Just then a lawyer stood up to test Jesus. "Teacher," he said, "what must I do to inherit eternal life?" He said to him, "What is written in the law? What do you read there?" He answered, "You shall love the Lord your God with all your heart, and with all your soul, and with all your strength, and with all your mind; and your neighbor as yourself." And he said to him, "You have given the right answer; do this, and you will live."—Luke 10:25-28

...Do This and You Will Live

A Justice Framework for Health Care

a publication by the Texas Impact Education Fund

Faith communities are deeply involved in health care. Religious groups founded many of the hospital systems in the U.S. and Texas. Congregations and local religious groups have been major providers of care for the poor, as well as providing insurance for their employees.

There are many suggested reforms for the American health care system. Before we can evaluate reform ideas, we must identify goals for the system. As we discuss problems with the current health care system and possible goals for a reformed system, it is important for religious communities to reflect on scriptural interpretations of justice and the importance our faith traditions place on human health.

How are you feeling today?

- *Maybe you ran five miles...or maybe a health condition keeps you from being active.*
- *Maybe you had a full physical and a clean bill of health, or maybe you didn't get a physical because you're worried something is wrong.*
- *Maybe your own health is fine, but you have a loved one who is seriously ill.*
- *Maybe a co-worker's chronic illness is causing you more work and stress.*
- *Maybe an outbreak of flu in your community is leading to longer waits at the emergency room.*
- *Whether we feel fit as a fiddle or under the weather, we all live within the limits health gives us—our own health and the health of others.*

Health isn't important only because of what it lets us do. Scriptures tell us that God made people in God's image, and that we are to treat our bodies as temples. This means that as individuals we are each responsible for taking care of the wonderful body God has given us in every way we can, including exercising, eating healthy food, and maintaining proper hygiene. It also means that collectively we must be concerned for the health of every member of our community.

Because health is so important to us, we invest a lot in it.

We respect health care providers and believe they should be compensated well for their skills.

We prize advances in technology and science that offer new ways to keep people healthy or alleviate suffering.

We dedicate public funds to provide health care for those who can't afford it so that the whole community can stay healthy.

Increasingly, there is concern that as Americans and Texans, we are not investing in health care as effectively as we could be. While no health care system will ever be perfect, we should be sure that we are using resources as wisely as possible and taking as good care of each other as possible.

Health and Faith Communities

Communities of faith in the U.S. and globally are health care leaders. Religious orders and denominations founded many of the hospitals, universities and other institutions that form our health infrastructure. Tithes and offerings of people of faith support care for those who can't afford it, and religious missionaries crisscross the globe providing health services to the human community.

Religious teachings concerning health include the affirmations that God cares for our physical being; that care for our bodies is one important form of worship; and that meeting the health care needs of God's children is an important charity. Many of Jesus' miracles center on healing, and the Jewish scholar Maimonides called the provision of health care an obligation for society. Alleviating suffering is a high calling. As the practice of medicine and our health care infrastructure have become increasingly complex, faith communities have been called to respond to ethical questions regarding treatment options; the role of families and community members as caregivers; and the responsibility each individual bears for their own health.

But all of these historic intersections between faith communities and health revolve around "charity"—the actions we take as individuals and communities to "make up" for inequities in our systems and relationships. In the Abrahamic tradition, charity as a responsibility of the life of faith stands distinct from another equally important responsibility to "do justice" by reforming systems and relationships to reduce inequities in the distribution of resources and balance power among all the members of the community.

Providing health care was not just an obligation for the patient and the doctor, but for society as well. It is for this reason that health care is listed first by Maimonides on his list of the ten most important communal services that had to be offered by a city to its residents. (Mishneh Torah, Sefer Hamadda IV:23)

Today in Texas and the U.S., the foundational questions regarding health care are questions of justice: Is health care an optional commodity, a necessity, or a right? Should all people have access to the exact same level of care in every situation? Should resources be distributed within the community to ensure that all members of the community receive the same quality of goods and services? Who gets to decide?

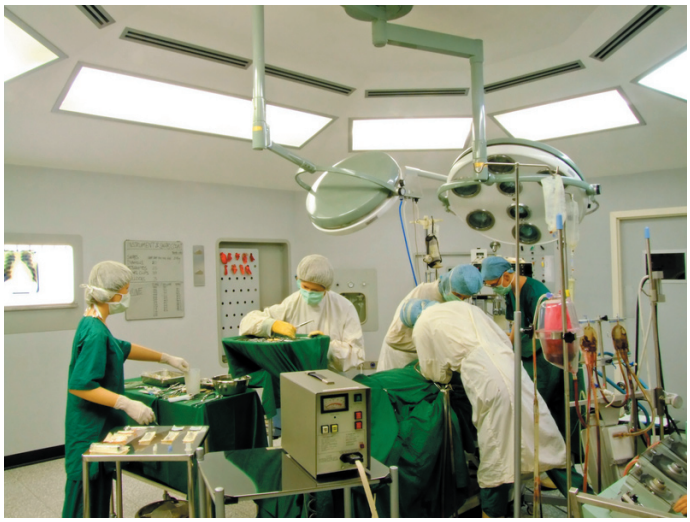
All these questions at bottom relate to the core issue of ***just***

distribution of scarce resources. If resources were infinite, everyone could have everything they want all the time—but because they are limited, we must develop systems as a community to ensure that resourcess are divided in ways that meet our collective and individual needs without unduly burdening some members of the community. In the area of health care, justice questions are primarily questions of health care finance.

A System in Crisis

There is broad agreement among politicians, academics, providers, and the public that the American health care finance system is in a state of crisis that is getting worse despite government and private-sector attempts to stabilize it.

Comparative international data show that Americans spend more on health care overall than residents of other countries, but receive less health care per capita than residents of other countries. The U.S. is the only nation in both the 24-nation Organization for Economic Cooperation and Development and NATO that does not provide some level of health insurance for all its citizens.



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Compared to other countries, especially considering our relative wealth as a nation, a large share of Americans have "insecure access" to health care services, meaning that either they can't afford care or that there are few or no providers where they live. And even Americans who have health insurance or can afford to pay for care are subject to systemic shortages and failures. For example, patients with insurance can be turned away at the emergency room because it is full of uninsured people seeking care for non-emergency problems.

Texas looms large in consideration of the U.S. health care system, because Texas is home to a disproportionate share of Americans who have insecure access to health care. If the health care finance system in the U.S. improved access to health care, Texans would benefit disproportionately.

An Insurance-Based System

Most health care spending in the U.S. and other industrialized nations is in the form of insurance, even when the government is purchasing the care. While there is some direct spending on health care by individuals and the government, most spending comes in the form of insurance premiums.

Most people in the U.S. and Texas have health insurance that pays some or all of the cost when they use healthcare-related goods or services. According to the Kaiser Family Foundation's analysis of data from the U.S. Census Bureau's 2007 Current Population Survey, about 83 percent of Americans under 65—216 million out of 261 million—have health insurance of some kind, and almost 72 percent of Texans under 65—15 million out of 21 million—have health insurance of some kind.

Financing health care through insurance pools the cost of care for a whole community. Instead of risking personal or household catastrophic financial loss, each individual in the group pays a set amount to help cover whatever costs arise in the community. A patient with insurance does not have to consider how much a service costs, beyond any co-payment they might owe, before deciding to seek treatment. Likewise, a doctor or other provider does not need to consider whether a patient can afford a particular treatment before prescribing it.

The majority of Americans under 65 who have health insurance, have "employer-sponsored" insurance. That means that an employer—either their own or that of someone they are related to—negotiates an insurance plan on their behalf, and in many cases pays some or all of the cost of the plan. About 61 percent of Americans under 65 (159 million) and 52 percent of Texans under 65 (11 million) have employer-sponsored insurance.

About 25 percent, or 76 million, Americans have insurance through a state or federal government program that covers people who are deemed to be especially needy, because they are poor or elderly, have exceptional healthcare needs, or a combination of the three. About 24 percent of Texans, or 5.6 million, are covered through a state or federal program.

The state of Texas buys health care or health insurance for millions of Texans through dozens of programs including state employee insurance, prison health care, and various programs for people with extreme medical needs and/or low income. For the 2008-2009 biennium, Texas appropriated nearly $40 billion for Medicaid, the state-federal partnership program that primarily serves children in low-income families, people with disabilities, and seniors who need long-term care. Texas appropriated about $2 billion for the Children's Health Insurance

Program (CHIP) for the same time period.

As in other states, most of Texas' state health care spending is in the form of health insurance premiums rather than direct health care services. The future of Texas' health care spending—and thus the state budget—will therefore be dependent to a large extent on national decisions regarding the overall health insurance system.

How We Got Here

Until the beginning of the 20th century, health insurance in every country where it existed was part of an overall system of income support. Medical costs were not very high because treatment options were limited; however, lost wages due to illness and injury were a real threat to individual households and general economic stability.

Before the industrial revolution, "friendly societies," guilds, and other trade associations provided wage replacement for sick days through member dues. These associations were quite extensive in Europe and much less so in the U.S.

After the industrial revolution, workers in European countries demanded comprehensive systems of income support as part of the Socialist movement. In 1888, Germany became the first country to establish a national health insurance program. The program included wage replacement as well as covering some costs of medical care. It initially applied only to workers themselves and gradually expanded to include their families and then other population groups. Other European countries followed; by the start of World War I, all the major European countries had national insurance programs.

In the U.S., guild-sponsored programs were not well-developed. There were a few isolated examples of employer-sponsored health care programs, notably company doctor programs for miners and timber workers in the American West, but health insurance was essentially unheard of for the American public.

In the late 1800s, American Progressives followed the lead of European workers and socialist activists in calling on Congress to enact legislation guaranteeing worker rights and a government-sponsored system of income supports. The Progressives achieved a workers' compensation program before the start of World War I. In the isolationist environment after the start of the war, however, social insurance programs, like other "foreign" ideas, became suspect. Movement toward a broad American health insurance system stagnated.

During the first two decades of the 20th century, medical costs rose dramatically because of advances in medicine leading to increasing hospitalizations and more expensive diagnostic procedures. When the Great Depression suddenly reduced the overall resources available to pay for health care, doctors suffered from high levels of bad debt, and hospitals were left with empty beds and unstable revenues.

One such struggling hospital—Baylor Hospital in Waco, Texas—established a prepaid hospitalization plan for employees of the Dallas Independent School District. This plan formed the seed of what eventually became known as Blue Cross, and Blue Cross plans sprang up quickly around the country.

Within a decade of Blue Cross' establishment, the U.S. had entered World War II. Blue Cross lobbied successfully to have health insurance benefits exempted from wartime wage controls, so employers began to pay for employees' health insurance premiums as a substitute for raising their wages. After the war, employer-paid health plans became ubiquitous. In 1940 only nine percent of Americans had hospital insurance; by 1966, more than 80 percent were covered.

Thus, when Congress returned to the question of income supports and social insurance, workers—who were the original target of health insurance in Europe—were largely covered through private insurance, with the uninsured being primarily individuals who did not have access to employer-sponsored coverage: the elderly, people with disabilities, and the poor.

In 1965, Congress acted to cover the elderly through Medicare, and people with disabilities and the poor through Medicaid. Since then, Congress has expanded Medicare and Medicaid to cover more individuals and established the State Children's Health Insurance Program for children in low and moderate-income families. At the same time, however, changes in the economy such as growth in part-time and temporary jobs have diminished the availability of employer-sponsored coverage.

Throughout the 20th century health care costs continued to rise, fueled by advances in medicine and by increased utilization stemming, at least in some measure, from the incentives associated with insurance. The cost of establishing a national health care system today would be much greater than the cost would have been of establishing one early in the 20th century.

When The System Fails

If you are an able-bodied Texan under the age of 65, the odds are about one in four that you will go at least part of this year without health insurance, according to the most recent U.S. Census data available. Your chances of being uninsured are higher than they would be in any other state in the U.S.

If you do not have health insurance and you get sick, at a minimum your illness could pose a financial hardship for you. Because private insurance is the backbone of the American health care finance system, your lack of insurance might also have larger ramifications for the stability of your community's health care infrastructure.

Although your chances of being an uninsured American are highest if you live in Texas, Americans in general are more likely than people in many other countries to lack health coverage. This means that Americans as a group have less secure access to health care than people in other countries, even though high quality care is available throughout the U.S.

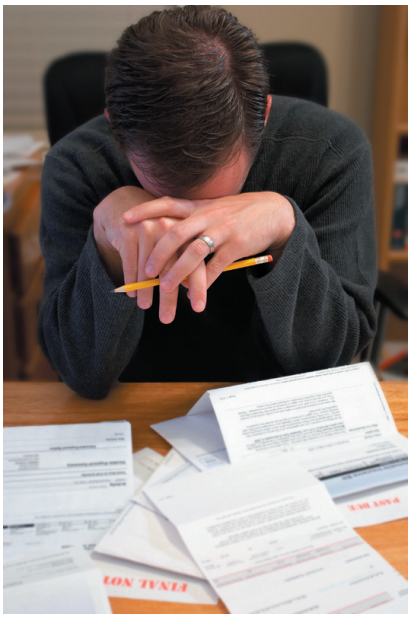
About 17 percent of Americans under 65 and about 28 percent of Texans under 65 were uninsured for at least part of the year during 2007. Texans have a higher rate of uninsurance than other Americans, especially for children. About 11 percent of American children were uninsured for at least part of 2007, compared to more than 22 percent of Texas children.

Texans account for about eight percent of all Americans under age 65, but nearly 13 percent of *uninsured* Americans in that age group. Because Texas has such a large population and such a high uninsured rate, Texas statistics skew those for the country as a whole. If Texas' uninsured rate were equal to the average of the other 49 states, the country's overall uninsured rate would significantly reduced and would be about one point lower than it is now.

Americans are most likely to be insured if they live in a family where at least one member has a full-time, full-year job. The kind of job and how much it pays are also important. Jobs that pay higher salaries are more likely to come with insurance in most cases, although certain kinds of occupations such as construction do not typically include insurance even though they pay well. Food service jobs are the least likely to offer health insurance. Employers with more than 200 employers and public sector employers are much more likely than are small, private employers to offer insurance coverage.

Race/ethnicity is a factor in predicting insurance status. In Texas, Hispanics are much more likely to be uninsured than other race/ethnic groups.

Although the extent of uninsurance in the U.S. is increasingly well-documented, there are significant differences of opinion about how big a problem lack of insurance actually is. To help develop a national consensus on the issue, the National Institute of Medicine in 2000 launched a multi-year project to "evaluate and consolidate our knowledge about the causes and consequences of lacking health insurance."



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Individual Health

Research has shown repeatedly that individuals without health insurance receive less care than do their insured counterparts. In particular, the uninsured are less likely to manage chronic conditions and illnesses effectively and they are more likely to wait to seek care, so that minor and manageable conditions become major problems.

Family Wellbeing

Lack of insurance has ramifications for families where one or more members are uninsured. Recent research has focused on the consequences for children—even if they have insurance—if their parents are uninsured.

A number of studies reviewed by the Institute show that a child's use of health care services typically corresponds to her parents'. Even if the child has health insurance, she still depends on her parent to take her to the doctor. Research shows that a parent who does not use health care services herself will be less likely to take her child for health care.

Uninsured parents, like other uninsured adults, are likely to delay treatment and forgo management of chronic conditions. They therefore can face increased stresses in providing for their children. Parents may lose income because of a preventable disability, or be unable to attend to their children's physical needs because of poor health.

Community Stability

High rates of uninsurance have destabilizing effects on the health care infrastructure of a local community. One of the most severe and increasingly well documented of these effects concerns availability of emergency room services.

Pervasive lack of insurance can also lead to shortages in health care personnel, because health care professionals cannot afford to practice in areas where there are no payors.

Health and Justice

If modern medicine did not exist, no one would claim a "right" to it. But since it does, and since Americans have decided that it is valuable enough to us as a community to mandate investment of public dollars, then it is only just that everyone in the community benefit equally from the publicly supported resource. Under the current health care finance system in the U.S., nearly all Americans pay into the system, not all Americans have equal access to the system, and the contributions of each individual are not related to their consumption of health care, their need for services, or their ability to pay.

On one occasion an expert in the law stood up to test Jesus. "Teacher," he asked, "what must I do to inherit eternal life?" "What is written in the Law?" he replied. "How do you read it?" He answered: " 'Love the Lord your God with all your heart and with all your soul and with all your strength and with all your mind'; and, 'Love your neighbor as yourself.'" "You have answered correctly," Jesus replied. "Do this and you will live."
—Luke 10: 25-28

It would not be just, however, to step back from public investment and declare health care a "luxury" with no public subsidy, available for purchase only for those who can afford it. In modern times medicine has developed practices and infrastructure that materially affect people's opportunity for self-determination—for example, children who don't get the same health care as others have different educational outcomes that impact their ability to support themselves in adulthood. Thus, if any child has access to health care that reasonably could be made available to all, then restricting access to care

creates inequality of opportunity.

Currently, everyone in the U.S. who pays taxes, pays for health coverage—if not for themselves, then for someone else. Health insurance premiums paid by employers are not subject to income taxes, so income taxes for all must be higher to offset the benefit to those with employer-sponsored coverage. Tax dollars also go towards providing health coverage for public employees and certain categories of needy individuals through programs like Medicaid, and to to subsidize health services directly through public hospitals and clinics.

American taxpayers spent as much as $200 billion in 2007 to subsidize the purchase of employer-sponsored health insurance. Both workers and employers benefit from this subsidy, which exempts premium contributions from income and payroll taxes. Workers whose employers do not offer health insurance—or who are offered coverage but cannot afford to pay the premium—must pay taxes to subsidize the health coverage of higher-wage workers who are offered employer-sponsored coverage and can afford to accept it.

The self-employed may deduct their health insurance premiums from income tax, but not payroll tax, if they do not have access to an employer-sponsored plan. In addition to the tax subsidy for employer-sponsored coverage and coverage purchased by self-employed workers, the government subsidizes individuals with health care expenses exceeding 7.5 percent of their adjusted gross income by allowing these individuals to deduct their health costs (including premiums) on their tax returns.

All taxpayers chip in for the health insurance that is provided to state, local and federal employees, from the local county clerk to the President of the United States. These payments are usually counted in the category of employer-sponsored private coverage (government as 'employer'), but they also constitute a form of public, state-sponsored health coverage.

Tax dollars go towards purchasing health care for prisoners—the only Americans with a legally defined "right" to health care. Tax dollars foot the bill for health coverage for military personnel, as well as individuals who qualify for Medicare, Medicaid, SCHIP and other means-tested programs. College students at public universities who are offered subsidized health insurance also receive this benefit through state dollars. Thus, individuals who fall into specific categories or meet established eligibility criteria are awarded health coverage that all taxpayers buy.

Large government grants go towards financing research, technology development, and other advances in health care. For example, all taxpayers support breast cancer research, from those in the lowest income bracket to those in the highest income bracket. Yet when new findings lead to the development of new treatments, only those taxpayers who can afford it will benefit.

Reforming the System

A number of proposals have been put forward to reform the U.S. health care finance system. Reform proposals are likely to increase in number and in inventiveness as health care costs and quality continue to be major concerns for Americans.

For people of faith, the central question around health care reform must be justice: Do the proposed reforms balance both the distribution of health care resources and the responsibility for funding them? For Texans, the central question about national reform proposals should be the extent to which suggested reforms address the unique issues that leave Texans so disproportionately uninsured.

Expanding Coverage

Most major health care reform plans focus on expanding coverage to some or all of the people who aren't covered currently. Proposals to increase the number of insured people have two options: they can propose to cover everyone with benefits similar to a "typical" plan such as a large employer might offer, or they can propose covering more people but changing the nature of the insurance package. For instance, a proposal could suggest covering only certain kinds of health care services such as hospitalization, but covering them for everyone in the population.

Some people say that the primary goal of insurance reform should be to provide some minimal level of coverage for everyone such as "catastrophic coverage" that doesn't cover most routine problems but protects the bearer from the high cost of a hospital stay or expensive course of drugs. Others would argue that health coverage must be comprehensive because if people skip preventive services that aren't covered, they will experience more frequent catastrophic health episodes and end up costing the system more in the end.

Expanding Private Programs

Strategies for increasing coverage in the private market can encourage or require employers to provide insurance for their employees, or they can encourage or require individuals to be insured—if not through an employer then through an individual plan they purchase directly from an insurer.

Tax credits are one popular proposal for increasing coverage through the private market. Tax credits can apply to employers or to individuals, and they have can be applicable to the purchase of any qualified insurance plan, so consumers can make choices.

Some people argue that mandating coverage is a bad idea that would distort the economy. For example, in a state like Texas, more employers than the national average are accustomed to not providing coverage to employees. If those employers were suddenly required to sponsor groups insurance, some people argue that employers might move away or cut jobs. Mandating individual coverage strikes many people as an unwarranted government intrusion into private life.

Expanding Public Programs

Some reform proposals focus on expanding Medicaid, Medicare and the Children's Health Insurance Program (CHIP) to cover new groups of people or to cover the same groups at higher income levels. Expanding public programs without requiring cost-sharing would require increased tax expenditures.

"Buy-in" options are popular proposals to expand public programs. Buy-in programs allow people who aren't eligible for publicly funded coverage to pay to join the program. A buy-in can be an effective way to cover all the members of a family where only some of the members are eligible for public coverage. However, many people argue that for families below certain income thresholds, even a modest buy-in cost may be enough to discourage participation.

Texas has one of the nation's least generous Medicaid programs; there are many uninsured Texans who would be covered under Medicaid if they lived in a different state. If Congress expanded Medicaid to cover more population groups but left states significant discretion as to how many of the new groups to fund, Texans might still be disproportionately uninsured. If Congress expanded Medicaid at the federal level and left states little discretion, Texas would face sudden disproportionate new costs.

I do not mean that there should be relief for others and pressure on you, but it is a question of a fair balance between your present abundance and their need, so that their abundance may be for your need, in order that there may be a fair balance. —II Corinthians 8:13-14

Creating New Programs

Some proposals focus on creating new programs to cover individuals left out of the current system. Many "new program" proposals involve new insurance pools

for individuals and small employers who have trouble finding affordable insurance in the market currently.

Personal Responsibility

Many health care reformers say that consumers should take more responsibility for their own health and managing their health costs. Prudent personal health habits can lower costs for individuals and taxpayers, and tying health costs to personal savings helps consumers understand the value of the goods and services they receive.

People can protect their health by avoiding behaviors known to be harmful to individual health, such as smoking. Individuals can reduce catastrophic costs associated with a chronic disease such as diabetes by taking proper preventive steps, and overall fitness can keep an individual's health care usage down over a lifetime.

But since no one is perfect, every person makes at least some choices that don't promote optimal health. A system that holds every individual to a rigid standard of accountability for self-care would penalize people for mere human frailty.

By separating health consumers from the cost of care, health insurance creates the problems of "no-holds-barred" medicine, in which health care providers spare no expense on patients with rich insurance packages and "moral hazard," in which insurance leads consumers to seek care that they would not seek if they had to pay for it out of their own pocket.

Health Savings Accounts (HSAs) and high-deductible insurance plans are designed to reward individuals for making wise spending choices on health care. They are intended to create incentives for consumers to shop for good prices and take care of their own health to minimize costs.

Detractors say that HSAs are unfair, because individuals with more income can save more for potential future health care needs. Detractors also point out that HSAs do nothing to pool risk. Instead of sharing the risk that one person will incur high health costs among all the members of the community, HSAs exemplify a strategy of "going it alone," where each person bears the full risk for potentially catastrophic costs. And individuals with high out-of-pocket limits may forego needed treatment for themselves or their loved ones just to save money.

Other Models

Single payer health insurance refers to a system where a single source—either a government or an entity under contract with the government—pays for all the covered health care services for everyone under that government's jurisdiction, using funds that the government collects through the tax system. The payments can go to providers, to a single public insurance sytem, or to a system of privately operated health insurace plans that in turn pay providers.

Under a system of socialized medicine, the government owns hospitals and clinics and controls day-to-day operation of the health care industry. Under socialized medicine, health care providers are full-fledged government employees.

Regardless of what reforms we make to our health care finance system, we will face difficult choices. Reforms that provide universal access must ration or exclude some high-cost services because of limited funds. But if consumers can go outside the system for services based on their ability to pay, then equality of opportunity may be compromised. The choices we make for our health care system therefore cannot be framed as "right" and "wrong," because any system will fail to meet all the conditions of justice perfectly.

Instead, we must frame health care reform as a project of ***community*** and ***balance***:

- The health care finance system must provide a level of care to every member of the community that those with the most means would consider necessary for themselves and their loved ones.
- Every member of the community should contribute to the system relative to their means.
- The system should serve the community as a whole, not individual members of the community.
- The system should create expectations of personal responsibility while acknowledging the certainty of irresponsible behavior by individuals.

Reforming our health care finance system offers Texans and Americans an opportunity to "love our neighbors as ourselves" through just public policy.

METHODIST HEALTHCARE MINISTRIES
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TEXAS IMPACT
people of faith working for justice