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**SAMPLER**

# Seeking Justice in Health Care



## A GUIDE for Advocates in Faith Communities

Linda Hanna Walling, MDiv  
Kenneth B. Frisof, MD  
Marie Frisof, JD

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## The 2010 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 has been the most severe economic downturn since the 1930s. Our national leaders implemented rescue plans and stimulus packages of a scope and size unimaginable even a few years ago.

In the 1930s, health care spending was approximately 1/30<sup>th</sup> 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 19<sup>th</sup> century, it took the Great Depression for it to take root in the United States. The current recession offered 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. 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.

The 2009-2010 battle over health care has been a monumental political, policy and financial struggle. President Obama learned the lessons of President Clinton's failed effort and insisted that the legislation be crafted in Congress. The Republicans sought to repeat their political success of 1994 through a "just say no" strategy. The financial crisis and budget deficits presented obstacles to major new public spending on health care.

What emerged was an omnibus bill, a complex package consisting of hundreds of separate yet often interlocking pieces. The signal accomplishment is health insurance reform, a reduction in the number of uninsured to less than 5% of the population. Health care delivery reform to improve value and constrain the growth of costs, is handled more indirectly and is less assured of success. Deliberation in health care over its nature and purpose, over the distribution of costs and benefits, and over its size in the economy will be ongoing.

The complex health insurance and health care reform passed in March 2010 was an important step that provides major opportunities to make progress. But there still are many challenges and obstacles in the path.

This Guide is offered as a resource to help answer the difficult questions and to help us make the best decisions as we continue to seek justice in health care in the United States.

# Preface to the First Edition

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## **“I know our health system is sick, but I don’t know what to do about it. And I sure couldn’t explain it.”**

It was such an expression of frustration that triggered the development of the First Edition (2004) of *SEEKING JUSTICE IN HEALTH CARE JUSTICE: A Guide for Advocates in Faith Communities*. Advisers to the Cuyahoga County (Cleveland, OH) Faith Project of the Universal Health Care Action Network (UHCAN) were contemplating a Speakers Bureau. Though participants were committed and willing to address groups, they felt overwhelmed by the complexity of health care issues in the U.S.

*How did we get here?*

*Doesn’t Medicaid cover people without insurance?*

*Why do prescription drugs cost so much?*

*Can anyone who really wants health insurance get it?*

*If we have “the best”, why are so many people left out?*

Simple questions. Not so simple answers. This *Guide* gives a basic overview of U.S. health care in user-friendly language. It is not meant as a textbook or a comprehensive discussion of health policy. It is meant to help faith leaders grow in their understanding of health delivery in our country.

In addition to information, this *Guide* offers a measurement by which to evaluate the system and proposals for change.

*What would a fair system that provides good health outcomes look like?*

*How can the needs of patients, providers and payers be met most fairly?*

*What stands in the way of a more just system?*

In short, the *Guide* hopes to provoke thinking in the direction of right relationships – justice.

Once knowing the difference between what *is* and what *could be*, users of the *Guide* hopefully will be led to action. Some may pursue more in-depth information, others will share what they have learned with others. Some may follow legislative proposals or write letters to the editor or contact elected officials. All hopefully will be motivated to act and to feel more comfortable making their own health care decisions.

In compiling this book, the editors have endeavored to be inclusive. Sources include literature in the medical, economics and health policy fields as well as the teachings of the major religions in the United States. Moreover, the life experiences of those impacted by the health system were considered. Real life stories of people serving in the system and those underserved by the system were part of the input. Indeed, it is those stories that most clearly point out the challenges to justice as health care delivery exists today.

This *Guide* is offered out of a passion for justice and in the hope that those who use it will be empowered to work for access to comprehensive and affordable quality health care for all.

# Introduction: Seeking Justice in Health Care

Imagine the U.S. health care system as an old family homestead. First built in the mid-1800s as a comfortable dwelling, it is now a structure with an aging foundation, drafty rooms, squeaky floors, peeling paint, broken windows, and leaky roof. Its demands exceed the family's resources to keep it in pristine condition.

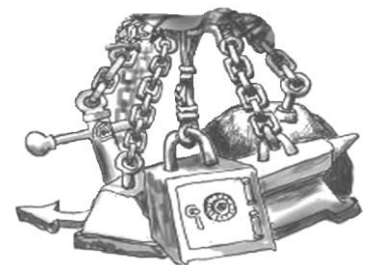
This house was assembled slowly over 150 years, evolving into a complex jumble of laws, policies, traditions, programs, practices, technologies, and bureaucracies – some of which were neither designed nor intended to work together. We have tinkered with it, painted it, replaced the roof, and updated the plumbing and the wiring. We have even remodeled it and added rooms as the needs of the family changed. But we have never had family agreement around a new design that would better meet our needs and consume a more reasonable portion of our money, time, and energy.

Imagine now that this house – the U.S. health care system – is collapsing. Yes, some of the rooms are still quite habitable, even comfortable to many in the family. But others find the house a disgrace; some feel insecure in it; some don't find it to be very welcoming; some have been injured by it; and, even as big as it is, some have no place in it.

If we look deeper, we find that this reality is not just about an expensive and deteriorating house, but about how the chaos of its construction and maintenance causes great harm to the millions of family members who call it home – and to those who remain outside. It results in widespread and deep human and social suffering.

Even so, this structure is deeply anchored in our society. Our culture has broadly accepted the status quo, fearful that change could be worse than the present reality. Our entrenched institutions worry about the impact of pulling up the anchor. Our laws validate its presence and impact.

**Seeking justice in health care and moving into a health care future that includes everyone and works well for all of us demands that we not only remodel or rebuild the house, but also address its role in perpetuating “chronic social injustice.”**



# Chapter 1

# Faith-Inspired Values in U.S. Health Care

## A new vision

Effective and sustainable solutions for addressing the difficulties and injustices in U.S. health care require grounding in a meaningful vision based in values that are broadly shared throughout the society. The history of how health care has evolved in the United States reveals that 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 have argued 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 more.

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 have been a part of changing that! Quite apart from any specific policy proposals, those who really care about this issue have raised 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 have identified 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.<sup>1</sup>



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

## Chapter 2

# Imperatives & Principles for U.S. Health Care

### 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."<sup>2</sup>*



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

- For the estimated 45,000 people in the U.S. who die prematurely each year because they lack access to the health care they needed,<sup>3</sup> we have been 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 have been too late.
- For aging Americans who agonize over the choice between needed prescription drugs and food or heat, we have been too late..
- For those whose families struggle in financial ruin because of medical expenses, we have been 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

<sup>2</sup> Robert McAfee Brown, *Saying Yes and Saying No – On Rendering to God and Caesar*, The Westminster Press, Philadelphia, 1986, p. 56.

<sup>3</sup> Harvard Medical School and Cambridge Health Alliance, *New study finds 45,000 deaths annually linked to lack of health coverage*, September 17, 2009, <http://www.harvardscience.harvard.edu>.



## Chapter 3

# Transforming U.S. Health Care

# 2010

The United States' century long struggle to enact affordable quality health care for all has not been a result of a lack of policy creativity. Rather, it has reflected failures of moral vision and political will.

President Obama was elected with a commitment to change the way politics is practiced in Washington DC, and to move beyond the gridlock of stale partisan ideologies of past decades. The depth of the Great Recession reinforced in public opinion a need for major change. It was evident to many, but not all, that measures to increase coverage needed to be part of the short-term economic recovery, and that comprehensive reform would be essential to long-term national economic health.

President Obama set out on the path of comprehensive reform in early 2009 having learned one of the key lessons of the political failure of national health reform in the Clinton Presidency. Rather than design it in the Executive Branch and present it to Congress for “ratification.” President Obama insisted that the legislation emerge from Congress, with policy and political coordination with the White House.

We began this round of legislative activity with the recognition that the proposal would have to address a comprehensive array of issues which could be organized into four big categories:

**Increase coverage | Improve quality | Improve value | Coordinate governance**

Subcommittee and committee deliberations in both the House and Senate, including hundreds of amendments by dozens of members of both parties addressed these issues.

The original goal of passage of a bill in the latter half of 2009 was not met. The leadership of the Republican Party chose to follow the partisan political strategy that was so successful in 1994 – “just say no.” With an inability to reach the broad bipartisanship that the President sought, months were spent in the Senate with a small number of Republicans who had committed to open-mindedness and policy flexibility, to assure at least some degree of bipartisanship, which in the end was unfruitful. In addition, grassroots energy that was broadly anti-Obama, but specifically focused on the current hot issue of health care reform, emerged in the summer of 2009.

In contrast, there was much less obvious opposition from stakeholder groups, many of whom signed pledges of support early in the process. They made broad commitments to reductions in revenues in some areas in return for guarantees of favorable treatment in others.

While the House version of comprehensive reform was passed on November 7, 2009, the Senate bill was not passed until December 24, 2009. The election of an anti-reform Republican from Massachusetts to the seat Senator Ted Kennedy had held for nearly four decades slowed progress at the beginning of 2010. Finally, the Democratic leadership unified around a two-part legislative strategy that included House support of the Senate bill as passed in December, followed by a set of revisions agreed on in advance that

# Chapter 4

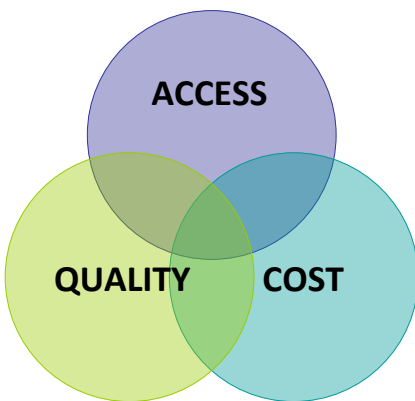
# Delivering Value & Values in U.S. Health Care

## 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



**Health care delivery consists of three spheres that are in constant interaction with each other – access, cost, and quality.**

**Legislative provisions focused exclusively on “fixing” just one of the spheres risk unintended consequences in the other two.**

**Comprehensive reform, by definition, makes it necessary to consider not only improvements in each sphere, but also the benefits and consequences of how they intersect and interact with each other.**

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.
- The requirement that insurance companies eliminate the practice of excluding persons with pre-existing conditions could result in higher premiums for everyone without maximizing the size of the risk pool by requiring that all persons have insurance.

# Chapter 5

# Insuring U.S. Health Care 2010 and beyond

## 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, after all. 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 21<sup>st</sup> 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.

# Chapter 6

# Transforming our thinking about health care

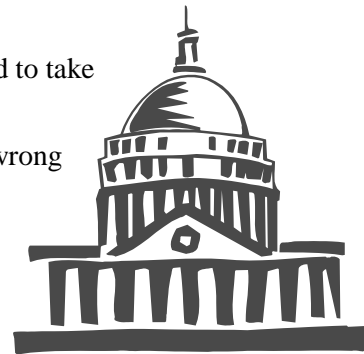
## Introduction

Congress passed and the President signed landmark legislation to reform health care in the United States. But there is no one who believes that the bill signed on March 23, 2010 marks the end to the debate about the shape of our health care future.

Rather, everyone understands that the health care bill was just a first step. The curious thing is that there are so many views about the direction of this initial step. For some, the new law offers a comprehensive blueprint that, when implemented, will create a very workable system of health care for almost everyone in the United States. Others see the new law as a tiny step in the right direction, with giant steps to follow at a later date. Others believe the legislation simply tinkered with what's broken with little hope that a major renovation is even possible. And, still others see the law as a step in the wrong direction, an untenable stretch for the federal government that must be undone.

### **What will it take to move us toward agreement about creating systems of health care delivery and financing that are truly inclusive, affordable, accessible, and accountable?**

- ? Will it happen through additional pieces of federal or state legislation?
- ? Will it take a number of smaller steps?
- ? At what level(s) of government does comprehensive 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 to fulfill our Vision?*



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, where we are in the “life-cycle” of health care reform as a policy concern – and where we are in the process of transforming our public conscience around this issue of social justice.

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 and possibilities for making change happen.