



Health Care: Responsible Christian Stewardship

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It is impossible these days to avoid in the news media opinions, options, and thoughts about health care in the United States. President Clinton has made this issue his number-one priority and, I believe, rightly so. The health of all Americans is vital to maintaining our national standard of living over the long run; giving all who live here access to health care will begin the process of assuring people a high quality of life regardless of their personal ability to pay for care. As Christians we should applaud this effort. And as Christians we should expect, maybe even demand, that certain principles be included in the Clinton health plan.

Mr. Clinton states that universal access, simplicity, and choice be key elements of the plan. As Christians we should ask for more. I believe we should demand, as additional elements, personal responsibility, personal accountability for our actions and our stewardship of resources.

God asks us to be stewards of creation, ourselves included. Certainly we are not all equal and do not possess the same abilities. Diversity in life and lifestyle are part of being human. Stewardship involves responsibility. As Christians we must be responsible for what we have been given, both what is natural (our person) and what we have accumulated. Stewardship requires us to be responsible both to ourselves and to others. A steward understands that resources are finite and must be managed well if they are to benefit all creation.

The present health care issue requires us, as the people of God, to use wisely the resources given us, not to use personal desire as our only measure of responsibility. Stewardship deals with consequences. Universal access is not necessarily equal to improved health. Having access to health care (preventive, primary, acute) does not give us license to overuse or misuse available resources. A smoker risks

not only his or her own life prematurely but also may end up using limited health care resources unwisely. This we should not tolerate.

Health care services are expensive and consume a large part of GDP (gross domestic product)—14%. Providing universal accessibility will increase, not decrease, these costs in the short term. Only responsible lifestyles, emphasizing health, wellness, and wholeness, will over time cause our increasing costs for health care to begin to slow down. No projection yet made shows any decrease in the total cost of health care, only a possible decrease in the rate of increase.

The amount Americans spend on health—from prevention to intervention to end of life—will continue to grow as a percentage of the GDP for some time to come. Since some claim

that 60% of all health care costs are sustained in the last 30 days of life, a big issue is coming to understand that death is a part of life—both at the time of birth (infant mortality) and for those in their most senior of years.

God, by making humankind mortal, made death a part of life. Humankind has struggled with this since Adam and Eve. We have been taught to fear death as evil, as an ending, rather than seeing it as anew beginning, a new life, an eternal life, one with the Father glorious, a culmination, a return from whence we came.

Responsible Christians should understand this issue and allow for death—and new life—to come forward, to allow one life to be completed so another can begin or be enhanced. This is truly being stewards—stewards of life and of resources.

The policy now being debated across this land will have as one of its outcomes universal access. Will this, however, improve health, enhance our personal well-being, bring forward a new and more responsible sense of stewardship, both personal and societal?

The Christian perspective must refocus on human responsibility—on stewardship of ourselves and the resources given us to use. Christians must understand that preservation of life at all costs may sound good but defeats God’s promise to us that death is only a transition to a greater life eternal.

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Health Care: Responsible Social Priorities

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Four things strike me to be of uppermost concern as we consider plans to meet our health care needs. First, coverage must meet the most widespread needs, not simply acute care needs; second, a well functioning home care program must be in place in order to reduce and perhaps avoid the high costs of reinstitutionalization; third, we must deal head on with prolongation of dying; fourth, we need the wisest and most effective use of health care personnel. Whatever health care system is put in place should meet these needs.

Several years ago I was invited to Brussels, Belgium to discuss the needs of the elderly with leading worldwide health care insurers. I made my presentation, documenting how we have (through the Block Nurse Program) enabled the frail elderly to remain in their own homes in a cost-effective manner. After along discussion the president of the organization said to me, “What you are talking about is a pre-paid health care system.” My reply was, “Okay, will health care insurers make this possible?” To this day, his reply continues to make me nervous: “Oh, no! We will cover what will not happen. We would rather cover heart transplants than stroke because there will be fewer heart transplants than the chronic problems associated with a stroke victim.” I certainly hope and pray that health care reform will be of such thoroughness that people’s common, chronic needs—less exciting perhaps than some other needs—will be met.

Coverage is one thing, the use of funds is another. I am not sure we need to put more money into the system. Better use of the money we are already spending is essential. For

instance, we have a super acute care system but we have quite a poor system for the chronically ill. We have poured great amounts of money into hospitals and been too cheap in covering home care and hospice care. Our hospitals

now are basically intensive care units where recovering patients are being sent home without the possibility of adequate follow-up and supervision. The clinical personnel in the hospitals, the physicians, nurses, and social workers, are becoming too busy to do the essential teaching and discharge planning needed. Without sufficient follow-up, the patient and family will not have the help they need, and readmission becomes quite likely. Such readmission might have been avoided if sufficient preparation and supervision had been possible.

Not only is this an issue of the use of funds, but also of the values that shape our health care attitudes. In particular, one needs to face the real possibility that today's hospitals unnecessarily prolong the dying process. As health care providers we are trained to preserve life at all costs, and we may not see the terrible human cost of prolonging death. Of course, we all want to live. But technology has made prolonging the dying process so easy that we can continue the process interminably. I urge church leaders and Christians to learn about the living will and the power of attorney for health care. Use of these should involve a family discussion because it is important that all family members know that we do not wish to prolong the dying process. We must make absolutely clear to both our families and our health care providers that prolongation of dying is not what we wish. I believe hospice provides a good part of the protection we need to prevent us, as a society, from relying on euthanasia. We might also note that the savings from hospice care alone will more than cover the needed home care and hospice development.

Finally, we need to rethink our use of personnel. We need to make better use of our health care providers. Educational and clinical preparations for nurses have improved dramatically. The advanced practice nurse who is prepared in a specialty area with a master's degree can be teamed with a medical specialist, and cost-effective care can result. We need more primary care providers—physicians, nurses, and associated personnel. Family practice physicians can team up with the advanced practice nurse to provide cost-effective care that is of high quality in both technological and human terms. Generally speaking, physicians have had more opportunity to practice to the maximum of their ability than have nurses and social workers. We, as the public, need to insist that nurses, social workers, occupational therapists, and physical therapists also be allowed to practice to their fullest. I have been involved in projects with Home Care for the Dying Child and the Block Nurse Program for the elderly where it has been thrilling to see the competence demonstrated by nurses—working with physicians as consultants—in providing high quality, cost-effective care. We need systems that work by cooperation rather than competition.

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