2009 Edition

SAMPLE PAGES:
- Table of Contents
- Preface
- 1st page of each chapter

Seeking Justice in Health Care

A Guide for Advocates in Faith Communities

AUTHORS

Kenneth B. Frisof, MD

Linda Hanna Walling, MDiv

Marie Frisof, JD

published by

Faithful Reform in Health Care

Contents

Preface

The 2009 Historical Context

Not all moments in history are equally ripe for change. The devastations of war and economic depression historically have led to the most significant changes in how societies see themselves and how they operate.

The recession that began in December 2007 is predicted to be the most severe economic downturn since the 1930s. Our national leaders are designing, debating and implementing rescue plans and stimulus packages of a scope and size unimaginable even a few years ago. Economists are predicting a prolonged economic crisis if these packages are inadequate.

In the 1930s, health care spending was approximately 1/30th of the national economy. Now it is one-sixth. On a sustained basis, it is impossible to fix the economy without fixing health care.

While health insurance had been initiated in Europe as early as the late 19th century, it took the Great Depression for it to take root in the United States. The current recession offers an opportunity to take additional major steps towards creating a health care system that is efficient, effective and equitable – one that provides everyone in America needed health services at a cost that can be afforded individually and collectively.

Some people say that tight budgets will make reform harder to achieve – that everyone will want to hold on to what they already have. But actually, the reverse is true. Serious financial

threats force individuals, businesses and institutions, and political leaders to think outside the box of political feasibility, to imagine and work for solutions that seemed impossible when the status quo seemed solid. Now there is no status quo. Now is the time for imagination about possibilities for a better health care future.

What will it take to create that health care future – one that includes everyone and works well for all of us? What will make comprehensive, compassionate, and sustainable reform happen? Will it happen in our states, or in steps, or with a single piece of legislation? Who will make the decisions? Who are the opponents and can their opposition be overcome? How much longer will it take?

Obviously, there are no easy answers to these questions. If there were, we could have solved this issue long ago! What we do know is that change is a process that involves visioning, education, dialogue, deliberation, and, ultimately, cultural transformation. We also know that such a process will require participation by both elected leaders and an informed electorate.

Nonetheless, we have a long way to go, particularly if we see our goal as getting all the way to cultural transformation and consolidated institutional change. The 2008 election was a mandate for change, not only in particular policies, but in our national culture and in how we see ourselves as a people. Will this be reflected in health care?

The year 2009 will offer historic opportunities to make progress. This Guide is offered as a resource to help answer the difficult questions and to prepare us for the possibilities and path forward as we continue to seek justice in health care in the United States.

Faith-Inspired Values in U.S. Health Care

A new vision

Few of us would venture out for that perfect vacation without a destination in mind. Instead, we envision the kind of experience we want and ponder the various options to make it real. We talk with family or friends who are taking the trip with us, arrive at consensus about where we want to go and finally make the plans and map the journey. Likewise, in other areas of our lives, we are just as goal-oriented. We've learned that progress forward is much more likely if we set goals, identify objectives to work toward the goals, and keep a clear focus on exactly what we want to accomplish.

In contrast, the history of how health care has evolved in the United States reveals that as a nation we do not have a clear goal that is shared among all those whose voices will be needed to make substantive change possible. Specifically, we have never made a national legislative commitment to a guarantee of needed health care for everyone who lives in the country. As a result, we argue about whether we should increase access, reduce costs, add people or benefits to public programs, increase the percent of the poverty level that should qualify someone for public assistance, set cost controls, and the list goes on *ad nauseum.*

Clearly, the United States' failure to achieve affordable health care for all does not result from a lack of policy creativity. Think tanks and politicians have developed large numbers of thoughtful plans that put the components of financing and delivery together in different ways to achieve their specific and general goals. But we have seen that simply having a plan is not enough.

What we lack is both a vision for where we really want to be and the political will to discern that vision and make it a reality. Some suggest that we simply have not prepared ourselves as a voting public to make such change happen. What we lack is broad and deep participation in the democratic process so that the choices our elected leaders make represent our will and our values.

People of faith can change that! Quite apart from any specific policy proposals, those who really care about this issue can raise their voices for a vision of a health care future that includes everyone and works well for all of us. The shared values that arise from the teachings of our various faith traditions, coupled with our commitments to working for the common good, position us to be leaders in the movement for the social transformation that will be needed.

Toward that end, we begin with identifying our shared faith-inspired values that inform our perspectives on health care reform: compassion, community, stewardship, abundance, generosity, and concern for those who are vulnerable, to name a few. One such set of values has been offered by members of the Faithful Reform in Health Care coalition.[1]

[1] Faithful Reform in Health Care, <http://www.faithfulreform.org>.

Imperatives and Principles for Reform

The moral imperative

The story is told of the Jewish ethicist Abraham Heschel who, as a young child in Poland, was deeply troubled upon hearing the biblical story of Abraham's pending sacrifice of his son Isaac. While listening to the Rabbi's conclusion of the story, he wept aloud. When asked why he was crying, even knowing that Isaac had been saved, Heschel replied: "But Rabbi, supposing the angel had come a second too late…?" The Rabbi comforted him by saying that an angel cannot come too late. Years later, tormented by his moral outrage over the Vietnam War, Heschel remembered his childhood revelation and concluded that "an angel cannot come too late, my friends, but we, made of flesh and blood, may come too late."[2]

The health care crisis in the U.S. points us to the reality that for many in this country we are too late.

- For the estimated 18,000 people in the U.S. who die prematurely each year because they lacked access to the health care they needed,[3] we are too late.
- For the persons with advanced stages of cancer who did not have access to medical care when the lump they discovered was more treatable, we are too late.
- For aging Americans who agonize over the choice between needed prescription drugs and food or heat, we are too late.
- For those whose families struggle in financial ruin because of medical expenses, we are too late.

> If you have a deficiency or challenge in your health, it is a pleasure for a Muslim to serve you. It is a fundamental human right because in the Koran it says that you shall never achieve piety unless you spend what you love most for those who need you.
>
> Dr. Ahmed Moen
> Howard University College of Medicine
> Video, Vision and Voice curriculum

While health care for all has been, and continues to be, debated from a variety of economic and medical perspectives, the moral agenda is unequivocal: Lack of health care for millions of people in the richest nation in the world is a *moral outrage.* As a nation that values the worth and dignity of every human life, we must affirm that sharing responsibility for health care for all is a *moral imperative.*

The tapestry of life in the U.S. is woven with threads that strengthen our constitutional guarantees to "life, liberty and the pursuit of happiness." Our lawmakers regularly approve legislation protecting us, our property and our environment so that we may enjoy the benefits of living in this great country. Our schools prepare us to lead independent and productive lives. The marketplace offers great

[2] Robert McAfee Brown, Saying Yes and Saying No – On Rendering to God and Caesar, The Westminster Press, Philadelphia, 1986, p. 56.
[3] Institute of Medicine, Care without Coverage: Too Little, Too Late, National Academy Press, Washington, DC, 2002, p. 163, Table D.1.

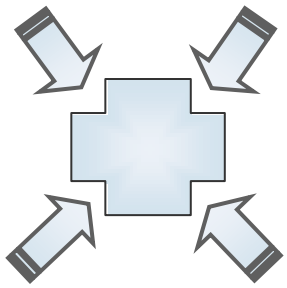
Challenges and Opportunities

Why is health care reform so difficult in the U.S.?

For nearly 100 years the United States has struggled with how to make health care accessible for all of us. Despite the facts that we live sicker and die younger than in other industrialized nations, health care for all in the U.S. still seems an elusive dream. Most of us agree that everyone should have needed health care, but we simply cannot agree on how to make it happen.

Possible reasons for our inability/unwillingness to craft a more just health care system:

1. **The moral dilemma: Am I my brothers' or sisters' keeper?**
2. **Competing goals for reform – to improve access or restrain the growth of costs.**
3. **The marketplace or the government?**
4. **Political partisanship.**
5. **Economic self-interests of key players.**



These competing values and perspectives have been regarded as *challenges* to making health care reform possible. Now, as health care moves to the forefront of our legislative agenda, it is becoming clear that dialogue across ideological divisions and discernment about the strengths and weaknesses of diverse perspectives will present *opportunities* for progress. The synthesis of what were once competing values can provide important insights into possible paths into our health care future.

1 The moral dilemma. The underlying challenge in our on-going struggle to reform U.S. health care is the absence of a strongly articulated moral vision. Without a guiding *moral imperative for affordable quality health care for all,* reform efforts remain locked in conflict over competing views of who we are as a nation and where our responsibilities lie in caring for those who live within our borders.

At the core of the debate is the age-old moral dilemma: Am I my brother's or sister's keeper? Are we all responsible for making health care accessible to everyone? Or is health care an individual responsibility? Since the beginning of human history, we have questioned just how much responsibility we have for one another. Some even ponder whether we have any responsibility at all to care for anyone but ourselves and our loved ones. The question of social responsibility is particularly challenging in a country that exalts rugged individualism. Our delight in rags-to-riches stories and our admiration of those who succeed in spite of insurmountable obstacles are woven into the fabric of American life.

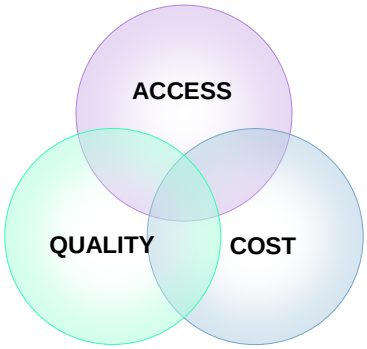
The question of responsibility for one another is repeated in every generation and time when the need for social reform emerges. Our country's health care crisis sets the stage for posing that question now: **Are we responsible for making health care accessible to everyone?**

Delivering Value and Values in U.S. Health Care

Introduction

As described in the previous chapter, the debate over expanding access and containing costs while improving quality has been a significant obstacle in the path to reform. Those concerned about justice need to pay attention, not just to equity in financing health care, but also to how health care is delivered. This chapter provides a perspective on key issues in health care delivery, beginning with an overview of how our delivery system evolved, and concluding with the current state of health care delivery in the United States.

HEALTH CARE DELIVERY



To organize the analysis of how to reform health care delivery, we are utilizing the access-cost-quality diagram to illustrate that these three spheres in our delivery system are in constant interaction with one another, or to use another metaphor, "inextricably intertwined."

Some examples of these interactions include:

- Low quality care causes a higher than necessary rate of complications and consequently higher costs. Inadequate access leads to poorer outcomes and lower quality.
- The cost of providing services of little value makes insurance less affordable and decreases access.
- In this century, a lot of attention has been paid to the data that conclusively demonstrates that higher cost does not guarantee better quality or better outcomes. Indeed, there is often an inverse relationship between cost and quality.

Legislative proposals focused exclusively on "fixing" just one of the spheres risk having unintended consequences on the other two. Comprehensive reform, by definition, will make it necessary to consider not only improvements in access, cost, and quality, but also the benefits and consequences of how they intersect with each other.

Insuring U.S. Health Care

Historical Overview

1776 – 1920s: Pre-Insurance: Out-of-pocket payments prevailed

The vast majority of payment for health care came directly from the pockets of patients – sometimes in cash, sometimes in goods, sometimes immediately, sometimes later. Doctors made house calls; fees were negotiated between the doctor and the patient. For those who were poor, local governments and religious organizations set up systems of charity care.

1930s – 40s: Private insurance was born; employers began to offer health benefits

Hospitals rose in importance and medical care was institutionalized. Private insurance emerged as the dominant payer for health care due to four influences: advances in medical technology, hard times during the Great Depression, the growing influence of organized labor, and the political recognition of the importance of security (fueled by the 1935 Social Security Act). Employer-sponsored health insurance surfaced during the World War II wage freeze and became a means by which employers could entice new workers with benefits rather than pay increases.

Mid-1960s: Public insurance was passed as another source of access to care

In 1965, two forms of public insurance were added to the Social Security Act: 1) Medicare for the elderly, and 2) Medicaid for those who are poor. Expanded and modified since their inception, both programs increased the role of both federal and state governments and the use of public money in making health care accessible for particular populations.

1990s: Managed care experiment failed; costs continued to escalate

It became clear the grand managed care, experiment, originally seen as a panacea for addressing escalating health care costs, was not a sustainable solution for addressing costs. Insurance premiums, services, prescription drugs, and medical supplies continued to rise. In 1997 the State Children's Health Insurance Program expanded public insurance to include more children in working families with low incomes.

2000s: Political environment favorable to undermining public insurance

The early 21st Century ushered in a political environment which presented a threat to the future and sustainability of both Medicare and Medicaid. The "modernization and improvement" of Medicare in 2003 provided more access to prescription drugs for the elderly, *and* set the stage for moving beneficiaries from traditional Medicare into private-for-profit insurance plans. Opponents of Medicaid were able to temporarily derail the re-authorization of the State Children's Health Insurance Program.

The Present: Recession; soaring costs, unaffordable insurance premiums

The annual premium for a family of four often equals or exceeds the salary of full-time minimum wage workers. More employers are dropping coverage for workers because of the strain on their human resources budgets. Others are shifting more health care costs to workers by increasing the worker share of premiums, raising deductibles, increasing co-pays, and/or reducing benefits. Publicly-funded insurance programs are being stretched as costs continue to escalate, businesses struggle or fail, and workers lose their jobs and employment-based insurance.

Making Change Happen in U.S. Health Care

Introduction

What will it take to improve health care in the U.S. to create systems of health care financing and delivery that are just, efficient, and sustainable?

- Will it happen through a single piece of federal legislation?
- Will it take a number of smaller steps?
- At what level(s) of government does reform need to take place?
- What steps move us in the right direction and what steps in the wrong direction?
- Which interest groups need to be on board?
- Whose opposition can be overcome?
- *How much longer will it take?*

There are no easy answers to these questions. Differences of opinion stem from usually unspoken, and often unconscious, differences in perspective on how the U.S. political system works and where we are in the "life-cycle" of health care reform as a policy issue.

This chapter does not purport to give **the** correct answer to these questions, but to help those seeking justice in health care better understand the challenges of making change.

Who makes change?

Citizens or organized special interests?

In theory, in a democracy, the laws and policies of the land are supposed to reflect accurately the desires of voting citizens.

In practice, the influence and power of organized groups play a key role in determining which issues are brought up for legislative consideration, how they are framed, and what the outcomes are.

No issue demonstrates the contradiction between theory and practice more vividly than health care.