This paper is a critique of Glenna Crooks’ Creating Covenants: Healing Health Care in the New Millennium, published in 2000 by Medical Vision Press. The paper consists of two parts: an overview of key points of the text and my own reflections, responses and observations.

**Background**

The author is the founder and president of Strategic Health Policy International, Inc., a consulting firm focused on helping clients manage policy and political issues in health care. She is a former Deputy Assistant Secretary for Health under the Reagan administration and has held numerous other government and private positions related to health and policy.

Dr. Crooks presents historical data from a myriad of sources including the academic literature to frame her discussion on the role of covenantal relationships generally and in health care specifically. Her theories expand upon this basis with current practices in health care policy, financing and delivery to create a vision for a future where health care is returned to its proper relationship between the provider and the patient. She indicates a primary purpose of this work, that it is “…intended as a practical exploration of selected pivotal issues for those interested in understanding the important system changes and public policies of tomorrow’s health care.”

She provides something like a development plan encompassing debate and demonstration, development of forums for discussion of complex issues among key stakeholders, and the integration of social/environmental and the international business market of health care supplies and services. She outlines the text in three parts: foundations of healing, millennium challenges and opportunities, and healing health care. This paper will discuss her ideas based on such historical, political, financial and market economy interactions and comment on her assumptions and incentives in the face of multiple global stakeholders.
PART ONE CREATING COVENANTS

The Covenantal Relationship and the Cure to Health Care

Crooks begins by stating emphatically that the challenge to the healing of the myriad problems of health care is rooted in the relationship between healers, patients and the community. She contends that the solution must involve all parties, though the responsibility is placed on those with the ability to understand and influence the process. She begins with a thorough, historic compilation of Healing as a Divine Gift. This is a fine introduction to the historical perspective on healing across cultures and religions as well as in the secular world. Crooks reveals a compelling and clear discussion of the shift of power in the United States from the healer to the federal government with the creation of Medicare and Medicaid. In chapter two, Healing within the Covenant Tradition, a deeper discussion of the origins and meanings of covenants is presented. The similarities and differences of covenants and contracts are discussed and the nature of grant and obligation are introduced. With a step back into history, a variety of historic covenants of grant and obligation are discussed. For some readers, particularly those with a background in Biblical history, these first two chapters may seem somewhat redundant as she makes clear the world history as it relates to covenant and contract relationships. One of the key points of the text is introduced here: the fact that patients are [no longer] a party to any covenant of obligation with their physicians. This lack of responsibility, fueled largely by health insurance, creates a disincentive to health on the part of patients. Although Crooks does not suggest this, a similar saying might be: If automobile insurance were like health insurance, we could be reimbursed for gas, oil and regular maintenance. Such a market relationship, driven again by the financial relationship, places the greatest burden on the physicians and other providers. Crooks charges the renewing of a covenantal relationship between patients and providers consistent with the historical origins of the patient-provider relationship. Nor does she leave out the community, for everyone must be engaged in a covenant of obligation if we are to address the most intractable of health care issues. Physicians and providers are
charged with the responsibility, in part out of the holding of specific knowledge on healing, and in part out of the leading role they play in the community. A rudimentary “model” is presented to begin a dialog on how the relationship between patient, provider and the community should be discussed in order to reestablish a more comprehensive healing relationship.

Beginning Part Two, Crooks describes these challenges as gifts, because they create the opportunity to move beyond our current condition. An apt and correct description for it is indeed only through discontinuous action will we move into the kinds of relationships she envisions. In *Independence: Covenant in Patients’ Rights*, the healer’s accountability for access and cost of care is presented. The physician’s oath, which has seemingly taken on different meanings over the years, coupled with the lack of reciprocity with patients and the market “success” of managed care have burdened and disheartened many if not all physicians. The limitations of these current covenants of grant, one way relationships without shared responsibility, fail to address the economics of health care financing and delivery, and also in the likelihood that optimum health outcomes will occur. Crooks indicates that “Accepting personal responsibility, understanding risk in the population, developing targeted group interventions, case management and multidisciplinary teams that will deal with social, juvenile justice and education problems will be required.” (Crooks, 2000, p. 67.) Crooks is convinced that patients and communities can come to recognize the benefits of good health as an investment, and that the process must include an interlocking covenant of obligation.

In *Curing Disease: Covenant in the Animal Research Conflict*, the myriad issues of tensions and conflicts in animal research are presented. I found this brief chapter informative and necessary, though not with the compelling draw of the remainder of the text. Animal activists must be part of the broader discussion of health and science so that any mutual efforts to embrace a higher level of population health are
fruitful.

The rapidly growing issue of privacy is broached in *Making Choices: Covenant in the Tradeoffs between Privacy and Efficiency*. Crooks continues with the remaining series of brief yet focused chapters on issues involving providers, patients, the community and other key stakeholders. Recognizing the rapid deployment of information systems and information sharing, rightly and wrongly, a discussion of issues dealing with patient consent, authorization, data collection and use, data management, patient rights, penalties for violations, and legislative authority are discussed. Subscribing to the covenant requires an acknowledgement of balancing and trading-off what may seem unalienable rights of the patient with the needs of the system through broad-based community and stakeholder discussion.

The often hidden aspect of pain and suffering is presented next in the context of patient, family and care giver realities juxtaposed against legal wrangling on moral issues. *Healing Beyond our Borders: Covenant and Medications for the Global Community* discusses historical issues on serving the health needs globally and indicates a prescription for action. Crooks charges the American pharmaceutical industry with the responsibility for leading the reform given their ability in technical arena and with their substantial capital structure compared to others (recognizing that American pharma has strong worldly relations.) This section contains a superb narrative of issues involving the extension of charity into the third world and the geopolitical and market realities that hinder it. Crooks summarizes by indicating that significant change must occur in donations policies, the balance of power among players (countries/governments, agencies, and donor organizations), and tax policies. By focusing on disease, the enemy is shifted from parties at the debate, with curative weapons, not the rhetoric of opposing sides.

In Part Three, Crooks introduces *Emerging Models: Healing within Covenants* with the focus on healing through the embracing of covenants by providers, patients and communities. She cites an impressive
list of examples of the beginnings of embracing covenants within many sectors of health care: physicians, individuals, and communities. The closing section, *Healing Health Care: Crafting Covenants in the New Millennium*, outlines a series of principles on which the road to covenants could be paved.

These series of principles build upon the guidance suggested and supported within the preceding text. The primary issues raised and the examples of successful beginnings bear tribute to the model presented. Covenants flowing from the “Senior Party” preceded by gifts continue not only the historical roots of many cultures, but acknowledge the responsibility of the elder in the care of the younger. Establishing that covenants are eternal, though they may evolve cements the relationship between parties even as they change over time. The recognition of mutual obligation benefits us all, though they require a series of thoughtful steps. Developing and confirming intention, letting go of the past, rooting the relationship, connecting the participants, giving pause for reconsideration of issues, and requiring stretch are the key steps Crooks lays out. The process is not unlike the thoughtful processes of organizational behavior and corporate culture. The text ends with some examples of how such covenants of obligation could be constructed.

Crooks presents these varied issues, some 300 questions are within the text, though they form a collected whole. She has fulfilled her intention of exploring pivotal issues and has supported her philosophy through case examples in the challenges and progress towards solutions embraced by others.

**PART TWO: REFLECTIONS**

Crooks’ text raises important questions about the current condition of our country’s health and of the global health condition. Her approach is in combination academic yet with a practical perspective that seems to compel one to greater thought. Despite the soundness of this need to focus on reestablishing
a relationship of healing, the reality of political will to make changes that impact careers, interest
groups, federal, state and national financial markets, and global interests will not likely exist in the short
term.

Political, financial and market indices

Resource allocation requires an understanding of the key drivers of the market interaction between
those who consume services and those who provide services, as well as a set of common definitions
about what constitutes a health outcome or the concept of health. The market perspective of managed
care will likely continue in our country in the absence of a need to change. Crooks rightly identifies the
downward pressure in reimbursement driven by purchasing power and its impact on provider-patient
relationships. This pressure will continue since employers will seek lower costs first and better health
second in their short-term planning horizons. The political will to evaluate radical change at the federal
health policy level will not exist as long as patients are not dying on the streets and the grassroots
efforts are not substantial. Combining these with the changing venues for political power and the
election cycle mentality of supporting issues leaves a legislature that can only consider incremental
change over time, not unlike the way our founding fathers envisioned our methods of policy formation.

Stakeholder resistance and barriers to acceptance

The stakeholders to the issues of covenants may be classified into four primary categories based on the
position and influence. This creates the perspective for the analysis over which stakeholders have
primary influence and/or control and which are affected directly and indirectly. The following
classifications of stakeholders are adapted from Austin and Boxerman (1995) and applied to Crooks’
model constituency.

- **Primary stakeholders.** The primary stakeholders include patients and family members who receive
and/or pay out of pocket for care. They also include the federal governments broadly that
dictate health policy and financing issues and are responsible for the amount of health care
consumed within their market economies. The change required by this group, patients in
particular, will be astounding. It has been over many years that U.S. citizens have come to live
with our current method of financing the delivery of health care. Requiring patients to accept
responsibility for their actions may come only through legislating their behavior via the
financing mechanism for health services. Evans and Stoddart (1994) suggest that patients will
only respond to adverse circumstances when they deem the severity to be of great consequence.
One can foresee that such care seeking will require higher levels of need as financial
responsibility is shifted to the patient, perhaps eschewing preventive and wellness related
activities. Other countries have had some success with a more socialized approach to medicine,
and their health outcomes as a percent of gross domestic product are a testimony to the
“quality” of their population health care system. Most of us live in a far different culture in the
U.S., free from the oppression of limited choice, waiting lists for elective procedures, and less
luxurious accommodations at our health facilities. Purchasing this health will be a unique
challenge for us despite the reasons why we should move in this direction.

- **Internal stakeholders.** Health care providers (institutions and individual providers), governing
boards, employees of provider organizations and investor-owned/operated groups comprise
those parties that are materially affected in the production of health care services. From Crooks’
perspective, providers could be considered the primary stakeholders, for they have the senior
status, the relationship of responsibility for moving the discussion of covenants along. Their
responsibility to the covenant cannot however come from within only. Crooks indicates that all
parties must be party to the covenantal relationship, though she holds that physicians have a
primary and unique responsibility. This may seem an impossible challenge without concomitant
change in the administrative, financial, market, and social pressures that they endure currently. Indeed Kindig (1997) argues that “…improving the public’s health at prices we can afford cannot and will not be achieved until basic financial and managerial mechanisms and incentives are aligned to the measures of health outcomes such as the length of and healthy related quality of life.” (p. 4.)

The fact that the first five leading health indicators, physical activity, overweight and obesity, tobacco use, substance abuse, and responsible sexual behavior are all behaviorally-oriented points to the tremendous challenge that must be embraced by all parties (Healthy People 2010, 2000.

- **External stakeholders.** Employers, insurers (public and private) purchasing cooperatives, managed care organizations, health care network members and external investors comprise those who share payment risk and sometimes participate in care coordination and delivery. These parties have increasingly become concerned with the health of the workforce as an economic good, which makes good sense. In this country however, market pressures force business decisions that require a short- to medium-term view on the future, which focuses necessarily on organization financial condition. Academics have developed convincing arguments that paying for long term health is a better business strategy than short-term fixes. Workforce issues, fluctuations in the economy, and unrelenting pressures in the business model tend to keep most organizations from pursuing this long-term health position.

- **Community stakeholders.** Consumer and community organizations and political leaders can serve either as advocates or stumbling blocks to the effective delivery of health services based on their roles and desires. Special interests, political and other, most often force parties to choose along the constituent’s lines. Such partisan perspective serves the individual or organizational rather than the common good and will not likely be resolved without bold efforts to create a
new and compelling future.

The stakeholders are many and each are impacted in significant and subtle ways though the changing of
the metric of health service delivery evaluation proposed. The federal governments will need to play a
strong role as interested parties in order to fuel the change effort necessary. Strong allies for Crooks’
cause might only be found when the financial incentives that affect the primary purchasers of health
care, governments and in the U.S., employers, are demonstrated to reduce expenses. Weil, Bogue and
Morton (2001) discuss seven strategies for linking performance expectations that hospitals and health
systems can use to enhance community health. The steps of visioning a health community, financing to
promote community health, educating, and inculcating personnel decisions, marketing, structures and
processes to foster community health help keep the service initiatives of the hospital directed toward
the community they serve. The perspective has been long held that value-driven health systems are
grounded in the principle that a healthy population is a paramount social good (The Blue Ridge
Academic Group, 2000.) This key leadership role played by the local health system is an investment in
long-term community health and should be considered.

The idea of resetting the covenantal relationship, a reciprocity between the patient, the provider and the
community as a whole has a desirable feel to it. Crooks’ assessment of the past and present are on
target. Whether we are able to move into such a shared commitment, I feel, may happen in selected
areas first. We may see a European country make a series of changes that moves it closer to such a
vision. We may see success in community coalition efforts in areas of the U.S., building on the
successes of programs like the ones Crooks highlighted. We may see global leadership begin to develop
from pharma and other players with the means and influence to create change. Whatever form it takes,
I believe that we will continue to see some form of Crooks’ thoughts and principles take root. They
have to if our global health is to improve.
References


