup> Justin Martin, *Who are the 36 Million Uninsured?*, FORTUNE, May 31, 1993, at 14.

<sup>31</sup> See R.A. Zaldivar, *Health Tax May Burden Businesses*, THE TIMES-PISCAYUNE, May 15, 1993, at C1.

<sup>32</sup> See Arnold S. Relman, *What Market Values are Doing to Medicine*, THE ATLANTIC, March 1992, at 98, 102 (explaining that altruistic concerns are subverted by the profit motive).

*B. Every Person is Sacred and Entitled to Human Dignity*

Second, every person is sacred and entitled to human dignity. This value suggests that human beings are never objects, and they are always subjects. What this suggests is that every person has a right to achieve his or her destiny as a human being. One cannot do that if one is chronically ill or bankrupt. Thus, we suggest that there is a right to healthcare. At a minimum, society has a fundamental obligation to make sure that everyone has access to healthcare because equality of opportunity makes no sense if you are sick or poor.

*C. Public Policy Must Serve the Common Good*

Third, public policy must serve the common good. This is the toughest value for Americans. Yet, it is one of the most important for us, and one that the Catholic community has a great deal to say about. There is no country in the world perhaps more individualistic than the United States. This was a concern of the founders of this country and it is a concern of many commentators throughout our history. Beginning with de Toqueville and continuing today with the communitarian movement, some are fearful that our individualism will split us into competing atoms and make it impossible for us to sustain community. However, while human rights inure to the individual, those rights cannot be achieved and sustained apart from community.

When individualism reigns supreme, the healthcare system breaks down because every element is trying to stick someone else with the costs and the burdens. Government is shoving its cost onto providers, providers are shifting their costs onto businesses, and businesses are placing the burden back onto employees by reducing benefits, raising costs or revoking entire programs.

Employees, concerned and angry about the tremendous cost of the system, are suing the system at every opportunity. Accordingly, malpractice and liability reform is a major issue in healthcare reform. A proper balance must be struck between individualism and community.

*D. Need for Responsible Stewardship of Resources*

Fourth, there must be responsible stewardship of resources. This value stems from a recognition that natural and other resources are not unlimited and must be managed wisely. Responsible healthcare reform requires creation of credible cost controls to maintain overall spending.

*E. Needs of the Poor to Have Special Moral Priority*

Fifth, the needs of the poor have a special moral priority.<sup>33</sup> In order to aid the poor, a program must tie the fate of the poor to the fate of the middle-class because the middle-class uses its right to vote. This is how both Social Security and Medicare work. The poor have been brought along with the interest of the middle-class.

*F. The Principle of Subsidiarity*

Finally, tasks should be performed at appropriate levels of organization. This is known as the principle of subsidiarity.<sup>34</sup> It simply means that what can and should be done at the local level should not be attempted at the national or state level. What can only be done at the national or state level should not be attempted at the local level. We have to properly identify what the bounds of organization should be for each group.

Thus, the debate about the future of healthcare delivery and financing in this country is as much a debate about values. Each person must accept common responsibility. This is the thrust of the CHA healthcare reform proposal.

### III. THE INTEGRATED DELIVERY NETWORK

The CHA task force has proposed an Integrated Delivery Network ("IDN"). IDNs are self-contained organizations of providers that are linked together on a contractual basis and provide a full continuum of services. They are client or patient-centered and focused organizations. From a financial point of view, these organizations would operate off a risk-adjusted capitated payment, i.e., they would receive a fixed payment for a defined population group and concomitantly must provide services for that fixed payment to that group for a year. Therefore, they are at risk for the health of a defined-population group. This kind of system would put a heavy emphasis on care coordination and on case management across providers, managing not only the services but the cost of those services.

The CHA further suggests that multiple integrated delivery networks be set up in communities that can sustain them. These networks would compete with one another, not economically, but on the basis of service and quality. Clients would be given a choice each year of which IDN to belong to. In other words, they would choose their doctors and

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<sup>33</sup> *Caring For the Poor*, 269 JAMA 2533, 2534-35 (May 19, 1993).

<sup>34</sup> See Thomas R. Oliver, *Ideas, Entrepreneurship and the Politics of Health Care Reform*, 3 STAN. L. & POL'Y REV. 160 (1991) (describing success of states and local communities in filling healthcare vacuum left by federal government).

hospitals by choosing a particular IDN. After a year, they would be free to choose a different one. The task force believes that this kind of competitive force is important to maintain the quality of a system over time. There would be cost-sharing in this system, but it would be income-related.

State health organizations would charter the IDNs, making sure that they provided a full range of services. State regulators would provide the IDNs with their risk-adjusted capitated payment. If a particular IDN, for example, serves a population that has a large group of HIV-infected individuals or potentially infected individuals, its fixed payment would be adjusted in some fashion to reflect that reality. The state health organization, which is an independent public agency, would periodically print for consumers comparative information about the quality and the effectiveness of the IDN so that consumers could make informed and thus, better choices.

A national health board would be at the level above the state health organizations. The national health board would be an independent public agency that would provide universal coverage through a basic comprehensive benefit package that would be comparable to a good Blue Cross plan. This plan would attract strong middle-class involvement. The national health board would set national health expenditure levels, and for the first time, would put our healthcare system on a budget. The rate of growth and healthcare spending would reflect changes in personal income, the GNP, and some other comparable statistics. The national board would fund the budget allocations to state health agencies, who, in turn, would funnel the dollars to state health organizations. Ultimately, the state health organizations would provide the allocated financial resources to the integrated delivery networks, thus maintaining accountability within the health care system.

Denoting the national health board as "independent" is important: the reason that they are independent—using the Federal Reserve System or the Securities and Exchange Commission as a model—is that the CHA has recognized that allowing elected officials to run the healthcare system is not in society's best interest.<sup>35</sup> The proposed national health board must be able to determine what it will cost to run the healthcare program for a given year, relate the estimated cost to the American people, and take a detailed budget to Congress for its determination. If Congress votes against the proposal, then a process of negotiation would en-

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<sup>35</sup> See Samuel Levey & James Hill, *Universal Health Insurance: Incrementalism or Comprehensive Reform?*, 3 STAN. L. & POL'Y REV. 189 (1991); see also Gerald W. Grumet, M.D. *America's Health Crisis: An Overview From the Trenches*, 3 STAN. L. & POL'Y REV. 42, 45-50 (1991) (describing failures of political leaders concerning number of prominent health issues).

sue. This would be a very public procedure, so that accountability would be built into the system from beginning to end.

#### CONCLUSION

The CHA's goals are premised on the notion that it is a unique organization. It is value-driven and it has a responsibility to work for an equitable and just healthcare system. Healthcare reform has large implications for our healthcare institutions and their future. The CHA needs to be very much involved in this debate from an advocacy point of view, to make sure that any reform that occurs is not one that makes it impossible for Catholic healthcare to operate in the United States. The CHA is involved to promote equity and justice and to make sure that the values that underlie Catholic healthcare continue to influence our healthcare system in the future.