15th Annual Kuyper Lecture

"Seeking Justice: The Imperiled Promise of Healthcare Reform"

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Because I have been an associate of the Center for Public Justice for over two decades, Jim Skillen's invitation to give the Kuyper Lecture was both an honor and a challenge. An honor to be in the company of so many previous lecturers, both friends and colleagues, such as Jonathan Chaplin (last year's lecturer), Stanley Carlson-Thies, and Jim Skillen himself, and in the company of others whose work I have long admired, such as Harold Dean Trulear, Mark Noll, and James Turner Johnson. At the same time, it is a challenge to address the topic of health care reform – a subject vast in its theological and moral implications and overwhelmingly complex in its policy dimensions. I hope that my remarks give depth and perspective to these elements, without oversimplifying them.

One disclaimer before I begin. I work for a faith-based health care system with deep Methodist roots that is owned by a larger Catholic health system. We operate multiple hospitals, a medical group, and outpatient facilities, and we employ about 5000 people. We have, in the overworked phrase, "skin in the game." My talk tonight is not incompatible with the mission and values of Covenant Health System, but it should not be interpreted as the *position* of my employer or its parent corporation. The positions I embrace are my own.

Introduction

When I taught health care policy and politics at Texas Tech, I would tell my students: "Either America will achieve health care reform, or the system will completely collapse. I was only partially correct. True: It is a question of reform or collapse; however, I now believe that we are living *in* the collapse. What is occurring in hospitals, clinics, emergency departments, homes,

and businesses across the nation is, in fact, the slow collapse of the system. This is what collapse actually looks like from the inside. And we are *all* inside!

The cost of care by physicians, hospitals, and nursing homes simply has become unaffordable, individually and collectively. The average cost of comprehensive family coverage is now above $13,000 annually. Tens of thousands are losing employment-based insurance, going either uninsured or resorting to Medicaid when they qualify.

Patients endure impersonal, crowded physician offices and emergency rooms. They experience medical errors, bankruptcy, and inability to locate a physician willing to accept Medicare or Medicaid. Insurance companies deny coverage for pre-existing conditions or engage in "rescission" of policies based on trivial application errors. Physicians and hospitals engage in mortal economic combat, with patients as the weapons of choice. Americans have discovered that they do not have anything like the "best health care in the world," and that other, similar nations furnish equal or better care, at lower cost, and without fear of penury as punishment for accident or illness.

These symptoms of health care system collapse generate both fear and anger. Yet there are two kinds of fear and anger: reasonable and righteous; unreasonable and unrighteous. It is reasonable to fear that, if I come down with cancer, I won't have the insurance to access the proper treatment. It is unreasonable to fear that health care reform is intended to create "death panels" to decide who will and will not be treated at the end of life. It is reasonable to be angry at the injustices of the current system. It is unreasonable for senior citizens to be screaming in Town Halls about the "take away" of their Medicare benefits. Fear and loathing imperil the promise of health care reform with which 2009 began.

The unreasonable and unrighteous fear and anger displayed over the last few months flows from features unique to American health care and how precious and precarious it can be. Yet, the intensity of fear and anger also stem from growing anti-government sentiment and from heated "ideological and cultural warfare" that, if anything, is more worrisome for Christians committed to the principle of public justice and to the rightful place of government within the panoply of institutions intended by God.

Fear and anger are deeply rooted in (contemporary) American culture, and there will be no genuine, systematic health care reform, unless we discover how to transform fear into hope. In a "nation with the soul of a church," in Chesterton's memorable phrase, we should not be surprised that our policy disagreements take on religious intensity. Yet, the same intense passion for justice that could assist genuine reform too often finds itself channeled into naked fear and aggression. Too many have connected worry about changes in the health care system with antipathy toward changes in the fabric of American life, changes that undermine some Americans' very identity, leading to a status anxiety manipulated by ideological partisans for narrow purposes.

Jesus tells his disciples numerous times, "Do not be afraid?" (e.g., Mt 10:26-28; Mt 28: 5, 10; Jn 14:27) Why are so many Christians, our friends and pew-mates, afraid of health care reform? The message of Jeremiah to the people of Judah was, "Do not fear the King of Babylon?" (42:1-16) How can so many Christian heirs of the prophetic tradition, fear and loath a mere President of the United States, whether his name is George or Barack?

What resources can we marshal to resist the forces of fear and loathing?

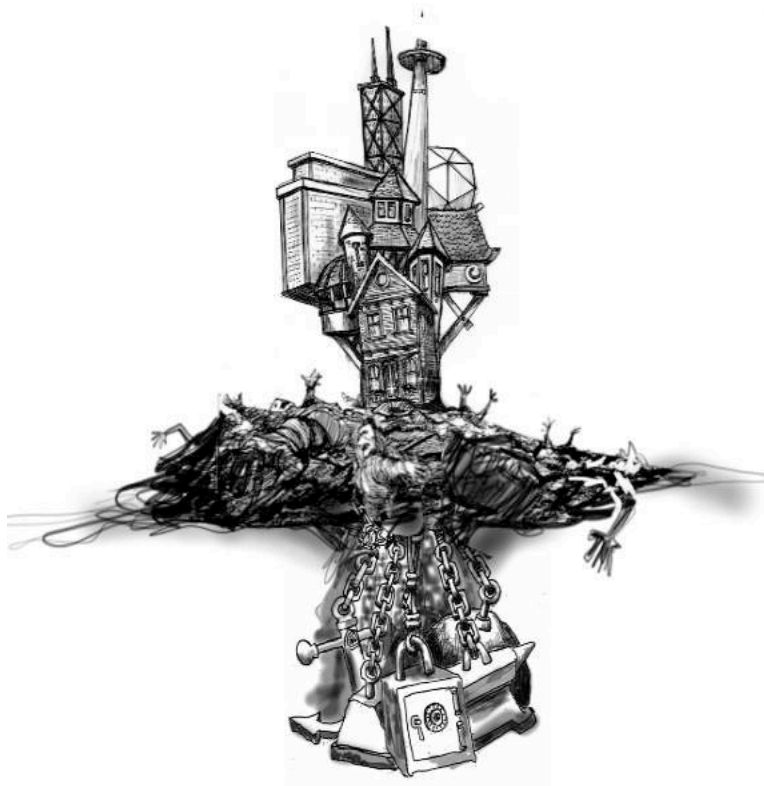
Before attempting to answer these questions, we need to get in touch with *reasonable and righteous* fear and anger at the American health care system.

Health Care System Chronic Social Injustice

I follow the analysis of chronic social injustices developed by Jack Glaser, Founder of the St. Joseph Health System Center for Healthcare Reform.[1] Consider the example of child labor in the 19th Century. It was a deeply embedded injustice, taken for granted by much of society and supporting numerous economic institutions. Glaser points out that there are three characteristics of any such chronic social injustice: visible structures, widespread suffering, and deep cultural anchors.

Here is the idea visually depicted.

Figure 1: The American Health Care System



In the topmost layer, we have elements that were thrown together over 40-50 years. Some of them worked OK individually and for a time. But as they piled atop one another, they grew into an inconsistent, illogical, wasteful, and unjust whole.

Not only this, but this top layer rests upon a middle layer of intense human suffering – pain, illness, financial ruin, fear, and premature death. And this middle layer is deeply anchored in cultural attitudes. These illogical and punishing structures are deeply anchored in our society. Many groups and individuals benefit handsomely from the status quo. Most of us are fearful of losing what we have; trying something different feels too risky. Limping along with the status quo seems to be everyone's second choice.

And the second choice prevails.

For our purposes tonight, it is also essential to recognize that American churches and religious institutions are embedded in each layer! Christian hospitals and nursing homes. Christian willful blindness to the suffering endemic among the uninsured and underinsured, among immigrants and other marginal groups. Christian churches unwilling to challenge a culture, even within parishes, that demeans the poor, rejects immigrants, and considers poor health mainly a matter of individual irresponsibility.

Health care reform is so arduous, because the top layer is highly complex, nearly impossible fully to understand, and full of cross-cutting interests. The middle layer of suffering is largely invisible. And the culture, as even *USA Today* is willing to admit, means that "Alone among the world's leading countries, the United States has perpetuated a you're-on-your-own way of health care that fits Americans' image as tough and self-reliant, but which routinely wrecks lives and causes unnecessary suffering."[2]

Christian faith intent upon real health care reform must be willing to recognize and address each layer. Let me describe key features of these layers more fully and in more familiar terms.

American Health Care: A Deeply Flawed System

An "unholy trinity" of trends batters and bruises American health care: rising number of uninsured and underinsured; escalating cost of health care; and accelerating technological innovation.

1. Injustices in access to care

Because she was uninsured and afraid, Norma Smith waited a year to have the lump in her breast checked. It made the difference between a curable and an incurable cancer. Because she was uninsured, Norma Smith went for years without seeing a dentist. Her teeth were in such bad shape, that the danger of infection once chemotherapy began required all her teeth be pulled.[3]

When Bob George's business failed, so did his medical insurance. Then cancer and its attendant medical bills struck. Ten weeks later, Bob George had a bill of $100,000 and climbing.[4]

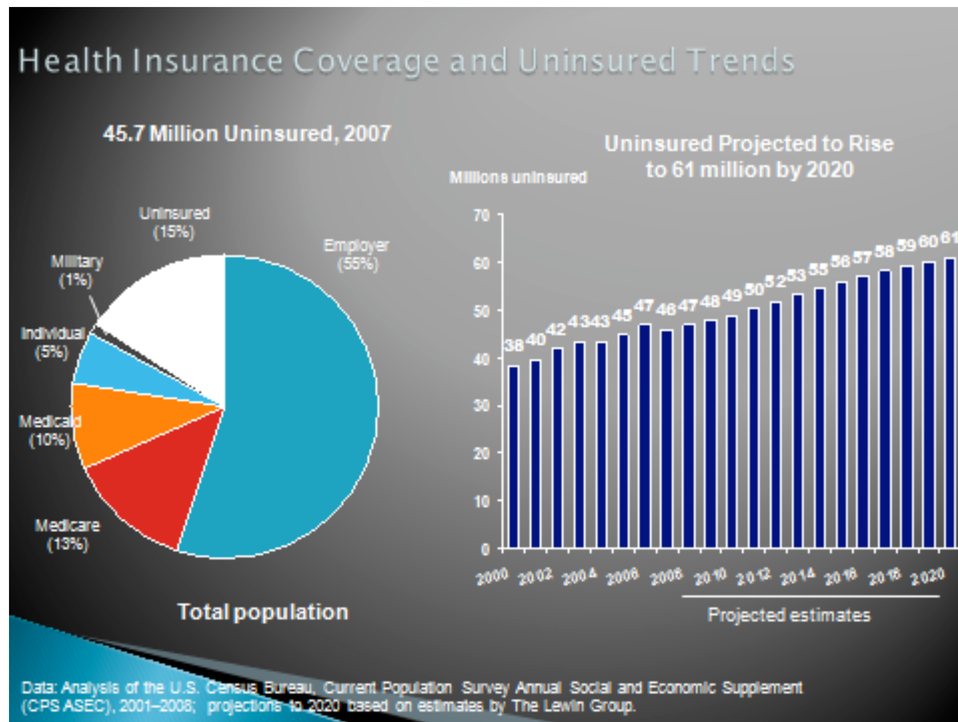
Earlier this week, Wisconsin papers carried the story of a man who, at age 40, enlisted in the army solely to obtain health insurance to cover his wife's treatment for ovarian cancer.

Most often it is the experience of *injustice* that produces insight into justice. If so, there are millions of Americans like Norma Smith and Bob George with hard-earned insight. Being without insurance is not an isolated phenomenon. Rather, the number and percentage of uninsured increases steadily, slowed only by the rise in the number of children covered by Medicaid and SCHIP. In 2008, about 46 million people (15.4% of the population; about *17 percent* of the under-65 population) were without health insurance, often for months at a time. Approximately 4 of every 5 uninsured persons lives in a family in which one or more members *works* full-time or at least part-time for a significant number of hours per month. The number of uninsured children was over 7 million (about 10% of all children). Young adults (18-24),

Hispanics (30%), African-Americans (19%), persons with less education, part-time workers, and foreign-born persons have the highest rates of uninsurance.[5]

Figures tell the same story in a different way, documenting the steady increase in the number and percentage of uninsured Americans.

Figure 2



A very large number of persons are uninsured for one to two years or more. Estimates are that about 26 million persons are in this situation.[6] These include a large percentage of persons with serious chronic medical conditions, who cannot afford proper management of their illness. For example, more than one in ten cancer patients under 65 lacks health insurance, including 20 percent of Hispanic cancer patients.[7]

Lack of insurance has dire consequences for uninsured persons themselves, but also for the rest of society. Uninsured persons (compared to insured persons) more frequently postpone needed medical care, cannot find physicians to care for them, enter hospitals sicker. They have

fewer physician visits, irregular sources of care, and fewer preventive services such as pap smears, mammographies, hypertension screenings, and cholesterol screenings. These are the kinds of differences that produce higher mortality and morbidity rates for the uninsured.

The burden of this increased illness and death ripples through society, first to the families of uninsured persons, but also the insured persons whose higher insurance rates cover some of the cost of caring for uninsured persons, to taxpayers who support public hospitals, to employers who lose productive work time, to physicians, hospitals, and other health care providers who must find ways to cover their costs for treating uninsured persons, and finally to society as a whole which ends up with a higher disease and disability burden.

A society that leaves one of every seven members to suffer such consequences has, in effect, told them that they are not deserving of full membership in the community. This violates the solidarity of the human community affirmed by Christ when He took on our flesh and formed church with the mission of drawing the entire world into His Body. Solidarity does not require an impossible absolutely equal health for every person. However, restricted access to care based on income or other factors unrelated to medical need both affects health status and, equally significantly, one's status as a respected and honored member of a community. Christian anthropology is communal. The virtue necessary to realize a communal principle is solidarity.

Health care justice also recognizes the fundamental dignity of all human persons and their equality as citizens. To refuse to cover some citizens or to make people wait in endless lines, jump through demeaning qualification procedures, and accept second-rate facilities while their fellow citizens have ready access to the best care, very clearly divides citizens into first and second class.

2. Refusal to Recognize limits: Unsustainable Costs

The second member of the "Unholy Trinity" is the cost of health care, rising at a long-term unsustainable pace.

Using any measure one might prefer, the cost of health care in the United States is dramatically higher than similar care in other nations. Most of these spend around 8 to 10 percent of Gross Domestic Product (GDP) on health care to attain universal coverage. The U.S. figure is 16-17 percent of GDP. Moreover, other nations have the same or significantly better health status than the United States. The United States lags most other developed nations in adult and infant mortality, longevity, preventable deaths, and health status. Given the ramshackle top layer of the health care system, it is no surprise that billions of dollars are wasted each year.

For the last half century, increases in the cost of medical care have exceeded by a large margin the general course of economic growth, producing an increase in health care's share of GDP from 6.5% in the mid-1960s to about 17% today. The story can be told graphically.[8]

Figure 3

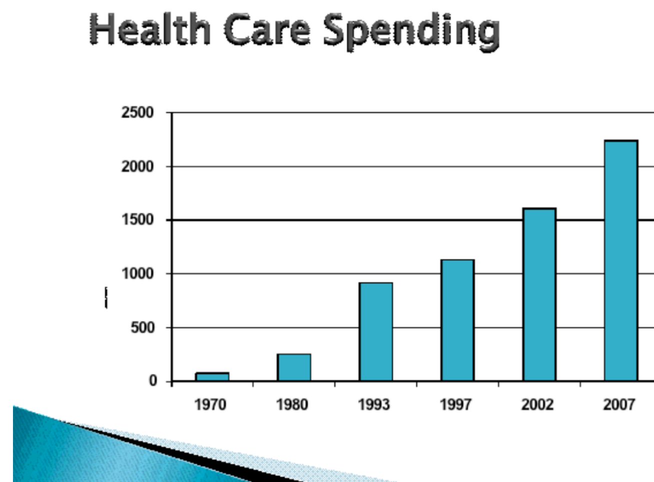
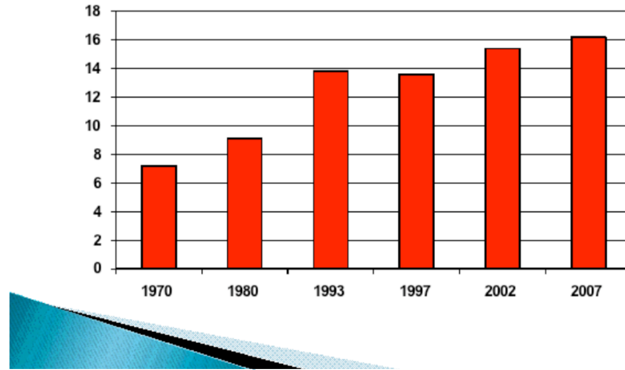
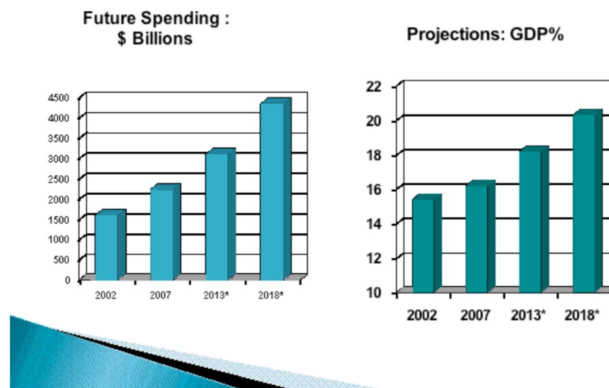


Figure 4



Moreover, current growth rates and official projections are for no change in this pattern in the foreseeable future.

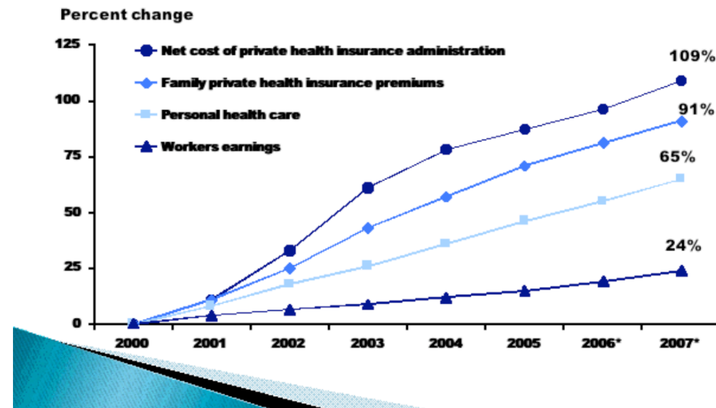
Figure 5



The average worker during the last decade has received no wage increase in inflation-adjusted terms.

Figure 6

Cumulative Changes in Annual National Health Expenditures, 2000-2007



Without some force to change this trend, one of every four, then one of every three dollars in the entire economy eventually will be in the health care sector. The rising cost of health care, in the absence of universal insurance coverage, is the chief reason for the growing number of persons without proper access to care.

There is a strong consensus that much of our spending on health care is wasted on administrative costs (which produce no medical benefit) or in unnecessary and even harmful procedures and tests.

3. Challenge of New Technologies

The third member of the "Unholy Trinity" may be termed "technological imperialism," and it is very closely related to the problem of medical expenditures just discussed. Technological imperialism is one of the strongest anchors of our unjust system.

Perhaps the deepest crisis in American health care (a crisis paralleled in rest of the world, but with a decade or more of lag time) is paradoxically the *success* of medical research and development. The looming crisis lies in deciding how to ration helpful, beneficial medical

treatments, especially new treatments resulting from the latest medical research and development. For it is these that make the increasing cost of care impossible to sustain in the long run, thereby imperiling access to essential care for all who need it.

Let me illustrate.

1. A recent study of the cancer drug, Erbitux, used to treat advanced lung cancer, showed that it prolonged life, on average, about 1.2 months at a cost of $80,000 for an 18 week regimen. Avastin and Nexavar demonstrate similar limited survival data, costing more than $34,000 for a standard course of treatment.[9]

2. Take another area of medicine – senile dementia. Advanced Alzheimer's patients at the end of their lives often receive extensive medical treatment – feeding tubes, IV fluids, orthopedic surgery, and ICU admissions for other medical conditions. Are aggressive, curative treatments (the U.S. standard of care) morally or economically optimal, especially if these resources could save or improve lives among persons with many more years to live?

3. Currently, new proton therapy cyclotrons costing $100 to 225 million per facility are proliferating in cancer centers across the nation with limited evidence of better outcomes than standard radiation therapy.[10]

4. Finally, the genetics revolution will produce numerous new treatment options from the womb to the end of life. There is no reason to believe that these treatments will be inexpensive. Indeed, there is every reason to believe that they will be very costly. Public policy will face new allocation dilemmas.

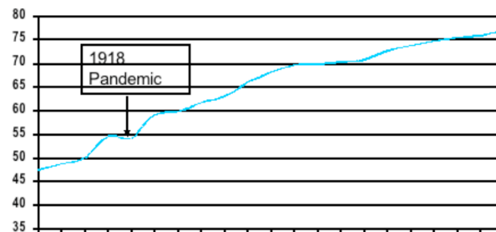
Technological innovation can, I believe, rightly be termed "technological imperialism." Technology is not morally neutral. It carries its own moral momentum. A substantial proportion of dollars are spent in a futile quest for immortality, spent in idolatrous worship of the promise of

human ingenuity to postpone aging and death indefinitely. That is, spending on medical care is often an explicit or implicit denial that earthly life is limited.[11]

American medicine is far more aggressive and curative in focus than medicine in other cultures.[12] Stressing acute care, it neglects chronic conditions and preventive care. Enamored of science and technology, it seeks ever further extensions of life and victory over illness itself, symbolized by the genetic revolution's promise to unlock the secrets of disease, defect, and aging. As William Haseltine, chairman and chief executive officer of Human Genome Sciences, put it, "Death is a series of preventable diseases."[13]

Figure 7

Life Expectancy at Birth



However, each advance in life expectancy and health status comes at a higher marginal cost. Look at the Figure. Notice that the curve of rising life expectancy begins to flatten just as the cost of health care begins to explode. What this means is that each extra month of life costs more to attain that the preceding extra month. We spend more and more to achieve less and less.

In the kingdom of technology, we no longer need accept the disciplines of eating less, exercising, and reducing alcohol intake. The genomic revolution promises interventions that will, in effect, allow us to eat our cake and have it too!

Medicine shaped by this model becomes more impersonal, dominated by machines, pharmaceuticals, and computer-generated images. Human touch and voice withdraw to the margin. Yet healing modeled on Jesus is *personal* and *incarnational*. It values care more than cure, regarding death as an enemy, but by no means the most dangerous enemy. Moreover, as the American population ages and as American culture produces more human wreckage in the form of addictions, mental illness, and serious injuries, need increases for long-term care, mental health care, and recovery programs. The culture of modern medicine and the modern need for healing increasingly are at odds. American medical culture is market-driven, entrepreneurial, and focused on specialization. These characteristics make it more costly than other world health care systems and more resistant to change.

Other anchors of the health care system and its injustices are certain American cultural values so deeply placed in the psyche that they imperil health care reform. First is the myth of American uniqueness and greatness, entailing the still common misconception that the United States has the greatest health care system in the world, a myth slowly being eroded by the evidence, but one that still exerts a powerful hold on the nation and retards reform.

American ideology too is a drag on reform. The classical liberal ideology of individualism and self-reliance, coupled with a naïve faith in free markets impedes the kind of commitment to solidarity and the common good that anchors systems of universal health care in other nations. Couple this with fear and distrust of government (and of insurance companies, indeed large institutions of any kind), and you get reluctance to pay the taxes necessary to support health care reform and extend insurance coverage to all.

Finally, an unacknowledged, but deeply entrenched and moralistic class system leads to fear of the “other.” Fear that extending health insurance will reward the “irresponsibility” and

“immoral” choices of those currently without insurance and will reinforce the perceived tendency of recipients to be lazy and dependent.

A Spiritual and Moral Imperative: The Health Care Covenant

National Health Insurance (NHI) as a moral imperative flows from justice and the common good, reflected in some possible slogans for health care justice: “No health care beggars,” “Health care that leaves no one behind,” and “A healthy society is a flourishing society.” God does not intend death or sickness (Wisdom 1:13-15); indeed, they did not exist in the Garden, and they will not exist in the “new Jerusalem.” (Rev 21-22) Therefore, it is incumbent upon followers of Jesus the healer to do what we can to ensure that such illness and injury as exist this side of paradise are not the fault of injustices that we create or tolerate. As Albert Schweitzer says, “We should take our share of the burden of pain that lies upon the world.”[14] David Gushee suggests that those of us who enjoy good access to health care should try the Golden Rule test. Are the current inequalities in access how we would like our children to be treated when they are sick?[15]

In the face of entrenched injustices, advocates for health care reform must hold fast to what David Hilfiker calls “apocalyptic hope” founded on the death and resurrection of Jesus the Christ: “Not a political ideology, not a social movement, not an economic system,” but “faith in the God who is love – who took flesh and died and rose in Jesus Christ – is the authentic basis for . . . hope.”[16] (Benedict XVI) Apocalyptic hope means to trust that history is not linear, that God breaks into seeming hopeless situations to set things right. Thus, a Christian orientation to health care reform holds onto hope and does the work God calls us to do, even when it seems naïve.

"Covenant" is a concept with deep resonance within the biblical tradition and within American political culture. I employ the concept of the "health care covenant" to summarize mutual responsibility for health care system reform that will include (1) a mandate for universal insurance coverage deriving from justice and the common good, (2) principles for limiting and allocating health care, (3) personal and familial responsibility for health enhancing behavior and for responsible use of the health care delivery system, and (4) a place for religiously-grounded health care institutions.

Justice and the common good require that all citizens have health insurance. This conclusion, however, tends to generate fear of health care rationing. It is politically impossible and morally unnecessary to attempt to provide every person with access to the most complete range of *highest quality care imaginable*. Maximal insurance is financially impossible to provide to all; providing the *best* care to *everyone* is physically impossible. Therefore, they are not morally obligatory. Systems of universal insurance or national health care commonly allow citizens to purchase from their discretionary funds medical services beyond those covered by the essential comprehensive plan held by every citizen. As long as insurance covers the full scope of reasonable needs for all, there should be no objection by Christians that some chose to spend their discretionary income on tummy tucks, while others choose high performance automobiles.[17]

This conclusion entails, first, that the shape and development of the health care covenant are subject to social determination through government action and other means of social control. These are matters of public debate in which religious voices have a part. Second, the goods of the earth are gifts from God held in trust for the good of all. They must be cared for and used prudently. *Sustainable* advance in health care and medical resources is the goal, not the most

rapid advance possible. And we must have the courage to admit that sustainable health care requires slowing of technological innovation in medicine.

Moral theology long has recognized that individual medical treatment may be removed when it is no longer beneficial or when its burdens – physical, financial, psychic, and spiritual – outweigh its benefits to the patient.[18] This might be thought of as the stewardship principle expressed at the individual level. Similarly, at the social level growth in resources devoted to advanced, curative medical technology may legitimately be decelerated in order to meet other medical goods – better outpatient care, better prenatal and post-partum care, or disease management programs for diabetes and chronic obstructive pulmonary diseases (COPD).

This social analogy to individual refusal of futile life-extending medical treatment directs research and development away from the goal of life-extension, for we all must die. Instead, it directs research and development toward reducing the gap between the morbidity and mortality curves. I mean by this that our focus should be on reducing the average time of disability before death, rather than on extending the life span.

Therefore, public justice, the common good, and stewardship point to a health insurance system somewhere between basic care and "supercare"; that is, toward guaranteed coverage for the set of health care interventions that assures a statistically good chance over one's lifetime of avoiding premature death and disability.[19] Under such a system, everyone has insurance coverage for diagnosis and treatment of illnesses and conditions most likely to interfere with living a full, normal life span. It includes coverage for those treatments most likely to allow persons to function as fully and normally as possible for their place in the life cycle. It includes commonly accepted, evidence-based curative and preventive medical treatments and diagnostic procedures. The idea of a normal life span draws on the Christian understanding that, although

physical death is an evil connected to human sinfulness, it is not the ultimate evil, which is spiritual death. Moreover, Jesus' own death and resurrection has already conquered death. Therefore, morality does not demand research on and insurance coverage for technologies of indefinite life extension.

Because, medical science over time will change the specific diagnoses and treatments entailed in the notion of decent, comprehensive health coverage, this account cannot specify detailed coverage. However, it can describe in general terms the kinds of interventions that would and would not qualify for coverage.[20]

Health insurance itself should cover at least the following: medical care effective in providing palliation of pain and symptoms of illness (regardless of the stage of life and whether the condition is acute, chronic, or terminal); primary care delivered by physicians, dentists, nurses, and other health professionals; emergency care for any life-threatening or serious illness or injury; and curative treatments for conditions that most interfere with normal growth and development of children and adolescents, as well as conditions that most interfere with persons contributing to society in adulthood; and that are most likely to cause premature death or disability. Pharmaceuticals and preventive health measures compatible with these goals also should be part of the plan. The health care covenant will include such measures as prenatal and infant care; rehabilitation services designed to return persons as closely as possible to normal functioning; health promotion and disease prevention; generous comfort care for the elderly and dying. It does not cover such things as fertility treatments; genetic selection or enhancement; abortion or euthanasia; cosmetic surgery designed to enhance natural abilities (as opposed to repairing injuries or abnormal features); non-cost effective screening tests; or high-tech rescue medicine for persons at the end of life. These “supercare” or experimental or morally

questionable procedures would be matters for discretionary, out of pocket spending or for insurance voluntarily purchased beyond the mandated universal coverage.[21]

Well-proven preventive medical interventions should be free at the point of service to encourage wide use. The key term here is "well-proven." For example, although we know that healthy eating and exercise would curb most of the obesity "epidemic" in America, we don't know what interventions will produce better eating and exercise. Until an intervention is proven, its funding should be voluntary, experimental, or grant-derived, not part of the universal guarantee.

It is important to note here that prevention is often oversold as a panacea for reducing the cost of health care and improving health. Prevention would certainly improve health, and proven preventative screenings and other measures should be covered by universal insurance. However, it is very difficult and costly to discover what prevention measures actually do work. Moreover, most prevention actually does not reduce the cost of health care, and many such measures, such as screenings, have their own associated risk of damage to health.[22] Indeed, because of new ability to detect early onsets of illnesses and "risk factors," modern medicine is actually increasing the proportion of the population that considers itself "ill" and in need of treatment, with enormous social, economic, and psychological consequences.[23]

Current Legislation – topmost layer (superficial but vital)

I want to treat the contemporary policy debate in Congress and among the people very briefly, though the temptation is to dive into the details and to parse each one for its ability to build the health care covenant. It is tempting to dive into the details in order to refute myths and

misconceptions. Yet, that strategy, at least in the present context, would distract from attention to the principles and goals just outlined.

So, I will keep my discussion of current legislative proposals at a very high level.

The reforms most likely to be adopted relate to remodeling the topmost layer, by tearing down its most antiquated structures and more closely connecting the effective parts. These are likely to be enacted principally because they are the most "behind the scenes" parts of the legislation. Moreover, the regulatory process through the Centers for Medicare and Medicaid Services has been moving in this direction for many years. Although they have the potential to work far-reaching changes in the structure of health care, most are primarily in the conceptual stage. Some with the potential for reducing the cost of health care in the long run (electronic medical records) will be very expensive to implement in the short run.

The measures that I am thinking of primarily focus on improving the quality of care (which could also lower cost) and re-aligning financial incentives among providers. I have in mind principally:

- Incentives to attract more medical students to enter primary care
- Incentives to attract faculty to teach nursing and thus alleviate the nursing shortage
- Rewarding quality of care, instead of volume of care
  - Pay for performance and penalties for sub-optimal performance of inpatient and outpatient quality measures (currently CMS 21, SCIP, and the like)
  - Non-payment for certain re-admissions to the hospital
- Creating a better "continuum of care" among primary and specialist physicians, hospitals, rehabilitation facilities, and other organizations
  - Clinical Alignment

- □ Accountable Care Organizations
- □ Bundled Payments

- ● Greater transparency in hospital and physician cost and quality data
- ● Comparative Effectiveness Research
- ● Electronic Medical Records

All of these measures, in one form or another, sooner or later, will be part of American healthcare. The principal question is whether they will indeed work to improve quality and lower cost, as well as eliminate the crazy inefficiencies and waste that plague the system. More to the point, we know that they will not work without substantial attention to the radical differences in payment between procedure-oriented specialists and time-oriented primary physicians. The current incentives have produced far too many of the former and too few of the latter.

Current Legislation – middle layer (vital, but imperiled)

The most contentious reform issue is how to extend coverage to most of the 46 million uninsured, because it involves insurance reform and taxes. The cost of universal coverage is about $1 trillion over ten years, with most costs coming in the later years, since reform would take many years completely to phase in. Debate has been most visible regarding the "public option" and what taxes to impose on individuals, insurance companies, employers, and health care providers.

Here is the vital thing: to keep one's eyes on the basic truth of universal access, to wit: insurance reform (elimination of pre-existing conditions and automatic coverage) cannot happen without mandatory coverage of the vast majority of the current uninsured. And vice versa. The reason for this is simple. If you require insurance companies to insure all comers, but don't require healthy persons to buy insurance, then the insurance companies will in the business of

insuring only sick people. Sort of like fire insurance companies only insuring burning buildings. Similarly, you cannot require persons to buy insurance unless they can afford it, and that requires insurance regulation.

Therefore, the current debates in Congress revolve around: taxes and other measures to fund the reform; employer and individual mandates; expansion of Medicaid and SCHIP; the size of subsidies to facilitate purchasing insurance and the penalties if one does not; and the insurance market, including insurance exchanges, public options, co-operatives, and regulations on the insurance companies themselves.

Whatever legislation, if any, emerges in the next weeks and months, it will have to figure out how to cover at least 35 million more persons. It will have to set penalties for not buying insurance high enough to be an incentive, but not too high to impact low-income persons disproportionately or to produce a backlash from relatively young and healthy persons. It will have to set subsidies for the purchase of insurance high enough to make insurance affordable for the middle class, but not too high to drive the cost over $1 trillion. Finally, it will have to combine Medicare expenditure reductions, insurance regulation, and taxes and fees in such a way as to seem fair to most. A rather high bar, indeed! One great, and very likely danger, is only a new health care entitlement will emerge, without the cost control and financing in place for long run sustainability.

Obstacles to Reform

There are major impediments to reform anchored in American politics and culture.

First, American political institutions are structured in such a way as to provide numerous blocking opportunities for groups opposed to major reform.[24] Indeed, with the current highly fragmented condition of American health care, there are numerous groups with contrasting

stakes in the system. The health care system is highly complex and constitutes 17% of the entire economy. Therefore, the number and wealth of the lobbyists ready to pounce if their interests are not met in the legislation is past imaging. The "Obama versus the insurance companies" combat of recent weeks is merely a taste.

Full disclosure: I spent all day yesterday lobbying senators and representatives on behalf of the interests of the health care system that I work for!

Second, the deep cultural anchors to the current system stymie reform. American political culture is market-oriented and strongly affirms individual responsibility for health care.[25] These translate into distrust of both government and insurance companies to lead reform and into resistance to paying higher taxes to fund care for those presently without it. The language of justice and common good have difficulty finding traction in a culture in which each is supposed to take care of himself/herself.

Third, major political and social reforms require broad and deep movements to generate the momentum to break public opinion apathy and to sustain public attention over time.[26] Although religious groups might have a place in developing such a movement, other natural allies (such as labor unions) are weak and frequently at odds with major health care institutions. Moreover, the health care reform movement has now run into the anti-immigration movement and the pro-life movement. The politics of abortion and immigration could help sink reform.

Fourth, we cannot underestimate the power of fear as a political motivator. Witness its manipulation regarding the "War on Terror." Fear on the part of the well-insured about losing some advantages interferes with their ability to perceive or commit to the common good. Fear of rationing; fear of "socialized medicine," higher taxes, and "death panels"; fear of undocumented persons; fear of lost autonomy and choice – all furnish very real momentum against reform.

Finally, "windows of opportunity," when public attention, legislative interests and structures, and presidential interests align, open rarely for sweeping social change.[27] The window clearly opened with the election of Barack Obama, but that window is also buffeted by the winds of recession and unprecedented budget deficits. The cost of the Iraq and Afghanistan wars and the economic recovery package will suck up funding that could have gone toward health care reform.

Subsidiarity and Sphere Sovereignty: Government, Professions, Churches

One concern that has emerged among some Catholic commentators is the proper role of government (state and federal), as well as the role of professions, particularly physicians. Subsidiarity and sphere sovereignty in the Catholic and Dutch Reformed tradition set limits on the ambitions of government to control areas of life that possess their own internal dynamics and systems of authority.

This is not the place to describe or critique either theological concept. I will only point to what I believe the principal roles of government to be with respect to health care:

● Ensure public justice; that is, enforce the health care covenant by guaranteeing to all citizens fair access to health care through comprehensive insurance by specifying the insurance package, fashioning subsidies and taxes to finance it, and enforcing mandates to purchase insurance.

● Cost control by managing the percentage of GDP available for medical care and by framing a fair system of allocation.

● Leadership in quality and payment reform.

It seems to me that these responsibilities may legitimately be divided between federal and state governments. Insurance exchanges and insurance company regulation, within national fairness standards, could be administered at the state level, the traditional place for insurance regulation in the American polity. Ensuring access for all, paying subsidies, cost control, and enforcing mandates are best done at the federal level.

Physicians, Daniel Sulmasy has argued, have become a "prodigal profession," led astray by the gods of technology and affluence. They need to be brought home again to the person to person patient encounter, to renewed devotion to primary care, and to the free giving of their resources to those in need; for example, through parish-based, hospital-based, or other medical missions.[28] Churches could also encourage and even fund medical students to commit themselves to primary care and to work for a period of time in church-sponsored clinics for poor and marginal persons. The Christian Community Health Fellowship is a model for such faith-based primary care.

The medical professions must maintain a certain level of autonomy to enforce ethical codes, specify standards of care, and police themselves. Moreover, the traditional ethic of the medical professional – care and advocacy for particular patients – should remain at the center of a reformed health care system.

At the same time, individual physicians must recognize their place both in a system of care on which patients with complex conditions depend and their responsibility to the common good not to waste the medical resources entrusted to them. "My patients" and "my livelihood" must accommodate a system of mutual responsibility and fair allocation of resources to all persons.[29] One way to do that is for physicians to embrace comparative effectiveness research as their responsibility to stewardship, instead of resisting it in the name of autonomy.

Churches and religious organizations operate numerous health care facilities: hospitals, clinics, and nursing homes being the most prominent. Even within a just system following the Health Care Covenant, there inevitably will continue to be multiple opportunities for exercise of the genuine virtue of charity.

For example, hospitals could fund, fully or partially, a variety of services that may not be included in the comprehensive insurance plan above. These could be offered on a free or on a sliding scale according to income. They would offer programs of community outreach to those persons who, even with insurance, experience the barriers to health care access. They should offer:

- Free or reduced cost services to persons illegally in the community.
- Mobile mammography, mobile dentistry, and a mobile medical vans travel inner cities or rural communities.
- Counseling centers for low income persons with mental health needs.
- Neighborhood centers in a low-income neighborhoods to provide health education, literacy training, parent-school cooperation, and other activities.
- Support for hospice and palliative care as exemplars of respectful caring for persons at the end of life and as alternatives to euthanasia.

Our churches have a delicate balancing act in the current political environment. We must find the courage to resist abortion (especially publicly-funded abortion in health care reform legislation), euthanasia, stem cell research, and the commodification of reproduction. Strong conscience protections must be part of health care reform. At the same time, we must discover how to counter the anti-government tendencies in the pews of our churches and replace fear with hope. There is a significant role for education in the theology of limits, a theology of resistance

to the technological imperative and the illusion of immortality. What better place for pulling up the cultural anchors of an unjust health care system than congregations dedicated to following the crucified and risen One?

Conclusion

There will be no genuine health care reform unless the political culture of fear and anger becomes a culture of hope and justice. Unless we deal with "chronic social sin," especially its deep anchors in our culture, we will not have genuine health care reform.

True security is found only in Christ. He is the source both of justice and hope. He is the inspiration both of *righteous* anger at the present system and of *energy* to carry forward the long struggle to overcome the "chronic social sin" of our health care system and to design a just and efficacious system of caring and healing. We are only mid-way through that long struggle. With faith in God's assistance, bearing apocalyptic hope, we shall continue the journey toward a health care system founded on public justice, solidarity, and stewardship of God's resources.

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[1] See, for example, John W. Glaser, "Tools for Ethical Discernment," *Health Progress*, (January-February 2008): 51-57.

[2] *USA Today* editorial, September 9, 2009.

[3] *Catholic Health World*, May 15, 2004, pp. 13-14.

[4] Ronald J. Sider, *Just Generosity: A New Vision for Overcoming Poverty in America* (Grand Rapids, MI: Baker Books, 1999), pp. 139-140.

[5] U.S. Bureau of the Census, *Income, Poverty, and Health Insurance Coverage in the United States: 2008* (Series P60-236, August 2009) (http://www.census.gov/prod/2009pubs/p60-236.pdf, accessed October 5, 2009).

[6] Kaiser Commission on Medicaid and the Uninsured, "Lack of Coverage: A Long-Term Problem for Most Uninsured" (January 2004).

[7] Kenneth E. Thorpe and David Howard, "Health Insurance And Spending Among Cancer Patients," *Health Affairs* Web Exclusive, April 9, 2003. (http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.189v1/DC1, accessed June 1, 2006).

[8] Data in the next slides are drawn from Andrea Sisko, et al., "Health Spending Projections Through 2018: Recession Adds Uncertainty to the Outlook," *Health Affairs*, 28, no. 2 (February 2009): W346-W357.

[9] Avery Johnson, "Cost-Effectiveness of Cancer Drugs is Questioned," *Wall Street Journal on-line*, June 30, 2009.
[10] *Modern Healthcare*, September 21, 2009: 12.
[11] There is a voluminous literature on the causes for high and rising health care costs in the United States. For a convenient summary, see Henry J. Aaron, *Financing America's Health Care* (Washington: Brookings Institution, 1991), Rashi Fein, *Medical Care, Medical Costs: The Search for a Health Insurance Policy* (Cambridge: Harvard University Press, 1986), Kenneth E. Thorpe, "Health Care Cost Containment: Reflections and Future Directions," in Anthony R. Kovner, ed., *Health Care Delivery in the United* States, 4th ed. (New York: Spring Publishing Company, 1990): 270-296, and Gerard E. Anderson, *et al.*, "It's the Prices, Stupid: Why the United States is so Different from Other Countries," *Health Affairs*, 22, no. 3 (May-June 2003): 89-105. Because initiatives to control costs have not reached the underlying causes, they have worked only in the short run. See Drew E. Altman and Larry Levitt, "The Sad History of Health Care Cost Containment as Told in One Chart," *Health Affairs*, Web Exclusive, 23 January 2002: 83-84.
[12] Lynn Payer, *Medicine & Culture: Varieties of Treatment in the United States, England, West Germany, and France* (New York: Penguin, 1989).
[13] Quoted in Daniel Callahan, "Death and the Research Imperative," *New England Journal of Medicine*, 342 (March 2, 2000), 654-656.
[14] Quoted in Edward O'Neil, M.D., *Awakening Hippocrates: A Primer on Health, Poverty, And Global Service* (Chicago: American Medical Association, 2006), p. 446.
[15] "The Moral Imperative of Health-Care Reform," Associated Baptism Press (www.abpnews.com; August 25, 2009).
[16] Pope Benedict XVI, address in Brazil, May 13, 2007.
[17] There are, of course, reasons in Catholic social theory to be concerned with the distribution of income. Everyone deserves an income that allows at least some discretionary spending. But consideration of income distribution would take us too far afield. However, there is a lively, unsettled debate on the extent to which income inequalities themselves contribute to poor population health.
[18] This principle, however, is not without controversy, especially regarding withdrawal of medical treatment at the end of life. Particularly vexed is the moral status of medically-assisted nutrition and hydration in persons with no hope of recovery from terminal illness or injury.
[19] The description of such this insurance scheme draws on Daniel Callahan's idea of "sustainable medicine" in *False Hopes: Overcoming the Obstacles to a Sustainable, Affordable Medicine* (New Brunswick, NJ: Rutgers University Press, 1999). It is indebted as well to Norman Daniels, *Just Health Care* (New York: Cambridge University Press, 1985). See also Joseph Cardinal Bernardin's, *Celebrating the Ministry of Healing* (St. Louis: Catholic Health Association, 1999), pp. 70-82.
[20] Callahan, *False Hopes*, pp. 252-274.
[21] My own understanding of Christian moral teaching suggests that public law should forbid some of these, abortion or euthanasia, for example.
[22] For example, Louise B. Russell, *Is Prevention Better than Cure?* (Washington: Brookings, 1986) and *Educated Guesses: Making Policy about Screening Tests* (Berkeley: University of California Press, 1994). See also Janet Adamy, "Prevention Efforts Provide No Panacea on Health Costs," *Wall Street Journal* (online), June 12, 2009 (accessed June 13, 2009).

[23] Robert A. Aronwitz, “The Converged Experience of Risk and Disease,” *Milbank Quarterly*, 87, no. 2 (2009): 417-442.
[24] Sven Steinmo and Jon Watts, "It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America," *Journal of Health Politics, Policy, and Law*, 20 (Summer 1995): 329-372.
[25] For example, Donald W. Light, “The Restructuring of the American Health Care System,” and James A. Morone, “Gridlock and Breakthrough in American Health Politics,” both in *Health Politics and Policy*, 3rd ed., ed. Theodore J. Litman and Leonard S. Robbins (Albany, NY: Delmar Publishers, 1997), pp. 46-74.
[26] Jacob S. Hacker and Theda Skocpol, "The New Politics of U.S. Health Policy," *Journal of Health Politics, Policy, and Law*, 22 (April 1997): 315-338. See also Theda Skocpol, *Boomerang: Clinton’s Health Security Effort and the Turn against Government in U.S. Politics* (New York: Norton, 1996).
[27] John Kingdon, *Agendas, Alternatives, and Public Policies*, 2nd ed. (New York: HarperCollins, 1995).
[28] Daniel P. Sulmasy, OFM, MD, *A Balm for Gilead: Meditations on Spirituality and the Healing Arts* (Washington: Georgetown University Press, 2006), chapter 4.
[29] David M. Eddy, “Principles for Making Difficult Decisions in Difficult Times,” *Journal of the American Medical Association*, 271 (June 8, 1994): 1792-1796.