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Equally Strange Fruit: Catholic Health Care and the Appropriation of Residential Segregation

Cory D. Mitchell and M. Therese Lysaught

It is necessary, therefore, for the privileged and the underprivileged to work on the common environment for the purpose of providing normal experiences of fellowship. This is one very important reason for the insistence that segregation is a complete ethical and moral evil.¹

The penalty of deception is to become a deception, with all sense of moral discrimination vitiated.²
~Howard Thurman

FROM THE EARLIEST BEGINNINGS OF CHRISTIAN history and from the moment the Ursuline Sisters opened the first Catholic hospital in the United States in 1728, charity toward the poor and marginalized has been the chief identifying characteristic of Catholic health care.³ Again and again, small groups of intrepid nuns sought out the poorest communities, set up hospitals, innovated on reimbursement methods, raised donations, lived in solidarity with and dedicated their lives to caring for the health needs of the poor, needs often exacerbated by extraordinarily difficult living conditions.⁴

Those Sisters would scarcely recognize Catholic health care today. In the second half of the twentieth century, United States health care delivery and payment systems underwent significant developments. Via ongoing consolidation and intense focus on the bottom line by highly trained management executives and corporate boards, Catholic

¹ Howard Thurman, *Jesus and the Disinherited* (Boston: Beacon Press, 1976), 88.

² Thurman, *Jesus*, 55.

³ For the most comprehensive history of Catholic health care in the U.S., see Christopher J. Kauffman, *Ministry and Meaning: A Religious History of Catholic Health Care in the United States* (New York: Crossroads Press, 1995).

⁴ For the vibrant stories of these founding Sisters, see Suzy Farren, *A Call to Care: The Women Who Built Catholic Healthcare in America* (St. Louis: Catholic Health Association, 1996).

health systems have evolved into multi-billion-dollar corporations.⁵ In 2016, the four largest systems in the country had combined revenues of nearly \$67 billion.⁶ Catholic health care has become an economic powerhouse, certainly the most profitable ministry in the history of the church.

Yet these astounding revenues have been generated within a system rife with structural injustices. One of these has been the *de facto* residential segregation and rapid black community disinvestment in the U.S. in the late twentieth century.⁷ Scholars have documented how intentional legislative and economic practices, amplified by tacit social dynamics, created urban pockets of concentrated poverty.⁸ Such neighborhoods damage health in myriad ways. As Paul Farmer has famously noted, “diseases themselves make a preferential option for the poor.”⁹ Not only is residential segregation a fundamental cause of health disparities between blacks and whites, sicker patients require more care; consequently, those living in segregated communities find themselves also disproportionately burdened by health care costs.

Thus, residential segregation, as configured in the U.S., inflicts increased morbidity and mortality on human persons and undermines human flourishing in a variety of ways. As such, a case could be made that residential segregation constitutes an intrinsic evil.¹⁰ Ordinarily, discussion of intrinsic evils in Catholic health care limits itself to abortion, tubal ligations, and physician assisted suicide. Yet, as John Paul

⁵ Barbra Mann Wall, *American Catholic Hospitals: A Century of Changing Markets and Missions* (New Brunswick: Rutgers University Press, 2011).

⁶ Laura Dyrda, “10 Largest US Health Systems: Which Had the Biggest Revenue Increase in 2016?” *Becker’s Hospital Review*, March 3, 2017, www.beckershospitalreview.com/hospital-finance/10-largest-us-health-systems-which-had-the-biggest-revenue-increase-in-2016.html.

⁷ In this article, we use the term “residential segregation” to encompass both racial segregation as well as the concentrated poverty or economic segregation with which it is currently inextricably intertwined in the United States. While thriving African-American communities are possible, such communities generally are often mixed-income communities and require external investment and intentionality on the part of residents and allies. They also presume the wider global context of oppression of black persons (as does even the mythical Wakanda in the film *Black Panther*). More specifically, residential segregation is a product of white housing policy and practice rather than a function of black preference (see footnote 8).

⁸ Douglas S. Massey and Nancy Denton, *American Apartheid: Segregation and the Making of the Underclass* (Cambridge: Harvard University Press, 1993). See also David Hilfiker, *Urban Injustice: How Ghettos Happen* (New York: Seven Stories Press, 2003).

⁹ Paul Farmer, “Medicine and Social Justice,” *America*, July 15, 1995, 13-17.

¹⁰ The evidence for this is supplied in part I below. We bracket the question of whether the category of intrinsic evil remains theologically tenable; we draw on it here insofar as it remains an operative category in Catholic moral theology, particularly within the *Ethical and Religious Directives for Catholic Health Care Services*.

II notes in *Veritatis Splendor*, the concept encompasses a much broader array of realities:

The Second Vatican Council itself, in discussing the respect due to the human person, gives a number of examples of such acts [which, in the Church's moral tradition, have been termed "intrinsically evil" (*intrinsece malum*)]: "Whatever is hostile to life itself, such as any kind of homicide, genocide, abortion, euthanasia and voluntary suicide; whatever violates the integrity of the human person, such as mutilation, physical and mental torture and attempts to coerce the spirit; whatever is offensive to human dignity, such as *subhuman living conditions*, arbitrary imprisonment, deportation, *slavery*, prostitution and trafficking in women and children; degrading conditions of work which treat labourers as mere instruments of profit, and not as free responsible persons: all these and the like are a disgrace, and so long as they infect human civilization they contaminate those who inflict them more than those who suffer injustice, and they are a negation of the honour due to the Creator" (no. 80).¹¹

African-American residential segregation in the United States is a ubiquitous vestige of slavery, and black ghettos certainly constitute subhuman living conditions. They are hostile to life itself; they violate the integrity of the human persons who live within them; and they are offensive to human dignity. Residentially segregated neighborhoods are therefore, as the pope continues, "by their very nature 'incapable of being ordered' to God, because they radically contradict the good of the person made in his image...they are such *always and per se* [evil]; in other words, on account of their very object, and quite apart from the ulterior intentions of the one acting and the circumstances" (no. 80).

Catholic health care publicly opposes discrimination. Many Catholic hospitals have signed the "Pledge to Act to Eliminate Health Care Disparities."¹² The U.S. Bishops open the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs) with a vision of "The Social Responsibility of Catholic Health Care Services" noting:

Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination: the poor; the uninsured and the underinsured; children and the unborn; single parents; the elderly; those with incurable diseases and

¹¹ Emphasis added. See also *Gaudium et Spes*, no. 27.

¹² Julie Minda, "Catholic Providers Pledge to Address Race, Class-Based Inequity in Health Care," *Catholic Health World* 32, no. 7 (2016): www.chausa.org/publications/catholic-health-world/archives/issues/april-15-2016/catholic-providers-pledge-to-address-race-class-based-inequity-in-health-care.

chemical dependencies; racial minorities; immigrants and refugees (no. 3).

This is certainly a who's-who of those in residentially-segregated neighborhoods.

Yet is there a shadow side? While the Catholic church provides a powerful public voice against abortion as an intrinsic evil, it remains painfully silent on the omnipresence of residential segregation. While Catholic health care draws a bright line around abortion and contraception, refusing to participate in them or benefit from them financially, is Catholic health care tacitly and perhaps unknowingly enmeshed in residential segregation, perhaps even benefiting from or perpetuating it? Providing health care to persons in poor communities is good, but the excess morbidity and mortality borne by African Americans due to residential segregation imposes upon them disproportionate health care expenditures, expenditures which flow into and thereby benefit care providers. If such care simply attends to symptoms produced by residential segregation, accruing financial benefits from it without curing the cause, we must ask whether Catholic health care participates in residential segregation in a way that is ethically problematic.

Certainly, Catholic health care does not will the evil of residential segregation. When faced with involvement in an evil one does not will, traditional moral theology turns to the concept of moral cooperation. M. Cathleen Kaveny provides an alternative tool for looking at this question, namely, what she calls "a new category of appropriation of evil."¹³ Following Kaveny, in this paper we ask: are there ways that Catholic health care *appropriates* the evil of residential segregation? Kaveny's analysis largely confines itself to traditional clinical questions considered within Catholic bioethics. We argue that her category is equally and perhaps more powerfully applicable at the interface of Catholic bioethics and social questions.

In what follows, we begin by detailing the myriad ways that residential segregation drives health disparities, using cardiovascular disease as a lens. We then point to subtle ways that such segregation benefits United States health care. Next, displaying Kaveny's category of appropriation of evil—and its concepts of moral seepage, self-deception, and ratification—we bring into visibility ways that Catholic health care institutions may materially appropriate the evils of subhuman living conditions. It also enables us to surface and develop implicit dimensions of Kaveny's framework, concepts we name moral inhibition, scandal, and implicit ratification. We close by suggesting

¹³ M. Cathleen Kaveny, "Appropriation of Evil: Cooperation's Mirror Image," *Theological Studies* 61, no. 2 (2000): 280-313.

remedies for such appropriation—moving from charity care and community benefit to community building—which enable Catholic health care to deploy tools already at their disposal to focus on *structural* or environmental determinants of health.¹⁴ In so doing, Catholic health care can not only bandage the wounds inflicted by residential segregation; it can begin to partner to dismantle it.

RESIDENTIAL SEGREGATION AS A DRIVER OF HEALTH DISPARITIES

Residential segregation is a fundamental reality for many African Americans. In 1990, slightly more than 45 percent of all African Americans lived in ghettos.¹⁵ Ghettos are herein defined as neighborhoods or census tracts of concentrated poverty where incomes for upwards of 40 percent of households fall below the federal poverty level. The federal poverty threshold for a family of two adults and one child was \$10,520 in 1990. Over the next three decades, this figure doubled to \$20,420, while the demographics became even more dire, with more than 60 percent of African Americans living in metropolitan statistical areas of moderate to high poverty and segregation.¹⁶

Such concentrated poverty impairs health both directly through biopsychosocial pathways and indirectly through the lack of goods and services necessary to maintain healthy living. Indirect effects—such as loss of medical infrastructure, lack of helpful public services, and inadequate allocation of goods and services—are widely recognized.¹⁷ Residential segregation concerns more than just housing; rather, it comprises a multi-dimensional assault. As Khaleeq Lutfi et al. note, “concentrated poverty is associated with the loss of resources out of a neighborhood resulting in the deterioration of neighborhood quality. These resources include quality medical care, quality education, and

¹⁴ Social and structural determinants alone account for about 50 percent of health status, while health behaviors account for 30% and clinical care alone for 20 percent. Bridget Booske, Jessica C. Athens, David K. Kindig, and Patrick L.A. Remington, “Different Perspectives for Assigning Weights to Determinants of Health,” *County Health Rankings Working Paper*, www.countyhealthrankings.org/sites/default/files/differentPerspectivesForAssigningWeightsToDeterminantsOfHealth.pdf.

¹⁵ Paul A. Jargowsky, “Ghetto Poverty among Blacks in the 1980s,” *Journal of Policy Analysis & Management* 13, no. 2 (1994): 288-310.

¹⁶ For data on the federal poverty level, see U.S. Department of Health and Human Services, aspe.hhs.gov/prior-hhs-poverty-guidelines-and-federal-register-references.

¹⁷ David R. Williams and Chiquita Collins, “Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health,” *Public Health Reports* 116, no. 5 (2001): 404-416. See also Irma Corral, Hope Landrine, Yongping Hao, Luhua Zhao, Jenelle L. Mellerson, and Dexter L. Cooper, “Residential Segregation, Health Behavior and Overweight/Obesity among a National Sample of African-American Adults,” *Journal of Health Psychology* 17, no. 3 (2012): 371-378.

employment opportunities.”¹⁸ In addition, the economic disinvestment concurrent with the process of ghettoization increases unemployment and results in poor education, delinquency, crime, and the physical decay of buildings and infrastructure.¹⁹

Yet direct impacts of ghetto infrastructure on residents’ health plays a more significant role. In a literature review, Harvard social epidemiologist David Williams and sociologist Chiquita Collins concluded that residential segregation is a fundamental cause of black-white health disparities.²⁰ They note that disparities in deaths from coronary heart disease and infant mortality have grown since 1950 despite advances in biomedicine and technology. According to the Institute of Medicine, disparities persist even when variables like insurance, individual-level income, and condition acuity are comparable.²¹ For example, infant mortality rates among African Americans should disturb every institution concerned about the sanctity of life. For every 0.1 point change (on a scale of 0 to 1) in residential segregation as measured by a dissimilarity index, which measures how much census tracts deviate from complete desegregation, we see a one percent increase in pre-term birth rates and low birth weight; both are risk factors for infant mortality.²²

While insurance, individual-level income and illness acuity may have small impacts on health disparities, neighborhoods exert a tremendous influence on health.²³ Well-established racial disparities in cardiovascular disease (CVD) provide a useful example to frame our

¹⁸ Khaleeq Lutfi, Mary Jo Trepka, Kristopher P. Fennie, Gladys Ibanez, and Hugh Gladwin, “Racial Residential Segregation and Risky Sexual Behavior among Non-Hispanic Blacks, 2006–2010,” *Social Science & Medicine* 140 (2015): 95-103.

¹⁹ Gregory Brown, James Vigil, and Eric Taylor, “The Ghettoization of Blacks in Los Angeles: The Emergence of Street Gangs,” *Journal of African-American Studies* 16, no. 2 (2012): 209-225.

²⁰ Williams and Collins, “Racial Residential Segregation,” 404-416.

²¹ Alan Nelson, “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,” *Journal of the National Medical Association* 94, no. 8 (2002): www.ncbi.nlm.nih.gov/pmc/articles/PMC2594273/.

²² Kwame Nyarko and George Wehby, “Residential Segregation and the Health of African-American Infants: Does the Effect Vary by Prevalence?” *Maternal and Child Health Journal* 16, no. 7 (2012): 1491-1499.

²³ Individual-level socioeconomic status (SES) contributes to CVD disparities. Using the National Health and Nutrition Examination Survey (NHANES), Kanjilal et al. found that while the prevalence of high blood pressure decreased from 1971-2002 for all four of their data-derived income groups—and the steepest decline was in the lowest income group—the prevalence for those in the lowest SES quartile was significantly higher than for those in the highest quartile (S. Kanjilal, E.W. Gregg, Y.J. Cheng, P. Zhang, D.E. Nelson, G. Mensah, and G.L. Beckles. “Socioeconomic Status and Trends in Disparities in 4 Major Risk Factors for Cardiovascular Disease among US Adults, 1971-2002,” *Archives of Internal Medicine* 166, no. 21 (2006): 2348-55). See also I. Grotto, M. Huerta, and Y. Sharabi, “Hypertension and Socioeconomic Status,” *Current Opinion in Cardiology* 23, no. 4 (2008): 335-339.

discussion. African Americans are 40 percent more likely than their white counterparts to have high blood pressure,²⁴ higher heart rates,²⁵ and higher age-adjusted heart disease death rates (30 percent higher for black men and 40 percent higher for black women).²⁶ Thus, blacks are at increased risk for CVD morbidity and mortality.

Like infant mortality, CVD prevalence and risk factors are more strongly correlated with neighborhood characteristics. In Harlem, New York, a study of 2,846 death certificates spanning a three-year period (1979-1981) found CVD-related deaths to constitute the majority of excess mortality rates.²⁷ Likewise, Major and colleagues prospectively analyzed 33,831 deaths in 18,603 census-tract derived neighborhoods in six states from 1995 to 2005.²⁸ CVD mortality risks were elevated by 33 percent for men and 18 percent for women living in the most deprived neighborhoods. A study of coronary heart disease incidence examined 13,009 participants from 595 census block groups for a maximum follow-up period of 11.1 years.²⁹ Even after adjusting for individual-level income, education, and occupation, the risk of incident coronary heart disease increased three-fold for whites living in the most deprived neighborhoods compared to those in the most advantaged neighborhoods and 2.5 times for blacks. Significantly, those living in neighborhoods of concentrated poverty are at increased risk of developing CVD *regardless of race*.

What about neighborhood disadvantage is so dangerous for health? Evidence points to the psychosocial stress correlated with residential

²⁴ National Center for Health Statistics, "Health, United States," in *Health, United States, 2011: With Special Feature on Socioeconomic Status and Health* (Hyattsville: National Center for Health Statistics, 2012); and F.L. Brancati, W.H. Kao, A.R. Folsom, R.L. Watson, and M. Szklo, "Incident Type 2 Diabetes Mellitus in African-American and White Adults: The Atherosclerosis Risk in Communities Study," *Journal of the American Medical Association* 283, no. 17 (2000): 2253-2259.

²⁵ J.J. McGrath, K.A. Matthews, and S.S. Brady, "Individual Versus Neighborhood Socioeconomic Status and Race as Predictors of Adolescent Ambulatory Blood Pressure and Heart Rate," *Social Science and Medicine* 63, no. 6 (2006): 1442-1453.

²⁶ K.D. Kochanek, J. Xu, S.L. Murphy, A.M. Miniño, and H.C. Kung, "Deaths: Final Data for 2009," *National Vital Statistics Reports* 60, no. 3 (2011): 1-116.

²⁷ Collin McCord and Harold P. Freeman, "Excess Mortality in Harlem," *New England Journal of Medicine* 322, no. 3 (1990): 173-177.

²⁸ Jacqueline M. Major, Chyke A. Doubeni, Neal D. Freedman, Yikyung Park, Min Lian, Albert R. Hollenbeck, Arthur Schatzkin, Barry I. Graubard, and Rashmi Sinha et al., "Neighborhood Socioeconomic Deprivation and Mortality: Nih-Aarp Diet and Health Study," *PLoS One* 5, no. 11 (2010): e15538.

²⁹ A.V. Diez Roux, S.S. Merkin, D. Arnett, L. Chambless, M. Massing, F.J. Nieto, P. Sorlie, M. Szklo, H.A. Tyroler, R.L. Watson, "Neighborhood of Residence and Incidence of Coronary Heart Disease," *New England Journal of Medicine* 345, no. 2 (2001): 99-106.

segregation as the primary etiology.³⁰ Across the United States, central city ghettos are typically the oldest and most deteriorated portion of a metropolitan area. Such environmental cues can generate a fear of real or perceived crime resulting in chronic stress and increased blood pressure.³¹ In fact, simply greening a few blighted or vacant lots in a neighborhood can decrease heart rate and blood pressure.³²

Three studies are helpful here. First, Ross and Mirowsky posited a theoretical model in which neighborhood disadvantage drove neighborhood-level physical and social disorder, which in turn drove individual fear and concomitantly inhibited walking, which ultimately impacted health.³³ Fear was hypothesized to over-activate the fight-or-flight stress response, which can cause increased blood pressure, heart

³⁰ The racial-genetic model and the behavioral model seek to locate the cause of disparities primarily or solely in flawed individuals rather than flawed social systems. While such factors play a role in health status, research substantiates that neither is sufficient to account for the magnitude of health disparities. See C.W. Kuzawa and E. Sweet, "Epigenetics and the Embodiment of Race: Developmental Origins of US Racial Disparities in Cardiovascular Health," *American Journal of Human Biology* 21, no. 1 (2009): 2-15; S.J. Elder, A.H. Lichtenstein, A.G. Pittas, S.B. Roberts, P.J. Fuss, A.S. Greenberg, M.A. McCrory, T.J. Bouchard, E. Saltzman, M.C. Neale, "Genetic and Environmental Influences on Factors Associated with Cardiovascular Disease and the Metabolic Syndrome," *Journal of Lipid Research* 50, no. 9 (2009): 1917-1926; American Anthropological Association, "American Anthropological Association Statement on 'Race,'" www.americananthro.org/ConnectWithAAA/Content.aspx?ItemNumber=2583; and National Research Council, "The National Academies Collection: Reports Funded by National Institutes of Health," in *Critical Perspectives on Racial and Ethnic Differences in Health in Late Life*, ed. N.B. Anderson, R.A. Bulatao, and B. Cohen (Washington, DC: National Academies Press, 2004); Kanjilal, Gregg, Cheng, Zhang, Nelson, Mensah, Beckles, "Socioeconomic Status and Trends," 2348-2355; and Thomas A. LaVeist and John M. Wallace, "Health Risk and Inequitable Distribution of Liquor Stores in African-American Neighborhood," *Social Science & Medicine* 51, no. 4 (2000): 613-617.

³¹ Catherine E. Ross and John Mirowsky, "Neighborhood Disadvantage, Disorder, and Health," *Journal of Health and Social Behavior* 42, no. 3 (2001): 258-276; Brian M. Curtis and James H. O'Keefe, Jr., "Autonomic Tone as a Cardiovascular Risk Factor: The Dangers of Chronic Fight or Flight," *Mayo Clinic Proceedings* 77, no. 1 (2002): 45-54.

³² Michael J. Duncan, Neil D. Clarke, Samantha L. Birch, Jason Tallis, Joanne Hankey, Elizabeth Bryant, Emma L.J. Eyre, "The Effect of Green Exercise on Blood Pressure, Heart Rate and Mood State in Primary School Children," *International Journal of Environmental Research and Public Health* 11, no. 4 (2014): 3678-3688; Eugenia C. South, Michelle C. Kondo, Rose A. Cheney, Charles C. Branas, "Neighborhood Blight, Stress, and Health: A Walking Trial of Urban Greening and Ambulatory Heart Rate," *American Journal of Public Health* 105, no. 5 (2015): 909-913.

³³ Ross and Mirowsky, "Neighborhood Disadvantage, Disorder, and Health," 258-276.

rate, and eventually CVD.³⁴ Neighborhood disorder included such objective measures as graffiti, vandalism, noise, crime, and abandoned buildings. Even when individual-level socioeconomic status (SES) and socio-demographics were controlled for, including, age, sex, race, education, household income, employment status, occupational status, marital status, and number of children, researchers found that both disadvantage and disorder were associated with poor self-reported health. Walking or outdoor physical activity was not a significant factor, discrediting sole reliance on the health-behavior model. Given their findings, the investigators state: "The daily stress associated with living in a neighborhood where danger, trouble, crime and incivility are common apparently damages health."³⁵ They concluded by calling for "a bio-demography of stress that links chronic exposure to threatening conditions faced by disadvantaged individuals in disadvantaged neighborhoods with physiological responses that may impair health."³⁶

Augustin and fellow researchers sought to measure the bio-demography of stress using a Neighborhood Psychosocial Hazards scale.³⁷ This scale captured social disorganization by measuring the percent of single parent families, percent of adults without a high school degree or equivalent, and percent of adults divorced, separated or widowed. Public safety was assessed by the number of 911 calls per person per year and violent crimes occurring in the neighborhood. Indicators of physical disorder included percent of vacant houses, number of complaints about street conditions, and number of liquor stores or off-site liquor licenses. Surveying 1,140 randomly selected residents from 65 contiguous neighborhoods in Baltimore with regard to self-reported CVD, they found that those living in the neighborhoods in the highest quartile of psychosocial hazards had four times higher odds of a history of myocardial infarction and more than three times higher odds of other CVD conditions compared to those living in neighborhoods in the lowest quartile, independent of individual-level measures such as age, gender, housing, residential history, smoking history, and education. Thus, the Neighborhood Psychosocial Hazards scale was a better predictor of CVD outcomes than neighborhood-level SES alone.

³⁴ Curtis and O'Keefe, "Autonomic Tone as a Cardiovascular Risk Factor," 45-54; Bruce S. McEwen, "Allostasis and Allostatic Load: Implications for Neuropsychopharmacology," *Neuropsychopharmacology* 22, no. 2 (2000): 108-124.

³⁵ Ross and Mirowsky, "Neighborhood Disadvantage, Disorder, and Health," 258.

³⁶ Ross and Mirowsky, "Neighborhood Disadvantage, Disorder, and Health," 258.

³⁷ Toms Augustin, Thomas A. Glass, Bryan D. James, Brian S. Schwartz, "Neighborhood Psychosocial Hazards and Cardiovascular Disease: The Baltimore Memory Study," *American Journal of Public Health* 98, no. 9 (2008): 1664-1670.

In a third study, using an area probability sample of 639 African Americans living in four different segregated Baltimore neighborhoods with differing socioeconomic and physical characteristics, Mitchell et al. created a neighborhood psychosocial hazards scale comprising the percent of the population living at or below the federal poverty level, the percent of abandoned buildings in the neighborhood, and the violent crime rate per neighborhood.³⁸ The scale predicted blood pressure, heart rate, history of cardiovascular disease, and smoking behavior. Interestingly, body mass index and waist circumference were not significantly correlated with the psychosocial hazards scale, ruling out obesity (resulting from behavior or genetics) as a cause for the differences.³⁹

Thus, the psychosocial stress model predicts health disparities for people living in neighborhoods of concentrated poverty. While certainly genetics, SES, and health behaviors contribute to differential health outcomes, studies suggest that psychosocial stress concomitant with residential segregation holds greater causal and explanatory power. If so, efforts to address, reduce, and perhaps eliminate health disparities should focus less on individual patients or the delivery of particular health care services, and more on initiatives that address concentrated poverty and transform low-income neighborhoods.

BENEFITS TO U.S. HEALTH SYSTEMS FROM RESIDENTIAL SEGREGATION

Given the foregoing, an important question to explore is: how does Catholic health care interface with residential segregation? While care for residents of impoverished neighborhoods is often framed as charity or community benefit, data suggests that the relationship is more mutual or bi-directional. The crux of the matter lies in the current realities of health care reimbursement and financing.

Current reimbursement mechanisms rely on volume. The more frequently a provider sees a patient or groups of patients, the greater the revenue. Like retailers, health care services are generally billed on a per unit basis: “The basic elements of a revenue budget are simple—price and volume. The revenue budget consists of the price charged

³⁸ Cory D. Mitchell, Shari R. Waldstein, Jessica Kelly-Moore, Michele K. Evans, and Alan B. Zonderman, “Neighborhood Socioeconomic Status Is Associated with Cardiovascular Disease Risk Factors in an African-American Cohort,” *Annals of Behavioral Medicine* 33 (2007): S31.

³⁹ Mitchell, Waldstein, Kelly-More, Evans and Zonderman, “Neighborhood Socioeconomic Status,” S31.

for each service provided by the unit, department, or organization multiplied by the number of units of service provided.”⁴⁰ Health care policy has historically attempted to rein in prices by using prospective payment systems such as Diagnosis Related Groups, which predetermine prices for diagnostic categories. But overall, the actionable levers for health systems using traditional reimbursement mechanisms are price and volume, rendering volume, therefore, as one primary factor in a system’s financial success.

Consider again our earlier example of CVD. CVD encompasses a cluster of conditions including: high blood pressure, high cholesterol, obesity, and diabetes. Managing these conditions requires frequent medical visits. In fact, patients with chronic conditions such as hypertension and CVD utilize health care services almost three times more than those with optimal cardiovascular profiles. Consequently, people with poor CVD profiles spend almost \$6,000 per year more than healthy people.⁴¹ Given its incidence, the total direct and indirect costs for CVD and cerebral vascular conditions in the United States for 2017 was estimated to be a staggering \$316 billion.⁴² This figure includes health expenditures (direct costs, which include physicians and other professionals, hospital services, prescribed medications, home health care, and other medical durables) and lost productivity resulting from mortality (indirect costs). CVD, as a cluster of conditions requiring high volume treatment, is also highly revenue generating.

What percentage of this spending might we estimate is spent in segregated neighborhoods? Direct calculations have not been published, but initial estimates can be generated statistically. The American Heart Association reports that almost half the adult African-American population (~46 percent) lives with CVD, which equates to approximately 11 million African Americans.⁴³ Insofar as 50-60 percent of African Americans live in segregated neighborhoods, CVD afflicts roughly 6.5 million residentially-segregated African Americans. This

⁴⁰ Steven A. Finkler, Cheryl B. Jones, and Christine T. Kovner, *Financial Management for Nurse Managers and Executives*, Fourth Edition (St. Louis: Elsevier Saunders, 2013), 251.

⁴¹ Javier Valero-Elizondo, Joseph A. Salami, Oluseye Ogunmoroti, Chukwuemeka U. Osondu, Ehimen C. Aneni, Rehan Malik, Erica S. Spatz, Jamal S. Rana, Salim S. Virani, Ron Blankstein, Michael J. Blaha, Emir Veledar, and Khurram Nasir, “Favorable Cardiovascular Risk Profile Is Associated with Lower Healthcare Costs and Resource Utilization: The 2012 Medical Expenditure Panel Survey,” *Circulation: Cardiovascular Quality and Outcomes* 9, no. 2 (2016): 143-153.

⁴²American Heart Association, “Heart Disease and Stroke Statistics 2017 At-a-Glance”, www.healthmetrics.heart.org/wp-content/uploads/2017/06/Heart-Disease-and-Stroke-Statistics-2017-ucm_491265.pdf.

⁴³ American Heart Association, “Statistical Fact Sheet 2013 Update: African-Americans and Cardiovascular Disease,” www.heart.org/-/media/data-import/downloadables/african-american-stat-fact-sheet-ucm_319568.pdf. See also American Heart Association, “Heart Disease and Stroke Statistics 2017 At-a-Glance.”

suggests that residents of segregated communities may be generating roughly \$22 billion in direct and indirect costs annually solely for CVD. Given, however, that CVD incidence is higher in segregated communities, the figure may well be greater.

Thus, though only two percent of the overall United States population, these patients are bearing roughly seven percent of the costs of CVD and thus pay into the United States health system at a disproportionate rate. While this may seem counter-intuitive, a recent study attempted to put cost estimates on this spending disparity. Released in 2012, the National Urban League Policy Institute totaled the costs of United States health disparities at approximately \$82.2 billion.⁴⁴ Of this, African Americans shouldered \$54.9 billion of the total burden—or 67 percent. This comprised \$45.3 billion in direct medical costs and \$9.6 billion in lost productivity. Many assume that these costs are primarily borne by taxpayers through Medicaid or Medicare. This assumption is wrong, as the study notes:

Private insurance plans paid 38.4 percent of the healthcare costs associated with disparities (\$23 billion). Individuals and families, through out-of-pocket payments, paid 27.7 percent of those costs (\$16.6 billion)—more than Medicare and Medicaid combined.⁴⁵

Thus, approximately 66 percent of the \$45.3 billion came from out-of-pocket and private insurance sources and was paid for direct health care charges like provider visits. Given that blacks constitute only 13 percent of the total U.S. population and that 26 percent of blacks are poor compared to approximately 12 percent of whites, this figure is even more astonishing. In short, African Americans are shouldering not only an undue burden of health impairments due to residential segregation; they are then financially burdened with an undue portion of health care expenditures for those disparities despite having less income to spend.

Because many health care systems still thrive on volume (rather than value), health systems under current reimbursement strategies not only benefit from adverse effects of residential segregation but may have a vested economic interest in treating the symptoms rather than

⁴⁴ National Urban League, “*State of Urban Health: Eliminating Health Disparities to Save Lives and Cut Costs*,” nul.iamempowered.com/sites/nul.iamempowered.com/files/tbe_attachments/TBE_2012_50.pdf.

⁴⁵ PR Newswire, “Health Disparities Cost U.S. Economy \$82b in Higher Healthcare Spending and Lost Productivity,” December 5, 2012, www.prnewswire.com/news-releases/health-disparities-cost-us-economy-82b-in-higher-healthcare-spending-and-lost-productivity-182190181.html.

addressing their complex causes.⁴⁶ Providers can rest comfortably after prescribing water pills and lifestyle interventions such as diet and exercise, which are only marginally successful for most people over the long-term. So, the more a provider sees Darnell for his diabetes and comorbidities, the more income that provider derives despite the fact that Darnell's condition does not necessarily improve. Providers may argue that this is standard evidence-based care; however, the problem remains. These prescriptions only treat the symptoms rather than the underlying conditions and their causes. In fact, providers have an incentive to maintain the status quo because, if Darnell's health did improve, they would lose much of the revenue he generates. If providers can see people like Darnell frequently while keeping costs as low as possible, the hospital, primary care clinic, or behavioral health practice will thrive even if their patients do not.

Even initiatives to increase access to health care for the underserved can contribute to this problem. Consider the Affordable Care Act (ACA). Recent data suggests that since its launch, the rate of uninsured adults has fallen from a high of 18 percent in Fall 2013 to approximately 12 percent, with approximately 1.8 million blacks being newly covered.⁴⁷ If the ACA stays in place, more African Americans will be insured. This will increase access to treatment, but it will also increase health system revenues, while bad or uncollectable debt—a key measure of charity care and community benefit—should decrease.⁴⁸ Yet, as before, the underlying causes of the health problems blacks present with their new access to care will remain unaddressed.

What might make a real difference? Compare the results of standard CVD treatment with evidence that moving from a ghetto to a mixed-income neighborhood with few psychosocial hazards can significantly decrease psychological distress, diabetes, and body mass index (BMI).⁴⁹ From 1994–1998, the Department of Housing and Urban

⁴⁶ This is not unique to disparities. U.S. health systems have a vested interest in maximizing reimbursement from the present system and will do so until forced to change. But while this may be equally true for poor black patients and rich white patients, insofar as residential segregation can be categorized as an intrinsic evil, Catholic health systems have an obligation to seek to dismantle this system rather than to profit from or help to maintain it.

⁴⁷ Samantha Artiga, Julia Foutz, and Anthony Damico, "Health Coverage by Race and Ethnicity: Changes Under the ACA," *Henry J. Kaiser Family Foundation*, January 26, 2018, www.kff.org/disparities-policy/issue-brief/health-coverage-by-race-and-ethnicity-changes-under-the-aca/.

⁴⁸ Michael Wyland, "Redefining Bad Debt and Charity Care," *Nonprofit Quarterly*, March 18, 2016, nonprofitquarterly.org/2016/03/18/redefining-bad-debt-and-charity-care/.

⁴⁹ Lisa Sanbonmatsu, Lawrence F. Katz, Jens Ludwig, Lisa A. Gennetian, Greg J. Duncan, Ronald C. Kessler, Emma K. Adam, Thomas McDade, and Stacy T. Lindau, "Moving to Opportunity for Fair Housing Demonstration Program: Final Impacts

Development led a demonstration project called, “Moving to Opportunity” (MTO) in which 4,498 single mothers with children were randomized into three groups: a treatment group of families that received vouchers to move into low-poverty neighborhoods, another group given traditional Housing Choice Vouchers (Section 8), and a control group. The women who moved into low-poverty neighborhoods experienced significantly lower body mass index and glucose levels compared to the traditional voucher and control groups, as well as better mental health.⁵⁰ Notably, these physical and mental health improvements occurred despite relatively no change in economic self-sufficiency or individual-level SES.⁵¹

The MTO study showed that systemic environmental interventions are effective at reducing or eliminating health disparities, but incentive schemes in current reimbursement systems work against organized efforts to engage in such interventions. Let us be clear, we are not saying that all blacks need to be moved from segregated neighborhoods. We are, however, saying that a highly effective solution to health disparities requires intervening at the problem’s cause: redeveloping neighborhoods of concentrated poverty into safe, affordable, aesthetically pleasing mixed-income communities, regardless of racial demographics. We do not need to move residents; we simply need to “move” neighborhoods in directions that address underlying causes of health disparities.

These realities, however, present a morally hazardous situation for Catholic health care ministries. The biblical mandate to care for the poor calls Catholic health systems not only to treat the symptom, which is health disparities across race and class lines, but to reduce their fundamental causes. Yet reducing health care disparities for non-integrated urban hospitals would mean a decline in patient revenues. Volume constitutes a significant operational aspect for all health systems, even those engaged in value-based reimbursement schemes. Therefore, most health systems have a vested interest in maintaining the status quo, which may be one reason health disparities have not significantly improved in modern American history despite drastic improvements in medication, clinical techniques, and medical technology.

Evaluation. Policy Development and Research” (Washington, DC: U.S. Department of Housing & Urban Development Office of Policy Development and Research, 2011).

⁵⁰ Jens Ludwig, Lisa Sanbonmatsu, Lisa Gennetian, Emma Adam, Greg J. Duncan, Lawrence F. Katz, Ronald C. Kessler, Jeffrey R. Kling, Stacy Tessler Lindau, Robert C. Whitaker, and Thomas W. McDade, “Neighborhoods, Obesity, and Diabetes—a Randomized Social Experiment,” *New England Journal of Medicine* 365, no. 16 (2011): 1509-1519.

⁵¹ “Moving to Opportunity (MTO) for Fair Housing Demonstration Project,” www.nber.org/mtopublic/.

The potential economic benefits that accrue to health care systems from residential segregation raises a question: are United States health systems complicit in residential segregation? More pointedly, given that Catholic health care provides about 15 percent of all United States health care, is Catholic health care appropriating benefits from the intrinsic evil of residential segregation? M. Cathleen Kaveny helps to illuminate this complex question.

APPROPRIATION OF EVIL

Catholic moral theology has long recognized that in the hurly-burly of real life, our actions are always and everywhere deeply intertwined with those of others. At times, such synergies pair partners committed to the good; other times, we willingly aid and abet others such that we become partners in crime. Most often, however, these interactions are morally murky. We tell ourselves that we seek to do the good, but we know that we are enmeshed—perhaps in ways we cannot fully articulate—with those whose actions strike us as morally problematic. Since the 1700s, the principle of cooperation with evil has helped Catholics wrestle with complex scenarios in an agent (the co-operator) who must decide whether to facilitate or contribute in a subordinate way to a morally unacceptable activity of another actor (the principal agent).⁵²

The principle of cooperation was long relegated to the dusty arcana of the moral manuals.⁵³ The 1994 revision of the ERDs breathed new life into this relatively obscure matrix, positioning it as a central tool for analyzing relationships between Catholic health care institutions and other faith-based or secular entities. More recently, it has been invoked in controversies around the ACA and the contraceptive mandate.⁵⁴ Across these loci, it is primarily deployed to negotiate areas deemed intrinsically evil: abortion, tubal ligations and contraception, and physician-assisted suicide.

⁵² M. Cathleen Kaveny, “Appropriation of Evil: Cooperation’s Mirror Image,” *Theological Studies* 61, no. 2 (2000): 282. For a comprehensive bibliography on and analysis of moral cooperation see M. Therese Lysaught, *Caritas in Communion: Theological Foundations of Catholic Health Care* (St. Louis: Catholic Health Association, 2014), 55-72, 146-155.

⁵³ For example, in that staple of pre-Vatican II medical ethics, Gerald Kelly, S.J., *Medico-Moral Problems* (St. Louis: The Catholic Health Association, 1958), the principle of cooperation only appears in the final four-page chapter, 332-335, being used to analyze involvement of Catholic nurses and physicians in “Cooperation in Illicit Operations.”

⁵⁴ Timothy Jost, “Zubik v. Burwell Briefs Explore Potential Compromise (Update),” *Health Affairs Blog*, April 13, 2016, www.healthaffairs.org/doi/10.1377/hblog20160413.054470/full/.

To date, Catholic health care ethics has yet to use this principle to analyze Catholic institutional engagement in structural sin.⁵⁵ Neither has the field taken up M. Cathleen Kaveny's insightful identification of a new analytical category, what she refers to as cooperation's mirror image—the category of the *appropriation* of evil. Kaveny rightly argues that cooperation does not sufficiently map the landscape of moral ambiguity, leaving invisible or confused the many ways in which “the actions of an agent who is trying to be virtuous can intersect with the morally objectionable acts of others.”⁵⁶ For Kaveny, a new category is needed to address situations where an agent does not *contribute* to another's act of wrongdoing but “must decide whether to make use of the fruits of another agent's morally objectionable action,” to *incorporate* these fruits into one's own actions in order to further one's own ends or projects.⁵⁷ She analyzes examples including: researchers using data from Nazi experiments; consumers purchasing clothing produced by child laborers in developing countries; stem cell researchers using fetal material from elective abortions; and a stay-at-home mother utilizing income from her husband's employment in the nuclear arms industry.⁵⁸

Kaveny's move is insightful and important. However, her analysis remains framed by traditional Catholic moral parameters—focusing primarily on decisions about specific acts made by individual agents. Yet her examples hint at something more. The category of appropriation holds a greater potential for engaging questions that are social and structural in scope. In this section, we briefly discuss Kaveny's understanding of appropriation, identifying additional aspects of the concept embedded in and beyond her original account, with an eye toward outlining a matrix for application.

Kaveny admits that she does not develop “a full-blown analytical framework for appropriation problems” but primarily identifies morally salient features of appropriation problems by carefully teasing out the relationship between cooperation and appropriation.⁵⁹ As she notes, cooperation and appropriation problems present the same basic and, in fact, parallel structure. Yet, within this structure, key facets are inverted. For example, cooperation problems are largely *prospective*; potential cooperators must decide if they will contribute to actions that have not yet occurred (e.g., the cabby driving the robber to the bank) or that are ongoing (e.g., providing janitorial services in an abortion clinic). Appropriation is largely *retrospective*; potential appropriators

⁵⁵ Julie Hanlon Rubio offers one of the few analyses applying the principle of moral cooperation to social ethics in “Cooperation with Evil Reconsidered: The Moral Duty of Resistance,” *Theological Studies* 78, no. 1 (2017): 96-120.

⁵⁶ Kaveny, “Appropriation of Evil,” 286.

⁵⁷ Kaveny, “Appropriation of Evil,” 280.

⁵⁸ Kaveny, “Appropriation of Evil,” 280.

⁵⁹ Kaveny, “Appropriation of Evil,” 307.

must decide if they will utilize products of past actions (e.g., Nazi experimentation) or concurrent actions (e.g., sweatshops) into their own lives and actions to forward their own goals. Likewise, the principal agent's identity differs:

In cooperation cases, the *auxiliary agent* is the morally conscientious decision-maker who must decide what to do in light of his or her prospective actions likely *contribution* to an evil act performed by the principal agent. In appropriation cases, the roles are reversed. Here, it is the *principal agent* who is the morally conscientious decision-maker, who must decide whether to go ahead with an action that *makes use of* the fruits or byproducts of a morally objectionable act by the auxiliary agent.⁶⁰

Over and against these inversions, the similarities highlight the moral dimensions of appropriation problems. One similarity is what we might call *incorporation*. For example, issues of cooperation do not arise simply by interacting with a wrongdoer (e.g., by sitting on the bus next to one doing something impermissible). Rather, cooperation arises only when one's action might contribute to a wrongdoer's nefarious purposes. Somehow, my action (and, in fact, my person) becomes incorporated into her action, furthering her evil end. Likewise, appropriation only arises when an intended or secondary byproduct of another's morally impermissible action contributes to my own project. In this case, I incorporate the byproduct—and by extension, potentially the act itself—into my own action; it becomes of a piece with my action as it furthers my own substantial ends.

Secondly, for both, *intention* is a crucial though not determinative pivot. In cases of *formal* cooperation—which are always illicit—cooperators “intend, either as an end in itself or as a means to some other end, the wrongdoing designed by the principal agent.”⁶¹ The cooperator assents to the wrongdoing and gladly bends her will toward a bad end. Likewise, an appropriator may approve of the wrongdoing that generated the byproduct—a white supremacist might applaud Nazi experiments or a stem cell researcher may support elective abortions. Kaveny refers to this as *ratification*:

In the appropriation context, ratification of evil is the equivalent of formal cooperation with evil. For an agent to ratify the action of another involves not only taking up its fruits or byproducts and weaving them into his or her own plans and objectives, for that happens in every appropriation case. It also involves stepping into the shoes of the auxiliary agent in a more fundamental manner. When an appropriator ratifies an appropriated action, he or she takes it up and makes

⁶⁰ Kaveny, “Appropriation of Evil,” 287, emphases in original.

⁶¹ Kaveny, “Appropriation of Evil,” 284.

use of it under the intentional description it was given by the auxiliary agent. In effect, the action of the auxiliary agent becomes the appropriator's by adoption. In addition, the appropriator may use that action for the same purposes that the auxiliary agent would have used it.⁶²

But what if appropriators do not approve of the actions that generate the by-product? Are they absolved from moral culpability? Here, Kaveny draws parallels with material cooperation. In cases of *material* cooperation, the cooperater does *not intend* the principal agent's morally objectionable actions—her will bends in a different direction. But depending on additional factors, the action may be illicit depending on questions of mediacy and remoteness, namely, “to what degree and in what respect the action of the cooperater overlaps with and contributes to the illicit action of the principal agent.”⁶³ All appropriation entails a material component; might some material appropriation be justified while other less so or illicit?

Parsing these questions requires a more nuanced understanding of intention. Intention, per Kaveny, involves not only assent or agreement with wrongdoers' actions or purposes (ratification); it also requires a dimension of control. Critical to the analysis is whether the appropriator has “any way of influencing decisions about whether or not [the impermissible action] is performed.”⁶⁴ As she notes, “Intention is purposeful causality; agents cannot intend outcomes over which they know they will have absolutely no influence. Provided that they have nothing to do with its planning or execution, [appropriators do not] intend the wrongful activity that becomes the basis for their own virtuous actions.”⁶⁵

Thus, Kaveny distinguishes between intention, wish, and prediction. Wishes and predictions do not cause outcomes. One might *wish* to harm another out of anger, but, if one has no ability to act on it, it cannot be an intention. Likewise, we may be able to make predictions about others' morally impermissible actions.⁶⁶ We can *predict* that a certain number of abortions will be performed in the US each year. Some may “build their action plans on the basis of predictions regarding the illicit actions of other people,” but, since they have no causal control over these actions, one cannot properly say they intend them.⁶⁷

As with material cooperation, absolving appropriators of intentionality does not necessarily justify their engagement. Even those engaged in remote, mediate material cooperation must do so only for a substantially (or proportionally) grave reason; a substantial good must

⁶² Kaveny, “Appropriation of Evil,” 306-307.

⁶³ Kaveny, “Appropriation of Evil,” 285.

⁶⁴ Kaveny, “Appropriation of Evil,” 296.

⁶⁵ Kaveny, “Appropriation of Evil,” 296.

⁶⁶ Kaveny, “Appropriation of Evil,” 299.

⁶⁷ Kaveny, “Appropriation of Evil,” 299.

be at stake. This is not primarily because cooperation trades on a utilitarian balancing of goods versus harms. Rather, as Kaveny carefully outlines, it functions within a Thomistic virtue framework. At issue is not solely the harms or evils produced in the world per the action; rather, a primary concern is how the action affects the cooperator's character. Cooperators must be seeking to preserve or promote a substantial good because only by aiming at that good can the ill effect on their character/will caused by the cooperation be mitigated or offset.

Likewise, for Kaveny, appropriation shapes the appropriator's character and, in fact, poses an equal—if not broader—range of moral danger than cooperation. It remains “virtually invisible”:⁶⁸

The main effect of a decision to appropriate the evil action of another is internal; by choosing to tie their action to the evil act of another, appropriators shape their characters in a way that may not have immediate, tangible consequences in the external world. In short, the immediate impact of the decision to appropriate the illicit act of another is a deeply interior one; it alters the character of the appropriator.⁶⁹

According to [the Catholic moral tradition], the most significant aspect of a human action is the way in which it shapes the character of the person who performs it. Thus, according to traditional Catholic doctrine, individuals who engage in deliberate evil-doing harm themselves far more than they do those who suffer injustice at their hands.⁷⁰

How might appropriation impact character? Kaveny names two potential moral dangers: *seepage* and *self-deception*. Seepage refers to the potential for regular involvement with a wrongdoing to desensitize us or subtly shift our moral assessment. As she notes, “If another agent's evil acts contribute in some way to our own objectives, particularly in an ongoing manner, it is difficult not to view them in a more positive light than we otherwise would.”⁷¹ Agents who repeatedly engage in a particular action—even the rare but perhaps justifiable taking of human life—“can accustom their hearts and minds to causing the death of another human being.... They can easily become desensitized to the sanctity of life, making it easier for them to choose acts that are deliberately disrespectful of other persons in the future.”⁷²

Likewise, seepage is the slow process of desensitization that leads to self-deception. Self-deception can work on both sides of the action: “In general, whenever an appropriator takes up an auxiliary agent's illicit action or its immediate consequences and makes use of them in

⁶⁸ Kaveny, “Appropriation of Evil,” 289.

⁶⁹ Kaveny, “Appropriation of Evil,” 289.

⁷⁰ Kaveny, “Appropriation of Evil,” 303.

⁷¹ Kaveny, “Appropriation of Evil,” 307.

⁷² Kaveny, “Appropriation of Evil,” 304.

a constructive way, the appropriator fuels the auxiliary agent's capacity to discount the wrongfulness of his or her action by pointing to the good that came from it."⁷³ Equally, appropriators might begin to deceive themselves. Might those who appropriate Nazi data or fetal tissue move beyond seepage and risk "the danger that their own descriptions of themselves as doing nothing more than 'bringing good out of evil'?"⁷⁴

Implicit in Kaveny's account are three additional moral dangers. A first we might call *moral inhibition*. If we come to depend on a by-product of a morally impermissible action or "accustom ourselves to the benefits that flow from appropriation," might we decide not to take steps "to eliminate the wrongdoing, if the opportunity presented itself,"⁷⁵ or might it "mute [our] opposition to the practice or hamper [our] effectiveness in opposing it should the occasion to do so arise?"⁷⁶ Here we begin to shade back into intentionality, through sins of omission. Do we find ourselves engaged in what we might call *implicit ratification* by contributing to the sustaining of the activity? Finally, analogous to *scandal*, might appropriation encourage others to more positively assess the morally impermissible act.⁷⁷ As she notes, unlike the Nazi experiments that ended fifty years ago, elective abortion remains an ongoing practice in the US. The fact that fetal remains can be put to a worthy scientific use may make others assess the practice of abortion in a morally more positive light.

The category of appropriation, then, provides us with a lens for analyzing those instances where a Catholic agent takes up the fruits or byproducts of other's morally problematic actions. The concepts of incorporation, ratification, seepage, self-deception, moral inhibition, scandal, and implicit ratification provide a matrix for assessing such actions' moral valences. How might this matrix illuminate our question of the relationship between Catholic health care institutions and the economic benefits of residential segregation? What is more, how might Catholic health care's engagement with the social and structural issue of residential segregation deepen the nuances and scope of the category of appropriation?

APPROPRIATION AND RESIDENTIAL SEGREGATION

Catholic health ministries gain revenue for services provided to patients whose health conditions largely result from residential segregation, accruing a benefit from a morally problematic reality. The cate-

⁷³ Kaveny, "Appropriation of Evil," 309.

⁷⁴ Kaveny, "Appropriation of Evil," 309.

⁷⁵ Kaveny, "Appropriation of Evil," 307.

⁷⁶ Kaveny, "Appropriation of Evil," 311.

⁷⁷ Kaveny, "Appropriation of Evil," 93.

gory of appropriation of evil illuminates moral contours of this engagement. Simultaneously, this issue helps further develop the framework of appropriation by applying notions of incorporation and intention, specified as ratification, seepage, and self-deception, to considerations of social-structural sin and making more explicit the three additional concepts of moral inhibition, an analog to scandal, and implicit ratification.

We begin with ratification. In potentially benefitting from residential segregation, do Catholic health systems ratify the auxiliary agent's (in this case, society's) wrongful action or structure? Do they "take it up and make use of it under the intentional description it was given by the auxiliary agent," effectively making the action of residential segregation their own by adoption, using it for the same purposes as society (i.e. economic exploitation)?⁷⁸ Although at one time Catholic hospitals under Jim Crow endorsed residential and other forms of segregation (by, for example, having separate hospitals for blacks and whites or Whites Only and Coloreds Only waiting rooms, drinking fountains, or other structures), today, at least in their formal rhetoric and mission and value statements, no Catholic hospital or health system explicitly affirms the evil of residential segregation.⁷⁹ Certainly, formal ratification is not an issue.

What about the material level? As noted earlier, intention involves not only assent or agreement with wrongdoers' actions or purposes but also a dimension of control or influence over the evil action or outcomes. Do health care organizations have any direct or indirect influence over the realities of concentrated poverty in local neighborhood environments around their facilities? Health care organizations alone cannot eliminate *de facto* residential segregation, but they do have some influence over conditions of local neighborhoods. Historically, Catholic health care located its work and facilities in the poorest communities. Yet, over the past three decades, as Catholic hospitals have merged into health systems, many Catholic hospitals in poor, urban centers have been closed. In fact, hospitals serving poor communities are more likely to close.⁸⁰ From 1985-2015, over 300 United States hospitals closed, ten hospitals in urban areas closing per year from 2010-2015.⁸¹ At the same time, health systems—including Catholic

⁷⁸ Kaveny, "Appropriation of Evil," 307.

⁷⁹ Minda, "Catholic Providers Pledge to Address Race, Class-Based Inequity in Health Care." See also Wall, *American Catholic Hospitals*, 74; Andrew S. Moore, "Catholicism and the Civil Rights Movement," *Encyclopedia of Alabama*, www.encyclopediaofalabama.org/article/h-1086.

⁸⁰ Melanie Evans, "When a Hospital Closes, Can a Community's Health Improve?" *Modern Health Care*, May 5, 2015, www.modernhealthcare.com/article/20150505/NEWS/150509963.

⁸¹ N. Garg, G. Husk, T. Nguyen, A. Onyile, S. Echezona, G. Kuperman, and J.S. Shapiro, "Hospital Closure and Insights into Patient Dispersion: The Closure of Saint

systems—have followed the strategy of simultaneously or subsequently opening new hospitals in more affluent areas.⁸² These decisions, of course, “have been associated with worsened healthcare for the community, especially for the most vulnerable populations.”⁸³ They also have a significant economic impact on poor communities. Many hospitals serve as an area’s major employer; closing a hospital negatively impacts a community’s employment profile. Research demonstrates the most effective industry at moving people from poverty to middle-income is health care.⁸⁴ Ironically, this type of local, community-based workforce development strategy could have the effect of increasing health system revenues because private insurance plans reimburse at higher rates than Medicaid and Medicare.⁸⁵ Consequently, by following the trend of closing urban hospitals, Catholic health care has, in fact, often exacerbated realities associated with residential segregation.

Secondly, Catholic hospitals have influence over poor communities through community benefit dollars. In 2011, not-for-profit health care organizations claimed an estimated \$24.6 billion in tax exemptions and reported roughly \$62 billion in community benefit spending.⁸⁶ The most recent study, from 2007, tallied Catholic health care’s aggregate community benefit contribution at \$5.7 billion.⁸⁷ However, despite the community benefit nomenclature, most spending goes to charity care, staff education, mission trips, and well-intentioned but

Vincent’s Catholic Medical Center in New York City,” *Applied Clinical Informatics* 6, no. 1 (2015): 185–199.

⁸² Phil Galewitz, “Why Urban Hospitals are Leaving for Fancy Suburbs,” *Kaiser Health News*, April 14, 2015, www.governing.com/topics/health-human-services/why-urban-hospitals-are-leaving-cities-for-fancy-suburbs.html.

⁸³ Galewitz, “Why Urban Hospitals are Leaving for Fancy Suburbs.”

⁸⁴ Marla Nelson and Laura Wolf-Powers, “Chains and Ladders: Exploring the Opportunities for Workforce Development and Poverty Reduction in the Hospital Sector,” *Economic Development Quarterly* 24, no. 1 (2010): 33–44. For a shining example of one Catholic hospital that has prioritized hiring from the local community—St. Bernard’s Hospital and Health Care Center in Englewood, Chicago—see Robert J. Gordon, “Inviting the Neighborhood into the Hospital: Diversifying our Health Care Organizations,” in *Catholic Bioethics and Social Justice*, ed. M. Therese Lysaught and Michael McCarthy (Collegeville: Liturgical Press, 2018).

⁸⁵ Susan J. Penner, *Economics and Financial Management for Nurses and Nurse Leaders*, Second Edition (New York: Springer Publishing Company, LLC, 2013).

⁸⁶ Sara Rosenbaum, David A. Kindig, Jie Bao, Maureen K. Byrnes, Colin O Laughlin, “The Value of the Nonprofit Hospital Tax Exemption Was \$24.6 Billion in 2011,” *Health Affairs* 34, no. 7 (2015): 1225–1233. See also National Health Care for the Homeless Council, “Hospital Community Benefit Funds: Resources for the HCH Community,” May 2016, www.nhchc.org/wp-content/uploads/2016/06/policy-brief-hospital-community-benefit.pdf; Bradley Herring, Darrell Gaskin, Hossein Zare, and Gerard Anderson, “Comparing the Value of Nonprofit Hospitals’ Tax Exemption to Their Community Benefits,” *Inquiry: The Journal of Health Care Organization, Provision, and Financing* 55 (2018): doi.org/10.1177/0046958017751970.

⁸⁷ Pamela Schaeffer, “Assessing and Evaluating Community Benefit,” *Health Progress* 95, no. 6 (2014): 54–63.

ineffective programs like farmers' markets.⁸⁸ In fact, a 2009 national study of non-profit health systems concluded:

Tax-exempt hospitals spent approximately 7.5 percent of their operating expenses on community benefits. Approximately 85 percent of these expenditures were devoted to charity care and other patient-care services. Of the remaining community benefit expenditures, approximately 5 percent were devoted to community health improvements that hospitals undertook directly. The rest went to education for health professions, research, and contributions to community groups.⁸⁹

Thus, Catholic health care organizations certainly have the resources to influence and address the concentrated poverty associated with residential segregation as a foundational *cause* of health disparities. Certainly, charity care or addressing other individual social determinants of health like individual-level poverty reduction, education, are worthwhile endeavors. However, if physical and subsequently economic structures do not support healthy and safe neighborhoods, these laudable efforts will be counteracted by powerful trends correlated to area of residence.

Thirdly, an even more pressing question must be asked: do Catholic health care organizations—in their staffing, geography, and ethos—reflect and reinforce residential segregation? Structures and financial profiles of health care institutions have changed radically since the Sisters founded Catholic health care in the nineteenth century—even more so since the 1970s. No longer do most health care associates live in the communities they serve. Corporate headquarters are often located in different states. CEOs make multi-million-dollar salaries with bonuses and other incentives. Do organizational decision-makers and the demographics of hospital staffing reflect the population(s) the institution serves? Or do they, in their daily lives, “step into the shoes” of those who affirm residential segregation by where they live? Are local communities given a real voice in institutional decision-making? In short, at issue is the question of intention. If an organization is just as segregated as society, it is hard to argue that the intention of the organization somehow differs from those who engage in and concretize residential segregation.

Thus, while Catholic health care systems might not actively and formally intend the intrinsic evil of residential segregation, they may

⁸⁸ Farmers' markets increase access to fresh fruits and vegetables, but they can serve to obscure the fact that people need affordable, reliable, and clean grocery stores (just like the suburbs) more than they need farmers' markets. They need structural change that creates jobs and well-being *in* their communities.

⁸⁹ Gary J. Young, Chia-Hung Chou, Jeffrey A. Lexander, Shouu-Yih Daniel Lee, and Eli Raver, “Provision of Community Benefits by Tax-Exempt U.S. Hospitals,” *New England Journal of Medicine* 368, no. 16 (2013): 1519.

exacerbate it by closing hospitals in poor communities, failing to deploy community benefit dollars to address causes of health disparities, and staffing in ways that reflect and embody societal segregation. Such actions might be called *implicit ratification* parallel to the notion of implicit formal cooperation developed elsewhere.⁹⁰ This possibility of *implicit ratification* requires sound multilevel organizational discernment in order to navigate the moral minefield of structural sin.

The concept of appropriation also pushes us to ask questions about other ways that appropriating the benefits of residential segregation might undermine the moral character and well-being of our institutions and associates via seepage, self-deception, moral inhibition and scandal. Seepage: does the fact that health systems benefit financially from residential segregation desensitize associates to the extraordinary dehumanization that these environments inflict? Most people use proxies such as quality of schools and crime rates to search for new neighborhoods in which to reside. By using these proxies, we seek to avoid health-harming neighborhoods. If a neighborhood in its current condition is not fit for health care associates to reside then it probably is not fit for *any* human being without substantial investments. However, our avoidance of these communities often blinds us to the real conditions in which *other* people must live. This willful blindness desensitizes us to the ongoing realities of concentrated poverties and slowly leads to self-deception.

Self-deception: does our ‘charitable work’ allow us to deceive ourselves, that via free clinics or unreimbursed Medicaid write-offs we are “bringing good out of evil”? Does it allow ourselves to get into habits of seeing ourselves as (largely) white saviors who make a great sacrifice for “these people” who do not even show up for their appointments or take their medications or engage in other actions about which health care associates can devolve into criticism or apathy?⁹¹ Do we allow others—agents of societal racism—to deceive themselves about the evil of these neighborhoods by saying that the Catholic hospitals are there to care for the poor as one of a thousand points of light, so that society does not need to attend to structural determinants?

Moral inhibition: Does our work in these neighborhoods or the way that we conceive health care as occurring only in hospitals or in clinics lead us to see ourselves as unable to do anything to eliminate the evil

⁹⁰ Thomas R. Kopfensteiner and James F. Keenan, “The Principle of Cooperation,” *Health Progress* 76 (1995): 23-27.

⁹¹ See David Hilfiker, *Not All of Us Are Saints: A Doctor’s Journey with the Poor* (New York: Hill and Wang, 1994), for a powerful description of how even those dedicated to caring for the poor can become callous, jaded, or agents who participate in blaming the poor for their own oppression.

of residential segregation, seeing the problem as too big or outside the focus of a health care institution?

Scandal: Might our focus on charity care, especially by focusing at the individual patient level, confirm the social biases of many that health disparities are rooted in individual health behaviors or lack of “personal responsibility” among the poor? Alternatively, might it allow others to believe that the ill effects of racial segregation are being taken care of, allowing them to absolve themselves from taking action?

At the root of our attempts to address the illicit appropriation of evil, we must be vigilant for the myriad ways we can devalue others and the ways in which it impacts our character and identity, as individuals and institutions. It is not sufficient to confine our moral discernment to individual level issues; as important as these issues are, as a ministry of the Church, we are called to struggle against dignity-denying principalities and powers (Ephesians 6:12). We are called to be leaven and light of love in dark corners of a world that hungers for the Bread of Life. The Lord asks: “Whom shall I send? And who will go for us?” (Isaiah 6:8). Will Catholic health care respond as Isaiah did? “Here am I. Send Me!” (Isaiah 6:8).

CONCLUSION

We hope this analysis catalyzes conversation in two directions. It appreciates Kaveny’s category of appropriation and seeks to develop it by exploring how it might be expanded to institutions, used to examine not only individual actions but structural issues, and to identify other dimensions of appropriation relevant to moral discernment. We call Catholic health care ethicists to take up these three challenges. In addition, we wish to affirm Sister Carol Keehan in pushing Catholic health care toward love and justice by stating, “When anyone is marginalized, because of their race or their ability to pay or their geographic location, all of us have an interest in *repairing the systemic problems at work*.”⁹² Equipped with new knowledge about relationships between residential segregation and health disparities, no longer is charity alone sufficient (necessary, yes; sufficient, no). Rather, sound community benefit strategies can allow health care institutions to do a sort of penance for the sins of society and their own participation therein. By reimagining and reorganizing community benefit dollars toward community building, Catholic health ministries can serve as witnesses and leaders, coordinating and cooperating with other local health care providers in initiatives that move neighborhoods of concentrated poverty toward health and wholeness; this is healing as

⁹² Carol Keehan, “Ending Healthcare Disparities: An Urgent Priority and a Growing Possibility,” *Frontiers of Health Services Management* 30, no. 3 (2014): 32. Emphasis added.

Christ healed. These benefits accrue not only to the targeted community, but to all communities as crime is reduced, more affordable housing is developed, more jobs are created, incarceration rates are reduced, cities become more livable and sustainable, and health care costs for providers *and* patients are reduced or stabilized.

To their credit, although community health improvement efforts still comprise only roughly 5 percent of community benefit spending (with community building being a smaller percentage of that), Catholic health systems have begun to take steps in this direction. In the ACA environment, the need for charity care and the problem of bad debt has begun to decline. Systems are feeling increased pressure to justify their tax-exempt status.⁹³ Consequently, some Catholic institutions are starting to engage in community change projects. For example, Dignity Health is working to make some of its communities safer by creating collective efficacy by utilizing mothers and volunteers to keep children safe as they walk to and from school. The system even went so far as to negotiate “with local gangs to keep children secure during the Safe Passage time window.”⁹⁴ Catholic Health Initiatives has also targeted violence in the communities it serves.⁹⁵ Providence focused on Hispanic social isolation in Wilmington, California.⁹⁶ Ascension Health is redeveloping communities in Baltimore and Toledo to include mixed-use housing, retail space, as well as space available for community use.⁹⁷

Such interventions need to happen on a larger scale and health outcomes should be measured. Catholic health care alone or in partnership could engage neighborhoods of concentrated poverty by working with community leaders to develop community redevelopment plans with organizations like Purpose Built Communities, which transform poor neighborhoods into thriving low-crime mixed-income neighborhoods without gentrification.⁹⁸ Moreover, health systems can engage urban designers to work with neighborhoods to redevelop communities using crime prevention through environmental design (CPTED)

⁹³ Beth Kutscher, “Hospitals Broaden Scope of Community-Benefit Work,” *Modern Healthcare*, November 21, 2015, www.modernhealthcare.com/article/20151121/MAGAZINE/311219988.

⁹⁴ Kutscher, “Hospitals Broaden Scope of Community-Benefit Work.”

⁹⁵ Betsy Taylor, “CHI, Robert Wood Johnson Foundation Map Road to Health,” *Catholic Health World*, October 15, 2017, www.chausa.org/publications/catholic-health-world/archives/issues/october-15-2017/chi-robert-wood-johnson-foundation-map-road-to-health.

⁹⁶ Renee Stovsky, “Providence Enlists Community to Break Down Isolation in LA Neighborhood,” *Catholic Health World*, October 15, 2017, www.chausa.org/publications/catholic-health-world/archives/issues/december-1-2017/providence-enlists-community-to-break-down-isolation-in-la-neighborhood.

⁹⁷ Kutscher, “Hospitals Broaden Scope of Community-Benefit Work.”

⁹⁸ See Purpose Built Communities at purposebuiltcommunities.org/.

principles.⁹⁹ This approach, along with working with communities to develop collective efficacy (e.g., neighborhood watch), helps to ensure that neighborhoods are not targets of over-aggressive policing, in which excessive and lethal force is often used as the primary strategy for conflict resolution. Also, as collective efficacy increases, fear of crime decreases.¹⁰⁰

To be sure, residential segregation will continue to exist, but sound community benefit strategies can ameliorate inhumane living conditions and negative health consequences that result from concentrated poverty. Such an approach to population health benefits communities and improves payer mix, and especially as incentives begin to realign, integrated health systems will also benefit by lowering costs of care, enhancing the common good. To be sure, Catholic health care identifies reducing health disparities as an urgent priority. Yet they must discern if they are working to dismantle unjust systems that lead to poor health outcomes for vulnerable populations or if they are helping to maintain unjust systems through tacitly accepting and maintaining the status quo. Where reimbursement systems do not incentivize actions to address social determinants of health, the mission of Catholic health ministry must serve as the guiding motivation.

The Roman Catholic Church sees itself as “the sacrament of the unity of the human race” (*Catechism*, no. 775). Thus, as a ministry of the Church, Catholic health care organizations must always strive to inculcate and actualize this lofty vocation. Otherwise, we are left with St. John’s admonishment:

We know love by this, that he laid down his life for us—and we ought to lay down our lives for one another. How does God’s love abide in anyone who has the world’s goods and sees a brother or sister in need and yet refuses help? Little children, let us love, not in word or speech, but in truth and action. And by this we will know that we are from the truth and will reassure our hearts before him whenever our hearts condemn us; for God is greater than our hearts, and he knows everything (1 John 3:16-20). **M**

⁹⁹ See International CPTED Association at www.cpted.net/.

¹⁰⁰ Marc L. Swatt, Sean P. Varano, Craig D. Uchida, Shellie E. Solomon, “Fear of Crime, Incivilities, and Collective Efficacy in Four Miami Neighborhoods,” *Journal of Criminal Justice* 41, no. 1 (2013): 1-11.